ACA Professional Liability Exposures: Not Just Medical PL
ACA PROFESSIONAL LIABILITY EXPOSURES: NOT JUST MEDICAL PL

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Pay or Play Mandate

Effective January 1, 2015, for calendar year plans, large employers must provide minimum essential, minimum value, and affordable health coverage to 95% of full-time employees and their dependents, or pay a penalty.
No Coverage Penalty

• Applies to employers denying employees access to minimum essential coverage & at least 1 employee qualifies for a tax credit or subsidized coverage.

• $2,000 penalty/year for each full time employee even if only 1 employee receives a premium tax credit or subsidy.

• Penalty applies to total # of F-T employees - 30.
Unaffordable or No Minimum Value Coverage Penalty

- Penalty assessed when coverage fails to meet quality or affordability standards
- $3,000/employee penalty applies only to employees actually receiving a premium tax credit or cost-sharing subsidy
- Total penalty cannot > total non-coverage penalty
Unaffordable or No Minimum Value Coverage Penalty

• QUALITY Standard -- Plan must expect to pay at least 60% of covered medical expenses.

• AFFORDABILITY Standard -- Employee’s contribution must not be > 9.5% of employee’s household income. (Applies to employee premium only; no regs yet on affordability for dependents.)
Interplay of COBRA and the ACA

- For group health plans, COBRA still applies
- Is COBRA obsolete?
- Employees in Catch-22 if they select COBRA rather than go on the exchange
Anticipated Litigation Against Employers

- Improper Calculation of Entitlement to Benefits/Timing of Benefits
- Challenges to Restriction on Benefits
- Affordability/Adequacy of Coverage; Non-Discrimination
- Improper Notice Claims/COBRA
- ERISA Section 510 Claims
- Challenges to Self-Funded Plans
- Wellness Plan Litigation
- Penalties?
Anticipated Litigation Against Payers

• Narrow Networks
• Inadequate Payment
• Mental Health Parity
• Liability for Delegated Expenses
Wellness Plans

- Final wellness regulations issued May 29, 2013
- Reflect changes ACA made to wellness programs (subject to the HIPAA nondiscrimination rules)
- Effective for plan years beginning on/after 1/1/14
- Applies to both grandfathered and non-grandfathered plans
Noteworthy Litigation

- **Watterson v. CVS**, Northern District of California Case No. 4:2014cv01721 (class action alleges wellness plan violates W&H laws)
- **EEOC v. Orion Energy Systems**, Eastern District of Wisconsin Case No. 1:14-cv-01019 (EEOC action alleges wellness plan violates ADA & privacy rights)
- **Almont v. UnitedHealth Group, Inc.**, Central District of California Case No. 2:14-cv-02139-MWF-VBK (provider litigation against TPA and plans)
- **Cigna v. La Peer Surgery Center**, Central District of California Case No. 2:13-cv-03726 (action by insurer acting as TPA vs providers dismissed)
- Narrow Network litigation
- *Mental health parity litigation*
Payment Reform

• Our Health Care System did not just magically evolve
• A Health Care System is shaped by *how* you pay for services & *what* you pay for (Pursuit of self-interest)
• Health Care activity is shaped by *reimbursement*: Follow the money!
• Health Care activity and provider behavior impact medical professional liability

Source: Thomas Campanella, Baldwin Wallace College
Health Care Economist
Payment Reform

Health Care Delivery in 2014

• Siloed
• Inappropriate use of high-cost technology
• Inappropriate end-of-life costly efforts vs. appropriate hospice services
• Excess Infrastructure and technology (e.g. MRI, CT Scan)
• Lack of focus on Primary Care, Preventive Services, Wellness
• Chronic diseases that are not addressed in a coordinated and sustained manner
Thoughts Regarding Health Care Reform

• Reform would have occurred without the ACA
• Pressure to reduce health care costs: CMS, employers
• Clinical integration began before the ACA in response to the need for reform: Reconfigure for value-based payment
• Clinical integration drives hospital M&A & buying practices.
• The ACO is truly a Medicare vehicle but is often used (incorrectly) to denote clinical integration. It can be a form of clinical integration.
ACOs: Accountable Care Organizations

- ACO is a legal entity composed of a group of providers that assume responsibility to manage & coordinate care for a defined group of patients in an effective (high quality) & efficient (low cost) manner.
- Encouraged by the ACA
- Promotes creation of networks & consolidation
- Manage minimum 5,000 lives for 3 years
Reform: Key Trends in 2014

• M&A Activity still high: primarily hospitals
• More contractual networks being created
• Deceleration of the purchasing Physician Practices
• Exception- Primary care groups/physicians
• Reimbursement is still primarily Fee-for-Service
• Some Hospitals/Systems/large groups taking financial risk
• Financial RISK is mostly capitation & bundled payments
• Increasing use of Physician Extenders: NPs and PAs
• Increasing move to Outpatient Care
Reform: Key Megatrends in Medical Professional Liability

- Payment Transformation: *Volume*-based to *Value*-based
- Hospitals **must** accept financial risk
- Focus on *Wellness*: Keep patients out of acute care
- Patient care: will be more *personally* accountable for care
- EMR is crucial to Coordination/Collaboration/Communication
- Will consolidation adversely affect attitudes towards hospitals?
- Physicians are critical for organizational success
Megatrends to Watch: The Impact on Underwriting

- Mergers & Acquisitions Accelerate
  - Fewer hospitals & physician buyers for Medical PLI
  - More Buyers: Misc Facilities, Allieds, Aging Services, Health Plans/HMOs
  - Due Diligence on MedPL Exposures: Loss history, Risk assessments
  - RM Assessment of Risks in Alignment: Acquisition, JVs, etc.

- Clinical Integration and ACOs
  - Cost of Creating (Medicare) ACO a barrier
  - But Clinical Integration Will Occur = CIO
  - Vicarious Liability/Ostensible Agency exposures are created
  - More risk of “negligent credentialing” claims
  - Continuity of Care = (New?) Standard of Care
Megatrends to Watch: The Impact on Medical Professional Liability

• Will financial incentives distort medical necessity decisions?
• When can utilization be decreased safely?
• Follow the money to track Health Care activity/financial risk
  – Hiccups in the transition from Fee-for-Service payment
  – Patient hand-offs to other providers & transfers to other facilities, e.g. EM to Hospitalist, Hospitalist to PCP, etc.
  – Delegable and non-delegable duties: Physician Extenders
  – Breaking down communication barriers: HUGE Risk Mgt. challenge
  – Physician as “Team Leader”
The Risk of Reform: The Future

What Should the Carrier/Broker Evaluate?

• Strategy/Review of new provider alignments/networks
• Provider financial risk: Impact on patient care
• Tracking of payment methodologies: Impact on patient care
• Credentialing alignment partners: facilities and allied medical professionals
• Physician employment & alignment: JVs, Contracts, Partnerships
• New models for Outpatient Care
• Physician exposures
• Potential for contractual liability
The Risk of Reform: Final Thoughts

- Reform may make medical malpractice cases more complex
- Multiple Co-Defendants due to contractual arrangements
- Will better care offset increased risk, over time?
- The greatest risk: more frequency of severity?
- Potential loss of good will towards the hospital & physicians?
- Medical PLI Industry has financial strength to manage adversity
- Still many factors in our favor in defending these cases
Underwriting Health Care Reform Risks

• ACOs as a Major Risk
• D&O
• EPL
• Cyber
• Fiduciary Liability
• Managed Care
ACO: New Paradigm

ACOs incentivize efficiency

– Tri-part Aim: Improve quality to individuals, populations and reduce costs.

– Shared Savings Program
  • The less you spend the more you get back
  • No requirement to use ACO Providers
  • Payback if you spend too much
Credentialing Risks

• Exclusion from ACO
  – Turf Issues
  – Non-Physician Providers
  – Clinical Guidelines

• Discipline of Providers
  – Economic Credentialing
  – Conflicts of Interest
Risks From Integration

- Increased mergers of Institutional Providers
- Employment of physicians by hospitals
  - Section One and Two Issues
- Are ACO's essential to competition?
- Increased collaboration between Plans and Providers (Private ACOs)
ACOs and Narrow Networks

• ACO Requirements
  – Network inclusion issues
  – ACA and Network Inclusion
    • "Essential Community Provider"

• State “Any Willing Provider” Laws
Challenges to Narrow Networks

• Providers
  – Seattle Children's Hospital

• Members
  – Cigna
  – Blue Shield of California
  – Anthem Blue Cross
Other Anti-Trust Issues

- Consolidation Issues
  - ProMedica
  - St. Luke’s

- Other Issues
  - Phoebe Putney
  - NC Board of Dental Examiners
  - Blue Cross Class Action Litigation
Other Risks

• Consolidation
  – Increased Antitrust Risks due to mergers

• Physician Employment
  – New risks under Title VII, ADA Etc.
  – No HCQIA Immunity

• Cyber
  – More data and more access to that data
Questions?