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Impact of Healthcare Changes on MPL Insurance Rating—Per-Patient-Visit Rating

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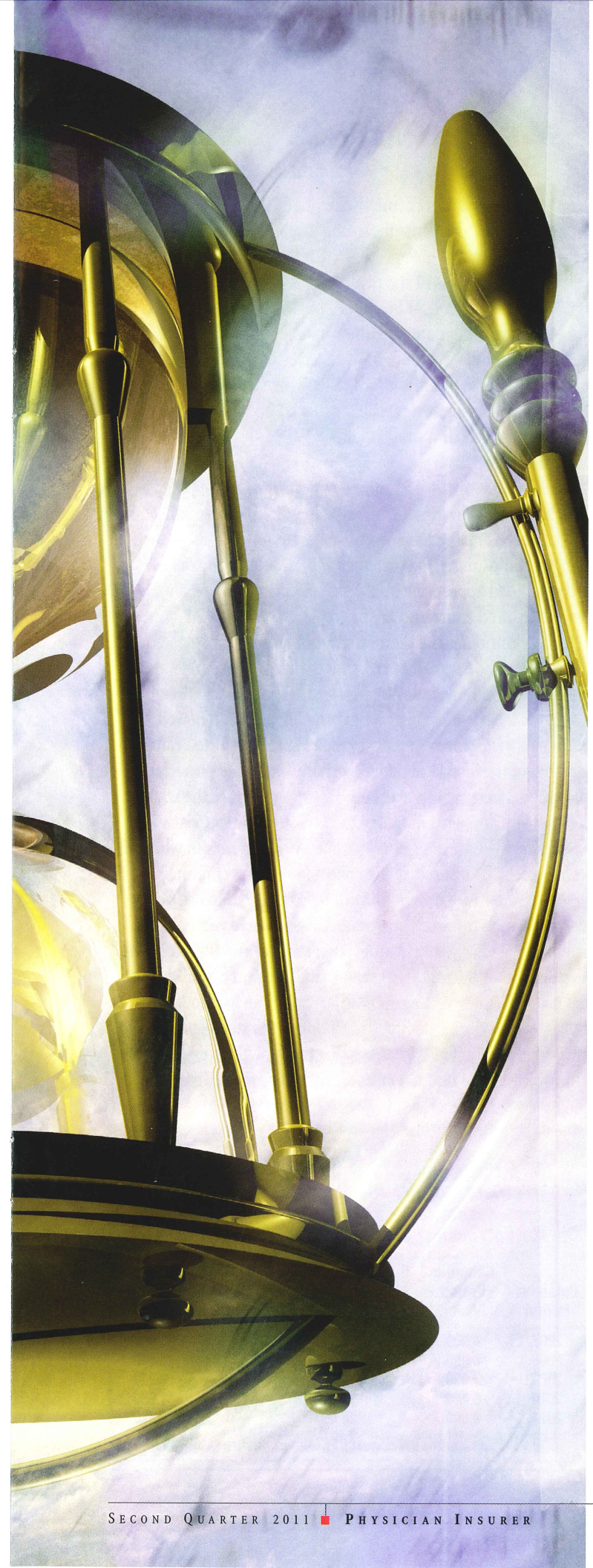


As more physicians move from independent practice to group or healthcare system employment, there is new interest in alternative procedures for medical professional liability (MPL) insurance rating. One method that is becoming more popular is a rating system based on the number of patient visits, procedures provided, or hours worked, as opposed to an annual per-physician rate. Given the likelihood of a continued shift from independent practice to employment, it is important to understand the benefits and complexities of this type of rating procedure. In this article, we will focus on per-patient-visit rating; however, a rating based on number of procedures performed or hours worked is similar in concept.

Benefits

Per-patient-visit rating is most often used in, and probably best suited for, rating physician groups or healthcare entities that consist of fairly homogeneous risk exposures. Emergency physician groups, urgent care centers, or other walk-in medical clinics are the ones most commonly rated on this basis. Per-patient-visit rating may be advantageous in these situations for several reasons.

First, there may be a relatively high rate of turnover among the employed physicians. The per-visit group rating eliminates the need to add or remove individual physicians from the policy as they come or go from the group.

Second, there may be significant uncertainty as to how many hours physicians will be working in these employment settings. For instance, some physicians may work only a few shifts a week, while others may work many shifts a week. A group purchasing liability insurance on behalf of its member physicians that is rated on an annual per-physician rate basis would presumably pay the same rate for each physician, assuming that they are all classified as full-time. In this case, the group is overpaying for the physician who works fewer hours and underpaying for the physician who works more.

The same is true for the group as a whole when they purchase liability coverage using annual per-physician rates. Under this rating method, premiums will be too low for a group with fewer physicians who work longer hours and provide more services, all else equal. The opposite will be true for a group that is more adequately staffed and working fewer hours per physician. It seems reasonable to assume that, generally speaking, the more adequately staffed group would be a better insurance risk. Ironically, however, this is the group that may be overcharged using an annual per-physician rate.

The number of patient visits is a better measure of the actual liability exposure. If utilized properly, per-patient-visit rating enhances the insurance company's ability to measure and price liability risk more precisely.

Third, when rating is done on a per-visit basis, the patient-visit total is usually audited at the end of the coverage year, and the premium is adjusted to reflect the actual amount of services provided during that year. When using annual per-physician rates, the premium is set at the inception of the policy and not adjusted in the event that a physician increases or decreases his workload during the policy period.

Last, in the case where a policy covers multiple locations or clinics, there is an additional advantage: it is easy to track and allocate insurance costs by location accurately. If physicians practice at various locations or rotate among locations, with per-patient-visit rating, there is little need to track the movement of individual physicians for allocating insurance costs.

Complexities

The main concept in per-patient-visit rating is this: the insurance company is no longer insuring the individual doctor, but, rather, the patient visits of the whole organization. This leads to issues and complexities that need to be well thought out before this type of rating structure is adopted.

First, although this type of insurance coverage attaches to the *patient visit* of the organization, the *individual physician* subject to an MPL claim will need to address that claim. This may create some difficulty when a claim insured under the group policy is made against a physician who is no longer with the group. Physician cooperation is a vital component of effectively defending or settling an MPL claim. A physician who has separated from a group may be less inclined to cooperate fully, particularly when the separation between the group and the physician has not been amicable.

Second, because there is limited underwriting of the individual physician, the insurer will find it difficult to reject a physician whom the group has decided to hire. This may be a challenging transition for traditional MPL underwriters. They will need to focus on assessing the organization as a whole, with an emphasis on risk management and patient safety procedures, as well as the extent of management's consideration of MPL risks in the hiring process.

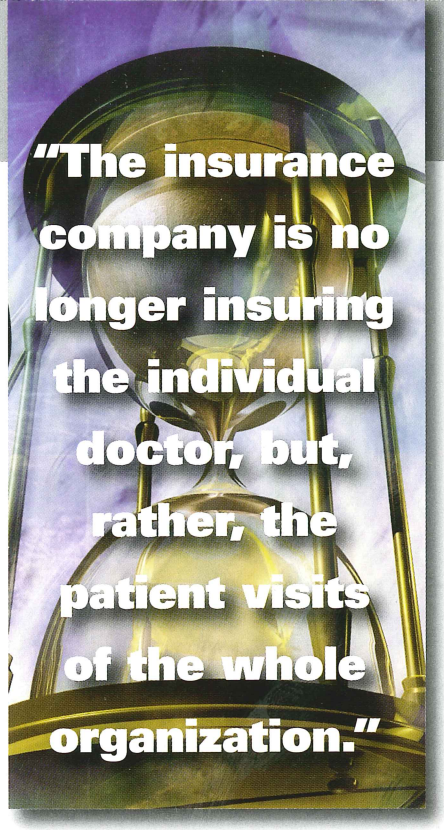
Third, several complexities are related to properly pricing the claims-made coverage that is most often offered by MPL insurers. One example: when mature claims-made coverage is provided to an organization and a new physician replaces another within the group, the insurer must still collect a mature claims-made premium for the patient visits of the new physician, even if that particular physician would otherwise be categorized as a first-year claims-made exposure. This is required because, as the group's claims-made policy is renewed, it insures all claims reported against the group that are related to patient visits serviced by the group. This includes claims associated with the patient visits of the prior doctor, and the insurance company needs to collect premium for this exposure. In the example above, the mature claims-made premium charged for the new doctor can be thought of as a combination of the first-year claims-made premium for the new physician and the tail exposure of the previous physician, picked up as part of the renewing group claims-made policy.

Similarly, an insurance company should be careful in developing the claims-made premium when the number of patient visits is changing over time. As stated previously, rating on a per-patient-visit basis lets the insurance company account for changing exposures. However, the rates and rating factors must be determined appropriately. Here is an example when physicians leave an insured entity and are not replaced. In this situation, if an insurer computes the premium by applying an unadjusted rate to the calendar-year patient visits for the prospective coverage year, as is commonly done, the insurer will not collect enough premium. As the organization's claims-made policy is renewed, the group policy continues to pick up the expected reported claim exposure of the historical patient visits, even for the physicians who are no longer with the group. However, because the insurer will apply the unadjusted rate to the projected patient visits for the prospective coverage year, which are now fewer than what has been historically insured, it will collect too little premium.

There are various ways to account for changes in exposure over time when rating claims-made coverage on a per-patient-visit basis. One way is to include the historical growth rate in the development of the mature claims-made rate and claims-made step factors. However, this approach requires an assumption about the growth rate of exposures. Unless the step factors are updated annually, it also assumes that the growth rate will be the same over time. Without some adjustment process, this proce-

Table 1 Conversion Chart

	(1)	(2)	(3) = (1) * (2)
Calendar Period	Calendar Period Visits	Expected Percent of Total Cost for Claims Occuring in Calendar Period and Initially Reported in 2011	Expected 2011 Reported Claim Exposures
2007	4,000	10.0%	400
2008	6,000	25.0%	1,500
2009	7,500	30.0%	2,250
2010	8,400	20.0%	1,680
2011	8,800	15.0%	1,320
Total 2011 Claims-made/Reported Claim Exposure			**7,150**



dure is still subject to unexpected changes in group size. Furthermore, if the same rates are applied to multiple insured organizations, it will be assumed that they all share the same underlying rate of growth.

A more precise approach is to convert the historical calendar-year visits to estimate the reported claim exposure and then apply an occurrence rate to the converted exposures. This is done by applying a claim-reporting pattern to the historical exposures, by year, to estimate what portion of each historical year's exposure will be expected to produce reported claims in the prospective coverage year, as demonstrated in Table 1.

Notice that the number of 2011 calendar-year visits is higher than the 2011 claims-made equivalent visits. If an insurance company applied an unadjusted per-visit rate directly to the 2011 calendar-year visits, it would in essence overcharge the insured group for claims-made coverage. This is because the exposure is growing over time, and the lag between the occurrence and reporting of claims creates a lag in reported claim exposure. The opposite is true if the number of exposures has been declining over time. Notice that this method eliminates the problem, previously discussed, of calculating the appropriate premium when a significant number of physicians join or leave the group.

Note that if patient visits are constant over the historical exposure period, there is no difference in the calendar-year or claims-made equivalent exposures. This assumption underlies per-physician rating. When we rate on a per-physician basis, we assume that all full-time doctors perform the same number of services each year. This unrealistic assumption is eliminated if rating is done on a per-visit basis and the actual historical exposures are used, as demonstrated above.

The example above illustrates the exposure calculation for a mature claims-made policy. If you were rating a first-year claims-made policy for 2011, you would need only the last line of Table 1, and the per-visit rate would be applied to the 1,320 visits. If you were rating a second-year claims-made policy, you would need the last two lines of reported claim exposure (1,680 + 1,320 = 3,000). Notice that in this example, it requires five years of calendar-year-exposure information to properly rate one mature claims-made coverage year. This is due to the assumed claim-reporting pattern in this example, which reflects an expectation that all claims occurring in a period will be reported in five years.

When an insurance company introduces a per-patient-visit rating option, it may not have the historical patient visits, and related claims experience, needed to directly project per-patient-visit rates. The company may need to convert an existing per-physician rate to a per-visit rate. This requires that the per-physician rate be divided by an estimated average number of visits provided by a physician per year. This estimate is critical. If the estimate is too high, the rate will be too low, and vice-versa. This problem is eliminated if the company has the historical patient-visit information, and related claims experience, needed to derive the per-patient-visit rate directly.

Prior acts and tail coverage need to be considered, and understood, as they relate to this coverage. Prior acts coverage may not be available, or insured separately from the standard claims-made group policy for new physicians joining a group. Including any prior acts within the claims-made group policy would require adjusting the historical exposures of the group to account for the added exposure. One way to address this issue is by requiring physicians to purchase tail coverage from their previous insurance carrier rather than obtaining their prior acts coverage within the new group's insurance structure. However, this approach may act as a disincentive for a physician to join a group.

Tail coverage can be a tricky issue, too. As long as the group continues to renew its claims-made coverage, there is no tail claim exposure for individual physicians who leave the practice, because the late-reporting claims will be covered under a renewing group claims-made policy. However, if the group stops renewing the claims-made coverage, all physicians, including those who have left the group in previous years, may be facing an uninsured tail exposure. The physician employment agreement must explain, in clear language, how tail exposure will be handled in this situation. Perhaps the most straightforward way to handle this exposure would be to require that the group buy a tail policy endorsement, attached to the group policy if it is non-renewed for any reason.

Conclusion

As changes in the healthcare landscape continue to entice doctors to leave private practice and instead become employees with physician groups or healthcare systems, group rating, and possibly per-patient-visit rating, will continue to assume increasing importance. In implementing and utilizing this type of rating, it is important to understand its subtleties and complexities, to ensure proper measurement and pricing of the exposure. †PIAA

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