



malpractice guide

Understand Your Policy Before you entrust your financial future to that medical malpractice policy, go through each section with your broker...and a fine-tooth comb. You need to know exactly what it says.

BY RICHARD VENTO



First you go through the painstaking process of choosing a malpractice insurance

broker, completing applications for malpractice coverage, providing seemingly endless documents, and waiting for quotes.

(Congratulations if you are fortunate enough to have choices.) Then, you suffer through the sticker shock when the quotes are received.

After resuscitation and treatment for post-traumatic stress syndrome, you will sit down with your insurance

broker and review the relative merits of the quote proposals you have received.

Relying heavily on your broker's knowledge, review the policies and the financial security and claims-paying reputation of each insurer. Ask about each insurer's A. M. Best, Standard and Poor's, and other ratings from reputable insurer rating organizations. Also, check their trend over the last three years.

What you are buying is a promise to defend you and pay claims on your behalf in

the future—possibly as much as twenty years in the future if the statute of limitations for minors is the age of majority (18) plus two years. The crucial question is, what are the chances that the insurer will still be in business when it is time to defend you and pay the claim(s) you present? If you have occurrence coverage, it is even more important that you have a reputable insurer. I am aware of doctors who have had three consecutive insurers become insolvent—basically, go bankrupt.

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Elements of the policy

When you buy a medical malpractice insurance policy, you expect that if you pay your premium and comply with every term and condition of the policy, then the insurance company will defend you and pay your claims. With a reputable company that will happen, but only if there is not some exclusion or a limitation that applies.

Since the policy is written solely by the insurer, yet is a binding contract, you need to read every word of that policy and all endorsements that are included. There are certain universal parts to every policy: the Declarations

(who), Insuring Agreement (what), Definitions, Exclusions, and Conditions (where, when and if). The insurer may use different names or terminology, but each of these sections is always included in some form or another.

The declarations (frequently referred to by insurers as the “face sheet”), is always the first section of the policy. In addition to naming you and possibly your professional corporation or LLC, it will specify the policy form (Physicians Surgeons and Dentists Professional Liability Insurance), whether it’s occurrence or claims-made, and it will list any separate endorsements that are attached. An endorsement is similar to a “rider” to a life insurance policy—it modifies some aspect of the policy and takes precedence over that particular portion of the policy. The policy number, the effective and expiration dates of the policy, and the limits of liability are also shown on the declarations page. [The effective date and the expiration date are always for the twenty-four hour period starting and ending at 12:01 a.m. in the time zone in which you are located.]

The limits of liability (the maximum the insurer will pay) are expressed in two parts—per claim and aggregate. The first limit of liability, the per-claim limit, may alternatively be referred to as per occurrence, per medical incident, per loss event, or other terms. The differences between these terms is important, depending on the particular definition the insurer applies. [Note: If it is expressed as per occurrence, it does not mean that your policy is an occurrence policy as opposed to claims-made.] The most significant difference is whether the limit applies

per claim or per medical incident (occurrence or loss event.) A per-claim limit is the broadest limit application. It means, for example, that if a woman is injured or killed, the woman’s estate may file a claim, the husband may file a separate claim, and children or other family members may also file separate claims. I’ve seen as many as five separate claims arising out of one injury to one injured party. The per-claim limit would apply to each of the five claims individually, subject to the aggregate limit of liability, the other limit of lia-

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bility that applies.

The per medical incident/occurrence/loss event limit is more restrictive—limits with these forms apply to any one injury, regardless of the number of claims asserted or the timing of those claims. For example, parents bring claim on behalf of a minor child, who then brings his own claim 15 years later. The per-incident limit applies to all the claims combined. It’s important to understand this difference since this limit of liability definition limits your protection.

To find the definition of the per-claim or per-incident limit for any policy, along with all other terms in the policy with special meaning, look

in the definitions section. The terms defined here are usually in boldface type anywhere they are used within the policy.

The aggregate limit of liability describes the total of all claims the insurer will pay in one policy year. The key is payments, not reserves on open cases. For example, if there are payments made on claims covered in a given year totaling \$270,000 and the aggregate limit is \$300,000 and another claim is filed, the most the insurer will ever pay on the new claim is \$30,000 (\$300,000 minus \$270,000 already paid on previous claims filed that year). The remainder of the settlement in question becomes your responsibility. Another important issue related to aggregate limit exhaustion is that once the aggregate limit is totally paid out, the insurer also stops paying for the defense of any outstanding claims remaining for that year—no additional claims will be defended or paid.

One more comment on the limits of liability, both per-claim and aggregate. The standard medical malpractice policy pays defense costs and other related claim expenses in addition to the limit of liability. More restrictive policies include those costs within the limits of liability. It is very important that you understand the difference because in a medical malpractice case the defense costs can run \$100,000 or more. If the defense costs are not covered in addition to the limit of liability but rather are included in the limits, and your per-claim limit is relatively low, say \$200,000 per loss, a \$100,000 defense expense will leave you with only \$100,000 to pay the claim.

Deductibles are sometimes used by insurers to control the frequency of

small claims and to eliminate their costs of handling such claims. They are also sometimes used to reduce your premium. Deductibles, if they apply, are also usually shown in the declarations section. The presence of a deductible means either you pay the amount of the deductible before the insurer owes any payments to the claimant, or you must reimburse your insurer for the deductible amount. Deductibles usually include amounts paid to claimants (indemnity), as well as defense costs paid by the insurer for investigation, attorney fees, and expert witness fees, among other costs.

The insuring agreement

The insuring agreement sets out the coverage provided—typically, “to pay on behalf of the insured all sums for which the insured is legally liable resulting from the rendering, or failure to render, medical professional services within the policy period.” If the coverage is claims-made, it is in this section that it will usually be spelled out with language similar to this: “...render medical professional services subsequent to the retroactive date shown in the declarations, provided the claim is first made within the policy period.”

If the policy is an occurrence form, the policy that responds to an incident is the policy that was in effect at the time the incident occurred. For example, a calendar year 1999 policy applies to any incident occurring in 1999 regardless of whether the claim is filed in 1999 or later. Alternatively, if it is a claims-made policy, the retroactive date sets the date beyond which the alleged injury must have occurred. In addition, the claim must be reported during the policy period. If the claim is reported

after the policy period expires, then the claim must be reported to the insurer who issues the policy for the next annual period. The claims-made policy will also address the extended reporting period (or tail), the purchase of which is to convert the claims-made coverage to occurrence coverage. The tail will be addressed in the policy or by an en-

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dorsement. Claims-made is a complex issue, so I'll discuss the topic more fully in a future article.

The other issue usually addressed in the insuring agreement is defense. The policy usually states that the insurer has both the right and duty to defend you from an alleged event, “even if such claims are groundless, false, or fraudulent.” The issue to be aware of here is whether the policy allows you to consent to or withhold consent for the insurer to settle that claim. The “soft market” approach was to require your consent. The hardening of the market

may mean the elimination or erosion of that privilege by using a “hammer clause.” Beware of such a clause—it means if you withhold consent to settle a claim, the insurer is not liable for more than the amount for which it could have settled if you had consented to the settlement.

Exclusions

Although I strongly recommend that you read every word of the policy, if you do not, at least read the exclusions section.

The exclusions section is one of the most important sections of the policy because it tells you what is not covered. Exclusions are always a part of a policy. The number of exclusions will vary, from as few as one to as many as 30. Exclusions are in the policy for a number of reasons—the risk is uninsurable at any price (i.e. war or terrorism), is against public policy (illegal behavior), is better covered by another type of insurance (workers compensation), or it may be available for an additional premium but not at the offered price.

The exclusions that are most likely to affect you are those related to some kind of limitation of coverage for procedures or events associated with your practice or generally anticipated for your specialty or a related specialty. An example would be an exclusion for abortions for an obstetrician or a family practice physician.

Most policies exclude other health-care businesses in which you actively participate or are financially involved, such as a surgeon who owns a surgery center or a radiologist who is part owner of an imaging center. All policies exclude illegal acts, such as substance abuse, sexual misconduct, and the practice of medicine if your license has

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been revoked. Be certain you understand each exclusion in either the policy or any endorsements, and how it might affect your practice. If a particular endorsement is troublesome to your practice, don't be afraid to ask if it can be changed or eliminated for an additional premium.

Conditions (and other nuances)

The catch-all for items that don't fit anywhere else in the policy is the conditions section. This is typically the section that tells you what your rights and duties are under the policy. You must report claims promptly, cooperate in the investigation and settlement, and not impede or compromise the claims process. If you have more than one policy, this section deals with how the claim is apportioned or which policy applies first.

Cancellation, bankruptcy, risk management inspections, and assigning the policy to others (not allowed) are dealt with in this section. Also included in this section are the conditions under which you can sue your insurer (you can't unless or until you've complied with all of the other terms required of you by your policy).

You would never prescribe an unfamiliar drug without at least first reading the package insert. Likewise, you should not buy your policy before reading it in its entirety and asking questions about anything you do not understand.

Here is my shopping list of the ideal features in a medical malpractice policy:

- Financially strong insurer with a great reputation for paying claims
- An occurrence form policy
- Limits of liability of at least \$1,000,000 per claim/ \$3,000,000 aggregate
- No deductible applies to the coverage
- Defense expenses are in addition to the limits of liability
- A requirement that you consent to any claims settlement without a penalty
- Few exclusions, with none limiting your practice parameters
- Cancellation provisions allowing you to cancel anytime without penalty
- Reasonable advance notice of intent by the insurer to cancel, non-renew, or increase your premium

If you can get all of these features in your policy, and have a choice of insurers to boot, then my next suggestion is to go buy lottery tickets...you are on a roll! ■

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