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Healthcare Reform and its Impact on Professional Liability Coverage

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ACO: Health Care's Unicorn?

- March 23, 2010: Patient Protection and Affordable Care Act Enacted
  - Law includes a number of provisions designed to:
    - Improve the quality of Medicare services
    - Support innovation
    - Establish new payment models
    - Better align Medicare payments with provider costs
    - Strengthen Medicare's financial footing

Affordable Care Act

- Introduces Value-Based Purchasing Programs
  - Section 3022 "requires" the Secretary to establish Medicare Shared Savings Programs
    - Intended to encourage development of Accountable Care Organizations ("ACO") in Medicare
      - Better care for individuals
      - Better health for populations of people
      - Lower costs for Medicare
      - Goal: rewarding better value, outcomes and innovation instead of rewarding volume

How MSSP's Work

- ACO is formed by network of providers:
  - Work together to minimize consumption of high cost services
  - All of the savings would accrue to Medicare
  - Medicare would share "some" of the savings with the ACO
  - ACO would distribute the savings among its providers

Why Many Healthcare Organizations are Not Embracing ACO's

- CMS estimates that it will cost about $1.8M to get an ACO started: AHA pegs 1st year cost at $26M
- ACO's will not know until after the first year which beneficiaries have been assigned to it
- Beneficiaries are free to seek care outside of the ACO
- Of the 65 quality metrics originally proposed, data currently available from Medicare addresses 11
    - Final regs just released lower that to 33 quality metrics
    - Getting data will require medical record searches or other expensive methods

Why Many Healthcare Organizations are Not Embracing ACO's

- The basic premise is that the ACO will reduce costs (fixed and variable) and Medicare would "share" a portion of the cost savings
- Many providers see a system where they get to reduce their revenue base year after year in exchange for getting back a piece of what they have given up

Fee For Service (FFS) Form of Payment Can Not be Sustained

- Few incentives for providers to reduce cost and coordinate care
- Volume is rewarded
- Providers actually financially penalized if they keep patients well (nothing to bill for)
- Healthcare costs in US eroding business competitiveness in global market
- Healthcare cost = primary driver of fiscal deficits for federal, state and local governments
- Providers in FFS World facing reduction in fees
  - Physicians working longer hours

Fee For Service:

"That you should go to a surgeon with a problem with your leg – when the surgeon has a pecuniary interest in cutting off your leg – is enough to make one despair.

But more appalling – the more the mutilation, the more the mutilator is paid."

George Bernard Shaw 1906

Example: Elective Inductions Prior to 39 Weeks

- Why Bad:
  - Studies have shown increased M&M from "prematurity"
  - Where eliminated-NICU Admissions Down
- Why So Hard to Stop
  - Delivery by Convenience for Mom and Doc
  - MFM's insist that FLM tests be done on all pre-39 weekers before induction
    - FLM tests are billed for separately
    - $$$$$ Fee for Service Strikes Again

Current "Norms" In Risk Finance Programs For Hospitals And Physicians

- Since 1970's, hospitals and physicians have moved in different directions regarding medical professional liability
  - Hospitals – captives and other self-insurance programs
  - Physicians – typical commercial coverage approach via physician-owned insurers and smaller regional carriers

Current "Norms" Will Need Updating As The Healthcare Delivery Model Changes

- Current model has led to conflict between hospital and physicians
  - 50% of claims against a hospital involve one or more private practice physician
- ACOs will cause them to want to have common approach to claim liability – common bottom line
- Potential big losers will be physician-owned insurers and smaller regional physician insurance carriers

Health Systems Employing Physicians
2010s vs. 1990s
"Déjà Vu All Over Again"????

- From the physician perspective
  - Current challenges include
    - Declining reimbursements
    - Rising practice expenses
    - Increasing technology requirements
  - Advantages of employment include
    - More time for patient care
    - Less time spent on practice administration
    - Better work/life balance

Health Systems Employing Physicians
2010s vs 1990s
"Déjà Vu All Over Again"????

- From the Health System perspective
  - Offensive strategy vs. defensive strategy
  - Necessary for ACO Development
  - Specialty & Primary Care Physicians targeted
  - Gap between demand for physicians and supply is widening
    - Fewer medical school graduates
    - Aging of baby boomers
    - Deficit of 150,000+ physicians projected by 2020

The Rush to Hire Physicians

- All across the country hospital systems are employing physicians at an unprecedented rate. Impacts to be considered include
  - Financing of tail coverage
  - Increased loss exposure in hospital captives
  - Need for increased attention to underwriting by captive
  - Claim management demands
  - Adjustments to actuarial models
  - Excess market attachment points
  - Reduced commercial market share as physicians leave private practice
  - Increased focus on ART programs as hospital-owned captives grow in numbers and size

% of Physician Practices Owned by Hospitals/Health Systems

- 2005: 25%
- 2008: 50%
- 2015: ?????????

- Source: Medical Group Management Association

Changing Delivery Model Will Impact Hospital System Loss Experience In Many Ways

- Claim frequency & severity
  - Combined defendants (hospital and physician are now 1 party)
    - Previously 2 policies with separate limits
    - Potentially some offset due to joint defense
  - Potential for higher awards (and settlement expectations) against corporate entity
    - Vicarious liability
    - Perceived deeper pockets
    - Potential differences in settle vs. fight considerations
      - Physicians concerned about NPDB reporting
      - Hospitals concerned about bottom-line and reputation
  - Physicians will be providing services in different venues
    - Hospitals over which the employer has no “control”
    - New Venues: Urgent Care Centers – In the Home

Changing Delivery Model Will Impact Hospital System Loss Experience In Many Ways

- Health system capacity and flow of services
  - Increased demand for services, especially in primary care
    - Greater use of physician extenders raises training/oversight issues and possibly increased potential for missed diagnosis
  - Could see improvement in outcomes
    - Earlier intervention for previously uninsured patients
    - Possibly greater adherence to protocols by physician extenders
    - Increased incentives for patient safety due to revisions in payment (reimbursement) criteria
      - E.g, reimbursement penalties if readmission percentages are out of line

Emergence Of ACOs Will Bring Additional Impacts To System Loss Experience

- Coordinated care plans could result in further improvement in outcomes
  - Increased collaboration and coordination of treatment plans (Concept of "Patient Centered Medical Home")
  - Greater adherence to treatment protocols
    - Potential for increased exposure if protocols not followed
- Could lead to higher quality expectations and more claims if expectations not met
  - Communication lapses will be harder to defend
  - Potential greater transparency of quality data could also increase exposure
- Will need continued attention to credentialing matters
  - Should already be in place

Increased Use Of Electronic Medical Records Also Brings New Benefits, And Possibly New Challenges

- EMRs required for every patient under the Affordable Care Act
  - According to an AHA poll as of 8/2010, only 12% of AHA members were consistently using EMRs
  - Increased usage of EMRs will allow complete medical records to be transferred quickly and efficiently
  - Consistent EMR usage will also facilitate use of electronic prompts and protocols to guide practitioner towards best practices
    - Potential for increased exposure if protocols not followed
- Potential challenges include:
  - Time required for accurate input of information
  - Possibility of input/software/system errors
  - Potential discovery implications
    - Will better data lead to increased claim frequency?

Similar Concerns Exist With Other "Efficient" Health Care Models Currently Emerging

- Retail stores – i.e., medical clinics at local CVS or Target
  - Expected to grow significantly over the next 5 years
- Medical hotels – alleviate some of the overcrowding at acute care hospitals by providing alternate setting for high acuity, short stay patients at locations near acute care hospital
- Workplace based care – limited medical care at workplace site, sometimes as an extension of primary care networks
  - Coordination with hospitals and specialists
- Remote patient monitoring – better use of technology to allow patients access to quality care, without visits to offices or outpatient care facilities

Actuarial Models Will Need Various Adjustments As Physician Employment Increases

- Overall volume of medical professional liability losses covered by captives will increase
  - Will likely impact both claim frequency and claim severity
    - Separate limits of physician insurer will no longer exist
    - Some offset due to better coordination of risk management efforts
      - Possible 10%-15% differential between experience of independent vs. employed physicians
    - Overall severity may grow due to higher limits available in hospital captives vs. physicians commercial insurance
    - Differences in settle vs. fight considerations
- Actuaries will need to work closely with hospital system
  - Understand how underwriting criteria is applied to newly acquired physician exposures
  - Collaborate to develop mutually acceptable assumptions on how conflicting forces noted above will interact
    - Assumptions will potentially differ significantly by system

An Immediate Issue Concerns The Impact Of Tail Coverage For Newly Employed Physicians

- Most physicians in private practice purchase claims-made coverage
  - Therefore, coverage for prior acts (before employment) is a major issue
- Tail premium can be as much as 250% of a physician's annual premium for mature claims-made coverage
  - Neurosurgery, obstetrics/gynecology, cardiac surgery, general surgery are among the more expensive specialties
- Financing the tail premium is a major factor in the employment deal
  - Significant expense for health care system
  - Impact on fair market value for the practice
  - Impact on the physician's income from the transaction

To Tail Or Not To Tail, That Has Become The Issue!

- Malpractice insurance issues are being addressed early in practice acquisition negotiations
- Employment agreement must address:
  - Pre-employment tail liability arrangement
  - Insurance coverage during employment
  - Post employment insurance consequences
- Three basic options:
  - Purchase tail coverage from commercial carrier
    - Transfers the risk
    - Simple, but expensive
  - Arrange for prior acts coverage to be assumed by hospital captive
    - Results in the hospital system retaining the risk
    - More complicated and less expensive
    - May provide a competitive advantage in employment negotiations
  - Continue claims-made coverage and assume prior retro dates