



# MEDICAL MALPRACTICE INSURANCE

## Medical Malpractice Insurance: An Overview

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Medical malpractice insurance exists as one of the most dynamic and complex forms of insurance inside of a fluid marketplace that can change overnight with the rise and fall of *new medical liability* insurance companies, tort reform on both the state or federal levels, law suit frequency and severity or a myriad of other factors. While there are many ways for physicians, surgeons and medical professionals to approach their practice's medical malpractice insurance; from intentional, blissful ignorance or over-simplification to obsession or even disdain, achieving a balance between basic knowledge of the subject and delegation of its details is the key to dealing with medical liability insurance.

Over the past several decades medicine has become a highly litigious and risky area of business. Physicians and surgeons are practicing defensive medicine in an effort to reduce their risk of having to utilize their *medical malpractice* insurance to defend a claim. It is critically important for doctors to understand how their insurance policy works. In fact, many doctors who are sued have not made a mistake that constitutes medical malpractice, however in these instances, like those where there has been medical malpractice, they will need to depend on their physician malpractice insurance carrier to vigorously defend them when a claim comes in. This exploration will help the reader understand the intricacies of medical malpractice insurance from both the physician the insurance carrier's view.

This brief exploration into the world of *medical malpractice insurance* will give physicians, surgeons, and medical practitioners important insight into one of the most critical protectors of their medical practice. A basic understanding of medical liability insurance will not only help guard a doctor's medical practice, but will also help save money on premiums, alleviate stress when it comes to renewing the insurance, ensure proper coverage, eliminate confusion and pacify worry if a claim comes in. This exposition will cover the topics of:

- The Basics of Insurance: What is insurance?
- What is Medical Malpractice Insurance?
- What is Medical Malpractice Risk?
- What Types of Companies Operate in the Medical Malpractice Insurance Marketplace?
- Physician Malpractice Insurance Company Financials
- You and Your Medical Liability Insurance Broker
- The Application/Underwriting Process
- Policy Form: What is it and how does it affect your medical practice?
- Hard Market vs. Soft Market
- Making a Claim
- Medical Malpractice Glossary of Terms, Jargon and Definitions

## 1 THE BASICS OF INSURANCE

### What is Insurance?

Before one can fully grasp the complexities of medical malpractice insurance, a basic understanding of general insurance principles must be had. Webster's dictionary defines insurance as this:

*"Coverage by contract whereby one party undertakes to indemnify or guarantee another against loss by a specified contingency or peril or in plain English, contract where the one entity, generally an insurance company, promises to restore or replace the property or assets of a second entity, this is generally an individual, but can also be a corporation, if it is lost, destroyed or damaged by a specific set of risks (risks can be fire, death, an auto accident or even a medical malpractice claim)."*

### The History of Insurance

The idea of insurance has been around for thousands of years. While medical malpractice insurance has only been in existence and defending physicians for the past several decades, it is a misconception that this form of financial defense is a new concept. The first example of insurance comes from Hammurabi's Code; a human-sized slab of solid stone, inscribed with 282 laws. The code was written in the 1700's B.C and ratified by the Babylonian's king, Hammurabi. In the code, exemptions from liability were made for debtors or agents who were responsible for transporting another person's goods if the goods were lost by a catastrophic, unavoidable incident. This led property owners of the day to charge merchants or movers additional fees while holding the property in case the property was lost, destroyed or stolen. While rudimentary, these were the first examples of insurance policies in recorded history.

### Insurance: A Manageable Known Action to Avoid an Unmanageable Unknown

Since then, many different types of insurance policies have been created and evolved to protect different types of assets such as physician practices. Simply put however, insurance is taking a known action to prevent or restore an unknown, potential catastrophic disaster. For example, when a person pays a premium for insurance, any kind of insurance, they are taking a known action in the form of the price of the premium. Physicians and surgeons seek to transfer their risk of malpractice to a *medical malpractice insurance* company. The insured works this premium payment into his or her budget every month in exchange for a promise of reparation if a disaster, that may or may not happen, occurs.

While medical malpractice insurance is only carried by physicians, surgeons, and other medical practitioners, one of the most common and simple forms of insurance is homeowners insurance and is explained in its simplest form in the following scenario.

### Example: Basic Insurance Concepts

An insurance company insures 1,000 homes with home insurance policies. Through statistical analysis applied to the law of large numbers, the insurance company can determine, with high probability, roughly how many homes within a certain period of time will burn down, flood or stay safe. But what the insurance company (*or the homeowner*) cannot determine which houses will stay safe or be destroyed, just that statistically a certain number will fall into each potential outcome.

The homeowners also know that there is a chance their house will burn down or be flooded. Individually, if this happened to one family's house, it would be catastrophic and they would not be able to afford to buy a new house.

Since the insurance company can statistically guess how many houses may be destroyed and what it will cost, it is able to formulate a rate or premium for each of the 1,000 homeowners to pay and spread these costs out among the group. The insurance company will then offer a rate to each homeowner. This rate will be higher than the companies predicted payouts to increase cash reserves if losses are higher than expected and to make a profit in exchange for the facilitation of the insurance policies and as retribution for accepting the risk from the homeowners. The homeowner, knowing they could not bare the burden of a destroyed house on their own, if it were destroyed (*an unknown loss*), can accept the much smaller, but known loss, in the form of a premium paid to the insurance company. This premium is paid in return for a promise of a new house if the homeowner's current house is destroyed.

The insurance company will take the premiums from all of the homeowners, pool the money, and pay out any losses experienced by the group. If the losses are greater than expected, the insurance company can lose money, if they are less than expected, the insurance company will make money. Either way, the homeowner took on a manageable and relatively small known loss to protect themselves against a catastrophic unknown loss.

### The Two Basic Principals of Insurance Risk Pooling the Law of Large Numbers

While there are numerous types of insurance, they all use two basic principles, as illustrated above; risk pooling and the law of large numbers. Risk pooling, or the transfer of risk, takes place on the part of the insured in the form of accepting risks from other insured individuals in the form of premiums. In its most basic sense, risk pooling, is simply taking the full potential risk off of a specific individual and spreading said risk between other individuals who are also susceptible to this risk. In the example above, that risk was fire or flood.

*Medical malpractice insurance companies* use the same basic models, however instead of spreading the risk over numerous homes; they spread their risk by insuring many physicians, surgeons and hospitals. The greater the spread of any potential risk over a large territory with many different physician specialties the lower the actual impact of claims to individual doctors and physicians and

the medical liability insurance company that facilitates the protection. Typically a large risk pool will result in lower premiums to the physicians or insured party.

The second major principal of insurance is undertaken and organized on the part of the insurance company. The law of large numbers states that with enough independent trials or tests of an incident, all with the same probability of success or failure, one can accurately predict the number of successes or failures with increasing precision as the number of trials rises. Take a coin flip for example. There is exactly a 50 percent chance of landing on heads and exactly a 50 percent chance of landing on tails. However, if a coin is flipped 3 times, without prior knowledge of the 50 percent odds, one's idea of heads vs. tails probably will be severely skewed in either 66 percent to 33 percent odds or 100 percent to 0 percent odds. If the trial was preformed 30 times, the results will reflect a percentage closer to 50 percent for either outcome. If the trial is preformed 300 times, these statistics will become even more accurate. And while it is impossible to accurately guess which side a coin will land on in an individual flip (*or which specific house will burn down in a risk pool*), with a large enough number of trials, one can predict the outcome for the group as a whole.

### The Law of Large Numbers

Take for example, another type of insurance, life insurance. The average life span in the United States of America is 78.3 years old. No one can predict which people will pass prior to or after that time. However, there are indicators that can give clues such as smoking, disease, obesity, exercise, hazardous activities and even gender all of which are factors that use their own law of large numbers to determine mortal age. Because the average age of death is derived from a large number (*the age averaged from everyone who passes away in the country*) the insurance company is able to set its rates based on this. It will pay the beneficiaries of those who pass away early from the premiums of those who don't with the goal of making a profit for the protection service they are providing and whose participants, the insured's, are voluntarily utilizing.

Medical malpractice insurance companies have spent years compiling data on all of the different medical specialties and the claims associated with them. As mentioned above, the larger the amount of data used the more accurate medical liability insurance companies can be in forecasting their future losses. More detail will be disseminated in future chapters regarding how the medical malpractice insurance companies use this data to determine appropriate premium charges. The above example is to illustrate the basics of how insurance companies, including medical liability insurance companies use statistical analysis and probability to accept the transfer of risk for physicians and other insured's, and to do so at a premium that is affordable for the transferring party.

## 2 WHAT IS MEDICAL MALPRACTICE INSURANCE?

Simply put, medical malpractice insurance protects doctors, surgeons, and other medical

practitioners against catastrophic financial loss as a result of a medical liability lawsuit, or allegation of medical malpractice or negligence brought forth by a patient. While the scope of medical malpractice insurance is as wide as the medical field is diverse, there are basic principles that tie the intricacies of this broad type of insurance together.

### The History of Medical Malpractice in the United States

One of the first major medical malpractice lawsuits in America was settled in the case of *M.L. Price v the South Florida Railroad Company*, which started in the circuit court in 1886, eventually working its way up to the Florida Supreme Court in 1893. Mr. Price, an employee of the rail company was seriously injured on the job when his arm became trapped in the iron couplings between two railcars. As a result, his arm was crushed and broken in several places. He was immediately taken to the railroad's own medical clinic in Tampa, which was staffed by doctors and surgeons, employed by and acting on behalf of the railroad. Mr. Price was attended to by a Dr. Weedon who proceeded to mend and set the broken arm. Mr. Price alleged that after the arm had completed the healing process, it was "misshapen" and unusable. He proceeded to accuse Dr. Weedon, and more financially beneficial, the railroad company, that employed them both, of negligence in the mending of his crippled arm. Mr. Price sought monetary compensation of \$20,000, and was awarded \$2,300. His victory was short lived as the state Supreme Court eventually reversed the decision, citing contributory negligence on the part of Mr. Price for the initial injury. While the suit was not directed specifically at the attending physician, the medical attention received and subsequent permanent damage the plaintiff endured were the occurrences which triggered the medical malpractice lawsuit.

From this suit and others like it in the late 19th century and early 20th century, evolved the medical malpractice environment in which we currently abide. As lawsuits became more frequent and more widespread, doctors eventually needed to develop a way to protect themselves. Thus, the market for medical malpractice insurance was born. An example of this explosion in the frequency of lawsuits occurred in the first of a string of medical malpractice insurance crises in the last 50 years; the number of *medical malpractice insurance* claims tripled between 1969 and 1975.

### Risk Pooling & the Law of Large Numbers as Applied to Medical Malpractice Insurance

As with any type of insurance, medical malpractice insurance uses risk pooling and the law of large numbers to spread the risk among many physicians and surgeons to protect the individuals within the insurance pool. All of the doctors in a specific risk pool pay their premiums to an insuring entity (*generally a medical liability insurance company*) and this money is used to pay for the defense costs and indemnity payments of any allegation of medical malpractice or medical malpractice insurance lawsuits that arise. This is the application of the aforementioned principal of insurance, "taking a known action, in the form of premiums, to avoid a potential, unknown catastrophic result." In a doctor's risk pool, this known action, or premium, *will be higher if the risk of a medical liability insurance lawsuit or higher* the amount of potential indemnity payouts, the unknown result.

## The Risk of Medical Malpractice

In the legal environment that has evolved in America, doctors must always be protected from potential claims. The reality is that every specialty and practice is susceptible to some amount of risk of a lawsuit. Many variables affect the potential of a lawsuit. They include; location, specialty, types of procedures, loss history, time spent working per week, length of time spent in practice, certifications, management of exposures, and limits of liability in the state of the medical practice. The sum of these variables is called "risk." That risk is transferred in the form of insurance policies to medical malpractice insurance companies who spread their risk over numerous physician specialties and generally over a large territory. For some medical liability insurance companies, a large territory means covering physicians throughout just one state, while others cover physicians and surgeons throughout the entire nation. Typically, the wider the spread of risk, the lower the risk is to the physician malpractice insurance company. The difference in risk between counties within a state can be quite large. This is evident by looking at the difference in premiums between different counties for the same specialty. As an example, physicians in Dade County Florida or New York County, New York will pay over 300 percent more in premium than other counties in the same state.

*Medical malpractice insurance* companies can reduce the risk they are carrying by insuring physicians in the more litigious counties by spreading their risk over counties that are not as litigious. This is a difficult task for medical liability insurance companies as the more litigious counties tend to be much more volatile making future liability difficult to predict. It is important to remember that claims take several years to get through the court system. Medical malpractice insurance companies are collecting premiums today based on models that are assuming what the claims defense costs and indemnity payments will be several years from now. Insuring physicians and surgeons in volatile counties is very difficult as the swings in appropriate premiums can be quite large. During periods of hard markets, times when the medical malpractice insurance companies are experiencing large numbers of claims, many medical liability insurance carriers will stop writing new physicians and surgeons in these counties.

## Determining the Right Rates

Determining what the appropriate rates are for each specialty and each county is a difficult task. Medical malpractice insurance rates are determined by the previous claim trends in the corresponding specialties and counties in an attempt to predict future trends. Typically, an insurance company will consult with actuarial companies and have actuarial studies prepared to determine what the appropriate premium rates should be. Medical liability insurance companies, and medical professionals, can get a quick idea of what the rates should be based on what one of their successful competitors premium rates are that have been filed with the Department of Insurance in their state. The actuarial results, used in conjunction with the medical malpractice insurance companies' market strategy, determine what the rates will be. Like all businesses, physician malpractice insurance companies have profit strategy, and this is contemplated while determining their rates. Admitted

carriers are required to file their rates with the Department of Insurance and must be approved before they are allowed to use those rates.

### What is Medical Malpractice?

The whole reason for medical malpractice insurance is, obviously, to protect against medical malpractice lawsuits. What is not so obvious is the description of what medical malpractice actually consists of. The term “negligence” is often associated with medical malpractice though it does not necessarily tell the whole story. Legally, there are four elements that must be established in a case purporting medical malpractice. All four elements must be established in a medical malpractice lawsuit for the case against the health care providers (*physicians, surgeons, nurse practitioners, physician assistants, hospitals etc*) to proceed.

### The Four Elements of a Medical Malpractice Lawsuit

1. Obligation or duty on the part of the medical provider to the patient
2. Breach of duty on the part of the medical provider
3. There must be an injury as a result of the breach
4. Proximate Cause must be established

The obligation or duty on the part of the doctor or surgeon to the patient is the first element of a medical malpractice lawsuit. It must be proven that a doctor or medical provider has in some way accepted responsibility for or agreed to treat a patient, there must be some sort of relationship between the physician and the one being, or needing to be treated. Without this connection or responsibility for the patient, the doctor has no liability.

Secondly, once a relationship has been established between the doctor and the patient, it must also be established that there was a breach duty or a failing in responsibility to the patient. In other words, the doctor or physician must have failed, in some way, to provide a reasonable standard of care. That does not, however, mean that every negative outcome of treatment constitutes a suit. Take, for example a heart transplant. The one-year survival rate for a male with this procedure is 88 percent due to the inherent risk associated with the transplant. A cardiologist and surgical team can do everything correct, medically speaking, and still, 12 percent of patients will not survive. If all of the physicians practiced a prudent and acceptable standard of care and precaution, the 2nd of the 4 elements of a medical malpractice lawsuit was not met, and therefore there can be no judgment against the defendants. If however, during the same procedure, a foreign object were left in the chest cavity, the doctors did not deliver an acceptable standard of care, or even did not adequately express the risks involved with such a procedure, this criteria may have been met and a lawsuit can be pursued against the surgeons.

Third, the patient must have experienced injury. For example, a breach of duty may occur if a chart is inaccurate and a patient receives penicillin instead of doxycycline. Barring an allergic reaction, no

injury has occurred. While the first two elements have been met, duty and breach of said duty, the patient was not effected in a negative way and therefore no suit is warranted. If however, the same scenario takes place and the patient who was supposed to have doxycycline receives penicillin and has an anaphylactic reaction, the result can be deadly. In this case, the first three elements have occurred.

Finally, there must be a link between the injury and the caregiver, in other words, the injury received by the patient must be a result of some action or inaction by the physician or physician's assistant. Take, for example, another type of insurance, workers compensation. Workers compensation insurance only pays an employee when an injury took place as a result of the job the employee has. If the employee is injured in an accident while driving a delivery truck to a distributor of the employer, worker's compensation will pay the employee. If the same employee is injured in an accident while driving to the grocery store on his off day, workers compensation insurance will not pay out. In the same way, the injury to a patient must be a result of a doctor or physician or another medical caregiver. One of the most prevalent examples of this in a medical facility is infection. A patient may receive an infection while in the hospital for another reason. If the doctor and staff have taken an acceptable amount of precaution to protect the patient and the patient dies as a result of the infection, this element of a medical malpractice suit has not been met. If the infection can be linked to a medical professional as a direct result of a specific action or inaction, a lawsuit may proceed to court.

*Once these four elements have been satisfied, a medical malpractice lawsuit is warranted if not eminent.* It is because of this worst case scenario that doctors carry medical malpractice insurance. As an aside, if a situation arises where doctor or surgeon or any medical care giver feels that these elements have been satisfied or may have been satisfied, it is best if they immediately notify their insurance carrier or insurance broker. Medical malpractice insurance companies can better manage adverse outcomes if they know about it and can advise the physician or surgeon that they insure on how to manage their patient before a claim is ever filed. This is referred to as claim prevention. This will be discussed more in the risk management chapter.

### **The Medical Malpractice Insurance Lawsuit**

Medical malpractice trials are very complex and involve jury members, expert witnesses, judges, and attorneys. Both the plaintiff and the defense have a lot at stake and argue their cases aggressively. Fortunately for doctors the numbers are on their side. Over 80 percent of medical malpractice insurance claims are dismissed or won at trial with no indemnity payment made to the plaintiff. These claims are often referred to as frivolous claims. *Many medical malpractice claims are frivolous, and there are a lot of variables that need to be accounted for to determine and prove why, so that unwarranted claims are dismissed.* In the event a claim is valid and a payout is made, the profits that law firms receive are quite hansom in most cases. Law firms typically charge roughly 40 percent of what the patient wins in an indemnity payment. If the patient wins \$1,000,000, the plaintiff's law firm will receive \$400,000 in compensation. The sum of these expenses potentially incurred by the

insurance company is referred to as “risk.”

### 3 WHAT IS MEDICAL MALPRACTICE INSURANCE RISK?

Risk can come in many forms, however the one constant is this; any medical practice that has any patient contact or affects a patient in any way, either directly or indirectly, carries with it medical liability risk. With risk comes the potential for a medical malpractice lawsuit, and ergo, the need for medical malpractice insurance. The common notion that some practices “carry no risk of a lawsuit whatsoever” is simply not true. While psychiatry, for example carries with it less risk than neurosurgery, there is still risk of a medical malpractice insurance claim. Understanding the risk of a doctor or surgeon’s medical practice is important for one shining reason; the higher the risk of a medical practice, the higher the premium for a doctor’s medical malpractice insurance will be.

Risk, as previously discussed is affected by a litany of variables; it is beneficial to understand the main contributors. They are; specialty, location, and claim history. These three variables affect risks and therefore the medical malpractice insurance premium. In addition to these three factors, which for the most part (*other than possibly location*) are fixed, there are additional steps a doctor can take to lower risk in his or her medical practice to lower medical liability insurance premiums.

#### The Risk Associated with a Medical Specialty

Different medical practices carry different levels of risk. Digging into a patient’s brain with the tools of words and listening as a psychiatrist does is much less risky than digging into a patient’s brain with a Kerrison rongeurs device and a swivel knife as a neurosurgeon would use. While every medical malpractice insurance company has a slightly different formula it uses to establish a risk classification for a certain medical specialty, the following is a general guideline for the amount of risk a medical malpractice insurance company will usually place on some of the most common specialties in the order of least risk to greatest.

#### The Specialty Risk Chart

*Psychiatry / General Preventive Medicine Physical Examinations*

*Allergic Treatment / Hematology / Dermatology (no chemobrasion / hair transplant or dermbrsion)*

*Hospice Medicine / Ophthalmology (no surgery) / Physical Medicine and Rehabilitation / Child Psychiatry*

*Pediatrics / Pathology General Practice (no surgery) / Geriatrics / Nephrology / Ophthalmology (minor surgery)*

*Pulmonary Disease (no bronchoscopies) / Pediatric Cardiology (no CC’s) / Internal Medicine / Neurology / Oncology / Endocrinology*

Anesthesiology / Infectious Diseases

Urology (no major procedures) / Surgical Assistant / Ophthalmology (major surgery) / Otorhinolaryngology (office, no surgery) / Pediatric Cardiology (CC's) / Physical Medicine and Rehabilitation / Office Gynecology / General Practice (minor surgery) / Emergency Medicine

Cardiovascular Disease (no CC's)

Family Practice (no surgery) / Cardiovascular Disease (CC's)

Gastroenterology

Therapeutic Radiology

Family and General Practice (limited major surgery) / Office Orthopedics / Otorhinolaryngology (no plastic surgery) / Urology

Neonatology Diagnostic Radiology Plastic Surgery Otorhinolaryngology (plastic surgery) / Gynecology Vascular Surgery / Thoracic Surgery / Head and Neck Surgery / Hand Surgery Orthopedic Surgery Thoracic Surgery (open heart) / Obstetrics & Gynecology Neurological Surgery

## Insurance Premium Theory

A medical malpractice insurance company places a higher risk classification as the risk of death, disability or human error during a medical procedure increases. For example, an annual checkup from a family practice doctor carries less risk of injury or lasting damage than a surgeon's open heart surgery, and therefore less risk of a lawsuit resulting in a lower premium needed to cover potential defense costs and any payouts to plaintiffs.

Each physician specialty carries a level of risk relative to that specialties frequency of claims and severity of claims. The frequency of claims defines how often a certain specialty receives a *medical malpractice insurance claim*. The severity of a claim defines how severe in dollar amounts, that medical specialties claims are on average. Medical specialties that have a low frequency of claims and a low severity of claims have very low medical liability insurance premiums. General Preventative Medicine would be an example of a medical specialty that has a low frequency and low severity of claims. An OBGYN has a very high frequency of claims and a high severity of claims, and carries a very high premium to compensate for this risk.

## Where You Practice Determines What You Pay

The second biggest factor in a physician's medical malpractice insurance premium is the physician's medical practice location. This is due to several factors, where a doctor's practice has an effect on the frequency and severity of medical malpractice insurance claims and lawsuits. These factors can have an extreme effect on premiums. An OBGYN in St. Louis, Missouri could expect to pay around

\$40,000. If that same OBGYN moved the practice to Manhattan, New York, the mature claims-made policy premium would jump to around \$156,000. Additionally, there is an upward trend in premium rates from rural areas to city centers, even within the same state.

*The reason for the higher frequency and severity of medical malpractice insurance lawsuits in urban areas can be partially derived from a complex set of variables spanning from cost of living to a patient's mind set to the availability and accessibility of legal council that specializes in medical malpractice cases. Take, for example, a medical malpractice case where a patient has been permanently disabled and is unable to work. If the physician, surgeon or medical practitioner has been found liable, the patient will receive a monetary indemnity payment that will cover, at a minimum, living expenses. Those expenses, and therefore the payout, will be lower, if paid in an area with lower living expenses. If the patient happened to live in downtown Chicago, those living expenses, and therefore, the payout will be much greater. These costs are transferred directly to the professional medical liability insurance company, which appropriates the increase in premium to the physician, surgeon or medical professional.*

Each state has different tort laws that help determine where a medical malpractice insurance claim can be filed. Most states with strong tort reform require the claim to be filed in the county that the alleged medical malpractice occurred. Plaintiff attorneys often use what is referred to as venue shopping in an effort to find the most plaintiff friendly county. This involves naming as many doctors, nurse practitioners, surgeons, radiologists etc, on a medical malpractice insurance claim in an effort to file the claim in whichever practitioner practices in the most plaintiff friendly county. Most strong tort reforms today do not allow the practice of venue shopping.

Many physicians, surgeons and medical practitioners practice in more than one county. It is common for doctors to have multiple office locations and see patients at multiple hospitals. In these cases, medical malpractice insurance companies charge the doctor whichever county has the highest premium to compensate for the increased risk of insuring the physician in that county.

## Loss History

The final major variable that will affect a doctor's medical malpractice insurance premiums is their "loss history." Loss history is the record of any medical malpractice insurance lawsuit which has named the doctor as a defendant. When a doctor or surgeon applies for medical malpractice insurance, their loss history will be reviewed by the medical liability insurance company. Several factors are surveyed including the number of claims, whether or not the cases were dismissed, settled or went to trial. If the cases did settle or make it to trial, the insurance company will want to know the expense incurred in defense and most importantly, if there was an indemnity payment to a plaintiff, the cost of that indemnity payment. The higher the costs incurred by previous medical malpractice insurance company, the higher the premium quote from the current medical liability insurance company. Most medical malpractice insurance companies will only look 5 years into the past, therefore, if a lawsuit was closed 6 years prior to the application for medical malpractice insurance,

it will not count against the applicant (*during periods of hard markets some physician malpractice insurance companies will require 10 years of claim history from the physician*). Many medical malpractice insurance companies offer discounts up to 10 percent for doctors with a clean claims history for the previous five year. If the doctor is willing to share 5 additional years, many companies will offer additional discounts for 10 years of no claim history.

Keep in mind that as with any legally binding document, if a doctor's representation of loss history is inaccurate or misrepresented on an application, if a claim comes in, the medical malpractice insurance company may withdraw coverage, leaving the doctor completely exposed to the liability of the claim. Doctors and surgeons will experience the most success by being as upfront and honest as possible as early as possible with their broker and or physician malpractice insurance company. Much of the business in the medical malpractice insurance market is based on relationships and trust. If an underwriter reviewing an application feels, for any reason, they can not trust the applicant, the premium quote may increase or the coverage may not be issued at all. Many physicians feel that their claim history does not accurately reflect their risk. With the high number of frivolous medical malpractice claims, many physicians feel they should not have to pay a higher premium to be insured for claims that have no merit. While this is perfectly understandable, it is important for physicians to recognize that each and every claim, whether frivolous or not, carries a cost to the medical malpractice insurance company. For most medical liability insurance companies, the average cost of defending a frivolous claim is over \$20,000 per claim. Therefore, it is beneficial for the physician to write a detailed summary of his or her past medical malpractice claims in an effort to completely explain their situation to the underwriter. Remember, underwriters are human and often base a part of their decision on how seriously a doctor takes his or her medical malpractice insurance. Underwriters want to insure physicians and surgeons who understand their risk as a doctor and are dedicated to strong risk management. This can be conveyed through a detailed narrative or summary of the doctors past claims.

Doctors can retrieve their claims histories from the National Practitioner's Databank. The National Practitioner's Databank was formed by the US Congress with the Health Care Quality Improvement Act of 1986 to serve several functions with the sole intention of improving the health care experience as a whole. With regards to medical malpractice, every payout to a plaintiff is reported to this database and therefore. The information collected about a specific doctor is not available to the general public. However a medical professional can access the website and view their own reported loss history.

### **Managing Risk – Managing Expenses**

For the most part, doctors do not change their specialty to avoid high medical liability insurance premiums; however the procedures they pursue may be curtailed to lower their cash outlay for medical liability insurance. And, for the most part, doctors do not change their location to avoid high premiums; however, in specific territories or counties where there is a sever lack of tort reform and/or a medical malpractice insurance crisis, this may also be difficult but a viable option. Physicians and

surgeons often can make a simple calculation to determine if the additional premium to practice in the higher rated county or higher rated procedure class is worth the additional revenue that they will earn. More prevalently however, is preemptively addressing loss history as a result of a claim, before the claim even presents itself. This anticipatory action can manifest itself in many ways, most of which are efficient and inexpensive.

*In many cases, medical malpractice insurance companies will offer discounts of up to 10 percent for the completion of Risk Management Courses. These courses are generally offered online, free of charge to doctors and surgeons who choose to participate in them and usually only take an hour or two to complete. Many medical malpractice insurance companies also offer risk management seminars that physicians and surgeons can attend to receive their risk management discount. Both the online courses and the seminars will also give the doctor CME credits. Some medical liability insurance companies have risk management teams in place that travel to physician offices and give the physician or group a medical practice review. They will go through patient charts and office protocols to help doctors understand what areas they are most vulnerable in, and what areas need to be improved upon to lower the risk of their medical malpractice insurance company defending them in a claim.*

The management of risk is one of the most important aspects a physician needs to consider in relation to their medical malpractice insurance and their medical practice in general. Risk management is a hot topic, and has received a lot of attention from the government. Some members of the government have pushed hard for "Sorry Works" legislation which allows physicians to say they are sorry to the patient without doing legal harm to themselves should the patient file a lawsuit. *Risk management is a broad topic covering everything from medical records, to patient communication and medical office protocols for nurse practitioners, physician assistants, and medical office staff. One of the most common mistakes that leads to medical malpractice insurance claims are poorly documented or incomplete medical records. Claims often result from physicians missing or forgetting critical information that either was or should have been included in the patients' medical records. These mistakes often lead to misdiagnosis of cancer or radiology results that needed immediate attention. Electronic medical records have become a big part of a physician or surgeon's medical practice. It is an important risk management tool, and important enough that medical malpractice insurance companies do give discounts if a physician has an electronic medical records system in place at their medical practice. Electronic medical records help tremendously in cutting down on missed items in the medical chart or poor handwriting that make it difficult to understand a physicians orders or worse a misdiagnosis. The government feels it is so important that it has given tax incentives for doctors who purchase an electronic medical records system. The premium discount received from the doctor's medical malpractice insurance will not come close to replacing the cost of implementing a system, but it is expected to lower the risk of a medical malpractice claim.*

It also is worth mentioning that while more laborious, discounts can be earned through board certification in their specialty. In fact, there are even companies emerging in the medical

malpractice insurance market that only consider doctors with board certification in an effort to manage and minimize risk. These companies generally offer lower premiums due to the lower expenses incurred as a result of a lower frequency of claims.

## 4 TYPES OF MEDICAL MALPRACTICE INSURANCE COMPANIES

There are many different types of medical malpractice insurance companies. Their structures all present different advantages and disadvantages to the doctors who purchase the companies' policies. Keep in mind that all medical malpractice insurance companies in America have some degree of governmental oversight and ideally every company is structured to be in a position to protect a doctor if a claim comes in, however this is not always accomplished. There is not one specific type of company that will be best for every doctor in every situation and each carries a different set of parameters in which a medical professional's policy will operate. Therefore it is important to understand the main differences between the different types of companies in order to make the right decisions with regards to protecting a medical practice.

### Admitted Carriers

The most common type of medical malpractice insurance company, is known as an admitted carrier. It is also commonly referred to as a "standard" carrier. These types of medical liability insurance carriers are called "admitted" carriers because the Department of Insurance in their respective state has approved them as a licensed medical malpractice insurance carrier to write business in that specific state. These admitted *medical liability insurance carriers* are then regulated by the Department of Insurance in the state in which they are issuing policies. The requirements and regulations are much more stringent for an admitted carrier than other types of professional liability insurance companies. The insurance policies, the premium rates and any changes to those policies and rates must be approved by the Department of Insurance. In return for the stiff rules and regulations admitted carriers have access to the state guarantee fund. The state guarantee fund will step in and cover outstanding claims in the event the medical malpractice insurance company becomes insolvent. This is a very important feature when physicians, surgeons, hospitals, surgery centers, urgent care centers and all medical providers are looking to purchase medical liability insurance. Having access to the state guarantee fund helps physician malpractice insurance carriers give insured's an additional level of comfort in knowing that they have an extra layer of protection if their carrier goes out of business. Admitted carriers are most commonly stock insurance or mutual insurance companies.

### Admitted Carrier Policy Form

One facet of the regulations the Department of Insurance requires is that admitted medical malpractice insurance carriers offer a "standard" policy. These standard policies ensure similar

coverage between the admitted carriers. The most important parts of a medical liability insurance policy are as follows:

#### **Consent to Settle –**

This is a clause in the policy that states the physician malpractice insurance carrier does not have the authority to settle a claim without the physician's consent. This is a very important clause for doctors and surgeons due to the fact that if there is a claim, the doctor has the final say on how the litigation will transpire. A claim that has an indemnity payment due to the carrier settling a claim is permanently on the doctor's record. Every time a doctor completes a CAQH form, applies for *medical malpractice insurance* coverage, a medical license, or hospital privileges that the doctor will have to answer questions stating that he or she has had a medical malpractice claim with an indemnity payment. In most cases the physicians and the physician malpractice insurance carrier are mutually aligned in regard to a claim, meaning that they are both seeking the same outcome. There are, however, situations where the medical malpractice insurance company might have a financial incentive to settle a claim to avoid a considerable amount of legal defense costs, which the physician feels they have a good chance of winning if the claim goes to trial. With the consent to settle clause, the *medical liability insurance* carrier cannot settle the claim without the doctor, or first named insured's consent.

#### **Non Assessable Policy –**

Medical malpractice insurance companies can be broken down into two categories; assessable carriers and non assessable carriers. Nearly all states require admitted carriers to be non assessable carriers. A non assessable carrier means that the carrier cannot charge additional premium during the policy period. An assessable carrier is just the opposite and, if the need arises, can charge or assess additional premium from the policy holders to keep the company solvent. Non assessable carriers give the doctor or insured the comfort of knowing that the premium listed on the declarations page of their medical malpractice insurance policy is the only premium they will have to pay during their policy period. Most admitted carriers are stock insurance companies, meaning the company is owned by its stock holders. If the company runs into financial trouble, they will most likely raise their premium rates, and if they need to, issue more shares or rely on their stock holders to infuse more money into the company. Usually raising premium rates is enough to satisfy the threat of insolvency.

#### **Legal Defense Costs –**

Medical malpractice insurance claims come with particularly large legal defense costs including defense attorneys, court costs, expert witness costs etc. Often medical malpractice claims can last several years. Legal defense costs can be in the hundreds of thousands of dollars when a claim goes to trial. A state's Department of Insurance requires admitted carriers to have the legal cost of defense outside or in addition to the limits of liability. This means that the insured physician, surgeon or hospital will not have their limits of liability lowered due to the defense costs. As an example, if a claim goes to trial and costs the medical malpractice insurance company \$150,000, the insured will still have the full \$1,000,000 limit of liability, or whatever the applicable limit of liability is for that policy. Many non admitted carriers are not required to have this provision and the limits of liability are lowered based

on the legal defense costs. This could potentially leave the physician with the balance of liability after the total costs of defense are subtracted from the limits of liability by the medical liability insurance carrier.

#### ***The Tail or Extended Reporting Period –***

Admitted medical malpractice insurance companies offering a claims-made policy are required to offer a physician a tail when the physician makes the decision to purchase the extended reporting period. A tail policy is formally known as an extended reporting period. A tail policy covers a physician or surgeon for their medical acts from the doctor's retroactive date listed on the declarations page of the policy, through the date that the tail policy is purchased. If a physician cancels their claims made policy without purchasing a tail or without getting retro active coverage with another claims made policy, they will have no coverage and will be fully liable for any claims that arise. Extended reporting period policies are typically 250 percent of their annual premium and do not have options for financing. Admitted carriers do have options for free tail policies though. Nearly all admitted medical malpractice insurance policies offer the doctor or insured free tail in the event that insured becomes permanently disabled or dies. Most of the admitted medical liability insurance carriers also offer a free retirement tail option if a physician has been with the medical malpractice insurance carrier for five years or more and permanently retires over the age of 55 (some carriers offer free tail coverage after age 50).

#### ***Admitted Medical Liability Insurance Carrier Premium Rates –***

A state's Department of Insurance requires admitted medical malpractice insurance carriers to file their premium rates with the department of insurance. Those rates must be approved before they can be used. Any premium rate increases or decreases must be approved by the Department of Insurance before they can be used. Most medical liability insurance carriers file a different premium rate for each specialty and county. In addition, all debits and credits to those rates must also be approved. These credits include, claim free credits, years of experience credits, board certification credits, risk management credits, electronic medical records credits etc. Each credit or debit is accompanied by a percentage discount or increase. Any changes to the credit or debit filings must also be approved. These stringent rules that apply the admitted medical malpractice insurance carriers ultimately help deliver premium rate stability to physicians, surgeons and other insured's.

#### ***Admitted Medical Liability Insurance Carrier Financials and Audits –***

Medical malpractice insurance companies are required to meet minimum financial standards to ensure that the carrier is financially capable of covering the expected amount of claims. The Department of Insurance has the ability to audit the policies and financials of any admitted medical malpractice insurance company. The two most important aspects of the physician malpractice insurance carrier's financials are the company's surplus and claim reserves. The surplus represents the amount of money they have one hand which exceeds it's liabilities. Claim reserves represent the amount of money the carrier has in reserve to cover existing claim costs and expected future legal defense and indemnity payments for those existing claims.

The Department of Insurance's main interest lies in ensuring the medical malpractice insurance carrier has enough money in reserves and surplus to be comfortable that the carrier can be financially solvent with its current rates. If the Department of Insurance feels that the carrier does not have enough surplus, or in other words, it does not have an adequate amount of money saved to cover existing or future claims, the Department of Insurance has the ability to require the medical malpractice insurance carrier to increase the filed rates to increase revenue. There are also situations in many states where one medical liability insurance carrier has a very large majority of the market share. If the Department of Insurance feels like the carrier has too much surplus on hand, it can require the admitted carrier to issue a rate decrease.

### **Risk Retention Groups – Medical Malpractice Insurance**

The Federal Risk Retention Act of 1986, created two new vehicles by which insurance buyers could more readily avail themselves of liability insurance: risk retention groups (RRG's) and purchasing groups (PG's). A risk retention group is simply a group of individuals who share a common liability and have banded together to spread their risk over a large number of insured's. A risk retention group is similar to a mutual company in that it is owned by the policy holders. Each physician or surgeon that the RRG insures is required to pay capital (*sometimes referred to as surplus*) in addition to the premium to help capitalize the company. Most risk retention groups offering medical malpractice insurance coverage will require the doctors to pay capital for a certain period of time, after which the medical practitioner is no longer required to pay additional capital, reducing the total outlay for the insurance. The doctors who pay their capital receive shares in the insurance company. While there usually is not a liquid market available to sell their shares, they will receive compensation if the company is sold to another entity. Additionally, the ideal situation when dealing with an RRG will include a return of premium in the form of a dividend payment to the owners of the company, in this case the doctors with shares.

Risk retention groups are not admitted carriers so they fall outside of most of the regulation of local state departments of insurance. Risk retention groups choose the state they will be domiciled in and then have the ability to write medical liability insurance business anywhere in the United States. Nevada and Arizona are two of the most common states that risk retention groups use as their state of domicile.

The goal of most risk retention groups is to lower the medical malpractice insurance premiums. They are typically more interested in providing the lowest physician premiums available as opposed to creating a profit or return for share holders. In fact most risk retention groups issue dividends back to the share holders if they have better than expected year and feel they do not need the money as additional surplus. Risk retention groups within the field of medical malpractice insurance have earned a bad reputation due to the much higher rate of insolvency. Since they are not as heavily regulated there has not been as much discipline to charge their members (*insured's*) the appropriate amount of premium causing the insurance company to go bankrupt. Since they are not admitted carriers they do not have protection from the state guarantee fund.

Risk retention groups have served a useful purpose however in creating a market to write hard to place business. Admitted medical malpractice insurance carriers tend to have much more conservative underwriting departments. Physicians and surgeons who have had an adverse claim history often have a difficult time finding coverage with the admitted carriers. In addition if physicians have had a medical license suspension, medical license probation or investigation, it is often an automatic declination from the admitted physician malpractice insurance carriers. Admitted carriers are also typically very conservative when it comes to insuring certain procedures that fall outside of the normal scope of medical specialties. This includes medical spa procedures, weight loss procedures, manipulations under anesthesia etc. Risk retention groups have served a very useful purpose to the market by offering medical malpractice insurance for the unusual fields of medicine as mentioned above. They have also done so with affordable premiums. Another area that they have been useful is for physicians and surgeons who have multi-state exposure. Risk retention groups have the ability to write business in multiple states with relative ease.

### **Excess and Surplus Lines Companies – Medical Malpractice Insurance**

Some of the largest insurance companies in the world write business in what is referred to as the Excess and Surplus Lines market. These companies are sometimes referred to as non standard or non admitted insurance carriers. These carriers including, medical malpractice insurance surplus lines carriers, are not required to be licensed in each state but are still allowed to write business in all states.

The largest value of the surplus lines market is that the companies have the freedom of form, allowing them to customize the policy forms and rates to each specific risk. They fall under federal regulation, allowing them to write business across all states. Since they are not admitted carriers they do not have access to the state guarantee funds to cover their insured's if the surplus lines medical malpractice insurance carrier becomes insolvent. Oddly enough, studies by A.M Best have shown that the number of surplus lines carriers that have gone insolvent compared to the number of admitted carriers that have gone insolvent is much lower. For physicians and surgeons who have their medical malpractice insurance through a Surplus lines company, are required to pay surplus lines taxes and in most states a stamping fee. The taxes are a percentage of the medical liability insurance premium and are different in each state. Most states charge roughly 4-5 percent. Surplus lines medical malpractice insurance companies are required in most states to file basic information including articles of incorporation, financial reports and general information.

The regulation for surplus lines carriers is similar to risk retention groups. There are some differences though, most notably the size of the companies and their A.M. Best Ratings. Most of the surplus lines companies that offer *medical malpractice insurance* have total assets that exceed \$1 billion. All of them write business in many different areas of insurance outside of medical liability, further spreading the risk over many policy holders. Nearly all of the surplus lines carriers that write medical malpractice insurance in the United States have an "A" rating or better through A. M. Best. A.M. Best is the leading insurance rating company in the world and the "A" ratings are very hard to achieve. Therefore

a *surplus lines medical malpractice insurance company* with an “A” rating is a company that is financially well positioned. Very few insurance companies offering medical malpractice insurance in the normal medical malpractice markets have an “A” or better rating from A.M Best.

One of the biggest uses for surplus lines companies in regards to medical liability insurance is insuring hospitals. Hospitals represent a complex risk for medical malpractice insurance companies. They have many different areas of liability and often have a need for very high limits of liability. *Surplus lines companies work in the market of hospital medical malpractice insurance because surplus lines companies have the freedom to craft the policy form however they need to in order to properly cover the risk for the hospital without the hassle of admitted carrier regulation.* Additionally, most admitted carriers and risk retention groups do not have the surplus on hand to accommodate covering tens of millions of dollars of liability. Surplus lines companies are accessed through a broker or agent.

Most surplus lines insurance companies require that individual agents work through a wholesale broker that is experienced and knowledgeable in the field of medical malpractice insurance. Agents who work directly with physicians and surgeons are required to have three declinations from admitted medical malpractice insurance carriers before the physician, surgeon, or hospital can be insured with a surplus lines company.

Again, one type of *medical malpractice insurance company* is not better than another type in all scenarios. They all have different qualities and can be more or less beneficial depending on a doctor's specific situation. It is generally best to consult a *medical malpractice insurance professional* about which would be best for a particular medical practice.

## 5 MEDICAL MALPRACTICE INSURANCE COMPANY FINANCIALS

### What to Look for & What to Ask About

While every purchaser of *medical malpractice insurance* can agree on the importance of finding the lowest premium rates, they should also realize the importance of a medical liability insurance company's financial statements. Put bluntly, what good is paying for medical malpractice insurance if the insurance company is not in a position to defend a doctor or pay claims? To preface the obvious answer to that question, it must first be understood that to some degree, every medical malpractice insurance company is held to certain minimum standards by either the state or federal government. Therefore, every physician malpractice insurance company should have some basic strategy or plan to pay claims arising from alleged medical malpractice.

### The Medical Malpractice Market vs. Future Liability

The problem medical malpractice insurance companies deal with is the volatility of the market in which they reside. One of the biggest contributors to the uncertainty of a professional medical liability insurance company is the time between when a premium is charged and when a claim comes in. For example, if a doctor buys a tail for his claims made policy, the insurance company has to make an actuarial educated guess upon the risk of a claim coming in at an unspecified time in the future based on what it knows today about average payouts and costs to defend a lawsuit. In the same way, an occurrence policy is, for all intents and purposes, always active even if the doctor, surgeon or medical professional has since changed to a different insurance carrier. This gap between the time the premium is paid and when a claim is made adds a great deal of uncertainty to the financial outlook of every medical malpractice insurance company.

Fortunately, there are several key pieces of financial data that are indicative of a medical malpractice insurance company's financial health. While there is no need to become designated as a CPA to decipher a medical malpractice insurance company's financials, a short introduction to two basic financial principals will be helpful.

### Seeing the Basic Financial Picture of a Medical Malpractice Insurance Company

First, it is important to understand what is meant by the term "reserves." Reserves, in this case, can be defined as "A portion of a medical malpractice company's assets, held in cash or in another highly liquid, monetary equivalent, set aside from assets used in day to day operations, as a means to defend the insured and, if need be, pay damages to a plaintiff as a result of a medical malpractice lawsuit." In plain English, a medical malpractice insurance company uses its cash reserves to protect a doctor in the event of a claim. There are many different factors that go into a company's decision process as it determines the assets it will dedicate to this "savings account" including: the number of physicians and medical professionals it insures, the estimated projected expenses the company may incur including defense costs and indemnity payments, and the financial rules of the state in which the medical liability insurance company operates to name a few. All this to say, the amount of money a medical malpractice insurance company has dedicated in its cash reserves can be indicative of the company's financial strength, and ultimately its ability to pay claims. *A company with \$200,000 in reserves will be in trouble when the time comes to defend a doctor whereas a company with \$17,000,000 will fare a bit better.* Keep in mind though; a company with 400 physicians will not require as bountiful reserves as a company with 4,000.

Medical malpractice insurance companies also have ways of hedging themselves against the risk of losing the entirety of their reserves to unexpected risk. Most prominently, liability companies rely on what is known as "reinsurance." Essentially, this is an insurance policy provided by "reinsuring" company for the *medical malpractice* insurance company. While these policies look different from company to company, they all serve to protect the cash reserves. The reinsurance policy will take effect after a certain amount of expense has been incurred by the medical malpractice company while defending or paying a claim. The dollar amount that the reinsurance company starts to incur risk is referred to as the attachment point. For example, a typical reinsurance policy may require

the medical malpractice insurance company to pay the first \$300,000 of a claim, almost like a large deductible. After the \$300,000 payout is made by the medical malpractice company, the reinsurance company will pay the rest of the liability up to the doctor's policy limits. Reinsurance contracts with medical liability insurance companies typically only cover indemnity payments and do not cover legal defense costs. This protects the medical malpractice insurance company from being exposed to the entire risk of the policy's limits of liability.

The benefit to the reinsurer is had as a result of the reduced probability that an individual malpractice claim will cost more than, in this example, \$300,000 to defend or indemnify, only when the primary insurance company incurs expenses greater than their contracted amount with the reinsurance company, does the reinsurer have to contribute. Most physician malpractice insurance companies attachments points range from \$200,000 to \$500,000. Reinsurance is an important tool to reduce risk and protect the *medical malpractice insurance* company and ergo, the doctor who has trusted them for protection. Reinsurance companies allow medical liability insurance carriers to insure large numbers of physicians without incurring overwhelming amounts of risk. If your insurance company has reinsurance, be sure it is with a reputable company such as the Lloyds of London.

### **The Premium to Surplus Ratio – Don't Overpay, Don't Underpay**

One of the most important and commonly used indicators of an insurance company's financial stability and sustainable outlook is what is called the "Premium to Surplus Ratio." The premium to surplus ratio measures a medical malpractice insurance company's efficiency and fiscal posturing with the premium dollars it receives. It requires a minimal amount of math while producing a clear picture into the financial prospects of a medical malpractice insurance company. The formula essentially shows how many dollars of premium a company collects from the doctors who hold an insurance policy compared to how many dollars the company has in surplus to pay claims. The formula is as follows:

#### **Annual Premium Dollars = Premium to Surplus Ratio (Assets – Liabilities)**

A *medical malpractice insurance* company will have a ratio no greater than 3:1. This means for every \$3 in premium the insurance company collects, said company has \$1 in surplus to defend and pay claims. Surplus is defined as assets minus liabilities. Companies are generally considered in a good financial position if their ratio is 3:1, but what if, for example the ratio is 4:1 meaning that for every \$4 of premium the company only has \$1 in surplus? In this case, the medical liability insurance company is overextending itself, its expenses or owner distributions are too high, resulting in a minimal amount of money being directed into surplus and therefore may not be running efficiently or able to pay claims in a worst case scenario. On the other hand, a medical malpractice insurance company with a premium to surplus ratio of 1:2 is probably setting its premium prices too high and overcharging its policy holders.

As previously mentioned A.M Best is the leading financial rating company for medical malpractice

insurance companies. They have been rating insurance companies for over 100 years and have become a household name for consumers. In order to get an “A” rating a carrier must have at least a 1:1 ratio, meaning they must have *at least \$1 in surplus for every \$1 of premium*. Many hospitals and credentialing departments use A.M. Best as a measuring stick for the physician malpractice insurance companies. In fact, many hospitals have a restrictive list of carriers that a physician, surgeon, or medical practitioner must be insured with if they want to have hospital privileges with that carrier. However, if the medical liability insurance carrier has an “A” rating from A.M. Best, the hospitals will accept the coverage even if the carrier is not on their “approved” list.

### The Financial Ratings of a Medical Liability Insurance Company

A.M Best's rating addresses their opinion of an insurance company's ability to meet its obligations; claims. *A.M. Best has 16 different ratings for insurance companies ranging from A++ down to F*. They also assign a forward looking rating based on their outlook of the company. They assign either a positive, negative, or stable outlook for each company that they rate. Physicians can rest assured that nearly all medical malpractice insurance carriers are rated “B” or higher, or don't carry a rating at all. Many *physician malpractice insurance* companies know that having a rating lower than “A” could be detrimental to their sales efforts and therefore do not carry a rating. In order to get a rating a medical malpractice insurance company must engage with A.M Best, including payment, and allow A.M. Best to fully review their financial statements in order to evaluate them and assign a rating to them. If an insurance company does not feel that they will be given an “A” rating, they typically do not request a rating from A.M. Best.

## 6 YOU AND YOUR MEDICAL MALPRACTICE BROKER

As the world of medical malpractice insurance coverage grows ever more complex, the need for experienced, empathetic and educated medical liability insurance brokers continues to rise. Most of the medical malpractice insurance bought and sold in the market today is a direct result of a doctor/broker relationship. Before discussing the relationship and potential pitfalls between a doctor, surgeon or medical professional and a medical malpractice insurance broker, there is one key distinction that must be made. While many use the words agent and broker interchangeably, there is a huge difference that may significantly affect the premium a physician or surgeon pays.

- Medical Malpractice Insurance Broker: Acts on the behalf of the doctor.
- Medical Malpractice Insurance Agent: Acts on behalf of a particular insurance company.

The role fulfilled by the broker and the one fulfilled by the agent differ significantly. An agent sells a particular company's product to the physician while the broker presents several different options from different companies, able to furnish information and details about the positives and negative aspects of each. Doctors should be aware if they are working with a broker or an agent.

Medical professionals use agents and brokers as a conduit and a resource allowing them to fulfill their need for medical malpractice insurance. The *medical malpractice insurance* market has a seemingly unending series of rules and regulations that should effect the decision making process when it comes time to purchase medical liability insurance coverage. If this knowledge is not readily accessible to the medical professional, financially detrimental mistakes can be made. For example: A company in New York state offers a free tail for a doctor's claims made coverage if the doctor keeps the policy with that physician malpractice insurance company for 5 consecutive years prior to permanent retirement. If the doctor does not have this knowledge, simply because he or she spends their time studying and practicing medicine instead of the medical malpractice insurance market, and rightly so, an offer to switch companies 3 years prior to retirement to save a few thousand dollars may seem like a good idea. In reality, this decision would cost the doctor 10's of thousands of dollars as a result of losing the free retirement tail, or more formally known, as extended reporting period.

This example, and many more like it, justifies the need for an experienced, trusted professional to be an advocate for the doctor as they, together, navigate the medical malpractice insurance marketplace. This knowledge retained by the broker could accurately be explained by trading the roles between a doctor and a broker. An insurance broker probably has had several check-ups throughout his life, given by his doctor. He has been through the process and has an elementary grasp on the steps and tools used through the medical examination. However, because the broker spends his days working with insurance instead of with patients, it would be unrealistic to believe he would possess the knowledge and skills to perform a physical remotely comparable to the high standards of a trained and experienced medical professional. In the same way, since the doctor rightfully spends his or her time in the medical field as opposed to studying the intricacies of the medical malpractice insurance market, the benefits of a broker start to become more obvious.

### **How is Your Broker Compensated?**

It is, however, beneficial for a doctor to know the motivation driving their broker. One of the most common questions a doctor has for his or her broker is "*How are you compensated?*" While a quick response of, "*I charge \$500 per hour and your invoice is in the mail*" usually draws a laugh; the question is a good one. Most brokers are compensated by whichever medical malpractice insurance company that the doctor, after making an informed decision based on the broker's options, ultimately purchases a policy from. The broker then becomes a no-cost recourse for the medical professional. If a doctor had, through intense study and experience, intuitively known which company was able to offer the best quotes, balanced with financial viability, purchased a policy directly from the medical malpractice insurance company, assuming said company worked directly with doctors, the premium would be no less expensive than the one purchased through a broker. In other words, the medical malpractice company does not add or subtract premium depending on whether a policy is sold direct or through a broker. In most states, admitted carriers are actually required to offer the same premium quote to doctors regardless of whether the physician or surgeon gets coverage directly with the physician malpractice insurance

company or through a broker.

### Why Use a Broker?

Brokers who specialize in medical liability insurance should know the coverage, the policy and the available discounts inside and out. Each doctor's practice is a little bit different and carries unique risk. The purpose of a *medical malpractice insurance policy* is to cover the physician or medical practitioners risk of a liability suit. While physicians are experts in medicine, they are generally not experts in medical liability and the risks associated with it. In this highly litigious society and career, doctors should not purchase a policy assuming it is right for them and then keep it in the filing cabinet until they need it. Doctors should work closely with their broker to assess the risks they have in their practice and work together to find the best coverage.

Each state has its own tort reform rules and regulations, and risk can differ drastically between counties. Some states allow physicians to carry very low limits of liability, as low as \$100,000/\$300,000. While the physician might be practicing within the law, these low limits might not be what are best or required by another entity such as a hospital for that physician's practice. Another integral part of a physician's medical practice is risk management. Not all medical malpractice insurance companies are the same, nor are their risk management departments. Some medical liability insurance companies have free risk management services that can significantly reduce a physician's risk of a medical malpractice claim. Physicians should choose a medical liability insurance broker who shows genuine interest in helping the physician transfer their medical malpractice risk to the appropriate physician malpractice insurance carrier, and work together to find the best risk management tools for the medical practice.

### Brokers: the Medical Professional's Liability Liaison

Brokers work directly with underwriters to get the best policy coverage and lowest rates possible for physicians. Many physicians inaccurately assume that brokers have the power to lower their rate, or that brokers can pick and choose their premium rate. The large majority of physicians are insured with admitted carriers; therefore admitted carriers are highly regulated by the department of insurance in their respective state. Underwriters use debits and credits along with the filed rate to determine the physician's premium. It is important for the broker to work with underwriting to make sure that the physicians are getting all of the credits that are available to the physician. The broker does not set the rates, he or she simply works to make sure the best rates apply to the physician they are working with.

*Paying the premium for a medical malpractice insurance policy is often a difficult reality for many physicians, surgeons, hospitals, and medical clinics.* While many medical liability insurance companies offer payment options such as quarterly or monthly payments, many of them do not. It is usually incumbent on the broker to find and present financing options for the physician. Good brokers are partnered with premium finance companies that offer financing options specifically for medical

malpractice insurance policies. These premium finance companies offer several payment options for the physician. Most common are monthly and quarterly payment plans. These premium finance companies charge an interest rate on the money that is loaned. Typically the rates that they offer are significantly better than most other loan options.

Brokers are also responsible for many other services that are a necessary part of medical malpractice insurance, including providing certificates of insurance, monthly invoices, hospital credentialing requests, working with claim departments, and working directly with underwriting to make sure that the physician's corporation is covered properly. Many medical liability insurance companies rely on brokers to provide certificates of insurance to both the physician and any hospitals or clinics that require proof of coverage taking work off of the shoulders of the physician's medical staff.

### Transaction or Important Practice Protection

The next important quality in a relationship between a broker and a doctor is more philosophical than tangible, but it is still important. The broker's understanding and disposition towards the job he is doing is of the utmost importance. To expound, a good broker will understand what this "transaction" of money for a promise and a piece of paper actually means for a doctor. Many brokers see a sale of *medical malpractice insurance* simply as a transaction they facilitate, and while that is, on the surface technically true, this sale represents so much more. While no doctor should expect their broker to be totally understanding of the emotional implications that come with purchasing coverage, since most brokers have never purchased medical malpractice insurance for themselves, empathy is key. It is advantageous for a doctor to work with a broker who realizes the importance of the policy being sold; someone who understands the policy being sold is essentially a line of important defense needed to protect the medical practice the physician has built. During the policy purchasing process, the doctor is writing a check for thousands, sometimes tens of thousands, sometimes hundreds of thousands of dollars in premium, for a promise from the medical malpractice insurance company, to protect a doctor and his or her medical practice in the event of a lawsuit. While spending that kind of money is significant in any circumstance, it is what that money purchases and ultimately represents that matters. *Medical professionals spend countless hours building their practice, after going to school for years, many times graduating with significant debt in an ultimate effort to care for their patients.* After all of that effort, money and time, no doctor would want to, in any way, endanger their practice by purchasing something inadequate or unable to satisfy the specific needs of their practice. That said, a broker who understands the significance of these policies, when compared to one that simply sees transactions, will ultimately be better poised to listen to and serve the specific needs of his clients. Keep in mind, most brokers act in an ethical way, working in the best interest of their clients. At its core, the job of a medical malpractice insurance broker is to be an experienced, ethical advocate for the doctor in the professional liability marketplace.

## 7 THE APPLICATION PROCESS

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### The Medical Malpractice Insurance Application Process

Applying for medical malpractice insurance can be a daunting task, culminating with the 20+ page application that most medical liability insurance companies require. Having a basic understanding of the application process, the doctor's responsibilities, the responsibilities of a broker and inner workings of the medical malpractice insurance company will help alleviate anxiety in the traditionally laborious process of applying for professional medical liability coverage.

### Getting a Quote for Your Medical Malpractice Insurance Policy

The medical malpractice insurance application process starts with a quote or an estimate of a doctor, surgeon or medical professional's potential premium. Quotes are generally produced by brokers working on behalf of the doctor. With a network of relationships in the medical malpractice insurance market, with limited information, a skilled broker can seek out which physician malpractice insurance company will offer the best rates to a doctor. Generally, the basic information needed includes:

- The doctor's specialty (Does the doctor perform surgery?)
- The county and state in which the doctor practices
- The type of insurance sought (claims made/occurrence)
- Retroactive Date (claims made) -or- Effective Date (occurrence)
- Is the doctor board certified?
- Limits of Liability Desired •Claims History

The above list constitutes the general information needed by a medical malpractice insurance company to generate an accurate indication. The broker then utilizes several methods of communication with different insurance companies to develop a set of options for a doctor. That said, a seasoned medical malpractice insurance broker will quickly have a general idea of the optimum company for the specific physician or medical practice presented simply through experience in the market.

Keep in mind that these quotes, or more accurately "indications" are not binding and are all subject to a completed application. It is in the medical malpractice insurance company's best interest to make the quotes as accurate as possible; too high and they will not receive an application, too low and their potential client will be frustrated by a perceived "bait and switch" when the final premium is returned after an application. A medical liability insurance company is essentially making its best guess regarding a specific doctor based on the limited information it has available without a full application. However, unless unforeseen factors are presented in the application, most indications will

be relatively accurate, if not a bit high as additional discounts can be applied from the information in the application.

### The Application & Supporting Documentation

After the broker spends time conversing with the doctor about the available options and quotes, a decision is reached and a medical malpractice insurance company is chosen. At this point the doctor generally is asked to complete two documents. The first one is the application for that particular medical malpractice insurance company. Every insurance company has their own application, in other words there is no "universal application" that all medical liability insurance companies will bind coverage from. However, applications from other companies can sometimes be used to provide an accurate quote, pending a completed application of the desired insurance company.

The second document the doctor will generally need to fill out is called a "Consent to Release" form. All insurance companies will require what is called "loss history" or "claims history." A "claims history" is a description of any claims that have been made, tried or settled within a certain timeframe, usually 5 to 10 years. These claims histories can include everything from whether a case was dismissed, sent to trial, settled or closed and what the defense expenses and indemnity payments cost. Essentially every medical malpractice insurance company in the country will require these histories before issuing coverage to a medical professional as a method of confirming what the physician states on their application. Additionally, it is the broker's job to acquire the claims history, and this process can generally take several weeks. As the broker's team contacts all previous physician malpractice insurance companies, the prior insurance companies are allotted a certain number of days to send the claims history to the broker. Generally, the limit is 14 days but can be as high as 40. In a case where medical malpractice insurance coverage is required in a short timeframe, it is crucial to start this process as early as possible.

Most *medical malpractice insurance* applications generally ask the same questions which essentially are seeking more details about the original questions a broker asked as discussed above. Each application will ask for:

- The medical professional's name and practice information
- The doctor's license and professional information (American board certification, education)
- Specialty information (specialty, procedures, number of patients, etc)
- Practice information (ancillary personnel, entity coverage, part time/full-time, location)
- Loss History and Insurance History
- Previous Policy Information (retroactive dates, limits of liability, policy coverage dates)
- New Policy information (limits)
- Hospital Admitting Privilege information

### Important Information to Keep in Mind While Applying for Medical Liability Insurance Coverage

While going through the application process and divulging the details of a medical practice, the physician must keep several things in mind. The following is a short list of key points will help protect a doctor as he or she applies for medical malpractice insurance.

A medical malpractice insurance application should be treated as a legal contract. Many doctors have lost their coverage due to inaccuracies, omissions, or understatements in an application. These imprecise answers range anywhere from simply forgetting some inconsequential information to a flagrant exclusion of prior claims or lawsuits. In EVERY medical malpractice application and policy, language is present that nullifies the contract in the event of a doctor intentionally misleading the insurance company. Therefore, if there are intentional inaccuracies that could have swayed an underwriter's decision, the medical professional is essentially paying a premium for medical malpractice insurance coverage that legally has no obligation to cover his or her practice. Keep in mind that your medical malpractice insurance broker is your advocate to the insurance companies. If the broker has all of the information up front about a physician, he or she can position the physician in a more positive light in to an insurance company underwriter than if negative information is made known for the first time, for example, in the loss history reports much further into the underwriting process.

Relationships are everything in the medical malpractice insurance market and any interaction between a doctor and an insurance company directly, through the broker or through the application will either enhance or detract from that relationship. Every medical malpractice insurance application is viewed by an underwriter, a highly trained employee of the medical liability insurance company responsible for accepting or denying every application that is submitted. The underwriters assess the risk a doctor presents to the insurance company. From the initial application to any follow up conversations and documentation, the underwriter is formulating an impression of a doctor. While it is the broker's job to be an advocate to the underwriter on behalf of the doctor, it is the doctor's responsibility to allow the broker to do that in an efficient and accurate way. Additionally, underwriters generally are not fond of surprises or being presented with conflicting information. In other words, the doctor's experience while buying medical malpractice insurance can be made more palatable and straightforward if consideration is given to the importance of the underwriter's judgment.

Always give ample information. Underwriters do not like to play guessing games with medical malpractice insurance applications. The more information a doctor can provide about their practice, procedures, history and training, the more satisfied the underwriter will be. Since the underwriter has the final say on issuing the premium and offering coverage, allowing the underwriter's job to flow as smoothly as possible will ultimately make the doctor's application experience smooth. In addition it is important to remember that underwriters are human and associate the quality of the application submission with the physician that they are considering offering medical malpractice insurance to. The more thorough and well completed application submission, the better the impression the underwriter will have of the doctor applying for coverage. A current and detailed CV, and well

documented claim narratives are very helpful. Underwriters also like to see that a physician finds risk management to be an important part of their practice. Doctors should include a copy of any risk management courses or CME's they have completed within the last 12 months. Good quality risk management reduces the risk of a claim. Since physician malpractice insurance carriers are in the business of cover physicians for medical malpractice claims that they receive, the lower the risk the carrier has of paying the claim the better. The ideal situation for any medical liability insurance company would be to cover physicians and never have to pay a claim. This of course will never happen, but it is the intention of underwriting departments to select physicians and surgeons who carry the lowest risk. Physicians who show they highly value risk management in their application submission have a much greater chance of receiving coverage at a lower premium rate.

Ask questions. The medical malpractice insurance market is dynamic and complicated and ultimately, the doctor is responsible for making the right decisions as they relate to his or her medical practice. Your broker is there to be a resource and a guide. If you have questions about your medical malpractice insurance coverage, filing a claim, or a confusing or legally worded question on an application, do not be afraid to ask for guidance or clarification.

After an application has been completed and the loss runs retrieved from any previous insurance company, the documents are sent to the underwriter as what is referred to as "a submission." The underwriter will assess the risk of the applicant to the medical malpractice insurance company and determine an appropriate premium based on statistically generated premium rates for the specialty and location of the medical practice.

As an aside, it must be understood that medical malpractice insurance companies are actually providing a service to doctors. While, from the doctor's perspective this may not always seem to be the case, medical malpractice companies are, for the most part, essentially managing risk to protect doctor's against claims. The insurance company is a business and does make a profit for absorbing this risk as it should, but make no mistake, they are under no obligation to stay in business and continue providing coverage to doctors, just as a doctor is under no obligation to continue treating patients for a profit. In fact, it is actually the medical malpractice insurance companies that are usually at the forefront of advocating tort reform in an effort to control costs and reign in the extreme volatility of the market. While not every medical malpractice insurance company operates ethically, most do prioritize the best interest of their clients.

### **"Bindable" Medical Malpractice Insurance Quotes**

After the submission has been assessed by the underwriter, he or she will issue a "bindable quote." A bindable quote is a formal offering of coverage for a set price to the doctor. In addition to the price, the policy form that is being offered is also included with the bindable quote. The doctor has the final say on whether or not he or she will accept coverage. If the doctor opts to accept the coverage, the insurance broker will bind coverage upon receipt of the signed paperwork and premium payment. Please note that no coverage is in force until coverage has been bound. For example,

if a doctor sends in an application on 3/25 and wants to start practicing on 4/1, a bindable quote probably will not be issued in time as the application process usually takes a minimum of two weeks, however an experienced broker may be able to bind coverage sooner. The doctor may choose to start practicing before coverage is issued with the intention of backdating the effective date to 4/1, however it must be understood that until a bindable quote is issued, the doctor is uninsured.

After coverage has been bound and at least a portion of the premium has been received, the broker or insurance company will issue a "Certificate of Insurance." *The Certificate of Insurance acts as the physicians proof of coverage and a stand-in until the physical policy is drafted by the medical malpractice insurance company.* The doctor is responsible for making all premium payments on time, if not there is a risk that the policy will be canceled and coverage will be cancelled.

While the application procedure may seem daunting, a knowledgeable and experienced professional liability specialist will be able to guide a doctor through the entire process with minimal interruption or anxiety.

## 8 CLAIMS MADE VS OCCURENCE POLICIES

### Policy Form & How it Affects Your Practice

In the domain of medical malpractice insurance, there are two main policy forms that are prevalent in today's market; claims-made policies and occurrence policies. While the ultimate goal of each is to protect a doctor and his or her practice, the process and execution of this task differs significantly. The question is often posed, "Which is better for my practice?" While there is no cookie cutter answer to this quandary, certain variables within a medical practice can provide an indication as to which would be better suited for a doctor's specific needs.

It should also be understood that most medical malpractice insurance companies in America have moved towards the claims-made policy form and therefore in many states, the claims made policy will be the most prevalent and readily available option. The occurrence policy form is more prevalent on the East Coast.

### What is in a Name? The Difference Between Claims-Made & Occurrence Policies

The main difference between these two policy forms can be derived from their names. If a doctor has a claims-made policy, he or she must have insurance in force whenever a medical malpractice claim is made, an event which can happen years after the incident that caused the claim took place. Similarly, with an occurrence policy, the insurance coverage must be in force when the incident or "occurrence" that caused the lawsuit transpired.

The occurrence policy was historically the most prevalent medical malpractice insurance policy.

It is simple to understand in the fact that a doctor only needs an active insurance policy while he or she is actively practicing. For example, if a doctor practiced for the duration of 2011 and had an occurrence policy for that year, the doctor would be protected against lawsuits brought by a patient for any adverse incident that occurred in 2011 no matter when the case was actually filed against him or her. If the doctor stopped practicing and did not renew the policy any *medical malpractice claims* brought 2012 and beyond would be covered. If the doctor continued practicing, but switched to a different medical malpractice insurance company in 2012, the original insurance company would still pay for any claims from incidences that occurred in 2011.

### **The Differences Between Current & Future Liability in the Ever-Changing Medical Malpractice Legal Environment**

While this medical malpractice policy form is relatively simple to understand, its main drawbacks became somewhat disconcerting to many insurance companies. Since the time of the policy period can be years before a medical malpractice claim is made, it can be difficult for an insurance company to predict the future liability that could be incurred. The frequency and severity of medical malpractice lawsuits can fluctuate dramatically in a short period of time do to several factors, the most prevalent of which is tort reform or the lack thereof.

For example, Illinois General Assembly passed a law in 2005 capping medical malpractice non-economic damages at \$500,000. If a doctor in Illinois had an occurrence policy that was in-force and priced for a legal environment with no caps and this legislation passed, the risk during a lawsuit would be lower for the insurance company due to lower potential payouts. In this case the doctor's premiums would have been too high for the potential risk experienced in court. However, in February 2010 the Illinois Supreme Court struck down this legislation in the case *Lebron v. Gottlieb Memorial Hospital*, effectively removing any caps on liability payments. If an occurrence policy was purchased while the caps were effective, but at a later date, the caps were removed the occurrence policy would be subject to a higher amount of risk that the *medical malpractice insurance* company would need to absorb. While the limits of a past occurrence policy would not increase with a changing medical malpractice environment, the lack of caps can breed an atmosphere of higher average payouts resulting in increased cost and uncertainty for the insurance company, which ultimately needs to pass its costs on to the policy holders. While this type of policy is generally more difficult for the insurance company to manage, it does provide several key benefits to the doctor. Primarily, its simplistic nature is attractive to doctors who do not want to worry about or manage their medical malpractice insurance. Compared to a claims-made policy, an occurrence policy can be described as "set it and forget it," meaning the doctor does not have to worry about purchasing a tail, covering retroactive dates.

### **The Conception & Current Aspects of Claims-Made Policies**

The uncertainty eventually made way for the claims-made policy form. As previously stated, the claims-made policy needs to be in force or active not only when a lawsuit causing incident occurred

but also when the medical malpractice insurance claim is made. From the insurance company's standpoint a claims-made policy is much simpler to account for due to the fact that the insurance company knows if any lawsuits will arise and what potential liability is present from that specific policy at the end of the policy period. This policy form does allow the insurance companies to more accurately assess their future financial needs.

The claims-made policy operates off of a specific date, called the retroactive date. The retroactive date signifies the start of the insurance policy's coverage and is the first day of the first year of a claims-made policy. Both the claim causing incident and the claim itself must take place on or after the retroactive date in order to be covered by the insurance company. Since both the incident and the claim must both happen within the time span of one policy, every subsequently purchased claims made policy will retroactively include all the time in the past back to the retroactive date. In other words, a doctor who buys a claims-made policy on 1/1/11 will have insurance until 1/1/12 with 1/ 1/11 being the physician's retroactive date. In order to ensure any potential claims from incidences occurring in 2011 would be covered, the doctor will need the 2012 claims made insurance policy to include all time in the past back to the retroactive date. Ergo the 2012 policy will actually cover two years, 2011 and 2012. Likewise the 2013 policy will cover 3 years and so on, every year basing the new policy on the retroactive date.

It is for this reason that the claims made policy sports its most attractive option, low initial premiums. Since the first insurance policy only has one year's worth of risk from just one year's worth of patient exposure, it carries with it less risk to the insurance company than the policy in year 2. This is because the new policy covers all time back to the retroactive date and carries 2 years worth of risk. Year 3 will carry three year's worth of risk and so on. Since medical malpractice insurance companies set their premium rates as a function of the amount of risk they are exposed to, the first years of a claims-made policy will cost less than later years simply because there is less risk of having to defend a lawsuit. This growing risk will eventually plateau between 4 and 8 years after the retroactive date, at which time the claims-made policy is said to be "mature" and the premium paid by the medical professional will be "mature." Generally, the mature premium is comparable to the occurrence policy for the same specialty and location, meaning the doctor was able to save a considerable amount of money over for the first few years of a practice compared to the occurrence policy. For example, if a doctor straight out of residency has received a quote of \$10,000 for an occurrence policy, initially he will pay about 25 percent of that for a claims-made policy, roughly \$2,500. In year two the occurrence policy will still be \$10,000 but the doctor will only pay about 50 percent of that or roughly \$5,000. In year three, the doctor will pay about 75 percent of the stagnant occurrence premium or \$7,500. Somewhere between year 4 and year 8 the premium will approach and may overtake the occurrence premium and the claims made policy will be around \$10,000 as well. This premium and policy are said to be mature. The claims-made policy holds steady at the mature rate for the duration of the doctor's claims-made policies barring additional risk by the doctor, changes in the medical malpractice market, or cheaper rates being offered by a different company. Through all of this, the doctor in the example was able to save a significant amount of money in the first few years of the claims-made policy.

## The Claims-Made Policy's Tail Explained

Despite the significant savings at the beginning of a claims-made policy, it is important to remember that coverage needs to be in-force when a claim comes in. Since claims can be made years after the incidents that cause them, a mechanism is needed in cases where a doctor stops practicing. If a doctor retires or ceases practice, he or she still needs coverage. For example, if a doctor has practiced for 40 years and ever year has purchased a claims-made policy, retires and does not buy any more insurance, the doctor is exposed and liable for any lawsuit that arises, hence the need for a medical malpractice insurance tail. Otherwise known as an extended reporting period, a tail covers a doctor after he or she has stopped practicing since lawsuits can still be brought. Remember on a claims made policy, coverage needs to be in force, covering the time when the incident happened and when the claim is made.

*Tail coverage can be expensive, generally 150 through 200 percent of the previous year's premium.* Essentially, the money saved in the beginning of the claims made policy will be roughly equivalent to the cost of the tail at a time where the doctor is no longer bringing in income from the medical practice. However, there are ways to avoid buying a tail. While death or disability will generally earn a doctor a free tail, most opt for a third, less taxing option. Many insurance companies will offer a free tail if a doctor stays with that insurance company for 5 subsequent years prior to the doctor's retirement. And while each medical malpractice insurance company has its own rules and specific stipulations, this is the generally accepted practice. That said, a medical professional should be aware of this provision and plan accordingly in the final years of a practice. Saving 10 percent in premiums by switching to a new medical malpractice insurance company within that final 5 years may seem attractive at the time, however if that action will forfeit a free tail worth 150 to 200 percent of the premium, it may not make long term fiscal sense.

## Know How Your Medical Liability Insurance Policy Form Will Affect Your Practice

As a medical professional, it is important to understand how your medical malpractice insurance policy form will affect your decision making in the future. The following are some general guidelines when deciding between these two policies.

1. Without earning a free tail, over time the occurrence and claims made policies will cost roughly the same.
2. If a doctor is in a position to take advantage of the free tail and low initial premiums, a claims-made policy may be the most fiscally sound option.
3. If a doctor does not want hassle with purchasing a tail after retirement when income from his or her practice has ceased or would rather simply spread the cost out over his or her career, the occurrence policy may be the better option.
4. Claims-made policies are portable, occurrence policies are not. A doctor's coverage, back to the retroactive date, can be completely moved to a new insurance company

- at any time. Once an occurrence policy is purchased, the liability and responsibility stay with that specific insurance company.
5. Claims-made policies are easy to get into with the initial low premiums, but hard to get away from due to the tail. Choosing a claims-made policy will make it difficult to switch to an occurrence policy (if available in your state) at a later time. It is easy to go from an occurrence policy to a claims-made policy, not the other way around.

Essentially, the claims-made policy and the occurrence policy both have advantages and disadvantages. Both are perfectly acceptable to use, however certain situations can cause one option to be much more reasonable than the other. A medical professional would be well served to understand both and approach the options with a long term perspective.

## 9 HARD MARKET VS SOFT MARKET

### The Hard & Soft Markets of Medical Malpractice Insurance

Medical malpractice insurance companies go through what is commonly referred to as “hard markets” and “soft markets.” The “hard” and “soft” refers to the cycle that the market experiences and is dependent on how many medical malpractice claims are being reported to medical liability insurance carriers. A hard market refers to the part of the cycle where a high number of medical malpractice claims are being reported. Conversely, a soft market refers to the part of the cycle where there very few medical malpractice claims being reported. It is important to note there are many theories and reasons why the medical liability insurance market goes through these cycles. This chapter will discuss the theories and reasons for the hard and soft markets while conveying the fact there is no singular, simple answer as to what definitively triggers and changes the medical malpractice market.

### Tort Reform or Lack Thereof is a Key Component of the Hard & Soft Markets Experienced by Medical Malpractice Insurance Companies

The most prevalent and most debated reason for market's sway between hard and soft periods is tort reform. Tort reforms are put in place by governments and periodically removed by courts, ultimately having a big impact on the number and severity of medical malpractice claims ultimately filed by plaintiff attorneys. Governments push to put laws in place reforming the medical malpractice tort system in an effort to improve patient access to physicians, surgeons, specialists and medical health providers. Physicians who have high medical malpractice insurance premiums or who practice in a highly litigious county have a higher percentage chance of leaving their county to practice in another state where the tort reform laws are more favorable. Simply put, tort reform established by state lawmakers to change the legal procedures and laws encompassing medical malpractice in an effort to prevent or avoid lawsuit abuse and make medical malpractice insurance more affordable.

For example, Texas is currently considered the pinnacle of effective tort reform and a forum upon which other state government should base their own tort legislation. In the years after Texas enacted their effective tort reform, the *Texas Medical Board* saw a huge influx of physicians requesting to be licensed to practice medicine in the state. Texas tort reform has brought patients access to more physicians, surgeons and health care providers by creating an environment where the heaviest medical malpractice insurance burdens experienced by doctors in other states have been alleviated.

### What Specifically Does “Tort Reform” Actually Reform

Tort reform carriers with it certain specific issues that are championed from state to state. Non-economic damage caps, or pain and suffering damage caps as they are more often referred to, are typically the integral part of tort reform. Most state lawmakers push to cap the amount of non-economic damages that a patient can win in a medical malpractice claim. Most states aim for non-economic caps of \$250,000. Pain and suffering damages are different than economic damages and most states do not seek to cap economic damages. Economic damages refer to lost wages, out of pocket expenses, medical bills, future earnings, etc. The amount of pain and suffering damages that medical malpractice insurance companies pay as a result of an award from a medical malpractice claim varies significantly from county to county and jury to jury. Many people with opinions in favor of non-economic damage caps believe that jury's are easily swayed by seasoned plaintiff attorneys; therefore a jury's feelings of sorrow translate into large awards. Non-economic damages do not have easily identifiable losses and are generally a matter of opinion. People with a persuasion against non-economic damage caps purport that is unconstitutional for lawmakers to decide the amount of damages that a plaintiff can win in a court. They argue that only a jury can make that decision.

It is important to note that pain and suffering caps are very efficient if the goal is to reduce medical malpractice insurance premiums. The goal of lawmakers is not to limit compensation to patients who are seriously injured as a result of medical malpractice. Their objective is to reduce the amount of frivolous claims that medical malpractice insurance companies must defend. *On average, over 80 percent of claims defended by medical malpractice insurance companies are dismissed with no indemnity payment made to the plaintiff.* Most people who are interested in filing a medical malpractice claim are not aware of the tort laws; however the plaintiff attorneys representing those claims know the state specific legislation very well and are able to efficiently work within those laws to receive a payout from the insurance company representing the doctor defendant. When tort reform is enacted, specifically with caps on non economic damages, plaintiff trial lawyers are not nearly as willing to take on cases. Since the award potential is much lower, plaintiff attorneys become very selective on the cases they take. Patients with cases that have a low probability of winning an award have a much more difficult time finding a plaintiff attorney willing to help in a lawsuit. Therefore fewer claims must be defended by medical malpractice insurance companies. This will reduce frivolous lawsuits. The fewer the number of claims a medical malpractice insurance companies needs to defend, the lower the company's expenses. As the insurance companies in the state become more

competitive due to the lower expenses, the savings will eventually be passed along to doctors in the form of lower premiums. This lowers operating costs for doctors and ultimately achieves the goal of the lawmakers by promoting an environment which is conducive to doctors in order to provide more access to healthcare for the citizens of the state.

### **Insurance Medical Malpractice Lawsuit Venue Shopping Explained**

Venue shopping is the informal term used when describing the practice plaintiff attorneys use while trying to get a medical malpractice claim filed in the most liberal county, seeking a more favorable and profitable judgment. This method is often to the great frustration of doctors, surgeons, nurse practitioners, physician assistants, hospitals, and all medical providers involved in a medical malpractice claim. It is very rare that a plaintiff attorney will file a claim naming just one doctor in the lawsuit. It is more common that the trial lawyer will name every medical provider that is connected to the patient in an effort to get the claim filed in the county that is most friendly to large medical malpractice awards. Instead of just one doctor or medical practitioner having their medical malpractice insurance company defend the case, there are numerous carriers all defending the same claim costing significantly more in legal defense costs. Medical malpractice insurance defense attorneys are highly specialized and charge expensive hourly rates. These legal costs contribute to the expenses incurred by medical liability insurance company and ultimately the doctor's who need to purchase coverage. The difference in how liberal courts rule from county to county is staggering. It is common for a medical malpractice insurance premium to be 5 times higher in the neighboring county simply because of difference in liberal awards from one court to the next. Venue shopping is a target of lawmakers with most tort reform models.

Tort reform plays a significant role in medical malpractice insurance company premiums as the amount of claims in the system is significantly reduced when tort reform is in place. The medical malpractice insurance market is usually in a soft market when strong tort reform is in place.

Hard markets are typically the reason why tort reforms are put in place. When the medical malpractice insurance market is very hard, premiums go up, often at tremendous rates. Doctors flee the state seeking to practice in a less litigious environment where the medical liability insurance premiums are affordable. Counties such as *Cook County Illinois (Chicago)*, *Dade and Broward County Florida (Miami)*, *Hidalgo County TX*, and *Kings County NY (Brooklyn)* have seen premium spikes resulting in coverage that has become almost unaffordable for some physician to practice in these counties. For example, many OBGYN's were forced to pay over \$200,000 per year just for their medical malpractice insurance. Patients in these counties had very limited access to many surgeons and medical specialists due to the medical malpractice environment in which doctor's were asked to operate.

### **What Happens When a Hard Medical Malpractice Market Starts?**

It is important to remember that medical malpractice insurance companies collect premiums today

based on what their actuarial assumptions are of what they will pay in claims several years from now. It takes several years for most cases to get through the court system. Therefore a claim received today, will likely not be resolved for several years. As plaintiff attorneys find liberal judges and juries, they begin to aggressively file medical malpractice claims and advertise for their services, ultimately making it easier for patients to find attorney representation for their medical malpractice case. The number of claims that are filed during the beginning of a hard market tends to escalate very quickly. This forces *medical malpractice insurance* companies to take on more staff and hire more defense attorneys, raising their expenses. As the claims continue to pour in the medical malpractice insurance company's surplus gets drained very quickly by paying for the legal defense costs and indemnity payments from claims. Carriers tend to panic as they realize they did not collect enough premiums to cover all of the claims and they quickly file for significant rate increases. The department of insurance must approve all rate increases for admitted carriers. If the state guarantee fund is in danger having to pay claims if many of the admitted carrier becomes insolvent, the state has added incentive for approving the rate increase as a result of the importance of keeping the guarantee fund solvent.

Physicians who have claims during a hard market are not as attractive to insurance companies while trying to secure medical malpractice insurance. *Often these physicians will see steep double digit percentage increases in their premium.* For example, a physician who receives a claim might lose his claims-free credit of 20 percent and in addition have a 25 percent rate increase from his medical malpractice insurance company. A 45 percent increase prompts the physician to seek other medical malpractice insurance companies for coverage but finds that other medical liability insurance carriers are not as interested in covering him since he has an open claim. This leaves the physician with no choice but to pay the significantly higher premium.

Medical malpractice insurance carriers have been known to increase rates by several hundred percent in just a few short years. These premium increases put strain on doctors, clinics, surgery centers, and all medical practitioners forcing them to seek alternatives. Often the alternative that makes sense for many health care providers is to move to another state that boasts a less litigious environment where the medical malpractice insurance is affordable. As physicians leave the state, patients are left with depleted health care availability. This lack of available doctors and specialists prompts state lawmakers to step in and pass tort reform in an effort to quickly bring down medical malpractice insurance premiums.

### **How Does the Market Transition from Soft to Hard?**

Soft market periods bring physicians and surgeons lower medical malpractice insurance premiums while also presenting more consistent profits for the carriers as the insurance company can more accurately assess future liability and price their products fairly and accordingly. These are obvious positives for all parties involved. Therefore it is worth exploring how the mutual benefits of a soft market can spiral out of control and into a hard market. The answer is found most often when tort reform is struck down by the court system, generally on the constitutionality of tort legislation, the number of claims that will be filed rises. Plaintiff attorneys work hard to get tort reform "thrown out"

by a judge, especially if it is being challenged before the Supreme Court in their respective state. As mentioned previously, it takes several years for a case to reach finality, and even longer if the case is heard by the Supreme Court. Plaintiff attorneys work together and pick the best case they can when attempting to get tort reform thrown out.

*The most common case that is used to test tort reform is a "bad baby case."* A bad baby case refers to a lawsuit the plaintiffs often win in connection to a failure to timely perform a cesarean section. This often results in a brain damaged or otherwise severely injured child. Juries tend to sympathetic to the mothers in these cases and award a large sum of money. Plaintiff attorneys argue that the pain and suffering that this mother and family will go through for many years can not have a price limit on it, and that state lawmakers cannot determine what that mother and family's pain and suffering is worth. The supreme courts often agree that it is unconstitutional for the legislature to decide the amount of damages that can be awarded, and that the constitution states that only a jury can make that decision. Once overturned by the Supreme Court, the caps are no longer in effect. The real tragedy in these cases is that the tragedy experienced by mother and her child is used as a pawn by the trial lawyers in an effort fosters a more lawsuit-friendly environment.

### **How The Soft Market Affects A Doctor**

During periods of soft markets, medical malpractice insurance carriers become very aggressive as they seek market share. Often new *medical liability insurance* carriers are formed or carriers from out of state begin to offer coverage in the state. While this drives premium prices down, the competition can sometimes have an adverse effect. Medical malpractice insurance carriers operate based from revenue equaling the total amount of premium that they receive from their physicians, otherwise referred to as insured's. If the medical malpractice insurance company's total premiums levels drop significantly, which often happens during a soft market their operating capital drops as well. In an effort to raise revenue, the insurance company must take a larger share of the market and insure more doctors. The best way to do this is to have the most competitive premiums. This forces medical malpractice insurance carriers to aggressively price their premiums for both their renewals and for new insured's they are seeking to cover. During very soft periods, or at the "bottom" of the soft market, all of the medical liability insurance carriers are pricing the premium for their insured's too aggressively. As soon as there is an uptick in the claims they receive, the premium they have been taking in is inadequate. Before long, the carrier must raise rates or risk insolvency effectively ending the soft market.

There are many other factors that trigger market change between hard and soft. Several reports that have attempted to show the correlation between medical malpractice insurance companies and interest rates, the general health of the overall economy, and the state of the stock and bond markets as they relate to the hard and soft market cycles. To this point, these cycles have never been accurately predicted and no one knows exactly when the changes in the medical malpractice market will occur. It is however, beneficial to understand and recognize the signs that are indicative of change.

## 9 REPORTING A CLAIM TO THE MEDICAL MALPRACTICE INSURANCE COMPANY

### Notifying a Medical Liability Insurance Company of a Claim

Unfortunately, medical malpractice claims are a reality of modern medicine. Physicians and surgeons do not have to make a mistake to be sued and as a result, medical malpractice insurance defends tens of thousands of claims every year. More than 80 percent of those medical malpractice claims are dismissed with no indemnity payment whatsoever to the plaintiff. While the statistics are on the side of the doctors, receiving a medical malpractice claim is common and there are important steps that doctors must take when they receive a claim.

### What a Doctor Needs to Know When a Claim is Made

When a physician, hospital or clinic receives a summons they are required to appear in court to answer the charges that have been made in the complaint. Fortunately, doctors have medical malpractice insurance for these situations.

Important steps that must be taken: A doctor who receives notice of a claim should notify their medical malpractice insurance carrier as soon as possible. The summons given to a doctor that accompanies a claim also comes with a deadline stating when the doctor must have an appearance filed with the court. If an appearance is not filed in time a default judgment can be issued. Notifying the medical liability insurance company that is responsible for covering a claim starts by sending a copy of the summons directly to the medical liability insurance carrier.

Most carriers will ask the physician, hospital or medical provider to fax a copy of the summons to the claim department. It is important to follow up and make sure that the fax went through and that the claim was officially received and acknowledged by the claim department. Some medical malpractice insurance companies accept claims via a scanned copy attached to an email and sent to the claim departments email address. This email address will be specifically for claims. Again, it is important to follow up with the claim department to verify that the email went through and was officially received. Sending your claim via fax or email directly to your medical malpractice insurance broker is also an acceptable so long as the doctor follows up with the carrier to make sure the claim was properly received.

### Claim Narrative

Medical liability insurance carriers will also ask for a brief summary or claim narrative from the physician. This summary should state the care that the doctor gave to the patient and what complications resulted from the treatment. This can be included with the summons when faxed, or it can be sent separately. The claim summary is not a requirement to have a claim accepted by the medical liability insurance company but is an important first step. Some carriers have a claim form

that they require when a doctor sends in the claim narrative, and some insurance companies require the claim form to be notarized.

### Medical Records Chart

It is very important that physicians do NOT alter or change the medical records in any way. It is tempting for physicians to look through the patients chart and examine it for any errors and then change the chart so it reflects better on the physician. If the physician is proven in court to have altered the medical record, it becomes very difficult for the physician to be defendable in front of a jury.

Once the claim has been received by the medical malpractice insurance company, they will assign an attorney to represent the doctor for the case. It is important that the physician work hand in hand with the defense attorney. The attorney will guide the physician through all aspects of the claim and court experience. Physicians should make sure that they consult with their attorney before making any contact with the patient and make sure their attorney is present for depositions.

Which medical malpractice insurance carrier should be notified: As discussed previously, there are two different types of medical malpractice insurance policies; occurrence policies and claims-made policies. A medical liability insurance company who insured a physician under an occurrence policy is required to cover medical malpractice claims that arise from incidents that occurred while the policy was in force. Therefore, if the physician receives a claim and the incident occurred while that physician was insured by an occurrence policy, that claim should be sent to the medical malpractice insurance company who issued that occurrence policy. The medical malpractice insurance carrier is still on the hook for the claim even if the policy is no longer in force. Claims-made policies are slightly different. A claims-made policy only covers medical malpractice claims while the policy is in force, and as long as the incident occurred after the retro active date listed on the policy. Therefore, if the physician is currently insured with a claims made policy, and the incident occurred after the retro active date, then the physician should send the claim to the medical malpractice insurance carrier they are currently insured with.

### Consent to Settle

Medical malpractice insurance companies and physicians who receive notice of a claim are mutually aligned. Both parties want the claim to go away as fast as possible, with as little expense as possible. This is important, as the medical malpractice insurance carrier and the physician need to work closely together to put up a good defense against the plaintiff. Many physicians are often worried that medical liability insurance carriers want to settle claims and not defend them. This concern is often misplaced. Carriers do not want to spend any more money than they have to. If the medical malpractice insurance company is advising to settle the case it is most likely because they have a much higher chance of losing if they go to trial.

Whether the physician goes to court or the insurance company settles the claim, as long as there is no deductible on the physician policy, the physician will not have to pay the settlement or the award if they lose in court. However, the physician will certainly be affected in the future by a large loss. As discussed in previous chapters, all claims are reported on a physician's loss run with his medical malpractice insurance company. The larger the settlement or trial award, the more expensive the future premiums will be. Most physician malpractice insurance policies have a clause known as "consent to settle." Simply stated, if this clause is included on the policy, the medical liability insurance company cannot settle a claim without the physician's consent. Physicians should be aware of this and should not give their consent if they feel they have a great chance of winning the case if they go to trial. Physicians should however keep in mind that medical malpractice insurance defense attorneys defend claims full time and are highly trained experts in their field. If they are advising settling a claim, physicians should seriously consider their advice.

## 10 CONCLUSION

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*Medical malpractice insurance is an extremely complex form of liability coverage that in no way can be completely explained in these past few pages. There are innumerable caveats and exceptions to every rule and guideline in this market. However the basics of this protection, as describe here, will help any person involved in the medical field understand the basic principals that are used in protecting a doctor's medical practice from lawsuits.*

Additionally, every doctor's situation is different and there are no "one size fits all" answers in the medical malpractice market. A medical professional should consult an educated and experienced professional regarding any specific questions or needs he or she might have with regards to medical malpractice insurance.

Finally, please keep in mind that a physician's single greatest assets while navigating their medical malpractice insurance coverage from year to year is a basic knowledge of the coverage that protects their practice combine with a trusted relationship with a professional confidant in the medical malpractice field. A doctor's needs *medical malpractice insurance* needs will change over time and the medical malpractice insurance market will change over time, but the one constant in the world of medical malpractice insurance is the need to have access to the most up-to-date information, allowing the doctor to make the best decisions to adequately protect his or her practice.

## GLOSSARY OF TERMS, JARGON, & DEFINITIONS

A doctor's ability to speak and understand the language of medical malpractice insurance will help him or her gain a stronger grasp of the policy that protects their practice. The following glossary of terms, jargon and definitions has been included as an important piece of information to help doctors and other medical professionals understand the language of their medical malpractice insurance.

**Admitted Carrier** – Describes the type of medical malpractice insurance carrier that is licensed and approved to write business by that particular state

**Agent** – A licensed insurance professional who acts on behalf of a particular insurance company.

**Ambulatory Surgery Center** – Outpatient medical surgical facilities not requiring overnight hospital stays. Surgical centers provide outpatient surgery for all medical specialties including orthopedic surgery, plastic surgery, and ophthalmology surgery.

**American Board Certified** – The designation a physician receives when they have passed the certification tests given by the American Board of Medical Specialties

**American Board of Medical Specialties** – A non-profit physician organization that provides physician specialty certification

**Application** – The forms a physician or medical professional must complete in order to apply for medical liability insurance coverage

**Broker** – A licensed insurance professional who acts on behalf of the doctor to serve their best interests

**Claim** – A legal action taken against a physician in an effort to obtain damages for medical malpractice

**Claims-Made Policy** – The type of medical liability insurance policy that covers the insured while the policy is in force

**Consent to Settle** – A clause in a medical liability

insurance policy stating the carrier cannot settle a claim without the physician's consent

**CV (Curriculum Vitae)** – A summary of a physician's work history and academic achievements

**Effective Date** – The annual date on a physician malpractice insurance policy that defines when the policy period begins

**Entity Coverage** – Medical malpractice insurance coverage designed to provide insurance coverage for a physician's entity or corporation including LLC, PC, PA, SC, etc.

**Expiration Date** – The annual date on a physician malpractice insurance policy that defines when the policy period ends/expires.

**Hard Market** – Describes the state of the medical malpractice insurance market when the amount of claims being filed is high, and medical liability insurance premiums are also high

**Hospital** – A healthcare facility that provides medical treatment for patients in all areas of medicine

**Limits of Liability** – Defines the amount of money the medical liability insurance carrier will cover in the event of an indemnity payment against the doctor

**Loss-Run** – A report from a medical malpractice insurance company that provides a list of all previous claims that a physician has had while insured with that carrier including data such as, dates of the claim(s), indemnity payments, legal defense costs, and amounts reserved for future indemnity payments.

**Medical Record** – A patient's medical history of all medical care given by a physician or hospital

**Medical Spa** – A facility that provides medical and spa services commonly including, Botox, chemical peels, laser hair removal, sclerotherapy, microderm abrasion, and Restylane.

**New to Practice Discounts** – A discount from the premium that a physician can receive on their medical malpractice insurance policy when they have just completed residency or fellowship and are just beginning private practice

**Non-Assessable Policy** – A policy form that does not allow physical malpractice insurance policies to assess additional premium to support the policy during the policy period

**Nurse Practitioner** – A trained registered nurse (RN), who has completed advanced education in nursing and often performs similar duties to a physician.

**Occurrence Policy** – The type of physician coverage that covers insured's permanently for the time period that the policy is in force

**Physician Assistant** – A midlevel medical provider who has completed a physician assistant training program and works under the supervision of a licensed physician

**Policy** – An insurance contract between a physician and a medical malpractice insurance company. The policy details in writing how the insurance company is covering the physician in the event of a medical malpractice claim

**Premium** – The amount of money a physician or surgeon or medical professional must pay for their medical malpractice insurance policy

**Quote** – A physician malpractice insurance carrier's offer of insurance including policy form and premium

**Retro-Active Date** – The date on a medical malpractice insurance policy that signifies how far back into the past the policy is covering for medical acts

**Risk Management** – Policies, procedures, and

activities designed to lower a physician's risk of a medical malpractice claim. These include proper medical chart keeping and implementation of electronic medical records (EMR).

**Risk Retention Group** – A type of medical malpractice insurance carrier in which the policy holders are also the stock holders of the company

**Soft Market** – Describes the state of the medical malpractice insurance market when the amount of claims being filed is low, and medical liability insurance premiums are also low

**Specialty** – Specific area of medical practice in which a physician or surgeon practices in

**Surplus Lines Carrier** – Describes the type of medical malpractice insurance carrier that is not licensed to write business in states, however is authorized to write business nationwide This carrier often writes unique risks or hard to place risks.

**Tail Policy** – A policy a physician purchases to cover his/her prior acts indefinitely. (Extended reporting period)

**Tort Reform** – Refers to proposed changes in the civil justice system in an effort to reduce litigation and reduce medical malpractice insurance premiums.

**Underwriting** – The department of an insurance company responsible for determining which risks are eligible for coverage and the premiums associated with those risks

**Urgent Care Center** – The clinic that provides ambulatory care in a facility outside of a hospital emergency room. Care is typically given on a walk-in basis.

**Weight Loss Center** – A medical clinic designed for treating patients for weight loss services including diet and exercise plans and providing weight loss drugs (most commonly phentermine and HCG)

## APPENDIX & REFERENCES

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The following is a list of the sources used, coupled with ample, first-hand medical malpractice market experience, to create this document. These sources may be helpful for any additional study or research the reader might pursue into the inner workings of medical malpractice insurance, the medical malpractice legal environment or the general state of our current medical field.

1. [The American Board of Medical Specialties](#)
2. [The American Congress of Obstetricians and Gynecologists](#)
3. [The American Hospital Association](#)
4. [The American Medical Association](#)
5. [American Tort Reform Association](#)
6. [Duval County Medical Society](#)
7. [Harvard Medical School](#)
8. [Illinois Supreme Courts](#)
9. [Medical Group Management Association](#)
10. [Medicine Net](#)
11. [Oxford Journals: Medical Law Review](#)
12. [The Wall Street Journal](#)