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Five healthcare management liability priorities in 2021

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As healthcare senior leaders face another potentially difficult year, addressing management liability risks — and a challenging insurance marketplace — will be crucial.

Healthcare risk professionals should watch the following trends closely in the remainder of 2021.

1. D&O CHALLENGES PERSIST

In the US, primary directors and officers liability (D&O) pricing for healthcare organizations increased an average of 20.7% in the fourth quarter of 2020, while total program pricing increased 28.2% on average.

As reinsurance markets continue to tighten, healthcare insurance buyers also face narrowing coverage. Primary capacity is being restricted and underwriters are no longer willing to provide some previously available coverage enhancements. Insurers are adopting firm negotiation stances for harder-to-place risks, such as publicly traded healthcare organizations and long-term care providers.

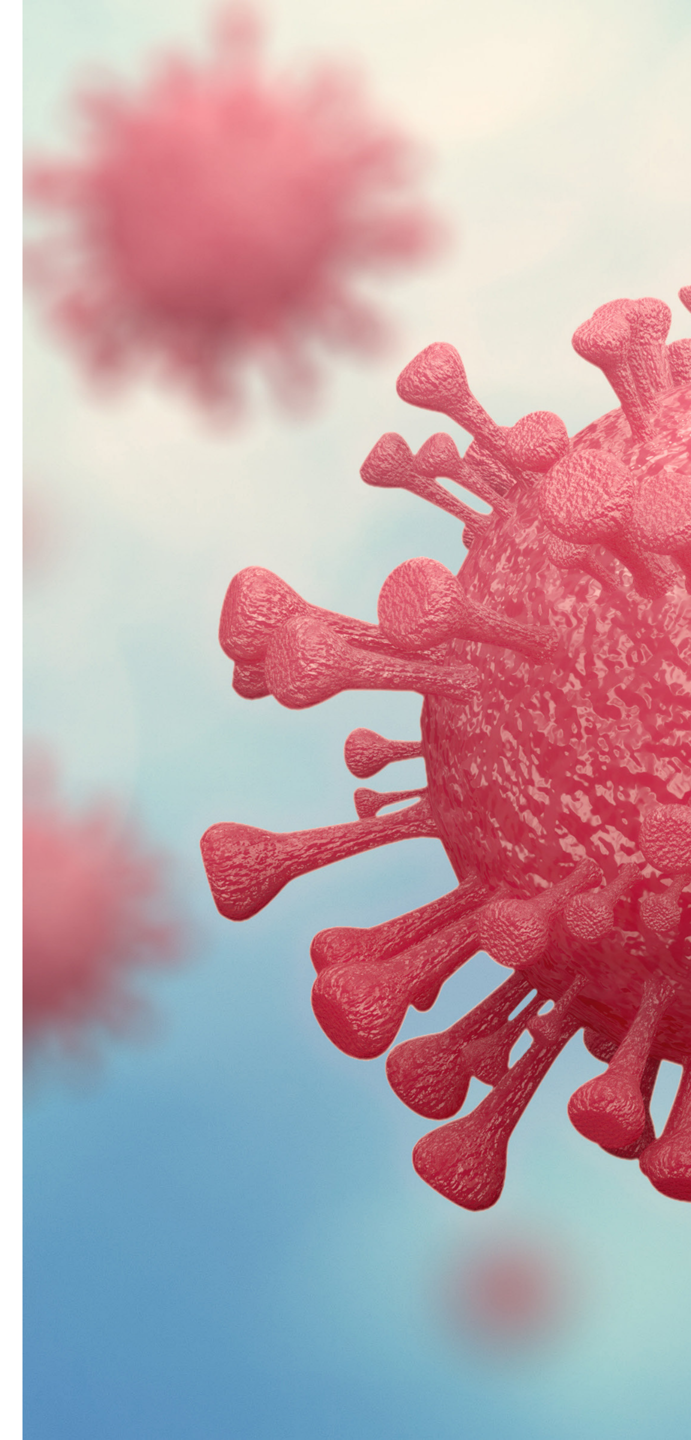
Insurers' concerns about the pandemic and its financial effects will likely persist long after COVID-19's health threat is contained. Leading insurers, however, are generally not imposing COVID-19 exclusions; instead, they are requiring more information about insureds' financial health and workforce policies, without which they are unlikely to offer terms.

2. EPL RISKS EXPANDING

Amid an unprecedented pandemic, the focus on the welfare and treatment of frontline workers has grown exponentially. Rising social inflation and a number of emerging trends are also driving up both the frequency and severity of employment practices liability (EPL) claims.

COVID-19 driving claims

The increase in volume of pandemic-related EPL claims in healthcare has not been as drastic as the industry feared in the early days of COVID-19. Still, workers who have taken issue with safety protocols, including those related to personal protective equipment, have lobbed a number of discrimination and retaliation claims against health systems. This highlights the importance of working with in-house and outside counsel to ensure robust safety measures and guidelines are in place and clearly communicated to employees on a regular basis.



#MeToo's continuing effects

EPL claims alleging sexual harassment and hostile environments continue in healthcare, driven primarily by nurses and administrative personnel. Healthcare leaders are being challenged to strengthen anti-harassment and anti-discrimination policies and procedures. Insurers, meanwhile, continue to closely monitor these claims as they will likely continue to drive costs and settlement outcomes.

Physician claim retentions increasing

Even before COVID-19 and the #MeToo movement, underwriters' mindset when assessing single-physician claims was shifting significantly. These claims can quickly escalate, and allegations of wrongdoing and resulting actions by insurers can have sizable long-term financial implications for providers. As defense and overall claims costs increase, many insurers are seeking higher retentions.

Biometric privacy risks growing

Ensuring patient confidentiality and safety remain paramount for the healthcare industry. As such, many providers have strict measures governing access to patient information. As laws related to the protection of employees' biometric information as a requirement for care are being enacted and considered in several states, new exposures are emerging for employers.

In 2008, Illinois passed the Biometric Information Privacy Act (BIPA), becoming the first state to regulate the collection of biometric information. Other states have since enacted similar laws and more are considering their own bills. The most recent state to pass such a law is California; biometric privacy is included in the California Consumer Privacy Act (CCPA), which took effect in January 2020.

EPL policies have historically contained language that includes invasion of privacy or failure to provide adequate corporate policies within the definition of "wrongful act," which may trigger coverage under EPL policies. Many cyber policies, however, contain similar language, with coverage often based on the definition of a privacy event, which may include the failure to protect confidential information, unlawful disclosure, or unlawful collection of data. Underwriters are thus intent on delineating the policies that should respond to these claims.

3. MORE REGULATORY SCRUTINY COMING

Still in its early days, the Biden administration has made clear that healthcare is one of its priorities. In addition to reestablishing COVID-19 as a national emergency, the administration is also focusing on reallocating federal funding and creating a more robust health exchange experience under the Affordable Care Act.

Surprise billing disputes claims plague providers and payers alike. As claims continue to emerge, underwriters have begun to express concerns, with many introducing revised policy language that potentially limits coverage.

Litigation and contract clarity are likely to follow as federal regulatory oversight increases. Many states, meanwhile, have pledged to help curb costs through legislation barring providers from charging patients out of network rates.

Antitrust regulation may also become a priority as the new administration seeks to ensure consumer prices and choice are not hampered by the already strained healthcare system post-COVID-19. The Federal Trade Commission, for instance, may take a closer look at payer and provider mergers and acquisitions going forward. Insurers will continue to look at key financial metrics and geographic footprints to determine acceptable retentions and pricing commensurate with their tightening underwriting guidelines.

4. FIDUCIARY MARKET EVOLVING

Healthcare organizations are seeing pricing in the fiduciary market grow at a quick pace as some notable excessive fee settlements in the last year have given underwriters pause.

Plaintiffs' attorneys have become increasingly interested in pursuing plan participant fees, often securing higher defense and settlement payouts. As a result, insurers are restricting capacity while increasing excess fee or class-action retentions. Insurers are also looking to sublimit excessive fee offerings, providing a fraction of the full limits they previously offered.

Some entities — particularly nonprofit and private organizations — are seeing significantly higher pricing, as historically lower pricing is no longer sustainable. Organizations with revenues of $1 billion or more can face significantly higher retentions and more questions from underwriters during renewal processes, which are generally taking substantially more time as underwriters more closely scrutinize submissions and require senior-level approvals before agreeing to renew existing accounts or write new business.

5. SIDE A COVERAGE IN THE SPOTLIGHT

Elective procedures are expected to pick up again after the threat of COVID-19 is contained. Still, healthcare organizations may continue to experience strains on their profitability post-pandemic. This underscores the potential value in purchasing dedicated Side A coverage.

A dedicated Side A policy can sit above a traditional ABC coverage tower, which can help to protect directors' and officers' personal assets. Premiums, however, are rising as insurers seek to mitigate their exposure to rising Side A difference in conditions (DIC) claims frequency and concerns about health systems' bottom lines.

In addition to pricing increases, insurers are increasingly applying newly developed absolute "for" bodily injury exclusions related to COVID-19. These could affect the recoverability of Side A DIC towers for corporate directors and officers.

DIC policies, which are generally broader than traditional Side A policies, are crucial, as these can drop down if traditional ABC policies do not respond. Although current market conditions are difficult, risk professionals should work with their advisors to explore purchasing such coverage and to negotiate as few exclusions as possible.

PROTECTING YOUR ORGANIZATION IN 2021

As healthcare organizations ready themselves for potentially more difficult management liability insurance renewals in the year ahead, planning and preparation — with the support of risk advisors — is vital. Starting early — at least 180 days before policy expiration — is also important, especially for buyers that intend to market their programs.

Before beginning renewal discussions, healthcare organizations should work with advisors to articulate their primary objective(s) given their unique risk appetites, cultures, and budgetary considerations. These advisors can also help to ensure underwriting submissions are complete, which is critical as management liability pricing continues to increase.

Risk professionals should also work with their advisors to weigh the implications of altering program structures, including adjusting deductibles/retentions, limits, and/or participating insurers. They should also explore alternative strategies, such as captives.

Looking to potential approaches for individual lines:

- **D&O buyers should involve senior leaders in negotiation processes and consider different approaches.** Personalizing the process through meetings involving senior leaders and key insurer executives can supplement robust data and qualitative information in submissions, helping to provide a more complete picture to underwriters and better differentiating health care organizations' risk.
- **Employers should be ready and willing to address EPL underwriters' specific concerns.** Insurers are likely to ask pointed questions about BIPA, employed physician retentions, COVID-19-related claims, and more during underwriting meetings. Risk professionals should be prepared to discuss these topics. Ahead of underwriting meetings, they should also work with their advisors to review policy definitions as insurers seek to limit coverage for specific risks.
- **Fiduciary liability buyers should prepare for more questions from insurers.** Before meeting with them, many fiduciary liability underwriters are requiring insureds to complete detailed questionnaires. Among other requirements, insurers are asking companies to describe their process for evaluating whether fees are justified, how records are maintained, the fiduciary training that investment committee members receive, and whether law firms have inquired about plan fees and expenses.

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