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Recent Developments in eHealth, and Ongoing Litigation Regarding "But-For" Causation Under the False Claims Act

By Robert M. Radick
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This edition of the Healthcare Enforcement column continues to follow recent developments in *United States ex rel. Shea v. eHealth, Inc. et al*., 21-cv-11777 (DJC) (D. Mass.), a significant False Claims Act (FCA) case in which the government alleged that major health insurers and brokers not only paid for beneficiaries to be referred to the insurers' Medicare Advantage Plans, but also discriminated against disabled beneficiaries to prevent them from joining those plans.

The defendants have now filed motions to dismiss the complaint, and the dismissal motion filed on behalf of all defendants will be the focus of the first part of the column.

The column then turns to two other recent and noteworthy decisions from district courts in the Sixth Circuit.

In those decisions, the district courts (a) applied the circuit's "but-for" causation requirement in FCA cases premised on alleged anti-kickback violations, and (b) dismissed the FCA causes of action because the plaintiffs failed to adequately plead in one case, and to adequately establish in another, that absent the alleged kickback, the challenged claims would not have been submitted to the government for payment.

Recent Motions to Dismiss the Government's False Claims Act Case Against Major Insurers and Insurance Brokers in the *eHealth* Matter


Robert M. Radick

The Aug. 19, 2025 edition of this column described the Department of Justice's (DOJ) complaint in partial intervention in the *eHealth* matter, by which DOJ alleged, in the District Court for the District of Massachusetts, that three major insurers (Aetna, Humana, and Elevance), and three insurance brokers (eHealth, GoHealth, and Select Quote), participated in a kickback scheme that violated the FCA.

As the prior edition of this column noted, the *eHealth* complaint consisted of two main theories: that payments from the insurers to the brokers were illegal kickbacks intended to cause the brokers to enroll Medicare beneficiaries into the insurers' Medicare Advantage plans, without regard for whether those plans were in the beneficiaries' best interests; and that the payments to the brokers were also intended to prevent the enrollment of disabled beneficiaries into the Aetna and Humana plans, because such beneficiaries require more medical services and thus are less profitable for the insurers.

The Aug. 19, 2025 edition of the column also noted, based on a preliminary court filing, that the defendants "intend[ed] to move to dismiss the government's complaint in its entirety (albeit on grounds that the defendants have not yet identified)."

Later that same day, the defendants in the *eHealth* matter followed through on their promise—they filed one primary memorandum of law seeking to dismiss the government's case in its entirety, and two supplemental memoranda of law, one addressing the claims against the brokers, and the other addressing the claims against defendants CVS Health Corporation and Aetna Inc., which are the parent companies of defendant Aetna Life Insurance.

Now that these briefs have been filed, this column describes the main arguments the defendants advance in their primary memorandum of law seeking dismissal. (The arguments advanced in the two supplemental briefs are beyond the scope of this column).

In their primary memorandum of law seeking to dismiss all causes of action against all defendants, the insurers and brokers break down their arguments into two parts: those related to the kickback claims, and those related to the discrimination claims.

Starting with the kickback claims, the defendants challenge the motivations behind the DOJ's complaint in intervention, asserting that the complaint and its accompanying allegations of illegal kickbacks and FCA violations are little more than a "classic attempt at regulation by litigation."

More specifically, the defendants note that the very sorts of marketing payments the complaint alleges to be illegal kickbacks have in fact long been permitted by statute and regulated by the Centers for Medicare & Medicaid Services (CMS).

Further, the defendants contend that starting in late 2023, CMS tried to fundamentally change the long-standing system for regulating the marketing and administrative payments that Medicare Advantage Organizations (MAOs) such as the defendants made to Third Party Marketing Organizations (TPMOs) such as the brokers, but those efforts failed when a district court in the Northern District of Texas struck down the regulatory changes as arbitrary and capricious.

That, according to the defendants, caused the DOJ to shift tactics and "retroactively insist[]" in the *eHealth* case "that... industry standard payments" from MAOs to TPMOs "are illegal kickbacks under the Anti-Kickback Statute."

In addition to arguing that DOJ's filing of the complaint in intervention was in effect a bad faith effort to achieve regulatory change through an FCA enforcement action, the defendants also argue in their motion to dismiss that, as to the payments from the insurers to the brokers, the government has failed to adequately plead a host of the elements required for violations of the Anti-Kickback Statute (AKS) and FCA. In particular, the defendants argue, among other things, that:

- The payments to the brokers do not constitute the type of "remuneration" that the AKS forbids, because the AKS only prohibits payments that are intended to induce the ordering of *goods and services*, and the enrollment of a patient into a Medicare Advantage plan is not a good or service;
- The challenged payments to marketers were not illegal under the AKS because, as cases such as *United States v. Sorensen*, 134 F.4th 493 (7th Cir. 2025), have required, the payments were not made to those whose positions allow them to influence patients' medical decisions; and
- The government's complaint does not adequately plead an FCA violation in part because the complaint fails to allege that any supposedly false aspects of the claims submitted for reimbursement were material to a payment decision, and also because the complaint does not permit one to infer that, "but-for" the alleged kickbacks, the enrollments in the defendants' Medicare Advantage plans would not have occurred.

Having thus argued that the payment of fees from Medicare Advantage plans to insurance brokers cannot satisfy the requisite elements of an AKS violation, the defendants (except Elevance Health, as to which there is no discrimination allegation) next turn to the government's assertion that by steering away disabled beneficiaries from the insurers' plans, the defendants committed a separate series of FCA violations.

On this issue, the defendants argue that any alleged discrimination against disabled beneficiaries would not have resulted in false claims but rather would have resulted in claims *not being submitted*.

And, addressing the elements of the FCA claims, the defendants argue that the pleading fails to allege violations of the non-discrimination regulations on

which the government relies; has not adequately alleged the materiality of any anti-discrimination violations; and has not alleged any loss or damages (nor could it, given that the alleged discrimination would have *prevented* claims from being submitted).

On Oct. 20, 2025—just one day before this column was submitted for publication—the government filed three memoranda of law, spanning a total of 104 pages, in opposition to the defendants' motion to dismiss. Given the timing and breadth of those filings, an analysis of the government's arguments must be reserved for another day, and will likely appear in a future edition of this column.

Two District Courts in the Sixth Circuit Apply the "But-For" Causation Standard to Dismiss False Claims Act Claims Premised on Anti-Kickback Statute Violations

In Sept. 2025, the United States District Court for the Middle District of Tennessee issued two decisions applying the Sixth Circuit's interpretation of what is required to prove the falsity element of FCA claims that are premised on alleged AKS violations.

Pursuant to a 2010 amendment to the AKS, one pathway to establishing the false or fraudulent nature of a claim for payment is to show that the claim includes "items or services *resulting from* a violation" of the AKS. 42 U.S.C. §1320a-7b(g) (emphasis added).

However, like the First and Eighth Circuits, the Sixth Circuit has held that the term "resulting from" in this context imposes a requirement of "but-for" causation, such that the plaintiff in an AKS-predicated FCA case must establish that the claim for reimbursement would not have been submitted absent the AKS violation. *United States ex rel. Martin v. Hathaway*, 63 F.4th 1043 (6th Cir. 2023).

Applying this "but-for" requirement, the two district court decisions from the Middle District of Tennessee found that the relationship between alleged kickbacks and the claims for reimbursement were too attenuated to establish the requisite causation.

On Sept. 5, 2025, in *United States, et al., ex rel. Folse v. Napper, et al.*, 3:17-cv-1478, Judge Aleta A. Trauger of the Middle District of Tennessee applied the Sixth Circuit's "but-for" standard of causation and granted summary judgment in favor of the defendants who sought the dismissal of the FCA claims against them.

The *Napper* decision, 2025 WL 2585680 (M.D. Tenn. Sept. 5, 2025), arose from a *qui tam* suit in which Tennessee and Louisiana had elected to intervene in part. The states contended that an arrangement between the defendants on the one hand (dental service providers and related management and billing companies), and on the other, long-term care facilities (LTCFs) that served Medicaid beneficiaries, constituted an illegal kickback.

Pursuant to the arrangement, the defendants would provide dental services free of charge to one indigent LTCF resident provided that, for each such indigent resident who received free dental services, the dental provider would also provide care to no fewer than six residents from the LTCFs who had the ability to pay.

Although the defendants contended that this so-called "six-for-one" provision "limited indigent care to one patient for every six paying patients as an 'economic guardrail,'" the intervening states alleged that the providing of free services to an indigent LTCF resident was an illegal kickback that was intended to induce the referral of the six other paying patients.

In a thorough decision that addressed a host of issues, the district court analyzed, among other things, the elements of FCA claims that are premised on AKS violations.

For example, the court expressed doubts about whether the free services provided under the six-for-one arrangement were "remuneration" to the LTCF under the AKS, but ultimately concluded that the arrangement constituted remuneration since the services "had value"; found that the defendants clearly received referrals from the LTCFs; and found the evidence of willfulness on the part of the defendants to be lacking, which in itself would have been enough to grant summary judgment in the defendants' favor.

The district court then turned to the issue that was at the core of its decision—namely whether there was sufficient evidence to find that but-for the alleged kickback arrangement, claims for reimbursement would not have been submitted to the states' Medicaid programs.

The court explained that, on this issue, the plaintiffs essentially alleged that the claims were "tainted" by the alleged AKS violation largely because the LTCFs would not have contracted with the defendants

without the alleged kickback arrangement. However, the court rejected this argument and opined that the plaintiffs could not meet the but-for standard because the link between the alleged violation and the submission of claims was "too attenuated."

In this regard, the court noted that the states did not directly pay the defendant dental providers; instead, consistent with state Medicaid rules, the payments that non-indigent LTCF residents made for dental services led to an equal reduction in the amount the residents owed the LTCFs, and the LTCFs were then permitted to submit claims in that same amount to offset the reduction in the payments they would receive from the residents.

The court also found it impossible to conclude that, but for the alleged kickback arrangement, these same claims would not have been submitted and approved. The court thus granted summary judgment in the defendants' favor and dismissed the FCA claims of the intervening states.

17 days later, on Sept. 22, 2025, Middle District of Tennessee Judge Waverly D. Crenshaw, Jr. ruled on the pleadings and dismissed kickback-predicated FCA violations in *United States, et al., ex rel. Nolan v. HCA Healthcare, Inc., et al.*, 3:20-cv-978. 2025 WL 2713747 (M.D. Tenn. Sept. 22, 2025).

In *Nolan*, after a 2012 change in federal billing regulations by which Medicare stopped paying pathology labs directly for the technical component (or "TC") of their services, the relators (who owned pathology labs) requested that the defendant hospitals agree to pay the TC component.

The hospitals in turn proposed that the relators' labs waive the TC component, and when the relators' refused, the hospitals broke off their business relationship with the relators and contracted with different labs that were willing to forego the TC payments. On these facts, the relators alleged that the hospitals had solicited a kickback when they requested the waiving of TC costs, and received a kickback when they entered into agreements with other labs that were willing to forego the TC costs.

In his ruling on the defendants' motion to dismiss, Crenshaw found that the alleged arrangement as pleaded in the complaint did not constitute a kickback because the hospital was under no obligation to pay the TC component.

Relying on language from the decision in *Napper* which "suggested that . . . an attenuated link is not enough to establish but-for causation," *Nolan*, 2025 WL 2713747, at *11, the court also found that the pleadings failed to adequately allege causation because nothing in the complaint suggested that, but for the supposed kickback, claims for reimbursement that sought the other component cost of the laboratory services (the professional component, which Medicare continued to reimburse) would not have been submitted.

Finally, although the relators had been asked by the hospitals to waive the TC component, the court found that this request was not the solicitation of a kickback. Instead, it was merely the unwillingness to voluntarily make a payment that was not legally required, and thus merely "described… normal marketplace competition."

The decisions in *Napper* and *Nolan* demonstrate the burden the "but-for" standard of causation can have in cases of kickback-premised FCA liability, and the difficulties that relators and intervening government entities will face in pleading claims that make out "but-for" causation.

Indeed, given that notice of appeals have not been filed in either *Napper* or *Nolan*, both cases show that plaintiffs in the Sixth Circuit (and likely elsewhere) will face considerable difficulty in overcoming what Crenshaw described as the Sixth Circuit's "warn[ing] [that] courts not... read causation too loosely."

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