

DOJ Reports Record \$6.8 Billion in False Claims Act Recoveries, Driven Largely by Healthcare Enforcement

Healthcare Law Update

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On January 16, 2026, the U.S. Department of Justice (DOJ) [announced](#) that False Claims Act recoveries totaled \$6.8 billion in fiscal year 2025, the highest annual total on record and more than double the \$2.9 billion recovered in fiscal year 2024. Approximately \$5.7 billion of the \$6.8 billion total arose from healthcare-related settlements and judgments. Notably, the government secured a \$1.6 billion verdict against Johnson & Johnson related to the promotion of HIV medications for alleged unapproved uses, and obtained \$289 million from CVS Caremark in connection with claims involving alleged overbilling under Medicare Part D.

The federal False Claims Act remains one of the government's primary civil enforcement tools for addressing fraud involving federal funds, especially considering the scale of federal healthcare program spending. The statute enables the government to seek treble damages and significant per-claim penalties from parties that knowingly submit, or cause the submission of, false or fraudulent claims for payment from the United States. According to the DOJ, enforcement activity in fiscal year 2025 focused heavily on the healthcare sector, including managed care, pharmaceutical pricing and marketing, and medically unnecessary services.

While large pharmaceutical and healthcare organizations continue to be prominent enforcement targets, the DOJ emphasized that liability under the False Claims Act extends across the healthcare industry, including to hospitals, physician groups, and other providers. The record-setting recoveries underscore the government's ongoing scrutiny of billing, coding, and reimbursement practices, and underscore the need for healthcare stakeholders to maintain strong compliance, monitoring, and

internal auditing programs to reduce enforcement risk.

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