2019 Benchmark Study of Healthcare Professional Liability Claims

Zurich is pleased to present our 14th annual Benchmark Study of Healthcare Professional Liability Claims. Our claims database is robust, including almost $16 billion in losses and representing nearly 6.3 million exposure units in the healthcare industry.

Numbers are meaningless without context, however. That is why our annual reports have always been produced to deliver useful insights on healthcare claims from hospital and outpatient care providers from all 50 states and Washington, D.C. Key findings and offerings from this year's Benchmark Study include:

- Average claim severity continues to illustrate an upward trend of just under 5% from 2008 to 2016. However, that trend is not uniform across all territories. Some territories are witnessing a significant increase in severity.
- Consistent with previous publications, claim frequency remains fairly stable, suggesting this trend may continue through the next report year.
- New this year: An in-depth analysis of claim reporting times, from accident to reporting, as well as from reporting to settlement. We found a strong correlation between severity of claims and settlement lag.
- As gleaned from previous Benchmark Studies, average severity for children's hospitals and teaching hospitals remains significantly higher than other facility types, despite children's hospitals' distinctly lower frequency.
- The ratio of expenses to indemnity has remained stable.
- We revisit our in-depth analysis, introduced last year, of the high-severity venues of Baltimore, Chicago and Philadelphia. These areas consistently have average loss costs per occupied bed equivalent (OBE) that are approximately three times the national average. This year we also look further into New Mexico and see high frequency, severity and loss cost relative to the national average.
- This year, we are sharing three articles that explore widely different emerging risks, each significant as it affects the healthcare industry. Our writers cast a thoughtful spotlight on the benefits and risks presented by medical marijuana, telehealth services and social media/digital communications and the potential impact on claims.

Since we introduced our first Benchmark Study, the healthcare sector has continued to navigate an ever-changing landscape of complex risks while serving the dual mission of providing high-quality patient care as cost-effectively as possible. This year's report, provided for your informational purposes, is designed to share claims insights to help you address these challenges. Our annual Benchmark Study is just one way that Zurich demonstrates its dedication to the healthcare industry and the larger community you serve.

This publication also represents our commitment to offering comprehensive insurance solutions, claims management and risk services to our customers. As you explore this year's report, we welcome your feedback and look forward to discussing the information shared here.

On behalf of everyone at Zurich Healthcare, I thank you for your continued support.

Joseph Sullivan  
Head of Healthcare Professional Liability  
Zurich North America

**Facts about the data**

Zurich's database contains 79,000 closed claims with expense payment, indemnity payment or both. Additionally, there are 11,000 open claims that are expected to close with payment, bringing the estimated total number of “ultimate claims” to 90,000.

Of the 90,000 ultimate claims, there are almost 20,000 with total incurred of at least $100,000. We expect an additional 1,000 claims to breach this threshold, bringing the number of claims with at least $100,000 in total incurred to approximately 21,000.

There are $15.6 billion in losses from across the country, Washington, D.C. included. Factoring in development on open claims yields an additional $1.6 billion in losses for a total of $17.2 billion in estimated ultimate losses. To limit much of the subjective component of claim evaluations, the year 2016 was used as the cutoff point.

**Uncertainty**

Although the database is very large, the results reported in this study have an inherent uncertainty because certain assumptions had to be made with respect to loss development and trends. These assumptions consider the long-tailed nature of many of the claims in the database and are unavoidable. However, they also create the possibility that results could be quite different depending on the interpretation of the data by each individual reviewer.

**Differences in results versus prior studies**

Results reported in this study differ somewhat from those in previous years because of the volatile nature of claims and claim maturity. Additionally, these results are based on data collected from healthcare facilities seeking quotes for professional liability insurance from Zurich over the past year. Although a large portion of the submissions we receive from one year to the next are from the same facilities, this is not always the case. The mix of business included in this publication tends to vary from year to year.

**Predictions**

Estimates of future costs are limited by the ability to forecast the course of future events such as jury decisions, judicial decisions, legislative changes, public attitudes and social and economic conditions that may impact losses. In addition, state or regional results vary in credibility because of the amount of available data. Therefore, we provide no assurance as to actual future results.
How much data is included in the study?*

<table>
<thead>
<tr>
<th>Data Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses</td>
<td>$15.6 billion</td>
</tr>
<tr>
<td>Losses including development</td>
<td>$17.2 billion</td>
</tr>
<tr>
<td>Occupied bed equivalents (OBEs)</td>
<td>6.3 million</td>
</tr>
<tr>
<td>Claims expected to close with defense or indemnity payment or both</td>
<td>90,000</td>
</tr>
</tbody>
</table>

*This is the total for reported years 2008 to 2016.

Why use an occupied bed equivalent (OBE)?

Using a standardized measure of exposure allows healthcare organizations to compare themselves against their peers. In order to use a standardized unit, several factors must be blended together.

Zurich's proprietary relativity standardization allows us the ability to combine dozens of different exposure types into an OBE. These exposures can range from bed type – such as acute care or long-term care – to emergency room visits, laboratory services, physicians and professionals of varying specialties.

Visualizing claim metrics: Frequency and severity

The exhibits below show an average frequency and severity for acute care facilities, children’s hospitals and teaching hospitals. The analysis looks at total metrics for 2008 to 2016. A more in-depth analysis by facility type and report year can be seen on page 10.

The severity of claims from teaching and children’s hospitals remains much higher than the national average claim severity. That’s not surprising given the relative nature of exposures in these types of facilities. The claim frequency for children’s hospitals is significantly lower than the national average. This may indicate stronger risk prevention programs in these types of hospitals, which could drive frequency down. Other factors, such as geographic location or patient mix, may also be impacting frequency.
Data fluctuations and a consistent message
Differences in historical figures are expected from one publication to the next. These differences may primarily be the result of:

- Movement in claim values, although mitigated by using a mature year as the cutoff (i.e., we use 2016 as the latest reported year instead of 2019)
- Changes in the mix of submission data underlying each study

The Indexed National Average Severity graph compares the national average severity from this year’s publication to that of last year’s publication indexed to each of their respective 2008 values. The graph shows consistency in severity patterns between publications.
Claim frequency

Consistent with previous publications, overall frequency continues to be quite stable. Our data suggest an average frequency of 1.4 claims per 100 occupied bed equivalents. In last year’s publication we made a frequency projection for 2016. As seen in the graph below, the actual frequency came in just below expectations. This minimal difference could be reflective of the change in the account mix of this year’s submission database compared to last year, a difference in claim activity versus what was expected, or a combination of the two.

New to this year’s publication, we look further into the state of New Mexico, with a claim frequency consistently higher than the national average.

Claim frequency in Texas remains significantly below the national average; as noted in prior publications, the lasting impact of reform in Texas cannot be understated. We have also included Wisconsin to highlight the effects both tort reform and Patient Compensation Funds have on healthcare professional liability claims.
FOCUS ON EMERGING RISKS

#PromiseandPerils: Healthcare claims in the social media age

Rita Hamilton
Assistant Vice President – Director
Professional Liability Claims
Group – Healthcare
Zurich North America

Most Americans – approximately 81%, in fact1 – own a smartphone, and with digital access comes an ability to share information at a dizzying rate of speed and flexibility. The new world of social media has transformed our society, and subsequently created both significant opportunities and profound challenges for the healthcare community.

It is becoming increasingly common for patients and their families to record interactions with healthcare providers. The intent is usually understandable: Photographs and/or recordings can help patients and loved ones review discussions about unfamiliar and/or stressful topics, and remember discharge or post-visit instructions.

However, this practice can introduce concerns, foremost among them the protection of a patient’s privacy. A guiding principle upon which the healthcare profession is founded is the assurance that a patient’s information is privileged. Improperly sharing or inadequately protecting patient information can be a betrayal of that trust.

Furthermore, privacy rights are not just for patients. Some healthcare providers question the real intent of recordings or photos, fearing for their safety as well as the integrity of their professional reputation.

In our digitally connected world, it’s not unusual for bystanders to raise their smartphones and record activity in emergency departments or other areas of a hospital, texting about and livestreaming videos involving patients they may not even know. It is also not uncommon for patients to make secret audio recordings; federal law, 38 states and the District of Columbia have “one-party consent” laws that permit audio recording, although some have caveats, such as distinguishing between electronic and in-person communications.2

In one example, a patient recorded her own surgical procedure and claimed it captured inappropriate sexual comments directed at her. When the recording was ruled unintelligible, the suit was dismissed. In another case, however, the recording was clear and the matter was settled out of court. Legal or not, hidden cellphones can create a host of potential risks for practitioners as well as patients, such as being unsafely stowed beneath sheets in an operating room.

This is not the only way social media can be used against healthcare providers. Another recent example involved an individual who had a huge following on a social media platform. Unhappy with his experience in an emergency department, he encouraged his followers to call the hospital to complain. The phone line was busy for days, at the expense of individuals seeking care and creating delays and distractions for the hospital staff.

Information found on social media is also replacing the practice of retaining private investigators. Both parties to a lawsuit now routinely conduct social media investigations as they evaluate the validity of their cases. A frequent plaintiff’s tactic is to instruct new clients to immediately take down all social media accounts. They are also told to ask family and friends to cease posting information about them. A patient’s own postings can be used to rebut their alleged physical injuries when online photos or postings document them engaged in activities such as grocery shopping or sports.

Searching the social media accounts of all relevant healthcare providers involved in a patient’s care is also common. This might include an unrelated post to a physician’s social media page at a time when their patient’s condition was deteriorating. (In one case, the plaintiff argued the physician was distracted at a critical time in the patient’s care.)

The impact of social media extends beyond the parties. At some trials, despite a judge’s orders, jurors conduct online searches for information about the case and the parties. When the court finds this has occurred, it can result in a mistrial.

All of these scenarios create problems for healthcare practitioners. The absence of national standards regarding the use of recording equipment adds to the complexity. For this reason, it’s crucial to be familiar with your state’s laws concerning audio and video recordings.

Some additional advice from a recent American Academy of Pediatrics article3 includes developing a policy for yourself and/or your organization as it relates to recording practices. Discuss it with your legal team or a malpractice attorney and, once created, share it with all stakeholders. Should you discover questionable online content involving yourself or your organization, avoid responding on social media or in public forums. You should also report content that concerns your professional reputation or that of your organization to your social media department or risk manager.

The age of technology has delivered countless benefits but also some sobering realities. Among the greatest challenges healthcare providers face is harnessing the power of digital communication and social media for good, while managing the potential pitfalls. Does the promise outweigh the perils? Given these new realities, the answer is largely up to each of us.

References on page 25.
Loss development
All open claims are developed to their projected ultimate settlement value using loss development factors. The inherent uncertainty of loss development in this report is mitigated by only using losses from 2016 and prior since 87% of claims are already closed.

Average claim severity: State
Average severity has increased steadily over the past several years. With respect to trends, the implied long-term national average annual trend is just under 5% for the period from 2008 to 2016.

Despite the increasing trend nationwide, we continue to see a notable difference between states. States such as Texas and Wisconsin continue to demonstrate low severity with minimal trend.

Illinois, Maryland, Pennsylvania and New Mexico vs. the national average
Consistent with the findings in prior publications, the states of Illinois, Maryland and Pennsylvania have an overall claim severity higher than the national average – in many cases significantly higher. Although these states exhibit both high severity and volatility, they are trending in line with the national average.

New to this year's publication, we look further into the state of New Mexico. As illustrated on the prior page, New Mexico not only demonstrates frequency higher than the national average; average claim severity is also notably higher than average. Could this high severity be driven by insurable punitive damage awards or jury decisions?

Metropolitan areas from these states are also analyzed in more depth in the section “High-severity venues revisited” on page 22.

* Note: In the graph above, the national average severity is unlimited. However, we have capped the severity at $600,000 by state for graphical purposes.
**Average claim severity: Profit status**

Aggressive claim management, differences in case-mix index and patient populations could be contributing factors driving the lower average severity of for-profit hospitals. As shown by the trend lines in the graph below, nonprofit hospitals continue to experience a higher severity trend than for-profit hospitals. One theory for the closing gap in severity could be due to the general increase in merger and acquisition activity among hospital systems.
Facility classifications
Zurich uses dozens of categories and subcategories to uniquely classify facility types. Having classifications at such a granular level creates the opportunity to perform deep-dive analyses and could prove important for future benchmarking. For publication purposes, we have placed our facility categories within four larger areas: acute care hospitals, outpatient facilities, teaching hospitals and children’s hospitals.

Average claim severity: Facility type
Children’s and teaching hospitals continue to have claim severities that are substantially higher than the national average severity. Absolute numbers have moved over time, perhaps partially driven by the mix of accounts in our database as well as changing claim values, but the overall message remains the same.

As emphasized in prior publications, providing lifetime care is possibly driving the high severities in children’s hospitals. Teaching hospitals may be experiencing this as well, due to their exposure to high-risk obstetrics cases, which can result in lifetime care for injured neonates.

* Note: In the graph above, the national average severity is unlimited. However, we have capped the severity at $600,000 by facility type for graphical purposes (similar to the severity by state graph on page 8).
Average claim severity: Community type

We continue to see that claim severity from facilities in urban areas is higher than those in rural and suburban areas. The spread between the two groups in terms of actual dollars has moved over time, but on a relative scale they are mostly stable, hovering around a ratio of 1.15 (i.e., on average, urban claims are approximately 15% more expensive than rural/suburban claims).

How do we classify geographic areas?
Areas with populations of 200,000 or higher are considered urban. Those with populations of fewer than 10,000 are considered rural and everything in between is considered suburban.
FOCUS ON EMERGING RISKS

Medical marijuana: Navigating the medical, legal and political conundrums

Krishna Lynch
Team Lead and Senior Healthcare Risk Engineering Consultant
Zurich North America Healthcare Professional Liability

Consider this scenario: John suffers from chronic, debilitating pain that traditional medicine has failed to address. He has found relief using medical marijuana. When he is admitted to a healthcare facility, John brings his medical marijuana to self-administer. How should the facility respond? Should they allow him to self-administer his medical marijuana off-premises? Send him home with a caregiver? Store the cannabis until discharge? Or prohibit its use and confiscate it as contraband?

This example is far from unique. With approximately 3 million medical marijuana users currently enrolled in state registries,1 healthcare facilities across the U.S. are being challenged to navigate this complicated, emerging risk.

Marijuana, derived from the cannabis plant, contains tetrahydrocannabinol (THC), a psychoactive compound that delivers the sensation of euphoria. Medical marijuana, or medical cannabis, uses the plant and/or chemicals within it to treat patients.

Medical marijuana has been legalized in 33 states and the District of Columbia. (Recreational marijuana has been legalized in the District of Columbia and 11 states.) The driving force behind legalization of medical marijuana appears to have been public opinion through state ballot initiatives and referenda, with laws that vary widely from state to state. All states that have legalized marijuana for recreational use also have whole plant medical marijuana laws. Some states have more stringent laws, which permit only the use of low-THC cannabidiol (CBD) oil and are not considered to have adopted broad medical marijuana laws.

However, the U.S. Drug Enforcement Administration (DEA) classifies marijuana as a Schedule 1 drug under the Controlled Substances Act, complicating the situation for healthcare providers. A Schedule 1 drug (the list also includes heroin and LSD) is deemed to have a high potential for abuse and no currently accepted medical use. Despite organized efforts to change federal law to legalize marijuana, reschedule its classification and decriminalize it for medical purposes, as a Schedule 1 drug medical cannabis remains illegal for doctors to prescribe, dispense or possess for any purpose.

Physicians and, depending on the state, physician assistants and certain nurse practitioners can only write a recommendation, which is different from a prescription. The physician may "recommend" or "certify" patients to obtain medical marijuana if they meet certain qualifying medical conditions, depending on applicable state law. Furthermore, some states require physicians to be registered with the regulatory agency, while other states allow any physician to recommend medical marijuana.

Meanwhile, consumer demand for medical cannabis continues to grow, primarily to relieve chronic pain and other symptoms associated with chronic conditions such as cancer and epilepsy. Chronic pain accounts for over 67% of qualifying medical conditions reported by patients who use medical marijuana.2 Legalized marijuana products have also become hugely profitable, with estimated sales revenues of $3.8 billion in 2018 alone.3

Marijuana legislation continues to stir emotional debates among the public, politicians, researchers, scientists and the medical community. Healthcare-related concerns include: Is it safe? Why can’t a physician prescribe it? Who qualifies for a registry card and for what conditions? Is it addictive? Has its effectiveness been proven? Why is it illegal at the federal level, but legal in so many states? Should healthcare facilities allow patients to have it on the premises? Should facilities allow their physicians to recommend it? Does recommending it violate the standard of care?

An alternative path to approval

However, a larger question looms for the healthcare industry: Is marijuana good medicine? Its medicinal approval appears to have been based on testimonials, legislative initiatives, public reports and/or low-quality scientific evidence, which departs from the traditional approach required for Food and Drug Administration (FDA) approval.

The lack of evidence for its medicinal use and questions about its overall effectiveness underscore the need for the research, safety studies and well-controlled clinical trials that typically support an FDA-approved medication. However, its Schedule 1 classification strictly limits the type, amount, availability and funding of such research. Subsequently, concerns remain about its toxicity, pharmacology, form, delivery method, dosage and, especially, its potency, which has slowly climbed over the past two decades and is introducing new challenges.4 Fortunately, the DEA recently announced an initiative to facilitate and expand scientific and medical research for marijuana in the U.S.5

There also is considerable variability in the profile of different forms of medical marijuana (i.e., smoking versus consuming edibles), which may affect the body differently. This, too, is obscured by a lack of research and a subsequent lack of standards for labeling and testing.

For example, a product may not be regulated or inspected for its chemical contents and purity, and the labeling may not tell the patient much about the product or how to use it. This presents a potential threat to patient safety by putting them at risk for adverse drug reactions, dose stacking, mixing with other intoxicants and even potential...
overdose. Medical complications may include gastrointestinal symptoms, psychosis, cardiovascular symptoms and cannabinoid hyperemesis syndrome, which is highly dangerous because it’s difficult to diagnose and treat.

Healthcare organizational leaders and physicians are concerned by the lack of medical standards and whether medical marijuana is the best treatment modality; the lack of dosage control; and how to protect patients from interactions with other medications. They’re also challenged with how to balance the patient’s experience while managing a physician’s right to refuse to recommend due to the stigma associated with being labeled a “pot doctor” or a resource for individuals seeking recreational marijuana.

**Proceed with caution**

Despite increased public demand for legalization and decriminalization of medical cannabis, many healthcare facilities ban it on their premises in states that have legalized it. Other facilities employ “don’t ask, don’t tell” policies, allowing patients to send it home with a caregiver or use it off hospital premises, which could create the potential risk of losing a hospital license and/or Centers for Medicare and Medicaid Services (CMS) funding.

Recommending patients for medical marijuana use poses a unique challenge for the medical community. Healthcare facilities are facing decisions about whether to allow its physicians to recommend. There is fear of potential liability, notwithstanding the Conant v. Walters decision, in which the U.S. Court of Appeals for the Ninth Circuit addressed the right of physicians to recommend medical marijuana, as well as First Amendment protections for professional-client speech.

Because laws vary widely from state to state, it’s critical for healthcare facilities to understand the laws governing each state, determine their position on this issue and develop appropriate policies and procedures. The Federation of State Medical Boards has developed guidelines to help state medical boards regarding the recommendation of marijuana for patient care. These guidelines note that an established patient relationship, a good faith medical exam, informed consent, and an evaluation of addiction potential are at the crux of safe, quality recommendations for patients seeking medical marijuana.

The exposure to significant malpractice liability when recommending medical marijuana is unknown and untested. However, given that more than half the states allow for some medical use, that will likely change. To better manage their risks, physicians and organizational leaders should understand their role and responsibilities under each state’s laws and any rules or guidelines stipulated by their state medical board. Risk managers may wish to encourage their organizations to develop policies and procedures regarding marijuana for medical use, where applicable. This is a great opportunity for risk managers to provide thought leadership and support their organizations in developing a position on this issue.

Healthcare facilities must continue to balance patient comfort, public opinion and stigma with federal prohibition. The challenge is to educate and engage all stakeholders while supporting safe and effective patient care.

**References on page 25.**
Average settlement time: Taking a deeper look

Average time from reporting to settlement
New to this year’s publication is an analysis of the time lag from reporting of a claim to settlement. For example, the pie charts below demonstrate that 41% of claims are settled within one year of reporting, versus only 10% of loss dollars settled in the same period.

Average time from reporting to settlement vs. severity
The graph below analyzes closed claims only and compares the average time from reporting to settlement versus the average severity. Our analysis is in line with expectations, where claims that settle quickly have a significantly lower severity than those taking longer to settle. The average severity for claims settled in less than one year steadily increases from $33,000 to $560,000 for claims that take greater than five years to settle.

We also analyzed the distribution of reporting to settlement lag by reported year. We noticed a stable trend year over year. As a result, we did not show a breakdown by reported year.
Average time from reporting to settlement: Facility type

Like the previous page, the graph below shows the distribution of the average time from reporting of a claim to settlement of a claim, as well as the time delay between accident and reporting of a claim. In addition, we analyze the difference by facility type versus severity. Outpatient claims settle faster, with 49% of claims settling within the first year with an average severity of $94,000. Conversely, given the significantly higher severity of children’s hospital claims at $430,000, only 39% of claims are settled within the first year.

Average time from accident to reporting: Facility type

We also analyze the time from accident occurrence to reporting of a claim by facility type. From the time of the accident, 67% of claims are reported within one year, whereas only 41% of claims settle less than one year after being reported.
Expense component of claims with indemnity: Acute care vs. children’s and teaching hospitals

The difference between the national average percentage of severity due to expenses and the same ratio exclusive to acute care hospitals is stable. These values have not materially converged or diverged over the years evaluated in this publication, despite increased numbers of early-offer claims management programs.

In contrast to acute care, the expense percentage of children’s and teaching hospitals has shown a slight decrease in trend over time. While the dollar amounts associated with those expenses have stayed flat, the increasing severity of the non-expense payments has caused the expense ratio to decrease over time.
FOCUS ON EMERGING RISKS

Telehealth services: Embracing the benefits, addressing the challenges

Mary Steffany
Senior Healthcare Risk Engineering Consultant
Zurich North America

As technology transforms the healthcare landscape, providers are implementing new opportunities to expand, improve and enhance patient care. Telehealth represents one of the more exciting innovations for the industry.

With the use of digital technology, telehealth programs can offer a broad range of remote healthcare services and activities, not necessarily clinical in nature, to benefit patients and healthcare professionals alike. The New England Journal of Medicine Catalyst recently outlined three leading telehealth examples:1

- **Videoconferencing** gives patients in rural locations, and those with limited ability to travel, newfound access to health specialists. Healthcare providers benefit, too: Primary care physicians can consult in real time with specialists and peers across the country, and care teams can collaborate on treatment plans for patients.

- **Mobile health apps** on smartphones and tablets can help patients become more engaged in controlling their well-being. Educational videos and apps can help people manage chronic conditions, participate in wellness activities and build emotional resilience with online support groups.

- **Remote patient monitoring** collects and transmits medical and other types of health data from patients to healthcare providers. Electronic monitoring devices such as wearables can be used to track blood pressure, respiratory rates and other vital sign data.

Telehealth programs have witnessed significant growth across the U.S. Approximately 76% of U.S. hospitals reported having some form of computerized telehealth systems in 2017, more than double the 35% reported in 2010.2

### Recognizing the challenges

Telehealth is not without challenges, however. A 2018 report3 from the American Society for Health Care Risk Management (ASHRM) highlighted three operational risks for healthcare organizations seeking to implement these programs:

- **Credentialing:** Licensing and credentialing of healthcare professionals can be complicated when a patient is in one state and the provider is in another. Hospitals must be diligent in aligning their credentialing process with the July 2011 final rule issued by the Centers for Medicare and Medicaid Services, which stipulates that the originating site (where the patient is) will rely on the credentialing and privileging decisions of the distant-site hospital (where the specialist is located) for telehealth practitioners. In other words, the site receiving the service does not have to duplicate the credentialing process.

- **Standard of care:** Some states have defined a specific standard of care for telemedicine that addresses the physician-patient relationship, electronic prescribing and in-person follow-up. Whether or not standards have been established, risk managers need to inform their organization of professional association positions. The American Telemedicine Association has issued discipline-specific guidelines, as has the American Medical Association, American Psychiatric Association and American College of Physicians. In addition, the Federation of State Medical Boards has published a model policy of voluntary guidelines. Consideration also needs to be given as to whether and how advance-practice professionals will be involved in telemedicine.

- **Documentation:** A patient-provider encounter, even a remote one, requires documentation in the patient’s health record. Access to this documentation by the patient and providers should align with existing rules and regulations, as well as institutional policies for privacy and security of this information. Documentation should include informed consent, prescribed medications, diagnostic test results, clinical evaluations and instructions.

The ASHRM report also emphasizes clinical/patient safety, recommending initiatives that “prevent or reduce errors, such as communication of test results, patient instructions, patient education and follow-up care.”

### Ready, set, launch

A successful telemedicine program starts with a well-designed plan. A multidisciplinary team, including medical staff, information technology, finance and human resources, must evaluate the community’s needs and identify the program’s goals and services, as well as the geographic areas where service will be provided.

Additional issues to address include finalizing contracts with distant sites and vendors; providing staff education and training; defining measures to assess program goals; and assessing effectiveness and security of telehealth equipment. Identifying and enlisting clinical and administrative champions can help assure that a telehealth program is widely accepted and utilized.

It’s also critical to understand reimbursement policies for telehealth services. Telehealth providers should investigate the varying Medicare and Medicaid rules, which may differ by state, regarding payment for telehealth services, as well as each state’s telehealth parity laws. The Center for Connected Health Policy website (cchpca.org) provides extensive information on telehealth laws and reimbursement policies by state.

The extent to which telehealth programs are embraced remains to be seen, but as technology evolves, so will the opportunities and risks associated with these services. Their myriad benefits point in a favorable direction for forward-looking organizations ready to keep pace with this new chapter in healthcare.

References on page 25.
Medium and large claims

Medium claims: On average, 4 claims exceed $1 million per every 100 ultimate claims.
Large claims: On average, 5 claims exceed $5 million per every 1,000 ultimate claims.

Medium and large claims: Frequency

There has been no major change in the general pattern or trajectory of medium and large claims since our prior review. The raw number of medium and large claims relative to the total number of ultimate claims has both increased over time and is trending at a similar rate.

Percentage of ultimate claims greater than $1M and $5M

- Percentage of claims > $1M
- Percentage of claims > $5M
Medium and large claims: Facility type

Claim severities from teaching hospitals are higher than those from acute care hospitals as seen earlier. Looking at raw counts of claims greater than $1 million as a proportion of total ultimate claim counts can help shed light on severity drivers. Based on the graph below, the high severity of claims from teaching hospitals is driven by a large quantity of large claims per year, rather than skewed by just a few very large claims.

Although not shown below, teaching hospitals represent only 16% of the ultimate claim counts in our database — yet represent 26% of claims greater than $1 million. For acute care, the relationship is just the opposite, where acute care ultimate claims represent 72% of claim counts in our database, versus 65% of claims greater than $1 million.

Are acute care claims increasing faster than expected?

Acute care claims greater than $1 million are trending at almost double the rate of those claims from teaching hospitals. From 2008 to 2016, the percentage of acute care large claims is trending at close to 6% per year compared to approximately 3% per year for teaching hospitals.
Medium and large claims: Further analysis

In this data set, we have almost 3,400 claims with an ultimate loss value greater than or equal to $1 million. While these claims represent just over 4% of total ultimate claims, in terms of loss dollars, these large losses amount to almost 60% of developed losses.

In addition, 63% of the claims fall into the bucket from $1 million to $2.5 million. However, the percentage of loss dollars in this category is only 31%. In contrast, losses greater than $5 million account for only 15% of the number of losses above $1 million, but represent almost 44% of the ultimate loss amounts.
Large loss severity: Facility type

Nationwide, average large claim severity exhibits little over the period from 2008 to 2016, compared to the trend of just under 5% seen with unlimited ground-up severity. Larger claims appear to be trending at a lower rate than small to mid-sized claims. It is worth mentioning that while severity is mostly flat on losses above $1 million, we have seen a slight uptick in frequency over this same period as evidenced by the “Medium and large claims frequency” on page 18.

Note that the severity in the graph below represents claims greater than $1 million and capped at $10 million (i.e., $9 million excess of $1 million). This helps minimize the variability due to some significantly large verdicts in the database.
High-severity venues revisited

In last year’s publication, we took a deeper look at high-severity venues. We focused on cities from three of the states in the “Average claim severity: State” exhibit on page 8, and highlighted the areas driving the high severity and loss costs.

This year’s analysis also concludes that the three cities of Baltimore, Chicago and Philadelphia, as well as the state of New Mexico, have an average unlimited severity of approximately 3 times the national average (excluding these high-severity areas).

Baltimore, Chicago, Philadelphia and New Mexico represent a total of only 5% of the number of claims in this study but over 14% of ultimate loss dollars, emphasizing the large loss potential.
Loss cost

Year-over-year changes in loss cost appear to be severity-driven, given the relatively benign movement in frequency. The implied annual trend in loss costs on an unlimited basis is approximately 4.6% from 2008 to 2016, consistent with industry views of increasing trends for healthcare professional liability.

Consistent with our frequency and severity analysis, New Mexico also exhibits a significantly higher average loss cost.

### Loss cost implied average annual trends

<table>
<thead>
<tr>
<th>Description</th>
<th>2008-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average</td>
<td>2008-2016</td>
</tr>
<tr>
<td>Claims limited to $1M each</td>
<td>4.0%</td>
</tr>
<tr>
<td>Unlimited claim values</td>
<td>4.6%</td>
</tr>
</tbody>
</table>
Loss costs by state

Average loss cost grouping per OBE:

<table>
<thead>
<tr>
<th>Ultra-Low</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>Ultra-High</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID</td>
<td>AR</td>
<td>AL</td>
<td>AK</td>
<td>CT</td>
</tr>
<tr>
<td>IN</td>
<td>CO</td>
<td>AZ</td>
<td>FL</td>
<td>DC</td>
</tr>
<tr>
<td>ND</td>
<td>DE</td>
<td>CA</td>
<td>KY</td>
<td>IL</td>
</tr>
<tr>
<td>NE</td>
<td>IA</td>
<td>GA</td>
<td>MA</td>
<td>MD</td>
</tr>
<tr>
<td>SD</td>
<td>KS</td>
<td>HI</td>
<td>MI</td>
<td>NM</td>
</tr>
<tr>
<td>TN</td>
<td>LA</td>
<td>ME</td>
<td>MT</td>
<td>NY</td>
</tr>
<tr>
<td>VT</td>
<td>MN</td>
<td>MO</td>
<td>NJ</td>
<td>PA</td>
</tr>
<tr>
<td>WI</td>
<td>NC</td>
<td>MS</td>
<td>NV</td>
<td>RI</td>
</tr>
<tr>
<td>OH</td>
<td>NH</td>
<td>OK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TX</td>
<td>OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WV</td>
<td>SC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WY</td>
<td>UT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: To determine state loss cost groupings, we analyze losses limited to $1 million per claim using a credibility-weighted methodology. For example, if a state has a high volume of exposure, we give more weight to this state’s own loss experience. Alternately, less weight is given to states with lower levels of exposure. This reduces the year-over-year variability in the database due to changes in the mix of accounts.
Conclusion

Zurich continues to aggregate a significant amount of our healthcare claims data from across the country. This information, coupled with our deeper analysis of its implications, can be a resource for enhanced insights to an organization’s individual loss history and qualitative information about risk management and patient safety programs.

Our extensive knowledge and risk management capabilities can help address existing and emerging challenges, with innovative solutions informed by many years of experience in the field as well as what we’ve learned from our customers.

The goal is to provide the tools to help you improve patient outcomes and reduce the total cost of risk. We look forward to sharing additional insights to healthcare organizations as our industry navigates the future.

We encourage our customers to contact our team of Healthcare Risk Engineers and Claims consultants for more specific insights tailored to their operations. Zurich is ready to help.

For additional information, contact:

Brian McDevitt  
Regional Vice President  
Zurich Healthcare  
brian.mcdevitt@zurichna.com

Christina Langenstrass  
Regional Vice President  
Zurich Healthcare  
christina.langenstrass@zurichna.com

References

“#PromiseandPerils: Healthcare claims in the social media age”

“Medical marijuana: Navigating the medical, legal and political conundrums”
5. “DEA announces steps necessary to improve access to marijuana research.” U.S. Department of Justice Drug Enforcement Administration. 26 August 2019.

“Telehealth services: Embracing the benefits, addressing the challenges”
Contributors

Joseph Sullivan is Head of Healthcare Professional Liability for Zurich North America. Joe is responsible for underwriting strategy, transactional underwriting and marketing of coverage written in North America. In this capacity, Joe oversees the underwriting of all Medical Professional Liability, General Liability, Umbrella/Excess and Captive reinsurance business for healthcare customers.

Previously, Joe was Head of the Professional Liability, Accident & Health, and Warranty portfolios within Zurich’s Technical Underwriting. He was responsible for underwriting strategy, portfolio management, pricing and product development for products within North America, including Errors and Omissions, Managed Care, Medical Professional Liability, and Security and Privacy, as well as Accident, Health and Warranty.

Joe has underwritten Professional Liability since 1990 and joined Zurich in 1999. He holds a Bachelor of Science in business administration and finance from Marquette University.

Kyle Kinkade is the Lead Pricing Actuary for Specialty Lines at Zurich North America. Kyle earned a Master of Science in mathematics from Kansas State University and a Bachelor of Science in mathematics and physics from Baker University. He is a Fellow of the Casualty Actuarial Society, a member of the American Academy of Actuaries, and holds the Chartered Property Casualty Underwriter designation.

Grace Buckley is a pricing actuary at Zurich North America, working on the Professional and Cyber Lines pricing team. Grace graduated from University College Dublin in Ireland with a Bachelor of Science in actuarial and financial studies. She is a Fellow of the Casualty Actuarial Society, as well as a Fellow of the Institute and Faculty of Actuaries in the UK.

Krishna Lynch is the Team Lead and Senior Risk Engineering Consultant for the Healthcare Professional Liability practice group at Zurich North America, and is a 2018 graduate of Zurich’s International Risk Engineering program. Krishna is a powerfully effective and highly engaging leader with over 15 years of experience effecting change in the healthcare industry. She holds a Master of Jurisprudence in health law from Loyola University Chicago School of Law, a Bachelor of Science in nursing from Illinois Wesleyan University and is a registered nurse. In addition, she holds the designation of Certified Professional in Healthcare Risk Management and is a Distinguished Fellow of the American Society for Health Care Risk Management.

Rita Hamilton is the Assistant Vice President and Director of the Healthcare Professional Liability Claims Group at Zurich North America. In this capacity, Rita is responsible for oversight of an experienced team of Claims counsel in the management of healthcare professional liability matters throughout the United States. Rita has years of experience in the healthcare arena, including both clinical and legal practice. Prior to joining Zurich, Rita was in private practice, specializing in healthcare law and the defense of healthcare providers. She holds a Juris Doctor degree from Texas Tech University and a Bachelor of Science in nursing from the University of Texas at El Paso.

Mary Steffany is a Senior Healthcare Risk Engineering Consultant for Zurich North America. She has over 25 years’ experience in healthcare risk management. Mary is a past president of The Association for Healthcare Risk Management of New York and continues to serve as an active board member of the organization. She is also a member of Sigma Theta Tau International Honor Society of Nursing. Mary is a registered nurse and holds a Master of Arts in nursing from New York University and a Bachelor of Science in nursing from Adelphi University. She is a Certified Professional in Healthcare Risk Management and a Fellow of the American Society for Health Care Risk Management.
The information in this publication was compiled from sources believed to be reliable for informational purposes only. All sample policies and procedures herein should serve as a guideline, which you can use to create your own policies and procedures. We trust that you will customize these samples to reflect your own operations and believe that these samples may serve as a helpful platform for this endeavor. Any and all information contained herein is not intended to constitute advice (particularly not legal advice).

Accordingly, persons requiring advice should consult independent advisors when developing programs and policies. We do not guarantee the accuracy of this information or any results and further assume no liability in connection with this publication and sample policies and procedures, including any information, methods or safety suggestions contained herein. Prior results and past performance are not indicative of future outcomes. We undertake no obligation to publicly update or revise any of this information, whether to reflect new information, future developments, events or circumstances or otherwise.

Moreover, Zurich reminds you that this cannot be assumed to contain every acceptable safety and compliance procedure or that additional procedures might not be appropriate under the circumstances. The subject matter of this publication is not tied to any specific insurance product nor will adopting these policies and procedures ensure coverage under any insurance policy.

Risk engineering services are provided by The Zurich Services Corporation. The Zurich Services Corporation does not guarantee any particular outcome and there may be conditions on your premises or within your organization, which may not be apparent to us. You are in the best position to understand your business and your organization and to take steps to minimize risk, and we wish to assist you by providing the information and tools to help you assess your changing risk environment.

© 2019 The Zurich Services Corporation

A1-112008214-D (10/19) 112012452