

Healthcare Regulatory Liability: Insurers Step up to the Plate

by Carolyn Connors

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Healthcare providers face substantial and growing exposure to government scrutiny of billing practices that can result in fines, penalties, and settlements that have the potential to run into millions of dollars. Relatively few providers carry adequate insurance for this liability: Most have historically relied only on nominal sub-limits provided by their D&O insurance policies. This can – and should – be changing as new policies make regulatory actions a more readily insurable exposure.

Healthcare providers, already stretched thin implementing the Affordable Care Act, must devote more resources than ever to keep their Medicare, Medicaid, and other billing reimbursement programs and practices beyond reproach. A federal task force, the Health Care Fraud Prevention and Environment Action Team (HEAT), is among the forces being deployed by regulators to make sure that they do.

Since the inception of the HEAT task force in 2009, the Department of Justice (DOJ) has recovered \$22.75 billion in penalties – that’s more than half of all funds recovered since the False Claims Act (FCA) was brought back to life in 1986. In 2014 alone, the federal government recovered nearly \$5.7 billion in civil settlements and judgments under the FCA, \$2.3 billion of which derived from healthcare fraud.¹ The pace has barely abated in 2015, with nearly \$862 million recovered from healthcare providers in the first six months of the year.²

What is the False Claims Act (FCA)?

The False Claims Act is the primary civil enforcement tool used by the federal government to combat healthcare fraud. The Act imposes liability on “[a]ny person who ... knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.” Offenses are punishable with penalties ranging from \$5,500 to \$11,000 – plus three times the amount of damages the government sustains because of the act.

To prove that an individual “knowingly” submitted a false claim under FCA, one must prove that the person has (a) actual knowledge of the falsity, (b) acts in deliberate ignorance of the truth or falsity, or (c) acts in reckless disregard of it. **No specific intent to defraud is required.**

Source: http://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

¹ <http://www.gibsondunn.com/publications/pages/2014-Year-End-False-Claims-Act-Update.aspx>

² <http://www.gibsondunn.com/publications/Pages/2015-Mid-Year-False-Claims-Act-Update.aspx>

Odds Stacked?

FCA actions can be brought directly by the federal government or by a private individual, a “whistleblower” who contacts the government with an allegation. A whistleblower has substantial incentives to initiate an action: Under government regulations, he or she stands to receive a significant share – estimated between 15 to 25 percent – of any proceeds recovered. In 2014, whistleblowers earned more than \$435 million in share awards. Not surprisingly, these “Qui Tam” cases are on the rise, with whistleblowers being by far the largest initiator of DOJ investigations.

Government-funded Recovery Audit Contractors add further manpower to federal efforts to retrieve fraudulently reimbursed funds. These contractors are financially incentivized to conduct audits that uncover improper billing. They work on a contingency basis, earning a percentage of the improper payment recovered, and face no penalty for actions unjustly pursued. The government continues to outsource its fight against healthcare fraud. With each dollar spent on enforcement from 2012 through 2014, the government’s return has been \$7.70.³

Meanwhile, the intricate process of coding for medical reimbursement just became far more complex, with the International Classification of Diseases (ICD) expanding its roster of disease codes from 17,000 to 141,000. Since October 1, the use of ICD has been mandated in the US. Even innocent coding errors can have extremely costly results.

Providers have other concerns as well. A commercial payor can bring suits against them for improper billing. The Stark Law and anti-kickback statutes need to be closely followed to avoid significant fines and penalties. Providers must allocate more time and money securing external counsel on these issues, while also establishing sound internal compliance and audit infrastructures.

Formal voluntary self-reporting to the Centers for Medicare and Medicaid Services (CMS) or the Office of the Inspector General (OIG) at the Department of Health and Human Services is a route that may be appealing to a growing number of healthcare providers. Voluntary self disclosure can lead to the imposition of far lower costs and penalties, but it can be a complex process involving extensive data gathering and the involvement of specialist legal counsel.

3 <http://www.hhs.gov/news/press/2015pres/03/20150319a.html>

A Valuable Protection: Healthcare Regulatory Liability Insurance

Healthcare providers are working hard to mitigate regulatory exposure, with many institutions continuing to add more compliance and coding personnel. In addition, the insurance market is beginning to offer healthcare providers dedicated coverage for this serious risk.

The process of responding to regulatory investigations can be extremely onerous for healthcare providers, draining both time and money. A provider can easily spend hundreds of thousands of dollars a year on defense costs, forensic auditor fees, medical expert costs, and billing and coding consultants. Along with coverage, insurers can provide loss control services to help prevent claims; consultants to assist at key junctures (such as evaluating self-disclosure); and access to healthcare claims specialists to help policyholders triage regulatory incidents, effectively navigate the audit process, and ultimately mitigate damages.

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Beazley Remedy

Earlier this year, Beazley launched Beazley Remedy, a comprehensive healthcare management liability insurance policy, which provides express coverage for directors and officers, employment practices liability and fiduciary liability as well as a separate clause dedicated to regulatory liability – a first of its kind offering in the admitted marketplace. The product provides coverage for healthcare providers in actions brought by or on behalf of government entities for billing errors and omissions. The policy is designed to pay fines and penalties and to reimburse costs of defense, forensic audits, regulatory investigations and negotiations that can stretch on for years. Beazley Remedy responds to claims involving billing errors and omissions from government sources, including FCA allegations, Stark & anti-kickback actions and lawsuits arising from commercial payers. Limits of up to \$15 million are available.

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