

Skilling and the Pursuit of Healthcare Fraud

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At its most basic level, the concept of providing honest services permeates the health care system. The ethical principle of beneficence requires physicians to place the interests of their patients above their own, and the physician-patient relationship is often described as a fiduciary one.¹ The financial viability of health insurance, both public and private, rests on the assumptions that health care professionals will undertake only those services that are necessary for a patient’s care and will seek payment only for what has been delivered.² Even patients are cautioned that their medical care may be compromised if they are not honest with doctors about their symptoms, eating habits, and drug or alcohol use. Honesty, it seems, is not only the best policy, it is a fundamental component of a functional health care system. Not surprisingly,

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1. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 166 (5th ed. 2001) (discussing beneficence). *But see* Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 268–69 (1999) [hereinafter Krause, *Reconceptualizing Informed Consent*] (discussing debate over fiduciary status of physicians); *see also infra* notes 134–39 and accompanying text.

2. See MALCOLM K. SPARROW, LICENSE TO STEAL: HOW FRAUD BLEEDS AMERICA’S HEALTH CARE SYSTEM 40 (2000) (“Insurers, public and private, pay on trust . . .”).

honesty also forms the basis for many of the health care fraud and abuse laws, including the prohibition on false and fraudulent billings found in the Civil False Claims Act (“FCA”) and the prohibition on paying or accepting remuneration designed to influence health care decisionmaking found in the Medicare and Medicaid Anti-Kickback Statute (“Anti-Kickback Statute”).³

A similar yet distinct concept of “honest services” also permeates the law of white collar crime. Since the early 1900s, the federal mail and wire fraud statutes have been applied to schemes to defraud another “not only of money or property, but also of intangible rights” such as the right to the honest services of an employee or public servant.⁴ The doctrine’s path has not been a simple one: the Supreme Court ruled in *McNally v. United States*⁵ in 1987 that mail and wire fraud applied only to the deprivation of *property* rights, only to have Congress quickly amend the statutes to specify that the prohibition indeed included “a scheme or artifice to deprive another of the intangible right of honest services.”⁶ This expansive theory of honest services fraud has since been applied to public officials and private businessmen alike—although, curiously, only rarely to physicians or others in the health care system.

In the summer of 2010, the Supreme Court used the case of former Enron CEO Jeffrey Skilling to impose significant limits on the reach of the honest services theory of mail and wire fraud.⁷ At first glance (or perhaps even second or third), the *Skilling* case has nothing to do with health care. The case stemmed from Skilling’s well-publicized prosecution for conspiracy, securities fraud, wire fraud, making false representations to auditors, and insider trading, all in connection with the company’s massive financial meltdown. In rejecting Skilling’s vagueness challenge to the honest services wire fraud theory underlying his conspiracy conviction, however, the Court read the statute in a very narrow way that focuses honest services prosecutions squarely on bribery and kickbacks—activities that, as we shall see, have particular salience in health care. As a result, while *Skilling* is widely considered to have narrowed the scope of honest services fraud overall, it may turn out to

3. The FCA imposes liability on a defendant who (1) presents or causes to be presented a claim for payment or approval, (2) the claim is false or fraudulent, and (3) the acts are undertaken knowingly. 31 U.S.C. § 3729(a) (2006). The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving any remuneration to induce someone to refer patients to any facility, or to purchase, lease, or order any item or service, for which payment may be made by a federal health care program. 42 U.S.C. § 1320a-7b(b) (2006); *see infra* notes 36–52 and accompanying text.

4. *Skilling v. United States*, 130 S. Ct. 2896, 2926 (2010); 18 U.S.C. §§ 1341, 1343, 1346 (2006).

5. 483 U.S. 350, 356 (1987).

6. 18 U.S.C. § 1346.

7. *See Skilling*, 130 S. Ct. at 2907.

have the paradoxical effect of inviting additional prosecutions of physicians and others in the health care industry.

I. THE PROBLEM OF HEALTH CARE FRAUD

Health care fraud is a curious concept.⁸ While most would agree that health care fraud is bad, determining the scope and prevalence of the problem has turned out to be surprisingly difficult. Depending on one's views, health care fraud may be the reason health care costs are so high;⁹ holds the key to funding the recent health care reform legislation;¹⁰ or has been taken over by organized crime.¹¹ Yet in the view of others in the industry, the health care fraud enforcement apparatus unfairly targets well-meaning health care providers who simply cannot keep up with the sheer volume of ever-changing reimbursement rules¹² and sacrifices individual doctors to a hidden government agenda of intruding into the physician-patient relationship¹³—just to describe a few perspectives.

Despite decades of political rhetoric and legislative handwringing,

8. For an overview of fraud, abuse, and waste in the health care system, see Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 *YALE J. ON REG.* 455 (1994).

9. One of the key goals of the Obama Administration's Health Care Fraud Prevention & Enforcement Action Team ("HEAT") initiative, jointly created in 2009 by the Departments of Health & Human Services ("HHS") and Justice ("DOJ"), is "[t]o reduce skyrocketing health care costs." See U.S. Dep't of Health & Human Servs. & U.S. Dep't of Justice, *HEAT Task Force Success*, STOP MEDICARE FRAUD, <http://stopmedicarefraud.gov/heattaskforce/index.html> (last visited Mar. 18, 2011).

10. See *Medicare Fraud: A \$60 Billion Crime*, CBS NEWS (Sept. 5, 2010, 8:36 PM), <http://www.cbsnews.com/stories/2009/10/23/60minutes/main5414390.shtml?tag=currentVideoInfo;videoMetaInfo> ("President Obama says rising costs are driving huge federal budget deficits that imperil our future, and that there is enough waste and fraud in the system to pay for health care reform if it was eliminated.").

11. In the words of Senator Charles Grassley, a key force behind Congressional anti-fraud efforts, "It says a lot when you hear organized crime has gotten into health care fraud because it's so profitable." See Press Release, Sen. Charles Grassley, Grassley Fights Fraud in Medicare and Medicaid (Mar. 2, 2011), http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=31295#; see also SPARROW, *supra* note 2, at 19 (describing the role of organized crime in health care fraud); Jay Weaver, *FBI Struggling to Catch Dozens of Fraud Fugitives Hiding in Cuba*, MIAMI HERALD, July 16, 2011, <http://www.miamiherald.com/2011/07/16/2317603/fbi-struggling-to-catch-150-plus.html> ("[R]umors have swirled for years that the Castro government has purposely trained and deployed immigrants to take over Medicare-licensed clinics in South Florida, and then harbored them after they returned home.").

12. "[H]onest providers . . . are sometimes error prone; perhaps not up-to-date on administrative requirements and regulations; on occasions sloppy and disorganized; often confused by complex or indecipherable rules." SPARROW, *supra* note 2 at 41; see also ROBERT FABRIKANT ET AL., HEALTH CARE FRAUD: ENFORCEMENT AND COMPLIANCE § 1.04[2], at 1–28 (Rel. 28, 2011) ("[T]he complexity of the regulations gives rise to a credible defense that intelligent, informed professionals simply did not understand or were unaware of essential regulations that govern billing and reimbursement.").

13. See, e.g., RONALD T. LIBBY, THE CRIMINALIZATION OF MEDICINE (2008).

serious definitional questions remain. Does health care fraud consist only of blatant efforts to trick government and private payers out of funds designated for health care, what Professor James Blumstein calls “raw” fraud?¹⁴ While it might seem a small step to extend liability from intentional actors to those who recklessly ignore billing rules, what about the providers who instead “game” the system by interpreting the rules creatively so as to claim the largest possible reimbursement?¹⁵ Should we differentiate between illegitimate “sham” providers created merely to bill the federal health care programs for as much money as possible before disappearing, and legitimate providers who may find themselves on the wrong end of a billing dispute?¹⁶ And if “fraud” describes only those activities for which criminal sanctions can be imposed, what then of liability under the myriad civil and administrative program restrictions?¹⁷ For such an oft-maligned problem, surprisingly few answers are clear.

Of course, *all* of these improper activities cost money, money that otherwise could and should be spent providing health care services to those who need them. But one problem is that we don’t know exactly how much money actually is at stake. Payers traditionally audit only a small portion of the claims they receive, usually long after those claims have been paid, and only then begin efforts to track down wrongdoers—a system that has come to be known as “pay and chase.”¹⁸ Besides being woefully inefficient, this system is far more useful for catching legitimate providers who stretch the rules; it is virtually useless, by contrast, at finding a nonexistent pharmacy that bills hundreds of thousands of dollars to Medicare from a fake address.¹⁹ Most importantly, the pay-and-chase system only works when fraudulent claims are caught during review. Claims that are never audited—and those submitted by “fraudsters” sophisticated enough to know how to avoid having their submissions flagged by screening software—never are identified as fraudulent. As Professor Malcolm Sparrow notes:

14. James F. Blumstein, *What Precisely is “Fraud” in the Health Care Industry?*, WALL ST. J., Dec. 8, 1997, at A25.

15. See Mashaw & Marmor, *supra* note 8, at 463 (describing “abusive” behavior).

16. See *Medicare Fraud: A \$60 Billion Crime*, *supra* note 10 (describing a “tiny pharmacy in a Hialeah strip mall [that] went from billing Medicare \$13,000 in May to billing nearly a million dollars a month later;” by August, “the owners had already burned the company, shut it down and moved on to another operation.”).

17. See, e.g., 42 U.S.C. §§ 1320a-7 (2006) (exclusion), 1320a-7a (civil monetary penalties).

18. See, e.g., *Medicare Fraud: A \$60 Billion Crime*, *supra* note 10 (“The FBI calls it ‘pay and chase.’”); Weaver, *supra* note 11 (describing problem of fugitive health care defendants who flee to Latin American countries, especially Cuba).

19. See, e.g., *Medicare Fraud: A \$60 Billion Crime*, *supra* note 10 (describing Miami-area pharmacy that billed Medicare for \$300,000 from an address that “turned out to be in the middle of a public warehouse storage area”).

The cases such methods turn up usually involve the less sophisticated and excessively greedy perpetrators who have billed so much, and in such a concentrated fashion, that they've made it into the "top 2 percent tail" of one of the industry's standard utilization distributions. The smart ones leave behind them no such trail; they fashion their lies on orthodox medical treatments and don't charge any more for *not* providing a service than honest doctors charge for providing it.²⁰

By definition, there simply is no way to know how much money we lose to fraud schemes we fail to identify.

The breadth and variety of fraudulent activities is reflected in the multi-faceted legal tools that can be used to stop them. Health care fraud is actionable under a wide range of federal and state criminal, civil, and administrative laws, covering both the public and private sectors. Some of these provisions, such as the Anti-Kickback Statute, apply only to improper activities involving the federal health care programs.²¹ In contrast, the FCA—the source of most recent high-dollar fraud recoveries, in part because it provides a private cause of action for whistleblowers as well as for litigation by the Department of Justice ("DOJ")—was enacted to prohibit general fraud on the government during the Civil War, and has been used against the health care industry only since the late 1980s.²² Health care fraud also can be prosecuted under general federal criminal statutes, such as mail and wire fraud, that apply to illegal conduct regardless of the industry in which it occurs.²³

To the extent many of these prohibitions overlap, prosecutors have a great deal of discretion in charging decisions. For example, a doctor who intentionally "upcodes" a claim for services to a Medicare patient by billing for a more complex and lucrative category of services than were provided, or for a longer therapy session than what took place, could face penalties that include: permissive exclusion from the federal health care programs (thus making the physician ineligible for payment); a civil penalty for filing an improper Medicare claim; criminal sanctions for making a false statement in an application for Medicare benefits; civil liability under the FCA for knowingly presenting a false or fraudulent claim for payment; and criminal prosecution under the general fed-

20. SPARROW, *supra* note 2, at 42.

21. 42 U.S.C. § 1320a-7b(b) (2006). These programs include not only Medicare and Medicaid, but also programs such as the Veterans Administration.

22. 31 U.S.C. §§ 3729–3733 (2006). The FCA was enacted in 1863 in response to reports of "rampant fraud" on the Union army during the Civil War. *See* S. Rep. No. 99-345, at 8 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, 5273. For a general discussion of the FCA, see Joan H. Krause, *Health Care Providers and the Public Fisc: Paradigms of Government Harm Under the Civil False Claims Act*, 36 GA. L. REV. 121 (2001) [hereinafter Krause, *Health Care Providers and the Public Fisc*].

23. 18 U.S.C. §§ 1341, 1343, 1346 (2006).

eral health care fraud, mail and wire fraud, criminal false claims, false statements, or conspiracy statutes.²⁴ Choosing among these options requires a balancing not only of program risks and objectives, but also consideration of which federal agency should have jurisdiction. While all fraudulent or abusive health care activities may not be equally harmful, enforcement decisions at times may appear to reflect political rhetoric more than a consistent analysis of comparative risk.

Beginning in the 1990s, the typical legislative response to concerns about health care fraud has been to increase enforcement by enacting new anti-fraud laws and channeling more money to investigatory and enforcement agencies. The trend began in earnest with the passage of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), which defined new crimes such as the 18 U.S.C. § 1347 “health care fraud” offense to apply to those who defraud either public or private health care benefit programs; directed more funds to federal investigatory and enforcement agencies; created the Fraud and Abuse Control Program to coordinate federal, state, and local fraud enforcement efforts; expanded the grounds for which and length of time that wrongdoers could be excluded from the federal health care programs; and increased the number of activities subject to civil monetary penalties (“CMPs”), as well as the penalty amounts.²⁵ Similar expansions of both new and existing anti-fraud authority occurred under the Balanced Budget Act of 1997 (“BBA”), the Deficit Reduction Act of 2005 (“DRA”), and the Fraud Enforcement and Recovery Act of 2009 (“FERA”).²⁶ The recent Patient Protection and Affordable Care Act of 2010 (“ACA”) similarly 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.²⁷

24. See 42 U.S.C. §§ 1320a-7(b)(7) (2006) (exclusion), 1320a-7a (civil monetary penalties), 1320a-7b(a) (criminal Medicare penalties); 31 U.S.C. § 3729(a)(1) (2006) (FCA); 18 U.S.C. §§ 287, 371, 1001, 1341, 1343, 1347 (2006) (crimes). Some of the latter crimes also constitute “specified unlawful activity” under the money laundering statutes, and may give rise to civil or criminal forfeiture sanctions as well. See 18 U.S.C. §§ 981–82, 1956–57 (2006).

25. See Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in 18 U.S.C. §§ 247, 669, 1035, 1347, 1518 (2006)) (revising criminal law provisions relating to health care fraud).

26. See Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 4304(b), 4314, 4331(c), 111 Stat. 251, 383–84; Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6031, 120 Stat. 4, 72–73 (codified as amended at 42 U.S.C. § 1909 (2006)); Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, 123 Stat. 1617.

27. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). The ACA went further than previous laws by also including a number of provisions designed to provide better control over the individuals and entities who bill the federal health care programs and more timely assessment of the claims they submit, such as additional background

The current anti-fraud agenda is perhaps best exemplified by the Obama Administration's Health Care Fraud Prevention & Enforcement Action Team ("HEAT"), an initiative announced in May 2009.²⁸ Jointly created by United States Attorney General Eric Holder and Department of Health and Human Services ("HHS") Secretary Kathleen Sebelius, HEAT is comprised of senior-level staff from both HHS and DOJ as well as representatives from state Medicaid Fraud Control Units and law enforcement. Unlike many prior interagency health care fraud efforts, the HEAT initiative clearly has a criminal focus: it builds on and expands the Medicare Strike Forces, an effort led by the DOJ Criminal Division that since 2007 has targeted particularly risky health care products and services (such as durable medical equipment) in cities known to be vulnerable to fraud, initially in South Florida.²⁹ One of the central goals of the initiative is to utilize state-of-the-art technology to analyze electronic claims data for patterns that might indicate fraud, in as close to real-time as possible.³⁰ HEAT had an almost immediate impact: barely a month after it was announced, more than fifty individuals in Detroit and Miami were indicted for Medicare fraud involving HIV-AIDS infusion drugs and physical and occupational therapy services; a month later, the Houston-area Strike Force unsealed indictments against thirty-two individuals accused of submitting false DME bills, including items ordered for deceased patients.³¹

screening for providers and suppliers, permitting the suspension of payments during a fraud investigation; and centralizing fraud information and increasing coordination among the agencies that share jurisdiction over these matters. *See, e.g., id.* § 6401 (imposing additional provider screening and enrollment requirements); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1304, 124 Stat. 1029, 1058 (providing for enhanced oversight for initial claims of certain new suppliers); Joan H. Krause, *Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road*, 36 AM. J.L. & MED. 343, 365-69 (2010) (discussing importance of these control measures in fighting health care fraud).

28. *See* U.S. Dep't of Health & Human Servs. & U.S. Dep't of Justice, *HEAT Task Force Success*, STOP MEDICARE FRAUD, <http://stopmedicarefraud.gov/heattaskforce/index.html> (last visited Mar. 18, 2011).

29. *See* U.S. Dep't of Health & Human Servs. & U.S. Dep't of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2009*, U.S. DEP'T OF JUSTICE ARCHIVE, 58 (May 2010), <http://www.justice.gov/archive/dag/pubdoc/hcfareport2009.pdf> (describing Strike Force model).

30. The new technology was rolled out in July 2011. *See* Press Release, U.S. Dep't of Health & Human Servs., Departments of Justice, Health and Human Services Highlight Joint Efforts to Combat Health Care Fraud in Philadelphia (June 17, 2011), <http://www.hhs.gov/news/press/2011pres/06/20110617a.html>.

31. Carrie Johnson, *53 Indicted in Medicare Sting*, WASH. POST, June 25, 2009 <http://www.washingtonpost.com/wp-dyn/content/article/2009/06/24/AR2009062401906.html>; Press Release, Office of Pub. Affairs, U.S. Dep't of Justice, Medicare Fraud Strike Force Operations Lead to Charges Against 32 Doctors and Health Care Executives for More Than \$16 Million in Alleged False Billing in Houston (July 29, 2009), <http://www.usdoj.gov/opa/pr/2009/July/09-odag-734.html>. The high point of HEAT enforcement thus far came in September 2011, when 91 individuals nationwide were charged in fraud schemes totaling \$295 million. *See* Press Release, U.S. Dep't of

This trend toward increasing criminalization (or overcriminalization, as some contend³²) is by no means limited to health care. Similar growth has taken place in the criminal oversight of areas such as corporate fraud, copyright law, and (of course) anti-terrorism efforts.³³ As Professor Geraldine Moohr notes, “[t]he cause of congressional activism in criminal law has been summed up in one word—politics.”³⁴ Yet despite the substantial increase in budgets and legal authorities, key players such as Senator Chuck Grassley (R-IA), the main Senate driver of recent anti-fraud legislation, believe we have not gone far enough in pursuing criminal health care fraud enforcement.³⁵

For the purposes of this Article, our focus will be on the Anti-Kickback Statute, the major federal law affecting financial relationships within the health care market. The statute 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.³⁶ Exemplifying the criminal-civil-administrative overlap, the statute is a criminal prohibition that also may be enforced through civil penalties and collateral sanctions imposed in administrative proceedings.

At its core the statute seeks to limit the influence of financial incentives over health care referral decisions, demanding that such decisions be made on the basis of the products and services that will best serve the needs of the patient rather than those of the provider—a typical demand for “honest” health care services.³⁷ This patient-protective rationale,

Health & Human Servs., Medicare Fraud Strike Force Charges 91 Individuals for Approximately \$295 Million in False Billing (Sept. 7, 2011), <http://www.hhs.gov/news/press/2011pres/09/20110907c.html>.

32. See, e.g., DOUGLAS HUSAK, *OVERCRIMINALIZATION: THE LIMITS OF THE CRIMINAL LAW* 3 (2008) (“In short, the most pressing problem with the criminal law today is that we have too much of it.”).

33. See, e.g., *Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA Patriot Act) Act of 2001*, Pub. L. No. 107-56, 115 Stat. 272 (naming Title VIII as “Strengthening the Criminal Laws Against Terrorism”); Geraldine Szott Moohr, *Playing With the Rules: An Effort to Strengthen the Mens Rea Standards of Federal Criminal Laws*, 7 J. L. ECON. & POL’Y 685, 687–88 nn.9–15 (2011) [hereinafter Moohr, *Playing with the Rules*] (citing examples of new federal criminal provisions).

34. Moohr, *Playing with the Rules*, *supra* note 33, at 687 n.9.

35. See Press Release, Grassley Fights Fraud in Medicare and Medicaid, *supra* note 11 (introducing the Strengthening Program Integrity and Accountability in Health Care Act of 2011 S.454, 112th Cong., 2011–2012).

36. 42 U.S.C. § 1320a-7b(b) (2006).

37. See, e.g., Thomas N. Bulleit, Jr. & Joan H. Krause, *Kickbacks, Courtesies, or Cost-Effectiveness?: Application of the Medicare Antikickback Law to the Marketing and Promotional Practices of Drug and Medical Device Manufacturers*, 54 FOOD & DRUG L.J. 279, 282 (1999) (“The main purpose of the antikickback law may be summarized most succinctly as preventing

however, is only part of the story: a second, equally compelling goal is to safeguard the public fisc. As the HHS Office of the Inspector General (“OIG”) has explained, “it is necessary for the fiscal integrity of the Medicare and Medicaid programs to assure that physicians exercise sound, objective medical judgment when controlling admittance to this market.”³⁸ While these two goals are not inherently incompatible, they do complicate the statutory narrative, making it difficult to discern whether the prohibition of kickback activity is primarily a moral or an economic condemnation.

Several aspects of the statute are notable. 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 exchange of money, but truly anything of value.³⁹ Remuneration must be offered or paid “knowingly and willfully,” although the ACA clarified that neither actual knowledge of the prohibition nor any specific intent to violate the statute is required.⁴⁰ Moreover, the law has been interpreted quite broadly to encompass situations in which even *one purpose* of the remuneration—rather than its sole or primary purpose—is to induce referrals.⁴¹

The Anti-Kickback Statute is a blunt rather than a precise weapon, an axe rather than a scalpel. It is very good at defining in the broadest possible terms the universe of financial entanglements that might impermissibly influence referral decisions; it is not very good at distinguishing truly problematic activities from ones that are neutral, or perhaps even beneficial. The statute does contain a number of exceptions for activities that were perceived by Congress to offer more benefit than risk, such as discounts and employee compensation, and HHS has issued numerous “safe harbor” regulations exempting other permissible prac-

inappropriate financial considerations from influencing the amount, type, cost, or selection of the provider of medical care received by a federal health care program beneficiary.”).

38. Medicare and Medicaid Programs; Fraud and Abuse OIG Anti-Kickback Provisions, 54 Fed. Reg. 3,088, 3,089 (Jan. 23, 1989) (to be codified at 42 C.F.R. pt. 1,001).

39. 42 U.S.C. § 1320a-7b(b)(1)–(2).

40. *Id.* § 1320a-7b(h).

41. *See, e.g.,* United States v. McClatchey, 217 F.3d 823, 835 (10th Cir. 2000) (“[A] person who offers or pays remuneration to another person violates the Act so long as one purpose of the offer or payment is to induce Medicare or Medicaid patient referrals.”); United States v. Greber, 760 F.2d 68, 72 (3d Cir. 1985) (“If the payments were intended to induce the physician to use [defendant’s] services, the statute was violated, even if the payments were also intended to compensate for professional services.”). The Tenth Circuit has acknowledged that “a hospital or individual may lawfully enter into a business relationship with a doctor and even hope for or expect referrals from that doctor, so long as the hospital is motivated to enter into the relationship for legal reasons entirely distinct from its collateral hope for referrals.” *McClatchey*, 217 F.3d at 834. The court, however, gave no indication of how to differentiate such “collateral” hopes or expectations from an impermissible “purpose.”

tices from the scope of the law.⁴² However, the law remains applicable to a wide variety of financial transactions that might be considered commonplace in other industries. In determining whether to prosecute, the OIG has said that it will look to factors that include: (a) the potential for increased charges or costs to payers, especially to the government; (b) the potential encouragement of overutilization (such as by encouraging the ordering or performance of health care services beyond what is medically necessary); (c) the potential for adverse effects on competition; and (d) the intent of the parties.⁴³

Penalties for violating the statute are severe, consisting of both criminal and civil/administrative sanctions. Violation is a felony punishable by up to five years in prison and/or a fine of up to \$25,000.⁴⁴ The ACA clarified that the statute is a “health care fraud offense,” thus subjecting offenders to liability under the money laundering and forfeiture statutes as well.⁴⁵ 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 such business; OIG also has the option of seeking permissive exclusion in lieu of criminal prosecution.⁴⁶ In addition, the government has the authority to impose a CMP of \$50,000 for each violation, plus three times the amount of remuneration involved.⁴⁷

Anti-Kickback allegations also may be brought in the form of FCA suits, both by federal prosecutors and by private *qui tam* relators.⁴⁸ Prior to enactment of the ACA, courts were split regarding the private cause of action. In *United States ex rel. Pogue v. American Healthcorp, Inc.*,⁴⁹ for example, a *qui tam* relator survived a motion to dismiss on the theory that several hospitals and physicians had submitted claims for services furnished pursuant to illegal referrals. The relator argued that because compliance with the Anti-Kickback Statute was a prerequisite for participation in Medicare and Medicaid, any claims submitted in violation of the statute were, by definition, false and fraudulent. The district court

42. See 42 U.S.C. § 1320a-7b(b)(3) (exceptions); 42 C.F.R. § 1001.952 (2010) (safe harbors).

43. See Medicare and State Health Care Programs, 56 Fed. Reg. at 35954, 35956 (July 29, 1991) (codified at 42 C.F.R. pt. 1,001).

44. See Medicare and State Health Care Programs, 56 Fed. Reg. at 35954, 35956 (July 29, 1991) (to be codified at 42 C.F.R. pt. 1,001).

45. The ACA also required changes to the Federal Sentencing Guidelines, increasing the potential sentences for health care offenses based on the amount of loss to the federal health care programs. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10606, 124 Stat. 119, 1006 (2010) (to be codified at 28 U.S.C. § 994).

46. See 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(7).

47. 42 U.S.C. § 1320a-7a(a)(7).

48. 31 U.S.C. § 3730 (2006) (causes of action, including *qui tam* actions by private persons).

49. 914 F. Supp. 1507 (M.D. Tenn. 1996).

agreed, finding that the FCA “was intended to govern not only fraudulent acts that create a loss to the government but also those fraudulent acts that cause the government to pay out sums of money to claimants it did not intend to benefit.”⁵⁰ In contrast, in *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*,⁵¹ the Fifth Circuit rejected this *per se* approach and limited FCA suits to situations in which a defendant had falsely certified compliance with a *specific* condition that was a prerequisite to payment—a category that did not clearly include the Anti-Kickback Statute. Resolving this long-standing debate, the ACA clarified that a violation of the Anti-Kickback Statute explicitly constitutes a false or fraudulent act under the FCA, thus inviting private relator suits in addition to government litigation.⁵²

II. SKILLING AND THE SHRINKING WORLD OF HONEST SERVICES FRAUD

In contrast to the health care-specific Anti-Kickback Statute, the mail and wire fraud statutes are wonderfully versatile laws that allow the federal government to prosecute crimes involving both public and private fraud as long as basic jurisdictional requirements are met. Both mail and wire fraud require that the defendant devise, or intend to devise, a scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses.⁵³ Mail fraud additionally requires the use of the United States mail or a private or commercial interstate carrier in furtherance of the scheme, while wire fraud requires the use of wire, radio, or television communication in interstate or foreign commerce.⁵⁴

Mail and wire fraud cases generally fall into three categories, involving a scheme or artifice to defraud the victim of: (1) tangible property, such as money; (2) intangible property, such as information or intellectual property; or (3) the intangible right to honest services.

A cognizable scheme to defraud . . . requires (at least) proof of: (1) fraud—i.e., the defendant, acting with an intent to defraud, either made a material misstatement or failed to disclose material information in the face of a legal duty; and (2) a cognizable object of that fraud—i.e., either the deprivation of the victim’s money or property . . . or some right the victim claimed to the defendant’s honest ser-

50. *Id.* at 1513.

51. 125 F.3d 899, 902 (5th Cir. 1997).

52. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(f), 124 Stat. 119, 759 (2010) (amending 42 U.S.C. § 1320a-7b(g) (2006)).

53. 18 U.S.C. §§ 1341, 1343 (2006).

54. *Id.*

vices⁵⁵

While intangible rights cases date back to the early 1900s, prosecutions were derailed in 1987 when the Supreme Court ruled in *McNally v. United States* that the statutes applied only to the deprivation of *property* rights.⁵⁶ In response, Congress quickly enacted 18 U.S.C. § 1346 to clarify that the statutes did indeed prohibit “a scheme or artifice to deprive another of the intangible right of honest services.”⁵⁷ The amendment offered no definition of honest services, however, nor any other indication as to when the prohibition might apply.

The structure of the honest services variant, sometimes called “fiduciary fraud,” is distinct from traditional forms of mail and wire fraud. In a traditional case, there is both simplicity and symmetry of harm and benefit: the perpetrator’s scheme defrauds the victim of money or property. Intangible rights cases depart dramatically from that model by eliminating the requirement that the victim suffer a financial loss *to* the perpetrator, in what might best be described as a form of “triangulated” harm.

In classic fraudulent schemes, the actor defrauds a victim of money or property by misrepresenting a material fact. The victim suffers a loss of money or property and the perpetrator benefits by the amount of the loss. In contrast, fiduciary fraud, which may be perpetrated by a failure to disclose a material fact, deprives the principal of a right to the fiduciary’s honest and faithful services. Such cases typically occur when the fiduciary receives a benefit from a third party . . . even though the fiduciary has not misled the third party. Theoretically, the arrangement between the fiduciary and the third party deprives the victim of a right to the intangible value of the fiduciary’s faithful and loyal services.⁵⁸

55. Julie R. O’Sullivan, *Honest-Services Fraud: A (Vague) Threat to Millions of Blissfully Unaware (and Non-Culpable) American Workers*, 63 VAND. L. REV. EN BANC 23, 30–31 (2010).

56. *McNally v. United States*, 483 U.S. 350, 360 (1987). The Court later clarified that the statutes did reach deprivations of *intangible* property, *Carpenter v. United States*, 484 U.S. 19 (1987), a phrase that has proven similarly difficult to define. *See, e.g., Cleveland v. United States*, 531 U.S. 12 (2000) (holding that state licenses to operate video poker machines were not property under the mail fraud statute because such licenses did not constitute property in the hands of the State).

57. 18 U.S.C. § 1346 (2006).

58. Geraldine Szott Moohr, *Mail Fraud and the Intangible Rights Doctrine: Someone to Watch Over Us*, 31 HARV. J. ON LEGIS. 153, 163 (1994) [hereinafter Moohr, *Mail Fraud and the Intangible Rights Doctrine*]; *see also* Samuel W. Buell, *The Court’s Fraud Dud*, 6 DUKE J. CONST. L. & PUB. POL’Y 31, 41 (2010) (describing this as “triangular fraud”). The Supreme Court originally granted *certiorari* in a companion case to *Skilling*, *Black v. United States*, 130 S. Ct. 2963 (2010), to determine whether § 1346 requires that the defendant’s scheme contemplate economic harm to the victim. *Petition for Writ of Certiorari, Black v. United States*, 130 S. Ct. 2963 (2010) (No. 08-876). However, the Court ultimately vacated and remanded *Black* in light of *Skilling* without addressing this issue.

Honest services fraud still requires use of the mails or wires, although few cases appear to rise or fall on these grounds alone.

A. *Criticism of the Doctrine*

The honest services theory of fraud has long been criticized by legal commentators.⁵⁹ Perhaps the most salient criticism is that the core concept of an “intangible right of honest services” is unconstitutionally vague (the basis, in fact, for Jeffrey Skilling’s own appeal).⁶⁰ As explained by the Supreme Court, “[t]o satisfy due process, ‘a penal statute [must] define the criminal offense [1] with sufficient definiteness that ordinary people can understand what conduct is prohibited and [2] in a manner that does not encourage arbitrary and discriminatory enforcement.’”⁶¹ Critics charge that the language of § 1346 provides little notice to would-be wrongdoers and few if any limits on the charging discretion of prosecutors—a state of affairs Professor Julie O’Sullivan has characterized as “vagueness on steroids.”⁶² The problem is magnified by the inchoate nature of the crime, as well as the fact that the jurisdictional element can be established by a mailing or wire transmission that is itself legal.⁶³

Concerns over vagueness are exacerbated by the diversity of views concerning the basic elements of the crime. As Professor O’Sullivan quips, “when courts (let alone ordinary citizens) cannot agree on what *conduct*—attended by what *mental state* and what *attendant circumstances*—constitutes a crime, it is a vagueness trifecta.”⁶⁴ The literature is replete with discussions of potential limiting principles that might ameliorate these problems. Among the primary points of contention are the nature of the underlying fiduciary relationship, the nature of the prohibited conduct, the requisite harm, the perpetrator’s intent, and the effect of the breach on the victim’s interests, as well as basic principles of federalism.

59. See generally John C. Coffee, Jr., *Modern Mail Fraud: The Restoration of the Public/Private Distinction*, 35 AM. CRIM. L. REV. 427, 432 (1998) [hereinafter Coffee, *Modern Mail Fraud*]; David Mills & Robert Weisberg, *Corrupting the Harm Requirement in White Collar Crime*, 60 STAN. L. REV. 1371 (2008); Moohr, *Playing With the Rules*, *supra* note 33; Moohr, *Mail Fraud and the Intangible Rights Doctrine*, *supra* note 58; Donald V. Morano, *The Mail-Fraud Statute: A Procrustean Bed*, 14 J. MARSHALL L. REV. 45 (1980); O’Sullivan, *supra* note 55.

60. *Skilling v. United States*, 130 S. Ct. 2896, 2926–28 (2010).

61. *Id.* at 2927–28 (quoting *Kolender v. Lawson*, 461 U.S. 352, 357 (1983)).

62. O’Sullivan, *supra* note 55, at 26; see also Moohr, *Mail Fraud and the Intangible Rights Doctrine*, *supra* note 58, at 178–83, 187–99 (noting that vagueness similarly encourages judicial crime creation, a violation of the Separation of Powers doctrine).

63. O’Sullivan, *supra* note 55, at 42.

64. *Id.* at 30.

1. UNDERLYING FIDUCIARY RELATIONSHIP. Honest services fraud is actionable only when the perpetrator owes a heightened duty, such as a duty of loyalty, to the victim; in the words of the Ninth Circuit, “there must be a legally enforceable right to have another provide honest services.”⁶⁵ In many (but not all) cases that duty is grounded in a fiduciary relationship, although neither the statute nor cases define the universe of fiduciary duties that will suffice.⁶⁶ Indeed, the concept of a “fiduciary” is granted almost talismanic significance in most discussions of honest services, despite the fact that its meaning varies widely.

Fiduciary duty, after all, is not a one-size-fits-all concept. The duties of a fiduciary depend almost entirely on the kind of fiduciary she is. To say that someone has a “fiduciary duty” is simply to say that the law has decided she has more duties than the man on the street.⁶⁷

While courts have acknowledged that “[n]ot every breach of every fiduciary duty works a criminal fraud,”⁶⁸ few guiding principles have emerged and the issue most often is resolved based on the specific facts of each case.

2. NATURE OF PROHIBITED CONDUCT. The failure to define the requisite fiduciary duty, coupled with the inchoate nature of the mail and wire fraud crimes, contribute to uncertainty regarding the nature of the criminal conduct. In short, what exactly must a fiduciary *do*, or fail to do, to violate the law? Fraud generally requires some type of “trickery or deceit” by the defendant in order to accomplish a goal. In honest services fraud, this deception is not so much the underlying breach of fiduciary duty as it is the failure to *disclose* that breach to the employer, citizenry, or other principal to whom the duty is owed.⁶⁹ As Professor John Coffee explains, “the fiduciary breach [is] the means to an ultimate end and not the end itself.”⁷⁰ The cases are unclear, however, as to

65. United States v. Milovanovic, 627 F.3d 405, 412 (9th Cir. 2010).

66. Compare *id.* at 409 n.11 (noting debate), and *id.* at 413 (proof of fiduciary relationship not required), with United States v. Neufeld, 908 F. Supp. 491, 499 (S.D. Ohio 1995) (requiring “a fiduciary relationship between the victim and the accused”); see also Offices of U.S. Attorneys, U.S. Dept. of Justice, *Criminal Resource Manual*, U.S. ATTORNEYS’ MANUAL, § 947, http://www.justice.gov/usao/eousa/foia_reading_room/usam/title9/crm00947.htm (“It may follow that to defraud one of the ‘right to honest services’ would generally require a fiduciary relationship that creates the right to provide or protect honest services.”).

67. Buell, *supra* note 58, at 39.

68. United States v. George, 477 F.2d 508, 512 (7th Cir. 1973) (finding breach because actual fraud had occurred).

69. Moohr, *Mail Fraud and the Intangible Rights Doctrine*, *supra* note 58, at 160–61.

70. John C. Coffee, Jr., *From Tort to Crime: Some Reflections on the Criminalization of Fiduciary Breaches and the Problematic Line Between Law and Ethics*, 19 AM. CRIM. L. REV. 117, 167 (1981) [hereinafter Coffee, *From Tort to Crime*]; O’Sullivan, *supra* note 55, at 43–44 (“Again, the fiction is that it is not the breach of duty . . . that is actionable, it is the failure to *tell* the employer about such breaches that constitutes criminal ‘fraud.’”). Yet the case law “has not always been clear whether the deception lies in the breach of fiduciary duty, the omission of

whether only serious breaches qualify, or whether the failure to disclose almost *any* breach will suffice—as well as what circumstances will impose a duty to disclose in the first place.⁷¹ As applied to the public sector, there is still further debate as to whether § 1346 must be predicated on an independent violation of state law by the defendant, rather than on violation of some intrinsic duty of honesty.⁷² These questions may turn out to have particular salience in the Anti-Kickback context.

3. HARM. Intangible rights cases target injuries that go beyond traditional financial harm: “By definition, honest-services fraud requires no actual harm to the employer be shown (if there were economic harm, it would have been charged as a money-or-property case).”⁷³ The prospect of untethering mail and wire fraud from *any* tangible injury, however, has given pause to many commentators. David Mills and Robert Weisberg, for example, lament that the “law has loosened any requirement of an identifiable harm other than a mistrust-inducing breach of fiduciary loyalty.”⁷⁴ Many argue that the statute must be read to incorporate an actual harm standard, meaning that no prosecution will lie without proof that actual harm at least was contemplated by the defendant.⁷⁵ But a focus on actual harm may eclipse the underlying goal of § 1346, which was, after all, “to extend the statute to cases *not* involving schemes to obtain money or property but involving a breach of the duty of honest services.”⁷⁶

failing to disclose that breach, or some [other] indicia of fraud.” Geraldine Szott Moohr, *Mail Fraud Meets Criminal Theory*, 67 U. CIN. L. REV. 1, 19 n.104 (1998).

71. O’Sullivan, *supra* note 55, at 32–34.

72. Compare *United States v. Brumley*, 116 F.3d 728, 735 (5th Cir. 1997) (requiring state official to owe duty under state law) with *United States v. Hasner*, 340 F.3d 1261, 1269 (11th Cir. 2003) (proof of state law violation by public official not required). This debate has led some to question whether the same analysis is appropriate for public and private fiduciaries. See Coffee, *Modern Mail Fraud*, *supra* note 59, at 432 (advocating that § 1346 be construed according to state law for private fiduciaries but according to federal common law for public fiduciaries). The Supreme Court granted *certiorari* in a third honest services case that squarely posed the question of whether a violation of state law is required for public sector cases, but as in *Black*, vacated and remanded the case in light of *Skilling*. See *Weyhrauch v. United States*, 130 S. Ct. 2971 (2010).

73. O’Sullivan, *supra* note 55, at 36. See generally Alice Anne Stephens, Note, *The Evolution of the Harm Requirement in Honest Services Fraud*, 36 AM. J. CRIM. L. 71 (2008).

74. Mills & Weisberg, *supra* note 59, at 1446. The authors fear the trend is to view the market as the ultimate victim, reconfiguring the statute into “a kind of reckless endangerment of capitalism.” *Id.* at 1427; see also David W. Mills & Robert Weisberg, *Honest Services*, STAN. LAW., Nov. 8, 2010, <http://stanfordlawyer.law.stanford.edu/2010/11/honest-services/> (lamenting “the continuing absence of any role for harm”) [hereinafter Mills & Weinberg, *Honest Services*].

75. See Coffee, *Modern Mail Fraud*, *supra* note 59, at 450–51 (explaining and rejecting actual harm standard); Morano, *supra* note 59, at 49–50 (arguing that prosecution should not be allowed if the victim was able to strike a bargain “well within the going rate,” even if the fraud prevented him from making a better bargain); see also *United States v. Jain*, 93 F.3d 436 (8th Cir. 1996).

76. Sara Sun Beale, *An Honest Services Debate*, 8 OHIO ST. J. CRIM. L. 251, 266 (2010).

4. INTENT. Even if honest services fraud requires no proof that tangible harm has occurred, a crime nevertheless requires proof of some criminal *intent*. Mail and wire fraud require a specific intent to defraud, which has been explained as an intent to deceive, coupled with the intent to deprive the victim of the right to honest services.⁷⁷ In practice, however, the defendant's intent to *deceive* often is inferred from his or her underlying failure to *disclose* the fiduciary breach, making the intent element not only circular but also exceedingly easy to prove.⁷⁸ Due to the inchoate nature of the crime, this weakened *mens rea* standard raises the specter that a defendant may be convicted on the basis of a "scheme" alone—or in other words, for mere thoughts. Thus, many commentators argue that the crime should be read to require proof of an *intent to injure or harm*, not simply an intent to deceive.⁷⁹

5. EFFECT OF BREACH ON VICTIM'S INTERESTS. Overarching vagueness concerns, combined with the debates over harm and intent, have led to calls for rules that might limit the expansive reach of the statutes, primarily by requiring a tighter link between the fiduciary's misconduct and the victim's interests—in essence, requiring some proof that the misbehavior actually *mattered* to the victim. The two most popular competing theories have been: (1) the *reasonably foreseeable harm* test, which requires the government to "show that it was 'reasonably foreseeable that the scheme could cause some economic or pecuniary harm to the victims'"⁸⁰ and (2) the *materiality* test, familiar from other fraud contexts, which requires instead that the misrepresentation or non-disclosure have "the natural tendency to influence or [be] capable of influencing the employer to change his behavior."⁸¹ Another approach, characterized by Professor John Coffee as the "honest services" approach, focuses on whether the breach truly *deprived* the victim of a service to which he or she was entitled: "Under this formula, if the defendant employee has performed the same services—no more, no less—that a totally honest employee would have performed, there has been no deprivation of honest services even if a conflict or a side pay-

77. O'Sullivan, *supra* note 55, at 35–36.

78. *Id.* at 37.

79. *Id.* at 42–43; Moohr, *Mail Fraud and the Intangible Rights Doctrine*, *supra* note 58, at 205 (arguing that the statute should require independent evidence of an intent to cause serious harm, beyond proof of the basic breach of fiduciary duty).

80. O'Sullivan, *supra* note 55, at 39 (citations omitted); *see also* Coffee, *From Tort to Crime*, *supra* note 70, at 124 (requiring proximate causation).

81. O'Sullivan, *supra* note 55, at 39–40 (quoting *Neder v. United States*, 527 U.S. 1, 25 (1999) (holding materiality to be an element of the mail, wire and bank fraud statutes)); *see also* Mills & Weisberg, *supra* note 59, at 1395 (noting "that even though the ultimate economic gain to defraud and cause a loss to a victim need not have occurred, the deceptive representations must be *material* to the contemplated transaction").

ment was not disclosed.”⁸² These approaches, however, have been criticized as lacking a statutory basis and failing to provide enough structure to effectively cabin prosecutorial discretion.⁸³

Finally, although not at issue in most health care honest services cases, in public sector cases the doctrine has been accused of violating federalism principles by encouraging the federal government to step in to prosecute state and local political corruption in the face of state inaction. Although some posit that federal intervention is necessary when intrastate conflicts of interest or power struggles prevent states from taking action against corruption, such federal efforts may interfere with state and local autonomy by forcing state prosecutors and politicians to respond to federal concerns rather than those of state residents.⁸⁴ Without adequate limits on when the doctrine can be used, some fear that the statute may tempt federal prosecutors to infringe on First Amendment rights to free speech and association by interfering with local political disputes, “creat[ing] a danger to the political process that may eclipse the danger posed by corrupt officials.”⁸⁵

B. Skilling’s Place in the Debate

Into this remarkably complex fray came the 2010 *Skilling* decision. In his appeal, Jeffrey Skilling asserted that the honest services theory of fraud was unconstitutionally vague because it failed to adequately define the prohibited behavior and thus granted law enforcement, prosecutors, judges, and juries nearly unfettered discretion.⁸⁶ Led by Justice Ginsburg, the Court declined to overturn the statute, favoring instead a path that would “construe, not condemn, Congress’ enactments.”⁸⁷ The Court did so by determining that Congress had a clear intention in enacting § 1346: to return to the state of the law prior to the 1987 *McNally* decision.⁸⁸ Acknowledging that the “decisions preceding *McNally* were not

82. Coffee, *Modern Mail Fraud*, *supra* note 59, at 452; *see also* *United States v. Milovanovic*, 627 F.3d 405, 412 (9th Cir. 2010) (statute applies only to “deprivation of services the value of which depends on their being performed honestly”); *United States v. Czubinski*, 106 F.3d 1069, 1076 (1st Cir. 1997) (“[T]he government must not merely indicate wrongdoing by a public official, but must also demonstrate that the wrongdoing at issue is intended to prevent or call into question the proper or impartial performance of that public servant’s official duties.”).

83. Coffee, *Modern Mail Fraud*, *supra* note 59, at 449–52; O’Sullivan, *supra* note 55, at 38–41.

84. Beale, *supra* note 76, at 261, 265–66 (addressing debate); Coffee, *From Tort to Crime*, *supra* note 70, at 169–72 (questioning “whether there really is a federal interest in disciplining fiduciaries” despite concerns over “state incapacity”); Moohr, *Mail Fraud and the Intangible Rights Doctrine*, *supra* note 58, at 175–78, 183–87 (noting federalism concerns).

85. Moohr, *Mail Fraud and the Intangible Rights Doctrine*, *supra* note 58, at 181.

86. *Skilling v. United States*, 130 S. Ct. 2896, 2928 (2010).

87. *Id.*

88. *Id.* at 2928–29 (citing *McNally v. United States*, 483 U.S. 350 (1987)).

models of clarity or consistency,” the Court nevertheless determined that the doctrine had a “solid core . . . involv[ing] offenders who, in violation of a fiduciary duty, participated in bribery or kickback schemes.”⁸⁹ Holding “that § 1346 criminalizes *only* the bribe-and-kickback core of the pre-*McNally* case law,” but not the type of undisclosed self-dealing that formed the basis for Skilling’s own conviction, the Court upheld the statute while remanding the case for further proceedings.⁹⁰

While *Skilling* effectively (albeit controversially) disposed of the vagueness issue, the opinion failed to address other doctrinal holes. The majority gave tacit recognition to the fiduciary requirement, at least as a historical matter, by noting that “[t]he ‘vast majority’ of the [pre-*McNally*] honest-services cases involved offenders who, *in violation of a fiduciary duty*, participated in bribery or kickback schemes.”⁹¹ It was left to Justice Scalia, in his concurrence, to disagree not only with the majority’s reading of precedent but also with the assumption that the fiduciary concept had a clear meaning:

None of the “honest services” cases . . . defined the nature and content of the fiduciary duty central to the “fraud” offense.

There was not even universal agreement concerning the *source* of the fiduciary obligation—whether it must be positive state or federal law . . . or merely general principles, such as the “obligations of loyalty and fidelity” that inhere in the “employment relationship.”⁹²

In Justice Scalia’s view, the fiduciary question remains “the most fundamental indeterminacy” of the statute.⁹³

The opinion similarly failed to shed light on the *mens rea*, harm, and federalism issues. The only reference to intent came in a discussion of whether potential defendants would have notice of the statute’s application to bribery and kickback schemes, where the majority noted that “the statute’s *mens rea* requirement further blunts any notice concern.”⁹⁴ To the surprise of many commentators, the Court refused to resolve, or even to entertain, the intent and harm debates.⁹⁵ And by remanding the companion cases, the Justices avoided any discussion of federalism con-

89. *Id.* at 2929–30.

90. *Id.* at 2931.

91. *Id.* at 2930 (emphasis added).

92. *Id.* at 2936 (Scalia, J., concurring in part and concurring in the judgment) (citation omitted); see generally Buell, *supra* note 58, at 32 (criticizing the Court for not exploring “the relationship between fiduciary duties and fraud”).

93. *Skilling*, 130 S. Ct. at 2938.

94. *Id.* at 2933.

95. See, e.g., Beale, *supra* note 76, at 268 (“Does it mean intent to deceive on some material matter? Or . . . does it mean intent to obtain private gain by deceptive and dishonest means?”); Buell, *supra* note 58, at 47 (noting the “genuine oddity” that the all the opinions “were nearly silent about mens rea”).

cerns, free speech and political expression, the necessity of proving an underlying violation of state or federal law, and whether there are irreconcilable differences between the honest services theory as applied to the private and public sectors. *Skilling* may have resolved a question, but it was a question few had thought to ask; the key debates remain unresolved.

III. THE RELEVANCE OF *SKILLING* TO HEALTH CARE FRAUD

Skilling is widely perceived to have narrowed the scope of honest services mail and wire fraud, particularly in the private sector.⁹⁶ Loss of the ability to prosecute corporate officers and directors for undisclosed self-dealing, in particular, may be a blow to the DOJ's post-Sarbanes-Oxley focus on corporate wrongdoing.⁹⁷ Yet given the prominence of kickback concerns in health care, the Court's focus on kickbacks and bribery may well have the paradoxical effect of reinvigorating the prosecution of health care intangible rights violations.⁹⁸

This would be a significant change from current practice. Although the Anti-Kickback Statute can be enforced through a criminal prosecution, many kickback cases instead are handled through the administrative CMP and exclusion processes. Cases brought under the FCA—either by DOJ or by private *qui tam* relators—certainly raise the specter of large civil settlements, but these civil penalties are limited to situations in which the government itself has been defrauded.⁹⁹ In addition to streamlining kickback cases into a purely criminal track, without the option of civil resolution, the mail and wire fraud statutes permit criminal prosecution for *private* kickback schemes as well as those involving government funds.

In a typical honest services kickback case, the heightened duty between the perpetrator and the victim allows the court to find harm to the victim from the deprivation of honest services; often that harm can

96. Indeed, a bill has been introduced in Congress to restore the crime's applicability to certain undisclosed self-dealing. See Honest Services Restoration Act, H.R. 1468, 112th Cong. § 2 (2011) (prohibiting undisclosed self-dealing by public officials).

97. Beale, *supra* note 76, at 270 (noting the need to incentivize corporate executives to better oversee company behavior).

98. While the Court cited several federal anti-kickback examples in support of the proposition that the phrase "bribes and kickbacks" gives sufficient notice to potential defendants, it did not cite the Medicare & Medicaid Anti-Kickback Statute. *Skilling*, 130 S. Ct. at 2933–34. This may be due to the relative obscurity of the Anti-Kickback Statute as compared to more widely applicable federal prohibitions, such as the 18 U.S.C. § 201 prohibition on the bribery of public officials and witnesses, as well as to the fact that because the current version of the Anti-Kickback Statute dates only to the late 1970s, there is little pre-*McNally* case law on point. See Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, 91 Stat. 1175 (1977).

99. See 31 U.S.C. §§ 3729–3733 (2006).

be characterized as the loss of a financial opportunity. In the classic case of *United States v. George*,¹⁰⁰ for example, a purchasing agent for Zenith Radio Corporation was convicted of mail fraud based on allegations that he received kickbacks from a cabinet supplier by having the supplier pay fictitious commission invoices from another company. While declining to adopt the government's view "that anytime an agent secretly profits from his agency he has committed criminal fraud,"¹⁰¹ the court found ample evidence that the agent had in fact injured his employer.

[His] duty was to negotiate the best price possible for Zenith or at least to apprise Zenith that [the supplier] was willing to sell his cabinets for substantially less money. . . . There was a very real and tangible harm to Zenith in losing the discount or losing the opportunity to bargain with a most relevant fact before it. . . . Here the fraud consisted in [the agent's] holding himself out to be a loyal employee, acting in Zenith's best interests, but actually not giving his honest and faithful services, to Zenith's real detriment.¹⁰²

The harm caused by the kickbacks, then, was the lost opportunity to bargain with full knowledge and thereby possibly to negotiate a better price—which was, after all, the essence of the purchasing agent's job.

What types of intangible losses of opportunity might fall within *Skilling's* ambit in the health care context? The focus thus far has been on two distinct categories of health care relationships in which a physician may function as a fiduciary and thereby owe a duty to provide honest services. First, a physician who violates either the law or a contract term by giving or accepting kickbacks in connection with services covered under insurance (including Medicare and Medicaid) might be viewed as depriving that *insurer* of honest and faithful services, an argument that is strengthened by the prevalence of laws and contract terms prohibiting such behavior. However, courts generally have viewed the physician-insurer relationship as more contractual than fiduciary in nature. Far more compelling has been the second argument, that a physician who pays or accepts kickbacks in connection with providing medical services thereby deprives *patients* of honest and faithful services. The fiduciary relationship at the heart of health care honest services, then, is most likely the one between physician and patient.

100. 477 F.2d 508, 510 (7th Cir. 1973).

101. *Id.* at 512.

102. *Id.* at 512–13. Of course, it is impossible to know whether this hypothetical better bargain in fact could have been struck. Moreover, the evidence regarding the untoward effects of kickbacks appears to be mixed. *See* Mills & Weisberg, *supra* note 59 at 1406, 1411–15 (noting that kickbacks are "something of an economic mystery" and reviewing the economics of commercial kickbacks); Beale, *supra* note 76, at 268 (noting that some bribes and kickbacks may be less harmful than some undisclosed self-dealing arrangements).

A. Limited Case Law to Date

Perhaps surprisingly, few reported cases have addressed the applicability of honest services fraud in the health care context. Indeed, the two opinions most often cited come to largely opposite conclusions. In the only federal appellate case directly on point, *United States v. Jain*, a psychologist was convicted of violating both the mail fraud and the Anti-Kickback statutes by accepting payments of \$1,000 per month from a local psychiatric hospital to which he referred patients.¹⁰³ While nominally characterized as compensation for the psychologist's "marketing services" for the hospital, the government alleged that these payments were nothing more than kickbacks made in return for his referral of patients.¹⁰⁴ The Eighth Circuit upheld the Anti-Kickback conviction, but found the government had failed to prove a scheme to defraud under the mail fraud statute because there was no evidence of *tangible harm* to any patient.¹⁰⁵

The evidence in the case established that the hospital had provided quality psychiatric services and was as good as or better than the alternative facilities in the area, that all the patients did in fact require hospitalization, and that there had been no financial harm to patients.¹⁰⁶ The government argued "that § 1346 encompasses unethical violations of a private professional's fiduciary duty to provide 'honest services' to his clients"—here, the failure to disclose these conflicts of interest.¹⁰⁷ Drawing on the honest services jurisprudence, however, the Eighth Circuit emphasized that the defendant must have *intended to harm* the victim, and that nondisclosure of information by a private fiduciary must be *material* in order to constitute a scheme to defraud.¹⁰⁸ Given all indications that the psychologist had provided high-quality, medically necessary treatment to his patients, there was "no evidence that any patient would have considered [the psychologist's] relationship with [the hospital] material if it did not affect the quality or cost of his services to that patient."¹⁰⁹ In essence, then, the court adopted the "honest services" limitation discussed above, questioning how the duty could be violated if the alleged breach did not affect the services that were delivered.¹¹⁰

103. 93 F.3d. 436, 438 (8th Cir. 1996). Dr. Jain also (unsuccessfully) challenged the jury instructions concerning *mens rea* under the Anti-Kickback Statute. *Id.* at 439–41.

104. *Id.* at 438–39.

105. *Id.* at 441–43.

106. *Id.* at 441.

107. *Id.*

108. *Id.* at 442.

109. *Id.*

110. See *supra* note 82 and accompanying text. Former prosecutors privately have told the Author that the *Jain* decision is largely responsible for the federal government's subsequent failure to bring more health care honest services cases.

A different conclusion was reached in *United States v. Neufeld*,¹¹¹ in which the government characterized a “consulting arrangement” as payment from a home infusion company (Caremark) in return for a physician’s referral of his Medicaid patients who suffered from AIDS. Denying a motion to dismiss the indictment, the District Court agreed that the honest services theory requires the existence of a fiduciary relationship between the perpetrator and victim, although it found no such relationship between Dr. Neufeld and either of the agencies responsible for administering the Ohio Medicaid program (HHS and the Ohio Department of Human Services Office of Medicaid).¹¹² But the court concluded there were “elements of a fiduciary relationship” between the physician and his *patients*: “[F]iduciary duty encompasses more than mere disclosure. If Dr. Neufeld solicited bribes or remuneration [sic] 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.”¹¹³ The judge’s disapproval of the alleged misbehavior was palpable throughout the opinion, which characterized the alleged kickbacks as “an inherently wrongful activity and one of which a physician should particularly be aware.”¹¹⁴

In rejecting Dr. Neufeld’s defense that he did not receive any per-

111. 908 F. Supp. 491, 493 (S.D. Ohio 1995). Similar to Dr. Jain, Dr. Neufeld also mounted an unsuccessful challenge to the Anti-Kickback allegations, this time on the grounds of vagueness. *Id.* at 493–97.

112. *Id.* at 499–500; *see also* N. Shore Med. Ctr., Ltd. v. Evanston Hosp. Corp., No. 92 C 6533, 1996 WL 435192, at *6 n.1 (N.D. Ill. July 31, 1996) (holding that only patients, and not competing hospitals, could be the victims of honest services mail fraud, and noting that neither the doctors nor the hospital “owe[d] the federal government a fiduciary duty with respect to Medicare claims . . .”).

113. *Neufeld*, 908 F. Supp. at 500.

114. *Id.* at 496. Dr. Neufeld eventually entered a plea bargain, after the litigation had taken a series of unpredictable turns. *See* Robert Ruth, *Physician Must Serve 3 Months, Pay \$5,000*, COLUMBUS DISPATCH, May 4, 2000, at 06C. Soon after trial began in 1996, the judge declared a mistrial when the prosecutor violated a pretrial order excluding evidence of the homosexual relationship between Neufeld and his co-defendant, Jon Mickle, a nurse working in Caremark management. *United States v. Neufeld*, 949 F. Supp. 555, 556–58 (S.D. Ohio 1996), *aff’d*, No. 97-3159, 149 F.3d 1185 (6th Cir. June 4, 1998). Defendants unsuccessfully moved to dismiss their indictments on the basis of Double Jeopardy, arguing that the government had elicited the prohibited testimony in “a deliberate attempt to goad the defense into moving for mistrial.” *Id.* at 558. Finding that “[t]he prosecutor resorted to gratuitous sensationalism to help him win the case, not to goad a mistrial”—a strategy that led the judge to wonder “whether the government was using the shock value of defendants’ relationship to make up for lack of substance”—the court denied the motion to dismiss. *Id.* at 562, 562 n.6. Charges against Mickle eventually were dismissed, but the government was permitted to re-indict Neufeld. When Neufeld eventually pleaded guilty to one count of filing false claims in 1999, the judge rejected the probation department’s recommendation of a fine and sentenced him to an additional three months in a halfway house. *See* Ruth, *supra*.

sonal gain from his patients, the alleged victims of the fraud, the District Court reaffirmed that the intangible rights doctrine implicates deception that goes beyond simply defrauding a victim of money or property.¹¹⁵ Yet the court also noted that the indictment *did* in fact allege a flow of money related to the fraud: the money paid by Caremark to Dr. Neufeld.¹¹⁶ The court departed from many formulations of the honest services theory, however, by holding that no misrepresentation of material fact would be required: the “bribery and kickbacks solicited by Dr. Neufeld in the face of a known fiduciary duty to his patients [served as] sufficient allegations of deceptive conduct . . . to withstand his motion to dismiss.”¹¹⁷

The lessons of *Jain* and *Neufeld* are unclear, beyond the commonality of finding that the physician-patient relationship is, at least in certain circumstances, sufficient to qualify as a fiduciary relationship under the honest services theory.¹¹⁸ It may be tempting to view the *Neufeld* facts as more compelling, particularly in light of the District Court’s condemnatory language; however, it is hard to ignore the fact that Dr. Jain already had been *convicted* of accepting kickbacks, while Dr. Neufeld’s trial had yet to begin. Similarly, it is easy to appreciate that Dr. Neufeld’s AIDS patients might have been particularly vulnerable to fraud given their debilitated medical conditions; yet Dr. Jain’s patients were in need of inpatient *psychiatric* care—were easily as vulnerable a population (if not more so). Perhaps the decision in *Neufeld* seemed obvious at the time, given that Caremark itself recently had pled guilty to defrauding the federal health care programs by paying physicians to refer patients to the company.¹¹⁹ At a doctrinal level, perhaps the

115. *Neufeld*, 908 F. Supp. at 500–01.

116. *Id.* at 501. There is, in fact, precedent for this type of tripartite fraud scheme involving the Anti-Kickback Statute. In recent years numerous pharmaceutical companies have settled allegations that they inflated the reported average wholesale price (“AWP”) of their drugs, on which Medicare reimbursement previously had been based, far above the price that physicians actually paid when they purchased the drugs to administer to their patients. This price differential, called the “spread,” often translated to a nice windfall for physicians—or, to prosecutors, a kickback received in return for using products with particularly high spreads. To the extent the spread was a kickback, however, it was a rather ingenious one paid to physicians by *Medicare* rather than by the manufacturer itself. For more on the AWP theory, see Joan H. Krause, *Regulating, Guiding, and Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURV. AM. L. 241, 265–72 (2004).

117. *Neufeld*, 908 F. Supp. at 501.

118. *But see infra* notes 134–39 and accompanying text for a more complete discussion.

119. See Press Release, Department of Justice, Caremark to Pay \$161 Million in Fraud and Kickback Cases (June 16, 1995), available at http://www.justice.gov/opa/pr/Pre_96/June95/342.txt.html. Ironically, the contemporaneous prosecution of another physician in the scheme, Dr. David Brown, was derailed when some of the jurors improperly shared extrinsic information about Caremark’s plea with the rest of the jury. *United States v. Brown*, 913 F. Supp. 1324, 1326, 1330 (D. Minn. 1996) (granting motion for new trial based on juror misconduct and jury exposure

Neufeld court erred in not analyzing the potential harm to patients, or in declining to require proof of the physician's intent to deceive in addition to the breach itself (a point for which the court relied, in fact, on the *Jain* District Court opinion that would later be overruled by the Eighth Circuit).¹²⁰ Or perhaps the difference is explained by the differential burden required to survive a motion to dismiss as compared to that required to overturn a conviction. Regardless, the dissonance has made it difficult to assess the likely approach to be taken in future honest services health care kickback cases.¹²¹

Other non-kickback cases addressing the honest services/health care fraud intersection have involved fairly unique circumstances, where courts seem to believe the contours of the physician's duty were clear. In *United States v. Morris*,¹²² for example, an unreported district court decision, a physician was accused of defrauding a patient into investing in his medical practice. Finding that the physician's fiduciary duty encompassed only those "services relating to medical diagnosis and treatment," however, the court rejected the honest services allegations because there had been no suggestion that the physician had "compromised" the patient's care.¹²³ Although focused on securities fraud and on the intangible property strain of mail fraud rather than on intangible rights, the decision in *United States v. Willis*,¹²⁴ involving a psychiatrist who purchased stock based on confidential information disclosed during a patient's therapy, also may be instructive. During therapy sessions, the patient disclosed her husband's plans to take over a publicly traded corporation prior to that information being made public; the psychiatrist

to extrinsic information). The Caremark plea bargain also gave rise to an unsuccessful Racketeer Influenced and Corrupt Organizations Act ("RICO") suit by the company's competitors. *See* *Pharmacare v. Caremark*, 965 F. Supp. 1411, 1419 (D. Haw. 1996) (refusing to allow Caremark's competitors to assert a property interest in patients' rights to honest services from their physicians).

120. *Neufeld*, 908 F. Supp. at 501 (citations omitted); *see* *United States v. Jain*, 93 F.3d 436, 442 (8th Cir. 1996).

121. At least one court, however, has managed to harmonize the two approaches in a case involving a physician who ordered unnecessary testing and made false entries in patient records in order to obtain additional insurance payments; unlike in *Jain*, the court found that the scheme *did* affect the quality and cost of patient care. *United States v. Vasquez-Ruiz*, No. 00CR1044, 2002 WL 1880127, at *2 (N.D. Ill. Aug. 12, 2002), *rev'd*, 502 F.3d 700 (7th Cir. 2007).

122. No. CRIM.A. 2:03-00275, 2004 WL 1242736, at *1 (S.D. W. Va. June 4, 2004).

123. *Id.* at *2-3. The allegations of simple mail/wire fraud were, however, upheld. Courts have found similar allegations involving attorneys to be actionable, although on slightly different grounds. *See, e.g., United States v. Hausmann*, 345 F.3d 952, 954, 956-58 (7th Cir. 2003) (affirming attorney's sentence for kickback scheme involving payment for referrals to chiropractor on basis that concealment of kickbacks from clients deprived them of knowing the truth about his compensation and violated duties set forth in the Wisconsin Supreme Court Rules of Professional Conduct for Attorneys).

124. 737 F. Supp. 269, 270 (S.D.N.Y. 1990).

told his broker, who purchased 13,000 shares of common stock.¹²⁵ The court noted that “central to the misappropriation theory of securities fraud[] is a breach of fiduciary or similar duty of trust and confidence. It is difficult to imagine a relationship that requires a higher degree of trust and confidence than the traditional relationship of physician and patient.”¹²⁶ Rather than involving kickbacks, however, the specific duty breached in this case was the duty of *confidentiality*, a well-defined and long-recognized duty (particularly in the mental health context).¹²⁷ It is difficult to discern a clear majority approach from these rather unique fact patterns. Perhaps the most that can be said is that honest services fraud remains a viable, albeit underutilized, theory of health care fraud under certain circumstances.

B. *Implications for the Future*

To the extent the *Skilling* opinion functions as an open invitation to bring more honest services cases based on bribery and kickback allegations in the context of fiduciary relationships, we are likely to see more health care cases in the future. Of course, these cases will not supplant more traditional kickback-based health care mail and wire fraud prosecutions in which there is evidence that either the kickbacks themselves or subsequent claims for services have traveled through the mails or wires.¹²⁸ In these more straightforward cases, adding an intangible rights count might be seen as overkill—or at the very least as risking unnecessary juror confusion.

Nevertheless, bringing Anti-Kickback cases as honest services mail and wire fraud does provide certain strategic advantages to the government. First, as a litigation strategy, it can be very effective to focus on the physician-patient relationship as the locus of the misbehavior.¹²⁹ By characterizing *patients* rather than a government agency or insurer as the true victims of the crime, a prosecutor may be able to garner signifi-

125. *Id.* at 271.

126. *Id.* at 272.

127. *Id.* at 274. Yet another oft-cited case, *United States v. Garfinkel*, turned on a researcher psychiatrist’s duties to a pharmaceutical company sponsor, the Food and Drug Administration, and his academic employer, rather than to any patients. 29 F.3d 1253, 1254–55, 1259 (8th Cir. 1994).

128. *See, e.g., United States v. Montgomery*, 379 F. App’x 527, 529–30 (6th Cir. 2010) (government established that a claim form seeking payment for diagnostic tests performed pursuant to a kickback arrangement between chiropractors and defendant’s company had been sent through the mail); *Baglio v. Baska*, 940 F. Supp. 819, 833–34 (W.D. Pa. 1996) (commission of mail fraud, based on mailing of kickback checks and Medicare/Medicaid reimbursement checks, alleged (unsuccessfully) as predicate acts for private suit under Racketeer Influenced and Corrupt Organizations Act (“RICO”), 18 U.S.C. §§ 1962(c)–(d)).

129. *See FABRIKANT ET AL., supra* note 12, § 1.04[2] at 1-30 to 1-31 (describing how “the presence of patients as victims of the fraud” may increase the chance of success).

cantly more sympathy from jurors and the general public. As Professor Pamela Bucy notes, “focus[ing] on the patient as a victim of the fraudulent provider[] allows proof of a sad truth: the health care provider, by virtue of expertise and status, is able to commit fraud by frightening the ill and trusting patient into parting with money, or more.”¹³⁰ The strategy may be particularly helpful in the absence of obvious physical or financial harm, as in *Jain* and *Neufeld*.

The strategic advantages of mail and wire fraud are evident at the negotiation stage as well. Recall that the maximum term of imprisonment for mail and wire fraud is *twenty years* in prison, compared to only five years for a violation of the Anti-Kickback Statute.¹³¹ This difference gives prosecutors an incentive to pursue otherwise run-of-the-mill health care kickback cases under mail or wire fraud, at least for the purposes of plea negotiations.¹³² Indeed, some already have criticized the government’s decision to use mail and wire fraud in these cases, questioning whether the charging decision was a ploy “to win long sentences for publicity—or to offer defendants plea bargains no sane defendant could refuse?”¹³³ As we have seen in other health care fraud contexts, most notably in cases brought under the FCA, the availability of severe penalties significantly increases the odds that defendants will settle rather than take their chances at trial.¹³⁴ Styling more health kickback cases as honest services mail and wire fraud could well have a similar effect on plea bargains.

Finally, the language of § 1346 applies not only to mail and wire fraud but also to the other crimes defined in 18 U.S.C. Chapter 63—including bank fraud, securities fraud, and for our purposes, the § 1347 health care fraud crime added by HIPAA.¹³⁵ The HIPAA crime applies to those who “knowingly and willfully execute [], or attempt[] to execute, a scheme or artifice . . . to defraud any health care benefit program,” which includes both public and private plans.¹³⁶ While the maximum penalty of ten years in prison is lower than that for mail fraud,

130. Pamela H. Bucy, *Fraud by Fright: White Collar Crime by Health Care Providers*, 67 N.C. L. REV. 855, 937 (1989).

131. See 18 U.S.C. §§ 1341, 1343 (2006); 42 U.S.C. § 1320a-7b(b) (2006).

132. See Beale, *supra* note 76, at 270 n.67.

133. Mills & Weisberg, *Honest Services*, *supra* note 74.

134. See, e.g., Krause, *Health Care Providers and the Public Fisc*, *supra* note 22, at 202–12 (analyzing settlement trends).

135. See 18 U.S.C. §§ 1346 (defining the intangible right of honest services “[f]or the purposes of this chapter”), 1347 (health care fraud); see also O’Sullivan, *supra* note 55, at 30.

136. 18 U.S.C. § 1347(1) (defining offense); *id.* § 24(b) (defining “health care benefit program”). The crime also prohibits a scheme to obtain by false and fraudulent pretenses money or property owned, controlled, or in the custody of a health care benefit program, thus tracking more traditional forms of mail and wire fraud as well. *Id.* § 1347(2).

it rises to twenty years if the violation results in serious bodily injury and to “any term of years or for life” if a death results.¹³⁷ Despite the fact that the honest services theory has been applied to this prohibition since its enactment, § 1347 cases premised on intangible rights violations (let alone on kickbacks) have not been common.¹³⁸ Yet *Skilling* may invite more of these cases to be brought, particularly in situations in which the breach of honest services may in some way be linked to serious harm or death. With the current emphasis on pursuing criminal as well as civil health care fraud sanctions, this kind of leverage may prove difficult for prosecutors to resist—and may force changes in the way that regulatory counsel, as well as the defense bar, approach common Anti-Kickback concerns.

IV. CONCLUSION

While the limitations that *Skilling* placed on the intangible rights doctrine have been viewed as closing the door to many honest services mail and wire fraud cases, including Jeffrey Skilling’s own, this Article has argued that the case may well lead to additional prosecutions based on health care kickbacks. There is ample precedent for such cases, although the theory has thus far not been favored by federal prosecutors. The litigation and negotiation advantages conferred by mail and wire fraud charges will dovetail nicely with the Obama Administration’s hard line against fraudulent health care activities.

Yet broader use of the honest services theory in health care kickback cases would raise a host of analytical issues, some stemming from the doctrine’s jumbled jurisprudence and others grounded in substantive health law. Although a topic deserving of far more analysis in another article, it is worth noting that the characterization of the physician-patient relationship as a fiduciary one is, perhaps surprisingly, far more complex than it first appears. One does not have to look far to find broad descriptions of the fiduciary nature of the relationship; in most discussions it is all but presumed. As Professor Tamar Frankel notes in her landmark work on *Trust and Honesty*, “[s]o long as the physician is in charge of the patient’s health, the patient is in no position to question the physician’s decision or to bargain.”¹³⁹ Yet some courts have cautioned that the duty is not all-encompassing: “The breach alleged must contravene the purpose of the parties’ relationship. . . . The honest services a

137. *Id.* § 1347.

138. *See, e.g.*, *United States v. Medina*, 485 F.3d 1291, 1294 (11th Cir. 2007) (§ 1347 prosecution based on kickback scheme).

139. TAMAR FRANKEL, *TRUST AND HONESTY: AMERICA’S BUSINESS CULTURE AT A CROSSROAD* 145 (2006).

patient is entitled to receive from his physician are services related to *medical diagnosis and treatment*.”¹⁴⁰

While physicians clearly are entrusted with power over patients,¹⁴¹ a characteristic fiduciary responsibility, other indicia of the relationship may be absent—the physician, for example, lacks the fiduciary’s traditional control over the beneficiary-patient’s money.¹⁴² As a legal matter, the physician’s duty to disclose information to patients generally is handled through the state-based law of *informed consent* rather than through broad federalized notions of fiduciary duty, and few informed consent cases or statutes require the disclosure of *financial* rather than treatment-related information.¹⁴³ In the few reported cases involving fiduciary suits based on physicians’ failure to disclose financial interests to patients (including, interestingly enough, one case involving undisclosed kickbacks from Caremark), courts have found that the claims sound more properly in the law of medical malpractice or informed consent.¹⁴⁴ While the fiduciary relationship between physician and patient may not exactly be a fiction, at present the characterization may well be more normative than descriptive in nature.

The confusion surrounding the physician’s duty is more than a theoretical issue: It has direct implications for the elements of honest services fraud in kickback cases, specifically for the nature of the required *deception*. Current case law supports several approaches. First, prosecutors might argue that the very nature of a kickback, given or accepted in violation of a clear statutory prohibition, is sufficient to establish decep-

140. United States v. Morris, No. CRIM.A. 2:03-00275, 2004 WL 1242736, at *2 (S.D. W. Va. June 4, 2004) (emphasis added).

141. TAMAR FRANKEL, FIDUCIARY LAW 43 (2011).

142. See Krause, *Reconceptualizing Informed Consent*, *supra* note 1, at 268–69 (discussing debate over fiduciary status). Consideration of the physician’s fiduciary status is further complicated by the distinct but related issue of when a physician is considered to be a fiduciary under the Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. §§ 1001–1461. See, e.g., Pegram v. Herdrich, 530 U.S. 211, 237 (2000) (holding that “mixed eligibility decisions” by health maintenance organization physicians are not fiduciary acts under ERISA).

143. See Krause, *Reconceptualizing Informed Consent*, *supra* note 1, at 267–78, 339–41 (discussing doctrine).

144. See, e.g., Neade v. Portes, 739 N.E.2d 496, 505 (Ill. 2000) (breach of fiduciary duty claim, based on allegation that physician failed to disclose financial incentives in his relationship with health maintenance organization, was duplicative of medical negligence claim); D.A.B. v. Brown, 570 N.W.2d 168 (Minn. Ct. App. 1997) (class action fiduciary suit based on physician’s acceptance of kickbacks from Caremark in violation of Minnesota law sounded instead in medical malpractice). Virtually the only case to the contrary, and then only tepidly, is *Moore v. Regents of the Univ. of Cal.* 793 P.2d 479, 483 (Cal. 1990) (holding that patient stated a cause of action for *either* failure to obtain informed consent *or* breach of fiduciary duty based on physician’s failure to disclose plan to develop a patentable, commercially viable cell line from patient’s cells).

tion *per se*.¹⁴⁵ A second variant would argue that to the extent kickbacks are usually disguised as legitimate forms of payment, such as the so-called “consulting” and “marketing” fees at issue in *Neufeld and Jain*, such kickbacks are presumptively deceptive unless proven otherwise.¹⁴⁶ In contrast, a third approach would extrapolate from the “honest services” limitation to argue that in the absence of a clear duty to *disclose* (rather than merely not to engage in) a kickback under fiduciary law or informed consent, violation of the Anti-Kickback Statute will not support an honest services prosecution unless there is additional evidence of harm to the patient—if not tangible harm, at least proof that the physician’s decisionmaking (i.e., the services owed) was in fact influenced in a way that could have affected the patient’s treatment.¹⁴⁷

No clear pathway is obvious from existing law. The first two theories are attractive bright-line rules, but would come close to converting all kickback violations involving the mails or wires into *per se* mail and wire fraud—an approach that appears to duplicate the traditional mail and wire crimes as well as the Anti-Kickback Statute itself. The third approach, by contrast, may perhaps be a truer reading of the doctrine, but likely will be found wanting by jurists who believe the disclosure duties imposed on physicians under current health law are incomplete. Understanding the source and scope of the physician’s fiduciary duty, and the way in which a breach of that duty may establish an illegal deception, is crucial. A deeper analysis of these issues—and of the implications for substantive health law should honest services kickback cases become more prevalent and should federal judges begin to question the contours of physician duties traditionally left to the states—clearly is in order.

145. *Cf.* *United States v. Neufeld*, 908 F. Supp. 491, 496 (S.D. Ohio 1995) (“Taking bribes for referrals . . . is an inherently wrongful activity . . .”).

146. The facts of *Black v. United States*, one of the companion cases vacated in light of *Skilling*, involved similar allegations of bonuses disguised as unwarranted “noncompetition” fees to a controlling shareholder. 130 S. Ct. 2963, 2966–67 (2010).

147. *See* *United States v. Jain*, 93 F.3d 436, 442 (8th Cir. 1996) (“But when the client was not harmed because the breach did not affect the services rendered, how has the client’s right to ‘honest services’ been violated?”); Coffee, *Modern Mail Fraud*, *supra* note 59, at 452.

