

EMPLOYING PHYSICIANS: INSURANCE DUE DILIGENCE

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One of the most dramatic shifts in the health care delivery system in the last several years is occurring in the relationship that physicians have with other physicians and with hospitals. Three factors increasingly prevalent throughout the health care industry are influencing this shift.

- Physicians are electing employment rather than solo practice
- Hospitals are electing to align with their physicians in strategic practice areas through employment
- Physician practice groups are merging or acquiring to form “super practices” in order to form accountable care organizations (ACOs)

The emphasis on ACOs contained in The Patient Protection and Affordable Care Act (PPACA) and The Health Care & Education Reconciliation Act (HCERA) of 2010 has accelerated the trend toward integration of physicians into larger and more powerful practices able to handle the needs of a diverse population and more fully integrated hospital-led delivery systems.

One key risk area arises in all of these scenarios – the extended reporting provision (ERP), related to the physician’s practice of medicine prior to becoming employed, otherwise known as the tail. The discussion of how to finance a physician’s prior liability typically arises at the end of the negotiations. The physician requests that the employing entity – either a hospital or larger practice – pay for the tail for the physician’s previous coverage. Tail coverage or ERP may be expensive, and physicians often have not accrued sufficient funds or do not have available cash to handle the expense.



However, a broader issue should be addressed – not at the end of the process but at the beginning. The continuing liability of the physician for his/her activities prior to the merger, acquisition or employment needs to be assessed as well as how these liabilities are to be financed and by whom. Whatever the expense calculation, it must be added to the overall cost/benefit analysis of hiring a particular physician.

ADDRESS THE ISSUE EARLY IN THE NEGOTIATIONS

The physician’s continuing liability for his/her prior activity is a risk that the employing or acquiring hospital or practice must face, because it may well affect the hospital or practice’s insurance or risk financing program going forward. In many cases the potential cost of financing the liability for prior acts is not considered until the end of otherwise successful negotiations and frequently arises only when a physician insists that the acquiring or hiring practice or hospital “pay for the tail.”

The purchase of an ERP, or tail, from the physician's current insurer and which party pays are not the only considerations or the only risk financing options. Additional information must be obtained and evaluated to determine if purchasing a tail is necessary and the most cost-effective risk financing solution. A well qualified insurance broker is the most appropriate professional to assist in the evaluation. They will have information on the current and past insurance marketplace and typical physician loss experience that most law firms do not have readily available.

PERSONAL LIABILITY

In most jurisdictions, physicians and other medical professionals are personally responsible for their professional acts (this applies not only to physicians but to all professionals), and forming or dissolving a corporation does not relieve the physician of his/her professional responsibility. It merely adds an additional layer of responsibility (i.e., the vicarious liability of the corporation for the acts of the employed physicians). Therefore, a physician cannot merely walk away from his/her prior acts or errors. The liability will continue to exist.

DETERMINING THE EXTENT OF THE PRIOR LIABILITY

The only way to determine the extent of a physician's liability for his/her prior acts is to review the physician's practice history. Key factors in determining the full value of the future liability for prior years are:

- How long has he/she been in practice? If a physician has a long and illustrious career, the extent of the information required will be much more than for a physician just starting his/her practice.
- What is his or her specialty and has it changed? The claims for several physician specialties routinely have a long lag time between the incidents and their discovery. Obstetrics and pediatrics head the list. However, even family practice physicians can have suits alleging failure to diagnose brought against them years after they last saw a patient.
- Where has the physician practiced? Each state has separate and substantially different laws on when a malpractice claim may be brought against a physician (the statute of limitations). In most states the statute of limitations is two to three years. However, statutes vary considerably and do not generally begin to run until the injury is discovered.
- In addition, several states have enacted tort reform that caps some or all of the physician's malpractice exposure, or they may have patient compensation funds available to limit the amount or type of insurance coverage a physician needs to purchase.
- On the opposite end of the spectrum are physicians who have practiced in the "judicial hell holes," i.e., states or specific counties within several states that have particularly litigious environments or a history of high jury verdicts.
- What claims have been made against the physician in the past and are there any ongoing claims?

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- Was the insurance sufficient to provide adequate coverage for the claims?

ENSURING THERE IS INSURANCE COVERAGE IN PLACE

One of the first steps in the due diligence process is to determine what type of coverage the physician currently purchases. This can only be done by obtaining the entire policy, not merely the declarations (face) page or a certificate and having a knowledgeable insurance professional review it.

Once the physician's practice history and specialty are established, an effort should be made to determine what malpractice insurance was in place throughout the physician's history. This process can be shortened significantly if the physician currently has a claims-made policy in force and the retroactive date is the date the physician left his/her residency program.

There are three types of insurance policies for physician's medical malpractice: 1) occurrence, 2) claims-made and 3) claims-made and reported. Each responds differently to a claim based on how the coverage is invoked or triggered. Below is a brief description of their respective responses.

OCCURRENCE

Policies written on an occurrence basis are triggered by the date on which the medical incident or error happened. If a surgeon left a foreign object in the patient during a procedure, the date the procedure was performed determines the coverage. It does not matter that the injury may not be discovered or the claim may not be made or the suit brought until years later. The policy in effect on the date of the surgery is the one that provides coverage.

Although policies with an occurrence coverage trigger provide the certainty of taking care of all future claims for incidents that happened within the year, they also have some distinct disadvantages:

- They are more expensive during the first several years coverage is in force.
- There are situations when the date of an error is not easy to determine. For example, if a physician has a long-standing relationship with a patient, it is often impossible to determine when exactly he/she failed to diagnose the patient's cancer.
- The limits purchased for an occurrence policy may not be sufficient to cover a suit that is brought years or even decades later under a different legal climate.

A hidden disadvantage to policies with an occurrence coverage trigger is the extent of due diligence required when employing a physician or acquiring a practice.

Since the policies apply to only those medical incidents that occur during the year the policy was in force, performing adequate due diligence requires that the acquiring or employing entity determine that coverage was in force for every year that the physician was in practice. For a physician who has been in practice for many years, this can be a daunting task and records simply may not exist. Even if the records still exist, the insurer or insurance program providing the coverage may not (see discussion below).

Although a few insurers continue to provide malpractice insurance with an occurrence coverage trigger, most have moved away from this model because it is impossible to determine the costs of claims until years after they have collected their premium and, therefore, it is difficult to promulgate adequate rates.

CLAIMS-MADE

When a claims-made coverage trigger is used, the policy in force at the time the claim is made or suit is brought is the policy applicable to the incident. The incident must occur on or after a specified date (the retroactive date). Claims that occur prior to the retroactive date are excluded. However, any incident which occurs on or after the retroactive date and prior to the end of the policy will be covered if a demand is made or suit is brought prior to the end of the policy term (subject, of course, to the policy's exclusions and other terms and conditions). The incident does not have to be reported to the insurer within the policy term.

Not only does claims-made coverage make it easier to pinpoint the policy that applies, but it also allows insurers to determine their claim obligations more quickly and develop adequate rates, which tends to stabilize the insurance marketplace.



CLAIMS-MADE AND REPORTED

A policy with a claims-made and reported coverage trigger is very similar to a pure claims-made policy. The policy provides coverage for any incident that occurs between the retroactive date and the end of the policy term if the claim is made during the policy term. However, they impose the additional requirement that a claim must also be reported to an insurer during the policy's term. Some policies provide a 30 or 60-day grace period after the policy expires to report claims made at the end of the policy term.

Although all claims-made policies address the issue of liabilities arising from prior activities at least back to their retroactive date, they do so only if the claim is made within their policy term. Any claim that is brought after their coverage expires will not be insured. Some claims-made policies, however, do provide an incident reporting trigger which allows the physician to report medical incidents that may give rise to a claim in the future. These policies may also exclude coverage for medical incidents known at the time that the coverage is placed; i.e., the policy's effective date.

If a claims-made policy is not renewed or is cancelled, there is a significant exposure for medical incidents which have already occurred but for which no claim has been made or suit yet filed. In order for the policy to continue to apply to these incidents, an ERP, or tail, must be purchased. Most insurers place a limit on the time in which a tail must be elected and the additional premium paid. Usually this is 30 days, with a few insurers allowing up to 60 days. Prompt action must be taken if a tail or ERP is to be purchased.

If the coverage is on an occurrence basis, the good news is that it will probably not be necessary to purchase a tail or ERP. However, the bad news is that the due diligence process may be more extensive.

If the physician's coverage is on a claims-made basis, a decision will have to be made regarding the most effective way to finance the incurred but not reported medical incidents. Purchasing a tail or ERP from the physician's current insurer may not be the only way to finance the exposure.

PRIOR INSURANCE COVERAGE CONSIDERATIONS

- Did the coverage contain a claims-made or occurrence trigger? If coverage was written with an occurrence trigger it is important to document coverage for all policy terms back to the beginning of the physician's career or at least through the period when a claim may foreseeably be made within the statute of limitations.

This may also be necessary if at any time during the physician's career he/she changed insurers. Was a tail purchased? Was the prior retroactive date assumed by the new insurer?

- Was the coverage written as part of a program in place for a larger practice or a hospital?

If so, was the coverage written through a captive insurance company or risk retention group? A well-structured captive or risk retention group can provide an excellent risk financing vehicle for large practices or hospitals. However, a poorly funded and/or inadequately reinsured captive or risk retention group may offer little or no protection to, not only its members, but those who have left the group.

Raise a red flag if coverage was purchased through a hospital or prior practice's captive or risk retention group and the hospital or practice is no longer in business or was acquired. Make an effort to determine what happened to the tail coverage for the entity.

Hospital or practice bankruptcies pose a particular problem and there have been several well publicized examples of hospitals that financed their risks through a captive and have filed for protection under the bankruptcy laws. The financial difficulties of a bankrupt hospital may have resulted in inadequate funding for the captive. In many instances entities in financial trouble have also reduced or declined to purchase reinsurance in an effort to reduce their costs.

In addition, give thought to whether the physician had separate limits that applied to him/her or shared in the limits available to the entire group. If shared limits were utilized for the group, the coverage may be reduced or even exhausted by claims made against other members of the group, leaving the physician you are considering for employment with little or no coverage for that period of time.

- If commercial insurance was purchased, are prior insurers still in business and financially sound? During the Millennium Malpractice Crises of 2000-2003, 23 insurers who specialized in underwriting professional liability for the health care industry became insolvent, withdrew from underwriting medical professional liability or had their ratings downgraded. Those that survived have in most cases recovered. However, a number of insurers did not survive. If past coverage was underwritten on an occurrence basis or a tail purchased from an insolvent insurer, the physician will have no coverage for the past period.

Some coverage may be available from state guarantee funds, but such coverage is extremely limited, if available at all.

NOTE: Many of the insurers that did not survive provided malpractice coverage on an occurrence basis.

FINANCING THE PRIOR LIABILITIES

Once the extent of the potential prior liabilities has been determined, the employing hospital or practice will need to determine the most effective method of financing the risks. The method used will be determined by what liabilities are disclosed through the due diligence process and the extent of those liabilities.

Some but not all risks may be cost-effectively insurable in the commercial insurance marketplace. Purchasing an extended reporting endorsement or tail from the physician's current insurer is one but not the only option.

- **Purchase an extended reporting endorsement or tail from the physician's current insurer.** This is the first option that most physicians and their potential employers consider. However, consider these potential problems.
 - A tail may not be available. A few insurers of medical malpractice coverage allow their insureds to purchase a tail **only** if the insurer cancels or non-renews the policy or if the physician retires or becomes disabled. This is known as a unilateral election provision and, although rare, a few insurers still use it. Therefore, the ability to purchase a tail should be reviewed, which is only possible if the entire policy (not merely the declarations page or a certificate) is available.



- Does the policy contain an incident reporting trigger which allows the physician to report known incidents that may give rise to a claim in the future? If so, the physician should report all such incidents prior to the coverage being cancelled.
- The duration of the available tail. A few insurers allow physicians to purchase an extended reporting endorsement that provides only a one, two or three-year period in which to report claims. This is simply not sufficient if the physician's practice includes exposures that may not be known for many years, as in the case of a pediatric practice. A tail should be sought that is unlimited in duration.
- The cost of the tail. The industry rule of thumb is that a tail that is unlimited in duration should not cost more than 200% of the last annual premium.

The downside to purchasing a tail from the physician's current insurer is that, if it is available and the duration is sufficient, it may be expensive and require an immediate cash outlay. The time for payment of the premium for the tail is specified in the policy but is usually 30 days. A very few insurers allow the tail to be paid in annual installments.

However, another consideration is equally important. Is the current insurer financially viable and likely to be available to pay claims for an indefinite period of time in the future?

- **Explore the option of whether a tail is available without additional cost to the physician; i.e. a "free tail."** Some insurers allow the physician to elect a tail if the physician has been continuously insured with them for a period of five or more years. However, this option is generally available only if the physician is retiring from the practice of medicine or becomes disabled. It will not be an option in most cases, but the possibility should be reviewed.

Once the extent of the potential prior liabilities has been determined, the employing hospital or practice will need to determine the most effective method of financing the risks. The method used will be determined by what liabilities are disclosed through the due diligence process and the extent of those liabilities.

- **Purchase a tail from a new insurer.** In the current soft insurance marketplace, options are available to purchase tail coverage from insurers other than the one that currently writes the coverage. However, such options are generally available only if there is a large premium available to entice the insurer and if the loss information is well documented.
- **Continue coverage with the same retroactive date.** The employing hospital or practice can elect to assume the risk. This can be accomplished with either the physician's current insurer or with a new insurer selected by the employing hospital or practice which may include the hospital's own captive or risk retention group.

However, this option poses a serious hazard. The limits available to the physician may be exhausted by claims arising from medical incidents occurring prior to the physician's employment with the hospital or practice. This would leave no coverage available to the physician for his/her activities on behalf of the employing entity. The hospital or practice would end up paying for coverage but may have no coverage available. This can be particularly problematic for physicians practicing in specialties that typically give rise to severe, high-valued suits, such as spinal surgery or obstetrics.

The worst case occurs if the physician is brought into the employing hospital or practice's captive or risk retention group without separate segregated limits for the tail. The entire available limit of the captive or risk retention group may be exhausted by claims that had nothing to do with the medical care rendered by the hospital or practice.

At a minimum, if the physician's exposure for his/her prior acts is assumed by the hospital's practice or other risk financing arrangement, a limit should be placed on this exposure to avoid depleting or exhausting the entire limits available for the hospital or practice.

We also advise consulting with reinsurers or excess insurers on their willingness to assume this risk.

SUMMARY

Malpractice insurance is a critical portion of the due diligence process when employing physicians or acquiring their practices. Important steps in the process:

- Begin the insurance portion early in the due diligence process. Do not wait until all other negotiations have been completed.

- Obtain the information necessary to adequately access the risk for the physician's prior acts. This should include:

- **A complete history of the physician's practice including:**

- ◆ The states in which the physician practiced
- ◆ His/her specialty

The physician may have moved or changed his/her specialty over the years. A complete history is needed to evaluate the extent of their exposure for prior incidents and is particularly important if the physician previously engaged in more hazardous activities. For example, many physicians stopped performing obstetrical procedures because of potential or actual claims or the unavailability or cost of malpractice coverage. In addition, many physicians left their practices in states with problematic legal climates.

The physician's prior activities may pose exposures that are very different from their current practice.

- **A complete copy of the current policy.** Do not settle for a copy of the declarations (face) page or a certificate. A complete policy copy is necessary to determine whether tail coverage is available as well as any situations in which coverage may be excluded.
- **A list of the physician's prior insurers and the limits he/she purchased.** Information for at least the last 10 years (or longer for higher risk specialties) should be requested.

- **Complete loss history for at least the past 10 years.** Don't be afraid to use the physician's ability or willingness to provide insurance information as a litmus test of his/her ability to maintain adequate records. For many physicians, malpractice insurance is one of the largest expenses for their practice. If a physician has not kept adequate insurance records, is he/she likely to maintain well documented medical records?

■ **Seek advice from a knowledgeable insurance professional on the insurance portion of the due diligence process.** They will be able to:

- Review the coverage to determine the availability of the tail and potential options for purchasing the coverage commercially
- Have information available on typical malpractice claim patterns for various physician specialties
- Provide insight into the financial viability of past and current insurers

Within the insurance portion of the due diligence process a knowledgeable insurance professional can provide more in-depth information and assistance more quickly than the attorneys used for other aspects of the transaction.

Finally, whether or not a hospital or practice decides to employ a particular physician is a business decision that should be based upon the advantages that a physician brings to the hospital or practice weighed against the risks. The due diligence process and particularly the insurance portion of that process should be utilized to determine what risks exist and whether financing vehicles are available to mitigate them. Ultimately the risks may be so severe that the physician may not be employable or could possibly negatively impact the overall branding of the organization in the future. In most situations, that will not be the case. No matter what the hiring outcome is, the insurance due diligence will result in an informed decision-making process.

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