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Kickbacks, Honest Services, and Health Care Fraud After *Skilling*

Joan H. Krause*

This essay considers how the 2010 Supreme Court decision in *Skilling v. United States*¹, which limited the situations in which mail and wire fraud cases may be premised on violations of the “intangible right to honest services,” has the potential to alter the future of health care fraud enforcement. To be clear, *Skilling* was not a healthcare case. Rather, the litigation stemmed from the investigation of Enron’s former CEO, Jeffrey Skilling, who was accused of engaging in a conspiracy to commit honest services wire fraud as well as multiple forms of securities-related fraud. In rejecting a vagueness challenge to the honest services theory, however, the Court read the statute in a very narrow way that puts kickbacks and bribery cases squarely in the crosshairs, an approach that may have serious implications for healthcare fraud.

To understand the significance of *Skilling*, it is necessary to appreciate the context in which healthcare fraud cases arise under current law. To that end, this essay begins by providing a brief overview of current health care fraud enforcement and of the Medicare & Medicaid Anti-Kickback Statute,² one of the main tools used to combat health care fraud and the law most likely to be affected by *Skilling*. After a brief introduction to the mail and wire fraud statutes, the essay turns to the implications of the *Skilling* decision for honest services in health care. I conclude that while *Skilling* is perceived to have narrowed the scope of the honest services doctrine overall, it may have the somewhat counterintuitive effect of encouraging the government to bring additional healthcare honest services prosecutions.

I. HEALTHCARE FRAUD IN CONTEXT

Recent years have seen many revisions to the health care anti-fraud laws,

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1. *Skilling v. United States*, 130 S. Ct. 2896, 2926 (2010).

2. 42 U.S.C. § 1320a-7b(b) (2011).

an escalation in anti-fraud rhetoric from the Executive and Congressional branches, and a host of stories in the popular media from sources such as *60 Minutes*.³ Lest we think healthcare fraud is a new phenomenon, however, we should remember that in the mid-1990's, then-Attorney General Janet Reno designated healthcare fraud as the “number two” priority of the Department of Justice (“DOJ”), second only to violent crime.⁴ While anti-terrorism concerns have of course been paramount since September 11, health care fraud remains a key element of the DOJ's post-Enron focus on corporate wrongdoing.

The main reason the federal government is concerned about health care fraud is the amount of federal money at stake, most notably through the Medicare and Medicaid programs. A major problem, however, is the uncertainty regarding how much money truly is at risk. While the claim often is made that up to ten percent of healthcare expenditures may be fraudulent (a total of somewhere between \$60 and \$100 billion dollars a year), these numbers really have no solid empirical basis. The sad truth is that we do not know for sure how much money we lose to healthcare fraud, in large part because if a scheme is successful, we may never even know it exists.

Since the mid-1990's, concern over the incidence of health care fraud has led Congress to appropriate more funds to the federal agencies with jurisdiction over the industry, including the DOJ and the Department of Health and Human Services (“HHS”) Office of the Inspector General (“OIG”). The framework for modern healthcare fraud enforcement derives from the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), which defined new crimes applicable to those who defraud public or private healthcare benefit programs; directed more funds to federal investigatory and enforcement agencies; expanded the grounds for and length of time that wrongdoers could be excluded from the federal health care programs; and increased both the number of activities subject to civil monetary penalties (“CMPs”) and the penalty amounts.⁵ HIPAA also created the Health Care Fraud and Abuse Control Program (“Control Program”) to coordinate federal, state, and local fraud enforcement efforts.

The Centerpiece of the Control Program is the Health Care Fraud and Abuse Control Account (“Control Account”), which provides funding for future HHS and DOJ anti-fraud efforts. In loose terms, the money recovered through federal health care fraud enforcement is deposited into

3. See, e.g., *60 Minutes: The \$60 Billion Fraud* (CBS News broadcast Oct. 25, 2009), available at <http://www.cbsnews.com/video/watch/?id=5419844n>.

4. See JANET RENO, 1994 ANN. REP. OF ATT'Y GEN. OF U.S. (1994), <http://www.justice.gov/archive/ag/annualreports/ar94/finalag.txt>.

5. Health Insurance Portability And Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

the Medicare Trust Fund, but can be transferred to the Control Account (within broad statutory limits) at the discretion of the Attorney General and the Secretary of HHS. This approach has been expanded in nearly all subsequent legislation related to the federal health care programs; indeed, the recent Patient Protection and Affordable Care Act of 2010 (“ACA”) contained no shortage of pro-enforcement provisions, ranging from increased enforcement budgets to the expansion of CMPs and significant amendments to the major civil and criminal anti-fraud laws.⁶

These enforcement efforts have paid off, at least to a certain extent. The federal government won or negotiated approximately \$2.5 billion in healthcare fraud judgments and settlements in fiscal year 2010. Approximately \$2.86 billion was returned to the Medicare Trust Fund, with an additional \$683.2 million returned to the Federal Treasury through Medicaid anti-fraud efforts.⁷ It is difficult to judge the effectiveness of anti-fraud efforts by focusing on recoveries in any single year, chiefly because numbers can be skewed by big recoveries that are negotiated in one year but not collected until subsequent years. Overall, however, more than \$18 billion has been returned to the Medicare Trust Fund since the Control Program began in 1997.

These recent efforts are perhaps best described as illustrating a “law enforcement” approach to healthcare fraud prevention. Everyone wants to be tough on fraud, and the easiest way to do that is to increase penalties, enact new laws prohibiting ever more specific types of fraudulent activities, and channel more money to federal investigators and prosecutors to use these new laws – essentially the model created by HIPAA. Unfortunately, it is not clear that increasing law enforcement, at least the way we have been doing it, is particularly effective. In fact, there is a compelling literature to suggest that the traditional law enforcement paradigm may be precisely the *wrong* way to go about reducing health care fraud.

Our current health care reimbursement model often is referred to as “pay and chase”: the federal health care programs (and private insurers) pay claims first, audit those claims months (or sometimes years) later, and only then try to hunt down the wrongdoers and recover benefits wrongly paid out. This is, to put it mildly, not a particularly efficient system. These enforcement efforts are consistent with basic criminal deterrence theory, which aims to deter unwanted behavior by (1) increasing the penalties for those who are convicted, and (2) increasing the chances of perpetrators being caught. In the context of a heavily regulated government program,

6. See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 (2010).

7. U.S. DEP’T. OF HEALTH & HUMAN SERVS. & U.S. DEP’T. OF JUSTICE (DOJ), HEALTH CARE FRAUD & ABUSE CONTROL PROGRAM ANNUAL REPORT FOR FISCAL YEAR 2010 1 (Jan. 2011), available at <http://www.justice.gov/dag/pubdoc/hcfacreport2010.pdf>.

however, a third strategy bears consideration: decreasing the *opportunities* for perpetrators to commit crimes in the first place. Strategies designed to decrease billing ambiguities and loopholes and to increase oversight over claims *before* they are paid may well have a more positive effect over the long term, yet they have not been our focus thus far.⁸

Fortunately, we have seen some recent movement in this direction, including certain provisions in the ACA itself. But perhaps the best example is the Health Care Fraud Prevention & Enforcement Action Team (“HEAT”), a joint 2009 HHS-DOJ initiative designed to proactively investigate and identify healthcare fraud, in part by utilizing state-of-the-art technology to analyze electronic claims data in near real-time to identify questionable billing patterns. The future of anti-fraud efforts likely will be focused much more closely on increased prepayment oversight and scrutiny of providers before they submit bills. But to the extent these more mundane tasks don’t tend to make headlines the way that passing new anti-fraud laws or increasing penalties might do, we likely will contend with the prominence of the law enforcement paradigm for a long time to come. In that context, *Skilling* may offer prosecutors an attractive tool.

II. THE MEDICARE AND MEDICAID ANTI-KICKBACK STATUTE

The Medicare and Medicaid Anti-Kickback Statute (“AKS”) is the main federal fraud law applicable to financial relationships within the health care market, including relationships between providers and their patients and between healthcare manufacturers and their customers. At its core, the law is designed to ensure that decisions about purchasing and ordering health care items and services are not swayed by impermissible financial influences. To accomplish that goal, the AKS prohibits the knowing and willful offer, payment, solicitation, or receipt of any form of remuneration designed to induce someone to refer patients or to purchase, lease, order, or recommend any item or service for which payment may be made under a federal health care program.⁹ Federal health care programs include not only Medicare and Medicaid, but also programs such as the Veterans Administration.

Several aspects of the statute are notable. Both parties to a transaction are vulnerable, although it is possible that only one will be found to have the requisite intent. Prohibited remuneration broadly includes payments made “directly or indirectly, overtly or covertly, in cash or in kind,” extending beyond simple kickbacks and bribes to reach not only the

8. See, e.g., MALCOLM K. SPARROW, LICENSE TO STEAL: HOW FRAUD BLEEDS AMERICA’S HEALTH CARE SYSTEM 222-24, 243-45 (2000).

9. 42 U.S.C. § 1320a-7b(b) (2011).

exchange of money, but really anything of value.¹⁰ While remuneration must be offered or paid “knowingly and willfully,” neither actual knowledge of the prohibition nor the specific intent to violate the statute is required.

The penalties for violating the statute are severe, including both criminal and civil/ administrative sanctions. A violation is a felony punishable by up to five years in prison and a fine of up to \$25,000.¹¹ Upon conviction, the defendant is subject to the administrative remedy of exclusion from all federal health care programs, a potentially fatal blow for entities that derive substantial revenue from federal program business. Alternatively, OIG may seek to impose permissive exclusion in lieu of criminal prosecution. The government also has the authority to impose a CMP of \$50,000 for each violation, plus three times the amount of remuneration. Finally, AKS allegations may be brought as Civil False Claims Act suits, both by federal prosecutors and by private *qui tam* relators.¹² Administrative enforcement of the statute is handled by OIG, while DOJ and the United States Attorneys’ Offices oversee criminal and civil litigation.

The AKS is well-known to attorneys who advise clients on health care transactions, to the OIG personnel who offer guidance on how the law will apply and enforce the law at the administrative level, and to federal prosecutors who focus on healthcare fraud. But, at least historically, many AKS allegations have been disposed of through civil or administrative negotiations rather than through criminal prosecution. The *Skilling* opinion has the potential to change that dynamic by strengthening the government’s motivation to pursue violations criminally – not as AKS prosecutions *per se*, but rather through the mail and wire fraud statutes.

III. MAIL AND WIRE FRAUD

The mail and wire fraud statutes are wonderfully versatile laws that allow the federal government to prosecute crimes involving both public and private fraud schemes. Both crimes require *devising a scheme or artifice to defraud* or to obtain money or property by means of false or fraudulent pretenses – a very broad reach that applies to fraud in both the public and private sectors. For what is now almost solely jurisdictional purposes, mail fraud requires the use of the mails in furtherance of the scheme (either the United States mail or a private or commercial interstate carrier), while wire fraud requires the interstate or foreign use of wire, radio, or television

10. *Id.* §1320a-7b(b)(1) & (2).

11. *Id.* § 1320a-7b.

12. 31 U.S.C. § 3729-30 (2011) (causes of action, including *qui tam* actions by private persons).

communications.¹³

Mail and wire fraud cases fall into three general categories: those involving a scheme to defraud a victim of (a) tangible property (in most cases, money), (b) intangible property (such as information or intellectual property) and, most importantly for our purposes, (c) the *intangible right to honest services*. Prior to 1987, courts routinely interpreted the mail and wire fraud statutes to encompass schemes to defraud victims of the “right to honest and faithful services” by a public official or private employee – for example, a bribe offered in connection with a state government contract. In the 1987 case of *McNally v. United States*, however, the Supreme Court held that the mail and wire fraud statutes did not reach frauds involving *intangible rights*, but were instead limited to frauds involving *money or property*.¹⁴ In response, Congress quickly enacted 18 U.S.C. § 1346, clarifying that the mail and wire fraud prohibitions indeed encompassed schemes “to deprive another of the intangible right of honest services.” While the amendment generally is accepted to have returned the statute to the pre-*McNally* state of the law, it remains controversial because it includes no definitions to narrow this potentially expansive theory of liability.

Against this background, Jeffrey Skilling challenged his conviction for conspiracy to commit wire fraud via an honest services theory by arguing that § 1346 was unconstitutionally vague. The Supreme Court, in an opinion written by Justice Ginsburg, rejected Skilling’s argument, holding that § 1346 should be construed more narrowly. Looking to the history of the pre-*McNally* case law, the majority determined “that § 1346 criminalizes *only* the bribe-and-kickback core of the pre-*McNally* case law,” not “undisclosed self-dealing by a public officer or private employee . . . to further his own undisclosed financial interests” – the crime that Skilling himself was accused of committing.¹⁵ The Court upheld this narrow construction of the statute, while remanding Skilling’s case for further proceedings.

IV. THE IMPLICATIONS OF *SKILLING* FOR ANTI-KICKBACK CASES

While *Skilling* has no direct application to health law, it nonetheless appears to open the door to more health care honest services prosecutions. As a preliminary matter, we have to consider what types of intangible rights might be implicated in health care. Two distinct categories of healthcare relationships come to mind in which a physician may owe a duty to provide honest services. First, a physician who violates either the law or a contract

13. 18 U.S.C. §§ 1341, 1343, 1346 (2011).

14. *McNally v. United States*, 483 U.S. 350 (1987).

15. *Skilling*, 130 S. Ct. at 2931.

term by giving or accepting kickbacks in connection with services covered under insurance (including Medicare and Medicaid) might be viewed as depriving the *insurer* of honest and faithful services. Second – and likely more compelling – a physician who pays or accepts kickbacks in connection with providing medical services might be said to deprive his or her *patients* of honest and faithful services. Both theories turn on the idea, which admittedly remains controversial, that a duty to provide honest services arises by virtue of the physician’s status as a *fiduciary* in these contexts.

Perhaps surprisingly, there are few reported cases on this issue. Indeed, the two most oft-cited cases, both dating back to the mid-1990’s, reached largely opposite conclusions. In the only appellate decision on point, *United States v. Jain*, the government alleged that payments of \$1,000 per month by a psychiatric hospital to a psychologist for “marketing” services were in reality payments made in return for his referral of patients to the hospital.¹⁶ Rejecting the allegations, the Eight Circuit found that the government had failed to prove a scheme to defraud because there was no evidence of any *tangible harm* to patients, nor any proof that Dr. Jain intended to cause such harm. Instead, the evidence established that the hospital provided quality psychiatric services and was as good (or better) than the alternative facilities in the area, that all the patients required hospitalization, and that there had been no financial harm to any patient. If the client is not harmed because the alleged breach did not affect the services that were rendered, the court asked, how can we say the right to “honest services” has been violated? While prosecutors argued that § 1346 applied to unethical violations of a professional’s fiduciary duty to provide honest services, the court held that nondisclosure by a fiduciary must be *material* in order to be actionable – and there was no evidence that the patients would have considered the hospital’s payments to be material under these facts.

In contrast, a federal district court came to a different conclusion in *United States v. Neufeld*.¹⁷ Dr. Neufeld had entered into an alleged “consulting” arrangement with Caremark, a home infusion company to which he referred his Medicaid patients with AIDS. As in *Jain*, the government claimed the payment really was compensation for his patient referrals. In denying a motion to dismiss, the district court held that the intangible rights theory required a *fiduciary relationship*, and no such relationship existed between the doctor and the Medicaid program. There was, however, evidence of a fiduciary relationship between the physician and his *patients*.

16. U.S. v. Jain, 93 F.3d. 436 (8th Cir. 1996).

17. U.S. v. Neufeld, 908 F. Supp. 491 (S.D. Ohio 1995).

[F]iduciary duty encompasses more than mere disclosure. If Dr. Neufeld solicited bribes or remuneration in return for referring his patients to Caremark, as it is alleged, then the health of his patients was certainly not his only concern. His patients deserved medical opinions and referrals unsullied by mixed motives.¹⁸

The Court went on to note that the intangible rights theory, by definition, implicates deception that goes beyond simply defrauding a victim of money or property. Moreover, the court noted, the case did in fact involve a stream of money flowing from Caremark to Dr. Neufeld. Citing long-standing precedent, the *Neufeld* court noted that the money need not be received *from the victim* in order to qualify as a violation of the doctrine.

It is not immediately apparent how to reconcile the *Jain* and *Neufeld* opinions, beyond the basic recognition that the physician-patient relationship may, at least in certain circumstances, be sufficient to qualify as a fiduciary relationship under the honest services theory. Perhaps the facts of *Neufeld* were more compelling, given that Caremark already had pleaded guilty to nearly identical allegations of defrauding the federal health care programs by paying physicians to refer patients to the company.¹⁹ Or perhaps the difference can be explained by the different burdens required to survive Dr. Neufeld's motion to dismiss as compared to that required to overturn Dr. Jain's conviction. Regardless, the dissonance has made it difficult to assess the likely approach to be taken in future healthcare honest services cases.

What is clear, however, is that to the extent the *Skilling* opinion functions as an open invitation to bring honest services cases based on bribery and kickbacks, we are likely to see more of these healthcare cases in the future. Of course, from one perspective this may not matter. The government already prosecutes mail and wire fraud cases involving healthcare kickback schemes in which money or property has travelled through the mail or wires (either for the kickback itself or for subsequent claims for services). *Skilling* does not change this, and an additional honest services count might well be considered overkill in many of these cases.

Nonetheless, bringing AKS allegations as honest services mail and wire fraud prosecutions may provide certain strategic advantages to the government. When cases go to trial, it can be extremely compelling to focus the jury on the physician-patient relationship as the locus of the honest services breach: patients are far more sympathetic victims than insurers and government agencies. Moreover, mail and wire fraud provide a distinct advantage at the negotiation and plea bargaining stage: the

18. *Id.* at 500.

19. See Press Release, DOJ, Caremark to Pay \$161 Million in Fraud and Kickback Cases (June 16, 1995), http://www.justice.gov/opa/pr/Pre_96/June95/342.txt.html.

statutory maximum penalty for AKS violations is five years in prison, compared to *twenty* years for mail and wire fraud.²⁰ Finally, § 1346 applies not only to mail and wire fraud but also to the rest of 18 U.S.C. chapter 63, which includes the HIPAA Health Care Fraud crime prohibiting a scheme or artifice to defraud any healthcare benefit program.²¹ The penalties are ten years in prison generally, twenty years if a violation results in serious bodily injury, and up to life imprisonment if the violation results in death. While few (if any) health care fraud cases so far appear to be based on a kickback-related honest services theory, *Skilling* invites additional prosecutions here as well, particularly where a death has resulted.

V. CONCLUSION

The *Skilling* opinion is widely perceived to have closed the door to several types of common mail and wire fraud prosecutions. This may not, however, turn out to be the case in health care. The renewed focus on kickbacks as evidence of an honest services breach instead may dovetail nicely with both the Obama Administration's emphasis on criminal health care fraud enforcement and the jurisprudence of the AKS itself. In the current "law enforcement" climate for healthcare fraud, this kind of leverage may prove very difficult for prosecutors to resist – and most certainly will require changes in the way the health law bar approaches common anti-kickback concerns.

20. 18 U.S.C. §§ 1341, 1343; 42 U.S.C. § 1320a-7b(b) (2011).

21. 18 U.S.C. § 1347 (2011).