Carnegie Financial

Healthcare Organization Executive Liability Program

Physicians Billing Errors Insurance with Administrative Disciplinary Proceeding Coverage and Breach of Security Coverage

A significant premium discount is available when this product is purchased in association with other Healthcare Organization Executive Liability Program products

Physicians, medical groups and other health care providers are increasingly subject to a complex structure of laws rules regulation and mandates, imposed by Government health benefit payer programs such as Medicare and Medicaid, and by the private health benefit payers.

Health care providers must comply with the following

- Regulations governing **Billing** of medical services from **Medicare**, **Medicaid** and other federal state and local **Government** benefit plans.
- Rules governing claims for **Billing** of medical services from **private payer** benefit plans.
- The privacy rules and regulations of **HIPAA** - Health Insurance Portability and Accountability Act.
- Emergency Medical Treatment and Labor Act; EMTALA.
- The **"Stark" laws** - prohibiting self-referral of Medicare patients.

Non-compliance with these regulatory mandates and rules is very expensive: physicians must pay attorney fees and auditor fees to defend or to appeal an adverse finding or demand for restitution; actual restitution of fees, profits, charges or benefit payments if there is a determination of an overpayment; civil fines and penalties imposed by the Government; suspension, limitation of medical staff membership or clinical staff privileges, even permanent exclusion from the Government or private payer program.

Physicians Billing Errors Insurance with Administrative Disciplinary Proceeding and Breach of Security Coverage is a carefully structured insurance policy that provides policyholders with broad insurance protection through the following features:

- Access to expert counsel for leadership, assistance and compliance with the administrative process of responding, investigating defending and appealing a **Claim**.

- Coverage for actual or alleged:
  - erroneous reimbursement (billing) claims to a commercial payer or government health benefit payer
  - violations of HIPAA privacy rules
  - violations of EMTALA (patient transfer rules)
  - violations of "Stark" (anti self-referral) law

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- Coverage for named physicians, medical groups and past or present non-physician employees;

- Insurance for **Claim Expenses**, hiring of specialty attorneys and auditors, other fees and costs resulting from investigation adjustment or defense/appeal of a claim.
- Insurance for **Loss** for which the Insured may be held legally liable including judgments, settlements and civil fines and civil penalties imposed by a government entity.
- Insurance of **Breach of Security Claim Expenses** including cost of compliance, notification and monitoring due to a breach of computer data that results in a violation of HIPAA or similar law.
- Insurance of **Administrative Disciplinary Proceeding Claim Expenses** - as defined.

Policy Limits: From $1,000,000 to $5,000,000 per physician per claim, and aggregate.

Retention: $1,000 to $10,000 per claim.

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A new regulatory paradigm for healthcare providers

With the national roll-out of the Medicare "RAC" billing audit program, the impending Medicaid billing audit program and fundamental changes to both HIPAA-privacy and Stark enforcement, physicians and medical organizations must reassess their exposure to allegations of non-compliance with government regulations and address the new paradigm of government audits, investigations and demands.

The "RAC" trial period in New York, California and Florida has shown that RAC auditors, who are paid solely on a contingency basis, will aggressively seek to deny and recover Medicare "over-payments" previously made to providers. Often RAC-based demands are based on statistical projections and other methods which are permitted, but which do not fairly reflect the provider's actual billing history.

The government will often effect restitution of "over-payments" by preemptively taking funds from the provider's accounts, and may also freeze future Medicare reimbursements, pending restitution of outstanding balances. This type of action often leaves the provider with few resources to continue in practice let alone able to find and hire counsel to mount an appeal or defense.

With the assistance of experienced legal counsel or specialty accountants, many such demands for restitution of payments from physicians and medical groups can be successfully contested and appealed. This work requires a thorough knowledge of the latest billing rules and the ability to carefully and timely navigate the multi-level Medicare appeals process. Often an appeal will culminate in a formal hearing before an Administrative Law Judge.

Given the short time available to respond or appeal a demand, it's difficult for physicians and medical groups to locate qualified legal and accounting professionals to represent them. And when located, this quality of professional support does not come cheap. Legal and accounting fees incurred to defend complex and high value audits and demands, involving hundreds or thousands of billed claims, can mount quickly.

In addition to these billing issues, physicians are now confronted with a dramatically higher schedule of civil fines and civil penalties for failure to comply with the privacy provisions of HIPAA, as amended by HITECH Act. HIPAA privacy enforcement will soon likely transition from a "patient complaint" driven model to an audit driven program outsourced to contractors who will be paid as a percentage of fines collected - similar to the Medicare RAC audit program.

Enforcement of the complex Stark laws, prohibiting self-referral of patients, is also changing. Traditionally Stark enforcement has largely been whistleblower driven, but the government now plans to require hospitals to provide a master-list of all associated physicians along with a disclosure of all their business affiliations. Eventually this data will be provided to auditors to compare with referral and billing patterns.

To address all these compliance and regulatory issues McDonald Insurance Group has arranged a new insurance program for medical groups featuring: **Physician's Billing Errors & Omissions Insurance.**

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Physician's Billing Errors & Omissions Insurance

The insurance policy is underwritten by Lloyd's Underwriters, and provides physicians and medical groups with

Access to a panel of expert legal and accounting professionals and
Insurance coverage * as *follows:*

Costs incurred by the Insured to defend investigate adjust and appeal formal investigations and audits or demands for restitution of payments, including fees charged by lawyer or accountant, including cost of appeal, attachment or similar bonds and

Indemnity for civil fines and civil penalties, including the multiplied portion thereof and for *certain settlements* that the insured becomes liable to pay in connection with:

- Actual or alleged errors in **billings** submitted by the insured for reimbursement of medical services/equipment. Includes actions brought by both governmental and by private healthcare benefit payers. Also includes *qui tam* claims brought under FCA.
- Actual or alleged non-compliance by the insured with patient privacy rules of **HIPAA .**
- Actual or alleged non-compliance by the insured with **EMTALA**.
- Actual or alleged non-compliance by the insured with **Stark** laws prohibiting self referral of Medicare patients.

In addition there is coverage for

- Expenses incurred to notify potentially affected parties as a result of an actual or suspected breach of electronically stored patient health information or financial data security, as required by law.
  Sub-limit $ 25,000
- Expenses incurred to defend Administrative Disciplinary Proceedings in connection with the regulatory issues covered under the policy where the insured's medical license, participation in health plans and/or clinical or staff privileges – are at risk.
  Sub-limit $ 50,000

Policy Type: Claims Made

Policy Limits: Physician can request limits up to $1 million each claim/ $5 million aggregate
Medical Group can request limits up to $5 million each claim/$5 million aggregate

Insured: The named Medical Group/Organization
Physicians named in the Declarations/their solo corporations
Non-physician employees of the Medical Group
Physicians added to the policy working under contract to the Medical Group

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Policy Features & Key Benefits

- The annual premiums are very competitive and don't vary by medical specialty.
- Premium discounts available when purchased in association with program EPL or D&O coverage.
- Significant premium discounts are available for part time providers and groups.
- The loss retentions are low, often nil or $1,000 each claim.
- Company provides defense and advances defense expenses, Insured has duty to defend.
- Retroactive coverage is automatically included for at least 2 years, on application for up to 6 years.
- Fully severable Application between all Insureds for all Application and Warranty information.
- If Insured currently has a similar insurance policy they are eligible for prior acts coverage back to existing Retroactive date and they will not be required to provide a new Warranty.
- Notice of Circumstance to underwriters is permitted.
- Self-reporting of wrongful act to government is permitted.
- Insured vs Insured exclusion amended to allow claim by Qui Tam plaintiff under False Claims Act.
- Fraud/dishonesty exclusion does not apply to claims brought under law or statute based "reckless conduct" (ie False Claims/ FMP)
- No wrongful act of any Insured shall be imputed to any other Insured.
- Minimum of one year Tail available at 100%.

* The foregoing is intended as general information and does not alter or amend the policy as issued by the carrier.

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