Update: Will Exchanges Treble Your Already Treble Damages?

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After reading the Affordable Care Act (ACA) provision aimed at maintaining financial integrity of the health insurance exchanges, one may conclude that the ACA dramatically increased the damages to be imposed for false claims made in connection with the exchanges.[1] This article takes a closer look at the three anti-fraud elements contained in that provision to determine what was actually accomplished.

First, Congress ensured that the government could use the False Claims Act (FCA)[2] to protect the financial integrity of the exchanges by declaring that "[p]ayments made by, through, or in connection with an Exchange are subject to the False Claims Act if those payments include any Federal funds."[3] By doing so, Congress engaged its primary civil anti-fraud tool so that government investigators or private individuals, known as qui tam relators,[4] can file suit on behalf of the government in the hopes of recovering three times the amount of damages sustained by the government as well as a penalty of between $5,500 and $11,000 for each false claim submitted.[5] Through this anti-fraud provision, Congress explicitly makes an individual or a small business liable under the FCA for a false statement made on an application for insurance coverage to gain tax credits. Similarly, an insurance company will be subject to the FCA if the company fraudulently misrepresents its eligibility for participation in an exchange.

Second, Congress reduced the burden for the government or a relator to prove a false claim by eliminating the need to prove a particular false statement would have affected the eligibility determination. Through legislative fiat, the conditions of eligibility for an insurer are now material to the company's entitlement to payments.[6] Because no qualifying language was included in this subsection, Congress appears to mean that *any* fraudulent statement regarding the numerous conditions,[7] no matter how small, is material. This provision provides an incentive for an insurance company to scrutinize its application to remove even small bits of information that the insurance company knows, or should know, are false.

At first blush, it appears that Congress created a third anti-fraud measure containing more deterrence than simply extending the FCA's reach to exchanges. The provision initially increased "*by not less than 3 times and not more than 6 times the amount of damages*" already applicable under the FCA (located at Section 1313(a)(6)(B) of Public Law 111-148).[8] This amounts to treble-treble damages (three times for FCA plus six times for ACA equals nine times). Imposing nine times the damages for a false claim made "in connection with" a health insurance exchange is an astonishing penalty. Lured by the possibility of a nine-times damages award, the government and relators may begin to look beyond individuals and insurance companies to find other fraud made in connection with the exchanges. For instance, would a physician group that upcodes claims submitted to an insurance company selected through the exchange be considered to have made false statements "in connection with an Exchange"? Would the resulting imposition of treble-treble damages be permissible?

Although the remainder of this article describes how courts may have interpreted this provision, an interesting legislative maneuver rendered the language of no effect. Rather than simply striking the language, the legislation contains a subsequent provision several hundred pages later, in Section 10104(j)(1), declaring the treble-treble damages provision "null, void, and of no effect."[9] Thereby, treble-treble damages were eliminated from the same legislation in which they were created.

Would the imposition of treble-treble damages in connection with exchanges have survived judicial scrutiny? Although the phrase "in connection with" has rarely been interpreted, courts could have looked to the scope afforded the phrase in criminal health care fraud statutes.[10] For example, the Third Circuit found a sufficient connection with the delivery of health care services when a defendant directed another employee of a rehabilitation center to misrepresent to the police the location where a patient was seen before she died.[11] Rejecting the defendant's argument that the false statements pertaining to a police investigation of abuse were unrelated to health care, the court held that the false statements concerned services provided to the patient on the night of her death.[12] One district judge declined to dismiss an indictment charging the chief financial officer of a nonprofit health care corporation with making false statements about the costs of a construction project.[13] The court rejected the defendant's argument that the statute required a direct connection to specific health care services and that other cases had not involved such a broad application of the statute. In so holding, the court opined that such cases "shed more light on how prosecutors have chosen to exercise their discretion, however, than on the outer bounds of the statute."[14]

In addition, it is possible that nine times damages could have been permissible. On one hand, the U.S. Supreme Court has said, "in upholding a punitive damages award, we concluded that an award of more than four times the amount of compensatory damages might be close to the line of constitutional impropriety."[15] On the other hand, the Court has specifically rejected a bright-line rule.[16] Instead, the Court scrutinizes an award using factors that include: (1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm

suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases.[17] In addition, the Court would afford Congress deference in deciding to impose nine times damages because "[a] higher ratio may also be justified in cases in which the injury is hard to detect or the monetary value of noneconomic harm might have been difficult to determine."[18] This rationale certainly applies to the financial stakes applicable in the expansion of health care due to the exchanges.

When creating exchanges, Congress enacted measures to deal with the inevitable potential for fraud that could occur in connection with the exchanges. Two of those measures made it into law: (1) the FCA is explicitly applicable to the exchanges; and (2) the conditions of eligibility for an insurer are material to the company's entitlement to payments. The effort to impose treble-treble damages failed to make it into law, even though it was included in the legislation that passed.

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1 *See* 42 U.S.C. § 18033(a)(6)(A-B).

2 *See* 31 U.S.C. § 3729 *et seq*.

3 42 U.S.C. § 18033(a)(6)(A). There are private exchanges that the FCA will not cover.

4 Relators are motivated to file suits because, if a suit is successful, the relator receives between 15-30% of the proceeds or settlement.

5 Although 31 U.S.C. § 3729(a) contains a statutory penalty of $5,000–$10,000 per violation, an inflation index increased the penalty effective September 29, 1999. 28 C.F.R. § 85.3(a)(9).

6 42 U.S.C. § 18033(a)(6)(A) ("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.").

7 45 C.F.R. § 156.200 *et seq*. establishes the eligibility requirements: § 156.200 Qualified Health Plan (QHP) issuer participation standards; § 156.210 QHP rate and benefit information; § 156.215 Advance payments of the premium tax credit and cost-sharing reduction standards; § 156.220 Transparency in coverage; § 156.225 Marketing and Benefit Design of QHPs; § 156.230 Network adequacy standards; § 156.235 Essential community providers; § 156.245 Treatment of direct primary care medical homes; § 156.250 Health plan applications and notices; § 156.255 Rating variations; § 156.260 Enrollment periods for qualified individuals; § 156.265 Enrollment process for qualified individuals; § 156.270 Termination of coverage for qualified individuals; § 156.275 Accreditation of QHP issuers; § 156.280 Segregation of funds for abortion services; § 156.285 Additional standards specific to Small Business Health Options Program; § 156.290 Non-renewal and decertification of QHPs; § 156.295 Prescription drug distribution and cost reporting; and § 156.298 Meaningful difference standard for QHPs in the federally-facilitated Exchanges.

8 PL 111-148 § 1313(a)(6)(B) codified at 42 U.S.C. §18033(a)(6)(B) ("[T]he civil penalty assessed under the False Claims Act on any person found liable . . . shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.").

9 March 23, 2010, P.L. 111-148, Title X, Subtitle A, § 10104(j)(1), 124 Stat. 901, provides: "Subparagraph (B) of section 1313(a)(6) of this Act [42 U.S.C. § 18033] is hereby deemed null, void, and of no effect.".

10 18 U.S.C. § 1035 (Prohibiting false statements); 18 U.S.C. § 1347 (Prohibiting a scheme or artifice to defraud or obtain by means of false or fraudulent pretenses "in connection with the delivery of or payment for health care benefits, items, or services").

11 *United States v. Bell*, 282 F. App'x 184, 188 (3d Cir. 2008).

12 *Id*.

13 *United States v. Cox*, 2006 U.S. Dist. LEXIS 17181 at 18-19 (D. Vt. Mar. 28, 2006).

14 *Id*. at 19.

15 *State Farm Mut. Auto Ins. Co. v. Campbell*, 538 U.S. 408, 425 (*citing Pac. Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 23-24 (1991)).

16 *State Farm*, 538 U.S. at 425.

17 *Id*. at 418 (*citing BMW of N. Am., Inc. v. Gore*, 517 U.S. 559, 575 - 576 (1996)).

18 *Id*. at 582.