Webinar Bonus Tracks

Holly Meidl, managing director and U.S. health care practice leader for Marsh and Larry Smith, vice president for risk management, MedStar Health and president of its captive, Greenspring Financial Insurance Ltd., Inc. were panelists in the Best's Review webinar "Workforce M.D.: How the Physician-Employment Movement Is Affecting Medical Liability Coverage." The following are responses to viewers' questions that weren't answered during the webinar.

Holly Meidl

Larry Smith

Watch the replay of the webinar at **http://www.bestreview.com/webinars/medical12**

How much does the future change if health reform completely unravels? This is not the first time we have seen attempted consolidation in the health care industry. In the late '80s and '90s firms like PhyCor were rolling up physician practices for some of the same reasons that physicians are rolling up now. Yet, this didn't work. Physicians were not happy taking orders from an administrator and a myriad of other issues caused this initiative to unravel. What is different today?

MEIDL: From my view, what is different today is that physicians are facing headwinds from four main areas that were not as much of a factor before. (1) The cost of care is higher than ever anticipated and there are no meaningful activities being done to bend the cost curve in the near or immediate term. (2) Government pay is a higher percentage of every practice and the government is moving to cut reimbursement and change the reimbursement models to be outcomes based, rather than services provided based. (3) The industry is far more regulated with more expected regulation to come and failure to comply with all of the regulations carries higher penalty amounts than ever before. (4) Technology investment is being required for reimbursement (the meaningful use standard) that requires a great deal of capital. From a business strategy perspective, these factors cause physicians to assess that going forward independently carries too much risk of financial failure.

SMITH: The forces that are causing the movement from the private practice model to the employed model for physicians are totally different than the forces that were causing health care organizations to recruit physicians in the past. Previously, such efforts were aimed at insuring that primary care physicians were in place as employees to direct the patients to the specialty care providers for whom, in a fee-for-service model, volume meant survival. This recent movement to employ physicians is being driven by health care's transformational shift from fee-for-service to population health care and wellness management. For this strategy, it will take not only primary care physicians but the specialists as well to be part of one economic family in order for population health to become a reality.

Do you have a method to address dilution of limits when hospitals employ physicians over time? I am not aware of a good way to help hospitals calculate their need for increased limits.

MEIDL: There is no set formula for determining limits based on numbers of physicians employed as it depends on the venue and specialty of the employment and a forecast of losses for the group. There are two different areas to be concerned with however – the point of the aggregate stop on the retention as well as the total limit of the tower of insurance. Typically, an aggregate stop is placed at some multiple of the forecast losses in the retained layer – usually two times the forecast. When you add a number of physicians, you would want to have an actuary forecast the expected losses in the retention, taking into consideration the venue, specialties and past loss experience of the group. Twice that forecast will tell you where the insurers will want to see the aggregate stop attachment placed. You will then need

to discuss mitigating factors with the markets about why that attachment should not be as high as they would like to place it.

On the tower limits, buying an additional $10 million or $15 million of coverage at the top of a program is very inexpensive so many hospitals look at that purchase as a safety net. At Marsh, we provide them with benchmarking data on what other like sized hospitals with similar employment profiles are buying in similar venues. That does not mean the benchmarking is the 'right' number but it helps the hospital consider the levels that might be appropriate for their organization.

SMITH: We at MedStar are working with our actuaries to address this very issue. There is no question that the current method of counting and weighing exposure units to help determine funding has to change. When physicians had their own separate liability coverage from the hospitals, it perhaps worked for hospitals to count beds and for physicians to count heads. However, in this fully integrated model of liability, the measurements of liability exposure are going to have to be reformed.

Why wouldn't new health care delivery systems consider carving out the physician liability and continue to separately insure individual physicians so the system (deep pockets) will not be exposed to such liability?

MEIDL: If the structure of the hospital integration with the physicians is one of employment, there is not a way to separate the liability of the physicians from the hospital itself as the principle of 'agency' comes into play. Even when physicians are not employed but 'appear' to have the authority of a hospital employee, such as wearing lab coats with the hospital logo or office addresses that use the hospital system name in them, the hospital can be pulled into claims under the 'apparent agency' doctrine. One way to carve out the liability is if all the physicians are employed by a stand alone organization that 'affiliates with' but is not owned by the hospital. However, this structure often does not meet the needs of the physician group and hospitals' strategic plan that prompted the integration and Stark provisions would continue to be an issue between the entities.

SMITH: There is no one right answer. Fairness dictates that you try to develop formula that allocate to each operating unit their "fair" share of liability expenses. Just by way of example, at MedStar Health each year we gather detailed exposure data for each hospital. These exposure data include patient care volumes, both inpatient and outpatient, the number of employees with direct patient care responsibility, and other information that allows us to quantify the exposure that we have as an organization. The second important data set for determining funding is an assessment of prior liabilities. Once these data are merged, we are able to establish a funding level for the organization. To determine the percentage of funding allocated to each hospital, we use a formula that is weighted 20% by the number of exposure units, and 80% by the loss experience of that hospital over the past six (rolling) policy years. We like to think that this basic formula gives credit to those who do well and responsibility for additional expense for those whose loss experience has been less than average.

Will it be possible that future policies will be primarily "assessable policies?"

MEIDL: If by 'assessable' you mean that policies would be retrospectively rated for liabilities in the current period, those types of programs already exist but are used more often in hard market cycles to keep premium outlays down and provide a measure of certainty of what premiums will be annually. In a soft market, as is the current environment, the credit for these types of programs is not as significant and clients can obtain full coverage for a fraction more in cost, without the ongoing commitment to 'true up' the programs in later years.

Are there differences in provider types between those providers who line up with facility systems and those that become part of payors? For example are surgeons, nurses, anesthetists likely to be aligned to hospitals while PCP and certain other specialties line up with payors?

MEIDL: You are correct that it is primarily the hospitals that are employing the specialists but they are actively recruiting primary care physicians along side all the payors. However, the models are morphing even now. As everyone looks to population management strategies, the need to 'fill the gaps' for the types of care givers required to serve all the needs of a group of patients makes specialists a target for payors as well. There is even the planned acquisition of the West Penn Alleghany Health System by Highmark in Pennsylvania, which is awaiting approval. In that situation, a payor is buying an entire hospital system.

What are a few examples of the negative outcomes that you would expect from this new model?

MEIDL: Acquisitions and mergers fail all the time when there are cultural differences between parties or goals are not adequately aligned. Health care is not any different. Some of the negative outcomes could be the unwinding of physician groups from hospital staffs and the impact to patients or conversely the disruption of operations when trying to integrate staffs.

SMITH: On one level, it is sad to see the private practice model represented by the hardworking entrepreneurial physician going away. As physicians, along with all other health care providers, become employees, we will begin to see pressures within health care organizations to address the concerns of a new population of employees. Many of the policies and procedures that apply to current population of health care employees will not meet the needs of this new diverse population of employees. Salary, fringe benefits and retirement programs will all have to be redesigned. Culture trumps strategy every single time. Perhaps the biggest risk will come as a result of our attempts to merge the entrepreneurial culture of the private practice model with the business model culture that exists in most health care organizations.

Do you expect that a sizable percentage of current MPLI carriers will disappear? When systems begin to realize they have made unprofitable choices, i.e., physician employment, how/when will they begin divesting providers? Or, what happens when docs realize they've made a mistake and want out? What then?

MEIDL: To answer the first question, I would expect that a sizable percentage of current MPLI carriers that focus only on physician MPLI, will be challenged significantly over the next few years. Will they disappear? I don't expect that but I do expect a corresponding uptick in mergers and acquisitions of these insurers just as any other industry experiences in shrinking markets.

To the second question, I know history tells us we have been down this road before with employment of physicians and then systems did move away from those models.

If docs are paying for their $1 million/$3 million coverage, where will the broker fit in? And what kinds of insurance options (company choice) will they have?

MEIDL: When physicians continue to buy insurance coverage in the open market, and they are employed by a health system or payor, it is up to the employer to decide if they want each physician to secure their own coverage with agents or brokers or if they want to control the purchasing for the group as a whole. The later scenario is the norm and the broker is engaged by the employer to set up appropriate program structures that best fit the goals of their organization.

One of the examples discussed in the webex was a separate contracted program with a single insurer that the hospital system arranges for the physician groups with pre-negotiated rates, credits and contract terms. In that situation, the physician would not have an outside choice to obtain coverage elsewhere and the broker for the hospital system would be handling all the administration of the transactions. BR