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*THE FALSE CLAIMS ACT AND HEALTH CARE
FRAUD: AN OVERVIEW*

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Abstract. The Federal False Claims Act, 31 U.S.C., 3729-3733, provides for judicial imposition of civil monetary penalties and treble damages for the knowing submission of false claims to the United States Government. Use of the False Claims Act for fraudulent health care claims has increased dramatically in the last few years. H.R. 352, and a companion bill, S. 2007, the Health Care Claims Guidance Act, would amend the False Claims Act to set forth special rules to be applied in cases where an action is brought under the False Claims Act based on claims submitted under Medicare, Medicaid, the Children's Health Insurance program, and CHAMPUS.

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The False Claims Act and Health Care Fraud: An Overview

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Summary

The Federal False Claims Act, 31 U.S.C. §§ 3729-3733, provides for judicial imposition of civil monetary penalties and treble damages for the knowing submission of false claims to the United States Government. Originally enacted in 1843, the statute was amended in 1986 in several respects, including increasing the penalty provisions, and making it easier for whistleblowers to file "*qui tam*" actions on behalf of the federal government. Use of the False Claims Act for fraudulent health care claims has increased dramatically in the last few years. H.R. 3523, and a companion bill, S. 2007, the Health Care Claims Guidance Act, would amend the False Claims Act to set forth special rules to be applied in cases where an action is brought under the False Claims Act based on claims submitted under Medicare, Medicaid, the Children's Health Insurance program, and CHAMPUS.

Background

The False Claims Act (FCA) dates back to the Civil War. Congress was concerned at that time with Union army contractors who were defrauding the government by schemes such as selling the same horses to the Union cavalry several times, and delivering musket boxes full of sawdust instead of guns.¹ The FCA was enacted in 1863 to combat contractor fraud and was popularly known as the "Lincoln Law." The law imposed a \$2,000 civil fine as well as double damages on wrongdoers for each false claim submitted to the government. The statute also contained a "*qui tam*" provision,² which allowed private citizens, called relators, to sue on the government's behalf, and to receive up to 50% of the amount the government recovered as a result of their cases.

¹ See 132 CONG. REC. H6479, H6482 (Sept. 9, 1986).

² The term "*qui tam*" derives from a Latin phrase, *qui tam pro domino rege quam pro se ipso in hac parte sequitur*, meaning "he who brings an action for the King as well as for himself."

The FCA was amended only once, in 1943, before 1986. At that time Congress altered the *qui tam* provisions, reducing the relator's reward, and providing that a whistleblower could not proceed with a FCA *qui tam* lawsuit if it was based on evidence or information already in the possession of the federal government.³ The effect of the 1943 amendments was to discourage *qui tam* suits, and the statute was seldom used until it was amended in 1986. Judicial precedents during this period also made use of the FCA more difficult for the government. For example, in *United States v. Ueber*,⁴ the Sixth Circuit Court of Appeals applied the common law standard and required the government to produce "clear, unequivocal and convincing evidence" that the FCA defendant had actual knowledge of fraud.⁵

During the 1980s, widespread reports of contractor fraud against the federal government, particularly in defense contracts, prompted Congress to take another look at the FCA. Government enforcement agencies cited difficulties in investigating and stopping fraud due to insufficient resources, inadequate legal tools, and the reluctance of employees with knowledge of fraud to speak up for fear of job reprisals. Senator Charles Grassley and Representative Howard Berman introduced bills amending the FCA in 1985, and Congress passed the amendments, with President Reagan signing the bill into law on October 27, 1986.⁶

The 1986 Amendments expanded the role of whistleblowers who became *qui tam* relators in FCA litigation, whether or not the federal government decides to intervene and take over the suit, by allowing the relator to remain a "party" to the case even if the government steps in. At the same time protections were provided for a *qui tam* relator against discrimination or retaliation by an employer. The potential *qui tam* bounty available to relators was increased from a minimum of ten percent to the range of fifteen to twenty-five percent of the recovery where the government intervenes,⁷ and from a maximum of twenty-five percent to the range of twenty-five to thirty percent where the government declines to intervene.⁸ The civil monetary penalty was raised from \$2,000 per false claim to between \$5,000 and \$10,000 for any such false claim.⁹ In addition, the amendments provided for treble, rather than double, damages for the amount of loss the government sustains.¹⁰ The relator is also entitled to receive attorneys' fees, costs, and

³ See 31 U.S.C. § 232(D) (1943).

⁴ 299 F. 2d 310 (6th Cir. 1962).

⁵ *Id.* at 314.

⁶ P. L. 99-562, 100 Stat. 3153 (1986).

⁷ 31 U.S.C. § 3730(d)(1).

⁸ *Id.*, § 3730(d)(2). More recent amendments in 1988, Pub. L. No. 100-700, limit a whistleblower's ability to benefit under the FCA's *qui tam* provisions if the person planned or initiated the wrongful action. In such a case a court may reduce the share of proceeds the relator would be entitled to, and a relator may be dismissed from any civil action (and excluded from receiving any proceeds from the action) if the person is convicted of criminal conduct arising from his or her role in the violation of the FCA. See 31 U.S.C. § 3730(d)(3).

⁹ 31 U.S.C. § 3729(a).

¹⁰ *Id.*

expenses from the defendant.¹¹ These attorneys' fees provisions apply even in cases where the government takes over the action.

The 1986 Amendments also clarified the burden of both the government and relators to plead and prove FCA violations. The Amendments established the plaintiff's burden of proof of "all essential elements" of a FCA case by the "preponderance of the evidence."¹² In addition, the definition of "know" or "knowingly" was defined to include "deliberate ignorance" and "reckless disregard" of the truth or falsity of the information.¹³ In clarifying the knowledge standard, the Senate committee report expressed the intent of Congress "to reach what has become known as the 'ostrich' type situation where an individual has 'buried his head in the sand' and failed to make simple inquiries which would alert him that false claims are being submitted."¹⁴ Accordingly, the 1986 Amendments make clear that no proof of specific intent to defraud is required to support a FCA violation.¹⁵

Current False Claims Act Provisions

Civil actions may be brought in federal district court under the False Claims Act by the Attorney General or by a person, called a relator, for the person and for the United States Government. Under the FCA, a defendant is liable to the United States government if the defendant knowingly presents a false or fraudulent claim to an officer or employee of the United States government for payment, or if the defendant knowingly makes or uses a false record or statement to get a false or fraudulent claim paid.¹⁶ A claim is actionable under the FCA even if the claim is made against a party other than the government, if the payment of the claim would eventually result in a loss to the United States.¹⁷ While the FCA covers claims made to the Armed Forces of the United States, it does not cover claims made to the Internal Revenue Service.¹⁸ The claim must have been presented "knowingly," i.e., the defendant must have had actual knowledge of the falsity of the information furnished to the government, acted in deliberate ignorance of the truth or falsity of the information, or acted in reckless disregard of the truth or falsity

¹¹ *Id.* at 3730(d)(1), (2).

¹² *Id.* at 3731(c). This ended a split in circuit court decisions regarding the appropriate burden of proof under the FCA. *See, United States v. Ueber*, 299 F.2d 310 (6th Cir. 1962) ("clear, unequivocal and convincing evidence"), and *Federal Crop Insurance Corp. v. Hester*, 765 F.2d 723, 728 (8th Cir. 1985) ("Because the Act neither requires a showing of fraudulent intent nor is punitive in nature, we find no justification for applying a burden of proof higher than a preponderance of evidence.").

¹³ *Id.* at § 3729(b). The amendments conformed the knowledge standard to that of the administrative remedies for false claims available under the Program Fraud and Civil Remedies Act, 31 U.S.C. § 3801 *et seq.*

¹⁴ S. Rep. No. 345, 99th Cong., 2d Sess. 21 (1986).

¹⁵ 31 U.S.C. § 3729(b).

¹⁶ *Id.* at § 3729(a)

¹⁷ S. Rep. No. 345, 99th Cong., 2d Sess. 10 (1986).

¹⁸ 31 U.S.C. § 3729(a)(1) and (e).

of the information.¹⁹ An innocent mistake or mere negligence in furnishing the information is not sufficient, but no proof of specific intent to defraud is required.²⁰

The statute of limitations for FCA actions is generally 6 years from the date of the violation of the Act.²¹ However, an action may also be brought within 3 years after the facts are known or should have been known by the government official charged with the responsibility to act under the circumstances, up to a maximum of 10 years after the date on which the violation occurred.

Health Care Fraud and the False Claims Act

Since its enactment in 1863, the False Claims Act has been applied to a variety of areas, including defense contractor fraud, food stamp fraud, fraud in housing programs, and health care fraud. When Congress amended the FCA in 1986, the House and Senate reports expressed the intent that the provisions of the Act be applied to false claims for reimbursement from the Medicare and Medicaid programs.²² Health care program false claims may involve various schemes including billing for services or equipment not rendered, billing for unnecessary medical services, double billing for the same service or equipment, billing for services at a higher rate than provided ("upcoding"), or billing separately for services included in a global rate ("unbundling").

In 1993 Attorney General Janet Reno made health care fraud one of her top priorities. Congress, in 1996, provided for new enforcement tools, greater coordination, and increased monetary resources for the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) to combat health care fraud and abuse.²³ In its report, *Department of Justice Health Care Fraud Report, Fiscal Years 1995-1996 ("Report")*, the DOJ described recent health care fraud and abuse investigation and enforcement efforts. The Department cited several investigations of hospitals which have resulted in lawsuits and/or settlements brought under the FCA. One investigation dealt with double billing practices in which a hospital submits bills for outpatient services that were already covered under a DRG for inpatient services. Other investigations involved fraudulent billing practices by teaching hospitals, and fraud in claims-processing by Medicare carriers and fiscal intermediaries. The DOJ Report cites statistics showing significant increases in FCA civil actions and recoveries under the Act. According to the Report, in fiscal year 1996, the Civil Division of the DOJ received more than three times as many health care fraud cases as in fiscal year 1993. Pending health care fraud cases jumped from 270 in FY 1992 to 2,488 in FY 1996. Total financial recoveries made by the DOJ's Civil Division for health care fraud cases in FY 1995 and FY 1996 exceeded

¹⁹ *Id.* at 3729(b).

²⁰ *Hagood v. Sonoma County Water Agency*, 929 F.2d 1416 (9th Cir. 1991).

²¹ 31 U.S.C. § 3731(b).

²² S. Rep. No. 345, 99th Cong. 2d Sess. 21-22 (1986); H. Rep. No. 660, 99th Cong. 2d Sess. 21 (1986).

²³ P.L. 104-191, the "Health Insurance Portability and Accountability Act." For example, this Act required the Attorney General and the Secretary of HHS to establish a "Fraud and Abuse Control Program" to promote the coordination of federal, state and local law enforcement efforts, as well as to coordinate investigations, inspections and audits involving health care fraud.

\$274 million, which was one-third of all recoveries secured by the Civil Division. A dramatic increase in health care fraud *qui tam* suits also occurred. In 1992, 14 *qui tam* cases were filed involving health care fraud allegations. In 1996, there were 200 such cases filed. In the ten years following the 1986 Amendments to the FCA, the United States recovered \$1.3 billion in *qui tam* cases, approximately one-quarter of which was recovered in health care fraud cases.

Hospital groups have responded to these investigations and the resultant civil lawsuits brought under the FCA by arguing that the Justice Department has begun to characterize practices that for many years were treated as simple mistakes or differences in interpretation as intentional wrongdoing, triggering severe civil monetary penalties under the FCA. They contend that the use of the FCA under these circumstances unfairly punishes providers for innocent billing errors, and that providers are forced to settle FCA lawsuits because the risk of liability under the Act is so onerous. In response to the issues raised by the hospital industry, Attorney General Janet Reno has promised to work with the nation's hospital leaders to address their concerns. Speaking at the American Hospital Association's annual meeting on February 2, 1998, Reno stated "[i]t is not the Department of Justice's policy to punish honest billing mistakes . . . or mere negligence. But where there is reckless disregard and people go beyond simple negligence, I will use the law."

Bills Introduced in the 105th Congress

On March 19, 1998, Representative Bill McCollum (R-FL) introduced H.R. 3523, the Health Care Claims Guidance Act, and on April 29, 1998 Senator Thad Cochran (R-MS) introduced a companion Senate bill, S. 2007. H. R. 3523, and the Senate bill, would add a new section to the False Claims Act specifying certain rules to be applied in cases where an action is brought under the False Claims Act based on claims submitted under certain federally funded health care programs. These programs are Medicare, Medicaid, the Children's Health Insurance program under Title XXI of the Social Security Act, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

H. R. 3523 and S. 2007 would provide that no action may be brought under the FCA based on a health care claim "unless the amount of damages (i.e., overpayment paid by the United States on a claim) is a material amount." Damages for more than one claim may be aggregated only if the claims were part of a pattern of related acts or omissions by a person or entity, and if they occurred during the same calendar year. The Secretary of HHS, in consultation with the Secretary of Defense, is to issue regulations defining how the term "material amount" would be determined, based on the definition of the term "material" used by the American Institute of Certified Public Accountants.

Two affirmative defenses to FCA actions would be permitted under this bill. The first defense would provide that no action may be brought under the FCA if the alleged false claim was submitted "in reliance on (and correctly using) erroneous information supplied by a Federal agency (or an agency thereof) about matters of fact at issue; or in reliance on (and correctly applying) written statements of Federal policy which affects such claim provided by a Federal agency (or agent thereof)." The second defense would provide that FCA actions may not be brought against persons or entities if they are "in substantial compliance with a model compliance plan issued by the Secretary of" HHS.

H.R. 3523 and S. 2007 would also change the government's burden of proof from the current "preponderance of the evidence" standard to a "clear and convincing evidence" standard. Thus, actions under the FCA would be subject to a higher standard of proof than required under the administrative civil monetary penalty provisions found in Section 1128 A of the Social Security Act,²⁴ which apply to Medicare, Medicaid, and other federal health care programs.

Support for H.R. 3523 and its companion bill S. 2007 has come from health industry groups as well as the American Hospital Association. On April 13, 1998, the American Society of Internal Medicine sent a letter to Representative Bill McCollum commending him for introducing the legislation, stating that "effective enforcement of fraud and abuse statutes shouldn't result in honest physicians, hospitals, and other providers being investigated, sanctioned, and coerced into making costly settlements with the federal government for unintentional errors or legitimate differences of opinion on how to bill for services provided to Medicare patients." On the other hand, the bill is strongly opposed by the Justice Department. In addition, on April 2, 1998, twenty-three groups representing the interests of the elderly, taxpayers, and unions, sent a letter to members of Congress urging them to fight H.R. 3523, which they claim "would take us in the wrong direction by eviscerating the False Claims Act — the government's most effective fraud-fighting tool . . . [The bill would provide] a free-fraud zone for billions of dollars of health care fraud by exempting hospitals and other medical corporations from prosecution under the False Claims Act in a broad range of circumstances."

²⁴ 42 U.S.C. § 1320a-7a.