2022 U.S. Healthcare Market Outlook

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The COVID-19 pandemic created a myriad of challenges for the U.S. healthcare market that few could have foreseen. From rising mortality rates to staffing shortages to postponement of routine medical care and screenings, every aspect of the healthcare market has been negatively impacted by this public health crisis. Yet while it would be easy to point to COVID-19 as the primary cause of the medical professional liability (MPL) market's current challenges, that would be misleading.

Well before COVID-19 triggered a healthcare crisis, the MPL market was grappling with a number of issues. In 2019, after more than a decade of relatively flat MPL premium rates, more than 25% of MPL policyholders saw rate increases. The industrywide combined ratio for MPL business had been moving steadily upward since 2011, exceeding 100 in 2017 and reaching nearly 110 by 2019. While current MPL rate increases are dependent on many factors across subclasses, on average, healthcare entities are experiencing a 15%–25% increase.

TRENDS HIT A BREAKING POINT

"For several years the MPL market was sending out clear signals that there were challenges ahead. And because of rising combined ratios, some insurance companies were increasingly relying on investment income and reserves to maintain profitability," said James McNitt, Healthcare practice leader for Risk Placement Services (RPS). "Insurance companies were slow to react to this reality, believing that with diligent underwriting standards, profitability was just around the corner. But it wasn't."

Over the past few years, some insurance companies decided to respond by either leaving certain segments of the MPL market that were particularly challenged, such as hospitals and long-term care (LTC) facilities, or exiting the market entirely. That exodus has made it increasingly difficult—and sometimes impossible—for retail brokers to place certain healthcare classes. Industry consolidation has also contributed to the decrease in MPL market participants.

Another capacity constraint factor is that many of the remaining insurers are now trying to reduce their loss ratios by lowering coverage limits. This has made it even more challenging for retail agents to construct MPL towers that meet their clients' needs for larger coverage amounts.

SOCIAL INFLATION

Social inflation has also had a negative impact on MPL as well as other coverages. The term refers to the rising costs of insurance claims due to societal expectations and views on litigation rather than what is fair compensation for damages.

The factors that have contributed to social inflation include:

- **Erosion of tort reform** due to either state courts or legislative bodies modifying existing laws that had limited punitive damages
- **Litigation funding** in which a third party agrees to fund the cost of litigation or arbitration in return for a set percentage of any award, which could be as high as 40%
- **Public sentiment**, as jurors have a tendency to assume that a large corporation or organization, and/or its insurance company, can afford to pay an award

"Because it's typically several years between when a lawsuit is filed and when it is settled, it takes time for MPL claim trends to surface," noted Kyle Pass, a broker with RPS. "As a result, insurance companies were slow to take into account the impact of social inflation on claims. They didn't realize the extent to which juries were getting tougher on their insureds and becoming more sympathetic to the plaintiffs."

Nuclear verdicts, often defined as those awarding damages in excess of $10 million, have been an outgrowth of the social inflation trend. Between 2016 and 2019, nuclear verdicts rose 50% according to the American Society of Healthcare Risk Management.[1] One of the most frequently cited nuclear verdict examples was a 2019 medical malpractice judgment for $205 million against Johns Hopkins Bayview Hospital, although a Maryland Court of Special Appeals overturned that verdict in February 2021.

Fortunately, while claim severity has jumped, claim frequency has gone down.

"While most of us agree on the reasons behind the significant change in claim severity, the reasons for the decline in claim frequency is a matter of opinion," explained Karen Bennett, area senior vice president, RPS.

"It might have resulted from changes in the delivery of healthcare or improved risk management," Bennett continued. "Or it could be related to either tort reform or attorneys diverting their focus to other industries. Whatever the reason, if we do see the frequency start to climb back to the levels we saw 15–20 years ago, coupled with the nuclear verdicts we are experiencing, the last challenging market will look like a cakewalk."

PRIVATE EQUITY INVESTMENT

Over the past decade, private equity firm ownership of for-profit hospitals and LTC facilities has grown. The estimated annual deal value of private equity investments in healthcare has grown from $45.1 billion in 2010 to a high of $119.9 billion in 2019.[2]

While deal value dropped in 2020 to $95.9 billion, deal volume held steady. This may have occurred because COVID-19 accelerated four major private equity healthcare investment trends:

- Alternative sites of care
- Telemedicine
- Modernization of clinical trials
- Healthcare provider consolidation[3]

SENIOR AND ADULT CARE FACILITIES—THE PRIVATE EQUITY SWEET SPOT

Demographic trends bode well for senior living, assisted living and LTC facilities as the U.S. population continues to age. Private equity investors have taken note of the trend. In recent years, they have supplied capital to help expand the number of facilities that serve an aging population. Indeed, many private equity investors see senior housing and adult care as an attractive alternative to multifamily housing, an underperforming market.

THE IMPACT OF COVID-19

There is no debate that this global pandemic created unprecedented challenges for the U.S. healthcare market.

Many people put routine healthcare and screenings on hold, which in some cases may have delayed disease diagnosis. Others delayed treatment or avoided emergency rooms for fear of contracting the virus. Many healthcare professionals, especially nurses and doctors, reported increasing feelings of burnout.

A 2021 *Washington Post*-Kaiser Family Foundation survey of approximately 1,300 front-line healthcare workers found that 62% of survey participants reported that worry or stress related to working during the COVID-19 pandemic had had a negative impact on their mental health.[4]

How and where healthcare is delivered has also changed.

Telemedicine has experienced a significant uptake in activity, both for diagnosis and as a screening tool to determine whether an office visit is essential. Responding to this pandemic-related trend, many states changed laws or policies to expand health insurance coverage for telemedicine. And because not all communications technologies are 100% secure, the federal government relaxed some HIPAA privacy rules to facilitate telehealth during the pandemic. In addition, Medicare expanded its coverage of telemedicine.

While the number of MPL claims related to telemedicine is historically low, that is likely to change. With a four-figure increase in the number of telemedicine visits since the start of the pandemic, it is inevitable that claims will rise because MPL claims have a positive correlation to patient encounters.

"While telemedicine allowed many patients to see a healthcare professional during COVID-19, ultimately it's difficult to replicate that in-person doctor/patient interaction," observed Pass. "Technology is wonderful, but it can create communication challenges, particularly if a doctor is new to telemedicine or a patient is either new to or less than comfortable with teleconferencing software. It's hard to build that true doctor/patient relationship when not in person."

State licensing laws have also created a unique exposure for telemedicine.

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According to the Federation of State Medical Boards, 49 state boards, plus the medical boards of the District of Columbia, Puerto Rico and the Virgin Islands, require that physicians engaging in telemedicine are licensed in the state in which the patient is located. And while MPL policies typically respond to allegations related to professional services performed throughout the country, such coverage also requires that providers be licensed in the state or states where the service is provided.

Just as states made pandemic-related accommodations for telemedicine, they did the same to protect doctors and other healthcare workers, who were forced to work long hours and often asked to take on roles outside their traditional areas of expertise. Several states even granted healthcare facilities immunity from civil liability from injury or death related to COVID-19.

At the federal level, the secretary of Health and Human Services invoked the federal Public Readiness and Emergency Preparedness (PREP) Act. The PREP Act provided healthcare professional liability immunity related to treating COVID-19 patients.

COVID-19 CLAIMS ARE THE GREAT UNKNOWN

COVID-19 brought the state and federal judicial system to a standstill for most of 2020. As the majority of medical malpractice cases that go to court have jury trials, which were on hold during the worst of the pandemic, there was a significant drop in MPL nuclear verdicts in 2020.

Some see COVID-19 cases waiting in the wings, including several publicly traded insurance companies that have set aside millions in reserves specifically to deal with pandemic-related claims.

Yet it's difficult to determine what constitutes sufficient reserves when it will take several years for these cases to either settle or go to trial. Interestingly, according to global law firm Hunton Andrews Kurth, of the more than 12,000 COVID-19-related lawsuits filed between January 2020 and September 2021, fewer than 500 were related to health/medical.[5]

"Proving causation on a virus is going to be really difficult to do," explained Bennett. "Attorneys are opportunistic. While negligence or misdiagnosis related to treating a COVID-19 patient may still find some coverage, an allegation of spreading the virus would be a tough verdict to win. Many attorneys may decide that it's simply not worth their time."

To help address the great unknown, many insurance companies are now specifically addressing COVID-19 in the underwriting process. Some insurers now exclude COVID-19 while others will include coverage at an additional cost.

Hospitals

A challenging MPL market is nothing new for U.S. hospitals. Academic and larger hospital systems have responded to the current market with their usual strategy of taking on more risk through larger retentions to keep MPL premiums manageable.

This time, however, community hospitals are employing the same strategy in response to double-digit rate increases.

After years of thinly priced MPL coverage, this year hospital rate increases have been in the 10%–30% range, but that top number can go higher in certain situations. While these rate increases largely depend on the insured's loss history and venue, the amount of capacity an insurance company is offering, as well as what layer they occupy in a coverage tower, also matters.

"Though there are some differences with this market compared to the last one, ultimately insurance is cyclical," observed Margaret Jacobs, area senior vice president, RPS. "While the higher rates and more restrictive coverage are in line with what we've seen in the past, what's different this time are exclusions related to COVID-19 and the opioid crisis."

Other exclusions that are becoming increasingly common include batch coverage (an aggregation of multiple claims or claimants into one bucket), punitive damages and sexual abuse.

HEALTHCARE'S DIGITAL TRANSFORMATION

Telemedicine is one of the most visible examples of how technology is changing healthcare. Yet there are other examples of digital medicine that have implications for MPL. Artificial intelligence (AI) is becoming increasingly important in diagnosis. AI-enabled equipment can make radiologists more efficient and accurate. It can also help avoid diagnosis delays when a radiologist isn't immediately available. Remote monitoring can be used for everything from tracking a patient's blood sugar levels to helping prevent slips, trips and falls in an LTC or assisted living facility.

Unfortunately, the insurance industry hasn't kept up with the pace of healthcare's digital transformation. Neither MPL nor cyber coverage is designed to address bodily injury related to a technology glitch, system outage or cyber attack. The failure of wearable technology and privacy issues are two additional exposures that could soon be feeding the MPL litigation pipeline.

Two insurance companies currently offer coverage that addresses the intersection of medical liability and technology. However, this capacity is likely inadequate for the market's current and future coverage needs.

While several insurance companies have exited the hospital MPL market, including one that had remained in the market through several insurance cycles, new insurers have also entered the market.

Although these market entrants may be new to hospital MPL, their management teams primarily comprise seasoned industry veterans. While these new entrants are replacing lost capacity, they are being cautious in both their underwriting standards and policy limits.

According to Jacobs, these new market entrants could represent the light at the end of the tunnel for the hospital market.

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While more insurance companies may exit the market in 2022, the potential for new capacity and higher rates may soon bring stability to what has recently been a volatile market.

Senior Care/LTC

Over the past few years, assisted living and other LTC facilities have faced some of the greatest MPL challenges in the healthcare sector.

Several insurance companies have departed this market, which has put additional pressure on rates.

As was the case throughout the industry class, loss ratios had been steadily rising over the past few years while rates remained relatively flat.

In certain situations, outdated underwriting standards, such as charging smaller facilities lower premiums based on the erroneous premise that they would have fewer claims, were to blame for the growing disconnect between premiums and loss ratios.

"Insurance companies that offered smaller LTC facilities a lower rate for the exact same coverage as a larger one got crushed by MPL claims," explains McNitt. "The original reasoning behind this underwriting decision was fewer beds, fewer claims. Eventually the data showed that the claim size was the same, they just happened less frequently."

Understaffing has been a chronic issue for LTC facilities for many years, and the correlation between staffing levels and resident care is widely recognized.

COVID-19 added to the pressures that overworked and underpaid caretakers were already facing and to the staffing pressures faced by the owners of these facilities. And while the pandemic pressures have lessened in many communities in 2021, hiring challenges haven't.

It has been well documented how hard the pandemic hit nursing homes and LTC facilities, whose resident and staff deaths are believed to account for about one-third of all U.S. fatalities. Because COVID-19-related deaths in these facilities were underreported to the federal National Healthcare Safety Network (NHSN), it may take some time before the full scope of this issue—and the resulting claims—is understood.

The American Medical Association's *JAMA Network Open* has reported that more than 16,000 COVID-19 deaths and 68,000 cases among nursing home residents nationwide were omitted from federal data in 2020.[6]

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Allied Healthcare

Allied healthcare facilities have fared well compared to other healthcare subsegments in the current insurance cycle. Allied healthcare encompasses a diverse range of businesses and practices, such as imaging centers, physical therapy, ambulatory surgery centers and medispas. That business diversity has protected this subsegment from the climbing loss ratios experienced through much of the healthcare sector.

Recent premium increases for allied healthcare facilities have often resulted from insurance companies trying to alleviate the pain of problem areas such as hospitals and LTC facilities.

Yet even in this industry bright spot, challenges exist. COVID-19 has created a booming business for staffing agencies that work with hospitals, acute care and LTC facilities.

Often a client such as a hospital will contractually require these facilities to hold a level of MPL coverage that exceeds the limits their insurance companies are willing to provide. Medispas and IV clinics, which frequently enjoy underpriced policies, have strong potential for MPL claims, as doctors often aren't trained in the procedures they offer, such as a primary care physician who offers Botox at a medispa to earn extra money.

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Ambulatory surgery centers are another subclass where rate and loss ratios could easily become out of sync. Pass suggests that insurers might want to consider raising premiums for certain facilities: "Most insurance companies view surgical centers as different from hospitals. However, even though they don't support the same range of care, they are essentially very small hospitals and their MPL rates should reflect that."

Physicians

While COVID-19 put a strain on hospitals and LTC facilities, many doctors saw a sharp reduction in hours, as patients postponed elective surgeries and were hesitant to visit their doctors' offices in the first months of the pandemic.

Because MPL is written on a claims-made form, insurers were reluctant to lower premiums, even though with fewer patient interactions, the doctors' exposures were temporarily reduced. Instead, they provided credits or deferred premium payments during this time when their insureds were feeling a financial crunch.

Other doctors, however, found themselves in the opposite situation, stretched by long hospital hours and being asked to work in areas outside of their areas of expertise. Some started to practice telemedicine. In the face of staffing shortages, doctors delayed or even came out of retirement to assist with this national health emergency.

The full impact of the pandemic on MPL claims against doctors remains to be seen. The PREP Act and state immunity laws will make it harder to prove negligence or failure to diagnose with front-line doctors.

And while doctors traditionally bear the brunt of MPL claims, some believe that the pandemic may have created a "halo effect" or "COVID glow" that may influence juries' perceptions of doctors.

In terms of rates, doctors' MPL coverage has seen sharp average premium increases over the past couple of years, according to the American Medical Association (AMA). In a 2021 paper, the association noted that more doctors faced an increase in MPL premiums than in any year since 2005.

This is consistent with RPS clients. Pass said: "Every year we are having to explain premium increases, especially with physicians, and it never gets easier. A doctor can have no change in exposure or any claims and still be hit with a 15% rate increase."

However, some now view the doctors' market as having turned a corner. Whether that means an improvement or simply stabilization remains to be seen. Indeed, that same AMA paper noted that the number of doctors who experienced an MPL premium decrease in 2020, 8.1%, was higher than it had been in the two previous years.[7]

Human Services

Social services agencies, particularly those that work with children, are finding it increasingly difficult to obtain affordable coverage in this market, as a limited number of insurance companies remain in that space.

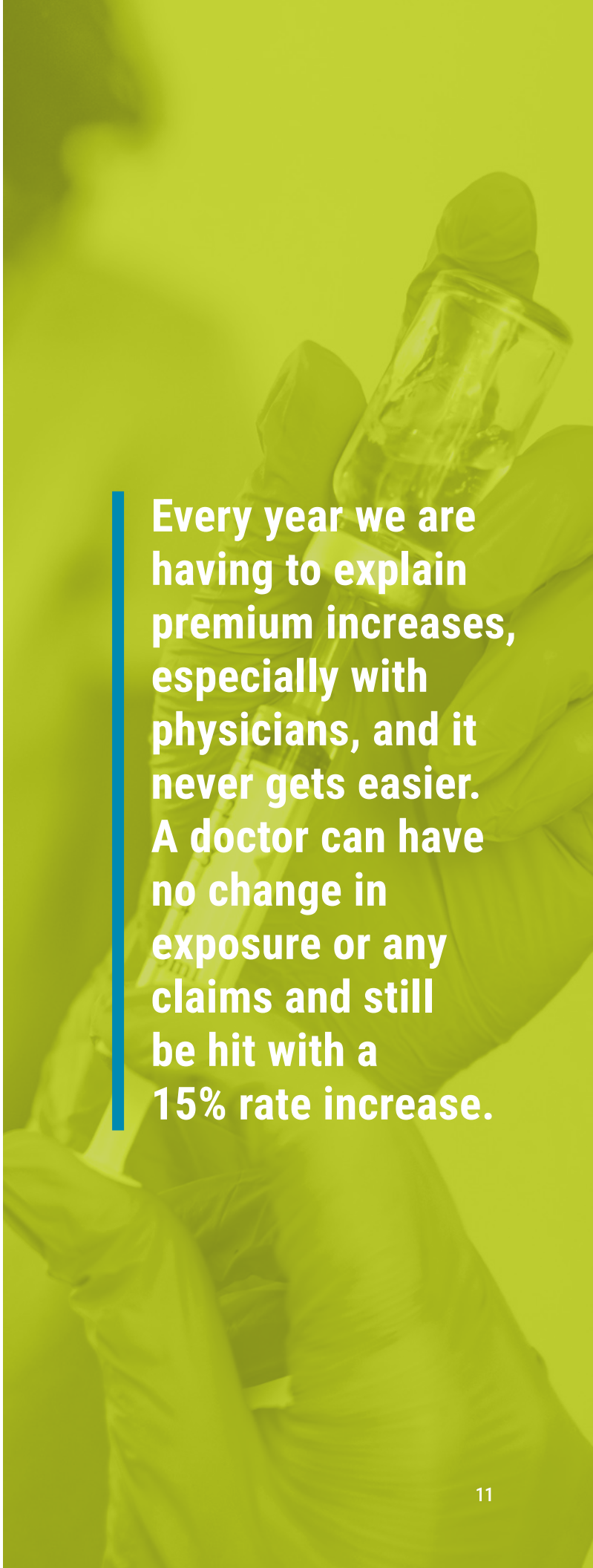
Going without coverage isn't an option for these organizations. Typically county or state contracts require them to maintain a certain level of coverage, generally a minimum of $1 million to $3 million.

The handful of insurance companies that have remained in this market have made several moves in an attempt to profitably underwrite this industry subclass. Many have switched from an occurrence to a claims-made form.

Some human services fields are more challenging than others from a coverage perspective. Agencies that work with children, such as group homes, foster care and organizations that serve children with special needs or troubled emotional needs, are finding it increasingly difficult to find affordable, comprehensive professional liability coverage.

The inherent dynamics of child welfare situations have made these organizations unattractive to professional liability insurers. Often carriers will sublimit the more catastrophic exposures such as physical or sexual abuse, elopement and self-inflicted injury. In situations where an organization has a history of claims, how they responded to the situation and whether or not the employee involved is still there can make a difference in the underwriting decision.

"Any claim situation becomes emotionally charged when a child is involved," observed Bennett. "Often there is tension between the child's biological parent or grandparent and the social services agency that is being accused of abuse, inappropriate supervision or neglect.



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With these emotionally charged scenarios, insurers almost never go to trial, even in situations where it's clear that no negligence was involved, because it's a no-win situation with a jury."

OTHER MARKET CHALLENGES

LTC facilities

Since summer 2021, many MPL insurers have made an abrupt change in direction when it comes to underwriting LTC facilities.

Out of the blue, insurance companies are now entering the market, and those already serving this market have begun to actively look for new business. Some MPL insurers are now offering LTC facilities two-year rate guarantees, and many premiums are now flat on renewal after several years of 12%–15% rate increases. McNitt questions the reasons behind this swift change.

"Nothing in particular has happened that would so quickly and drastically change the MPL LTC environment," McNitt observed. "Perhaps after several years of double-digit rate increases and changes to policy forms, MPL insurers in the LTC space now feel that the market is at a place where they can compete and even become profitable. Or it could simply be fear of missing out. Only time will tell."

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Sexual misconduct and abuse

Sexual misconduct and abuse continues to be one of the most significant contributors to MPL claims. Insurance companies are now placing lower sublimits on sexual misconduct and abuse in primary policies while excluding it entirely from excess policies. In particular, insurance companies have ceased covering abuse for human services and hospitals. Ultimately, this may become an uninsurable exposure.

Non-owned auto

Many employees of human services and allied healthcare use their own cars for nonemergency transportation, such as taking a senior living resident to and from dialysis. Loading and unloading these individuals is the largest source of claims related to non-owned auto.

CORRECTIONAL HEALTHCARE

Challenging takes on a new meaning when it comes to MPL coverage for doctors and other healthcare professionals who serve patients in correctional facilities, such as prisons and juvenile detention centers. RPS' McNitt calls this the toughest healthcare market to insure.

Over the past few years, MPL claims against doctors and nurses working in correctional facilities have escalated. Few insurance companies will serve this market, and those that do often exit within a few years.

A challenge specific to this market is the patients and healthcare providers themselves. In addition to having the same healthcare issues as the overall population, many prisoners have abnormal injuries sustained either during a crime or in prison. Mental health issues and addiction are also rampant in these populations.

Often the doctors, nurses and other healthcare professionals who are willing to work in these facilities have a history of medical errors or past misconduct. And because it can be difficult to recruit and retain healthcare professionals, many facilities either rely on staffing facilities or even outsource healthcare to companies that specialize in this market, such as Centurion Health, Wexford Health Sources and Corizon Health.

LOOKING AHEAD

While some healthcare subclasses, such as senior living facilities, will continue to see 15%–25% rate increases on renewals, others, such as doctors and allied providers, may have stabilized and could even be on the verge of improvement. As RPS' Bennett quipped, "Our industry has proven to have a short memory."

What is more certain is that coverage terms and conditions will continue to change as insurers add exclusionary language via endorsements.

Insurance companies are tightening policy language to eliminate any areas of coverage ambiguity and address gray areas between coverages, such as MPL and cyber. They are also asking policyholders to share more of the risk through deductibles and retentions.

Whether MPL claim severity and nuclear verdicts will continue to climb remains to be seen. Even with most state and federal courts reopened, a backlog of cases remains, with criminal trials receiving priority over civil ones.

To date, the number of COVID-19-related MPL cases has been modest, but that could change in the months ahead. However, should these cases go to trial, proving causation tied to a virus won't be the only challenge facing plaintiffs' attorneys.

"It will be difficult to assemble a jury that doesn't have at least one member who lost a colleague, friend or family member to COVID-19," said Jacobs. "They'll be thinking of the doctor who tried to save that person's life, or the nurse who held their hand in their final hours because family wasn't allowed in the hospital. It will be hard to find them grossly negligent."

Beyond insurance, the industry faces some institutional challenges that will affect the profitability—as well as the viability—of certain subclasses. For example, LTC facilities, already grappling with rising MPL rates and staffing issues, are now having trouble filling beds because of lingering COVID-19 concerns, though the availability of the vaccine has begun to reverse that trend. They're also facing competition from the growing array of home healthcare services, which make it easier to age in place. Even with a demographic pipeline, some facilities may need to close, which could create a healthcare crisis for an aging U.S. population in the decade ahead.

These critical factors that are to be determined speak to the need for healthcare businesses, facilities and professionals to work with a retail broker who understands this landscape and is adept at addressing these evolving coverage issues.

In many situations, retail brokers who are generalists would also benefit from working with a wholesaler that is experienced in the healthcare market. As McNitt concluded, "Wholesalers are built for challenging markets."

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