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**COVID-19's
Impact on
Medical
Professional
Liability
Litigation**

In March 2020, as the world braced itself for the unknowns of a global pandemic, the medical professional liability (MPL) industry battened down the hatches and prepared itself for the storm. Shortages of critical supplies, inadequate testing capabilities and pop-up morgues painted a frightening picture for healthcare professionals and the medical professional liability industry.

Fast forward to June 2021, and though the COVID-19 clouds still loom above the insurance industry, the anticipated storm did not make landfall. Did it go out to sea? Are we in its eye? Is it still building and intensifying? Despite our best radar, we cannot predict the forecast with pinpoint accuracy. Further, due to the long tail of our business, it may take another two to three years to experience the potential impact. What we can do, however, is analyze current trends impacting MPL as well as factors, such as legal immunity, that will contribute to potential outcomes.



COVID-19 Medical Professional Liability Lawsuits

As of May 19, 2021, the U.S. has documented millions of COVID-19 positive cases, resulting in hundreds of thousands of deaths. With the increasing perception that these deaths were preventable, comes the specter of litigation.

To date, it has been estimated that over 10,000 lawsuits have been filed, including suits against prisons, hospitals, long-term care facilities, medical providers, airlines, cruise lines and municipalities. Though only a small percentage of these are estimated to be health and medicine-related filings, the MPL cases that have been filed need to be viewed through the lens of both federal and state immunity.

Immunity Laws

At the federal level, the Public Readiness and Emergency Preparedness (PREP) Act was invoked on February 4, 2020, as the pandemic took hold in the U.S. Already in existence before the pandemic began, the PREP Act requires the secretary of the Department of Health and Human Services to issue a declaration to put its liability immunity provisions into effect. It provides immunity from liability (except for willful misconduct) for claims resulting from administration or use of covered countermeasures to diseases that present a public health emergency (e.g., COVID-19) to entities and individuals involved in deploying those countermeasures to combat that emergency.

Covered countermeasures include any approved drug, biological product, device or respiratory protective device used for COVID-19 or other harms COVID-19 may cause (including treatment and prevention). Some examples include COVID-19 tests and vaccines, therapeutics (such as hydroxychloroquine and remdesivir) and personal protective equipment (PPE). Put simply, the PREP Act declaration is specifically for the purpose of providing immunity from liability for those working to combat the pandemic.

CONTACT

To learn more about how Amwins can help you place coverage for your clients, reach out to your local Amwins broker.

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At the state level, many jurisdictions already had Good Samaritan laws in place to protect healthcare providers from liability in emergency circumstances. In addition, many states have enacted some measure of liability immunity for healthcare providers and facilities in response to the COVID-19 crisis by enacting liability protection through legislative action and/or executive order. Though the state immunities range in scope and depth of protection, they all share a common thread of providing an exception for intentional or gross misconduct.

In March 2020, New York became the first state to offer COVID-19-specific immunity to healthcare providers and facilities. Gov. Andrew Cuomo's executive order provided civil liability immunity to all physicians, physician assistants, specialist assistants, nurse practitioners, licensed registered professional nurses and licensed practical nurses for any injury or death alleged to have been sustained directly as a result of an act or omission in the course of providing medical services in support of the state's COVID-19 outbreak response, except in the case of injury or death caused by gross negligence.

Later in 2020, Cuomo signed into law the Emergency Disaster Treatment Protection Act which granted qualified immunity to hospitals, nursing homes, administrators, board members, physicians, nurses and other providers from civil and criminal liability arising from decisions, acts and omissions occurring from the start of Cuomo's March 7 emergency declaration through its expiration. It covered liability stemming from the care of individuals with COVID-19 or suspected of having COVID-19. The law also covered liability stemming from care unrelated to COVID-19, including any delay in nonessential care.

Since last year, more than half of all states have enacted some type of immunity; most have enhanced and/or extended their immunity protections in response to peaks in COVID-19 cases.

In April 2021, however, New York became the first and (thus far) only state to roll back its immunity protections when the legislature repealed the Emergency or Disaster Treatment Protection Act. The law does not explicitly address whether the repeal applies retroactively; however, standing New York case law should prevent the statute from being applied retroactively.

Application of Immunity Law

As many states were comparatively slow to enact immunity laws, early COVID-19-related claims relied upon the PREP Act for protection. To avail themselves of the PREP Act, the defense attempted removal to federal court. To date, this has received a mixed response from the federal judiciary. While some courts have allowed removal to federal court and dismissal under the PREP Act, most federal judges are trending toward remanding the case to state court to force the application of the state's immunity protection (if any).

Immunity laws will continue to be tested for their means of application and their constitutionality. For example, in a recent case, a U.S. district court judge ruled that despite an executive order providing immunity to nursing homes from COVID-19 claims, a plaintiff's suit may proceed. The plaintiff claims that the rehabilitation center knowingly exposed residents to COVID-positive employees resulting in 12 deaths in the past year. The judge cited case law asserting that "an immunity defense usually depends on





the facts of the case.” The court also stated, “There’s a difference between allowing the virus to spread by taking no preventative measures and spreading the virus while affirmatively treating it or trying to prevent spread.” The judge also opined that the families suing the nursing home “have plausibly alleged that [defendant] engaged in willful misconduct.”

With this decision, two issues have been raised:

- 1) immunity is fact-dependent (and not a given) and
- 2) willful misconduct will be applied broadly.

As litigation proceeds, we expect plaintiff expert witnesses to phrase their opinions in a way to circumvent both state and federal immunity law. This may impact coverage as willful and intentional conduct are standard policy exclusions. Even if these allegations lack merit, if they are pleaded in this fashion, coverage may be compromised.

Impact on Claim Frequency

While we may not have seen the deluge of claims some expected at the start of the pandemic, it is too early to say that the storm has passed. After an initial dip in claim activity, new claim frequency reverted to pre-pandemic levels and remains flat compared to prior years. In addition to strategic delays (e.g., plaintiff attorneys waiting to file suit until after the healthcare hero mystique is gone), we face the standard delays inherent to the MPL industry. The adverse or unexpected outcomes that form the foundation of malpractice suits may not be readily apparent. Considering that the majority of MPL claims involve a delay in diagnosis, these delays may be equal to, if not greater than, the delayed diagnosis experienced in the pre-pandemic setting.

Further, though there may be a short-term reduction in claims due to the limited number of routine check-ups, elective surgeries and screening procedures, this is not likely to be sustained. Once elective procedures and routine in-person visits resumed, providers and hospitals have faced not only the risks associated with managing the backlog but managing the risk within the context of strict COVID-19 protocols.

Adhering to these protocols, in addition to the myriad of “typical” administrative demands, places providers at an increased risk of burnout. Burnout is a major cause of medical errors, and recent studies show that U.S. healthcare providers exhibit some of the highest rates of burnout. Both the physical and psychological stresses of treating patients during a pandemic impact provider performance and outcomes. Even as increasing rates of vaccination allow for a resumption of more normal daily living, healthcare will be one of the last industries to revert to its prior norms.

Finally, we cannot underestimate the potential exposure caused by the dramatic spike in the use of telehealth. While the healthcare industry’s pivot has been truly laudable, the impact on liability of the unanticipated shift to delivering virtual healthcare remains to be seen. Did providers have the necessary follow-up mechanisms in place? Were protocols established and followed with respect to referrals and documentation? These are just a few of the unanswered questions that contribute to the uncertainty of future unanticipated medical outcomes and claims.



What's Next?

As we continue our efforts to predict (and prevent) future claims, we must also focus on identifying and responding to adversarial tactics. For example, plaintiff attorneys have countered requests for removal with requests for attorneys' fees. And while federal law permits this for "frivolous removal," no court has granted them under these circumstances to date.

Plaintiff attorneys have also been strategic with allegations in their complaints. To prevent preemption, they may "plead around" the issues related to COVID-19 (e.g., focusing on the patient's pressure ulcers to which the patient ultimately succumbed, in addition to the allegation that the ulcers were the result of a COVID-19 diagnosis).

As these issues have not been fully adjudicated through the appellate process, many plaintiff attorneys are taking a "wait and see" approach prior to filing COVID-19 or pandemic-related claims, which contributes to the uncertainty and collective unease of the healthcare community.

Partnering with a knowledgeable wholesale broker like Amwins, who specializes in healthcare placements and has deep expertise in professional liability insurance and other commercial insurance coverages, can help you navigate this space as it continues to evolve.

About the Author

This article was written by Stephanie Sheps, JD, Vice President of Claims at Coverys. Coverys is a nationally recognized medical professional liability insurer and a leader in helping the medical community address the challenges of healthcare delivery in today's rapidly changing landscape. Throughout the COVID-19 pandemic and as its impacts are felt for years to come, Coverys will continue to be an industry leader in risk management, analysis, claims acumen and litigation strategy.