MEDICAL LIABILITY INSURANCE: THE BASICS OF COVERAGE

Malpractice Insurance 101

(7/11/07)

Please see attached claim scenario to illustrate how the different policy forms and features would respond to an actual claim.

OCCURRENCE FORM OF COVERAGE

Coverage for malpractice claims under an occurrence policy form is provided by the policy that is/was in effect as of the incident date, or date(s) treatment was rendered (or failed to be rendered), regardless of when the claim is actually presented.

An occurrence policy is always triggered by the incident or treatment date (or date treatment failed to be rendered).

CLAIMS MADE FORM OF COVERAGE

Coverage for malpractice claims under a claims made policy form is provided by the policy that is in effect at the time a claim is actually presented, so long as the incident date, or date(s) treatment was rendered (or failed to be rendered) was on/after the retroactive coverage date on the policy.

Note: *claims made policies may be triggered by the reporting of an actual claim or, the reporting of an incident that could give rise to a claim at a later date, depending upon the actual wording of the policy form. This may be referred to as the claim or incident trigger of the policy, or referred to as claim or incident sensitive claims made coverage.*

RETROACTIVE DATES

All claims made policies must have a retroactive coverage date ("retro date"). The retro date is often the date that claims made coverage was first purchased by the policyholder, which has then been carried forward as coverage renews annually.

TAIL COVERAGE

Claims made policies cover claims that are made only while the policy is in effect. When a claims made policy is cancelled or non-renewed for any reason, additional claims made coverage must be obtained for any claims that may be reported after the cancellation or non-renewal date. This coverage is provided in the form of an endorsement ("Reporting Endorsement") to the cancelled/non-renewed policy. This endorsement is also more commonly referred to as "tail" coverage. It is generally issued for an indefinite period of time to cover this additional claims made exposure.

ADMITTED VS. NON-ADMITTED INSURERS

The insurance industry is regulated at the state, rather than the federal level. Every state must have a mechanism (an insurance department within state government) established to meet this requirement. In Massachusetts, the Division of Insurance (part of the Consumer Affairs Division of the Attorney General's Office). In every state there are "admitted" and "non-admitted" (Sometimes called Surplus Lines) insurance carriers, among others, approved or allowed to do business. Admitted carriers are those both licensed by the state to conduct business, and those that file their products (insurance policies) with the state for approval, prior to offering those products/policies for purchase. The carrier's rules, rates and policy forms must be approved. Policyholders doing business with admitted carriers are potentially protected from that carrier's insolvency by state guaranty funds. Non-admitted carriers are those that are licensed to do business in the state but do not file their products/policies for approval but they do have to have approval for each type of coverage. Non-admitted carriers are not subject to state guaranty fund protection. Most non-admitted insurance carriers have A. M. Best financial ratings of "A" or higher. They are non-admitted so they have more flexibility in offering coverage.

RETAINING FINANCIAL RISK: SCLLC Program Transformation

Malpractice Insurance 201

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WHAT IS FINANCIAL RISK?

Currently neither SCLLC nor its members have any financial risk in its malpractice program. The physicians pay a premium to Promutual and there is no premium returned or reinvested in the program if financial performance is good. All financial risk and reward is retained by the insurer. When a physician group retains some of the financial risk of malpractice, they generally either seek a group deductible and/or form a company that allows them to self-insure for some component of the coverage. Both vehicles allow the group to save money if performance is favorable.

WHY TAKE ON RISK? (Long term risk)

There are many reasons for an entity to assume risk. The more risk that is assumed under an alternative program, the greater the potential benefit that may be derived as outlined below. It is generally recommended to begin assuming risk in steps. Some key reasons for SCLLC to consider include the following:

1. Year to year premiums change significantly – large premium increases cause financial hardships.

When an organization assumes risk they have more control over their premium, can reduce drastic fluctuations in premium over time. The result may be that premiums do not go as low as the traditional market during more competitive periods, but neither do they go as high during less competitive periods.

2. Pricing Inequities – pricing may currently be too high for projected losses.

3. Risk Management activity may not be sufficiently rewarded by the current insurer.

4. Insurance company expenses are too high – an alternative vehicle can offer coverage more economically.

A large organization can many times provide their own insurance for less cost than some insurance companies. This savings can be used to pay claims and reduce the total cost of the insurance. The administrative/operating expenses of most insured owned insurance vehicles is less than standard insurance companies.

5. Lack of availability of coverage –needed coverage may not be available.

While availability of coverage for physician malpractice is mandated by Massachusetts law, certain terms of coverage can be limited by traditional insurers; alternative programs can be established to provide broader coverage forms if the entity wishes.

5. Additional insurance companies can be used to provide more competitive premiums.

Alternative insurance programs, involving the assumption of risk at significant levels, usually give an organization access to more insurance (and reinsurance) company options willing to underwrite the program. As such, competition may be increased, further reducing the costs of the program.

7. Investment funds from claims reserves can be captured – in a traditional program the income is retained by the insurance carrier.

It normally takes 5 or more years for a claim to be settled. During this time the money in reserve to pay the claim is invested and kept by the insurance company. When risk is assumed the investment income from the money in reserve stays with the organization.

8. Profits can be taken out by physicians when they retire with a potential return on their investment over time.

The physician-owners of an organization that successfully assumes risk also own the profit. Profits are used year-in and year-out to reduce premiums and build surplus to operate in the most financially sound way. When a physician-owner retires from an organization that that has successfully assumed their malpractice risk over time, their share of the surplus (profit) is due as a return on their investment.

NOTES ON RETAINING RISK

- Usually, when an entity assumes risk, they do not assume 100% of the exposure but rather assume some tolerable financial level of risk, as opposed to insuring the risk at the level of the "first dollar". The amount of risk assumed (e.g., $100,000, $500,000, $1,000,000) meets both a pre-determined comfort level for the entity and represents an amount where the law of large numbers offers the best opportunity for the entity to derive financial benefit in return for assuming that level of risk.

- Depending upon the level of financial risk assumed and also upon the type of alternative program selected, an insurance company or a reinsurance company will provide the coverage between the deductible and the limit of the policy over and above the deductible. The premiums paid to the insurer are collected to fund payment of claims that exceed the deductible amount. When a totally separate new entity is formed to issue policies and assume risk at higher financial levels (e.g., captives or risk retention groups/RRG's), reinsurance companies issue policies to cover any losses excess of the amount retained by the new entity.

- Regardless of the amount of risk assumed and the structure of the program, the excess insurance provides coverage for claims over the retained amount of risk, and also limits the maximum amount of risk assumed as an annual aggregate, so that the annual retention is capped regardless of the number of claims that may be filed in an annual period.

SPECIFIC ADVANTAGES OF RETAINING RISK FOR SCLLC

- Historical data for the SCLLC program indicates that annual malpractice premiums paid by members has significantly exceeded the actual claims paid by the insurer to date. If the investment income from the premium and loss reserves held by the insurer annually is included, the dollar difference increases. This applies even for paid claims, as loss reserves are held for several years by an insurer prior to a claim settlement, allowing for investment income on reserves that are ultimately paid out. This difference between premium and actual paid claims is caused by SCLLC's credentialing and risk management.
- An insurer's operating expenses are higher than those of an organization that assumes a significant amount of their own risk.

SPECIFIC DISADVANTAGES OF RETAINING RISK FOR SCLLC

- SCLLC must act as a responsible insurer - if an above average number of claims are reported in any given year, premiums may well need to be increased.
- There are additional upfront and administrative costs needed.
- If the medical malpractice market place reduces premium as they did a few years ago the alternative risk may cost more for a short period of time.
- SCLLC will need to continue to recruit suitable members to sustain current critical mass, maintain favorable claims experience as well as to grow the program cost effectively.

PREREQUISITES: RISK MANAGEMENT PROGRAM; GROUP MENTALITY

The strength and success of the current SCLLC malpractice program is based, among other factors, on its on-going risk management program and credentialing process. These factors have been key to maintaining a program that provides its members with the lowest cost malpractice coverage available. These same factors become essential to assuming risk as a means of further reducing and controlling malpractice costs annually.

BASIC RISK: THE DEDUCTIBLE

A deductible represents a basic first step in the process of assuming risk. The policyholder is responsible for the deductible amount on a per claim and annual (aggregate) basis. The program being considered would involve SCLLC being the policy holder and assuming the deductible rather than each physician/practice assuming the deductible. A deductible will result in a reduction in premium in exchange for the assumption of risk; however, the insurance company will still be responsible for all claims handling expenses, settlement negotiations and/or litigation.

NOTE ON DEDUCTIBLE

Although a deductible is paid when individual claims/losses trigger it, SCLLC and RTIA will be planning for the organization to pay all deductible loses from a fund that is created by a portion of SCLLC's collected premiums.

BASIC RISK: ANNUAL AGGREGATE

Because a policyholder may have more than one claim during a policy year, there is the potential to have financial responsibility for more than one deductible amount. However, the annual aggregate deductible amount caps, or limits, the total deductible responsibility the policyholder will have during a single policy year. A policyholder may select an annual aggregate amount equal to the deductible amount, thereby limiting deductible exposure to only one claim during the policy year, or a higher amount may be chosen. The amount of premium reduction taken in exchange for the deductible will vary based on the amount of deductible on a per claim and aggregate basis, and will also be greater if the deductible applies to claim expenses as well as indemnity payments.

IMPORTANCE OF COMBINING CLAIMS MADE FORM OF COVERAGE WITH THE DEDUCTIBLE

At the end of a claims made policy term, all potential claims and deductible liabilities can be realized for that period, and an appropriate "year end" accounting can be made against the funds that have been set aside to fund the group deductible even though there will be claims reserves. If the group to takes a deductible on an occurrence basis, appropriate accounting for the deductible can truly never be known. Claims against occurrence coverage go back several years at a minimum, so the exposure can truly never be assessed – the statute of limitations in Massachusetts is 3 years from date of treatment to filing of a claim; however, several other legal principles serve to extend the statute, even indefinitely. Admitted carriers who offer deductibles on an occurrence basis often require deductible collateral to be held for such a lengthy period of time (5-7 years) that any financial savings realized for the deductible are negated by the reality of the collateral requirements.

NOTE ON TAIL COVERAGE

Tail coverage is needed for individuals who leave a claims made policy (without retiring), but SCLLC and RTIA believe that coverage for these occasional events can be funded by SCLLC's collected premiums. An appropriate portion of thee premiums could be set aside to grow with investment for those few instances.

ADVANCED RISK: FULL CAPTIVE

If an organization desires to take on all of the insurance risk, it forms a captive insurance company of its own and pays, in effect, all of the premium to its own organization. SCLLC and RTIA are not considering this step now but may take steps in this direction if successful with the more intermediary steps under development.

CURRENT VISION OF SCLLC PROGRAM TRANSFORMATION

CM Policy from PMG, MedPro, or AIG.

- Approx. $200,000/$500,000 deductible funded by SCLLC
- Tail coverage policy from separate company

Level Premium Charged to SCLLC Physicians

- There will be a savings from the difference between this charge and the new policy
- Savings will fund deductible and tail coverage