

Welcome to the third issue of *Beazley Diagnosis*, the newsletter of the Beazley Healthcare team.

In this issue we focus on rehospitalization rates and co-ordination of chronic illness care, and on wrongful life claims. We also profile two new forms of coverage we have developed for healthcare providers: management liability tailored to the particular risks that healthcare organizations run, and data breach coverage for hospitals and other healthcare organizations handling large volumes of personal patient data, both financial and medical.



**Rehospitalization rates on the radar: Potential ramifications in care and in court** (Iain Newton)

No wonder rehospitalization rates are capturing so much attention: According to a study published in the April 2009 *New England Journal of Medicine*, unplanned rehospitalizations cost Medicare \$17.4 billion in 2004. Some 20 percent of discharged Medicare beneficiaries were rehospitalized within 30 days; 34 percent within 90 days.

As rehospitalization data becomes more transparent, it can have multifaceted implications for healthcare providers.

**Savings upon savings?**

Effectively coordinating patient care is key to reducing rehospitalizations. And like rehospitalization itself, the common approach to coordinating chronic care comes with many potentially avoidable costs. Exactly how much is available remains to be seen, but when you consider that \$1.7 trillion of the total \$2.2 trillion in US healthcare spending in 2007 went for chronic care, the immensity of the potential upside is clear.

The medical home is one model for delivering chronic care and, hence, reducing rehospitalizations. The medical home concept, and approaches like it, aims to bring continuity and integration to medical care, promoting a high degree of communication between the various professionals and providers involved and a centralized, comprehensive record of such services.

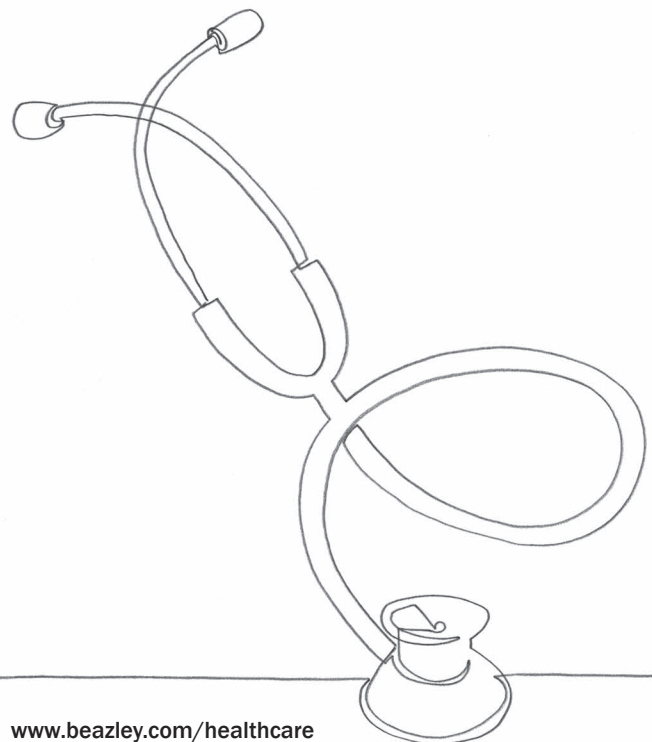
Part of the promise of this approach for lowering rehospitalizations in particular is that most medical home models have physicians or hospitals as the fulcrum. That's important, considering 50 percent of rehospitalized beneficiaries in the aforementioned *NEJM* study had no billing evidence of any physician visit between hospital discharge and readmission.

The medical home concept has been around for a few years, yet its practical application is only just beginning to be explored. One initiative launched this summer by the Institute for Healthcare Improvement aims to reduce avoidable rehospitalizations by improving patient care transitions through interventions like enhanced communication and timely post-discharge follow-up. Known as the State Action on Avoidable Rehospitalizations (“STAAR”), it involves hospitals in Massachusetts, Michigan and Washington state, and draws on many of the characteristics of a medical home as it targets a 30 percent reduction in readmission rates within four years.

An article recently published in the *Annals of Family Medicine* highlights various limitations and pitfalls observed to date in the first pilot project involving physicians’ practices seeking to apply the medical home approach, noting; “...change is hard enough; transformation to a patient-centered medical home requires epic whole-practice reimagination and redesign. It is much more than a series of incremental changes.”<sup>1</sup>

The article emphasizes the high level adoption of health information technology (HIT) required to successfully deliver the medical home approach. While US stimulus has provided major carrots (and sticks) linked to adoption of HIT, research has shown very low level use across the range of healthcare providers thus far. This sheds doubt on how swiftly and effectively coordination of care – and subsequently, meaningful reductions in rehospitalization rates – can be achieved.

1. ‘Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home’ (May 13, 2009). Taken from *Annals of Family Medicine*.



### Possible penalties

Rehospitalization data could also potentially be deployed as the basis for Medicare reimbursement penalties in circumstances where the model for preventing rehospitalizations is untried or deficient (similar to the policy of withholding Medicare reimbursement in acute care settings where a “never event” has occurred, as discussed in *Beazley Diagnosis*, issue two). Over time, such a penalty could also be applied to other providers involved in co-ordinated care where rehospitalization occurs.

Another point under discussion in the healthcare reform debate is the bundling of payments for services, especially for those involving chronic conditions. The concept is that one provider would receive payment, then distribute it among others delivering elements of care. Various providers, notably home health agencies and skilled nursing facilities, are raising concerns that they would lose out under this approach.

### Risk management consequences

Of course, data on “revolving door” use of hospitals will not escape the attention of plaintiffs’ attorneys. From the perspective of the risk manager, adverse rehospitalization rates should be seen as a potential tool plaintiffs can use to portray a facility as providing below average or sub-standard care.

*“Revolving door use of hospitals will not escape the attention of plaintiffs’ attorneys.”*

Consequently, it is prudent for facilities to ramp up attention and resources to track rehospitalization rates and identify means of reducing them.

Numerous other risk management considerations would arise from the introduction of the medical home and other care coordination models. Those that assume primary responsibility for coordinating care are likely to face increased exposure for failure to organize and monitor the delivery of care by other participants. This could involve both direct liability exposure to claims for wrongful credentialing and/or wrongful supervision of other providers, as well as vicarious liability for the errors of others.

Exposure could also arise from failing to feed data or concerns “up” to those exercising primary responsibility for care or “down” to other partners in delivering care.

The bottom line? Whatever path healthcare reform ultimately takes, medical malpractice claims continue to become increasingly complex. New terrain will give rise to new and untested responsibilities, expectations and exposures.

One bright spot: Ever committed to helping our insureds overcome the obstacles in their path, Beazley would be happy to make rehospitalization rates the newest benchmark to be incorporated into our Quality Indicator Return Premium (QuIRP) measure. QuIRP is our innovative program designed to reward hospitals for success in pursuing specific quality initiatives that reduce their vulnerability to malpractice lawsuits by providing a pre-agreed return of premium for goals met.

*Iain Newton coordinates Beazley’s Intelligence Network, researching new and emerging professional liability exposures.*



## Wrongful life claims

(Steve Chang)

In 1975, the Texas Supreme Court ruled in *Jacobs v. Theimer*, 519 SW2d 846 (Tex 1975), that the parents of an impaired

child were entitled to damages related to the birth of an infant with severe birth defects. The case involved the alleged failure of the treating obstetrician to advise the mother of her increased risk of delivering a child with a birth defect secondary to her contraction of Rubella during her pregnancy. The plaintiff-mother ultimately delivered a significantly impaired child, and she claimed that she would have aborted the pregnancy had she known of the increased risk. The Court held that this unique cause of action was sustainable, but expressly limited damages to the extraordinary costs associated with raising a severely impaired child. The Court prohibited non-economic damages. Since that time, however, more than half of all states have recognized wrongful birth claims, and some states now permit non-economic damages such as damages for negligent infliction of emotional distress.

Generally, wrongful birth cases allege that the negligence of a healthcare provider deprived the plaintiff-parents of the opportunity to abort a pregnancy or to prevent conception resulting in the birth of an impaired infant. The latter of these two are often referred to as wrongful conception claims. These cases are distinguishable from wrongful life cases, in which suit is brought on behalf of the injured child, and damages are demanded for being born with an impairment. The majority of jurisdictions continue to bar wrongful life claims under the rationale that “all life is good.” Inherent to both types of cases, however, is an underlying ethical and legal dilemma. Unlike a typical birth injury case, a jury confronted with a wrongful birth claim must first determine if the life of an impaired child is worth less than the life of a “perfect” child. The jury must then determine if the plaintiff-parents would be better off had the child not been born and had the pregnancy been aborted. In the context of a wrongful life claim, a jury must attempt to quantify the difference in value between the life of an impaired child versus that of a healthy child and determine if the plaintiff-child would have been better off if he or she was never born. To many, these basic premises of wrongful birth/life claims are offensive as they run counter to deeply rooted religious and political beliefs.

From a legal perspective, wrongful birth/life claims are also quite different from birth injury cases in that the defendant(s) in a wrongful birth/life case are rarely the actual cause of the impairment. Instead, the cause of the impairment is, more often than not, genetic. To paraphrase a physician involved in a wrongful birth case, “I didn’t cause the birth defect, God did.” Thus, fundamental to any wrongful birth/life jury deliberation is whether a defendant who did not, in fact, cause the injury, or could not have otherwise prevented the same, can be deemed liable. A jury may also be confronted with complex standard of care issues. Indeed, the mere existence of a specific genetic test for a particular disorder or defect is not dispositive. As there are hundreds of genetic tests currently available, the determination of liability will flow from whether the test at issue is the standard of care in the community and not whether a particular test to screen for the disorder exists.

The differences between states' recognition of wrongful birth/life claims may further complicate these cases. For example, a Maryland couple filed suit against a North Carolina laboratory several years ago for the wrongful birth of their child. The parents alleged that Maryland law was proper as the child was born there, but the defendant laboratory took the position that North Carolina law should control as the alleged negligent act, testing, occurred in North Carolina. Not surprisingly, Maryland recognized wrongful birth claims whereas North Carolina did not. The Court ultimately ruled in favor of the plaintiff-parents and applied Maryland law. The case, however, highlights the broad differences between various states' handling of these complex claims.

The most obvious specialties exposed to wrongful birth/life claims are obstetrics and reproductive genetics, and the majority of cases arise from these practice areas. In most obstetrics cases, the plaintiff-parents typically allege that the obstetrician: (1) failed to appreciate their increased risks of giving birth to an injured child due to medical/family history; (2) failed to refer them to a geneticist; (3) failed to order specific tests; (4) failed to appreciate sonogram findings; and/or (5) failed to properly interpret amniocentesis results. For geneticists, the typical claim seems to involve allegations that the geneticist: (1) failed to order appropriate carrier screening tests; (2) failed to properly administer a test; (3) failed to properly interpret the test results; and/or (4) failed to properly communicate the test results to the plaintiff-parents.

Significantly, however, wrongful birth/life claims have also arisen in the context of assisted reproductive technology services such as sperm banks and in vitro fertilization clinics. In *Johnson v. Super Court*, 101 Cal. App. 4th 869, 124 Cal. Rpts. 2d 650 (2002), Cyrobank, a sperm bank, was sued for wrongful birth and wrongful life for allegedly failing to screen the donor for a hereditary kidney disorder. In *Paretta v. Medical Offices of Human Reproduction*, 760 N.Y.S.2d 639 (2003), suit was brought against a fertility clinic for an alleged failure to inform the prospective mother that the egg donor was a carrier for cystic fibrosis. In both instances, the Courts rejected the wrongful life claims, but found that the plaintiff-parents could proceed with their respective negligence claims. These types of claims are likely to increase as in vitro fertilization is made more readily available.

Several of our insureds have been confronted with wrongful birth claims, and, from a practical perspective, these claims present much uncertainty for both plaintiffs and defendants. In most instances, the defense will have strong causation and liability defenses available to them, but the potential damages may nevertheless be very significant depending on the degree of impairment. Moreover, given the ethical/moral considerations discussed above, it is very difficult to predict how a jury will react to the case.

Indeed, a jury may find it very difficult to feel any sympathy for plaintiff-parents who testify that they wish their child was never born and some jurors may be unable to set aside their personal beliefs on abortion. Conversely, if the departure from the standard of care is particularly egregious, a jury may be more likely to overlook applicable causation and liability defenses and award a substantial verdict. It is no surprise then that trial outcomes have ranged from defense verdicts to plaintiff awards of in excess of \$20,000,000.

With each new development in reproductive and genetic technologies, new theories for wrongful birth/life claims are likely to evolve. The complex ethical, moral and legal issues, however, will persist, and predicting the outcome of a particular case will remain difficult.

*Steve Chang, based in New York, heads Beazley's healthcare claims team.*

## Healthcare management liability coverage now available

Following requests from our insureds and prospects, we have developed a healthcare management liability capability, so that we can now offer D&O, EPL and PCL products to healthcare organizations.

This is an adaptation of our successful BeazleyOne management liability package policy and provides coverage that is precisely tailored to the needs of healthcare organizations, including hospitals, long term care facilities and academic medical centers.

A number of risks loom large for healthcare providers that are less of a concern for other organizations. These risks, all of which are covered under our new policy, include:

- Failure to perform provider selection, credentialing or peer review activities.
- Defense coverage for governmental return of funds claims, triggered when reimbursements from government administered programs such as Medicare and Medicaid are subsequently called into question.
- Affirmative antitrust coverage. Antitrust laws, not always well understood by healthcare organizations, can entail severe penalties when efforts to share services or jointly negotiate better reimbursement terms are deemed to constrain competition and harm consumer interests.
- Full defense coverage for EMTALA (Emergency Medical Treatment and Active Labor Act), Excess Benefit and HIPAA (Health Insurance Portability and Accountability Act) claims.

## Beazley Breach Response brings radical change to healthcare data breach insurance market

Healthcare organizations that routinely hold and process large volumes of personal data find themselves at increasing risk of unauthorized data breaches. In response to this, Beazley has developed what we believe is the insurance market's most comprehensive solution to privacy and information exposures.

Beazley Breach Response is not simply an insurance product. It is a unique insurance, loss control and risk mitigation service tailored to the needs of healthcare organizations in the United States. The policy, written on a non-admitted basis for the account of Beazley's syndicates at Lloyd's, covers healthcare organizations including hospitals, doctors' groups and health insurers with revenues of more than US \$50 million.

Unique coverage features include breach notification and credit monitoring services for up to two million affected individuals, provided in addition to a separate coverage limit for third party claims. Breach response coverage includes:

- Notification costs;
- 3-bureau credit monitoring program from TransUnion Interactive offered to each person notified;
- Attorneys' fees and computer expert expenses of up to \$250,000; and
- Loss prevention services.

Beazley Breach Response also features low retentions – between \$10,000 and \$20,000 for attorneys' fees, computer expert expenses and notification costs, and a retention of between 100 and 250 notified individuals for credit monitoring services. A free loss prevention information service is also included with each policy.

In addition to breach response services, the policy provides a separate limit of liability of up to \$10 million in coverage for privacy, network security and internet media claims. Additional enhancements for first party and other exposures are also available.

Beazley Breach Response provides a turn-key breach response service, starting with information on avoiding losses, compliance and incident response, and if a breach occurs, providing coverage for computer security expertise to determine the extent of the data breach (how the event or events occurred and how much personal information was lost or stolen) and attorney fees to itemize the steps the insured must take under applicable breach notice laws. If notification is required, the policy also provides this service, along with the offering of a credit monitoring solution to the notified individuals. The standard policy limit includes notification for up to two million individuals.

We believe these services represent a significant advance on any comparable offering in the insurance market. Instead of including notification and credit monitoring costs – typically offered with high deductibles – within policy limits we are offering them with modest deductibles in a separate insuring agreement where their value cannot be eroded by third party claims.

## Team news

### Expanding the team

Since our last issue we have welcomed Kati Bynon to our claims team, which now comprises three former medical malpractice defense attorneys based in New York, and Greg Morris, who joined our long term care team in Chicago. In June we welcomed Tom McNally to our Chicago office to help Evan Smith with the development of our miscellaneous medical portfolio. In July Kelly Webster (also based in Chicago) and Jason Binette (based in Farmington), moved across from our management liability team to help underwrite our new healthcare management liability product.

## Upcoming events

The Healthcare team will be attending:

- **2009 PLUS International Conference**  
Chicago, November 11-13

## ASHRM 2009 Conference

Come and visit us at booth #438 to win one of three elegantly framed copies of this cartoon from *The New Yorker*.



“I don't like the look of these. I better send them up to legal.”

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