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## Health Benefit Exchanges: False Claims Gold Mines?



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### Overview

The Affordable Care Act enables the establishment of Health Benefit Exchanges of several types, including (i) State-based, (ii) State-Federal partnerships and (iii) Federally Facilitated Exchanges.<sup>1</sup> The purpose of the Exchanges is to, among other things, “provide competitive marketplaces for individuals and small employers to directly compare available private health insurance on the basis of price, quality and other factors.”<sup>2</sup>

In theory, the information provided by the exchanges will “give small businesses the same purchasing clout

as larger businesses.”<sup>3</sup> Those goals are laudable and hard to quarrel with—anyone who has tried to buy individual health insurance knows that the available information on comparability of insurance plans is at best insufficient and at worst opaque.

The ACA and its implementing regulations attempt to remedy this insufficiency by requiring health insurers who are “issuers” of health plans seeking to participate on an Exchange to, first, be certified by the Exchange after demonstrating that each of the plans it offers as a Qualified Health Plan (“QHP”) meets certain minimum requirements, including compliance with benefits standards, design standards, ability to implement and report on a quality improvement strategy and to implement appropriate enrollee satisfaction surveys.<sup>4</sup>

So, health insurers wishing to obtain and maintain certification of their plan offerings as eligible for participation on an Exchange must provide very substantial amounts of information to the Exchange. Among the required categories of information, two provide excellent illustrations of the demands the law and regulation place on issuers:

- First, “to make available to the public, accurate and timely information” that enables “transparency in coverage”;
- Second, to provide to the Exchange and HHS voluminous amounts of complex data relating to reinsurance and risk adjustment with the goal of providing “certainty” and protecting “against adverse selection in the market while stabilizing premiums in the individual and small group markets as market reforms and Exchanges begin in 2014.”<sup>5</sup>

<sup>1</sup> Health Affairs, Health Policy Brief, *Federally Facilitated Exchanges*, (Jan. 31, 2013) at 1, available at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=84](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=84).

<sup>2</sup> Final Rule and Interim Final Rule: *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers*, 77 Fed. Reg. 18310 (March 27, 2012). (hereafter citation to *Federal Register* number and pages only.) This final and interim final regulation is addressed in part to the standards applicable to state establishment of an Exchange. However, those provisions referring to the functions of Exchanges are plainly applicable to all types of Exchanges. All provisions discussed in this paper are generally applicable to all types of Exchanges.

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<sup>3</sup> *Id.*

<sup>4</sup> 45 C.F.R. § 156.200(a)-(e).

<sup>5</sup> CMS; *Reinsurance, Risk Corridors and Risk Adjustment Final Rule*, 77 Fed. Reg. 17220 (March 23, 2012) available at

The insurance industry understandably sees the above requirements as part of the cost of continuing to stay in business, which is to say that most insurers likely view the Exchanges as presenting an opportunity that a rational business person would be reluctant to forego. As one senior industry executive succinctly put it:

This is a growth opportunity. It's also, if not well attended, a significant opportunity to take a loss. So, we will be there."<sup>6</sup>

The above observation is, like the goal of transparency and empowerment of individuals and small businesses in their dealings with the health insurance market, hard to quarrel with. Insurers would obviously incur a huge opportunity cost by refusing to participate in the ACA-created Exchange program. But Congress has assured that this opportunity is accompanied by significant risk.

Thus, the above requirements must be read in light of ACA § 1313(a)(6), codified at 42 U.S.C. § 18033(a)(6), which provides for significant State and Federal oversight and explicitly applies the Federal False Claims Act to “[p]ayments made by, through, or in connection with an Exchange . . . if those payments include any Federal funds.” (emphasis added.)

In this regard, it is clear that federal funds are to be a permanent element of the flow of funds through Exchanges because ACA § 1401, codified at 26 U.S.C. § 36, establishes a premium subsidy in the form of an advanceable, refundable tax credit for taxpayers “. . . whose household income for the taxable year exceeds 100 Percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.”<sup>7</sup> The amount of the subsidy will be determined based on a statutory formula whose elements include household income and the type of plan selected.

This article briefly discusses the risks to health insurers arising from the coupling of (i) requirements for issuers of QHPs to provide significant quantities of complex information to Exchanges whose accuracy and completeness the issuers will be required to certify, with (ii) the application of the Federal False Claims Act to payments that include any amount of Federal funds “made by, through, or in connection with an Exchange.”

## Transparency Information Required of Issuers

The transparency information that Exchanges must require from issuers is as follows:

- (1) Claims payment policies and practices;
- (2) Periodic financial disclosures;
- (3) Data on enrollment;
- (4) Data on disenrollment;
- (5) Data on the number of claims that are denied;

<http://cciio.cms.gov/resources/files/3rs-final-rule.pdf>. (hereafter citation to *Federal Register* number and pages only)

<sup>6</sup> Japsen, “Health Insurers Will Be Ready for Obamacare Exchanges, Blue Cross CEO Says,” *Forbes* (12/17/12); available at <http://www.forbes.com/sites/brucejapsen/2012/12/17/health-insurers-will-be-read-for-obamacare-blue-cross-ceo-says>

<sup>7</sup> 26 U.S.C. § 36B(c)(1)(A) (2013)

(6) Data on rating practices;

(7) Information on cost-sharing and payments with respect to any out-of-network coverage; and

(8) Information on enrollee rights under title I of the Affordable Care Act.<sup>8</sup>

The issuer is to submit the above transparency information at the plan or QHP—not the issuer—level to the Exchange and HHS “in an accurate and timely manner . . . and make the information . . . available to the public.”<sup>9</sup> However, HHS has yet to prescribe specific formats, definitions or frequency of reporting.<sup>10</sup>

## Reinsurance and Risk Adjustment Information Required of Issuers

Congress was and remains concerned about the risk of market destabilization arising from implementation of the ACA, particularly as to the individual and small group markets when the Exchanges and other market reforms begin in 2014.<sup>11</sup> To address this concern and enable stabilization of premiums for coverage in those markets, the ACA establishes three separate but related programs:

1. Reinsurance
2. Risk Corridors
3. Risk Adjustment

“These risk-spreading mechanisms, which will be implemented by HHS through the States, are designed to . . . provide stability for health insurance issuers in the individual and small group markets.”<sup>12</sup>

The first two of these programs are in effect for three years starting Jan. 1, 2014. The third is permanent.<sup>13</sup>

Each of these programs is complex and, taken together, will require issuers of QHPs to provide voluminous amounts of data to the Exchanges and HHS. As with the requirement for submission of transparency information, the Risk Corridor and Risk Adjustment programs require that relevant data be provided on an individual QHP—not health insurance issuer—basis.

This approach places a burden on issuers because they have previously maintained this type of data only at the issuer level rather than at the much more “granular” plan level.<sup>14</sup> Moreover, “[d]eveloping a risk adjustment program is methodologically and operationally

<sup>8</sup> 42 U.S.C. § 18031(e)(3); 45 C.F.R. §§ 155.1040, 156.220(a). (2013)

<sup>9</sup> 45 C.F.R. § 156.220(b).

<sup>10</sup> This delay is due to requirements to coordinate with other agencies. Thus, (i) the ACA amends the Public Health Service Act to require insurers offering group or individual health plan coverage in the regular commercial market to provide transparency information to enrollees similar to that identified above in connection with Exchanges requiring, in turn, (ii) that the commercial market transparency standards be appropriately aligned with the Exchange transparency standards, which means that (iii) HHS must coordinate with the Departments of Labor and the Treasury regarding guidance on the standards overall. “As a result, we are not describing data formats, definitions, or frequency of reporting . . . in this final rule. 77 Fed. Reg. 18417 (March 27, 2012).

<sup>11</sup> 77 Fed. Reg. 17220 (March 23, 2012).

<sup>12</sup> *Id.*

<sup>13</sup> See, e.g., chart at 77 Fed. Reg. 17220, 17221 (March 23, 2012).

<sup>14</sup> 77 Fed. Reg. 17220, 17238 (March 23, 2012).

complex”<sup>15</sup> and much of the data provided will be generated in the first instance by providers, which places the issuer in the position of, among other things, monitoring the quality of data generated by large numbers of providers.

If the information is to be useful, it must reflect with at least reasonable accuracy the true price of the benefits offered and some reasonable assurance to the issuers of the benefits that they are protected against inaccurate rate setting caused by, among other things, adverse selection, which “results when a health insurance purchaser understands his or her own potential health risk better than the issuer does, resulting in the health plan having higher costs than anticipated.”<sup>16</sup>

### **ACA § 1313(a)1)-(a)(6)<sup>17</sup> ; Exchange Functions Include Oversight of Issuers of QHPs**

The ACA tasks Exchanges with a wide array of functions, including fulfillment of “five core functions: eligibility, enrollment, plan management, consumer assistance and financial management.”<sup>18</sup>

However, within each of these broad core functions Exchanges are responsible for numerous specific tasks, including, certification of issuers of QHPs, notices, oversight of involvement of agents and brokers, premium payments and privacy and security.<sup>19</sup> Moreover, Exchanges “. . . must perform required functions related to oversight and financial integrity in accordance with Section 1313 of the Affordable Care Act.”<sup>20</sup>

All of the above requirements are intended to “represent a floor that can be exceeded by the Exchange.”<sup>21</sup> That said, the regulation’s reference to Section 1313 does not provide clear guidance to the Exchanges as to their oversight and financial integrity functions because the language of the section is for the most part addressed to the secretary of health and human services, not the Exchanges.

Thus, for example, the “Secretary may take [appropriate steps] to oversee Exchanges and ensure their financial integrity, including conducting investigations and partially suspending Federal financial support from a State in which the exchange has engaged in serious misconduct.”

The only explicit references in Section 1313 to the duties of the Exchange are (i) to “keep an accurate accounting of all activities, receipts and expenditures . . .” and to report the results annually to the Secretary and (ii) to cooperate with the Secretary regarding investigations and audits.<sup>22</sup> Recognizing that the regulation’s simple reference to Section 1313 may provide insufficient guidance, HHS is “currently exploring mechanisms for performance measures and oversight tools available under section 1313 of the Affordable Care Act.”<sup>23</sup>

Despite the absence of explicit direction from HHS as to the specifics of Exchange responsibility for oversight, it is clear that the Exchanges are to oversee issuers and QHPs and, in turn, HHS is to oversee the Exchanges.

### **ACA § 1313(a)(6); Application of the False Claims Act to Payments Made With Federal Funds “by, through or in connection with an Exchange”**

The FCA creates civil liability for any person who “knowingly presents, or causes to be presented” to the government “a false or fraudulent claim for payment or approval,” requiring only that the false or fraudulent claim be presented by a person with actual knowledge of the information submitted and who has acted in deliberate ignorance, or with reckless disregard as to the truth of that information.<sup>24</sup>

An FCA action may be brought directly by the Department of Justice or by a relator in a *qui tam* action in which the government may intervene. Liability for violation includes treble damages and civil penalties ranging from \$5,500 to \$11,000 per false claim.<sup>25</sup>

Subparagraph (a)(6) of ACA Section 1313, entitled “Application of the False Claims Act,” is part of a statutory scheme that ensures that, in the end, issuers of QHPs and health care providers will bear the brunt of any allegations that inaccurate or incomplete data was submitted intentionally or in reckless disregard or willful ignorance of its inaccuracy or incompleteness.

The plain language of the subparagraph renders this conclusion inescapable:

#### **(6) Application of the False Claims Act**

(A) In general. Payments made by, through, or in connection with an Exchange are subject to the False Claims Act if those payments include any Federal funds.<sup>26</sup> Compliance with the requirements of this 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.

Health insurer issuers of QHPs and their providers obviously receive “payments made by, through, or in connection with an Exchange and, as noted above, due to the subsidy for low income taxpayers, some significant portion of those payments will include federal funds.

In short, the language of 42 U.S.C. § 18033(a)(6) on its face assures that issuers and providers—not the Exchanges—will be the targets of actions under the False Claims Act, whether brought directly by the Government or by a relator.

### **HHS Looks to FCA as an Enforcement Mechanism**

That the drafters of the ACA intended the FCA to be an integral part of enforcement of the rules governing Exchanges is clear from the plain language of ACA § 1313(a)(6). HHS has recognized that point.

<sup>15</sup> 77 Fed. Reg. 17220, 17230 (March 23, 2012).

<sup>16</sup> 77 Fed. Reg. 17220, 17221 (March 23, 2012).

<sup>17</sup> ACA § 1313 is codified at 42 U.S.C. § 18033

<sup>18</sup> Health Affairs, Health Policy Brief (Jan. 31, 2013) at 2 available at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=84](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=84)

<sup>19</sup> See, e.g., 77 Fed. Reg. 18310, 18323 (March 27, 2012).

<sup>20</sup> 45 C.F.R. § 155.200 (c).

<sup>21</sup> 77 Fed. Reg. 18310, 18324 (March 27, 2012).

<sup>22</sup> See: 42 U.S.C. 18033(a)(1)-(a)(5).

<sup>23</sup> 77 Fed. Reg. 18310, 18324 (March 27, 2012).

<sup>24</sup> 31 U.S.C. § 3729(a) (1) and (b).

<sup>25</sup> 31 U.S.C. § 3729 (a). See, e.g., *United States of America, ex. Rel: Karen J. Hobbs v Medquest Associates Inc.*, No. 11-6520 (Sixth Circuit, April 1, 2013).

<sup>26</sup> 31 U.S.C. 3729 et. seq.

Even a moderately close reading of the regulations and accompanying HHS commentary makes clear that the government has its eye out for the FCA as a useful tool for encouragement of compliance and, for that matter, pouring funds into depleted government coffers.

For example, HHS has stated with regard to its process for validating risk adjustments:

We believe that the data validation conducted during the first two years of the program will serve an important educational purpose for insurers. *Although we are proposing not to adjust payments and charges as a correction based on error estimates discovered, we note that other remedies, such as prosecution under the False Claims Act, may be applicable to issuers not in compliance with the risk adjustment program requirements.* (Emphasis added.)<sup>27</sup>

Read literally, the above HHS comment seems to be saying that payments won't be adjusted based on issuer error estimates during the first two years of the risk adjustment program but the government or a relator might decide to pursue the issuer anyway under the False Claims Act.

In any event, any doubt as to HHS's view of the importance of the False Claims Act to the Exchange program, is laid to rest by the regulations issued relating to reinsurance, risk adjustment and risk corridors, which provide that "*the States [will] be required to maintain all records related to the reinsurance program for 10 years consistent with requirements for record retention under the False Claims Act.*" (emphasis added.)<sup>28</sup> Similarly, records related to risk adjustment must be retained for ten years.<sup>29</sup>

### **ACA Amendments to FCA Strengthen Relators' Hand by Restricting Two Jurisdictional Defenses to FCA Qui Tam Actions**

The application of the FCA to Exchanges, together with the ACA's restriction of two jurisdictional limits on qui tam suit, suggests that Exchanges may turn out to be gold mines for qui tam relators and the qui tam bar who wish to bring False Claims actions against issuers, providers or both, as discussed below.

### **'Public Disclosure' and 'Original Source' Jurisdictional Limitations on Qui Tam Suits**

The False Claims Act of 1986 contained two related limitations on *qui tam* jurisdiction:

No court shall have jurisdiction over an action under this section based upon public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional administrative, or Government [General] Accounting Office report, hearing, audit or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.<sup>30</sup>

An original source was defined either as someone who had reported the allegation to the government prior to its public disclosure or could demonstrate that

<sup>27</sup> 77 Fed. Reg. 73,117, 73,149 (Dec. 7, 2012)

<sup>28</sup> 77 Fed. Reg. 172229 (March 23, 2012). (emphasis added.)

<sup>29</sup> 45 C.F.R. 153.620(b).

<sup>30</sup> 31 U.S.C. § 3730(e)(4)(A) (2006)

he or she had knowledge of the facts underlying the allegation independent of the public disclosure.<sup>31</sup>

The judiciary generally read the above public disclosure language expansively, to include state and local proceedings, except for one circuit, which excluded state and local administrative reports, audits and investigations.<sup>32</sup>

The U.S. Supreme Court addressed the split between the Circuits in 2010, when it held that the FCA's reference to administrative reports, hearings, audits and investigations included state and local along with federal public disclosures.<sup>33</sup>

Thus, under the 1986 version of the FCA, the public disclosure and related original source provisions served to "limit the availability of qui tam lawsuits."<sup>34</sup>

### **Restriction of the Public Disclosure Limitation; State and Local Proceedings No Longer Vehicles for Public Disclosure**

The first of these amendments restricts the public disclosure defense to the FCA by, first, confining "public disclosure" to (i) disclosures made in Federal civil and administrative proceedings when the government was a party, (ii) a Congressional \GAO\ report or other federal report or (iii) the media.

Even when those restricted criteria are met, the FCA as amended instructs Courts to dismiss a case on public disclosure grounds *unless the Department of Justice objects*. That latter provision effectively empowers the Department to interpose a dispositive objection when the public disclosure question is raised.<sup>35</sup>

Most importantly, however, the new language means that disclosures made in connection with private Federal lawsuits, state and local administrative and judicial proceedings, administrative reports, hearings, audits and investigations are not "public disclosures" for the purposes of the FCA.

### **Elimination of 'Direct Knowledge' Requirement From Original Source Defense**

The second of these changes severely limits the value of the "original source" defense by eliminating the requirement that the relator have "independent knowledge" of the alleged false claim itself, requiring only that the relator have "independent knowledge that "materially adds" to the false claim despite its prior public disclosure.<sup>36</sup>

To the extent an Exchange is facilitated or run by the Federal government this change in the original source rule would likely be important.<sup>37</sup>

<sup>31</sup> 31 U.S.C. § 3730(e)(4)(B) (2006)

<sup>32</sup> Cohen, "Kaboom! The Explosion of Qui Tam False Claims Under the Health Reform Law," *Penn State Law Review*, Vol. 116 (2011).at 90-91. This article is a highly readable, informative and detailed analysis of the effects of the ACA amendments on FCA litigation.

<sup>33</sup> *Graham County Soil and Water Conservation Dist. V. United States ex. Rel. Wilson*, 130 S. Ct. 1396 (2010).

<sup>34</sup> Cohen, *Kaboom! The Explosion of Qui Tam False Claims Under the Health Reform Law*, *Penn State Law Review*, Volume 116 (2011), at 96

<sup>35</sup> 31 U.S.C. 3730(3)(4)(A).

<sup>36</sup> 31 U.S.C. § 3730(e)(4)(B)

<sup>37</sup> The question of whether a Federally Facilitated Exchange is an arm of the Federal Government so that publica-

However, if the Exchange is state-based, then the documentation containing the information which could be the basis for an allegation of a false claim would be of state origin and not subject to the limitations of the public disclosure rule in the first place, rendering the original source rule irrelevant.

In any event, the ACA's limitation of two important defenses is on its face a boon to the qui tam relator bar and seems likely to lead, first, to a very substantial increase in the number of qui tam actions filed in general and, second, to a burst of qui tam actions filed in connection with payments made through Exchanges.<sup>38</sup>

### **ACA Elimination of the Defense Against FCA Claims Alleging False Certification as Applied to Exchanges**

A third defense also has been eliminated, at least in the context of false claims allegations made in the context of "payments made by, through, or in connection with an Exchange." This third defense relates to allegations of false claims liability under a "false certification theory," which the Sixth Circuit recently and succinctly described in the context of payment of health benefit claims, specifically Medicare claims, as follows:

... a claim may be false under a "false certification" theory, as "when the claimant knowingly falsely certifies that it has complied with a statute or regulation the compliance with which is a condition for Government payment." (citation omitted.) The success of a false certification claim depends on whether it is based on "conditions of participation in the Medicare program (which do not support a FCA claim) or on "conditions of payment" from Medicare funds (which do support FCA claims) ... (citations omitted)<sup>39</sup>

Congress obviously anticipated the possibility that a health insurance issuer, accused of making a false claim because it falsely certified compliance with the conditions of participation in an Exchange might assert the affirmative defense that the certification in question goes only to participation in the Exchange program but does not constitute a condition of payment from federal funds.

The second sentence of subparagraph (a)(6) obliterates the participation/payment distinction by providing that, as to "payments made by or through and exchange", the conditions for "eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments."<sup>40</sup>

### **'Educated Health Care Consumers' as an Elite Class of Qui Tam Relators**

One might think that Congress had done enough to encourage False Claims actions in connection with Ex-

changes simply by amending the FCA as noted above. It appears Congress may have gone a step further by creating an elite class of potential qui tam relators positioned to focus on Exchanges. The ACA defines "educated health care consumers" as "... individual[s] who ... [are] knowledgeable about the health care system, and ... [have] background or experience in making informed decisions regarding health, medical and scientific matters."<sup>41</sup>

Whether meaningful numbers of such highly informed consumers actually exist is highly doubtful. If you disagree, try identifying the number of people you know personally who are (i) knowledgeable about the health care system and (ii) have actual experience in making informed decisions in the highly technical areas identified.

In any event, to the extent such consumers do not exist within the literal terms of the statute, HHS must act as though they do because the ACA says they exist and mandates and that, if they are enrollees in qualified health plans, then they are "stakeholders" with whom the Exchange must "regularly consult" on matters "relevant to carrying out the activities" of the Exchange.<sup>42</sup>

HHS has deftly sidestepped the question of the actual existence of this type of consumer by opining that "[a]n Exchange can interpret and apply the term in the way that is most appropriate for its environment consistent with this definition," thereby delegating to the Exchanges the identification—and where necessary the invention—of these unusual creatures.<sup>43</sup>

Leaving aside the definitional issues, when Congress created the concept of "educated health care consumer[s]" who, because they *must* be consulted by the Exchanges *vis-a-vis* the transparency and risk adjustment information submitted by insurers will, if their consultation is to be meaningful, be required or at least encouraged to critically review that information and, importantly, be in a position either to identify a false claim *ab initio* or, possibly, have independent knowledge of information that "materially adds" to information already publicly disclosed.

Such consumer-consultants will, in other words, have both motive and opportunity to review Exchange information with an eye to possible falsity.

It follows that, when Congress created the myth of the "educated health care consumer," it may simultaneously have created a class of potential whistleblowers who, because of their unique position *vis-a-vis* Exchange information, including both transparency information and risk adjustment data, might turn out to constitute an elite class of relators. The possible existence of this elite class of potential relators will not be missed by the *qui tam* bar.

### **Effect of Application of False Claims Act on Issuers**

Although, as noted above, the language of ACA § 1313 appears to be directed primarily at the Exchanges, its actual effect is to place the issuers of QHPs and healthcare providers directly in the line of FCA fire, whether the initial shooter is DOJ or a relator.

tion of, say, its audit reports would constitute "public disclosure" is one that undoubtedly will be litigated.

<sup>38</sup> See, e.g. Cohen, "Kaboom! The Explosion of Qui Tam False Claims Under the Health Reform Law," *Penn State Law Review*, Vol. 116 (2011).

<sup>39</sup> *United States v. MedQuest, et. al.* No 11-6520 (Sixth Circuit, April 1, 2013).

<sup>40</sup> 42 U.S.C. § 18033(a)(6)(2013). Note that this provision is apparently limited to the context of Exchanges and, unlike the two defenses restricted by the ACA, the text eliminating the participation/payment distinction appears only in Title 42 and is not explicitly incorporated into the text of the False Claims Act itself.

<sup>41</sup> 42 U.S.C. § 18003(a)(6); 42 U.S.C. § 18031(a)(6); 45 C.F.R. § 155.20.

<sup>42</sup> 42 U.S.C. § 18031(d)(6)(A); 42 C.F.R. §§ 155.20, 155.30.

<sup>43</sup> 77 FR 18310, 18320 (March 27, 2012).

Thus, the ACA provides that the FCA applies to any payments made “by, through, or in connection with an Exchange.” For example, suppose an Exchange is audited or investigated by DHHS under the extensive authority granted it under ACA § 1313(a)(1)-(5).

Suppose further that the audit or investigation reveals that some of the transparency or risk adjustment data generated and provided by the Exchange is erroneous and, in the judgment of the auditor or investigator, is clearly erroneous, which suggests that the issuer provided the data either in reckless disregard or willful ignorance of its accuracy and completeness.

The Exchange, which presumably has required the issuer to certify as to the completeness, accuracy and currency of the data, is of course not going to take the blame and will turn to the issuer of the QHP for an explanation. The issuer will, if possible, look to see if there is a way to blame the provider or providers who generated the data in the first place.

Meanwhile, the Exchange has, in an excess of caution, referred the matter to the HHS Office of Inspector General, who, in turn, has referred the matter to the Department of Justice with a request to consider filing a Complaint under the FCA.

Or take another, and perhaps equally likely scenario, which is an action brought by a qui tam relator. Suppose, for example, that the Exchange is state-based and a state auditor or an outside auditor engaged by the Exchange generates a report containing information along the lines discussed, above. The report is made public. At this point anyone with access to the report could use it as the basis for a qui tam suit against the issuer.

The potential litigation scenarios under the FCA as amended are myriad; any attempt to enumerate them further would be beyond the scope of this brief article. That said, given the number of potential relators that will exist once the exchanges are established, including but not limited to the elite “educated health care consumers,” the ACA’s restrictions of the jurisdictional public disclosure and original source rules, and the elimination of a key defense to false claims allegations based on false certifications, the likelihood of qui tam actions against issuers of QHPs on Exchanges would seem to be very high.<sup>44</sup>

It follows that health insurers who aim to participate in the Exchange program should take special steps to assure the accuracy, currency and completeness of the

information they provide, including the establishment of compliance programs and internal control systems so as to establish establishing a first line of defense against allegations of deliberate ignorance or willful disregard.

### Summary: False Claims Risk to Health Insurance Issuers and Providers

Health insurance issuers and providers need to know:

- The ACA aims for transparency of QHP information and a stable individual and small group market during the early years of health care reform.
- To these ends, the statute requires issuers of QHPs to provide the public timely and accurate transparency information to at the plan level and, as well, to provide the Exchange and HHS extremely complex data relating to reinsurance, risk adjustment and risk corridors.
- The possibility of issuer error in either of these categories of information is significant, albeit that possibility may be greater with regard to the information relating to reinsurance and risk adjustment.
- The False Claims Act applies to payments made by, through, or in connection with Exchanges that include any Federal funds and, therefore, to issuers of QHPs and to providers.
- That Federal funds will be included in a substantial portion of payments is assured by the premium subsidy.
- Congress has amended the False Claims Act to severely limit the “public disclosure” and “original source” defenses and, as to payments made in connection with Exchanges, to eliminate the defense against “false certification” based on the distinction between “conditions of participation” and “conditions of payment.”
- HHS has made clear its awareness of the False Claims Act as an enforcement mechanism while the above amendments render development and assertion of False Claims allegations in the context of Exchanges a much less complex undertaking.
- Congress has created an elite class of relators who will have opportunity and motive to bring False Claims actions against issuers and providers.
- In light of the above, health insurer participation in the Exchange program is high-risk and should be undertaken with the greatest care, including institution of effective compliance and internal control programs which provide “reasonable assurance” of accuracy, thereby establishing a first line of defense against allegations of deliberate ignorance or willful disregard.

<sup>44</sup> As one qui tam Plaintiff’s lawyer has stated the matter:

It is safe to predict that the Exchanges will be fertile ground for fraud given the wideranging functions and responsibilities of the Exchanges; the number of individuals they will be serving . . . the sheer magnitude of the federal money in play . . . and the government’s constant lack of adequate enforcement resources . . .

Suzanne E. Durrell; *New Frontiers in False Claims Act Litigation; Liability for Fraud Related to “Health Benefit Exchanges” Under the Patient Protection and Affordable Care Act of 2010*, Whistleblower Law Collaborative, Thomas & Associates and Durrell Law Office, available at: <http://www.thomasandassoc.net/Articles/New-Frontiers-in-False-Claims-Act-Litigation.shtml>.