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Twenty-Five Years of Health Law Through the Lens of the Civil False Claims Act

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Among the most striking health law developments in the last quarter-century has been the increasing focus on healthcare fraud and abuse. In 1985, the healthcare fraud landscape looked quite different than it does today; the Stark I self-referral prohibitions, for example, were not enacted until 1989. Times have changed, perhaps illustrated nowhere as clearly as in the expanding role of the Civil False Claims Act (FCA).[1] Thanks to major amendments in 1986, the FCA now lies at the heart of the federal government's war on healthcare fraud. From its origins as a tool to ward off "rampant fraud" on the Union Army during the Civil War, to its most recent incarnation in 2009 as the basis for $2.4 billion dollars worth of settlements and judgments (two-thirds of that attributable to the federal healthcare programs), the evolution of this once-obscure military fraud statute into the centerpiece of the anti-fraud agenda has been nothing short of astounding.

Given the prominence of recent healthcare fraud investigations, it is easy to forget that the FCA was not enacted with healthcare in mind. The drafters of the 1863 "Informer's Act" had far more mundane war-time concerns: suppliers who sold blind and deaf mules to the military, substituted sand for gunpowder, and packed crates with sawdust in lieu of muskets. From the beginning, the statute included a virtually unique—and uniquely problematic—*qui tam* provision that permitted private relators to bring suit on the government's behalf and to share in the proceeds. Historically, controversy over the *qui tam* provisions has been the driving force behind major amendments to the statute. In 1943, Congress substantially limited the reach of the *qui tam* provisions after the Supreme Court permitted relators to sue based on information already in the government's possession—in that case, information copied directly from an indictment accusing the defendants of collusive bidding on government

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1. 31 U.S.C. §§ 3729.

contracts.[2] The 1943 amendments established the so-called jurisdictional bar, prohibiting "parasitic" suits based on previously disclosed information and drastically reducing the utility of the private cause of action.

With the growth of the administrative state, however, new challenges arose. The proliferation of federal programs after World War II, including the eventual creation of Medicare and Medicaid in 1965, provided new opportunities for abuse and raised awareness about the problem of federal program fraud. By the 1980's, the Department of Justice estimated that up to 10% of the federal budget was being lost to fraud and by mid-decade, nearly half of the country's major defense contractors were under investigation.[3] The FCA seemed a natural solution to these concerns, but its usefulness was hampered by a number of factors: the statutory penalties were low (a mere $2,000 per false claim), the circuit courts disagreed on basic issues such as the required mental state and whether a falsity had to be material to the government's payment decision in order to violate the law, and the jurisdictional bar kept many *qui tam* cases out of court. These limitations became clear in a 1986 Seventh Circuit decision barring Wisconsin from bringing a *qui tam* suit based on a psychiatrist's submission of fraudulent Medicaid bills because the federal government already was in possession of that information—thanks to the State itself, which had dutifully notified the federal government of the psychiatrist's state court Medicaid fraud conviction.[4]

Concluding that "only a coordinated effort of both the Government and the citizenry will decrease this wave of defrauding public funds," Congress increased the statutory penalties to $5,000 to $10,000 per claim plus treble damages (subsequently expanded to $5,500 to $11,000 by regulation), increased the relator's award to 15% to 25% of the proceeds (25% to 30% if the government declines to intervene in the suit), prohibited employers from retaliating against whistleblowers who filed *qui tam* suits, and created an exception to the jurisdictional bar for a relator who qualified as an "original source" of the government's information.[5] After 1986, the most common FCA cause of action imposed liability where a defendant presented or caused to be presented a claim for payment or approval, the claim was false or fraudulent, and the defendant's acts were undertaken knowingly (defined to include not only actual knowledge but also deliberate ignorance or reckless disregard of truth or falsity). While the amendments did not

2. *See* United States ex rel. Marcus v. Hess, 317 U.S. 537 (1943); Act of Dec. 23, 1943, ch. 377, § 3491(C), 57 Stat. 608-09.

3. S. REP. NO. 99-345 at 2-3, (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266-68 (citations omitted).

4. *See* United States ex rel. Wisconsin v. Dean, 729 F.2d 1100 (7th Cir. 1984).

5. S. REP. NO. 99-345 at 2, (1986) *reprinted in* 1986 U.S.C.C.A.N. 5267; False Claims Amendments Act of 1986, Pub. L. No. 99-562, 100 Stat. 3153.

explicitly target healthcare, it is clear that both the much-scrutinized defense industry and the fast-growing federal healthcare programs were on legislators' minds.

If the 1986 amendments did not change the substance of the federal healthcare laws, however, they did forever change the procedural context in which healthcare fraud and abuse cases would arise. Although often overshadowed by the *qui tam* revisions, the 1986 legislation gave federal prosecutors substantially more power over those engaged in business with the federal government, including the healthcare providers who treat Medicare and Medicaid patients. Increased statutory penalties, coupled with a scienter requirement that could be satisfied by mere recklessness, raised the specter of litigation over almost any billing-related misrepresentation other than a true mistake. The structure of the penalties and damages provisions proved to be particularly (although perhaps inadvertently) powerful against physicians, who usually bill on a fee-for-service basis. Unlike in the defense industry, where a contractor may submit a small number of very large payment requests to the government each year, physicians submit thousands of bills for relatively small amounts. In the defense context, treble damages are likely to be the major deterrent, with the additional $11,000 per-claim penalty merely a nuisance. For a physician, in contrast, the per-claim penalties may rise quickly even as treble damages remain small. In the infamous case of *United States v. Krizek*, for example, a psychiatrist was accused of submitting 8,000 improper claims, each inflated by about $30, for a total of $245,000 in damages; invoking the $10,000 per-claim penalty, the government sued him for nearly *$81 million dollars*.[6] Faced with potential exposure in the tens or hundreds of millions of dollars, it is no wonder that most defendants choose to settle FCA allegations rather than testing their luck at trial.

When the *qui tam* provisions are added to the mix, it is easy to see how the FCA has transformed the healthcare fraud landscape. FCA suits can be filed not only by federal prosecutors but also by competitors, current or former employees, attorneys, and even patients and their families—vastly increasing exposure. Relators and their attorneys have been instrumental in pushing the boundaries of the statute, for example, by filing suit not only in cases where medical care was not provided as claimed, but also where care was delivered in violation of other federal healthcare program laws that do not themselves permit a private right of action (such as the Anti-Kickback Statute and Stark Law). The result likely has exceeded what even the drafters of the 1986 amendments envisioned: while the federal healthcare programs accounted for only 12% of *qui tam* suits in 1987, by 1998 that number exceeded 61%, far displacing the defense industry as the primary

6. 859 F. Supp. 5 (D.C. Cir. 1994).

target. In 2008, 228 new healthcare *qui tam* cases were filed, resulting in recoveries of almost $9.7 million. Despite the fact that most *qui tam* suits do not succeed, those that do have had enormous impact on the industry: many of the largest healthcare fraud settlements, particularly involving pharmaceuticals, began as *qui tam* suits.

Not surprisingly, the very aspects of the 1986 amendments that have led to increased healthcare fraud recoveries have also generated heavy criticism. In recent years, for example, *qui tam* cases have been filed against an increasingly broad array of health-related entities that do not directly bill the government for services—including billing consultants, accountants, and pharmaceutical manufacturers—on the theory that such entities have "caused" false claims to be submitted as a result of their improper advice. Moreover, the focus has gradually shifted away from traditional *false* claims to those that instead are *fraudulent* in some manner, such as where violations of underlying program requirements may render an otherwise accurate claim ineligible for payment.

Critics of these developments often place the blame squarely on *qui tam* relators, who are free to pursue virtually any theory of FCA liability—in large part because, by definition, they exist outside the governmental enforcement apparatus. While relators do in many cases provide crucial information about fraud, there is considerable suspicion that many are tempted more by the prospect of financial reward than by righteous indignation (as if the two must be mutually exclusive). Recent *qui tam* litigation has focused heavily on the complicated legal provisions governing who can serve as a relator, including considerations of what it means for a suit to be based on publicly disclosed information, whether a relator qualifies as an original source of the information, and whether a relator must allege fraud with enough specificity to satisfy Federal Rule of Civil Procedure 9(b). Because the checks on *qui tam* suits are largely procedural rather than substantive, to many critics the system appears ripe for abuse by self-interested relators with few, if any, real whistles to blow.

While those who fear relator self-interest may prefer to have the Department of Justice control the filing of FCA suits as part of a centralized anti-fraud agenda, however, direct FCA enforcement has also generated substantial criticism. The post-1986 penalty structure permits the government to demand extraordinarily large sums of money, as in *Krizek*, leading to accusations of heavy-handed attempts to force settlements. Hospitals, in particular, have characterized recent enforcement initiatives as "border[ing] on extortion;" even the courts have on occasion acknowledged that FCA enforcement has been "rather draconian."[7] As a result, there has

7. GOV'T ACCOUNTING OFFICE, [untitled report], B-279893, at 15 n.30 (July 22, 1998); Ass'n of Med. Coll. v. United States, 217 F.3d 770, 781 (9th Cir. 2000).

been a continuous stream of efforts to further amend the law, with defense-oriented attempts to reduce the uncertainty and severity of FCA exposure countered by competing proposals from those who believe statutory loopholes allow too many defendants to escape liability purely on procedural grounds. While the Supreme Court has weighed in on a variety of FCA procedural issues, such as standing, it has remained largely out of the fray concerning the application of the statute to common theories of healthcare fraud.

In the spring of 2009, nearly a quarter-century after the 1986 FCA amendments, Congress passed the Fraud Enforcement and Recovery Act of 2009 (FERA).[8] FERA broadened the scope of the FCA by addressing many provisions—such as defining a "claim" and specifying how it must be linked to government funds, requiring materiality, expanding liability for conspiracies, and broadening the anti-retaliation protections—that critics had long alleged were permitting unwarranted defenses to liability. The legislation also gave the government greater power over FCA cases by permitting the Attorney General to delegate the approval of civil investigative demands, permitting greater sharing of information with law enforcement while a case is under seal, and clarifying that the government's complaint in intervention relates back to the date of the original complaint. Yet it is interesting to note that FERA did *not* address many of the most pressing *qui tam* procedural concerns, such as the jurisdictional bar or Rule 9(b), perhaps leaving those issues for another day (or at least for the subsequent healthcare reform legislation).

A quarter-century after the landmark 1986 FCA amendments, then, where do we stand? The FCA, now even more potent, remains the centerpiece of the government's anti-fraud agenda. To the extent FERA clearly benefits prosecutors by expanding the universe of actionable claims, it does little to address procedural *qui tam* hurdles, perhaps the legislation signals Congress' desire for greater governmental control over FCA litigation. This goal would seem to comport with the Obama administration's coordinated approach to healthcare fraud, most notably the cabinet-level Health Care Fraud Prevention & Enforcement Action Team (HEAT) initiative announced in May 2009. Yet at the same time, HEAT has committed the government to using the full range of both civil and *criminal* penalties applicable to healthcare fraud—suggesting that the FCA's role may, in some cases, eventually be supplanted by criminal prosecution. Whether the dawning of the FERA/HEAT era ultimately signals an even deeper commitment to the FCA-based anti-fraud agenda, or one that instead begins to relegate the FCA to merely one among many powerful anti-fraud tools, only the next twenty-five years will tell.

8. Pub. L. No 111-21, 123 Stat. 1617.