Malpractice Insurance: What You Need to Know

If you are just starting practice as an employee with a physician group, you may think you don't really need to know that much about malpractice insurance. Most likely, your insurance is paid for by the group, which has already chosen the carrier and negotiated the policy details. So what's to know? Plenty, as many physicians have found out the hard way. At a minimum, you should understand the insurance coverage you have, what happens if a suit is filed, and what happens if you leave the group.

If you are a shareholder in a practice, you need even more information to make sound decisions about choosing a carrier, negotiating policy options, and deciding on allocation of premium expenses to individual physicians.

If you are employed by an institution that is self-insured, as are some county and university hospitals, a representative from your risk management department can give you details about your coverage and steps to take if a claim is filed or an incident occurs.

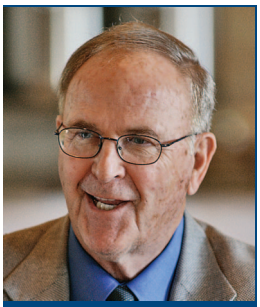
Know the Types of Policies Available

Professional liability insurance comes in two basic forms: occurrence or claims-made. In today's insurance market, the overwhelming majority of policies available are claims-made, but a few companies do offer occurrence policies.

Claims-Made Policies

Claims-made insurance provides coverage only for incidents that occurred and were reported while you are insured with that carrier. Thus, both the incident and the filing of the claim must happen while the policy is in effect.

If you drop a claims-made policy, you are not covered for any suits filed later unless you pay for what is known as "tail coverage," the term used for an extended reporting endorsement. Tail coverage is expensive—often three times the amount of an annual premium—but it's essential to be insured for any claims that could arise later.



J. Michael Wormley, MD

"That can be a real speed bump for an oncologist just coming out of a fellowship and joining a group," explains J. Michael Wormley, MD, chairman of Mutual Protection Trust, a California physicians' trust (Los Angeles). "The group pays for malpractice insurance, and tail coverage is often not spelled out if the physician leaves. After 2 or 3 years, the doctor wants to leave the group. Who pays the tail?"

Make sure responsibility for tail coverage if you leave the group is specified in your employment contract. For more information on negotiating this contract detail, see "Employment Contracts: What to Look For" in the November 2006 issue of the *Journal of Oncology Practice.*

Sometimes the coverage for liability from a claims-made policy that has been dropped can be included in your new insurance policy. This alternative to tail coverage is called "nose coverage," the colloquial term for prior acts coverage.

Richard E. Anderson, MD

"When physicians move from one carrier to another, they can choose between tail coverage with the expiring carrier or nose coverage with the new carrier," says Richard E. Anderson, MD, chairman and chief executive officer of The Doctors Company, a national physician-owned malpractice carrier, based in Napa, California. Anderson formerly chaired the department of medicine and was senior oncologist at Scripps Memorial Hospital in La Jolla, California.

If you are changing carriers, ask your new carrier for a quote for nose coverage and compare it with the cost of buying tail coverage from your old insurance carrier. When you purchase either tail or nose coverage, be sure the retroactive date covers the period of your previous policy. Also, clarify the terms of coverage, including the aggregate limits. The aggregate limits are what the policy will pay for all claims combined for a stated period. An annual policy has aggregate limits for 1 year, but sometimes the aggregate limits in tail insurance apply to all the years the policy was in effect. The "Does Your Policy Coverage Match Your Practice?" section below has more information on coverage limits.

Occurrence Policies

Occurrence coverage provides lifetime coverage for incidents that occurred while the policy was in effect, regardless of when the claim is filed. Thus, if you have an occurrence-type policy in effect for the calendar year 2007, and a patient files a claim in 2010 for an incident that happened during 2007, the policy covers you for that claim, even if you no longer have insurance with that carrier.

Claims-made policies are cheaper than occurrence policies for the first several years of coverage because the potential for claims builds slowly as policy years accumulate. The first-year

Additional Resources

- Physician Insurers Association of America, a trade association of more than 50 professional liability insurance companies owned and operated by doctors and dentists: www.piaa.us; (301) 947-9000
- A.M. Best Company, an independent industry analyst with carrier ratings that are considered an industry benchmark: www.ambest.com; (908) 439-2200
- Anderson R (ed): Medical Malpractice: A Physician's Sourcebook. Totowa, NJ, Humana Press, 2004

premium of a claims-made policy may be very inexpensive, such as 10% to 30% of what is called the "mature rate." The premium then increases each year for a period such as 3 to 5 years until it reaches the mature rate. In comparing costs of malpractice insurance policies, be sure to ask how much the premium will increase after the first year.

Does Your Policy Coverage Match Your Practice?

Most policies offer limits of coverage ranging from $100,000 to $300,000 and $1 million to $3 million. The first number is the maximum amount the insurance company will pay per claim during the policy period, which is usually 1 year. The second amount is the maximum the company will pay for all claims during the same policy period. If there are claims or judgments against you, you will be personally responsible for paying any damages that exceed your insurance policy limits.

Anderson notes that limits are something an oncologist just starting practice should look for in a policy. "You want to have limits that are what everyone else has," he advises. "Having higher limits may help you sleep better, but it means you will be the deep pocket in a lawsuit naming other defendants. Normally, you want prevailing limits based on your geographical area and your specialty."

Some states, including California, Florida, and Texas, have caps on damages that can be awarded, so you may not need limits as high as elsewhere. Policy coverage also specifies what incidents are covered. Be sure your insurance covers your full scope of clinical activities.

If you are a practice owner or shareholder, verify that the coverage applies to your professional corporation and employees. Determine if these limits are shared by all or apply to each person individually. If you are in solo practice or a small practice, you may want your policy to include insurance for locum tenens coverage. Many policies include such coverage for 30 to 120 days annually, with no additional premium.

How Are Premiums Set?

Insurance carriers estimate how much money will be needed for claims and break up the total among those they insure to spread the risk and determine annual premiums.

Your specialty, geographic location, and personal claims history will affect your premium. "We set rates by analyzing the losses by specialty, state, territory, and trend," Anderson says of The Doctors Company. "Each specialty stands on its own, and we don't ask docs in California to subsidize docs in New York."

Anderson notes that the long time before claims are settled is a challenge in setting medical malpractice premiums. "Even once you know how many claims there were in a year, you don't know how much the claims cost until they are resolved—an average of 3.5 years later. In oncology practice, it would be like buying drugs for your patients and having to collect money from them when you deliver the drugs, but not knowing for 3.5 years how much your supplier was going to bill you for the drugs."

Comparison Shopping

Anderson cautions that physicians should understand clearly whether their insurance is assessable, meaning the insuring entity has the right to assess a surcharge if losses are excessive. "Many risk-retention groups and captives and all trusts are assessable. In the malpractice crisis between 2001 and 2004, there were a number of companies that were forced to come back and assess their members."

Wormley, at the head of a trust, acknowledges that the negative side of trusts is the possibility of being reassessed in the same year. (In an insurance trust, the initial premium is called an "assessment.") "When a traditional insurance company sets a premium for a particular year, it overassesses to build its reserves for future losses," Wormley says. "A trust doesn't build reserves, which is why our rates are cheaper."

Clarify if your carrier is assessable, and weigh the likelihood of a reassessment against other advantages, such as a lower premium before making a decision. Carriers vary widely. Wormley notes that his trust has "lots of layers of reinsurance" and has not had a second assessment for 18 years. "We are a very strict, preferred-risk company and cover only well-trained, board-certified physicians," he adds.

In comparing premiums, consider the details of the policies and the services of the carriers to be sure you are comparing apples to apples. If an insurer's rates seem abnormally low compared with those of other companies, find out why. For example, some carriers offer lower premiums and charge a

high deductible that you must pay before the policy pays for costs, awards, or settlements.

Patricia Legant, MD, PhD

Look for a Consent-to-Settle Clause

"Be sure to check to see if your insurance policy contains a clause specifying that a claim against you can't be settled without your written consent," advises Patricia Legant, MD, PhD, who has a solo oncology practice in Salt Lake City and serves on the board of directors of the Utah Medical Insurance Association, a physician-run malpractice insurance company.

Some carriers prefer to settle a suit, even one without merit, because the cost of defense might exceed the amount of settlement. But any settlement made on your behalf must be reported to the National Practitioner Data Bank, so a settlement can adversely affect your insurance status, ability to participate in a managed-care group, and application for hospital privileges.

If your policy does not have a "consent-to-settle" clause, the insurer can settle a case against your wishes, even if you are blameless. If the policy grants you this right, you must be consulted before any settlement offers or counteroffers are made. This is something you want and should try to negotiate to be included.

Nevertheless, you should be aware that there can be good reasons to settle a claim. A settlement could allow you to avoid a verdict that exceeds your insurance coverage. Another reason you may wish to settle is to avoid spending additional time, energy, and money on the litigation process. The attorney assigned to your case should inform you of the choices, the risks with each approach, and the alternatives that are available. Disagreements between the physician and the insurer concerning a settlement are sometimes referred to a committee for resolution.

Some policies have what is called a "hammer clause" instead of a consent-to-settlement clause. The terms of a hammer clause take effect if you refuse the insurer's settlement recommendation and choose to go to trial instead. Then, if the trial results in an award higher than the settlement recommendation, you must pay the amount over the recommendation.

Before you purchase a policy, try to negotiate the terms so that your policy includes a consent-to-settlement clause and omits a hammer clause.

Who Pays for Defense Costs?

Check on the policy's coverage of defense costs, which are the expenses involved in defending and processing a suit—not the amount of the award or settlement. Defense costs include the fees of the defense attorney retained by the insurance company, the fees of expert witnesses, court reporters' fees, and clerical expenses.

Some policies do not pay for defense costs or put a limit on the amount the insurance company will pay. If your policy does cap the amount of defense costs it will pay, be sure the overall policy limit is high enough to cover defense costs in addition to a settlement or judgment amount. This means that coverage should be for ultimate net loss instead of pure loss. Ultimate net loss coverage pays for attorney fees and defense costs in addition to any awards.

If you are sued for more than the amount of coverage or your carrier is defending you under a reservation of rights, you should retain your own defense counsel in addition to the carrier's attorney. Having ultimate net loss coverage may allow you to recover expenses you have if you retain your own defense attorney.

What to Look for in a Carrier

While premium costs can't be ignored, a company's fiscal soundness, claims handling, and sensitivity to policy holders are also important considerations. It's a good idea to talk to a physician who has experienced a claim with the carrier. Find out how the claim was handled, how much the physician was involved in resolving the claim, and whether he or she was satisfied with the carrier's handling of it.

Ask whether the carrier has risk management programs for physicians and whether a program is in place to provide emotional support for defendants. Legant's insurance association, for example, offers a discount to policy holders who participate in the risk management program offered by the carrier. Wormley's company makes participation in risk management education a requirement for both physicians and their office managers, in addition to conducting an onsite risk evaluation every 3 years.

"Physicians should avail themselves of any risk management programs offered by their medical malpractice insurer," Legant suggests.

Your state insurance commissioner's office can provide information about insurers licensed in your state and may also be permitted to give information about complaints that have been filed against the insurer.

You should also research the financial health of an insurance company. This is not just an academic exercise—numerous insurance companies have not had the stability to weather difficult times and have become insolvent.

Good Practices

Meticulously Complete Your Application

Complete your insurance application thoroughly and accurately so as not to jeopardize coverage in the event of a claim.

Keep Good Files

Always keep a copy of your insurance coverage, including for each year during your training. If you were not given a copy, ask your program director for one. The policy itself is the best proof you were insured, and the carrier is not obligated to retain a record of your coverage. Also, keep copies of all of your communications with the carrier.

Verify Tail Coverage Payment

If you leave a group that agreed to pay for your tail coverage on departure, verify directly with the carrier that the required payment was received.

"Ask about the carrier's A.M. Best rating," advises Legant. (A.M. Best Company is an independent industry analyst, and its carrier ratings are considered an industry benchmark.) "The Best rating is a fair estimation of the solvency of the company," says Legant. "Given the current state of the medical malpractice climate, a rating of A minus is good."

Types of Insurance Carriers

Insurers vary in how they are organized, who owns or controls them, their financial stability, and whether and how they are regulated by state laws. The most common types of insurance carriers are as follows:

- Commercial
- Mutual
- Captive
- Trust
- Risk-retention

An overarching characteristic that many point to as important is whether a carrier is owned and run by physicians.

More Strategies for Career Success

- Deciding about practice options. J Oncol Pract 2:187-190, 2006
- The interview: Make it work for you. J Oncol Pract 2:252-254, 2006
- Employment contracts: What to look for. J Oncol Pract 2:308-311, 2006
- Joining a practice as a shareholder. J Oncol Pract 3:41-44, 2007
- Principles and tactics of negotiation. J Oncol Pract 3:102-105, 2007
- Professional advisors: They're worth it. J Oncol Pract 3:162-166, 2007
- Building and maintaining a referral base. J Oncol Pract 3:227-230, 2007

Physician-owned companies insure more than half of US physicians who buy their own insurance. They may be formed as trusts, captive companies, mutuals, risk-retention groups, or profit-making corporations.

Physician-owned companies cite a number of advantages for the insured, such as more control over underwriting and claims decisions. Legant agrees. "My sense is that the physician-run ones tend to be more sympathetic to physicians because their goal is to serve physicians and give them a fair shake," she says. "For example, they would be less likely to settle for the sake of just saving money."

Wormley, the head of a physician-owned trust, offers an example of the way claims are handled: "A peer review committee meets face to face with the doctor being sued, who is there with his attorney." Wormley stresses that although the attorney is being paid by the carrier, he or she is definitely representing the physician. The goal is to determine how defensible the claim is. "We try not to make the decision based on dollars involved—we don't want to settle if the claim has no merit."

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