SUPREME COURT OF THE UNITED STATES

No. 99–116

JEFFREY ALLAN FISCHER, PETITIONER *v.* UNITED STATES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

[May 15, 2000]

JUSTICE KENNEDY delivered the opinion of the Court.

The federal bribery statute prohibits defrauding organizations which "receiv[e], in any one year period, benefits in excess of $10,000 under a Federal program." 18 U. S. C. §666(b). We granted certiorari to determine whether the statute covers fraud perpetrated on organizations participating in the Medicare program. Upon consideration of the role and regulated status of hospitals as health care providers under the Medicare program, we hold they receive "benefits" within the meaning of the statute. We affirm petitioner's convictions.

I

Petitioner Jeffrey Allan Fischer was president and partial owner of Quality Medical Consultants, Inc. (QMC), a corporation which performed billing audits for health care organizations. In 1993 petitioner, on QMC's behalf, negotiated a $1.2 million loan from West Volusia Hospital Authority (WVHA), a municipal agency responsible for operating two hospitals located in West Volusia County, Florida. Both hospitals participate in the Medicare program, and in 1993 WVHA received between $10 and $15

million in Medicare funds.

A February 1994 audit of WVHA's financial affairs raised questions about the QMC loan. An investigation revealed QMC used the loan proceeds to repay creditors and to raise the salaries of its five owner-employees, including petitioner. It was determined that petitioner had arranged for QMC to advance at least $100,000 to a private company owned by an individual who had assisted QMC in securing a letter of credit in connection with the WVHA loan. QMC, at petitioner's directive, also committed portions of the loan proceeds to speculative securities. These investments yielded losses of almost $400,000. The investigation further uncovered use of the loan proceeds to pay, through an intermediate transfer, a $10,000 kickback to WVHA's chief financial officer, the individual with whom petitioner had negotiated the loan in the first instance. QMC defaulted on its obligation to WVHA and filed for bankruptcy.

In 1996 petitioner was indicted by a federal grand jury on 13 counts, including charges of defrauding an organization which receives benefits under a federal assistance program, 18 U. S. C. §666(a)(1)(A), and of paying a kickback to one of its agents, §666(a)(2). A jury convicted petitioner on all counts charged, and the District Court sentenced him to 65 months' imprisonment and a 3-year term of supervised release. Petitioner, in addition, was ordered to pay $1.2 million in restitution.

On appeal petitioner argued that the Government failed to prove WVHA, as the organization affected by his wrongdoing, received "benefits in excess of $10,000 under a Federal program," as required by 18 U. S. C. §666(b). Rejecting the argument, the United States Court of Appeals for the Eleventh Circuit affirmed the convictions. 168 F. 3d 1273 (1999). It held that funds received by an organization constitute "benefits" within the meaning of §666(b) if the source of the funds is a federal program, like

Medicare, which provides aid or assistance to participating organizations. *Id.*, at 1276–1277. Entities receiving federal funding under ordinary commercial contracts, the court stated, fall outside the statute's coverage. *Ibid.* (citing and discussing *United States* v. *Copeland*, 143 F. 3d 1439 (CA11 1998) (holding that federal funds received under a contract to construct military aircraft did not constitute "benefits" within the meaning of §666(b))). The court added that its construction furthered "the statute's purpose of protecting from fraud, theft, and undue influence by bribery the money distributed to health care providers, and WVHA in particular, through the federal Medicare program and other similar federal assistance programs." 168 F. 3d, at 1277. It rejected the view that the Medicare program provides benefits only to its "targeted recipients," the qualifying patients. *Id.*, at 1278 (disagreeing with *United States* v. *LaHue*, 998 F. Supp. 1182 (Kan. 1998), aff'd, 170 F. 3d 1026 (CA10 1999)).

We granted certiorari, 528 U. S. ____ (1999), and we affirm.

II

A

The nature and purposes of the Medicare program give us essential instruction in resolving the present controversy. Established in 1965 as part of the Social Security Act, 42 U. S. C. §1395 *et seq.* (1994 ed. and Supp. III), Medicare is a federally funded medical insurance program for the elderly and disabled. In fiscal 1997 some 38.8 million individuals were enrolled in the program, and over 6,100 hospitals were authorized to provide services to them. U. S. Dept. of Health and Human Services, Health Care Financing Administration, 1998 Data Compendium 45, 75 (Aug. 1998). Medicare expenditures for hospital services exceeded $123 billion in 1998, making the Federal Government the single largest source of funds for partici-

pating hospitals. See U. S. Dept. of Health and Human Services, Health Care Financing Administration, Highlights, National Health Expenditures, 1998, Table 9 (May 11, 2000), http://www.hcfa.gov/stats/nhe-oact/tables/t9.htm. This amount constituted 32% of the hospitals' total receipts. *Ibid.*

Providers of health care services, such as the two hospitals operated by WVHA, qualify to participate in the program upon satisfying a comprehensive series of statutory and regulatory requirements, including particular accreditation standards. Hospitals, for instance, must satisfy licensing standards, 42 CFR §482.11 (1999); possess a governing body to "ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of patient care," §482.21; and employ a "well organized" medical staff accountable on matters relating to "the quality of the medical care provided to patients," §482.22(b). Medicare's implementing regulations also require hospitals, among many other standards, to maintain and provide 24-hour nursing services, §482.23; complete medical record services, §482.24; "pharmaceutical services that meet the needs of the patients," §482.25; and organized dietary services staffed with qualified personnel, §482.28. The regulations go further, requiring hospital facilities to "be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community." §482.41. Compliance with these standards provides the Government with assurance that participating providers possess the capacity to fulfill their statutory obligation of providing "medically necessary" services "of a quality which meets professionally recognized standards of health care." 42 U. S. C. §1320c–5(a). Peer review organizations monitor providers' compliance with these and other obligations. §1320c–3(a); 42 CFR §466.71 (1999). Sanctions for non-

compliance include dismissal from the program. 42 U. S. C. §1320c–5(b)(1).

Medicare attains its objectives through an elaborate funding structure. Participating health care organizations, in exchange for rendering services, receive federal funds on a periodic basis. §§1395g, 1395*l*. The amounts received reflect the "reasonable cost" of services rendered, defined as "the costs necessary in the efficient delivery of needed health services to individuals covered [by the program]." §1395x(v)(1)(A). Necessary costs are not limited to the immediate costs of an individual treatment procedure. Instead they are defined in broader terms: "Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." 42 CFR §413.9(b)(2) (1999). Allowable costs include amounts which enhance the organization's capacity to provide ongoing, quality services not only to eligible patients but also to the community at large. By way of example, amounts incurred for "certain educational programs for interns and residents, known as [graduate medical education] programs, are 'allowable cost[s]' for which a hospital (a provider) may receive reimbursement." *Regions Hospital* v. *Shalala*, 522 U. S. 448, 452 (1998) (citing 42 CFR §413.85(a) (1996)); see also §413.85(b) (1999); *Thomas Jefferson Univ.* v. *Shalala*, 512 U. S. 504, 507–508 (1994) (describing regulation of education programs). "These programs," the Medicare regulations explain, "contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. . . . [M]any communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing healthcare. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities." 42 CFR §413.85(c) (1999).

Medicare also permits, indeed encourages, these providers to deposit the amounts of reimbursements received for depreciation costs and other cash into sinking funds called "funded depreciation accounts." §413.134(e). Investment income earned on these funds does not operate to reduce a provider's interest expense, §413.153(b)(2)(iii), creating incentives to maintain modern medical equipment and facilities.

The Medicare regulations, furthermore, afford certain provider organizations "special treatment," intended to ensure the ongoing availability of medical services for qualifying patients. See 42 CFR pt. 412G (1999). Providers qualifying as "Medicare-dependent, small rural hospitals," for instance, are entitled to additional, "lump sum" payments to compensate for significant declines in demand for patient care. §412.108. The additional funds enable a provider to "maintai[n] [its] necessary core staff and services" and to satisfy its "fixed (and semi-fixed) costs." §§412.108(d)(3)(A), (B). So too does the Medicare program authorize "special treatment" for, among other providers, "sole community hospitals," "renal transplantation centers," and "hospitals that serve a disproportionate share of low-income patients." See §§412.92, 412.100, 412.106. The subsidies assist providers in satisfying those financial obligations necessary to continue as going concerns in accordance with the program's requirements. See, *e.g.*, §412.92(d)(2).

In the normal course Medicare disbursements occur on a periodic basis, often in advance of a provider's rendering services, 42 U. S. C. §1395g(a); 42 CFR §§413.60, 413.64 (1999). The payment system serves to "protect providers' liquidity," *Good Samaritan Hospital* v. *Shalala*, 508 U. S. 402, 406 (1993), thereby assisting in the ongoing provision of services. 42 CFR §413.5(b)(1) (1999) (requiring reimbursement method to "result in current payment so that institutions will not be disadvantaged, as they sometimes are

under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement"); §413.5(b)(6) (reimbursement system must operate under "recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements"). The program, then, establishes correlating and reinforcing incentives: The Government has an interest in making available a high level of quality of care for the elderly and disabled; and providers, because of their financial dependence upon the program, have incentives to achieve program goals. The nature of the program bears on the question of statutory coverage.

B

Section 666 of Title 18 of the United States Code prohibits acts of theft and fraud against organizations receiving funds under federal assistance programs. The statute in relevant part provides as follows:

> "(a) Whoever, if the circumstance described in subsection (b) of this section exists–
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> "(1) being an agent of an organization, or of a State, local, or Indian tribal government, or any agency thereof–
>
> "(A) embezzles, steals, obtains by fraud, or otherwise without authority knowingly converts to the use of any person other than the rightful owner or intentionally misapplies, property that–
>
> "(i) is valued at $5,000 or more, and
>
> "(ii) is owned by, or is under the care, custody, or control of such organization, government, or agency; or
>
> "(B) corruptly solicits or demands for the benefit of any person, or accepts or agrees to accept, anything of value from any person, intending to be influenced or rewarded in connection with any business, transaction, or series of transactions of such organization,

> government, or agency involving anything of value of $5,000 or more; or
>
> "(2) corruptly gives, offers, or agrees to give anything of value to any person, with intent to influence or reward an agent of an organization or of a State, local or Indian tribal government, or any agency thereof, in connection with any business, transaction, or series of transactions of such organization, government, or agency involving anything of value of $5,000 or more;
>
> "shall be fined under this title, imprisoned not more than 10 years, or both.
>
> "(b) The circumstance referred to in subsection (a) of this section is that the organization, government, or agency receives, in any one year period, benefits in excess of $10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance.
>
> "(c) This section does not apply to bona fide salary, wages, fees, or other compensation paid, or expenses paid or reimbursed, in the usual course of business."

Liability for the acts prohibited by subsection (a) is predicated upon a showing that the defrauded organization "receive[d], in any one period, benefits in excess of $10,000 under a Federal program." §666(b). Those benefits can be in the form of "a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance." *Ibid.* All agree Medicare is a federal assistance program, see 42 CFR §400.200 (1999), and that WVHA, as the organization defrauded by petitioner's actions, received in excess of $10,000 in payments under the program. The sole point in contention is whether those payments constituted "benefits," within the meaning of subsection (b).

Petitioner argues that the Medicare program provides benefits to the elderly and disabled but not to the health

care organizations. Provider organizations, in petitioner's view, do no more than render services in exchange for compensation. Under petitioner's submission the Medicare program envisions a single beneficiary, the qualifying patient. The Government, in opposition, urges that a determination whether an organization receives "benefits" within the meaning of §666(b) turns on whether the Federal Government was the source of the payment. Funds received under a federal assistance program, the Government asserts, can be traced from federal coffers, often through an intermediary or carrier, to the health care provider. Under its view, the "federal-program source of the funds" satisfies the benefits definition. Brief for United States 11.

We reject petitioner's reading of the statute but without endorsing the Government's broader position. We conclude Medicare payments are "benefits," as the term is used in its ordinary sense and as it is intended in the statute. The noun "benefit" means "something that guards, aids, or promotes well-being: advantage, good"; "useful aid"; "payment, gift [such as] financial help in time of sickness, old age, or unemployment"; or "a cash payment or service provided for under an annuity, pension plan, or insurance policy." Webster's Third New International Dictionary 204 (1971). These definitions support petitioner's assertion that qualifying patients receive benefits under the Medicare program. It is commonplace for individuals to refer to their retirement or health plans as "benefits." So it ought not to be disputed that the elderly and disabled rank as the primary beneficiaries of the Medicare program. See 42 U. S. C. §§1395c, 1395j; 42 CFR §400.202 (1999) (defining "beneficiary" as the "person who is entitled to Medicare benefits"); *Shalala* v. *Guernsey Memorial Hospital*, 514 U. S. 87, 91 (1995) ("Under the Medicare reimbursement scheme . . . participating hospitals furnish services to program beneficiaries and are reim-

bursed by the Secretary through fiscal intermediaries"); *Good Samaritan Hospital*, 508 U. S., at 404 (same).

That one beneficiary of an assistance program can be identified does not foreclose the existence of others, however. In this respect petitioner's construction would give incomplete meaning to the term "benefits." Medicare operates with a purpose and design above and beyond point-of-sale patient care, and it follows that the benefits of the program extend in a broader manner as well. The argument limiting the term "benefits" to the program's targeted or primary beneficiaries would exclude, for example, a Medicare intermediary (such as Blue Cross and Blue Shield), a result both parties disavow. For present purposes it cannot be disputed the providers themselves derive significant advantage by satisfying the participation standards imposed by the Government. These advantages constitute benefits within the meaning of the federal bribery statute, a statute we have described as "expansive," "both as to the [conduct] forbidden and the entities covered." *Salinas* v. *United States*, 522 U. S. 52, 56 (1997).

Subsection (b) identifies several sources as providing benefits under a federal program– "a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance." 18 U. S. C. §666(b). This language indicates that Congress viewed many federal assistance programs as providing benefits to participating organizations. Coupled with the broad substantive prohibitions of subsection (a), the language of subsection (b) reveals Congress' expansive, unambiguous intent to ensure the integrity of organizations participating in federal assistance programs.

Subsection (c) of the statute bears on the analysis. The provision removes from the statute's coverage any "bona fide salary, wages, fees, or other compensation paid, or expenses paid or reimbursed, in the usual course of business." §666(c). Petitioner argues that the subsection oper-

ates to exclude the payments in question because they are either "compensation" or "expenses paid or reimbursed," or some combination of the two, and that the payments are made in the "usual course of business." We disagree.

The subsection provides that the specified sorts of payments are not ones to which the section applies. One inference from this formulation is that the described payments would have been benefits but for the subsection (c) exemption. We need not go so far. Even assuming the examples of subsection (c) bear upon the definition of benefits, statutory examples of nonapplicability do not necessarily give rise to the inference that absent the enumeration the statute would otherwise apply. To define all subsection (c) payments as exempted benefits would go well beyond the ordinary meaning of the word. On the other hand, the statute is not written to say "The term 'benefits' does not include bona fide salary, wages, fees, or other compensation paid, or expenses paid or reimbursed, in the usual course of business." We must construe the term "benefits," then, in a manner consistent with Congress' intent not to reach the enumerated class of transactions. See S. Rep. No. 98–225, p. 370 (1984) (stating that "not every Federal contract or disbursement of funds would be covered [under §666]. For example, if a government agency lawfully purchases more than $10,000 in equipment from a supplier, it is not the intent of this section to make a theft of $5,000 or more from the supplier a Federal crime").

We do not accept the view that the Medicare payments here in question are for the limited purposes of compensating providers or reimbursing them for ordinary course expenditures. The payments are made for significant and substantial reasons in addition to compensation or reimbursement, so that neither these terms nor the usual course of business conditions set forth in subsection (c) are met here. The payments in question have attributes and

purposes well beyond those described in subsection (c). These attributes and purposes are consistent with the definition of "benefit." While the payments might have similarities to payments an insurer would remit to a hospital quite without regard to the Medicare program, the Government does not make the payment unless the hospital complies with its intricate regulatory scheme. The payments are made not simply to reimburse for treatment of qualifying patients but to assist the hospital in making available and maintaining a certain level and quality of medical care, all in the interest of both the hospital and the greater community.

Here, as we have explained, the provider itself is the object of substantial Government regulation. Medicare is designed to the end that the Government receives not only reciprocal value from isolated transactions but also long-term advantages from the existence of a sound and effective health care system for the elderly and disabled. The Government enacted specific statutes and regulations to secure its own interests in promoting the well being and advantage of the health care provider, in addition to the patient who receives care. The health care provider is receiving a benefit in the conventional sense of the term, unlike the case of a contractor whom the Government does not regulate or assist for long-term objectives or for significant purposes beyond performance of an immediate transaction. Adequate payment and assistance to the health care provider is itself one of the objectives of the program. These purposes and effects suffice to make the payment a benefit within the meaning of the statute.

The structure and operation of the Medicare program reveal a comprehensive federal assistance enterprise aimed at ensuring the availability of quality health care for the broader community. Participating health care organizations, as our above discussion shows, must satisfy a series of qualification and accreditation requirements,

standards aimed in part at ensuring the provision of a certain quality of care. See 42 CFR pt. 482 (1999). By reimbursing participating providers for a wide range of costs and expenses, including medical treatment costs, overhead costs, and education costs, Medicare's reimbursement system furthers this objective. This scheme is structured to ensure that providers possess the capacity to render, on an ongoing basis, medical care to the program's qualifying patients. The structure, moreover, proves untenable petitioner's assertion that Congress has no interest in the financial stability of providers once services are rendered to patients. Payments are made in a manner calculated to maintain provider stability. §413.5(b); *Good Samaritan Hospital*, 508 U. S., at 406. Incentives are given for long-term improvements, such as capital costs and education. §§413.85, 413.134(e), 413.153(b)(2)(iii). Subsidies, defined as "special treatment," are awarded to certain providers. *Id.*, pt. 412G. In short, provider organizations play a vital role and maintain a high level of responsibility in carrying out the program's purposes. Medicare funds, in turn, provide benefits extending beyond isolated, point-of-sale treatment transactions. The funds health care organizations receive for participating in the Medicare program constitute "benefits" within the meaning of 18 U. S. C. §666(b).

Our discussion should not be taken to suggest that federal funds disbursed under an assistance program will result in coverage of all recipient fraud under §666(b). Any receipt of federal funds can, at some level of generality, be characterized as a benefit. The statute does not employ this broad, almost limitless use of the term. Doing so would turn almost every act of fraud or bribery into a federal offense, upsetting the proper federal balance. To determine whether an organization participating in a federal assistance program receives "benefits," an examination must be undertaken of the program's structure,

operation, and purpose. The inquiry should examine the conditions under which the organization receives the federal payments. The answer could depend, as it does here, on whether the recipient's own operations are one of the reasons for maintaining the program. Health care organizations participating in the Medicare program satisfy this standard.

The Government has a legitimate and significant interest in prohibiting financial fraud or acts of bribery being perpetrated upon Medicare providers. Fraudulent acts threaten the program's integrity. They raise the risk participating organizations will lack the resources requisite to provide the level and quality of care envisioned by the program. Cf. *Salinas*, 522 U. S., at 61 (stating that acceptance of bribes by an official of a jail housing federal prisoners pursuant to an agreement with the Government "was a threat to the integrity and proper operation of the federal program").

Other cases may present questions requiring further examination and elaboration of the term "benefits." Here it suffices to hold that health care providers such as the one defrauded by petitioner receive benefits within the meaning of the statute. The judgment of the Court of Appeals is affirmed.

It is so ordered.