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10 Health Care Financial and Professional Insurance Trends to Watch in 2019

The opioid crisis. Workplace sexual harassment. Active shooter events. Never-ending regulatory scrutiny. And a federal court ruling the Affordable Care Act (ACA) unconstitutional. 2018 was a busy year for the health care industry and 2019 is shaping up to be another challenging one. The following are the top 10 financial and professional risks we expect health care organizations to face in the year ahead.

The Top 10 List:

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1 Far Reaching Implications of the Opioid Crisis

The opioid crisis is quickly proving to be among the most devastating events the health care industry has ever grappled with. According to a recent report by the National Safety Council, an accidental opioid overdose is a more likely cause of death than an auto collision. And the impacts of the crisis are expected to continue well into the future.

Unsurprisingly, the crisis has led to litigation, with the targets including manufacturers, distributors, and pharmacy benefit managers. Shareholders have also entered the fray, filing suit against the directors and officers of publicly traded opioid manufacturers and distributors, in an example of the event-driven securities class action phenomenon.

It is unlikely that plaintiffs will stop with manufacturers and distributors. Instead, they may look farther down the distribution chain for new targets, including health care providers. In fact, the next wave of opioid litigation is already building; a handful of West Virginia cities have sued the Joint Commission for allegedly spreading misinformation about the dangers of prescription opioids. A number of suits have also been filed against providers for alleged negligent opioid prescribing practices.

The opioid crisis is also putting financial pressure on health systems and bad debt associated with the uptick in opioid-related medical care. A recent analysis found that caring for patients who experienced an opioid overdose costs American hospitals $1.94 billion annually.

Regulators are also increasing their oversight in light of the crisis, including applying pressure to identify physicians and other providers with suspicious records of prescribing opioids. Investigations of providers could, in turn, lead physicians and other providers to file retaliation claims against health systems, or their employers, if they are not hired or face other adverse employment-related actions, potentially triggering directors and officers (D&O) or employment practices liability (EPL) coverage. Physician retaliation claims have been on the rise in recent years and settlements have steadily increased.

While health care D&O carriers have not required opioid exclusions, they are closely monitoring legal and regulatory developments. The crisis, meanwhile, is already affecting the managed care errors and omissions liability insurance market.

2 What's Next in the ACA Saga?

In December, a federal court in Texas declared the ACA unconstitutional. This latest twist highlights obstacles that providers and payers will face as the future of health care reform hangs in the balance.

The ruling, which potentially invalidates the entire ACA, will not take effect immediately. But if the law is struck down, the health care industry will need to consider how to unwind practices — including providing certain types of preventive care at no cost, lifting lifetime payment caps, and ending coverage denials based on pre-existing conditions — that are universally favored by patients and providers.

Following the ruling, D&O underwriters may more closely scrutinize future profitability for hospitals, skilled nursing facilities, and other health care providers, especially those offering medical services in states that have expanded Medicaid to cover more low-income adults. If the ACA decision stands, patients that currently receive care under expanded Medicaid may need to transition to charity care, for which providers are not compensated. This would add additional pressure on many providers' already thin profit margins, especially those serving rural and lower-income populations. In light of the potential negative financial impact, it is important to explore D&O Side-A difference in condition policies, which could provide dedicated coverage for directors and officers in the event of a bankruptcy or other event that may prevent an insured company from indemnifying a director or officer.

The decision could also have significant ramifications on health insurers. Since 2014, there has been uneven participation by health insurers in ACA marketplaces. Slowly, these insurers are entering or re-entering the ACA market. As with providers, continued uncertainty about the law's future can negatively affect insurers' bottom lines.

Moreover, many health insurers in the ACA market are exploring ways to successfully maintain healthy populations and control costs, which has often led them to tilt closer to the direct provision of medical care. These services, however, may not be covered under managed care errors and omissions (E&O) policies. It is thus important to examine whether such policies extend to any new services being provided.

Because the future of the ACA remains uncertain, it is a good time for health care organizations to re-evaluate the scope and breadth of coverage of their insurance programs.

3 #MeToo: Health Care Too

Sexual harassment and similar allegations are not new to health care. A 2016 study of academic medical faculty, for example, reported that approximately 30% of female physicians had personally experienced sexual harassment by superiors or colleagues, compared with just 4% of men. A BuzzFeed News analysis, also found that employees of general medical and surgical hospitals filed more than 3,000 sexual harassment claims with the Equal Employment Opportunity Commission (EEOC) between 1995 and 2016.

Across all industries, the #MeToo movement has led to an increase in internal complaints and attorney demand letters alleging sexual harassment, and state employment agencies have noted an uptick in charge filings. This suggests that more suits and claims are likely to come, including against hospitals and other health care organizations.

Managing and settling the claims that have been filed to date, meanwhile, has become more expensive and complicated, in part due to new laws designed to discourage or prevent nondisclosure provisions in settlement agreements and mandatory arbitration of harassment claims. These claims have already had a significant impact on the EPL market, prompting insurers to seek higher retentions, raise premiums, and potentially seek to add exclusions for sexual assault and similar risks to some employers' policies, and are beginning to affect the D&O market.

With no sign of abating, sexual harassment will likely remain a critical issue for employers for years to come. In the era of #MeToo, health care entities should be prepared to address employment-related policies during D&O and EPL underwriting meetings. Given the plaintiffs' bar's focus on these types of claims, employers should review the limits and the scope of coverage under their EPL programs to prepare for potentially challenging claims in the future.

4 Active Shooters: A Moving Target for Preparedness

Across all industries, acts of violence are among the major causes of death in the workplace. In 2017, 807 American workers were killed as a result of violence and other intentional injuries, according to the US Bureau of Labor Statistics, including 351 as a result of intentional shootings. The health care industry is not immune to this threat: Between 2000 and 2011, there were 154 hospital-related shootings involving 148 hospitals, according to a Johns Hopkins University study. And according to FBI data, 10 active shooter events — which involve individuals using firearms to actively kill or attempt to kill people in confined and populated areas — occurred in health care settings from 2000 to 2017.

Private or nonprofit D&O or EPL policies may offer limited coverage for active shooter events and other forms of workplace violence, usually with a relatively low sublimit. Similarly, kidnap and ransom policies may also include sublimits for workplace violence incidents for a relatively modest additional premium. Property, workers' compensation, and general liability coverage can also respond.

As active shooter events have grown more frequent, however, insurers have developed dedicated policies to address them. These policies can provide primary coverage and a broad array of services, including access to crisis management expertise; reimbursement for lost income and extra expenses for employees and other victims, death benefits, funeral expenses, extra security expenses, public relations fees, and post-event counseling; and potentially prevention training.

5 What's Next for HIPAA?

Patient privacy, including the security of health information, will remain vital to the health care industry. In a long overdue step, the Department of Health and Human Services (HHS) is now requesting information on how regulatory requirements can be improved — or, in some cases, eliminated. HHS is focusing specifically on aspects of the Health Information Portability and Accountability Act (HIPAA) that may be placing unnecessary hardships on health care organizations and stalling efforts to improve care. Among other items, the department is seeking comments on how to appropriately share information related to patients facing health emergencies, with a focus on mental illness and the opioid crisis. Better coordination of patient data without fear of overburdening already taxed health care entities is a welcome development.

HHS seems more poised than ever to enable organizations to provide important feedback that could improve federal policy around personal health information in 2019. Health care organizations, however, should not forget that the HHS Office for Civil Rights (OCR) imposed a record $25.7 million in HIPAA penalties in 2018. This included a $16 million fine against a large health insurer — the largest-ever fine assessed by the OCR — arising out of a 2014-2015 breach of 79 million enrollees.

With privacy and security concerns at the top of the list of priorities for the HHS in 2019, health care organizations should review their cyber coverage to ensure they have appropriate limits and coverage terms.

6 Ransomware: An Inevitable Ailment

While privacy remains a critical focus area for health care organizations, technology-driven business interruption has become a prominent risk for all businesses, on par with natural disasters. In mid-2017, a large-scale global attack known as NotPetya encrypted files on computers around the world. A leading health care transcription provider's services were knocked out, leading to costs of more than $98 million. Several health care providers were also affected when they lost access to the organization's transcription and other services.

In response to NotPetya and similar events, health care organizations are increasingly seeking coverage for cyber business interruption. Such coverage continues to evolve, with insurers expanding policies to respond to interruptions caused by programing and operating errors and supply chain and receiver interruption and to mirror the traditional property approach to calculating loss.

7 IoT Devices Increase Security and Privacy Risks

Connected medical devices — including pacemakers, glucose monitors, telehealth applications on mobile devices, sub-cutaneous chips, watches with electrocardiograms, and other health monitoring capabilities — have the potential to be hacked by attackers looking to disrupt networks and extort money. As cyber criminals increasingly use Internet of Things (IoT) devices as a gateway to larger computer networks, health care organizations that connect with these products face significant risks. The myriad connection points and mountains of confidential data they collect mean that security incidents, privacy events, product risk, intellectual property risk, and cyber extortion can create increasingly severe losses for organizations. Greater connectivity also means increased risk to patient safety and the potential for medical malpractice issues, regulatory investigations, class action lawsuits, and reputational harm.

Health care entities that rely on connected devices must rethink how they manage network security, including how their insurance coverage is structured. Risk professionals should work with advisors to ensure their cyber and other forms of coverages will respond to claims involving connected devices.

8 More M&A on the Horizon

Health system mergers continued at a rapid pace in 2018, with many of the largest deals involving vertical integrators. These deals are expected to continue in 2019, which could lead to more claims and suits by competitors, regulators, and employees.

Increased merger and acquisition (M&A) activity raises several potential insurance issues. For example, EPL claims may be asserted by former employees who have been part of subsequent reductions in force. For publicly traded health care companies, merger objection claims are the most pressing issue for D&O coverage; for private and nonprofit companies, M&A and other claims alleging anti-competitive conduct are among most frequent and severe D&O claims, with a single claim potentially costing millions to defend. To date, insurers have responded by demanding higher retentions for antitrust claims and requiring that policyholders pay a higher percentage of antitrust claims as co-insurance. A few carriers have gone a step further by sublimiting antitrust coverage.

As industry consolidation continues, health care organizations must consider several critical questions. Should separate pre-M&A programs be placed into runoff? For coverages not placed in runoff, what insurance will be in place for pre-M&A conduct? Is representations and warranties insurance needed for transactions or regulatory billing exposures? Health care risk professionals should work with their insurance brokers now to answer these questions instead of waiting until their organizations are in the midst of deals.

9 The Evolving MCE&O Market

In 2018, primary and total program pricing for managed care errors and omissions (MCE&O) liability insurance for organizations with $1 billion or more in revenue steadily increased each quarter. At the same time, market capacity shrank, with several insurers no longer offering coverage to these companies.

The opioid crisis also affected the MCE&O market in 2018. For organizations with pharmacy benefits management operations, insurers mandated adding opioid exclusions. A few carriers required opioid exclusions on all MCE&O renewals.

As claims costs increase, we expect MCE&O insurers to remain focused on profitability and push for higher rates and retentions, reduced capacity, and narrower coverage. This could be a long-term trend; some insurers have warned that this will not be a one-year "restoration" or "correction." We also expect MCE&O insurers to remain willing to walk away from business or reduce capacity if they cannot secure the pricing they need and to be less inclined to negotiate policy wording requests and enhancements. For some MCE&O clients, sufficient capacity has become an increasing concern.

For all these reasons, it is imperative to start renewal discussions early. When it comes to selecting MCE&O insurers, organizations should evaluate each insurer's claims reputation and continued commitment to insuring managed care organizations. It is also important to consider alternative forms of risk management, such as captives and other self-insurance vehicles.

10 Disruptors and the Future of Health Care

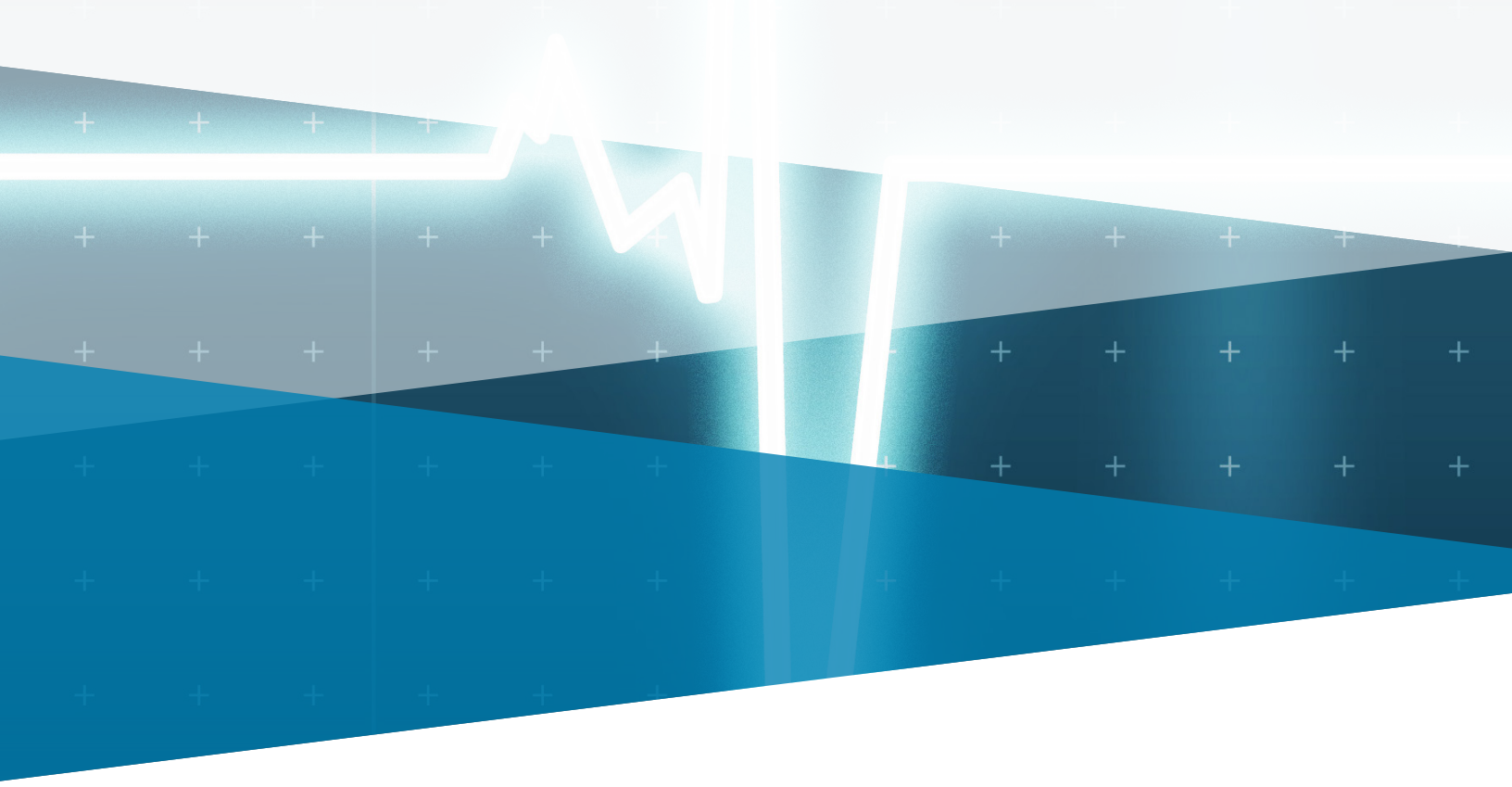
As nontraditional players set their sights on health care and consumers demand more from traditional providers, the health care industry is facing significant disruption. Retail clinics are already fast-growing players in the primary care landscape and vertical mergers are likely to lead to even more change in how care — especially primary care — is delivered. According to a recent Oliver Wyman report, those who have tried alternative forms of health care delivery — such as retail health clinics, urgent care centers, telehealth consultations, and mobile apps — are satisfied with them, although just 10% of consumers have tried such offerings.

So far, traditional health care entities have not experienced the level of disruption that new entrants and new technologies have brought to transportation, retail, and other industries. However, disruption is coming — and it could affect every aspect of the industry, including the financial health of traditional organizations as disruptors strive to gain market share.

Some traditional health care organizations are striving to be their own disruptors. For example, several leading health systems have formed a pharmaceutical company to manufacture generic drugs. Health care organizations are also exploring how to best use newer technologies, such as artificial intelligence and blockchain. Some may also seek to work with disruptors; health systems, for example, have contracted with ride-sharing services for patient transportation.

For those organizations that are offering new products or services amid this industry disruption, it is important to consider the risks and potential liability and the insurance implications for these new activities.

There will likely be some surprises in 2019. But we are confident that some of the trends that have already started will persist and intensify. This environment makes it more important than ever to begin strategic discussions well in advance of your next renewal to ensure a healthy coverage portfolio.



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