

**Identifying and Pricing Managed Care
Errors and Omissions Exposures**

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Biography

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Acknowledgments

We would like to thank Clive Keatinge for his review and pertinent criticisms of our initial draft of this paper.

ABSTRACT

In response to increasing healthcare costs and threats from the public sector to play a larger role in the delivery of healthcare products, the private sector has worked frantically to provide more efficient healthcare services. As a result, managed care continues to grow in appeal and scope. The organizations participating in the managed care process come in many forms, entering and exiting at various points in the delivery process. The emergence of these diverse managed care organizations (MCOs) has led to an increase in the requests for insurance covering their Errors and Omissions (E&O) exposures.

The demand for a product that is current and complete has fallen specifically on two types of insurance underwriters: medical malpractice specialists and D&O/E&O specialists. The lack of a definitive source for insurance protection is a reflection of the blended exposures of managed care organizations. This void in comprehensive expertise has led to myriad products and perhaps an even greater number of pricing approaches.

The primary cause of the varied industry approaches to pricing managed care E&O is that there are two distinct underlying types of covered actions: claims alleging bodily injury and claims alleging economic loss. Our analysis shows that it is difficult to price E&O coverage for managed care organizations accurately and consistently without a rating program that accounts for both of these causes of action.

This paper is divided into seven sections. The first section serves as an introduction to the history of managed care. The second section describes the different types of managed care organizations and where they tend to fit into the delivery process. The next section discusses the need to distinguish between economic loss and bodily injury damages and how they tend to interface with D&O, E&O and medical malpractice policies. Section four outlines exposures of managed care organizations, focusing on those

that would typically be covered specifically by an E&O policy. A review of existing pricing frameworks in the marketplace is provided by section five. The sixth section provides suggested criteria for pricing including exposure units and underwriting criteria. The final section outlines our conclusion.

I. INTRODUCTION

Healthcare expenditures in the United States rose to nearly \$1 trillion in 1995, up 5.5% from the previous year.¹ This equates to nearly \$4,000 per person. Although the rate of growth of healthcare expenses has slowed, it continues to outpace the rate of growth of the overall economy, and, as of 1994, it comprised 13.9% of the nation's gross domestic product (GDP). As a measure of comparison, Canada spent 10.3% of GDP on healthcare, Germany spent 8.7%, the United Kingdom 7.1% and Japan 6.9%.²

The Impetus for Innovation

Most Americans receive healthcare coverage through their employers. This phenomenon has slowly developed during this century starting in the early 1940s when companies were limited as to what they could pay employees during war-time. As a fringe benefit, many employers arranged to provide for healthcare. This type of compensation became increasingly popular as years went by, exploding in the early 1970s when the Nixon administration put wage and price controls in place. This circuitous method of providing healthcare benefits has distorted both the distribution and purchasing of healthcare because, in many instances, the user of the services is not the true buyer of the coverage.

As healthcare costs increased, they became an alarmingly large percentage of a corporation's compensation expense. Companies, acutely aware of the inefficiencies of the existing arrangement for medical care, looked for a better way to manage such costs. This search ultimately led to the "managed care" concept that Kaiser Permanente pioneered in the 1940s. At America's entry into World War II, tens of thousands of inexperienced workers, many in poor health, poured into the Kaiser Shipyards in Richmond, California to build the nation's Liberty Ships and aircraft carriers. Faced with the problem of providing healthcare to 30,000 employees, Kaiser developed a pre-paid group health practice for the workers in the shipyards. This healthcare delivery model emphasized preventive medicine, health maintenance and screening for early detection and treatment of ailments of all kinds. The success of this

experiment, lead Kaiser to open the Permanente Health Plan officially to the public in 1945. Today, Kaiser remains one of the largest managed care systems, operating in over 20 states and offering services to other companies.

A Shift In Focus

The success of Kaiser Permanente, rising corporate cost pressures and government limitations on Medicare / Medicaid fee and reimbursements combined to spur demand for additional managed care alternatives. However, continued interaction between business decisions and healthcare choice has raised the age-old cost-benefit analysis to a new height. Managed care organizations are trying to prioritize and price a service that generally has inelastic demand. This trend toward "value-based" healthcare and the colliding of payer and provider has increased the liability exposures of many healthcare organizations. Certain types of healthcare companies that previously were insulated from the bodily injury exposure that dominates the physician and hospital world may now have larger liability for these acts as they control when and how healthcare will be provided. Conversely, hospitals and doctors, who may have previously run nonprofit or sole-proprietor businesses, are now joined in economic competition, as they form and operate for-profit businesses, often answering to shareholders.

Thus, the priorities of healthcare providers are different today than they were 10 years ago. Healthcare institutions have moved from a patient focused organization that emphasized the *quality* of care to a customer focused business that emphasizes the *value* of healthcare. The result has been a movement away from a practice that has pure medical malpractice risk to an integration of practices that includes a significant element of operations risk as well. Financiers interact with administrators who interact with physicians. This can occur within one entity or several independent organizations. This integration of operations, whether through ownership or contracts, has caused the bodily injury exposure to permeate all MCOs rather than remaining concentrated in entities that have substantial control over the healthcare provider. This wider bodily injury exposure combined with a business attitude that focuses on bottom line results has produced complex liability issues that the insurance community is striving to address.

II. TYPES OF MANAGED CARE ORGANIZATIONS

There are so many types of organizations in the managed care arena that it is nearly impossible to define them on a broad basis. Each organization will have unique characteristics, with new ideas and approaches being developed as the healthcare delivery system continues to evolve. Traditionally, underwriters and the medical community have divided the organizations on the following basis:

Health Maintenance Organizations (HMOs)

HMOs basically provide for the financing and delivery of comprehensive services to enrollees for a prepaid fee. Thus, HMOs and their contracted affiliated providers bear all or most of the financial risk that the cost of services will be more than revenue received. The three most common types of HMOs are as follows:

1. *Staff Model* - This model has physicians as employees who are paid a salary and provide care exclusively to HMO enrollees at an HMO owned and/or operated site. Staff models are estimated to account for 10% of HMOs.
2. *Group or Network Model* - This type of HMO contracts with groups of independent physicians under a capitated or fee-for-service basis. Capitation means that the physicians agree to provide certain services to the HMO for a fixed payment, which is typically calculated on a per member basis. If the physician or the physician organization provides these services for less than the preset amount, it keeps all or a portion of the balance. If the physician organization spends more than the capitated payments received, then the physician usually suffers the financial loss. Sometimes the physicians or their organization will agree to provide services on a discounted fee-for-service basis, which would not have a cap on the total amount of fees collected from the HMO.

Group or Network model HMOs usually require physicians to devote a specified amount of time to its own enrollees. Physicians may treat regular fee-for-service patients or other Managed Care Organization (MCO) enrollees only after their obligations to the HMO are fully satisfied. Group and network models account for 13% of HMOs.

3. *Independent Practice Association (IPA) Model HMO* - IPA model HMOs contract with associations of independent doctors, but do not require a specified percentage of time to be devoted to enrollees. Compensation may be on a discounted fee-for-service or on a capitation basis. Physicians may treat non-HMO enrollees as well. IPA structure models account for 65% of HMOs.

It should be noted that it is increasingly common for HMOs to combine these approaches as they expand into other territories. For example, it is often more cost effective to initially enter a market by contracting with doctors or hospitals and then perhaps moving more toward a staff-model HMO as it becomes more established.

Independent Practice Associations (IPAs)

These organizations are formed for the purposes of contracting with HMOs or other MCOs. IPAs may be aligned by specialty, region, both or neither. They can provide a range of services, including credentialing, peer review or claims review for third parties.

Management Service Organizations (MSOs)

MSOs provide services to healthcare providers (usually physician groups) for a fee. Services are of a management, administrative and billing nature, providing negotiation and/or monitoring of contracts, claims processing, insurance placement, hiring and firing of non-medical staff, credentialing, utilization review and quality assurance.

Physician Hospital Organizations (PHOs)

These organizations are joint ventures between physicians (usually via an IPA) and hospitals in an effort to negotiate and contract with employers, insurers, or MCOs. Typically, there is a shared responsibility for capitalization and operation. Generally, the physicians and hospital members continue to operate separately and the organization is not structurally integrated. Physicians handle treatment decisions and hospital employees handle finances and administer payment systems. Because some sort of capitation or risk sharing is common, PHOs are usually financial risk-bearing organizations, although this is not always the case. In addition some will employ physicians to serve as medical directors or consultants, or to perform utilization review.

PHOs can be "open", where all hospital doctors can join, or "closed" where only select doctors can join. Furthermore, they may be "non-exclusive", in which case the doctors can contract with other MCOs, or they can be "exclusive", where they can only be tied to the PHO.

Multiple Hospital Organizations (MHO)

Although it is rare at this point, hospitals are beginning to band together in an effort to compete against HMOs rather than just form partnerships to leverage their services to HMOs. That is, these MHOs are looking to manage the whole healthcare delivery process, including the financing, just like an HMO. This approach puts them more in control of access to patients and makes them potentially more appealing to doctors.

Preferred Provider Organization (PPO)

This is an organization or association composed of independent physicians that assists members in contracting with various employers or insurers on a discounted fee-for-service basis.

Group Practices

A group practice is a corporation or partnership that employs physicians and other professionals to render healthcare. All revenues and expenses are channeled through the organization.

A Continuing Evolution

As of 1994, 52 million Americans, or more than 25% of the insured population, had joined Health Maintenance Organizations.³ Nevertheless, HMOs had decreased in actual number from over 700 in 1987 to slightly over 500 in 1994. This decrease is a reflection of industry consolidation in a drive to attain cost savings through economies of scale. It should be noted that the sophistication and market penetration vary considerably by region with the Pacific Coast tending to have more HMOs and HMO enrollees while the Midwest area of the United States tends to have the fewest. Cultural differences and state laws are the primary drivers of this disparity.

Although the number of HMOs may be falling, the number of other types of managed care organizations is growing rapidly. This trend is fueled by physicians who are banding together to attain negotiating power as HMOs control access to patients, which means the HMOs increasingly control the source of a doctor's income. The more Americans that enroll in HMOs, the more physicians will have to rely on HMOs for patients. By forming networks, physicians can offer a greater depth and breadth to HMOs through a single organization, making contracting with their doctors more attractive to HMOs. In addition, other types of managed care organizations have formed in related areas, such as claims handling or credentialing, in order to take advantage of the potential out-sourcing of services that sometimes comes with cost control.

The key issue in trying to get a handle on the managed care liability exposure is not necessarily to classify the risk into one of these MCO categories, but rather to understand exactly where in the healthcare process the organization participates.

III. A MACRO VIEW OF MCO EXPOSURES

Bodily Injury Damages vs. Economic Loss Damages

Because the buyers of managed care insurance products are varied, there is a broad range of exposures that need to be underwritten and priced. These exposures, however, can generally be broken down into two categories: those that produce claims for bodily injury damages and those that produce claims for economic loss damages. Both types of claims usually ask for monetary damages as compensation, but the causes of action are very different.

Bodily injury claims will ask for compensation for medical costs, death, disability, mental anguish, emotional distress, and loss of consortium, all of which represent some sort of physical or mental damage to an individual. Often, punitive damages are also involved. Medical malpractice policies have generally covered this exposure.

Claims for economic loss will seek compensation for a monetary loss to an individual or company which was caused by negligence on the part of the insured. The monetary loss may be foregone profits, excessive costs or overcharging, stock devaluation, lost wages or damaged reputation. For any service organization, these claims may arise from poorly performing a service, failing to perform a service, or misrepresenting its product or financial health. Directors and officers liability policies and errors and omissions policies have generally protected service organizations from lawsuits seeking damages for economic loss.

In order to understand where coverage for certain exposures may lie and how to price for those exposures, it is first important to understand the intentions of the D&O, medical malpractice and E&O policies when they were designed.

Directors and Officers Liability

D&O policies historically were designed to cover directors and officers for third party claims alleging economic loss caused in the course of meeting their corporate governance responsibility. The corporation was only covered for indemnification of directors and officers for liability incurred while acting on behalf of the company. Typical types of exposures covered would include securities litigation resulting from misrepresentations in SEC documents, bankruptcy, regulatory violations, employment-related suits and, potentially, anti-trust litigation (at least for defense costs). Today, there is a trend toward adding the corporation as an additional insured for its own liability for some, if not all, of these exposures. It is important to note that D&O policies are always on a claims made basis, have defense costs included within the limit of liability, a large corporate deductible and usually no duty to defend the insured (that is, the insured selects and controls defense counsel subject to insurer approval. The insurer will reimburse the insured for these costs in excess of the deductible.)

Medical Malpractice

In direct contrast to the D&O policy, medical malpractice policies for physicians and surgeons can be written on a claims made or an occurrence basis, typically have defense costs in addition to the limit, no (or low) deductibles and a duty to defend (insurer hires and controls defense counsel.) Medical malpractice coverage primarily was designed to protect physicians from litigation resulting from the bodily injury of a patient during the course of direct care and treatment. Direct care and treatment would include any failure to diagnose, misdiagnosis or negligent referral to another doctor in addition to any actual operation or physical treatment. Sometimes an entity may be an additional insured because it may be held liable, under the doctrine of respondeat superior, if the physician was an employee. Respondeat superior is the legal theory that holds that employers may be held vicariously liable for the negligent acts of their employees.

In addition, even if the physician is not an employee, liability may exist under the ostensible or apparent agency doctrine. This doctrine states that an entity may be held vicariously liable for the negligent acts of non-employed physicians if the entity **implies** that the physician is its employee and the patient relies reasonably and detrimentally on that appearance.⁵

Note that, in theory, if the organization is only facilitating and not providing healthcare services, it does not have any medical malpractice exposure and therefore limited responsibility for a bodily injury that occurs during direct patient care and treatment. Typically, a hospital, which owns the equipment, employs nurses and allows doctors practicing privileges, would fall under the ostensible/apparent agency theory and has a high degree of medical malpractice exposure. On the other hand, HMOs that are not staff-model (physicians are not employees) would not have a significant medical malpractice exposure as they only facilitate the patient care through financing and contracts rather than providing the direct treatment. Unfortunately, while the medical malpractice exposure may be diminished, there may be an extensive exposure to bodily injury claims under the E&O policy to the degree that the MCO (HMOs, IPAs, or otherwise) sets forth the critical path for treatment or makes representations about its control and relationship with its providers and services.

Errors and Omissions

Errors and omissions coverage grants protection to entities that provide a professional service of some sort to a third party and are sued for economic loss for negligence in performing or failing to perform such service. Traditionally, these policies have excluded any bodily injury exposures. It should be noted here that most E&O policies are written on a claims-made basis, have defense costs within the limit, a moderate deductible and a duty to defend provision, which represents a hybrid of the characteristics of the D&O and the medical malpractice policies. Through the years, softening market conditions and the idea that there was little or no exposure led underwriters to remove or modify the bodily injury exclusion. It was widely believed that organizations that provided such services as computer consulting, mortgage

processing or general administration could rarely, if ever, negligently provide or fail to provide a service that would cause bodily injury.

Errors and omissions underwriters, however, have issued many of these same policies without the bodily injury exclusion to MCOs. This coverage for the bodily injury exposure is commonly referred to in the marketplace as "vicarious liability" coverage (even though some of the exposure is, in fact, direct liability). Therefore, MCOs can be covered for bodily injury claims under these policies where they are not providing direct patient care and treatment but acting only as a facilitator whose policies and procedures may contribute to a bodily injury. While underwriters certainly understand that they are covering healthcare institutions for bodily injury as well as economic loss, there are indications that they do not fully appreciate and price for both exposures.

In theory, the D & O, medical malpractice and E & O policies should be mutually exclusive. In practice, that will not be the case for most managed care organizations, as the E&O policy will often be broadly exposed to both economic loss and bodily injury claims. Even if indemnity ultimately is not provided under the E&O, often significant defense costs and loss adjustment expenses will be incurred. A closer examination of the causes of bodily injury and economic damages exposures will underscore this fact.

SECTION IV. A MICRO VIEW OF MCO EXPOSURES

We have identified 13 key exposures that are the most likely causes to produce claims to managed care organizations. These exposures are outlined below, including a description of the negligent act or service, what type of damages will be alleged and under which type of policy coverage would typically be provided.

Securities Laws Violations: D&O (Economic Loss)

Many MCOs are financing formation and growth in the capital market through offerings that solicit money in exchange for ownership. The offering may be made available to doctors who join the group, to a private group of carefully selected investors or to the public. Any offering will require a circular or prospectus outlining the organization, its business plan, the use of the funds raised, risk factors and financial statements. Misrepresentations in these documents can lead to an investor suit or a government action. A sample claim might be a suit brought by shareholders after a drop in stock price alleging that the company did not disclose its reliance on a key contract that had been subsequently non-renewed. Although this exposure ties into SEC laws, there need not be an offering on a stock exchange to have liability. This is the most traditional D&O exposure. Financial Insolvency:

D&O (Economic Loss)

Because bankruptcy usually implies mismanagement or misstatement in financial statements, creditors and shareholders alike will sue. Often, the D&O policy may be the most valuable asset left for the company, especially if the entity itself is specifically insured for its negligent acts.

Mergers and Acquisitions: D&O (Economic Loss)

In the course of an acquisition or merger, management makes representations to the buyers about the company and has to act in the best interest of shareholders. Buyers may allege that the value of the assets or relationships was not what the seller represented. Suits may also be brought by shareholders who believe management did not properly explore other options to sell the company. This will be a major exposure area as the consolidation trend continues.

Mistake in treatment or diagnosis: Medical malpractice (Bodily Injury)

This exposure is for direct patient care and treatment. It may range from misinterpretation of tests to being referred to a negligent doctor to an unsuccessful operation. This is the core of the medical malpractice policy.

Improper Accreditation of Providers: Medical malpractice or E&O (Bodily Injury)

The process of evaluating and admitting doctors for practice at a hospital or MCO is called credentialing or peer review. This task can be done by a variety of institutions. This process is referred to as peer review because a board of peer doctors performs the evaluation. Hospitals traditionally established boards who performed the service, but that is changing quickly as other MCOs may now perform this service on a stand-alone or ancillary basis.

If a doctor is sued for bodily injury, allegations will usually be made against the entity that credentialled the doctor, claiming he or she was not fit to practice. If the entity named is liable for the bodily injury under the ostensible/apparent agency theory and was involved in the direct care and treatment of the patient, then the medical malpractice policy will pick up the credentialling exposure as well. However, if a third party facilitator provided the credentialling service, then that third party, which did not provide direct patient care, will look to the E&O policy for protection.

Employment Practices: D&O or E&O (Economic Loss)

Employment Practices Liability (EPL) arises from the failure to hire or promote an individual or from the wrongful termination of an employee. Allegations will usually include some form of discrimination.

Since the credentialling/peer review process is the focal point for allowing doctors practicing privileges (essentially the right to work), this procedure is likely to be cited in a suit that a provider brings against an MCO for wrongful termination or failure to hire the practitioner. By citing negligent credentialling or

peer review, the firing or failure to hire would likely be an E&O exposure in that peer review is usually part of the definition of professional services depending on the exclusions of the E & O policy. It should be noted that since the E&O policy will name the entity as a direct insured, these EPL claims can get quite expensive just from a defense cost standpoint.

Although credentialing implies that a doctor is evaluated based on his or her medical competence, managed care has expanded the criteria to include economic performance and the type of medicine practiced. Thus, a physician's allegations may include that he or she was dismissed for not seeing enough patients in addition to the standard claims of discrimination based on age, race, sex or the type of medicine practiced. This extra criteria makes the wrongful termination exposure much more acute as it brings the "profitability" of the doctor in to question along with his or her competence

On the other hand, if an employee that is not a healthcare provider, and thus not subject to credentialing, sues for an employment practices related cause, then there should be no E&O coverage because it is a pure employment practices exposure. If there is coverage, it is probably unintentional. There may be some coverage under the D&O policy for employment practices liability depending on exclusionary language, the deductible and whether or not the entity is covered. Many markets now offer a separate EPL policy for this exposure.

Antitrust: D&O or E&O (Economic Loss)

Antitrust comes in many forms. The first is price-fixing and restraint of trade where an HMO or like organization controls too many enrollees or too many doctors in any area and, therefore, can control the supply of healthcare. The MCO may control so much of the market in terms of enrollees that there is no alternative access to patients for doctors. Alternatively, by contracting with all or most of an area's qualified physicians, MCOs may form artificial barriers to entry and keep out other organizations.

It is interesting to note that the Department of Justice has established certain guidelines on what percentage of specialty doctors or total doctors in a territory a PHO can control before it will begin to

examine a potential anti-trust action. The percentage threshold depends on whether or not the PHO is exclusive (20%) or non-exclusive (30%). Cases of interest would include *US v. Health Choice of Northwest Missouri* and *US v HealthCare Partners*.⁶

The best known case citing antitrust. *Blue Cross v. Marshfield Clinic*, occurred in Wisconsin when a Blue Cross/Blue Shield company, a large MCO in its own right, alleged that the defendant controlled the market on qualified physicians. Blue Cross won the initial case and was awarded a \$48,000,000 jury verdict that was reduced to \$20,000,000 including trebled damages and attorney fees. The Seventh Circuit of Appeals, however, has reversed the damages award and order a new trial to determine the ultimate damages that will be paid. This type of antitrust suit is usually a D&O exposure, however, in a softening market some E & O carriers will include the antitrust coverage as well.

Another form of antitrust is at the individual physician level where an IPA or other type of MCO excludes a certain doctor or type of doctor from joining the group. One example of this antitrust exposure is a multi-specialty IPA that refuses to admit chiropractors to the group and thus prevents them from gaining access to the contracted managed care plans. Allegations would center on restraint of trade issues. A doctor dismissed from a group may also allege restraint of trade, among other charges, in a wrongful termination suit. Generally, the first example has more general policies and practices overtones and would be a D&O claim with possible E&O elements. The second example is more specific and would likely be an E&O claim with potential D&O elements.

Network Design: D&O or E&O (Economic Loss)

The managed care organization's network design is embodied in the contractual relationship in force between doctors and an IPA or an IPA (or similar MCO) and an HMO. The economic loss exposure ties to the compensation basis set forth in the contracts that IPAs and other MCOs sign with HMOs or other financiers of healthcare. One liability exposure arising from network design results from whether doctors are compensated on a fee for service or capitation basis. Managers may be sued by the doctors if the agreement entered into by the MCO is decidedly one-sided or too restrictive

These contracts will also point to what may motivate the physician's choice of care. Contract terms may encourage physicians to choose the cheapest route of care rather than the best in terms of quality of care. The contract will also indicate whether or not the physicians have alternative sources of practice or are exclusive to the HMO, which can lead to more antitrust exposures. Coverage for these economic loss related exposures will be found under the D&O or E&O policy.

Gag Orders - E&O (Bodily Injury)

Bodily injury exposure under the E&O policy may also lie in contracts that include "gag provisions" between providers and health plans. There are three types of gag orders:

1. where the doctors are forbidden to discuss uninsured treatment alternatives for the patient;
2. those which prevent physicians from referring patients to specialists outside the plan; and,
3. the inability to discuss with the patient any financial incentives which may influence the physicians recommendation for care.

Liability arises if these provisions are in place due to the Informed Consent Doctrine, which states that the physician has a common law duty to disclose all information, including financial incentives, to the patient that is relevant to treatment. See *Moore v. Regents of the University of California, 1990.*⁸

It is important to note that several states have begun to pass legislation outlawing these gag provisions, and at least one HMO, U.S. HealthCare, has voluntarily lifted these orders.⁹

Benefit Denial: E&O (Bodily Injury)

This area is probably the most frequent cause of claims for MCO liability. Exposures tend to lie in the utilization review process as well as the marketing materials, including "welcome letters", that an MCO produces.

Utilization review refers to the process of determining which steps and procedures will be acceptable for identifying and treating various illnesses and situations. Utilization review can be retrospective where an MCO reviews past procedures and the treatment path taken; concurrent, where the MCO reviews the procedures as they progress; or prospective, where the MCO sets future procedures and treatment paths. Obviously, the liability of an MCO increases as it moves from retrospective reviews to prospective reviews. The MCO, whether an HMO, PHO, or an entity that specifically specializes in the process review, will almost certainly be sued if a bodily injury occurs and there was a point where a physician had to forego a test, delay a procedure or use an alternative treatment according to the policies laid out in the interest of cost. A critical issue is what kind of grievance procedure is in place if the patient wants to appeal the MCO's decision on treatment. An example of a case resulting from this exposure is *Moore, Ph.D. v. Anchor HMO; Rorig, M.D.*¹¹ in which the plaintiff was not referred to a neurologist after complaining of leg spasms. The plaintiff was rendered a quadriplegic and received a verdict of over \$6,000,000.

A frequent source of disagreement with regards to utilization review and benefit denial which has given rise to numerous claims is what constitutes "experimental" treatment since MCOs exclude payment for experimental practices. The most noteworthy example is *Fox v. Healthnet of California* in which a 38 year old patient with breast cancer was denied health benefits for a bone marrow transplant on the grounds that it was experimental. This procedure had been previously approved for other patients. In addition, the HMO executives allegedly had bonus incentives tied to the reduction of costly medical procedures. The initial judgment was made in favor of the plaintiff for \$89.3 million including \$77 million in punitive

damages, on the premise of negligent prospective utilization review and benefit denial. The case was later settled while on appeal for an undisclosed amount of money.¹¹

Marketing materials that contain representations or guarantees about quality of care and the relationship between the doctors and the MCOs can lead to a host of problems. Exposure to loss will be generated if marketing brochures make assurances about the outcome of treatment or do not clearly outline the status of physicians (employees or only contractual relationship). The statements can be referenced by patients suing for being misled about the caliber and outcomes of medical treatment they thought they would receive.

A case in Idaho, in which a patient was diagnosed with cirrhosis of the liver and then denied coverage for a liver transplant, resulted in total damages awarded in excess of \$26 million. \$25 million of this award was for punitive damages. Bad faith was alleged because the marketing brochure stated that "transplants" were covered.¹²

"Welcome letters" are typically sent by MCOs to new enrollees, thanking them for selecting their physician and promising a high standard of care. Often, these are sent by an IPA (who has contracted with the HMO on behalf of its member physicians) after one of its physicians have been selected. In many cases, the enrollee would not even have known of the IPA's existence, and would have believed his or her relationship was solely with the physician who was affiliated with an HMO. Direct communication between the IPA and the enrollee is really unnecessary since the IPA is usually not setting policy or procedures nor financing the cost of care. The only true outcome is that the communication would then make manifest the presence of the IPA and open it up as a potential defendant should something go wrong. In fact, any inference of providing a high standard of care may be interpreted as an enforceable contract or warranty after an unfavorable utilization review is made.

Quality Assurance: E&O (Bodily Injury)

Quality assurance is the process in which the MCO ensures that the procedures that are used are operating at optimum efficiency. Again, there are retrospective, concurrent and prospective reviews. Obviously, any process representing an opinion on quality carries large exposures if something goes wrong. A typical exposure would be to a third party who does quality assurance reviews for an HMO or a hospital and had approved the methods of operation. Subsequently, a patient sues the doctor / hospital /MCO for a bodily injury claim and then these parties sue the quality assurance provider, claiming a contribution toward negligence since they had previously reviewed and approved the standard of care utilized.

Invasion of Privacy: E&O (Economic Loss)

Access to medical history, especially drug and alcohol abuse and mental illness treatment, must be strictly guarded. Mental anguish, emotional distress, libel and slander are all large exposures if confidential information seeps out orally, electronically or physically. This is especially dangerous if the information concerns prominent local residents, politicians or celebrities.

There is a known case where a reporter duped an assistant at a managed care organization into disclosing confidential medical information about a person running for local office who had a previous drug problem. The MCO was sued for libel and slander and later settled for an undisclosed amount.

Libel / Slander / Defamation / Piracy: E&O (Economic Loss)

Marketing brochures can sometimes be too eager to make comparisons with competitors or tout their services as unique or original. These representations can expose an MCO to litigation alleging advertising injury or unauthorized use of business ideas and styles. For HMOs, generally the less said, the better off it is, and what has been put in writing should be reviewed by counsel.

In addition, the EPL exposure outlined earlier may also have elements of libel and slander as a physician may maintain his or her reputation was sullied by the revoking of or failure to approve practicing privileges.

The Effects of Economic Integration

A primary factor in analyzing the liability of broader scope MCOs, such as HMOs, PPOs and PHOs, is the degree of economic integration. For these organizations, the higher the degree of economic integration between the organization and its providers, the greater the likelihood that the bodily injury exposure will fall under a medical malpractice liability policy, assuming one exists. This correlation exists because the tighter the economic control exercised by an HMO or similar organization, the lesser the discretion a physician has in whom he or she treats and how he or she administers treatment. If a managed care company is tightly controlling physician decisions via economic incentives or critical care decision paths, it is essentially dictating treatment. The more it controls treatment, the closer it comes to providing direct patient care. In addition, closer economic integration implies that physicians have less freedom to associate with other MCOs. This rigidity will give more of an appearance of acting as an agent of the HMO, thus increasing the risk that the company will fall under the ostensible/apparent agency doctrine.

It naturally follows that the lower the degree of economic integration, the more likely it is that any coverage that exists for bodily injury claims will fall under an E&O policy. While the insured's defense against such claims may be stronger, it can quickly incur substantial defense costs and loss adjustment expenses. Just because the MCO may not theoretically be liable to pay damages on a claim does not mean that substantial costs will not be incurred in defending such claim. In addition, if there is little other insurance protection available elsewhere, losses may ultimately be paid under the E & O policy no matter how far removed from the direct liability the insured may be. In fact, a key consideration in underwriting may be what kind of medical malpractice insurance the organization carries and what kind of protection it requires its doctors to carry.

Summary

The following table summarizes where each of the thirteen managed care exposures described above would be covered under the three types of insurance policies discussed earlier.

Exposure	Type of Damages	Insurance Policy
Securities Law Violations	Economic	D & O
Financial Insolvency	Economic	D & O
Mergers and Acquisitions	Economic	D & O
Mistake in Treatment or Diagnosis	Bodily Injury	Medical Malpractice
Improper Accreditation	Bodily Injury	Medical Malpractice or E & O
Employment Practices	Economic	E & O or D & O
Antitrust	Economic	E & O or D & O
Contract Structure	Economic	E & O or D & O
Gag Orders	Bodily Injury	E & O
Benefit Denial	Bodily Injury	E & O
Quality Assurance	Bodily Injury	E & O
Invasion of Privacy	Economic	E & O
Libel, Slander, Piracy	Economic	E & O

Nine of the thirteen exposures outlined above may be covered under an E&O policy. Even more noteworthy is the fact that five of these E & O exposures can lead to economic loss suits and four can lead to bodily injury suits, while D&O is exclusively covering economic damages and medical malpractice is exclusively covering bodily injury damages.

There is also a fair degree of ambiguity of where each exposure might be covered. The more important issue, however, is just how difficult it is to determine where one act or series of acts stops and another begins. If a doctor did not perform a test and missed a diagnosis, it may have been for a number of

different reasons. The omission may have occurred because the doctor forgot, decided it was unnecessary, was worried about capitation fees or was limited by the HMO procedural manual. Doctors may be denied entrance into an IPA for various reasons including a justly denied request, real discrimination, or part of a bigger restraint of trade issue.

The fact that each policy tends to differ in terms of deductible, treatment of defense costs, and responsibility to defend makes allocation of the exposures and claim allegations that much more sensitive. First, the insured will want coverage to fall where it is the broadest. Second, if the policies are issued by separate carriers, then the insurance companies may disagree as to where the claims should go. And, finally, if the same carrier writes more than one of the policies, but has separate reinsurers for each, then it may have a problem with its reinsurers as to where coverage should lie. If one can picture how difficult it is to decide what exposures will be covered under the E&O policy, it is not hard to imagine how difficult it is to price the product.

V. OVERVIEW OF EXISTING PRICING MODELS

In response to the fresh and evolving E&O exposures, several stock property and casualty companies have come forth with various products to meet these needs. Among them are major D & O carriers and medical malpractice writers. In addition, some of the physician-owned mutual insurance companies have introduced products. The approaches of these companies vary immensely. Not all of the companies offer both medical malpractice and E&O products, let alone a centralized underwriting unit. Some offer endorsements to medical malpractice policies, some have combined policy forms, and some use separate forms. Many companies offer D&O, although they have little or no experience underwriting this exposure. Typically, a buyer will encounter a medical malpractice carrier underwriting and pricing the E&O exposure or an E&O carrier underwriting and pricing the bodily injury exposure.

Therefore, the major concern is that E&O policies will cover both the bodily injury and economic damages exposure for MCOs, but the rating will be in line with traditional approaches for one side or the other.

For certain types of institutions, the bodily injury exposure under the E&O policy is much greater than normal and should have a separate rating component.

Existing Plans

Rating plans currently in use vary greatly. The most common exposure base being used is the number of enrollees in the MCO. In some cases, the rate is a flat rate per enrollee irrespective of the size of the organization. Other rating plans have a decreasing rate as the enrollment size increases. Only a few plans differentiate between the administrative exposure and the vicarious bodily injury exposure by including a charge for administrative exposures based on revenue. In addition, rating plans may also use physician count as the exposure base for IPAs.

Most of the HMO E & O rating plans do not specifically contemplate the exposure to administrative errors. An example of an administrative claim which is typically not contemplated in the rating plan is an HMO organization acting as a TPA administering health benefits and over-paying those claims on behalf of a self-insured corporation.

Problems with Member only Based Approach

A managed care rating plan that bases its rate on a per member basis encounters several problems. Many types of MCOs contract with multiple HMOs; however, they will likely only handle a certain segment of the HMO enrollees as determined by specialty or territory. For example, for a New York City HMO, one IPA may be contracted to handle Queens, another for Brooklyn, and a third for the Bronx. Thus, to rate simply off enrollee count for the whole HMO, means that the insurer may be charging for far more exposure units than are actually exposing the entity. It is usually difficult to quantify exactly how many enrollees of the various HMOs it contracts with that the IPA may be serving.

A member based approach also does not take into account doctor class or territorial relativities that give rise to higher or lower exposure to loss. This is a key oversight given that a specialty IPA of obstetricians

is generally more risky than an IPA of general practitioners. In addition, there are some states whose courts have interpreted the ostensible agency doctrine more or less favorably to MCOs thus giving rise to more or less liability. The per member approach also may be inappropriate for reflecting the economic damages exposure from advertising, network design, anti-trust or peer review activities. This is a notable oversight as it represents a significant portion of the coverage.

Problems with Revenue only Based Approach

Some E&O carriers covering MCOs use the traditional revenue based approach to rate all types of HMOs. However, a revenue based approach omits pricing for the large bodily injury exposures from utilization review, quality assurance and credentialling. In addition, revenue only pricing does not account for any relativity factors such as practice specialty and territory that affect the frequency and severity of bodily injury claims. Finally, given the immaturity of many MCOs, revenues may be very low and not a true reflection of the risk at hand.

Comparison of Rating Methods

The following is a comparison of hypothetical premiums generated by typical rating plan structures currently being used in the market. The plans have been ordered by degree of responsiveness each has to the characteristics of the MCO. Assuming a rate of \$.50 per enrollee, \$3.00 per \$1,000 revenue and \$75 per physician, resulting rates for a \$1,000,000 each and every claim limit are as follows:

Rating Method \$.50 per enrollee \$3 per \$1,000 revenue \$75 per physician	Network model HMO 2,300,000 enrollees \$186M revenues	IPA 150,000 enrollees \$3M revenues 90 class 5 doctors
Revenue only Based Rate	\$558,000	\$9,000
Flat Rate per enrollee - no differentiation between MCOs	\$1,150,000	\$75,000
Flat rate per enrollee for HMOs and PPOs. Flat rate per physician for IPA.	\$1,150,000	\$6,750
Flat rate per enrollee with modifier by degree of economic integration	\$1,150,000	\$25,000
Flat rate per enrollee for bodily injury exposure. Flat rate per \$1,000 revenue of administrative exposure	\$1,708,000	\$75,000
Flat rate per enrollee for HMO bodily injury exposure, rate per physician varied by territory and specialty for IPAs, rate per \$1,000 revenue for administrative exposure	\$1,708,000	\$33,750

The range of premiums exhibited here mirrors the market fairly well in that most plans were created with HMOs in mind and thus the premiums for these organizations are more consistent though increasing as the rating plan becomes more responsive to the attributes of the MCO. Applying these plans to a non-HMO type of MCO such as an IPA, results in an extreme range of premiums.

The rates currently being used in the market typically have been developed by modifying hospital medical malpractice outpatient visit rates, physicians medical malpractice rates or competitor's managed care rates. Using the medical malpractice rates will require an adjustment for the vicarious nature of the bodily injury exposure. This factor typically being used in the marketplace is 10% or less of the medical malpractice rate. This adjustment factor, when used, has been determined largely by judgment.

When considering where to start in calculating appropriate rates for this coverage it is important to consider some differences between the types of claims costs that occur under the managed care E & O

product as compared to those under medical malpractice policies. One public source of data that can be valuable in quantifying some of these differences is the Jury Verdict Research data. There are many cases in this database involving managed care claims. This database is available at a cost on CD ROM from JVR®. Many cases indicate the amount of liability which has been assigned to the MCO as compared to the other defendants.

Another public database available is HEDIS which stands for health plan employer data and information set. HEDIS was created as a set of data specifications and reporting guidelines to be used as a starting point for health plan comparison. HEDIS provides comparative data for health plans on member access and satisfaction, membership and utilization, quality of care, finance, and management and care delivery. Included are statistics on certification, credentialing, performance review, education and staffing. One can also determine from the HEDIS data, the portion of employees who are salaried versus those that are capitated as well as the types of utilization reviews each MCO uses.

Allocated Loss Expense

The portion of claims costs consumed by allocated loss expense should be expected to be extensive for managed care E & O. In this evolving environment, managed care is a whole new arena for lawyers to pursue with regard to determining relevant case law. As exhibited in the jury verdict data, many claims close with defense verdicts resulting in no indemnity against whatever allocated loss expense was needed to defend the claim. Also, in cases in which ERISA preemption exists (see appendix), the insurers must pay to have the venue moved from state to federal jurisdiction, again resulting in allocated loss expense costs with no indemnity payments.

Punitive Damages

Some policies include punitive damages automatically whereas others may include them at an additional premium. The jury verdict data shows amounts of punitive damages versus indemnity awards.

Considering the claims that have already been discussed, it is evident that punitive damage costs can be extensive. With the amount of bad publicity in the press with regard to managed care quality of care, it can be expected that juries may be more sympathetic to plaintiffs against managed care organizations and award higher punitive damages.

The most frequent cause of claims to managed care E & O policies exhibited to date result from denial of benefits, failure to diagnose and failure to refer. These activities are considered "gatekeeper" exposures because they take place at the beginning of the healthcare provider chain with the primary care physician. The most frequently used proxy to calculate managed care rates are hospital outpatient visit rates multiplied by the vicarious liability adjustment factor discussed earlier. This method will tend to understate the bodily injury exposure to MCOs because the outpatient visit rate does not contemplate these "gatekeeper" exposures associated with MCOs. Further, the outpatient visit rate does not fully reflect the credentialing exposure to managed care. This exposure is often the same for hospitals and MCOs and therefore it may not be appropriate to multiply by the vicarious liability adjustment factor.

With the lack of public data available to determine rates for this new product, it is reasonable to start with hospital and physician rating plans to determine the bodily injury rating as long as the differences between HPL and physicians' exposures and the managed care E & O exposures are considered carefully. It may be more reasonable to separately determine rates for the administrative exposures using standard E & O rates for TPA liability exposures with regard to economic damages.

VI. BUILDING AN EFFECTIVE RATE MODEL

It is not effective to use a single exposure base to account for the two distinct exposures of economic loss and bodily injury claims that are covered in an E&O policy. After examining the various approaches to pricing the E&O product and comparing them to our observations outlined earlier, we feel a more refined approach should be used to account more fully for bodily injury exposure as well as where the organization fits in the healthcare provider process. Our model will begin with an approach to forming

the base rate, which focuses on exposure units and then will move to modifiers of the base rate that include key questions that should be asked of the applicant MCO.

As shown in the review of pricing models, most existing models are not flexible enough to handle the diversity of exposures that MCOs encounter. An effective rate plan will adjust to where the MCO fits into the healthcare process and account for the types of services provided. The rating plan will also properly weigh the bodily injury and the economic damages exposures.

A Blended Approach

A truly effective rate model should have a two-tiered system: One part that accounts for economic damages and one that, where appropriate, accounts for the bodily injury exposure, including practice and territorial relativities.

Economic Damages Exposures

Traditionally, E&O carriers, which only rate for economic loss claims, use revenues as the exposure base while medical malpractice underwriters, which insure the bodily injury claims, use doctors, occupied hospital beds or patient visits as an exposure base. As noted, many managed care underwriters have tried to use a variation of these approaches depending on their underwriting experience. Virtually none combine various methods.

STAFF MODEL HMO AND TPAs - Revenue based pricing would be appropriate for TPAs as they do purely administrative services such as claims servicing where the bodily injury exposure is reduced. Revenue based pricing is also appropriate for staff model HMOs because, unless it is performing services for other organizations, all of its bodily injury exposure will be covered under its medical malpractice policy. Thus, an E&O policy issued to a staff-model HMO or a TPA is typically covering only its economic damages exposure and should be rated as such. Keep in mind, however, the earlier discussion about the importance of the entity and its doctors maintaining adequate medical malpractice coverage,

because if that is insufficient than courts and attorneys will turn to the next deep pocket, which may be the E&O policy.

NETWORK MODEL HMO, FINANCIAL RISK-BEARING PHO OR PPO - These organizations are responsible for all of the enrollees, provide all types of medical care, function in a wide territory and have limited medical malpractice exposure if they are formed and operated correctly. Institutions like these that manage the whole process from the top down only for its own enrollees may be rated for the economic damages exposure on the total number of enrollees since all members truly bring exposure to the whole system.

IPA OR NON-FINANCIAL RISK BEARING PHO - These organizations should be rated on the number of providers (including nurses and assistants) as this better represents the exposure base. That is, the providers see a limited number of enrollees. they control who can join the IPA or PHO and they negotiate their own contracts with HMOs and PPOs.

Bodily Injury Exposures

The second component that we recommend is to also rate the MCO for the bodily injury exposure. The most practical approach rates it as if it was being covered for medical malpractice exposure and then adds a percentage of that premium to the economic loss base rate. Taking a percentage of the medical malpractice premium charged is especially effective since it accounts for territorial and specialty relativities and these organizations tend to buy little or no medical malpractice coverage as it is (as it usually falls on the doctors to purchase their own protection). The percentage of medical malpractice charged should vary with the degree of perceived bodily injury exposure as determined by economic integration. This vicarious liability adjustment factor should, therefore, not be a constant for all entities but vary based on the organization's degree of economic integration.

STAFF MODEL HMO - Because this type of organization *employs* doctors, it will buy extensive medical malpractice coverage and the bodily injury risk has already been predominately accounted for. A staff

model HMO that buys a managed care E&O policy is looking for the economic loss coverage. It should, therefore, be simply rated off the revenues and not surcharged for the bodily injury exposure at all, provided that it purchases adequate medical malpractice coverage.

MSOs - Any managed care service organization that does not handle patients but simply performs administrative work for third parties could also be rated solely on revenues as well. It is not necessary to introduce the specific bodily injury rating component for MSOs since it would be difficult to track the details of all of the parties with which they contract, plus they will be even one party further removed from the actual bodily injury claim.

GROUP OR NETWORK MODEL HMO AND FINANCIAL RISK BEARING PHO - The bodily injury surcharge would be calculated as a percentage of the premium it would be charged as if it were a staff-model HMO and bought a medical malpractice policy.

IPAs AND NON-FINANCIAL RISK BEARING PHOs - Rate all of the physicians for medical malpractice coverage and take a percentage of the total to add to the economic damages base rate. Thus, if it is a group of neurosurgeons, it will have a higher medical malpractice rate and thus a higher E&O bodily injury surcharge. If it is a group of dentists, then the medical malpractice rate and the subsequent surcharge will be less. If it is a multi-practice IPA, then the rate will be blended. Territorial issues will also be accounted for this way.

SUMMARY

The following tables summarizes the exposure base recommended for each loss component and type of organizations:

TYPE OF ORGANIZATION	ECONOMIC DAMAGES	BODILY INJURY
Staff Model HMO	% of Revenues	None
TPA	% of Revenues	None
Network Group HMO	Per enrollee charge	% of "as if" med mal
PPO	Per enrollee charge	% of "as if" med mal
Financial Risk Bearing PHO	Per enrollee charge	% of "as if" med mal
Non-Financial Risk Bearing PHO	Per provider charge	% of "as if" med mal
IPAs	Per provider charge	% of "as if" med mal

Because even within these MCO types there is significant variation in exposure, it is important to have a flexible rating plan that recognizes these differences. Flexibility could also be provided in a debit and credit scheme based on the exposures discussed earlier. Some of the key areas of focus would be peer review procedures, utilization review procedures, financial condition, management, litigation history, marketing brochures, contracts review, ERISA, document controls and anti-trust. The appendix outlines some of the key issues to examine.

CONCLUSION

The development of managed care continues to produce many new liability exposures that do not fall neatly into the traditional D&O, E&O and medical malpractice coverage. As such, it is crucial that underwriters are careful not to accept traditional pricing approaches too readily.

Although the medical community tends to combine managed care organizations into just a few generic classes, clearly the liability exposures vary greatly with the services provided by these companies. It is important that underwriters take the time to identify what the managed care organization is doing rather than relying on what it is called. The MCO can be properly rated for its managed care E&O exposures only after close examination of the functions it performs.

The rating plan used for managed care E&O should have as much diversity as the entities the underwriter intends to insure. This flexibility can be obtained by varying the base rate calculations according to where the organization fits into the healthcare providing process. A surcharge calculated as a percentage of the insured's medical malpractice premium should then be applied to cover the bodily injury exposure. The percentage surcharge will vary with the vertical economic integration of the organization.

APPENDIX - Underwriting checklist

A. Credentialling/ Peer Review

1. For whom is it performed?

Least Risk - Contracts Out

Moderate Risk - Does its own

Most Risk - Does its own and does it for others.

2. Review the procedures manual.

Least Risk - Meets JCAHO or other appropriate guidelines. Annual Reviews

Moderate Risk - Review every 2 years

Most Risk - Infrequent Reviews and does not meet JCAHO guidelines.

3. Look at turnover of physicians.

Least Risk - Low turnover with strict requirements and reviews.

Moderate Risk - Average turnover

Most Risk - High turnover exposes to disgruntled doctors suing.

4. Are there "Any Willing Provider" laws?

Any Willing Provider (AWP) laws require that certain MCOs (mainly HMOs and PPOs) contract with any provider who meets the MCO's eligibility requirements and also accepts the terms and conditions offered by the MCO. AWP statutes typically require MCOs to base their provider selection decisions on objective quality and accessibility considerations. Some statutes also dictate requisite procedures for terminating providers.

Least Risk - Group accepts and abides by the law unconditionally.

Most Risk - Group not in compliance.

5. What are grounds for removal?

Least Risk - No economic criteria and follows Any Willing Provider laws.

Most Risk - Surcharge or possibly decline if economic factors are used.

6. Watch for certain types of doctors that are banned, such as chiropractors

or other specialist or quasi-medicine areas

7. Does the organization have quotas for certain types of providers?

Least Risk - No quotas and within DOJ guidelines

Most Risk - Quotas exist which could be an anti-trust or discrimination issue.

8. How does the organization determine which provider to let in next?

Least Risk - Defined Process

Most Risk - Random Process

B. Utilization Review / Claims Handling

1. For whom is it done?

Least Risk - someone else does it for the group.

Moderate Risk - group does its own.

Most Risk - done for itself and others.

2. Is it prospective, concurrent or retrospective?

Least Risk - Retrospective

Moderate Risk - Concurrent

Most Risk - Prospective

3. Where does the final determination lie and who is responsible for transmitting the decision?

Least Risk - With the doctor

Most Risk - With the group

4. Examine the appeal process.

Least Risk - Timely, formal grievance procedures, fast track procedures in place for life threatening illnesses

Most Risk - grievance procedures longer than 14 days

5. How is investigative and experimental treatment handled? Is it defined? Is it allowed?

6. Look closely at the financial incentives for doctors and administrators.

Least Risk - Doctors purchase capitation insurance on capitated programs.

Most Risk - Capped fee and profiting from cost cutting may congest decision-making process and provide wrong incentives.

7. Is the patient allowed to "opt out" of the prescribed critical path for treatment?

Some plans will allow patients to seek alternative physicians or treatment in exchange for less comprehensive reimbursement of costs. This may help defray some of the denial of benefits exposure, but there is still a risk of suit to recover shortfalls in costs. Many believe this is an important plan facet in an effort to mitigate the denial of benefit claims.

C. Financials - Should be examined to ensure the entity will not be cutting corners.

D. Management -

1. Diversity of Management background

2. Senior officers have some business experience or background. Ideally, CFO or treasurer has a business background rather than a medical one.

3. Some sort of balance of power among owners / management / physicians?

E. Claim or Litigation History - Should examine litigation over the last five years, looking for frequency and severity trends.

F. Marketing Materials

1. Make sure disclosure is accurate, complete and clear.
2. Materials should be viewed by legal counsel.
3. Watch for representations as to the quality of care.
4. Reference should be made to the doctors as independent contractors, if that is the case.
Should be clear that HMO or hospital is the financier.
5. Make sure the brochure is always made available to everyone.
6. Examine the size, quality and composition of sales force. Watch for uncontrolled, unlicensed and unwieldy sales force.

G. Contract Review

1. Least Risk - agreement is non-exclusive to both payer and provider. No gag orders.
Moderate Risk - Mix of exclusive and non-exclusive clauses.
High Risk - Majority of payers under exclusive arrangements and strict exclusivity with providers. Gag orders in place.
2. Where is the liability? Usually see it being pushed from top down. Examine hold harmless agreements. Whom does it benefit? Are duties of the parties clearly outlined?
3. Compensation structure for doctors - What will motivate them? Can they practice on non-enrollees? Is it discounted fee-for service or a set amount of money?

4. Are there unusual services provided? Are there any warranties?
5. How long is the contract? One year should be normal given all the changes going on. Who can cancel it? Did the insured have legal counsel review it?
6. What are the medical malpractice coverage requirements?

H. ERISA

The Employee Retirement Income Security Act (ERISA) regulates most employee benefit plans through which a vast majority of individuals receive their health insurance. The ERISA preemption is part of the initial law that confines and restricts a plaintiff's ability to claim damages against a health provider or the provider's employer. Thus, the higher the percentage of enrollees that come to the organization via ERISA, the lower the risk for high damages. For example, government employees are exempt from ERISA so a proper rating scheme will determine the percentage of government enrollees and surcharge for this population.

This law is continually under review and, with the emergence of managed care, we can expect that the law will be eroded to allow plaintiff's better access to awards. As such, discounting should be minimal.

I Patient Confidentiality

Financial condition may play a part in determining risk here. Even more important, however, is the organization's infrastructure. It is key to make sure the company is properly staffed.

Automation is also a good sign of controls as opposed to manual records kept in unlocked files or boxes. Some controls or restriction of access to records is also favorable.

J Anti-trust charge

1. Market share: What percentage of potential area enrollees does the group have? The justice department has established guidelines:

Least Risk - under 15% of area enrollees

Moderate Risk - 15 to 30%

High risk - above 30%.

2. Determine if organization controls a high percentage of area physicians, especially if a specialist group. May be more inclined to keep people out or fix prices. Any Willing Provider statute comes into play here as well. The same percentages outlined above for enrollees apply for providers.

REFERENCES

1 Jury Verdict Research ® Personal Injury Database on CD ROM - may be ordered from LRP publications by calling 1-800-341-7874. Information available on the Internet at www.lrp.com.

2. HEDIS information is available from the NCQA - National Committee for Quality Assurance Publications Center.

1-800-839-6487
www.ncqa.org
NCQA Publications Center
PO Box 533
Annapolis Junction, MD 20701-0533

3. How To Pet A Bumblebee. A legal view of healthcare industry exposures as put together by select partners from Sedgwick, Detert, Moran and Arnold, 209 South La Salle Street, Chicago, IL, 312-641-9050.

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- ¹ Coopers & Lybrand. An Overview/Background of Managed Care, December 1995.
- ² Ibid.
- ³ Ibid.
- ⁴ Kerns, Christopher, Ryan, Ciara, and McMahon, Karen, Sedgwick, Detert, Moran and Arnold. How To Pet a Bumblebee, *Managed Care Organizations and Their Liability Exposures*, 1996, p 14.
- ⁵ Ibid, pp 15-16.
- ⁶ Fitzgerald, Joseph, ERMA and Lederman, Bonnie, Peterson & Ross. Developing PHOs to Avoid Liability, November 1995.
- ⁷ Op. Cit., Kerns, p.55.
- ⁸ Lindgren, Karin J., Sedgwick, Detert, Moran and Arnold. How To Pet a Bumblebee, *Liability Risks in Managed Care*, 1996, pp 13-14.
- ⁹ New York Times, February 2, 1996, p.D-2.
- ¹⁰ Jury Verdict Research® JVR Case #:160815
- ¹¹ 1995 California Large Loss Study, produced by MICRA
- ¹² Kurtson, Gigi M. and Lucas, Carol K., Partners at Rogers, Majeski, Kahn and Bentley. The Law Journal, Sacramento, California, *Managed Care Produces new Areas of Potential Liability*, December 1995.

