The Qui Tam Provision of the Federal False Claims Act: The Statute in Current Form, Its History and Its Unique Position to Influence the Health Care Industry

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THE QUI TAM PROVISION OF THE FEDERAL FALSE CLAIMS ACT: THE STATUTE IN CURRENT FORM, ITS HISTORY AND ITS UNIQUE POSITION TO INFLUENCE THE HEALTH CARE INDUSTRY

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Detecting those who engage in the practice of defrauding the United States Government is generally hard for Government investigators, as outsiders. Concurrently, those on the inside are reluctant to report Government fraud because they are benefitting from the fraud, unwilling to report superiors or co-workers, or they believe that disclosure would not bring results. In an effort to decrease instances of the Government being defrauded, Congress has resurrected an old statute, enacted after the Civil War. The original intent of the statute was to ferret out and combat fraud among Civil War defense contracts. The statute, in its current form, was amended in 1986. Congress loosened restrictions on the use of the statute and, in effect created a powerful tool that enables the private sector to help the Government (and ultimately themselves as taxpayers) combat fraud committed against the Government.

The Federal False Claims Act, (hereinafter the FCA) allows the Government to sue an individual who has knowingly submitted a false claim to the Government for return of the money. The qui tam provision of this act allows a private individual, commonly referred to as a relator (one who relates information to the Government), to bring suit on behalf of the Government against a person in violation of the FCA. In other words, the statute allows the relator to act as a temporary attorney general and prosecute a claim on behalf of the Government. If the case is successful, the relator gets a percentage of the money returned to the United States Treasury, in addition to reasonable attorney's fees.

Although the original purpose of the statute was to combat defense fraud, the 1986 amendments create incentives and give relators power to bring qui tam actions in response to fraud in other areas of Government spending. A logical step beyond defense is Medicare/Medicaid; the second largest area of

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1 The Economic Crime Council has been trying to discern through hearings why fraud in government programs is so "pervasive yet seldom detected and rarely prosecuted . . . Detecting fraud is usually very difficult without the cooperation of individuals who are either close observers or otherwise involved in the fraudulent activity." This problem is referred to by Congress as the "Conspiracy of Silence." S. REP. No. 345, 99th Cong., 2d Sess. 6 (1985), reprinted in 1986 U.S.C.C.A.N. 5266, 5269, 5271.

2 Id. at 5269-70.

3 Id. at 5273.

4 Id.


6 § 3729(a)(1-7).

7 "An informer, the person upon whose complaint, or at whose insistence certain writs are issued . . . and who is quasi the plaintiff in the proceeding." Black's Law Dictionary 1159 (5th ed. 1979).

8 § 3730(b)(1).

9 § 3730(d).
Government spending and one of the only areas where Government spending is increasing.\textsuperscript{10}

Unlike the defense industry (which has relatively little contact with the general public), the health care industry, as a service industry, is largely reliant on the general public. A lawsuit involving fraud in health care threatens to harm the public's opinion of the health care industry. For this reason, the \textit{qui tam} provisions of the FCA are in a unique position to generate action and changes and have a substantial impact on the health care industry. This note will discuss the history of the \textit{qui tam} element of the FCA; a breakdown of the statute; areas in the new amendments that are encouraging relators to come forward with information; its application to health care; and the positive and negative impact the act stands to have on the health care industry.

\section*{II. History of the Statute}

\textit{Qui tam} actions date back to English common laws. The term \textit{qui tam} is an abbreviation of the Latin \textit{qui tam pro domino rege quam pro se ipso in hac parte sequitur} which means "who brings action for the king as well as himself."\textsuperscript{11} The United States Congress included a \textit{qui tam} provision in the False Claims Act. The False Claims Act was enacted in 1863 to deal with fraud against the U.S. Defense Department committed by defense contractors during the U.S. Civil War.\textsuperscript{12} Commonly referred to as the Lincoln law, the \textit{qui tam} provision allowed any person to prosecute a claim on behalf of the United States against any person who knowingly submitted a false claim to the Government.\textsuperscript{13} If successful, the relator was entitled to one half of the amount the government recovered.\textsuperscript{14}

The statute went through a period of relative inactivity from the late 1800's until the 1940's. In the 1940's the statute went through a series of interpretations by the courts and adjustments to the statute by Congress in response to those interpretations.

In the 1940's, people began to simply copy information out of Government indictments and sue under the \textit{qui tam} provision of the False Claims Act.\textsuperscript{15} This type of lawsuit was commonly referred to as a parasitic lawsuit because the

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\textsuperscript{10} "In 1984, the Economic Crime Council of the Department of Justice targeted two major federal programs—defense procurement and health care benefits—as economic crime areas which stronger enforcement and deterrence was needed." S. REP. No. 345, supra note 1, at 4, \textit{reprinted in} 1986 U.S.C.C.A.N. at 5269.


\textsuperscript{13} \textit{Id.} at 5275.

\textsuperscript{14} \textit{See Act of March 2, 1863, Ch. 67, 12 Stat. 696.}

\textsuperscript{15} United States ex rel. Stinson v. Prudential Insurance, 944 F.2d 1149, 1153 (3d Cir. 1991).
individual simply copied the information previously made public by the Government. Parasitic law suits exploited the *qui tam* provision, not helping the Attorney General’s office combat fraud or provide a deterrent to the commission of fraud, but instead created a “race to the courthouse” between Government attorneys and the private relator in order to file the actions and recoup the Government’s losses. Relators were receiving a percentage of the Government’s recovery and reasonable attorney’s fees without providing any new information to the case or helping the Government break the "conspiracies of silence" surrounding Government fraud. In *Marcus v. Hess*, the United States Supreme Court held that this type of suit was legal under the statute.

In response to *Marcus*, Congress amended the statute, reflecting that the intent of the act was not to encourage parasitic lawsuits, but instead, for relators to provide the Government with new information regarding false claims. The 1943 amendments to the FCA denied jurisdiction for *qui tam* actions that were based on evidence or information that the Government already possessed when the action was brought.

In response to the 1943 amendments, courts barred jurisdiction whenever the Government possessed the information concerning the fraud on which the claim was brought—even when the information had been provided to the Government by the *qui tam* plaintiff before the filing of the claim. In the 1983 case of *Wisconsin v. Dean*, the Court refused jurisdiction over a *qui tam* action brought by the State of Wisconsin because the state itself reported the fraud to the Government as required under the Act. As exhibited by Congress’ actions discussed infra, this was not the intent of that Act either.

*Wisconsin v. Dean* attracted quite a bit of negative attention. The National Association of Attorneys General adopted a resolution strongly urging Congress to rectify the unfortunate result of *Wisconsin v. Dean*, calling it "an unnecessary inhibitor to the detection of fraud on the Government."

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17*Id.*

18*Id.*

19*Marcus v. Hess*, 317 U.S. 537 (1943) (a relator can bring a *qui tam* action based solely on information derived from a government criminal indictment).

20*Prudential*, 944 F.2d at 1153.

21The 1943 amendments denied jurisdiction over *qui tam* actions that were "based on evidence or information the government had when the action was brought." 31 U.S.C. § 3730(b)(4)(1982) (superseded).

22*Prudential*, 944 F.2d at 1153, 1154.

23*Wisconsin v. Dean*, 729 F.2d 1100 (7th Cir. 1984) (district court has no jurisdiction over a *qui tam* action brought by Wisconsin based on information of Medicaid fraud the state had uncovered because the state had reported the Medicaid fraud to the Federal Government as required under the Act).
Concurrently, Congress was being frequently embarrassed by press accounts during the 1980's exposing Government waste while the national debt was continuing to grow. Examples included paying defense contractors over $500 apiece for coffee pots, tools and toilet seats. Members of Congress began actively looking for ways to halt Government fraud. The old, "crippled" law was stumbled upon by the Co-director of the Center for Law and Public Interest, John Phillips, who recognized the potential it had for decreasing Government defraudment and providing revenue for public interest work. After further inquiry, the Center for Law and Public Interest sent a series of proposed amendments to Senator Charles Grassley and Congressman Howard Berman. "For the next two years this unlikely duo of a liberal Democratic Congressman and a conservative Republican Senator skillfully guided the amendments through Congress." The amendments passed by wide margins in both the Senate and the House. Despite a last minute attempt by defense contractors to kill the bill, it was signed into law by President Reagan the last day before a pocket veto would have taken effect.

In encouraging members of Congress to amend the statute, statements made by Senator Grassley seemed to accurately reflect the intent of Congress "to resolve the tension between . . . encouraging and preventing parasitic lawsuits." Congress saw the Act as a way to stop the "conspiracy of silence among employees of corporations engaging in fraud by enlisting the cooperation of those individuals who are either close observers or otherwise involved in fraudulent activity."

24 Prudential, 944 F.2d at 1154.

25 See John R. Phillips, Qui tam Litigation: A new forum for prosecuting False Claims against the Government, American College of Legal Medicine, Symposium on Qui Tam litigation, 14 J. LEGAL MED. 267, at 267 (June 1993).

26 Id. at 268.

27 "It became immediately evident that this law offered both the potential to do interesting and important public interest work—ferreting out fraud against the Government—while at the same time providing a new and much needed source of revenue to fund future public interest litigation." Id. at 269.

28 Id. at 268.

29 Phillips, supra note 25, at 269.

30 Id. at 269.

31 Id. at 270.

32 Prudential, 944 F.2d at 1154.

33 Id.
III. BREAKDOWN OF THE STATUTE

A. §3729 False Claims

1. The Elements

In order to establish the elements of a false claim under the FCA, the relator must prove that the defendant presented a claim to the Government, that the claim was false or fraudulent and that the defendant had knowledge that the claim was false. The statute defines a "claim" as:

any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

"Knowingly" according to the statute means that a person, with respect to information—

(1) has actual knowledge of the information;
(2) acts in deliberate ignorance of the truth or falsity of the information; or
(3) acts in reckless disregard of the truth of falsity of the information, and no proof of specific intent is required.

This definition of the knowledge element in the current version of the statute is significantly different from the previous version. Under the former statute, a relator had to prove actual knowledge. The more liberal post-1986 version is more expansive. By not requiring specific intent or actual knowledge but instead requiring "reckless disregard" or "deliberate ignorance" of the information, the statute extends liability to virtually anybody involved with the claim to make sure there has been no mistake or fraud. Under the new knowledge requirement, it would be unwise for one to sign a claim without knowing that it was a correct and accurate statement of the goods or services provided to the Government. Additionally, supervisors and administrators

36 § 3729(c).
37 § 3729(b).
may no longer "look the other way" or simply avoid involvement with the processing of the claims. Data entry and clerical employees should feel compelled to question any claims that do not appear correct or else they too, may face liability under the statute. It appears from the new construction of the knowledge element Congress is holding employees at all levels of companies receiving government money responsible.

2. Damages

If the relator proves that the defendant presented a claim to the Government, that the claim was false or fraudulent, and the defendant had knowledge that the claim was false, the statute sets forth the following penalty that the defendant "is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 plus three times the amount of damages which the Government sustains because of the act of that person . . . ."40

It is important to note that the damages are now structured to make litigation worthwhile for the plaintiff. If the defendant has made only one or a few claims, but they are of large amounts, the damages portion of the statute which requires the defendant to pay three times the amount of the fraudulent claim has some bite.41 If the defendant has regularly made a great number of claims for small dollar amounts, the civil penalty of not less than $5,000 per claim makes it financially worthwhile for the plaintiff to bring a suit.42

B. § 3730 Civil Actions for False Claims

1. The Qui Tam Provision

The qui tam provision allows for an individual to sue, on behalf of the Government, a person whom the relator knows to have violated § 3729.43 "A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government . . . ."44

To start a qui tam action, the private plaintiff must first file a complaint with the Government.45 It is kept under seal for 60 days, without being served upon

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40§ 3729(a).

41 Id.

42 Even if each false claim is only for a small amount, with a civil penalty of up to $10,000, if there have been enough false claims submitted, it would be worthwhile for a relator to bring an action for small, repeated claims. Robert Vogel, Invasion of the Bounty Hunters, LEGAL TIMES, Nov. 16, 1992 at 14.


44 § 3729(b).

45 § 3730(b)(2).
the defendant, to allow the Government to investigate the allegations. This permits the Government to investigate the claim without the defendant's knowledge and at the same time protect the defendant from false allegations.

After the 60 days, the Government must either proceed with the case or notify the jurisdictional court that it declines to take the action any further. If the Government proceeds, it has primary responsibility in the action, but the plaintiff has the right to continue as a party to the action. If the Government proceeds and wins the action, the plaintiff is entitled to at least fifteen percent and up to twenty five percent of the recovery.

If the Government does not take over the case and the private plaintiff proceeds alone,

the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds.

Additionally, if the plaintiff is successful, he or she receives reimbursement for reasonably incurred expenses, attorney's fees and costs. However,

[I]f the government does not proceed with the action, ... the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

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46 § 3730(b)(2).
47 See Reece, supra note 38, at 42.
48 The Government can have this time period extended upon a motion to the court if good cause is shown. Such motions must be in the form of affidavits or other submissions in camera. 31 U.S.C.S. § 3730(b)(3) (Law. Co-op. 1993).
50 § 3730(b)(4); However, the qui tam plaintiff's rights to continue the action are subject to § 3730(c)(2)(A) "The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity to be heard." Id.
52 § 3730(d)(2).
53 § 3730(d)(1)-(2).
54 § 3730(d)(4).
2. Bars to Action

Although the 1986 version of the statute intended to make it easier for relators to bring an action, there are still several strong bars to action in the statute. A plaintiff may not bring an action based on "allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party."\(^{55}\) Also, the court shall have no jurisdiction over an action based on "... public disclosure of allegations or transactions in a criminal, civil or administrative hearing, ... or Government Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General, or the person bringing the action is an original source of the information."\(^{56}\)

Original source is defined by the statute as an "individual who has direct and independent knowledge of the information on which allegations are based and has voluntarily provided the information to the Government before filing an action under this section which is based on the information."\(^{57}\) These bars are reflective of Congress' desire to avoid the "parasitic lawsuits" that provoked the 1943 amendments.

3. Whistleblower Protection

The current statute provides protection for relators who bring actions against their employers:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.\(^{58}\)

Whistleblower protection contributes significantly toward achieving the congressional desire to encourage those within the "conspiracy of silence" to come forward with information concerning false claims.\(^{59}\)

The result is a powerful statute with multiple rewards. The Government gets the option of taking over the action with a key witness as a co-plaintiff, or taking a back seat and simply observing—either way getting the majority of the

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\(^{55}\)§ 3730(e)(3).

\(^{56}\)§ 3730(e)(4)(A).

\(^{57}\)§ 3730(e)(4)(B).

\(^{58}\)§ 3730(h).

recovery. Instead of adding detectives and law enforcement personnel to the payroll, the Government gets inside information from the relators and is only responsible for paying them if the action is successful. The relator gets the chance to help the Government recoup taxpayer money that has been taken by fraud and also receives a substantial payout with protection against employer retaliation. The statute also protects defendants against frivolous law suits by forcing the plaintiff to pay the expenses and costs of the defendant if the court considers the lawsuit frivolous and by keeping the filing of the claim under seal until the Government has a chance to investigate.

IV. SPECIFIC PARTS OF THE NEW AMENDMENTS THAT ENCOURAGE RELATORS

As discussed in the history section, supra, the qui tam provision evolved from a broad cause of action allowing virtually anybody to bring a claim, and if successful receive fifty percent of the recovery, to a very narrow, virtually unused provision with a limited recovery that was in most cases not financially worthwhile. Now, after the 1986 amendments, the provision is a compromise between the two extremes making it easier to bring a cause of action if the person has original information that can actually help the Government while still avoiding parasitic lawsuits.

Under the 1943 amendments the relator could recover up to ten percent—but was guaranteed nothing even if the suit was successful. The 1986 amendments guarantee a minimum of fifteen percent (plus attorneys' fees) if the case is successful. This larger guarantee, if the case succeeds, makes the risk much more financially worthwhile.

The 1943 version also had a strict jurisdictional bar. Congress wanted to discourage the parasitic lawsuits in which the plaintiff got to share in the Government's recovery when all the plaintiff did was copy the information off a Government indictment as in Marcus v. Hess. Under the 1943 version, relators were denied jurisdiction if the Government had any information about the fraud alleged in the suit, even if the Government had undertaken no investigation or prosecution. In the post-1986 version, the jurisdictional restrictions were relaxed. Now jurisdiction is only barred when a Government

60§ 3730(c)(i)-(c)(3).
61§ 3730.
62§ 3730(b)(2), (d)(4).
63The 1943 amendments significantly narrowed the cause of action and "weakened the effectiveness for the qui tam legislation." Broody, supra note 16, at 593.
64See Phillips, supra note 25, at 268-69.
67See Phillips, supra note 25, at 271.
The qui tam plaintiff, under the new amendments may remain a party to the case even if the Government intervenes. Additionally, the qui tam plaintiff may even object to a settlement proposed by the Government. This is in contrast with the old law, whereby if the Government joined the action, the plaintiff could no longer play an active role in the lawsuit.

The new amendments allow reasonable attorneys' fees paid by the relator based upon hours reasonably spent in addition to the percentage of the recovery the attorney and client have already agreed upon. This is important in the area of Medicare/Medicaid fraud because some of the potential recoveries are small. Without provisions for the payment of attorneys' fees, it may be too expensive for many qui tam plaintiffs to file small, but otherwise meritorious claims.

The new amendments offer whistleblower protection. While the old law depended on the law of the state in which the suit was brought, the new amendments provide a federal standard that will deter employers from retaliating against qui tam plaintiffs.

The new, relator-friendly amendments are a significant contribution to the False Claims Act. The benefits are structured to allow expansion into areas of Government spending beyond those that are defense-related. The law that has haunted defense contractors since it was enacted in 1863 has now begun to make its mark in the health care industry, where the Government spends a great deal of money in the funding of the Medicare and Medicaid programs. "The government believes that an estimated 3 percent to 5 percent of domestic health care expenditures—$738 billion in 1991—don't pay for actual or necessary care but instead are lost to health care fraud." The changes to the law have made it much easier and very profitable for plaintiffs with knowledge of fraud in the health care area to report their knowledge to the Government. Since these

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68 Id.

69 § 3730(c)(1).

70 See Phillips, supra note 25, at 271.

71 Id.

72 § 3730(c)(1)-(2)(1993). See also Phillips, supra note 25, at 271.

73 See Phillips, supra note 25, at 271.

74 § 3730(h).

75 See Phillips, supra note 25, at 271.

76 "As the federal government rolls out the big guns against health-care fraud, health-care providers will begin to understand how defense contractors have felt over the past few years—as targets of the civil False Claims Act." Vogel, supra note 42, at 13.

amendments were instituted, the number of qui tam suits in the area of health care increased from 2 in 1987 to 22 in 1992.\textsuperscript{78}

V. AREAS WHERE QUI TAM ACTIONS ARE LIKELY TO OCCUR IN MEDICARE/MEDICAID

Health care fraud most often occurs in the areas of false billing and overutilization.\textsuperscript{79} False billing occurs in a variety of ways such as billing for services never provided; charging for more expensive services than were provided;\textsuperscript{80} private insurers charging Medicare/Medicaid when the patient was actually covered primarily by the private insurer;\textsuperscript{81} charging patients who received outpatient treatment or tests as if they had received inpatient services or tests because Medicare/Medicaid pays more for inpatient treatment;\textsuperscript{82} and faulty computer systems that either intentionally or accidentally overbill.\textsuperscript{83}

Overutilization occurs when unnecessary tests and services are ordered.\textsuperscript{84} Sometimes this happens in the form of multiple tests being ordered when one test would have provided the necessary diagnostic information, but extras were ordered because of the profit to be made by billing Medicare/Medicaid for more than one test. Another form of overutilization occurs when surgery is used before medication has been tried. In some instances the malady never actually existed.\textsuperscript{85} In one recent example, this overutilization went beyond doctors, practitioners, hospitals and clinics to testing laboratories. The laboratories designed order forms in a manner that "tricked" doctors into ordering unnecessary blood tests that only cost the doctors pennies for each test, but the lab then billed the Government sixteen dollars each for the tests.\textsuperscript{86}

The majority of the qui tam actions brought against health care providers are settled quickly and quietly. As previously mentioned, the health care industry is very sensitive to public opinion. A lawsuit involving fraud by a health care


\textsuperscript{79}Vogel, supra note 42, at 13.

\textsuperscript{80}Id. at 14.

\textsuperscript{81}See Stinson, 944 F.2d. at 1151.

\textsuperscript{82}David Burda, AHM to pay $500,000 to Settle Dispute, MODERN HEALTHCARE, Apr. 8, 1991 at 32.


\textsuperscript{84}Feinstein, supra note 77, at 8.

\textsuperscript{85}See M. Carroll Thomas, This Doctor Turned in a Colleague for Medicare Fraud, 68 MED. ECON. 48, at 49-50 (1991).

\textsuperscript{86}Matt Siegel, Big Suits, THE AM. LAW., Nov. 1993, at 94-96; Pamela Wilson, Health Scams Becoming More Sophisticated, SAN DIEGO DAILY TRANSCRIPT, Mar. 22, 1993 at 1A.
provider against the Government and the taxpayers can be very harmful to the
industry because the general public may lose confidence in the particular
provider, which would be harmful to that provider's business. Additionally,
the cost of litigation is very high. It is probably for these reasons that most of
the cases settle. Included in virtually all of the settlements are a denial of any
guilt and a secrecy clause.

A. Cases

Qui tam actions in relation to Medicare/Medicaid are very uncertain. In
addition to the incentives to settle, jurisdictional bars to action have prevented
many qui tam actions in the area of Medicare/Medicaid from being heard on
their merits. Recall, the jurisdictional bars were added to the qui tam provision
in the 1940's to prevent "parasitic" lawsuits where the relator simply copied
from previously published material and brought an action without providing
any new information.\footnote{Marcus, 317 U.S. 537.} For example, one case that "became entangled in
questions concerning the relator's eligibility, thus preventing a determination
on the action's merits" was brought by a group of attorneys.\footnote{Prudential, 944 F.2d at 1149.} They alleged that
it was common practice in the insurance industry to allow Medicare to pay as
the primary provider for working senior citizens who were actually covered
under their employer's health plans.\footnote{Id. at 1151.} The plaintiffs learned of this alleged
practice during a deposition of Provident Insurance Co. while representing an
employed senior citizen in a personal injury case.\footnote{Id. at 1151.} In the course of discovery,
the plaintiffs obtained two Provident memoranda which suggested that other
insurance companies had similar claim processing practices. They brought a
qui tam action against Provident and five other insurance companies.\footnote{Id.}
In the Prudential case, the United States District Court for the District of New Jersey
Third Circuit Court of Appeals upheld the ruling, holding that information
obtained during a deposition is information that "came out in a public hearing,"
thus falling under one of the jurisdictional bars in the False Claims Act.\footnote{Id. at 1149, 1152.}

\footnote{Prudential, 944 F.2d at 1149, 1152.}

\footnote{Id. at 1149, 1154-57.}
The jurisdictional bar was used to dismiss another case before getting to its merits. The plaintiff was a patient who suspected that he had been subjected to unnecessary surgery which was paid for by Medicare. He had seen a story about the clinic at which he had been a patient on a news broadcast alleging that the clinic was frequently performing the same unnecessary surgery on other Medicare recipients. The court granted defendant's motion to dismiss the class claims based on the jurisdictional bar which denies *qui tam* plaintiffs jurisdiction when the action is based on "public disclosure of allegations . . . in (a report from) the media . . ." His information, according to the court, came primarily from what he learned from watching a newscast.

**B. The Impact of Settlements**

Judging from the cases, *qui tam* actions do not appear to have had much impact in the area of health care. However, one must look beyond the case law to find the true impact of *qui tam* litigation in the area of Medicare/Medicaid. As discussed previously, there are great incentives for defendants in the health care field to settle cases quickly and anonymously before they are harmed by the deterioration of public opinion which would accompany a dramatic lawsuit brought against them.

Hospitals, doctors, insurance companies and medical laboratories have all paid out large settlements in *qui tam* cases. According to recent reports, Blue Cross and Blue Shield of Florida, National Health Labs and Sacred Heart Hospital have all settled lawsuits with the Government. Each concerned unrelated incidents, with the allegations in each complaint accusing each company of presenting false claims to the Government for payment through Medicare or Medicaid. Although none admitted to any violation of the law, they paid $10 million, $110 million, and $3.25 million respectively.

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95Id. at *2 and n.2.

96Id. at *2.

97Plaintiff's claim as an individual was also barred by res judicata and release because Robbins had already recovered damages in a medical malpractice action based on his own information that he underwent unnecessary surgery. Id. at *3-4.


99See "Largest Medicare Fraud Case in History Uncovered," CNN, June 2, 1993. Byline, Mark Feldstein; see also Wilson, *supra* note 86, at 1; see also 60 Minutes, January 18, 1994.

100David Burda, *Watchdog Gets Tough on Medicare Fraud*, MOD. HEALTHCARE, Apr. 8, 1991 at 32.


102Siegel, *supra* note 86, at 95-96.

103Burda, *supra* note 100, at 33.
These settlements have not been widely publicized because the settlement agreements also included secrecy stipulations.\textsuperscript{104} In each of these cases a \textit{qui tam} plaintiff was awarded a substantial amount of the settlement: approximately $2.5 million went to the plaintiffs from Florida Blue Cross,\textsuperscript{105} $23 million from National Health Labs,\textsuperscript{106} and $650,000 from Sacred Heart Hospital.\textsuperscript{107}

All of these settlements occurred after the 1986 amendments to the False Claims Act. Each of the relators was employed in the industry and had personal information concerning the alleged fraudulent claims that the defendants submitted to the Government. These examples suggest that Congress is seeing some success in reaching its goal of creating an incentive for those "within the web of silence" to come forward with information. Although the high number of settlements keeps the courts from interpreting the statute and thereby presenting clear rules of law, it cannot be denied that \textit{qui tam} actions have the potential to greatly influence the health care industry. The number of \textit{qui tam} cases continues to grow.\textsuperscript{108} If cases consistently settle for high dollar amounts, more attorneys and bigger law firms will be attracted to this type of lawsuit. The \textit{qui tam} provision of the False Claims Act is in a position to play a significant role in changing our health care system.

VI. THE POSSIBLE EFFECTS ON THE HEALTH CARE SYSTEM RESULTING FROM INCREASED ACCESSIBILITY TO THE FALSE CLAIMS ACT THROUGH THE QUI TAM PROVISION

A. Positive Effects

1. The Effect on Fraudulent Billing

\textit{Qui tam} litigation is a way to ensure that Government money intended for health care will actually be spent on health care. One way to achieve this goal is to stop fraudulent billing practices. Complicated schemes defrauding the Government have evolved that are not easily detected by Government

\textsuperscript{104}Modern Healthcare petitioned the Inspector General for copies of the civil monetary settlements reached with hospitals from October 1983 through January 1991. The request generated forty-three agreements. By settling, the hospitals do not admit wrong doing. According to the article, "few of the 43 settlements have received any measure of publicity, and one reason for the secrecy is the inclusion of confidentiality clauses in the agreements." Twenty-five of the forty-three settlements reviewed by Modern Healthcare had provisions that bar the Government from publicizing the agreements. Typically, the clauses prohibit the Government from issuing a press release or commenting on anything other than what is included in the settlement agreement. Burda, \textit{supra} note 100, at 32.

\textsuperscript{105}\textit{Burr}, 1992 WL 521775 at *11.

\textsuperscript{106}\textit{id.}

\textsuperscript{107}Burda, \textit{supra} note 100, at 38.

\textsuperscript{108}Boese, \textit{supra} note 78, at 61.
inspectors. By allowing others to bring *qui tam* actions, the Government is able to specifically enlist the help of those working within the industry. *Qui tam* actions provide increased incentives for potential relators to come forward and also provide relators protection by retaliation from their employers.

This was illustrated in a *qui tam* action that was brought in California against American Healthcare Management.109 The action was brought by a former employee at Linda Vista Community Hospital in Los Angeles against the hospital and one of its physicians, Dr. Pablo Nankin.110 According to the complaint, the hospital billed Medicare for outpatient cardiovascular tests at the hospital when they were actually performed at mobile clinics owned by Dr. Nankin.111 A profit was made under this arrangement because Medicare pays more for outpatient tests done in the hospital than at the clinics because hospitals have higher overhead.112

Another example of a *qui tam* action used to halt a complex scheme of fraudulent billing was a case brought in Florida against Blue Cross Blue Shield of Florida, Inc. [hereinafter BCBSF] by a former employee of BCBSF.113 The employee was familiar with BCBSF’s billing practices and, according to her, BCBSF took advantage of the fact that it was having difficulties installing a new computer system that processed Medicare Part B claims.114 The employee alleged that since the system was not fully developed it was not capable of processing the claims and that BCBSF knowingly concealed the deficiencies in its system and used it to defraud the Medicare program.115 The alleged scam included billing for claims that were never processed, bypassing or overriding inquiries in the system regarding eligibility, coverage, payment, duplicate claims and overutilization, causing ineligible claims to be paid.116 The allegations also included recycling previously processed claims in order to hide the backlog and to falsely inflate payment to BCBSF.117 Because of this fraudulent billing scheme, the Government was forced to pay legitimate claims late, with interest.118 The backlog required the Health Care Financing Administration (HCFA) to approve advances of Medicare funds to physicians, vendors and other health care suppliers who accepted assignment on Medicare.

109 Burda, *supra* note 82, at 32.
110 *Id.*
111 *Id.*
112 *Id.*
114 *Id.* at *7.
115 *Id.* at *8, 9.
116 *Id.*
118 *Id.*
claims. This placed the providers in financial jeopardy as a result of the lack of timely and accurate processing of Medicare claims.120

Often, schemes of this complexity could only be detected by employees or individuals working within a system who have knowledge of its operations. Before the 1986 amendments to the qui tam provision of the FCA, there was little incentive for these people to come forward even if they had a strong cause of action. Since the 1986 amendments, plaintiffs in cases such as these have had a forum and an incentive. The BCBSF case settled for $10 million. American Healthcare Management settled for $500,000 and Dr. Nankin settled for $875,000.121 All of the parties denied any violation of federal law.122 In each case, the plaintiffs a substantial recovery.123 Because the Government is recovering millions from people who have tried to defraud it, the threat of a FCA suit that may be brought by anybody (competitors, current and previous employees or patients) will be an effective deterrent against greed-motivated individuals who may be tempted to submit fraudulent claims.

This deterrent goes beyond those with fraudulent intent. It encourages everyone in the industry submitting claims to the Government to actively look for mistakes that overcharge the Government in their systems. This point is illustrated by a qui tam action that was brought against Sacred Heart Hospital in California.124 According to the allegations of the relator, a former director of quality assurance and interim administrator, the hospital had errors in its computer codes that "switched the codes for patients' principal and secondary diagnoses," causing the hospital to bill Medicare for more costly procedures which resulted in charging Medicare about $900,000 more than it should have been charged.125 Sacred Heart, a charity hospital with a tradition of caring for migrant farm workers, prisoners and the indigent, claimed that this was a mistake; the overbilling a result of a faulty system and inexperienced employees.126 Sacred Heart settled for $3.5 million with the relator receiving

119 Id.
120 Id.
121 Burda, supra note 82, at 32.
122 "It is expressly understood and agreed between the parties that this Settlement Agreement is made in compromise of disputed claims. This Settlement Agreement shall not be construed or used as an admission of wrong doing on the part of BCBSF." Burr, 1992 WL 521775 at *4,11; "AHM and Doctor Nankin admit no violation of Federal Law." Burda, supra note 82, at 32.
123 Burr, 1992 WL 521775 at *3; Burda, supra note 82, at 32.
124 Burda, supra note 100, at 38.
125 Id. at 32.
126 Commentary, MODERN HEALTHCARE, Apr. 8, 1991, at 31, quoting A. Diane Moeller, President of Catholic Health Corporation, a co-sponsor of Sacred Heart Hospital.
$650,000 (20 percent).\textsuperscript{127} Sacred Heart vehemently denied any intent to commit fraud but claimed that litigation would have cost far more than the settlement.\textsuperscript{128}

Regardless of intent (or lack thereof) this case should serve as a warning to all health care providers to review their procedures, work out any "bugs" and see that the procedures for which Medicare is being billed have actually been provided and in a reasonable manner. This is an area in which the 1986 amendments give the statute significant power because of its liberal knowledge requirement.\textsuperscript{129} The 1943 version required actual knowledge. The current version only requires that either there be actual knowledge or reckless disregard for truthfulness or falsity.\textsuperscript{130} In a case like this, the knowledge requirement spreads the responsibility throughout the hospital to anyone who has failed to take accurate measures to detect falsity. Therefore, the responsibility ranges from the data entry clerk processing the claims to the top administrative officials to attempt to actively detect fraud and correct it.\textsuperscript{131}

The present \textit{qui tam} action is a powerful vehicle for detecting fraudulent billing and recouping the money that has been fraudulently billed. Additionally, it deters others in the industry from attempting fraudulent schemes and encourages everyone submitting claims to the Government to review their systems to ensure that they are not falsely billing the Government by accident. The end result is that money that was intended to provide health care for those who cannot afford it is actually going to its intended purpose.

2. The Effect on Overutilization

Perhaps even more harmful and certainly more inhumane than false billing, where money is taken for services not provided, is overutilization. Overutilization occurs when patients undergo tests and treatments that are medically unnecessary so that unscrupulous providers make a profit. The improved accessibility of \textit{qui tam} actions may help decrease these practices. An example of this is exhibited in a case where a \textit{qui tam} action was brought against the Scripps Clinic & Research Foundation in La Jolla, California, and one of its doctors for performing unnecessary surgery on Medicare recipients.\textsuperscript{132} The relator in the action was an ophthalmologist at the clinic, Dr. Paul Michelson.\textsuperscript{133} He suspected that another ophthalmologist was doing unnecessary surgery and

\begin{itemize}
\item \textsuperscript{127}Prudential, 944 F.2d at 1149, 1152.
\item \textsuperscript{128}Commentary, \textit{supra} note 126.
\item \textsuperscript{129}31 U.S.C.S. § 3729(b) (Law. Co-op. 1993).
\item \textsuperscript{130}Id.
\item \textsuperscript{131}Boese, \textit{supra} note 78, at 17.
\item \textsuperscript{132}Thomas, \textit{supra} note 85, at 48; Clara Spiegel, \textit{Whistleblower's Lawsuit Accuses Scripps Clinic Eye Doctor of Fraud}, \textit{L.A. Times} Sept. 9, 1987, at 3.
\item \textsuperscript{133}Thomas, \textit{supra} note 85, at 48.
\end{itemize}
cheating Medicare after noticing the high rate of surgeries performed by a
colleague on new patients when it was standard practice to try to treat the eye
problems with drugs first.134 The relator went to his supervisors and when
nothing happened, he spoke up repeatedly and eventually was fired.135 He
considered reporting the practices to various state medical boards and
Medicare authorities but was afraid nothing would be done.136 He feared this
would expose him to a defamation or restraint of trade suit.137 He was
searching for a safe, effective way to proceed against both his former employer
and his colleague when he;

happened upon a September 17, 1986, newspaper account of recent
amendments to the False Claims Act . . . . It allowed "whistleblowers"


to bring suit on their own and collect a small portion of whatever was


returned to the government . . . . The report said nothing about
Medicare fraud, dwelling instead on the sins of defense contractors
and how the 1986 amendments would make it easier to nail them.138

Michelson filed a complaint, which alleged that the doctor and the clinic
were profiting from performing "laser procedures for glaucoma on patients
who either hadn’t been diagnosed as having the condition or hadn’t been
treated conservatively first" and subjecting patients to experimental, unusual
or dangerous procedures not approved by Medicare, then billing for expensive
reimbursable operations.139 The case settled in April, 1988, when Scripps
agreed to pay $355,000 plus $100,000 in attorney’s fees, and the doctor paid
$250,000 plus $75,000 in attorney’s fees.140 Michelson and Co-plaintiff
Taxpayers Against Fraud recovered twenty percent.141 As a result of a qui tam
action, this inhumane practice has been halted in at least one large facility and
is hopefully serving as a deterrent in others. This case also suggests that there
may be more plaintiffs out there who simply need to hear that there is a cause
of action of this sort. As a result of the publicity generated by this case John
Phillips, Michelson’s attorney, has said, "we’re hearing from nurses, doctors,
and others who have their own allegations of fraud."142

134Id. at 49.
135Id.
136Id.
137Thomas, supra note 85, at 49.
138Id. at 50.
139Spiegel, supra note 132, at 3.
140Thomas, supra note 85, at 52.
141Michelson decided to donate his portion of the recovery to charity, including
programs for vision research and medical ethics, stating that "[M]y concern was to stop
someone from subjecting patients to unnecessary risks." Id.
142Id. at 49.
Another example of a *qui tam* action being used to put an end to overutilization can be found in the complaint brought against National Health Laboratories [hereinafter NHL]. According to reports, this is the largest *qui tam* action in history. The fraud was detected by a former sales manager at Tarzana, California-based affiliate of MetWest (a competitor of NHL). NHL revised blood-screen order forms and price structures in the 1980's so that a blood cholesterol screen was added to the list of frequently ordered tests. The format of the request form misled doctors into ordering unnecessary tests; the doctors were only charged pennies for the additional tests, while the Government was billed $16 extra for each additional test. Requests for the tests for cholesterol and Ferritin "multiplied about 60 times, from $500,000 in orders in 1980 to $31 Million in 1990. Profits at NHL ballooned accordingly." Also named as defendants were two other medical testing laboratories: MetPath, a division of Corning Laboratories and MetWest (UniLab corp). Without admitting guilt, they settled for $35 million and $5.226 million respectively in 1993. The relator filed a *qui tam* action which the government never formally joined. He received a total of $23 million. Following the settlement, NHL announced that . . . [I]t would distribute new forms to its customers to facilitate the ordering of the Heath Survey profile without the Ferritin or cholesterol tests. It also adopted a new compliance program to ensure that its sales and marketing practices were compatible with the government's interpretation of the regulations.

The amended *qui tam* provision has created a forum for plaintiffs to come forward. Dr. Michelson, the relator in Scripps, testified before Congress that the current statutory guarantees of being able to retain his own counsel, a 60 day sealed Department of Justice investigation and the promise that he would be

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143 Siegel, * supra* note 86, at 95-96; Wilson, * supra* note 86.
145 Siegel, * supra* note 86, at 94.
146 Wilson, * supra* note 86, at 1.
147 *Id.*
148 *Id.*
151 According to the 60 minutes report, Dowden has bought himself a Jaguar (automobile), a Lexus, and a million dollar house since he won his lawsuit. Siegel, * supra* note 86, at 94.
152 See National Health Care Labs Again Subject to HHS Fraud Abuse Investigation, BNA Washington Insider, Sept. 21, 1993.
able to participate fully in the litigation from start to finish gave him the confidence and assurance to come forward with his claim.153 These changes will redirect Medicare/Medicaid money, private insurance money and patients money out of the pockets of the medical labs and back to the American citizens for whom the monies were originally intended.

3. The Impact on the Quality of Health Care

A next logical step is that *qui tam* lawsuits can be used to establish health care quality "floor".154 If the quality of health care provided is so poor that signing a claim for reimbursement can be considered a false claim, the provider should be reachable under the Act.155 The FCA can be used by patients, families of patients, social workers, nursing homes, clinics, hospitals and other providers to assure an adherence to acceptable levels of quality being paid for by Medicare/Medicaid. This goes farther than simply making sure that money intended for health care is actually going for health care, it is a way of seeing to it that the Government is getting its money's worth within the health care field.

4. *Qui tam* in relation to Malpractice

A combination of two types of litigation, *qui tam* and medical malpractice, may operate as a vehicle to drive the health care industry toward the social, political and economic ideal of high quality health care at reasonable prices. Malpractice litigation can be considered an assuror of quality health care with the threat of a malpractice lawsuit as a deterrent from falling below acceptable standards of care.156 However, there are at least two major problems that keep malpractice from assuring the aforementioned ideal.157 First, a malpractice action depends on damages, which is not always a true measure of the care provided.158 Poor quality of care may be provided, but if there are no significant damages, there is no malpractice recovery. This waters down the deterrence factor. If the provider is lucky and the low quality of care has no long term effects, the threat of malpractice litigation effectively disappears. Second, threat of malpractice litigation tends to drive up health care costs.159 As the defensive

153Thomas, *supra* note 85, at 51.

154See David Hsia, *Application of Qui Tam to the Quality of Health Care, from the Symposium on Qui Tam Litigation*, 14 J. LEG. MED. 2, at 315-16 (June 1993).

155*Id.* at 315-16.

156*Id.* at 309.

157*Id.* at 310.

158"The primary legal elements of malpractice litigation—duty, negligence, causation, damages militate against consistent remediation of poor quality . . . . Thus, if the defendant rendered poor care, but by good fortune the plaintiff suffered little injury, litigation is unlikely." Hsia, *supra* note 154, at 310.

159*Id.*
medicine argument suggests, health care providers may tend to overprescribe, overtест or overtreat to isolate themselves from a malpractice action.

The False Claims Act, made more accessible to plaintiffs through *qui tam*, deals with both of these problems. First, it is not dependent upon the outcome (damages). Instead, it is dependent upon the quality of care itself, since the cause of action arises out of the fact that the provider signed the forms requesting reimbursement for a particular type of care provided.\(^{160}\) If this care was of such a poor quality that the request can be seen as a false claim, a *qui tam* lawsuit may provide an additional recovery (and deterrent) to complement the recovery and deterrence provided by malpractice. As for malpractice’s tendency to drive up health care costs and force over-treatment, the FCA addresses this also. The threat of a false claims/*qui tam* lawsuit encourages the opposite type of defensive medicine—undertreatment. While neither type of defensive medicine is by itself desirable, the combination of the two set outer boundaries for health care providers. Both causes of action encourage a high quality of care, malpractice based on the outcome of the treatment, *qui tam* based on the level of quality provided. Malpractice encourages overtreatment, false claims encourages undertreatment. The duo may help to bring us closer to our current national goal, quality health care at reasonable prices.

**B. Negative Effects**

These "boundaries" appear to be much needed in as much as the health care situation has been declared a crisis in the United States. However, those in the health care industry may not see it this way. False claims litigation may be seen as the removal of the malpractice safety net because of its penalties for prescribing too many tests and extensive treatment. This could be a hard blow to an industry already heavily burdened with malpractice insurance premiums. It is easy for a court to find that a particular test or procedure was unnecessary when there has been time to review the situation and ponder the circumstances in hindsight, but many times the decisions are made in emergency situations under circumstances in which the utility of the test or treatment is not as clear.

*Qui tam* "actions" may apply too much pressure on providers by tending to shrink what may be seen as an already narrow zone of safe practice into an unintelligible line.\(^{161}\) It may force good practitioners to practice a new kind of "defensive medicine" through underutilization.\(^{162}\) A prime example of this is inpatient psychiatric care,

currently under intense government scrutiny, partially because of lost credibility and the intangible nature of ailments and treatments and

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\(^{161}\)Feinstein, *supra* note 77.

\(^{162}\)Id.
the negative press recently surrounding the psychiatric care system in general, insurers have begun to reduce psychiatric benefits and increase demand rates. As a result many psychiatric hospitals believe that on average, patients are being discharged too early.\textsuperscript{163}

These factors create a disincentive for treating Medicare/Medicaid patients. Thus, \textit{qui tam} litigation may arguably actually harm those it was intended to protect.

Another way \textit{qui tam} could serve to harm the very people it intends to protect is illustrated in the Sacred Heart Hospital case.\textsuperscript{164} The final chapter to this story is that after the FCA/\textit{qui tam} settlement, the hospital was no longer able to operate as a non-profit institution and was sold. It became a for-profit hospital with no guarantee that it would continue to do any charity work.\textsuperscript{165} Thus, a charity hospital with the same goals as the Medicare/Medicaid program (to provide health care for those with no other means of affording it) was effectively put out of business under the auspices of furthering Medicare/Medicaid.

Despite these potential negative effects, under a cost/benefit analysis this harm may be of limited significance on a large, national scale. The loss is one charity hospital, an "admittedly poorly managed hospital."\textsuperscript{166} On the positive side, all charity and small hospitals have received a wake-up call. They have all been alerted to the necessity of going over their systems, making sure that there are no mistakes that may be cheating the government, and scrutinizing questionable practices to correct them before they come to the government's attention. The overall good \textit{qui tam} actions will do in potentially saving the government hundreds of millions of dollars in Medicare/Medicaid payments easily outweighs the loss of a very few poorly run, poorly managed "charitable" institutions.

Although the negative factors of the \textit{qui tam} provision of the False Claims Act create a possible threat to some in the health care industry, it is a necessary threat. If estimates on the amount of fraud in the health care industry are anywhere near accurate, a powerful method of prevention is imperative.

\textbf{VII. CONCLUSION}

Recipients of Medicare/Medicaid are dependent on these programs for healthcare that they would not otherwise be able to afford. As cuts to these programs are currently being proposed, many people in need of medical care will have to go without this care. Meanwhile the defendants discussed in this

\textsuperscript{163}\textit{Id.}

\textsuperscript{164}Jay Greene, \textit{Troubled Catholic Hospital Sold to Groups}, MODERN HEALTHCARE 26, Feb. 15, 1993.

\textsuperscript{165}\textit{Id.}

\textsuperscript{166}See Commentary, supra note 126.
article have realized extreme, unearned profits by fraudulently billing Medicare and Medicaid programs.

The *qui tam* provision of the False Claims Act has been and should continue to be, used to curtail these fraudulent practices of false billing and overutilization. The act has potential to provide an additional service to the public by influencing the quality of care provided to Medicare and Medicaid recipients.

As this article notes, some negative effects may result from use of *qui tam* actions to combat fraud in the health care industry. However, there is also a serious need for detection and prevention of government fraud. Fraud detection is necessary in order to assure that money intended to provide healthcare to those who cannot afford it actually goes to those in need, instead of the pockets of individuals such as the defendants discussed in this article and other individuals committing fraud on the government who have gone undetected.

The *qui tam* provision of the False Claims Act, cause of action drafted by President Lincoln with the intention of stopping Civil War defense contractors from bilking the Government by selling shells filled with sawdust instead of gunpowder, with its current revisions and amendments, is now being used to call attention to fraudulent practices in the health care industry against the U.S. Government. The *qui tam* provision of the False Claims Act is in a position to safeguard against Medicare and Medicaid abuse and influence the quality of healthcare in the United States.

Carolyn J. Paschke