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PHYSICIAN LIABILITY RISK FINANCING IN THE POST-HEALTH CARE REFORM WORLD

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INTRODUCTION

This summer's U.S. Supreme Court decision[1] upholding the major provisions of the Patient Protection and Affordable Care Act (PPACA) and, more recently, the re-election of President Barack Obama, taken together make it clear that health care reform is here to stay for the foreseeable future. *(Note: Current references to the federal law are generally abbreviated to ACA.)* Since the President's signing of the legislation early in 2010, and even earlier, the health insurance industry has been moving apace to reshape its provider alignment and payment models. Thus we expect to see the emergence of commercial models along the lines of accountable care organizations (ACOs), essentially running on parallel tracks to the federally legislated ACOs applicable to government funded programs for Medicare and Medicaid. In short, a new world of provider alignment and payment is upon us, which creates profound implications for physicians and the entities that will bear the liability risk for physicians' activities in the future.

IMPACT OF PROVIDER/PHYSICIAN RE-ALIGNMENT ON LIABILITY RISK FINANCING

Insuring (or otherwise financing) physician liability risk used to be a fairly straightforward proposition. The majority of physicians were private practitioners, either in solo practice or with physician groups. Solo practitioners and small groups typically bought professional liability insurance from the ground up, bearing no risk themselves, while larger groups might venture into alternative risk financing via

deductibles or self-insured retentions, or, for very large and well-funded groups, by participating in or creating captive insurance companies or risk retention groups.

The individual physician's relationship with a hospital was usually as an independent contractor granted privileges (legally, the concept of a "license") to admit and treat the physician's patients in that facility. The hospital was and is legally responsible for the conduct of its nurses and other employees, but, barring certain recognized legal exceptions, the hospital was not legally responsible for the conduct of independent physicians. Hospitals as a matter of prudence would and still do set minimum requirements for physicians to carry professional liability insurance as part of the hospital's credentialing process, but the hospital did not purchase insurance or otherwise fund liability risk for physicians.

Direct employment of physicians by hospitals or integrated health systems today is fairly common and is, in fact, a rapidly accelerating trend. This trend includes both the hiring of individual physicians – generally in areas of need for the hospital (hospitalists, for instance) – and the acquisition of medical group practices as part of a health system's strategy to add sources of revenue and patient referrals within the integrated system.*

A significant majority of hospital systems expects to employ more physicians and to acquire medical groups over the next 12 months. **(See Figure 1.)** Further, direct physician employment covers a range of specialties from primary care to surgical and other interventional specialties, e.g. cardiology. **(See Figure 2.)**

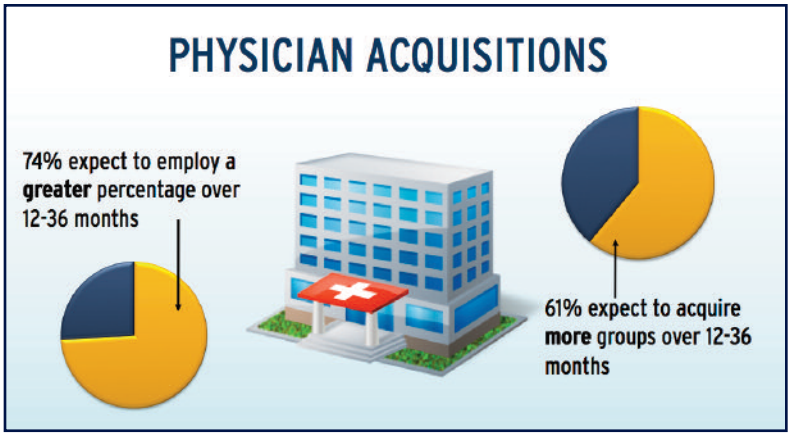

Figure 1

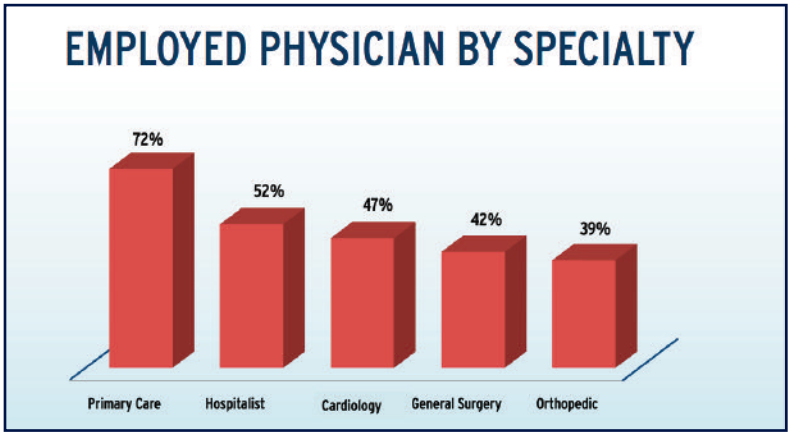

Figure 2

** Three separate federal provisions, together called 'StarkLaw,' govern physician self-referral for Medicare and Medicaid patients.*

A wave of physician practice acquisitions by hospitals 15 to 20 years ago proved financially disadvantageous for many hospitals. By 1998 the Office of Inspector General (OIG) of HHS estimated that 62% of all for-profit and not-for-profit hospitals owned physician practices.[2] During this era, according to OIG, one of the major reasons hospitals purchased physician practices was to establish physician networks to compete with managed care products offered by insurance companies.[3] Unfortunately, many hospitals proved not adept at fairly valuing physician practices and significantly overpaid for these acquisitions. At the same time, physicians who were used to practicing independently did not, in many instances, adjust to working within a hospital or health system's more regimented structure and productivity substantially eroded. The acquisition trend was reversed to a large degree early in this decade, and many previously acquired practices were divested.

The difference now is that the ACA is designed to, among other features, promote collaboration among networks of providers with respect to the transformation of payment models and care delivery. The years between 2011 and 2015 are particularly important within the transformation timeline, as illustrated by The Commonwealth Fund below.[4]

TIMELINE FOR PAYMENT AND SYSTEM INNOVATION

2010	2011	2012	2013	2014	2015
Productivity Improvement	10% Medicare Primary Care Increase	Medicare Shared Savings (ACOs)	National Medicare Payment Bundling Pilot	Independent Payment Advisory Board (IPAB)	Value-based Purchasing for Physicians
Patient-Centered Outcomes Research	Innovation Center (CMMI)	Pioneer ACOs	Medicaid Primary Care up to Medicare Levels		Reduce Payment for Hospital Acquired Infections
	All-Payer Demos and Health Innovation Zones	Bundled Payment for Care Improvement Initiative			
	Physician Group Practice Transition Demonstration	Value-based Purchasing for Hospitals			
		Improve Physician Feedback			
		Reduce Payment for Preventable Readmissions			

Thus, interest in health system physician employment and acquisition of physician practices has been rekindled. Notably, with the advent of accountable care organizations under the ACA, physicians will be employed and engage in a variety of collaborations not previously contemplated. Physicians may contract with ACOs as providers, they may be employed by health systems establishing ACOs, or they may themselves be engaged in the creation of and directly employed by ACOs or other entities. We have recently observed medical services organizations (MSOs) being formed with private capital to contract with physician practices to provide an array of practice management services, such as staffing, billing, credentialing and contracting with payers. In some instances the end game of the business model is for the MSO entity to create or evolve into an ACO itself.

What do we make of physician liability in the post-reform world?

EXPANDING THEORIES OF LIABILITY CREATE ADDITIONAL RISK

The situation with respect to the liability for the acts of physicians is fluid and volatile within the process of transformation. ACOs, for instance, under the ACA, are distinct legal entities. The legal responsibility that ACOs and other entities contracting with or employing physicians bear for the acts of physicians will likely evolve over time. Insuring (or financing risk via alternative vehicles) physician liability is bound to be more challenging in this environment. Legal theories of vicarious liability, such as ostensible agency and *respondeat superior* are likely to be tested as well.

Various state tort claim limitations, such as caps on non-economic damages, will be challenged as to their applicability to various entities that effectively control physicians, where these entities themselves do not fall within the definition of "health care provider." For its part, the most the federal government has offered to date to help clarify this muddy water and set some parameters around tort liability is a study project, the details of which are yet to be developed.

The legacy liability represented by claim "tails" for professional liability claims arising from prior acts of acquired physician groups is a significant risk financing consideration and an important area of negotiation for both acquiring entities and physician practices seeking to be acquired. Questions must be addressed, such as: Whose responsibility is it to provide tail coverage? How will the cost be determined? Who will pay for the coverage? Are there tax implications to any proposed solution? Further, entity liability with respect to activities such as credentialing, peer review, managed care contracting, coding and billing, etc. must be evaluated anew as the transformation process unfolds.

Also, pre-loss, clinical risk management is an important component of the overall equation. Financial success under any ACO model, whether of the federally legislated variety or as a "virtual" ACO contracting with commercial payers, will be increasingly quality driven as time goes by. The development of protocols relating to reducing physician risk and improving patient safety, and the cost of implementing and maintaining quality-focused programs are key considerations impacting liability.

THE ROLE OF INSURANCE

Traditional physician liability insurers, hospital/health system liability insurers and managed care organization liability insurers, as well as reinsurers are all working to understand the evolving physician liability landscape. How will insurers address not only the direct liability of physicians as health care providers but also the liabilities arising from an array of contractual requirements that are likely to be complex? For example, liability insurers have taken varying positions with respect to exclusions relating to contractual liability, medical director liability, credentialing/peer review and other committee service liability.

A range of proposed commercial market solutions will emerge, but any sort of one-size-fits-all set of solutions will likely prove unsatisfactory. Alternative risk financing structures, such as self-funded trusts, single parent captives, risk retention groups and segregated portfolio companies come with their individual sets of perceived advantages and challenges. The uncertain liability issues in the post-reform era may transcend the liability concerns addressed by previous approaches to physician channeling programs utilized by health systems seeking to finance physician risks in the past.

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Further, with respect to alternative risk financing structures, such as captives, in most instances risks that a captive seeks to underwrite will still have to be reinsured at some level, meaning that the attendant risks will have to be understood and deemed acceptable to commercial reinsurers. Obviously, health systems and other entities financially positioned to retain substantial levels of risk will have more leverage in negotiating risk transfer solutions. But start-up entities of various natures may not be well enough capitalized at the outset to effectively employ alternative risk financing strategies.

A thorough understanding and clear articulation of any proposed physician alignment business model will be necessary for a health care entity to assess its risk and develop optimum risk financing solutions. We think it is important for this understanding to be developed as part of the planning process for any particular entity, with the organization's risk management team fully engaged.

CONCLUSION

Physician alignment models are in a significant state of transition, largely as a result of health care delivery transformation under both the ACA and commercial payer restructuring. A prudent director of risk management or chief risk officer will recognize that organizational risk relating to relationships with physicians is likely to be increased. The increased risk arising from physician liability has a material influence on the cost of risk financing, whether with commercial liability insurers or in a self-funded risk financing vehicle, such as a captive insurance company. Whether serving on behalf of a hospital or health system employing (or contemplating employing) physicians, a medical practice group, or, potentially, an ACO, financial risk managers are well advised to thoughtfully evaluate:

- The terms of any contracts speaking to indemnification, hold harmless and requirements to maintain insurance for physician liability
- The physician's legal status within the contemplated delivery model, whether direct employment, contracted service provider, equity participant, or other
- The impact of increased physician risk on the cost of primary and excess liability insurance and reinsurance
- Legacy claim exposure arising from a physician or practice group's prior acts
- Increased demands on internal clinical risk and claim management staff

In short, a thorough risk assessment around the liability issues associated with physicians in any particular integration model will make for informed decision making as to the preferred risk financing alternative.

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The observations, comments and suggestions we have made in this report are advisory and are not intended nor should they be taken as medical/legal advice. Please contact your own medical/legal adviser for an analysis of your specific facts and circumstances.

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[1] *National Federation of Independent Business v. Sebellius,* 132 S. Ct. 2566. The case was heard together with Florida v. Department of Health and Human Services.

[2] U.S. Department of Health and Human Services. OIG, Hospital Ownership of Physician Practices. **http://oig.hhs.gov/oei/reports-and-publications/oei-05-98-00110; 9/99pdf.**

[3] Ibid.

[4] *How Payment Reforms Can Help Achieve a High Performance Health System,* K. Davis, The Commonwealth Fund, presentation to Second National ACO Congress, 11/1/2011.