

Healthcare Fraud: A World Beyond the Anti-Kickback Statute

by Seth Goertz, Nicole Engisch, Mara Sanders, and Sarah Malham

Americans spend more than \$3 trillion per-year on healthcare-related expenses. Of that, the National Health Care Anti-Fraud Association estimates that between \$60-250 billion is lost to fraud every year.[1] Not all of those losses, however, relate to taxpayer-funded health insurance programs—such as state and federal Medicaid/Medicare—but involve losses to private payers and other non-traditional funding sources.

To combat fraud occurring beyond the scope of taxpayer-funded healthcare plans—where laws such as the Anti-Kickback Statute and the Stark Law don't reach—the Department of Justice (“DOJ”) has become increasingly creative. One of DOJ's most creative avenues is the utilization of honest services fraud (18 U.S.C. § 1346) to prosecute bribes, kickbacks, and other improper payments in the health care industry.

Traditionally, the Anti-Kickback Statute (42 U.S.C. § 1320a-7b)—alone or in conjunction with the Federal False Claims Act (31 U.S.C. § 3729 *et seq.*)—has been the primary mechanism for prosecuting healthcare bribes and kickbacks. The Anti-Kickback Statute works to ensure that decisions regarding purchasing, delivering, or providing healthcare-related services are not driven by improper financial arrangements. As written, the Anti-Kickback Statute does well to prohibit those arrangements, but it only applies to federally funded healthcare programs; meaning, it has very limited application, if any, to private payers or other non-traditional payment platforms.

Honest Services Fraud—a Novel Approach

Codified as 18 U.S.C. § 1346, honest services fraud prohibits “schemes to defraud” that “deprive another of the intangible right of honest services.” In plain English, a person commits honest services fraud when, in violation of a fiduciary duty, that person participates in a bribery or kickback scheme. *See Skilling v. United States*, 561 U.S. 358, 407 (2010).

Because an underlying fiduciary duty is a predicate for honest services fraud, it does not apply in most consumer contexts. Broadly speaking, however, courts have found that

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healthcare providers owe a fiduciary duty to their patients. For instance, in the *United States v. Nayak*, the Seventh Circuit Court of Appeals upheld an honest services fraud conviction against the owner of several ambulatory surgery centers because he was making under-the-table payments to physicians who referred patients to his centers. 796 F.3d 978 (7th Cir. 2014). Even though the government admitted that the scheme did not cause patients any physical or monetary harm, the court found that the bribes were material to the physicians' decisions as to where they ultimately referred their patients, thereby depriving the patients of their right to the physicians' honest services. "The intangible harm from a fraud can often be quite substantial, especially in the context of the doctor-patient relationship, where patients depend on their doctor—more or less completely—to provide them with honest medical services in their best interest."

More recently, in *United States v. Simon, et al.*, the First Circuit Court of Appeals upheld RICO[2] convictions against seven former executives and managers of the pharmaceutical company, Insys. 12 F.4th 1 (1st Cir. 2021). One of the predicate offenses underlying the RICO conspiracy was honest services fraud. And among the many issues on appeal, Insys lead executive, Dr. John Kapoor, argued that he didn't owe or otherwise breach a fiduciary duty because he didn't intend for any doctors to write illegitimate prescriptions. The Court disagreed. By incentivizing practitioners to prescribe the drug "Subsys" outside the usual course of professional practice, Dr. Kapoor directed a scheme that caused physicians to violate their fiduciary duties.

DOJ's Recent Application of Honest Services Fraud

Just this year, in a case from the Northern District of Texas, DOJ indicted ten doctors, two pharmaceutical reps, and two separate business entities for sharing fees derived from certain prescriptions.[3] In that case, several pharmacies recruited doctors to write prescriptions for lucrative pain creams in return for a share of the profits. The pharmacies tracked each prescription by doctor and then funneled a share of the profits to the doctors through marketing firms and shell management organizations—all of which, according to DOJ, deprived patients of their right to honest services.

Likewise, in January 2024, two surgical sales representatives pleaded guilty to conspiracy to commit honest services fraud after selling medical devices and equipment—which were otherwise unnecessary—to a local VA Medical Center for inflated prices. The two sales representatives also admitted to paying bribes to specific employees of the VA Medical Center.[4]

Key Takeaways

Within the healthcare industry, DOJ continues to apply honest services broadly. In particular, prosecutors have demonstrated a willingness to deploy honest services fraud in place of the Anti-Kickback Statute and the False Claims Act when federally funded healthcare programs are not at issue. As a result, it is imperative that practitioners and administrators carefully scrutinize payment arrangements, and their own financial interests, whenever they intersect with the delivery of patient services. In particular, providers should review carefully their own patient disclosures to ensure that any

relevant financial interests are fully disclosed.

[1] The Challenge of Health Care Fraud – NHCAA.

[2] Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C.A. § 1962(c).

[3] Northern District of Texas | Fourteen Indicted in Pharmaceutical Kickback Case | United States Department of Justice.

[4] Eastern District of Tennessee | Surgical Sales Representatives Plead Guilty To Conspiracy To Commit Bribery And Honest Services Wire Fraud Against The Quillen VA Medical Center | United States Department of Justice.