

Business Law & Governance

Table of Contents

There's A Reason for Walls: A Defense of Compartmentalized Borrowing and Lending in the Healthcare World <i>Joseph Brown, Esq.</i>	1
Editor's Note <i>William Horton, Esq.</i>	5
Falling Through the Cracks: Qui Tam Lawsuits and the Prior and Pending Litigation Exclusion <i>Michael Rosen, Esq.</i> <i>David Shedd, Esq.</i>	6
The Current Status of the Patient Care Ombudsman Program Mandated by the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 <i>Victoria Powers, Esq.</i> <i>R. Brent Martin</i>	12
Will the Landscape of Corporate Prosecutions Change? <i>Kevin Di Gregory, Esq.</i> <i>Becky Walker, Esq.</i> <i>Lauren Teitelbaum, Esq.</i>	17



Business Law & Governance © 2009 is published by the American Health Lawyers Association. All rights reserved. No part of this publication may be reproduced in any form except by prior written permission from the publisher. Printed in the United States of America. "This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought."
—from a declaration of the American Bar Association

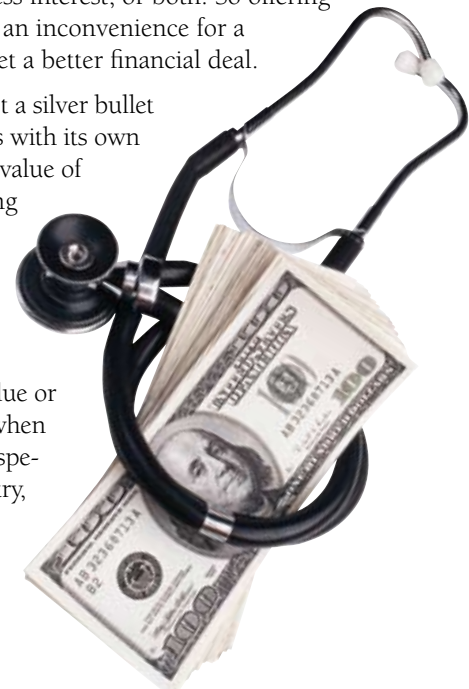
There's A Reason for Walls: A Defense of Compartmentalized Borrowing and Lending in the Healthcare World

Joseph Brown, Esquire
Seyfarth Shaw LLP
Chicago, IL

An Introduction: The Problems with Collateral

"Secured lending" in a nutshell means giving a borrower a loan in exchange for more than just a naked promise of repayment. Instead, a lender asks that the promise of repayment be backed by pledged assets—collateral. In the event that the borrower does not pay, the lender may thereafter seize the collateral to repay the loan—a process called foreclosure. The extra protection that a lender secures from collateral allows it to lend more money than it otherwise would, charge less interest, or both. So offering a lender collateral is not just an inconvenience for a borrower; it's also a way to get a better financial deal.

Unfortunately, collateral is not a silver bullet against lender risk and comes with its own problems. Like all assets, the value of collateral can swing depending on market conditions. Land that was worth millions yesterday might be worth only thousands today. Equipment worth something brand new may lose value or become obsolete, especially when not properly cared for (and especially in the healthcare industry, where obsolescence pushes the value of fully functional machinery down). Accounts



receivable that are relatively new and arise from the provision of top-notch healthcare services to satisfied customers are worth nearly 100 cents on the dollar. By contrast, accounts that are old or that arise from the provision of subpar services to disgruntled patients are worth very little and will create high collection costs that further diminish their aggregate value. Fluctuations in the government's reimbursement policies cause further value uncertainty for accounts receivable that remain uncollected for too long.

The value of collateral is not only dependent on general market conditions, but also on how well a particular borrower is doing. The value of collateral pledged by a borrower generally rises and falls in unison with the borrower's general business health. A borrower close to bankruptcy cuts costs on maintenance, which causes its buildings and equipment to fall into disrepair. As explained below, accounts receivable become increasingly uncollectible as the borrower nears insolvency. Almost all assets contain "synergistic" value because they are part of a larger economic system or "going concern." A hospital bed is not just a metal bed; it's part of a system that routes patients to lie in it and bills third parties when it's filled. Bank foreclosure on healthcare assets destroys "going concern" value unless the bank decides to operate the entire collateral system cohesively—effectively becoming a healthcare provider. Banks do not want that risk. So the system is broken apart in foreclosure and the bed becomes just an object again, rather than part of a money-making system.

Bankers (and banking lawyers) have long known that when things go wrong they cannot count on collateral to bail them out. In fact, the value of collateral is usually lowest just when a lender needs it. And once the lender forecloses, the value drops further.

Another concept to understand about collateral and that is crucial to this article is that each type of collateral has a different economic personality. Compare real estate with equipment. Real estate can swing widely in value from year to year, but usually keeps its value or gains value over the long run. Alternatively, equipment almost always depreciates at a fairly predictable rate over its lifetime.

Fixing Collateral Problems Through Compartmentalization

In recognition of these problems, healthcare borrowers and lenders have long separated their asset holdings in order to maximize the value of the collateral that they can pledge to lenders. By compartmentalizing assets and the operations that they empower, risks associated with such assets can also be kept separate. Each class of assets can be pledged as collateral in a separate loan financing that is designed and tailored to accommodate the risks associated with just that class. Indeed, certain lenders specialize in lending just in connection with one type of collateral because they have expertise in managing and hedging against risks of a particular type.

The aggregate borrowing power of a healthcare organization may be higher with separate financings than if a single lender were simply offered everything that a healthcare organization owns. The reason for this is that an unspecialized lender with many

types of collateral—who may not be familiar with the intrigues of the healthcare industry—cannot adequately tailor the loan documents to the risks of just one type of collateral. The risk profile becomes too complex, and what might work to curtail one type of risk might exacerbate another. So the lender dealing with too wide of a mix of collateral tends to control its risk in a less-imaginative way by simply lending fewer dollars than it might otherwise. A healthcare organization's borrowing power may be partially wasted through intermixing collateral types.

In the financial world at least, the pie can get bigger when you cut it into pieces.



The typical way that nursing homes, hospitals, and intermediate care facilities achieve asset and risk compartmentalization is by creating separate legal operating and land-holding entities. A so-called healthcare organization is (usually) not just one legal entity. Rather, it operates more like a basketball team consisting of individual legal entities passing the financial ball back and forth between them. In the most simple example, sister companies are set up—one to own the land and building that a healthcare facility uses, and one to function as the operating entity itself. The operating entity then pays rent to its landlord (i.e., its sister company) to service the mortgage on the land. The land-owning entity has no healthcare operations and therefore none of the economic risks and significant potential legal liabilities associated with healthcare providers. This is extremely important because healthcare operations remain a very mysterious and frightening affair for many lenders. While this fear is partially the result of inexperience, some of the fear is quite legitimate. Healthcare operations remain a relatively risky enterprise because of their highly regulated nature, their propensity for litigation, the extremely complex way in which healthcare is paid for in this country, and the potential for account collection difficulties.

By contrast, bankers are more comfortable with mortgage loans, which are understandable and familiar to them. The land-holding sister company can therefore obtain a mortgage loan that focuses purely on the real estate as its source of security. Real estate, untainted and undiluted by healthcare operating risks, has traditionally been perceived as more of a blue chip collateral that commands borrowing power.

After their sister companies obtain mortgage loans, operating entities usually enter into asset-based loans secured only by operating assets. These assets are known as “personalty” in the legal world and generally consist of every type of asset other than real estate or “realty.” Personalty generally includes accounts, equipment, stock, patents, trademarks, copyrights, and other tangible or intangible personal property types. Often these operating loans take the form of “revolving loans” that allow the bank’s lending commitment to theoretically shrink when the collateral to support the loan—the “borrowing base”—shrinks. A borrower that finds that its outstanding revolving loans are now bigger than its borrowing base must immediately pay down those loans until they are back “within formula.” The borrowing base can be measured as often as the loan documents provide, and this allows over-borrowing to be quickly corrected before it grows out of control. The safety of the borrowing base concept allows the lender to lend against economically volatile assets.

This borrowing base feature is necessary because personalty is less permanent than land and can suffer from even wider variations in value, depending on the total “going concern” value of the healthcare business. For example, “accounts” generated by a business that is widely perceived to be failing will often lose much of their value because the third parties who owe on such accounts are much less inclined to pay if they believe that the business is doomed anyway. A healthy business can cut off further service to a client until invoices are paid, but failing entities are perceived as having their days numbered and few future services to provide. While a borrowing base loan exposes the borrower to potentially shrinking borrowing power, a general truism still applies: some borrowing power—even shrinking borrowing power—is better than none at all. The safety that borrowing base loans provide lenders converts personalty into a loan-inducing form of collateral under economic conditions in which it might otherwise be unattractive to lenders. The borrowing base lending concept allows borrowers to wring the last borrowed dollar out of a relatively unstable collateral base.

Compartmentalization Under Pressure

Because of the hard economic times and difficult credit environment, lenders are tempted to demand recourse to not one—but various classes of collateral. Lenders seek to tear down the legal walls between separate legal entities in order to obtain security interests on as much collateral as possible. Rather than taking a collateral interest in just one sister company’s assets, the lender demands everything that both sisters own as collateral for a loan made only *to one of them*.

Lenders have a variety of legal tools for doing this, but secured guaranties and cross-collateralization provisions are the most

common tools. When a lender requires an entity operating a hospital to give a secured guaranty of a loan to an affiliated landlord, for example, both sister companies (and both asset classes) are put “on the hook” for the mortgage loan, and the legal distinction between them is effectively circumvented. The same result occurs when a lender requires that a mortgage loan be collateralized with operating assets.

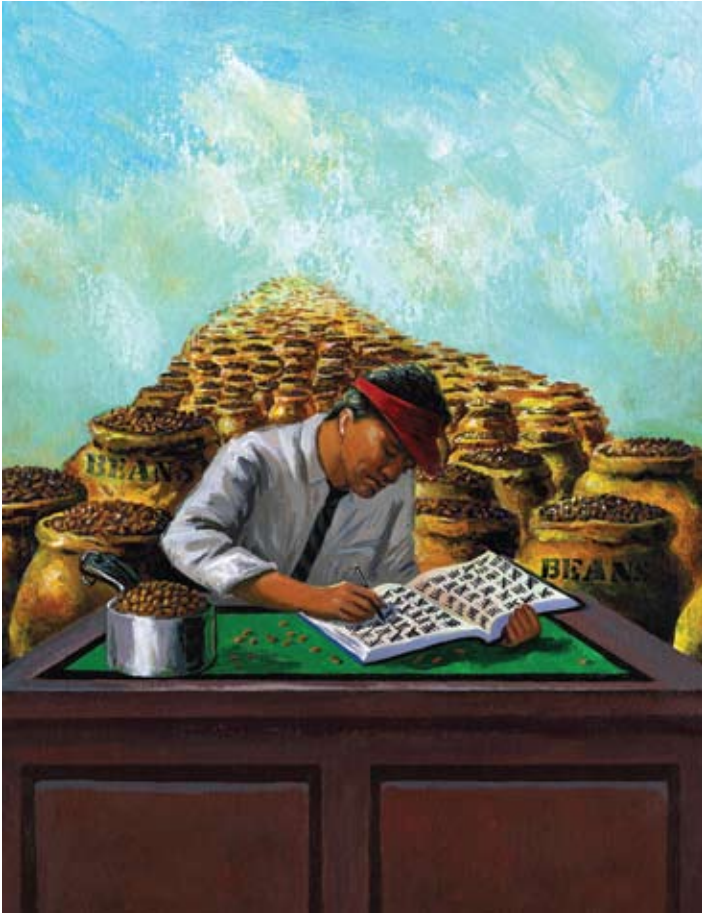
By mixing the different collateral classes back together after they had once been separated, the lenders create a complicated mishmash of collateral, both realty and operating assets. The risks arising from each type of collateral can no longer be separately dealt with. The result is weakened healthcare borrowing power at a time when healthcare sorely needed private capital. What is worse, once the legal distinctions between affiliate borrowers have been circumvented by one lender, they are effectively lost on all other lenders. Few borrowing base lenders, for example, would be willing to lend against collateral that is already pledged to a mortgage bank.

Tearing down the legal walls that compartmentalize assets and risk also dampens equity investment. Potential equity investors know full well that they will stand in line behind debt in the borrower’s capital structure. When the borrower’s assets can be easily measured against the debts they collateralize, the balance sheet that the potential investor is buying into is clear enough. On the other hand, when healthcare assets become pledged on a contingent basis to support a borrower’s affiliate’s loans, prospective investors become reasonably wary. The year 2008 made it painfully clear to equity investors what happens when they buy securities that they do not fully understand. Any blurring of the lines between two previously separate entities makes an analysis of either balance sheet difficult—and the difficulty in itself is enough to scare away capital in this environment.

One Example of Compartmentalization Under Pressure

Some of the current pressure on asset compartmentalization is strangely enough coming from the U.S. government. The Department of Housing and Urban Development (HUD) recently provided “guidance” to healthcare facilities with government-insured mortgage loans under HUD’s so-called Section 232 program.¹ The program facilitates the construction and rehabilitation of nursing homes and other care-providing facilities by having the government insure private loans made to qualifying institutions. The “guidance” in question suggested ways that a Section-232-covered borrower might seek the “consent” of HUD in order to allow an affiliate (a distinct entity) to enter into a distinct asset-backed loan facility with a completely different lender and a different collateral base.

The HUD notice in question, Notice H 08-09, even suggested a certain form intercreditor agreement that could be entered into between the real estate backed lender and the incoming lender whose loan would be backed by operating assets. Intercreditor agreements are necessary when creditors have overlapping and conflicting claims on the same collateral. To avoid disputes and



uncertainty, the creditors enter into an agreement where they divide up the common collateral and decide who will have first priority. HUD's form intercreditor agreement allows the mortgage lender a second lien on the operating affiliate's assets. The dividing wall between healthcare operating assets and realty is seriously weakened.

While HUD might reply that its form agreement still allows a separate lender to have priority with respect to a particular collateral class, the damage may still be done. Lenders do not enjoy having to share collateral, even when they are first in line. Unwanted complications arise. Priority lienholders find it inconvenient having a second lender with claims on their collateral. This is of course why HUD's policy has to come with a form intercreditor agreement in the first place. In Chapter 11 bankruptcy proceedings, the existence of a voting class of secured second lienholders can cause first lienholders any number of troubles. While the bankruptcy code theoretically protects first lienholders' rights, practically speaking bankruptcy offers second lienholders many opportunities for obfuscation and delay. This often leads to their being "bought off" to move the proceedings forward. That is, they are offered economic benefits by the higher priority lienholder in return for not obstructing the proceedings. So, banks will lend less (or charge more interest) when they have to put up with secondary "lien-mates" sharing a particular collateral class.

For those healthcare entities for which HUD financing is the only financing available, it may make little difference if HUD

blurs the lines between operating asset-backed and mortgage-backed loans, or even if HUD imposes yet another condition to receiving HUD insurance backing. In HUD's defense, the policy contained in Notice H 08-09 certainly makes sense if one focuses narrowly on the goal of recovering and protecting the financing that HUD extended. For entities that might not have to totally rely on HUD financing however, the pressure on asset compartmentalization found in Notice H 08-09 causes borrowing power to slowly erode.

HUD's policy certainly protects the taxpayer and is consistent with the rest of the credit industry (assuming that the goal is strictly defined as improving HUD's own financial position). But, Notice H 08-09 clashes with much of the current administration's strategy for activating and facilitating private investment to assist in paying for national healthcare reform.

Potential Borrower Defenses

Healthcare borrowers should therefore do what they can to avoid giving away cross-collateralization in pre-loan negotiations. The simplest way to do this is to just say no. Certain lenders ask for cross-collateralization during negotiations only because they feel that they have nothing to lose. A simple refusal may be all that is needed for these lenders. Admittedly, this first technique may not prove too successful in today's environment. Many lenders today will insist that their loan be collateralized across entities and across collateral types. Borrowers may need to offer persistent lenders more than just a "no," such as a "yes" on some other negotiable point. It will be up to borrowers' CFOs and their attorneys to decide how far to go, what price to pay, or how many other points to concede to avoid cross-collateralization. At times, the existing loan documents that a borrower has may prohibit certain liens from being granted to new lenders. This is a good pretext for denying a new lender cross-collateralization, although an insistent and sophisticated prospective lender may simply request that the old loan documents be amended to remove the obstacle. Obviously, at a certain point the costs of avoiding cross-collateralization will become higher than the costs of giving in. Perhaps the best technique for avoiding cross-collateralization, albeit one not available to all borrowers, is to deal only with specialist lenders who focus on only one type of collateral anyway.

Improve Healthcare Finance and You Improve the Economy

The recent movement towards cross-collateralization has certainly not caused the healthcare communities' financial problems. HUD is not to blame. If anything, the movement is the natural and understandable consequence of the lending communities' reactions to the healthcare crisis. But, the result is that the financial crisis for healthcare providers worsens as they lose the ability to fully and efficiently leverage their assets on a class-by-class basis. HUD's actions, although singled out above as an example, are certainly consistent with the rest of the credit market. Nevertheless, HUD is not a private lender and seems politically out of step at a time when the rest of the federal government attempts

to open the credit market and pump billions into the healthcare industry.

Healthcare providers and financiers will be paying close attention to policies coming from government agencies other than the Department of Health and Human Services (HHS). While HHS creates the lion's share of healthcare policy, HUD's and many other government agencies' policies can have large and unforeseen effects on the healthcare community.

And there can be no doubt that the community is in crisis. A January 2009 report by the American Hospital Association (AHA)² reported that nine out of ten hospitals find it more difficult to access capital through bank loans. Seventy-two percent of hospitals reported that banks and financial services companies were either very or moderately important sources of external capital.

Consequently, 82% of hospitals have put facilities projects on hold. While hospitals are not nursing homes and therefore are not directly affected by HUD's Section 232 program, the point suggested by the data remains. The evidence surely suggests that the current plight of nursing homes is just as bad as that of hospitals. The AHA report would suggest that HUD's attempt at conflating the mortgage and asset-backed lending worlds may

have an indirect and negative effect on the number of nursing home facilities that are built or rehabilitated in the United States in the coming years.

Fewer healthcare facilities being built and fewer old ones being renovated result in obvious negative effects. Less obvious are the secondary economic effects. Healthcare expenditures help fuel the American economy. Indeed, national expenditures on healthcare are now approaching 20% of GDP. Nationally, millions of people are employed in the healthcare industry, with five million alone employed by hospitals. Healthcare is therefore one of the largest and strongest horses pulling the American economic wagon and will very likely be a dominant factor in any future economic revival. It is therefore imperative that the healthcare industry have access to the private capital that it needs. This means that consistent with the present administration's stated policies, government agencies need to take care in avoiding policies that unintentionally alienate private lenders and investors.

-
- 1 See U.S. Department of Housing and Urban Development, Notice H 08-09, Issued November 17, 2008, entitled "Subject: Account Receivable (AR) Financing."
 - 2 *Report on the Capital Crisis: Impact on Hospitals*, American Hospital Association, January 2009.

Editor's Note

William W. Horton, Esquire

*Haskell Slaughter Young & Rediker LLC
Birmingham, AL*

Friends and Colleagues:

Welcome to the latest issue of *Business Law & Governance*. Aside from being chock full of important information for you and your clients, this issue really reflects the broad scope of interests encompassed by AHLA's newest Practice Group. In these pages, we offer a timely discussion on the outlook for corporate prosecutions. We explore what the new "patient care ombudsman" provisions of bankruptcy law do—and what they don't do. We tell you about an important consideration for healthcare organizations seeking to maximize their access to capital in today's turbulent markets. Finally, we let you in on a common trap for the unwary in D&O insurance policies and show you how to protect against it. These diverse topics share one thing in common, though—they reflect cutting-edge business and governance issues facing healthcare organizations and their lawyers today, and they are part of the focus of the Business Law and Governance Practice Group (BL&G PG).

That's what we're about with this newsletter and in the BL&G PG. We want to bring you the information and resources you need to keep you on top of the business law and governance challenges that healthcare organizations face today—and those

that they will face tomorrow. Thus, whether your interests lie in directors' and officers' liability, mergers and acquisitions, nonprofit and for-profit governance, corporate investigations and prosecutions, joint venture transactions, corporate finance, or just the day-to-day business of healthcare—we have something for you.

More importantly, we think you have something for us—the other members of *your* BL&G PG. If you have a topic you'd like to see covered or an article you'd like to submit, please get in touch with me or with any of the BL&G PG leaders. If what you have is more suited for a Member Briefing, Executive Summary, or email alert, we'd like to hear about that too. The collegial exchange of information and ideas is one of the best things about the healthcare bar, and we encourage you to be a part of it.

Let us know what you like about this newsletter and about what we can do better. Let us know what contribution you'd like to make to the next issue or to the other BL&G PG activities. Let us know what resources you need to make you better able to serve your clients. Mostly, though, just let us hear from you. Your contributions and input are what drive this newsletter and the BL&G PG, whatever role you can play.

Enjoy this issue, and stay tuned for more.

**Best,
Bill**

Falling Through the Cracks: Qui Tam Lawsuits and the Prior and Pending Litigation Exclusion

Michael J. Rosen, Esquire*

David A. Shedd, Esquire

Boundas Skarzynski Walsh & Black LLC
Chicago, IL

Introduction

A lawsuit is never a welcome guest. Once one appears uninvited at the door of a hospital or other healthcare entity, however, the entity will immediately put in motion a plan to meet the threat, including notifying its insurance carriers and retaining defense counsel. With regard to insurance coverage, the date the lawsuit was filed is often a pivotal fact affecting which policy or carrier should respond. This article considers the possible coverage implications that might result when a healthcare entity learns for the first time about a potentially significant lawsuit months or even years after the plaintiff files his complaint.

In examining this issue, we construct a hypothetical situation in which the entity renews its insurance policies between the time the plaintiff files his lawsuit and the time that the entity learns about the pleading. Under certain circumstances, such a sequence of events may result in the entity's receiving no coverage whatsoever under any of its relevant policies—through no fault of its own. Qui tam lawsuits brought to enforce the federal False Claims Act (FCA) present a heightened risk of a healthcare entity's falling into such a predicament because those suits must, by statute, remain under seal for at least two months from the date that they are filed. Accordingly, we begin this discussion by outlining the nature of qui tam FCA lawsuits in general. Then, after elaborating on the hypothetical mentioned above and related coverage implications, we offer our observations on how healthcare entities may coordinate their resources to avoid any such unexpected loss of coverage in similar situations.

Qui Tam False Claims Act Lawsuits

When a medical facility (or other healthcare entity, such as a managed care organization) submits a claim to Medicare or Medicaid, it certifies—among other things—that its bills are accurate and that they reflect services rendered in compliance with all mandated standards of care and applicable anti-kickback regulations. If that broad certification is in any way untrue, the facility may be liable under the FCA for submitting a false claim for payment by a government healthcare program.¹ Although the United States is the injured party (and proper plaintiff) in any such action under the FCA, the law allows individual civil plaintiffs (relators) to initiate qui tam actions on behalf of the government, subject to the government's right to oversee or intervene in the action if it so chooses.² The incentive for whistleblowers

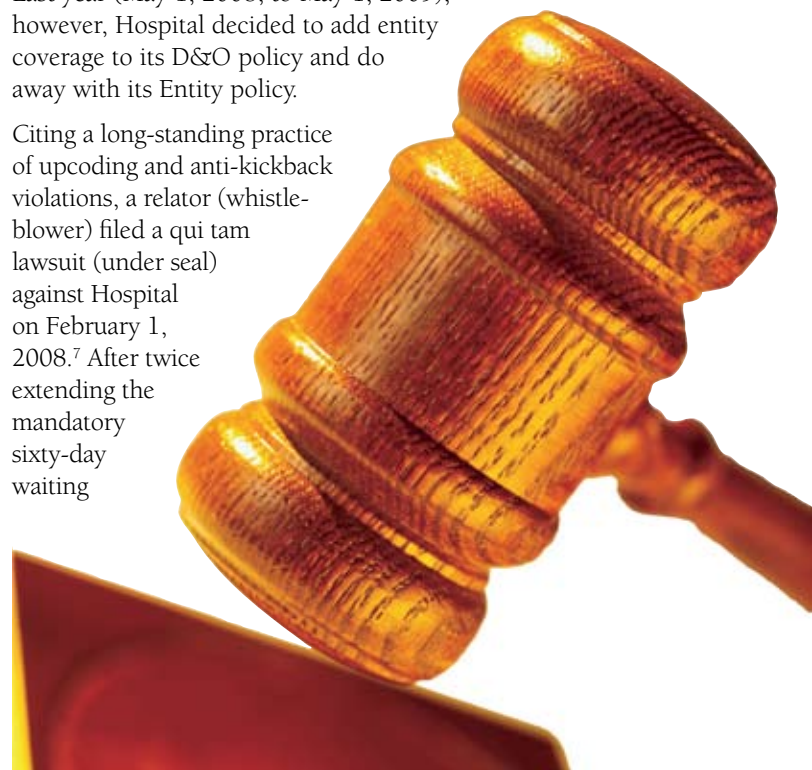
to initiate a qui tam lawsuit is significant, as qui tam plaintiffs are entitled to between 25% and 30% of any damages assessed, plus attorneys' fees and costs, if the government does not intervene in the action.³ An entity found to have submitted a false claim will be subject to a civil penalty between \$5,500 and \$11,000 and will further face an assessment of three times the amount of the claim that was submitted.⁴ Accordingly, in addition to the statutory penalty assessed per false claim, damages could potentially equal three times the total amount of Medicare/Medicaid reimbursements that the facility received in connection with any systemic billing irregularities—whether those irregularities arise from coding or accuracy problems, standards of care issues, or anti-kickback violations.

Because FCA damages are assessed for each false claim submitted to the government, the amounts at issue in a qui tam lawsuit can be crippling. For example, in late July 2008, the Amerigroup organization agreed to pay \$225 million to settle a lawsuit arising from its alleged practice of excluding individuals perceived as "high-risk" (including pregnant women) from participation in its plans despite certifying in its Medicaid reimbursement forms that it did not employ such tactics to filter its pool of participants.⁵ The court originally assessed a total of \$334 million in trebled damages and penalties.⁶

Explanation of Hypothetical Scenario

A regional hospital group (Hospital) maintains directors' and officers' (D&O) insurance coverage with an annual policy period of May 1 to May 1. For the 2007-2008 policy period (May 1, 2007, to May 1, 2008) and previous years, Hospital purchased a D&O policy to cover only its directors and officers, and it purchased a separate policy to cover its own wrongful acts (Entity policy). Last year (May 1, 2008, to May 1, 2009), however, Hospital decided to add entity coverage to its D&O policy and do away with its Entity policy.

Citing a long-standing practice of upcoding and anti-kickback violations, a relator (whistle-blower) filed a qui tam lawsuit (under seal) against Hospital on February 1, 2008.⁷ After twice extending the mandatory sixty-day waiting



period to allow the government to complete its investigation and determination of whether to intervene, the court unsealed the complaint on September 1, 2008, and the whistleblower served the Hospital on September 15, 2008. Upon receipt of the complaint, Hospital tendered the lawsuit to its D&O carrier as a Claim (as defined in the policy) under its 2008-2009 policy.

Because a claim is typically considered “first made” when an insured receives it (i.e., through service of a complaint), the insurer deemed the qui tam lawsuit to qualify as a “claim first made” on September 15, 2008—within the D&O policy’s term. After discovering that the Claim directly arose from a lawsuit that was filed prior to the May 1, 2008, inception date of the 2008-2009 policy, however, the insurer denied coverage per the policy’s Prior and Pending Litigation (PPL) Exclusion—even though Hospital could not have known about the lawsuit until it was unsealed in September 2008. Hospital then attempted to tender the lawsuit under its prior D&O policy (that expired on April 30), but the insurer denied coverage based on the fact that the case did not name a director or officer as a defendant. Because the previous policy did not provide for entity coverage, the qui tam lawsuit would not fall under its coverage agreements. When Hospital attempted to submit the Claim under its prior Entity policy, that carrier also denied coverage citing a provision in the policy requiring Hospital to provide notice of a Claim no later than sixty days after the policy period’s expiration (i.e., no later than June 29, 2008). Therefore, Hospital—through no fault of its own—must face what could be an extremely expensive lawsuit without any insurance coverage.

Effect of Sealed Complaint on Applicability of PPL Exclusion

Hospital’s 2008-2009 D&O policy (with entity coverage) contains the following PPL Exclusion:

The Insurer shall not be liable to make any payment for Loss resulting from any Claim based upon, arising out of, relating to, directly or indirectly resulting from or in consequence of, or in any way involving, any prior and/or pending civil, criminal, administrative or investigative proceeding as of May 1, 2008 involving Hospital, or any fact, circumstance or situation underlying or alleged in such proceeding.

Such exclusions are used by insurance carriers to “bookend” the risks that they agree to underwrite for a particular policy period. By limiting the coverage available to claims made on or after the policy’s inception date, a carrier can eliminate the risk of an insured’s submitting a claim under a current policy that it should have submitted under a previous policy.

As mentioned above, the relator filed his original FCA complaint on February 1, 2008—approximately three months prior to the inception date of Hospital’s 2008-2009 D&O policy. Therefore under the plain language of the PPL exclusion, Hospital’s 2008-2009 D&O policy will not cover the relator’s qui tam lawsuit.

Hospital may contest the coverage denial on the grounds that the original complaint was filed under seal, and that it could not

have known about the lawsuit before the inception date of its 2008-2009 D&O policy. While our research has not uncovered any cases interpreting prior and pending litigation exclusions in the context of a sealed case filed unknown to the insured prior to a policy’s inception date, there is case law generally supporting the insurer’s position. In *ML Direct, Inc. v. TIG Specialty Ins. Co.*, the plaintiffs sought coverage under a D&O policy for a securities fraud class action filed within the policy period.⁸ The insurer denied coverage based on the policy’s prior and pending litigation exclusion, citing two previously filed cases arising from the same alleged pattern of fraudulent activities but brought against a different group of defendants.⁹ The two earlier cases did not include the *ML Direct* plaintiffs as defendants, and it is unclear from the *ML Direct* court’s opinion whether the plaintiffs knew about those prior proceedings.¹⁰ Nevertheless, as described below, it appears that the plaintiffs relied on such an argument in seeking a ruling that their policy’s prior and pending litigation exclusion should not bar coverage under that set of facts.¹¹

The prior and pending litigation exclusion at issue in *ML Direct* stated:

This insurance does not apply to any Claim made against any Insured arising out of any of the following: [. . .] Any litigation, proceeding, or administrative act or hearing brought prior to or pending as of the Prior or Pending Litigation Date as shown in Item 8 of the Declarations, as well as any future litigation, proceeding, administrative act or hearing based upon any such pending or prior litigation, proceeding, administrative act or hearing or derived from the essential facts or circumstances underlying or alleged in any such pending or prior litigation, proceeding, administrative act or hearing¹²

The trial court found that the exclusion was valid and barred coverage for the “new” lawsuit.¹³ On appeal, the insured argued among other things that because it was asked to list all known claims in the policy application, the prior and pending litigation exclusion should be read in conjunction with that request and should not apply to bar claims the insured did not know existed.¹⁴ The appellate court flatly rejected this argument, stating:

As for the policy application and proof whether applicants knew about the [prior lawsuits] when they applied for the policy, appellants’ argument again tries to add language that is absent from the policy’s terms. Nothing in the prior litigation exclusion states that it applies only as to prior proceedings which the insureds knew about. Instead, it applies to any prior litigation or proceedings which bear the requisite factual relationship to a claim made during the policy period.¹⁵

More recently, in *North American Specialty Ins. Co. v. Correctional Medical Services, Inc.*, a Missouri federal court applied the reasoning of *ML Direct* to a similar situation in which a previous lawsuit not naming the insured triggered the policy’s prior and pending litigation exclusion to bar coverage for a later filed lawsuit arising

from the same factual circumstances.¹⁶ *Correctional Medical Services* involved a medical malpractice lawsuit filed by an inmate at a state prison managed by Correctional Services Corporation (CSC).¹⁷ CSC contracted with Correctional Medical Services (CMS) to provide the inmates with medical care.¹⁸ The inmate's complaint named CSC instead of CMS, and CSC attempted on two occasions (unsuccessfully) to tender the defense of the case to CMS, which was required to carry its own liability insurance.¹⁹ CMS' liability carrier agreed to provide CSC with a defense, but another court placed that liability carrier into rehabilitation before it could carry out its agreed-upon obligation.²⁰

The court presiding over the inmate's lawsuit entered a \$5 million judgment in his favor.²¹ CSC's liability carrier then paid the award and brought a separate contribution action against CMS that CMS submitted to its subsequent liability insurer.²² CMS' subsequent insurer denied coverage for the contribution lawsuit based on its policy's prior and pending litigation exclusion.²³

The prior and pending litigation exclusion at issue in *Correctional Medical Services* stated:

This policy does not apply . . . to any claim against an insured . . . arising from any pending or prior litigation or other proceeding as of the inception date of this policy, as well as all claims or litigation based upon the pending or prior litigation or derived from the same, or essentially the same, facts (actual or alleged) that gave rise to the prior or pending litigation or proceeding²⁴

Unlike the insured in *ML Direct*, CMS could not credibly argue that it was unaware of the prior lawsuit because CSC tried twice to tender the inmate's case to CMS. Regardless, the court held for the insurer, stating:

Like the exclusion discussed in *ML Direct*, [the prior and pending litigation exclusion in *Correctional Medical Services*] is written in broad, unambiguous terms, which bar coverage for any claim that derives from pending or prior litigation as of [the prior and pending litigation date]. The exclusion does not distinguish between litigation "against the insured" and other litigation, nor will [this court]. The language only requires that a claim be "based upon" or "derived from" pending or prior litigation.²⁵

Although the *ML Direct* and *Correctional Medical Services* decisions would support the insurer's position with regard to Hospital's qui tam claim, Hospital may attempt to challenge the PPL exclusion's application under the facts of the hypothetical scenario based on the "reasonable expectations" doctrine.

Reasonable Expectations Doctrine

The "reasonable expectations" doctrine can provide an insured with a defense to a denial of coverage independent of the policy's language. As Professor (and later United States District Court Judge) Robert Keeton summarized, the reasonable expectations doctrine operates on two principal tenets: (1) the insurer will be

denied any unconscionable advantage in the insurance transaction; and (2) the reasonable expectations of applicants and intended beneficiaries will be honored.²⁶ Of course, insurance law varies from state to state, and only a few jurisdictions have applied the doctrine as formulated by Judge Keeton.²⁷ Indeed, some courts take issue with the doctrine—seeing it as an attack on parties' freedom to contract. For example, before rejecting the doctrine, the Michigan Supreme Court remarked on its origin as follows:

Whether Professor Keeton intended [his reasonable expectations analysis] to spawn a frontal assault on the ability of our citizens to manage, by contract, their own affairs, it had that effect because numerous courts, to one degree or another, adopted some form of the rule.²⁸

Nevertheless, the majority of jurisdictions that have considered the doctrine have acknowledged it in one form or another.²⁹

Of those jurisdictions that have accepted the reasonable expectations doctrine, some courts have embraced Section 211 of the Restatement (Second) of Contracts as the doctrine's "black letter law" equivalent.³⁰ Section 211 states:

- (1) Except as stated in Subsection (3), where a party to an agreement signs or otherwise manifests assent to a writing and has reason to believe that like writings are regularly used to embody terms of agreements of the same type, he adopts the writing as an integrated agreement with respect to the terms included in the writing.
- (2) Such a writing is interpreted wherever reasonable as treating alike all those similarly situated, without regard to their knowledge or understanding of the standard terms of the writing.
- (3) Where the other party has reason to believe that the party manifesting such assent would not do so if he knew that the writing contained a particular term, the term is not part of the agreement.³¹

The reasonable expectations portion of Section 211 is found in its sub-section (3) that allows for relief from an ambiguous—or, arguably, an *unambiguous*—contract term if (in the insurance context) the insurer has a reason to believe that the insured would not assent to the term. The drafters of Section 211 included the following comment to expand on the "reason to believe" concept:

Reason to believe may be inferred from the fact that the term is bizarre or oppressive, from the fact that it eviscerates the non-standard terms explicitly agreed to, or from the fact that it eliminates the dominant purpose of the transaction. The inference is reinforced if the adhering party never had an opportunity to read the term, or if it is illegible or otherwise hidden from view.³²

In the jurisdictions following Section 211, the relevant question in our hypothetical would turn on whether the insurer had reason to believe that Hospital would not have assented to the

PPL exclusion if it knew that knowledge of a prior lawsuit was not required for the exclusion to apply. It is possible that a court may never reach that fact question, however. Indeed, the answer may depend on whether the PPL exclusion is deemed *ambiguous*.

In its purest form, the reasonable expectations doctrine would apply regardless of whether the policy language in question is ambiguous.³³ Although courts might apply a reasonable expectations doctrine based on Section 211's formulation to *unambiguous* policy terms, in a 1996 case the Oklahoma Supreme Court noted:

[T]he jurisdictions which have adopted [the reasonable expectations doctrine] apply it to cases where an ambiguity is found in the policy language or where the exclusions are obscure or technical or are hidden in complex policy language. In these cases, the doctrine is utilized to resolve ambiguities in insurance policies and considers the language of the policies in a manner which conforms the policies with the parties' "reasonable expectations."³⁴

Echoing the Oklahoma Supreme Court's observation, the Massachusetts Court of Appeals stated, "When reasonable expectations analysis comes into play, it is more likely to do so when the task is to interpret an ambiguous provision rather than an *unambiguous* one whose meaning . . . no one disputes."³⁵ Accordingly, it is likely that if faced with Hospital's argument that the PPL exclusion frustrates its reasonable expectations of coverage, a court would first require Hospital to establish that the exclusion is ambiguous.

Some courts that have reviewed prior and pending litigation exclusions have found them to be clear and unambiguous.³⁶ Other courts, however, find ambiguity in the typically broad "all claims having any relationship whatsoever with prior litigation"-type language found in such exclusionary provisions (including the PPL exclusion).³⁷ Importantly, those courts that find ambiguity in such exclusions typically focus on policy language that would expand the scope of the exclusion to bar claims with only an attenuated or tangential factual relationship with a prior lawsuit.³⁸ In Hospital's claim, the "prior lawsuit" and the "current lawsuit" are one and the same, and as a result, the PPL exclusion's broad prefatory language is not at issue. As our hypothetical coverage scenario does not implicate the section of the PPL exclusion that most often triggers a finding of ambiguity, it is more



likely than not that a court would find *no ambiguity* in the PPL exclusion under such facts. To the extent that Hospital fails to overcome that threshold issue, it may never even get to the point at which it could present an argument on its "reasonable expectations."

Importance of Proactive Risk Management

As discussed above, it is unclear (at best) whether a court would circumvent the language of the PPL exclusion in our hypothetical scenario. In view of such uncertainty, the need is readily apparent for facilities and other healthcare industry insurers to monitor on a continuous basis whether circumstances exist that may support a future *qui tam* lawsuit. Typically, "claims made" liability policies marketed to business entities contain a provision similar to the following:

If, during the Policy Period, the Insured first becomes aware of a Wrongful Act which may subsequently give rise to a Claim and, as soon as practicable thereafter but before the expiration or cancellation of this Policy:

- (a) provides written notice of such Wrongful Act to the Insurer, including a description of the Wrongful Act in question, the identities of potential claimants, the consequences which have resulted or may result from such Wrongful Act, the damages which may result from such Wrongful Act, and the circumstances by which the Insured first became aware of such Wrongful Act; and
- (b) requests coverage under this Policy for any subsequently resulting Claim for such Wrongful Act;

then the Insurer will treat any such subsequently resulting Claim as if it had been first made during the Policy Period.

These provisions are commonly known as "notice of circumstance" clauses. They create a mechanism for an insured to put down a marker during a current policy period for a scenario that has not yet, but may one day result in a claim. In this sense, a "notice of circumstance" clause serves as a counterpoint to a PPL exclusion's potentially harsh results. Importantly, it is not necessary for an insured to have a full picture of the "circumstances" in hand before it may report them to its insurer. Generalized and non-specific "notices of circumstances," however, could anchor a large variety of future claims in a particular policy period—expanding the risks

associated with the policy far beyond what the insurer anticipated when it priced the coverage. For this reason, such clauses, including the example above, require some degree of specific detail about the circumstances discovered.

In the context of a healthcare entity, it is essential for the entity to ensure that its risk management representatives work closely with its compliance counsel to stay apprised, where possible, of any developments that could be notified to the entity's insurance carriers as "notices of circumstances"—even those developments or facts that might not trigger the entity's mandatory self-reporting duties. With a coordinated effort between risk management and compliance counsel to spot potential problem areas, an entity can position itself to take full advantage of its insurance coverage in all situations, including situations where the entity may not learn of a qui tam lawsuit until months after it is filed.

Another mechanism available to shore up the risk of uncovered litigation in situations similar to our hypothetical is a common optional policy provision called the "extended reporting period." These provisions allow an insured to submit claims for a certain period after the policy's expiration date so long as the claims arise from wrongful acts that occurred prior to the expiration date. They are especially useful when switching insurance carriers because most PPL exclusions are keyed to the inception date of the first policy in a line of renewals with a particular carrier. In other words, renewal policies' PPL exclusions typically will exclude only those lawsuits that predate the first consecutive policy issued by that insurer. Therefore, extended reporting periods are helpful when an insured moves from one carrier to another—and restarts the applicable PPL date in so doing.

In our hypothetical, had Hospital purchased a one-year extended reporting period from its Entity policy carrier, it would have been able to tender the qui tam claim to that prior policy. Several states require claims-made policies issued in those states to offer at least a one-year extended reporting period option.³⁹ Likewise, some states require insurers to provide an automatic extended reporting period, though only for a period of thirty to sixty days.⁴⁰ However, many states do not mandate such policy provisions. Moreover, it is important to note that for certain types of insurance (often including D&O coverage), all states allow insurers to issue policies on a "non-admitted" basis—which means that those policies are not subject to the state's regulatory requirements. In light of the nature of qui tam lawsuits in general, healthcare entities should always be mindful of the dangers inherent in switching carriers and should discuss the extended reporting period options available with their risk management representatives and insurance broker.

Conclusion

Should a healthcare entity suddenly face a qui tam FCA lawsuit, it may also face the possibility that its insurance coverage will be jeopardized by a procedural quirk of the FCA. As a practical matter, in view of the expertise regularly offered to healthcare entities by risk managers and insurance brokers, the chances are slim that a worst case scenario, such as that described above, would occur. Nevertheless, the hypothetical highlights the need for healthcare entities to ensure that they have a full

understanding of how their various insurance policies function. Because it is uncertain in such situations whether courts would refuse to apply a policy's PPL exclusion, healthcare entities should make every effort to discover and report potential problems under their policies' "notice of circumstances" clauses, and to secure any appropriate extended reporting periods for expiring policies that are not being renewed. By coordinating with risk management representatives and compliance counsel, entities can work closely with their carriers to ensure that no claims fall through the cracks of two consecutive policies.

** Michael J. Rosen is a principal and David A. Shedd is an associate with the firm of Boundas Skarzynski Walsh & Black LLC in Chicago, IL. Mike represents numerous domestic and foreign insurance companies, primarily with respect to the analysis and evaluation of significant liability claims involving a variety of insurance coverages. Mike's expertise includes directors and officers liability, private and public company risk analysis, healthcare and managed care liability, nonprofit corporate risk management, employment practices liability, government and regulatory matters, professional liability, coverage and bad-faith litigation, and underwriting counseling and policy drafting. Since joining BSWB in 2005, David has represented insurers in complex coverage matters arising from directors' and officers' liability, professional liability, employment practices liability, and media liability policies, in addition to financial institution bonds. As a corollary to his coverage and litigation work, David also has taken an increasing role in assisting insurance company clients in their efforts to offer new insurance products into the marketplace.*

This article is not meant to provide legal advice. Healthcare entities with concerns or questions about their insurance policies or risk management practices should obtain the assistance and independent advice of their own legal counsel. The views expressed herein are the views of the authors and are not intended to reflect the views of their law firm or of any of their firm's clients.

1 31 U.S.C. § 3729 (West 2008).

2 31 U.S.C. § 3730 (West 2008). Incidentally, qui tam is an abbreviation of the Latin phrase "qui tam pro domino rege quam pro si ipso in hac parte sequitur," which translates to "who sues on behalf of the King as well as for himself." BLACK'S LAW DICTIONARY 1251 (6th ed. 1990).

3 31 U.S.C. § 3730(d) (West 2008).

4 31 U.S.C. §§ 3729, 3730 (West 2008); 20 C.F.R. § 356.3 (West 2009).

5 Press Release from the United States Dept. of Justice, *Amerigroup To End Appeal And Pay \$225 Million To United States And Illinois To Settle Pregnancy Discrimination Case* (Aug. 14, 2008), available at www.usdoj.gov/usao/iln/pr/chicago/2008/pr0814_01.pdf.

6 *Id.*

7 For purposes of this discussion, it is important to note one of the FCA's procedural quirks: the law requires qui tam plaintiffs to file their lawsuits under seal. 31 U.S.C. §§ 3730(b)(2) – 3730(b)(4) (West 2008). To allow the government time to determine whether it will intervene, the law mandates that qui tam complaints be hidden from public view (and from the targeted defendants) for at least sixty days after they are filed. *Id.* The court may extend that sixty-day period upon petition from the government. *Id.* Therefore, an entity will not know about a qui tam lawsuit pending against it for at least two months (and possibly longer).

8 *ML Direct, Inc. v. TIG Specialty Ins. Co.*, 79 Cal. App. 4th 137, 142-43 (Cal. Ct. App. 2000).

9 *Id.* at 143-44.

10 *Id.* at 142-44.

- 11 *Id.* at 144.
 12 *Id.* at 142.
 13 *Id.* at 144.
 14 *Id.* at 146.
 15 *Id.* (court's emphasis).
 16 *North American Specialty Ins. Co. v. Correctional Med. Servs., Inc.*, No. 4:04CV798 CDP, 2006 WL 208635 (E.D. Mo. 2006).
 17 *Id.* at *1.
 18 *Id.*
 19 *Id.*
 20 *Id.*
 21 *Id.* at *2.
 22 *Id.*
 23 *Id.* at *5.
 24 *Id.* at **2-3.
 25 *Id.* at *6 (citations omitted).
 26 Paul N. Farquharson, David L. Leitner, Reagan W. Simpson, and John M. Bjorkman, 1 LAW AND PRAC. OF INS. COVERAGE LITIG. § 5:7 (West 2008) (citing Robert Keeton, *Insurance Law Rights at Variance With Policy Provisions*, 83 HARV. L. REV. 961 (1970)).
 27 *See, e.g.*, Farquharson, Leitner, Simpson, and Bjorkman, *supra* note 26 ("While commentators have opined that the precepts outlined in Judge Keeton's article have blossomed into a full grown doctrine, reasonable expectations remains in most cases a flexible concept, where courts pick and choose among reasonable expectations principles as the facts and language of the particular policy and claim permit, in order to rationalize a pro-policyholder interpretation of the insurance contract.")
 28 *Wilkie v. Auto-Owners Ins. Co.*, 664 N.W.2d 776, 783 (Mich. 2003).
 29 *Max True Plastering Co. v. United States Fidelity and Guaranty Co.*, 912 P.2d 861, 863-64 (Okla. 1996) (acknowledging the doctrine and citing thirty-two other jurisdictions acknowledging the doctrine at that time). *See also* Roger C. Henderson, *The Doctrine of Reasonable Expectations In Insurance Law After Two Decades*, 51 OHIO ST. L. J. 823, 827-38 (1990); and Allan D. Windt, 1 INSURANCE CLAIMS AND DISPUTES 5th § 6:3, n. 1 (West 2008).
 30 Henderson, *supra* note 29, at 844-846. *See, e.g.*, *Max True Plastering*, 912 P.2d 861; *Sutton v. Banner Life Ins. Co.*, 686 A.2d 1045 (D.C. 1996); *Aguiar v. Generali Assicurazioni Ins. Co.*, 715 N.E.2d 1046 (Mass. App. Ct. 1999); *Gibson v. Callaghan*, 730 A.2d 1278 (N.J. 1999); *First Am. Title Ins. Co. v. Action Acquisitions, LLC*, 187 P.3d 1107 (Ariz. 2008); and *Buckeye Ranch, Inc. v. Northfield Ins. Co.*, 839 N.E.2d 94 (Ohio Ct. C.P. 2005).
 31 RESTATEMENT (SECOND) OF CONTRACTS § 211 (2008).
 32 RESTATEMENT (SECOND) OF CONTRACTS § 211, Comment f. (2008).
 33 Henderson, *supra* note 29, at 827. *See also* *Bensalem Township v. International Surplus Lines Ins. Co.*, 38 F.3d 1303, 1312 (3d Cir. 1994) (reversing lower court's finding of no coverage pursuant to a prior and pending litigation exclusion to allow insured to raise issue of its reasonable expectations of coverage, despite holding that the language of the exclusion was unambiguous).
 34 *Max True Plastering*, 912 P.2d at 868-69 (internal citations omitted).
 35 *Aguiar*, 715 N.E.2d at 1048-49 (court's emphasis).
 36 *See, e.g.*, *Bensalem*, 38 F.3d at 1312; *Comerica Bank v. Lexington Ins. Co.*, 3 F.3d 939, 943-44 (6th Cir. 1993); *ML Direct*, 79 Cal. App. 4th at 142-43; *Correctional Med. Servs.*, 2006 WL 208635; *Pereira v. National Union Fire Ins. Co. of Pittsburgh, PA*, 525 F. Supp. 2d 370, 376-77 (S.D.N.Y. 2007); *Chapman v. National Union Fire Ins. Co. of Pittsburgh, PA*, 171 S.W.3d 222, 229 (Tex. Ct. App. 2005); *Global ADR, Inc. v. City of Hammond* No. Civ. A. 03-0457, 2004 WL 2694902, *8 (E.D. La. 2004); and *Zunenshine v. Executive Risk Indemnity, Inc.*, No. 97 Civ. 5525 (MBM), 1998 WL 483475, *4 (S.D.N.Y. 1998).
 37 *See, e.g.*, *Whitworth v. Chiles Offshore Corp.*, Civ. A. No. 92-1504, 1993 WL 177186, *1 (E.D. La. 1993); *Church Mut. Ins. Co. v. United States Liability Ins. Co.*, 347 F. Supp. 2d 880, 889-90 (S.D. Cal. 2004); and *American Med. Security, Inc. v. Executive Risk Specialty Ins. Co.*, 393 F. Supp. 2d 693, 703 (E.D. Wis. 2005).
 38 *See* cases cited *supra* note 37.
 39 States mandating a one-year extended reporting period for claims-made policies include Colorado, Connecticut, Maine, New York, North Dakota, and Texas.
 40 States mandating a thirty- to sixty-day automatic extended reporting period include Alaska, Arkansas, Connecticut, Georgia, Maine, New York, and Texas.



Practice Groups Staff

Trinita Robinson

Vice President of Practice Groups
 (202) 833-6943
 trobinson@healthlawyers.org

Emilee Hughes

Practice Groups Manager
 (202) 833-0776
 ehughes@healthlawyers.org

Magdalena Wencel

Practice Groups Administrator
 (202) 833-0769
 mwencel@healthlawyers.org

Brian Davis

Practice Groups Editorial Assistant
 (202) 833-6951
 bdavis@healthlawyers.org

Crystal Taylor

Practice Groups Coordinator
 (202) 833-0763
 ctaylor@healthlawyers.org

Denis Vidal

Practice Groups Associate
 (202) 833-0761
 dvidal@healthlawyers.org

Mary Boutsikaris

Art Director/Graphic Designer
 (202) 833-0764
 mboutsik@healthlawyers.org

Alex Leffers

Production Specialist
 (202) 833-0781
 aleffers@healthlawyers.org

The Current Status of the Patient Care Ombudsman Program Mandated by the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005

Victoria E. Powers, Esquire*

Schottenstein Zox & Dunn Co. LPA
Columbus, OH

R. Brent Martin

Healthcare MCR
Cleveland, OH

In October 2005, a bankruptcy reform bill that had been bumping through Congress for years became law. The 2005 bill was first introduced in 1998. Similar bills were approved in the House of Representatives and the Senate; in 2000, a final bill was passed but pocket vetoed by President Clinton. In 2002, passage appeared imminent but failed because of disagreement in Congress over proposed amendments. At the time President Bush signed the bill in April 2005, the most focused upon aspect of the law, known as the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 or BAPCPA, was the “means test,” designed to ensure that individuals filing for bankruptcy who had adequate “means” be required to repay a portion of their debts over a period of three to five years under a Chapter 13 plan. Much less attention was paid to the numerous changes to the Federal Bankruptcy Code¹ addressing healthcare issues. One such area of change is the BAPCPA provision requiring the appointment of a patient care ombudsman when a “health care business” files bankruptcy.

Healthcare Business Bankruptcies and the Patient Care Ombudsman

The idea of requiring an advocate for patient care issues had been proposed by bankruptcy practitioners and members of Congress.² However, detailed information is lacking in the House Report of the legislative history of the provision, which merely summarizes the provisions.³

BAPCPA added a very broad definition of “health care business” to the Bankruptcy Code that includes any public or private entity (whether for profit or nonprofit) that is primarily engaged in offering to the general public facilities and services for “(i) the diagnosis or treatment of injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care,” and includes any general or specialized hospital; ancillary ambulatory, emergency, or surgical treatment facility; hospice, home health agency, and other similar healthcare institution; and any long term care facility.⁴



Under BAPCPA, if a healthcare business files for bankruptcy protection under Chapter 7 (straight liquidation), Chapter 9 (municipal bankruptcy), or Chapter 11 (reorganization), the bankruptcy court is required to order appointment of a patient care ombudsman unless the court finds that the appointment is not necessary for the patients’ protection under the specific facts of the case.⁵ If a patient care ombudsman is to be appointed, the Office of the United States Trustee, a branch of the United States Department of Justice that oversees bankruptcy, selects and is required to promptly file a notice of appointment of the ombudsman.⁶

The revised Bankruptcy Code provides that the duties of the patient care ombudsman are to monitor the quality of patient care, represent the interests of the patients of the healthcare business, report to the court at sixty-day intervals as to the quality of patient care, and alert the court and constituents if the quality of care is declining significantly or is otherwise being materially compromised.⁷ The ombudsman’s costs, like those of the attorneys, accountants, and other professionals appointed to represent the debtor and any appointed committee (such as a creditors’ committee), are to be paid from the bankruptcy estate.⁸

Courts grappling with whether appointment of a patient care ombudsman is necessary for the protection of patients in a given case evaluate factors such as: (1) the healthcare entity’s business practices; (2) the relative financial ability of the business to maintain high-quality patient care; (3) the existence and experience of external oversight (licensing or supervising entities) as well as internal procedures directed at ensuring quality patient care; (4) whether the patients are inpatient or outpatient; (5) the ability of patients to protect their rights; (6) whether the debtor’s patient care quality had been high prior to the filing of the bankruptcy; and (7) the impact of the added cost to the estate.⁹ Many of the reported opinions are in cases in which the court has concluded that appointment of a patient care ombudsman would not be necessary, at least at the outset of the bankruptcy case.¹⁰

The weight to accord to each of the factors to be evaluated in considering whether to appoint a patient care ombudsman is left to the court’s discretion.¹¹ Factors that tend to receive significant

focus include the healthcare business' track record with patient complaints and the existence of reliable oversight and internal controls to safeguard quality of patient care. While the initial determination of whether to appoint a patient care ombudsman in a healthcare business bankruptcy must be made in the first thirty days of the bankruptcy,¹² the applicable bankruptcy rules provide that a motion can be made at any time in the case for appointment of a patient care ombudsman, or for termination of the appointment if the court finds that the appointment is no longer necessary for the patients' protection.¹³

There are reasons for a court weighing appointment of a patient care ombudsman to be wary of reliance on existing programs to ensure the reporting of patient quality care. The debtor's existing programs typically will not bring the objectivity of a disinterested third party, and regulating and certifying bodies generally assess healthcare businesses only on a periodic basis. Annual, quarterly, or surprise inspection provides ongoing protection of patients' right to quality care and privacy, but when a provider is in bankruptcy, circumstances may change rapidly, making periodic assessment potentially inadequate to timely identify quality-of-care issues. Regulating agencies may not be attuned to the issues of competing uses of cash and the changes in company infrastructure during a bankruptcy. Because adequate finance and infrastructure are integral to the delivery of patient care, assessment of patient quality of care may require a focus not only on outcomes, but also on the ability of the healthcare business and its infrastructure to support quality care in the future. While appointment of an independent patient care ombudsman does not guaranty high quality patient care, it does provide a voice that is independent of financial pressures faced by the debtor.

Once appointed, the patient care ombudsman typically starts with a baseline review of patient quality of care as compared to industry norms. Depending on the debtor's area of business, the patient care ombudsman's preliminary review may include a review and assessment of the debtor's policies, procedures, and compliance; emergency room access and referrals; access to care; availability of supplies; vendor shortages; availability and maintenance of necessary equipment; clinical and non-clinical staffing turnover and shortages; continuing education; clinical staff certification and licensure; matters documented by certification reviews such as CLIA,¹⁴ The Joint Commission,¹⁵ and other regulatory and certifying agencies; clinical quality-assurance programs; clinical criteria for treatment, drug storage, expiration, and stability; care planning; psychosocial status; and patient privacy compliance. The review process should include on-site inspection as well as financial and clinical staff interviews. A sampling of patient records should be reviewed, and patients should be interviewed to determine any existing issues. The preliminary review and data supplied by the debtor will form the baseline and can be used to assess subsequent quality of care, including any decline in care.

As required by the statute, the ombudsman reports its findings to the bankruptcy court every sixty days.¹⁶ Patients are to be notified of the timing of the reporting, ensuring open communication for individual issues and concerns. The patient care ombudsman

immediately reports to the court and notifies the interested parties of any significant decline in or material compromise of the quality of patient care during the course of the engagement.¹⁷

Appointment of a patient care ombudsman will result in contemporaneous reporting of significant declines in patient quality of care, and may provide an ancillary "halo" effect of potentially improving patient care. Objective observation and reporting regarding patient care policies, processes, and results can result in an improvement in the quality of care, and may provide comfort to patients, families, and caregiver staff. Some have observed that patients who report feeling content heal faster, and that contented staff that perform a common mission with the healthcare business for healing patients have reduced anxiety and turnover.¹⁸

Compensating the Patient Care Ombudsman

When a patient care ombudsman is appointed, BAPCPA is clear that the ombudsman is entitled to reasonable compensation from the bankruptcy estate.¹⁹ Unlike the case with the debtor's counsel, committee counsel, and other professionals paid from the bankruptcy estate, however, Congress did not provide the patient care ombudsman the specific right to seek to be paid periodically during the pendency of the bankruptcy case.²⁰ Without periodic payment, the ombudsman could be required to wait a year or longer for payment. This presents significant risk to the patient care ombudsman.

Many Chapter 11 bankruptcy cases do not result in a confirmed plan of reorganization. Indeed, many Chapter 11 cases end up unable to support the costs of the bankruptcy's administration itself. A Chapter 11 debtor may face increased financial pressure as the bankruptcy case proceeds. With threatened administrative insolvency, it would not be surprising to see deterioration in support from the debtor's vendors and suppliers, distraction of or resignation by the debtor's employees, and staff reductions and other cuts. When the healthcare business debtor is forced to make choices about how to spend a decreasing volume of cash flow, the quality of patient care may be compromised. Under these circumstances, the role of the patient care ombudsman to monitor the impact of the debtor's deteriorating financial situation and to report to the court and represent the patient's interests may be critical to the well-being of the patients, who may have no other advocate.

The failure to include the patient care ombudsman among the professionals who may be paid periodically during the case seems likely to have been an oversight. A leading bankruptcy treatise takes this position.²¹ In the absence of a specific provision in the Bankruptcy Code permitting interim payment to a patient care ombudsman, payment may be awarded in reliance on the traditional equity powers of the bankruptcy court. Section 105 of the Bankruptcy Code provides that the court may issue any order, process, or judgment that is "necessary or appropriate" to carry out the provisions of the Bankruptcy Code.²² Case law makes it plain that Section 105 cannot be used to accomplish what the Bankruptcy Code specifically prohibits.²³ While the Bankruptcy

Code does not specifically provide for the interim payment of the patient care ombudsman, it also does not prohibit it, and the statutory design does not indicate an intention to relegate the ombudsman to a second-class status among court-approved professionals.

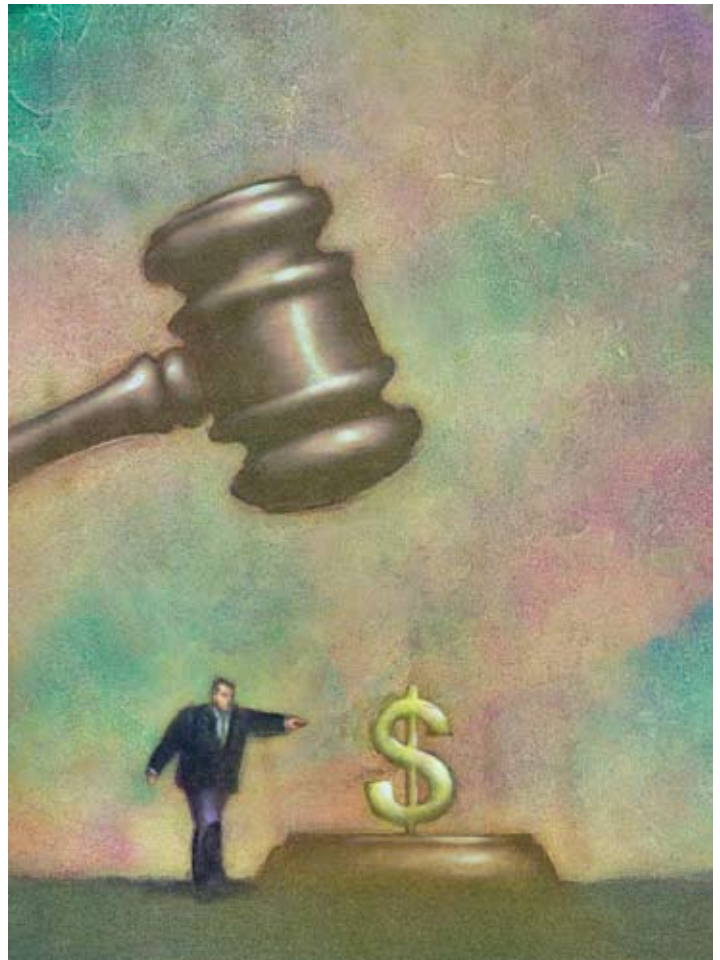
Many bankruptcy courts presiding over healthcare business bankruptcies are allowing the patient care ombudsman to be paid periodically, relying on Section 105.²⁴ Bankruptcy Code Section 330(a) permits the ombudsman compensation; Section 105 is used merely to affect the timing of that payment. Other courts, however, have refused to include the patient care ombudsman in the periodic payment scheme based on the failure of the Bankruptcy Code to specifically provide for such interim payment.²⁵

Frequently, a bankruptcy court will permit interim compensation subject to the possibility of subsequent disgorgement in the event that the bankruptcy estate becomes administratively insolvent. Disgorgement—requiring funds to be paid back to the bankruptcy estate—is a relatively rare but known hazard to the bankruptcy professional. Should a patient care ombudsman that is paid on an interim basis be subject to disgorgement of those payments if the bankruptcy estate becomes administratively insolvent? The ombudsman may argue for different treatment.

Distinct from the appointment of many other professionals, the Bankruptcy Code requires the appointment of a patient care ombudsman in Chapter 7 and Chapter 11 cases.²⁶ Moreover, while the role and activities of the patient care ombudsman may result in improved quality of patient care that may in turn help with stabilizing the census or value of the healthcare business, it remains the case that the patient care ombudsman has no financial or operational responsibility for the bankrupt healthcare business and is not focused on limiting the prospect of administrative insolvency of the business. Some courts may conclude that there is therefore little or no basis to subject the patient care ombudsman to the risk of the bankruptcy estate's becoming administratively insolvent, and that instead the ombudsman should be paid similarly to a vendor who supplies goods or services to the healthcare business while in bankruptcy and is paid in the ordinary course of business. As such, the ombudsman can be viewed as more closely akin to an administrative creditor that is paid in the ordinary course of the debtor's business. Such expenses are typically not subject to disgorgement.²⁷ It will be interesting to see whether courts adopt this approach.

Counsel for the Patient Care Ombudsman

In addition to failing to add the patient care ombudsman to the list of professionals who could be paid periodically, BAPCPA also failed to include a provision specifically permitting a patient care ombudsman to employ counsel. Nevertheless, in many cases where a patient care ombudsman has been appointed, bankruptcy courts have authorized the appointment of professionals to support the ombudsman's work.²⁸ Again, bankruptcy commentators support the retention of professionals by the patient care ombudsman.²⁹



The recently decided case *In re Renaissance Hospital-Grand Prairie, Inc.*,³⁰ holds that there are specific functions for which the patient care ombudsman reasonably should be permitted to retain counsel, including understanding the laws intended to protect the patients and related regulations on the healthcare business, and interacting with the Bankruptcy Court as is required pursuant to Bankruptcy Code Section 333 and the related Bankruptcy Rules. In a typical case, these roles could include filing motions with the Bankruptcy Court and otherwise addressing: (1) the appointment of the patient care ombudsman and counsel; (2) access to protected health information;³¹ (3) the requirements for service and filing the required ten-day notices of the patient care ombudsman's reports as well as the sixty-day reports themselves; (4) reporting and related review concerning compliance with privacy regulations; (5) applications for allowance of fees of the ombudsman and counsel; and (6) relief requested by other parties which, if granted, would cause patient care to deteriorate or could otherwise adversely affect patients' rights.³²

Because BAPCPA does not provide guidance to the patient care ombudsman, different approaches have been taken to the appointment of counsel to the ombudsman. In *In re Haven Eldercare, LLC*, the court suggested that a proper reading of the statutes dictates that the costs of counsel to the patient care ombudsman "should be the responsibility of an [o]mbudsman, who may then seek to have such expenses reimbursed under

Section 330(a)(1)(B).³³ In other words, the court indicated that the patient care ombudsman should simply hire and pay counsel, then seek reimbursement of the costs of counsel as one of the expenses it incurred in discharging its duties as patient care ombudsman.³⁴

In the *Renaissance Hospital* case, however, the court took a different approach. There, the court held that although the BAPCPA revisions to the Bankruptcy Code do not provide for it, the patient care ombudsman should be permitted to retain counsel for limited functions, and the court was emphatic that counsel must be retained through the application process set out in the Bankruptcy Code, differing from the *Haven* court's thoughts. In reaching this conclusion, the *Renaissance Hospital* court relied on cases holding that that parties may not avoid the disclosure and similar requirements of the Bankruptcy Code incident to employment of professionals by entering into "subcontracting" arrangements that would "eviscerate the protections of [the Bankruptcy Code] and allow a third party (rather than the debtor or the Court) to determine who should render professional services for the estate."³⁵

While the views of the *Renaissance Hospital* court are not unreasonable and are in keeping with the provisions of the Bankruptcy Code that apply in analogous situations where professionals are employed under Bankruptcy Code Section 327(a), a patient care ombudsman trying to sort out available options in light of the lack of direction provided by BAPCPA might be surprised to learn that what the *Haven* court suggested was intended by Congress is considered by the *Renaissance Hospital* court to be tantamount to an effort to eviscerate the protections provided for by the Bankruptcy Code. The *Renaissance Hospital* approach will result in additional expense to the bankruptcy estate due to the costs of filing a motion for authority to employ counsel. Perhaps a reasonable compromise would be for the *Haven* court's suggestion to be followed with the requirement that the ombudsman's counsel provide an affidavit of disinterestedness similar to that required in connection with retentions under Bankruptcy Code Section 327(a).

HIPAA Considerations

Another area in which Congress was clear in enacting BAPCPA is that the patient care ombudsman must maintain any information relating to patients—including information relating to patient records—as confidential information. The ombudsman may not review confidential patient records unless the court provides approval in advance and imposes restrictions to protect the confidentiality of the patient records.³⁶ Review of patient records and communication with the patients can be critical to assessing quality of care and to effectively advocating for patient quality of care and rights. Patient complaints and feedback are effective tools that permit the patient care ombudsman to evaluate the practical outcome of patient encounters and associated quality. Absent the required authority to review patient records and identify patients for interview, the scope of the assessment and reporting by the patient care ombudsman will be significantly limited.

The Federal Rules of Bankruptcy Procedure require that a motion by a patient care ombudsman under 11 U.S.C. § 333(c) to review confidential patient records must be served on each patient and any family member or other contact person whose name and address has been given to the debtor for the purpose of providing information regarding the patient's healthcare, among others, subject to applicable non-bankruptcy law relating to patient privacy.³⁷ Applicable non-bankruptcy law includes the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which permits disclosure of "protected health information," under and as defined in HIPAA, in limited circumstances, including in the course of any judicial proceeding in response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by the order.³⁸ Therefore, the patient care ombudsman typically must seek court approval for the debtor to provide the ombudsman access to confidential patient information in accordance with HIPAA. Until the court enters an order authorizing the disclosure of protected health information to the ombudsman, the debtor likely will not be in the position under HIPAA to provide the ombudsman with the names and addresses of patients for the service provisions in Rule 2015.1, as that information may itself constitute protected health information under HIPAA.

Patient care ombudsmen have addressed this problem in different ways. In some cases, the ombudsman has sought a waiver of the requirement that the patients and their contact persons be served with the motion. In others, the ombudsman has worked with the debtor who has agreed to provide the patients and other parties with the notice required by Rule 2015.1 in order to avoid any sharing of confidential patient records prior to issuance of an order permitting such sharing while still ensuring that the patients will receive notice as contemplated by Rule 2015.1.

BAPCPA brought about many changes including important changes for healthcare business bankruptcies. BAPCPA reflects Congress' intent that there be an independent ombudsman appointed in healthcare business bankruptcies to monitor the quality of patient care. How effectively this mandate can be carried out will depend on how Bankruptcy Courts, and perhaps a new Congress, resolve open issues relating to the role of the patient care ombudsman.

**Ms. Powers is a partner with and co-leader of the Business Restructuring and Creditors' Rights Practice Group at Schottenstein Zox & Dunn. The authors gratefully acknowledge the assistance of Daniel M. Anderson, partner at Schottenstein Zox & Dunn, with portions of the article.*

Mr. Martin is the president of Healthcare MCR. In addition to various restructuring and turnaround engagements, he has been appointed patient care ombudsman in bankruptcy cases in numerous jurisdictions.

1 11 U.S.C. § 101, *et seq.*

2 See 3 Collier on Bankruptcy ¶ 333.LH., at 333-11 – 333-12 (15th ed. rev. 2005).

3 H.R. Rep. No. 109-31, 109th Cong., 1st Sess. 139-140 (2005), reprinted in H.R. REP. 109-31(I), 2005 U.S.C.C.A.N. 88.

- 4 11 U.S.C. § 101 (27A).
- 5 11 U.S.C. § 333(a)(1); Fed. R. Bankr. P. 2007.2(a).
- 6 Fed. Rules Bankr. P. 2007.2(c).
- 7 11 U.S.C. § 333(b).
- 8 11 U.S.C. § 330(a).
- 9 See, e.g., *In re Alternate Family Care*, 377 BR 754, 758 (Bankr. S.D. Fla. 2007).
- 10 Recent such decisions include *In re Valley Health System*, 381 B.R. 756 (Bankr. C.D. Cal. 2008) and *In re North Shore Hematology-Oncology Associates, PC.*, 50 BCD 267, 2008 WL 5233109 (Bankr. E.D.N.Y. 2008).
- 11 *In re North Shore Hematology-Oncology Associates*, 2008 WL 5233109 at *3 (citing *In re Alternate Family Care*, 377 BR at 762).
- 12 11 U.S.C. § 333(a)(1).
- 13 Fed. Rules Bankr. P. 2007.2.
- 14 Clinical Laboratory Improvement Amendments.
- 15 The Joint Commission of Accreditation of Healthcare Organizations.
- 16 11 U.S.C. § 333(b)(2).
- 17 11 U.S.C. § 333(b)(3).
- 18 Reduction of turnover, maintaining census, and improved quality of patient care can also lead to a higher value for the business as a going concern, though this is not a duty or focus of the patient care ombudsman, and parties cannot view an ombudsman as being charged with improving an estate's value. *In re Renaissance Hospital-Grand Prairie, Inc.*, 399 B.R. 442, 446 (Bankr. N.D. Tex. 2008) (A patient care ombudsman's cost to the estate will not be (or at least is unlikely to be) offset by any accretion of value to the estate.).
- 19 11 U.S.C. § 330(a).
- 20 11 U.S.C. § 331.
- 21 See 3 Collier on Bankruptcy ¶ 333.05 [1], at 333-11 (15th ed. rev. 2005).
- 22 11 U.S.C. § 105(a).
- 23 See, e.g., *Jove Engineering, Inc. v. IRS*, 92 F.3d 1539, 1554 (11th Cir. 1996).
- 24 See, e.g., *In re Our Lady of Mercy Medical Center, Inc.*, et al., Case No. 07-10609 (Bankr. S.D.N.Y.); *In re Bayonne Medical Center*, Case No. 07-15195 (Bankr. D.N.J.). This use of Section 105 is consistent with the Second Circuit's man-
date that exercises of the Bankruptcy Court's powers under Section 105 must be tied to another provision in the Bankruptcy Code and not simply used to create substantive rights that otherwise do not exist. See, *In re Dairy Mart Convenience Stores, Inc.*, 351 F.3d 86, 92 (2nd Cir. 2003).
- 25 See, e.g., *In re Haven Eldercare, LLC*, 382 B.R. 180 (Bankr. D. Conn. 2008).
- 26 11 U.S.C. § 333(a)(1).
- 27 See, e.g., *In re Vernon Sand & Gravel, Inc.*, 109 B.R. 255 (Bankr. N.D. Ohio 1989); *In re Pacific Forest Ind., Inc.*, 95 B.R. 740, 742 (Bankr. C.D. Cal. 1989). The patient care ombudsman's fees and expenses would, however, be subject to Bankruptcy Court review and approval. 11 U.S.C. § 330(a).
- 28 See, e.g., *In re Ambumed Corp.*, Case No. 2:07-bk-20716 (Bankr. C.D. Cal.); *In re Bayonne Medical Center*, Case No. 07-15195 (Bankr. D.N.J.); *In re Our Lady of Mercy Medical Center, Inc.*, et al., Case No. 07-10609 (Bankr. S.D.N.Y.); *In re Atlanta Health Services, Inc.*, Case No. 06-10356 (Bankr. D. Md.); *In re Upland Surgical Institute, a Medical Corporation*, Case No. 06-11298 (Bankr. C.D. Ca.).
- 29 See, 3 Collier on Bankruptcy ¶ 333.05 [1], at 333-10 (15th ed. rev. 2005).
- 30 399 B.R. 442 (Bankr. N.D. Tex. 2008).
- 31 Protected health information is covered by and defined in HIPAA at 45 CFR § 164.501.
- 32 Some of these factors are laid out in *In re Renaissance Hospital-Grand Prairie, Inc.*, 399 B.R. at 450.
- 33 *In re Haven Eldercare, LLC*, 382 B.R. at 183-184 (italics in original).
- 34 Whether the patient care ombudsman's counsel should be retained through the retention process laid out in the Bankruptcy Code for professionals to other parties or should be employed by the ombudsman without application to the court with the costs passed through as an expense of the ombudsman was not directly before the Haven court and was discussed by the court in dictum.
- 35 *In re Renaissance Hospital-Grand Prairie, Inc.*, 399 B.R. at 447-448.
- 36 11 U.S.C. § 333(c)(1).
- 37 Fed. R. Bankr. P. 2015.1(b).
- 38 45 C.F.R. § 164.512(e)(1)(i).

Business Law and Governance Practice Group Leadership

Stuart I. Silverman, Chair

Office of the Inspector General for the
District of Columbia Government
Washington, DC
(202) 727-2246
stuart.silverman@dc.gov



Matthew A. Aiken, Vice Chair – Educational Programs

Balch & Bingham LLP
Birmingham, AL
(205) 226-3425
maiken@balch.com



Susan G. Duffy, Vice Chair – Research

Davis Wright Tremaine LLP
Seattle, WA
(206) 757-8032
susanduffy@dwt.com



Catherine T. Dunlay, Vice Chair – Membership

Schottenstein Zox & Dunn Co. LPA
Columbus, OH
(614) 462-2236
cdunlay@szd.com



William W. Horton, Vice Chair – Publications

Haskell Slaughter Young & Rediker LLC
Birmingham, AL
(205) 254-1448
wwh@hsy.com



Dale C. Van Demark, Vice Chair – Strategic Activities

Espstein Becker & Green PC
Washington, DC
(202) 861-4187
dvandemark@ebglaw.com



Will the Landscape of Corporate Prosecutions Change?

Kevin V. Di Gregory, Esquire

Becky S. Walker, Esquire

Lauren Teitelbaum, Esquire

Manatt Phelps & Phillips LLP

Washington, DC, and Los Angeles, CA

Corporate criminal liability and the manner in which the federal government investigates allegations of the misconduct of a corporation, its officers, and its employees have garnered considerable attention with the latest revision of the Justice Department's Principles of Prosecution of Business Organizations.¹ The specter of a protracted investigation possibly leading to an indictment of the corporation significantly affects a publicly traded company's decision whether or not to cooperate with the government. Contributing to the government's leverage when seeking cooperation is the breadth of the doctrine of corporate criminal liability.

Three significant recent developments have affected the legal landscape for corporations facing the possibility of criminal prosecution. First, as previously noted, the U.S. Department of Justice revised its Principles of Prosecution of Business Organizations. The revisions make several changes to the factors the government may consider in determining whether and how to prosecute corporate crimes. Specifically, the Principles now restrict (but do not entirely eliminate) the government's ability to consider a company's (1) decision whether to waive the attorney-client or work product privileges; (2) participation in a joint defense arrangement with individual employees, officers, or directors; (3) decision not to discipline or terminate employees whom the government believes have engaged in wrongdoing; and (4) decision to pay attorneys' fees for employees, officers, and directors.

Coincidentally, on the same day that those changes were announced, the U.S. Court of Appeals for the Second Circuit issued its opinion in *United States v. Stein*,² affirming the dismissal of an indictment against employees of the accounting firm KPMG LLP, holding that establishment and enforcement of the firm's policy that led to a halt in the advancement of legal fees to the defendants amounted to a violation of the defendants' Sixth Amendment right to counsel. The defendants, former partners, and employees of KPMG were indicted after a grand jury investigation of fraudulent tax shelters. During meetings and communications between attorneys representing KPMG and federal prosecutors, the government attorneys inquired whether KPMG would advance legal fees to its employees who were subjects of the grand jury investigation and noted that such support would run counter to any assertion by the company that it was cooperating with the investigation. After previously assuring both present and former employees that KPMG would pay their legal fees, the firm changed course and adopted and implemented a policy that capped fees, conditioned

the payment of those fees on the employees cooperating with the government, and terminated the advancement of those fees if the employee was indicted. Partially as a result of these policy changes, KPMG was not indicted and entered into a deferred prosecution agreement with the government. The Second Circuit held that KPMG's policy change regarding the payment of legal fees was "a direct consequence of the government's overwhelming influence, and that KPMG's conduct therefore amounted to state action."³ The court went on to hold that the government's actions "unjustifiably interfered with the defendants' relationship with counsel and their ability to mount a defense, in violation of the Sixth Amendment."⁴

Finally, earlier this year the Second Circuit Court of Appeals rejected perhaps the most vigorous attempt yet to narrow the doctrine of vicarious criminal liability for corporations in *United States v. Ionia Management, S.A.*⁵

The Department's corporate prosecution policies, implemented by former Deputy Attorneys General (including current Attorney General Eric Holder), have long been vilified by the business and legal communities as frontal assaults on the attorney-client privilege, the Sixth Amendment right to counsel, and the self-incrimination clause of the Fifth Amendment. The outcry prompted Congress to consider legislation to counter the assaults on these policies, most recently in a bill introduced by Senator Arlen Specter (D-PA) on February 13, 2009, entitled "The Attorney-Client Privilege Protection Act of 2009."⁶ The Justice Department's voluntary revisions to its corporate prosecution policies were a response to these assaults and threatened legislation, but it remains to be seen whether the revisions will be enough to head off congressional action.

The revised Principles coupled with the *Stein* decision may satisfy some of the concerns that critics have expressed. In particular, concerns regarding advancement of attorneys' fees and the termination or sanctioning of employees may be ameliorated by the recent developments. The new Principles bar the government from considering the advancement of legal fees to corporate employees except in the unusual circumstance in which the payment of fees itself constitutes an obstruction of justice (such as conditioning payment on the employee's adherence to a version of facts known to be false). And with the added force of the *Stein* decision and its implicit threat of dismissal of a prosecution, the government can be expected to scrupulously avoid improper interference with a company's decision to advance legal fees to its employees, officers, or directors.

On the other hand, although the Principles say that federal prosecutors will no longer consider participation in a joint defense agreement or in sharing information with suspected wrongdoers when evaluating the quality of a company's cooperation, prosecutors still may ask a corporation not to share information with others about the investigation and consider whether the corporation has done as requested. This purported change in policy is a distinction without a practical difference. So long as the government can make the request that a corporation not share information, the corporation still faces the same dilemma; i.e., that mounting any effective defense may undermine the corporation's ability to secure favorable treatment from the government.

Moreover, with respect to attorney-client privilege, the revised Principles retain the Department's existing distinction between factual information gathered by counsel during the course of an internal investigation on the one hand and privileged communications and non-factual attorney work product on the other. Prosecutors will continue to be able to demand "factual" privileged information but may not demand classic privileged communications or attorney opinions. This line may be difficult to draw as a practical matter. And as critics have argued, providing notes of interviews or factual summaries of internal investigations in order to be deemed cooperative still poses problems because it transforms counsel for the corporation into an agent for the government, and undermines the employer-employee relationship and the employee's constitutional rights.⁷ Finally, to appease federal prosecutors, some corporate leaders may decide to waive the attorney-client or work product privileges voluntarily, and the new Principles expressly acknowledge this possibility.

Even more importantly, regardless of the Department's formal policies, or even legislation or court opinions, pragmatic considerations will continue to have a profound effect on a corporation's decision whether and how to cooperate with the government. A corporation and its shareholders begin to suffer potentially calamitous consequences not when the government decides to indict or when a company decides not to cooperate, but when a federal investigation becomes public knowledge. When that happens, the pressure on a corporation to cooperate with the investigation may be far greater than any that could be exerted by a prosecutor's threat to indict if the corporation fails to waive the attorney-client privilege or make other concessions. To achieve a swift and favorable result, cooperation may be viewed by corporate leaders as essential. That pressure can intensify because of the legal doctrine that a company may be held criminally responsible for the actions of its officers and employees acting within the scope of their employment.

The most recent test of the use of this doctrine of respondeat superior in the criminal context occurred in *United States v. Ionia Management, S.A.*⁸ Ionia, a Greek shipping corporation, was convicted following a jury trial of conspiracy, pollution in violation of the Act to Prevent Pollution from Ships, and obstruction of justice stemming from actions of the engine room crew of the *M/T Kriton*, an oil tanker managed but not owned by Ionia. Ionia was fined \$4.9 million in addition to probation and assessments.

Ionia, along with an amicus brief filed by a group of six business, legal, and defense organizations, argued that the jury instruction on *respondeat superior* was overly expansive and unfairly subjected corporations to criminal liability based on unknown actions by low-level employees that violated corporate policy. The challenged jury instruction, commonly employed in federal district courts, allowed for a finding of vicarious liability where an employee's misconduct lies within the scope of employment—regardless of the employee's position within the company—so long as the acts benefited the company.

The amicus brief argued that only Congress can make decisions about respondeat superior in the context of criminal statutes. Citing *Faragher v. City of Boca Raton*⁹ and *Burlington Industries, Inc. v. Ellerth*,¹⁰ as well as practice in state courts, amici argued that

that courts should limit the applicability of vicarious liability to supervisors and offer an affirmative defense where reasonable policies designed to deter employee misconduct are in place. Where "corporations have done everything reasonable to prevent criminal conduct on the part of their employees, the corporation itself is not morally culpable yet is disincentivized from taking steps to expose the wrongdoing because of the risk that expansive respondeat superior principles will lead to its own criminal liability."¹¹

The court resoundingly rejected the argument that *respondeat superior* was improperly defined, holding that corporate criminal liability is not restricted to the actions of managerial employees and that a compliance program does not immunize a corporation from liability regardless of Supreme Court cases in other areas of law. "[A] corporate compliance program may be relevant to whether an employee was acting in the scope of his employment, but it is not a separate element."¹²

For now, the legal standard for a finding of criminal vicarious liability under a theory of *respondeat superior* in federal court remains broad. The Second Circuit's affirmation of the sweeping scope of corporate liability has given the government another boost in its leverage to secure corporations' cooperation in criminal investigations involving their employees. Whether other circuits will heed the call for reform in spite of the Second Circuit's decision in *Ionia Management* remains to be seen. In the meantime, compliance programs and other preventive measures remain as important as ever, but corporations need to be aware that even taking these precautions may not immunize them from corporate liability.

Thus, while the revised Principles and the *Stein* decision represent a positive change in the landscape for businesses, they probably will not result in a sea change as long as corporations are vulnerable to an investigation's public disclosure and to being held accountable for their officers' and employees' actions. Corporations facing potential criminal prosecution will still have to carefully balance the need to zealously protect their rights and privileges, and those of their employees, officers, and directors against the need for quick and expedient resolution of criminal investigations.

1 See UNITED STATES ATTORNEYS' MANUAL at Ch. 9-28.000 (2008).

2 541 F.3d 130 (2d Cir. 2008).

3 *Id.* at 136.

4 *Id.*

5 2009 U.S. App. LEXIS 902, 2009 AMC 153 (2d Cir. 2009).

6 S. 445, 111th Cong. (2009).

7 See, e.g., N. Richard Janis, *Deputizing Company Counsel as Agents of the Federal Government: How Our Adversary System of Justice Is Being Completely Destroyed*, WASH. LAWYER (Mar. 2005), available at www.dcbar.org/for_lawyers/resources/publications/washington_lawyer/march_2005stand.ofm; Robert L. Del Giorno, *Corporate Counsel As Government's Agent: The Holder Memorandum and Sarbanes-Oxley Section 307*, CHAMPION MAGAZINE (Aug. 2003) at 22, available at www.nacdl.org/_852566CF0070A126.nsf/0/62E85840CDEDC3D985256E540074C19A?Open.

8 2009 U.S. App. LEXIS 902, 2009 AMC 153 (2d Cir. 2009).

9 524 U.S. 775 (1998).

10 524 U.S. 742 (1998).

11 Brief of Association of Corporate Counsel, et al., as Amici Curiae Supporting Appellant, *United States v. Ionia Management S.A.* (2d Cir. June 6, 2008) (No. 07-5801-CR), at 18.

12 *Ionia Management*, at *17.

2009 Annual Meeting

June 29–July 1, 2009
Marriott Wardman Park Hotel
Washington, DC

As the culmination of AHLA's educational year, the Annual Meeting provides a forum for networking and interaction with colleagues, friends, and family, as well as an outstanding educational event. Throughout the program, members attend breakout sessions on various topics delivered by leading private practitioners, in-house counsel, and government representatives. Spend time networking with colleagues during breakfasts, Practice Group luncheons, and a number of receptions, and enjoy all that Washington, DC, has to offer.



Attend the Business Law and Governance Practice Group Annual Luncheon

Tuesday, June 30, 2009



**Title: Healthcare Restructuring and the Capital Crunch—
A Report from the Front Lines**

Presenter:

Martin E. Winter

Managing Director and Co-Head of the Healthcare Industry Group,
Alvarez & Marsal, New York, NY

Mr. Winter will report on the state of affairs of the healthcare marketplace in light of limited capital available to all but the strongest participants, challenges and uncertainty on reimbursement, continued payor pressure, increasing unemployment and resulting bad debts, reduced charitable contributions and investment income, and operating challenges that were unanticipated as recently as a year ago. Attorneys seeking to better advise their clients on navigating these turbulent waters will want to hear what the leading healthcare advisory and restructuring firm is seeing and doing to meet these challenges.



To register for the luncheon only, please call the
Member Service Center at (202) 833-1100.

For more information about the Annual Meeting and to register for the
program and luncheon, please visit: www.healthlawyers.org/Annual.



Teleconference CD Recordings— A Great Addition to Your Resource Library!

Practice Group sponsored teleconferences are held throughout the year on hot topics and analyses of healthcare law related issues and cases. If you are unable to participate in any given teleconference, you may purchase a CD recording (includes materials) by calling our Member Service Center at (202) 833-0766, or online at www.healthlawyers.org/teleconferences/CDs.

To view a listing of available CDs, please visit:
www.healthlawyers.org/teleconferences/CDs

For more information about future teleconferences, please visit:
www.healthlawyers.org/teleconferences



1025 Connecticut Avenue, NW
Suite 600
Washington, DC 20036-5405