2023 Risk Issues for Hospitals and Health Systems in Management Liability

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The last three years have been incredibly challenging for healthcare providers on so many levels, and in this paper we focus on the developing risk issues for healthcare entities in management liability.

The healthcare regulatory, business and social environment continues to change rapidly, accelerated in many ways by COVID-19. Management liability risks are keeping pace — the traditional concerns still exist albeit in developed form, and new risks exposures have arrived in areas such as excessive fee litigation against benefit plan fiduciaries; COVID-19-triggered financial and employment challenges; and website tracking litigation against hospitals.

This paper considers these issues, with a focus on how hospitals and health systems can think about the risks when assessing the organization's insurance needs.

EXCESSIVE FEE LITIGATION

Hospitals have become particular targets in a recent new wave of class action lawsuits against plan fiduciaries and sponsors, alleging that the plans allowed for excessive recordkeeping fees and imprudent investment options. Originally, jumbo plans were the target for this type of litigation but, since 2020, medium-sized plans have been more the focus of plaintiff lawyers' attention, drawing many hospitals into scope.

The 2022 US Supreme Court ruling on Hughes v. Northwestern University was disappointing in lack of applicable guidance regarding excessive fee litigation. However, favorable decisions for plan sponsors were put forth in the sixth (CommonSpirit), seventh (Oshkosh) and eighth (MidAmerican) circuits in 2022. If this trend spreads to other circuits in 2023, we may finally see relief in the number of excessive fee claim filings and settlements.

Defense of these claims is expensive, with most lawsuits surviving a motion to dismiss and settling for increasingly large sums. The frequency of claims is high and merits attention from senior management (many of which will also be fiduciaries under ERISA) who will want to understand:

- What makes a plan a target, including use of funds with high expense ratios, not performing regular RFP's for recordkeepers, excessive or uncapped fees to service and investment providers, and not removing underperforming funds.
- Which funds attract the attention of plaintiff lawyers — it's often target date and actively managed funds.
- The pattern of settlements, as defendants avoid the risk of litigation. Euclid Fiduciary, an insurer of fiduciary liability insurance reported that plans under $1 billion in assets typically settle for approximately 30%–40% of the damages model.[1]

Addressing these factors can help hospitals to implement the necessary controls and protocols, not only to reduce the risk of claims but also to present the best possible risk to fiduciary liability insurers.

COVID-19 CHANGED MANY MANAGEMENT LIABILITY RISKS

The pandemic led to numerous new and worsened risks in the areas of Directors & Officers (D&O) Liability and Employment Practices Liability (EPL) insurances all of which are relevant to hospital management.

The hospital's financial situation is a key factor in underwriting D&O insurance. In particular, insurers want to understand the hospital's income statement and balance sheet, to see whether adverse events are likely during the forthcoming claims-made policy period. The insurer is concerned to see that the hospital has sufficient funds (cash or credit) to finance operations and service its debt.

COVID-19 placed stress on hospital financials, even on top of the existing margin pressure from value-based reimbursement; lower per capita Medicare spending; low Medicaid reimbursement rates; rising pharmaceutical costs; increasing employment costs; the trend to care outside the hospital; etc. There is some concern from D&O insurers that the financial support to financially at-risk hospitals during COVID-19 may have masked serious, underlying financial problems that are now waiting to unwind.

[1]Special Report from Euclid Fiduciary: Insights from the First Twenty-Five Excessive Fee and Investment Imprudence Cases of 2022
https://www.euclidspecialty.com/fiduciary-insights-from-the-first-twenty-five-excessive-fee-and-investment-imprudence-cases-of-2022/

Pandemic-induced financial stress manifested in lost revenue, increased supply and labor costs, pressure on liquidity, cash flow and borrowing. Of course, D&O insurers want their insured hospitals to be successful (and claim free) and so hospitals will want to explain to D&O insurers the steps they take to avoid claims by addressing the continuing and post-pandemic issues of:

- How the hospital will handle the ending of the Public Health Emergency,[2] announced for May 11, 2023.
- Staffing levels and the cost of using contract labor.
- Meeting debt covenants and the need for new debt.
- How the hospital is navigating the ups and downs of Medicare reimbursement rates, disproportionate share payments, the cost of uncompensated care and bad debt.
- Managing the stresses in the supply chain.
- Liquidity, cash flow, reduced federal funding, and in some cases the need to still return federal funds.
- Hospital margins, especially after such a difficult 2022 when approximately half of US hospitals experienced a negative margin.[3]

From an EPL perspective, COVID-19 brought claims from traditional and new situations. While some hospitals did carry out layoffs during 2020 COVID-19, others pledged to keep their staff in place regardless. The process of reducing staff should be understood by now, and yet the unique situation still brought claims of discrimination and wrongful termination.

What was new was the question of mask exemption on-site, complicated by conflicting positions at the federal and many state levels, and the need to establish protocols in the middle of a difficult and stressed time. Decisions on how to treat requests for exemption on medical and religious grounds, and the degree of investigation that could be imposed, did bring forward claims particularly from providers, especially when they felt that they were being denied their usual patient-facing roles.

Hospitals (and corporate entities) continue to employ a growing share of the physicians in the US, up from 62.2% in January 2019 to 73.9% as of January 2022,[4] and this represents a particular EPL risk since claims by high-earners typically have higher costs to defend and settle.

Single physician claims often cost in the millions of dollars to defend and settle. This is compounded by insurers of healthcare D&O/EPL policies often imposing higher retentions for claims by and against physicians, because those claims have been more expensive to close. Claims by physicians can take many forms, from merger and acquisition (M&A) related claims alleging under/overpayment, to EPL claims that start as a D&O credentialing issue but then expand to include allegations of wrongful termination, discrimination and antitrust as physicians allege their ability to practice in the community is impaired by being credentialed out.

Physicians have the will and financial resources (and need to protect their ability to practice) to pursue a case for longer and to settle for higher amounts. Similarly, claims by hospital senior executives typically cost more to settle, particularly when supported by contracts that specify break-up terms.

WEBSITE TRACKING AND PIXEL CLAIMS AGAINST HOSPITALS

There has been a recent rush of claims against hospitals alleging that their use of website tracking tools, and then sharing the tracking information with third parties such as Facebook, is a potential disclosure, without consent, of patients' sensitive health information in violation of the Health Information Portability and Accountability Act (HIPAA), and other federal and state laws.

The website tracking tools use pixels, which are pieces of code embedded in the hospital's website, that are often used to gain insight into individuals by analyzing how they use the website, with the goal of enhancing marketing efforts via targeted digital marketing. So, when the patient is using the website in relation to health issues, the disclosure of that information may violate HIPAA, attracting class action lawsuits and the attention of regulators.

This is an interesting example of how new technology and practices can mask a dormant exposure that is both a business process and compliance issue. However, this issue is now well and truly in the open, and insurers and regulators have clear expectations on compliance. The Office for Civil Rights (OCR) at the US Department of Health and Human Services has issued guidance[5] and Gallagher has published both a discussion paper[6] and a webinar.[7]

[2]Manatt, Phelps & Phillips, LLP https://www.manatt.com/insights/newsletters/health-highlights/what-changes-if-the-covid-19-public-health-emergen#:~:text=The%20Biden%20Administration%20has%20announced,in%20effect%20since%20January%202020

[3]Beckers Hospital Review. Hospitals suffer worst financial year since the pandemic https://www.beckershospitalreview.com/finance/hospitals-suffer-worst-financial-year-since-the-pandemic.html?utm_campaign=bhr&utm_source=website&utm_content=most-read

[4]Beckers Hospital Review. 74% of physicians are hospital or corporate employees, with pandemic fueling increase https://www.beckershospitalreview.com/hospital-physician-relationships/74-of-physicians-are-hospital-or-corporate-employees-with-pandemic-fueling-increase.html

[5]HHS.gov. Use of Online Tracking Technologies by HIPAA Covered Entities and Business Associates | https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-online-tracking/index.html

[6]Arthur J. Gallagher. Pixels and the Rising Cyber Risk of Tracking Technology | Gallagher USA https://www.ajg.com/us/news-and-insights/2023/feb/pixels-and-the-rising-cyber-risk-of-tracking-technology/

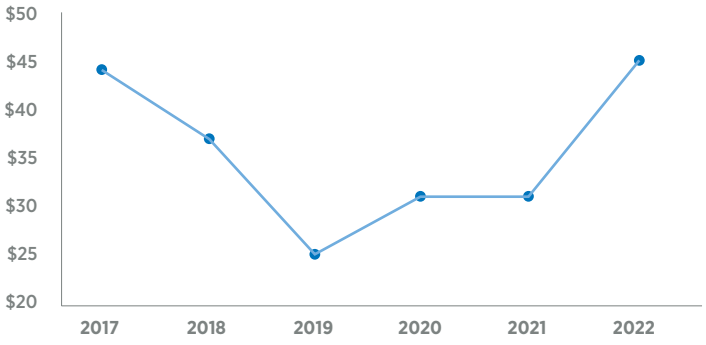
[7]Arthur J. Gallagher. Pixels: An Emerging Cyberthreat https://event.on24.com/wcc/r/4098132/E2377AEC0BA4C4E37F8F51B649E3913A?partnerref=EmailThankYou&j=70991&sfmc_sub=3335088&l=14_HTML&u=772593&mid=110006093&jb=1&utm_source=sfmc&utm_medium=email&utm_campaign=GGB_2023_US_CYB_CRP-GP_Webinar-Series-March-Thank-You&utm_term=BTN%3a+Watch+the+Replay&sfmc_e=3335088

Insurers are taking an increasingly firm position on providing coverage, seeking exclusions if the hospital cannot say that it is in compliance with OCR's guidance, and that there are policies and procedures in place to ensure continued compliance.

M&A AND ANTITRUST

The number of hospital mergers recovered somewhat in 2022, although still below pre-pandemic numbers, but in aggregate set a new record for combined revenues transacted, at $45 billion,[7] inferring larger deals generally.

Total Transacted Revenue (2017–2022 in billions)



Source: Kaufman, Hall & Associates, LLC

Hospitals continue to face competition from all directions — locally and from larger systems that are themselves growing outside their traditional markets; and from retailers, health plans and technology companies. The offensive goals remain to search for economies of scale, to integrate services for better delivery of care and to repeat existing expertise in new markets.

Healthcare D&O policies cover loss (damages, settlements, defense costs, etc.) arising from claims for antitrust activities including price fixing, restraint of trade, monopolization, unfair trade practices, as well as violations of the Federal Trade Commission Act, the Sherman Antitrust Act and other similar regulations. Claims and allegations can come from various parties, including customers/patients, competitors, employees and regulators.

M&A brings antitrust exposure to the hospital entity and its directors and officers (and their D&O insurers) in a number of scenarios. Hospital mergers, particularly in close geographic and specialty markets, can have anticompetitive effects giving rise to concerns as to whether the hospital will exploit merger-created market power in ways harmful to consumers, or lessen competition on specialty, quality, service or innovation.

Any analysis of a merger needs to be balanced by considering efficiency gains, enhanced negotiating strength with payers to the real benefit of patients, and whether the deal will protect either party from having to fail, causing assets to exit the market.[8] In analyzing the effects of a hospital merger, the FTC will refer in particular to merger guidelines that mergers should not be permitted to create or enhance market power or to facilitate its exercise.[9]

M&A also brings lawsuits in the form of merger objection claims, whereby dissatisfied shareholders of an acquired (or soon to be acquired) company assert that the acquisition was unfairly managed, that the directors had conflicts of interest (personal enrichment), and that there was inadequate consideration paid, resulting in a deal that disadvantages the shareholders.

Similarly, healthcare entities need to be sure that there is proper EPL cover in place after an acquisition that will respond to new claims that arise out of misconduct that may well have happened after the deal but in fact commenced prior to the acquisition — a new insurer will likely take the position that such a claim is not covered under the acquiring company's regular EPL policy language.

From insurers' point of view, the risk has changed over the years through increased scrutiny of M&A and anticompetitive behavior, the high compensation levels and imbalances in healthcare, social change, and the increased scale of many organizations and systems as they combine to control costs and quality. As mentioned above, M&A events can both bring reorganization and lay-offs and longer term risk from past social issues.

The larger organizations not only represent greater, aggregated and concentrated risk to a single policy limit, but also have the financial ability to bear larger self-insured retentions. Insurers do want to tackle this issue but are generally prevented from doing so to the degree they would like, by a reasonable level of competition in the market.

[7]Kaufmann Hall. 2022 M&A in Review: Regaining Momentum | Kaufman Hall https://www.kaufmanhall.com/insights/research-report/2022-ma-review-regaining-momentum

[8]US Department of Justice Antitrust Division. See https://www.justice.gov/atr/chapter-4-competition-law-hospitals

[9]US Department of Justice Antitrust Division. Horizontal Merger Guidelines. See https://www.justice.gov/atr/horizontal-merger-guidelines-0

One response to upward pressure on retention levels is for the organization to use its captive insurance company to take EPL risk in the coming years. If the D&O/EPL market cannot provide acceptably low retentions for the risk, then it is natural for insureds to wonder whether they should retain more risk, just as they generally do on their hospital professional liability programs.

The number and size of hospital mergers, presents the risk of increased frequency and severity of antitrust claims against D&O and their organizations. Any failure of these deals will also create D&O risk in later years as the consequences come to light in terms of poorer financials, reorganizations or divestitures. Insurers are also interested to understand the integration process (financial, systems, IT, employees), timing, lay-offs and cultural fit as important risk factors.

Hospitals and systems will want to take into account their M&A history and plans for the next 18 months, when assessing their policy limits for both D&O and EPL.

FALSE CLAIMS ACT, FRAUD AND ABUSE

Fraud and abuse exposures continue to grow for healthcare providers. The US Department of Justice (DOJ) announced[10] that it recovered $1.7 billion in settlements and judgments from across the healthcare industry, partly reflecting its new focus and priority on fraud in pandemic relief programs and also alleged violations of cybersecurity requirements in government contracts and grants.

The DOJ has a strong focus on billing fraud, as well as referral sources under Anti-Kickback Statutes and Stark Law, inducements to use patient assistance programs, and the use of unnecessary services.

For example, telemedicine grew greatly during the pandemic, and is now a focus for investigation as a service ripe for billing abuse, whether for unnecessary consultations; advice by nonqualified persons (i.e., physician not present); overcharging and upcoding; unrealistic number of consultations by the same provider in a single hour; and even questions as to whether the call ever took place.

The DOJ is not the only government body pursuing fraud-related violations — HHS, US Attorneys Offices, OIG and CMS are all pursuing entities and individuals, helped of course by the substantial incentives offered to whistleblowers.

Directors & Officers Liability insurance for healthcare entities goes some way to addressing these exposures, but only reluctantly. D&O insurers see this fraud and abuse exposure as overwhelming larger (and different) than the corporate breach of duty D&O exposure.

A standard healthcare D&O policy includes only a $1 million sublimit for defense costs for claims alleging billing errors to the government. This is bare-bones coverage in an area where settlements regularly run in the many millions (or tens or hundreds of millions) of dollars.

Coverage can be broadened in the D&O policy (while sharing, and potentially eroding the limit for D&O claims) by purchase of stand-alone coverage, in order to also address claims for billing errors by commercial payors; damages; fines and penalties; violation of the False Claims Act; and violation of other fraud and abuse laws including the Anti-Kickback Statute, Stark Law, Exclusion Statute and Civil Money Penalties Law.

Insurers, when underwriting the risk, are particularly interested in understanding the hospital's financials, payor mix, compliance program, billing practices, audit appeal rate, M&A due diligence and integration, and also the steps taken to not repeat past losses.

[10] DOJ — https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-2-billion-fiscal-year-2022

NON-INDEMNIFIABLE CLAIMS AGAINST DIRECTORS & OFFICERS

D&O insurance policies cover non-indemnifiable claims against the D&O (Side A claims) within their typical program structure of covering both claims against individuals and the organization. Side A claims are those where the organization does not or cannot indemnify the individual D&O, leaving the D&O to defend the claim using their own money and Side A insurance coverage.

Side A coverage, as mentioned, is included in the regular D&O program, but can also be purchased as an excess layer too, typically with almost no exclusions and often wrapping around the main D&O policy on a difference in conditions basis.

Side A coverage is important for healthcare executives since it acts as an ultimate resource and funding for defense and outcomes that are not indemnified, and (when purchased as a dedicated excess layer) reserves the policy limit solely for the protection of the D&O (not the organization).

One typical Side A claim is a derivative suit, brought by a stakeholder for the benefit of the organization, alleging that loss has been suffered by the organization (rather than a direct financial loss to a stockholder) as a result of a wrongful act by the D&O.

Side A claims are comparatively rare in nonprofit healthcare, but the impact on the individual D&O underlines the importance of maintaining sufficient policy limit for Side A claims.

CONCLUSION

Healthcare generally, and hospitals in particular, remain a comparatively difficult and developing risk for D&O/EPL insurers. The risks are changing as the regulatory, business and social environment develops.

At the organization level, M&A activity together with the trend toward larger entities, continuing financial pressure, and the need to change the business model to stay ahead, all present challenges for management.

For individual D&O, there is a growing focus on their own behavior and a readiness for stakeholders to hold them responsible for alleged failures.

Hospitals and health systems will want to understand how D&O/EPL insurers view the risks and exposures that their organizations and people represent. This will help the risk managers and management to explain their business to insurers, including the steps taken to reduce risk, whether in M&A, HR practices or otherwise. The broker's healthcare expertise is central to this process, and to advising on coverage and limits, and program structure.

About the Author

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