

A photograph of a business meeting. Several people in business attire are gathered around a wooden table. One person is holding a pen and pointing at a document with a bar chart. Another person is holding a smartphone. The table is covered with various documents, including one with a large bar chart and another with a line graph. The background is slightly blurred, showing more of the meeting environment.

PARTNERSHIP FOR COMMERCIAL INSURANCE & RISK MANAGEMENT

DIRECTORS & OFFICERS' COVERAGE FOR REGULATORY ACTIONS & INVESTIGATIONS

THE USI  ONE ADVANTAGE[®]

www.usi.com



Executive Summary

USI provides directors, officers, and organizations financial protection from fraud and abuse investigations from various federal and state agencies

CONTROL**COST****COVERAGE**

Why is it Important

- Healthcare organizations are regulated by numerous federal and state agencies
- These agencies are targeting fraud and abuse in the healthcare industry
- These investigations can generate costs for a defense, audits, fines, and penalties
- HCFAC's return on investment was \$4.20 returned to \$1.00 invested (2017 – 2019)
<https://oig.hhs.gov/publications/docs/hcfac/FY2019-hcfac.pdf>



Impact and Benefits to Clients

- In 2019 the average **cost** for defending this type of an investigation was \$300,000
- In 2019 the average **fine** related to this type of an investigation was \$400,000
- Properly designed policies include coverage for defense costs, external forensic audits, imposed fines, and penalties as a result of various regulatory actions

HIPAA – Enforcement and Impact

Criminal and Civil Investigations into Healthcare Fraud and Abuse

- The Health Insurance Portability and Accountability Act (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS), acting through the Office of Inspector General (OIG).
- HCFAC is designed to coordinate federal, state and local law enforcement activities with respect to [health care fraud and abuse](#).



During Fiscal Year 2019, the Federal Government won or negotiated over \$2.6 billion in health care fraud judgments and settlements. As a result of these efforts, as well as those of preceding years, \$3.6 billion was returned to the Federal Government or [paid to private persons](#) in FY 2019.

Key Observations

- In FY 2019, the Department of Justice (DOJ) opened 1,060 new **criminal** health care fraud investigations.
- Also, in FY 2019, DOJ opened 1,112 new civil health care fraud investigations.
- In FY 2019, investigations conducted by HHS's Office of Inspector General (HHS-OIG) resulted in 747 **criminal** actions against individuals or entities.
- In the same year, the FBI's investigative efforts resulted in over 558 operational disruptions of healthcare organizations.

D&O Liability Policy – USI's Broadened Wording

USI policy endorsement expanding coverage for Regulatory actions

“Claim” of the **Directors, Officers and Corporate Liability Insurance Coverage Part** of this “Policy” is replaced by the following:

“Claim” means any of the following:

1. Written demand presented for monetary “Damages” or non-monetary relief for a “Wrongful Act”;
2. Complaint initiated by a judicial, civil, criminal, administrative, regulatory, alternative dispute, mediation or arbitration proceeding, including any appeal resulting from it, to which an “Insured” is provided notice and which subjects and “Insured” to a binding adjudication of liability for monetary or non-monetary relief for a “Wrongful Act”;
3. Civil, criminal, administrative or regulatory proceedings of an “Insured Individual” once such “Insured Individual” is identified by name in a Wells Notice, subpoena or target letter by such authority as a person against whom a proceeding may be commenced.

[Next Steps](#)

Broadened Regulatory Coverage – Financial Impact

Expanded Definition of a Directors & Officers Claim

Improves standard insurance coverage.

Standard Market Coverage



Policy does not include coverage for defense costs, fines and penalties associated with Criminal, Civil, Administrative or Regulatory Proceedings.

USI's Approach



Coverage enhanced to include Criminal, Civil, Administrative or Regulatory Proceedings in the D&O policy's definition of a "Claim."

Financial Impact



The Directors, Officers, and Entity are provided coverage for defense of these allegations including forensic audits, and fines and penalties after the investigation is concluded, up to a \$1,000,000 sublimit.

Next Steps

D&O COVERAGE FOR REGULATORY ACTIONS & INVESTIGATIONS

Highlights of Significant Criminal and Civil Investigations

Examples of 2019's Investigations and Charges

[Next Steps](#)



Items requested for assessment

- Current Directors & Officers Liability Policy
- Description of any past or current Regulatory Proceedings
- Organizational Chart



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Highlights of Significant Criminal and Civil Investigations

Ambulance & Transportation Services – False Statements

- An ambulance company, and their owners, agreed to a judgment against them jointly and severally in the amount of \$459,907 to resolve allegations made by the United States in the Eastern District of Pennsylvania that they made repeated **false statements** to state and federal officials.
- As part of the settlement, each defendant has also agreed to a term of exclusion of not less than five years from all federal health care programs.
- According to the allegations in the complaint filed in U.S. District Court, the defendants individually or collectively made repeated false statements in order to avoid overpayment debts to the United States' Medicare program and to hide the fact that one of the owner's state paramedic license had previously been suspended because he had admitted to forging a physician's signature.



Highlights of Significant Criminal and Civil Investigations

Clinics – False Claims & Kickbacks



- A multi facility clinic agreed to pay at least \$3.8 million and up to \$18.3 million over five years, to resolve civil **false claims** allegations that it billed Medicare for non-reimbursable procedures performed in an alleged **kickback** scheme related to referrals for certain procedures.
- The government alleged billing of Medicare for unnecessary surgical procedures.
- The government also alleged **false claims** to Medicare for services that resulted from referrals through improper remuneration to physician investors and medical directors, in violation of the **Anti-Kickback Statute**.

Highlights of Significant Criminal and Civil Investigations

Home Health – Kickbacks and False Claims

- The owner of two home health agencies was sentenced to 84 months in prison and ordered to pay \$8.3 million in restitution, following a guilty plea.
- The charges stem from the defendant's role in a fraud scheme involving illegal **kickbacks** for Medicare beneficiary referrals and the provision of medically unnecessary services not eligible for reimbursement.



Highlights of Significant Criminal and Civil Investigations

Hospice – False Claims



- A hospice operator entered into a **false claims** settlement agreement to resolve allegations that it submitted false claims to Medicare for certain patients when the patients did not meet applicable Medicare eligibility requirements or documentation for the hospice benefit was not satisfied.
- The hospice operator agreed to pay over \$5.8 million to resolve its alleged liability.

Highlights of Significant Criminal and Civil Investigations

Hospitals – Kickbacks & False Claims

- A hospital agreed to pay \$35 million to resolve civil **false claims** allegations that a subsidiary paid kickbacks to a physician group in exchange for referrals through a series of service contracts.
- The government alleged that **kickbacks** were paid under the guise of professional services agreements in return for physician referrals.
- The settlement also resolved allegations that the hospital received Medicare payments for medically unnecessary procedures.



Highlights of Significant Criminal and Civil Investigations

Nursing Homes – False Claims



- A multi facility nursing home operator agreed to pay more than \$18 million to resolve a civil **false claims** lawsuit brought by the United States and the State of Tennessee for billing the Medicare and Medicaid programs for grossly substandard nursing home services.
- The CEO and former director of operations also agreed to pay \$250,000 to resolve allegations against them.
- The United States and Tennessee alleged that the nursing facilities failed to administer medications as prescribed, provide standard infection control and wound care as ordered, to take prophylactic measures to prevent pressure ulcers and used unnecessary physical restraints on residents, and failed to meet resident's basic nutrition and hygiene requirements.
- The lawsuit alleged that the defendants submitted hundreds of preadmission forms to Medicaid containing forged signatures.