**Enhanced Penalties**

**Summary**: Subjects persons who fail to grant the Department of Health and Human Services Office of Inspector General (HHS OIG) timely access to documents, for the purpose of audits, investigations, evaluations, or other statutory functions, to civil monetary penalties (CMPs) of $15,000 for each day of failure. Also, persons who knowingly make, use, or cause to be made or used any false statement to a Federal health care program would be subject to a CMP of $50,000 for each violation. The violations that could be subject to the imposition of sanctions and CMPs by the Secretary would include Medicare Advantage (MA) or Part D plans that: (1) enroll individuals in a MA or Part D plan without their consent, (2) transfer an individual from one plan to another for the purpose of earning a commission, (3) fail to comply with marketing requirements and CMS guidance, or (4) employ or contract with an individual or entity that commits a violation. Penalties for MA and Part D plans that misrepresent or falsify information would be increased to up to three times the amount claimed by a plan or plan sponsor based on the misrepresentation or falsified information.

**Next steps:**

- January 1, 2010 – Provisions go into effect

**Additional information:**

- HHS OIG testimony regarding new tools within health reform, including enhanced penalties - [http://oig.hhs.gov/testimony/docs/2010/testimony_levinson_09222010.pdf](http://oig.hhs.gov/testimony/docs/2010/testimony_levinson_09222010.pdf)
- Coalition on Insurance fraud article on provision - [http://www.insurancefraud.org/article.lasso?RecID=1787](http://www.insurancefraud.org/article.lasso?RecID=1787)
- National Association of States United for Aging and Disabilities article on transparency provisions - [http://www.nasuad.org/documentation/aca/NASUAD_materials/Title_VI_Analysis.pdf](http://www.nasuad.org/documentation/aca/NASUAD_materials/Title_VI_Analysis.pdf)

**Long summary:**

Sec. 6408. Enhanced penalties.

Makes conforming changes to civil monetary penalty provisions in light of other changes being made in the bill.

**False claims.** Effective January 1, 2010, imposes financial penalties for submission of false claims data under a Federal health care program of a CMP of $50,000 for each violation.

**Timely access.** Effective January 1, 2010, imposes financial penalties for failure to grant timely access to OIG auditors and investigators to CMPs of $15,000 for each day of failure.

**Medicare Advantage and Part D.** Effective January 1, 2010, amends current law to ensure timely inspections by the OIG relating to contracts with Medicare Advantage Organizations. Also imposes
enhance penalties for Medicare Advantage and Part D marketing violations, such as: (1) enrolling individuals in a MA or Part D plan without their consent, (2) transferring an individual from one plan to another for the purpose of earning a commission, (3) failing to comply with marketing requirements and CMS guidance, or (4) employing or contracting with an individual or entity that commits a violation. Effective January 1, 2010, broadens existing penalties relating to investigation obstruction to apply to audit obstruction. Penalties for MA and Part D plans that misrepresent or falsify information would be increased to up to three times the amount claimed by a plan or plan sponsor based on the misrepresentation or falsified information.

**Legislative text:**

**SEC. 6408. ENHANCED PENALTIES.**

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7(a)), as amended by section 5002(d)(2)(A), is amended—

(1) in paragraph (6), by striking “or” at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

“(8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

“(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;”;

and

(3) in the first sentence—

(A) by striking “or in cases under paragraph (7)” and inserting “in cases under paragraph (7)”;

(B) by striking “act)” and inserting “act, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph)”.

(b) MEDICARE ADVANTAGE AND PART D PLANS.—

(1) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(A) in subparagraph (A), by inserting “timely” before “inspect”; and

(B) in subparagraph (B), by inserting “timely” before “audit and inspect”.

(2) MARKETING VIOLATIONS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(A) in subparagraph (F), by striking “or” at the end;

(B) by inserting after subparagraph (G) the following new subparagraphs:

“(H) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

“(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

“(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

“(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;”;

and

(C) by adding at the end the following new sentence: “The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.”.

(3) PROVISION OF FALSE INFORMATION.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w–27(g)(2)(A)) is amended by inserting “except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,” after “for each such determination,”.

(c) OBSTRUCTION OF PROGRAM AUDITS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting “OR AUDIT” after “INVESTIGATION”; and

(2) by striking “investigation into” and all that follows through the period and inserting “investigation or audit related to—”

“(i) any offense described in paragraph (1) or in subsection (a); or

“(ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(f)).”.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to acts committed on or after January 1, 2010.

(2) EXCEPTION.—The amendments made by subsection (b)(1) take effect on the date of enactment of this Act.