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**CHOOSING A MEDICAL
LIABILITY INSURANCE CARRIER**
A Comprehensive Guide

Choosing a Medical Liability Insurance Carrier *A Comprehensive Guide*

Choosing a professional liability carrier is one of the most important practice decisions that you will make, and it is not a decision to be taken lightly.

Today—more than ever—physicians cannot afford to be wrong in selecting a professional liability carrier to protect them against allegations of medical malpractice. A number of medical malpractice insurers have gone bankrupt or have withdrawn from the field. Defense costs have skyrocketed, and medical malpractice settlements and judgments have reached an all-time high. Without the protection of a dedicated professional liability insurer, a devastating financial blow can be incurred.

The premium must be weighed against the protection, service, financial strength, and the long-term stability provided by the carrier. Doctors should also review a carrier's claims defense performance, risk management services, underwriting standards, actuarial discipline, and whether its rules of assessability adequately protect its policyholders from unlimited personal liability.

Whether you're a physician in a solo practice or a group in search of coverage, it's important to research your options and select medical malpractice liability insurance that meets your needs. You'll find that we have provided a list of questions that we believe every medical liability carrier should answer. It is your right—and your responsibility—to ask frank questions and to carefully consider the answers you receive before making a decision.

We hope that this brochure helps you understand insurance industry terminology and guides you through that important decision. If you would like more information, please visit www.thedoctors.com/whychoose.



Richard E. Anderson, M.D., F.A.C.P.
Chairman and Chief Executive Officer

Questions You Should Ask When Selecting a Carrier

- What kind of carrier is it? (Is it a stock company, a mutual or reciprocal carrier, or is it an alternative market carrier?) If it is a mutual or reciprocal carrier, is there a dividend policy in place?
- How long has the carrier been in the business of writing medical malpractice insurance?
- Does the carrier offer policy deductibles? Does it offer discounts for physicians with favorable claims histories?
- Is the carrier endorsed or sponsored by any medical associations, and does it offer discounts for membership?
- Does the carrier have a certificate of nonassessability? (A certificate of nonassessability protects policyholders from unlimited personal liability for losses incurred by the carrier's past claims.)
- What payment plan options does the carrier offer?
- If I take family leave, disability leave, leave for military service, or a sabbatical, will the carrier charge me while I'm not practicing?
- Will I have easy access to the carrier's decision makers and to its policyholder services?
- Does the carrier have designated claims and risk management departments to handle these services internally? If not, who handles these services for them?
- What avenues are open to me if I disagree with a decision by the carrier?
- If I have a claim, will it be reviewed by a consultant of my own specialty?
- Can the carrier settle a claim without my consent?
- Will the carrier cover my locum tenens?
- What does the policy cover beyond traditional malpractice insurance? Will it cover actions and reviews by Medicare, Medicaid, medical licensing boards, credentialing agencies, and professional review organizations?
- Will I be reimbursed for lost income if I have to go to court? What kinds of services are provided as part of my defense?
- Does the company cover punitive awards?
- How do the carrier's insurance industry ratings compare with its competitors? How sound are the carrier's asset base and surplus?
- Does the carrier actively support national medical-legal reform?
- In the event that my coverage is non-renewed, will I have the right to appeal and, if so, who rules on the appeal?
- If I move my practice to another state, can I carry my coverage with me?
- What are my extended reporting (tail) coverage options if I retire or decide to move to a practice covered by another carrier?

Types of Insurance Companies

Physicians have several possible sources for obtaining professional liability insurance. In the United States, physician-owned carriers cover the majority of office-based and practicing nongovernmental physicians. Commercial carriers, owned by stockholders, provide coverage for many of the remaining physicians.

Insurance companies are generally organized as a stock company, a mutual company, or a reciprocal company:

A stock insurance company is formed as a public, for-profit corporation with stockholders who have invested capital. As with any such company, its primary goal must be the enhancement of stockholder wealth.

A mutual insurance company has no stockholders. It holds the company's assets, and the company is owned by its policyholders.

A reciprocal insurance company, or inter-insurance exchange, is an unincorporated association. Like a mutual company, its assets are owned by its policyholders, who are members of (or subscribers to) the exchange. The fundamental difference between mutual and reciprocal companies is that insurance laws and regulations require that reciprocals be operated by an attorney-in-fact that functions on behalf of the policyholders.

In addition to those three types of companies, insurance syndicates also exist, such as those supporting insurance at Lloyd's of

London. A syndicate is not an insurance company but a group of individuals or companies that agree to share liability and profits in making contracts of insurance.

Most physician-owned companies in the United States are organized as mutuals or reciprocals. If a carrier is not sufficiently sound, a policyholder might be assessed an initial capital contribution (a deposit for security against future claims). The same company might also issue assessable policies. This means that the policyholder could be required to pay additional money for past claim losses if reserves prove inadequate. (Reserves are funds set aside to cover claims that have been reported but have not yet been resolved or paid.)

A carrier that is sufficiently sound and well financed can apply for regulatory approval in its home state to remove its policyholders' contingent liability for the debts and liabilities of the carrier. Once the carrier receives regulatory approval, it can issue nonassessable policies. This approval frees its policyholders from any obligation to pay additional money for past losses if reserves are inadequate.

Another advantage of mutual and reciprocal companies is that the insureds are the owners, and they do not have the divided loyalties of stockholders versus policyholders. Any profits that a mutual or reciprocal company makes are either used to strengthen the company's financial position or are paid back to policyholders in the form of dividends.

Alternative Markets

Alternative markets provide other sources of coverage. Some state laws provide for special-purpose vehicles or trusts that may operate on an assessable basis. These laws generally provide for ease of start-up for such organizations by exempting them from certain insurance laws such as minimum capital requirements. Other alternative market mechanisms might include joint underwriting associations, risk retention groups, and risk purchasing groups.

If you are considering coverage through the alternative market, you should carefully investigate all aspects of the policy, especially provisions regarding extended reporting (tail) coverage requirements, the organization's financial solvency, its regulatory requirements, and rules regarding a policyholder's assessability. Assessability is the policyholder's obligation to cover past company losses for which reserves have proven to be inadequate. This means that if the organization cannot meet its financial obligations, it can require its insured physicians to make up the deficit.

Trusts have become an increasingly common—although controversial—alternative to insurance companies. In some states, trusts are not regulated by state insurance departments nor are they protected by state guarantee funds in the event of insolvency. Trusts frequently require capital contributions in order to join, and trust members are retroactively assessable if assets prove insufficient to pay losses. Coverage through trusts may also be provided on a claims-paid basis, which means

that premiums are based only on claims settled during the previous year or those projected to be settled in the coming year. Many claims-paid policies are assessable for a number of years, or even indefinitely, after a physician's policy has terminated.

Some trusts stop defending and paying open claims for members who go elsewhere for coverage if the members do not agree to remain assessable or if they do not purchase tail coverage from the trust.

Joint underwriting associations (JUAs) are state-sponsored programs for physicians who have no access to other sources of professional liability insurance, typically as a result of some problem that causes the standard medical malpractice insurers to refuse to insure them. Some JUA insureds bear infinite assessability for losses incurred by the organization during prior years of insurance activity. In some states in which JUAs operate, all casualty insurers in the state are assessable. In others, only the insured doctors are assessable. In those instances in which only the insureds of the JUA are assessable, ultimate financial obligations are unpredictable and can be significant.

Risk retention groups (RRGs) came into existence as a result of the federal Risk Retention Act of 1986, which allows a group to form as an insurance company and requires that it follow the insurance laws of at least one state. When first joining an RRG, a physician is typically required to pay a capital contribution in addition to the annual insurance premium.

An RRG is governed by the regulations of the state in which it is domiciled. If an RRG is appropriately capitalized and operated, it can be a viable insurance alternative. Due to less regulatory scrutiny in some states, however, an RRG can be inadequately capitalized by charging inadequate premiums. As a result, insolvencies imperiling the financial assets of the insureds have occurred among RRGs.

A risk retention group must file an annual financial statement in its chartering state and in all states in which it operates. Doctors considering purchasing insurance from an RRG should review the group's financial statements. They should also carefully evaluate the degree to which the state in which the RRG is domiciled requires that RRGs meet the high standards of solvency and effective management necessary to ensure that the company is able to fulfill its insurance obligations.

Risk Purchasing Groups (RPGs) also came into existence as a result of the Risk Retention Act of 1986. Unlike an RRG, an RPG is not an insurance company but an association of insurance buyers with a common identity, such as a medical specialty society, who form an organization to purchase liability insurance as a group. Since an RPG purchases coverage from an insurance carrier, no capital contributions are required in order to join.

The company from which the RPG purchases insurance need not be licensed in every state. The purchasing group's insurer must indicate how much premium was generated by the purchasing group in

each state in its National Association of Insurance Commissioners' Annual Statement. Physicians considering purchasing insurance through an RPG should inquire about the strength of the insurance company that provides coverage to the purchasing group.

Types of Policies

Today, almost all professional liability insurance carriers offer claims-made policies. Two less common types of coverage are claims-paid and occurrence. Since these three types of insurance provide fundamentally different protection, you should clearly understand their differences.

A claims-made policy is a form of insurance in which coverage is limited to liability for claims arising from incidents or events that occur and that are reported to the insurance company while the policy is in force. Thus, once reported to the insurer, the insurer remains liable for the ultimate resolution of the claim or suit.

A claims-paid coverage policy's premiums are based only on those claims settled during the previous year or those projected to be settled in the coming year. Many claims-paid policies are assessable for a number of years, or even indefinitely, after a physician terminates the policy. When leaving a claims-paid carrier, physicians often have difficulty obtaining retroactive, or prior acts, coverage from their new carriers, and they may be forced

to purchase tail coverage from the claims-paid carrier. Of course, the price for such tail coverage may consider all open claims as well as future claims from that coverage period.

An occurrence policy covers the insured for any incident that occurs (or that did occur) while the policy is (or was) in force, regardless of when the incident is reported or when it becomes a claim. Occurrence insurance for medical liability coverage is rarely offered today because of the difficulty of projecting long-term claims costs under this type of policy.

Evaluating a Carrier

A comprehensive evaluation of a medical malpractice carrier should include a review of its corporate ownership and structure, financial strength and performance, management philosophy, and coverage options.

It is vitally important that an insurance carrier have sufficient financial resources to meet all current and future claims against policyholders. A carrier's annual report and other financial statements should help you evaluate a company's surplus, net written premium, and loss reserves, as explained below:

Surplus is an important financial element because it is the amount by which a company's assets exceed its liabilities. Surplus is determined by adding the balance sheet items: capital paid in, surplus, surplus paid, and earned surplus. Surplus is actually the working capital of the company. It

is required by regulators before companies are allowed to accept premium and must meet minimum legal standards. However, prospective policyholders will want their company's surplus to exceed minimum standards. Surplus is necessary to allow a company to grow (i.e., to accept more premium) and to cover unanticipated loss costs. Thus, a secure company accumulates substantial surplus to assume risk and to pay for unanticipated deficiencies in loss reserves, thereby assuring its ability to maintain its strength and fiscal integrity.

Net written premium is the premium retained by a company after it has paid for reinsurance. This item is usually shown on the annual report's statement of income. Since medical liability carriers typically pay out 100 percent or more of premium in the form of losses and expenses, net written premium can be compared to surplus to make sure the company is not becoming over-leveraged by writing too much business for its capital base (surplus) to support.

Loss reserves are shown on the balance sheet under reserves for future claims, loss reserves, and claims reserves. The three categories of claims reserves are indemnity reserves, allocated loss adjustment expense (ALAE) reserves, and unallocated loss adjustment expense (ULAE). Indemnity reserves are set aside for the portion of claims costs paid directly to claimants. ALAE reserves are set aside to pay present and future costs attributable to specific claims, such as defense attorney fees or expert witness fees. ULAE reserves are set

aside for the future management of open claims by the insurer. The level of aggregate loss reserves is important when compared to the insurer's surplus. Loss reserves are generally a multiple of surplus. If this multiple is too high (generally above 3.5 to four times surplus for medical liability insurers), then concern is again raised about over-leveraging. In other words, the margin for error is diminished.

The financial and operating strength of a company is also indicated by the rating it receives from insurance industry analysts such as A.M. Best Company or Fitch. A company's rating is an assessment of its ability to pay future claims, but it is also based on the profitability and margins achieved. Thus, higher-rated companies are financially sound and profitable. From the policyholder's point of view, the financial security of an insurance company is critical.

On the other hand, individual policyholders may be less concerned with the size of a company's profits. Company size is a critical component of financial security that is not directly reflected in these ratings. For example, a small company (say, with \$50 million in surplus) could end up with a higher rating than a company with hundreds of millions of dollars of surplus because of higher profit margins. Yet, the smaller company may be only one runaway verdict from insolvency. It is important that your company have a secure rating. Beyond that, context is extremely important in interpreting individual ratings.

How Much Insurance Should You Carry?

The dollar amount of liability coverage a physician should carry depends on many factors, including the physician's specialty, the procedures performed, the type and location of the practice, group, or entity.

Each state follows its own department of insurance regulations and restrictions; there is a great deal of variation in state insurance laws.

Standard policy coverage options may include limits of \$1 million per claim and \$3 million annual aggregate, and some states have commonly prevailing limits. Coverage limits vary in states with patient compensation funds; higher-limit options may be available subject to underwriting approval.

The precise amount of coverage you choose will depend on your state's laws, your assets, your comfort level, and the affordability of the coverage.

Management Philosophy

You should carefully evaluate a carrier's management philosophy, which is reflected in its underwriting standards, claims management, risk management, and actuarial policies. A carrier's approach in these areas influences its pricing policies and the level of service it provides to its policyholders.

Underwriting standards—Well managed carriers are staffed by experienced underwriters who have thorough knowledge of the medical procedures necessary to properly evaluate doctors' applications for coverage. A financially stable carrier exercises a firm hand in refusing coverage for doctors who are unqualified or whose practices might result in indefensible claims. Such claims would imperil the assets of the company and, in the case of a doctor-owned company, the security of the insureds.

Claims management—Claims should be reviewed promptly by skilled claims investigators. Policyholders should be vigorously defended against nonmeritorious claims. In those instances where there is negligence, the company should attempt to settle quickly and fairly with the physician's consent. Where permitted, a guaranteed consent-to-settle provision should be included in the policy. Such a provision requires that the carrier must obtain the physician's written consent in order to settle any claim. This gives the physician control over how claims are settled. An insurance company should also provide its policyholders with a written explanation of

how to proceed in the event of a claim and provide support and guidance to a doctor who experiences a claim.

Risk management—A company's risk management and claims-prevention programs should be an integral part of the service provided by a medical liability insurer. The company should conduct regular claims reviews and provide its policyholders with ongoing risk management information such as newsletters, bulletins about issues of vital concern, and symposia that focus on specific topics or specialties.

Actuarial principles—Sound actuarial principles acknowledge probability and statistics, contingencies, loss distribution, risk theory, and forecasting, among other factors. To ensure that premiums are neither insufficient nor excessive, they should be reviewed on an ongoing basis, taking into account the constantly changing nature of the liability environment.

Making the Right Choice

Finding the right professional liability carrier can be time consuming, but it is one of the most important practice decisions you'll make. Take the opportunity to learn all you can about the quality of the carrier and the people you'll entrust to watch over your interests.

Ask around: What kind of reputation does the carrier have? Does it treat its policyholders fairly and with respect, and does it vigorously defend claims?

By thoroughly investigating your options, you can make the right choice in selecting a strong, reputable, and financially stable professional liability carrier who will stand behind you when you need it the most.

About The Doctors Company

Founded by California physicians in 1976 in response to a crisis in insurance affordability and availability, The Doctors Company is the nation's leading physician-owned medical malpractice insurance provider. Thousands of physicians across the country rely on us to protect their careers and professional reputations.

With a broad range of specialties represented on our physician-dominated Board of Governors, we have a comprehensive, firsthand understanding of the specific liability issues that affect each specialty. Our unique combination of medical, legal, risk management, and claims expertise is backed by solid financial strength and an

unwavering commitment to protecting the practice of good medicine.

Our financial strength is reflected by A.M. Best Company's consistently secure ratings for The Doctors Company for more than two decades. We have also been named seven times to Ward's Benchmark Group of the 50 top-performing property and casualty insurers in the world.

In June 1986, after determining that our financial strength was more than sufficient to cover losses and expenses, the California Department of Insurance conferred the status of Perpetual Non-assessability on The Doctors Company. This status protects our policyholders in all states from ever having to pay retroactive assessments for losses incurred from past claims.

Many prestigious medical organizations and societies endorse or sponsor The Doctors Company as their chosen professional liability insurance carrier. These include the American Academy of Otolaryngology—Head and Neck Surgery, the American Association of Neurological Surgeons, the American College of Physicians, the American College of Surgeons, and the American Society of Plastic Surgeons. We have earned these exclusive endorsements and sponsorships through our commitment to the practice of good medicine and to the physicians we represent. Like us, at the heart of each of these organizations is a dedication to excellence and integrity in medical care.

To learn more about The Doctors Company, please visit www.thedoctors.com.

Glossary

Absolute Liability—Liability regardless of fault.

Adjudication—The act of determining an issue or settling a dispute in court.

Admitted Assets—See *Assets*.

Allocated Loss Adjustment Expense (ALAE)—Expenses directly attributable to specific claims. Include payments for defense attorneys, medical evaluation of patients, expert medical reviews and witnesses, investigation, and record copying.

Annual Aggregate Limit—For claims-made carriers, the annual aggregate limit is the maximum amount the carrier will pay for all claims arising from incidents that *occurred and were reported* during a given policy year. For occurrence carriers, the annual aggregate limit refers to the maximum amount the carrier will pay for all claims arising from incidents that *occurred* during a given year of insurance.

Assessability—An obligation of policyholders to pay additional money, in excess of premium amounts, to cover past company losses for which reserves have proven to be inadequate.

Assets—The property and financial resources owned by an insurance company. Admitted assets are those that can be liquidated to raise cash to pay claims. Nonadmitted assets are assets such as real estate (other than home office), furniture, and other equipment that are not recognized for solvency purposes by state insurance laws or insurance department regulations.

Assumed Premium—The consideration or payment an insurance company receives for providing reinsurance for another company.

Attorney-in-fact—The entity that manages an interinsurance or reciprocal exchange and to whom each

subscriber (policyholder or owner) gives authority to exchange insurance among subscribers.

Best's Rating—A rating given to insurance companies by the A.M. Best Company, an insurance industry ratings agency. The ratings range from A++ (Superior) to D (below minimum standards). Ratings of E and F are given to companies under state supervision or in liquidation. The ratings reflect A.M. Best's evaluation of an insurance company's financial strength and operating performance relative to the norms of the property and casualty insurance industry.

Claim—A written notice, demand, lawsuit, arbitration proceeding, or screening panel in which a demand is made for money or a bill reduction, and which alleges injury, disability, sickness, disease, or death of a patient arising from the physician's rendering or failing to render professional services.

Claims-made Insurance—Claims-made is a form of insurance in which coverage is limited to liability for those claims that arise from incidents or events that occur and are reported to the insurance company while the policy is in force. As premiums for claims-made insurance reflect ongoing claims experience, they can be readily adjusted as experience changes.

Claims-paid Coverage—Under a claims-paid policy, premiums are based only on those claims settled during the previous year or those projected to be settled in the coming year. Many claims-paid policies are assessable for a number of years, or even indefinitely, after a physician has terminated the policy. When leaving a claims-paid carrier, physicians often have difficulty obtaining retroactive (prior acts) coverage from their new carriers, and they may be forced to purchase tail coverage from the claims-paid carrier.

Claims Reserves—Under a claims-made policy, claims reserves are funds set aside to satisfy those claims that have been reported to the company but have not yet been resolved or paid. Under an occurrence policy, an additional reserve must be set aside for incidents that occurred but were not formally reported during the policy year and are expected to be reported after the close of the policy year. A company that underestimates its claims reserves may face future financial difficulties. A company that overestimates its reserves could be charging unnecessarily high premiums.

Credentialing Report—Provides up-to-date information on a physician's policy and claims experience.

Date of Incident—The date on which a situation of alleged malpractice took place. It can also be called the date of occurrence.

Date of Reporting—The date on which an incident was reported to the insurance company. The shorter the time between the date of incident and the date of reporting (i.e., if the insured promptly reports the incident or claim), the easier it is for the insurer to investigate the case and handle the insured's defense.

Declaration—Also called Declarations Page, this portion of an insurance policy states information such as the name and address of the insured, the policy period, the amount of insurance coverage, premiums due for the policy period, and any coverage restrictions.

Deductible—There are two types of deductibles:

A voluntary deductible allows the insured to pay an amount of the "first dollars" of a claim payment and to pay a lower premium for assuming this risk.

An involuntary deductible is imposed by the insurance company because of the adverse risk charac-

teristics of an insured. Involuntary deductibles do not include a premium reduction.

Deductibles may take one of two forms:

A straight deductible provides that all loss payments are reduced by the amount of the underlying deductible with no other considerations.

A franchise or quota share deductible provides that the insured and the insurance company share costs within the deductible amount.

Deductibles may apply to indemnity only or to both indemnity and allocated loss adjustment expense (ALAE). In the latter situation, the insured pays, up to the total amount of the deductible, for claims in which allocatable expenses (such as legal fees) have been incurred, even if no indemnity is ever paid. If the deductible applies to indemnity only, the insured pays only if indemnity is paid. A limit on the total number of claims or total amount paid in a given year may be specified.

Direct Written Premium—A carrier's gross premium written, adjusted for cancellations, before deducting any premiums paid or ceded to a reinsurer.

Dividend—A partial return of premium to policyholders. In an interinsurance exchange, the company's governing board would normally declare a dividend to be disbursed for a particular state or specialty if the company's claims and financial experience for one or more past years resulted in funds exceeding those needed to pay the claims for that year or prior years.

Domiciled—Refers to the state in which an insurance company receives a license to operate. The company is then regulated by that state's department of insurance.

Earned Premium—The portion of premium that applies to an actual coverage period. Insureds usually pay a calendar quarter or more in advance of the actual coverage period; the advance payment is initially unearned and becomes earned incrementally during the ensuing coverage period.

Economic Damages—Out-of-pocket expenses, such as medical bills incurred, lost wages, etc.

Endorsement—An amendment, sometimes referred to as a rider, added in writing to an insurance contract or policy.

Excess Insurance—A separate insurance policy with limits above the primary (or “first dollar”) policy.

Exemplary Damages—See *Punitive Damages*.

Experience Rating—A system of pricing insurance in which the future premium reflects the actual past loss experience of the insured.

Extended Reporting Coverage—See *Tail Coverage*.

Incident—An occurrence that the plaintiff claims has led to culpable injury.

Incurred But Not Reported Losses (IBNR)—An estimate of losses for incidents that have occurred during a policy period (usually one year) but have not yet been reported to the company. Mainly applicable to occurrence policies, these apply to claims-made policies only when extended reporting endorsements (tail coverage policies) are in effect.

Incurred Losses—These losses include both paid and unpaid (reserved) losses.

Indemnity—An insurance company’s payment to a plaintiff in settlement or adjudication of a claim.

Indemnity Reserves—Claims reserves that are set aside to pay the portion of claims costs paid directly to claimants.

Joint Underwriting Associations—Joint underwriting associations (JUAs) are state-sponsored insurance vehicles for physicians who do not have access to other sources of professional liability insurance. Insureds of some JUAs bear infinite assessability for losses incurred by the organization during prior years of insurance activity. In some states in which JUAs operate, all casualty insurers in the state are assessable. In others, only the insured doctors are assessable. In those instances in which only the insureds of the JUA are assessable, ultimate financial obligations are unpredictable and can be significant.

Limit—The maximum amount paid under the terms of a policy. A professional liability insurance policy usually has two limits, a per-claim limit and an annual aggregate limit. (See *Annual Aggregate Limit*.)

Loss Ratio—The result of losses incurred (indemnity and ALAE) divided by net earned premium.

Loss Reserves—The amount set aside to pay for reported and unreported claims. For an individual claim, a case reserve or estimate of the expected loss is set aside.

Loss Reserves-to-surplus Ratio—See *Reserves-to-surplus Ratio*.

Malpractice—Professional negligence—an abrogation of a duty owed by a health care provider to the patient; it is the failure to exercise the degree of care used by reasonably careful practitioners of like qualifications in the same or similar circumstances. For a plaintiff to collect damages in a court of law, the plaintiff’s attorney must show that the provider owed the patient a duty and that the provider’s violation of the standards of practice caused the patient’s injury.

Net Earned Premium—Net written premium (plus assumed premium for reinsuring risk) less unearned premium.

Net Written Premium—Direct written premium less payments to reinsurers.

Nonassessable—A condition under which an insurance company is sufficiently sound to free policyholders of any obligation to pay additional money for past losses for which reserves are inadequate.

Noneconomic Damages—Pain, suffering, inconvenience, loss of consortium, physical impairment, disfigurement, and other nonpecuniary damages.

Nose Coverage—Also called retroactive or prior acts coverage, nose coverage extends the effective date of claims-made policies to a prior date. See also *Retroactive (Prior Acts) Coverage*.

Occurrence Insurance—A type of policy in which the insured is covered for any incident that occurs (or that did occur) while the policy is (or was) in force, regardless of when the incident is reported or when it becomes a claim. Occurrence insurance for medical liability coverage is rarely offered today because of the difficulty of projecting long-term claims costs under this type of policy.

Paid Losses—The amount paid in losses during a specified time period.

Policy—The contract between an insurance company and its insured. The policy defines what the company agrees to cover for what period of time, and it describes the obligations and responsibilities of the insured.

Policy Term—The length of time for which a policy is written.

Premium—The amount of money a policyholder pays for insurance protection. The amount is deemed necessary to pay current losses, to set aside reserves for anticipated losses, and to pay expenses and taxes necessary to operate the company during the time period for which the policies are in force. Premiums allow the company to generate a reasonable profit that reinforces future solvency and contributes to the company’s growth. In the case of a reciprocal insurer, the premiums allow the company to offer insurance to new applicants without the need for additional capital contributions.

Premium Credits—A credit included in the premium computation that recognizes a reduction in hazard, which makes the account a better risk.

Premium-to-surplus Ratio (P/S)—The ratio of net written premium to surplus. This ratio reflects a company’s financial strength and future solvency. The ratio should not exceed 3:1.

Profit or Loss—Underwriting results are combined with investment income, expenses, and taxes to calculate profit or loss. Actual profit results from underwriting profit plus investment income that exceeds losses, expenses, and taxes or from investment income that offsets the underwriting loss, expenses, and taxes. Actual loss results if the investment income does not offset the underwriting loss, expenses, and taxes. Actual losses must be offset by drawing on the company’s surplus. Companies offering assessable policies can impose payments on their policyholders to amend the loss. (See also *Underwriting Results*.)

Punitive Damages—Also called exemplary damages. Optionally covered by professional liability insurers. A few states require that punitive damages be covered. Other state laws prohibit insurance companies from covering punitive damages because such damages

are intended to punish the defendant for willful, fraudulent, oppressive, malicious, or otherwise outrageous behavior that should not be covered by insurance.

Rate Maturation—In the early period of coverage (typically the first four to seven years), claims-made insurance rates rise annually until they are considered mature. Increasing the premium is necessary because the longer the physician is insured, the greater the potential for a claim. That is because of the delay between incidents occurring and patients filing claims from those past incidents.

Reinsurance—An agreement between insurance companies under which one accepts all or part of a risk or loss of the other. Most primary companies insure only part of the risk on any given policy. The amount varies among carriers. The remainder of the policy limits is covered by reinsurance entities. The less primary risk that a company insures, the more premium it has to pay to the reinsurer to cover the remaining policy limits. In general, smaller companies are able to cover only a relatively small proportion of the liability limit. This results in large premium payments to reinsurers. Larger companies can safely cover a large proportion, thus reducing the payments they must cede to reinsurers, which indirectly reduces the cost of insurance to their policyholders.

Reserves—See *Claims Reserves*.

Reserves-to-surplus Ratio (R/S)—Measures a company's financial ability to pay claims if reserves prove to be inadequate. Such payments must come from the insurer's surplus. This ratio should not exceed 4:1.

Retroactive (Prior Acts) Coverage—Under a claims-made policy, retroactive coverage provides insurance for claims arising from incidents that occurred while a

previous claims-made policy or policies were in effect, but that were not reported until that policy (or the last in a succession of policies) was terminated. With retroactive coverage, the new policy covers such claims. With retroactive coverage, purchase of tail coverage from the previous carrier is not necessary. (See also *Tail Coverage*.)

Retrospective Rating—A formula of premium calculation that reviews the previous loss experience and, after the policy year ends, adjusts the premium based on the loss experience. Some plans provide a guaranteed maximum cost; some guarantee that the premium will not exceed the standard premiums otherwise applicable.

Reunderwriting—The process by which a company re-evaluates policyholders and imposes surcharges, deductibles, or nonrenewal as necessary in cases where the policyholder's claims history or other experience presents a consistent pattern that creates an undue liability risk.

Risk Classification—A risk classification is based on the number and amount of losses that can be expected from a physician'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 and thus prevent both the injury of patients as a result of negligence and the loss of financial assets resulting from such injury.

Risk Purchasing Group—Risk purchasing groups (RPGs) came into existence as a result of the federal Risk Retention Act of 1986. Unlike a risk retention group (RRG), an RPG is not an insurance company but an association of insurance buyers with a common identity (e.g., a medical specialty society) who form an

organization to purchase liability insurance on a group basis. Since an RPG purchases coverage from an insurance carrier, no capital contributions are required in order to join. The company from which the RPG purchases insurance need not be licensed in every state. The purchasing group's insurer must indicate how much premium was generated by the purchasing group in each state in its National Association of Insurance Commissioners' annual statement. Physicians considering purchasing insurance through an RPG should inquire about the strength of the insurance company that provides coverage to the purchasing group.

Risk Retention Group—Risk retention groups (RRGs) came into existence as a result of the federal Risk Retention Act of 1986. That act allows an RRG to form as an insurance company and requires that it follow the insurance laws of at least one state. When first joining an RRG, a physician is typically required to pay a capital contribution in addition to the annual insurance premium.

An RRG is governed by the regulations of the state in which it is domiciled. If an RRG is appropriately capitalized and operated, it can be a viable insurance alternative. As there is less regulatory scrutiny in some states, however, some RRGs are inadequately capitalized and charge inadequate premiums. As a result, insolvencies that imperil the coverage of the insureds have occurred among RRGs.

An RRG must file an annual financial statement with its chartering state and all other states in which it operates. Doctors considering purchasing insurance from an RRG should review that statement. They should also carefully evaluate the degree to which the state in which the RRG is domiciled requires them to meet the high standards of solvency and effective management necessary to ensure that the company is able to fulfill its insurance obligations.

Standard Risk—A person who, by the company's underwriting standards, is eligible for insurance without restrictions or surcharges.

Substandard Risk—A person or entity that must pay higher premiums and is subject to special coverage restrictions based on underwriting standards.

Surplus—The amount by which a company's assets exceed its liabilities. A company's surplus allows it to take on risk and serves as a cushion in the event that the losses from that risk exceed the premiums intended to cover the risk. Stated another way, surplus can be used to make up for deficiencies in loss reserves that were set aside from earned premiums. Surplus thus serves to provide strength and to maintain fiscal integrity in the face of adverse loss experience that was not actuarially anticipated.

Surplus Contributed and Surplus Earned—Surplus contributed is the amount of capital that insureds must provide for a mutual company or reciprocal exchange during the early years of the company's operation. Surplus earned represents the earnings of the company after losses, expenses, and taxes. As the company stabilizes and grows in financial strength, earned surplus from profits is added to the contributed surplus, and the contributed surplus can be returned to the early policyholders.

Tail Coverage (Extended Reporting Coverage)—Coverage that protects the physician against all claims that arise from professional services performed while the claims-made policy was in effect, but which were reported after the termination of the policy. Some insurers offer this feature free of charge for retiring doctors who meet certain requirements.

Trusts—An alternative to insurance companies. In some states, trusts are not regulated by state insurance

departments nor are they protected by state guarantee funds in the event of insolvency. Trusts frequently require capital contributions in order to join, and trust members are retroactively assessable if assets prove insufficient to pay losses. Typically, coverage through trusts is provided on a claims-paid basis. Some trusts stop defending and paying open claims for members who go elsewhere for coverage if the members do not agree to remain assessable or do not purchase tail coverage from the trust.

If considering coverage through a trust, RRG, or RPG, a physician should carefully investigate all aspects of the policy, rules regarding assessability, tail coverage requirements, and the financial solvency of the organization.

Unallocated Loss Adjustment Expense (ULAE)—Claims expenses of a general nature that are not directly attributable to specific claims. They include the salaries of claims personnel and the other costs of maintaining a claims department.

Underwriting Results—The profit or loss of the insurance company, calculated by subtracting from earned premium those amounts paid out and reserved for losses and expenses. Any residual amount is called an underwriting profit. If deductions exceed earned premium, it is called an underwriting loss. Underwriting results do not include investment income. (See also *Profit or Loss*.)

Unearned Premium—That portion of a premium that is paid in advance of a coverage period. Insureds usually pay a calendar quarter or more in advance of an actual coverage period; the advance payment is initially unearned and starts to become earned on the first day of the coverage period and incrementally thereafter during the ensuing coverage period.

Vicarious Liability—Liability for the acts of someone else.

Written Premium-to-surplus Ratio—See *Premium-to-surplus Ratio*.