

# NAVIGATING THE REAL WORLD

of Medical Professional  
Liability Insurance

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**IN THIS ENVIRONMENT,  
IT IS ESSENTIAL TO SPEND  
THE TIME TO BECOME  
EDUCATED *BEFORE*  
CHOOSING A CARRIER  
AND A POLICY,  
RATHER THAN FINDING OUT AFTER  
A CLAIM IS FILED THAT THERE IS  
LIMITED COVERAGE, NO CONTROL  
OVER SETTLEMENT DECISIONS, OR  
WORSE, NO COVERAGE AT ALL.**

## WELCOME

"Navigating the Real World of Medical Professional Liability Insurance" is a reference guide designed to outline the issues to consider and the questions to ask during the process of purchasing medical malpractice insurance. This guide will provide the tools necessary to recognize the substantive differences between not only the policies presently offered in the market, but also between the carriers that offer them.

**Note that each section in this guide has a list of questions at the end. We recommend that you review the questions, pare them down to the ones that apply to your particular circumstances, and raise them to each potential medical malpractice carrier.**

We hope you find that this guide makes you more informed about medical malpractice insurance, ultimately easing the purchasing process and allowing you to better meet your insurance needs. After all, a policy that provides a million dollars in coverage is worth nothing if that policy excludes ordinarily performed procedures, or unexpectedly results in denied coverage.

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# INTRODUCTION

The purpose of medical malpractice (MedMal) insurance is to defend healthcare providers against claims and to pay out judgments or settlements when necessary. Therefore, when choosing a MedMal carrier, one needs to examine the policy provisions, the ability of the carrier to pay a judgment or settlement and the quality of the defense provided. Furthermore, given the importance of a healthcare provider's reputation, it's imperative to understand the healthcare provider's role in determining whether to fight or settle a claim.

Practicing medicine without liability insurance, or "going bare," is something healthcare providers should never do. Instead, all healthcare providers should view medical malpractice insurance as a necessity. In fact, state law, state licensing boards, hospitals, employers, or healthcare benefit payers may require healthcare providers to obtain MedMal coverage. If required, there may be specific requirements regarding the types and amounts of coverage.

## STATISTICS SHOW ALL MEDICAL PROVIDERS ARE VULNERABLE TO LAWSUITS.

The difficulty does not lie in deciding whether to obtain coverage, but rather determining the right type of coverage and identifying which of the carriers are financially sound. Healthcare providers need to be confident they're choosing the best coverage and carrier for their needs.

Physicians and other healthcare providers face some of the most difficult, demanding, and lengthy training of any profession. However, this training does nothing to prepare them for the financial, professional and personal toll that comes with a medical malpractice lawsuit. The grim statistical reality facing all healthcare providers – regardless of their field, experience, or even skill level – is that they are vulnerable to lawsuits. In fact, the current legal climate in the United States has made the medical community prey to more claims of negligence, and demands for money, than any other professional field.<sup>1</sup>

Beyond the obvious financial strain, a medical malpractice lawsuit generates enough emotional distress to affect your job performance and your health. As a matter of fact, 95% of physicians describe periods of emotional distress during the litigation process.<sup>2</sup> Many medical providers view a lawsuit as a personal attack on their competence, a personal failure and a professional shame.<sup>3</sup>

of physicians describe periods of emotional distress during the litigation process.

1 Highline Data 2010

2 Charles SC, Pyskoty CE, Nelson A. Physicians on trial: Self-reported reactions to malpractice trials. *West J Med.* 1988; 148:358-360

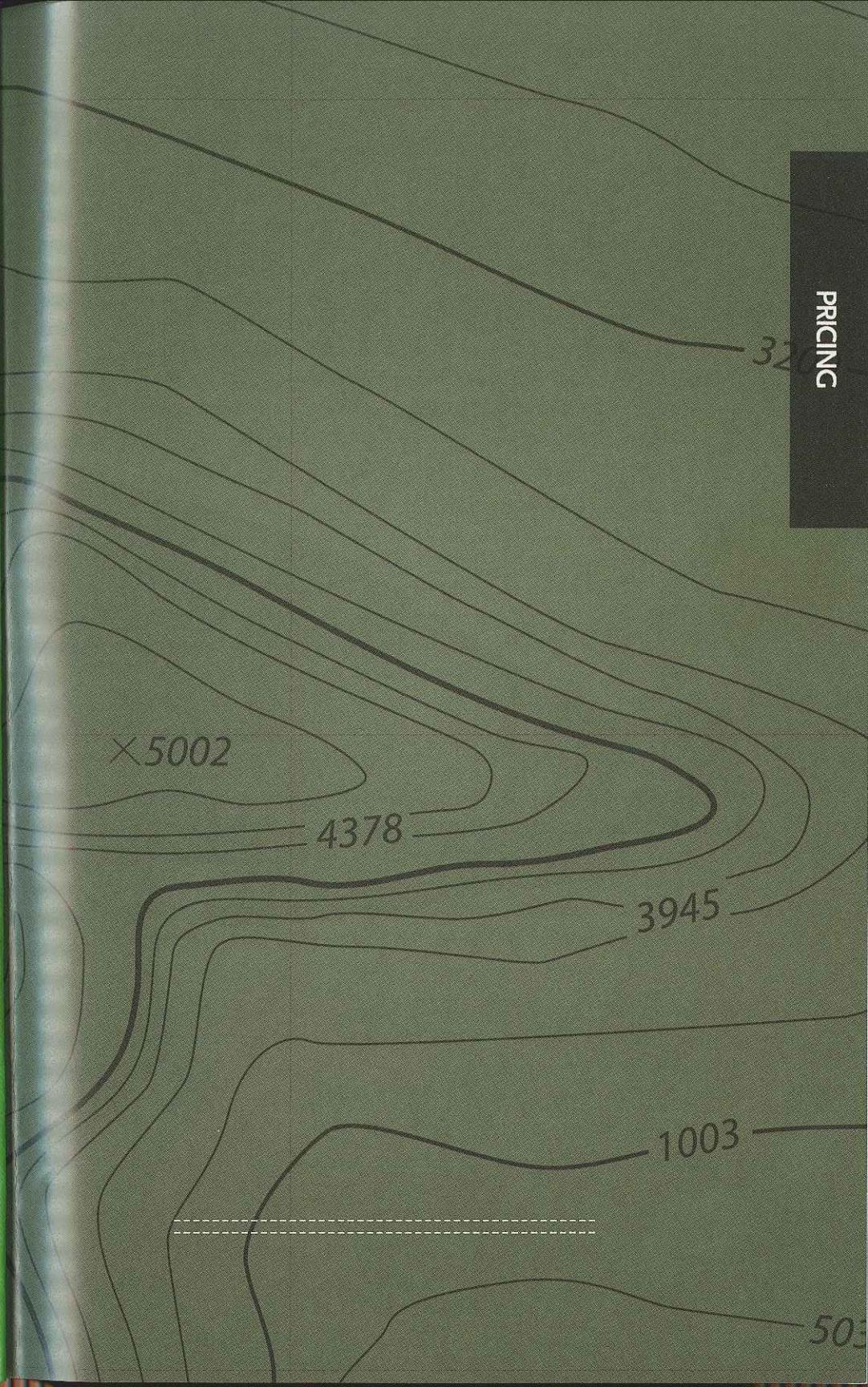
3 Charles SC. Coping with a medical malpractice suit. *West J Med.* 2001; 74:55-58

## CONSIDER A FEW STATISTICS:

- According to the National Association of Insurance Commissioners (NAIC), there are approximately 70,000 medical liability claims filed each year in the United States. Despite the fact that approximately two-thirds of such claims do not result in any payment to the claimant, the sheer volume of claims that are filed requires responsible providers to seek MedMal coverage.<sup>4</sup>
- Five percent of healthcare providers will have a suit filed against them in any given year. Twenty-two percent of those same providers will face another claim.<sup>5</sup>
- According to Medical Protective's own data collected over the last five years:
  - Average defense cost for frivolous cases – \$13,000
  - Average defense cost, if case is dismissed – \$15,000
  - Average defense cost, if claim is settled before trial – \$42,000
  - Average defense cost with trial – \$76,000
  - Average payment per claim nationwide – \$226,030

<sup>4</sup> NAIC, 2010

<sup>5</sup> Policy Research Perspectives: Medical Liability Claim Frequency:  
A 2007-2008 Snapshot of Physicians, American Medical Association 2010



# PRICING

## SHOULD YOU SHOP JUST ON PRICE?

There is a lot to consider when comparing MedMal policies. Although price will always be a factor, one should not shop based on price alone or assume that policies are all the same. The most expensive policy is not necessarily the best policy, nor is the least expensive policy likely to be the best value. Because MedMal policies vary dramatically in their scope of coverage as well as in the financial strength and experience of the carrier, it is wise to look beyond price.

## "ASK YOURSELF, HOW MUCH IS MY REPUTATION WORTH?"

Choosing a carrier based primarily on price can result in unexpected costs down the road. For example, if a healthcare provider loses a lawsuit, not only can their reputation and revenue suffer, but their insurance premiums may increase. If this occurs, the true cost to the healthcare provider is substantially more than the premium saved by choosing a less expensive policy from a less capable carrier.

***The sole purpose of purchasing an insurance policy is to be protected in the event of a claim,*** thus the true economic cost of an insurance policy is not just the initial premium, but additional costs such as loss of reputation, loss of business, and increased premiums down the road.

All of this aside, it is still important to understand as many facts as possible about the cost of the policy including who sets the premium, the carrier's method for calculating premiums, how to determine the best value for the money, and where the premium dollars go.

## TYPES OF INSURANCE PROFESSIONALS INVOLVED IN THE PRICING PROCESS

Several types of insurance professionals are needed to perform the pricing analysis, including:

**Actuaries** — The actuarial team is responsible for determining premium base-rates by performing statistical analyses of current and historical industry trends, past claims, inflation, interest rates and other data. The premium base rates are computed by determining how average policyholders perform in different specialties and geographical regions.

**Underwriters** — Underwriters assess the risk by reviewing the unique characteristics of each applicant. In ranking exposure to risk, underwriters review each healthcare provider's education and experience, while at the same time considering the practice environment, claim history, practice location, and whether the specialty is surgical or non-surgical. Underwriters then tailor the coverage offered based on whether the specific level of risk posed by a healthcare provider is higher or lower than the standard risk of similarly situated healthcare providers. This analysis determines whether or not a policy will be offered, and if so, whether the premiums charged will vary from the base rate ordinarily charged for similarly situated policyholders.

**Attorneys** — The legal department is the liaison between each state's Department of Insurance (DOI) and the carrier. Unlike defense counsel who litigate claims, a carrier's legal counsel files materials for approval with states, drafts policy language, analyzes policy coverage, and otherwise ensures that the carrier is compliant with state law. Additionally, they work with the claims department to assist with certain litigation issues and track legal trends.

**Claims Handlers/Managers** — The claims staff acts as the liaison between the policyholder, defense counsel, the claimant and the claimant's attorneys. The claims staff also assists the defense counsel in formulating a customized litigation plan, setting claims reserves, and arranging for expert witnesses.

## THE METHOD FOR CALCULATING PREMIUMS

The MedMal market has experienced a number of "crises" over the last several decades. These crises were caused by an unexpected rise in the number of claims being filed, many resulting in large verdicts. Consequently, premium rates fluctuated widely. Nevertheless, the process for determining rates is anything but arbitrary, and a quote is provided only after a careful analysis of actuarial and statistical data, historical trends, market conditions, claims information, specialty and the practice locale. The analysis has become so detailed that many carriers not only review the practice location, selected specialty and procedures performed, but also consider the historical, current and prospective legal climates of these areas.

The premium calculation for a particular policy holder begins when the carrier receives an application and starts the underwriting process.

**A certain amount of information is needed to assess risk and determine premiums for a healthcare provider, including:**

- Training
- Degree
- Specialty
- Number and type of surgeries performed
- Years in practice
- Practice location
- Prior claims:
  - How many?
  - How much paid to defend and settle?
  - How long ago?
- Group affiliation
- Hours worked (part time or full time)
- Professional program membership(s)
- Current carrier
- Policy type
- Limits of coverage requested
- History of alcohol or drug abuse
- Emergency room coverage
- Treatment of certain types of patients (e.g., pro athletes or prisoners)

After receiving an application from a potential customer, the underwriter reviews the documentation provided and determines the appropriate premium based upon rate information on file with the DOI in the applicable state. Those rates may be adjusted by using credits (discounts to the premium) and debits (increases to the premium). These credits or debits are translated into dollar amounts that are added to or subtracted from the standard premium rate. Before applying for a policy, it is important to inquire about applicable credits and debits in order to obtain the lowest possible rate.

## EXAMPLES OF CREDITS<sup>\*</sup>:

- **Loss Free/Claims Free** – credits offered to healthcare providers who have been loss free/claims free for a certain period of time
- **Risk Management** – credits offered for maintaining certain risk management standards
- **Part Time** – credits offered when a healthcare provider practices only part time
- **New to Practice** – credits offered to healthcare providers new to the practice of medicine
- **New to Company** – credits offered to new customers of certain carriers
- **Program Membership** – credits offered based on the benefits to members or participants in certain programs, societies or associations

## EXAMPLES OF DEBITS<sup>\*</sup>:

- **Claims frequency** – premiums may be increased when a healthcare provider has experienced an above-average number of claims
- **Claims severity** – premiums may be increased when a healthcare provider has had a claim or claims with above-average payouts
- **Performing certain medical procedures** – premiums may be increased when a healthcare provider performs risky medical procedures
- **Risk Management procedures** – premium may be increased when a healthcare provider's risk management procedures do not meet certain standards

\* Based upon state regulatory approvals.

## PREMIUMS

Once received by carriers, premiums are usually allocated to three basic categories of expense – **loss reserves**, **defense costs** and **underwriting expenses**.

**Loss Reserves** – Ordinarily, more than half of any premium dollar received is paid to claimants for claims losses. When a healthcare provider is sued, and a settlement or a judgment is reached, these reserved funds are used to pay such obligations.

**Defense Costs** – Approximately twenty-five percent of every premium dollar pays the costs incurred defending policyholders, including the attorney fees paid to a lawyer hired to defend a policyholder, and expert witness fees paid to experts who testify regarding the level of care provided.

**Underwriting Expenses** – The remaining twenty-five percent of every premium dollar is used for general business expenditures, such as legal and support staff, clinical risk programs, salaries, actuarial analyses, sales and marketing. Anything left is the underwriting profit margin.

## PRICING QUESTIONS TO ASK A CARRIER:

- How will the premium be determined?
- What credits are available?
- What credits and debits can the carrier apply to the premiums in this circumstance?
- What can be done to lower premiums, e.g., risk management courses or membership in an association?
- How does the policy type impact the price of the policy?
- What is the carrier's history of raising/lowering rates in the applicable state? If volatile, why?
- Does the price of the policy include any deductibles?
- How do the premiums compare to those charged by other carriers? If they are significantly less than the rest of the market, why? Has the carrier properly analyzed the risk?

# POLICY TYPES

The MedMal insurance market offers healthcare providers two basic policy types: **occurrence** and **claims-made**.

## THE OCCURRENCE POLICY

An occurrence policy is a type of policy that offers coverage for claims arising from an event that took place during the policy period, typically one calendar year. For example, if a claim is made in 2010, based upon services rendered in 2005, such claim would be covered under the 2005 occurrence policy – despite the fact that the claim was made in 2010.

Occurrence policies are relatively rare in today's MedMal market, largely because of the challenge carriers face in projecting the long-term costs associated with claims that may be reported long after the end of the policy period.

### The features of an occurrence policy include:

- Coverage for claims arising out of incidents that occurred during the policy period
- Coverage for a particular year doesn't end when the policy terminates – if a healthcare provider retires, takes a leave of absence, or changes location, coverage is retained for those occurrence policy years
- Initially, an occurrence policy tends to be more expensive than a claims-made policy, at least until the claims-made policy reaches its mature rate (typically after about five years) and/or when the need arises to purchase tail coverage

- The policy limits stay in place even after termination of the policy, unless reduced by the payment of claims, so with respect to alleged incidents occurring during the policy period, no tail coverage is needed
- As long as the healthcare provider was insured at the time of an alleged incident, coverage is in place subject to the terms and conditions of the policy

### Any Policy Type is Better than Going Bare

Often, going bare is not an option as most hospitals and practices require healthcare providers to obtain liability coverage. Moreover, state law, state licensing boards, hospitals, employers, or healthcare benefit payers may require healthcare providers to obtain MedMal coverage. If required, there may be specific requirements regarding the types and amounts of coverage.

A risk in going bare is that doing so can make it difficult for the healthcare provider to later obtain coverage from the admitted market. Most carriers require proof of previous coverage as a condition to issuing a policy. Additionally, when healthcare providers go bare, they forego the litigation support and the claims-handling expertise offered by most MedMal carriers. A carrier with a well-trained claims unit has widespread jurisdictional experience, local defense attorneys, a national database of expert witnesses, and successful strategies for particular types of claims – all of which are lost to those who go bare. Healthcare providers also lose access to risk management training and assistance designed to keep them out of the courtroom in the first place.

## THE CLAIMS-MADE POLICY

A claims-made policy is a type of policy that offers coverage for claims made during the policy period. For example, if a claim is made in 2010, based upon services rendered in 2005, such claim would be covered under the 2010 claims-made policy – despite the fact that the services were rendered in 2005.

The features of a claims-made policy include:

- Coverage for claims made, or incidents reported, during the policy period
- Claims-made policies are generally “claims-made and reported” policies, which also require that a claim or incident be reported to the carrier within the same policy period as it was made, and failure to report the claim can result in denial of coverage
- Claims-made coverage is generally inexpensive at first and gradually increases or “steps up” over a period of time (commonly five years) to a mature premium amount that is then charged for subsequent years
- Coverage for a particular year ends when the policy terminates – unless tail coverage is purchased or earned
- If a healthcare provider retires, takes a leave of absence, or changes location, tail coverage is usually required
- Termination of coverage without the purchase of a new claims-made policy usually requires the purchase of tail coverage to ensure that claims occurring after the policy period are covered; without securing tail coverage, the policyholder will have no coverage for claims made after termination of the last claims-made policy
- If a policyholder plans on purchasing a new policy, an alternative to purchasing tail coverage would be to purchase “prior acts” coverage from the new carrier to ensure that claims occurring prior to the new policy period are not left uncovered

### Prior Acts vs. Tail Coverage

When a policyholder switches from one carrier to another, but remains covered under a claims-made policy (as opposed to an occurrence policy), then the policyholder can either: (1) purchase tail coverage from the prior carrier, or (2) purchase prior acts coverage from the new carrier. Prior acts coverage, also called a “nose,” can be added to a newly purchased claims-made policy to cover claims occurring prior to the new policy period. In contrast, tail coverage is added to the prior claims-made policy to cover claims occurring after the termination of the old policy. Tail coverage is the only option when a policyholder ceases claims-made coverage entirely, such as in the case of death, disability or retirement.

The key to claims-made coverage is continuity of coverage. If a policyholder continually renews a claims-made policy with a carrier, the coverage will continue uninterrupted. However, if there is a lapse in coverage because, for example, the policyholder retires or moves out of state, then the individual may need to obtain tail coverage – which then continues coverage.

For example, consider a healthcare provider who has carried claims-made coverage with the same carrier since 1990. She decides to retire in 2008, and cancels her policy effective on the date of retirement. She is then sued in 2010 in connection with an incident that occurred in 2001. Although she was covered by a policy in 2001, she is no longer covered for any claims made after her policy terminated in 2008. Because she did not purchase tail coverage, there is no coverage for claims made after 2008, ***even though the incident occurred years earlier.*** Had tail coverage been purchased, the 2010 claim would have been covered subject to the terms and conditions of the policy.

## OCCURRENCE VS. CLAIMS-MADE

**Because claims can be reported long after services are rendered, carriers cannot determine their actual exposure under a particular occurrence policy for many years after that policy period ends. In contrast, under a claims-made policy, a carrier usually knows its exposure at the end of that claims-made policy period, as it is limited to only those claims made during that policy period.**

**Example:** A heart patient has surgery in 2008, where there is a significant complication. A claim, based upon those services rendered in 2008, is made in 2010.

**Under an occurrence policy:** Since the services were rendered in 2008, the 2008 occurrence policy would be triggered – even though the claim was made in 2010.

**Under a claims-made policy:** Since the claim was made in 2010, the 2010 claims-made policy would be triggered – even though the services were rendered in 2008.

## OCCURRENCE COVERAGE

### Advantages

**Fixed costs** – There are no additional costs for the occurrence policy at the end of the policy period. In contrast, claims-made policies often require the purchase of tail coverage at the termination of the policy for claims made after the expiration of the policy.

**Limits Accumulation** – With occurrence policies, each year's limits stay in place after the end of the policy period to the extent they are not exhausted by claims. For example, at the end of a 20-year practice, an insured would have 20 individual years of policy limits, which would have been exhausted only by any claims that were paid under one of those occurrence policies in that 20-year period.

**Mobility** – Physicians can easily change insurers or states without the somewhat expensive "tail coverage" cost associated with the claims-made policy. This may be especially advantageous for healthcare providers who want to take extended vacations, a leave of absence, military leave, or maternity leave.

### Disadvantages

**Fixed Limits** – Current limits cannot be increased for incidents occurring in the past. Thus, the limits of previous policy years cannot be increased to offset anticipated higher claims' values. Inflationary factors may affect the value of claims which may result in a need for higher limits. With an occurrence policy, increased limits are available only for current and future policy periods.

## CLAIMS-MADE COVERAGE

### Advantages

**Pricing** – Claims-made policies are less expensive in the short-term.

**Variable Limits** – Claims-made coverage offers the option for increasing limits of the current policy, which covers incidents occurring long in the past. This provides a means for increasing limits for anticipated future higher costs of claims. The granting of higher limits is at the insurance company's discretion, and generally, the insured must attest to the fact that no known potential claims exist.

### Disadvantages

**Policy Costs** – The premiums for claims-made policies gradually increase over time until they reach a "mature" rate – typically five years. In addition, claims-made policies may require the purchase of tail coverage at termination, unless free tail coverage is earned under the provisions of the policy. The expense associated with tail coverage cannot be calculated until the claims-made policy is actually cancelled.

**Complexity** – The nature of a claims-made policy is complex and requires diligence to ensure no coverage "gaps" arise. Claims-made coverage must be kept in force continuously, and/or tail coverage must be purchased to ensure that coverage exists for any claims that may be asserted against the insured in the future.

**No Limits Accumulation** – When a claims-made policy is cancelled and tail coverage is purchased or earned, the limits provided in the tail coverage represent the total protection afforded to the insured to pay all claims arising in the future. Some insurers also limit the duration of the tail coverage, as well as the amount of limits that may be purchased.

**Lack of Mobility** – Conversion to another policy type, switching insurers, or moving to another state is often difficult with a claims-made policy. In these instances, the insured may be required to purchase tail coverage or secure prior acts coverage at an additional cost.

## QUESTIONS TO ASK A CARRIER ABOUT OCCURRENCE AND CLAIMS-MADE POLICIES:

- Does the carrier offer both claims-made and occurrence policies? If not, why not?
- Does the carrier offer prior acts coverage?
- What are the conditions for earning free tail coverage?
- What is the immediate price difference between claims-made and occurrence policies?
- What are the long-term cost differences between claims-made and occurrence policies?
- How is the carrier going to calculate the cost of tail coverage?
- Does the carrier offer a product designed to easily convert claims-made coverage to occurrence coverage?
- Does the carrier offer tail coverage with an unlimited duration to report claims?
- How does the carrier determine the limits of tail coverage?
- Can the policyholder easily transfer the policy in connection with an out-of-state move or a switch in practice location or employer?
- Is there any right to obtain an offer of tail coverage? When does such an offer have to be made/accepted?
- Does the policy offer portability with prior acts coverage?

# COMMON POLICY DETAILS AND PROVISIONS

Every policy has different terms and conditions which can be confusing and, if not understood properly, could result in gaps in coverage and exposed assets. However, most policies share some commonly used definitions and provisions, which, if recognized and understood, help policyholders know exactly what coverage they have and what coverage they don't.

## Basic Steps in Reviewing A Policy

To ensure that a particular policy is the best fit, and to understand the coverage and rights provided in a policy, always do the following:

- Read the policy and the attached endorsements carefully and compare it against other policies.
- Ask the carrier if there are any other documents that might impact a policyholder's rights or obligations.
- Consult with an attorney experienced in insurance and contract law.

The following is a list of those most common policy provisions, as well as an explanation of their significance.

## POLICY PERIOD

Traditionally, a MedMal policy has a one year term and renews annually. Most renewals occur either on January 1 or July 1. Occasionally, a short-term policy is issued to obtain a common effective date among policyholders, or to accommodate a change in circumstances such as graduation or group and employer changes.

## COVERAGE TERRITORY

Most policies contain a geographical limitation on coverage, which should be reviewed carefully. Coverage may be denied if a healthcare provider practices in a location outside the coverage territory – whether traveling, doing volunteer work in another location, or simply filling in for a colleague at another facility. Furthermore, if a healthcare provider moves his/her practice, the carrier should be contacted immediately as a new insurance policy may be needed.

## LIMITS OF LIABILITY

Limits of liability are caps on how much the insurance carrier will pay for claims made against a policyholder that are covered under the provisions of the policy. Limits are usually comprised of a "per occurrence" or "per incident" amount (depending on the type of policy) and an "aggregate" amount. These dollar amounts are typically written together in the following fashion: \$1,000,000/\$3,000,000. Under this example, the carrier would pay up to \$1 million per occurrence/incident and up to \$3 million in aggregate. The occurrence/incident limit is the maximum amount the carrier will pay per occurrence/incident that occurs during the 12-month policy period. The aggregate limit is the maximum the carrier will pay over the policy period (usually one year).

For example, if a policyholder has a policy with a \$1,000,000/\$3,000,000 limit and has a \$500,000 claim in one year, the carrier could still pay up to \$2.5 million in additional claims over the policy period. The most common MedMal limits nationwide are \$1,000,000/\$3,000,000. Limits may vary in each state due to: (1) statutes setting a required minimum amount of coverage, (2) statutory caps on damages, and (3) state Patient Compensation Funds and the available coverage.

### State Patient Compensation Fund's Impact on Limits of Liability

Several states (Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina and Wisconsin) have established Patient Compensation Funds as a tort reform measure. Participation in Patient Compensation Funds can be either voluntary or mandatory. Policyholders pay a surcharge to participate in the Patient Compensation Fund, which provides a second layer of coverage above a certain amount. The intent is to keep premiums low by helping defray the costs of larger claims. In Kansas, for example, healthcare providers are responsible for obtaining an initial layer of coverage of at least \$200,000/\$600,000. Then, for claims exceeding \$200,000, the remaining amount is paid by the Kansas Health Care Stabilization Fund (HCSF) up to the limit set by the HCSF. Many carriers in states with voluntary Patient Compensation Funds will not insure healthcare providers unless they participate in the state's Patient Compensation Fund. For the most part, Patient Compensation Funds have helped to stabilize volatility in both claims and rates within the states that have adopted them.

### COVERAGE TRIGGERS

With respect to MedMal coverage, the term "trigger" is industry lingo for the event that activates the carrier's duties under a policy. Triggers are typically specific to claims-made policies (with occurrence coverage, as long as the policy was in place during the time of the incident, coverage is automatically triggered). Trigger provisions define how and when a policyholder must inform the insurance carrier about potential claims. If a carrier is not properly informed of a claim, the claim may not be covered. There are two types of triggers – "incident triggers" and "demand triggers" – and the distinction between the two types is important.

**Incident Trigger** – With an incident trigger, the carrier's obligations under the policy are triggered when an incident (what the healthcare provider believes could be a potential future claim) is reported to the carrier. An incident trigger may be worded differently to obligate the policyholder to report under different circumstances and time periods. Common incident trigger verbiage includes provisions that require the policyholder to report:

- (1) any incidents that could turn into a claim in the future;
- (2) only incidents he or she reasonably believes might result in a claim, as long as the policyholder first became aware of the incident during the coverage period; or,
- (3) incidents within a specified timeframe (e.g. 30 days); these can be problematic – if for some reason an incident is not reported within 30 days of occurrence, the claim may not be covered.

**Demand Trigger** – This type of trigger is activated only when there is a formal written demand for compensation in the form of a claim or lawsuit. By requiring such formal action by the claimant, it may be more difficult to trigger coverage for a known incident that has not yet been the subject of a formal written demand. Nevertheless, unlike an incident trigger, there is little question as to what triggers coverage.

Changing carriers, or changing types of coverage, can result in unanticipated gaps in coverage due to changing coverage triggers. For example, if a policyholder has a policy with a demand trigger, the carrier may still request (or even require) that the policyholder report not just demands, but also various incidents that arose during the policy period – even if no demands have yet been made. If that policyholder were then to switch to a policy with an incident trigger, the new policy would typically exclude any coverage for incidents that were previously reported to another carrier, or under a prior policy. The unfortunate result is that both policies exclude coverage. The incident trigger policy excludes coverage because it was previously reported, while the demand trigger policy excludes coverage because the policyholder never received a “demand” as defined by the policy. Because neither trigger activated the carrier’s obligation for coverage under either policy, this created a gap – although the policyholder did everything right.

**To ensure this does not occur, policyholders should double check with their agent or new carrier to confirm that there is no gap in coverage created by changing policy types from a policy with a demand trigger to a policy with an incident trigger.**

## EXCLUSIONS AND LIMITATIONS

Certain exclusions and limitations are common in MedMal insurance policies. As a threshold matter, coverage under a medical malpractice policy generally applies only to claims resulting from medical services provided to a person. Thus, claims resulting from general commercial liability, such as a slip-and-fall in the office, are typically not covered. Furthermore, not all medical services are covered; risky, controversial or experimental procedures may be excluded. Policies may contain exclusions for intentional or criminal acts, such as sexual misconduct with the patient. In addition, coverage limitations may lie in unexpected sections of a policy, such as in a restrictive definition of “professional services.”

## CONSENT TO SETTLE

A consent-to-settle provision gives the policyholder the right to refuse to settle a claim – even if the carrier recommends otherwise. This often overlooked provision is one of the most important factors to consider when selecting a carrier. Without this provision, a carrier can settle a claim without the policyholder’s consent, even if the claim is considered frivolous. This is important because settlements and judgments typically must be registered with the NPDB and other state reporting entities – and could potentially harm a healthcare provider’s reputation and practice. Because not all consent-to-settle provisions are created equal, each should be reviewed carefully.

Consent-to-settle provisions often set out who has the final say in determining whether or not to settle a claim. Specifically, some consent-to-settle provisions control the circumstances under which a claim will be presented to a jury, or whether a carrier can force its policyholder into arbitration to determine whether to settle a claim when the policyholder and the insurance company disagree.

Other consent-to-settle provisions have a “hammer clause,” which can result in a reduction of policy limits when the carrier is willing to agree to a settlement but the policyholder refuses to settle. For example, if a plaintiff demands \$50,000 to settle a claim, and the carrier recommends acceptance of that offer but the policyholder refuses, a hammer clause would make the policyholder personally liable for any amount of a judgment in excess of \$50,000. This added exposure puts pressure on the policyholder to settle. In essence, a hammer clause operates to shift the risk of a larger judgment from the carrier to the policyholder.

## Patient Compensation Fund – Losing the Right to Consent to Settle

In states with a Patient Compensation Fund (PCF), if a claim has a value in excess of the carrier’s policy limits, the PCF may become involved in the claim. When this occurs, the PCF may take control of the case, retain counsel of its choosing, and/or deprive policyholders of their right to consent to settle.

### Some policies contain provisions limiting the policyholder's right to consent to settle by:

- revoking the right to consent after the policyholder ceases to practice medicine
- revoking the right to consent in settlements occurring after the policyholder is no longer insured by that carrier
- placing a limit on the amount of time that a policyholder has to object to settlement, and deeming the policyholder's objection waived if no response is received by the deadline imposed by the carrier
- mandating that the policyholder's consent to settle cannot be unreasonably withheld, without defining what is "reasonable" or specifying who determines whether consent is being unreasonably withheld
- forcing the policyholder to arbitrate any dispute regarding the reasonableness of the policyholder's refusal to consent, with costs assessable against the policyholder

### DEFENSE COSTS

Defense costs are the costs incurred by the carrier while defending a policyholder after a claim is made, including expert witnesses and attorneys' fees. Under most MedMal policies, these costs are considered "outside of the limits" of the policy, meaning payment of these defense costs do not affect the policy's limits of liability. Policyholders should be wary of policies that include defense costs "within policy limits". This means that for every dollar spent to defend a policyholder, the limits of coverage are reduced by a dollar. Such costs can easily eat up the limits available to pay claims.

For example, if a policy includes defense costs within the limit of \$500,000, and the carrier incurs defense costs in the amount of \$400,000, only a small portion of the limit, \$100,000, remains to pay the claim. This is important because the national average cost incurred in defending a medical malpractice suit (that is ultimately settled) is \$42,000. If the claim goes to trial, the average defense cost rises to \$76,000, which may not leave much left to pay for an actual judgment or settlement.<sup>6</sup>

### DEDUCTIBLES AND SELF-INSURED RETENTIONS

Deductibles and self-insured retentions both function to place a certain amount of financial responsibility on the policyholder for any claim paid. Deductibles and self-insured retentions are more common for large groups than for individual healthcare providers. At the individual level, deductibles are somewhat unusual because in order to result in reduced premiums, the deductible would need to be fairly large. Larger groups that can afford a fairly substantial deductible or a self-insured retention usually see decreased policy premiums.

### DEATH, DISABILITY AND RETIREMENT PROVISION FOR CLAIMS-MADE POLICIES

Claims-made policies often include provisions for free tail coverage in the event of death, total disability or permanent retirement of the healthcare provider. Generally, the coverage is free in the event of death or disability, regardless of age or years with the carrier. However, in order to qualify for free tail coverage at permanent retirement, a policyholder generally must have been insured by the company for a set time and have reached a certain age.

### VALUE-ADDED COVERAGE

Value-added coverage refers to policy provisions that are added to a professional liability policy for the purpose of paying the costs incurred if, in connection with a claim, a healthcare provider must respond to state licensing boards, Medicaid/Medicare inquiries, or other professional peer reviews.

### VICARIOUS LIABILITY

Vicarious liability refers to a healthcare provider's legal responsibility for the actions of his or her employed staff. State law determines the amount and scope of such liability, but the general rule is that an employer is 100% responsible for the actions of employees. Many policies provide coverage for the vicarious liability of a healthcare provider so long as liability arises from employees acting in the course and scope of their duties.

## ALLIED HEALTHCARE PROFESSIONALS

Nurses, Physician's Assistants, Certified Registered Nurse Anesthetists and other employees – collectively referred to as "allieds" or "healthcare professionals" – also often require malpractice insurance. Moreover, their employer can be sued for the acts of these healthcare professionals. Therefore, employers often mandate specific insurance requirements applicable to healthcare professionals. Nonetheless, many coverage options exist for healthcare professionals; they can secure their own insurance coverage with separate limits, or in most states, are allowed to share the limits of their supervising physician or entity employer.

## ENTITY COVERAGE

Entity coverage can be provided to both multi-shareholder corporations and corporations owned by a single shareholder (solo corporations). Typically, both types of entities can be sued based upon the acts of their employees either for their direct negligence or for vicarious liability, and therefore, may need MedMal insurance coverage.

Entities also have options for professional medical liability insurance. In most states, the corporation can purchase a policy that includes coverage for everyone employed by the corporation. Under this type of policy, doctors and healthcare professionals can be added or removed as needed, subject to underwriting approval and premium differences. Another option is a group policy that provides separate coverage for each individual doctor with his or her own limits and premiums. This may be a good choice for multi-specialty groups, as different specialties are charged different amounts.

## ASSESSABLE PREMIUMS

Most MedMal carriers are "advance premium" carriers. This means that the premiums paid by the policyholders are established at the beginning of the policy period and are generally guaranteed not to increase for that policy period, unless material changes are requested by the policyholder, such as, requests to change specialty or practice location may result in a mid-term change in a premium. Without such a request, state law usually prohibits carriers from increasing premiums mid-policy.

Other MedMal carriers offer assessable policies allowing them to increase premiums as needed for adverse development during the policy period. This means that the premiums paid by policyholders at the beginning of a policy period are estimates only. Thus, if the carrier who issues an assessable policy has losses or expenses that exceed the premiums collected, it can collect extra premium (i.e., assessments) from policyholders – possibly even after the policy period ends or the policy is cancelled.

## MODIFICATION

The policy itself will have a provision regarding modification that sets out how, when and whether a policyholder or the carrier can modify the terms, conditions or exclusions of the policy. Policyholders can request a modification of the policy for changes in practice, procedures performed, location of practice and certain staffing changes. Carriers are also allowed to make modifications to the policy either during the policy period or at renewal. However, state law often requires that carriers give advanced written notice for premium increases or coverage decreases at renewal.

## MID-TERM CANCELLATION

Typically, a policy ends at the expiration of the policy period. The carrier then decides whether to renew or non-renew a policyholder. If the carrier offers renewal to a policyholder, then the policyholder can accept or decline coverage. At times, a policy may be cancelled mid-term by either a policyholder or a company. If a policyholder cancels a policy mid-term, the carrier must return any unearned premium. However, the policy may contain a provision which allows the carrier to levy a financial penalty on the policyholder for canceling mid-term.

Alternatively, a carrier may cancel the policy mid-term in certain limited circumstances. State law generally dictates when, how, and for what reasons a carrier may cancel a policy mid-term, including: how many days notice the carrier must give prior to cancellation, the delivery method of the notice, the persons or entities to whom the notice must be sent, and any requirements to offer tail coverage. The carrier must then return unearned premium to the policyholder.

## QUESTIONS TO ASK A CARRIER ABOUT POLICY PROVISIONS:

### Policy Period

- If needed, does the carrier offer short-term policies?

### Coverage Territory

- Are there any restrictions on practice locations that would exclude coverage?
- Is coverage provided when a policyholder travels out of state? Abroad?

### Limits of Liability

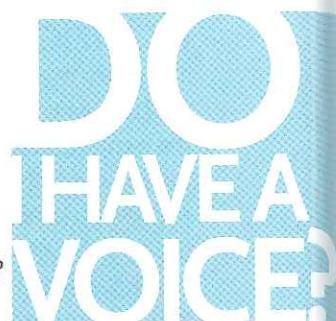
- Does the carrier offer shared and/or separate limits? Under what circumstances?
- What are the typical limits purchased by similar healthcare professionals or entities?

### Coverage Triggers

- When is coverage triggered under the policy—is it an incident or demand trigger?
- If an incident trigger, is there a time limit for reporting an incident?
- If a demand trigger, must the policyholder wait for a formal action by the claimant before the carrier's obligations arise?
- How is the policyholder protected during times of transition between policies? Is there a risk that occurrences may not be covered during such a transition?

### Exclusions and Limitations

- What exclusions are contained in this policy?
- Is volunteer work excluded?
- Does the policy exclude coverage for "hold harmless" agreements?
- Does the policy exclude coverage for intentional, criminal, or sexual acts?
- Does the carrier exclude coverage for claims resulting from treatment rendered while under the influence of drugs or alcohol?



### Consent to Settle

- What type of consent-to-settle provision does the policy include?
- Does the policy include a "hammer clause"?
- Is there a requirement for arbitration?
- Does the policy require that policyholders respond to requests to settle within a certain time period?
- Are there any circumstances where the carrier can deem that the policyholder has consented to settlement?

### Defense Costs

- Are defense costs included in the limits of liability?

### Deductibles and Self-Insured Retentions

- Does the policy offer deductibles or self-insured retentions for individuals? For entities?
- Can premiums be lowered by paying a deductible?

### Death, Disability and Retirement Provisions for Claims-Made Policies

- How is free tail coverage earned?
- After how many years of coverage, or at what age, can a policyholder retire and earn free tail coverage?
- What constitutes total disability or permanent retirement?
- Does volunteering, working for charitable organizations, or treating friends or family violate the retirement provision of the policy?

### Value-Added Coverage

- Does the policy provide coverage for defense costs, fines or penalties resulting from administrative hearings or similar actions taken against the policyholder?

### Vicarious Liability

- Does the policy offer vicarious liability coverage?

### Allied Healthcare Providers

- Does the policy offer shared limits or separate limits for allied healthcare providers?
- What is the cost to add an allied healthcare provider to the policy?
- Do allied healthcare providers need separate limits?

**Entity Coverage**

- Does the carrier offer entity coverage?
- Can an individual share limits with an entity?
- Can an entity share limits with an individual?

**Assessable Premiums**

- Are the premiums guaranteed? Or, are they advanced premiums?
- What would constitute a need to assess policyholders?

**Modification**

- In what circumstances may the policy be modified?
- What provisions of the policy can be modified?
- When will the carrier notify a policyholder of a policy modification? How?
- Under what circumstances are the policyholders required to notify the carrier of changes to their practice?

**Cancellation**

- When can the policy be cancelled mid-term?
- For what reasons can a policy be cancelled mid-term by a policyholder? By a carrier?
- If a policyholder cancels a policy mid-term, what notice must be given to the carrier?
- If a policyholder cancels the policy mid-term, will unearned premiums be returned pro rata, or will there be a financial penalty?
- If a carrier cancels the policy mid-term, what notice must be given to the policyholder?

# TYPES OF CARRIERS

There are many types of insurance carriers, some that are highly regulated by state law, and others that are virtually unregulated. The level of regulatory oversight applied to each type of carrier has significant repercussions for healthcare providers with respect to the type of protection provided by state authorities. Common types of carriers include:

- **Admitted Carrier** – an insurance carrier that is licensed and authorized to write insurance in a particular jurisdiction. Its rates, rules and forms must be approved for use by the jurisdiction's Department of Insurance (DOI). These entities are subject to the highest level of regulatory oversight and scrutiny.

## State Legislatures Are in Control

Currently, each individual state is in control of regulating the admitted insurance carriers doing business in their state. Each state's DOI is responsible for keeping tabs on those admitted carriers by approving their rates and forms, and otherwise acting as an advocate for policyholders. While the federal government rarely gets involved in insurance regulation, they frequently consider increasing their oversight through federal legislation.

- **Non-Admitted Carrier** – an insurance carrier that is not licensed to do business in a particular jurisdiction, but is otherwise permitted to do business there. Generally, non-admitted carriers are not required to follow the stringent rules and regulations that apply to admitted carriers (for example, non-admitted carriers are not required to have their premium rates, rules or policy/application approved by the DOIs). The most common type of non-admitted carriers are surplus lines carriers, followed by RRGs and captives (all discussed in this section). Non-admitted carriers provide an important alternative for insurance buyers to obtain coverage outside of the traditional admitted commercial market – either because the type of insurance they are seeking is unavailable in the admitted market, or because they can realize cost savings with a non-admitted carrier.
- **Stock Company** – an insurance carrier that issues stock and is owned by its stockholders.
- **Mutual Company** – an insurance carrier for which the incidents of ownership generally reside with the policyholders.
- **Trusts** – a type of captive that is owned by its policyholders. As such, most are also assessable. Trusts are set up to operate like RRGs and, as a non-admitted carrier, are not regulated by state insurance departments. Trusts receive more lenient governmental and financial oversight.
- **Joint Underwriting Association (JUA)** – a state-run insurance carrier. In the MedMal world, JUAs are often established by state legislatures to act as carriers of last resort for substandard risks that are unable to obtain coverage elsewhere. JUAs are designed to ensure that healthcare providers are provided reasonable coverage during volatile market cycles.

■ **Surplus Lines Insurance (E&S)** – Sometimes called “excess and surplus lines” or “E&S” insurance, this coverage is usually limited to “substandard risk” policyholders who cannot obtain coverage in the traditional or admitted market. Most states require that policyholders be rejected by three or more admitted carriers before allowing the policyholder to seek coverage from these non-admitted, surplus lines carriers. In past hard market cycles, many riskier healthcare providers were forced to seek coverage in the E&S market because of the shortage of available coverage in the admitted market. E&S insurance can be more expensive and, because it is non-admitted, provide fewer benefits. Surplus lines carrier coverage can vary substantially. Important issues to consider include:

- Policyholders may become partial members (sometimes referred to as “owners”) of the E&S carrier, allowing the carrier to assess such policyholders an additional premium if the losses exceed what has been set aside to pay for claims.
- The risk is sometimes shared by a small group of carriers, with some non-admitted carriers not well diversified in terms of venue or specialty.
- Some non-admitted companies may require a capital contribution as an initiation. This may make a policyholder feel that they should not move to another carrier until they have recouped the perceived value from the initial investment.
- Many E&S carriers do not offer clinical risk management resources and benefits.
- Some E&S carriers do not have a proven defense strategy, or the strategy varies upon their financial standing at any given time.

■ **Risk Retention Group (RRG)** – a non-admitted insurance carrier that is owned by its members, all of whom share similar business activities and are therefore exposed to similar risks. RRGs are formed under a particular state’s law, but pursuant to federal law, may operate in any state after formal registration in those states. The registration process is simple when compared to the requirements placed on an admitted carrier. As a non-admitted carrier, RRGs operate outside most state regulations and oversight (e.g. their rates and forms are not reviewed or approved).

■ **Captive Insurer** – a non-admitted insurance carrier formed primarily to insure the risk of its parent corporation (and sometimes affiliates). It is often compared to self-insurance, with the difference that a captive usually provides greater tax benefits. As a non-admitted carrier, it operates with limited regulatory oversight.

## QUESTIONS TO ASK ABOUT THE TYPE OF CARRIER:

- Is the carrier admitted in the jurisdiction where the healthcare provider is practicing?
- If the carrier is non-admitted, does it have strong financial backing, such as being reinsured through an existing reputable carrier?
- If the carrier is non-admitted, is it registered with the state?
- What happens if a policyholder switches carriers? Does the policyholder lose any initiation fee, capital contribution, or scheduled dividend distribution?
- Where is the carrier domiciled? Is it offshore? What recourse do policyholders have if the carrier and its funds are located outside of the U.S.?
- If the carrier is non-admitted, is the carrier recognized and accepted by relevant hospitals and employers?
- Does the carrier take all-comers or utilize sophisticated underwriting standards?

## EVALUATING THE CARRIER'S FINANCIAL STRENGTH AND LONGEVITY

In considering a carrier, financial strength should be the main consideration. Because medical malpractice claims often take years to develop (sometimes referred to as having a "long tail") and because this line of business frequently encounters wide shifts in the marketplace, a carrier's long-term financial strength is critical. Consider this: 18% of all claims arise at least three years after the incident. Once a claim is made, it generally takes two to three years to resolve. Thus, it's no surprise that the average claim takes up to seven years to resolve after the initial incident.<sup>7</sup>

Given this reality, longevity and financial stability – characteristics that are far from common in this line of insurance – are paramount. In fact, since 1900, approximately 46 medical malpractice insurance companies have entered and exited the market.<sup>8</sup> The average length of time a carrier spends in the medical malpractice line of insurance is only 20 years.<sup>8</sup> Carriers have typically exited the marketplace because they were unprofitable, could not adequately manage the often wide swings in claims severity and frequency, or were forced out by insolvency. This dynamic is likely to have been exacerbated by carriers' unfamiliarity with the market and their inability to appropriately price and underwrite.

When carriers exit the marketplace, policyholders can be left with inadequate or even no coverage, leaving their personal assets exposed. Therefore, it is imperative to research and understand the carrier's financial strength and ability to pay claims over the long haul.

## FACTORS TO USE IN DETERMINING FINANCIAL STRENGTH

Some basic factors used to determine financial strength include:

- **Ratings** – The financial strength rating of a carrier is one of the most important indicators of financial strength. A.M. Best is the leading independent analyst of the insurance industry. It analyzes the financial and operating strength of insurance carriers and awards ratings that range from A++ (superior) to F (in liquidation). For a more complete explanation of the A.M. Best Rating System, please visit its website at [www.ambest.com/ratings/pcbirpreface.pdf](http://www.ambest.com/ratings/pcbirpreface.pdf). Other rating organizations that assess the financial strength of carriers include Standard and Poor's, Duff & Phelps, Moody's and Weiss Research.
- **Surplus** – A carrier's surplus is the amount by which a company's assets exceed its liabilities. Since projecting future claims costs and establishing reserves (assets backing the estimated liabilities) to cover such costs is not an exact science, a healthy insurance company routinely maintains a cushion (surplus) above its reserve amount. If losses exceed reserves, the cushion protects the company and its policyholders from insolvency. A healthy surplus serves to provide strength and to maintain fiscal integrity in the face of adverse loss experience that is not actuarially anticipated, and is an important barometer of the financial health of an insurance carrier.

7 Medical Protective Data

8 Estimate based on Highline Data and A.M. Best information

## Guide to A.M. Best's Financial Strengths Ratings

An A.M. Best Rating is an independent opinion, based on a comprehensive quantitative and qualitative evaluation, of a company's balance sheet strength, operating performance and business profile. A.M. Best's Financial Strength Ratings are not a warranty of a company's financial strength and ability to meet its ongoing obligations to policyholders.

Rating	Descriptor	Definition
A++, A+	Superior	Assigned to companies that have, in our opinion, a superior ability to meet their ongoing obligations to policyholders.
A, A-	Excellent	Assigned to companies that have, in our opinion, an excellent ability to meet their ongoing obligations to policyholders.
B++, B+	Very Good	Assigned to companies that have, in our opinion, a good ability to meet their ongoing obligations to policyholders.
B, B-	Fair	Assigned to companies that have, in our opinion, a fair ability to meet their ongoing obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.
C++, C+	Marginal	Assigned to companies that have, in our opinion, a marginal ability to meet their ongoing obligations to policyholders and are financially vulnerable to adverse changes in underwriting and economic conditions.
C, C-	Weak	Assigned to companies that have, in our opinion, a weak ability to meet their ongoing obligations to policyholders and are financially vulnerable to adverse changes in underwriting and economic conditions.
D	Poor	Assigned to companies that have, in our opinion, a poor ability to meet their ongoing obligations to policyholders and are financially vulnerable to adverse changes in underwriting and economic conditions.

Source: <http://www.ambest.com>

- **Net Written Premium** – Net written premium is the amount of insurance premiums written by a carrier, less any amounts it has paid for reinsurance.
- **Financial Statements** – For the best financial picture of a carrier, make sure to review their financial information from the past five years, because this is often the best record of whether the carrier has a good history of maintaining financial strength year after year. From there, a policyholder can objectively determine three key ratios – loss reserve to surplus, risk-based capital and liability to liquid assets – on which the National Association of Insurance Commissioners (NAIC) and the major rating agencies evaluate insurance carriers.
- **Loss Reserves** – Loss reserves are the value of assets set aside by a carrier to cover future indemnity payments and expenses for both known and unknown claims.

### Basic Financial Ratios

These ratios measure the level of financial cushion a company has in the event actual losses are greater than forecasts. If this cushion is not adequate to cover shortfalls in forecasts, companies may:

- Assess healthcare providers (require them to pay for additional capital contributions), or face premium rate increases to build sufficient capital
- Obtain capital from other sources, e.g., companies may sell out to a larger carrier
- Become insolvent

- **Ratios** – Financial ratios commonly used to assess the financial health of insurance carriers are:

- **Ratio of net written premiums to surplus** – indicates the carrier's ability to assume additional risk. Regulators suggest a ratio of between 1 to 1 and 3 to 1, all other things being equal.

The lower the ratio, the less leveraged the carrier, so carriers with lower net premium-to-surplus ratios are recommended.

- **Ratio of loss reserves (indemnity plus loss adjustment expenses) to surplus** – indicates the carrier's ability to cover unanticipated reserve deficiencies. Again, a lower ratio indicates the carrier is less leveraged, and regulators recommend this ratio not exceed 4 to 1.
- **Loss ratio** – this ratio represents the total amount of incurred losses (indemnity payments plus loss adjustment expenses) expressed as a percentage of earned premium. In other words, this ratio depicts the percentage of every dollar of premiums collected that is used to defend and pay claims.
- **Expense ratio** – this ratio represents the total amount of operating expenses expressed as a percentage of earned premium. Lower ratios mean the carrier has lower expenses than competitors.
- **Combined ratio** – this ratio represents the total amount of incurred losses and operating expenses expressed as a percentage of earned premium. A combined ratio of more than 100% in any given year indicates an unprofitable year and the carrier may need to make some type of adjustment to return to profitability.
- **Risk-based capital (RBC) ratio** – this complex financial measure is used by state regulatory agencies as well as independent rating agencies such as A.M. Best. It essentially measures the carrier's policyholder surplus against all of their liabilities including investment activities and business risks associated with underwriting. An RBC ratio below 2:1 can result in various levels of regulatory action (for those companies subject to DOI regulation).
- **Liabilities to liquid assets ratio** – measures an insurance carrier's ability to pay existing liabilities with assets that can be easily liquidated such as cash, bonds, stocks and other investments. The higher the ratio, the less likely a carrier will be able to meet all its financial obligations. NAIC guidelines recommend a ratio no higher than 1.05:1. A higher ratio may indicate that a carrier's financial cushion is inadequate.

# LONGEVITY

Many carriers dabble in professional medical liability insurance when trends in the marketplace make it profitable for them to do so. During these times, states experience an influx of new insurance carriers, or start-ups, that enter the marketplace to take advantage of market conditions. However, the MedMal insurance industry is not for the inexperienced. A surge of claims can be triggered by advances in technology, changes in healthcare trends, or just an increase in patients. Additionally, due to MedMal's "long tail", newer carriers can appear deceptively strong during their initial years.

## MedMal's "Long Tail"

Medical liability lawsuits often take years to surface and to reach a resolution. In the insurance world, this is referred to as having a "long tail." The average claim **takes up to seven years to resolve** after the initial incident.<sup>9</sup>

Part of the reason for this long tail is that many claims may not become evident until several years after an incident. For example, consider an incident that occurs at childbirth. Certain injuries to the child might not become apparent for several years. Furthermore, most states allow minors to file a claim for birth-related injuries up to and beyond their eighteenth birthday. Thus, a suit can be filed against an obstetrician/gynecologist over eighteen years after the birth of a child for injuries allegedly occurring at birth. Such a claim might not be resolved even 25 years or more after the original incident.

For these reasons, it is important to choose a carrier with both the knowledge and experience to defend claims and the financial strength to pay on those same claims now, and well into the future.

<sup>9</sup> Medical Protective Data

During market surges, less stable carriers exit the MedMal insurance market, often leaving healthcare providers without coverage. Clearly, the longer the carrier has continuously written a line of business, the more likely it will continue to write that same line and the more experience it has in meeting the needs of its policyholders by properly managing claims and correctly analyzing and underwriting risk. Thus, when reviewing a carrier, longevity should be a key concern, as should whether the carrier has a history of moving into a line of business, leaving when things get tough, and then re-entering when the market conditions change once again.

## QUESTIONS TO ASK ABOUT A CARRIER'S FINANCIAL STRENGTH AND LONGEVITY:

### Carrier's Ratings

- Have A.M. Best and S&P ranked the company? If so, what is the rating?
- How have these rating companies ranked the carrier's outlook? Negative? Stable? Positive?
- If the carrier has not been rated by A.M. Best or S&P, why not?

### Surplus

- What amount has the carrier set aside as surplus?
- Is the carrier setting aside enough capital to defend and pay future claims?

### Financial Statements

- Does the carrier have five or more years of financial statements? Are the statements readily available for review?
- How is the carrier capitalized? Are the investors dedicated to the industry and financially sound?

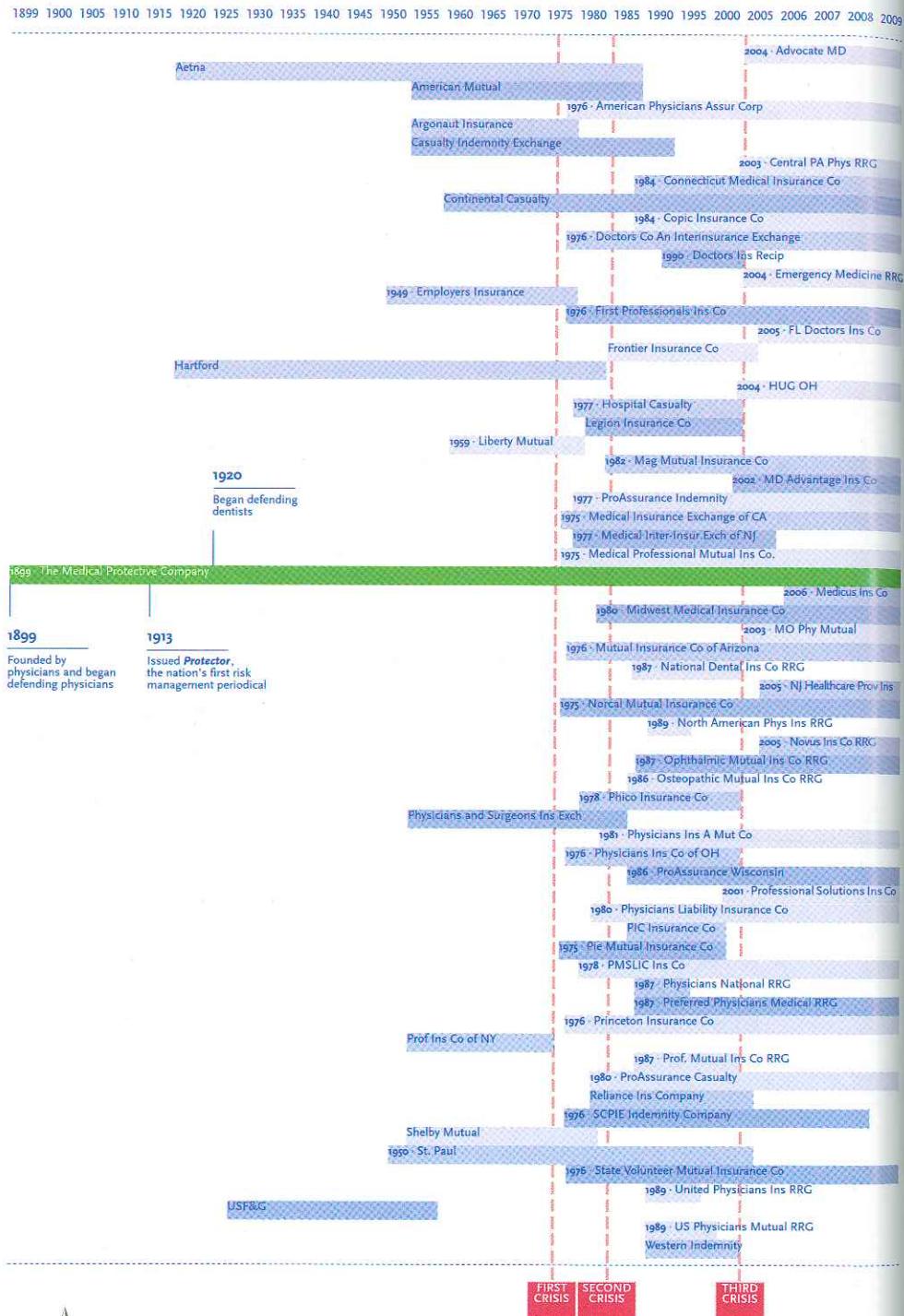
### Ratios

- What is the carrier's ratio of net written premiums to surplus?
- What is the carrier's ratio of loss reserves to surplus?
- What is the carrier's loss ratio?
- What is the carrier's expense ratio?
- What is the carrier's risk-based capital ratio?
- What is the carrier's liabilities-to-liquid-assets ratio?

### Longevity

- How long has the carrier been writing MedMal insurance?
- Has the carrier withstood any of the past volatile MedMal cycles?
- Does the carrier's management team have extensive experience and a good track record within the MedMal industry?
- How much of the carrier's business is focused on the long-term protection of healthcare providers?
- How long have they been in the state? If not long, are their rates accurately reflecting the environment in the state?
- Are all of the carrier's policyholders limited to one state, one area or only a limited number of specialties? (i.e. do they have all their eggs in one basket?)

## Reliability and longevity are irreplaceable in the medmal business



Sources: Internal information, A.M. Best, Weiss Ratings, CAO Report on Risk Retention Groups, 2009, ©2010 The Medical Protective Company®  
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# RISK MANAGEMENT

Effective risk management is critical for all healthcare providers as it helps mitigate risk and avoid lawsuits. Risk management solutions also enhance productivity and improve patient safety. Quality carriers provide risk management tools which outline processes and procedures designed to accomplish these objectives. These tools may include:

- Personalized risk consultations, either in person, on the phone or online
- On-site seminars, self-study and online learning
- Courses on a wide range of relevant and specialty-specific risk management topics including:
  - Delay in diagnosis
  - Informed consent
  - Informed refusal
  - Retaining and keeping the appropriate documentation
  - Following up with diagnostic tests
  - Managing referrals
  - Coordinating care
  - Upholding the standard of care
  - Updating surgical techniques
  - Administering proper medication and dosage
  - Wrong site surgeries

Those who complete such courses usually earn accredited Continuing Education hours, and may qualify for a premium credit for participation.

## QUESTIONS TO ASK A CARRIER ABOUT RISK MANAGEMENT SERVICES

- Does the carrier offer risk management services? Are the services provided by the carrier or a third party?
- Where are the carrier's clinical risk consultants based?
- How committed is the carrier to helping its policyholders improve patient safety and reduce risk?
- Is the policyholder given access to the tools and resources necessary to support clinical risk initiatives?
- Is a clinical risk management consultant assigned to a policyholder and readily available for phone consultations or an on-site risk evaluation?
- What are the credentials of the carrier's clinical risk management team and what experience do they have?
  - Do they have experience in the healthcare environment? If so, how and where?
  - Are they experts and do they provide their policyholders up-to-date information on emerging issues through Internet and traditional print mediums?
- What risk management tools are being provided to policyholders? Can they be accessed conveniently?
- Are self-evaluation tools available to help identify and address practice concerns?
- Is it possible to receive a credit towards premium reduction for completing continuing education courses? If so, how easy is it to earn these credits?
- Does the carrier offer a variety of educational programs in different formats that accommodate varying schedules? Are these programs tailored to relevant healthcare specialties?
- Can the carrier support and educate the policyholder on issues of advanced data management?
- Are credits available for electronic management of health records?
- Does the carrier have other practice-enhancement solutions?

## QUICK TIPS TO HELP HEALTHCARE PROVIDERS AVOID A MEDICAL MALPRACTICE CLAIM

1. **Practice a good “beside manner.”** Develop a good relationship your patient. Show compassion for the patient and his or her medical condition or treatment.
2. **Spend time with the patient.** A quality patient visit may increase patient satisfaction.
3. **Educate and communicate.** Talk openly with your patient. Invite the patient to ask questions and answer their questions as completely as possible.
4. **Make sure you have a complete, accurate and legible medical record.** A complete and accurate medical record may increase the defensibility of a particular claim.
5. **Be aware of the patient’s entire medical condition/history.** Look to the patient’s past medical history, new patient questionnaire and old medical records before treating the patient, instead of limiting your treatment to the current patient complaint.
6. **Explain risks and side effects of recommended course of treatment/procedure and prescribed medications.** Discuss the risks and benefits of a particular medical treatment with the patient, and allow the patient to ask questions. This process is more likely to result in informed patient consent.
7. **Personally obtain informed consent.** Do not rely on a nurse or hospital to obtain a signed informed consent form. Talk with the patient about the medical treatment and confirm that the patient understands the risks and benefits involved with the proposed treatment.
8. **Avoid overly aggressive bill collecting.** Sending a patient through the collections process can irritate an already frustrated patient, particularly where there are less than optimal outcomes. Before sending a patient to collections, review the patient’s chart to ensure that the collections process is a prudent course of action.
9. **Complete patient follow-up.** Remember to report test results to the patient and return patient calls in a timely manner. Document the telephone calls and other patient follow-up in the patient medical record.
10. **Hire and train competent staff.** Remember, you may be held accountable for staff actions or inactions. Hire and train your staff in a manner that best represents you and your practice.
11. **Request consults in a timely manner.** Request consults in cases of uncertainty or for issues outside of your specialty. Follow-up with the specialist to ensure the patient kept the scheduled visit and to ensure that you receive a report from that visit for continuity of care.
12. **Continue your medical education.** Keep up-to-date on the latest information on medical care, new treatment, advancements in treatment and other pertinent information, such as risk management strategies or changes in applicable laws.

# CLAIMS MANAGEMENT AND DEFENSE

MedMal insurance is purchased to protect policyholders during the worst-case scenario – a claim or a lawsuit. Understanding how a carrier manages, defends, and resolves a claim is critical and should be important factors to consider when selecting a carrier. Ideally, the carrier should be able to provide the following:

- Extensive experience in handling medical liability claims
- Strong connections with the best local law firms that intimately understand the particular judicial climate in that jurisdiction
- A nationwide network of expert witnesses
- A history of superior litigation results
- Proven financial strength necessary to support an aggressive defense – even in difficult economic times

## Why It Is Important to Report an Incident Immediately

Reporting an incident to the carrier as soon as it happens allows everyone involved to start working proactively to resolve the potential claim. Certain claims-made policies require that the policyholder report an incident within a certain time period to ensure coverage. More importantly, reporting an incident quickly will help preserve important documentation and allow parties to memorialize and corroborate facts relevant to the claim while memories are still fresh. Ordinarily, reporting an incident does not affect a policy's limits or premium, so it is best for a policyholder to be forthright with the carrier.

The claims management process begins when a policyholder is sued or receives notice from a claimant of the intent to seek damages against the policyholder for negligence. The policyholder is required to notify their carrier of the claim as soon as possible. The carrier then begins the process of managing the claim and defending their policyholder from the allegations of wrongdoing. The claims process may involve the retention of an attorney, efforts to settle the case, arbitration, mediation, depositions, retention of experts, and trial.

## KEY PARTICIPANTS IN THE CLAIMS PROCESS

**Policyholder/Defendant** – As the best source of information available, a policyholder should be involved in the defense from the beginning as cooperation and full disclosure are crucial to an effective defense. Furthermore, the policyholder may be required to consult frequently with the defense team, testify at a deposition, and attend trial.

**Claims Manager** – Claims managers are the carrier's liaison between the policyholder and the defense attorney. They assist the policyholder and defense attorney as needed, and aid in preparing the policyholder for any proceedings. They also independently assess the strength and value of the claimant's case.

**Defense Attorney** – Although the defense attorney is retained and paid by the carrier, he or she represents the policyholder in any proceeding involving the claim. The defense attorney handles the entire legal process, including researching state specific laws and recommending a case-specific defense strategy. He or she is also responsible for keeping a finger on the pulse of the relevant legal environment, and apprising the carrier and the policyholder of any significant characteristics of the jurisdiction, the judge and the jury. The defense attorney also recommends and retains the services of expert witnesses, as well as prepares witnesses for trial and for depositions.

**Claimant/Plaintiff** – The claimant/plaintiff is the person (or entity) who is pursuing a claim against the policyholder. A claimant could be an estate, a guardian, a spouse, or a parent.

**Experts** – Experts are persons retained to assist in evaluating and explaining the issues relevant to the claimant's allegations. Medical experts are usually physicians practicing in the same specialty as the policyholder involved in the claim. Experts may also be financial planners, life-care plan experts, or accountants. Separate experts are retained by the plaintiff and the defendant to testify to the jury regarding negligence, standard of care and damages.

**THE AVERAGE CLAIM COULD TAKE UP TO SEVEN YEARS TO RESOLVE AFTER THE INITIAL INCIDENT.**

## ROLES AND RESPONSIBILITIES OF THE KEY PARTICIPANTS IN THE CLAIMS PROCESS

The claims process involves cooperation between the policyholder, the carrier and the defense attorney. This section provides an overview (in bullets) of what should be the "best practices" of the participants.

### After becoming aware of a claim or a lawsuit, a policyholder should:

- Call the insurance carrier immediately to obtain guidance regarding the claim; if the insurance carrier is involved from the beginning, risk could be minimized
- Never respond to correspondence or inquiries from the claimant's lawyers without consent and review by the carrier and/or defense counsel
- Never contact the claimant directly, unless directed by the claims manager or the defense attorney assigned by the carrier to do so
- Discuss the case only with the defense attorney and the claims manager (except to the extent approved by either)
- Notify staff in writing to collect all of the relevant records concerning the claimant and maintain them in a separate and secure location
- Never destroy any records or information, even if doing so would be in compliance with state law or applicable retention/destruction policies
- Only provide copies of patient records regarding the claim with the approval of the claims manager or defense attorney

- Avoid altering, amending or updating relevant medical records unless doing so is in compliance with state law or other acceptable practice standards, and documented accordingly
- Consider ceasing all billing and collection activity regarding the claimant
- File all correspondence and any other communications from the defense attorney and claims manager in a file separate from the patient's files
- Become an active participant in the defense

#### **After receipt of notice of a claim or lawsuit, the carrier will:**

- Open the claim electronically in the carrier's claims database
- Acknowledge the claim by sending acknowledgment letters to the policyholder
- Verify coverage, including sending the policyholder a "Reservation of Rights" letter if there are allegations made against the policyholder that may not be covered by the policy
- Assign the case to a claims manager

#### **In managing the claim, the carrier will:**

- Gather relevant records including the entire medical file
- Obtain releases from the claimant in order to access the medical records in the custody of other healthcare providers
- Investigate the allegations of negligence, and if needed, have the claim reviewed by an expert
- Retain defense counsel if needed (usually if a lawsuit has been filed) to protect the policyholders' interests
- Request and gather "discovery" data including responses to requests for production (claimants' requests for records) and interrogatories (claimants' written questions)
- Participate in the development and continuation of the defense of the claim
- Communicate with the defense counsel and the policyholder
- Assess potential damages
- Decide to defend or settle the case (policyholder participation depends on the consent-to-settle provision in the policy)

#### **When closing a claim, the carrier will:**

- Issue payment, if any
- Complete statutory reporting as required by state or federal law including reports to the National Practitioner Data Bank, state licensing boards, DOIs, or other governing departments
- Pay all final defense and attorney fees
- Gather legal closing documents (releases, legal orders)

## Fight or Settle?

Deciding whether to fight or settle a claim depends on the situation. Up front and honest communication between the policyholder, the claims manager and the defense attorney is crucial. Such communication gives the defense attorney a clearer picture of the case and allows them to better evaluate the chances of winning and any potential exposure of the policyholder's assets. Then, the policyholder, the claims manager and the defense attorney can discuss, and, in some cases, determine as a group whether to fight or to settle.

## THE LITIGATION PROCESS

When a claim develops into a lawsuit, the rules of law and the court set out the applicable processes and procedures.

The first stage of litigation is the "discovery" process, which involves gathering records and testimony regarding the facts and allegations. Discovery includes:

- **Interrogatories** – written questions from an opponent in litigation requiring a written response in a specified format and time period
- **Depositions** – sworn testimony outside of court with a court reporter present
- **Requests for Production of Documents** – written requests from an opponent for documents to be provided within a specified time frame
- **Subpoenas Duces Tecum** – a court order requiring a third party to produce written documents to a party in litigation
- **Requests for Admissions** – written requests seeking that a party stipulate to certain facts

The second stage of the litigation process involves the filing of various motions by each party with the court. A motion is a written request from a party for a review of, and a ruling on, an unresolved issue in the litigation. This may be a request to exclude or include evidence (such as a witness or a document) or even to prevent the case from moving forward, such as in a motion for summary judgment or a motion to dismiss.

The third stage of the litigation process is the trial. The trial includes selection of a jury, opening statements, presentation of witnesses (including introduction of medical records), cross-examination of witnesses and closing statements. During a medical malpractice trial, expert testimony is a necessary element of the plaintiff's case, without which (in most cases) a suit is not allowed to proceed.

After closing statements, the jury, or in a bench trial, the judge, renders a verdict either for or against the defendant. Part of the verdict may allocate percentages of fault to defendants, where allowed by law. Juries also award damages which may include non-economic damages, economic damages and punitive damages. Non-economic damages include pain and suffering, while economic damages include lost wages, medical bills and future medical expenses. Punitive damages are typically reserved for egregious or intentional actions where the jury determines there is a need to penalize the defendant by awarding the plaintiff an amount over and above the economic and non-economic damages.

If either party is dissatisfied with the results of a trial, appeal may be considered. However, grounds for appeal are narrow, and are allowed only in limited circumstances.

## Tort Reform Measures

To help reduce frivolous lawsuits, some states have enacted tort reform measures in the form of **screening panels, affidavits/certificates of merit, penalties, and mediation/arbitration**.

- **Screening panels** are typically panels made up of similarly situated healthcare providers (ordinarily three) whose role is to review the medical records and allegations and reach a conclusion, usually in the form of a non-binding opinion, as to whether the provider acted within the standard of care.
- **Affidavits/Certificates of Merit** are sworn statements from an "expert" healthcare provider, usually of the same specialty, that support the claimant's allegations and that the healthcare provider deviated from the standard of care.
- Some states will impose **penalties** against claimants, and/or their attorneys, for bringing frivolous cases.
- Other states compel or recommend **mediation or arbitration** prior to bringing a medical malpractice lawsuit. Mediation/arbitration can be binding or non-binding, voluntary or compelled, formal or informal, and can vary in the number and types of mediators/arbitrators.

These tort reform measures are intended to add a step in the claims process to protect healthcare providers, help keep frivolous lawsuits out of the courtroom and generally reduce costs.

## AFTER PAYMENT OF A CLAIM

If a claimant recovers damages against a policyholder, whether by settlement, judgment or other final award, policyholders would then need to consider the various implications that necessarily follow. Specifically, the policy limits may be reduced, premiums may increase, nonrenewal may occur, and certain reporting requirements may be triggered.

### a. Limits

The immediate result of a successful claim is that the policy's limits are reduced by the amount paid to the claimant. For example, if a policyholder has policy limits of \$1,000,000/\$3,000,000, and a claim results in a payment of \$750,000, that policyholder's limits are reduced to \$1,000,000/\$2,250,000. If three additional covered claims are paid under this same policy, for \$750,000 each, then no limits remain, and the policy has been exhausted. At this point, the carrier will have no further duty under the policy, including any duty to defend the policyholder if additional claims arise or suits are brought.

Note however, policy limits decrease more rapidly if defense costs are included within the limit of the policy. In the first example given above, if defense costs are included in the limits of liability, and the defense costs were \$250,000, then the limits would be reduced to \$1,000,000/\$2,000,000, after payment of only one claim.

### b. Judgment in Excess of Limits

In some circumstances, the limits provided under the policy will not be sufficient to protect the policyholder completely. Using the same limits set forth in the example above, assume that a judgment is entered against a policyholder in the amount of \$1,500,000. The carrier will pay \$1,000,000 towards satisfaction of the judgment, and the policyholder will owe the remaining \$500,000 out of his/her own assets. If this occurs, the policyholder should work with the carrier and the claimant to attempt to settle the claim within policy limits, if at all possible. In addition, the policyholder should consider retaining a separate attorney to provide advice solely to the policyholder on how to minimize personal exposure.

### **c. Renewal or Nonrenewal**

Losses paid on a policy may cause premium increases, and in a worst-case scenario, prevent the policyholder from obtaining coverage in the admitted market. Subsequent to a loss, the carrier will review the policyholder's claims history to determine whether it will offer a renewal policy at the time of expiration of the existing policy. If the carrier chooses to offer renewal, the premiums for the policy may increase because of the increased risk due to the recent claim payment. Such premium increases result from either removing credits or adding debits. For example, a policyholder may no longer be eligible for previously applied credits such as a "loss free" credit. Further, premiums may be increased if the carrier applies a debit to the policy premium due to claims severity or frequency.

Where the policyholder's claims history includes numerous claims or particularly severe claims, a carrier may no longer choose to insure the policyholder. When this occurs, state law will ordinarily require the carrier to send a nonrenewal notice explaining when the policy will end, the reason for the nonrenewal, and, if on a claims-made policy, provide an offer of tail coverage. In instances of nonrenewal, a policyholder may be unable to find coverage with an admitted carrier and be forced to seek coverage in the alternative market.

### **d. Reporting**

Carriers, and sometimes even policyholders, are subject to both state and federal reporting requirements that are triggered when claims are first made or ultimately paid.

#### **(i.) Federal Reporting Requirements**

Under the federal scheme, no reporting is required until a payment is made to a claimant. There are two distinct federal entities to which reports are made in the event that a claim is paid on behalf of a policyholder.

##### **■ National Practitioner Data Bank**

Federal law requires that if any money is paid out on behalf of a healthcare provider as the result of a medical malpractice claim, information regarding that payment must be reported to the National Practitioner

Data Bank (NPDB). The purpose of this database is to create a permanent record of a healthcare provider's medical liability history. This database is not available to the public, but it is available to insurance carriers, a doctor's employer and state licensing boards. Physicians can request and review their own records. For more information about NPDB, visit the web site at [www.npdb-hipdb.com](http://www.npdb-hipdb.com).

##### **■ Centers for Medicare Services (CMS) Reporting**

If a policyholder settles a patient's claims directly without reporting the settlement to the carrier, this may violate federal law due to federal reporting requirements implemented in 2010 regarding payments to Medicare beneficiaries. Any settlement made on or after October 1, 2010 (depending upon the thresholds set by statute) must be reported to CMS if the settlement is made to a Medicare recipient. Moreover, when policyholders make medical payments on behalf of patients on an ongoing basis, different rules apply, and reporting is required on payments made on or after July 1, 2009. Failure to timely report can result in civil penalties being assessed of up to \$1,000 per violation per day.

#### **(ii.) State Reporting Requirements**

States often have reporting requirements for both the carrier and the healthcare provider in the event of claim. Reports are usually made to the DOIs, the Departments of Health, or the appropriate state licensing boards. State law may require the report to be made by the carrier, the healthcare provider, or both.

Some states require the reporting of only those claims for which a payment is made to the claimant. Others require reporting for all claims, regardless of whether a payment is made. For those that require that all claims be reported, requirements vary as to when the claim must be reported—at commencement, at closing, or both.

## QUESTIONS TO ASK A CARRIER ABOUT ITS CLAIMS MANAGEMENT AND DEFENSE

### Carrier's Philosophy

- What percentage of the carrier's claims are closed without payment?
- What is the carrier's trial win percentage?
- How many claims has the carrier handled in the past five years? Thirty years?
- Has the carrier handled claims in the policyholder's specialty?
- Does the carrier handle medical malpractice claims nationwide?
- How long has the carrier been handling medical malpractice claims?
- What is the carrier's defense philosophy?
  - Is the carrier committed to spending the money necessary to adequately defend the policyholder?
  - Does the carrier mount an early, aggressive defense that considers all outcomes? If so, how?
  - How does the carrier decide whether to take a case to trial?
  - Does the carrier routinely seek input from the policyholder during the defense of the claim?
  - Does the carrier keep the policyholder adequately informed during the claims process?
- Are appeals vigorously pursued?

### Claims Managers

- Does the carrier have local claims managers?
- Does the carrier provide ongoing litigation support? What tools and resources does the carrier provide to help prepare, educate and support the policyholder during the litigation process?
- Does the carrier directly manage a claim, or does it outsource this responsibility to a third party?
- How many years of experience, on average, does each member of the carrier's claims team have in medical malpractice?
- Are any members of the claims team licensed attorneys? If so, how many?
- Does the carrier have nurses, physicians or other healthcare providers on staff to assist in the management and analysis of the claim?

### Defense Attorneys

- Does the carrier utilize local law firms that specialize in defending medical malpractice claims?
- How is the defense team chosen? Is it a one-size-fits-all approach, or is the firm (and its attorneys) assigned by its knowledge of a particular specialty and based upon its prior trial successes?

### Experts

- Does the carrier bring in national, regional or local experts? Under what circumstances are they used?
- Does the carrier have access to a proprietary database of highly credentialed expert witnesses who can thoroughly evaluate the treatment and testify regarding the standard of care, the treatment and an alleged injury?

## EDUCATED CONSUMERS MAKE EDUCATED DECISIONS

We've armed you with the important questions you should ask any professional medical liability insurance company when considering coverage. We believe that when you are armed with the right information, you'll make a decision that is right for you.

Remember to evaluate each carrier on the following criteria:

- **Pricing**
- **Policy Options**
- **Financial Strength**
- **Longevity**
- **Defense**
- **Risk Management Solutions**

The decision of where you place your trust for your professional medical liability insurance is one of the most important decisions you will make in your career. Your assets and reputation depend on it.

# GLOSSARY

**Admitted Carrier** – A carrier that is licensed and authorized to write insurance in a particular state using rates, rules and forms that have been approved for use by that state's Department of Insurance (DOI). These entities are subject to the highest level of regulatory oversight and scrutiny.

**Annual Aggregate Limit** – For claims-made policies, the annual aggregate limit is the maximum amount the carrier will pay for all covered claims first made against the insured during a given policy year. For claims-made and reported policies, the annual aggregate limit is the maximum amount the carrier will pay for all covered claims first made against the insured and reported to the carrier during a given policy year. For occurrence policies, the annual aggregate limit refers to the maximum amount the carrier will pay for all covered claims arising from incidents that occurred during a given policy year.

**Assessable Policy** – A type of insurance policy that allows the carrier to make assessments

against insureds over and above the original premium charged to assure sufficient reserves and capital surplus are maintained.

**Cancellation** – The termination of an insurance policy either by the carrier or the insured prior to the expiration of the current policy term. State law generally sets out the required notice and acceptable reasons for cancellation or non-renewal of medical malpractice policies by the carrier, including: non-payment of premium; mutual consent of the parties; fraud or material misrepresentation; revocation or restriction of the healthcare professional's license; or an increase in the hazard insured against.

**Claim** – An express, written demand upon an insured for money or services as compensation for civil damages.

**Claims-Made Policy** – A type of policy that offers coverage for a claim arising from a healthcare event that not only occurred on or after the retroactive date (as set forth

in the Declarations Page of the policy), but also was first made against an insured during the policy period. Claims-made coverage is generally inexpensive at first, and gradually increases or "steps up" over a period of time (commonly five years) to a "mature" claims-made premium.

**Consent to Settle** – A policy provision that requires an insured's consent before the carrier may settle a claim on behalf of the insured. An example of sample language: "Written consent of the first-named insured only is necessary and sufficient for the Company to settle any claim or other matter brought against an insured facility or its agents."

**Credit** – A discount applied to the policy premium based on underwriting criteria.

**Debit** – An increase applied to the policy premium based on underwriting criteria.

**Declarations Page** – Issued by a carrier along with the insurance policy, this document states basic information about the policy, including policy period, types of insurance coverage, limits of liability, premiums due and coverage restrictions.

**Demand Trigger** – A type of claims-made policy provision that requires a claim actually be made against an insured during the policy period for coverage to apply.

**Endorsement** – An amendment added to an existing policy modifying its terms.

**Event** – An accident. Typically, all injuries arising from (1) the same or related acts, errors, or omissions or (2) the continuous or repeated exposure to substantially the same harmful conditions is considered one event.

**Exclusion** – A policy provision setting forth a specific loss or risk the policy does not cover.

**Extended Reporting Endorsement (Tail Coverage)** – Applicable to claims-made policies, this coverage allows the insured to report claims first made after a policy termination date. However, such claims must result from an event that occurred on or after the retroactive date, but prior to the policy termination date. Some carriers waive the additional premium for this coverage in the event of an insured's death, disability or permanent retirement.

**Guaranty Association / Fund** – A statutorily created entity designed to protect consumers by providing limited benefits for the payment of claims on behalf of authorized insurance companies that have become financially insolvent. State law typically prohibits advertising that policyholders are protected by a guaranty fund because the existence of a guaranty fund is not, and should not be, a substitute for the prudent selection of an insurance company that is well-managed and financially stable.

**Hammer Clause** – A policy provision that diminishes the value an insured receives from a consent-to-settle provision by reducing the available limit of liability if the insured refuses to provide consent to settle a claim. Under a hammer clause, the carrier is typically released from any exposure beyond the amount the claim could have been settled for had the insured given consent.

**Healthcare Provider** – A healthcare provider (HCP) includes doctors, dentists, nurses, hospitals, facilities and other healthcare professionals who render professional services to a patient.

**Incident** – An event the insured knows or reasonably should know is likely to result in a claim such as death, amputation, loss of a major organ function, loss of vision or hearing, paralysis, permanent neurological injury or injuries related to the birth of a child.

**Incident Trigger** – A type of claims-made policy provision that does not require that a claim actually be made against an insured to trigger coverage, but rather requires only that the insured reasonably anticipate that a claim is likely to result from an otherwise covered incident. Claims-made policies with this provision are often referred to as “incident trigger” policies.

**Indemnity** – As used in this informational document, indemnity is generally intended to mean the payments made by an insurance carrier on behalf of its insured to cover loss arising from liability claims for which the insured has become responsible, and for which the insurance policy issued by the carrier provides coverage.

**National Practitioner Data Bank (NPDB)** – As described on the NPDB website ([www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov)), the NPDB is “primarily an alert or flagging system intended to facilitate a comprehensive review

of healthcare practitioners’ professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner’s licensure, professional society memberships, medical malpractice payment history and record of clinical privileges.” Federal law requires that each entity that makes a medical malpractice payment for the benefit of a physician, dentist, or other healthcare practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or a judgment against that practitioner, must report certain payment information to the NPDB. A payment made as result of a suit or claim solely against an entity (for example, a hospital, clinic or group practice) that does not identify an individual practitioner, is not reportable. The purpose of this database is to identify and create a permanent record of HCPs who have repeated medical liability issues.

**Non-Admitted Carrier** – A carrier that is not licensed to do business in the jurisdiction in question, but which may otherwise be approved or permitted to do business there. Generally, the rates, rules and forms of such carriers are not approved by the DOIs,

and they are not required to follow the stringent rules and regulations that an admitted carrier is required to follow. Generally, surplus lines carriers are the most common type of non-admitted carrier, although other non-admitted types include RRGs and captives. Non-admitted carriers provide an alternative way for insurance buyers, including those who cannot obtain traditional insurance due to underwriting considerations, to obtain coverage through a means other than the traditional commercial market when, for example, the type of insurance they are seeking is unavailable in the admitted market.

**Non Renewal** – Termination of a policy at the expiration of a policy term by the decision of either the carrier or insured.

**Occurrence Policy** – A type of policy that offers coverage for claims arising from an event that took place during the policy period.

#### **Patient Compensation**

**Fund (PCF)** – Currently, eight states (Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina and Wisconsin) have statutorily established entities

commonly referred to as patient compensation funds. These funds are designed to improve access to medical care by helping to stabilize volatility in the cost of medical malpractice claims and medical malpractice insurance. In these fund states, eligible HCPs can participate in the PCF (some states have mandatory participation) by maintaining specified primary insurance limits and paying a required fee or premium surcharge. Participating HCPs obtain a second layer of insurance coverage (similar to excess coverage) above and beyond specified primary insurance limits, as well as other statutory benefits in some cases (such as a hard cap on damages and mandatory pre-litigation claim review procedures). For example, a participating Indiana HCP can purchase a \$250,000 per occurrence/\$750,000 aggregate primary layer of coverage from an admitted carrier and pay the required surcharge. Before a patient can file a malpractice lawsuit against the HCP, the patient must submit the claim to a claims review process that requires three physicians to evaluate the HCP's culpability. Only after that review is completed can the patient pursue litigation. If such litigation results in a verdict above \$250,000, Indiana's PCF would provide coverage up to the current

statutory cap of \$1,250,000. Any damages beyond this hard cap are not collectible. Many carriers in these eight states will not insure eligible HCPs unless they participate in the patient compensation fund.

**Prior Acts Coverage** – Similar to an extended reporting endorsement or tail coverage, this coverage allows the insured to report claims arising from events that occurred after the retroactive date but prior to the effective date of the insured's current policy. Prior acts coverage is offered by an HCP's new carrier when coverage is purchased under a new policy. In contrast, tail coverage is provided by the prior carrier and allows the reporting of claims after the expiration of coverage with that carrier.

**Retroactive Date** – Generally listed on the declarations page of a claims-made policy, this is the date after which an event must occur to be eligible for coverage under the policy.

**Risk Classification** – A classification based on the number and amount of losses that can be expected from an HCP's specialty and procedures.

**Risk Management** – A systematic approach used to identify, evaluate and reduce or eliminate the possibility of an unfavorable deviation from the expected outcome of medical treatment. The primary purpose of risk management is to prevent injury to, and the loss of assets of, patients due to negligence or perceived negligence.

**Risk Retention Group (RRG)** – An RRG is an insurance entity formed under one state's law but, pursuant to federal law, may operate in any state after formal registration in those states. The registration process is simple when compared to the requirements placed on an admitted carrier. Because RRGs operate outside the regulations and oversight applicable to admitted carriers, their rates and forms are not reviewed or approved by the states' DOIs. RRGs are generally owned by their members and, in order to join, HCPs may be required to make capital contributions beyond the payment of premium.

**Substandard Risk** – A person or entity that fails to meet standard underwriting criteria. In order to secure coverage (often only found in the surplus lines market), these insureds must pay higher

premiums and/or be subject to special coverage restrictions.

**Surplus Lines** – Sometimes referred to as Excess and Surplus (E&S) insurance, surplus lines insurance is coverage secured through a non-admitted surplus lines insurance carrier. Surplus lines carriers are typically not regulated by states' DOIs and do not file rates, rules or forms (other than for informational purposes). The coverage available through a surplus lines carrier is typically limited to those coverages that are not available from an admitted carrier and cannot be accessed merely to secure more favorable pricing.

**Tail Coverage** – See definition of "Extended Reporting Endorsement."

**Underwriting** – The process by which the carrier evaluates policyholder risk, including the application of applicable credits and debits, and determines if non-renewal is warranted in cases where the risk no longer meets acceptable underwriting guidelines.

After reading through "Navigating the Real World" and carefully analyzing the topics discussed therein, we invite you to contact a Medical Protective representative and see how we stack up to the competition. We are confident you will see why more than 70,000 physicians and dentists trust us to protect their professional reputations.

Consider the following:

- Medical Protective was the first exclusive medical liability insurance company in the United States
- Medical Protective has been in business since 1899 – triple the time of the nearest competitor
- Medical Protective is the only primary MedMal company with A.M. Best's highest rating of "A++"
- Medical Protective is the only primary MedMal company with S&P's "AA+" financial strength rating

**For more information, or to set up a speaking engagement call 800-4MEDPRO. We can also be found at [www.medpro.com](http://www.medpro.com).**

## How do other insurance carriers measure up to Medical Protective?

### Strength

"A++" (Superior) A.M. Best rating?

"AA+" (Extremely strong) S&P rating

### Defense

Dedicated claims professionals, averaging 20 years of experience?

Winning: 90% of cases that go to trial?

Your consent before any settlement?

Specialized 'local defense counsel' who are experts in your jurisdiction?

Nationwide network of the best expert witnesses?

Litigation support services preparing you for testimony or the courtroom?

### Solutions

Dedicated risk management professionals averaging 20 years of experience?

Home study, internet and seminar programs for healthcare providers and staff?

Continuing medical and dental education credit available?

2.5% premium credit when you implement accredited e-health records?

Financing and other practice-enhancement solutions?

### Since 1899

Over a century of proven results for healthcare providers?

Medical Protective	Insurance Carrier B
Yes	_____
Yes	_____
Yes*	_____
Yes*	_____
Yes†	_____
Yes	_____
Yes*	_____
Yes	_____

\* Medical Protective Data 2005-2009

† Product availability varies based upon business and regulatory approval and may be offered on an admitted or non-admitted basis. ©2010 The Medical Protective Company®. All Rights Reserved.



# CONTACT US.

If you have questions, or need more clarification, please don't hesitate to contact Medical Protective at **800-4MEDPRO**, your independent agent or visit us at [www.medpro.com](http://www.medpro.com).



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