Telemedicine and the Challenge of Patient Compensation Funds

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Telemedicine offerings and utilization are on the rise in the US and around the globe. According to a 2021 report by McKinsey & Company, new analysis indicates telehealth use has increased 38X from the pre-COVID-19 baseline.[1] This increase in patient utilization is being met by a number of large telemedicine providers with a national footprint.

Along with the growth in telemedicine utilization comes the need to address potential claims alleging medical malpractice by those providing such services. Telemedicine providers usually provide medical professional liability insurance (MPL) to their employed and third-party contracted physicians and other clinicians through a corporate program. Many telemedicine providers offer services in multiple or all 50 US states. MPL is often structured with a single insurance limit that covers all providers and entities across the practice and in all states. This shared limit approach is beneficial to all parties because it provides a simple solution that allows for a single coordinated defense in litigation and offers coverage for individual providers for events that may have occurred while delivering services on behalf of the telemedicine company, even after termination of their relationship with that organization. Limits can be tailored to provide sufficient coverage in US venues and is readily available in the marketplace.

Most telemedicine companies and their respective employees and clinicians are insured under an excess & surplus lines policy (E&S) for MPL coverage. E&S coverage is defined as "any type of coverage that cannot be placed with an insurer admitted to do business in a certain jurisdiction."[2] While originally introduced as a means to place substandard insureds, the E&S market routinely allows insurance carriers to provide terms and conditions that are specific to a given insured or class of business. Insurance brokers often access the E&S markets to obtain coverage that may be much broader than what may be available with admitted carriers. Carriers that are admitted within a given state have filed their policy forms and rates with the state's insurance department, and in the event that the insurance company fails, the state will step in and make claim payments[3]; however, the claim payments made by the state may not represent the full value of the claim as there may be caps on the total the state will provide. E&S insurance policies do not have the protection of the state for insolvency, but because they are not subject to some of the state regulations they are able to provide some terms and conditions that may not be available with admitted carriers.

Telemedicine companies that provide physician services have benefited from the flexibility of E&S policies and custom policy language. By utilizing such programs, the availability of coverage for such exposures as sexual abuse and molestation allegations by patients against healthcare providers and punitive damages coverage (in states where this is legally insurable) are routinely available. Special endorsements providing protection for the unique exposures associated with telemedicine can also be negotiated and added to an E&S policy. These exposures are often not covered by admitted polices. Most coverage written on hospitals and other allied healthcare organizations are written with E&S policies due to this flexibility.

There are several states in the US that feature patient compensation funds (PCFs). PCFs, which may also be called excess recovery funds, are state-operated programs that afford excess insurance coverage for healthcare providers, including physicians, hospitals, dentists and some allied healthcare professionals as defined by the International Risk Management Institute. These PCFs provide the advantage of certain caps for healthcare providers relative to damages to a plaintiff based on the respective statute of the state in question. The PCF will then provide amounts of a claim exceeding the threshold amount. Healthcare providers carry private insurance for the amount that they are responsible for and then pay a surcharge to the PCF.[4]

A major challenge for all telemedicine providers operating with a national footprint are with PCFs and the various requirements that individual states will dictate. These requirements often are in conflict with the flexibility and benefits that are afforded by utilizing E&S insurance coverage for an MPL program.

Participation in a PCF requires individual limits for each provider, which adds more cost and complexity to the overall insurance program for the telemedicine company. If an admitted policy is required, the telemedicine company may be forced into procuring an additional policy for the provider or providers practicing in the PCF state.

A review of the respective states with PCFs follows. The requirements referenced in this outline are specific to physician providers, as requirements for hospitals and other providers may vary.

Indiana: The Indiana PCF requires that healthcare providers carry underlying limits of $250,000 per occurrence and $750,000 annual

aggregate in individual limits by a state-approved provider of underlying MPL coverage. The state will not allow the use of shared limits, but an E&S carrier is acceptable. Participation in the Indiana PCF is not compulsory, but it does provide an overall cap on damages of $1 million in addition to the underlying $250,000 provided by the insured. Surcharges are determined by the PCF and updated periodically.[5]

Kansas: The Kansas Health Care Stabilization Fund (HCSF) requires providers to carry underlying limits of $500,000 occurrence and $1.5 million annual aggregate in individual limits by a state-approved provider of underlying MPL coverage. Kansas is the most challenging state for telemedicine providers, as participation in the HCSF is compulsory and medical licensure is dependent on participation. Surcharges are determined by the PCF and updated periodically. Kansas requires use of an admitted carrier for resident physicians, but nonresident physicians may use an E&S carrier.[6]

Louisiana: The Louisiana PCF requires a provider to have responsibility for the first $100,000 per claim exposure through either private insurance or by security deposit. Minimum underlying insurance requirements are $100,000 per occurrence and $300,000 annual aggregate in individual limits. Surcharges are determined by the PCF and updated periodically. The use of either an admitted carrier or an E&S carrier on the state's approved list is acceptable.[7]

Nebraska: The Nebraska Excess Liability Fund is not compulsory. It requires that healthcare providers carry underlying limits of $500,000 per occurrence and $1,000,000 annual aggregate in individual limits by a provider of underlying MPL coverage issued by a carrier admitted in that state. The state does provide an overall cap on patient damages of $2,250,000.[8]

New Mexico: The New Mexico PCF is not compulsory. It requires that healthcare providers carry underlying limits of $250,000 per occurrence and $750,000 annual aggregate in individual limits by provider of underlying MPL coverage issued by a carrier admitted in that state. Surcharges are determined by the PCF and updated periodically.[9]

Pennsylvania: The Medical Care Availability and Reduction of Error Fund (Mcare) is mandatory for all providers that spend 50% or more of their practice in the state of Pennsylvania. This requirement often allows part-time telemedicine providers with minimal patient activity in the state to opt out of Mcare. Participation in Mcare requires that healthcare providers carry underlying limits of $500,000 per occurrence and $1,500,000 annual aggregate in individual limits issued by a carrier admitted in that state. Mcare provides excess protection of an additional $500,000 per occurrence and $1,500,000 annual aggregate. Surcharges are accessed based on a percentage of the underlying premium and are currently set at 19%.[10]

South Carolina: The South Carolina PCF is not compulsory. It requires that healthcare providers carry underlying limits of $200,000 per occurrence and $600,000 annual aggregate in individual limits by a provider of underlying MPL coverage issued by a carrier admitted in that state. Resident and nonresident physicians who practice a minimum of 80% in the state are eligible for participation. Coverage in the PCF is available as excess insurance above the underlying private insurance and is rated by the state's insurance department.[11]

Wisconsin: In Wisconsin, the Injured Patients and Families Compensation Fund provides protection above the required underlying layer of MPL insurance, which is set at $1,000,000 per occurrence and $3,000,000 annual aggregate in individual limits. The fund pays all patient costs and awards above the underlying limits. Underlying coverage must be provided by a carrier that is approved to do business in that state and is on the approved list. Wisconsin has specific requirements for telemedicine providers. Participation is mandatory if the physician meets the following criteria:

- More than 50% of the patients are from Wisconsin.
- More than 50% of the individual provider's revenue is from Wisconsin.
- The individual's practice in Wisconsin exceeds 240 hours per year.

Physicians that are under the minimums above may participate in the fund if they so choose. Surcharges are rated by the state's insurance department, based on the physician classification.[12]

The financial benefit of PCF participation will have to be made on a state-by-state basis by the telemedicine provider. Since participation in most PCFs is voluntary and based on individual physician volume in others, one must weigh the cost benefit of participation and associated caps on damages versus the amount of surcharges one would incur. While PCFs may offer discounting for part-time exposure in their respective states, these discounts may not be sufficient for an individual provider who only sees very few patients in that state.

Conclusion

State PCFs can be a nice benefit to healthcare providers in terms of limiting the caps on certain damages to patients. However, they bring about a big complexity for telemedicine providers with a large geographic footprint. PCFs require individual physician limits, which are usually in conflict with the preferred insurance limit structure of telemedicine providers. Most PCFs require the use of an admitted insurance carrier, where the majority of telemedicine providers utilize E&S carriers. The PCF can be especially costly for telemedicine physicians who may hold licenses in many states and only do a minimal number of patient encounters in the PCF state, where sufficient part-time credits may not be sufficient to justify participation. As telemedicine continues to gain popularity and utilization increases, we can hope that the various PCF states will provide more incentives and part-time discounting for providers.

[1]https://www.mckinsey.com/industries/healthcare/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality
[2]https://www.irmi.com/term/insurance-definitions/excess-and-surplus-lines-insurance
[3]https://www.investopedia.com/terms/a/admitted-insurance.asp
[4]https://www.irmi.com/term/insurance-definitions/patient-compensation-funds
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[8]https://doi.nebraska.gov/public-info/medical-malpractice
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[10]https://www.insurance.pa.gov/SpecialFunds/MCARE/Pages/default.aspx
[11]https://scmma.net/applications-forms/
[12]https://oci.wi.gov/Pages/Funds/IPFCFOverview.aspx

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Larry Hansard, M.S.M., is the National Director of the Digital Health & Telemedicine team. Larry has over 33 years of experience in the insurance industry and has worked in national brokerage firms as well as small regional organizations. He is a noted speaker on topics affecting the healthcare industry, including captive insurance companies, medical professional liability and general risk management issues. Larry previously served as an account executive on a large portfolio of healthcare accounts and as the National Healthcare segment leader for industry-specific teams.

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