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The true driver behind the FY25 false claims recoveries

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The Department of Justice's January 2026 announcement (https://bit.ly/4bepMLK) of over $6.8 billion in False Claims Act (FCA) recoveries for fiscal year 2025 drew wide attention for the size of the headline number, which more than doubled the $3.1 billion recovered the prior year and marked the highest total FCA recoveries on record.

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However, a closer examination of the FY25 data — including from the FY25 FCA Fact Sheet (https://bit.ly/4scyeka) released earlier in January and prior case-specific press releases — reveals that the recoveries were highly concentrated, with a disproportionate share driven by large healthcare matters.

More importantly, those outcomes are increasingly driven by how damages are constructed and scaled, given the nature of government healthcare programs, rather than by liability determinations alone.

For litigators, perhaps the most instructive insight to be drawn from the FY25 FCA data is that the handful of cases with outsized recoveries have distinguishing economic mechanisms that drive damages. Understanding how those mechanisms operate — and why they produce different outcomes — helps explain both the concentration of recoveries in healthcare and the growing importance of damages analysis in high-stakes FCA matters.

Healthcare FCA cases dominate

Healthcare cases dominated both the number of FCA cases in FY25 and, disproportionately, the dollar value of recoveries. The 458 healthcare-related FCA cases in FY25 represented 27% of all 1,698 FCA cases and roughly 83% of all FCA recoveries for the year: approximately $5.7 billion of the over $6.8 billion total.

The eight largest publicly reported healthcare matters listed in Figure 1 alone account for roughly $4.7 billion, or about two-thirds of total FCA recoveries in FY25.

The contrast between the largest cases and the typical FCA resolution is a matter of scale. Recoveries at the top of the distribution exceed those in a typical FCA case by hundreds of millions of dollars. Setting aside these eight largest cases, the $2.2 billion in total recoveries across all 1,690 other FCA cases in FY25 is just $1.2 million on average — just over half of the $2.2 million average recovery in FY24.

What is most notable is not merely that a small number of healthcare cases produced outsized recoveries, but *why* they did so — differences in the economic mechanisms underlying the conduct at issue. Healthcare-related cases lend themselves to damages frameworks that scale rapidly through high claim counts, program-wide extrapolation, or statutory penalty multipliers.

For litigators, this economic reality matters because it shifts the focus in high-stakes FCA cases. Once liability is established — or assumed for settlement purposes — the outcome swings widely on a few key economic questions: what is the appropriate unit of harm, how many units should be counted as within the scope of the conduct at issue, and whether the resulting figure remains economically appropriate in light of the alleged conduct.

Healthcare as an economic system, not just a regulated industry

The dominance of healthcare among the largest FY25 FCA recoveries can be explained by the scale and design of government healthcare programs. Medicare, Medicaid,

Figure 1: Largest Healthcare FCA Cases of FY25

Case	Recovery	False Claim Type
1. Janssen Products LP (*Penelow*)	$1,600M	Misleading marketing; medically unnecessary prescriptions
2. Omnicare / CVS Health (*Bilotta*)	$949M	Dispensing without valid prescriptions
3. Kaiser Permanente Affiliates	$556M	Inflated Medicare Advantage risk scores; unsupported diagnosis coding
4. Teva Pharmaceuticals	$450M	Kickbacks/copay assistance; reimbursement benchmark distortion
5. Walgreens	$350M	Systemic pharmacy practices; false claims across federal programs
6. McKinsey & Co.	$323M	Alleged inducement of opioid prescriptions
7. CVS Caremark (*Behnke*)	$290M	False drug price reporting; Medicare Part D overpayments
8. Gilead Sciences	$202M	Inducement-driven prescribing
Total	**$4,720M**	

Sources: FY25 FCA Fact Sheet and case-specific DOJ press releases.

and related programs are built on standardized reimbursement formulae, diagnostic coding systems, and pricing benchmarks. These structures promote regulatory consistency and administrative efficiency — but they also mean damages can scale rapidly in the FCA context.

Figure 2 depicts the eight largest FY25 healthcare FCA recoveries by the primary economic mechanism that drives damages. While all of these cases involve healthcare programs, the underlying economic mechanisms differ meaningfully across them.

In the two largest matters, damages were driven by statutory penalties applied across very large numbers of claims. In others, damages turned on program-wide extrapolation from alleged coding or risk-adjustment errors.

In a third category of cases, damages depended on whether pricing benchmarks or prescribing decisions were distorted in ways that affected reimbursement across thousands or millions of transactions.

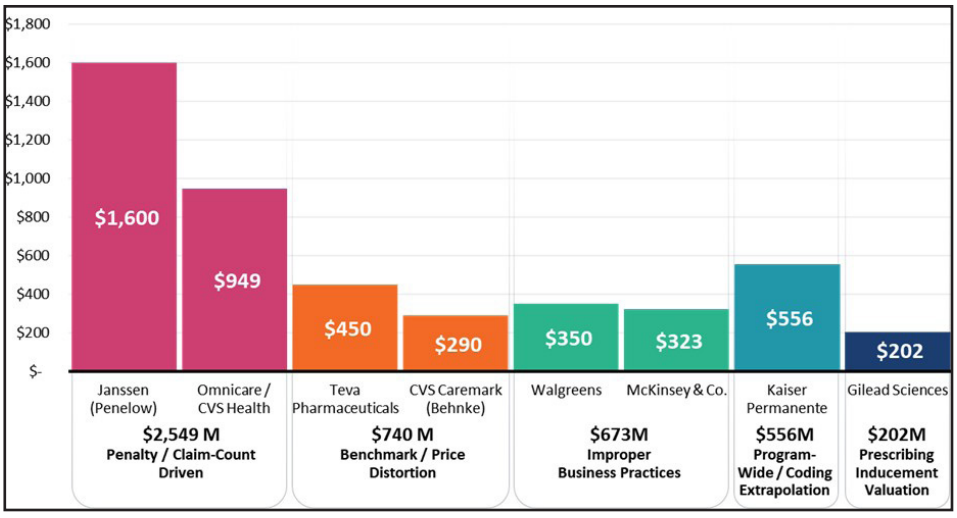

Figure 2: Largest Healthcare FCA Cases of FY25 by Economic Mechanism Driving Damages

Together, these eight cases reflect five distinctive economic mechanisms that drive the dollar value of recoveries differently across each case type. These economic mechanisms include:

Penalty or claim-count driven cases characterize the two healthcare FCA cases with the largest recoveries in FY25 – $2.5 billion collectively. In this type of FCA case, damages grow largely because statutory penalties and treble damages are applied across very large numbers of reimbursed claims, so the sheer volume of implicated claims — not the size of any one claim — determined damages.

Benchmark or price-distortion accounted for $740 million in recoveries from two of the other six cases. These cases focus on alleged misreporting or manipulation of pricing inputs — such as drug prices or copay structures — that flow through reimbursement formulae and affect payments systemically.

As a result, damages depend less on claim-by-claim evaluations and more on modeling the downstream payment effects of corrected pricing inputs across the affected claims population.

Improper business practices generated false claims amounting to $673 million in two other cases (excluding prescribing-inducement matters, which are discussed separately

below). In these cases, the economic focus is on how routine business processes are carried out at scale.

Damages are therefore calculated by identifying the affected population of transactions and valuing the cumulative financial impact of the business practices across that population, rather than by isolating individual claims or adjusting a single reimbursement formula.

Program-wide extrapolation or coding cases, such as the $556 million Kaiser settlement above, focus on alleged defects in diagnosis coding or documentation that affected payment formulas across an entire population, allowing damages to be calculated by recomputing payments for the population rather than claim by claim.

The $6.8 billion-plus in FY25 FCA recoveries speaks loudly to the continued focus on, and high-stakes nature of, FCA cases in white-collar investigations and litigation.

The damages in these cases are estimated by defining the affected population and determining how payment amounts would change under corrected coding assumptions. Small adjustments to coding inputs can translate into large payment differences when applied across thousands or millions of affected individuals.

Prescribing-inducement valuation cases, such as the $202 million Gilead settlement above, center on allegations that financial or promotional activities influenced prescribing behavior, with damages tied to valuing the downstream volume of reimbursed prescriptions attributable to those inducements.

Damages, therefore, depend on establishing links between the alleged inducements and subsequent prescribing decisions, and on quantifying the incremental prescriptions paid for by government programs as a result. The scale of recovery reflects how broadly those prescribing effects are assumed to extend across providers and time periods.

Different roads to large scale

Although the specific method used to calculate damages differs across these cases, they share a common economic mechanism: specific conduct translated into much broader damages amounts given how federal healthcare payment systems operate at scale. Damages can grow rapidly when a narrow set of actions is applied across a large economic system.

In healthcare-related FCA cases, applying specific actions — such as coding practices, pricing inputs, or promotional activities — across large numbers of dispensings, beneficiaries, or payment formulas, means damages can grow rapidly.

These very different economic mechanisms can all yield very large damages amounts, and similar amounts across cases, even though the underlying conduct and factual predicates differ. This suggests that, at the high end of the distribution of FCA cases, outcomes are less about the type of conduct at issue and more about the economic mechanism of damages.

Put differently, the most critical question for determining damages is often not what happened, but how what happened scales via the economic mechanisms listed above. That scaling exercise — how a discrete allegation becomes a $200 million, $500 million, or $1 billion-plus recovery — is inherently economic.

Courts appear increasingly attentive to this distinction. Where damages theories scale rapidly relative to the conduct at issue, judges and juries are being asked to evaluate not only statutory formulas, but also whether the resulting damages awards make economic sense in context.

That scrutiny places a premium on sufficiently detailed analysis and clear explanations of program mechanics, pricing systems, and counterfactual outcomes.

Looking beyond the headline numbers

The $6.8 billion-plus in FY25 FCA recoveries speaks loudly to the continued focus on, and high-stakes nature of, FCA cases in white-collar investigations and litigation. But more importantly, this headline number reinforces a broader lesson for litigators on either side of these cases: the damages awards in the biggest FCA cases are being decided on how the underlying economics scale.

Establishing liability is necessary to trigger damages, but liability is not sufficient to understand the potential magnitude of damages in cases involving similar conduct but different scaling mechanisms. The decisive battleground is increasingly the damages calculations that dictate scale — loss attribution, per-claim valuation, and the interaction between statutory penalties and actual economic harm.

For litigators, this trend points to a common conclusion. In high-stakes FCA matters — particularly those where potential exposure reaches into the hundreds of millions of dollars or more — understanding and explaining how complex economic systems function, why those systems matter, and how the conduct at issue did or did not change key outcomes is increasingly important.

The FY25 FCA data do not merely report results; they reveal the economic underpinnings of how those results are being achieved.

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