

Title V – Preventing Fraud and Abuse

Subtitle A- Establishment of New Health and Human Services and Department of Justice Health Care Fraud Positions

Sec. 501. Health and Human Services Senior Advisor

Current Law

There are multiple federal and state agencies that share responsibility for preventing health care fraud, waste, and abuse. These include the Department of Health and Human Services (HHS) Office of the Inspector General (OIG), the Department of Justice (DOJ), the Federal Bureau of Investigations (FBI), and state and local law enforcement agencies. The OIG is an independent unit within HHS that has the primary responsibility for detecting health care fraud and abuse in all federal health care programs. Most of its work, however, relates to the Medicare and Medicaid programs. The FBI is the lead investigative agency in the fight against health care fraud. Unlike the OIG, which has the authority to investigate fraud impacting federal health care programs only, the FBI has jurisdiction over federal and private sector insurance programs. The FBI does not have the authority to impose sanctions. The OIG, FBI, and state and local law enforcement agencies all refer potential health care fraud cases to the DOJ for prosecution.

Proposed Law

This provision would require the Secretary to appoint a Senior Advisor for Health Care Fraud within the Office of the Deputy Secretary in Health and Human Services. The Senior Advisor would serve as the principal advisor on policy, program development, and oversight with respect to the detection and prevention of fraud involving public and private health insurance coverage as well as the coordination of anti-fraud efforts within HHS, the DOJ, state and local law enforcement agencies, and private health insurance plans. The Senior Advisor would be required to be a Schedule C appointee and would not be subject to confirmation by the Senate or any House or Senate committee or subcommittee. The Senior Advisor would also not be a current career or career-conditional Federal executive branch employee as defined in regulations.

Sec. 502. Department of Justice Position

Current Law

There are multiple federal and state agencies that share responsibility for preventing health care fraud, waste, and abuse. These include the Department of Health and Human Services (HHS) Office of the Inspector General (OIG), the Department of Justice (DOJ), the Federal Bureau of Investigations (FBI), and state and local law enforcement agencies. The OIG is an independent unit within HHS that has the primary responsibility for

detecting health care fraud and abuse in all federal health care programs. Most of its work, however, relates to the Medicare and Medicaid programs. The FBI is the lead investigative agency in the fight against health care fraud. Unlike the OIG, which has the authority to investigate fraud impacting federal health care programs only, the FBI has jurisdiction over federal and private sector insurance programs. The FBI does not have the authority to impose sanctions. The OIG, FBI, and state and local law enforcement agencies all refer potential health care fraud cases to the DOJ for prosecution.

Proposed Law

This provision would require the Attorney General to appoint a Senior Counsel for Health Care Fraud Enforcement within the Office of the Deputy Attorney General. The Senior Advisor would serve as the principal advisor to the Attorney General on policy, program development, and oversight with respect to the investigation and prosecution of health care fraud involving public and private health insurance coverage as well as the coordination of anti-fraud efforts within HHS, the DOJ, state and local law enforcement agencies, and private health insurance plans.

Subtitle B – Health Care Program Integrity Coordinating Council

Sec. 511. Establishment

Current Law

None

Proposed Law

The provision establishes a new section in Part C of title XXVII of the Public Health Service Act.

Sec. 2797. Health Care Program Integrity Coordinating Council.

This provision would require the establishment of a Health Care Program Integrity Coordinating Council to be composed of the Secretary of Health and Human Services, the Attorney General, the Inspector General for Health and Human Services, the Secretary of Labor, the Secretary of Defense, the Director of the Office of Personnel Management, the Under Secretary of Health for the Veterans Health Administration, the Commissioner of the Social Security Administration, the President of the National Association of Insurance Commissioners, and the President of the National Association of Medicaid Fraud Control Units. The Council would also have the authority to appoint other members, provided a majority of the Council determines that it's necessary, and provided that the individual does not represent a regulated entity under this Act.

The duties of the Council would be the following: 1) No later than 6 months after the enactment date of this legislation, develop a strategic plan for improving the coordination

and information sharing among Federal and State agencies and private health insurance coverage with respect to the prevention, detection, and control of fraud, waste, and abuse, including fraud and abuse related to consumers and private health insurance issuers; 2) submit an annual report to Congress on any actions taken to implement the plan; 3) while recognizing that private health care coverage may be responsible for fraud, waste, and abuse, evaluate ways to ensure that private health insurance coverage, with adequate protections in place for sensitive data extracted from law enforcement agencies, is included in investigative and data sharing programs; 4) no later than one year after this legislation is enacted, develop and issue guidelines for executing the strategic plan, recognizing that health care fraud can impact both public and private sector health insurance coverage and that the prevention, detection, investigation, and prosecution of fraud against private health insurance coverage is integral to fraud control efforts; 5) update the strategic plan and guidelines for implementation at least once every five years; 6) develop recommendations, in consultation with the Office of Management and Budget (OMB), for measures to estimate the amount of fraud, waste, and abuse impacting public and private health insurance coverage, and the annual savings resulting from program integrity initiatives; 7) identify improvements needed for the purposes of information sharing systems and activities used in implementing the strategic plan; and 8) establish a consultative panel composed of representatives of the private sector health insurance industry and consult with this panel when formulating the Council's recommendations. The Council would be required to allow for reasonable public participation in all matters before the Council provided that such participation would not compromise the Council's or any other Federal or State agencies fraud control efforts.

This provision would exempt the Council from administrative requirements related to the rulemaking process and the procedures for conducting hearings, as well as the Federal Advisory Committee Act to protect against the release of information which might undermine Federal, State and local fraud control activities.

Subtitle C – False Statements and Representations

Sec. 521 Prohibition on False Statements and Representations

Current Law

The Employment Retirement Income Security Act of 1974 (ERISA) protects the interests of participants and beneficiaries in private sector employee benefit plans. Governmental plans and church plans generally are not subject to the law. ERISA generally supersedes state laws relating to employee benefit plans except for matters related to state insurance, banking and securities laws, and divorce property settlement order by state courts. An employee benefit plan may be either a pension plan (which provides retirement benefits) or a welfare benefit plan (which provides other kinds of employee benefits such as health and disability).

A Multiple Employer Welfare Arrangement (MEWA) is an employee welfare benefit plan established and maintained to provide specified benefits, including health insurance

coverage, to the employees of two or more employers. MEWAs may not include plans covering collective bargaining agreements, rural electric cooperative and rural telephone cooperative associations.

Proposed Law

This provision would prohibit individuals from making false statements in connection with the marketing or sale of a plan sponsored by a MEWA. False statements could not be made to employees, members of employee organizations, beneficiaries, employers, employer organizations, the Secretary, or the State concerning the following items: 1) the financial condition of the plan; 2) the benefits provided by the plan; 3) the regulatory status of the plan governing collective bargaining, labor management relations, or internal union affairs, or the regulatory status of the plan regarding exemption from state regulatory authority under ERISA. Any representative of a MEWA who willfully violates the reporting, disclosure and other related provisions of ERISA may be fined up to \$100,000, imprisoned up to 10 years, or both.

Subtitle D – Federal Health Care Offense

Sec. 531 Clarifying Definition

Current Law

Title 18 of the U.S. Code provides for the definition of Federal health care offenses.

Proposed Law

This provision includes clarifying definitions for amending the definition of Federal health care offenses in the U.S. Code by including sections 411, 518 and 511 of ERISA in the definitions.

Subtitle E – Uniformity in Fraud and Abuse Reporting

Sec. 541 Development of Model Uniform Report Form

Current Law

None

Proposed Law

The Secretary would be required to request that the National Association of Insurance Commissioners (NAIC) develop a model uniform report form for private health insurance issuers seeking to refer suspected cases of fraud and abuse to State insurance departments or other State agencies for investigation. The Secretary is required to request that the NAIC develop uniform reporting standards for such referrals.

Subtitle F – Applicability of State Law to Combat Fraud and Abuse

Sec. 551 Applicability of State Law to Combat Fraud and Abuse

Current Law

The Employment Retirement Income Security Act of 1974 (ERISA) protects the interests of participants and beneficiaries in private sector employee benefit plans. Governmental plans and church plans generally are not subject to the law. ERISA generally supersedes state laws relating to employee benefit plans except for matters related to state insurance, banking and securities laws, and divorce property settlement order by state courts. An employee benefit plan may be either a pension plan (which provides retirement benefits) or a welfare benefit plan (which provides other kinds of employee benefits such as health and disability).

A Multiple Employer Welfare Arrangement (MEWA) is an employee welfare benefit plan established and maintained to provide specified benefits, including health insurance coverage, to the employees of two or more employers. MEWAs may not include plans covering collective bargaining agreements, rural electric cooperative and rural telephone cooperative associations.

Proposed Law

This provision would authorize the Secretary to promulgate regulations mandating that any person engaged in the business of selling insurance through a MEWA would be subject to state insurance laws, regardless of whether or not the law is preempted under other such provisions. The provision would only apply to MEWAs.

Subtitle G – Enabling the Department of Labor to Issue Administrative Summary Cease and Desist and Summary

Seizure Orders Against Plans that are in Financially Hazardous Condition

Sec. 561 Enabling the Department of Labor to Issue Administrative Summary Cease and Desist and Summary Seizure Orders Against Plans that are in Financially Hazardous Condition

Current Law

A cease and desist order is an order issued by a court or agency prohibiting the recipient from continuing a particular course of conduct. Summary seizure orders can authorize a government official to immediately take possession of the subject of the order. Currently ERISA provides no authority for the Secretary of Labor to issue cease and desist orders or summary seizure orders regarding the conduct or assets of a multiple employer welfare arrangement (MEWA).

Proposed Law

This legislation would authorize the Secretary of Labor to issue cease and desist orders against a MEWA prohibiting alleged fraudulent conduct, or any conduct that creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. These orders would be issued ex parte, but may be reviewed in a hearing before the Secretary upon request by any adversely affected party. Such hearings may be confidential if the Secretary requires, and the party requesting the hearing bears the burden of demonstrating why a cease and desist order should be modified or set aside. This legislation would also authorize the Secretary to issue a summary seizure order if it appears that a MEWA is in a financially hazardous condition. The Secretary would also be authorized to promulgate regulations or other guidance necessary to carry out cease and desist orders or summary seizure orders.

Subtitle H – Requiring Multiple Employer Welfare Arrangement (MEWA) Plans to File a Registration Form with the Department of Labor Prior to Enrolling Anyone in the Plan

Sec. 571 MEWA Plan Registration with Department of Labor

Current Law

The Secretary is authorized to require MEWA's, which are not group health plans, to report at least annually on their compliance with requirements related to portability, access, and renewability, among other requirements.

Proposed Law

This provision would require the Secretary to promulgate regulations mandating that MEWA's, which are not group health plans, to register with the Secretary prior to operating in a State and report at least annually on their compliance with requirements related to portability, access, and renewability, among others.

Subtitle I – Permitting Evidentiary Privilege and Confidential Communications

Sec. 581 Permitting Evidentiary Privilege and Confidential Communications

Current Law

Evidentiary privileges protect information covered by the privilege from disclosure during the course of a judicial or administrative proceeding. Some privileged information may also be protected from disclosure under the Freedom of Information Act.

Proposed Law

This provision would authorize the Secretary of Labor to create, through regulation, an evidentiary privilege that would protect communications related to an investigation, audit, examination, or inquiry conducted or coordinated by: state insurance departments and attorneys general; the National Association of Insurance Commissioners; the United States Departments of Labor, Treasury, Justice, and Health and Human Services; or any other federal or state regulatory authority that the Secretary determines is appropriate. The privilege also covers communications made by these entities or their agents, consultants, or employees.