Health Care Fraud, Waste and Abuse Laws

To combat the increasing problem of health care fraud, waste and abuse, federal and state fraud prevention laws have been established. Each of these laws has its own purpose in preventing health care fraud, waste and abuse. Some examples of these laws include:

U.S. Federal & State False Claims Acts:

The U.S. False Claims Act prohibits any person from knowingly presenting or causing the presentation of a fraudulent claim for payment. The Act also protects reporters from retaliation, including the following: harassment, demotion and wrongful termination. In addition to the U.S. Federal False Claims Act, a number of U.S. states have also enacted False Claims Acts to discourage fraud against U.S. state government programs.

- *Citation: False Claims Acts (31 U.S.C. §§ 3729-3733)*

U.S. Federal and State Anti-Kickback Statutes:

These statutes make it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a U.S. federal health care program. The intent of anti-kickback statutes is to ensure referrals for health care services are based on medical need or benefit and not based on financial or other types of incentives.

- *Citation: Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))*

U.S. Stark Law:

The U.S. Stark Law, which focuses on physician self-referrals, is related to anti-kickback statutes and they are both intended to prevent health care providers from inappropriately profiting from referrals. This means a physician generally may not refer a patient for certain designated services to an entity where the physician has an ownership or financial arrangement if the service is covered by U.S. government programs such as Medicare or Medicaid.

- *Citation: Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn)*

U.S. Federal Health Care Fraud Statute:

In addition to the laws that address the protection of U.S. government dollars, the U.S. Federal Health Care Fraud Statute makes it a crime to defraud any health care benefit program – not just programs funded by the U.S. government.

- *Citation: Health Care Fraud Statute (18 U.S.C. § 1347)*

Title II of HIPAA:

Title II includes multiple provisions including but not limited to the creation of a fraud, waste, and abuse control program for coordination of U.S. state and federal health care fraud investigation and enforcement activities. It also created new criminal provisions that expanded what actions could be considered 'health care fraud' and made it a federal crime to defraud health care benefit programs - any benefit program - not just Medicare or Medicaid.

- *Citation: Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191) ; 42 U.S. Code § 1320a–7c - Fraud and abuse control program; 42 U.S. Code § 1395ddd - Medicare Integrity Program*

Related Organization Policies

UnitedHealth Group Code of Conduct -

Our Principles of Ethics & Integrity:

Provides guidelines for helping us sustain the highest possible standards of ethical behavior in our work.

False Claims Act Compliance Policy:

Outlines key information about the federal and state false claims act(s).

Anti-Kickback Policy:

Outlines key information about the federal Anti-Kickback Statute and similar state and local laws .

Reporting Misconduct Policy:

Outlines expectations and resources available to report possible misconduct.

Code of Conduct is available on The Hub – Policies are available via eGRC Policy Center