

CHOOSING A MEDICAL MALPRACTICE INSURANCE CARRIER

A Guide for Physicians and Practices



We provide expert guidance and resources that keep you in the know, no matter how you practice.



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CHOOSING THE RIGHT INSURER IS ONE OF THE MOST IMPORTANT DECISIONS YOU'LL MAKE.

When your reputation and livelihood are on the line, you need a strong, proactive insurance partner on your side. This guide will help you understand insurance industry terminology and take you through the array of important decisions you must make.

Be sure to factor these principles into your research:

- ▶ The policy premium must be weighed against the protection, service, financial strength, and long-term stability provided by the carrier. Doctors should also review a carrier's claims defense performance, risk management services, underwriting standards, and actuarial discipline.
- ▶ One of your primary concerns should be the carrier's fiscal stability. Make sure the carrier you are considering is strong and stable, so you can take comfort knowing they can pay all of their claims—including yours.
- ▶ Just like people, each carrier has a different concept of its responsibilities and presents a complex personality. The carrier's leadership—the executives who designate policy and make operational decisions—guides its philosophy. It can, for example, make a difference if a majority of the carrier's decision makers are physicians.

In this guide, you'll find a list of questions that we believe every medical liability carrier should answer. It is your right—and responsibility—to ask questions and consider the answers carefully before making an informed decision.

AS A PHYSICIAN, IT'S NOT A MATTER OF IF YOU'LL BE SUED, BUT WHEN.

Research your options and ask the right questions to prospective insurance providers.

If a claim is filed against you, how will the insurer defend you?

Few things in a doctor's professional life generate more stress and disruption than an allegation of medical malpractice—so it's important that physicians know what to expect when they are sued and how to navigate the legal process to ensure success. The litigation process can be long and drawn out. The process typically lasts two to five years, with claims being filed a year to two years after a negative event or the date of discovery of an injury—depending on state laws. Effective claims management starts with the prompt review of a claim by an experienced claims specialist.

Select the insurance provider that offers the strongest defense and provides you with individual support to help alleviate the stress and anxiety that accompany a malpractice claim.

What is the carrier's financial strength?

It's essential that the medical malpractice insurer has sufficient financial resources to pay all current and future claims against policyholders. Consider the following when evaluating a carrier's financial strength against its competitors:

- ▶ A.M. Best Company and Fitch Ratings.
- ▶ Assets.
- ▶ Surplus.

What additional tools and resources are offered by the insurer?

Select an insurer that offers the tools and resources you need to help reduce risk and keep your practice safe. Your coverage should include access to CMEs, online disclosure resources, and health literacy tools, as well as personalized risk management services and patient safety programs. An insurer with deep expertise in this area could help you make sustainable improvements to your practice by using data to help you reduce adverse events, and by helping you focus on claims analysis, practice risk and safety culture, patient communication, team building, and more.

Does the insurer provide coverage solutions that meet your needs?

In today's changing healthcare environment, it's important to choose an insurer that knows the business risks inherent in medical practices and provides innovative solutions to protect you from emerging exposures, including:

- ▶ Cyberattacks and data breaches.

Make sure you're covered.

Cost of healthcare data breach per record* (highest of any industry): **\$380**

- ▶ HIPAA violations and Medicare reviews.

Does the insurer offer dividend and loyalty programs to its members?

An insurer owned by policyholders, e.g., a mutual or reciprocal, may pay dividends or loyalty rewards to those policyholders. Some provide both. A stock insurance company focuses solely on building wealth for its stockholders.

Is the insurer committed to being your strategic partner?

Navigating today's complex healthcare environment requires an insurer that does more than pay claims. A strong, effective business partner will also:

- ▶ Provide data that reveals liability trends in your medical specialty and helps improve safety in your practice environment.
- ▶ Successfully support medical liability reform and vigorously advocate in defense of the practice of good medicine.

Does the insurance provider have local expertise?

A strong national reach provides the scope and resources to identify emerging risks and respond with innovative solutions for all specialties, while local experts lend unique regional insights. An insurer that has an established multistate presence may have a portable policy that will allow you to be covered wherever you practice.

*Source: Ponemon Institute, 2017

PHYSICIANS HAVE SEVERAL POSSIBLE SOURCES FOR OBTAINING PROFESSIONAL LIABILITY INSURANCE.

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.

An 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.

Most of the top 20 medical professional carriers in the United States are physician-owned, and are organized as mutuals or reciprocals.

Find Out If Your Policy Is Assessable

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.

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 are an alternative to insurance companies. In some states, trusts are neither regulated by state insurance departments nor 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) allow a group to form as an insurance company and require that it follows the insurance laws of at least one state. An RRG is governed by the regulations of the state in which it is domiciled—and if appropriately capitalized and operated, can be a viable insurance alternative.

When first joining an RRG, a physician is typically required to pay a capital contribution in addition to the annual insurance premium—so the RRG has surplus before issuing policies. RRGs formed with initial capital do not require those contributions from members.

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 to ensure the RRG meets high standards of solvency.

Risk purchasing groups (RPGs) are not insurance companies but are associations 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 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.

In addition to those 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.

TODAY, ALMOST ALL PROFESSIONAL LIABILITY CARRIERS OFFER CLAIMS-MADE OR OCCURRENCE POLICIES.

A less common type of coverage is claims-paid. 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 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 several years, or even indefinitely, after a physician terminates the policy.

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.

There are also two types of endorsements intended to provide coverage either before or after your claims-made policy or policies are in effect.

Tail coverage (extended reporting) 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.

Nose coverage (retroactive or prior acts) 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 and purchase of tail coverage from the previous carrier is not necessary.

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 net written premium, loss reserves, and surplus, as explained below.

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 the amount set aside to pay for unpaid claims, both reported and unreported. This amount is an estimated liability—the company's best estimate of what it will pay for claims, including indemnity payments to injured parties plus all costs associated with litigation. Loss reserves are necessary because medical malpractice insurers do not know actual claims costs until after claims are paid—sometimes years after loss reserves are set aside. Reserves are key to the evaluation of an insurer's financial condition because they signal whether the company will be around to honor its financial obligation to claimants.

Surplus is an important financial element because it is the amount by which a company's assets exceed its liabilities—and is actually the company's working capital. Surplus 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 and cover unanticipated loss costs. Thus, a secure company accumulates substantial surplus to assume risk and to pay for unanticipated losses, thereby assuring its ability to maintain its strength and fiscal integrity.

Financial and operating strength are indicated by the insurer's ratings from insurance industry analysts such as A.M. Best Company or Fitch Ratings. 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 could end up with equal or even higher ratings than a company with hundreds of millions of dollars in surplus—because of higher profit margins. Yet, the smaller company may also be unable to withstand large-scale losses. 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, and 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.

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—Few things in a doctor's professional life generate more stress and disruption than an allegation of medical malpractice. Effective claims management starts with the prompt review of a claim by an experienced claims specialist. Select the insurance provider that offers the strongest defense and provides you with individual support to help alleviate the stress and anxiety that accompany a malpractice claim. 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.

Patient safety and 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. Select an insurer that offers the tools and resources you need to help reduce risk and keep your practice safe. Your coverage should include access to CMEs, live seminars, webinars, and on-demand courses; online disclosure resources and health literacy tools; as well as personalized risk management services and patient safety programs—all provided by qualified, experienced clinical risk managers. Make sure your insurer works to identify potential sources of injury and enhance patient safety, and that it takes a data-driven, collaborative approach to helping you reduce adverse events while increasing patient satisfaction.

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? Navigating today's complex healthcare environment requires an insurer that does more than pay claims. A strong, effective business partner will also:

- ▶ Provide data that reveals liability trends in your medical specialty and helps improve safety in your practice environment.
- ▶ Actively and successfully support medical liability reform and vigorously advocate in defense of the practice of good medicine.
- ▶ Give insureds control over whether to settle a claim.
- ▶ Provide the flexibility of portable coverage in the event you plan to expand to another state.

By thoroughly investigating your options, you can make the right choice in selecting a reputable and financially stable professional liability carrier that meets your insurance needs.

THE NATION'S LARGEST PHYSICIAN-OWNED MEDICAL MALPRACTICE INSURER.

Founded by doctors in 1976, The Doctors Company has a nationwide membership of 79,000 and more than \$4.8 billion in assets.

We are rated A by A.M. Best Company and Fitch Ratings. Members can count on us to have the power and financial resources to protect them today and for many years to come.

Our national perspective and local experts enable us to anticipate emerging threats and deliver innovative solutions—for example, our medical liability policy includes protection against cyber threats and regulatory action. We also provide comprehensive risk solutions for large groups, healthcare systems, and hospitals.

No matter how you practice, we'll be there for you with expert guidance, resources, and coverage. The doctors we insure are members, not just policyholders.

Your defense starts with a promise to never settle a claim without your consent.* If you are sued, seasoned advocates will support you throughout the litigation process. And through our national and state advocacy efforts, we defend reforms that are in place, prevent legislation from being enacted that would undermine the defense of our

members, and take opportunities to enact new measures that would limit liability exposure for our members and physicians across the country.

Members have access to a wealth of resources, including industry-leading INSIGHT programs that help doctors and practices implement effective protocols, resulting in significantly fewer allegations of malpractice. And the industry's largest claims database gives us an unparalleled understanding of lawsuits against doctors. This data-driven approach enables us to anticipate emerging trends and deliver innovative patient safety tools to help our members reduce risk.

A decade ago, we created the Tribute® Plan to reward members for their loyalty to The Doctors Company and for their commitment to superior patient care. We've paid more than \$67 million in Tribute awards, and the highest award paid to date is \$147,692. Eligible members also participate in our generous multiyear dividend program, which has returned more than \$415 million in dividends.

*Where permitted by law.

Tribute Plan projections are not a forecast of future events or a guarantee of future balance amounts. For additional details, see thedoctors.com/tribute.

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A

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.

Arbitration

An alternative method for resolving disputes that allows the parties to define the process.

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.

B

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.

C

Captive

In its simplest form, a captive is a wholly owned insurance company that is formed by a noninsurance entity or group to insure or reinsure some or all of the risks of its parent. A captive is usually administered by specialized consultants.

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.

D

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 characteristics 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.

E

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.

I

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.

J

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.

L

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.

M

Malpractice

Professional negligence—an abrogation of a duty owed by a healthcare 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.

N

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.

O

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.

P

Paid Losses

The amount paid in losses during a specified time period.

Patient Compensation Fund

A fund usually established by state law, sometimes referred to as excess coverage or excess liability funds, that pays for medical

malpractice judgments or settlements that exceed a statutorily established amount.

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 Credit

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.

R

Rate Maturation

In the early period of coverage (typically the first to fifth 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 Classifications

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 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 Liability 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 on 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.

S

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.

T

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.

U

Unallocated Loss Adjustment Expenses (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.

V

Vicarious Liability

Liability for the acts of someone else.

W

Written Premium-to-Surplus Ratio

See Premium-to-Surplus Ratio.

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