



onpoint

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So Attention Must Be Paid

What impact will the recession have on the risk profile of U.S. Hospitals?

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“So attention must be paid.” This now famous line from the Arthur Miller play, “Death of a Salesman” was intended to address and remedy the awful ignominy that characterized the bleak and fading days of Willy Loman, the play’s main character. This same fate could await the unwitting professional liability underwriter who fails to appreciate the significant risk faced by U.S. hospitals in today’s economic environment.

It is no secret that U.S. hospitals are under financial stress and that the underwriting risk of hospitals is more challenging than it was two or three years ago. As hospital profit margins decline, numerous studies indicate that adverse patient safety events increase for both nursing and surgical events. Yet, the continued rate softening in the hospital professional liability insurance market suggests that the underwriting community is not properly evaluating the increased risk profile of these financially stressed institutions. While well run health care organizations are more effective in navigating through the challenges and limitations of their operating environment, none are completely immune.



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48%

of hospitals reported
negative margins in the
third quarter of 2008

Economic Challenges Facing U.S. Hospitals

U.S. hospitals have experienced rapid and significant financial strain in recent months. The sharp reduction in investment earnings (and loss of invested assets), the rising cost of capital as a result of the nation's financial crisis, lack of patient demand for services, declining reimbursements from Medicare, Medicaid and private insurers, and increasing delinquency or default in payments by uninsured or underinsured patients, have all resulted in almost half of the nation's hospitals reporting negative margins in the third quarter of 2008.¹ In many hospital settings, capital spending has come to a halt. More than half of all U.S. hospitals have cut staffing expenses and more than one-fourth have eliminated or reduced services.² In November of 2008, Moody's, citing many of these issues, revised its outlook on the not for profit hospital sector to negative from stable.³

Hospital patient volume has plummeted as financially-strapped patients postpone or forego elective procedures. The increasing number of uninsured hospital patients seeking care has also had a negative impact on hospital finances. Finally, uninsured or under-insured patients are forced to make difficult priority decisions when it comes to their own health – predictably, people who lose their jobs and their insurance tend to put off or delay needed care. Consequently, hospitals are presented with a higher acuity patient population with a diminished ability to pay. So, the required response and attendant resource expense is greater and the prospects for reimbursement are less, at the same time that these organizations are already struggling with investment losses and weakened balance sheets.

A Negative Relationship Between Hospital Finances and Patient Safety

While the definitive study has yet to be published, there have been numerous reports published that suggest a direct correlation between hospital financial performance and patient safety. In 2005, the Stanford University School of Medicine released a report which studied hospitals in 18 states covered by the Agency for Healthcare Research and Quality ("AHRQ") and Healthcare Cost and Utilization Project ("HCUP") data,

including 1100 hospitals and 15 million discharges, and concluded that hospitals that experience a decline in key financial performance metrics also experience significant declines in performance on several key patient safety indicators. Other published studies conclude that, as hospital margins decline, adverse patient safety events increase within a hospital for both nursing and surgical events.⁴ A set of 24 likely preventable patient safety events occurred with 12% higher frequency when the hospital was in the lowest, compared with highest, profit margin quartile. Significantly, the effect of a hospital's financial performance on safety outcomes was more likely to be manifest in the year following decreased profit margin due to the time it takes for cost-cutting changes in staffing and quality control to affect patient safety. In light of the direct correlation between hospital finances and patient safety adverse outcomes, hospitals must safeguard against the possibility that patient safety will become a casualty of the recession.

Lessons Learned From the Nursing Home Industry

Insurers face significant potential danger when they fail to appreciate the impact of environmental issues on both the risk profile of their insureds and, more importantly, the cumulative impact on their risk portfolios. The nursing home industry is a case in point. The changes in the financial climate of the nursing home industry over the last 20 years created a seismic change in that industry's risk profile, and eventually, near disastrous results for its liability insurance carriers.

In the U.S., the nursing home industry exploded in the early 1990s, after the government recognized that per diem costs in nursing homes were substantially lower than in hospitals. Publicly-traded corporations scooped up mom-and-pop operations and nonprofit homes, and subsequently squeezed out the competition. By 2000, nursing homes had become a \$100 billion industry. However, the industry soon faced several major challenges, most notably the implementation of Medicare's Prospective Payment System ("PPS") for skilled nursing facilities which was included as part of the Balanced Budget Act of 1997. Following implementation

12%

more patient safety events occur in hospitals with the lowest profit margins

Short memory could be costly

1990s • government finds cost savings in nursing homes

2000 • nursing homes become \$100 billion industry

cheap, abundant capacity ➔ risk transfer is call of the day

record verdicts awarded ➔ huge loss costs

Balanced Budget Act of 1997
• PPS
• estimated savings \$9.5 billion over 5 years

1998
• estimate of PPS savings revised upward by nearly double

2001
• nursing home abuse violations on the rise due to understaffing and fraud, among other things
• states adopt patient "bill of rights"

2002
• at best, LTC insurance difficult to obtain, if not cost prohibitive

of PPS, Medicare reimbursed nursing homes on a fixed-cost prospective basis, rather than on a per-diem fee-for-service basis. The Congressional Budget Office (CBO) initially estimated that PPS would cut payments by \$9.5 billion over five years. However, one year after the law went into effect, CBO revised its estimate to almost twice that amount. Many nursing home operators with large financial exposure to Medicare rapidly became distressed. The dramatic change forced a number of companies into bankruptcy, and corporations that survived increased belt-tightening measures, namely, cutting payroll, eliminating staff and reducing expenditures on patient care initiatives. In 2001, the U.S. House of Representatives released an investigative report that chronicled the increased number of nursing home abuse violations resulting from, among other problems, understaffing and fraud.⁵ At the same time, many states began adopting patient "bill of rights" legislation, which codified standards of care and created enforceable obligations regarding quality of care.⁶

This convergence of factors in the long term care industry – rapid growth fueled by profit-motivated business strategies, strained infrastructure, a more acute patient population and significantly reduced revenues, combined with the passage of patient bill of rights legislation – created an environment that was ripe for meaningful adverse change. Nursing home patients and their attorneys were able to successfully link poor patient care with the industry's strained infrastructure and financial condition to obtain large jury awards, including punitive damages which were previously uncommon in the nursing home setting. From April 2000 to October 2001, record verdicts of \$312 million and \$82 million in Texas⁷ and \$20 million in Florida were awarded.

While the long term care industry was experiencing significant adverse impact in its operating environment, the liability insurance marketplace was in the throes of one of the softest market cycles in its history. Capacity was cheap and abundant. Oblivious to the rapidly changing and deteriorating nursing home risk environment, professional liability carriers allowed – and even encouraged – long term care insureds to transfer their risk rather than manage it. The insurance marketplace, in rabid pursuit of

easy risk transfer,
the underwriter's weapon
of self-destruction

top line growth, failed to appreciate the underlying environmental forces at play in the long term care space, and failed to appreciate that the nursing home industry, once little more than a general liability risk, was undergoing a radical risk profile transformation. Loss costs were about to explode and the insurance marketplace, through the use of large limit, low or no deductible programs, and little ability or inclination to differentiate risk, was willfully “throwing itself on the grenade.” Nursing home litigation grew dramatically after 2000 and became recognized as one of the fastest growing areas of health care litigation in the country. Sure enough, liability insurance carriers writing long term care business suffered enormous losses, leading to dramatic decreases in available insurance capacity and increases in insurance premiums. By 2002, professional liability insurance for long term care facilities was difficult to obtain; if available at all, the cost to purchase it was almost prohibitive.

U.S. hospitals are now faced with challenges similar to those experienced by the nursing home industry in the late 1990s: significant financial stress; reduced staff, strained infrastructure, a more acute patient population, and decreasing revenues. This contextual backdrop should give hospital professional liability underwriters cause for concern, and should prompt those underwriters to question the validity of an underwriting approach that simply looks at past loss trends as predictive of future results. As stated in the 2007 Conning Study, *Medical Malpractice, Getting Ahead of the Curve* –

The insurance mechanism proper remains essentially a pass through. Insured losses are pooled and the charged premium is adjusted accordingly. ***Sudden or abrupt changes to the risk landscape can wreak havoc on the insurer’s ability to finance loss at a profit.*** (Emphasis added.)

The risk transfer component of an insured’s broader risk management strategy should be a mechanism to accommodate uncontrollable or unforeseeable risk in the form of medical errors. Too often, however,



U.S. hospitals' risk landscape

a view from experience

especially in a soft market, commercial risk transfer becomes both a convenient way to hedge against encroaching environmental issues and an inexpensive alternative to investing in necessary internal risk management. Hospital professional liability underwriters today are in danger of repeating the sins of long term care professional liability underwriters 10 years ago by making insureds' cost-benefit calculation too easy – commercial risk transfer capacity is abundant and relatively cheap, thereby reducing insureds' incentive to invest in internal risk management process. This is happening even while the government is taking steps to reduce preventable medical errors. Recently, the Center for Medicare and Medicaid Services (CMS) has recognized the potential for financial savings to the government, and improvement in the rate of preventable medical errors, by refusing to reimburse hospitals for costs associated with those preventable medical errors (often referred to as “never events”). This initiative places responsibility for the significant cost and expense associated with “never events” directly onto hospitals. In an ideal world, this should create a strong incentive for hospitals to embrace patient safety and invest in internal risk management. But as long as commercial risk transfer is readily available and cheap – that is, the cost-benefit scale is tipped toward buying commercial insurance instead of investing in internal risk management – that incentive is dramatically reduced.

Conclusion

It is a cautionary tale that has more than a little application to some of the financial issues confronting hospitals today. But, rather than seeing a significant divergence in how the underwriting community is weighing this risk – as might be evidenced by an ever-widening rate distribution – we are seeing rates compress with outlier status only afforded to conspicuously poor performers with a history of loss rather than to those who, due to their financial challenges, have an increased susceptibility to losses in their future.

An insured's propensity for loss is driven by myriad factors. Medical errors, rather than isolated events of misjudgment, are more often

financial stress
reduced staff
decreasing revenues
strained infrastructure
acute patient population



the by-product of how these factors converge to create a high risk environment. Without question, deteriorating financial condition is one of the factors that contribute to creating that high risk environment. And without question, many hospitals are facing significant financial pressure today. While the federal stimulus plan will certainly help many hospitals, specifically those with high Medicaid patient base, it will take time for those dollars to wash through the system. In addition, over the long term, the funding for healthcare reform is likely to reduce reimbursements from Medicare and commercial payers, thereby adding to the strain. The financial situation of hospital insureds, and the response of their management in addressing that situation, will be a significant contributor to the loss performance of this industry segment in the coming years. Underwriters would be well-advised to give this issue appropriate weight and consideration.

¹ See, http://www.healthimaging.com/_news/company/Thomson+Reuters.

² *Report on the Capital Crisis*, January 2009 by the American Hospital Association.

³ See, Moody's report, "Not-for-Profit Healthcare Medians for Fiscal Year 2008 Show Weakening Across All Major Ratios and All Rating Categories," finds that medians for days cash on hand, cash-to-debt and Moody's-adjusted debt to cash flow have weakened, as have operating margin, operating cash flow margin.

⁴ *Ecinosa WE and Bernard DM. Hospital Finances and Patient Safety Outcome. Inquiry Spring 2005; 42; 60-72.*

⁵ The report, "Abuse of Residents is a Major Problem in U.S. Nursing Homes," showed that between January 1999 and January 2001, more than 30% of the nation's 5,283 nursing homes were cited for an abuse violation — physical, sexual or verbal — with the potential to cause harm. The report also said that 92% of the nation's nursing homes were understaffed and 54% were "dangerously understaffed."

⁶ In 1987, Congress passed the Omnibus Budget Reconciliation Act (OBRA), known as the Nursing Home Reform Act which codified standards of care and created enforceable obligations regarding quality of care.

⁷ See, "Texas Federal Jury Orders Horizon To Pay \$312 Million To Fort Worth Family," Mealey's Litigation Report: Nursing Homes (February 2001), citing *Fuqua v. Horizon/CMS Healthcare Corp.*, No. 4:98-CV-1087-Y (N.D. Tex., verdict February 9, 2001). See also, *Ernst v. Horizon/CMS Healthcare, et al.*, 285th Bexar County District Court (The plaintiff alleged that the facility was understaffed and that this led to inadequate resident care of 53 year old post stroke patient who developed constrictors of his extremities, bed sores, and ultimately

Within our arsenal for mitigating key exposures? Strength. Perspective. Expertise. And a clear understanding of the risk landscape.

death. The defense contended that Ernst's contractures and pressure sores were caused by complications from the stroke. On Feb. 22, 2001, a San Antonio jury awarded \$7 million in compensatory damages and added \$75 million in punitives the next day. There was no appeal. On the fourth day of trial, the parties reached a high-low agreement. Within 30 days after the trial, Horizon had paid the Ernst estate \$20 million to settle the case.)

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