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THE MISSING VICTIMS OF HEALTH CARE FRAUD

Anthony Kyriakakis*

Abstract

Over the past few decades, combating criminal health care fraud has become one of the highest priorities of federal law enforcement, which views and treats it as a financial crime that causes vast economic losses to the government and private insurers. But the crime also causes, or threatens, physical harms to individual health care patients, a class of victims that the criminal justice system often fails to recognize. This Article is the first to explore how structures and hidden levers of power within the criminal justice bureaucracy lead agents and prosecutors to select—and ignore—particular harms and victims and, more importantly, what drives their selections. The implications extend beyond health care fraud.

Questions about this form of prosecutorial discretion are surprisingly absent in the scholarly literature. Through the lens of health care fraud, I show that features of statutory frameworks and sentencing guidelines can have an outsized influence on the selection of harms and victims in complex cases, often in unintended ways that merit greater scrutiny. Internal dynamics within the criminal justice bureaucracy, including those driven by governmental interests as well as the interests of agents and prosecutors themselves, also play a significant role. These factors combine to spur our criminal justice system to treat health care fraud as just another flavor of fraud, devaluing victims and skewing punishments of offenders who exploit patients as a means to enrich themselves.

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I. INTRODUCTION

In August 2013, federal agents in Michigan arrested a doctor based on allegations that he deliberately misdiagnosed patients with cancer so he could profit from “treating” them, including by causing them to undergo unnecessary chemotherapy.¹ Predictably, patients of the doctor and members of their families reacted to news of the arrest with outrage and distress.² From the outset of the case, law enforcement officials emphasized their own concerns about the welfare of patients. In a press release announcing the arrest, the United States Attorney for the Eastern District of Michigan declared, “Our first priority is patient care.”³ Officials from the Federal Bureau of Investigation (FBI) and the Department of Health and Human Services (HHS) issued similar statements concerning the impact of the doctor’s alleged misconduct on patient health and safety.⁴

In light of the initial focus on the alleged mistreatment of the doctor’s patients, members of the public could have reasonably anticipated the indictment, when filed and made public, would elaborate upon how the doctor had victimized the patients. Yet, in the nineteen paragraphs that made up the eight-page charging document, just a single sentence was devoted to describing how the doctor had allegedly caused

¹ See Zlati Meyer, *Oakland County Cancer Doctor Accused of Unnecessary Treatments, Defrauding Medicare of Millions*, DETROIT FREE PRESS (Aug. 7, 2013, 11:34 AM), <http://www.freep.com/article/20130806/NEWS05/308060139/Oakland-County-oncologist-charged-with-Medicare-fraud>, archived at <http://perma.cc/FTM8-FZZY>. The criminal complaint against Dr. Farid Fata also claimed, among other things, that he directed the administration of chemotherapy to end-of-life patients who would not benefit from it and that he fabricated diagnoses such as anemia and fatigue to justify providing unnecessary hematology treatments. Complaint at 2, *United States v. Fata*, No. 2:13-mj-30484 (E.D. Mich. Aug. 6, 2013).

² See, e.g., Orlander Brand-Williams et al., *Doctor’s Arrest Has Patients Worrying—Prosecutors Urge \$9M Bond for Physician in Medicare Fraud Case*, DETROIT NEWS, Aug. 13, 2013, at A5; Tony Briscoe, *Cancer Patients Meet for Answers—After Doctor’s Arrest, Gathering 400 Lays Out What Happens Next*, DETROIT NEWS, Aug. 22, 2013, at A4; Zlati Meyer, *‘I Trusted This Man Implicitly’—Patients Reel Over Arrest of Cancer Doctor*, DETROIT FREE PRESS (Aug. 8, 2013, 12:04 AM), <http://www.freep.com/article/20130807/NEWS05/308070173/>, archived at <http://perma.cc/U662-6H83>.

³ Press Release, U.S. Attorney’s Office, E. Dist. of Mich., *Oakland County Doctor and Owner of Michigan Hematology and Oncology Centers Charged in \$35 Million Medicare Fraud Scheme*, (Aug. 6, 2013), available at <http://www.fbi.gov/detroit/press-releases/2013/oakland-county-doctor-and-owner-of-michigan-hematology-and-oncology-centers-charged-in-35-million-medicare-fraud-scheme>, archived at <http://perma.cc/Z5N5-PGSM>.

⁴ An FBI representative stated that “[v]iolating patients’ trust and placing them at risk through fraudulent abuse of our nation’s health care system is deplorable and a crime which the FBI takes most seriously,” and an official from HHS affirmed that “[t]he conduct alleged in this complaint is serious, not only in terms of potential Medicare dollars improperly obtained, but patient safety as well.” *Id.*

patients to receive unnecessary treatments.⁵ The bulk of the indictment, which charged one count of health care fraud, instead included an extensive description of the Medicare program, the intricacies of its reimbursement mechanisms, and the claims for reimbursement submitted by the doctor.⁶ The only victim mentioned was Medicare itself, which was alleged to have been defrauded by the doctor and to have paid out over \$62 million based on his claims for reimbursement.⁷ Our criminal justice system transformed a tale of unthinkable betrayal and patient abuse into something that looked more like an accounting scandal.

What happened? Remarkably, the indictment in the Michigan case is not an anomaly. This Article will show the Michigan case reflects a widespread phenomenon in which criminal health care fraud cases are conceptualized, investigated, and prosecuted as classic *fraud* cases, not as cases that speak to the abuses of patients' *health* and *care*. With rare exceptions, the only victims who are recognized in criminal courtrooms are the ones that pay the bulk of the fraudulent bills, namely private insurers and the government. To be sure, traditional concepts of fraud play a central role in many cases of health care fraud. But treating criminal health care fraud as if it were transsubstantive to other types of fraud discounts a material difference between health care fraud and crimes like mortgage fraud and tax fraud: health care fraud can, and often does, threaten physical harm to the health of individuals—to *patients*.⁸

Why should we care about the failure to recognize patients as victims of criminal health care fraud? For starters, the phenomenon is important because health care fraud itself has become an important, if not dominant, part of the federal criminal justice system. Since the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the number of federal defendants convicted of crimes related to health care fraud has increased by an astonishing 169%.⁹ Top law enforcement officials repeatedly describe health care fraud as one of the nation's

⁵ Indictment at 5, *United States v. Fata*, No. 2:13-cr-20600 (E.D. Mich. Aug. 14, 2013).

⁶ *Id.* at 3.

⁷ *Id.* at 6.

⁸ In its financial crime reports, the FBI has repeatedly said “[o]ne of the most significant trends” in health care fraud cases is medical professionals’ willingness to risk patient harm. *2009 Financial Crimes Report: Fiscal Year 2009*, FED. BUREAU INVESTIGATION, <http://www.fbi.gov/stats-services/publications/financial-crimes-report-2009>, archived at <http://perma.cc/CWF8-Y85Z> (last visited Apr. 6, 2015); see also *Reports and Publications*, FED. BUREAU INVESTIGATION, <http://www.fbi.gov/stats-services/publications>, archived at <http://perma.cc/6QJG-AK4P> (last visited Apr. 6, 2015) (cataloguing FBI Crime Reports between the years 2005 and 2011).

⁹ See DEP’T OF HEALTH & HUMAN SERVS. & DEP’T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM: ANNUAL REPORT FOR FISCAL YEAR 2012, at 1 (2013) [hereinafter HCF ANNUAL REPORT FOR FY 2012], available at <http://oig.hhs.gov/publications/docs/hcfac/hcfareport2012.pdf>, archived at <http://perma.cc/R4XH-DDBE>; DEP’T OF HEALTH & HUMAN SERVS. & DEP’T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM: ANNUAL REPORT FOR FY 1997, at 1 (1998), available at <http://oig.hhs.gov/publications/docs/hcfac/hcfareport1997.PDF>, archived at <http://perma.cc/5S6D-GDM4>.

highest law enforcement priorities,¹⁰ a fact borne out by the most recent FBI Financial Crimes Report, which revealed the number of pending cases for health care fraud in fiscal year 2011 outnumbered those for securities and commodities fraud, financial institution fraud, corporate fraud, money laundering, insurance fraud, and mass marketing fraud.¹¹ As national health expenditures continue to swell, the meteoric rise of health care fraud shows no signs of abating, a fact recognized by the Patient Protection and Affordable Care Act (“Affordable Care Act”), which, among other things, significantly increased criminal penalties for health care fraud and provided an additional \$350 million to support enforcement efforts.¹²

For all the rapid growth and prominence of health care fraud, it remains a surprisingly undertheorized area of the law. This Article charts new ground by bridging the gap between theory and practice. In the process, it demonstrates that the criminal justice bureaucracy’s treatment of patient-victims is at odds with fundamental principles underlying theories of harm, punishment, and the purposes of criminal law. Moreover, the Article finds the omission of patient harms is inconsistent with the commonsense notion that we should be using scarce criminal

¹⁰ Over the past two decades, top government officials have consistently described health care fraud as one of federal law enforcement’s highest priorities. *See, e.g.*, FIN. CRIMES SECTION, FED. BUREAU OF INVESTIGATION, FINANCIAL CRIMES REPORT TO THE PUBLIC: FISCAL YEAR 2006, at 15, available at http://www.fbi.gov/stats-services/publications/fcs_report2006/financial-crimes-report-to-the-public-2006-pdf, archived at <http://perma.cc/RQM9-TYLG> (describing health care fraud investigations as “among the highest priority investigations within the FBI’s White Collar Crime Program”); Kathleen Sebelius & Eric Holder, Op-Ed., *We’re Finding the Cures for Fraud*, TAMPA BAY TIMES, Feb 11, 2013, at A11 (stating that President Obama “has made fighting health care fraud a top priority”); Elizabeth Shogren, *Rampant Fraud Complicates Medicare Cures*, L.A. TIMES (Oct. 8, 1995), http://articles.latimes.com/1995-10-08/news/mn-54796_1_medicare-fraud, archived at <http://perma.cc/VN4A-3P4G> (reporting that U.S. Attorney General Janet Reno cited health care fraud as her second-highest priority in 1993); Press Release, Dep’t of Justice, Statement by Attorney General Janet Reno on Health Care Fraud (Mar. 6, 1997), available at <http://www.justice.gov/archive/opa/pr/1997/March97/095ag.htm>, archived at <http://perma.cc/4TB3-BK5Q> (“Fighting health care fraud is one of this Administration’s highest priorities.”).

¹¹ *See Financial Crimes Report to the Public: Fiscal Years 2010–2011*, FED. BUREAU OF INVESTIGATION, <http://www.fbi.gov/stats-services/publications/financial-crimes-report-2010-2011>, archived at <http://perma.cc/CS4Z-WQEZ> (last visited Mar. 30, 2015) [hereinafter *Financial Crimes Report 2010–2011*]. The only financial crime listed in the report that had more pending cases was mortgage fraud, which surpassed health care fraud by a single case. *Id.*

¹² *See Patient Protection and Affordable Care Act*, Pub. L. 111-148, § 10606, 124 Stat. 119, 1006 (2010) (codified as amended at 18 U.S.C. § 1347(b) (2012)); Press Release, Dep’t of Justice, Office of Pub. Affairs, Departments of Justice and Health and Human Services Team Up to Crack Down on Health Care Fraud (Nov. 5, 2010), available at <http://www.justice.gov/opa/pr/departments-justice-and-health-and-human-services-team-crack-down-health-care-fraud>, archived at <http://perma.cc/B4MP-8L5P>.

enforcement resources to stand up for the people who cannot stand up for themselves. A primary aim of this Article is to reorient the social meaning of criminal health care fraud back towards individual patient-victims.¹³

But to do that, we first must understand why this is happening. We must determine why the criminal justice system is failing to recognize patients as victims of health care fraud. This Article posits the answers should trouble us for reasons that extend well beyond the crime of health care fraud. That is because they apply more broadly to many other complex crimes involving multiple harms and large arrays of potential victims—i.e., crimes that I describe as having “malleable harms.” Such crimes include most “white collar” offenses.

For classic, long-established mala in se crimes like murder, rape, robbery, or assault, we have well-developed intuitions about harm and punishment tied to the real, natural persons whom we know to be victims.¹⁴ These intuitions are important

¹³ Criminal prosecutions are just one component of an extensive enforcement framework that targets health care fraud. It would be difficult to overstate the significant role played by administrative and civil tools, such as the civil False Claims Act and the so-called “Stark Law” (a limitation on referrals of Medicare and Medicaid patients to providers who have a financial relationship with the referring physician), in curbing health care fraud and in recovering billions of dollars annually for the government. *See generally* Pamela H. Bucy, *Growing Pains: Using the False Claims Act to Combat Health Care Fraud*, 51 ALA. L. REV. 57, 58 (1999) (discussing the penalties under the False Claims Act) (“The statutorily set damages and penalties are formidable: treble damages plus a mandatory penalty of \$5,000 to \$10,000 per false claim. This mounts up. Between 1986 . . . and 1998, total fraud recoveries as a result of FCA actions filed by private persons have exceeded \$2.085 billion.” (citations omitted)); Pamela H. Bucy, *Civil Prosecution of Health Care Fraud*, 30 WAKE FOREST L. REV. 693, 694 (1995) (“[C]riminal prosecution may not be the best deterrent. . . . [P]owerful civil and administrative remedies are needed.”); David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust “Reposed in the Workmen,”* 30 J. LEGAL STUD. 531, 536 (2001) (stating that statutory penalties from causes of action arising from the False Claims Act “quickly rise to staggering levels,” and that “[i]n one recent case, a provider accused of receiving an overpayment of \$245,392 was sued for statutory penalties of \$81 million”); Joan H. Krause, *A Conceptual Model of Health Care Fraud Enforcement*, 12 J.L. & POL’Y 55 (2004) (discussing the False Claims Act and Stark Law’s effect on health care providers). The scope of this Article, however, is limited to the criminal side of health care fraud enforcement—to an analysis of how the unique forces and frameworks within the criminal justice system, as well as the day-to-day practices that are a part of its bureaucracy, influence the treatment of patient harms in criminal cases and of the resulting consequences for criminal justice. It bears noting, however, that civil mechanisms have the potential to play a larger, more significant role in helping to *compensate* patients who suffer harm as a result of health care fraud, an idea that has been explored in the writings of Professor Joan Krause. *See* Joan H. Krause, *Can Health Law Truly Become Patient Centered?*, 45 WAKE FOREST L. REV. 1489, 1496, 1498 (2010); Joan H. Krause, *A Patient-Centered Approach to Health Care Fraud Recovery*, 96 J. CRIM. L. & CRIMINOLOGY 579, 595–608 (2006) [hereinafter Krause, *Patient-Centered Approach*].

¹⁴ *See* Alice Ristroph, *Criminal Law in the Shadow of Violence*, 62 ALA. L. REV. 571, 576–84 (2011); Paul H. Robinson & Robert Kurzban, *Concordance and Conflict in Intuitions*

because they help us formulate punishments that are proportional and closer to the ideal of “just deserts.”¹⁵ But for crimes with malleable harms, such as those involving a fraudulent health care scheme or even a Ponzi scheme, our intuitions tend to be far less grounded. We may be inclined to punish a Ponzi schemer who swindles an elderly grandmother out of \$200,000 in life savings far more severely than one who fraudulently obtains double that amount from a large corporation, barely affecting its bottom line. Punishment intuitions tend to seesaw based on a variety of factors, including the nature of the harm and whether the victim is a person, a corporate entity, or the government. These pathologies are worse at the federal level, where the widespread use of fraud charges often represents more of a jurisdictional hook than the true gravamen of the wrong.¹⁶ The result is that federal agents and prosecutors wield enormous power to shape our intuitions about such crimes through their selection of harms and victims.¹⁷

The scholarly literature on prosecutorial discretion has focused mostly on the selection of crimes and on the punishment of criminals. For instance, much has been written on prosecutors’ control over charging decisions,¹⁸ their ability to induce guilty pleas,¹⁹ and the extraordinary influence that prosecutors have over sentencing.²⁰ But the criminals we choose to prosecute and punish are on just one

of Justice, 91 MINN. L. REV. 1829, 1891 (2007).

¹⁵ See Paul H. Robinson & John M. Darley, *Intuitions of Justice: Implications for Criminal Law and Justice Policy*, 81 S. CAL. L. REV. 1, 38–41 (2007).

¹⁶ Perhaps the most famous example of a pretextual prosecution is the federal case against Al Capone, who was ultimately charged with tax evasion, not murder or the illegal sale of alcohol. For background and analysis of the prosecution against Capone, see Daniel C. Richman & William J. Stuntz, *Al Capone’s Revenge: An Essay on the Political Economy of Pretextual Prosecution*, 105 COLUM. L. REV. 583 (2005) (suggesting that federal courts could help ameliorate pretextual prosecutions with proper jurisdictional and statutory interpretation doctrines).

¹⁷ See generally Daniel Richman, *Prosecutors and Their Agents, Agents and Their Prosecutors*, 103 COLUM. L. REV. 749 (2003) (describing ways in which prosecutors and law enforcement agents and officers work together on criminal investigations).

¹⁸ See, e.g., Sara Sun Beale, *The Many Faces of Overcriminalization: From Morals and Mattress Tags to Overfederalization*, 54 AM. U. L. REV. 747, 757–58 (2005); Josh Bowers, *Legal Guilt, Normative Innocence, and the Equitable Decision Not to Prosecute*, 110 COLUM. L. REV. 1655, 1656–63 (2010); John C. Coffee, Jr., *Does “Unlawful” Mean “Criminal”? Reflections on the Disappearing Tort/Crime Distinction in American Law*, 71 B.U. L. REV. 193, 201–05 (1991); Daniel S. Medwed, *Emotionally Charged: The Prosecutorial Charging Decision and the Innocence Revolution*, 31 CARDOZO L. REV. 2187, 2188–91 (2010); William J. Stuntz, *The Pathological Politics of Criminal Law*, 100 MICH. L. REV. 505, 546–72 (2001).

¹⁹ See, e.g., Stephanos Bibas, *Regulating the Plea-Bargaining Market: From Caveat Emptor to Consumer Protection*, 99 CALIF. L. REV. 1117, 1131 (2011); Alafair S. Burke, *Prosecutorial Passion, Cognitive Bias, and Plea Bargaining*, 91 MARQ. L. REV. 183, 184 (2007).

²⁰ See, e.g., Rachel E. Barkow, *Sentencing Guidelines at the Crossroads of Politics and Expertise*, 160 U. PA. L. REV. 1599, 1622–25 (2012); Richard A. Bierschbach & Stephanos Bibas, *Notice-and-Comment Sentencing*, 97 MINN. L. REV. 1, 2–8 (2012); Sonja B. Starr &

side of the coin. On the other side are the individuals harmed by crime—the *victims*. Somewhat surprisingly, questions about how the criminal justice bureaucracy identifies and selects the victims and harms that populate such cases are absent in the literature.

This Article is the first to excavate the structures and hidden levers of power within the machinery of the federal criminal justice system for the purpose of showing how agents and prosecutors select specific harms and victims in complex cases and, perhaps more importantly, what drives their decisions. By focusing on the shaping of health care fraud, I show how largely arbitrary features of statutory frameworks and sentencing guidelines can influence agents' and prosecutors' decisions about which harms to focus upon, often in unintended ways that merit greater scrutiny. Internal dynamics within the criminal justice bureaucracy, including those driven by governmental interests as well as the interests of the agents and prosecutors themselves, also play a role. All of these factors have contributed to the prevailing tendency to treat health care fraud as just another flavor of fraud against the government or private insurers. This has caused the harms suffered by patients to be minimized, overlooked, or ignored.

A final objective of this Article is to show the phenomenon of missing victims in health care fraud raises deeper questions about the machinery of criminal justice. Who are the clients and constituencies of prosecutors? Are we misusing scarce criminal resources to benefit rich and powerful entities that could or should be availing themselves of civil or other regulatory mechanisms? Do we need a more fundamental reorientation of criminal law that centers upon the harms suffered by individual victims, real people who cannot stand up for themselves? At a fundamental level, there is reason to question whether our system of criminal justice should be recalibrated to achieve what may be its most basic and legitimate purpose—preventing people from causing harm to other people.²¹

Part II places the discussion in context by endeavoring to describe criminal health care fraud and the various kinds of harm that flow from it. Part III explores how and why patient harms get relegated to the periphery. It anchors the discussion first by describing the extraordinary discretion and power of criminal justice insiders to shape the malleable harms of complex criminal cases.²² It then excavates the federal criminal justice bureaucracy to identify the external frameworks and internal forces that influence the day-to-day practices of the agents and prosecutors who handle cases of health care fraud. Part IV describes previously unexplored consequences of omitting patient harms from cases of health care fraud, including

M. Marit Rehavi, *Mandatory Sentencing and Racial Disparity: Assessing the Role of Prosecutors and the Effects of Booker*, 123 YALE L.J. 2, 13–15 (2013).

²¹ See LARRY ALEXANDER & KIMBERLY KESSLER FERZAN, *CRIME AND CULPABILITY: A THEORY OF CRIMINAL LAW* 3 (2009) (explaining that, “[u]ltimately, what underlies the criminal law is a concern with harms that people suffer and other people cause”).

²² Professor Stephanos Bibas has described those individuals who act within the criminal justice system as “insiders” who greatly influence its processes and outcomes. See Stephanos Bibas, *Transparency and Participation in Criminal Procedure*, 81 N.Y.U. L. REV. 911, 911–18 (2006).

with respect to the rights of patient-victims, the punishment of offenders, and the social meaning of the crime itself. It argues that the omission of patient harms causes health care fraud to be viewed as less morally blameworthy than it would otherwise be seen, which hampers the overall efficacy of law enforcement efforts to prevent it. Finally, Part V begins by proposing a set of reforms to relevant statutes, sentencing guidelines, and bureaucratic structures. Some constitute relatively minor adjustments to existing frameworks while others call for more systemic changes in how health care fraud is investigated and prosecuted. It then concludes by addressing broader normative implications.

II. THE HARMS OF CRIMINAL HEALTH CARE FRAUD

This Article uses the term “criminal health care fraud” to describe a range of health care crimes that involve knowing misrepresentations or concealments of the truth that are generally intended to deceive victims into parting with their money or property—in other words, health care crimes that include traditional elements of *fraud*.²³ As used here, the term does not apply to those crimes that target abuses within the health care system but are not rooted in fraud. For example, in 1996, Congress enacted statutes that punish acts of theft or embezzlement from health care benefit programs, false statements that relate to health care matters (but that are not necessarily part of a fraudulent scheme), and the obstruction of criminal health care investigations.²⁴ While it is true that such crimes are sometimes described as being part of the broader apparatus that targets health care fraud,²⁵ the conduct that they proscribe does not normally qualify as “criminal health care fraud” under this Article’s narrower, more literal interpretation of the term. This is so in part for the sake of clarity, and in part because, as explained below, the term has already been stretched to cover an exceedingly large patchwork of crimes.²⁶

²³ In criminal health care fraud cases involving kickbacks, however, the theory of fraud, which was first upheld by courts in 1941, is premised not on an intent to deceive victims into parting with money or property, but rather to deprive them of “the intangible right of honest services.” *See Skilling v. United States*, 561 U.S. 358, 402–05 (2010) (reviewing the history of the intangible rights theory of fraud).

²⁴ *See* 18 U.S.C. § 669 (2012) (theft or embezzlement in connection with health care); *id.* § 1035 (false statements relating to health care matters); *id.* § 1518 (obstruction of criminal investigations of health care offenses).

²⁵ *See, e.g.*, Tim Drake et al., *Health Care Fraud*, 50 AM. CRIM. L. REV. 1131, 1173 (2013) (including theft, embezzlement, false statements, racketeering, and obstruction offenses in an analysis of statutes that target health care fraud).

²⁶ So-called off-label marketing, in which a drug manufacturer promotes a prescription drug for a use that has not been approved by the Food and Drug Administration (FDA), is another type of misconduct often described as health care fraud. Such cases have resulted in eye-popping financial recoveries in recent years. *See, e.g.*, David Sell, *Glaxo Fined a Record \$3 Billion*, PHILA. INQUIRER, July 3, 2012, at A1; Katie Thomas, *J.&J. to Pay \$2.2 Billion in Risperdal Settlement*, N.Y. TIMES, Nov. 5, 2013, at B1. However, because off-label marketing is rooted more in the FDA’s marketing and labeling regulations than it is in fraud, it is beyond the scope of this Article.

The fact that modern prosecutors use a multitude of statutes to charge health care fraud is consistent with the history of health care prosecutions during most of the last century. In a review of all reported prosecutions of health care providers between 1908 and 1988, one scholar found thirty different statutes were used to prosecute health care providers in federal courts and twenty statutes were employed in state courts.²⁷ Even if the number of statutes used today is not quite as large, prosecutors continue to employ a significant array of criminal laws to charge health care fraud. They use broad federal laws (health care fraud, mail fraud, wire fraud, and conspiracy statutes)²⁸ in cases where public and private health care benefit programs have been victimized. In the subset of cases where only government programs, such as Medicare, have been targeted, prosecutors can select from a set of federal statutes with narrower applicability (Medicare and Medicaid fraud, anti-kickback, and criminal false claims statutes).²⁹ There are also a considerable number of state laws, largely analogous to the federal statutes, available for prosecutors to use in state courts. Because health care fraud is prosecuted primarily in federal courts under federal statutes, this Article focuses on the federal statutes and federal law enforcement.

It is useful to examine the language and features of these different statutes because together they set the parameters for what specific conduct will normally fall within the realm of criminal health care fraud. A good starting point is the federal health care fraud statute, 18 U.S.C. § 1347, which has emerged as one of the laws that prosecutors use most frequently.³⁰ Enacted by Congress less than two decades ago as part of HIPAA, § 1347 criminalizes the knowing and willful execution, or attempted execution, of any scheme to defraud a health care benefit program, if the scheme relates to the delivery of or payment for health care benefits, items, or services.³¹ “Health care benefit programs” are defined elsewhere to include public plans, such as Medicare, as well as plans offered by private insurers.³² The decidedly broad language of § 1347 appears to reflect a congressional intent to cover most, if not all, of the different kinds of schemes that might be used, now or in the future, to defraud health care benefit programs.³³

²⁷ Pamela H. Bucy, *Fraud by Fright: White Collar Crime by Health Care Providers*, 67 N.C. L. REV. 855, 883 (1989).

²⁸ 18 U.S.C. § 1341 (2012) (mail fraud); *id.* § 1343 (wire fraud); *id.* § 1347 (health care fraud); *id.* § 1349 (conspiracy).

²⁹ 42 U.S.C. § 1320a-7b(a) (2012) (Medicare and Medicaid fraud); *id.* § 1320a-7b(b) (Medicare and Medicaid anti-kickback); 18 U.S.C. § 287 (criminal False Claims Act).

³⁰ *Health Care Fraud Prosecutions for 2011*, TRAC REPORTS (Aug. 17, 2011), <http://trac.syr.edu/tracreports/crim/258>, archived at <http://perma.cc/PA6S-EGHK> [hereinafter TRAC REPORTS].

³¹ 18 U.S.C. § 1347(a).

³² *Id.* § 24(b).

³³ See *United States v. Lucien*, 347 F.3d 45, 51 (2d Cir. 2003) (“The broad language of § 1347 shows that Congress intended for this statute to include within its scope a wide range of conduct so that all forms of health care fraud would be proscribed, regardless of the kind of specific schemes unscrupulous persons may concoct.”).

Much of the basic structure and language of § 1347 mirrors the federal mail fraud and wire fraud statutes,³⁴ which are also widely known for the vast breadth of conduct they can be used to prosecute.³⁵ At a basic level, all three statutes criminalize the intentional use of fraudulent schemes to deceive others out of money or property.³⁶ Because nearly all modern health care fraud schemes call for the use of at least some mailings or interstate wire transfers for the submission of claims or for the processing of payments, it is rare that a case charged under § 1347 could not have also been charged under the mail fraud or wire fraud statutes.

It does not come as much of a surprise, then, that for most of the twentieth century, the mail fraud statute was the most frequently used federal law to prosecute health care providers.³⁷ The first successful use of the mail fraud statute in a case of health care fraud appears to have been in 1915, when it was wielded to prosecute a physician in Philadelphia who defrauded patients by falsely diagnosing them with “serious ailments” as a means of inducing “them to part with their money.”³⁸ Even after the enactment of the health care fraud statute in 1996, federal prosecutors continued to use the mail fraud law, sometimes in lieu of § 1347, as a vehicle to bring charges in a significant number of cases alleging health care fraud schemes.³⁹

³⁴ See 18 U.S.C. § 1341 (mail fraud); *id.* § 1343 (wire fraud).

³⁵ Chief Justice Burger described the mail fraud statute as a “stopgap device” that can be used when a new fraud develops until Congress has the opportunity to pass particularized legislation to deal with the new fraud directly. *United States v. Maze*, 414 U.S. 395, 405–06 (1974) (Burger, C.J., dissenting).

³⁶ Where the statutes differ from one another is mostly with respect to their distinct jurisdictional hooks. The wire fraud statute requires that execution of the scheme involve the use of an interstate wire transmission, the mail fraud statute requires the use of a mailing, and the health care fraud statute requires the targeted benefit program be one that affects commerce. See 18 U.S.C. §§ 24(b), 1341, 1343.

³⁷ Bucy, *supra* note 27, at 882–83 (reporting that 18 U.S.C. § 1341, which regulates mail fraud, was the statute most commonly used to prosecute health care providers between 1908 and 1988).

³⁸ *United States v. Smith*, 222 F. 165, 166 (E.D. Pa. 1915). This early health care fraud case was prosecuted by the United States Attorney’s Office for the Eastern District of Pennsylvania. I served in the same office as an Assistant U.S. Attorney for over six years in a section tasked with prosecuting health care fraud, an experience that provided helpful insights for this Article.

³⁹ TRAC REPORTS, *supra* note 30. Data from the Department of Justice shows that over the past ten years mail fraud has been the lead charge in nearly as many health care fraud prosecutions as § 1347. *Id.* Some of these earlier charging decisions may have been influenced in part by concerns over whether the phrase “knowingly and willfully” in the health care fraud statute, a term not present in the mail fraud and wire fraud statutes, gave rise to a “specific intent” requirement. *Cf.* Katrice Bridges Copeland, *Enforcing Integrity*, 87 IND. L.J. 1033, 1047 (2012) (noting the circuit split over whether Congress’s use of “knowingly and willfully” in the Medicare and Medicaid Anti-Kickback statute, 42 U.S.C. § 1320a-7b(b), required “specific intent” to violate the law). The Affordable Care Act put any such concerns to rest, however, by amending § 1347 to make clear that “a defendant does not have to have actual knowledge of [§ 1347], or specific intent to commit a violation of [it].” *Id.* (citations omitted).

Among the narrower statutes used by prosecutors is the criminal False Claims Act, which prohibits the knowing presentation of a false claim to any department of the United States.⁴⁰ The False Claims Act applies to fraudulent claims for reimbursement made to government benefit programs, such as Medicare, but not to those submitted to private benefit plans.⁴¹ Fraud against the government can also be charged under the Medicare and Medicaid fraud statute, which criminalizes, among other things, the knowing and willful misrepresentation of material facts in any application for payment under a federal health care program.⁴² Finally, the Medicare and Medicaid anti-kickback statute punishes those who offer, solicit, pay, or accept money or something of value, in exchange for the referral of a patient for services or items that are paid for by a government health care program.⁴³ Despite the availability of these narrower government fraud statutes, criminal prosecutors often select from the broader fraud laws even in cases when the defrauded benefit programs all qualify as federal,⁴⁴ perhaps owing in part to the more severe penalties faced by defendants at sentencing under the health care fraud, mail fraud, and wire fraud statutes.⁴⁵

A. Common Behaviors

Beyond their overlapping elements, the above-described laws are also similar because they say very little about the actual behaviors that might rise to the level of a *material* misrepresentation or form the basis of a *fraudulent* health care scheme. This is a longstanding problem in defining offenses rooted in fraud.⁴⁶ As one Civil

⁴⁰ 18 U.S.C. § 287.

⁴¹ *Id.*

⁴² 42 U.S.C. § 1320a-7b(a)(1) (2012).

⁴³ *Id.* § 1320a-7b(b)(1).

⁴⁴ Pamela H. Bucy, *Crimes by Health Care Providers*, 1996 U. ILL. L. REV. 589, 591–92. There is a notable exception with respect to cases involving kickbacks: prosecutors favor the Medicare and Medicaid anti-kickback statute over the broader fraud laws. James G. Sheehan & Jesse A. Goldner, *Beyond the Anti-Kickback Statute: New Entities, New Theories in Healthcare Fraud Prosecutions*, 40 J. HEALTH L. 167, 167–68 (2007) (“Kickbacks, understood as improper payments to obtain referrals of business or favorable treatment, have been prosecuted as healthcare fraud violations since the early 1970s. Until recently, prosecutions have been based almost entirely on the Medicare-Medicaid Anti-Kickback Statute” (citations omitted)). This is so even though Congress made clear, through the enactment of 18 U.S.C. § 1346, that the reach of the generic fraud laws extends to schemes depriving others of the intangible right to honest services—understood to mean services free of kickbacks and bribes. *Skilling v. United States*, 561 U.S. 358, 408–09 (2010).

⁴⁵ For example, the twenty-year maximum period of imprisonment permitted by the wire fraud statute is four times as high as the five-year maximum offered by the criminal False Claims Act and the Medicare and Medicaid fraud statute. *See* 18 U.S.C. § 287 (criminal False Claims Act: five-year maximum); *id.* § 1341 (mail fraud: one-year maximum); *id.* § 1343 (wire fraud: twenty-year maximum); 42 U.S.C. § 1320a-7b(a) (Medicare and Medicaid fraud: five-year maximum).

⁴⁶ *See* Samuel W. Buell, *Novel Criminal Fraud*, 81 N.Y.U. L. REV. 1971, 1988–92

War era judge observed, fraud is a term that “admits of no positive definition, and cannot be controlled in its application by fixed and rigid rules,” but must instead “be inferred or not, according to the special circumstances of every case.”⁴⁷ An attempt to identify and delineate all behaviors that qualify as fraud under the law seems destined to fail, in part because new behaviors are likely to arise or be conceived over time.⁴⁸

As Professor Samuel Buell has explained in his work examining the meaning of criminal fraud, developing an answer to the question “[w]hat is fraud?” requires that we study the facts of individual economic encounters in an effort to isolate and identify what qualifies as an impermissibly deceptive practice.⁴⁹ Such an approach seems especially likely to bear fruit in the context of criminal health care fraud, which normally occurs in an environment with a high volume of economic encounters between parties who interact with one another regularly and repeatedly within a highly regulated system. Under such circumstances, one would expect it to be relatively easy to identify which kinds of economic encounters stand out as impermissibly deceptive.

Indeed, a review of prosecutions and reports from law enforcement shows a limited set of behaviors—when coupled with an intent to defraud—have emerged to form the basis of most of the health care fraud schemes prosecuted today.⁵⁰ They can be grouped into seven different categories, described below. The first six all involve fraudulent billings for health care services or items, and the seventh relates to the use of kickbacks:

1. *No services or items provided*: even though a bill claims the provision of services (e.g., a medical exam) or items (e.g., an oxygen tank) to a patient, no service or item was actually provided to the patient;
2. *Medically unnecessary services or items provided*: a bill claims reimbursement for services or items that were provided to a patient even though the patient had no medical need for the services or items (e.g., a bill for unnecessary medicine or tests provided after a doctor purposely renders a false diagnosis);
3. *Excessive services or items provided*: a bill claims reimbursement for services or items that were provided to a patient with some but not sufficient medical needs to justify provision of the services or items (e.g.,

(2006) (describing a series of historical accounts of fraud’s “chameleon-like quality” that extend as far back as the Elizabethan era).

⁴⁷ *Fenner v. Dickey*, 8 F. Cas. 1138, 1139 (C.C.N.D. Ohio 1861) (No. 4729).

⁴⁸ Samuel W. Buell, *What Is Securities Fraud?*, 61 DUKE L.J. 511, 520 (2011). Professor Buell observes that “[t]his need for flexibility in the definition of fraud arises because fraud involves a category of human wrongdoing that is characterized by inventiveness and that is often situated within realms of economics, technology, and industry that are sites of rapid social and economic development.” *Id.* It is difficult to think of a sector today with more sites of rapid development in those areas than the health care sector.

⁴⁹ Buell, *supra* note 46, at 1973.

⁵⁰ *E.g.*, *Financial Crimes Report 2010–2011*, *supra* note 11.

a bill for daily medical office visits when monthly visits would have been adequate);

4. *Upcoding*: a service or item was provided to a patient, but the bill was submitted with the wrong procedure or item code, resulting in payment that is higher than what would have been paid if the correct code had been used;
5. *Duplicate claims*: a service or item was provided to a patient, but two separate bills for the same service/item were submitted, one of which was altered in some way (e.g., by changing the date of service) to evade detection of the double payment;
6. *Unbundling*: billing rules require that a reimbursement claim for a set of procedures or tests (e.g., tests performed on a blood sample) be submitted in a single bill, but multiple bills were submitted to obtain higher payment (e.g., multiple bills falsely claimed tests were performed separately on different dates); and
7. *Kickbacks*: offender pays or accepts money, or something of value, in exchange for the referral of a patient for health care services (e.g., laboratory owner pays \$50 to doctor for each Medicare patient a doctor sends to laboratory for testing).

Some cases of criminal health care fraud involve just one of the above behaviors, and others involve multiple groupings of them in different combinations. While novel schemes will undoubtedly arise and become more prevalent over time, familiarity with these behaviors provides a rich, if not complete, understanding of what it generally means to commit criminal health care fraud today.

B. Categories of Harm

The behaviors that form the basis for criminal health care fraud cause a variety of harms to those who participate in the health care system. Those who make payments premised upon fraudulent health care billings suffer direct *economic* harms. When the schemes behind fraudulent billings have an impact on the medical services provided to patients, those patients can suffer direct *physical* harms. And because of the myriad consequences that flow from decisions about the provision of health care, criminal health care fraud can also result in an assortment of *miscellaneous* harms and consequences to patients. Each of these three categories is discussed below.

1. Economic Harms

The most readily apparent economic harm from health care fraud occurs when payments for the reimbursement of health care goods and services are premised upon claims that are fraudulent. The dollar amounts of those financial losses can be staggering. If, as some estimates suggest, health care fraud accounts for somewhere

between 3% and 10% of all national health expenditures,⁵¹ then it would be projected to account for a colossal \$93 billion to \$309 billion of the nation's anticipated spending on health care in 2014.⁵² Yet, if history is a guide, nowhere close to that amount will actually be detected and identified as fraudulent, and of the health care fraud that ultimately is identified, only a subset will be attributed to *criminal* behavior. Despite that, the amount of economic harm suffered by victims of criminal health care fraud that *is* recognized remains enormous, numbering billions of dollars annually.⁵³

To ascertain which parties bear the brunt of those losses, we need to look at who actually pays the nation's health care bills. However, doing so is more complicated than one might expect. A defining characteristic of health care financing in the United States is its complexity, much of which arises from the fact that payments flow through multiple third-party insurers and payers. Each has its own rules governing the submission of claims and different policies for determining what services and items qualify for reimbursement. Further complicating matters, many bills, including fraudulent ones, are paid in part by patients themselves through deductible and copayment structures.

Despite the complexities of health care financing, it is not difficult to identify the parties that pay the greatest amounts for health care and the approximate portions they pay. For example, spending data shows the federal government pays for the largest part of the nation's collective health insurance bill. In 2012 the federal government, through public programs such as Medicare, Medicaid, and smaller health plans and contracts, made expenditures totaling over 45% of the \$2 trillion spent on health insurance.⁵⁴ Medicare spending alone accounted for over \$572 billion.⁵⁵ On top of that, state and local governments spent over \$187 billion on health insurance.⁵⁶

⁵¹ *Id.*

⁵² See *National Health Expenditure Projections 2012–2022*, CENTERS FOR MEDICARE & MEDICAID SERVICES 5 tbl.1, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf>, archived at <http://perma.cc/N55C-HHGM> (last visited Apr. 6, 2015) (projecting that national health expenditures will top \$3 trillion in 2014).

⁵³ The FBI and HHS reported that federal health care fraud enforcement efforts led to the collection of approximately \$4.2 billion during fiscal year 2012 with a little under \$1.4 billion attributable to criminal fines. HCF ANNUAL REPORT FOR FY 2012, *supra* note 9, at 1, 5. That amount is a small fraction of the roughly \$84 billion to \$281 billion estimated to have been produced by health care fraud in calendar year 2012. *Financial Crimes Report 2010–2011*, *supra* note 11.

⁵⁴ See *Table 19: National Health Expenditures by Type of Expenditure and Program: Calendar Year 2012*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>, archived at <http://perma.cc/FUU8-4X4J> (last visited Apr. 6, 2015).

⁵⁵ See *id.*

⁵⁶ See *id.*

The dozens of insurers that offer private health care coverage to the majority of U.S. health care consumers and beneficiaries account for the next biggest slice of all health insurance expenditures. These insurers include commercial insurance companies, managed care organizations, the nonprofit Blue Cross and Blue Shield associations, and employers who offer self-insured health plans. In 2012, these private insurers collectively spent over \$916 billion on private health insurance.⁵⁷

Of course, the economic consequences of criminal health care fraud are felt well beyond the parties that suffer them directly. To understand the broader impact of those massive financial losses, it is important to recognize how public and private benefit programs are funded. Taxpayers finance government programs like Medicare, and employers and beneficiaries are responsible for paying the premiums that fund the bulk of private health insurance. As a result, most of the direct economic harms third-party payers and insurers suffer are eventually passed along to taxpayers, employers, and beneficiaries in the form of higher tax burdens, more expensive premiums, and less comprehensive coverage.

Other economic consequences include those associated with the costs of prevention and enforcement that health care fraud makes necessary. Public and private insurers spend considerable sums to prevent and detect fraud through audits and other mechanisms, and the government spends hundreds of millions of dollars annually to support enforcement efforts. For fiscal year 2012, the appropriation of funds for the national Health Care Fraud and Abuse Control Program exceeded \$604 million.⁵⁸

2. *Physical Harms*

Far less examined than the widely reported economic harms of criminal health care fraud are the physical harms (and risks of physical harm) that health care fraud causes patients. The harms can range in seriousness from those resulting in brief moments of discomfort, such as the pinprick sensation from an unnecessary shot of medicine, to those causing serious bodily injury or death. At a fundamental level, all such harms occur when decisions concerning the care and treatment of a patient are influenced in some way by a fraudulent scheme. However, just as there are specific kinds of behavior that most commonly form the basis for criminal health care fraud, there are recurring types of schemes that have a greater tendency to result in physical harms.

Among the schemes most likely to result in physical harms are those in which an offender attempts to obtain fraudulent reimbursements by providing patients with medical services or items that are completely *unnecessary*. These include the oncologist in the case described in the Introduction who rendered false cancer diagnoses so that he could prescribe chemotherapy for patients who did not need it.⁵⁹ Beyond prescribing unnecessary medicine, offenders sometimes harm patients by

⁵⁷ *See id.*

⁵⁸ HCF ANNUAL REPORT FOR FY 2012, *supra* note 9, at 7.

⁵⁹ *See supra* notes 1–7 and accompanying text.

performing unnecessary procedures. For example, a cardiologist performed unnecessary angioplasty and stenting procedures in a case that resulted in serious complications for patients, including blood loss, hematomas, jaundice, and arterial damage.⁶⁰ In a similar case, a dermatologist performed hundreds of unnecessary surgeries on elderly Medicare patients, two of whom suffered serious physical injuries as a result.⁶¹

Some fraudulent schemes are premised on the administration of unnecessary tests, the performance of which can yield significant financial gain for offenders. While one might think unnecessary medical tests, as opposed to medicine or procedures, would pose little risk of physical harm, patients can experience serious side effects even from diagnostic services, as demonstrated in a recent case involving a family practice physician who administered nuclear cardiac stress tests to her patients repeatedly, even after the patients' initial test results came back normal, exposing them to dangerously high levels of radiation amounting to the equivalent of at least 80 to 120 chest x-rays per test.⁶² Unnecessary testing can also be harmful because test results will in some cases return false positives, which in addition to producing unnecessary anxiety can cause patients to undergo increasingly invasive testing and procedures.

When offenders fabricate test results, falsify diagnoses, or alter medical records to make it falsely appear that treatments or services are medically appropriate, patients face risks of harm beyond those associated with the unnecessary treatments or services themselves. A patient's health may be jeopardized, for example, if a future medical provider renders a diagnosis or devises a treatment based on false information previously entered into a patient's medical chart as part of a fraudulent scheme.⁶³

Another significant category of cases involves those in which patients have a legitimate medical need for medicine, but do not receive appropriate amounts of it as a result of the offender's scheme. For example, offenders have sought to personally enrich themselves by giving patients inappropriately low or diluted

⁶⁰ Brief for the United States at 11, *United States v. Patel*, 485 F. App'x 702 (5th Cir. 2012) (No. 09-30490), 2011 WL 3287924, at *15.

⁶¹ See *United States v. Rosin*, 263 F. App'x 16, 25 (11th Cir. 2008) (noting that the defendant's former employees testified that he had falsely diagnosed cancer on biopsy slides in which skin tissue had been replaced with gum and Styrofoam).

⁶² See Press Release, U.S. Attorney's Office, E. Dist. of Mich., Southfield Family Practice Doctor, Dr. Gwendolyn Washington, Sentenced to 120 Months for Public Corruption, Illegal Prescription Drug Trafficking and Health Care Fraud (Nov. 28, 2011), available at http://www.justice.gov/usao/mie/news/2011/2011_11_28_gwashington.html, archived at <http://perma.cc/DWH2-6UAX>.

⁶³ See, e.g., *United States v. Sriram*, No. 00 CR 0894, 2003 WL 22532800, at *8-9 (N.D. Ill. Nov. 6, 2003) (finding that a defendant convicted of health care fraud created a serious risk of physical injury to his patients by creating false medical records that could cause patients to be misdiagnosed and given inappropriate medical treatment based on inaccurate medical history).

amounts of medicine while billing insurers for the full amounts.⁶⁴ In other cases, offenders have given patients toxically high doses of medicine in furtherance of their schemes.⁶⁵ Many offenders have sought financial gain by exploiting the addictive properties of some drugs (especially pain medicines) to exacerbate substance abuse in their patients, causing them to come in for frequent appointments to refill prescriptions and receive additional services.⁶⁶

Sometimes risks of harm come not from the amounts of medicine but from the quality of the medicine or items provided to a patient as a result of a fraudulent scheme.⁶⁷ In other cases, the problem arises less from the quality of the medicine

⁶⁴ See, e.g., *United States v. Moon*, 513 F.3d 527, 533 (6th Cir. 2008) (stating that an oncologist instructed employees to “short” medication to cancer patients); *United States v. Silber*, No. 09-20223, 2010 WL 5174588, at *2 (E.D. Mich. Dec. 15, 2010) (finding that asthma and arthritis patients were administered diluted doses of medication at clinic); Press Release, U.S. Attorney’s Office, Cent. Dist. of Cal., Doctor Who Pleaded Guilty to Health Care Fraud for Giving AIDS and HIV Patients Diluted Medications Sentenced to 15 Months in Federal Prison (Feb. 22, 2010), available at <http://www.justice.gov/usao/cac/Pressroom/pr2010/036.html>, archived at <http://perma.cc/SK98-TTCT> (finding that a guilty doctor subdosed AIDS and HIV patients by sometimes providing the patients with saline, while submitting bills for full doses of medication).

⁶⁵ See, e.g., *United States v. Valdez*, 726 F.3d 684, 693 (5th Cir. 2013) (citing a presentence investigation report finding that employees of offender’s pain management clinic told patients that their prescriptions for pain medicine would not be filled unless the patients agreed to be injected with additional, unnecessary medicine that risked causing pain, numbness, weakness, and permanent nerve damage); Government’s Motion for an Upward Departure from Advisory Sentence and Supporting Memorandum of Law at 3–4, *United States v. Achille*, No. 06-20496-CR-MOORE (S.D. Fla. Mar. 5, 2007) (citing trial testimony of a medical expert who stated that high doses of prescribed AIDS medications, which received high payments from Medicare, were toxic, potentially resulting in hair loss, neuropathy, paralysis, walking impairments, and death).

⁶⁶ See, e.g., *United States v. Schneider*, 704 F.3d 1287, 1296–97 (10th Cir. 2013) (holding that there was sufficient evidence to find that a doctor and nurse executed a fraudulent scheme to provide patients with pain management treatments that did not constitute legitimate medical services and resulted in death of three patients); *United States v. Webb*, 655 F.3d 1238, 1258 (11th Cir. 2011) (holding that there was “overwhelming evidence” of a doctor’s fraudulent scheme involving prescribing pain medications for other than legitimate medical purposes, which caused death of at least one patient); *United States v. Martinez*, 588 F.3d 301, 307, 327 (6th Cir. 2009) (citing evidence establishing that an anesthesiologist who operated a pain-management clinic provided at-risk patients with treatments that left them dependent on him for pain-suppressant prescriptions and that resulted in the death of two patients); *United States v. Hill*, 254 F. App’x 405, 405 (5th Cir. 2007) (citing the sentencing court’s finding of facts, which established that the physician dispensed addictive painkillers to his patients as part of a health care fraud scheme); *United States v. Sidhu*, 130 F.3d 644, 655 (5th Cir. 1997) (holding that a psychiatrist specializing in addiction and pain management “preyed upon vulnerable patients by addicting them to morphine in order to support his fraudulent billing scheme”).

⁶⁷ See, e.g., *United States v. Bradley*, 644 F.3d 1213, 1289 (11th Cir. 2011) (holding that the offender caused physicians to provide recycled blood-derivatives of uncertain quality

than from the competency of the individuals tasked with providing care to patients.⁶⁸ Even when the medicines or treatments provided to a patient do not themselves have harmful side effects, the health of a patient with legitimate medical needs may be compromised by a scheme that causes the patient to forego legitimate, more effective, or safer treatments elsewhere.⁶⁹

Another segment of cases involves schemes that take advantage of the long-term care and nursing needs of the elderly, the disabled, and other vulnerable victims. Offenders in such cases often profit from benefit programs that cover disadvantaged groups, such as Medicaid, by operating residential-care and nursing-home facilities that provide substandard levels of care.⁷⁰

Schemes involving kickbacks can also compromise patient health by causing medical decisions to hinge on a health care provider's personal financial interests, as opposed to the best interests of the patient or sound medical judgment. Patients can receive inadequate treatment as a result. For example, in a recent case involving fraudulent claims totaling over \$205 million, the defendants paid kickbacks to managers of an assisted living facility and halfway house, who in turn sent patients to two healthcare facilities operated by the defendants.⁷¹ The scheme caused

to AIDS and hemophilia patients); *United States v. Richardson*, 117 F. App'x 931, 933 (5th Cir. 2004), *vacated* 544 U.S. 970 (2005) (affirming that patients suffered harm or at least potential harm because they received substandard items, including dirty hospital beds with worn mattresses); Press Release, U.S. Attorney, N. Dist. of Ill., Ringleader Sentenced to Nine Years in Federal Prison for Allergy Testing Health Care Fraud Scheme that Bilked Insurance Companies and Deceived Thousands of Patients (June 29, 2009), *available at* http://www.justice.gov/usao/iln/pr/chicago/2009/pr0629_01.pdf, *archived at* <http://perma.cc/LM6A-DY7E> (finding that allergy shots administered to over 800 patients were prepared in unsanitary conditions by individuals not licensed or qualified to prepare them).

⁶⁸ *See, e.g.*, *United States v. Bonham*, No. 97-10786, 1999 WL 511349, at *2-4 (5th Cir. June 22, 1999) (holding that a psychiatrist billed for services under his own name when, in reality, psychiatric services were provided by individuals not licensed in psychiatry).

⁶⁹ *See, e.g.*, *United States v. Bachynsky*, 949 F.2d 722, 735 (5th Cir. 1991) (holding that patients at weight loss and smoking cessation centers qualified as victims in part because they may have foregone legitimate treatments while relying on the offender's ineffective courses of treatment); Government's Memorandum in Aid of Sentencing at 2-3, *United States v. Willner*, 11-CR-20100-SEITZ (S.D. Fla. Sept. 20, 2012) (arguing that \$205 million Medicare fraud involving a program for patients suffering from dementia, Alzheimer's disease, and other conditions was exacerbated by the fact that patients who may have needed partial hospitalization treatments did not receive them at the illegitimate program prescribed by the offender).

⁷⁰ *See, e.g.*, *United States v. Fake*, 269 F. App'x 208, 210-12 (3d Cir. 2008) (holding that the operator of residential home for care-dependent and elderly individuals engaged in a scheme that resulted in bodily harm to as many as ten patients through acts of neglect and abuse that included failing to provide adequate food to patients, refusing to provide medical care, and failing to clean patients or provide sanitary living conditions); *United States v. Bolden*, 325 F.3d 471, 480-83, 500 (4th Cir. 2003) (finding that a husband and wife operated a nursing facility as part of an elaborate Medicaid scheme that caused residents of the facility to receive inadequate care).

⁷¹ *United States v. Negron*, 517 F. App'x 692, 692-94 (11th Cir. 2013).

approximately 7,500 patients, most of whom were mentally ill, elderly, or addicted to drugs, to be “forcibly shuffled” through the facilities where they “rarely met with doctors” and received either improper treatment or no treatment at all.⁷²

Anecdotal evidence can help illustrate the kinds of physical harms that result from criminal health care fraud and the different ways in which such harms arise, but it cannot speak meaningfully about their prevalence. Why does this Article suggest that incidents of patient harm are “substantial?” How often do fraudulent schemes actually put patients at risk of harm? These are not questions that lend themselves to empirical study. No record is created when an investigator decides not to investigate patient harms or when a prosecutor decides not to reference them in an indictment or in a sentencing memorandum. However, I use the term “substantial” for two reasons. First, I draw upon insights from my own experience working over seven years as a federal prosecutor, six years of which were spent in a unit tasked with prosecuting health care fraud. It is from that experience that I first began noticing the not uncommon tendency for potential patient harms to be minimized, overlooked, or ignored. Second, I rely on the large segment of reported health care fraud cases from across the country that describe schemes involving obvious risks to patient health and safety but that seem to give little, if any, meaningful weight to those risks, such as many of the cases that I cited and described above. The reasons these kinds of patient harms tend not to be recognized are explored in Part III of this Article.

3. *Miscellaneous Harms and Consequences*

In addition to harms that are economic or physical in nature, criminal health care fraud can give rise to a variety of other, less tangible harms and consequences to patients. They are diverse in character, but many relate to the tremendous power that providers of health care can have over the daily lives of their patients. When providers abuse that power to further a fraudulent scheme, they can disrupt the lives of patients dramatically.

One kind of disruption relates to the mental distress that fraudulent schemes can cause patients, some of whom are especially vulnerable at the time of a scheme’s commission due to their medical conditions. From the fears and anxieties that may arise from false diagnoses to the feelings of anger and resentment that may stem from betrayals of trust, victimized patients can experience severe emotional distress from criminal health care fraud, anguish that can serve to compound the negative impact of other economic and physical harms. The experience of victimization may also discourage some patients from seeking necessary medical care in the future.

Fraudulent schemes can also cause distress to patients’ daily lives, impacting their ability to function and meet obligations at home and work. When a physician prescribes unnecessary physical therapy in furtherance of a health care scheme, for

⁷² Brief for the United States at 51–53, 68, *Negron*, 517 F. App’x 692 (No. 11-16125) (internal quotation marks omitted) (citing undisputed facts from the presentence investigation report).

example, patients may come to waste substantial amounts of time and effort participating in unneeded therapy sessions.⁷³ Patients experience even greater disruptions in their lives from unnecessary hospitalizations, especially when a physician causes a patient to be hospitalized involuntarily.⁷⁴

Because the execution of a scheme often involves the creation of false medical records to further the scheme or conceal its existence, other harms may arise in connection with the falsified documents themselves. For example, in a case where a psychiatrist created false records purporting to show that patients had grave mental and emotional problems, the sentencing judge noted the misinformation would likely have an impact on patients' lives in the future, stating "[i]t may determine whether an individual will be given a health insurance policy; it may decide whether he or she will receive government clearance; it may affect a whole host of other situations."⁷⁵

When offenders misuse patients' medical records and personal information in service of their schemes, they also risk causing violations of their patients' privacy.⁷⁶ The submission of a claim for reimbursement can set off a cascade of disclosures regarding an individual's personal health information as part of the regular billing process, and when a claim is submitted without a patient's knowledge and premised on services not rendered, such disclosures themselves serve to breach the patient's privacy interests. The prospect of subsequent investigation of the fraudulent claim by the government or private parties has the potential to result in further disclosures of the patient's personal health information. Even when safeguards are used to limit the impact of such additional disclosures, each diminishes the privacy rights of patients and increases the risk that they will suffer negative consequences as a result. The potential harms include adverse effects on their prospects for future employment, damage to their personal relationships, and possible public embarrassment.

Health care fraud can also harm patients by compromising their ability to get coverage for future health care needs. In one case, unnecessary hospitalizations had exhausted patients' treatment benefits by the time of discharge, including the lifetime benefits of some patients.⁷⁷ While the Affordable Care Act now provides

⁷³ See, e.g., *United States v. Thomas*, 724 F.3d 632, 638 (5th Cir. 2013) (holding that a physician who operated a physical therapy business billed for medically unreasonable and unnecessary physical therapy sessions and sent employees with little or no medical background to the homes of elderly Medicare patients to provide "physical therapy" services).

⁷⁴ See *United States v. Burgos*, 137 F.3d 841, 842, 844 (5th Cir. 1998) (holding that a psychiatrist furthered a fraudulent scheme by causing unnecessary hospitalization of patients for periods ranging from ten days to six months); Brief for the United States, *supra* note 72, at 52–53 (stating that 7,500 patients were forcibly shuffled through and confined at healthcare facilities due to fraudulent scheme).

⁷⁵ *United States v. Skodnek*, 933 F. Supp. 1108, 1121 (D. Mass. 1996).

⁷⁶ See Krause, *Patient-Centered Approach*, *supra* note 13, at 593.

⁷⁷ See *Burgos*, 137 F.3d at 844.

protection to patients by forbidding lifetime limits on certain essential benefits, some benefits still remain subject to annual or lifetime per beneficiary caps on coverage.⁷⁸

Finally, another kind of miscellaneous harm relates to the deprivation of the intangible right to honest services, which occurs as a result of a kickback scheme. While it can sometimes be challenging to describe which parties were impacted by the deprivation of honest services and the ways in which the deprivation impacted them,⁷⁹ the use of kickbacks can generally result in overutilization of health services, increased costs, and, as already described above, inferior quality of treatment for patients.

III. FAILURES TO RECOGNIZE PATIENT HARMS

Despite the diversity of harms caused by health care fraud, including the significant physical harms experienced by patients, criminal cases of health care fraud are widely viewed and treated as white-collar crimes that cause only economic harms.⁸⁰ The prevailing enforcement paradigm involves treating health care fraud like a traditional fraud offense. Federal agents “follow the money.”⁸¹ Federal prosecutors charge offenders with seeking to enrich themselves by deceiving and defrauding victims—generally, private insurers and government benefit programs, such as Medicare. And federal judges fashion sentences using sentencing guidelines driven primarily by the amount of economic loss. Under this model, the government recovers billions of dollars annually.⁸²

⁷⁸ See 42 U.S.C. § 300gg-11 (2012).

⁷⁹ See generally David Mills & Robert Weisberg, *Corrupting the Harm Requirement in White Collar Crime*, 60 STAN. L. REV. 1371 (2008) (discussing the complexities of describing harms arising from the deprivation of the intangible right to honest services).

⁸⁰ See, e.g., BENSON WEINTRAUB & ROBERT DAVID MALOVE, WHITE COLLAR CRIME: HEALTH CARE FRAUD xiv–xv (2013) (“[A] practice guide for white collar practitioners . . . focus[ing] . . . on the salient legal, social, economic, and political issues which are consequences of health care fraud.”); Darryl K. Brown, *Street Crime, Corporate Crime, and the Contingency of Criminal Liability*, 149 U. PA. L. REV. 1295, 1327–28 (2001) (describing health care fraud as a form of “white-collar wrongdoing”); Catharine Goodwin, *The Case for a New Loss Table*, 13 FED. SENT’G REP. 7, 10 (2000) (citing health care fraud as an example of an “economic crime”); Ellen S. Podgor, *Criminal Fraud*, 48 AM. U. L. REV. 729, 732 n.20 (1999) (labeling health care fraud as a “white collar offense[.]”); Brooke A. Masters, *Investigators Try to Keep Up with Growing Problem of Health Care Fraud*, WASH. POST, Apr. 6, 1997, at B1 (“Health care fraud, once dismissed as part of the cost of medicine, has become the Justice Department’s top white-collar crime priority . . .”).

⁸¹ Joan H. Krause, *Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road*, 36 AM. J.L. & MED. 343, 344, 353–63 (2010).

⁸² The federal government recovered approximately \$14.9 billion as a result of health care fraud and prevention efforts in fiscal years 2009 through 2012. See Press Release, Dep’t of Health & Human Servs., Departments of Justice and Health and Human Services Announce Record-Breaking Recoveries Resulting from Joint Efforts to Combat Health Care Fraud (Feb. 11, 2013), available at <http://www.hhs.gov/news/press/2013pres/02/>

While the white-collar framework may be adept at returning funds to the public fisc, we should not lose sight of the fact that it does so at the expense of patients—the victims who happen to be the least powerful and who suffer harms that are the most serious.⁸³ How did this come to pass?

This Article posits a two-part answer. The first part starts from the premise that the harms and victims in many complex federal cases are highly malleable. Health care fraud, like many white-collar offenses involving multiple harms and victims, is endogenous to the frameworks we use to prosecute it. Agents and prosecutors acting under the influence of those frameworks make an assortment of decisions that ultimately shape the harms and victims that become part of a criminal case. This is a phenomenon that should trouble us. It occurs in the shadows of the criminal justice bureaucracy. There are few checks on agents and prosecutors to assure the federal apparatus of criminal justice is used to address the kinds of harms and victims (real people) that we, as a society, care about most.

The second part of the answer excavates the frameworks that specifically pertain to health care fraud to show how and why statutory structures, sentencing guidelines, internal incentives, and other forces encourage agents and prosecutors to shape the harms of health care fraud in ways that focus all the attention on the dollars lost by the government and private insurers while effectively omitting the physical harms suffered by patients.

A. *The Malleability of Harm in Complex Cases*

Judges determine the seriousness of offenses based largely on assessments of the harm done.⁸⁴ John Stuart Mill famously wrote in his essay *On Liberty*, “the only purpose for which power can be rightfully exercised over any member of a civilized

20130211a.html, archived at <http://perma.cc/4ZKL-8T8H>.

⁸³ Most of us view the most serious offenses meriting prosecution to be those that involve actual or threatened physical harm to the body—as opposed to crimes resulting in pecuniary harm. See, e.g., PETER H. ROSSI & RICHARD A. BERK, JUST PUNISHMENTS: FEDERAL GUIDELINES AND PUBLIC VIEWS COMPARED 12 (1997) (noting that a review of prior studies revealed that a “[f]airly strong consensus exists on the seriousness ordering of crimes, with those involving actual or threatened physical harm to victims generally considered to be the most serious”); Jeffrey Bellin, *Crime-Severity Distinctions and the Fourth Amendment: Reassessing Reasonableness in a Changing World*, 97 IOWA L. REV. 1, 30–32 (2011) (describing “offenses involving the intentional infliction, or threatened infliction, of serious physical harm” as a “workable shorthand for the category of ‘grave’ offenses,” consistent with the social-science literature (emphasis omitted)); Ristroph, *supra* note 14, at 580 (noting that “crimes against the person reflect societal concerns with physical injuries”); Robinson & Kurzban, *supra* note 14, at 1854 (describing “intuitions on the relative seriousness of wrongdoing”).

⁸⁴ See STANTON WHEELER ET AL., SITTING IN JUDGMENT: THE SENTENCING OF WHITE-COLLAR CRIMINALS 54 (1988) (reporting that the authors’ interviews of judges reflected that “the key element” in assessing the seriousness of a criminal offense was an assessment of the harm done).

community, against his will, is to prevent harm to others.”⁸⁵ This harm principle has been the subject of longstanding debate among legal philosophers and criminal law scholars.⁸⁶ More broadly, the concept of harm has received considerable attention from criminal law theorists.⁸⁷ Far less studied are the real-world processes that shape which harms and which victims ultimately are identified, recognized, and made part of complex federal cases.

The degree to which harm can be shaped and manipulated depends largely on a case’s complexity. Classic *mala in se* crimes, such as those involving acts of violence, typically present harms that are easy to perceive and, as a result, largely immune to manipulation. If Person A intentionally uses a gun to shoot Person B in the leg without legal justification, which constitutes the crime of aggravated assault in some jurisdictions, the immediate harm of the resulting crime (a gunshot wound in the leg) and the victim of the crime (Person B) would be readily apparent. Regardless of how the case is investigated or prosecuted, it is unlikely a jury at trial or a judge at sentencing would be confused about the basic nature of the harm or the identity of the victim. Those essential facts, which could be conveyed through a photograph of Person B’s leg, flow naturally from Person A’s violent act. We have well-established intuitions about the wrongfulness of Person A’s conduct and the need for punishment.⁸⁸

As criminal cases increase in complexity, however, their harms and victims tend to become less self-evident. This is especially true with respect to nonviolent federal crimes, which do not leave visible injuries that can be examined or bloodied victims lying in the street. Jurors usually require some context and explanation to understand the harmful consequences of a bribe. They need background to apprehend the nature and extent of harms inflicted by insider trading. To identify the victims of a Ponzi scheme, a judge will often need to see and hear a combination of evidence, such as testimony from witnesses, cashed checks from victims, or perhaps emails sent from offenders promising spectacular investment returns. And even after identifying a victim, a judge may need to examine more evidence to understand the

⁸⁵ JOHN STUART MILL, ON LIBERTY 9 (Elizabeth Rapaport ed., Hackett Publ’g Co., 1978) (1859).

⁸⁶ See generally Bernard E. Harcourt, *The Collapse of the Harm Principle*, 90 J. CRIM. L. & CRIMINOLOGY 109, 120–38 (1999) (describing the general contours of the debate). One of the most extensive discussions of the harm principle unfolds in Professor Joel Feinberg’s four-volume series, *The Moral Limits of the Criminal Law*. See 1 JOEL FEINBERG, THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO OTHERS (1984); 2 JOEL FEINBERG, THE MORAL LIMITS OF THE CRIMINAL LAW: OFFENSE TO OTHERS (1985); 3 JOEL FEINBERG, THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO SELF (1986); 4 JOEL FEINBERG, THE MORAL LIMITS OF THE CRIMINAL LAW: HARMLESS WRONGDOING (1988).

⁸⁷ For example, in more recent years, scholars have debated whether the harm of a crime must be realized in order to justify punishment. See ALEXANDER & FERZAN, *supra* note 21, at 171–96 (arguing that the harm resulting from a crime is “immaterial to what the [criminal] actor deserves” and that “current law is incorrect to the extent that it provides that resulting harm makes an actor more blameworthy and deserving of more punishment”).

⁸⁸ See *supra* note 14 and accompanying text.

full extent of harm—did the victim lose \$10,000 or \$100,000? In most complex cases, agents and prosecutors are the ones who need to find and assemble the evidence and then connect the dots. But when a crime results in multiple harms to multiple victims, there are no guarantees that all or most of the harms and victims will become known to a judge or jury, let alone the public.

The criminal justice system cannot identify *all* the harms and victims of crimes for the same reason it cannot prosecute all the criminals who commit them—the finite and scarce nature of criminal justice resources.⁸⁹ With respect to decisions about whom to prosecute, Professor William Stuntz explained that budget constraints tend to focus resources on those criminals who are most cheaply caught and convicted, a dynamic that he showed results in discriminatory punishment.⁹⁰ In this Part, I will show that we cannot neglect the effects of budget constraints on how federal agents and prosecutors exercise analogous discretion in the selection of harms and victims in complex federal cases. The discussion is organized into three key areas—policymaking, investigation, and prosecution. In the face of limited resources, we need to pay greater attention to how the frameworks established by policymakers and various other forces within the criminal justice bureaucracy influence fundamental decisions about which harms and which victims do or do not get recognized. Failure to do so risks outcomes that do not align with societal values or the fundamental purposes of our criminal justice system.

1. Policymaking

For classic *mala in se* crimes, policymakers do little to define relevant harms or victims. There is not much room to debate who qualifies as a victim of a murder, and the relevant harm is obvious. But for many of the complex crimes prosecuted federally, who qualifies as a victim is not always apparent from the elements of the offense, and what counts as a relevant harm can be subject to debate. Under such circumstances, the language used by federal policymakers in statutes and sentencing guidelines can have a tremendous influence on the identification of victims and harms.

In rare instances, policymakers make explicit value-laden judgments about who should be counted as a victim for a particular kind of offense. For instance, after some judges interpreted the sentencing guidelines governing bank fraud to exclude bank customers whose identities were stolen as a part of a fraudulent scheme from the tally of total victims, the U.S. Sentencing Commission amended the guidelines to make clear that “any individual whose means of identification was used unlawfully or without authority” should be counted as a victim, even if he suffered no pecuniary loss.⁹¹

⁸⁹ See WILLIAM J. STUNTZ, *THE COLLAPSE OF AMERICAN CRIMINAL JUSTICE* 52 (2011) (noting “the United States’ justice system lacks the capacity to punish all major crimes—much less all crimes, period”).

⁹⁰ See *id.* at 50–56.

⁹¹ U.S. SENTENCING GUIDELINES MANUAL app. C, at 307 (Supp. 2009).

More commonly, however, federal policymakers shape the identification of victims and harms by establishing statutory frameworks and sentencing structures that influence the actions of the agents, prosecutors, and other insiders who operate within the criminal justice bureaucracy. For some federal crimes, policy decisions about how to measure and punish harm have an enormous impact on how agents conduct an investigation. This is especially true for crimes where our notions of harm and punishment are not grounded in the ways they are for *mala in se* crimes.

Consider how we gauge punishment for drug trafficking crimes—drug weights.⁹² This metric encourages agents and prosecutors to allocate resources towards developing proof of drug weight, including by focusing on obtaining search warrants for drug locations, by seeking wiretaps to record traffickers’ conversations about drug amounts, and by eliciting information about drug quantities from cooperators and informants. However, as some have argued, drug weight can be an unreliable proxy for culpability.⁹³ It can also lead to questionable investigative practices, such as sting operations where undercover agents encourage targets to participate in large-scale drug deals for purposes of manipulating sentences.⁹⁴

In the over 500 pages that compose the U.S. Sentencing Commission Guidelines Manual, scores of sentencing provisions influence how federal agents and prosecutors carry out investigations and prosecutions, for drug crimes and hundreds of other federal offenses. With finite resources and limited time, criminal justice insiders have no choice but to be strategic about how they go about collecting and presenting evidence. As a result, in complex cases involving multiple harms and an array of potential victims, the frameworks established within the sentencing guidelines steer agents and prosecutors to focus on the harms and victims that will provide the biggest bang for the buck.

Consider the structures in the sentencing guidelines that would govern a basic case of mail fraud, in which the amount of loss drives punishment more than anything else. If an investigative team had reason to believe that an offender defrauded twenty victims of \$2 million, but the team’s three-month investigation yielded evidence sufficient to establish losses of only \$1 million to ten victims, the relevant guidelines would provide them with no incentive to dedicate more time and investigative resources to uncovering evidence pertaining to the remaining losses and victims. That is because the guidelines set arbitrary cutoffs that would recommend increased punishment in such a case only if the government could establish losses totaling \$2.5 million or victims totaling fifty or more.⁹⁵ Under such

⁹² See 21 U.S.C. § 841(b) (2012) (outlining the penalty provisions of the federal drug trafficking statute).

⁹³ See, e.g., Carol S. Steiker, *Lessons from Two Failures: Sentencing for Cocaine and Child Pornography Under the Federal Sentencing Guidelines in the United States*, 76 LAW & CONTEMP. PROBS. 27, 48 (2013) (describing the weight of drugs as a “very weak prox[y] for the culpability and dangerousness of offenders”).

⁹⁴ See Eda Katharine Tinto, *Undercover Policing, Overstated Culpability*, 34 CARDOZO L. REV. 1401, 1402–04, 1411–12 (2013) (examining the doctrine of sentencing manipulation and the tactics used by law enforcement).

⁹⁵ See U.S. SENTENCING GUIDELINES MANUAL § 2B1.1(b)(1) (2013) (loss amount); *id.*

circumstances, it would not be surprising for a case agent or prosecutor to decide that three more months of investigative time would be better spent elsewhere. Of course, if the Sentencing Commission had set the next punishment cutoffs at \$1.5 million or at fifteen total victims, the calculus would have changed.

2. *Investigation*

An initial question that bears upon the recognition of harms and victims is whether to investigate a potential crime in the first place. A decision against investigating particular conduct will foreclose the possibility of a criminal charge, and no resulting harm will be recognized as part of a criminal case. However, when agents do decide to initiate an investigation, a similarly pivotal question relates to when that investigation should *end*. Finding the stopping point for an investigation of an offense that has a single victim who suffered a single clearly identifiable harm, such as in most cases of violent crime, is less challenging than determining when to conclude a complex investigation involving multiple victims who suffered multiple harms. The increased complexity of a case can obscure the amount of harm, the nature of the harm, and the identities of harmed parties. Unearthing that kind of information often requires a lengthy investigation.

In complex cases, federal investigators exercise tremendous discretion in deciding which harms and victims to focus on.⁹⁶ Many factors can influence the exercise of investigative power. Some of the most important external influences, already described above, arise from the incentivizing frameworks created by policymakers. Other incentives exist within the administrative apparatus of the criminal justice bureaucracy, sometimes described as the “machinery” of criminal justice.⁹⁷ As with other kinds of machinery, outside evaluations are based on assessments of output. Agencies are measured in large part based on arrests. Prosecuting offices are evaluated based on indictments. Whether quantitative or qualitative, such measurements give rise to a cascade of incentives that influence how an investigation addresses potential harms and victims.

Quantitative measurement can create pressures to speed investigations towards the formal charging of targets so that limited resources can be shifted to other investigations that in turn lead to more arrests and more indictments. At the level of the case agent or line prosecutor, supervisors may attempt to boost an office’s arrest or indictment numbers by instituting formal or unwritten expectations regarding

§ 2B1.1(b)(2) (number of victims).

⁹⁶ See, e.g., U.S. DEP’T OF JUSTICE, UNITED STATES ATTORNEYS’ MANUAL § 9-27.110(B) (1997), available at http://www.justice.gov/usao/eousa/foia_reading_room/usam/title9/27mcrm.htm#9-27.110, archived at <http://perma.cc/5GYP-3CMW> (“Under the Federal criminal justice system, the prosecutor has wide latitude in determining when, whom, how, and even whether to prosecute for apparent violations of Federal criminal law.”).

⁹⁷ See STEPHANOS BIBAS, *THE MACHINERY OF CRIMINAL JUSTICE* 15–24 (2012); Erik Luna, *Rage Against the Machine: A Reply to Professors Bierschbach and Bibas*, 97 MINN. L. REV. 2245, 2256–57 (2013) (collecting examples in which courts and scholars have referred to the administrative apparatus of criminal justice as “machinery”).

their employees' "stats"—the total number of each employee's arrests or indictments.⁹⁸ With looming performance reviews in mind, those employees can feel pressure to expedite investigations toward indictment, garnering an additional stat. Not surprisingly, the significance of stats in assessing the performance of federal agents and prosecutors increased markedly after the General Accounting Office intensified efforts in the late 1990s to pressure the Department of Justice to make greater use of performance measures with clear targets.⁹⁹

Yet, pressures to hasten the completion of investigations do not seem to have led to an epidemic of half-baked criminal charges unsupported by sufficient evidence.¹⁰⁰ Prosecutors generally refrain from commencing a prosecution when they believe the amount or quality of admissible evidence would not support conviction.¹⁰¹ Besides ethical concerns, prosecutors have personal incentives to avoid getting mired in prosecutions with weak evidence because they are more likely to result in resource-intensive trials or even acquittals.¹⁰²

Accordingly, the pressures to complete an investigation tend not to jeopardize efforts to amass the evidence necessary to establish the legal elements of the offenses to be charged in an indictment—in other words, the evidence needed to prove guilt at trial. Those parts of an investigation are generally treated as essential and non-negotiable. Where there *is* room for flexibility, however, is with respect to the areas of an investigation pertaining to harms and victims.

Consider a wire fraud charge premised on a scheme that caused each of 100 victims to be defrauded of \$10,000. At trial, the government would merely need to establish that the defendant (1) participated in a scheme to defraud, (2) that he

⁹⁸ See Todd Lochner, *Overdeterrence, Underdeterrence, and a (Half-Hearted) Call for a Scarlet Letter Approach to Deterring Campaign Finance Violations*, 2 ELECTION L.J. 23, 28 n.26 (2003) (observing the author's interviews with U.S. Attorneys revealed that "a major criticism of the federal prosecutorial system was that it tended to define 'excellent' prosecutors largely by their ability to generate 'stats'—specifically, number of prosecutions brought and number won, with oftentimes little regard to the complex[ity] or difficulty of the cases involved").

⁹⁹ See Mary De Ming Fan, *Disciplining Criminal Justice: The Peril Amid the Promise of Numbers*, 26 YALE L. & POL'Y REV. 1, 18–24 (2007).

¹⁰⁰ The federal rate of conviction (either through a guilty plea or a trial) was 93% in fiscal year 2012, and it has been over 90% every year since fiscal year 2001. See U.S. DEP'T OF JUSTICE, UNITED STATES ATTORNEYS' ANNUAL STATISTICAL REPORT 8 (2012), available at http://www.justice.gov/usao/reading_room/reports/asr2012/12statrpt.pdf, archived at <http://perma.cc/C4UD-FC4R>.

¹⁰¹ The *United States Attorneys' Manual* advises "both as a matter of fundamental fairness and in the interest of the efficient administration of justice, no prosecution should be initiated against any person unless the government believes that the person probably will be found guilty by an unbiased trier of fact." U.S. DEP'T OF JUSTICE, *supra* note 96, § 9-27.220(B).

¹⁰² See generally Mary Kreiner Ramirez, *Criminal Affirmance: Going Beyond the Deterrence Paradigm to Examine the Social Meaning of Declining Prosecution of Elite Crime*, 45 CONN. L. REV. 865, 885–89 (2013) (discussing how prosecutors evaluate the sufficiency of evidence in making charging decisions).

intended to defraud, and that (3) an interstate wire was used in furtherance of the scheme.¹⁰³ Because the government would not have to prove the defendant realized any gain from the scheme or that any victims actually suffered any losses, the investigative team would have wide latitude to decide how much time and how many resources to allocate towards the identification of the scheme's 100 victims and their respective losses. It could decide the testimony of five victims would be enough to obtain a conviction and stop the investigation there. Of course, with sufficient time and resources, the investigative team would likely be able to identify more of the victims and harms. But in the face of pressure to conclude the investigation, the team would almost certainly curtail the collection of evidence regarding those unidentified victims and harms before limiting other, more essential parts of the investigation.

However, the investigative output of the machinery of criminal justice is not measured solely by numbers of arrests and indictments. More qualitative assessments are reflected in press releases that tout the issuance of charges in especially noteworthy cases, the kinds of "career-making" cases that can be attractive to ambitious agents. However, rendering qualitative assessments of complex cases, especially those featuring multiple kinds of harm spread across a large number of victims, is no easy task. The headlines of agency press releases and newspaper articles often reflect a propensity to simplify public portrayals of such cases by reducing them to metrics that are easier to convey and understand—namely, dollar amounts. Agents in search of "big cases" understand that they tend to be measured in dollars, at least in the eyes of those who write and read the headlines. As a result, in complex cases involving both economic and noneconomic harms, strong incentives exist for agents to build cases by focusing attention on the economic harms.

Another factor that influences the treatment of harms and victims relates to how the investigative components of the criminal justice machine are organized. Many agencies specialize in particular categories of crime, especially at the federal level, and organize themselves into smaller working groups that are even more specialized. A large FBI field office, for example, may have a group of agents assigned to investigate white-collar crime, with smaller groups segmented into clusters that focus on more specific categories of crime, such as mortgage fraud or bank fraud. Prosecuting offices can be organized in similar ways, with larger offices tending to be more specialized.

Such specialization can benefit investigations by harnessing the expertise of law enforcement agents and prosecutors in ways that increase efficiencies. At the same time, however, it can have broader, unintended consequences for how agents and prosecutors approach their jobs.¹⁰⁴ When a nascent investigation of a complex

¹⁰³ See *United States v. White*, 737 F.3d 1121, 1129 (7th Cir. 2013) (listing the elements of wire fraud).

¹⁰⁴ See generally Kay L. Levine & Ronald F. Wright, *Prosecution in 3-D*, 102 J. CRIM. L. & CRIMINOLOGY 1119 (2012) (exploring how the office structures of prosecutors' offices affect prosecutors' professional identities and how they approach their duties).

case could go in one of several directions, an investigative team with expertise in a particular area will naturally seek to explore and develop evidence and facts within that area before venturing into other, less familiar directions. As a result, the harms and victims that could be discovered in those less familiar places are more likely to remain unrecognized.

3. Prosecution

Through charging decisions, prosecutors have the power to delineate who is recognized as a victim in a complex criminal case. In cases where a prosecutor knows that an offender's conduct resulted in harm to multiple victims and could form the basis for dozens of criminal charges, a prosecutor may choose to craft an indictment that includes only a handful of charges relating to only a subset of victims. Decisions to limit the scope of the charges could be premised upon a target's pre-indictment offer to plead guilty to some but not all of the possible charges, a prosecutor's trial strategy (simple is often better at trial), concerns about the resources needed to prosecute a more complicated case, or a variety of other considerations.¹⁰⁵ Some prosecutors might simply seek to avoid structuring a case in a way that includes a large number of individual victims, fearing the victims will cause administrative headaches, complicate plea negotiations, or otherwise slow the progress of the case.

Even after indictment, crime victims can effectively lose their status as victims in a criminal case through a prosecutor's decision to engage in plea bargaining.¹⁰⁶ A prosecutor may offer to drop certain charges relating to a subset of victims as an inducement to plead guilty, even in cases where there is ample evidence to prove the charges. Malleable harms can also be manipulated through stipulations in plea agreements in which the prosecutor and defendant might agree, for example, that financial losses did not exceed a specific dollar amount or that there were fewer than ten victims of a crime. A prosecutor may offer such concessions as inducements for the defendant to plead guilty.¹⁰⁷

While the harm suffered by crime victims may or may not be relevant to the issues that a fact finder must decide at trial, questions pertaining to an offender's harms and victims normally are of central importance at sentencing. In preparing for sentencing, prosecutors make a host of decisions that affect the presentation of harms and victims. If a prosecutor anticipates that a sentencing guidelines range for an offender will be too low, the prosecutor will have an incentive to take a more aggressive tact in seeking sentencing enhancements, some of which will likely turn

¹⁰⁵ See Paul G. Cassell et al., *Crime Victims' Rights During Criminal Investigations? Applying the Crime Victims' Rights Act Before Criminal Charges Are Filed*, 104 J. CRIM. L. & CRIMINOLOGY 59, 61, 99 (2014) (discussing state and federal laws giving crime victims rights to participate in criminal prosecutions).

¹⁰⁶ See, e.g., *id.*

¹⁰⁷ While the Department of Justice has had a longstanding policy against "fact-bargaining" in plea negotiations, several studies have shown that such bargaining continues to occur. See Starr & Rehavi, *supra* note 20, at 12.

on the amount and nature of victim harm. By the same token, if a prosecutor believes the default guideline range is sufficiently high, he may decide against seeking to maximize certain harm-based enhancements. Prosecutors also shape victim harms through their decisions about how to present them. A prosecutor may simply describe the harms herself, submit written victim statements, or call the victim or other witnesses to give first-hand accounts of the harms.

It bears noting, however, that a prosecutor's ability to present victim harms will be limited by the amount of information the prosecutor has about the victims. If certain harms were not uncovered during the investigative process prior to indictment, the prosecutor is unlikely to learn about them prior to sentencing. While a prosecutor may, in her discretion, seek to restart an investigation after indictment with an eye towards discovering new information relevant to sentencing, the reality in most cases is that other ongoing investigations of unindicted targets will take precedence.¹⁰⁸ As a result, most of the victims and harms not revealed during the initial pre-indictment investigation are likely to remain unidentified.

B. The Shaping of Criminal Health Care Fraud

As shown in Part II, health care fraud can be among the most complex of crimes, causing multiple kinds of harm to a variety of victims, including government entities, private insurers, and patients. But by the time the crime passes through the machinery of criminal justice, it takes the shape of a traditional white-collar fraud against the powerful entities that pay the bills. The components of the crime that threaten the *health* and *care* of individual patients—real human beings—are relegated to the periphery, if recognized at all.

When it comes to complex crimes like health care fraud, if we want the output of the criminal justice machine to correspond to our intuitions about harm, punishment, and the purposes of the criminal law, it is not enough to sit back and wait for the machine to do its work. We need to pay attention to the inner workings of the machine, identify flaws in the system, and be ready to make adjustments. Below I explore the statutory frameworks, sentencing structures, internal incentives, and other forces that shape the malleable harms of health care fraud.

1. Statutory Frameworks

The federal laws used to prosecute health care fraud, which account for the majority of health care fraud prosecutions, can be separated into two groups. The first includes broad fraud statutes of general applicability, such as the mail fraud and wire fraud statutes, which were not specifically enacted to address offenses relating to health care fraud. The second encompasses laws that policymakers crafted with

¹⁰⁸ See Adam M. Gershowitz & Laura R. Killinger, *The State (Never) Rests: How Excessive Prosecutorial Caseloads Harm Criminal Defendants*, 105 NW. U. L. REV. 261, 292–93 (2011) (discussing how excessive prosecutorial caseloads can negatively impact the treatment of crime victims).

the express purpose to combat health care fraud, such as the Medicare and Medicaid fraud statute and the federal health care fraud statute. The laws in both categories give rise to frameworks that influence how criminal justice insiders investigate and prosecute health care fraud.

The framework established in the first category by the generic mail fraud and wire fraud statutes is among the most well known to prosecutors. Breadth is the hallmark of these statutes, and beyond their respective jurisdictional requirements, they essentially require proof that an offender devised a scheme to defraud and acted with intent to defraud. The statutes authorize maximum penalties of up to twenty years of imprisonment and fines up to \$250,000.¹⁰⁹ Increases in the maximum penalties are triggered when violations affect a financial institution or involve benefits relating to major disasters or emergency relief, in which case the maximum penalties increase to thirty years of imprisonment and \$1 million in fines.¹¹⁰ The statutes reference no other kinds of harm.

It is not difficult to see why this framework is so attractive to prosecutors. It requires proof of relatively simple, straightforward elements that could be applied to countless fact patterns¹¹¹ while at the same time offering the possibility of a significant twenty-year hammer at sentencing. Thus, the fact that this framework is used extensively in health care fraud prosecutions is not surprising.¹¹² From a policy perspective, however, one widely overlooked disadvantage of this one-size-fits-all framework is that it does nothing to steer the attention of agents or prosecutors towards the unique problems and harms endemic to particular kinds of criminal schemes (outside of those that affect financial institutions or emergency/disaster relief). Moreover, as an inchoate offense, its structure does not require proof that an offender completed her course of conduct or caused a prohibited harm.¹¹³ As long as it can be established that an offender devised a fraudulent scheme with intent to defraud, it is immaterial whether the fraud succeeded in its goal, and so the consequences of the fraud are irrelevant to proving its elements.¹¹⁴

As a result, when this framework is applied to health care fraud, it does not incentivize agents and prosecutors to discover the full range of harmful consequences caused by an offender. If an investigation reveals that a doctor devised a fraudulent scheme involving the provision of unnecessary medical services to patients, the effects of those services on patients are immaterial.

The second category of statutory frameworks comprises those established through laws that relate specifically to health care fraud, such as § 1347 and the

¹⁰⁹ 18 U.S.C. §§ 1341, 1343, 3571(b) (2012).

¹¹⁰ *Id.*

¹¹¹ See John C. Coffee, Jr., *The Metastasis of Mail Fraud: The Continuing Story of the "Evolution" of a White-Collar Crime*, 21 AM. CRIM. L. REV. 1, 27 (1983) (describing the utility of the mail fraud statute to lie in "its historic ability to 'evolve' over time so as to cover any new form of misbehavior without need for congressional action").

¹¹² See *supra* note 37 and accompanying text.

¹¹³ See Miriam H. Baer, *Linkage and the Deterrence of Corporate Fraud*, 94 VA. L. REV. 1295, 1322–24 (2008).

¹¹⁴ See 18 U.S.C. § 1347.

Medicare and Medicaid fraud statute. Unlike the structure of the mail fraud and wire fraud statutes, the structure of the statutes in the second category has an element that is victim-specific. The reach of § 1347 is explicitly limited to those schemes that seek to defraud or obtain money from any *health care benefit program*, such as Medicare or a private health plan.¹¹⁵ The scope of the Medicare and Medicaid fraud statute is even narrower because it requires the target of the fraud to have been a *federal* health care program.¹¹⁶ In both cases, the statutes focus attention on the economic aspects of health care fraud.

However, after describing the offense elements, which clearly style health care benefit programs as victims, § 1347 takes an interesting turn by shifting focus to physical harms. It provides for increased maximum sentences triggered by bodily injuries. More specifically, the maximum punishment of ten years' imprisonment increases to twenty years if a violation results in "serious bodily injury," and it increases to a lifetime sentence if a violation results in death.¹¹⁷

These sentencing enhancements reflect Congress's recognition that health care fraud can cause serious physical harms to patients, and that when such harms occur, they should be factored into criminal prosecutions. At least on the surface, the penalty structure of § 1347 would seem to encourage agents and prosecutors to broaden the scope of their investigations to take meaningful account of serious physical harms suffered by patients. In practice, however, the patient-based enhancements of § 1347 rarely influence how criminal justice insiders actually handle health care fraud cases.

First, given that prosecutors almost always have the option to charge health care fraud as a case of mail or wire fraud, which would allow for a twenty-year maximum penalty, the enhancement for serious bodily injuries does not afford prosecutors anything not already available to them. In fact, while the twenty-year maximum would apply automatically to any mail or wire fraud conviction, prosecutors who seek the enhancement under § 1347 face the burden of proving beyond a reasonable doubt at trial that the health care fraud violation resulted in serious bodily injury.¹¹⁸

A second reason why the penalty structure of § 1347 has so little impact is because only the most egregious kinds of physical harm can trigger the increased penalties. All physical harms that fall below the level of death or serious bodily injury are irrelevant under the statute. And the bar is set high for a harm to qualify as a "serious bodily injury." It must involve (1) a substantial risk of death, (2) extreme physical pain, (3) protracted and obvious disfigurement, or (4) protracted loss or impairment of the function of a bodily member, organ, or mental faculty.¹¹⁹ Under that high standard, many if not most of the physical harms in the cases described in Part II would be deemed insufficient. Even the Michigan case in the

¹¹⁵ *See id.*

¹¹⁶ 42 U.S.C. § 1320a-7b(a) (2012).

¹¹⁷ *See* 18 U.S.C. § 1347(a).

¹¹⁸ *See* *Apprendi v. New Jersey*, 530 U.S. 466, 476 (2000) (holding that, other than a fact of prior conviction, any fact that increases the penalty for a crime beyond the prescribed statutory maximum must be submitted to a jury and proved beyond a reasonable doubt).

¹¹⁹ 18 U.S.C. §§ 1347(a), 1365(h)(3).

Introduction, in which the defendant allegedly caused patients to receive unnecessary chemotherapy treatment premised upon false cancer diagnoses, might not present harms that would qualify as serious bodily injuries.¹²⁰

2. Sentencing Frameworks

On the surface, the sentencing guidelines governing health care fraud seem to take into account a variety of factors, including whether an offender's conduct threatened the health of patients. In practice, however, the guidelines rely almost exclusively on economic loss as a proxy for measuring harm and culpability and, as a result, channel investigative resources away from patients and towards dollars.

By far the most consequential decision made by the Sentencing Commission regarding health care fraud was to associate all the major statutes used to prosecute it with section 2B1.1, the sentencing guidelines written to govern "Basic Economic Offenses."¹²¹ Those provisions were written to cover a broad category of offenses involving "Fraud and Deceit" and a host of other economic crimes.¹²²

In general, the mechanism used by the sentencing guidelines to account for the aggravating and mitigating facts and circumstances of individual cases is to adjust an offender's offense level based on the presence or absence of delineated offense characteristics. The final offense level, together with an offender's prior criminal history, determines the applicable sentencing guidelines range.¹²³ Section 2B1.1 lists nineteen sets of specific offense characteristics.¹²⁴ Of those, only five are relevant to the facts that recur in most cases of health care fraud. They are the provisions relating to (1) the total loss amount, (2) the loss amount suffered specifically by government health care programs, (3) the offender's use of sophisticated means, (4) the total number of victims, and (5) the conscious or reckless risk of death or serious bodily injury.¹²⁵

While those five sets of specific offense characteristics might appear balanced between economic and physical harms, in reality they focus nearly all of the attention of agents and prosecutors on pecuniary losses. The enhancement premised upon a total loss by itself has the potential to increase an offender's offense level by

¹²⁰ Interestingly, without explicitly taking a position on the victim status of patients, defense counsel in the Michigan case suggested in a court filing that whether the defendant's patients could be considered "crime victims" under the Crime Victims' Rights Act was a "not inconsiderable question[]." See Answer in Opposition to Motion to Authorize Procedures Under 18 U.S.C. § 3771(d)(2) at 2, *United States v. Fata*, No. 2:13-cr-20600 (E.D. Mich. Sept. 24, 2013).

¹²¹ See U.S. SENTENCING GUIDELINES MANUAL app. A (2013).

¹²² See *id.* § 2B1.1.

¹²³ See *id.* § 1B1.1 (outlining sentencing application instructions).

¹²⁴ See *id.* § 2B1.1.

¹²⁵ See *id.* § 2B1.1(b)(1) (total loss amount); *id.* § 2B1.1(b)(2) (number of victims); *id.* § 2B1.1(b)(7) (loss to government health care programs); *id.* § 2B1.1(b)(10)(C) (sophisticated means); *id.* § 2B1.1(b)(15)(A) (risk of death or serious bodily injury).

up to thirty levels, depending on the amount of loss.¹²⁶ No other enhancement comes close to having that kind of impact. For example, a \$400,000 loss by the government or private insurers would result in a fourteen-level increase in offense levels.¹²⁷ If the same offense had resulted in the death or serious bodily injury of a patient (or even five patients), the offense level would increase by only two levels.¹²⁸

The disparity of impact between economic and physical harms was made even starker by the Affordable Care Act, which directed the Sentencing Commission to strengthen the penalties for health care offenses by adding a separate “government loss” enhancement to section 2B1.1.¹²⁹ Now, economic losses suffered specifically by government health care programs can result in as many as six additional offense levels under section 2B1.1(b)(7),¹³⁰ on top of those already calculated from the “total losses” under section 2B1.1(b)(1).¹³¹

Putting aside the two provisions that explicitly relate to financial loss, the remaining three do little to shift attention to conduct that threatens patients’ health and safety. The “sophisticated means” enhancement applies only when an offender’s efforts to execute a scheme or to avoid detection are especially complex or intricate,¹³² and proof of such circumstances typically does not call for evidence relating to patient harm.

Perhaps more surprisingly, the enhancement for the total number of victims also does not succeed in attracting significant attention to patient harms. It provides for a two-level increase if an offense involved ten or more victims, a four-level increase for at least fifty victims, and a six-level increase for 250 or more victims.¹³³ Even though the guidelines define “victims” to include individuals who sustain “bodily injury” as a result of the offense (as opposed to the higher standard of “serious bodily injury”),¹³⁴ the provision fails to induce agents and prosecutors to shift substantial focus from economic to physical harms for several reasons.

¹²⁶ See *id.* § 2B1.1(b)(1).

¹²⁷ See *id.* § 2B1.1(b)(1)(H).

¹²⁸ See *id.* § 2B1.1(b)(15)(A). The number of individuals exposed to a risk of death or serious bodily injury under this subsection has no bearing on how it operates.

¹²⁹ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10606(a)(2)(C), 124 Stat. 119, 1007 (2010).

¹³⁰ See U.S. SENTENCING GUIDELINES MANUAL § 2B1.1(b)(7) (2013).

¹³¹ The Affordable Care Act also heightened the importance of pecuniary harms by making it easier for the government to establish higher total loss amounts. It directed the Sentencing Commission to amend the guidelines “to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss by the defendant.” Patient Protection and Affordable Care Act § 10606(a)(2)(B); U.S. SENTENCING GUIDELINES MANUAL § 2B1.1 cmt. n.3(F)(viii) (2013).

¹³² See U.S. SENTENCING GUIDELINES MANUAL § 2B1.1 cmt. n.9(B) (2013).

¹³³ *Id.* § 2B1.1(b)(2).

¹³⁴ *Id.* § 2B1.1 cmt. n.1. The sentencing guidelines define “bodily injury” elsewhere as “any significant injury,” such as “an injury that is painful and obvious, or is of a type for which medical attention ordinarily would be sought.” *Id.* § 1B1.1 cmt. n.1(B).

First, as noted previously, the magnitude of the sentencing increases under the victim enhancement pale in comparison to those available for economic loss. Moreover, after the first two-level increase for offenses involving ten or more victims, which in many cases can be satisfied merely by reference to the victimized public and private insurers, the enhancement requires relatively steep climbs to reach the 50-victim and 250-victim thresholds. The modest increases gained by reaching those high thresholds rarely spur prosecutors to allocate the time and resources necessary to collect sufficient proof of bodily injury for so many victims.¹³⁵ Lastly, because the provision does not apply where an offender merely threatened bodily injury by exposing patients to significant risks of harm (e.g., by administering unnecessary tests involving high doses of radiation)¹³⁶ many patient-victims do not qualify for inclusion.¹³⁷

Finally, the enhancement that most directly speaks to patient harms, applicable to offenses involving “the conscious or reckless risk of death or serious bodily injury,”¹³⁸ has minimal impact for several reasons. First, the increase that it provides—a mere two levels—is too modest to encourage significant investigative attention. Second, by requiring the risk of harm to have been at the level of death or serious bodily injury, the provision excludes many of the significant risks to patients that do not rise to that level. Finally, the provision fails to differentiate between a case that results in physical injuries to one patient and one that causes injuries to five, ten, or even a hundred patients. Once a prosecutor establishes that an offender’s conduct created a conscious or reckless *risk* of death or serious bodily injury, the actual impact of that conduct on patients, including with respect to the number of patients harmed, is irrelevant.

¹³⁵ Part A of Chapter Three of the guidelines provides for various victim-related enhancements, including a potential increase of up to four offense levels for cases involving “vulnerable victims,” an enhancement that is sometimes applicable to cases of health care fraud involving patients deemed vulnerable due to their physical or mental condition. *See id.* § 3A1.1. However, the potential impact of that enhancement is blunted by the fact the full four-level increase, which is only available for offenses that involved a large number of vulnerable victims, is not applicable to cases where an enhancement was already applied under § 2B1.1(b)(2)(B) or (C) for an offense involving at least fifty or 250 victims, respectively. *See id.* § 2B1.1 cmt. n.4(D).

¹³⁶ *See supra* note 62 and accompanying text.

¹³⁷ In a recent case in New Jersey, for example, a press release announced that a cardiologist admitted to participating in a \$19 million billing fraud scheme that “subjected thousands of patients to unnecessary tests and potentially life-threatening, unneeded treatment, as well as treatment by unlicensed or untrained personnel.” Press Release, U.S. Attorney’s Office, Dist. of N.J., Prominent Tri-State Cardiologist Admits Record \$19 Million Billing Fraud Scheme, Exposing Patients to Unskilled and Unnecessary Medical Treatment (Apr. 10, 2013), *available at* <http://www.justice.gov/usao/nj/Press/files/Katz,%20Jose%20Sentencing%20News%20Release.html>, *archived at* <http://perma.cc/AMX-6TDZ>. Despite the risks of harm to patients from the defendant’s conduct, the government stipulated to a sentencing guidelines calculation that included no victim enhancement. *See* Plea Agreement with Jose Katz, *United States v. Katz*, No. 2:13-cr-00246 (D.N.J. Apr. 10, 2013).

¹³⁸ U.S. SENTENCING GUIDELINES MANUAL § 2B1.1(b)(15)(A) (2013).

3. *Bureaucratic Channeling*

Internal organizational structures within the criminal justice bureaucracy also channel health care fraud cases into investigative avenues that focus on uncovering pecuniary loss. The primary agency charged with investigating health care fraud, the FBI, includes its health care fraud investigations within the “FBI White Collar Crime Program.”¹³⁹ Prosecutors’ offices often assign health care fraud cases to those units designated to handle crimes traditionally described as white collar, such as mortgage fraud and tax fraud.¹⁴⁰

What does it mean for a case to be white collar? While the precise definition of “white-collar crime” has been debated ever since Edwin Sutherland first coined the term in 1939,¹⁴¹ the definition offered by Black’s Law Dictionary, which defines it as “[a] nonviolent crime usu[ally] involving cheating or dishonesty in commercial matters,”¹⁴² resonates with how the term is used within the criminal justice bureaucracy.¹⁴³

Over time, investigative agents and prosecutors tasked to handle white-collar cases develop expertise in the techniques and practices that are most effective in uncovering nonviolent (i.e., financial) harms caused by deceptive conduct.¹⁴⁴ They hone their skills for conducting complex analyses of financial records, improving their ability to identify and isolate relevant transactions that help them to “follow the money” to the bad actors that become targets of investigations. They develop an understanding of what qualifies as an impermissibly deceptive practice by familiarizing themselves with the common features and qualities of economic encounters that take place in assorted business environments. In an increasing number of cases, they become experts at collecting, processing, and organizing gigantic volumes of electronic records and data obtained from computer hard drives and other electronic storage media, assembling the evidence necessary to meet their burdens of proof.

¹³⁹ HCF ANNUAL REPORT FOR FY 2012, *supra* note 9, at 91.

¹⁴⁰ *See, e.g., Criminal Division*, U.S. ATT’Y’S OFF. N. DISTRICT OHIO, <http://www.justice.gov/usao/ohn/divisions/criminaldivision.html>, *archived at* <http://perma.cc/8JA6-T8NU> (last visited Apr. 8, 2015); *Criminal Division*, U.S. ATT’Y’S OFF. S. DISTRICT N.Y., <http://www.justice.gov/usao/nys/criminal.html>, *archived at* <http://perma.cc/A5T6-DAY6> (last visited Apr. 8, 2015); *Major Frauds Section*, U.S. ATT’Y’S OFF. CENT. DISTRICT CAL., <http://www.justice.gov/usao/cac/divisions/mf.html>, *archived at* <http://perma.cc/FG8F-938A> (last visited Apr. 8, 2015).

¹⁴¹ *See* STUART P. GREEN, LYING, CHEATING, AND STEALING: A MORAL THEORY OF WHITE-COLLAR CRIME 9–20 (2006).

¹⁴² BLACK’S LAW DICTIONARY 1734 (9th ed. 2009).

¹⁴³ The FBI’s website declares that “[l]ying, cheating, and stealing” is “white-collar crime in a nutshell.” *See White-Collar Crime*, FED. BUREAU INVESTIGATION, http://www.fbi.gov/about-us/investigate/white_collar, *archived at* <http://perma.cc/F8H5-84ZC> (last visited Apr. 8, 2015).

¹⁴⁴ *See supra* note 104 and accompanying text.

When agents and prosecutors who operate within these white-collar units are assigned to handle health care fraud cases, they bring to those cases the practices and expertise acquired from their general white-collar experience. Not surprisingly, when a case presents both economic harms to insurers and physical harms to patients, agents and prosecutors gravitate to what they know best—the investigation and development of evidence pertaining to pecuniary harms of fraudulent schemes.

For instance, rather than seek to interview a criminal target's patients or to analyze their medical records to uncover the physical injuries of a scheme, white-collar agents typically focus more on collecting claim submission data, studying voluminous payment records, and interviewing coworkers about a target's billing practices. Most efforts to interview patients are geared toward developing proof of fraud against third-party payers, not of physical harms.

Moreover, white-collar prosecutors inclined to view health care fraud as a traditional fraud are less likely to designate patients as “crime victims” for purposes of the Crime Victims' Rights Act (CVRA).¹⁴⁵ As a result, the omitted patients, including those who suffered bodily harm, are less likely to receive notice of the rights afforded to crime victims under the CVRA.¹⁴⁶

4. *Insider Interests*

Both quantitative and qualitative assessments of the work done by criminal justice insiders, and of the collective output of their offices, incentivize the insiders to steer resources away from developing evidence of patient harms. Pressures felt by agents and prosecutors to increase their stats create incentives to expedite investigations towards indictment by focusing on what is needed to establish the raw statutory elements of health care fraud. Because harms to patients do not meaningfully factor into the current statutory frameworks, agents and prosecutors are reluctant to devote time searching for and developing evidence of patient harms.¹⁴⁷

Moreover, investigating patient harms can be far more time-consuming than other kinds of harm. After gaining access to the names and medical records of individual patients, an investigative team faces significant challenges in identifying patients who might have been exposed to risks of physical harm. Interviews of individual patients, which themselves could take up considerable investigative time, may need to be supplemented by physical examinations conducted by medical experts. Medical experts may also be needed to review and interpret patients'

¹⁴⁵ See 18 U.S.C. § 3771 (2012). The CVRA defines a “crime victim” as “a person directly and proximately harmed” by a charged offense. *Id.* § 3771(e). Because the statute designates the government as the party responsible for seeing that crime victims are notified of their rights, prosecutors exercise discretion in determining which parties fit within the definition of “crime victim.” See *id.* § 3771(c).

¹⁴⁶ Among the rights afforded by the CVRA are the right to receive notice of public court proceedings; the right to be heard at proceedings involving release, plea, or sentencing; and the right to confer with the prosecuting attorney in the case. *Id.* § 3771(a).

¹⁴⁷ See *supra* Part III.A.3.

medical records. Further complicating matters, it is difficult to predict patients' reactions to an investigation. While some might be cooperative and knowledgeable about their medical health, others could be defensive about a trusted doctor's behavior or confused about the details of their medical conditions or past treatments.

Far less complicated are the numbers on a spreadsheet listing Medicare payments or those on a target's billing records. That kind of evidence is fixed, secure, and relatively easy to rely upon. Documentary records can be presented to a grand jury and summarized through a case agent's testimony within minutes. Preparing a patient to provide grand jury testimony, however, might require an initial interview, a medical examination, and a meeting to prepare for the grand jury. And each additional patient will require the same kind of time and attention. In environments where insiders feel pressure to conclude an investigation and move on to others, it is not difficult to see why they opt to focus on developing proof of economic harms.¹⁴⁸

Moreover, as with other complex cases, the dominant measure used to assess the significance of individual cases of health care fraud is the dollar amount of the fraud.¹⁴⁹ To the extent that a prosecutor views the length of a defendant's sentence as correlative to the perceived import of a case, that metric again returns the focus

¹⁴⁸ The most recent annual report from the FBI and HHS on the Health Care Fraud and Abuse Control Program provides a clear example of how pervasively quantitative measurements can dominate descriptions of the results of agency enforcement efforts. Under the heading "Enforcement Actions," the first paragraph of the first page of the report begins as follows:

In FY 2012, the Department of Justice (DOJ) opened 1,131 new criminal health care fraud investigations involving 2,148 potential defendants. Federal prosecutors had 2,032 health care fraud criminal investigations pending, involving 3,410 potential defendants, and filed criminal charges in 452 cases involving 892 defendants. A total of 826 defendants were convicted of health care fraud-related crimes during the year.

HCF ANNUAL REPORT FOR FY 2012, *supra* note 9, at 1.

¹⁴⁹ Most press releases issued about health care fraud reflect a clear emphasis on the dollar amount of the fraud. *See, e.g.*, Press Release, U.S. Attorney's Office, S. Dist. of Fla., Patient Recruiter and Therapy Staffing Company Owner Sentenced for Roles in \$7 Million Health Care Fraud Scheme (Dec. 20, 2013), *available at* <http://www.justice.gov/usao/fls/PressReleases/2013/131220-03.html>, *archived at* <http://perma.cc/95SX-JS3C>. For instance, of the twelve press releases concerning health care fraud issued by the U.S. Attorney's Office for the Southern District of Florida during the last two months of 2013, only one does not reference the dollar amount of the fraud in its headline. *See* Press Release, U.S. Attorney's Office, S. Dist. of Fla., Two Miami Women Sentenced to Ten Years in Prison for Conspiring to Pay Healthcare Kickbacks (Dec. 23, 2013), *available at* <http://www.justice.gov/usao/fls/PressReleases/2013/131223-01.html>, *archived at* <http://perma.cc/K2NB-BRV2>; *see also News and Press Releases*, U.S. ATT'Y'S OFF. S. DISTRICT FLA., <http://www.justice.gov/usao/fls/newsArchive/news2013.html>, *archived at* <http://perma.cc/D2B3-VHLR> (last visited Apr. 8, 2015) (providing links to all 2013 press releases).

to dollars, given applicable sentencing frameworks.¹⁵⁰ Given the infrequency with which physical harms get recognized as the most significant aspect of a health care fraud case, it is not surprising when career-minded agents and prosecutors do not prioritize their identification.

5. *Government Interests*

Another contributing factor that can turn the focus of investigations away from patient harms arises from the federal government's multiple roles when it comes to the prosecution of health care fraud. In most cases, the government serves as a victim of the offender's conduct—often, the victim with the biggest financial losses—and as the enforcer of the criminal laws that proscribe that conduct.¹⁵¹ More broadly, the government is the largest beneficiary of the billions of dollars in financial recoveries that it obtains through criminal cases of health care fraud, including not only with respect to restitution but also through criminal fines and the forfeiture of assets.¹⁵² While the government's roles as victim and financial beneficiary do not necessarily conflict with its role as protector of the public interest, there is at least the potential that the government's own financial interests in health care fraud recoveries could influence *how* it performs its enforcement duties.

As the enforcer of the criminal laws, the government has the burden of demonstrating the amounts of loss sustained by the victims of an offender's crime by a preponderance of the evidence.¹⁵³ If the government meets its burden, and if the crime was committed by fraud or deceit, then the Mandatory Victim Restitution Act of 1996 (MVRA) requires the sentencing judge to issue restitution orders in those amounts.¹⁵⁴ As a victim, the government has a clear interest in maximizing the amount of criminal restitution that an offender pays. Thus, in cases involving both economic and physical harms, when there are limited or insufficient resources to collect and assemble evidence sufficient to establish all the different kinds of harm, the government's broad interest as a restitution-maximizing victim naturally incentivizes it to focus its enforcement resources on developing evidence of the economic harms.

However, more significant than the government's interest in collecting restitution is its broader financial interest in maximizing the overall amount of monies, including criminal fines, collected through its health care fraud enforcement efforts. The funds recovered through those efforts do not simply get deposited back into the general federal Treasury. HIPAA, which controls the disposition of health care fraud recoveries, provides for a significant part of the recovered monies to be appropriated back annually to the Health Care Fraud and Abuse Control Account

¹⁵⁰ See *supra* Part III.B.2.

¹⁵¹ See *supra* notes 54–56 and accompanying text.

¹⁵² See HCF ANNUAL REPORT FOR FY 2012, *supra* note 9, at 1, 5.

¹⁵³ See 18 U.S.C. § 3664(e) (2012).

¹⁵⁴ See *id.* § 3663A.

(the HCFAC Account), a special account created to fund law enforcement activities that specifically target health care fraud.¹⁵⁵

Because large sums from the HCFAC Account are distributed back to law enforcement agencies and prosecutors' offices each year,¹⁵⁶ those agencies and offices (namely, the FBI, HHS, and the United States Attorney's Offices) have a significant interest in maximizing the health care fraud recoveries that fund the HCFAC Account and, indirectly, fund their own future budgets. Some have described this structure as a sort of "bounty system" that raises potential conflicts of interest.¹⁵⁷

There is a risk, for instance, that government agencies with a financial interest in monies recovered through criminal fines might tailor investigations and prosecutions with an eye toward maximizing the amounts of those fines. Given that judges determine minimum and maximum fine amounts based in part on the offense levels applicable to an offender under the federal sentencing guidelines,¹⁵⁸ and in light of the fact that the offense levels for health care fraud offenders are determined largely based on the amount of economic loss,¹⁵⁹ the government's interest in maximizing those fines constitutes yet another incentive that steers resources toward developing proof of economic harms.

IV. CONSEQUENCES OF OMITTING PATIENT HARMS

Why does it matter if the physical harms suffered by patients as a result of criminal health care fraud do not get recognized and incorporated into criminal cases? After all, the law provides other avenues for redress of patient injuries, such as through civil lawsuits for medical malpractice. Why should prosecutions premised on deceit and fraud be bogged down with concepts of harm that seem more befitting a tort action or an assault case?

¹⁵⁵ See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 201(b), 110 Stat. 1936, 1993. For fiscal years 2010 through 2012, the FBI and HHS reported that the average return on investment for the Health Care Fraud and Abuse Control Program was "\$7.90 returned for every \$1.00 expended." HCF ANNUAL REPORT for FY 2012, *supra* note 9, at 8.

¹⁵⁶ In fiscal year 2012, the FBI received \$136.2 million in funding, which was used to support 478 agent positions and 320 support positions, and the HHS Office of Inspector General received \$225.8 million to support law enforcement efforts against health care fraud. Collectively, the United States Attorney's Offices received \$35.4 million to support civil and criminal health care fraud enforcement and litigation, and an additional \$8.5 million was allocated to the Criminal Division of the Department of Justice in support of criminal health care fraud litigation and interagency coordination. See HCF ANNUAL REPORT FOR FY 2012, *supra* note 9, at 7, 78, 83, 91.

¹⁵⁷ See Roger Feldman, *An Economic Explanation for Fraud and Abuse in Public Medical Care Programs*, 30 J. LEGAL STUD. 569, 573-74 (2001); Krause, *Patient-Centered Approach*, *supra* note 13, at 597.

¹⁵⁸ See U.S. SENTENCING GUIDELINES MANUAL § 5E1.2 (2013).

¹⁵⁹ See *supra* Part III.B.2.

I offer three sets of reasons. The first relates to punishment. Failing to meaningfully account for patient harms skews judicial assessments of important factors relevant to the sentencing of offenders. The second pertains to the social meaning of criminal health care fraud. The omission of patient harms undermines the expressive power of punishment and limits the social meaning of health care fraud in ways that hinder the effectiveness of law enforcement efforts to combat it. Finally, the third relates to patients. There is reason to doubt whether many of the patients harmed by offenders can meaningfully seek and obtain redress outside the scope of a criminal prosecution. Moreover, their recognition as crime victims can be important for reasons that extend beyond restitution.

A. *Skewed Punishments*

Failures to account for patient harm at sentencing can undermine the accuracy with which judges assess the seriousness of offenses. Defects in such assessments compromise decisions about what constitutes “just deserts” for purposes of retribution or how much punishment is enough under a deterrence rationale.¹⁶⁰ If, for example, a health care fraud offender defrauds Medicare of \$100,000 by providing patients with unnecessary treatments for diabetes, a judge’s assessment of the seriousness of the crime will be distorted if she bases it solely on the economic loss without knowledge that the treatments caused three patients to suffer significant bodily injury. Punishment premised upon flawed assessments of the seriousness of an offense will be skewed.

Some criminal law theorists reject the view that the harm from an offender’s conduct makes the offender any more deserving of punishment.¹⁶¹ Professors Larry Alexander and Kimberly Kessler Ferzan have argued the exclusive focus should be on an actor’s culpability or, more specifically, the “actor’s choice to release an unjustifiable risk of harm.”¹⁶² Most people agree, at the very least, that an offender’s mindset should bear upon the issue of punishment.¹⁶³ However, just as with

¹⁶⁰ Retributivists generally believe punishment is justified by an offender’s moral culpability. Michael S. Moore, *The Moral Worth of Retribution*, in RESPONSIBILITY, CHARACTER, AND THE EMOTIONS: NEW ESSAYS IN MORAL PSYCHOLOGY 179, 179 (Ferdinand Schoeman ed., 1987). The theory of deterrence is premised upon the idea that wrongdoers are deterred when the cost of their conduct, multiplied by the probability of being punished for it, outweighs the expected benefits of the conduct. See Gary S. Becker, *Crime and Punishment: An Economic Approach*, 76 J. POL. ECON. 169, 172–80 (1968); Frank G. Carrington, *Deterrence, Death, and the Victims of Crime: A Common Sense Approach*, 35 VAND. L. REV. 587, 588–89 (1982).

¹⁶¹ See ALEXANDER & FERZAN, *supra* note 21, at 171 (“[C]urrent [criminal] law is incorrect to the extent that it provides that resulting harm makes an actor more blameworthy and deserving of more punishment.”).

¹⁶² See *id.* at 228.

¹⁶³ See Francis X. Shen et al., *Sorting Guilty Minds*, 86 N.Y.U. L. REV. 1306, 1354 (2011) (concluding from an empirical experiment that punishment decisions of study participants across the purposeful, negligent, and blameless categories adhered to the

assessments of harm, a judge's assessments of a health care fraud offender's culpability is compromised when she lacks awareness that an offender *knowingly* or *recklessly* exposed patients to harm or risks of harm in furtherance of a fraudulent scheme.

It seems intuitive that, all else being equal, a doctor who defrauds Medicare of \$500,000 by submitting multiple bills for legitimate medical services deserves markedly less punishment than a doctor who commits the same amount of fraud but does so by administering unnecessary tests that the doctor knows will expose patients to unsafe levels of radiation. Yet, at sentencing, without the benefit of evidence concerning those physical risks of harm, a judge would not be able to distinguish between the defendants' dissimilar levels of culpability.¹⁶⁴

B. Social Meanings of Criminal Health Care Fraud

When we, as a society, punish, we do so mainly to avert future harm and to inflict deserved suffering, but under the expressive theory of punishment, the act of punishment itself has independent meaning. As Professor Joel Feinberg observed, "punishment is a conventional device for the expression of attitudes of resentment and indignation, and of judgments of disapproval and reprobation, on the part either of the punishing authority himself or of those 'in whose name' the punishment is inflicted."¹⁶⁵ The expressive power of punishment reflects society's moral condemnation of an offender's behavior. As a result, what conduct a society punishes reflects whose interests are valued.¹⁶⁶

When the criminal justice bureaucracy omits patients and their harms from cases of health care fraud, the patient-harming aspects of offenders' behavior escapes society's judgment, and sentences are unable to signal the degree to which such behavior is morally wrongful. We lose the opportunity to show that we, unlike the offender, value the interests of patients and are committed to protecting them.¹⁶⁷

hierarchy assumed by the Model Penal Code).

¹⁶⁴ This is not to say that health care fraud defendants should be receiving more time in prison than they already do, although that may be the case with respect to some offenders who knowingly or recklessly expose patients to harm. The point is that a system that fails to recognize victimized patients is one that cannot properly calibrate sentences to advance traditional purposes of punishment.

¹⁶⁵ JOEL FEINBERG, *DOING AND DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY* 98 (1970). Punishment expresses society's judgment in a way that mirrors the symbolic meaning of an offender's decision to commit the crime. As Professors Stephanos Bibas and Richard Bierschbach observed, "[t]he crime . . . carries a symbolic message from the wrongdoer that the community's norms do not apply to him and that he is superior to the victim and others like him." Stephanos Bibas & Richard A. Bierschbach, *Integrating Remorse and Apology into Criminal Procedure*, 114 *YALE L.J.* 85, 109 (2004).

¹⁶⁶ See Dan M. Kahan & Martha C. Nussbaum, *Two Conceptions of Emotion in Criminal Law*, 96 *COLUM. L. REV.* 269, 352 (1996).

¹⁶⁷ See Tracey L. Meares et al., *Updating the Study of Punishment*, 56 *STAN. L. REV.* 1171, 1200 (2004).

We, as a society, miss the chance to reinforce social norms that denounce an offender's disrespect for an injured patient's moral worth. When we fail time and again to express those social norms, there are consequences.

One of the biggest consequences has to do with *perceptions* of the crime of health care fraud—perceptions of insiders who investigate and prosecute the crime, individuals who contemplate committing the crime, and the public. Under current frameworks, health care fraud is widely perceived as a white-collar crime about money, not about the abuse of patients. As a result, we regard it to be less morally blameworthy than crimes known to cause physical injury, such as assault or robbery.¹⁶⁸

Our failure to incorporate patient harms into the social meaning of health care fraud does more than prevent us from recognizing the moral worth of patients or from expressing the appropriate moral condemnation due to offenders. It also risks hindering our success in combating the crime and preventing the enormous financial drain that it inflicts upon our health care system each year. For example, individuals, including those contemplating whether to commit health care fraud, take social meanings into account when making decisions about their actions.¹⁶⁹ According to several empirical studies, people are more willing to obey a law if they believe that others view the law as worthy of obedience.¹⁷⁰ When it comes to health care fraud, however, some who view enforcement efforts as overly intrusive into the patient-physician relationship or as unfairly targeting well-meaning doctors who are unable to keep up with arcane billing rules voice considerable ambivalence.¹⁷¹

The popular notion that the only victims of health care fraud are the government and faceless insurance companies, not the most sympathetic of entities, contributes to a climate in which some question the wisdom of aggressive enforcement. If patient harms were more firmly established within the social meaning of health care fraud, it seems likely that complaints against aggressive enforcement would be muted and that potential offenders would be less willing to risk incurring the moral condemnation of others. Because the deterrence effects of punishment would be significantly amplified, each conviction and sentence could have greater potential to reduce the number of future acts of health care fraud. Incorporating physical harms into the social meaning of health care fraud could be a potent means of reducing its vast economic harms to society, private insurers, and the federal government.

If offenders, criminal justice insiders, and the public all recognized patient harms as being a part of the social meaning of health care fraud, there likely would be significant ripple effects across a variety of actors within the criminal justice bureaucracy, strengthening overall enforcement efforts and promoting greater recognition of patient harm. Presumably, there would be fewer instances of jury

¹⁶⁸ See *supra* note 83 and accompanying text.

¹⁶⁹ See Dan M. Kahan, *The Secret Ambition of Deterrence*, 113 HARV. L. REV. 413, 419–21 (1999).

¹⁷⁰ See Dan M. Kahan, *What Do Alternative Sanctions Mean?*, 63 U. CHI. L. REV. 591, 604 & n.54 (1996) (citing and describing several studies).

¹⁷¹ Joan H. Krause, *Skilling and the Pursuit of Health Care Fraud*, 66 U. MIAMI L. REV. 363, 365 (2012).

nullification if jurors were less prone to view an offender at trial as a “well-meaning doctor” whose conduct merely caused a minor reduction in an insurance company’s yearly profits. During the course of grand jury investigations, grand jurors would be more likely to have potential patient harms in mind, causing them to press prosecutors and witnesses, including testifying investigators, to address the issue. Similarly, it would be more common for judges at sentencing to probe how an offender’s scheme could have impacted the health and treatment of patients, and they would be better prepared to factor such information into their assessments of harm and culpability. Finally, because qualitative assessments of the work of investigators and prosecutors tend to be keyed to the social meaning of a crime, the criteria for those assessments would likely place greater weight on unearthing evidence of patient harms.

C. Patients

Health care patients in the United States do not have a reputation for being shy about filing medical malpractice lawsuits. If a patient receives unnecessary medicine or undergoes medically inappropriate procedures, the criminal justice system does not provide the only avenue for redress. Why, then, should thin criminal justice resources be spread more thinly to account for patient harms?

The first part of the answer has to do with the reality faced by patients who seek redress through civil claims.¹⁷² There is reason to believe patients’ access to remedies through medical malpractice actions is more limited than might be expected. In a recent national survey of attorneys conducted by Professor Joanna Shepherd, over 75% of surveyed malpractice attorneys indicated they reject more

¹⁷² As the cases described in Part II demonstrate, many patients are exposed to latent harms and risks of harm they might not discover on their own, such as from unnecessary exposure to high levels of radiation, unneeded chemotherapy, or diluted medicine. *See supra* notes 59–66 and accompanying text. In some instances, harmful consequences might not manifest until years later. Without receiving notice of a criminal case, patients might never learn that criminal conduct contributed to their declining health.

This problem is exacerbated by secrecy rules that govern federal grand jury investigations, which forbid prosecutors and agents from disclosing “matter[s] occurring before the grand jury.” *See* FED. R. CRIM. P. 6(e)(2)(B). The secrecy rules apply even after the conclusion of an investigation and related criminal proceedings. *See* *Douglas Oil Co. of Cal. v. Petrol Stops Nw.*, 441 U.S. 211, 222 (1979). As a result, when agents and prosecutors gain knowledge through a grand jury investigation that a target’s conduct had the potential to expose patients to harm or risks of harm, that information is likely to stay a secret unless the prosecutors incorporate it into the prosecution of the criminal case. Outside the context of a criminal prosecution, they cannot disclose grand jury information directly to hospitals or to patients that might have been affected by a scheme. *See* FED. R. CRIM. P. 6(e)(2)(B). Generally, the parties cannot even disclose the information to the investigators and prosecutors conducting a parallel civil investigation. *See* *United States v. John Doe, Inc. I*, 481 U.S. 102, 114–16 (1987). If they charge and prosecute the criminal case as a traditional fraud case and focus only on the economic harms suffered by payers, then harms or potential harms caused to patients might never come to light.

than 90% of cases they screen.¹⁷³ Citing high costs of litigation, the majority reported they would not consider accepting a new case unless it met certain threshold damages values.¹⁷⁴ Even for a case almost certain to be successful on the merits (such as one involving a civil defendant already convicted of criminal health care fraud), medical malpractice attorneys reported they would not accept the case unless expected damages amounted to at least \$250,000.¹⁷⁵ Without access to legal representation, patients have miniscule chances of receiving compensation through medical malpractice claims.¹⁷⁶ In contrast, restitution for crime victims' bodily injuries are automatic under the MVRA, which requires sentencing judges to issue restitution orders covering, among other things, the costs of medical treatments needed to address injuries, the costs of physical and occupational therapy and rehabilitation, and income lost by victims as a result of offenses.¹⁷⁷

However, being recognized as a victim of a crime is about more than restitution. Scholars have explored how recognition can be important in other ways. It can dignify victims' personal experiences by providing them with opportunities to address the court.¹⁷⁸ It can have healing effects, countering the parts of victimization that leave some victims feeling powerless and ashamed.¹⁷⁹ The presence of victims in the courtroom also gives criminal defendants important opportunities to express remorse and apologize to those they have wronged.¹⁸⁰

While being victimized can be a traumatic experience for many crime victims, violations felt by health care patients can be especially destructive. Professors Stephanos Bibas and Richard Bierschbach describe a relational concept of crime premised upon the idea that crime "disrupts status relationships among offenders, victims, and [their] communities."¹⁸¹ They note, for example, the victim of a

¹⁷³ See Joanna Shepherd, *Uncovering the Silent Victims of the American Medical Liability System*, 67 VAND. L. REV. 151, 154 (2014).

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ See David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1094 (2006) (conducting an empirical study from a data set of medical malpractice claims in Texas and finding that only 0.1% of claims that resulted in payment were brought by claimants who represented themselves in litigation).

¹⁷⁷ See 18 U.S.C. § 3663A(b)(2) (2012).

¹⁷⁸ See Mary Margaret Giannini, *Equal Rights for Equal Rites?: Victim Allocation, Defendant Allocation, and the Crime Victims' Rights Act*, 26 YALE L. & POL'Y REV. 431, 455 (2008).

¹⁷⁹ See Paul G. Cassell & Steven Joffe, *The Crime Victim's Expanding Role in a System of Public Prosecution: A Response to the Critics of the Crime Victims' Rights Act*, 105 NW. U. L. REV. COLLOQUY 164, 182–83 (2011). Professor Dan Kahan has described the distinctive meaning of criminal wrongdoing as the "denial of some important value, such as the victim's moral worth." Kahan, *supra* note 170, at 597.

¹⁸⁰ Bibas & Bierschbach, *supra* note 165, at 87 (explaining how criminal procedure neglects the power of remorse and apology, even though victims and victimized communities have traditionally viewed them as essential parts of criminal justice).

¹⁸¹ *Id.* at 109.

mugging feels distress not only because of lost money from a wallet but also because of natural feelings of violation and belittlement caused by the perpetrator and his act.¹⁸² Such feelings are undoubtedly magnified when commission of the crime involves betrayal of the significant trust commonly associated with patient-doctor relationships. Many patients have no choice but to trust deeply in their physicians, owing in part to the complexity of medical information, the immeasurability of the quality of health care, and the general uncertainty and inability of patients to make informed health care decisions.¹⁸³ When patients suffer from especially poor health, they can feel even more powerless and dependent on their physicians. Under such circumstances, violations associated with health care fraud have the potential to be particularly devastating to patients, and the cathartic experience of gaining recognition as a crime victim can be all the more important.

V. IMPLICATIONS FOR CRIMINAL HEALTH CARE FRAUD AND BEYOND

The phenomenon of missing victims in health care fraud has normative implications not only for how we conceptualize, investigate, and prosecute criminal cases of health care fraud, but also for how the machinery of criminal justice approaches and defines all complex crimes with malleable harms, including many white collar offenses. Before I address the broader implications, I offer a package of reforms specific to criminal health care fraud.

A. *Recasting Criminal Health Care Fraud*

Today, criminal health care fraud is out of sync with some of our most basic intuitions about harm, punishment, victims, and the purposes of the criminal law. In Part III, I explained how statutory and sentencing frameworks, organizational structures, and forces within the bureaucracy of the federal criminal justice system influence agents and prosecutors to channel scarce resources towards identifying the economic losses suffered by the government and private insurers. However, they do so at the expense of the real people who suffer the worst kinds of harm and who are the least powerful. To begin the process of recasting health care fraud in a way that better recognizes the physical harms suffered by patient-victims, I suggest the following combination of modest adjustments and large-scale, systemic reforms.

1. *Statutory Gradations of Harm*

Given that § 1347 is the primary health care fraud statute and can be used to prosecute the broadest range of schemes, it seems a logical place to concentrate statutory reform efforts. As I explained in Part III, although the statute includes a penalty structure that increases maximum penalties when violations result in serious

¹⁸² *Id.*

¹⁸³ See Barak D. Richman, *Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, 90 CORNELL L. REV. 705, 733–34 (2005).

bodily injury or death,¹⁸⁴ § 1347 fails to account meaningfully for most patient harms and risks of harm.

An example of a law from the realm of violent crime that has a more effective and comprehensive penalty structure is the bank robbery statute, 18 U.S.C. § 2113. Like the health care fraud statute, § 2113 criminalizes certain kinds of conduct aimed at obtaining money from particular classes of victim (banks vs. health care benefit programs).¹⁸⁵ The two statutes are also similar in that they both provide increased penalties based on the harmful nature of the means used by an offender to achieve her goal of unjust enrichment. But § 2113 does so in a way that is far more comprehensive. Mere theft from a bank of over \$1,000 without the use of force, violence, intimidation, or entry into the bank is punishable by up to ten years.¹⁸⁶ The cap increases to twenty years, however, if the offender uses force, violence, or intimidation, or if the offender actually enters or attempts to enter the bank.¹⁸⁷ The cap increases again to twenty-five years if the offender assaults any person or puts a person's life in jeopardy by the use of a dangerous weapon.¹⁸⁸ If an offender forces a person to accompany her without the person's consent or kills any person, a ten-year mandatory minimum applies.¹⁸⁹ If the offense results in a person's death, the statute penalizes the offender with a mandatory life sentence or death.¹⁹⁰

Essentially, the structure of § 2113 dispenses punishment for conduct meant to enrich the offender based on a sliding scale keyed to the offender's willingness to risk harm to others in achieving her goal. Using a threatening demand note to obtain money triggers a higher maximum than merely taking money when no one is looking. Bringing a loaded handgun into the bank results in more potential punishment than the demand note. Forcing a hostage to walk to the getaway car yields not only a higher maximum but also a mandatory minimum sentence. Finally, causing the death of another person results in a mandatory life sentence with the possibility of a death penalty.

Notice that, aside from the most severe penalties reserved for robberies that result in death, the other penalty increases are not contingent on anyone actually suffering physical harm. Rather, the statute punishes knowing or reckless conduct that puts the health and safety of others at risk. In contrast, the health care fraud statute does not differentiate between offenses that put patients at risk of harm and those that do not. It does not even distinguish between schemes that actually cause bodily harm to patients and those that do not. And the relatively meaningless bump in the maximum for causing serious bodily injuries applies only to a small sliver of cases.

Amending § 1347 to include a penalty structure resembling that of § 2113 could be a significant first step both in shifting the attention of criminal justice insiders to

¹⁸⁴ See *supra* note 117 and accompanying text.

¹⁸⁵ 18 U.S.C. § 2113 (2012).

¹⁸⁶ *Id.* § 2113(b).

¹⁸⁷ *Id.* § 2113(a).

¹⁸⁸ *Id.* § 2113(d).

¹⁸⁹ *Id.* § 2113(e).

¹⁹⁰ *Id.*

patient harms and in broadening the social meaning of health care fraud to express moral condemnation of conduct that risks the well-being of patients. Such a structure, as applied to health care fraud, could signal that exposing patients to any *risk* of physical harm merits differential treatment, and that causing any bodily injury, even if below the level of “serious bodily injury,” is deemed worthy of consequence. Mandatory minimum penalties for schemes that result in death or serious bodily injury also seem worth consideration.

2. *Discrete Sentencing Guidelines*

More than anything else, the primacy of economic loss in the sentencing of health care fraud cases is attributable to the fact that the guidelines’ ranges for all health care fraud offenders are calculated under section 2B1.1, the set of provisions applicable to all cases of fraud and theft.¹⁹¹ It seems that one of the most effective ways to give greater weight to patient harms, as well as to signal the moral condemnation appropriate for offenders who violate patient trust, would be to establish a separate set of guidelines applicable to all cases of health care fraud bearing upon issues of patient health and safety.¹⁹²

The mere act of creating a new set of guidelines for cases that present risks to patient health and safety could yield fruit simply by prompting investigators, prosecutors, judges, and others to ask themselves whether the particular case before them fits within that category. For example, prior to indictment, prosecutors often prepare memoranda applying relevant statutory and sentencing frameworks to the facts and evidence of particular cases. Nudging prosecutors earlier in an investigation to be more cognizant of how a fraudulent scheme might have impacted patients could encourage them to channel more resources toward the investigation of patient harms.

Similar to the kinds of gradations I described above in reference to an amended § 1347, the specific offense characteristics of a new set of guidelines could gauge the seriousness of health care fraud offenses based in part on factors pertaining to the exposure of patients to risks of bodily or psychological injury, actual instances of bodily or psychological injury, instances of serious bodily injury, and instances of death. The provisions could also account for the magnitude of patient harms by differentiating more precisely between cases that affect a single patient, five patients, ten patients, twenty patients, and so forth.¹⁹³ Perhaps most importantly, while the

¹⁹¹ See *supra* Part III.B.2.

¹⁹² Assuming § 1347 was amended to distinguish between schemes that expose patients to risks of harm and those that do not, then it would be relatively easy for the Sentencing Commission to key offenses charged under the “patient risk” section of § 1347 to a new, separate set of sentencing provisions.

¹⁹³ Just as bank robbers face increased sentencing ranges for each additional bank they rob, we may want to adjust the grouping rules for health care fraud so that offenders face increased sentencing ranges for each additional patient harmed. U.S. SENTENCING GUIDELINES MANUAL § 3D1.2 (2013) (explaining the grouping rules for closely related offense counts).

amount of economic harm contemplated by a scheme should remain a significant factor in cases involving patient harm, it should not be so weighty as to overshadow the patient-harm elements.

3. *Notice Mechanisms*

Presently, no reliable mechanism exists to provide notice to patients exposed to risks of harm from health care fraud. Only those individuals known by agents and prosecutors to have been directly and proximately harmed as a result of a scheme qualify as “crime victims” under the CVRA, and unless identified during the course of the investigation, even their names may not make it onto the list of victims designated to receive notifications of CVRA rights.¹⁹⁴

One potential fix for this notification problem involves developing a notice mechanism applicable to all cases in which an alleged health care fraud scheme may have exposed patients to risks of harm. Such a mechanism could provide for automatic notification at the time of indictment to all known patients who received treatment, services, or devices from the charged defendant (perhaps limited by a certain window of years).¹⁹⁵ The content of the notification could be narrow in scope, advising that the defendant had been charged with participating in a health care fraud scheme that involved some risk to patients, and that the recipient was receiving notice by virtue of his status as a past patient. The notice would not advise the recipients that they were “crime victims,” but it should provide sufficient information to enable recipients to obtain copies of the indictment and to contact the case agents or prosecutors.

This kind of notification system could be useful in several ways. It could improve the chances that actual crime victims receive notice of a crime that harmed them. It could assist investigators and prosecutors in identifying patient harms and gathering evidence about them for later use at trial and sentencing. It could alert patients to latent injuries that could benefit from medical attention. And, finally, the broad use of such a mechanism over time could help expand the social meaning of health care fraud to better reflect the risks of harm to patients.

4. *Dynamic Enforcement*

As criminal acts of terrorism became more sophisticated and dangerous, the FBI gradually recognized that it needed to make changes to the internal organization of its agents and resources to maximize the effectiveness of prevention and enforcement efforts. It shifted agents to new investigative units, created multi-agency task forces, and dedicated resources to develop expert knowledge in several relevant areas, such as cyber warfare, international financing, and technologies

¹⁹⁴ See *supra* note 145 and accompanying text.

¹⁹⁵ The notification process under this mechanism could be triggered at the time of indictment for all cases charged under the “risk of patient harm” prong of an amended § 1347.

central to the development and detection of weapons of mass destruction.¹⁹⁶ In contrast, the internal organization of the investigators and prosecutors who handle health care fraud remains fixed on a white-collar model that is ill equipped to detect and address patient harms. A reform agenda should include efforts to reconfigure the criminal justice bureaucracy in ways that enhance its ability to identify and treat the harms suffered by patients.

After government officials began recognizing health care fraud as a high priority in the 1990s, the government took steps to increase the effectiveness of enforcement efforts, such as by creating the Health Care Fraud and Abuse Control Program (HCFAC) in 1996 and the Health Care Fraud Prevention & Enforcement Action Team (HEAT) in 2009.¹⁹⁷ While those programs resulted in additional enforcement resources and enhanced coordination among federal agencies and state and local law enforcement, the resources and task forces created through those programs were not used to make systemic improvements to the identification and treatment of patient harms. The anti-fraud provisions of the Affordable Care Act focused even greater attention on economic harms.¹⁹⁸ The FBI continues to assign the bulk of health care fraud investigations to its white-collar crime unit, and most resources remain dedicated to auditing claims for reimbursement, scrutinizing payments to providers, and calculating estimates of economic loss.

Reform of the bureaucracy should begin with a close look at how we can create a more balanced approach to detecting and addressing the harms wrought by health care fraud. For instance, the makeup of investigative task forces could be diversified to include more medical experts who would have the ability to evaluate potential health risks raised by a target's conduct. Resources dedicated to review of claim submissions could be shifted in part to allow for more comprehensive review of patient medical records. Agents could make it a more regular practice to conduct interviews of a target's patients. Investigative teams could include more agents and prosecutors with experience handling cases involving individual victims. We should also strive to improve coordination between those law enforcement personnel with experience operating within white-collar units and those from the outside who have skill sets more adept at developing evidence pertaining to physical harms.

Finally, we should consider decoupling the funding of law enforcement efforts against health care fraud from the monetary recoveries that result from those efforts. When the annual report on health care fraud enforcement efforts touts that the return on investment from enforcement efforts was \$7.90 for each \$1.00 expended,¹⁹⁹ that sends a strong signal that the *value* of enforcement efforts should be measured in terms of dollars recovered, creating unnecessary bureaucratic pressures to keep that ratio high by focusing on financial harms.

¹⁹⁶ See *Counterterrorism*, FED. BUREAU INVESTIGATION, <http://www.fbi.gov/about-us/ten-years-after-the-fbi-since-9-11/just-the-facts-1/counterterrorism>, archived at <http://perma.cc/A978-EYX2> (last visited Apr. 9, 2015).

¹⁹⁷ See HCF ANNUAL REPORT FOR FY 2012, *supra* note 9, at 3, 8–9.

¹⁹⁸ See *supra* notes 129–131 and accompanying text.

¹⁹⁹ See *supra* note 155.

B. Broader Normative Implications

The phenomenon of missing victims in health care fraud is an increasingly urgent problem now that health care fraud itself has become such a dominant part of federal law enforcement. But it also raises a set of deeper issues concerning the machinery of criminal justice, issues that suggest a research agenda for further work.

At a fundamental level, we need to think more about which kinds of harms and victims justify deployment of our powerful, yet limited, criminal justice resources. Because the scarcity of those resources is a feature, not a bug, of our criminal justice system, it is all the more important that we use them in ways that comport with societal values and best serve the purposes of criminal punishment. In areas where we expend those limited resources to remedy only economic harms suffered by only the most powerful entities, such as the government or large corporations, there is reason to question whether our system has gone astray. If resourceful entities have the capacity to seek redress elsewhere, perhaps we should be conserving the precious tools of our criminal justice apparatus to better stand up for those victims who need them the most, the real people who suffer the kinds of harms that can devastate a person's life.

A related area of inquiry centers on *how* agents and prosecutors make decisions about harms and victims. The malleability of harms and victims in health care fraud should trouble us for what it reveals, more generally, about the inconspicuous shaping of criminal cases occurring in places outside the realm of public accountability. The further we get from classic *mala in se* offenses, the greater the risk that external statutory and sentencing frameworks, in combination with internal bureaucratic forces and incentives, will motivate insiders to shape cases in ways that do not comport with our fundamental beliefs about which wrongs and which victims most merit recognition. If insiders in the deep recesses of the criminal justice bureaucracy are the ones deciding who gets to be a victim and which harms get to be recognized, we should ensure that there are sufficient checks to steer their decisions towards the societal values that we choose to promote. As an initial matter, more work needs to be done to identify and understand the underlying forces and hidden levers of power within the machinery of criminal justice. We cannot make adjustments to its output without a more thorough understanding of the inner workings of the criminal justice machine.

The recent trend in scholarship on law enforcement has been toward focusing on police officers and local prosecutors at the state level, in part out of recognition that the federal system is distinct and accounts for a relatively small share of all criminal cases. But there is good reason to shift more of the focus to the agents and prosecutors who operate at the federal level. Federal cases tend to result from investigations that are more proactive and have far more resources to target the kinds of complicated criminal conduct that might otherwise escape prosecution, like health care fraud. These are precisely the kinds of cases most likely to present malleable harms and victims. The federal system also merits greater study in light of the growing impact of health care fraud and other complex federal crimes on the

economy and law enforcement. To better align our values with the shaping processes that take place at the federal level, we need to improve our understanding of the practices of federal agents and prosecutors in particular. Who are their constituencies? How can we encourage them to be more responsive to the needs of individual victims? How do we ensure the interests of the public, as opposed to agent-driven or prosecutor-driven interests, are what control the winding paths taken by complex federal investigations and prosecutions?

Finally, more work is needed to understand how the investigative and prosecutorial decisions of agents and prosecutors affect intuitions about punishment in white-collar cases rooted in fraud. Punishment intuitions in such cases, unlike classic *mala in se* crimes, are particularly untethered and appear to seesaw depending on who was harmed, how they were harmed, and why they were harmed. All of those factors speak to the gravamen of the wrong, but none of them prove the elements of the crime. At trial, it is enough for the government to show a defendant acted with intent to defraud, regardless of the harmful consequences. As a result, agents exercise enormous discretion in gathering (or not gathering) evidence about those harm factors, and prosecutors can exert tremendous power by using them as leverage during the plea bargaining process. By offering stipulations that cap the amount of harm or limit the number or kinds of victims, for example, prosecutors can exploit the ungrounded nature of our intuitions for punishing white-collar offenses for the purpose of inducing plea agreements. These kinds of bargaining chips are off the books and, for that reason, raise concerns. We need to better understand the power that derives from being able to shape the contours of a malleable white-collar offense, and then be prepared to explore whether it is being exercised in ways that best serve the interests of the public.

VI. CONCLUSION

The names of the missing victims of health care fraud appear in plain sight on the claim submission forms and payment records that agents and prosecutors collect and review during the course of their financial investigations. But in many cases, the dollar figures next to their names tell only part of the health care fraud story. The time has come to implement reforms that will spur criminal justice insiders to take the steps necessary to seek out and tell the rest of the story. When we fail to identify and recognize the patients whose health and well-being are threatened by acts of health care fraud, we devalue those patient-victims and skew the punishments of the offenders who exploit patients as a means to enrich themselves. The effectiveness of our enforcement efforts suffers as a result.

The phenomenon of missing victims has ramifications that extend beyond health care fraud. It highlights the importance of being more alert to the forces in the shadows of our criminal justice bureaucracy that shape and define the contours of criminal cases, especially many of the traditional white-collar offenses that present the most malleable harms and victims. Failure to do so risks resulting in a system of criminal justice that protects the interests of powerful corporate and government entities while neglecting the flesh-and-blood victims who need its protection the

most. We need to consider how investigative and prosecutorial discretion impacts not only criminals but also victims and, more generally, our intuitions about punishment and the social meanings of particular crimes. When criminal justice insiders exercise that discretion in ways that diverge from societal values and the public interest, we should be prepared to implement checks that steer them back in the right direction.