On Your Behalf …
Legislative and Practice Affairs Division

Tail Coverage: Whose Responsibility Is It?

By Phillip Goldberg, Esq., CSA Legal Counsel

As more anesthesiologists join group practices, they find themselves having to address issues that were not a concern as solo practitioners. These issues include compensation, term and termination of the group affiliation, management and governance of the group, and medical liability insurance. As a solo practitioner, an anesthesiologist needs medical liability insurance for his or her own negligent acts or omissions. In an anesthesia group, medical liability insurance coverage is necessary for both the individual anesthesiologist and the group, because the group may be vicariously (i.e., automatically) liable for the negligence of group members. Medical liability insurance companies usually require all members of a group practice to be covered by the company for their individual negligence as a condition of covering the group. This means some physicians may have to change their medical liability insurance company as a condition of joining a group practice. Virtually all physician medical liability coverage in California is written on a "claims made" basis, which means "tail" coverage may have to be purchased when a member leaves to ensure that the group (and the individual anesthesiologist, for that matter) has insurance coverage when a claim is made after withdrawal for an act or omission that occurred before withdrawal. In this article I will discuss the need for tail coverage in a group practice context and who assumes responsibility for tail coverage premiums when the need arises.

Understanding tail coverage requires an understanding of claims-made insurance coverage. Under a claims-made policy, a claim is covered only if it is first made against the physician and reported to the insurance company during the policy period. A further condition is that the act or omission that gave rise to the claim must have occurred on or after the "retroactive date" applicable to the policy. This is to be contrasted with "occurrence"-based coverage in which the insurance company agrees to defend and indemnify the policyholder for an act or omission during the policy period, irrespective of when that claim is made. Unlike an occurrences policy, when a claims-made policy is terminated, special action needs to be taken to protect against claims made in the future that relate to events occurring in the past. One way to protect against these

claims is to buy "nose" coverage from the new insurance company providing a claims-made-policy to a withdrawing physician. With nose coverage, the new policy has the same retroactive date as the previous policy. This can best be described with an example. If an anesthesiologist commences private practice out of training on July 1, 2005, and secures claims-made coverage as of that date, July 1, 2005 will be the anesthesiologist's retroactive date. If a claim were made against the physician for an act or omission during his or her residency, it would have occurred prior to the retroactive date and would not be covered under the anesthesiologist's claims-made policy, even though the claim was first made and reported to the company during the policy period. (In this case, the claim would likely be covered under the occurrence-based coverage secured by the hospital where the anesthesiologist trained.) If, on July 1, 2006, this anesthesiologist joined another group that was covered by another insurance company and secured nose coverage from the new company, the retroactive date under the new policy would be July 1, 2005, even though the policy inception date was July 1, 2006. When a claim is made on July 1, 2007, for an act or omission occurring on January 1, 2006, it would be covered under the anesthesiologist's new claims-made policy, and his or her former group would be covered under its claims-made policy that continued in effect after the anesthesiologist withdrew. If the anesthesiologist does not secure nose coverage when he or she leaves the group, it is a practical (but not a legal) necessity that tail coverage be obtained to ensure that the physician is covered for any claim brought after withdrawal from the group for an act or omission that occurred while with the group. In the situation above, if the physician withdrawing from the group did not obtain nose coverage with a new insurance company, it would be a practical necessity to obtain tail coverage from the old insurance company. If this occurred, the claim made on July 1, 2007, for an act or omission occurring on January 1, 2006, would be covered under the tail policy issued by the former insurance company.

If the anesthesiologist leaves the group because of death, disability, or retirement, tail coverage is usually provided by the insurance company without payment of additional premium. However, if the anesthesiologist leaves the group for any other reason, the question of who pays for the tail policy is one that needs to be addressed by the physician and the group. Ideally, the question is addressed before the need for the tail policy arises. There is cost significance to tail and nose coverage that may lead the physician and the group parties to prefer one type of coverage to another. If a physician secures tail coverage from his or her former insurance company when changing insurance, the physician will pay lower rates with the new company because he or she does not have a history that could give rise to claims made in the current year for acts or omissions in prior years. Physicians just out of training also pay lower "new

physician rates" for the same reason. Accordingly, an anesthesiologist who can have his or her former group pay for tail coverage may have an incentive to do so because this allows the anesthesiologist to pay lower annual premiums with the new insurance company for a few years.

The most common tail coverage arrangement in my experience is where the physician assumes financial responsibility for tail coverage while the group pays for the claims-made coverage during the term of employment. This arrangement makes sense when you consider the withdrawing anesthesiologist's actions affect the need for tail coverage. If the physician is old enough to retire and has been a policyholder of the insurance company long enough to be entitled to tail coverage without additional premium, it may seem fair and reasonable to saddle that individual with the cost of tail coverage when he or she decides to work part-time in "retirement" so that free tail coverage is not available. By contrast, it may be more appropriate for the group to pay for the cost of tail coverage on the withdrawal of a group member in other circumstances. Consider the situation where the withdrawing group member was required to change his or her long- time insurance company when joining the group to conform to underwriting requirements for the group's insurance company. If the physician subsequently retires but is not entitled to a tail policy without additional premium because he or she has not been covered by the new company for a long enough period of time, it may be more appropriate for the group to bear the cost of tail coverage. There are, of course, an unlimited number of situations in which an anesthesiologist may withdraw (or be expelled) from a group practice.

Provisions of California law restrict the ability of an employer to saddle an employee with the "costs of doing business." More precisely, the law requires that employers indemnify their employees for necessary expenditures or losses incurred by the employee in the discharge of his or her duties.[1] Physician employees, who are contractually responsible for their own tail coverage on withdrawal from the group, have used this law to refuse to pay for a tail policy, asserting that they cannot be compelled to purchase tail coverage because this is a cost of doing business that the employer must bear. Although the law does not compel the group to pay for the tail coverage for its terminating member when the anesthesiologist refuses to pay, the group runs the risk of a claim for indemnity by that former employee when and if a claim is brought against the employee for an act or omission during the period of affiliation with the group. If the former member was ultimately found liable, the group may assert it is entitled to reimbursement of defense costs it paid and that the former employee

[1] California Labor Code section 2802(a)

has to pay any judgment in the action because those liabilities result from the employee's negligence. The group and its former employee do not want to find themselves in a situation where there is no insurance coverage and then sue each other over who is responsible for defense and indemnity of a pending malpractice claim.

Once individuals and groups recognize that a lapse in medical liability coverage is not in anyone's best interest, it may be easy for them to see that the best way to deal with financial responsibility for tail coverage is in severance payment provisions of the anesthesiologist's contract with the group. It is a fairly common matter for anesthesiologists (and especially those who are owners of their group practice) to be entitled to severance pay after their withdrawal from the group. Typically, severance represents the withdrawing member's interest in the accounts receivables of the group practice. There are tax advantages to the group in passing out the receivables as severance pay as opposed to part of the repurchase price for the anesthesiologist's ownership interest in the group practice. The parties are free to calculate severance pay in a fashion that takes into consideration the cost of tail coverage. For instance, the severance payment formula could indicate the payment otherwise due is reduced by the cost of the tail policy. Under this formula, if the tail policy is provided without additional premium or the withdrawing anesthesiologist secures nose coverage so that the purchase of a tail policy is not required, there would be no reduction in the basic severance payment because the cost of tail coverage is zero. The severance provision should also specify who has financial responsibility for the tail coverage in other situations. For instance, severance pay may not be reduced by the cost of tail coverage for a physician who retires from the practice of medicine but does not get a tail policy issued without additional premium because he or she was compelled to move to a new insurance company just before retirement when a new group was formed and anesthesiologist joined the group. In fairness, the group may assume financial responsibility in this situation. A significant benefit to addressing tail coverage in the context of severance pay is that payment for the tail coverage, if any, is paid by the group. The group retains the funds for payment of the tail policy and does not have to rely upon the withdrawing member to take care of this important detail. The former member cannot assert California law which prevents the employer from shifting the cost of the tail coverage to the withdrawing employee in the severance payment context. Since there is no statutory obligation to pay severance, it can be calculated in any manner the employer and employee determine without being subject to challenge later.

The statute that prevents an employer from shifting costs to employees applies only in the context of a group organized as a medical corporation. If the group is formed as a partnership, there is no prohibition on requiring the withdrawing partner to pay for the cost of tail coverage. Nevertheless, I still recommend that the partnership agreement reduce the payment otherwise due to the withdrawing partner by the cost of tail coverage. Where the group retains the funds to pay for the tail coverage, it is much more likely to ensure that both the group and the former member are protected.

When it comes to tail coverage, an ounce of prevention is worth a pound of cure.

PacifiCare's Court Loss Makes Useful Point

By David E. Willett, Esq.
CSA Legal Counsel

An April 27, 2007, decision by the California Court of Appeal in a suit against PacifiCare by the husband of a deceased Secure Horizons patient makes a point that physicians should also bear in mind. The rights of persons contracting with health plans depend on the agreement that was made, aside from statutory requirements. Unilateral health plan efforts to impose different rules are not enforceable, absent agreement by the other party.

Elsie Martin enrolled in PacifiCare's Secure Horizons HMO in 2001, signing an enrollment agreement that included an evidence-of-coverage (EOC) form requiring arbitration of differences "between myself and Secure Horizons." Elsie suffered a brain aneurysm in August 2003, and died in January 2004. Her husband sued, claiming that Secure Horizons delayed treatment and refused to permit needed referrals to specialists outside the plan.

PacifiCare thereafter asked the court to compel arbitration, relying on a new 2003 EOC that extended the arbitration requirement to heirs of beneficiaries. Although purporting to be effective January 1, 2003, the EOC was not mailed

until July of that year, and there was no notification that it changed the arbitration requirement.

The Court's decision notes that determining the effectiveness of the 2003 EOC requires "applying ordinary state law principles that govern the formation and interpretation of contracts." The fundamental principle here is the requirement for *agreement* on contract terms. The decision recites that "PacifiCare argues that it was entitled to enlarge the scope of the 2001 EOC by simply sending Martin the 2003 EOC. But, PacifiCare fails to identify where Martin agreed that PacifiCare could unilaterally do so."

Because Elsie Martin had never accepted the 2003 change in terms, and inasmuch as the original agreement did not allow unilateral changes in the arbitration clause, the Court concluded that the 2003 EOC has no effect. Elsie Martin's husband was allowed to continue with his suit for bad faith and wrongful death.

Unilateral changes to agreements between anesthesiologists and health plans, IPAs or medical groups are not infrequent. When such an effort occurs, the anesthesiologist must determine whether the contract itself permits the other party to make the change. If there is language describing such a right, the next question is whether any required notice has been given, and whether the change meets contractual requirements.

This case illustrates a further point that anesthesiologists should bear in mind. When reviewing a contract, prior to signature, provisions for unilateral changes require careful examination. This is true as to all contracts, whether with payers, employers, hospitals, or others. Vaguely described provisions allowing the other party to change rules, requirements, or other governing conditions require caution. A guiding principle is the need to couple a provision allowing you opportunity for contract termination, or some dispute resolution process, before any unilateral change can become effective. If there is no provision allowing unilateral change, efforts to change the agreed-upon arrangement may be unenforceable, as PacifiCare learned in this case.

What We Do for CSA—Updated

By William Barnaby, Jr.
CSA Legislative Advocate

A little over three years ago, this column attempted to inform CSA members about our role and the benefits we bring to the organization. More recently, a member of the Legislative and Practice Affairs Division (LPAD) observed, "We hear you guys do a good job, but nobody really knows what you do."

The message was received. The CSA membership and even some in leadership positions are not clear on how our efforts support and further CSA goals of promoting the specialty of anesthesiology in providing high quality medical care in a manner that is in the best interests of patient safety while also addressing other core concerns of CSA members (e.g., reimbursement and quality of life issues).

Hence, this is an updated and more tightly focused reprise of the prior offering in hopes that Bulletin *readers will better understand "what we do for CSA" and specifically what each one of us, Bill Sr. and Bill Jr., brings to CSA as your lobbyists.*

The role of lobbyists in representing private citizens and organizations before government often is unclear even to those who use their services. Lobbying sometimes is depicted as mysterious, manipulative or even insidious. Conversely, the role can be seen as putting the right information before the right decision-makers to produce good public policy and the result most helpful to the client. We try to fit into the latter category.

Just as the lives of CSA members have changed, so has the lobbying profession. As government becomes more complex and technology quickens communication, the challenge becomes greater. It entails far more than lurking around the halls of the Capitol.

For example, our work for CSA involves:

- Identifying proposed legislation and regulations of interest. Usual issues of interest for CSA include physician licensing, Medi-Cal, workers' compensation, scope of practice, hospital and clinic regulation, managed care and medical malpractice. We analyze these proposals, recommend positions to CSA leadership as appropriate, and work with allies to pass or defeat proposals as they are considered. For legislation, this requires development of background information, face-to-face conversations with legislators and staff, arranging expert witness testimony when necessary, monitoring amendments and following bills through as many as six committees,

debates on the Senate and Assembly floors and to the Governor's desk. In sum, it is an effort to influence the outcome at each stage in a manner most favorable to the CSA. It is worth noting, however, that rarely is an issue decided solely on public testimony, contrary to the belief of many. Frequently legislators have conflicting time commitments so they may only get to a committee hearing at its end to add their votes to the roll without hearing any of the discussion. That is where the individual lobbying and a good reputation come into play. In sum, you need not be an orator to be an effective lobbyist.

- Understanding and articulating how these proposals substantively affect CSA members and their patients. This frequently means consulting with CSA members, officers, staff or other relevant experts.
- Establishing relationships and credibility with decision-makers, whether they are members of the Legislature or the Executive Branch. Getting to know 120 legislators in this era of term limits, their staffs, and committee consultants is a full-time job in itself. But it is essential if one expects to make a difference at critical times. The same is true of those holding administrative positions in key agencies such as the Department of Health Care Services (DHCS), the Medical Board of California (MBC) and an entire array of state agencies. And it does not hurt to have a few friends or acquaintances among the Governor's key advisors located in the "horse-shoe" within his "corner office."
- Maintaining rapport with other lobbyists. Besides working with allies and coalitions on certain issues, especially those within the medical community, this is an important source of information. Early warning of impending actions is often gained and problems avoided before they become serious. Lobbying the lobbyists is extremely important, especially our colleagues at the CMA. In fact, both of us are members of CALPAC, in addition to GASPAC, and take part in weekly CMA staff meetings by telephone or in person.
- Helping CSA members with problems associated with their practices, such as Medi-Cal reimbursement and Medical Board issues.
- Keeping track of almost continuous campaign fund raising events, both in Sacramento and in legislative districts. Invitations and campaign literature arrive daily by mail, fax and e-mail. At critical times during an election cycle, as many as 100 campaign events occur in a month. Campaign fund raisers never cease and this function occupies a lot of our time. We coordinate GASPAC contributions to legislative and statewide office incumbents and candidates based on their sensitivity to issues of concern to CSA members and their accessibility. Campaigns for public office are expensive in California, and GASPAC helps greatly in maintaining the

visibility of CSA. These donations are used for our attendance at Sacramento events (breakfasts, lunches and evening receptions) as well as for local events for GASPAC contributors. Key contacts between CSA members and legislators often are formed in this way. **Discussion of specific issues, bills or votes with the recipient of a donation at these events is illegal and must be avoided.** But conversations can establish social rapport or even pave the way for subsequent meetings of a substantive nature.

- Reporting to the CSA and the membership about state government and political activities that potentially impact their practices and patients. This can be much more difficult than is apparent at first glance and is a reason why our efforts are sometimes not all that visible to the membership. Legislative and political developments can move rapidly at times, which renders the *Bulletin* as an ineffective reporting vehicle. The electronically transmitted *Gasline* usually is too brief for our material. Recently we began submitting periodic legislative updates for posting on the CSA Web Site in the members only section, but the information on presently active bills certainly does not convey all of what we do, nor do we want opponents to be privy to our plans.
- The foregoing is just an outline of what we do. It really does not fully describe the constant give and take between decision-makers and the so-called "Third House," the lobbying community. Knowing partisan implications, intra-party relationships, and personal preferences of legislators all can be factors in tailoring how an issue is advocated. Good bills have been lost because a committee chair is angry at a legislative author or a sponsoring organization. Knowing what *not* to say can be more important at times than what is said.

Lobbying is not an office-based business. **The more time we spend in the office rather than in the Capitol, the less effective we are.** However, there are times when it is necessary for one of us to hold down the fort and the other to be in the Capitol. As in recent weeks, I work the phones/e-mails as legislators and staff members call for background information needed ASAP while Bill Sr. provides the testimony. We split it that way because Bill Sr. is more experienced testifying, and I can find relevant background on the Internet and/or in our office in a fraction of the time it would take him. It works very well for us!

Answering telephone calls and responding to individual e-mails are necessary but detract from our core tasks. As for representing CSA, it is important for us to be visible, ethically correct, tolerant of opposing points of view, truthful and careful not to be offensive. We are expected to have some knowledge about

medical matters, or at least be capable of obtaining reliable information when needed.

Reputations are gained over time and are passed on from previous to current office holders. A good reputation is a great asset. Lobbyists with questionable reputations usually are not around very long. They begin to lose their effectiveness when word gets around they cannot be trusted, and they lose their credibility—which is the key to being a successful lobbyist.

Longevity for those who survive over the years can also be an asset as the elder of our team can attest. Having known parents, relatives and friends of current office holders can be most beneficial. Experience also gives perspective on how laws and programs began, evolved, and why they need to be continued or changed, especially in this term-limited era.

For us, the father and son team works well. Our appearance together at fund raisers tends to be remembered better than that of individuals. It does not bother us at all to be known around the Capitol as the "Barnaby boys," or the "Barnaby brothers," or "Team Barnaby." The younger member of our firm is the designated contact for his contemporaries in the Capitol for obvious reasons.

Lobbyists, or "legislative advocates," are defined by law as individuals who are paid to "attempt to influence state action." We are attorneys although being a member of the State Bar is not required to be a lobbyist, and many lobbyists are not. But it helps to understand how laws are constructed, interpreted and enforced.

Lobbying is a dynamic, ever-changing field. Issues and public officials come and go. Over the years more and more interests and organizations have found formal representation before government as helpful, if not essential. We strive to bring timely information to bear on how proposed government actions will affect our clients and their patients.

Lobbying can be exciting, exhausting and frustrating. But representing solid clients who perform services valuable to society, such as the CSA and its members, makes it worthwhile.

We hope this article may help some better understand "what we do for CSA," and also invite suggestions as to how we could better inform CSA members what we are doing for them WITHOUT tipping our opponents (health insurers, CRNAs, etc.) about what we are trying to do to them.