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BNA's
Health Care Fraud Report™

Fraud Enforcement and the Upcoming Health Insurance Exchanges

As health care providers and insurers count down the remaining days until enrollment begins for the Affordable Care Act's health care marketplaces, formerly known as exchanges, they are facing numerous operational and compliance issues related to fraud, waste, and abuse.

BNA spoke with several health care experts to piece together the new enforcement world awaiting the health care industry, as well as what can be done to minimize risk.

However, several experts told BNA that the government may downplay enforcement measures during the start-up of the marketplaces to allow organizations to take part in them and grow more comfortable with them.

Fraud risks include False Claims Act liability and violations of the anti-kickback statute, and providers and insurers will have to ensure they are maintaining effective compliance programs.

Additionally, the Department of Health and Human Services June 10 published a proposed rule outlining program integrity measures for the health insurance marketplaces (17 HFRA 586, 6/26/13).

For example, the proposed rule says ''the State Exchange must submit to HHS financial reports and must oversee its activities to ensure that it is complying with Federal requirements, such as those governing eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions.''

The annual reports to HHS would also disclose any incidences of fraud and abuse, as well as any made in determining a patients eligibility for the exchange.

The health insurance marketplaces themselves are scheduled to open for enrollment in October, and go live in January 2014.

Under the marketplaces, individuals will be able to compare, select, and purchase an insurance plan from a menu of qualified options. Additionally, some individuals will be eligible for tax credits that they can use to purchase insurance.

Currently, 17 states and the District of Columbia are working to create state-based health insurance marketplaces. Exchanges within the remaining 33 states will be run by the federal government.

Different Compliance Standards. Kirk Nahra, an attorney with Wiley Rein, Washington, told BNA that compliance standards may be lighter for some elements of the marketplaces.

''For the new specifics about the exchanges (pricing, premiums, refunds, evaluation of appropriate coverage, etc.), where the details are complicated and new, the government still has to make sure that these programs will work,'' Nahra said.

''I think the government will give those entities a reasonable amount of time to work things out, as long as they seem to be trying to get them right,'' he said.

Nahra said that for anything that is currently covered by general fraud laws, such as billing for treatment, the standards will most likely be applied in exactly the same as they are in other government program.

He said the start-up of the marketplaces could be similar to the early days of the Medicare Part D program, where the government let organizations work through their issues without strict enforcement.

''There is real pressure to make the exchanges work, and being too aggressive on fraud, particularly where there are reasonable compliance efforts in place, will be totally counter-productive,'' Kirk Nahra, an attorney with Wiley Rein, Washington, said.

Ankur Goel, an attorney with McDermott Will & Emery LLP in Washington, also told BNA that the enforcement is not likely to be a priority during the beginning of the marketplaces.

''HHS has said that its early focus will be on compliance assistance and education, as opposed to enforcement,'' Goel said.

''There is a real focus on getting the exchanges up and running and at this time enforcement is a secondary message,'' he said.

However, Goel said states will still play a significant role in monitoring and enforcement related to the exchanges, and insurers will also have to be wary of the Department of Justice and qui tam whistleblower relators.

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OIG Areas of Interest

OIG has several insurance exchange-related reviews in progress, according to the Fiscal Year 2013 Work Plan, including:

- a review of CMS oversight of the insurance exchange establishment grant program, as well as a review of state plans for preventing fraud, waste, and abuse in their marketplaces (a report is expected in FY 2014). States that are developing their own exchange can apply to CMS for an establishment grant to help with exchange development;
- a review of eligibility and enrollment requirements for state marketplaces (a report is expected in FY 2013);
- a review of CMS oversight of the Consumer Operated and Oriented Plan (CO-OP) Loan and Grant Program. The CO-OP program is designed to assist in the creation of qualified non-profit insurers who can offer plans in the marketplaces. OIG will make sure CMS is monitoring the program to ensure that loans are being used appropriately (a report is expected in FY 2013);
- a review of the process CMS uses to select recipients of CO-OP funding. The Affordable Care Act designates $3.4 billion in funding for the CO-OP program (a report is expected in FY 2013);

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—KIRK NAHRA, WILEY REIN

Enforcement Questions Remain. Beyond a potential de-emphasis on enforcement of the marketplaces, it remains to be seen whether the Department of Health and Human Services will announce that exchange-offered quality health plans (QHPs) are federal health care programs, according to Kirk Ogrosky, an attorney with Arnold & Porter LLP and former head of criminal enforcement for the Department of Justice.

''To the extent that QHPs obtain federal funding to subsidize premiums and cost-sharing for certain enrollees, I presume that OIG will categorize the plans in a way to make the anti-kickback statute (AKS) applicable,'' Ogrosky told BNA.

If QHPs are designated as being federal health care programs, Ogrosky said he would look for OIG to focus on issues related to beneficiary inducement, loss-ratio certification, risk adjustment, and pull-through arrangements.

''Declaring QHPs to be federal health care programs will have dramatic repercussions for AKS and qui tam enforcement,'' Ogrosky said.

Policing Pull-Through Arrangements. Pull-through arrangements, Ogrosky said, are similar to allegations contained in a $214 million 2011 settlement between Quest Diagnostic and California (15 HFRA 461, 5/18/11).

In the settlement, California alleged that Quest provided insurers with below-cost pricing in exchange for the insurers directing their in-network physicians to refer testing to Quest.

Subsequent to the settlement, Sens. Max Baucus (D-Mont.) and Chuck Grassley (R-Iowa)—the chairman and former ranking member on the Senate Finance Committee, respectively—sent letters in November 2011 to Cigna, Aetna, and UnitedHealth, LabCorp, and Quest Diagnostic, asking for further information on pull-through arrangements (15 HFRA 898, 11/16/11).

OIG issued advisory opinions in 1999 and 2004 stating that pull-through arrangements are ''particularly suspect.''

Ogrosky said that while insurers have some experience with ''enforcement-style regulation,'' they have not subject to a flood of qui tam cases.

''Given the amount of money flowing through QHPs, relators' counsel will be lining up to bring cases against QHPs,'' Ogrosky said.

He said he anticipated DOJ, OIG, and relators to allege AKS violations against QHPs as the basis for FCA liability.

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Unique Environment. Goel said that the upcoming health insurance marketplaces present a unique environment for health care insurers.

While the marketplaces are designed to let individuals buy health insurance, they also include a significant amount of government funding, he said.

''The entity running the exchange (the state or federal government depending on the state) will have an interest in monitoring the overall conduct of health insurance issuers that sell products on the exchanges, and the federal government will have an interest in monitoring the money it spends,'' he said.

For example, Goel said, the government will have an interest in the accuracy of issuers calculations of the portion of individuals' claims expenses that are eligible to be subsidized by the government, such as cost-sharing subsidies and reinsurance.

''Not all issuers will be participating on the exchanges and there may be some that are unfamiliar with government programs,'' he said.

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As a result, insurers should review their compliance programs and modify them based on issues that are specific to the exchanges, Goel said.

Provider Enforcement. While the main focus of exchange enforcement is likely to be focused on insurers, Goel said the exchange federal funding also has an indirect effect on hospitals and other providers, as in some case a portion of their claims be eventually be paid by the federal government, due to the cost-sharing subsidies and reinsurance program.

''Providers' compliance efforts to accurately bill services will help them avoid any risks from this federal funding,'' Goel said.

Additionally, providers' diagnoses will also affect transfers of money between issuers under the risk adjustment program, Goel said, and as a result providers may see additional medical record requests for purposes of auditing their diagnosis coding.

Unknown Fraud Risks. While insurers and providers can work to improve their compliance programs prior to the start of the exchanges, it's still unknown what OIG will be looking for in terms of enforcement, Jana Kolarik Anderson, an attorney with Nelson Mullins Riley & Scarborough LLP, told BNA.

''Based on discussions that I have had with OIG personnel, they are aware that abuses could occur, so the OIG will be vigilant, but as far as a list of what OIG will be looking for, it does not exist yet,'' Anderson said.

Anderson said that OIG's *Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2012* included a section on the challenges associated with implementing the Affordable Care Act, including the marketplaces (16 HFRA 936, 11/28/12).

According to the OIG report, HHS employees responsible for Affordable Care Act contracts and grants ''should be trained on effective internal controls and best practices for preventing and detecting fraud, waste, and abuse.''

BY JAMES SWANN

The HHS proposed rule on exchange program integrity is at http://www.gpo.gov/fdsys/pkg/FR-2013-06-19/pdf/2013-14540.pdf.

The OIG 2013 Workplan is at http://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf.