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Covering Doctors' Prior Exposure Vexes Some Healthcare RRGs

A change in the U.S. healthcare landscape is causing some risk retention group members to rethink the way they provide malpractice insurance to physicians whose practices have been acquired by or affiliated with hospital systems. The problem arises during the transition, when physicians with claims-made medical professional liability (MPL) policies become employed or affiliated with a hospital that provides coverage to medical personnel through a captive RRG.

The question affects not only the physician, who becomes liable for any claims filed for events that occurred before the hospital affiliation, but also the hospital that provides his or her new MPL policy, according to Larry Smith, vice president for risk management at Maryland-based **MedStar Health** and president of **MedStar Liability Limited Insurance Co., a RRG**. Smith told a meeting of the **Captive Insurance Council of the District of Columbia** (CIC-DC) in October that the issue has become more prominent since passage of the *Patient Protection and Affordable Care Act of 2010* as hospital systems bring in more physician practices to create accountable care organizations that qualify for special shared savings and other programs under Medicare (*see RRR, October 2011*). Smith cited data indicating that by 2013 77% of all physicians will be employed by an insurance company or healthcare system.

"When the healthcare system brings these physicians on as employees, the healthcare system becomes responsible for their liability," Smith said in an interview with the *Risk Retention Reporter*. "Many healthcare systems are self-insured, and if we bring their 'tail' exposure into the self-insurance program we would find ourselves responsible for any claims that result from their . . . events that occurred before they became our employees." Until recently MedStar bought commercial "tail" insurance to cover the newly employed physician's previous exposure. However, as the pace of physician practice affiliations has picked up recently, "this tail insurance expense has caused us to experience big cost increases."

One model the company is considering is to have the MedStar RRG insure newly affiliated or employed physicians with previous claims-made policies, funding $1M per-claim coverage through the RRG and covering any excess liability in **Greenspring Financial Insurance Limited**, Inc. of Cayman, MedStar's offshore captive. This plan would give MedStar companies complete control over management of any future claims that arise, whether they involve employment-related events or prior acts, Smith explained.

The alternative to using the RRG is to use a commercial carrier for the first $1M of exposure and cover the excess risk in the captive. That way, Smith said, "I don't have to worry about the prior-act-related claims, don't have to manage these claims—I don't need to be involved." The downside to this approach is that "if the commercial carrier wants to manage a claim differently than I would, I don't have control over that claim—but I also do not have any responsibility for the outcome."

Not all big healthcare systems are approaching the issue this way. Harvard-affiliated medical institutions are handling coverage for newly affiliated physician practices on a case-by-case basis, with the physicians picking up the tab for insurance covering their previous practice, according to Garrett Parker, chief financial officer of **Controlled Risk Insurance Company of Vermont, Inc. (A RRG)** (CRICO), which covers members of **The Risk Management Foundation of the Harvard Medical Institutions, Inc.** (RMF) and their affiliated physicians.

Parker said the Harvard RRG's "new member program" includes elective "nose" coverage along with a risk management component designed to ensure that "there's some alignment with the group of physicians coming in and our organization's patient safety approach." As part of the underwriting process, the RRG requires newly affiliated physician practices to provide quotes for tail coverage from the carriers they are leaving. However, he noted that some groups coming into a Harvard medical institution still have occurrence coverage and would not need to purchase tail or nose coverage.

CRICO has criteria in place to protect itself from "adverse selection," Parker said, noting that the company requires a certain number of doctors in each practice to sign up for nose coverage through the RRG. He stressed that the program is elective, "and if they meet the underwriting criteria then they still have the option of getting coverage outside or internally. My sense is that our pricing is attractive more than half the time."

The physicians have other factors to consider in deciding how to cover their prior liabilities. For example, Parker said, "We generally write a larger limit than what

physicians have externally, so that factors into their analysis." CRICO's policies have $5M limits.

MedStar's Smith continues to look at options for covering newly affiliated physicians' prior exposures and has not decided what avenue to take. Using the commercial carriers' infrastructure, such as underwriting and customer-service functions, is attractive and would address the highly competitive nature of the MPL marketplace, which is going through a transition period as physicians go to work for healthcare systems and no longer seek coverage independently. "Now's the time to think through what this huge increase in the employment of physicians means—to establish partnerships that will allow us to utilize the best of both worlds, the commercial market and the alternative risk market. The options are multiple, and healthcare organizations that are bringing in physicians in large numbers have to think creatively."

One change is that Smith expects to pool the exposure of physicians covered by these tail policies rather than buying individual $1M or $3M policies. This transition period offers opportunities for new solutions that blend the alternative risk and commercial markets, making use of the advantages of both.

"My sense is that this is the time for the alternative market (service providers, brokers, actuaries as well as owners and operators) to really think creatively about the opportunities offered. . . . I see the RRG structure needing to be different—some kind of risk sharing with a commercial carrier, where they pick up prior acts and I pick up the current coverage, or maybe a quota-share with a commercial carrier. I don't have all the answers for what all the options are, but . . . we need to figure out what's going to be sustainable in the long run. If commercial insurers say their biggest competitors right now are the hospital systems, healthcare systems need to be changing the way they have been looking at physician risk."

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