UNITED STATES DISTRICT COURT

for the

District of Hawaii

United States of America
v.
HENRY QUAN

Case No. MJ26-00588 WRP

Defendant(s)

CRIMINAL COMPLAINT

I, the complainant in this case, state that the following is true to the best of my knowledge and belief.

On or about the date(s) of Jan. 2, 2018 through Feb. 26, 2025 in the county of Honolulu in the _____ District of Hawaii, the defendant(s) violated:

Code Section	*Offense Description*
18 U.S.C. § 1347	Health Care Fraud

This criminal complaint is based on these facts:

See attached Affidavit in Support of Criminal Complaint.

☑ Continued on the attached sheet.

Lucas Alfaro

Complainant's signature

Special Agent Lucas Alfaro, HHS-OIG

Printed name and title

Sworn to under oath before me telephonically, and attestation acknowledged pursuant to Fed.R.Crim.P. 4.1(b)(2).

Date: June 22, 2026

City and state: _____

Wes Reber Porter
United States Magistrate Judge

AFFIDAVIT

I, Lucas Alfaro, being duly sworn, declare and state as follows:

I. INTRODUCTION

1. I am a Special Agent with the United States Department of Health and Human Services, Office of Inspector General ("HHS-OIG") and have been so employed since January 2018. I am currently assigned to the Pacific Regional Office. I received formal training at the Federal Law Enforcement Training Center, and specialized training through the HHS-OIG National Training and Operations Branch. During the time I have been employed as an HHS-OIG Special Agent, I have participated in investigations relating to health care fraud and have learned from other agents who are experienced in investigations of health care fraud. As a result of my training and experience, I am familiar with the federal laws relating to health care fraud, as well as common health care fraud techniques and schemes operating in Hawaii ("HI").

2. I have led and participated in many aspects of criminal investigations, including: collecting and reviewing physical and electronic evidence; conducting surveillance; utilizing informants; interviewing witnesses, subjects, and targets of investigation; and preparing and serving subpoenas, search and arrest warrants, and other legal process. Currently, my duties include investigating fraud, waste, and

abuse within the Department of Health and Human Services ("HHS"), with the majority of time spent on Medicare fraud investigations.

3. As an HHS-OIG Special Agent, I am a federal law enforcement officer within the meaning of 5 U.S.C. § 406, in that I am empowered by law and authorized by the Attorney General to conduct investigations, seek and execute warrants, and make arrests for federal offenses.

4. I am working jointly with Federal Bureau of Investigation Special Agents Melissa Ammons and Kristen Hood in the investigation of the subject of this affidavit.

5. Because this affidavit is being submitted for the limited purpose of establishing probable cause, I have not included every detail of every aspect of the investigation. Unless specifically indicated, all conversations and statements described in this affidavit are related in substance and in part. In addition, the events described in this affidavit occurred on or about the dates provided herein. Where figures, calculations, dates, and times are reported herein, they are approximate.

II. PURPOSE OF AFFIDAVIT

6. This affidavit is made in support of a criminal complaint against and arrest warrant for HENRY QUAN ("QUAN") for a violation of 18 U.S.C. § 1347 (Health Care Fraud), in that QUAN knowingly executed and attempted to execute

a scheme to defraud a health-care benefit program, namely Medicare, by submitting or causing the submission of Medicare claims for health care services not provided. In sum, QUAN, the pharmacist in charge of Wellness Pharmacy, located in Honolulu, HI, knowingly submitted false claims to Medicare for medications that he did not dispense to patients.

7. The facts set forth in this affidavit are based upon my personal observations, my training and experience, and information obtained from various law enforcement personnel and witnesses. This affidavit is intended to show merely that there is sufficient probable cause for the requested complaint and does not purport to set forth all of my knowledge of our investigation into this matter. Unless specifically indicated otherwise, all conversations and statements described in this affidavit are related in substance and in part only. In addition, the events described in this affidavit occurred on or about the dates provided herein. Where figures, calculations, dates, and times are reported herein, they are approximate.

III. SUMMARY OF PROBABLE CAUSE

8. QUAN is a Registered Pharmacist and owner of Wellness Pharmacy, Inc. ("Wellness Pharmacy"). From January 2, 2018, through February 26, 2025, QUAN used Wellness Pharmacy to submit more than $32 million in pharmacy claims for purported medications dispensed to Medicare beneficiaries, for which Medicare paid more than $30 million. Interviews of Medicare beneficiaries,

Wellness Pharmacy employees and other evidence showed that in some cases, Wellness Pharmacy billed Medicare for drugs that were not dispensed to Medicare beneficiaries.

9. On August 28, 2024, agents executed search warrants of Wellness Pharmacy (24-00913 KJM) and Wellness Pharmacy Store 2, Inc., doing business as Wellness Pharmacy Store #2, (24-00914 KJM), signed by the Honorable Barry M. Kurren on or about August 21, 2024.

10. During the execution of the warrant at Wellness Pharmacy, agents identified QUAN on site and interviewed him. Agents also seized medical records, business records, and digital evidence from computers. Agents compared electronic prescription records obtained from the Wellness Pharmacy computers with corresponding claims it submitted to Medicare. The electronic prescription records did not match the Medicare claims submitted by Wellness Pharmacy. Therefore, Wellness Pharmacy was paid for prescription drugs that were never dispensed to Medicare beneficiaries.

11. Additionally, an invoice reconciliation comparing the Medicare claims with the prescription drugs purchased by Wellness Pharmacy was conducted, identifying shortages with hundreds of drugs reviewed. The lack of invoice purchases for drugs billed by Wellness Pharmacy is indicative of

fraudulent activity such as phantom billing, generic substitution and/or billing for drugs not dispensed.

12. Ultimately, Wellness Pharmacy did not have adequate purchases to support their Medicare billing for the drugs that were purportedly dispensed to beneficiaries (i.e., the pharmacy did not have enough drugs in its inventory to cover the amount it claimed was dispensed to patients).

IV. STATEMENT OF PROBABLE CAUSE

13. Based on my review of Medicare documents, electronic prescription records, conversations with others involved in this investigation, my training and experience, and my own participation in this investigation, I am aware of the following information.

A. Background of Medicare Program

14. Medicare is a federal health insurance program for individuals 65 years of age and older, certain younger people with disabilities, and people with End-Stage Renal Disease. Medicare is a "health care benefit program," as defined by Title 18, United States Code, Section 24(b). The Centers for Medicare & Medicaid Services ("CMS") is the federal agency that runs the Medicare Program. CMS is a branch of HHS. Medicare is paid for through two trust fund accounts held by the U.S. Treasury.

15. Individuals enrolled into Medicare are Medicare beneficiaries ("beneficiaries") and are assigned a unique health insurance claim number and/or Medicare Beneficiary Identifier.

16. All physicians, as well as eligible professionals (hereinafter "providers") as defined in Section 1848(k)(3)(B) of the Social Security Act must complete a Medicare enrollment application[1] to enroll in the Medicare program.

17. By signing and submitting the Medicare enrollment application, the provider agrees to adhere to all Medicare program requirements and applicable laws to include, but not limited to, the following: The provider will not misrepresent or falsify any information on the Medicare enrollment application; the provider will not submit false or fraudulent claims for payment by Medicare; and the provider will not submit claims based on underlying transactions that violate applicable laws and regulations, including the Anti-Kickback Statute.[2]

18. Providers can submit Medicare claims electronically pursuant to an Electronic Data Interchange ("EDI") enrollment or with the appropriate hardcopy claim submission form. Medicare claims must contain the following: beneficiary's

[1] Medicare enrollment applications can be submitted electronically through the Provider Enrollment, Chain and Ownership System ("PECOS") or with the appropriate hardcopy CMS-855.

[2] The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash.

name and date of birth; the date of the service; diagnosis code; and the provider. A Provider agrees to be responsible for all claims it submits to Medicare for payment; that it will submit claims that are accurate, complete, and truthful; and it will retain all original source documentation and medical records for at least 6 years and 3 months after the claim is paid.

19. Medicare commonly pays provider claims electronically pursuant to an Electronic Funds Transfer Authorization Agreement ("EFT") also known as a CMS-588 form, which contains the provider's bank routing and account numbers.

20. Medicare programs are organized into "parts" based on the types of benefits the program is covering. The Medicare Part D Program ("Medicare Part D") subsidizes the costs of prescription drugs for Medicare beneficiaries in the United States.

21. To receive Medicare Part D benefits, a beneficiary chooses and enrolls in a Medicare drug plan based on drug coverage and premium costs. Medicare drug plans are operated by private companies approved by Medicare, such as Aetna, Cigna, and Humana, which are often referred to as drug plan sponsors. Each sponsor offers numerous plans tailored to a beneficiary's needs. Once enrolled in a Medicare drug plan, a beneficiary can fill a prescription at a pharmacy and use his or her drug plan to pay for some or all of the prescription.

22. A pharmacy can participate in Medicare Part D by entering into a retail network agreement directly with a Medicare drug plan, with Pharmacy Benefit Managers ("PBMs"), or with a Pharmacy Services Administration Organization ("PSAO"). A PBM acts on behalf of one or more Medicare drug plans, and a pharmacy can join a drug plan's network through the plan's PBM. PSAOs contract with PBMs on behalf of a pharmacy. When a Medicare Part D beneficiary presents a prescription to a pharmacy, the pharmacy submits a claim either directly to the Medicare drug plan or to a PBM that manages the beneficiary's Medicare drug plan. The plan or PBM determines whether the pharmacy is entitled to payment for each claim and periodically pays the pharmacy for outstanding claims. The Medicare drug plan sponsor reimburses the PBM for its payments to the pharmacy.

23. A pharmacy can also submit claims to a Medicare drug plan to whose network the pharmacy does not belong. Submissions of such out-of-network claims are not common and often result in smaller payments to the pharmacy by the Medicare drug plan sponsor.

24. Medicare, through CMS, compensates the Medicare drug plan sponsors. Medicare pays the sponsors a monthly fee for each Medicare beneficiary enrolled in the sponsors' plans. Such payments are called capitation fees. The capitation fees are adjusted periodically based on various factors, including the

beneficiaries' medical conditions. In some cases where a sponsor's expenses for a beneficiary's prescription drugs exceed that beneficiary's capitation fee, Medicare reimburses the sponsor for a portion of the additional expenses.

25. In Hawaii, Medicare Part D is administered by Noridian Healthcare Solutions, which serves as a contract carrier to receive, adjudicate, and pay Medicare Part D claims, pursuant to a contract with the United States Department of Health and Human Services.

B. QUAN's Control of Wellness Pharmacy

26. I have reviewed records from the Hawaii Business Registration Division, Department of Commerce & Consumer Affairs website that show QUAN owned, controlled, and/or has been associated with Wellness Pharmacy since June 7, 1999. Wellness Pharmacy had a registered mailing address in Honolulu County within the District of Hawaii.

27. On December 26, 2006, the National Plan and Provider Enumeration System ("NPPES") assigned NPI[3] number 1457416059 to Wellness Pharmacy. According to NPPES, QUAN was the President and Authorized Official for Wellness Pharmacy. The primary practice address for Wellness Pharmacy was 100 N Beretania Street, Suite 148, Honolulu, Hawaii, 96817-4712.

[3] NPI stands for National Provider Identifier, a unique identification number for health care providers to use during financial transactions.

C. QUAN Used Wellness Pharmacy to Execute a Health Care Fraud Scheme

28. Agents interviewed at least 15 Medicare beneficiaries for whom Medicare received prescription drug claims for prescription drugs provided by Wellness Pharmacy, which was controlled by QUAN. At least one of the beneficiaries told QUAN they no longer wanted a medication but were still billed for the drug.

D. Wellness Pharmacy Fraudulently Billed Medicare for Medication that was Not Dispensed to Beneficiaries

29. Based on Medicare claims data from March 9, 2026, Wellness Pharmacy submitted approximately 311,130 claims to Medicare on behalf of approximately 2,562 beneficiaries and prescriptions dispensed between January 2, 2018, and February 26, 2025. In total, Wellness Pharmacy was paid over $30 million for these pharmacy claims.

1. Wellness Pharmacy Beneficiary Interviews

30. Law enforcement interviewed at least 15 beneficiaries whose Medicare benefits were billed by Wellness Pharmacy for prescription medications. Based on my review of the Medicare data, Wellness Pharmacy billed Medicare for these beneficiaries between April 6, 2021, and December 29, 2023, and received approximately $81,380 for those claims. Below is a summary of those interviews.

a. Medicare Beneficiary W.L.

31. According to Medicare data, Wellness Pharmacy purportedly dispensed medications to W.L. from April 7, 2021, to December 29, 2023. Wellness Pharmacy's claims -- including Medicare claim, 212866713444063998, submitted on October 13, 2021, in the amount of $671.46 -- listed the medication dispensed for W.L. as Restasis.

32. On October 6, 2025, FBI Special Agents Ammons and Hood interviewed W.L. and learned that W.L. told QUAN they no longer wanted to receive Restasis and preferred to use over-the-counter eye drops instead. However, according to Medicare claims data, QUAN continued to bill for dispensing Restasis to W.L.

33. In total, W.L. was billed for Restasis on at least seven different occasions, totaling more than $4,685 in Medicare payments to Wellness Pharmacy. However, based on a comparison of Medicare claims and the associated electronic prescription records, Restasis was only billed dispensed to W.L. on five occasions. Therefore, Wellness Pharmacy fraudulently billed Medicare for Restasis that was purportedly dispensed to W.L. on at least two different occasions, totaling more than $1,328 in payments from Medicare.

b. Medicare Beneficiary K.C.

34. According to Medicare data, Wellness Pharmacy purportedly dispensed medications to K.C. from April 16, 2021, to December 7, 2023.

Wellness Pharmacy's claims -- including Medicare claim, 210495173400025999, submitted on February 18, 2021, in the amount of $671.46 -- listed the medication dispensed for K.C. as Restasis.

35. On October 8, 2025, law enforcement interviewed K.C. and learned that K.C. picked up eye drops from Wellness Pharmacy every month. K.C. reported that the eye drops came in a bottle and were not individually packaged, which is inconsistent with the manufacturer's packaging for Restasis. Based on my training and experience, this inconsistency suggests that K.C. did not receive Restasis, the name brand medication for which Medicare was billed, and may have received a lower cost, generic substitute instead.

36. In total, K.C. was billed for Restasis on at least 24 different occasions, totaling more than $15,428 in Medicare payments to Wellness Pharmacy. However, based on a comparison of Medicare claims and the associated electronic prescription records, Restasis was only dispensed to K.C. on six occasions. Therefore, Wellness Pharmacy fraudulently billed Medicare for Restasis that was purportedly dispensed to K.C. on at least 18 different occasions, totaling more than $11,765 in payments.

c. Medicare Beneficiary F.C.Y.

37. According to Medicare data, Wellness Pharmacy purportedly dispensed medications to F.C.Y. from April 6, 2021, to December 19, 2024.

Wellness Pharmacy's claims -- including Medicare claim, 241904437760054997, submitted on July 8, 2024, in the amount of $659.00 -- listed the medication dispensed for F.C.Y. as Restasis.

38. On October 8, 2025, law enforcement interviewed F.C.Y. and learned that F.C.Y. received Restasis from Wellness Pharmacy.

39. In total, F.C.Y. was billed for Restasis on at least 57 different occasions, totaling more than $39,039 in Medicare payments to Wellness Pharmacy. However, based on a comparison of Medicare claims and the associated electronic prescription records, Restasis was only dispensed to F.C.Y. on 15 occasions. Therefore, Wellness Pharmacy fraudulently billed Medicare for Restasis that was purportedly dispensed to F.C.Y. on at least 42 different occasions, totaling more than $28,258 in payments from Medicare. In other words, Medicare was billed for Restasis on 42 occasions where the electronic prescription records do not show that Restasis was dispensed to F.C.Y.

2. Invoice Reconciliation

40. At the request of HHS-OIG, the Medicare contractor conducted an invoice reconciliation of the prescription wholesale purchases made by Wellness Pharmacy compared to the claims it submitted to Medicare. HHS-OIG subpoenaed the wholesale suppliers for invoices to determine whether Wellness Pharmacy had an adequate supply of medications on hand to cover the claims that

it was submitting for Medicare payment. The invoices reflected all drug wholesale purchases and returns made by Wellness Pharmacy for the time periods of January 2, 2018, through May 26, 2021, and April 1, 2021, through January 10, 2024. The invoice reconciliations identified shortages with 771 of the 2,264 drugs reviewed. The lack of invoice purchases for drugs billed by Wellness Pharmacy is highly atypical and indicative of fraudulent activity such as phantom billing and/or billing for drugs that were not dispensed.

41. For several high-cost medications, such as Restasis, mentioned above, the invoice reconciliations determined that Wellness Pharmacy did not have a sufficient supply of medications on hand to cover the number of medications that it claimed to have dispensed to patients. For example, for the years analyzed above, Wellness Pharmacy was short more than 25,500 units of Restasis during those time frames. Additionally, Wellness Pharmacy purchased 0 units of Pradaxa but submitted claims to Medicare for dispensing more than 2,700 units. In total, Wellness Pharmacy did not have adequate purchases to support their Medicare billing for the drugs reviewed during the above time periods, resulting in a total loss to Medicare of more than $1.5 million.

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E. CONCLUSION

42. For all the reasons described above, there is probable cause to believe that QUAN has committed a violation of 18 U.S.C. § 1347 (Health Care Fraud) by submitting or causing the submission of a fraudulent Medicare claims during the period of January 2, 2018, to February 26, 2025.

DATED: June 22, 2026

LUCAS ALFARO, Special Agent
Department of Health and Human Services – Office of Inspector General

Sworn to under oath before me telephonically, and attestation acknowledged pursuant to Fed R. Crim. P. 4.1(b)(2), this 22nd day of June, 2026 at Honolulu, Hawaii.

Wes Reber Porter
United States Magistrate Judge