



WHEN THE GOVERNMENT ALLEGES HEALTH INSURER FRAUD, IS THERE COVERAGE?

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It is no secret that during the last several years, the U.S. government has invested substantial resources in detecting, investigating and prosecuting health care fraud and abuse. Managed care entities are not immune from this scrutiny.

In fact, on October 7, 2010 the Department of Health and Human Services, Office of Inspector General (OIG) posted its 2011 Work Plan setting forth the initiatives and priorities which the OIG will pursue through audits, investigations, inspections, industry guidance (including advisory opinions) and enforcement actions (including actions to impose civil monetary penalties, assessments and administrative sanctions, such as exclusions). Below are some of the areas targeted for enforcement as outlined by the OIG in connection with Medicare and Medicaid Managed Care Initiatives.¹

MEDICARE

- Duplicate Medicare payments to cost-based health maintenance organization plans
- Review of MA-special needs plans (SNP) compliance with chronic condition enrollment
- Medicare Advantage Plus oversight of durable medical equipment suppliers to prevent fraud, waste
- Investment income earned by Medicare Advantage plans on monthly capitation payments (including evaluation of whether it should be included in computation of excess funds that must be returned to the Medicare trust fund)
- Credentialing by Medicare Advantage plan sponsors

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- Review of accuracy of managed care encounter data
- Determination of whether CMS adjusted payments to Medicare Advantage plans are consistent with risk adjustment data validation process (i.e., verification of diagnosis codes)
- Medicare Advantage plans' oversight of contractors

MEDICAID

- State agency oversight of Medicaid managed care entities' marketing practices
- Use of prepayment review to detect and deter fraud and abuse in Medicaid managed care

- State agency oversight of medical loss ratio experience adjustment
- Medicaid managed care payments for deceased beneficiaries

As more fully set forth in Table A below, managed care organizations have incurred millions in defending and resolving allegations of health care billing fraud and abuse, and the trend will no doubt continue.

TABLE A

MCO	DATE OF SETTLEMENT	SUMMARY OF ALLEGATIONS	SETTLEMENT AMOUNT	LINK
CareSource	2011	Alleged submission of false data to create the appearance of creating special needs patient services to retain funds received from Ohio Medicaid	\$26M	http://www.ohioattorneygeneral.gov/briefing-room/newsreleases/february-2011/attorney-general-mike-dewine-announces-\$26-million
BCBS IL	2011	Allegedly advised policy holders that children were not covered for private duty nursing during the claim review process after initial denials	\$25M	http://www.justice.gov/usao/iln/pr/chicago/2011/pr0224_01.pdf
WellCare	2011	Alleged fraudulent inflation of medical expenses to Florida and New York Medicaid and red-lining unprofitable Medicaid beneficiaries	\$137.5M	http://www.ama-assn.org/amednews/2010/07/12/bisa0712.htm
Omnicare Pharmacies	2010	Allegedly defrauded Medicaid programs in Michigan and Massachusetts by knowingly charging the agencies as much as four times the amount charged private health care insurers for the same drugs	\$21M	http://www.taf.org/total2010.htm
AmeriHealth Mercy	2010	Alleged defrauding of KY Medicaid by misrepresenting the number of cervical screening performed, leading to unwarranted bonus payment	\$2M	http://migration.kentucky.gov/Newsroom/ag/amerihealthmercy.htm
Amerigroup IL	2008	Alleged defrauding of the Illinois Medicaid program by systematically avoiding enrolling pregnant women and other high risk patients	\$225M	http://www.justice.gov/usao/iln/pr/chicago/2008/pr0814_01.pdf
BCBS MI	1995	Allegedly defrauded the federal government by performing cursory and inadequate audits of Medicare Part A hospital cost reports	\$27.6M	http://www.justice.gov/opa/pr/Pre_96/January95/32.txt.html

In an effort to highlight the types of exposure presented by an MCO when the government comes knocking at its door, we provide the following hypothetical fact pattern.

KNOCK, KNOCK: THE HYPOTHETICAL FALSE CLAIM ACT INVESTIGATION AND ACTION – ARE YOU READY?

Since 1996, ABC Health Plan (ABC), a privately held managed care organization, has been arranging for delivery of affordable, quality care to those who depend on government assistance. ABC's approach to care is viewed favorably by disparate groups including members and investors. In late 2009, federal and state authorities began investigating claims processed by ABC in connection with certain Virginia provider contracts with ABC, at the Virginia provider sites. That investigation focused on the providers' billings for services they did not render.

In the third quarter of 2010 the FBI appears on the door step of ABC's Virginia headquarters with search warrants demanding information on all transactions between ABC and several exclusive provider groups. The FBI's investigation of ABC was prompted by a tip from an ABC Accounts Payable "whistleblower" employee claiming that ABC has been fraudulently submitting inflated provider reimbursement requests, and that ABC executives were aware of the billing scheme. The Department of Justice (DOJ) joined the whistleblower's False Claims Act (FCA) action filed under seal against ABC; VA and NY brought parallel state-based false claim actions.

IS YOUR MANAGED CARE ENTITY COVERED FOR THESE REGULATORY ACTIONS?

With the knock on the door and the media attention surrounding the DOJ False Claims Act whistleblower, your CEO is focused on media damage control and is probably not thinking about whether insurance will cover the significant costs of defending, let alone settling, these FCA actions. The urge to hire counsel the CEO trusts, with price no object, is strong. But as the Risk Manager, you know insurance policies are corporate assets that have cooperation provisions, requiring both insurer consent to retention of counsel and counsel's fee schedule – up front. Of course, if there is no insurance that will respond to the action, the cooperation provisions become moot. However, based on our analysis below, there will likely be some coverage afforded by your Managed Care Errors & Omissions policy. Hence, coverage considerations must remain primary from the moment your organization becomes the target of an FCA investigation or action.

GIVE ME COVER

The damage components of a False Claim violation listed at 31 U.S.C. § 3729(a) for which an MCO might be seeking coverage include: (1) recoupment of overpayments; (2) fines and penalties; (3) trebled damages inclusive of the whistleblower's share, if any; and (4) awarded attorney fees.

Here's the decision tree that guides us:

1. Do the FCA allegations satisfy the insuring agreement of either your Directors' & Officers' (D&O) or Managed Care Errors & Omissions (E&O) policies?
2. Has the managed care organization satisfied the necessary conditions of the policy (e.g., paid premium, timely reporting, cooperation with carrier)?
3. Is there a regulatory exclusion?
4. Are there other exclusions which restrict or eliminate coverage?
5. Are there insurance or financial products beyond the MCO E&O and D&O policies to consider?

1. Do the allegations of violation of the False Claim Act satisfy the insuring agreement of either the D&O or E&O policy?

The insuring agreement is the insurer's "Promise to Pay." At first glance, the D&O and E&O policies' insuring agreements are confusingly similar:

- **E&O:** The Insurer will pay...**Loss**...as a result of a **Claim** ...arising from a **Wrongful Act** in the *rendering of or failure to render Professional Services by or on behalf of the Insured*...(italics supplied)
- **D&O:** The Insurer will pay...**Loss**...as a result of a **Claim** ...arising from a **Wrongful Act** committed or alleged committed by an Insured [*in the management of the company*]... (italics supplied)

Which policy does one look to for coverage? Both D&O and E&O policies use similar Wrongful Act wording; the difference is the capacity in which the insured is acting. In our introductory fact pattern, ABC was acting to process provider claims and submit them to the government, allegedly knowing the claims were false. Since ABC is rendering **Claim Services** for or on behalf of another party – one of many defined **Professional Services** – in the administration or management of an MCO, the E&O policy insuring agreement is arguably triggered. However, should a private shareholder suit be filed naming individual directors and officers and alleging injuries as a result of ABC's mismanagement of the targeted provider claims and breach of fiduciary duties, the D&O policy may arguably be triggered as well.

Two more defined terms in the E&O insuring agreement need to be satisfied before moving on: do our facts describe a **Claim**? And is there **Loss**?

- **Claim** – Typically MCO E&O policies define claim as “written notice of intent to hold you responsible for a Wrongful Act.” While receipt of a subpoena may or may not satisfy the claim definition (more about defense expense coverage of subpoenas that are not deemed claims later), once the Department of Justice joins the FCA action against ABC, and VA and NY file parallel state-based false claim actions, the definition of claim appears to have been satisfied.
- **Loss** – This boils down to **Damages** and **Defense Expenses**; but piecing together how we find coverage for each Damage and Defense Expense component of a FCA action is akin to finding the prize in a treasure hunt.

- **Defense expenses** are a component of Loss and owed to ABC, even in the absence of covered **Damages** based on the MCO's insuring agreement's promise that “The Insurer will pay...**Loss**...as a result of a **Claim** ...arising from a **Wrongful Act** in the *rendering of or failure to render Professional Services*...” Note that the regulatory exclusion could take away this obligation to pay defense expenses, but every commercially available MCO E&O policy, even those with regulatory exclusions, typically grant partial or full limits coverage for defense expense incurred by MCOs for government **Claims** (unlike a standard medical professional liability policy). Full limits defense costs is critically important when an insured is battling the deep pockets of state or federal enforcement agencies.

- **Damages** – Observations with respect to the potential match up of the standard MCO E&O policy form and the damage components ABC's subsequent settlement may entail are set forth below in Section 4 and our chart in Table B below.

2. Has the insured satisfied the necessary Notice and Cooperation conditions of the MCO E&O Policy?

In order to tap the insurance asset for at least defense costs incurred on a government claim, it is imperative that the MCO timely report these claims within the policy period or within the grace period of up to 60-90 days after the policy's expiration. It is also critical to secure the consent of your MCO carrier with respect to the identity and hourly rate of defense counsel that you wish to retain so as to start the legal meter running on the insurer's dime.

3. Does the MCO E&O Policy's regulatory exclusion bar coverage?

Some MCO E&O policies contain no government entity action exclusion; others

do, with affirmative coverage carve-backs for: 1) defense costs even if no indemnity is covered; 2) government actions if the claim is brought in its capacity as a customer. This last carve-back may be broad enough to respond to claims brought by federal and state agencies acting as Medicare and Medicaid payers. In this aspect, the regulatory coverage in the MCO E&O policy is more generous than that in the D&O policy – which typically grants a sublimit for regulatory actions. One should note that not all MCO E&O forms grant the same scope of regulatory coverage and this is an important term to be negotiated.

4. Does the Conduct Exclusion or other policy terms (i.e., loss definition) restrict or eliminate coverage for an FCA action?

Here, consider the “conduct” exclusion. This is another high-impact policy term that warrants stiff renewal negotiations so that the insurer will have the burden to demonstrate that the MCO *intentionally committed* dishonest acts or *willful* violations of law (italics supplied) to avoid coverage; and even then, the conduct exclusion should require a final adjudication or an admission by an insured person with authority to bind the company. Since the penalties that the government may assess against a managed care entity in an FCA action are severe – exclusion from government programs and commensurate loss of revenue – the target MCOs often settle rather than go to trial. Significantly, the MCO civil settlement agreements with the OIG do not contain an express admission of fault or liability. The OIG is more concerned with repayment, the corrective action plan, recovery of fines and penalties, treble damages (inclusive of the whistleblower’s share) and attorneys’ fees. As such, the insurer may have a difficult time negating coverage based on application of the conduct exclusion.

Even if the MCO’s insurer does not meet its burden with respect to enforcing the conduct exclusion, one must examine the MCO E&O policy’s loss definition to obtain insight on the extent of coverage for any damages/ indemnity that the MCO must pay.² Many standard MCO E&O forms exclude coverage for civil and criminal fines and penalties and the restitution or repayment of overpayments. Some forms will cover treble damages if insurable and attorneys’ fees in proportion to covered loss.

Defense expenses incurred by an MCO in responding to a government subpoena require separate comment. Typically, pre-claim expenses are not covered by an MCO Policy. Private action litigants must conduct discovery post-claim while the government has unique subpoena powers allowing it to conduct pre-claim discovery. Shouldn’t the MCO insurer cover defense expenses associated with discovery in both instances? While the insurer has an interest in the manner and quality of the MCO’s response to the subpoena because it wishes to avert assertion of a formal claim/suit against the MCO, it is hesitant to cover expensive investigations wherein the government is often engaged in a fishing expedition and casts a broad net to obtain support for some type of claim.

However...One Beacon pioneered an endorsement to its policy to provide limited pre-claim subpoena expense coverage. Another approach is to expressly define loss to include subpoena defense expenses if the investigation ultimately materializes into a claim.

THE COVERAGE DISCUSSION DILEMMA?

Here’s the dilemma: Is it worth pursuing confirmation of coverage with the MCO underwriter based upon potential ambiguity in an existing policy form? One must weigh the possibility that the underwriter may either (1) exclude from loss any indemnity relating to fraud and abuse-type activities involving Medicare or Medicaid or (2) charge additional premium which the insured believes is exorbitant. The answer may be to “let sleeping dogs lie” with respect to the standard MCO E&O policy and pursue some free-standing solutions, discussed below, in which the underwriting intent is clear and certain.

5. Are there insurance or financial products beyond the MCO E&O and D&O policies to consider for coverage of an FCA claim?

Carriers are beginning to assess their appetite for MCO FCA exposure. Ironshore has rolled out a standby capital approach wherein an MCO can purchase an option to purchase a government billing errors and omissions coverage grant which would provide \$5M in coverage for essentially all aspects of an FCA suit, including

finer, penalties, restitution, attorneys' fees, etc. NAS provides a government billing E&O product for providers that includes defense costs coverage and civil fines or penalties, but does not extend coverage to criminal fines or penalties, treble damages, etc. In Table B below, we set forth the various components of a False Claim Act action and then compare how the standard MCO E&O form, the Ironshore and NAS forms would respond.

For now, the way forward is to evaluate, case-by-case, our client's interest in explicit negotiations with its MCO E&O carrier (which for now may be its own captive or RRG). Willis will keep working with the MCO market's underwriters to develop a product with meaningful False Claims Act coverage – a game-changing coverage in a lackluster market.

TABLE B

COMPONENTS OF A FALSE CLAIM SETTLEMENT AND INSURABILITY

	STANDARD MCO E&O FORM	IRONSHORE GOVERNMENT BILLING E&O	NAS PROVIDER GOVERNMENT BILLING E&O
Who is Policy's Intended Purchaser?	MCO	Provider; being adapted to MCO	Provider; being adapted to MCO-MAYBE
Risk Financing Approach	risk transfer	standby capital	risk transfer
Defense Costs	YES - regulatory exclusions typically carve back defense costs	up to max agg of \$5M	YES
Subpoena/Investigation Defense Expenses	Emerging as endorsement	up to max agg of \$5M	NO
Civil Fines & Penalties	NO - excluded from Loss	up to max agg of \$5M	YES up to \$10M
Criminal Fines & Penalties	NO - excluded always	up to max agg of \$5M	NO
Repayment of Overpayment	NO - excluded always	up to max agg of \$5M	NO
Treble Damages (3x Repayment Amount)	YES - endorse so multiplied damages if most favorable venue deems insurable	up to max agg of \$5M	NO
Whistleblower Share	Part of treble damages	up to max agg of \$5M	NO
Awarded Attorney Fees	YES if silence as p/o Loss or in proportion to Covered Loss	up to max agg of \$5M	NO
Conduct Exclusion Voids Coverage	Final adjudication/admission of liability generally does not occur/trigger exclusion	NA	Final adjudication/admission of liability generally does not occur/trigger exclusion
Evidence of Intent of U/W to Cover FCA	NO - unless AP charged or explicitly endorsed	YES	YES

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The observations, comments and suggestions we have made in this report are advisory and are not intended nor should they be taken as medical/legal advice. Please contact your own medical/legal adviser for an analysis of your specific facts and circumstances.

¹The complete OIG Report can be found at http://oig.hhs.gov/publications/workplan/2011/FY11_WorkPlan-All.pdf.

²For a more thorough description of the types of damages available in a False Claims Act suit, please refer to <http://www.falseclaimscase.com/about-qui-tam>. We further outline the types of damages available in Table B on page six of this article.