Fact Sheet
False Claims Act Settlements and Judgments
FY2025

Representative examples of False Claims Act matters pursued by the government and whistleblowers this past fiscal year are discussed below.

HEALTH CARE FRAUD

Health care fraud remained a leading source of False Claims Act settlements and judgments. These recoveries restore funds to federal programs such as Medicare, Medicaid, and TRICARE, the health care program for service members and their families. The Department continued and expanded its success in three major areas: Managed Care, Prescription Drugs, and Medically Unnecessary Care.

Managed Care

The Justice Department continued to pursue cases alleging false claims in managed care, particularly the Medicare Advantage (or Medicare Part C) program. As Medicare Part C is now the largest component of Medicare, both in terms of federal dollars spent and the number of beneficiaries impacted, the work of the Justice Department in this area is of critical importance.

Independent Health Association and its affiliate, Independent Health Corporation (collectively, Independent Health) agreed to pay up to $98 million to resolve false claims allegations of unsupported and invalid diagnosis codes submitted for Medicare Advantage Plan enrollees to increase payments that Independent Health received from Medicare. The United States alleged that an Independent Health subsidiary retrospectively searched medical records and queried physicians for information to add improper diagnoses for enrollees.

Seoul Medical Group Inc. and its subsidiary Advanced Medical Management Inc., and its former president and owner agreed to pay over $60 million to resolve allegations that they caused the submission of false diagnosis codes for spinal conditions that patients did not have in order to increase payments from the Medicare Advantage program. Renaissance Imaging Medical Associates Inc., a radiology group that worked with Seoul Medical, agreed to pay $2.35 million for allegedly conspiring with Seoul Medical Group to create radiology reports that appeared, falsely, to support the diagnosis for one of the spinal conditions.

The Justice Department intervened in a qui tam against national insurers Aetna Inc., Elevance Health Inc., and Humana Inc., as well as three insurance brokers eHealth Inc., GoHealth, Inc., and Select Quote Inc. The Department alleged that the insurers agreed to pay hundreds of millions of dollars in illegal kickbacks to the brokers in exchange for steering Medicare beneficiaries to enroll into the insurers' Medicare Advantage plans, regardless of the suitability of those plans for the beneficiaries. The complaint further alleged that the brokers incentivized their employees and agents to sell plans based on the insurers' kickbacks and, at times, refused to sell plans of insurers that did not pay them kickbacks. With respect to Aetna and Humana, the Department alleged that they each conspired with the brokers to avoid enrollment of Medicare beneficiaries with disabilities, which the insurers perceived to be less profitable for them. It is alleged that Aetna and Humana did this by threatening to withhold kickbacks to pressure brokers to enroll fewer disabled Medicare beneficiaries in their plans.

The Justice Department also filed suit against Local Initiative Health Authority for Inland Empire Health Plan, doing business as Inland Empire Health Plan (IEHP). The Government alleged that IEHP made false statements to Medi-Cal, California's Medicaid program, and retained surplus Medi-Cal Expansion funding that should ultimately have been returned to the federal government. It is further alleged IEHP misspent Medi-Cal Expansion funding for impermissible purposes, including simply giving away federal funding in exchange for no value in return. To make this spending seem legitimate, the complaint alleged that IEHP made false statements about the nature, timing, and purposes of its payments.

The Justice Department also continued to litigate matters against other major health insurance companies UnitedHealthCare, Kaiser, and Anthem, alleging that they added improper diagnoses to increase reimbursement from the Medicare Advantage program.

Prescription Drugs

The Justice Department continued its pursuit of entities that engaged in misconduct related to drug pricing, drug dispensing, and illegal kickbacks that risk injecting improper financial motivations into the drugs prescribed to beneficiaries. These include matters that hold accountable those actors that contributed to and exacerbated the opioid crisis.

Teva Pharmaceuticals USA Inc., the largest generic drug manufacturer in the country, agreed to pay $425 million to resolve allegations that it violated the False Claims Act by paying copays for Medicare patients for the multiple sclerosis drug Copaxone while steadily raising the drug's price. Teva further agreed to pay $25 million to resolve allegations that it conspired with other generic drug manufacturers to fix prices for certain drugs and that the benefits Teva received under its price fixing scheme constituted illegal kickbacks.

A unanimous jury found Omnicare, the country's largest long-term care pharmacy, and its parent CVS liable for fraudulently dispensing drugs without valid prescriptions to elderly and disabled people in assisted living facilities and other residential long-term care facilities. After a four-week trial, the jury found that Omnicare and CVS billed Medicare, Medicaid, and TRICARE for over three million false claims. In August 2025, the court entered a judgment including treble damages and penalties for a total amount of $948.8 million.

Medisca Inc. (Medisca) agreed to pay $21.75 million to resolve allegations concerning the establishment of false and inflated Average Wholesale Prices (AWPs) for two ingredients used in compound prescriptions. Compounding pharmacies purchase ingredients or chemicals from ingredient suppliers, such as Medisca, to prepare and fill compound prescriptions for patients who require a specially made prescription that is not generally available in the marketplace. The United States alleged that Medisca knowingly inflated the AWPs for ingredients to increase the reimbursement that its pharmacy customers received from the federal healthcare programs, often by thousands of dollars per prescription.

Gilead Sciences, Inc. agreed to pay $176 million for offering and paying kickbacks in the form of honoraria payments, meals, and travel expenses to healthcare practitioners who spoke at or attended Gilead speaker events to induce them to prescribe certain Gilead HIV drugs. As part of the settlement, Gilead admitted it paid many high-volume prescribers of HIV drugs tens or hundreds of thousands of dollars in honoraria payments to prepare and present as HIV speakers.

Biohaven Pharmaceutical Holding Company Ltd. (Biohaven), a Pfizer subsidiary, agreed to pay $59.7 million to resolve allegations that, prior to Pfizer's acquisition of the company, Biohaven paid kickbacks to health care providers to induce prescriptions. The government alleged that Biohaven selected and paid certain health care providers with the intent that the speaker honoraria and meals would induce them to prescribe its drug. The government further alleged that certain prescribers who attended multiple programs on the same topic received no educational benefit from attending repeat programs and that certain Biohaven speaker programs were attended by individuals with no educational need to attend, such as the speakers' spouses, family members, friends, or colleagues.

QOL Medical LLC and its co-owner and CEO, Frederick Cooper, agreed to pay $47 million to resolve allegations that they offered kickbacks in the form of free breath testing services to induce claims for QOL's drug Sucraid. QOL, with the CEO's approval, distributed free breath test kits to health care providers and asked providers to give the kits to patients with common gastrointestinal symptoms, claiming that the test could "rule in or rule out" the condition for which it was approved. In fact, the test did not specifically diagnose the condition and other conditions could cause a patient to test "positive."

The United States pursued several pharmacies for filling prescriptions for controlled substances that lacked a legitimate medical purpose, were not valid and/or were not issued in the usual course of professional practice. In those matters, the government alleged that the prescriptions included those for dangerous and excessive quantities of opioids, prescriptions for early refills of opioids and prescriptions for the especially dangerous and abused combination of drugs known as the "trinity," which is made up of an opioid, a benzodiazepine and a muscle relaxant. The government filed a complaint against CVS and various subsidiaries asserting such allegations. The government also filed a complaint against Walgreens and various subsidiaries, which Walgreens resolved, agreeing to pay up to $350 million. The government also resolved such claims against K-VA-T Food Stores, Inc., doing business as Food City, for $8.48 million. In addition, in a case that was the first of its kind, the Department held consultant McKinsey & Co., Inc. United States (McKinsey) accountable for its role providing advice to drug company Purdue Pharma L.P. that caused the submission of false and fraudulent claims to federal healthcare programs for medically unnecessary prescriptions of OxyContin, as well as allegedly failing to disclose to the U.S. Food and Drug Administration conflicts of interest arising from McKinsey's concurrent work for Purdue. McKinsey agreed to pay $323 million to resolve the allegations.

Relators, too, were successful in pursing actions against entities in the prescription drug arena, most notably in two trials that returned favorable verdicts for claims asserted by relators on behalf of the United States: U.S. ex rel. Penelow v. Janssen Products LP, resulting in a $1.6 billion verdict arising from allegations that prescription drug claims to federal healthcare programs were induced by false and misleading claims about the safety and efficacy of the drugs Prezista and Intelence; and U.S. ex rel. Behnke v. CVS Caremark Corp., resulting in a $289 million verdict for causing two Medicare Part D plans to report false and inflated prices for generic drugs.

Unnecessary Services and Substandard Care

The Justice Department also pursued and resolved matters in which providers billed federal health care programs for medically unnecessary services and substandard care that puts at risk the health and safety of vulnerable patient populations.

The United States filed a complaint against Vohra Wound Physicians Management LLC (Vohra) and its founder and majority owner, Dr. Ameet Vohra, for allegedly causing the submission of false claims to Medicare for overbilled and medically unnecessary wound care services. The United States alleged that the defendants engaged in a nationwide scheme to falsely bill Medicare for surgical debridements – procedures to remove dead or unhealthy tissue that could impede wound healing – to maximize revenue. The defendants subsequently agreed to pay $45 million to settle this matter.

Oroville Hospital agreed to pay $10.25 million to resolve allegations that it billed Medicare and Medicaid for medically unnecessary inpatient hospital admissions, billing for more expensive inpatient hospital admissions when observation status or outpatient care was appropriate. The government further alleged that the hospital illegally incentivized inpatient admissions by paying financial bonuses to doctors who worked full time at the hospital and were in a position to influence whether patients were admitted to the hospital.

American Health Foundation and three affiliated nursing homes agreed to pay $3.61 million to resolve allegations relating to billing Medicare and Medicaid for grossly substandard skilled nursing services. The United States alleged that the nursing homes failed to follow appropriate infection control protocols and did not maintain adequate staffing levels. The United States further alleged that Cheltenham Nursing & Rehabilitation Center, one of the nursing homes named, housed its residents in a dirty, pest-infected building, gave its residents unnecessary medications, subjected residents to verbal abuse, and failed to safeguard their possessions. The United States alleged that two of the facilities also failed to create and maintain crucial resident care plans and assessments.

The Justice Department filed claims against ProMedica Health System, Inc., affiliated entity HCR ManorCare, and four nursing homes owned and controlled by ProMedica. The complaint alleged that ManorCare owned and operated the nursing homes prior to ProMedica's acquisition of ManorCare. The complaint further alleged that the nursing homes provided non-existent, grossly substandard skilled nursing facility care, including failing to provide adequate wound care, maintain residents' hygiene and provide showers when required, and provide residents with appropriate assistance with feeding. In addition, the complaint alleged that defendants falsely documented that care and services had been provided to residents when it had not been.

PROCUREMENT, LOAN, AND GRANT FRAUD

The government continued its pursuit of fraud matters involving the purchase of goods and services by the government, including fraud in military procurements, violations of critical cybersecurity requirements in federal contracts and grants, and misuse of pandemic relief program funds.

Military Procurement Fraud

The Department pursued multiple matters involving the submission of false and inflated cost and pricing data to the U.S. military for contracts for essential defense systems and equipment. In the Department's second-largest procurement fraud case in history, Raytheon Company agreed to pay $428 million to resolve allegations that it knowingly provided false cost and pricing data when negotiating with the Department of War for numerous government contracts and double billed on a weapons maintenance contract, leading to Raytheon receiving profits in excess of negotiated

rates. L3 Technologies Inc. agreed to pay $62 million to resolve allegations that it failed to disclose accurate, current and complete cost or pricing data relating to labor, material and other costs for communications equipment. Lockheed Martin Corp. agreed to pay $29.74 million to resolve allegations of defective pricing on contracts for F-35 military aircraft.

Booz Allen Hamilton Holding Corporation agreed to pay $15.875 million to resolve allegations that its subsidiary, Booz Allen Hamilton Engineering Services LLC (BES) submitted fraudulent claims to the United States in connection with a General Services Administration task order to supply computer military training simulators and systems. The United States alleged that BES employees improperly used confidential government contracting and budget information, a competitor's confidential bid or proposal information, and source selection information to influence the agency to award the task order to BES.

DRI Relays Inc. agreed to pay $15.7 million to resolve allegations that it supplied military parts that did not meet military specifications. DRI's parent company disclosed to the government that DRI failed to conduct certain required tests on relays and sockets but invoiced for military grade electrical relays and sockets when it knew those parts had not met testing requirements to be deemed military grade.

DynCorp International LLC agreed to pay $21 million to resolve ongoing litigation with the government in which it alleged that DynCorp inflated subcontractor charges under a State Department contract to train Iraqi civilian police forces. The United States alleged that one of DynCorp's subcontractors charged excessive, uncompetitive, and unsubstantiated rates for hotel lodging and guard, translator, driver, and supervisor services and that DynCorp, contrary to its obligations as a government prime contractor, knowingly passed on those charges to the State Department for reimbursement.

Cybersecurity Fraud

In the cybersecurity arena, the Department continued its success in bringing matters to resolution and highlighting the importance of compliance with essential contract terms to ensure the security of government information. In this year alone, the Department has recovered over $52 million in nine cybersecurity fraud settlements and civil cybersecurity fraud settlements have more than tripled in each of the past two years.

Health Net Federal Services Inc. (HNFS) and its corporate parent, Centene Corporation, agreed to pay $11.2 million to resolve allegations that HNFS falsely certified compliance with cybersecurity requirements in a contract to administer health benefits for servicemembers and their families. The United States alleged that it failed to timely scan for known vulnerabilities and remedy security flaws and ignored reports from third-party security auditors and its internal audit department of cybersecurity risks.

Illumina Inc. agreed to pay $9.8 million to resolve allegations that it sold to federal agencies certain genomic sequencing systems with cybersecurity vulnerabilities and lacked an adequate security program and sufficient quality systems to identify and address those vulnerabilities. The United States alleged that Illumina failed to incorporate cybersecurity in its product's software design, development, installation, and on-market monitoring, failed to properly support and resource product security, failed to adequately correct design features that introduced cybersecurity vulnerabilities, and falsely represented that the software adhered to cybersecurity standards.

MORSECORP Inc. agreed to pay $4.6 million to resolve allegations that it failed to comply with cybersecurity requirements in its government contracts. MORSECORP used a third-party company to host emails without requiring and ensuring that the third party met contract security requirements, failed to implement all required cybersecurity controls, and lacked a system security plan for its covered information systems. MORSECORP submitted an inaccurate score for its implementation of required security controls and when a third-party cybersecurity consultant notified MORSECORP that the score was wrong, MORSECORP did not promptly update it or notify the government.

The Department also obtained settlements with the Pennsylvania State University (Penn State) and Georgia Tech Research Corporation (GTRC). Penn State agreed to pay $1.25 million to resolve allegations that it failed to comply with cybersecurity requirements in certain government contracts by failing to implement required cybersecurity controls and adequately develop and implement action plans to correct identified deficiencies. GTRC agreed to pay $875,000 to resolve allegations that it failed to meet cybersecurity requirements in connection with certain Air Force and Defense Advanced Research Projects Agency contracts. The United States alleged, among other things, that GTRC failed to install, update or run anti-virus or anti-malware tools on desktops, laptops, servers and networks at Georgia Tech's Astrolavos Lab while the lab conducted sensitive cyber-defense projects for the government.

Pandemic Fraud

In response to the COVID-19 crisis, Congress authorized historic levels of emergency funding for federal agencies to provide direct financial assistance to individuals, businesses, and state, local, and Tribal governments. The Department's enforcement efforts in this area have included the pursuit of cases involving improper payments under the Paycheck Protection Program (PPP), administered by the U.S. Small Business Administration (SBA), and alleged fraud affecting Medicare and other federal healthcare programs for services related to COVID-19 testing and treatment. During fiscal year 2025, the Department obtained more than 200 False Claims Act settlements and judgments, which collectively exceeded more than $230 million, resolving allegations of pandemic-related fraud. To date, the Department has collected over $820 million in civil settlements and judgments relating to alleged fraud or improper payments in connection with pandemic relief programs.

For example, the Department pursued cases against borrowers for alleged false information about employee rosters and payrolls when seeking a PPP loan, such as a $20 million consent judgment with Patrick Walsh and 10 companies he owned or operated. It also pursued matters involving other pandemic-era programs, such as an $8.1 million settlement with Delta Air Lines Inc., to resolve allegations that the company awarded compensation that exceeded limits Delta agreed to as part of its participation in the Treasury Department's Payroll Support Program. As part of the Department's efforts to hold accountable individuals for their role in these schemes, it filed a complaint against three former executives of Kabbage Inc., a now bankrupt financial technology company, alleging they submitted false claims for loan forgiveness, loan guarantees and processing fees to the SBA in connection with Kabbage's role in the PPP.

The Department also pursued cases against medical providers who sought to defraud pandemic-related healthcare programs, such as a $3.5 million settlement against Dr. Samad Khan to resolve allegations that he billed for medical evaluations that were not performed at COVID-19 testing sites, and an $8 million settlement with Vault Medical Services, P.A. and Vault Medical Services

of New Jersey, P.C., to resolve allegations that Vault billed a federal healthcare program designed for uninsured patients for COVID-19 services provided to patients with active health insurance. In addition, the Department obtained an $8.2 million settlement with Covid Test DMV LLC to resolve allegations that the company billed the government for COVID-19 tests that were not provided to Medicare beneficiaries.

TARIFF AND CUSTOMS AVOIDANCE

Those who import and sell foreign-made goods in the United States must comply with all trade laws. The government relies on honest representations to levy and collect duties on imported merchandise. The Department had continued its efforts to root out and hold accountable actors that seek to evade tariffs and other duties.

For example, this past fiscal year, the Department obtained settlements against those who attempted to misrepresent the type of goods imported from the People's Republic of China (China) in order to avoid antidumping and other duties, such as a $12.4 million settlement with Allied Stone Inc. and its president, Jia "Jerry" Lim. The Department pursued matters involving companies misrepresenting an item's country of origin in order to avoid duties, as in an $8.1 million settlement with Evolution Flooring Inc. and its owners, Mengya Lin and Jin Qian, and a $6.8 million settlement with Global Plastics LLC and Marco Polo International LLC. The Department also pursued matters involving attempts to disguise items in order to evade duties, as in the $4.9 million settlement with Grosfillex Inc. to resolve allegations that the company attempted to camouflage aluminum extrusions by packaging the parts as sham furniture "kits."

The Justice Department filed claims against Barco Uniforms Inc., Kenny Chan, David Chan, and companies operated and controlled by the Chans, alleging that they underpaid customs duties owed on imported apparel. The complaint alleges that defendants conspired to avoid or decrease customs duties owed by undervaluing imported garments Barco purchased from foreign suppliers. The complaint further alleges that certain of the defendants provided false entry summaries to Customs that undervalued imported goods, thereby reducing the duties paid on the merchandise, and also continued to underpay duties even after a third-party auditor recommended that Barco double-check its duty calculations relating to its foreign suppliers.

In addition the settlements, judgments, and suits from the last fiscal year, the Department recently announced a record-breaking settlement with Ceratizit USA LLC, a distributor of tungsten carbide products, which agreed to pay $54.4 million to resolve allegations that it violated the False Claims Act by knowingly and improperly failing to pay duties owed on such products imported from the People's Republic of China. This is the largest customs fraud resolution ever under the False Claims Act.

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Except where indicated, the government's claims in the matters described above are allegations only and there has been no determination of liability. The numbers contained in this press release may differ slightly from the original press releases due to accrued interest.