APPENDIX B

HCSC COMPLIANCE PROGRAM
SELECTED HEALTH CARE CRIMINAL AND CIVIL PENALTIES

I. Selected Relevant Statutes and Penalties

A corporation may be prosecuted and held criminally responsible for criminal acts committed by its employees or agents if those acts were committed within the scope of their employment and with the intent to at least partially benefit the corporate business. When the act is within the scope of the employee's authority, the corporation may be liable even if the act is expressly prohibited by corporate policy.

The federal and state governments apply a number of different criminal and civil statutes governing the Companies' conduct, provide for fines, imprisonment, civil money penalties and business exclusions:

A. Health Care Fraud

1. Federal Health Care Offense Defined: 18 U.S.C. § 24

In 1996, Congress passed a broad new health care and privacy statute commonly referred to as HIPAA. Under this law, a federal health care offense includes a violation of (or conspiracy to violate) a number of specified laws, including ERISA, if related to a health care benefit program. A health care benefit program is defined as "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract." The breadth of this definition is obvious.

2. Health Care Fraud: 18 U.S.C. § 1347

This health care fraud offense, created as part of HIPAA, expands significantly the scope of federal criminal jurisdiction in that it applies not just to claims made to public benefits programs, but to those made to private insurers as well. The statute makes it a felony for any person to knowingly and willfully execute or attempt to execute a "scheme or artifice" to defraud any health care benefit program or to obtain any money or property owned by or under the custody or control of any health care benefit program. A conviction for this offense carries an array of possible imprisonment scenarios up to ten years, unless the violation results in serious bodily injury or death, in which case the penalty can rise to twenty years or life, respectively.

3. Embezzlement of Health Care Funds: 18 U.S.C. § 669

This section makes it an offense to embezzle, steal, or intentionally misapply the assets of a health care benefit program. The penalty for violating this statute is dependent on the value of the assets at issue. The possible penalties include a fine and/or imprisonment for up to ten years.

4. Health Care Related False Statements: 18 U.S.C. § 1035

This statute makes it a crime for any person in connection with the delivery of or payment for health care benefits, services or items to falsify or conceal a material fact, to make materially false or fraudulent statements, or to use any materially false documents. A violation of this provision may result in a fine and/or imprisonment for up to five years.

5. Obstruction of Criminal Investigations of Health Care Offenses: 18 U.S.C. §1518

This statute makes it a crime for anyone to willfully prevent, obstruct, mislead, delay or attempt to obstruct the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator, including any authorized governmental department or agency. Those convicted may be either fined and/or imprisoned for up to five years.

6. Civil Monetary Penalties Act: 42 U.S.C. §1320a-7a

In the Civil Monetary Penalties Act, Congress established civil monetary penalties that target upcoding, medically unnecessary services, and improper inducements to Medicare and Medicaid beneficiaries. See section H.2 below and 42 C.F.R. § 1003.

7. Health Care Fraud and Abuse Data Collection Program: 42 U.S.C. § 1320a-7e

As part of HIPAA, Congress directed the Secretary for Health and Human Services (HHS) to establish a national health care fraud and abuse data collection program for reporting and disclosing certain final adverse actions taken against health care providers, suppliers and practitioners, and to maintain a database. The database is known as the National Practitioner Data Bank ("NPDB"). This database was originally known as the Health Integrity and Protection Data Base, but both databases were merged in May of 2013.

Through regulation, 42 CFR Pt 60 *et. seq.*, HHS has clarified the reporting requirements upon health plans with regard to the database. Most notably, health plans are required to report, among other things, (i) civil judgments against health care providers, suppliers or practitioners related to the delivery of a health care item or service, and (ii) other adjudicated actions or decisions related to the

delivery, payment or provision of a health care item or service, against health care providers, suppliers or practitioners. These reporting requirements apply regardless of whether the civil judgment or other action is subject to a pending appeal. The failure to report such information subjects a health plan to a penalty of up to $25,000 under the Civil Monetary Penalties Act, 42 U.S.C. § 1320a-7a.

B. Federal Health Care Program Fraud: 42 U.S.C. §§ 1320a-7b(a), (c)

Prior to HIPAA's expansion of federal jurisdiction, Congress had sought specifically to prevent fraud and kickbacks (discussed below) in the operation of the Medicare/ Medicaid programs. In addition to creating new criminal offenses, HIPAA expanded the anti-kickback statute to cover all federal health care programs (defined as any plan or program that provides health benefits, which includes Medicare, Medicaid, and Tricare and excludes the federal employees health benefits program). Federal health care program applicants and providers may be subject to criminal prosecution for, among other things, knowingly making any false statement or misrepresentation of a material fact in any application for any federal health care program benefit, or for use in determining the rights to such benefit or payments.

They also face criminal liability for concealing or failing to disclose one's knowledge of any event that would affect a person's initial or continuing right to receive Medicare/ Medicaid; and knowingly making false statements or misrepresentations with respect to the conditions or operation of any institution, hospital, or health care facility or entity for which certification is required for federal health care program eligibility.

C. Federal Health Care Program Anti-Kickback Statute: 42 U.S.C. § 1320a-7b(b)

Congress specifically sought to prohibit the payment of kickbacks or illegal remunerations in association with the federal health care programs. The "Anti-Kickback Statute" (AKS) prohibits any person from knowingly and willfully offering, paying, soliciting, or receiving any remuneration (including kickbacks, bribes or rebates) directly or indirectly, in return for patient referrals or purchasing, leasing, ordering, arranging for, or recommending any goods, facility, service or item(s) which are reimbursable under federal health care programs. Given the breadth of the statute, there are a number of statutory exceptions and regulatory safe harbors that protect certain types of remuneration from prosecution even if one purpose is to induce or reward referrals. Compliance with these exceptions and safe harbors is not required, however. Arrangements that do not fit within a statutory exception or regulatory safe harbor are subject to a facts and circumstances analysis to determine the potential risks of running afoul of the purposes behind the AKS, which are preventing overutilization, excessive federal health care program costs, corruption of medical decision-making concerning patient care, and unfair competition. A violation of this section will result in fines up to $25,000 and/or up to five years in prison.

A kickback is not limited to cash referral fees; "in kind" payments for having received special consideration in the purchase of items or in the making of referrals will qualify as a kickback. Examples of possible kickbacks include routine waiver of copayments and deductibles; tickets to sporting events, education materials, educational grants, medical equipment, rebates, and consulting fees offered by health care providers or pharmaceutical drug representatives to physicians, HMOs or hospitals as a quid pro quo for business, etc. Due to the complexity of this law, consult the Company's policies or a Supervisor of the Legal Department for more information regarding the scope of potential kickbacks.

D. <u>False Claims Acts:</u> 18 U.S.C. § 287 and 31 U.S.C. §§ 3729 *et seq*.

Congress passed the criminal False Claims Act ("FCA") to punish individuals who undermine or disrupt the operation or integrity of federally funded programs. The statute prohibits making false, fictitious, or fraudulent claims against the federal government. The FCA has been used to prosecute a wide range of frauds, including Medicare, Medicaid, and Social Security fraud, claims for services not rendered under special government programs, false claims for worker's compensation, and false claims to insurers who then submitted claims to the federal government. Criminal penalties include fines and up to five years incarceration.

Most claims that would be actionable under the FCA could also be prosecuted under the Federal health care program Civil Monetary Penalties Act, 42 U.S.C. **§** 1320a-7a, and the Federal health care program fraud and abuse statute, 42 U.S.C. **§** 1320a-7b. In addition, under the civil False Claims Act, a person may be liable for improperly avoiding an obligation to refund money to the federal government (such as under rules governing refunds of Medicare and Medicaid overpayments).

The civil FCA defines "knowingly" to mean the person (1) has actual knowledge that the information is false; (2) acts with deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. This standard requires more than mere negligence and something less than specific intent to disobey the law. Gross negligence or deliberate indifference to the falsity of the information must be shown.

In addition to direct prosecution of civil or criminal false claims by the Justice Department, *qui tam* or whistleblower suits can be brought under the civil False Claims Act. 31 U.S.C. § 3730. Such suits are brought in the name of the government and allow the whistleblower to recover 15 to 25 percent of the government's recovery resulting from that individual's information, or up to 30 percent if the government does not intervene and take over litigating the case. The civil False Claims Act provides for penalties of $5,500 to $11,000 per false claim (periodically adjusted for inflation) plus three times the amount of damages the government sustained.

E. HIPAA Privacy, Security, and Breach Notification Standards: The Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d) and its implementing regulations at 45 C.F.R. Parts 160, 162, and 164; as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, Pub Law 111-5, § 13001, et seq.

HIPAA's privacy and security requirements apply to PHI which, generally, means any identifiable information that is created or received by a health care provider, health plan, or health care clearinghouse, and that relates to the past, present, or future health of an individual. HIPAA regulates "covered entities," which are health plans, health clearinghouses (i.e., entities that process non-standardized health information received from a covered entity into standardized data elements), and health care providers that conduct certain financial and administrative transactions electronically (e.g., electronic billing and funds transfers).

HIPAA mandates that every covered entity have a "business associate contract" with its business associates containing certain mandated privacy, security, and breach notification provisions. Broadly, a business associate is any entity that creates, receives, maintains, or transmits PHI on behalf of a covered entity for a function regulated by HIPAA, or that provides certain services to a covered entity (such as management or administrative services) that require the disclosure of PHI to the entity. Covered entities are responsible for violations of their business associates (as defined in the regulations) if the covered entity knew of a pattern of activity or practice that constituted a material breach of the mandated business provisions of the business associate contract and failed to cure the breach. If such steps prove unsuccessful, covered entities must terminate the business associate contract or report the violation.

On January 25, 2013 HHS published a final rule modifying HIPAA and implementing statutory amendments under HITECH to strengthen the privacy and security protection for an individual's health information. This rule also modified breach notification requirements under HITECH and strengthened privacy protections for genetic information. Under the rule, business associates are now directly liable for noncompliance with certain HIPAA requirements. HITECH's "harm" threshold for breach notification has also been replaced with a more objective standard.

In addition, 42 U.S.C. § 1320c-9(c) also makes it a crime to unlawfully disclose confidential patient information by an entity engaged in peer review of quality management and utilization if such disclosure is not mandated by statute or regulation.

F. General Crimes Relevant to Health Care Providers

1. False Statements: 18 U.S.C. § 1001

One of the statutes mostly commonly used to prosecute fraud, including health care related frauds, is the prohibition against false statements or misrepresentations with regard to "any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States". This statute applies to those statements, either oral or written, sworn or unsworn, made by any provider or employee who falsifies or conceals any material fact; makes any materially false statements or representations; or makes or uses any materially false documents or writings.

Because the defendant must make a false statement both "knowingly and willfully," it should be noted that the intent requirement of §1001 is higher than that required under §287 (False Claims). The fraudulent statements need not be made directly to the federal government to be subject to prosecution. Each offense carries potential imprisonment of up to five to 8 years and fines of up to $250,000 for individuals and $500,000 for corporations.

2. Obstruction of Justice: 18 U.S.C. §§ 1512, 1519, 1520

These provisions prohibit corruptly destroying documents or other evidence (or persuading others to destroy documents or other evidence) with the intent to obstruct an official proceeding. Depending on the circumstances, maximum penalties may include a fine and/or a term of imprisonment of up to 20 years.

Additionally, accountants who fail to retain the audit or review "workpapers" of a covered audit for a period of 5 years can be found guilty of a felony, punishable by up to ten years imprisonment. "Workpapers" are those documents necessary to explain and substantiate the work performed as part of the audit or review. This provision, codified at 18 U.S.C. § 1520, imposes fines and up to a 10-year prison term on any person who "knowingly and willfully" violates this retention requirement.

3. Retaliation: 18 U.S.C. § 1513

Under previous law, there was no explicit protection from retaliation for an individual who provides truthful information to a law enforcement officer concerning the commission or possible commission of a Federal offense. However, subsection (e) of 18 U.S.C. §1513 now creates a felony offense for any person who knowingly takes any action, with intent to retaliate, that is harmful to a person who provided such information concerning a Federal offense. A violation of this statute may result in fines and/or up to ten years in prison.

4. Money Laundering: 18 U.S.C. § 1956

The addition to the money laundering statute of health care fraud makes it a crime to launder monetary instruments, specifically (a) to conduct or attempt to conduct a financial transaction involving property known to be the proceeds of an unlawful activity; (b) to transport or attempt to transport funds intending to promote an unlawful activity or knowing that the funds are proceeds of an unlawful activity; or (c) to conduct or attempt to conduct a financial transaction with proceeds of, or represented to be of, an unlawful activity with the intent either to promote the unlawful activity, conceal the property, or avoid a reporting requirement under state or federal law. Here, the "unlawful activity" now includes any federal health care offense. The penalties for each of these violations vary but do not exceed a fine in the amount of $500,000 or twice the value of the property involved and/or imprisonment for up to twenty years.

5. Conspiracy: 18 U.S.C. §§ 371 and 286

A conspiracy is a group of two or more persons who have agreed together to commit an illegal act. The agreement between two or more conspirators to accomplish an illegal objective is the very essence of a criminal conspiracy. The conspiratorial agreement does not need to be formal or detailed, nor does it even have to be expressly stated. A tacit understanding of the agreement will suffice. Proof of the agreement between conspirators is usually shown by a defendant's actions.

The general federal conspiracy statute (18 U.S.C. **§** 371) prohibits combinations of two or more persons to violate any law of the United States or to defraud the United States or any government agency. The maximum penalty is five years imprisonment and/or a fine. Under 18 U.S.C. **§** 286, it is unlawful to conspire to make false claims on the government. The maximum penalty for §286 is ten years imprisonment and/or a fine. The conspiracy or agreement itself constitutes a crime separate and distinct from the actual crime committed by any of the conspiracy's members. For example, if two persons conspire to defraud someone and they use the mails to do so, they have committed two crimes: conspiracy and fraud. Even if the fraud never occurs, or even if the fraud scheme is unsuccessful, the conspirators may still be prosecuted for criminal conspiracy.

6. Insurance Business Affecting Interstate Commerce: 18 U.S.C. §§ 1033 and 1034

In 1994, Congress made a number of acts involving the insurance industry federal crimes where the business "affects interstate commerce." Thus, frauds, false statements, embezzlement, deception of auditors and false book entries, among other acts, all carry criminal penalties of imprisonment for up to ten years, and in cases where it jeopardized the safety and soundness of an insurer, up to fifteen years. Section 1033 also requires those convicted of felonies involving breach of trust or dishonesty, to obtain written consent of insurance regulatory officials before engaging in the insurance business. Finally, Section 1034 gives the

government injunctive relief and sets forth civil penalties of up to $50,000 for each violation or the amount of compensation which the violator received or offered, whichever is greater.

7. Major Government Fraud: 18 U.S.C. § 1031

In 1988, Congress expanded its antifraud remedies with this criminal statute focusing on schemes to defraud the United States or to obtain money or property by false or fraudulent representations as a prime contractor to the government or a sub-contractor or supplier to a prime government contractor where "the value of such grant, contract, subcontract, subsidy, loan, guarantee, insurance, or other form of Federal assistance, or any constituent part thereof" is $1 million or more. Criminal fines range up to $10,000,000 and imprisonment up to 10 years, or both. The statute also authorizes payments by the Justice Department of up to $250,000 to persons furnishing information relating to a possible Section 1031 prosecution.

8. Mail and Wire Fraud: 18 U.S.C. §§ 1341 and 1343

If a person or entity devises a scheme to commit fraud and utilizes the United States mail or interstate wires (e.g., telephone, facsimile, or electronic mail) to help the fraud along (e.g., mailing a false document to the recipient or making a misrepresentation to a potential customer over the phone in another state), then such fraud - regardless of whether the government or a private citizen was the intended victim - is subject to federal prosecution as a mail or wire fraud. The elements of mail and wire fraud are: (1) intentionally devising or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent, pretenses, representations or promises; and (2) using or causing the use of mails or interstate wires in furtherance of the scheme.

In 2002, Congress passed 18 U.S.C. §1349, which provides that attempts and conspiracies to commit the substantive Federal fraud offenses (including health care fraud - 18 U.S.C. §1347) will have the same punishment as the substantive crime. While the penalty had been five years imprisonment, and a variety of possible fines, the federal mail and wire fraud statutes were amended to increase the maximum penalty to 20 years imprisonment.

9. State Benefits and Medicaid Fraud Laws

In addition to federal laws, states have their own criminal laws prohibiting state benefits fraud or Medicaid fraud. Unlike the federal statutes, however, it is not necessary to use the mail or interstate wires to be criminally prosecuted. The following is a summary of some of the state laws.

a. Illinois: State Benefits Fraud: 720 ILCS 5/17-6

In Illinois, a person is guilty of state benefits fraud if he or she obtains or attempts to obtain money or benefits from the state through the knowing use of false identification documents, or through knowing misrepresentation of his age, place of residence, number of dependents, marital or family status, employment status, financial status, or other material fact upon which his or her eligibility for benefits may be based.

b. <u>Oklahoma: False Claim for Payment of Public Funds or on Employment Application</u>: 21 Okl. St. §§ 358, 359

Oklahoma statutes provide for a criminal offense when any person knowingly presents a "false, fictitious or fraudulent claim for payment of public funds upon or against the State of Oklahoma, or any department or agency thereof." Such an offense is punishable by a fine of up to $10,000 or by imprisonment of up to two years, or both.

The statute also prohibits anyone applying for employment with the state of Oklahoma to knowingly make a "materially false, fictitious or fraudulent statement or representation on an employment application." This offense is punishable by a fine of up to $1,000 or by imprisonment of up to one year, or both.

c. <u>Texas: False Claims & Anti-Kickback Law; Medicaid Fraud</u>: Tex. Human Res. Code § 32.039, § 36.001 et seq.

Texas law generally provides that it is unlawful to knowingly or intentionally make false statements of a material fact, or to fail to disclose a material fact, in relation to a Medicaid application, benefit, payment or eligibility requirement. Tex. Human Res. Code §§ 36.001 et seq. Related fraudulent activities are also prohibited, such as converting Medicaid benefits for use by persons other than the intended recipient, making false statements regarding facilities that are certified by Medicaid, or presenting false claims for payment, among other activities. The Texas Medicaid Fraud Prevention statute contains civil damage, injunctive, and suspension remedies. There are also special provisions prohibiting managed care organizations from engaging in certain fraudulent or wrongful conduct. Tex. Human Res. Code § 32.039.

d. <u>New Mexico: Medicaid Fraud Act</u>: N.M. Stat. Ann. § 30-44-1 et seq.

The New Mexico Medicaid Fraud Act, N.M. Stat. Ann. § 30-44-1 et seq., criminalizes a variety of behavior relating to the misuse of program funds. The Act prohibits the paying, soliciting, offering or receiving of kickbacks and bribes, as well as any rebates for referring a recipient to a provider. N.M. Stat. Ann. § 30-44-7. Under the Act, it is also illegal to pay, solicit,

offer or receive anything of value with the intention of retaining it and knowing it to be in excess of amounts or rates authorized under the program for the provision of treatment, services or goods. In addition, the Act criminalizes the conduct of individuals and entities that provide below-quality treatment, services or goods with the intent that a claim be relied upon for the expenditure of public money. Related behavior, such as presenting false claims, making false or fraudulent representations, and engaging in intentionally deceptive marketing practices also violates the New Mexico Medicaid Fraud Act. Depending upon the value of the benefit improperly provided and the extent of any physical or psychological harm suffered, a violation of the New Mexico Medicaid Fraud Act can range from a petty misdemeanor to a second degree felony. An entity that commits Medicaid fraud is subject to fine of not more than $50,000 for each misdemeanor and not more than $250,000 for each felony. N.M. Stat. Ann. § 30-44-7.

e. <u>Montana: False Claim to Public Agency:</u>
45-7-210, Montana Code Annotated

A person commits a false claim to a public agency if the person knowingly presents for allowance, for payment, or for the purpose of concealing, avoiding, or decreasing an obligation to pay a false or fraudulent claim, bill, account, voucher, or writing to a public agency, public servant, or contractor authorized to allow or pay valid claims presented to a public agency. A person convicted of an offense under this section shall be fined not to exceed $1,500 or imprisoned in the county jail for a term not to exceed 6 months, or both. If a false or fraudulent claim is knowingly submitted as part of a common scheme or if the value of the claim or the aggregate value of one or more claims exceeds $1,500, a person convicted of an offense under this section shall be fined not to exceed $10,000 or imprisoned in the state prison for a term not to exceed 10 years, or both.

10. <u>Program Embezzlement</u>: 18 U.S.C. § 666

Embezzlement is the wrongful or willful taking of someone else's money or property by one who lawfully came into its possession or control. One common example of embezzlement occurs when an employee working in collections "skims" money from customer payments that were made to his or her employer. Embezzlement differs from larceny in that the embezzler's original possession of the property is lawful or is pursuant to the consent of the owner. The federal program embezzlement statute prohibits (1) any agent of any agency, government, or organization (2) that received benefits in excess of $10,000 in the previous twelve months from a "Federal program" (3) from embezzling, stealing, obtaining by fraud, corruptly solicits, demands or accepts anything of value with the intent to influence, or converting to one's use without authority (4) property in excess of

$5,000 that is owned or controlled by such agency, government, or organization. A violation of this statute may result in fines and/or up to ten years in prison.

11. Obstruction of Federal Audit: 18 U.S.C. § 1516

Congress made it an offense to intentionally influence, obstruct or impede any federal auditor performing duties relating to the audit of a person, entity or program receiving more than $100,000 of United States funds in any one year. The funds need not come directly from the federal government, as where an entity subcontracts with another who receives federal contract funds.

12. USA Patriot Act: 115 Stat. 272 (107 P.L. 56)

The United and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act (USA PATRIOT Act) of 2001, ("Patriot Act"), amended a number of provisions of the federal Bank Secrecy Act ("BSA") and was signed into law on October 26, 2001. It also added terrorism and a number of other crimes to the list of money laundering crimes and increased civil and criminal penalties for such crimes. These changes, which have a number of important ramifications for insurance companies and other financial service companies, are in addition to the rules and regulations administered for the Office of Foreign Assets Control ("OFAC"), which requires the blocking of assets and prohibit certain transactions with individuals and entities engaged in or suspected to be engaged in terrorist activities.

13. International Money Laundering Abatement and Financial Anti-Terrorism Act (Title III of the Patriot Act): 115 Stat. 296 (107 P.L 56); 31 CFR 1010.100, 1025.500

Unless exempted by regulation, the broad range of financial services and other companies, including insurance companies, subject to the Bank Secrecy Act are required by the Patriot Act to establish anti-money-laundering ("AML") compliance programs. These programs must include, at a minimum, the following:

- Development of internal policies, procedures and controls
- Designation of an AML compliance officer
- An ongoing employee training program
- An independent audit function to test programs

On October 31, 2005, the Financial Crimes Enforcement Network (FinCEN) announced a final rule that requires certain insurance companies to establish AML programs. Insurance companies have 180 days from the date of publication of the final rule in the Federal Register (November 3, 2005). AML compliance programs must be established only by insurance companies that issue, underwrite or reinsure life insurance policies, annuities or insurance products with investment

features similar to life insurance policies or annuity contracts or which can be used to store value and transfer such value.

The regulations for insurance companies reiterate the statutory requirements and provide that covered insurance companies must develop policies, procedures and controls that are risk-based, reflecting the anti-money laundering risks that the particular company encounters. According to the regulations, in developing such a program, the insurance company should consider, at a minimum, the money laundering and terrorist financing risks posed by the type of specific products it offers, its customers, distribution channels and geographic locations.

The program must include policies and procedures and controls for complying with applicable BSA requirements and obtaining all necessary information to make the program effective. The AML compliance officer must be responsible for effectively implementing the AML program; updating the program as necessary to reflect current regulatory requirements; and providing appropriate employee education and training about AML responsibilities. Ongoing education and training must be provided for appropriate personnel concerning their responsibilities. Independent audits must be conducted with a scope and at a frequency commensurate with the money laundering risks posed by the business. They may be conducted by either an outside party or by an officer or employee of the entity other than the compliance officer. The AML compliance program must be in writing and approved by senior management.

a. <u>Currency Transaction Reports</u>: 31 U.S.C. § 5331

Health insurance companies still must file currency transaction reports for the receipt of cash and cash equivalents in one or more related transactions of $10,000 or more. Reports of foreign bank and securities accounts must also be filed. In addition, health companies that are subject to the provisions of the United States criminal code prohibiting money laundering could be found to be aiding and abetting should a violation occur without proper procedures in place.

b. <u>Special Due Diligence for Correspondent and Private Banking Accounts: FinCEN Final Rule</u> pursuant to 31 U.S.C. § 5311 *et. seq.*; 31 CFR 1010.600 *et. seq.*

On August 9, 2007, FinCEN issued a final rule regarding special due diligence programs for certain foreign accounts. 72 Fed. Reg. 44768.

Under this rule, any financial institution, including an insurance company, that establishes, maintains, administers or manages private banking accounts or correspondent accounts in the U.S. for non-U.S. persons or their representatives must establish appropriate, specific and, where

necessary, "enhanced" due diligence policies, procedures and controls that are reasonably designed to detect and report instances of money laundering. For purposes of this statute, a private banking account is an account or combination of accounts that (i) has $1 million minimum deposit or asset requirement, (ii) is established on behalf of one or more individuals who have a direct or beneficial interest in the account, and (iii) is assigned to or administered or managed by, in whole or in part, a financial institution officer, employee or agent who acts as a liaison between the institution and the direct or beneficial owner of the account.

Minimum due diligence standards for private banking accounts requested or maintained by, or on behalf of, non-U.S. persons include (i) ascertaining the identity of the nominal and beneficial owners of the account as well as the source of the deposited funds as needed to guard against money laundering and report suspicious transactions, and (ii) conducting enhanced scrutiny of any such account that is requested or maintained by or on behalf of a senior foreign political figure, any immediate family member or a close associate that is reasonably designed to detect and report transactions that may involve the proceeds of foreign corruption.

c. <u>Reporting Suspicious Activity: FinCEN Final Rule</u> pursuant to 31 U.S.C.A. § 5318A; 31 CFR 1025.320

On November 3, 2005, FinCEN published a final rule requiring certain insurance companies to file Suspicious Activity Reports (SARs). 70 Fed. Reg. 66761. The rule mainly applies to only life insurance companies, but may also apply to any insurance product with features of cash value or investment. This requirement does not include agents or brokers. Insurance companies are now instructed to file a SAR report form for insurance companies – "FinCEN Form 108 – Suspicious Activity Report by Insurance Companies." All suspicious transactions involving $5,000 or more, whether in an individual transaction or in aggregate and whether in funds or other assets, must be reported. Additionally, this threshold amount is not limited to individual insurance policies with premiums that exceed $5,000. Rather, any policy in which the premium or potential payout exceeds $5,000 meets FinCEN's suggested protocol. Importantly, insurance companies are encouraged to file voluntary SARs, as appropriate, and are protected from liability on the same level as when a SAR is required.

G. <u>Sanctions Relevant to Medicare Advantage Organizations and Part D Plan Sponsors</u>:

42 U.S.C. §§ 1395w-27(g)(1) - (4), (h); 42 U.S.C. § 1395w–151(b)

1. Program Violations. The HHS Secretary may impose sanctions on a Medicare Advantage (MA) organization or Part D Plan Sponsor (collectively, "MA organization") in a number of situations. In particular, the Secretary may impose sanctions if she determines that the MA organization: (1) fails substantially to provide medically necessary items and services that are required (under law or under the contract); (2) imposes excess premiums on Enrollees; (3) expels or to refuses to re-enroll an individual in violation of the related MA program provisions; (4) does anything to deny or discourage enrollment (except as permitted) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services; (5) misrepresents or falsifies information that is furnished to the Secretary, to an individual, or to any other entity; (6) fails to comply with the applicable requirements relating to provider participation and balance billing; (7) employs or contracts with an excluded entity or individual; (8) enrolls an individual in an MA plan, or transfers an individual from one plan to the other, without prior consent; or (9) fails to comply with applicable marketing restrictions.

2. Remedies for Program Violations. In addition to any other remedies authorized by law, the Secretary may impose any of the following sanctions: civil money penalties of up to $25,000 for most violations ($100,000 in some instances) and/or suspension of marketing, enrollment, or payment. In addition, the Secretary has authority under some circumstances to terminate a contract for program violations. For less significant noncompliance, CMS may issue a notice of noncompliance or other type of notice. Civil money penalties, sanctions, and less significant compliance notices all may impact an MA organization's past performance evaluation, thereby limiting options for the MA organization to expand product lines or service area.

H. The Possible Consequences of Unlawful Conduct

Some of the federal statutes listed above and most of their state statutory counterparts are felony offenses. For individuals, convictions can result in a substantial term of imprisonment and/or fines and restitution. As an organization, HCSC is obviously not subject to imprisonment. In the event of criminal conviction, however, an organization can be held liable for enormous fines and restitution. For example, in 2002, one pharmaceutical drug company was found guilty and made to pay $875 million. Many other such examples often occur. Criminal misconduct committed by an employee could also subject the organization to additional civil penalties that could be more burdensome than a criminal conviction.

1. Exclusion from Federal Programs: Any provider, health care facility, or claims processor, including HCSC, is subject to a five year mandatory exclusion from receiving federal health care program payments or reimbursements in the event the Company, provider or health care facility is convicted of a criminal offense related to the delivery of an item or service under federal health care programs. 42 U.S.C. **§** 1320a-7(a).

"Permissive" exclusion is also a possibility under 42 U.S.C. **§** 1320a-7(b). A provider, health care facility or claims processor may, at the discretion of the Secretary for the Department of Health and Human Services, be subject to a period of exclusion from receiving federal health care program payments or reimbursements for other criminal violations and civil infractions. For HCSC, the most pertinent criteria for permissive exclusion include: (1) conviction of a criminal offense under state or federal law relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct connected with a program operated or financed in whole or in part by any government agency; (2) conviction for obstructing an investigation or audit; and (3) engaging in fraud, kickbacks or any other act proscribed by the Anti-Kickback Statute. Related provisions for debarment and suspension from participation in federal health care programs are found in the Federal Acquisition Regulations, FAR 9.406 and 9.407.

The Balanced Budget Act of 1997 (111 Stat. 251) broadened the exclusion period for individuals that have been subject to mandatory exclusion under 42 U.S.C. **§** 1320a-7(a). Their exclusion shall be (i) 10 years if the person has been convicted of *one* prior offense for which exclusion may be imposed; and (ii) permanent if the person has been convicted of *two* prior offenses for which exclusions may be imposed. 42 U.S.C. **§** 1320a-7(c)(3)(G).

The Balanced Budget Act of 1997 also granted the Secretary of the Department of Health and Human Services ("HHS") the authority to refuse to enter into a Medicare agreement with a physician or supplier who has been convicted of a state or federal felony that the Secretary deems inconsistent with the best interest of program beneficiaries (42 U.S.C. **§** 1395u(h)).

2. <u>Civil Monetary Penalties</u>: In addition to the criminal statutes and penalties noted above, a health care provider may also be subject to both private lawsuits and other governmental sanctions for engaging in unlawful conduct. For example, the Civil False Claim Act, 31 U.S.C. § 3729 *et seq*., described above, provides for treble damages and penalties of not less than $5,500 and not more than $11,000 per claim for any false or fraudulent claim for payment submitted to the federal government. False or fraudulent federal health care program claims for health care related items or services are also subject to harsh civil penalties under the Civil Monetary Penalties Act, 42 U.S.C. § 1320a-7a.

The Civil Monetary Penalties ("CMP") Act gives the OIG an enforcement tool analogous to the False Claims Act. In fact, legislative enhancements brought the penalties available under the CMP Act in line with those provided by the FCA. The statute allows the OIG to impose CMPs on an individual or entity that has committed one of several enumerated acts of fraud and abuse or billing/coding violations, including but not limited to the submission of claims for:

- items or services that the person knows or should know were not provided as claimed;
- items or services that the person knows or should know are false or fictitious; and
- physician's services provided by a person not licensed as a physician.

The statute also imposes civil monetary penalties for patterns of upcoding or the provision of medical or other items or services that are not medically necessary, and for improper remuneration likely to influence a beneficiary's choice of provider. HIPAA increased the amount of potential civil monetary penalties from up to $2,000 per item or service to $10,000. It also increased the damages available under the CMP Act from two to three times the amount improperly claimed for each time or service.

The Balanced Budget Act of 1997 ("BBA '97") created civil monetary penalties for anti-kickback violations, thus providing an alternative to the harsh criminal penalties and exclusion options previously available for such infractions. Individuals or entities that violate the anti-kickback law now confront a maximum $50,000 penalty and damages of up to three times the amount of remuneration involved in the prohibited activity.

HIPAA also gave the OIG the authority to impose CMPs on individuals who have an ownership interest in or control of an entity that has been excluded from federal health care programs and who knows or should know of the action creating the basis for the exclusion. Civil monetary penalties may likewise be imposed against an officer or managing employee (e.g., an office manager) of an excluded entity.

BBA '97 likewise created a civil monetary penalty for persons or entities that arrange or contract (by employment or otherwise) with an individual or entity that the person or entity knows or should know is excluded from a federal health care program. This provision will require physicians to exercise even greater care in doing business with other individuals and entities in the health care delivery and payment system. Violations will involve damages three times the amount claimed and a civil money penalty of $10,000 per claim. 42 U.S.C. 1320a-7a(a)(6).

Further, a civil money penalty of up to $25,000 is imposed against a health plan that fails to report information on an adverse action required to be reported under the health care fraud and abuse data collection program established under HIPAA 42 U.S.C. 1320a-7e(b).

I. Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act are known collectively as the Affordable Care Act ("ACA"). This law involves broad-ranging reform of the health insurance industry as well as many of the

legal authorities addressed above. ACA implements numerous new statutory and regulatory requirements for health insurers, modifies some of the other enforcement authorities discussed herein, and places additional emphasis on governmental enforcement efforts.

* * *

In short, our organization can never benefit as a result of any employee's misconduct. Our very mission of service can be threatened as a result of an employee's criminal acts.

J. U.S. Foreign Corrupt Practices Act

The United States' main international anti-bribery law, the U.S. Foreign Corrupt Practices Act ("FCPA"), prohibits providing, directly or indirectly, anything of value to a foreign government official in order to obtain or retain business or otherwise gain a commercial benefit. Foreign government officials may include office-holders, employees of state owned/operated enterprises (*e.g.*, doctors, technicians, employees at a public hospital), military officials, royal family members, or representatives of international organizations (*e.g.*, United Nations or World Bank). The FCPA also imposes record keeping and internal accounting and control requirements to ensure integrity and accuracy in the recording and reporting of all business transactions.

The FCPA is both a criminal and civil statute (enforced by the Department of Justice and Securities and Exchange Commission respectively) and it applies to both entities and individuals. The potential sanctions for FCPA violations can be severe. For violations of the anti-bribery provisions of the FCPA the criminal penalties for individuals are up to $250,00 and/or 5 years imprisonment per violation and for entities up to $2 million per violation. Civil penalties for anti-bribery violations are up to $10,000 per violation for both individuals and entities. Entities may also have to disgorge ill-gotten gains in connection with a bribe and may also be debarred or suspended from participating in multilateral development bank (*e.g.*, World Bank) or federal government procurement programs. For violations of the accounting/controls and record keeping provisions of the FCPA, the criminal penalties for individuals can be up to $5 million and/or 20 years imprisonment per violation and for entities can be up to $25 million per violation. Civil penalties for accounting/controls and record keeping violations for individuals range from $5,000 to $100,000 per violation and for entities from $50,000 to $500,000 per violation.