# Retiree Drug Coverage under Medicare Part D: Employers At Risk for Violation of Medicare Fraud and Abuse Laws

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The Centers for Medicare and Medicaid Services (CMS) expect that 10 million Medicare beneficiaries will obtain their Medicare Part D drug coverage through employer-sponsored retiree health plans. If you are an employer offering retiree health benefits, you may not realize that you are potentially at risk for violation of the Medicare fraud and abuse laws and other federal criminal and civil fraud and abuse laws.

How do you know if you are at risk? The answer is simple: You are at risk if you are offering a prescription drug plan as part of your retiree health plan and you are receiving federal dollars, on or after January 1, 2006, to subsidize any part of the costs of your prescription drug plan. More specifically, the Medicare Part D program allows an employer to receive federal assistance with the costs of its retiree prescription drug program under two options: (1) contracting directly with CMS to operate a Medicare Part D prescription drug plan (PDP) specifically and exclusively for the employer's retirees; or (2) offering a prescription drug program to the employer's retirees that is actuarially equivalent to Medicare Part D benefits. On the other hand, you are not at risk if you contract with one of the CMS-approved prescription drug plans (PDPs) or provide "wrap around" or supplemental drug coverage to your retirees.

If you are at risk, you should know that those who enforce Medicare program compliance, i.e., the DHHS Office of Inspector General (OIG) and the Department of Justice (DOJ), are focusing their attention on Medicare Part D compliance. Officials have announced that violations may be prosecuted under several different fraud and abuse laws – the criminal False Claims Act, the civil False Claims Act, the Medicare Anti-Fraud and Abuse Amendments (including the Anti-Kickback Law), the Public Contracts Act and the Travel Act. The fines and penalties for violation of these laws range from $10,000 to $25,000 per violation. Each individual prescription wrongly claimed for payment under the False Claims Acts is a separate violation; thus, penalties can quickly add up to significant amounts.

What kinds of activity constitute a violation of the fraud and abuse laws?

- Any payment (rebate, discount, etc.) to an employer from a drug manufacturer (other than the typical manufacturers' rebates) that would tend to influence a decision about the administration of the prescription drug plan could be deemed a kickback under the Travel Act.
- Any payment to limit the drugs available to certain chronic users could be deemed a kickback under the Medicare Anti-Fraud and Abuse Amendments.
- Any submission of erroneous claims data that results in overpayment by CMS can trigger a fraud investigation, regardless of whether the submission was intentional or unwitting, because CMS routinely forwards overpayment cases to the OIG and DOJ for review.

The health care industry, which has been subject to Medicare fraud and abuse laws for the last twenty-five years, has managed to control the risk posed by these laws by educating staff about potential fraud pitfalls and by implementing internal auditing and monitoring programs, including routine review of vendor and provider contracts for potential anti-kickback implications. You, as an employer offering federally-subsidized retiree drug coverage, may want to consider implementing these proven strategies to minimize your risks.

If you would like assistance in educating your staff on how to avoid Medicare fraud and abuse violations or in establishing a compliance program to prevent and/or identify potential fraud and abuse concerns, contact any of the attorneys in the Holland & Hart Employee Benefits Group or the Holland & Hart Health Care Group.

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