Fraud, Waste & Abuse:

Health Plan Compliance under the False Claims Act

November 12, 2012

Goals/Objectives of COHBE:

- Protect the organization and our customers and business partners against Fraud, Waste & Abuse
- Ensure Exchange funds are properly managed
- Ensure compliance under Section 1313(a)(6) of the Affordable Care Act

Background:

Section 1313(a)(6) of the Affordable Care Act states that carriers acknowledge that payments made by, through, or in connection with the Exchange are subject to the False Claims Act to the extent those payments include Federal Funds. It further states that compliance with this requirement shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

The State False Claims act pertains specifically to Medicaid; should there be a change in that law to expand it to include other types of coverage, COHBE will incorporate contractual language to abide by State regulations.

This sub-section of Fraud, Waste & Abuse was considered by COHBE's Finance Committee in June 2012 and a legal opinion was requested.

Applicable law:

False Claims Act §§ 3729 through 3733 of Title 31, USC

Affordable Care Act § 1313(a) (6)

Legal Opinion:

The following legal opinion is provided by Kelly Ryan, COHBE In-house counsel:

In response to your request on behalf of the Finance Committee for a legal opinion on the application of the False Claims Act to carrier/QHP certification through the Exchange, I have reviewed the proposed contract language that you forwarded as well as the applicable law under the ACA, specifically Section 1313(a)(6). I believe we can largely mitigate any risk to the Exchange on this issue through the inclusion of language in our agreements with carriers as a condition of participation and a requirement for certification of those carriers' QHPs in the Exchange, as proposed below. I think we can and should take additional steps around this issue that may have already been identified, such as False Claims Act training in the carrier/QHP certification process and Exchange customer service center contexts.

Recommendation:

- COHBE includes specific contract language to address this issue with carriers that states compliance is a condition of participation and a requirement for certification of those carrier's QHPs in the Exchange.
    - Carrier, its providers and subcontractors, are subject to the False Claims Act, §§ 3729 through 3733 of Title 31, United States Code. As provided in Section 1313(a)(6) of the Affordable Care Act, Carrier specifically acknowledges that payments made by, through, or in connection with the Exchange are subject to the False Claims Act to the extent those payments include Federal funds. Compliance with the requirements of the Affordable Care Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.
- COHBE includes specific contract language to ensure that carriers have written policies and processes for their internal training and management of activities that relate to the False Claims Act.
    - Carrier shall establish written policies for employees, within 30 days of the effective date of this contract, requiring all employees to be informed of and detailing compliance with: 1) The False Claims Act, 31 USC §§ 3729, et seq.; 2) Administrative remedies for false claims and statements; and 3) Whistleblower protections under such laws.
    - Carrier shall establish a process for training existing and new employees on the compliance program and on the items in 1) through 3), above. All training shall be conducted in such a manner that it can be verified by the Exchange.
- Compliance testing and measuring is performed at least annually.