American Academy of Actuaries

Issue Brief

Medical Professional Liability: Considerations Stemming From the COVID-19 Pandemic

SEPTEMBER 2021

Key Points

- There have been fewer medical professional liability insurance claims related to COVID-19 than expected and telehealth remains widely utilized despite being lower than the amount used early in the pandemic.
- The Public Readiness and Emergency Preparedness Act, the Coronavirus Aid Relief and Economic Security Act, and similar state bills may have provided immunity and protection to providers but it is not a certainty.
- Reserving considerations such as whether there are changes in settlement timing, coverage considerations such as extended reporting endorsements, and exposure considerations such as COVID-19 treatment and delays in non-essential care all should be considered in MPL analysis going forward.

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The COVID-19 pandemic raises multiple issues in pricing, funding, and reserving for medical professional liability (MPL) insurance exposures. For the discussion on these issues provided in this issue brief, considerations are divided into three areas: changes in health care delivery; regulatory responses and economic circumstance; and coverage and exposure considerations.

Changes in Health Care Delivery

COVID-19 has impacted health care delivery materially for both providers and patients in the United States. Early in the pandemic, capacity was strained in emergency rooms and intensive care wards in certain areas of the country. Other regions prepared for a strain on the delivery system that did not materialize to the same extent. An increased portion of health care during the pandemic, including care that might be labeled essential, was and continues to be provided via telehealth.

Direct medical professional liability insurance claims from COVID-19 may have resulted or may result due to an adverse outcome related to a treatment plan, a failure to diagnose or delay in diagnosis, or failure to prevent transmission. The significant number of individuals presenting with the disease in certain geographic areas early in the pandemic resulted in capacity strains for certain medical systems, both on equipment and services. Such strains could have impacted the care provided to any one individual. To provide capacity relief, providers worked outside of their specialty, retirees returned temporarily to the practice of medicine, and some medical school students graduated early. Such actions are unusual and might also give rise to liability concerns. Furthermore, quality and availability of testing for COVID-19 were inconsistent early in the pandemic, possibly leading to instances of delayed diagnoses.

However, based on early indications, medical professional liability insurance claims directly related to COVID-19 have been minimal to date.[1] Of direct claims or lawsuits filed, the overwhelming majority relate to long-term care facilities.[2] Few direct claims have been filed against providers or other facilities.

Additionally, medical care protocols by certain providers were adjusted to delay nonessential care (both routine and elective). This temporary suspension of care could expose medical providers in unintended ways, as delay in care may result in adverse outcomes—possibly leading to increased frequency and severity of future MPL allegations. Conversely, some providers and systems saw patient loads decrease at certain points throughout the pandemic. Actuaries may want to consider how impacts from each of these factors differ by specialty and geography.

The use of telehealth has become more widely utilized during the COVID-19 pandemic. Although it subsided somewhat since the early part of the pandemic, reports are that telehealth remains at significantly higher levels than pre-pandemic levels and is projected to continue at higher levels.[3] This increase could impact the frequency or severity of MPL claims in ways that are difficult to predict given its limited use historically. The nature of MPL claims could change with greater utilization of telehealth, including as a result of factors that go beyond frequency and severity, such as time to report and time to close, or defense costs relative to indemnity.

COVID-19 may alter the public's perception generally (which could impact juror perceptions in particular) of health care providers, who may be viewed more sympathetically, perhaps lowering claim frequency or the portion of claims closing with indemnity payment. The impact of any potential changes in public attitude toward health care providers may or may not be a sustained one. Actuaries could consider such impacts in pricing, funding, and reserving for MPL coverage, while recognizing that any prospective impact is inherently speculative.

1 "Have clouds of uncertainty dissipated? Covid-19's impact on medical professional liability"; *MedCity News*; July 19, 2021.
2 "What COVID-19 Means for Claims"; *The Curator*; Spring 2021.
3 "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?"; McKinsey & Company; July 9, 2021.

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Regulatory Responses and Economic Circumstance

There have been multiple federal and state governmental responses addressing civil liability related to health care provided during the COVID-19 crisis. Responses have included both legislative and regulatory actions. As some of these responses either impact or have the potential to impact the delivery of health care, they may affect the risks associated with providing health care. As such, actuaries who work with MPL insurance might consider these responses and their potential impact on the frequency and severity of MPL claims. The responses have included federal certain liability immunity (e.g., for certain therapeutics and those providing health care without compensation, i.e., volunteers), a variety of state liability immunities, and change of licensing requirements for providers. The state responses are obviously unique to those states' applications of the immunities as well as court interpretations. Discussion of the variety and complex nature of these immunities is beyond the scope of this document but nonetheless is a consideration in evaluating the impact of COVID-19 on MPL claims. As discussed later in this issue brief, the economic circumstances resulting from the crisis may also impact MPL claims.

Federal Actions

The Public Readiness and Emergency Preparedness Act (PREP Act)[4]

Under the authority contained in the PREP Act, the secretary of the Department of Health and Human Services (HHS) issued a declaration on February 4, 2020,[5] to provide immunity from suit under federal and state law (but not immunity for enforcement actions by the Food and Drug Administration [FDA] or other federal agencies) related to select drugs and devices used to treat COVID-19, referred to as "covered countermeasures." Immunity under the PREP Act was extended to those (including qualified persons) who manufacture, distribute, administer, or use covered medical countermeasures. In issuing the declaration, the HHS secretary is required by the PREP Act to consider the desirability of encouraging the manufacture, distribution, and administration of the covered countermeasures such as personal protective equipment, vaccines, etc. Willful misconduct is the only exception to the immunity provided by the PREP Act.

4 Public Law 109-148, Division C, § 2.
5 "Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19"; *Federal Register*; March 17, 2020.

The definition of "covered countermeasures" has been a point of contention in lawsuits brought related to purported medical malpractice and PREP Act declarations made previously as well as with the 2020 declaration associated with the COVID-19 pandemic. These cases bring into question whether there are exceptions to the immunity for medical professionals and facilities. Specifically, the issue of whether or not "covered countermeasures" were provided is key.[6]

In addition, the Families First Coronavirus Response Act[7] enacted March 18, 2020, specifically identified personal respiratory protective devices as covered countermeasures under the PREP Act and thus granted protections from certain liabilities for these devices. There have also been a number of FDA-issued COVID-19 emergency use authorizations (EUAs) for personal protective equipment, specified medical equipment, and diagnostic tests. These fall within the definitions used by the PREP Act and hence liability protection would extend to covered countermeasures under EUAs as well.

As of the date of this writing, the PREP Act liability immunity extends through the earlier of the final day of the emergency declaration or October 1, 2024.

Coronavirus Aid Relief and Economic Security Act (CARES Act)[8]

The CARES Act, enacted March 27, 2020, includes a provision that provides immunity for physicians and other health care professionals who provide volunteer (non-paid) medical services during the public health emergency related to COVID-19. As a result of the CARES Act, health care volunteer providers may not be held liable for services that relate to the diagnosis, prevention, or treatment of COVID-19 or the assessment or care of a patient related to an actual or suspected case of COVID-19. The care provided needs to be within the scope of the license of the individual provider. The immunity took effect upon the enactment of the act and is in effect for the length of the COVID-19 public health emergency.

These protections preempt state and local laws that are inconsistent with the CARES Act, although state laws that provide greater liability protections are not preempted. Limited exceptions apply for such things as gross negligence, criminal misconduct, and providing care while under the influence of alcohol or other drugs.

6 "PREP Act civil liability immunity: a public health emergency defense of rare applicability"; *Reuters*; June 16, 2021.
7 H.R.6201—*Families First Coronavirus Response Act.*
8 H.R.748—*CARES Act.*

The PREP Act and CARES Act can be considered limited in their application to MPL coverage. The protection of the PREP Act is limited to covered countermeasures and hence arguably more aligned with product liability immunity and less with the medical care of providers and facilities. Similarly, the protections of the CARES Act are limited to medical volunteer providers acting within the scope of their licenses.

State Actions

The individual state responses to the COVID-19 pandemic with respect to MPL-related liability vary in part in regard to their tort laws. In certain states, tort law provides liability immunity to health care providers during a declared state of emergency (such that the immunity would extend currently to all health care within the state, not just health care related to COVID-19). Governors in other states have issued executive orders with liability immunities specific to the treatment of COVID-19. However, some states have extended immunity only to volunteer providers or have issued no declarations specific to health care immunity under COVID-19. To the extent immunities exist for a state, most are limited to civil liability and do not include immunity for willful misconduct, gross negligence, etc.

When assessing the depth and breadth of how a specific state liability immunity will affect MPL claims, actuaries, public policymakers, and other stakeholders might consider the following questions:

- Is there a directive such as a statute that provides liability immunity upon the declaration of a public health emergency, or is the immunity reliant on the timing of an executive order that may not provide immunity in the time period prior to the order or after the order's expiration?
- Does the liability immunity only apply for a specified time period? If so, what is the trigger for immunity: the date care is provided or the date a claim is reported?
- Does the liability immunity apply to both individual providers and health care facilities?
- If health care facilities are included in the immunity, does it apply to all types of facilities, e.g., hospitals, urgent care centers, surgicenters, rehabilitation facilities, nursing homes, etc.
- Is the liability immunity limited to emergency assistance?
- Is the liability immunity provision specific (as in the CARES Act, for example) in covering only the diagnosis, prevention, and treatment of COVID-19 or the care of an individual related to an actual or suspected COVID-19 case? Alternatively, is the immunity provision broader such that health care services more generally are covered

during the protected time period? How might this be interpreted in cases where claimants assert harm due to failure to diagnose, medical misadventure, or where the condition worsened due to limited medical treatment as a result of COVID-19 restrictions on the practice of nonessential services?

- What are the limitations of the immunity (is it civil immunity only, or does regulatory immunity—such as the relaxation of telehealth licensing restrictions between states—also apply?
- Does it cover willful misconduct, gross negligence, etc.?

Economic Circumstance

Economic circumstance and other factors external to health care and governmental impacts generally can also influence claim frequency and severity. Impacts could result from changes in timing and outcomes for known and future claims related to court closures, economic circumstances, and other factors related to shelter-in-place mandates. Those who are unemployed may bring claims that otherwise would not have been pursued. Claimants who are struggling financially and facing a longer than usual wait for a court date may be willing to settle for lower amounts than before the pandemic. Economic conditions can affect claim frequency as well as the likelihood of claims closing with indemnity payment and the severity of claims. Financial stress on physician practices may encourage future consolidation, possibly also impacting claim frequency.

Coverage, Exposure, and Reserving Considerations

Practicing actuaries working with MPL coverages might incorporate the types of observations discussed above into reserving, pricing, and funding analyses. Additional considerations stem from the provisions of MPL policies and the nature of insurance coverage more generally.

For example, the impact of the above considerations can differ between claims-made coverage, occurrence coverage, and extended reporting endorsements. Extended reporting endorsements may be particularly impacted by delays in claim reporting from court closures and the related tolling of statutes of limitation and repose. That said, implementing distinct changes to the different coverages could be impractical. It might also be unwarranted in light of the uncertainty involved in timing.

Timing can also impact reserving considerations in ways that are difficult to measure. Court closures will cause delays in indemnity payments of certain claims as well as potential delays in defense costs as claim activity slows. Alternatively, defense costs could increase as the time to closure is extended. Delays in payments could also lead to higher reserves while those conditions persist. It is possible that there will also be an impact on the rate at which adequate case reserves are established due to difficulties in performing thorough claim investigations. Understanding of the claim environment for the jurisdiction(s) under review is an important aspect in deciding if adjustments are appropriate.

Traditional methods of calculating exposure bases could be impacted both by COVID-19 treatment and by the delay in nonessential care. Physician exposure is typically measured using base class physician years. Such calculations could misstate exposure to claims for physicians covered by liability protections or who are temporarily working outside their usual specialty. They could also misstate exposure for physicians working fewer hours. However, hours worked might be a poor adjustment for exposure as cases seen may be more severe and may present greater MPL risk.

Similarly, hospital exposure is typically measured based on occupied beds and patient visits. Such measures would also not reflect reduced exposure due to liability protections. In addition, the nature of patient visits or inpatient stays underlying such exposure measures may be materially different during the COVID-19 pandemic, even in regions with lower rates of serious COVID-19 cases. Such differences could result in claim potential greater than or less than in the preceding health care environment.

Providers and patients delayed nonessential medical care during the early months of the pandemic. Some providers have expressed concern that patients delayed and could continue to delay essential medical care due to fears of contracting the coronavirus in the process of seeking treatment. Many studies have been performed that support these concerns of reduced health care utilization. Delays in essential medical care can result in delays in diagnoses and potentially higher acuity diagnoses, which could have an impact on allegations of medical malpractice.

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The above considerations affect actuarial analyses applied to MPL coverages beginning in 2020 and will continue into subsequent years. In future years, actuaries will be faced with determining whether and to what extent to rely on indications from the pandemic time period as well as whether to adjust them. The considerations noted in this issue brief will affect frequency and severity, as discussed here, but items such as development factors and other parameters of actuarial analyses may be impacted as well. Finally, the pandemic may permanently alter the delivery of health care in the United States. If so, it could also permanently alter MPL risk. These are concerns that can significantly affect MPL coverage and also health care delivery that bear further and ongoing examination by actuaries, public policymakers, and other stakeholders as more study is done of the complex interactions of the factors presented here in the days to come.