Compliance Issues Under the Affordable Care Act

Enforcement of Federal Requirements

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2014 BLUE NATIONAL SUMMIT

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Orlando World Center Marriott
Orlando, Florida

BlueCross BlueShield

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

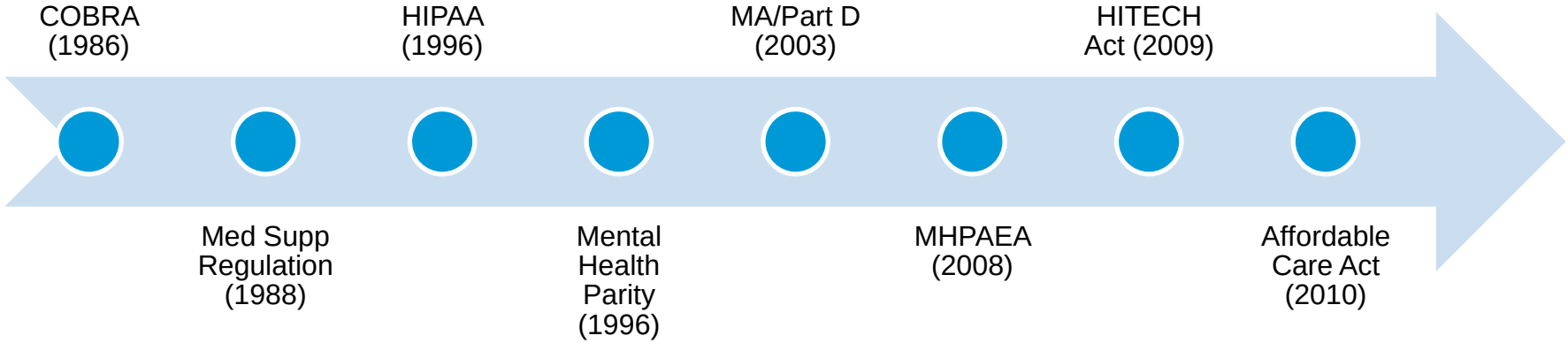
Unfair Trade Practices

- 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



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

ACA Compliance and Federal Anti-Fraud Laws

QUESTIONS

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