Health Insurers in the Fraud Area Today: The Good, the Bad, and the Ugly

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The Payors, Plans, and Managed Care Practice Group (PPMC PG) is pleased to present the inaugural article for a periodic column sponsored by the PPMC PG's Health Plan Affinity Group.

Health insurers have been at the forefront of the anti-fraud battle, even before this effort became a significant government activity. Throughout this time, extending back more than twenty years, health insurers have been leaders and innovators on anti-fraud activities, bringing knowledge, information, and cases to government investigators and prosecutors as a partner in the overall fight against healthcare fraud.

This effort continues to this day. In recent years, however, this "partnership" increasingly involves partners who also may be adversaries—as law enforcement agencies, prosecutors, and even whistleblowers increasingly are turning their attention to the activities of health insurers. With the new healthcare reform legislation, this problem becomes even more pronounced, as regulatory complexities for health insurers are growing at the same time that government agencies are focusing more attention on healthcare fraud with increasing expectations about the volume of fraud recoveries. As health insurers become more entwined in a broader range of government healthcare programs, the risks for health insurers under the various federal healthcare fraud statutes are growing.

This leads to the "good, the bad, and the ugly" for health insurers in the fight against fraud. On the positive side, there are more resources than ever before being devoted to fighting fraud, with new legislative and regulatory tools being supported by increasing levels of expertise from prosecutors and investigators. However at the same time, on the "bad" side, there is an increased concern that these new tools and resources will be devoted, in an increasingly high percentage, to fighting fraud only in public healthcare programs. This places a new burden on health insurers to develop their own effective anti-fraud programs, despite certain disincentives stemming from the new medical loss ratio rules.

On the "ugly" side is the even bigger risk for health insurers—the risk of being targets of healthcare fraud investigations from the government, where the government has been increasingly aggressive. Therefore, health insurers need to understand these new risks and develop appropriate means of responding to this realistic threat of becoming a target of fraud investigations.

The Good

Healthcare fraud enforcement remains one of the key areas of attention for law enforcement officials across the country. Today, virtually every kind of healthcare provider faces a significant threat of healthcare fraud investigations, affecting daily operations and long-term corporate strategy.

In addition, healthcare fraud is receiving attention at the highest levels of the federal government. According to recent comments from U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius, the Obama Administration has "zero tolerance" for healthcare fraud, and preventing fraud is a "personal priority" for President Obama.

These anti-fraud efforts have received renewed resources through the healthcare reform legislation. This legislation:

- Provided substantial new financial resources for fighting fraud;
- Provided opportunities for HHS to impose new and higher thresholds on certain categories of providers for entry into the Medicare system;
- Allowed HHS to "suspend payments" to certain healthcare providers, based on "credible evidence" of fraud;
- Requires healthcare providers to implement compliance programs;
- Implements certain changes to the False Claims Act (primarily, ensuring that a failure to return overpayments and kickbacks can be viewed as a false claim);
- And modifying various other authorities to close certain "loopholes."

Accordingly, we can anticipate even more substantial and aggressive enforcement activity from the government to attack healthcare fraud wherever it occurs.

In addition, there is renewed interest in some of the "partnership" activities between the government and private sector resources. More than a decade ago, as part of the implementation of the Health Insurance Portability and Accountability Act (HIPAA) statute, the U.S. Department of Justice (DOJ) took significant steps to enhance a public/private cooperative effort against fraud by announcing its principles for information sharing between healthcare fraud prosecutors and health insurers. The DOJ statement's general approach was to recognize the importance of sharing information with health insurers and the benefit to the overall fight against fraud from these cooperative efforts. These principles supported the primary goals of organizations, like the National Health Care Anti-Fraud Association, who support a cooperative public-private sector anti-fraud program. While the goals of these principles were important, they often were not followed or, more precisely, prosecutors either were unaware of the principles or were not strongly encouraged to follow them.

In the intervening years, while these programs were never formally shut down, they received little attention from many in the government. The good news is that there appears to be new interest in reviving this partnership between public and private

fraud investigators, with the recognition that most fraud affects both the public and private sectors (along with the recognition that there is much less of a clear line between the public and private sectors in healthcare.)

The Bad

The bad news for health insurers about these new anti-fraud efforts is straightforward. While there were efforts by industry groups such as the National Health Care Anti-Fraud Association and America's Health Insurance Plans, through education and otherwise, to include private sector anti-fraud efforts in the healthcare reform legislation, the legislation essentially did nothing whatsoever to benefit healthcare fraud activities of private health insurers. All of the new legislative provisions—and there are many of them—focus exclusively on public healthcare programs and improving the ability of prosecutors and investigators to develop and pursue fraud cases involving public healthcare programs.

In addition to the failure to include private health insurers in these new tools, the importance of anti-fraud activities as a cost control mechanism for public programs also has received new attention. This means that there is an increasingly high likelihood that government prosecutors and investigators will focus their attention even more heavily than they have in the past on pursuing fraud in public programs, without paying attention to pursuing private sector cases.

The third leg of this bad news trilogy involves the new medical loss ratio rules. Despite an aggressive lobbying campaign, the new rules that have been issued make explicit that most anti-fraud activities are not viewed by the regulators as costs that "improve quality," and therefore anti-fraud expenditures will be treated as administrative costs rather than claim or quality-related costs. Running contrary to the emphasis on fighting fraud in government programs, these new regulations therefore impose strong disincentives for health insurers to engage in anti-fraud programs.

The Ugly

While these factors combine to mount challenges to the ability of private health insurers to develop and maintain aggressive anti-fraud programs, health insurers also face a more substantial concern in this area—the increasing likelihood that health insurers will become *targets* of government fraud investigations. With the government's new resources for fighting healthcare fraud and the creativity with which prosecutors are pursuing varieties of health insurer-related fraud cases (building on recent successes such as the Amerigroup and CareSource cases1), as well as the significant expansion of the health insurance industry's involvement in a broad new range of government healthcare programs, health insurers now have to be concerned about being *defendants* in fraud cases, whether driven by whistleblowers seeking a large paycheck or otherwise.

The primary challenge for health insurers, therefore, is how to balance an aggressive posture toward fighting fraud, where the health insurer is the victim of fraudulent practices, with an effective and responsible strategy for dealing with situations where the same health insurer may have committed fraud (or may be under investigation for having done so). Understanding and responding to this challenge will be a major undertaking for health insurers.

Building an Aggressive Anti-Fraud Program

The first means for a health insurer to handle this potential duality of roles is by building an aggressive and visible anti-fraud program. As the federal government continues to expand its anti-fraud activities, some health insurers have reduced their attention to anti-fraud programs. Today, health insurers should view an aggressive anti-fraud program not only as an important part of controlling the cost and quality of healthcare services, but also (as discussed below) as an important component of a health insurer's risk management strategy.

Relationships With Law Enforcement

Beyond an aggressive anti-fraud program (or as an integral component of this program), health insurers also should strive for a strong relationship with the law enforcement agencies that have primary responsibility for their geographic areas of business. The goal of any health insurer should be to develop a working partnership with both law enforcement and other insurers operating in the same area on healthcare fraud investigations.

Health insurers should always be on the lookout for situations where they can:

- Alert law enforcement to an ongoing fraud problem;
- Provide information in response to government inquiries;
- Educate law enforcement about new trends in fraud cases; and
- Provide assistance in data analysis or other areas where law enforcement (particularly generalized law enforcement rather than healthcare experts) can benefit from health insurer expertise.

If these steps are taken, this can create a "win-win" for law enforcement and health insurers. First, a health insurer will be more effective at fighting fraud by providers, and will be able to build more effective cases and recover more dollars. The health insurer also can provide significant assistance to law enforcement efforts against healthcare fraud. These proactive efforts will be necessary to address the growing incentives of investigators and prosecutors to pursue only federal program dollars in fraud cases.

In the bigger picture, however, an aggressive anti-fraud program and a strong working relationship with law enforcement on healthcare fraud matters also will provide law enforcement with a sense of commitment and confidence about dealing with the health insurer. This does not mean in any sense that law enforcement will give a company a "free pass" if it is under investigation, but it will be much more effective for health insurers to be perceived as being part of the solution, even if the company is under investigation for being part of the problem. The alternate choice—to be unfamiliar to law enforcement—cannot be favorable in the many areas where law enforcement has discretion in how to conduct its investigation.

In addition, by working effectively with law enforcement in fighting fraud, health insurers build up credibility that will allow defensive arguments to be heard, even though the case ultimately will be resolved on the merits. This is particularly true under many of the new programs affecting health insurers because law enforcement investigators are still learning the ropes on how health insurers operate and what kinds of fraud health insurers can perpetrate. Fraud investigators and prosecutors typically understand what healthcare providers do; they often do not understand what health insurers do. Therefore, there is a significant opportunity to address potential concerns through education. Regardless of the subject of an investigation against a health insurer, it is better to go in with a positive reputation than a bad one or no reputation at all.

Recognizing Opportunities to Prevent Fraud by Others

Health insurers also need to recognize the special opportunities that exist to help police the activities of healthcare providers. The concept of preventing and discouraging fraud has been a key focus of both the Medicare program and the HHS Inspector General's Office, with new support for this "prevention" concept through the reform legislation. There are two primary means for health insurers to influence others' future behavior. First, health insurers can use the contractual arrangements that are at the heart of managed care to develop anti-fraud "wish lists" for inclusion in managed care contracts, provisions that will help prevent fraud or make it easier for fraud to be investigated (e.g., specific audit provisions, obligations to cooperate in investigations, specific compliance program requirements, or billing practices, etc). Second, health insurers should focus on provider compliance programs to encourage proper behavior. When entering into relationships with providers, health insurers should examine whether the providers have strong compliance programs in place, and should review how the providers are in fact utilizing their compliance programs. As a further step, if these programs are included as a significant part of the managed care program, health insurers may wish to establish units in their companies that can monitor provider behavior on a regular basis and that can evaluate whether providers are effectively implementing the requirements of their own compliance programs.

Compliance Programs on Practices

Health insurers also need to be aware of the need to develop an effective compliance program that encompasses all of the risk areas for health insurers. *There is no more effective tool against preventing fraud and detecting problems early than an effective compliance program.* This compliance program must encompass all of a health insurer's operations where law enforcement might be concerned, including government contracts, direct or indirect participation in any government programs, managed care laws, and Employee Retirement Income Security Act compliance issues. If your company has an effective compliance program, it will be perceived more favorably by law enforcement. It also will allow you to address concerns raised by employees and others—before these complaints lead to whistleblower filings. Making sure that a health insurer's compliance plan is appropriate and current is a significant challenge for health insurers, but it is a critical step that must be taken to reduce enforcement risk.

Anticipating the Fraud Investigation

Health insurers also must recognize that the government will be conducting investigations regarding health insurer activity—whether the health insurer has committed any wrongdoing or not—so that the health insurer can be prepared both financially and operationally in the wake of an investigation.

Because many fraud issues arise because of entanglements with entities that do not follow the law, health insurers should review contractual arrangements with a full range of business partners (including managed care providers, subcontractors, vendors with delegated responsibilities, etc.) to ensure that the health insurer does not take on inappropriate financial responsibility for the actions of others. This requires a broad review of contractual entanglements. It also requires the health insurer to be aware of investigations that may involve business partners rather than the health insurer directly—although the line between being a witness to an investigation and a potential perpetrator often is very blurry.

On an operational front, health insurers should also have in place a contingency plan in the event of a significant fraud investigation. These investigations can take enormous tolls on organizations. This contingency plan should cover actions ranging from control of documents to the protection of attorney-client privilege to maintaining communication with current and former employees, both to manage the investigation and control the risk of internal difficulties through qui tam litigation. This is a challenging chore that requires a health insurer to recognize the risks that an investigation can bring, even if ultimately the health insurer is vindicated.

The Health Insurer's Posture in Defending Investigations

The last step to consider in addressing these new enforcement risks is to assess how the health insurer will respond when a law enforcement investigator arrives at the door. If the initial stages of an investigation are not handled effectively, all of the advance preparations may be for naught.

For example, one opportunity for health insurers faced with a law enforcement investigation is to attempt an internal investigation first. Obviously, this is a preferred alternative when the health insurer uncovers wrongdoing on its own. Even where law enforcement brings allegations to the health insurer, however, having an effective relationship with law enforcement may allow the health insurer to conduct an internal investigation on its own, with law enforcement's blessing. However, to have any chance of allowing this option to succeed, law enforcement must view the health insurer as trustworthy. The best way to achieve this goal, therefore, is to have a strong track record of honesty, integrity, and full disclosure with the relevant law enforcement agencies.

Health insurers also typically will be best positioned with a forthcoming posture toward law enforcement as well. Taking a too-aggressive position against a law enforcement investigation will eradicate any good will that has been built up in the past. While in an individual case the stakes may be sufficient to justify a defensive stonewall, this typically will not be the best way to handle healthcare fraud investigations. By having an effective relationship with law enforcement and by fully understanding the health insurer's rights and obligations, the health insurer will be in the best position to resolve an investigation at a reasonable level and allow the health insurer to continue to do business with the government as appropriate.

This posture does not in any way mean that a health insurer should "roll over" because of a law enforcement investigation. Because government contracts and managed care investigations are quite new for most investigators, there is substantial room for effective advocacy and thorough explanations of health insurer behavior. The overall goal of a health insurer in this area should be to have a strong reputation in the law enforcement community so that this advocacy can be heard.

Conclusions and Tips

There is a new enforcement environment today for health insurers. While there always are possibilities of a cooperative relationship in fighting healthcare fraud, health insurers must recognize that they also are likely to be targets of government fraud investigations. When a health insurer is considering the risks in connection with these investigations, it should keep the following tips in mind.

- Make sure the health insurer is visible and active with the healthcare fraud enforcement community.
- Make sure the health insurer's compliance program is keeping pace with developments and is updated regularly.
- Ensure that employees understand the importance of the compliance program in the health insurer's operations.
- Make sure that any internal investigations are thorough and accurate.
- Make sure that the health insurer addresses complaints about potential fraudulent activity quickly and completely.
- Always consider the ramifications of disclosures and the information that is being provided to law enforcement.
- Always consider the privilege implications of disclosures, especially if a lawyer is involved in an investigation.
- Pay close attention to high-risk areas that are affecting the health insurer's peers, such as Medicare Part D and medical identity theft. And,
- Always consider whether there is an opportunity to educate prosecutors and investigators about the health insurer's business operations.

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1 In 2008, Amerigroup settled a longstanding fraud case related to allegations that it refused to enroll certain high-risk Medicaid patients into its Medicaid plan, paying $225 million to resolve the allegations. In 2011, Care Source, a Dayton, OH-based managed healthcare company, paid $26 million to resolve allegations that it submitted false data and received reimbursements from Medicaid for healthcare services it did not provide.

Did You See . . . ?

. . . the HHS Office of Consumer Information and Insurance Oversight's (OCIIO's) new website? It includes recent issuances on healthcare reform initiatives, such as a report on the Early Retiree Reinsurance Program, "Report on Implementation and Operation of the Early Retiree Reinsurance Program During Calendar Year 2010" . . . .

. . . The U.S. Department of Labor, Office of Federal Contract Compliance Programs, issued Transmittal 293, which "provides comprehensive guidance for assessing when health care providers and insurers are federal contractors or subcontractors based on their relationship with a Federal health care program and/or participants in a Federal health care program." The transmittal, released on December 16, 2010 (and the subject of much debate!).

. . . the AHLA Member Briefing on the U.S. Department of Justice's and Michigan Attorney General's Office's suit against Blue Cross Blue Shield of Michigan over its use of so-called most favored nation clauses in contracts with Michigan hospitals has brought renewed attention to the use of these contractual provisions. The Member Briefing was jointly issued by the PPMC, Antitrust, and Healthcare Liability and Litigation Practice Groups.

. . . HHS' OCIIO-approved Maine's application for a waiver of the 80% medical loss ratio (MLR) standard for the state's individual health insurance market. A 65% MLR standard will be applied for three years, although the availability of the lower MLR standard in 2013 is conditioned upon the provision of data in 2012 that indicates the continued need for the adjustment. Access the HHS letter and related documentation.