The Liability Implications of Healthcare Reform

An Advisen Special Report Sponsored by OneBeacon Professional Insurance

February 2013

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Executive Summary

Healthcare reform was a hotly contested issue in the recent presidential campaign. Republican candidate Mitt Romney pledged to “repeal Obamacare” if elected, but with the re-election of President Obama, it is nearly certain that the roll out of the Patient Protection and Affordable Care Act (PPACA, or Affordable Care Act) will continue as scheduled. Signed into law on March 23, 2010, PPACA is intended to lower healthcare costs and guarantee access to medical insurance for tens of millions of Americans. The 906 page piece of legislation represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

Changes in how healthcare is delivered and paid for may have a major impact on the liability exposures of healthcare organizations and providers. Many of the most significant liability exposures are related to the Medicare Accountable Care Organization enabled by PPACA and similar collaborative healthcare delivery models. These entities require healthcare providers to operate in new relationships which could result in heightened malpractice, errors and omissions (E&O) and data security exposures. Risk managers are now faced with the challenge of understanding how the risk profiles of their organizations are being transformed by healthcare reform, and to develop and implement risk management and insurance solutions to respond to a risk landscape whose features are only now coming into view.

PPACA and Changing Healthcare Delivery Models

A 2008 report from the Commonwealth Fund Commission characterized the healthcare system as “fragmented,” and notes that “fragmentation fosters frustrating and dangerous patient experiences, especially for patients obtaining care from multiple providers in a variety of settings.” It further observes that “our fragmented system rewards high-cost, intensive medical intervention over higher-value primary care, including preventive medicine and the management of chronic illness.” Among the goals of the Affordable Care Act is to address the fragmentation, high costs and suboptimal outcomes of the American healthcare delivery system, a system that accounts for nearly 18 percent of the country’s GDP – by far the highest in the developed world – but is ranked 37th by the World Health Organization.

In terms of controlling costs and improving outcomes, a cornerstone of the Affordable Care Act is an incentive plan for the formation of Medicare Accountable Care Organizations (ACOs). According to the Centers for Medicare and Medicaid Services (CMS), an ACO is “an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.” To provide an incentive for forming an ACO, an organization will be eligible for Medicare shared savings based on its annual incurred costs relative to CMS-established benchmarks.
In July, 2012 CMS said that more than 2.4 million Medicare beneficiaries will receive care from more than 150 ACOs that have signed on to participate in the shared savings program. In fact, according to a late-2012 report by consultant Oliver Wyman, ACOs now serve as many as 31 million patients, indicating that the ACO model is gaining traction in the private sector as well. The report concludes: “ACOs in a remarkably short period of time have become a substantial part of American healthcare, with the potential to catalyze lasting, positive change as they begin to deliver the results they promise.” Dr. Michael Cryer, national medical director for Aon Hewitt, characterized this momentum as “the beginnings of a tsunami” in a New York Times article.

As the Oliver Wyman report suggests, even without the incentives provided by the Affordable Care Act, momentum has been building for new healthcare delivery models. Hospitals, for example, have for a number of years attempted to address the negative consequences of fragmentation by providing coordinated healthcare services through networks of employed physicians and an array of community-based services. The Oliver Wyman report’s definition of an ACO reflects the fact that the term and the concept increasingly go beyond the four corners of the Medicare Shared Savings Program, and now is a “catch-all term for providers participating in population-oriented, value-based care delivery and reimbursement models.”

The success of these new healthcare delivery models relies in large measure on a network of healthcare practitioners efficiently coordinating their activities. As a result, the Affordable Care Act offers incentives for converting paper records to electronic health records (EHRs) that can be shared across various healthcare settings. The term “Electronic Health Record” is often used interchangeably with “Electronic Medical Record,” (EMR), but technically they are not the same thing. An EMR contains principally medical information and is a component of an EHR, which typically also contains billing information, demographic information, and other types of information about a patient. According to the U.S. Department of Health and Human Services, “using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care.” According to a survey of doctors in 10 countries by the Commonwealth Fund, more than two-thirds of U.S. primary care physicians reported using EHRs in 2012, compared to less than half in 2009.

The proliferation of ACO-style healthcare delivery models and the move to EHRs are only two of a vast numbers of changes to the American healthcare system affected by PPACA and related healthcare reforms. They are, however, two aspects that have significant implications for the liability risks of healthcare organizations and individual healthcare providers, and which pose an array of new challenges to healthcare risk managers.

**Liability issues**

Healthcare reform does not necessarily create new liability exposures, but it does change the likelihood that healthcare organizations will experience certain types of liability events. For example, all healthcare organizations must adhere to the patient privacy requirements imposed by HIPAA, but the adoption of EHRs creates new avenues of potential HIPAA violations that now must be managed.

The areas in which healthcare reform is most likely to have an impact on the risk profiles of healthcare organizations are in privacy and data security exposures, and in malpractice and related professional liability risks.
Privacy and data security

Health records are highly sought after by data thieves and sell for about $50 each on the black market. Despite the sensitivity of the information contained in these records, the healthcare industry has a poor track record for data security. A recent survey of 80 U.S. healthcare organizations by the Ponemon Institute found that 75 percent don’t secure medical devices containing sensitive patient data, while 94 percent have had data leaked in the last two years. ACOs and related healthcare delivery models can pose significant data security risks since digitized records are passed among an array of practitioners and other users who likely vary widely in their data security practices. A large data breach could easily cost a healthcare provider hundreds of thousands of dollars in mitigation costs, notification expenses, and legal fees. The same Ponemon study found that, on average, a data breach ends up costing an organization $2.4 million.

The government is encouraging healthcare organizations to share data more broadly, but at the same time it is imposing larger penalties for improper disclosures. In one case, in 2012, a Massachusetts healthcare organization agreed to pay $1.5 million to settle potential HIPAA violations. The alleged violations of the Health Insurance Portability and Accountability Act’s security rule stemmed from the theft of a laptop computer storing 3,621 patient records.

In addition to data security concerns, healthcare organizations also need to be aware of the sometimes complex legal issues associated with sharing data within an ACO context. According to a PwC study, few healthcare providers have thoroughly addressed the potential legal issues involved with sharing patient data. While 38 percent of healthcare providers share patient information externally, only 26 percent have identified contractual, policy or legal restrictions on how the data can be used. Additionally, only 17 percent have processes in place to manage patients’ consent for how their information can be used. According to one attorney, complying with HIPAA can require a large number of separate contracts among the parties involved with an ACO: between the ACO and its participants, subcontractors and any applicable health information exchange (HIE), as well as between the HIE and the ACO participants.

Malpractice and other professional liability risks

New healthcare delivery models are expected to improve outcomes, and therefore have an overall positive effect on malpractice and other medical professional liability risks. Nonetheless, certain aspects of ACOs in particular, and of collaborative models in general, may modify patient expectation, develop new standards of care, and create new types of information that can be used against a healthcare provider in court. In addition to understanding the risks associated with the individual functions within these models, it is necessary to understand how interrelationships and incentive structures may lead to new or heightened malpractice and professional liability exposures. Specific concerns include:

- New healthcare delivery models may require participants to function in unfamiliar roles or adapt to new processes. In the long run, coordinated care is likely to benefit patients, but shorter term realigning of resources and implementing new processes and procedures may increase the likelihood of a medical error.
- ACO-type models may increase professional liability risk by raising patient expectations. An ACO that falls short in delivering fully coordinated care may be more likely to become a target for a lawsuit.
- ACOs may result in standards of care that exceed prevailing standards. This could occur broadly, with regional or national standards of care defined by practice specialty, or it could be specific to an organization. For example, CMS requires ACOs to define processes to promote evidence-based medicine, which could result in creating, and documenting, a heightened standard of care for that organization.
Many hospitals have accelerated the acquisition of physician practices in preparation for providing the full continuum of care to ACO beneficiaries. With employed physicians, more risk is shifted from the physician to the hospital (or to the ACO itself). For example, a hospital may be seen as vicariously liable for the actions of employed physicians, whereas it may have been dismissed from the lawsuit if the physician were considered an independent contractor. Additionally, with employed physicians, healthcare organizations are more likely to be sued under direct negligence theories.

Coordinated health care may result in additional discoverable documentation that can be used against healthcare providers in a malpractice case. Additionally, since an ACO must issue public reports on certain aspects of its performance and operations, it may inadvertently provide plaintiff attorneys with a roadmap to problem areas of the organization.

Some observers have expressed concern the payment model runs the risk of providing incentives for physicians to not refer patients for needed treatment.

Some new healthcare delivery models expand the responsibilities of nurse practitioners and other types of providers, potentially increasing credentialing exposures and malpractice risk.

Some legal experts note similarities between ACOs and Managed Care Organizations (MCOs), and anticipate that ACOs will face many of the same liability issues as MCOs. Theories of liability asserted against MCOs vary according to structure and payment methodology, but organizations typically face tort liability in connection with care management, peer review, credentialing and network management functions. When MCOs employ physicians, they have been held responsible for selecting and retaining competent providers, properly overseeing the care provided and establishing and adhering to policies necessary to ensure quality care.

ACOs also could result in new dynamics of claim management. Physicians typically prefer vigorous defenses of malpractice claims, but if decisions to settle claims are made by ACO management, the emphasis could shift to settling claims early in order to manage costs.

Other risks

Data privacy and security, along with malpractice and other professional liability exposures, represent some of the most significant risks facing healthcare organizations as a result of healthcare reform, but they are far from the only risks. Emerging healthcare delivery models require establishing new relationships among healthcare providers and vendors. Decisions about how to share payments and expenses can result in significant risks, potentially leading to antitrust allegations, contractual liabilities or lawsuits from patients, competitors, or regulators. Additionally, directors and officers of sponsoring organizations as well as the ACO may be subject to executive liability for poor execution of the ACO business plan.

Risk management and insurance

ACOs and related entities typically are multidisciplinary collaborations among a number of institutional and individual providers along the continuum of care. Since many are comprised of both affiliated and otherwise unaffiliated individuals and entities, a significant challenge for risk managers is to develop and implement risk management programs that address the exposures of both employed and independent healthcare professionals, as well various service vendors, operating in a collaborative environment where both risks and rewards are shared. Among the challenges faced by risk managers dealing with this type of organization is to understand how liability should be apportioned among the various participants, to be sure that participant agreements contain appropriate indemnification wording, and to assure that insurance coverages are appropriate to the entity.
The optimal insurance program for an ACO or similar organization will depend to a degree on how the healthcare entity is structured and organized. Healthcare-specific coverages typically will include Managed Care (or ACO) E&O, Medical Malpractice (including extended reporting period coverage for newly-employed physicians) and Provider Stop Loss. Other important coverages include Directors & Officers Liability Insurance (D&O) and Cyber/Data Security protection. Given the complexity of the risk profiles of many of these entities, it is especially important that risk managers work with a broker with expertise in ACOs and related healthcare delivery models.

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NOTES:
4. The ACO Surprise, Oliver Wyman http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf
6. ACO Surprise, Oliver Wyman http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf
7. “Key Features of the Affordable Care Act, By Year,” HealthCare.gov http://www.healthcare.gov/faw/timeline/full.html. A recent Rand Corporation report, however, notes that EHRs thus far have not lived up to their potential for improving care and reducing costs.