JONES DAY

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HEALTH INSURERS OFFERING QUALIFIED HEALTH PLANS NEED TO ANTICIPATE SCRUTINY UNDER THE FALSE CLAIMS ACT

Health insurers that offer qualified health plans on the new state insurance exchanges and receive advance payments of the new federal premium tax credit should prepare to be subject to scrutiny for potential violations of the False Claims Act. The United States federal government will be transferring billions of dollars each year to insurers to help pay premiums and reduce cost-sharing for individuals who qualify for advance payments of future premium tax credits. The Department of Health and Human Services will have responsibility for ensuring integrity, and with a new program of this size, it is not surprising that the Inspector General for the Department of Health and Human Services has already told Congress that his office will be engaged in oversight to protect against fraud and abuse.

The new exchanges may offer only qualified health plans that have been certified. Plans and their sponsoring insurers must meet a long list of qualifications to be certified. The incentive to meet the requirements and receive certification is the potential for attracting significant new business. The exchanges are intended to provide a convenient and widely publicized way for consumers to find and compare individual policies. Moreover, consumers with household incomes between 100 percent and 400 percent of the federal poverty level may be eligible for new premium tax credits that will help pay some or all of their premiums, but only if they enroll in coverage through an exchange. Millions of individuals are expected to qualify for premium tax credits each year starting in 2014. Individuals can have advance payments of their expected future premium tax credit made directly to their insurance company each month to help pay their premiums. Consumers with household incomes between 100 percent and 250 percent of the federal poverty level may be eligible for additional financial assistance with cost-sharing (i.e., deductibles, co-pays, and co-insurance), again only if they enroll in coverage through an exchange. Consumers who are eligible will have a reduction

in the cost-sharing they must pay out of pocket, and their insurers will receive an additional payment each month based on estimates the insurers submit before the coverage year begins.

In order to offer a qualified health plan on an exchange, an insurer must apply to have the plan certified using the process established by that exchange. Applications are due April 30, 2013 for plans seeking certification from the federally operated exchanges. The deadline may be earlier or later than that for state-based exchanges. The insurer must make numerous attestations and submit a compliance plan as part of the application. Any attestations or commitments that insurers make as part of the application process could become a basis for liability under the federal and, where applicable, state False Claims Acts should any of those statements be found inaccurate. Liability may also arise under an implied certification theory, which imposes liability for violations associated with a continuing duty to comply with regulations on which payment is conditioned.

The contents of the compliance plan are generally the same as that required for compliance plans for contractors in the Medicare program:

- Written policies, procedures, and standards of conduct,
- Identification of a compliance officer,
- Compliance committee and high-level oversight,
- Effective training and education,
- Effective lines of communication,
- Well-publicized disciplinary standards,
- An effective system for routine monitoring and identification of compliance risks, and
- Procedures and systems for prompt response to compliance issues.

Once an exchange has certified a plan, it will be offered to the public through the exchange. The exchange will then offer the public the opportunity to apply for (i) coverage under plans offered on the exchange and (ii) financial assistance with premiums and cost-sharing through the exchange.

The development and execution of the compliance plan will need to take account of the way in which data and payments flow among the exchanges, the Centers for Medicare and Medicaid Services ("CMS"), and issuers. Once an individual who is determined eligible for advance payments of the premium tax credit enrolls in a qualified health plan, the individual is notified of the maximum advance payment that can be made to the insurer each month. The individual can elect to take the maximum, something less than the maximum, or no advance payment. If the individual has chosen to take advance payments, that information will be combined with enrollment information and information about applicable cost-sharing reductions at the exchange, and forwarded to CMS on a monthly basis. CMS, in turn, will aggregate enrollment data, advance payment data, and data on cost-sharing reductions; determine the payments due to each insurer for the month; and send payment instructions to the Treasury Department, which will make the advance payments and cost-sharing reduction payments each month directly to the insurer.

Insurers will have to reconcile the payments received every month to account for errors and data discrepancies. They will also have to reconcile periodically for the difference between the advance payments of the cost-sharing subsidies received and the actual costs incurred. Although payments will flow between Treasury and the insurers, reconciliation of data will need to be done with CMS, which will have the data from the exchanges on enrollment, advance payments, and cost-sharing reductions. CMS has issued an enrollment guide with technical specifications for the data flows from federally facilitated exchanges and issuers to CMS, including monthly reconciliation of enrollment data, and CMS has asked the state-based exchanges to use the same guidance when sending enrollment files to CMS or to issuers. As CMS works with issuers on the details of these

file exchanges, more specifics will likely appear about coordination with the payments issuing from Treasury. Timely and accurate payment reconciliation will be important because if an insurer receives payments to which it is not entitled, i.e., overpayments, it must return the overpayment within 60 days or it can be found liable under the federal False Claims Act, pursuant to what is referred to as the reverse false claim theory, for having kept payments to which the insurer is not entitled.

Insurers that offer Medicare Advantage plans or Medicare Part D prescription drug plans will already be familiar with compliance plan requirements and the types of internal procedures that help protect their companies from liability under the False Claims Act. These companies and companies that are new to receipt of federal funds will need to incorporate procedures and recordkeeping into the management of their qualified health plans so they are prepared to respond to the oversight that lies ahead. While the structure and contents of the compliance plans will be familiar, insurers will need to think carefully about how they can effectively monitor compliance given the new data flows in the exchange system, the complexity of eligibility requirements, the need to reconcile payments against enrollment records, and the volume of activity as millions of consumers enter the system.

LAWYER CONTACTS

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