Compliance Issues Under the Affordable Care Act

Enforcement of Federal Requirements

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State Regulation

Insurance regulated by States
- McCarren-Ferguson Act

Enforcement mechanisms
- Form Filing
- Market Conduct Exams
- Unfair Trade Practices Act
- Unfair Claims Settlement Practices Act
State Regulation

Unfair Trade Practices

• False statement to Commissioner’s office
• Violating various State statutes
• Cease & desist order; penalties ($1,000/violation, $100,000 cap)

Unfair Claims Settlement Practices Act

• Prompt, fair settlement of claims
• Reasonable standards for prompt investigation
• Cease & desist order; penalties ($1,000/violation, $100,000 cap)
Increasing Federal Regulation

- **COBRA** (1986)
- **HIPAA** (1996)
- **MA/Part D** (2003)
- **HITECH Act** (2009)
- **Med Supp Regulation** (1988)
- **Mental Health Parity** (1996)
- **MHPAEA** (2008)
- **Affordable Care Act** (2010)
Federal Enforcement 1: CMS

Public Health Service Act

- HIPAA non-discrimination
- Mental Health Parity
- Premium rating
- Guaranteed availability/renewability
- Lifetime/annual limits
- Internal claims & appeals
- Essential health benefits
Federal Enforcement 1: CMS

*Not* other ACA provisions

- Rate increase review
- Reinsurance, risk corridors, and risk adjustment
- Medical loss ratio (including rebate requirements)
- Exchange standards/QHPs
CMS Enforcement

Primary enforcement by States

• Delegation of authority?

State failure to enforce

• State gives notice
• CMS determines lack of “substantial enforcement”
CMS Enforcement

Basis for investigation

- Complaints
- Reports from DOI, NAIC, other agencies
- Any other information indicating potential issue

Enforcement actions

- Market Conduct Exams
- Civil Money Penalty: $100 / affected individual / day (no cap)
Federal Enforcement 2: OIG

OIG oversight of other ACA provisions

- Rate increase review
- Reinsurance, risk corridors, and risk adjustment
- Medical loss ratio (including rebate requirements)
- Exchange standards/QHPs

No enforcement rules
Fed Enforcement 3: Fraud Laws

Health care Anti-Fraud laws

- Anti-Kickback Statute
- False Statements (Federal health care programs)
- False Statements (health care benefit programs)

General Federal Anti-Fraud laws

- False Claims Act
- False Statements (Executive Branch jurisdiction)
Anti-Kickback Statute

Prohibits “kickbacks” (42 U.S.C. § 1320a-7b(b))

- Solicits or receives remuneration; offers or pays remuneration
- In return for referral paid for by
- Federal health care program

Very broad

- Broker commissions
- Provider discounts to health plans
- Pharmaceutical manufacturer rebates
False Statements (1)

Prohibits false statements/representations
(42 U.S.C. § 1320a-7b(b))

- Application for or supporting payment under
- Federal health care program

Very broad

- Medicare Advantage/Part D applications
- Medicaid MCO applications
- Any submission related to payment by program
Federal Health Care Program

Provide benefits funded by U.S. or State

- Medicare, Medicaid, TRICARE
- Medicare Advantage/Part D,
- [Exception for FEHBP]

HHS: *not* Federal health care programs

- Qualified Health Plans
- Exchanges/Marketplaces
- Risk adjustment, reinsurance, and risk corridor programs
False Statements (2)

Prohibits making materially false: (18 U.S.C. § 1035)

- Statement
- Representation
- Writing

In any matter:

- Involving a health care benefit program and
- Relating to payment for health care
False Statements (2)

Health care benefit program

- Public or private plan
- Providing medical benefit, item, or service to
- Any individual

Prohibits false statements in:

- Risk adjustment, reinsurance, and risk corridor programs submissions
- Qualified Health Plan applications
General Anti-Fraud Laws

Criminal statutes

• Broad application – not just health care
• Enforced by:
  • Department of Justice
  • U.S. Attorneys

False Statements (3)

False Claims Act
False Statements (3)

Prohibits false statements (18 U.S.C. § 1001)

- About material fact in any matter
- Within executive branch jurisdiction

Prohibition includes material:

- False statement or representation
- False writing or document
- Concealment of fact
False Statements (3)

Applicable to submissions for:

- Medical loss ratio
- Premium rate review
- Risk adjustment, reinsurance, & risk corridor programs
- Federally-facilitated Exchanges
- Administrative Simplification Compliance Certification

Any other document/report submitted to HHS
False Claims Act

Claims subject to FCA include:

- Advance payment of:
  - Premium tax credit
  - Cost-sharing reductions
- Risk adjustment, reinsurance, & risk corridor programs
- Medicare Advantage/Part D payments
- Medicaid MCO payments

“Reverse” claims subject to FCA:

- Overpayment from HHS/Exchange/State
False Claims Act

Prohibits knowing: (31 U.S.C. § 3729)

- Submission of false claim to Government
- Use of material false record related to claim
- Use of material false statement related to claim

Reverse false claims: prohibits knowing:

- Avoidance of obligation to pay Government
- Use of material false record to avoid paying Government
- Use of material false statement to avoid paying Government
False Claims Act

“Knowing” means:

• Actual knowledge
• Deliberate ignorance
• Reckless disregard

No specific intent to defraud Government

“Material” means

• Natural tendency to influence payment
False Claims Act

Penalties:

- $5,500-$11,000/claim
- Three times Government damages*
- Costs of civil action

* ACA provision to increase damages “null, void, and of no effect”
ACA Provisions

FCA applies to Exchange payments

• To the extent payments include Federal funds

Material condition of payment

• ACA requirements concerning
  • Eligibility to participate in Exchange

Any failure to comply implicates FCA
False Claims Act

Exchange participation requirements:

• Network adequacy
• Obtain and *maintain* accreditation with respect to:
  • Quality measures (*i.e.*, HEDIS)
  • Patient experience ratings (CAHPS)
  • Seven other measures
• Any other State or Exchange requirement for QHPs
• Marketing requirements (discouraging enrollment)
• Compliance with Risk Adjustment program standards
FCA Whistleblowers

Private civil ("Qui Tam") action

- No notice to defendant
- Government decision to intervene
- Private party may conduct case
- No other interveners allowed
- Prove by "preponderance of the evidence"

Public disclosure limitation

- Allegations must be from "original source"
Qui Tam Actions

Government intervention

- Primary responsibility for prosecuting
- “Relator” remains party to action
- Significant controls over relator
- Government intervenes in 25% of cases

Relator award

- 15%-25% (or 25%-30%) of award/settlement
- Costs of action (including attorneys’ fees)
- Whistleblower’s reasonable expenses
Qui Tam Actions

Intervention factors

- Harm to Government
- Patient harm
- Pervasiveness of false claims
- Compliance plan?
- Contact with agency? (i.e., HHS/Exchange/State Medicaid)

Statistics (2011-2013)

- Nearly 500 health-related actions/year
- Over $2.7 billion/year
- 88% of total when government intervened
Whistleblowers

Retaliation prohibited, including

- Discharge
- Demotion, suspension
- Threats, harassment

Whistleblower entitled to be “made whole”

- Reinstatement
- Double back pay with interest
- Special damages, including attorneys’ fees
FCA Examples

Rx America: Part D
- $5.25 million
- False submissions to Part D Plan Finder

Wellcare: Medicaid MCO
- $137.5 million
- Retained overpayments
- Misrepresented patients’ medical conditions
QUESTIONS

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