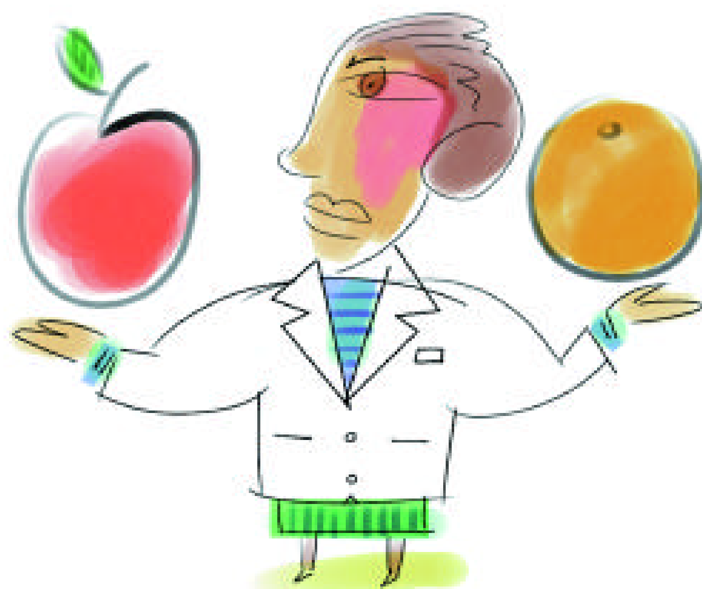

A Savvy shopper's guide to MALPRACTICE Insurance

Everything you ever wanted to know about malpractice policies.

What you learn now could be critical if you ever make a claim.

BY RICHARD VENTO

On New Year's Day, a suburban Philadelphia paper reported that at Frankfort Hospital's three facilities in Northeast Philadelphia and Bucks County, all 12 active orthopedic surgeons decided to put down their scalpels after their malpractice rates nearly doubled to $106,000 each.

The medical malpractice market is changing, in some places, drastically. Perhaps you have, for the first time in your career, the responsibility of finding your own medical malpractice coverage. You are not certain where to begin. Medical malpractice may be the largest total expense of your professional career. What do you need to know? How and when do you start? The marketplace and the products offered are complex. The search and due diligence required to make an informed buying decision could take as long as 60 to 90 days.

The changing market

Understanding the market conditions that you may face will better prepare you to make the best decision on this important issue. Historically cyclic, the market—availability and cost—for medical malpractice has been in its "soft," or competitive, phase for the past 12 or more years. Since the mid-1980s, many

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insurance carriers wanted to write medical malpractice policies. The premiums they charged were relatively cheap and the policy terms were liberal. Now the cycle is reverting to its "hard" period.

"It's turned to absolute chaos," says James Gillespie, Jr., the senior vice president and practice leader in Philadelphia for Aon Risk Services, Inc., the world's second largest insurance broker and risk management consulting firm. "That's a result of a number of things but it's principally based on the fact that carrier results have been extremely poor. The number of claims (frequency) and the settlement costs (severity) of those claims and the related legal expenses have risen. To compete in the fierce market, many carriers sold policies much too cheaply for too long."

Many carriers have paid out as much as $1.50 for every $1.00 taken in. To continue to be viable, companies have dramatically cut back on the policies they sell, and some have even withdrawn from the market altogether. A few have even become insolvent and gone out of business. This results in a "hardening" of the market—increased costs, shrinking availability, and more restrictive coverage.

Why you need it

At its most basic, malpractice insurance is a future promise to pay claims and provide legal defense for alleged acts, errors, or omissions arising out of your professional activities as a physician. It is financial protection for you, your family, and your practice. Gillespie estimates that over the course of your professional career, there is a 66 percent chance that you will get sued at least once. Even if you win the suit, legal costs can run to six figures.

Most managed-care organizations and health-care institutions have strict medical malpractice insurance requirements for all physicians participating in their programs, admitting patients, or using their facilities. Professional relationships are an issue as

Claims-Made or Occurrence: Which is Better?

YEAR ONE		YEAR TWO		YEAR THREE		YEAR FOUR		YEAR FIVE	
Occurrence	Claims Made	Occurrence	Claims Made	Occurrence	Claims Made	Occurrence	Claims Made	Occurrence	Claims Made
$1,000	$750 / $250	$1,000	$550 / $450	$1,000	$300 / $700	$1,000	$150 / $850	$1,000	$50 / $950

OCCURRENCE PREMIUM — CLAIMS MADE PREMIUM — IMPLIED TAIL PREMIUM

MALPRACTICE POLICIES HAVE finite effective and termination dates, and a new policy must be purchased when the previous policy expires. There is an inherent time lag between when an incident (alleged injury to a patient) occurs and a claim for damages is presented. This time lag is called the "tail." An example of time lag would be a sponge or instrument left in a patient during surgery that is not discovered for years. There is no way to file a claim before discovery of the incident. Since coverage has to fit under one policy or another, there must be an arbitrary way to determine which medical malpractice policy defends you and pays the settlement or judgment. There are two basic forms of policies offered—occurrence and claims-made. The difference in the two is the "trigger" that determines when that particular form of the policy pays.

The occurrence policy only requires that the alleged event occurred (hence the name "occurrence") during the policy period. It is irrelevant when a claim is presented. The "tail" is not important.

The claims-made trigger, however, requires the alleged event happen and the claim be made during the same policy period—hence the name "claims-made." Herein lies the problem.

Claims-made policies must have a mechanism that deals with the "tail." That mechanism is called the retroactive date. The retroactive date is the effective date of the first claims-made policy you buy. When a claims-made policy expires and a new claims-made policy is purchased, the retroactive date of the new policy, and all subsequent policies, must remain the same as the expiring policy. Coverage for a claim attaches to the policy that is in force when the claim is made if the event occurred after the retroactive date. It serves as an anchor for continuous claims-made coverage without gaps.

More about the tail

There are, however, times when you may want to terminate your claims-made policy. Perhaps you've joined a practice that will include you in their group policy. Perhaps you choose to eliminate obstetrics and practice only gynecology. The nature of claims-made coverage requires some mechanism to deal with covering the "tail"—those potential claims yet to be made from alleged injury during your claims-made tenure. Remembering that the claim must be made before the end of the policy period, how do you get coverage for the continuing "tail?" The mechanism for dealing with the "tail" is an Extended Reporting Period endorsement (rider) or "ERP."

ERP is an endorsement to your expiring policy which, when purchased for an additional premium, will extend the period of time to report claims which would have

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well, since every provider with whom you share patient care responsibilities exposes you to liability—and vice versa.

Lastly, many states have recognized a social responsibility to protect the consumer from negligent health care and have implemented mandatory medical malpractice for all licensed physicians practicing within that state. Contact your state licensing board if there is a question of whether or not such a mandate exists.

How to access the market

Historically, malpractice carriers have used two distribution systems to sell their policies. One system, commonly called the "direct" system, sells directly to physicians using an employed sales force and does not offer products of any other carrier. A "direct" writer argues its premiums are lower than a carrier using an independent agency system because it does not pay commissions to a sales force.

The carriers using the "independent agency" system sell through independent agents or brokers who may represent any number of malpractice carriers. The physician who buys through the independent agent has an advocate to assist in evaluating the products offered, negotiating the purchase, and assisting when issues arise.

Phillip Ruhl, MD, a board-certified anesthesiologist, is one of eight partners of Anesthesiologist Consulting Medical Inc. in Stockton, California. "We have to have a broker because there is just no way for an individual such as myself to really know anything about insurance… Don't let yourself assume that you do [know insurance] because there's just no way you can. You study it like you study anything else."

A third potential distribution system is emerging—the Internet. Ida Havens is a senior vice president of Healthcare Insurance Services in Houston. A medical malpractice insurance broker, she has worked extensively to develop an

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been otherwise covered by that policy. It can vary from 90 days to as long as indefinite. An indefinite ERP in effect converts the coverage from claims-made to occurrence since it totally eliminates the time restriction to report claims for that policy as well as any previous claims-made policy with the same retroactive date. The cost of an indefinite ERP is usually significant—from 150 to 200 percent or more of the expiring policy premium. A closer look at the pricing differences will illustrate the pricing of tail coverage.

Pricing differences

Claims-made policies are less expensive than similar occurrence policies because of their more restrictive nature. Let's consider this example: Dr. Jones buys a claims-made policy for the first time on January 1, 2000. Carrier A issues the policy with a retroactive date of January 1, 2000. Carrier A only has to pay for a claim where the injury both happened and the resulting claim is presented during the year 2000. If, on the other hand, Dr. Jones had purchased an occurrence policy for the year 2000, Carrier A would have to pay every claim ever presented as long as the injury event happened during 2000. Therefore Carrier A is exposed to a much greater chance of paying claims under its occurrence policy than under its claims-made policy. Carrier A charges much less premium for the claims-made policy in the first year. The premium for the claims-made policy may be as low as 25 percent of the cost of an occurrence policy.

In 2001, Dr. Jones continues a claims-made policy with the same carrier. His retroactive date remains January 1, 2000. There are now two years (2000 plus 2001) of claims that Carrier A can pay under this policy where both the event happened and the claim was presented. Two years to present claims is still much less than as much as 20 years to present claims under an occurrence form, hence the premium for the second year's claims-made policy is maybe only 45 percent of a corresponding occurrence policy. This process repeats for the next few years, yielding "step" increases in pricing each year. A typical progression might be 70, 85, 95 percent of a similar occurrence policy, respectively, for years three, four, and five.

The premiums level out or "mature" after four to six years, and should be either slightly less than or equal to what an occurrence form premium would be. This is because most medical malpractice events are at least known about in four to six years. Once "mature," for every additional year of claims-made coverage, even though more claims can be made, the earlier years of the coverage are much less likely to yield new claims. Carrier A is more confident it is charging enough premium to pay for the claims it sees in a given "mature" claims-made year.

Dr. Jones has paid, in a five-year, claims-made step progression, a total of 320 percent of one year's occurrence premium (25 plus 45 plus 75 plus 85 plus 95 percent), assuming no overall rate increases. By contrast, over the same five-year period, Dr. Jones would have paid 500 percent of one year's occurrence premium. claims-made coverage saved Dr. Jones 36 percent plus investment income.

Claims-made and occurrence are merely two different cash-flow methods of paying for the same medical malpractice insurance. You pay more initially for occurrence coverage, and the insurance company earns the investment income. Claims-made has a lower front-end cost and you get the investment income. At some point, you may have no choice but to buy the "tail." When that occurs, count on paying the difference between the claims-made premium you paid already and what the occurrence coverage would have cost, plus some. ■

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Internet distribution system for medical malpractice. She predicts that over the next 18 to 24 months, the Internet will be used mainly to get pricing information, not as a vehicle for selling policies.

Types of companies

There are several types of medical malpractice insurance companies, all with pros and cons. Physician-owned insurance companies are specialty companies that write only medical malpractice. Physicians may have major input with respect to the operation of the carrier; these carriers tend to be more responsive to the needs of physicians. They typically sell in a limited number of states, and, their continued viability is totally dependent on their malpractice losses, since they have no spread of risk to other kinds of insurance.

Commercial carriers usually write several kinds of insurance in many states. They tend to be less sensitive to physicians' needs and operate independently of any major physician management or influence. They have a larger spread of risk with more territories and kinds of insurance, but adverse results in other lines can influence their continued interest or ability to provide medical malpractice.

Some states have created medical malpractice carriers to assure that physicians always have at least one carrier. These companies often have the highest premiums but may accept all physicians who apply for coverage.

There are also alternative insurance vehicles created to fill voids in the market or provide independence from the cyclical nature of insurance premiums and availability. These alternatives may be formal self-insurance programs, captive insurance companies, and risk retention groups. They may be well run and financially strong, or they may not be. Due diligence is strongly recommended when considering any of these vehicles.

One of the most important concepts to grasp is the difference between admitted (or licensed) and non-admitted carriers. All insurance companies fall into one or the other category. Insurance is regulated by individual states, and these two terms refer to the medical malpractice carrier's status and relationship with each state insurance regulatory authority.

Admitted carriers' rates, policy forms, and financial conditions are closely regulated by the state insurance department. Admitted carriers are protected by guaranty funds that respond to claims made against policyholders of bankrupt insurance companies. Non-admitted carriers (or surplus lines) are carriers that write in a state free from regulation by the state's insurance department. Non-admitted carriers have the flexibility to alter coverage or pricing to meet their needs and those of the market. Typically, their medical malpractice products are more expensive and restrictive, and their clients do not enjoy the protection of the state guaranty fund. Self-insurance programs, captive insurance companies, and risk retention groups almost always are outside of the state purview.

Claims-made or occurrence

The two basic forms of medical malpractice policies, claims-made or occurrence, differ in the way they accept responsibility for a given claim. On the simplest level, the claims-made policy requires that both the alleged injury to a patient and the filing of the claim happen during the policy period in order for that policy to defend and pay the claim.

The occurrence policy requires only that the alleged injury to the patient occurs during the policy period. Occurrence is the more physician-friendly form, and also the most expensive. (See "Claims-Made or Occurrence: Which is Better?" on page 40 for a more detailed comparison as well as the premium pricing differences.)

It's all in the details

The definition of a claim is significant when changing from one claims-made carrier to another. The issue is this: When does an event likely to give rise to a claim first become known and by whom, and when did the claim actually get presented to the carrier? The most restrictive definition considers a claim to be made only when a written demand for damages from a third party is presented to the carrier. This prevents the physician from reporting incidents likely to give rise to a claim. (The classic example is operating on the wrong body part—you know you're going to get sued, you just don't know when.)

The most liberal definition allows reporting of incidents likely to give rise to a claim to trigger coverage. Switching coverage from a carrier with the more restrictive definition of a claim to one with the more liberal definition leaves open the possibility that a given claim could not be covered—an event to be avoided at all costs.

Suppose that a surgical instrument was left in a patient's abdomen, and after some period of time, an x-ray brings the matter to light. If your policy contains the restrictive definition of a claim requiring written notification, you are prevented from turning the claim into your current carrier before your policy expires. The patient has not discovered the event, so he has not had time to file a claim. Suppose further that you are considering switching to a new carrier who has the liberal "incident likely" definition of what constitutes a claim. PROBLEM! All malpractice carriers exclude coverage for claims if the physician has prior (before the start of the policy) knowledge. The intent is that you should report those to your prior carrier. Your new carrier would deny the claim because you knew of the incident likely to give rise to the claim and therefore should have reported it to the previous carrier. Yet your old carrier would not accept a

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report of an incident until a written demand from a third party was received. You now have a gap—no coverage from either carrier. It is imperative that the definition of claim be the same when switching claims-made carriers unless the "tail" is purchased from the previous carrier.

Another extremely important policy issue lies in the exclusions, a part of every policy. Be especially sensitive to any exclusion that acts to exclude or restrict any portion of your past or current practice. An example is a family practice physician doing obstetrics. If your coverage is claims-made, you need to be continuously covered for your prior OB practice as long as you remain insured by a claims-made policy.

The consent to settlement clause is a sensitive issue for many physicians. The ideal medical malpractice coverage requires the carrier to obtain the consent of the insured physician prior to settling any claim. This consent provision should not include any form of "hammer clause"—a provision that increases the physician's personal liability by limiting the carrier's liability to the plaintiff's settlement offer if the physician withholds consent. The effect of the hammer clause is to intimidate the physician to approve settlement regardless of the merits of the case.

Some carriers provide consent to settle, but offer premium discounts of five to 10 percent if you waive the settlement provisions. You must decide how important this feature is to you.

Another important factor relates to defense costs. Some carriers require that defense costs be subtracted from policy liability limits. For example, if you have a $1 million policy, and it costs $500,000 to defend the suit, you only have access to $500,000 to pay the judgment, should there be one. Since medical malpractice defense costs can typically run as high as 50 percent or more of the indemnity payments, having defense costs covered in addition to the limit of liability is important.

What does it cost?

Malpractice premiums vary significantly by region and specialty and can run from $1500 to $150,000 or more per year. Many factors determine the rates the malpractice carriers charge physicians.

THESE INCLUDE:

- Geographic location of the practice—the legal jurisdiction influences the value of claims and jury awards
- Specialty or sub-specialty
- Specific practice features such as family practice doing OB
- Full- or part-time status
- Length of time in practice—new physicians have smaller practices and less exposure
- Claims history over the last five to 10 years
- Limits of liability requested
- Policy form—claims-made or occurrence
- Deductibles

Most carriers must file their rates, policy forms, and underwriting criteria with the insurance department of each state in which they do business. The state does not set the rates. Rather, the insurance department tries to control unfair pricing and discrimination.

That's not to say that all carriers charge the same premiums for the same physician. Carriers have different appetites for certain specialties or geographic regions, and malpractice underwriters have their own personal preferences and prejudices that influence the premiums and availability of coverage.

It is helpful if the physician knows what credits or discounts are available. These discounts are typically related to claims-free history, part-time status, new in private practice, group discounts, use of practice protocols or technology, and the elimination of a consent to settle clause.

Evaluating options

As you can see, there are many factors to consider in your purchase decision. It is helpful first to decide whether to use direct writers or brokers or both. Interview two or three brokers and two or three direct writers. Your colleagues can probably provide suggestions. In addition, Ruhl suggests that "the (county) medical society may have some good information because they've usually been around for a while and have several hundred physicians in their society from whom they receive input."

A broker should have substantial medical malpractice experience, preferably with other physicians in your specialty. He should have policies from a number of companies available. The broker's reputation, experience, and integrity are important considerations. He should discuss with you his customer service philosophy as well as provide information about claims reporting and risk management services. Don't be afraid to ask questions, and by all means meet the specific people that will service your business.

Once the market access decision has been made, the first step is the completion of the application. It is imperative that you provide complete, accurate information. Most companies make the application a permanent part of the policy, and false or misleading statements could result in the carrier voiding or denying coverage if the proper information would have resulted in the carrier deciding not to insure you.

The right company

The insurance company you choose is the most important decision in this process. Havens of Healthcare Insurance Services in Houston emphasizes that you are buying a promise to pay your claims and defense expenses; it is imperative to evaluate thoroughly the financial strength of every carrier you are considering. Consider these factors:

- **Surplus**—the excess of assets over the

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sum of liabilities, loss reserves, and capital. This equates to a carrier's net worth and the amount of money available to pay new (perhaps your) claims.

• **Ratings**—a number of national services publish annual ratings of insurance companies, looking at the same issues as the state insurance departments. They evaluate both financial strength and claims-paying ability. The most prominent rating services are A. M. Best & Co., Standard and Poors, Moody's, Duff & Phelps, and Weiss Research. Your broker or prospective carrier should be able to supply you with the ratings from each service.

• **Admitted/Non-Admitted status**—this is a real consideration. Remember that only admitted carriers enjoy guaranty fund protection.

Carrier comparison

You will be expected to cooperate in the investigation and defense of any claim, whether meritorious or false and fraudulent. You should establish the claims philosophy of a carrier prior to purchasing the policy. Does the company take a proactive approach to investigation and does it settle meritorious claims quickly to keep defense and interest payments down? Does it delay settling claims as long as possible, hoping they go away? Does it prefer to settle claims with a smaller indemnity payment if that's cheaper than defending that claim?

How does the company choose the defense attorneys it pays to represent you? Note that the carrier has a duty to pay and defend, not to consult with you on attorney selection. The ideal situation is one where you have the ability to suggest defense attorneys with whom you have prior experience and who are well versed in the particular areas of medicine involved in your claim.

More importance is being placed on physician risk management practices. The sophisticated malpractice carrier is going to have a variety of risk management tools available. The portfolio may include self-assessment tools, seminars and workshops, audio/video media presentations, on-site assessment, and Internet and e-mail services such as "Ask a Risk Manager." The carrier may provide some of its services through accredited CME courses.

Buying your policy

Once you have made your decision to buy a certain carrier's policy, then what? Make sure you receive a policy or at least a binder of insurance confirming you have the coverage you purchased and that it begins on the correct date. Payment terms vary, and many brokers and carriers offer payment plans with little or no handling charges. Premium finance plans are also frequently available for single-digit interest.

If certificates of insurance are needed, make certain the company or broker issues them so that managed-care organizations or institutions do not suspend your privileges.

When the actual policy is received, be absolutely certain you read it in its entirety and confirm coverage is provided as you requested and understood. While most courts will construe ambiguities in favor of you since you didn't write the contract, it is best to avoid legal disputes down the road by understanding what the contract provides and requires of you.

Good luck! Hopefully, you will never need the policy you have purchased. If you should face a lawsuit, however, you'll be thankful for your diligence in selecting the right malpractice coverage. ■

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