

LARGEST HEALTH CARE FRAUD SETTLEMENTS

1997- JANUARY 25, 2006 (LAST UPDATE)

Taxpayers Against Fraud Education Trust

www.taf.org

Since 1986, False Claims Act judgments and settlements against fraud feasons have totaled over \$12 billion. Below are the top 20 recoveries to date.

1) Tenet Healthcare -- \$900,000,000 under the False Claims Act

In July 2006, Tenet Healthcare (formerly known as NME, see #9 on this list) agreed to pay the Federal Government \$900 million for billing violations that include manipulation of outlier payments to Medicare, as well as kickbacks, upcoding, and bill padding. The DoJ press release notes that the settlement was based on the company's ability to pay; a nice of saying that Tenet stole more money than was recovered in this settlement.

2) HCA -- \$731,400,000 under the False Claims Act

In December 2000, HCA The Healthcare Company (formerly known as Columbia HCA), the largest for-profit hospital chain in the United States, pled guilty to criminal conduct and agreed to pay more than \$840 million in criminal fines, civil penalties and damages for unlawful billing practices. Of this amount, \$731,400,000 was recovered under the False Claims Act. Under the settlement agreement, HCA's payment will resolve five allegations regarding the manner in which it bills the U.S. government and the states for health care costs. HCA 's frauds on the taxpaying public included: billing for lab tests that were not medically necessary and not ordered by physicians, "upcoding" medical problems in order to get higher reimbursements for more serious medical issues, billing the government for advertising under the guise of "community education," and billing the government for non-reimbursable costs incurred in the purchase of home health agencies around the country. Note that the December 2000 agreement does not resolve allegations that HCA unlawfully charged the U.S. Government for the costs of running its hospitals, and that it paid kickbacks to physicians to get Medicare and Medicaid patients referred to its facilities.

3) HCA -- \$631,000,000 under the False Claims Act

In June 2003, HCA Inc. (formerly known as Columbia/HCA and HCA – The Healthcare Company) agreed to pay the United States \$631 million in civil penalties and damages arising from false claims submitted to Medicare and other federal health programs. This settlement resolves HCA's civil liability for false claims including cost report fraud and the payment of kickbacks to physicians. In a separate administrative settlement with the Centers for Medicare & Medicaid Services (CMS), HCA agreed to pay an additional \$250 million to resolve overpayment claims arising from its cost reporting practices. Combined with the December 2000 settlement, the government has recovered \$1.7 billion from HCA, by far the largest recovery ever reached by the government in a health care fraud investigation.

4) Serono-- \$567,000,000 under the False Claims Act

In October of 2005, Serono agreed to pay \$704 million to settle a fraud case involving Serostim, a human growth hormone product used to fight AIDS-related wasting. The charges involved kickbacks to doctors for prescribing Serostim, kickbacks to specialist pharmacies for recommending Serostim, illegal off-label marketing of the drug, and non-FDA approved diagnosis equipment designed to spur more Serostim prescriptions. Serostim cost as much as \$20,000 for a three-month regime. Of the total \$704 million settlement, \$567 million is earmarked to settle federal and state civil claims (\$305 million federal), with \$136.9 million paid as a related criminal fine.

5) TAP [Taketa-Abbott Pharmaceutical] Pharmaceutical Products Inc. -- \$559,483,560 under the False Claims Act

In October 2001, TAP Pharmaceutical Products Inc. agreed to pay \$875 million to resolve criminal charges and civil liabilities in connection with fraudulent drug pricing and marketing of Lupron, a drug sold for the treatment of prostate cancer. Of this amount, \$559,483,560 was recovered under the False Claims Act. In addition, TAP pled guilty to a conspiracy to violate the Prescription Drug Marketing Act and paid a \$290 million criminal fine, the largest criminal fine ever in a health care fraud prosecution. Under the Lupron scheme, TAP gave doctors kickbacks by providing free samples with the knowledge that the physicians would bill Medicare and Medicaid \$500 per dose. At the time the Lupron fraud was discovered, Lupron accounted for 10% of the money spent on prescription drugs under Medicare Part-A. As part of the settlement, TAP entered into what prosecutors called a "sweeping" corporate integrity agreement.

6) Abbott Labs-- \$400,000,000 under the False Claims Act

In July of 2003, a unit of Abbott Laboratories, Inc. pled guilty to obstructing a criminal investigation and defrauding the Medicare and Medicaid programs and agreed to pay \$400 million to resolve civil claims. In addition, the subsidiary of Abbott Labs, CG Nutritionals, Inc., agreed to a criminal fine of \$200 million. The Abbott/CG Nutritionals scam involved the sale of enteral products which pump special foods into the stomachs and digestive systems of patients who, because of disease or some other disorder, are not able to ingest meals in a normal manner.

7) Fresenius Medical Care of North America (National Medical Care) -- \$385,000,000 under the False Claims Act

In January of 2000, Fresenius Medical Care of North America, the world's largest provider of kidney dialysis products and services, agreed to pay the United States \$486 million to resolve a sweeping investigation of health care fraud at National Medical Care, Inc. (NMC), a kidney dialysis subsidiary owned by Fresenius. Of this amount, \$385,000,00 was recovered under the False Claims Act. Three NMC subsidiaries also pled guilty to three separate conspiracies and were levied fines of \$101 million. Fresenius has also entered into a corporate integrity agreement with the U.S. Department of Health and Human Services. The Fresenius/NMC scam involved fraudulent and fictitious blood testing claims by LifeChem, Inc., NMC's clinical blood testing laboratory, kickbacks to dialysis facilities to obtain blood testing contracts for LifeChem, and fraudulent claims submitted to Medicare for intradialytic parenteral nutrition (IDPN), a nutritional therapy provided to patients during their dialysis treatments.

8) SmithKline Beecham Clinical Laboratories Inc. doing business as GlaxoSmith Kline -- \$325,000,000 under the False Claims Act (tie)

In March of 1997, SmithKline Beecham Clinical Laboratories Inc. (SBCL) was ordered to pay \$325 million for filing of false claims relating to laboratory tests paid for in whole or in part by the federal government. SmithKline Beecham Clinical Laboratories also agreed to adopt a corporate compliance agreement. The multiple scams involved adding on laboratory tests not requested by doctors and which were not medically necessary, billing for lab tests that were not actually performed, giving kickbacks to doctors in order to get their business, and billing Medicare for dialysis testing already paid for by kidney dialysis centers.

8) HealthSouth -- \$325,000,000 under the False Claims Act (tie)

In December of 2004, HealthSouth Corporation, the nation's largest provider of rehabilitative medicine services, agreed to pay the United States \$325 million to settle allegations that the company systematically defrauded Medicare and other federal healthcare programs. Said Assistant Attorney General Peter Keisler, "HealthSouth's fraud on Medicare was driven both by longstanding business practices in its outpatient physical therapy business and improprieties in its inpatient rehabilitation business."

9) Gambro Healthcare -- 310,000,000 under the False Claims Act

In December 2004, Gambro Healthcare agreed to pay \$310.5 million to resolve civil liabilities stemming from alleged kickbacks paid to physicians, false statements made to procure payment for unnecessary tests and services, and payments made to Gambro Supply, a sham durable medical equipment company. The settlement also requires Gambro to allocate \$15 million to resolve potential liability with various state Medicaid programs. Gambro Healthcare has also entered into a comprehensive Corporate Integrity Agreement. The Gambro Supply Corporation, a wholly-owned subsidiary of Gambro Healthcare, has also agreed to plead guilty to criminal felony charges; admit to execution of a healthcare fraud scheme; pay a \$25 million fine; and be permanently excluded from the Medicare program.

10) Schering-Plough-- \$292,969,482 under the False Claims Act

In July 2004, Schering-Plough, a major pharmaceutical manufacturer, agreed to plead guilty to fraud in the pricing of Claritin sold to the Medicaid program. The settlement agreement included a criminal fine of \$52.5 million, \$117 million to settle state claims, and nearly \$176 million to settle federal False Claims Act claims

11) AstraZeneca Pharmaceuticals -- \$266,127,844 under the False Claims Act

In June 2003, AstraZeneca Pharmaceuticals LP, a major pharmaceutical manufacturer, pled guilty to health care fraud and agreed to pay \$355,000,000 to resolve criminal charges and civil liabilities in connection with its drug pricing and marketing practices with regard to Zoladex, a drug sold for the treatment of prostate cancer. Of this amount, \$266,127,844 was recovered under the False Claims Act, and the remainder was levied as criminal fines. AstraZeneca pled guilty to giving doctors kickbacks by providing free drug samples knowing that the doctors would then turn around and bill Medicare and Medicaid hundreds of dollars per sample.

12) St. Barnabas Hospitals -- \$265,000,000 under the False Claims Act

In June 2006, St. Barnabas Healthcare, a nonprofit chain of eight hospitals in New Jersey, agreed to pay \$265 million to settle a False Claims Act lawsuit filed by three whistleblowers. The case dealt with "outlier" Medicare payments which a hospital can

claim if a procedure is particularly difficult or complex. St. Barnabas generated 41% of its total inpatient Medicare revenue from outlier payments as compared to the national average of 4.75%. The government estimated damages in the case at \$630 to \$700 million, but the settlement was based on St. Barnabas' ability to pay.

13) Bayer Corporation -- \$257,200,000 under the False Claims Act

In April 2003, Bayer Corp. paid \$257,200,000 to settle Medicaid fraud charges involving a "lick and stick" scheme in which Bayer sold re-labeled products to an HMO at deeply discounted prices, and then concealed this price discount in order to avoid paying additional rebates to the government. \$143 million of the Bayer settlement went to resolve a whistleblower's allegations that Bayer defrauded the Medicaid and Public Health Service programs by relabeling products sold to a health maintenance organization at deeply discounted rates and then concealing the discounts to avoid paying rebates, in violation of the Medicaid Rebate program. In addition, Bayer paid \$108 million to reimburse state Medicaid programs for the same conduct. An additional \$5.5 million criminal fine was also levied.

14) Schering-Plough -- \$255,000,000 under the False Claims Act

In August of 2006, Schering-Plough agreed to pay a total of \$435,000,000 to resolve criminal charges and civil liabilities in connection with illegal sales and marketing programs for its drugs Temodar for use in the treatment of brain tumors and metastases, and Intron-A for use in treatment of superficial bladder cancer and hepatitis C. The settlement also involved claims involving best price violations for Claritin RediTabs, an antihistamine, and K-Dur, used in treating stomach ulcers.

15) First American Health Care of Georgia -- \$225,000,000 under the False Claims Act

In October of 1996, a home health care organization and its purchaser agreed to reimburse the federal government \$255 million for overbilling and making fraudulent Medicare claims. Under the agreement, First American Health Care of Georgia, Inc., the nation's largest home health care provider, and its new owner, Integrated Health Services, Inc, agreed to reimburse the federal government for money stolen from Medicare through fraudulent billing practices. The alleged fraud was that First American billed Medicare for costs unrelated to the care of patients in their homes, including the personal expenses of First American's senior management, as well as for the company's marketing and lobbying expenses. In a related criminal action, the company's two major principals, Jack and Margie Mills, were found guilty of defrauding Medicare, and were sentenced to prison terms of 90 months and 32 months respectively for their participation in the fraud. An Epilogue: IHS never paid the Federal Government under the terms of the settlement, and IHS itself filed for bankruptcy in February of 2000. The bankruptcy courts later collected 7.5 cents on the dollar, or \$19.1 million of the original \$255 million settlement.

16) BankAmerica -- \$187.5 million under the California False Claims Act

In 1998 BankAmerica Corp. paid \$187.5 million to settle charges that it illegally kept unclaimed bond proceeds from the state of California and more than 1,000 cities, counties and public agencies statewide. This is the single largest state False Claims Act settlement to date.

17) Laboratory Corporation of America -- \$182,000,000 under the False Claims Act

In November 1996, Laboratory Corporation of America Holdings (LabCorp), agreed to

pay \$182 million to resolve charges that it submitted false claims for medically unnecessary laboratory tests to federal and state health care programs. The fraud involved bundled lab tests that were billed to Medicare as free-standing tests, resulting in an eight-fold increase in charges to Medicare.

18) Beverly Enterprises Inc. -- \$170,000,000 under the False Claims Act

In February 2000, Beverly Enterprises Inc., the nation's largest nursing home chain, agreed to pay \$175 million to resolve civil and criminal charges that it defrauded Medicare. In addition to \$170,000,000 collected under the False Claims Act, the company agreed to pay a \$5 million criminal fine and divest itself of ten nursing homes. The fraud involved nursing home workers charging Medicare for time not spent on Medicare patients. Instead of recording the true time spent on Medicare patients, Beverly-California fabricated records based on set formulas designed to maximize profits while avoiding detection by Medicare auditors. In addition to the guilty plea, the settlement requires Beverly to divest itself of 10 nursing homes and to submit to extensive monitoring by the Department of Health and Human Service's Office of Inspector General.

19) Medco Health Solutions (tentative) - \$163,000,000 under the False Claims Act

In May of 2006, Medco Health Solutions announced that it had agreed to pay \$163 million to settle three False Claims Act lawsuits previously joined by the Federal Government. The lawsuits charged Medco with improperly switching, shorting and canceling prescriptions for federal employees. While Medco has said it has worked out a financial agreement "in principle," a corporate integrity agreement has not yet been worked out, and the U.S. Department of Justice has not formally announced the settlement as a consequence.

20) Pfizer/Warner-Lambert -- \$152,000,000 under the False Claims Act

In May of 2004, Pfizer/Warner-Lambert agreed to pay \$430 million to resolve civil and criminal charges that it defrauded Medicaid by engaging in an aggressive and complex scheme to illegally promote Neurontin for at least 11 off-label uses. In addition, Warner-Lambert is alleged to have made kickbacks and payments to doctors in the form of trips to Puerto Rico, Florida, Hawaii and elsewhere as an inducement for them to give speeches promoting the off-label use of the drugs, as well as paying doctors to "author" medical journal articles that were actually written by a medical marketing firm. Of the total \$430 million payout, \$152 million will settle the False Claims Act aspects of the case, and an additional \$240 million represents criminal penalties. Another \$38 million will go to state consumer-protection agencies.
