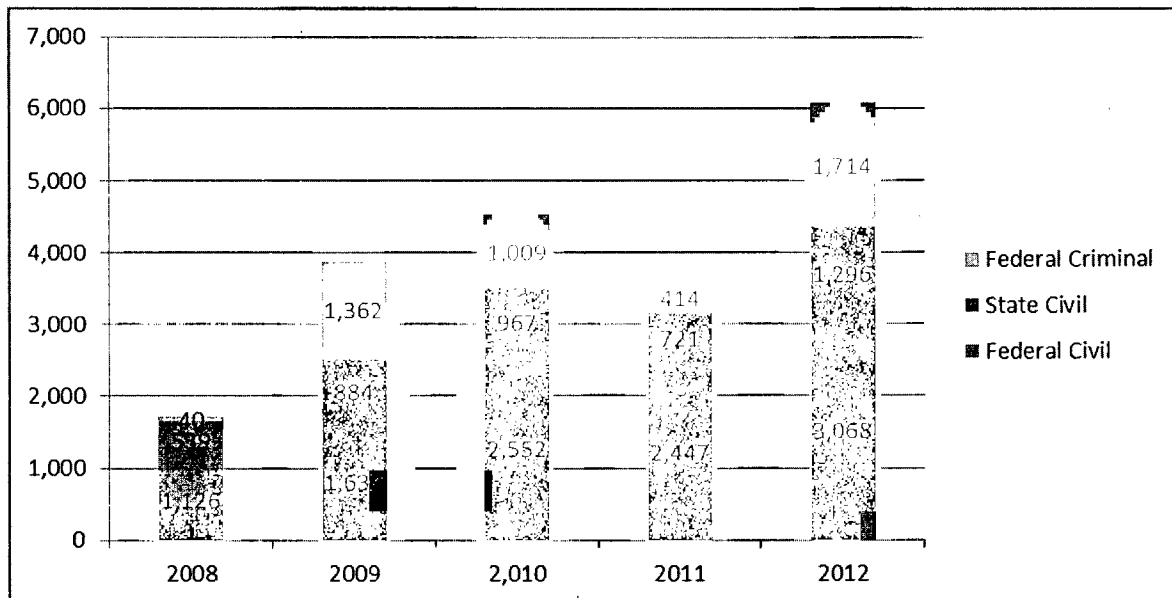


Fighting Medicare & Medicaid Fraud

The Return on Investment from False Claims Act Partnerships



prepared for

Taxpayers Against Fraud Education Fund

By

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October 2013

ACKNOWLEDGEMENTS

The author would like to thank Patrick Burns, Co-Director of Taxpayers Against Fraud Education Fund, for very helpful contributions to the research and analysis in this study. Alexandra Scott also provided thorough and careful research to support the project. This work was supported by a grant from the law firm of Nolan Auerbach & White, and the Smart Family Foundation.

Statement of Purpose Summary of Findings

The purpose of this report is to provide an estimate of the benefits and costs to the federal government of fighting fraud in the nation's Medicare and Medicaid programs.

This report updates earlier published studies conducted by the author for Taxpayers Against Fraud Education Fund.

Since the last study was published in 2006, several new factors have emerged in this field.

- We have seen an increase in the number of cases filed, as well as a major increase in the size of the largest settlements and judgments.
- In recent years, states and the federal government have become much more involved in investigating and prosecuting Medicaid fraud.
- There has been a substantial rise in criminal penalties.
- The major cases now include more investigations of pharmaceutical companies.

Summary of Findings

Based on an analysis of data for the five-year period FY 2008–FY 2012, we conclude that the federal government is getting a return on investment in civil health care fraud enforcement that is more than double the rate of return identified in our first study, published in 2001.

“If all costs and benefits are accounted for, the benefit to cost ratio of False Claims Act law enforcement now exceeds 20:1.”

The benefit-to-cost ratio of federal civil recoveries noted in this report, however, dramatically underestimates the real return taxpayers are receiving on outlays for False Claims Act law enforcement in the health care arena. This is because civil fraud recoveries now represent only a portion of all False Claims Act recoveries in the health care arena, as increasingly large settlements are now associated with large criminal fines and state Medicaid recoveries that not accounted for in federal FCA statistics keeping.

While it is difficult to quantify federal and state costs associated with recovering these federal criminal and state civil dollars, we are confident that if all costs and benefits are accounted for, the benefit to cost ratio of False Claims Act law enforcement now exceeds 20:1.

Even this number is too low, however, as it does not account for the deterrent effect of False Claims Act law enforcement. Major settlements with large recoveries have a ripple effect that reduces the likelihood of similar fraud against federal and state health care programs. Though these deterrent effects cannot be measured accurately at this time, they may be a substantial multiple of the direct, measurable benefits in the form of actual monetary recoveries.

Introduction and Background

The US spends \$2.8 trillion annually on health care. Our system funds innovative research and technology, provides world leadership in cancer care, but also demands improvement in areas such as providing care to millions of uninsured and treating chronic illnesses. But, with nearly \$3 trillion flowing through the system and insufficient accountability, there has been widespread fraud in both public programs and private insurance. This fraud erodes our ability to improve and extend care to the needy and corrodes support for such assistance.

Fraud is a major concern in the Medicare and Medicaid programs. Nearly 50 million Americans are enrolled in Medicare. In any given month, an estimated 62 million are enrolled in Medicaid, with some 75 million people enrolled at some point during a year's time.¹ Medicare spent \$555 billion in 2012.² Medicaid spending totaled \$459 billion in 2012.³ This poses a tempting target for fraud.

Since 1987, the federal government has brought in \$24 billion in settlements and judgments in health care fraud. Another \$15 billion in criminal fines and civil settlements returned to the states brings the total amount recovered to nearly \$40 billion. To put that figure in perspective, it is enough money to fund the entire Children's Health Insurance Program (CHIP), serving over 5 million people, for approximately four years.⁴

In 2012 alone, the Federal Government won or negotiated \$3.1 billion in health care fraud judgments and settlements. As a result of efforts by the Federal Government to investigate and prosecute health care fraud in 2012 and preceding years, approximately \$4.2 billion was deposited with the U.S. Department of the Treasury and the Centers for Medicare & Medicaid Services (CMS), transferred to other federal agencies administering health care programs, or paid to private persons during fiscal year 2012. The Health Care Fraud and Abuse Control Program (HCFAC), set up under the HIPAA legislation of 1996, has returned over \$24 billion to the Medicare Trust Funds since the inception of the program in 1997.⁵

In recent years, the health care fraud caseload has grown significantly. In the first six years after the False Claims Act Amendments were enacted (1987-1992), a total of 62 health care qui tam cases were "newly received referrals, investigations, and qui tam actions," called "new matters." In 2011 and 2012, respectively, there were 417 and 412 of these "new matters" in the health care arena alone. In

¹ Some nine million people are enrolled in both programs, and they are referred to as "dual eligibles."

² <http://www.cbo.gov/topics/health-care/medicare>

³ Vernon K. Smith, Kathleen D. Gifford, and Jack Meyer, "The Economics of Medicaid Expansion: A Look at the Direct and Indirect Fiscal Considerations for States, Stakeholders, and Policy Makers." *Health Management Associates*, November 30, 2012.

⁴ "CHIP Enrollment: June 2011 Data Snapshot," last modified June 1, 2012, <http://www.kff.org/medicaid/upload/7642-07.pdf>.

⁵ The Department of Health and Human Services and Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012," OIG (February 2013): 1. <https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf>.

contrast, the number of non-qui tam new health care matters has been relatively stable over the past two decades.

Relators (also called *whistleblowers*) received a total of \$284.3 million out of the total of \$2.5 billion in health care qui tam settlements and judgments in 2012. This represents 11.3 percent of the total federal civil recovery, but as we shall show, less than 6 percent of the total federal recovery (federal civil plus federal criminal).

“The combination of whistle-blower initiation of a case of suspected health care fraud, and assistance from the U.S. government, forms a very powerful tool in returning money to the US Treasury.”

The bottom line here is that the combination of whistleblower initiation of a case of suspected health care fraud, and assistance from the US government, forms a very powerful tool for returning money to the US Treasury that was obtained fraudulently by actors in the health care system.

Legislative History

The False Claims Act (FCA) was first enacted under President Abraham Lincoln. The intent was to deter people from fraudulently billing the U.S. government for supplies for the Union Army fighting in the Civil War. In 1986, Congress realized that the penalties under the so-called “Lincoln Law” needed to be strengthened. Under the False Claims Act Amendments enacted that year, people who submit, or cause another person to submit, false claims for payment of government funds are liable for up to three times the government’s damages plus civil penalties of \$5,500 to \$11,000 *for each false claim*.

The False Claims Act contains “*qui tam*” provisions, which allow people with evidence of fraud against the government to sue on behalf of the government. People who sue under the FCA are called “relators” or “whistleblowers,” and are eligible for 15 to 30 percent of the civil recovery attributable to the information they provided, as original sources, to the government.⁶ Of the \$24 billion in settlements and judgments for civil health care matters recovered by the federal government, \$18.4 billion, or 76 percent, were cases involving whistleblowers. Further, of the \$18.4 billion in health care settlements and judgments involving whistleblowers, \$18.0 billion involved cases in which the U.S. government intervened or otherwise pursued the case.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Care Fraud and Abuse Control program, known as HCFAC. In 2012, The Secretary of HHS and the Attorney General certified \$294.8 million in mandatory funding as necessary for the HCFAC program and Congress appropriated \$309.7 million in discretionary funding. Of this total of \$604.6 million, \$513.7 million was provided to HHS and \$90.9 million to Department of Justice (DOJ). From the DOJ funding, U.S. attorneys

⁶ “False Claims Act Story,” Taxpayer’s Against Fraud, accessed September 3, 2013 <http://www.taf.org/false-claims-act-story>.

received \$35.5 million and the Civil Division received \$24.2 million, while the Criminal Division obtained \$8.5 million and the FBI got \$3.4 million.⁷

“Large FCA cases are now increasingly associated with criminal judgments and settlements.”

Under the joint control of the US Secretary of Health and Human Services (HHS) and the US Attorney General, the HCFAC program goals include:

- Coordinating Federal, state, and local law enforcement efforts relating to health care fraud and abuse;
- Conducting investigations, audits, inspections, and evaluations relating to the delivery of and payment for health care;
- Facilitating enforcement of all applicable remedies for fraud;
- Providing guidance to the health care industry on fraudulent practices;
- Establishing a national data bank to receive support and report final adverse actions against health care providers and suppliers.

Money paid to Medicare in restitution or for compensatory damages must be deposited in the Medicare Trust Funds. Recoveries from health care investigations—civil settlements and judgments, criminal fines, forfeitures, etc.—must also be deposited in these Funds.

The law requires the Attorney General and the HHS Secretary to submit a joint annual report to Congress identifying the amounts deposited to the Trust Funds for the previous fiscal year and the amounts appropriated from the Trust Funds and the justification for the expenditures.⁸

Criminal Investigations

Large FCA cases are now increasingly associated with criminal judgments and settlements. These actions are a significant element of the overall benefit of FCA litigation. Not only do they bring in additional recoveries, but also they create the possibility of criminal conviction, which serves as a deterrent to committing fraud against the government. *Thus, criminal investigations of health care fraud are now a significant element of the benefit of FCA litigation to the government.*

Further, civil and criminal investigations are frequently related. A matter that begins as a civil fraud investigation may uncover evidence of criminal behavior, and federal health care law enforcement increasingly involves close cooperation between diverse federal and state agencies at both the civil and criminal level.

⁷ The Department of Health and Human Services and Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012,” OIG (February 2013): 7.

⁸ The Department of Health and Human Services and Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012,” OIG (February 2013): 1.

The HEAT Initiative and the Medicare Fraud Strike Force

An important objective in the federal government's anti-fraud activity in health care is the closer collaboration between key federal agencies — particularly HHS and DOJ. The federal government decided this relationship was particularly important to investigate and prosecute fraud related to pharmaceuticals and medical devices.

To foster this objective, the Health Care Fraud Prevention & Enforcement Action Team (HEAT) was initiated in May 2009 to initiate and coordinate collaborative action between DOJ and HHS in preventing and prosecuting health care fraud. HEAT is jointly led by the Deputy Secretaries of the two cabinet-level agencies. Data sharing across agencies permits the federal government to track patterns of fraud and increases the efficiency of investigating and prosecuting complex fraud schemes.⁹

Strike Force teams have used advanced data analysis techniques to identify high-billing levels in health care fraud hot spots, to target emerging or migrating schemes, and identify chronic fraud by criminals masquerading as health care providers or suppliers. Based on the success of the first Strike Force team, in South Florida in 2007, the Strike Force concept was expanded to nine cities.

In the five and a half years since the beginning of the Strike Force effort, prosecutors filed more than 724 cases charging more than 1,476 defendants who collectively billed Medicare over \$4.6 billion.¹⁰

It should be noted that while a great deal of fraud has been stopped by the HEAT Initiative and the Medicare Fraud Strike Forces, these new programs may be given more credit in False Claims Act recoveries than is warranted. Cases filed by whistleblowers and developed by private lawyers years before the HEAT initiative started are sometimes credited to HEAT in DOJ press releases.¹¹

In addition, while HEAT and Strike Force press releases and progress reports detail how much was billed to the U.S. Government, they are not as forthcoming in detailing how much was recovered due to law enforcement action. While the Strike Force initiative has no doubt prevented and deterred a great deal of fraud, it cannot yet be credited with returning to the U.S. Treasury the very large sums that we see coming in from whistleblower-initiated cases under the False Claims Act. For example, a February 2013 press release issued by HHS notes that "government teams" of all kinds recovered \$4.2 Billion in FY 2012.¹² Buried at the bottom of the press release is the fact that more than \$3 billion of this sum was

⁹The Department of Health and Human Services and Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012," OIG (February 2013): 8-10.

¹⁰ The Department of Health and Human Services and Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012," OIG (February 2013): 11.

¹¹"Medicare Fraud Strike Force Charges 89 Individuals for Approximately \$223 Million in False Billing," last modified May 14, 2013, <http://www.justice.gov/opa/pr/2013/May/13-crm-553.html>.

¹²"Departments of Justice and Health and Human Services announce record-breaking recoveries resulting from joint efforts to combat health care fraud," last modified February 11, 2013, <http://www.hhs.gov/news/press/2013pres/02/20130211a.html>.

recovered due to False Claims Act cases, almost all of which were initiated and developed by whistleblowers and their private attorneys.^{13 14}

The Benefits and Costs of Federal FCA Activities

This section of the report presents the findings of the cost-benefit analysis of the federal government's activities to investigate and civilly prosecute health care fraud under the federal False Claims Act.

It is important to note that the federal government also recovers large sums of money from criminal fines associated with federal False Claims Act cases, and that the states also recover large sums associated with these same cases. We will quantify the size of these returns in an additional section of this report. In all instances, our analysis covers the period from fiscal year 2008 through fiscal year 2012.

Civil Recoveries Under the Federal False Claims Act

As shown in Table 1, from 2008 through 2012, the federal government recovered a total of \$10.8 billion from matters related to civil health care fraud enforcement under the Federal False Claims Act. Relators received a total of \$1.4 billion over the same five-year period. When those payments to relators are subtracted from the total recoveries, we get an estimate of the federal government's civil "net recoveries" under the federal False Claims Act. Over the 2008-2012 period, civil net recoveries amounted to \$9.4 billion (Table 1).

Table 1: Recoveries to the Federal Government, FY 2008-FY2012 (millions of dollars)

	2008	2009	2010	2011	2012	Total
Total recoveries	1,126	1,633	2,552	2,447	3,068	10,826
Relators share	186.1	164.0	338.4	470.2	284.3	1,443
Net recoveries	939.9	1,469.0	2,213.6	1,977.8	2,783.7	9,384

Source: HCFAC reports, FY 2008-FY 2012.

¹³ "DOJ FCA Statistics," Taxpayer's Against Fraud, accessed September 3, 2013, <http://www.taf.org/DoJ-FCA-statistics-2012.pdf>.

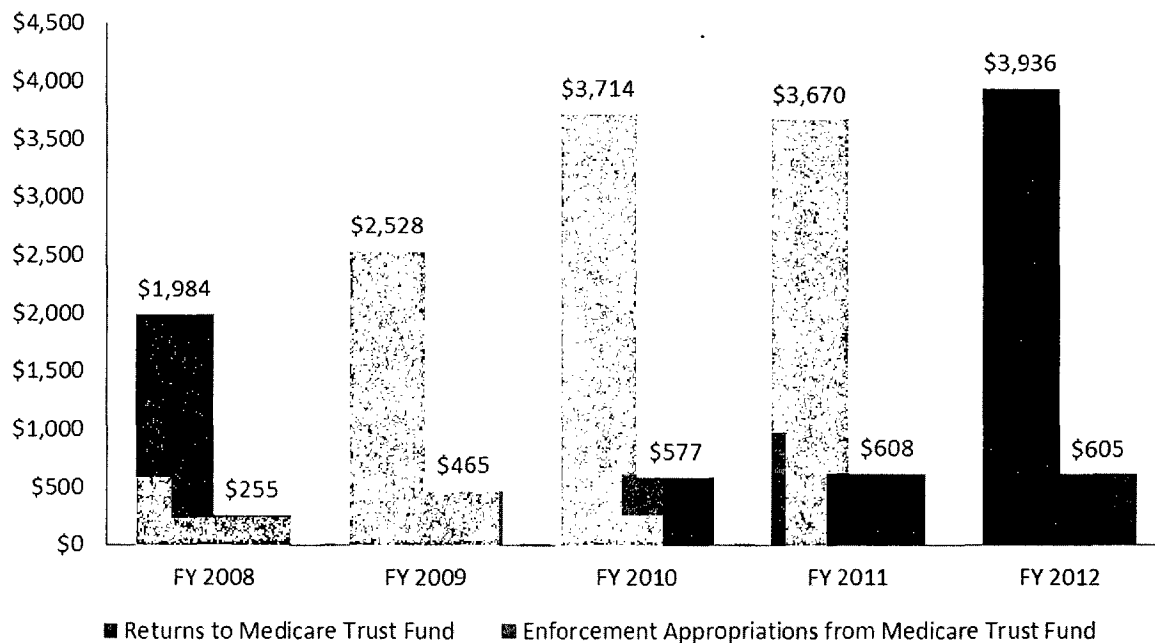
¹⁴ "FY 2012 Is Record Year for FCA Recoveries," Taxpayer's Against Fraud, <http://www.taf.org/blog/fy-2012-record-year-fca-recoveries>.

The next step in the analysis is to determine the relationship between the money coming into the Medicare Trust Fund versus the money appropriated from the Fund for health care fraud enforcement. Recoveries in any given year are not the same as the money going into the Funds, because some of the money that is collected during any given year was

“The amount of funds deposited in the Trust Fund was six and a half times as great as the FY 2012 HCFAC allocation.”

actually won or negotiated in a prior year. The chart on the following page shows the flow of funds into and out of the Funds over the five-year period examined in this study. The striking feature of this chart is that the amount of money flowing into the Medicare Trust Fund greatly exceeds the allocations to the various agencies that are fighting fraud. For example, in FY 2012, the amount of funds deposited in the Trust Fund was six and a half times as great as the FY 2012 HCFAC allocation. Moreover, most of the allocations went to CMS and OIG (\$265 million and \$226 million, respectively). In contrast, the Civil Division and the Criminal Division at DOJ were each allocated \$24 million. These are relatively small sums in light of the billions of dollars recovered and deposited into the Fund (see Chart).

Total Funds Returned to the Medicare Trust Fund (MTF) versus Total Funds Appropriated from the MTF for Health Care Fraud Enforcement, FYs 2008-2012 (in millions)



Outlays

We estimated federal outlays to investigate and prosecute health care fraud for three federal agencies—U.S. Attorneys, the Office of the Inspector General (OIG) in the US Department of Health and Human Services, and the Civil Division of the U.S. Department of Justice. These agencies are the key participants in the federal government’s anti-fraud activities.

U.S. Attorneys

To estimate the cost of U.S. Attorneys, we begin with the total USAO budget from 2008 through 2012. Using government budget documents, we determined that this was \$9.413 billion. We estimate that 22 percent of the total USAO budget went to Civil Litigation over this period. This produces a figure of \$2.071 billion over the five-year period.

The next step is to estimate the proportion of this civil litigation outlay that was devoted to civil fraud litigation. Based on input from USAOs, we estimated that 26 percent of the staff and related costs for civil litigation were devoted to civil fraud litigation. This translates into \$538.5 million in outlays for US attorneys’ civil fraud investigations and prosecutions from 2008 through 2012.

The final step is to estimate the proportion of civil fraud litigation that is devoted to health care fraud. We estimate this, based on interviews with key DOJ personnel, to be 70 percent. Thus, the five-year cost for the efforts of US attorneys related to health care fraud is \$377 million (see Table 2).

Table 2: Health Care Fraud-related Outlays for US Attorneys, FY 2008-FY 2012 (millions of dollars)

2008	2009	2010	2011	2012	Total
70.5	73.5	77.1	77.4	78.5	377

Source: US Department of Justice

Office of the Inspector General

The mission of the Office of the Inspector General (OIG) is to “protect the integrity of HHS programs as well as the health and welfare of beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; providing industry guidance; and holding accountable those who do not meet program requirements or who violate Federal laws.”¹⁵

¹⁵ Department of Health and Human Services. Office of the Inspector General. “Justification of Estimates for Appropriations Committees: Fiscal Year 2013.” 3.

To estimate the outlays for OIG, we obtained data from OIG. We received information on the number of people (full-time equivalent workers, or FTEs) who worked at OIG, and then a breakdown that showed how many of these employees were involved in work related to CMS (OIG staff work on many other HHS programs including those in the Public Health Service). We excluded senior managers and focused on staff in three areas—the Office of Audit Services, the Office of Investigations; and the Office of Evaluation and Inspections. We then obtained information on the full cost of each FTE.

Table 3: Health Care Fraud-related Outlays for OIG, FY 2008-FY 2012 (millions of dollars)

2008	2009	2010	2011	2012	Total
17.6	19.7	20.1	21.0	24.8	103.2

Source: Department of Health and Human Services, Office of the Inspector General. Justification of Estimates for Appropriations Committees. FY 2009 and FY 2013.

US Department of Justice, Civil Division

The Fraud Section of the Civil Division of the Justice Department works with US attorneys to investigate and litigate matters involving fraud against the US government. Since 2009, the Fraud Section has obtained settlements and judgments that exceed \$6.2 billion. This includes health care fraud, but also fraud involving federal mortgage lenders, defense contractors, government research grants, student loans, firms constructing federal buildings and prisons, information technology organizations, and the receipt of foreign aid. In FY 2011, the total recovered from all of these sources was greater than \$3.3 billion. The Civil Division took actions against manufacturers filing false and inflated prices, fraud promoting harmful drugs and devices, violations of the Anti-Kickback and Stark laws, online drug companies selling counterfeit drugs, and home health organizations that inflate or invent claims.¹⁶

Table 4: Health Care Fraud-related Outlays for DOJ, Civil Division, FY 2008-FY 2012 (millions of dollars)

2008	2009	2010	2011	2012	Total
16.8	18.1	19.6	19.5	20.4	94.4

Source: U.S. Department of Justice, Civil Division

Total Health Care Fraud-related Outlays

We now sum the outlays for the three agencies over the period from FY 2008 through FY 2012.

¹⁶“Civil Division FY 2013 Budget and Performance Plans,” last modified February 2012, <http://www.justice.gov/jmd/2013justification/pdf/fy13-civ-justification.pdf>

**Table 5: Total Health Care Fraud-related Outlays for Three Agencies,
FY 2008-FY 2012 (millions of dollars)**

USAO	377.0
OIG	103.2
DOJ, Civil Division	94.4
Total	574.6

Sources: US Government agencies

Benefit to Cost Ratio

The bottom line is the relationship between total benefits, as measured by net recoveries, and total outlays, both over the five-year period. The results are shown in Table 6.

Table 6: Benefit-to-Cost Ratio (millions of dollars and benefits to costs), FY 2008-FY 2012

Benefits	Costs	Benefit/Cost Ratio
9,384	574.6	16.33 to 1

Source: HMA Calculations

These results indicate that for each dollar spent by the federal government in investigating and prosecuting civil health care fraud against the federal government, \$16.33 was recovered to the federal government, after allowing for the amounts paid to whistleblowers.

The Missing Numbers in DOJ's Presentation

The benefit to cost ratio of 16.33 to 1 is an understatement of the full "rate of return" from the federal government's anti-fraud activities.

First, as noted above, there are many criminal cases involving health care fraud. In fact, from 2008 through 2012, criminal fines associated with federal False Claims Act cases totaled over \$4.5 billion, but these fines are not counted in official Department of Justice False Claims Act settlements.

Why not?

Simple enough; when the U.S. Department of Justice first started compiling FCA statistics more than 25 years ago, criminal fines associated with FCA cases were nonexistent, and there were almost no Medicaid recoveries. DOJ False Claims Act statistics record-keeping remains an artifact of that era. The

result is that criminal penalties and state recoveries associated with False Claims Act cases do not appear in the official FCA statistics sheet. This results in an incomplete picture of how effective the partnership between whistleblowers, DOJ, HHS, and private lawyers is when they work together to recover America's stolen billions.

“DOJ civil False Claims Act data dramatically underestimates the amount of money recovered to government – the real number of interest to voters and policy makers alike. “

Federal Criminal Recoveries

Associated with federal False Claims Act Cases, 2008-2012 (in millions of dollars)

2008	2009	2010	2011	2012	Total
40.0	\$1,362.2	\$1,009.2	\$414.2	\$1,713.5	\$4,539.0

State Civil Recoveries

Associated with federal False Claims Act Cases, 2008-2012 (in millions of dollars)

2008	2009	2010	2011	2012	Total
\$539.4	\$883.9	\$967.4	\$721.2	\$1,295.7	\$4,407.7

When the two numbers above are added we find that official DOJ False Claims Act data dramatically underestimates the amount of money recovered to government – the real number of interest to voters and policy makers alike. Does it matter if the money recovered is “criminal” money or “civil” money or if the money is “federal” money or “state”? Not to most taxpayers. As far as they are concerned, it's all one set of pants, and whether it's coming out of, or going into, the left pocket or the right is largely a technical abstraction.

**Total Recoveries (Civil, Criminal and State Penalties)
Associated with Federal False Claims Act Cases, 2008-2012 (millions of dollars)**

	2008	2009	2010	2011	2012
Federal civil healthcare recoveries reported by DOJ ¹⁷	1,126	1,633	2,552	2,447	3,068
Federal criminal recoveries associated with FCA cases (in millions)	40	1362	1009	414	1714
State recoveries associated with federal FCA cases (in millions)	539	884	967	721	1296
Totals	1705	3879	4528	3582	6078

When a \$3 billion whistleblower-initiated case was announced by GlaxoSmithKline in July 2012, the Department of Justice's press release stated that \$3 billion was recovered.¹⁸ Of this sum, the press release notes, \$1 billion was ascribed to a criminal penalty and of the remaining \$2 billion, \$1.043 billion was paid for off-label promotion of various drugs, and of this sum the federal share was \$832 million, and the state share was \$210 million. Additionally, GSK agreed to pay \$657 million related to false claims arising from misrepresentations about Avandia. The federal share of this settlement was \$508 million, and the state share was \$149 million. Finally, GSK agreed to pay \$300 million to resolve allegations of price-gouging, including about \$161 million that went to the federal government as part of a civil settlement, about \$119 million that went to the states, and about \$20 million that went to Public Health Service entities.

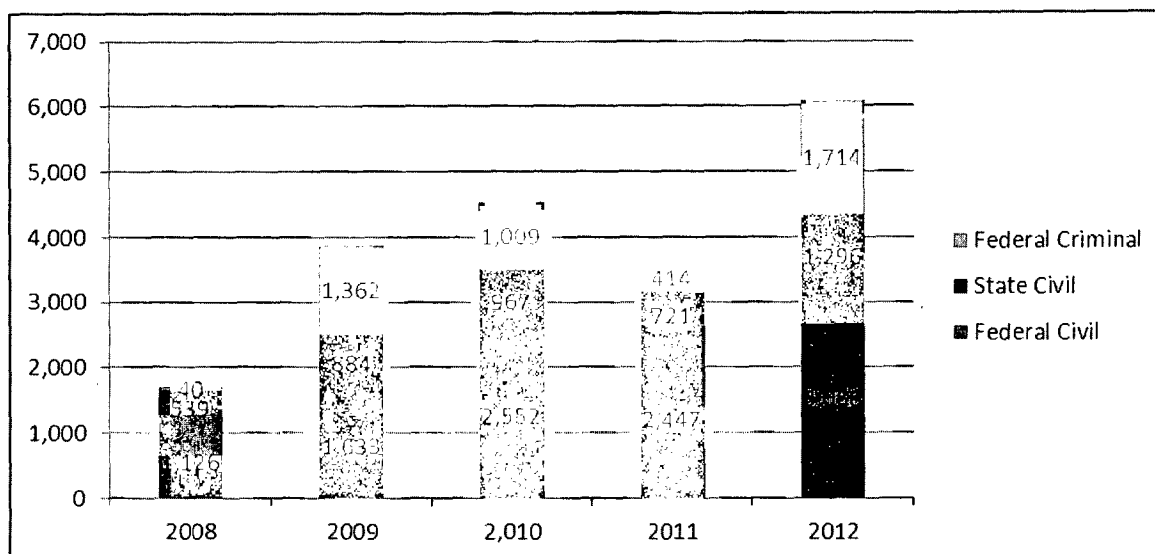
The bottom line: Of the \$3 billion recovered to government solely due to whistleblower-initiated False Claims Act cases first filed by private attorneys, the federal government only booked \$1.5 billion under the Federal False Claims Act, and DOJ end-of-year statistics did not include the other \$1.5 billion.

If we look at total recoveries attributed to health care False Claims Act cases, we see that a very large percentage of recent recoveries involve non-civil or non-federal dollars.

¹⁷ "DOJ FCA Statistics," Taxpayer's Against Fraud, accessed September 3, 2012, <http://www.taf.org/DoJ-FCA-statistics-2012.pdf>.

¹⁸ "GlaxoSmithKline to Plead Guilty and Pay \$3 Billion to Resolve Fraud Allegations and Failure to Report Safety Data," last modified July 2, 2012, <http://www.justice.gov/opa/pr/2012/July/12-civ-842.html>.

**Total Funds Returned to Federal and State Governments
as a Result of FCA-Initiated Cases, FYs 2008-2012 (in millions)**



We do not have adequate information on the cost to the federal government and the states of investigating and prosecuting activities that result in criminal judgments and settlements and state Medicaid recoveries. Thus, we cannot calculate what the benefit-to-cost ratio would be if we had the full set of information on costs.

The chart above, however, makes it clear that the additional recoveries are quite substantial, and it is very likely that the added cost of collecting these funds is not proportionally as great as the added recoveries. One reason is that the same investigation frequently leads to both civil monetary recoveries and criminal fines collected. As a result, it is almost certain that if all costs and benefits were accounted for, the taxpayer benefit-to-cost ratio of False Claims Act law enforcement exceeds 20:1.

Conclusion

There is no doubt that the federal government's initiatives to fight health care fraud have returned large sums of money to US taxpayers. These initiatives also improve the integrity of federal health care programs and make a substantial contribution to their solvency. In times of constrained government budgets, we can ill afford to have federal money wasted or stolen. It is clear that the federal

government is getting a tremendous “bang for the buck” in its anti-fraud activities in health care. There are various ways of calculating that bang for the buck, but this report makes clear that accounting for only federal civil returns associated with FCA cases still shows a better than 16:1 return on investment, while a more robust calculation of the federal return that factors in both civil and criminal fines and recoveries show a far greater return. It is our estimate that a total taxpayer benefit-to-cost return from False Claims Act law enforcement exceeds 20:1.



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Taxpayers Against Fraud Educational Fund is a nonprofit, public interest organization dedicated to combating fraud against the government and protecting public resources through public-private partnerships.

TAFEF is supported by successful whistleblowers and their counsel, as well as by membership dues and foundation grants. TAFEF is the 501(c)(3) arm of Taxpayers Against Fraud, which was founded in 1986.