Obama's Health Care Act: Consequences for California Insurers

By Shawn Hanson and Ezekiel Rauscher

It is well known that under the Federal False Claims Act, whistleblowers who report fraudulent claims made to the government stand to recover large awards. This monetary incentive essentially makes everyone a bounty hunter.

It is less well known that in California, insurance companies can be whistleblowers for false claims made to them. Under California's Insurance Frauds Prevention Act (IFPA), Insurance Code Section 1871.7, large payments can be awarded to insurers who report fraudulent claims made to private insurance companies, and the very insurance companies that are victims of insurance fraud may recover up to 50 percent of hefty civil penalties imposed on the fraudsters.

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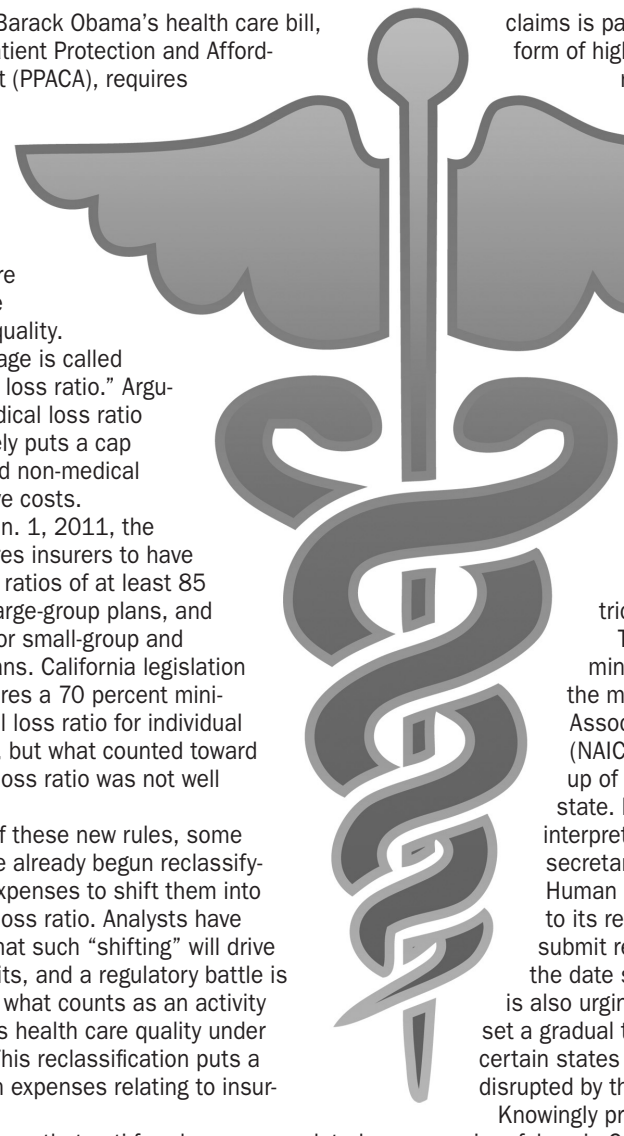
The stakes for these kinds of claims are high. Health insurers nationwide claim to lose more than $60 billion to insurance fraud every year. These and similar rewards in other states no doubt contribute to Blue Shield's impressive three-year average of $7 recovered for every $1 spent fighting insurance fraud.

A little known part of the health care reform law is only going to make the stakes higher for health insurers.



President Barack Obama's health care bill, called the Patient Protection and Affordable Care Act (PPACA), requires insurers to spend a certain percentage of adjusted premiums on health care or to improve health-care quality. This percentage is called the "medical loss ratio." Arguably, the medical loss ratio rule effectively puts a cap on profits and non-medical administrative costs.

Starting Jan. 1, 2011, the PPACA requires insurers to have medical loss ratios of at least 85 percent for large-group plans, and 80 percent for small-group and individual plans. California legislation already requires a 70 percent minimum medical loss ratio for individual health plans, but what counted toward the medical loss ratio was not well defined.

Because of these new rules, some insurers have already begun reclassifying certain expenses to shift them into the medical loss ratio. Analysts have recognized that such "shifting" will drive industry profits, and a regulatory battle is brewing over what counts as an activity that improves health care quality under the PPACA. This reclassification puts a new focus on expenses relating to insurance fraud.

Insurers argue that anti-fraud expenses related to fighting insurance fraud should count toward the medical loss ratio, because the cost of fraudulent claims is passed on to other consumers in the form of higher premiums, and money spent reducing fraud therefore improves the quality of health care. According to insurers, their fraud investigations also uncover unnecessary medical procedures performed by physicians, procedures that are detrimental to patients' health.

Consumer Watchdog counters that classification of anti-fraud expenses as health care costs is just a trick to increase profits.

The PPACA left the task of determining what costs will count toward the medical loss ratio to the National Association of Insurance Commissioners (NAIC), a non-profit organization made up of insurance regulators from each state. NAIC must submit its proposed interpretations to be certified by the secretary of the U.S. Dept. of Health and Human Services.Citing a heavy response to its request for comments, NAIC failed to submit recommendations by June 1, 2010, the date set by Secretary Sebelius. NAIC is also urging the Obama administration to set a gradual transition period of three years for certain states whose insurance markets may be disrupted by the Jan. 1, 2011, deadline.

Knowingly presenting a false claim to an insurer is a felony in California under Penal Code Section 550.

Originally signed in 1993 in an effort to combat worker's compensation fraud, California's IFPA now allows insurers to recover damages and civil penalties from those who violate Penal Code Section 550 by knowingly submitting false claims for many kinds of insurance, including health insurance. Under the IFPA, the government essentially deputizes insurers to fight fraud.

An IFPA plaintiff may recover between 30 percent and 50 percent of the proceeds of a claim brought under the Act, or a resulting settlement, depending on the Government's role in prosecuting the case. The Act provides for civil penalties of between $5,000 and $10,000 for each false claim submitted, plus an additional penalty of up to three times the aggregate value of the claims, in addition to any other civil or criminal penalties. This allows insurers to potentially recover more than they paid out in fraudulent claims, creating a strong incentive to investigate fraud.

The IFPA and its regulations also require insurance companies to maintain special investigative units at the expense of the insurer. Special investigative units staff and other integral anti-fraud personnel must receive special anti-fraud training. When sufficient facts exist to support a reasonable belief that a claim was filed fraudulently, the insurer must submit a referral to the Department of Insurance, summarizing the case and listing the relevant evidence. Each insurer's special investigative units must submit an annual report to the Department of Insurance, which also conducts periodic audits to encourage compliance.

The debate raging over what is or is not a medical loss ratio may alter the way insurers and others perceive the IFPA.

Inclusion of anti-fraud expenses in the regulatory definition of medical loss ratio may incentivize insurers to refocus and expand their existing special investigative units. Further, the outcome of this debate may have a huge effect on the IFPA because the combination of the new regulations on the medical loss ratio may enhance the existing incentives for insures to bring these kinds of claims under the IFPA.

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The Breadth of An Insurer's Duty to Defend

By Kirk Pasich

In *Gray v. Zurich Insurance Co.*, 65 Cal. 2d 263 (1966), the California Supreme Court addressed the broad scope of the duty to defend. It held that an insurer must defend a suit that "*potentially* seeks damages within the coverage of the policy…," and that the insurer "bears a duty to defend its insured whenever it ascertains facts which give rise to the potential of liability under the policy." As the court subsequently explained, the duty arises when the carrier "is informed of [an] accident and learns of even the potential for liability under its policy." *Samson v. Transamerica Ins. Co.*, 30 Cal. 3d 220, 239 (1981).

An insurer's duty to defend is triggered by allegations in a complaint or by facts extrinsic to the complaint "that reveal a possibility that the claim may be covered by the policy." *Horace Mann Ins. Co. v. Barbara B.*, 4 Cal. 4th 1076, 1081 (1993). The duty arises even when a complaint alleges covered and non-covered acts, and even when those non-covered acts predominate. As the *Horace Mann* court explained, the question is not whether non-covered acts predominate, but "whether there is *any* potential for liability under the policy."

Courts construe the allegations in the underlying complaints liberally so that the duty does not depend on inartful drafting by the underlying claimant. See, e.g., *Pension Trust Fund for Operating Eng'rs v. Fed. Ins. Co.*, 307 F.3d 944, 951 (9th Cir. 2002) ("California courts have repeatedly found that remote facts buried within causes of action that may potentially give rise to coverage are sufficient to invoke the defense duty.") Similarly, coverage is not governed by any label attached to allegations. See *Gray*, 65 Cal. 2d at 268 (insurer's duty not measured by technical, but rather by potential for coverage as revealed by facts alleged in complaint or otherwise known to insurer); *CNA Cas. v. Seaboard Sur. Co.*, 176 Cal. App. 3d 598, 609 (1986) ("it is not the form or title of a cause of action that determines the carrier's duty to defend, but the potential liability suggested by the facts alleged or otherwise available to the insurer").

As the 9th U.S. Circuit Court of Appeals has explained: The *CNA* [*Casualty*] court cited approvingly to *Ruder & Finn v. Seaboard Sur.*, 52 N.Y.2d 663, 439 N.Y.S.2d 858, 422 N.E.2d 518 (1981), wherein a New York court determined that an insurance company had a duty to defend its insured against an antitrust action that included an allegation of "false disparagement." See *CNA*, 176 Cal. App. 3d at 611-12. The court rejected the insurer's argument that "two solitary, unsubstantiated words" buried within "completely unrelated federal antitrust cause of action, which was, itself, undisputedly *not* covered" could not trigger the duty to defend.

Pension Trust, 307 F.3d at 951 n.4.

An example of how the duty to defend is triggered is provided by a decision involving the legendary rock band, The Doors. In *Manzarek v. St. Paul Fire & Ins. Co.*, 519 F.3d 1025, 1031 (9th Cir. 2008), Robby Krieger and Ray Manzarek, two of the founding members of The Doors, had been sued by John Densmore,

the drummer of The Doors. Densmore alleged that Krieger and Manzarek, who were touring as members of the band "The Doors of the 21st Century," were liable for infringing on The Doors name, trademark, and logo in conjunction with tours and marketing. He also alleged that because of Krieger and Manzarek's actions, he suffered economic damages. Densmore claimed in a single paragraph in his 68-paragraph complaint, that he had suffered damage to his "reputation and stature" insofar as the infringement caused people to believe that he was not, and is not, an integral and respected part of The Doors band or is one member who can easily be replaced by another drummer."

Krieger and Manzarek notified their insurer, which denied coverage. The insurer first contended that there was no coverage for the copyright infringement and related claims because the policy had an exclusion for claims arising in the "field of entertainment." The insurer next claimed that Densmore was not alleging "bodily injury" because he had suffered no physical injury.

The 9th Circuit disagreed. It began by analyzing the duty to defend, emphasizing that, "'Any doubt as to whether the facts establish the existence of the defense duty must be resolved in the insured's favor.'" The court held further that the field of entertainment exclusion would not apply because some of the activities in which Krieger and Manzarek potentially could have been engaged could have included the sale of a product, such as "a line of t-shirts or electric guitars with The Doors logo," which would not be subject to the exclusion and would otherwise be covered by the policy.

The court next turned to the question of whether the policy's "bodily injury" coverage obligated the insurer to defend. It rejected the insurer's argument that there was no potential for "bodily injury" coverage. It held that the allegations that Densmore's "reputation and stature" had been damaged were "sufficient to raise the potential of an award of mental anguish or emotional distress damages." The court recognized that such emotional or mental distress, even if it did not theoretically constitute "physical" injury, could be accompanied by physical manifestations that would constitute bodily injury.

If there is a potential for coverage under these liberal standards, an insurer must immediately assume its insureds defense if there is a potential for coverage; it cannot sit back and conduct an investigation, leaving its insured to fend for itself. "The defense duty is a continuing one, arising on tender of defense and lasting until the underlying lawsuit is concluded, or until it has been shown that there is *no* potential for coverage.... Imposition of an immediate duty to defend is necessary to afford the insured what it is entitled to: the full protection of a defense on its behalf." *Montrose Chem. Corp. v. Superior Court*, 6 Cal. 4th 287, 295 (1993).

An insurer also cannot unilaterally attempt to limit the scope of its duty to defend by point to the existence of other insurance policies that might obligate other insurers to defend. An insurer cannot satisfy its duty to defend by only paying a pro-rata share of the defense. Indeed, an insurer's offer to pay only a share of the insured's defense is "the equivalent of a defense denial. Such a unilateral limitation of [an insurer's] responsibility is not justified. If it owes any defense burden it must be fully borne…with allocation of that burden among other responsible parties to be determined later." *Haskel Inc. v. Superior Court*, 33 Cal. App. 4th 963, 976 n.9 (1995). See also *Aerojet-Gen. Corp. v. Transport Indem. Co.*, 17 Cal. 4th 38, 70 (1997) ("[T]he insurers each had a duty to defend all the…actions in their entirety — to be precise, *each* had such a duty *separate* and *independent from the others*."

An insurer also cannot "properly avoid its duty to defend by relying upon a coverage defense related to a critical issue in the underlying lawsuits, to wit, that there was no 'occurrence' during the policy period...." *County of San Bernardino*, 56 Cal. App. 4th 666 (1997). Likewise, an insurer cannot avoid its duty to defend by arguing that the insured will prevail in the underlying lawsuit. Furthermore, a carrier cannot ignore its duty to defend by arguing that the underlying plaintiff will not recover against the insured, or that the allegations are meritless. As another court has explained:

An insurer cannot avoid the duty to defend merely by concluding, based on its own investigation, that the insured has done no wrong. The duty to defend does not evaporate simply because the insurer has decided that the insured will ultimately be exonerated (or because evidence supporting that conclusion has been introduced in a declaratory relief action over coverage). Indeed, the duty of defense…covers third party claims that are "groundless, false or fraudulent." In short, an insurer's determination that an insured is not liable on a third party claim does not provide a basis for escaping the duty to defend. That duty extends to those insureds whom the insurer believes to be innocent of the conduct alleged in the third party complaint.

A&H Plating Inc. v. Am. Nat'l Fire Ins. Co., 57 Cal. App. 4th 427, 442-43 (1997); see *Garriott Crop Dusting Co. v. Superior Court*, 221 Cal. App. 3d 783, 796 (1990) (duty to defend exists "regardless of potentially meritorious defenses to [*underlying*] claims" and insurer must defend until resolution of underlying lawsuit). Indeed, the defense duty continues even after a lawsuit results in a judgment against an insured solely on a non-covered ground, an insurer remains obligated to pay for the insured's defense through the resolution of the lawsuit, on appeal.

Finally, an insurer's duty to defend does not end simply because a judgment is entered against its insured in a trial court. As one court of appeal explained: "Just because evidence has closed in the underlying case does not mean the facts against the policyholder have necessarily calcified. Here, a new trial might have been granted. Witnesses might have changed their stories or their memories might have improved. The…judgment against [the insured] could have been overturned, yet another takes its place on remand. In short, the potential for indemnification liability continued into the appeal period." *Prichard v. Liberty Mut. Ins. Co.*, 84 Cal. App. 4th 890, 903-04 (2000).

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