

Medical Professional Liability Insurance

Emergency medicine physicians are keenly aware of the need for purchasing insurance. They are less familiar with many of the details associated with personal and professional insurance. Whether it is car, life, health or professional liability, our lives and careers are impacted significantly by the availability and affordability of insurance. The insurance business is complex and few physicians understand the vocabulary, structure and detailed mechanics of medical malpractice insurance. Yet in America's litigious society physicians must have professional liability insurance to protect their assets and careers. Insurance is big business with billions of dollars spent annually. In the United States last year, approximately \$24 billion alone was spent on medical professional liability insurance. Although this is a small part of the almost \$300 billion in total U.S. tort litigation costs, it is equivalent to approximately 3% of total health care costs. This paper will assist in outlining the general concepts, some details and overall operational mechanics of the medical malpractice insurance business from a physician's perspective.

Insurance, what is it?

Insurance takes many forms but generally serves to provide security to those who purchase it in an attempt to provide predictability in uncertain situations. Insurance makes dollars available to compensate for losses that are incurred from unpredictable or undesirable events. Insurance is one mechanism used to protect individuals and organizations against the risk of loss by distributing the burden of losses over a large number of individuals. Based on the law of averages, actuarial projected losses drive formulas for premium dollars that are then paid to contribute to the coverage reserves. These reserves are used to provide compensation for any member of the group who suffers from a defined loss.

Medical professional liability insurance (MPLI) is often identified under the misnomer of medical malpractice insurance (MMI). It is purchased to protect a physician or health care institution from the financial risks-the liability-of practicing medicine. More specifically it protects the physician from the consequences of a patient's claim that he or she was injured as a result of the physicians' negligence. This insurance is purchased through a contractual agreement called the policy, in exchange for a premium. Through this agreement the insurance company agrees to financial responsibility for the defense and payment of claims against the policy holder (physician) up to a fixed ceiling of coverage (liability limit) for a specified length of time (the policy period). When physicians purchase commercially available professional liability insurance they "transfer risk" to the insurance company. That is, with the payment of premium dollars they transfer responsibility for any claim against them and place the insurance company instead of themselves at risk for any dollars paid on claim defense or resolution. The policy typically identifies certain excluded coverage. This excluded coverage describes or lists acts not covered by insurance ie, intentional misconduct - acts that fall outside of the actual practice of medicine ie, sexual misconduct.

Medical professional liability insurance provides third-party coverage, which means it reimburses a person (usually the injured person or their family) who is not one of the two original parties to the insurance contract. This reimbursement is called indemnity. In addition most insurance policies provide for first-party coverage to the physician for the cost incurred in defending a claim, whether or not indemnity is ever paid.

In spreading the risk of loss, insurance companies seek to insure as many physicians as possible and collect appropriate premiums. The premiums are based on considerations of numerous issues including physician specialty, practice patterns, past claims history, and geographical location. It is common for insurers to consider "experience ratings" of a physician based on claims experience, with higher

premiums charged for physician's greater claims experience. Premiums are calculated using complex formulations that consider how much the insurer believes they will have to pay in losses, so necessary dollars can be set aside in reserves (for future losses), costs of business, desired financial margins, and any returns on invested premium dollars. By preference, insurers would sooner seek out those physicians with less likelihood of incurring costs through claims. Insurers believe a predictor of future claims is a history of past claims. Once collected, premium dollars are invested in order to generate additional reserve dollars and maximize investment income.

Interestingly, insurers also buy insurance, called reinsurance. Reinsurance is essentially a sharing of loss between insurers in which a primary insurer assigns part of its total loss exposure to the reinsurer. The greater the risk to the primary insurer, the lower the secondary insurers premium. In a world filled with risks and unpredictable jury awards secondary insurers are harder to find in the medical professional liability market, and if available, rates are high, requiring primary insurers to collect more in premium dollars to bolster reserves.

Historically the insurance business has been highly competitive with large numbers of providers offering fairly uniform policies. A competitive market often drives premiums downward in the primary insurance arena as companies try to enhance their market share. As the insurance market "hardens," fewer dollars are available for secondary insurance and companies must compete to get those dollars. As the costs of doing business increase primarily through increasing numbers of claims (frequency) or high dollar indemnity payments for claims (severity) insurers must adjust premiums to account for rising costs. The combination of rising costs from frequent and large liability judgments and settlements, and a hardened secondary market that does not allow insurers to pass risk and costs on, requires insurers to raise premiums to make up for risk costs, find workable solutions to dramatically reduce risk of claims, or leave a specific insurance market or risk financial insolvency. Insurance companies, like all commercial business must either make a profit or terminate their business. In a post 9/11 unpredictable world with frequent medical liability claims and unprecedented jury awards, medical professional liability insurers have increasingly left the insurance market for more predictable business lines. This leaves fewer options to physicians for insurance, and those companies remaining offer insurance products that are often very different from what the Emergency Physician understands and has traditionally expected.

Prior to the 1970s, medical malpractice insurance was entirely provided through occurrence policies. Occurrence policies cover all claims that arise from incidents that take place during a given policy period, regardless of when the claims are reported to the insurer during that period. An incident or occurrence was typically defined as an event that causes unanticipated harm to a patient from an omission or affirmative act. Such policies were typically more expensive since they covered large periods of time from an event to over 20 years after an event, when the statute of limitations in filing a claim "tolled" thus preventing a claim from being filed. This long "tail" of responsibility for liability exposure required insurers to carefully predict future indemnity payments and thus accurately predict current premium rates so as to have enough reserve dollars for future payouts in claims.

The unpredictability of medical malpractice claims and awards, with costs spiraling upward triggered the development of a new insurance product referred to as "claims made." Claims made policies in many ways run counter to the common understanding of what insurance is supposed to cover, future claims. Yet, claims made policies allow insurers to more accurately adjust premium and reserve dollars based on trends and projections in various markets and business lines. Under claims made policies, claims have to be asserted against a physician before the end of the insurer-insured relationship and the incident being reported must have occurred after the physician first purchased a policy so the policy typically does not cover "prior acts." If a physician stops practicing medicine, changes insurers ie, switching jobs, or has the insurance terminated, events occurring after the insurance policy terminates are not covered unless "tail or prior acts insurance" is purchased. Purchase of tail insurance provides coverage of claims for incidents

that may have occurred under the old policy but that do not arise until after its expiration. A physician should carefully understand how the insurance company defines a claim to understand how coverage is provided, but to be safe it is best that tail coverage considers claims from the time of the event, not just the date of a demand or lawsuit. Various “tail coverage” may be prorated to account for varying periods of time to be covered when the policy terminates ie, 90 days, 10 years, 20 years, etc. post policy termination. There is generally a strict time period during which a physician can purchase tail coverage and this may be regulated by the state insurance laws. Most state laws require an automatic coverage for up to 90 days post termination. Once the deadline has passed for establishing coverage the insurer has no obligation to provide it. Some policies allow lower tail costs by reducing the policy coverage limits or a higher deductible for each claim. In some claims made policies premiums may increase as the policy matures. This allows the premiums to build reserves as the increase in practice exposes the insured to the potential for increased frequency of claims. In claims made policies, premiums may also vary as companies chose to accrue more dollars to account for an ultimate “tail coverage” in the future. This may alleviate or diminish the one time “tail premium” when the individual is no longer insured but means a higher initial premium rate. In the past some insurance companies provided “nose coverage” or what is technically referred to as prior acts coverage. This is essentially a “tail policy” purchased at the time of a new claims-made policy. If it is offered, it is usually very expensive and in today’s insurance market it is very difficult to find a reliable and affordable “nose coverage” product.

Both the physician and the insurer have a right to non-renew or cancel a policy if appropriate notice is provided. This notice is typically 90 days. Insurance companies typically must act in good faith and have a “cause” if they decide to cancel a policy. Some reasons for canceling a policy include false or fraudulent statements on an insurance application, changes in a medical practice that creates unacceptable exposure to claims, failure to comply with the business relationship ie, not paying premiums, or loss of a license to practice medicine.

All insurance is not the same!

Physicians should be aware that not all insurance is the same. It is important to understand what is covered under the policy and what is excluded. Some policies only cover direct patient care and exclude care outside of geographical boundaries ie, state or nation. Some policies allow for coverage in work related activities such as EMS supervision, committee work or peer review. Some insurance may assist with legal expenses related to adverse actions against the physician’s credentials or license. Many physicians desire to find coverage for activities outside of direct patient care such as supervising residents, providing community services for events, or while serving as an event physician or as a good Samaritan. In the current litigious environment with insurers sensitive to high risk exposures to litigation, it is best to ensure associated activities are covered through a policy by having a letter stipulating the activity is covered under the policy. Often it is necessary and safest for the physicians to have the event provide the physician coverage.

It is also important to understand how the insurance provides coverage. Physicians must understand how claims should be reported. This is a sensitive subject since physician’s worry that frequently reported ‘potential claims’ might adversely affect their ‘experience rating’ and if they are considered too great a risk, their policy could be cancelled. Yet it is prudent to promptly report potential claims early so that the facts and circumstances of any event can be accurately provided in the event of litigation. Once a claim is filed, there are specific procedures that must be under taken to inform the insurance company. Typically this is a specific notice to the insurer via telephone, e-mail and regular mail to include any summons or claim. Knowing how to accomplish this and doing it in an expedited fashion is critical.

Different policies allow for variable defense costs if a claim is filed. Most policies provide for costs of defense including court costs, attorney’s fees and miscellaneous expenses. Some insurance has a

deductible for defense costs, requiring the policy holder to pay the first \$50,000 or \$100,000 of defense costs. Others cover defense expenses up to a certain limit or may subtract defense costs from the indemnity liability limits thereby decreasing the amount of coverage the insured has as litigation proceeds.

The issues surrounding a claim get even more complicated and may be confusing. Some insurers may be required to provide defense costs even if the previous claims have exhausted the policy limits. Insured physicians usually want to and should actively participate in defense of claims but may not have an ultimate say in how the claim proceeds. While insurers want to allow physicians to participate in decisions to defend or settle the claim, the policy may well allow the insurer, not the insured, to make the final decision to settle the claim or go to trial.

There is considerable variability in insurance companies. Different companies are legally structured to provide an array of services by offering products with varying benefits and costs. These are marketed and sold to physicians directly by company representatives or through brokers who search for the appropriate policy for their client's needs. Insurance agents are often the first contact in purchasing insurance. The efforts of an agent are viewed as soliciting offers for insurance. An agent for an insurance company is different from a broker. A broker is an agent for the insured. An agent of the insurance company typically has the authority to "bind" the company to policies, accept payments on behalf of the company, and represents the interests of the company in other authorized ways when dealing with the insured.

There are different types of insurance carriers. The most common traditionally have been commercial carriers. These are known as "traditional line" companies that offer numerous lines of insurance including medical professional liability insurance. The carriers are regulated by the state in which they provide services. The carrier applies for a license to offer insurance and is regulated by the state insurance departments. The state often can control the company's business practices including rate setting. Larger companies have traditionally had the advantage of offering better rates since their volumes of insured's were higher. The larger companies also were traditionally "safer" in that the larger companies have higher reserve accounts to protect the insured against large judgments and awards. The large commercial carriers often could transfer policies between states, allowing flexibility for the provider who might chose to change practice locations. These large companies, however, tend to view Medical Professional Liability Insurance as a small business line and one with great fluctuations and high risk. Thus most commercial companies have historically left the market during a crisis (hard market) including the current medical professional liability crisis.

Captive insurance companies are a form of "self insurance." A captive is a wholly owned subsidiary of an entity, or group that takes on all the formalities of an insurance company. It exists for the sole purpose of insuring the risks of the parent organization. Members of a captive company allocate funds to cover their own liability exposure and retain the risk themselves. A captive is not licensed by a state and most are formed "off shore" at locations where regulation is less stringent. In order to do business in a given state, the captive may contract with a "front company" that is licensed to use its licensed name to offer insurance, but the captive retains responsibility for all dollar losses that accrue from claims. Captives offer a form of protection that focuses on offering insurance at a more reasonable rate than a commercial company. Since the captive does not have to make a profit premium rates can be adjusted to claims experiences and actual expenses. The members of the captive can focus on and it benefits them to actively participate in loss prevention strategies that are specific to the group. During periods of time when commercial companies leave the market or must charge high premiums, captives enjoy lower premium rates. But captives, being a smaller company than most commercial insurers run a significant financial risk if they cannot control their losses since the captive cannot spread it losses over as large a physician group as commercial insurers.

Physician-owned and directed professional liability insurance companies were first established during the insurance crisis of the 1970's as a result of most commercial insurers withdrawing from the market. Currently there are approximately 60 such companies who insure a large majority of all physicians. Many of the not-for-profit companies do business in a single or limited number of states and may be sponsored by medical societies. Most of these companies are organized around a national organization known as Physician Insurers Association of America (PIAA) that is established to study issues and seek solutions to problems of common concerns. Most of the physician owned companies claim they can better control risk and claims decisions because they have direct physician participation. They can also avoid brokers or agent fees and pass these savings on to their insured's. The companies income can be used to directly offset claims and operating costs and the companies argue they are more aggressive in defending their represented physicians than attempting to settle claims early to avoid expenses. However, a physician that moves to a state not represented by the physician owned company may not be able to transfer the insurance and may face a tail or prior acts coverage charge.

State joint underwriting associations or trusts may exist that allows physicians to find professional liability insurance at lower costs. In this insurance model, similar to captives, the trust is operated on behalf of the insured's but the insured's are covered by a states guaranty funds that protect the insured from insolvency but unlike a captive the company falls under the state insurance regulations. It may be expensive to join the trust and premiums are often unpredictable. Since trusts have lower surpluses, a large number of claims or large indemnities may require additional assessments to replenish operating funds and cover losses. Physicians with troublesome claims histories may be denied coverage. This denial strengthens the product but creates controversy among the physician group.

Out of federal legislation passed in 1986, the Liability Risk Retention Act (15 U.S.C. sec. 3901) various types of self- insurance are permitted to assist in providing professional liability insurance. One of these programs allows self insurance through risk retention groups (RRG). Risk retention groups are corporations or other limited liability associations that are organized for and whose primary activity consists of assuming and spreading some or all of the liability exposure of its members. It is a self-insurance mechanism that must be owned either by its members or by an organization that is in turn owned by members of the group. Its members must contribute capital to the group and membership is limited to individuals engaged in similar or related business or activities. The RRG must be incorporated and licensed as a liability insurance company in at least one state but it is permitted to solicit business and write insurance in all other states. It must have as its primary activity the spreading of risk of liability, not making profits. Though premiums may be lower, RRGs do not have the benefits of participating in state guaranty funds that might otherwise allow physicians protection. RRGs are often not well represented in a given state and thus access to resources may be difficult. In addition, defense costs for claims may be included in liability limits and thus legal expenses reduce indemnity dollars available on each claim, placing the physician at risk for judgments above the indemnity limits.

Risk purchasing groups (RPGs) are also a spin off of the 1986 Liability Risk Retentions Act. RPGs are a group of individuals or entities with similar or related liability risks that form an organization to purchase liability insurance coverage on a group basis. It is not an insurance company. The group does not underwrite its risks, but instead purchases coverage for its members, usually from an established insurance company licensed in at least one state. The RPG can take many forms and different states cannot impose specific structure on the RPG and it operates more freely than a RRG. Many state protections afforded to other insurance vehicles are not applicable to RPGs and the financial viability of the insurance product must be carefully researched.

Joint underwriting associations (JUAs) are not-for-profit risk-pooling associations that were created by many state legislatures in response to the insurance availability crisis of the 1970s. They are operated as a branch of state government and have appropriated fund to ensure that insurance would be available. JUAs

operate by charging premiums for operating expenses and indemnity obligations but allow additional premium contingency assessment if a deficit is experienced. Thus retroactive adjustments may be charged to individuals. Often the JUA may not reject applicants and must accept even higher claims histories. This can result in a rise in premiums across the board and has led to the insolvency of some JUAs, particularly during times when other insurance products are more affordable and predictable.

Patient compensation funds or “excess recovery funds” are state-operated programs established in a few states to provide excess insurance coverage for health care providers, hospitals and other health care workers. Under these programs a defendant’s liability exposure is capped at an amount that is specified by state statute. The fund pays any portion of a claim that is in excess of that statutory amount. The funds are generally financed through an annual surcharge against health care providers, typically a percentage of a provider’s annual liability premium. The individual providers who participate are required to maintain liability insurance in an amount not less than a predetermined level at which the fund activates. Once a provider settles with a litigant for a certain amount, the litigants then pursue against the fund for additional dollars.

No-fault compensation funds are available in a limited number of states for specific conditions. In the past this has focused primarily on birth related litigation but increasingly attention is turning towards no fault systems for general medical liability. The benefit of such a system is to reduce the costs associated with the complicated legal process including plaintiff, defense and trial costs. These costs can consume as much as 70% to 80% of insurance dollars.

Self insurance allows the insured to directly assume the risk for a malpractice claim. Funded self insurance is when dollars are allocated for potential claims and is rarely used by physicians. Institutions such as hospitals may use this insurance device if they are large enough to support necessary costs. Unfunded self-insurance is referred to as “going bare” and means that funds are not reserved for liabilities. Physicians who go bare and are never involved with professional liability claims may save large amounts of money. If potential liability premiums are invested by a physician who goes bare, there is potential great economic gain. Going bare also makes the physician a less attractive target of litigation. There are significant problems with going bare. The physician risks the loss of individual assets in order to defend any claim or risk the personal assets may be seized in satisfaction of a judgment. Since most physicians will be sued in their life time and with the average cost of defending even a frivolous claim before dismissal ranging in the \$10,000 to \$20,000 range, it is difficult not to maintain insurance. In addition most physicians practice in hospitals that require the physician to have a minimal amount of liability insurance. This requirement ensures the hospital that in case of litigation there will be shared liability costs and the hospital will not be the only “deep pocket.” To effectively protect assets against litigation and judgments means establishing impenetrable legal devices that will prevent clever attorneys from accessing past and future revenues. Such devices are costly, inconvenient and not practical for most physicians in this litigious society.

The Professional Liability Policy

Physicians should be aware of the parts of a professional liability insurance policy. The policy should be carefully read so as to avoid coverage disputes. Although policies, language and definition of terms vary some examples can be provided that typically are part of most policies. A typical policy would contain the following sections:

The ‘schedule of declarations’ typically summarizes basic information concerning the insurance provided in a policy. It typically includes the name and address of the insured, the policy period, the limits of liability and the retroactive date and the premium amount.

The 'named insured' provides the name of all individuals insured in the policy. It distinguishes the named insured from others who are protected by the policy definition. The named insured has rights and responsibilities not attributed to additional insured. These include premium payments, premium return, and notice of cancellation.

Each policy contains basic but specific policy information including who is insured, policy limits, policy period, premiums and other necessary details. Policy limits are an important component under declarations. Policy limits are typically defined according to per occurrence limits, and an aggregate limit. Under claims made insurance, occurrence limit defines the amount of coverage available for each incident occurring and reported during the policy period. The aggregate limit represents the maximum amount of coverage during the policy period regardless of the number of claims reported.

The amount of coverage obtained depends on numerous variables including affordability, requirements of institutions, degree of protection desired to protect assets, and trends in judgments and settlements. The willingness of individuals to accept risk and protect assets is a strong consideration of determining policy limits. Most policies provide \$1 million for each incident with a maximum of \$3 million per policy period. It should be clear whether this "1/3" policy covers an entire group, or each physician in a group. Some institutions require variable amounts ie, \$2 million/\$4million, \$5 million/\$10 million policies. Since many claims are settled or judgments are awarded with-in policy limits, there is a trend to keep the incident limits in a narrow range. If the physician is insured through an insurance pool it is important to understand how limits provide adequate protection when the entire risk pool is examined

Insuring agreements

Each policy typically outlines the specifics of coverage afforded. The specific name of the physician insured should be in the policy language. If the physician is a member of a group insured, then the policy should clearly state that each physician working with the group through contract or employment is covered while providing professional services. It is appropriate to ask for a certificate of insurance to be issued for each physician.

Indemnity clauses specify what the policy will cover in terms of claims by an injured party (damages) and defense costs. The specifics of what is covered under damages should be spelled out in the policy so it is clear what specifically is covered.

It is also important to determine what professional services will be covered. In the past many physician activities outside the ED may have been indemnified but current trends in insurance may not allow non-ED activities to be covered

Defense issues in a policy should outline an insurer's responsibility to provide a defense to its insureds. The responsibility of cost for defense should be clarified. While most insurers bear the costs of defense, some policies include defense costs in the policy limits thus reducing the indemnity dollars available for damages and placing the physician at risk of bearing financial losses above policy limits.

Definitions are important to understand. Specific definitions are often included in a policy and should be read to help determine the policy meaning on specific terms.

Settlements sections assist the insured in understanding the insurers approach to including the physician in settlement decisions.

Exclusions in a policy describe specific exclusions from coverage for the policy. The specifics of exclusions vary but include particular types of medical treatment or practices, coverage offered under other policies, business associated activities that are not directly related to the primary coverage ie,

administrative work. Additional activities for which coverage is desired that may be excluded must be included under endorsements.

Conditions in a policy include specific provisions that must be met by an insured in order for the policy to cover a claim. The risk of violating conditions of insurance is that the individually insured may be denied coverage. Some of the more important conditions of insurance include, notice, other insurance, cooperative defense, and hold harmless. Notice refers to a requirement that the insured notify the insurer as soon as practical of any claim so an appropriate defense can be mounted. Failure to do so could hinder a defense and cause denial of coverage. Other insurance clauses identify how an insured's policy will provide benefits relative to other policies in effect for the insured. Hold harmless agreements must be identified so the insurer is aware of any indemnification agreements between the insured and third parties. Cooperative defense agreements clarify the need for the insured and insurer to work together for a common defense.

Endorsements address changes in a policy. Endorsements explain how the policy is changed. When an individually insured is added or excluded, when a geographical area is changed, or when other specific applications are altered, an endorsement should clarify the change.

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Definitions

Actuary – A mathematician who uses statistical analysis to compute insurance risks and premiums.

Admitted Carrier – An insurer who is licensed to do business in a particular state and is therefore subject to the rules and regulations of the insurance department of that state.

Affidavit – A voluntary, written statement of facts made under oath before an officer of the court or before a notary public.

Affirmative defense – A response to allegations in a complaint that constitutes a defense, even assuming the alleged fact to be true. These may include statute of limitations, contributory negligence.

Allegation – A statement of a party to an action, made in a pleading, setting out what the party expects to prove.

Annual statement – A financial statement that an insurer must file each year with the insurance commissioner in a state in which the insurer is licensed or does business

Answer – A document filed with the court that contains the defendant's response to allegations set forth in the plaintiff's complaint.

Appeal – A process by which a decision of a trial court is brought for review to a court of higher jurisdiction, typically known as an appellate court.

Appellate court – A court that reviews trial court decisions to determine whether errors of law were committed by the trial judge.

Application – A written statement by a prospective insured that provides information about the applicant to be used in determining his or her insurability.

Arbitration – An alternative to court trial for resolution of a claim between two or more parties. In arbitration a case is heard and resolved by an arbitrator or a panel of arbitrators. Arbitration may be entered into by agreement or may be mandated by statute, and the arbitration decision may be binding or non-binding. A binding decision cannot be retried in the courts.

Assessability – A characteristic of some insurance policies in which policyholders are obliged to pay money, in addition to experiences losses.

Attorney-in-fact – An entity that manages an interinsurance exchange. Each policyholder gives authority to the attorney-in-fact to exchange insurance with the other policyholders.

Best Ratings – A rating system that indicates the operation condition of insurance companies. The data is developed and published by A. M. Best Company.

Binder – A temporary coverage agreement that is used until an insurance policy is formally in effect.

Burden of Proof – The responsibility in a legal proceeding for presenting sufficient evidence to prove a fact or facts in dispute. The plaintiff typically has the burden of proof.

Captive – An insurance company that normally insures the risks and exposures of its parent company and affiliates, or it may be owned by a number of companies in the same industry insuring risk common to the group. Captives can be further identified by type ie, pure captive, association captive, reinsurance captive.

Case – A legal action or cause of action; a matter in dispute; a suit or lawsuit.

Case Law – The legal principles derived from judicial decisions, also known as common law. Case law differs from statutory law, which is enacted by legislatures.

Cause of Action – A set of alleged facts that forms the basis for a plaintiff to file a complaint

Certificate of Authority - A document issued by a state insurance department that gives an insurer the authority to write insurance in that state.

Claim – The filing of a lawsuit, notice of intent to file a lawsuit or to arbitrate, a demand for money or service, or an occurrence involving injury or disability of which the insured becomes aware and which in the opinion of the names insured may result in the filing of a lawsuit or the receipt of a demand for money.

Claims-Made Policy – Policy providing coverage for claims arising from incidents that both occur and are reported to the insurance company while the policy is in force. A claims-made policy is in force from the starting date of the initial policy period (the retroactive date) and continues in force from that date through each subsequent renewal. When a claims made policy is terminated, future claims arising from incidents that occurred during the policy period.

Commercial Carriers – For profit insurance companies, also know as traditional or traditional-line insurers. Commercial carriers are regulated by state laws and must qualify financially to do business in a state.

Complaint- A legal document that is the initial pleading filed by the plaintiff in a civil lawsuit. A complaint, sometimes known as a declaration, gives a defendant notice of the alleged facts constituting the cause of action. The complaint, accompanied by the summons, is served on the defendant by a process server, or in some states, by certified mail.

Conditions – Qualifications attached to the promises made by an insurer.

Contingency Fee – A fee agreement between a plaintiff and an attorney whereby the plaintiff agrees to pay the attorney a percentage of the damages recovered.. If no damages are recovered, no fee is owed to the attorney.

Contract – An agreement between competent, consenting parties that creates, modifies, or terminates rights and responsibilities. To be legally enforceable, a contract must be supported by “consideration” which may be thought of as a promise for or transfer of something of value, usually money or services.

Counter claim – A defendant’s claim against a plaintiff or another defendant, usually asserted with the answer to the complaint.

Court costs – The costs of litigating a lawsuit, no including attorneys’ fees. Court costs are something awarded to the winning party in a lawsuit but are not usually awarded in medical malpractice cases.

Covenant – A legal document that is used to settle claims. A covenant constitutes a promise not to sue or not to execute on a judgment.

Damages – All monetary sums that the insured has a legal duty to pay, including defense costs, charges, and expenses incurred in the defense of actions.

General – Intangible damages such as pain and suffering, interference with ordinary enjoyment of life, or loss of consortium(marital services).

Special damages – out of pocket damages that be quantified such as medical expenses, lost wages or rehabilitations costs.

Punitive/exemplary damages – damages awarded to the plaintiff incases of intentional tort or gross negligence to punish the defendant or act as a deterrent to others.

Date of Incident – The date on which an alleged incident of malpractice occurred.

Date of Reporting – The date on which an incident is reported to an insurer.

Declaration – A component of an insurance policy also known as a “face sheet.” The declaration personalizes the policy by specifying certain information.

Deductible – The amount of a claim payment that is subtracted from the insurer’s payment and for which the insured is financially responsible

Defendant – In a lawsuit, a party against whom a suit is brought.

Defense Attorney – An attorney who defends a person being sued (defendant).

Deposition – A discovery procedure whereby each party may question the other parties and possible witnesses in a lawsuit. Depositions are conducted before the trial under oath and are admissible at trial under certain circumstances.

Direct Writer – An insurer that sells policies through salaried employees instead of through independent agents or brokers.

Discovery – Pretrial procedures to learn of evidence in the possession of or known to an opposing party or witnesses. Discovery is designed primarily to minimize the element of surprise at the time of trial.

Dismissal – An act of termination by a court; for example, the dismissal of a lawsuit or portion thereof, or of a party.

Dividend– A partial return of insureds' premiums, when, for example, the insurer's financial position is especially good.

Endorsement– An addition to an insurance policy that changes the original policy provisions in some manner, also called a rider, policy change or amendment.

Excess Liability Coverage – Insurance coverage that provides limits of liability over and above the limits of an underlying primary policy.

Exclusions – The component of an insurance policy that sets forth the circumstances under which the physician will not be covered.

Experience rating – The practice of basing insurance premiums on past loss history.

Frequency of Claims – Refers to the number of claims that are filed in a given period. The frequency and average severity of claims are the fundamental variables used in determining insurance premiums.

General Liability Insurance – A type of liability insurance, other than automobile, workers' compensation and employer's liability, that covers damage or bodily injury. In the health care setting, general liability insurance covers such incident as visitor slipping on a wet floor of a hospital or the theft of a patient's belongings.

Good Samaritan Statute – A statute enacted to encourage individuals to stop and assist injured person by granting immunity from liability for any negligence resulting from an attempt to give emergency aid without the expectation of payment.

Guaranty Fund – Established by law in every state, these funds are typically maintained by a state's commissioner of insurance to protect policyholders in the event that an insurer becomes insolvent or otherwise unable to meet its financial obligations. The funds are usually financed by assessments against all property and casualty insurers regulated by a state.

Hold Harmless Clause – A clause in some contracts and leases that attempts to shift liability from one party to another.

Incident – An event or happening that causes unanticipated harm to a patient.

Indemnity – Reimbursement made to an injured party.

Insurance – A contractual relationship that exists when one party (insurance carrier), in consideration of a fixed sum (premium), agrees to reimburse another (an insured or policy holder) for any losses, up to the limits of the policy, caused by designated contingencies.

Insurance Company – A company, also known as an insurer, a carrier, or a provider, that is licensed by a state to sell some or all types of insurance.

Insured – The party or parties covered by an insurance policy. Also called a policyholder.

Injury – Bodily injury, sickness, or disease sustained by any person that occurs during the policy period, including pain and suffering, mental anguish, loss of income or death at anytime resulting from the injury.

Interinsurance Exchange – An association of insurance policy holders, also known as a reciprocal exchange, in which the policyholders join together and “exchange” their rights and obligation, thereby insuring one another.

Joint Underwriting Association – A government-administered risk-pooling arrangement established by law in a number of states to provide professional liability insurance to health care providers. A JUA is structured to be financed by assessments against its participants but typically also has the authority to assess property and casualty insurers licensed to do business in the state in the event of a deficit.

Judgment – The final entry in the record of a legal case, which is binding upon the parties unless it is overturned or modified upon appeal. A judgment usually consists of a finding in favor of one or more of the parties and an assessment of damages and costs. In a jury trial, the judgment may follow or under certain circumstances, modify the jury’s verdict.

Jury Trial – A trial in which six to twelve registered voters are impaneled to hear the evidence determine the facts, and render a verdict.

Lawsuit - A generic term of comprehensive significance referring to a proceeding by one person or person against another or others in a court of justice. The plaintiffs pursue the remedy the law affords for the redress of an injury or the enforcement o a right, whether at law or in equity.

Liability – Obligation that a person has incurred or might incur through any breach of a legally enforces duty: responsibility for conduct falling below a certain standard that is the causal connection of the plaintiff’s injury.

Limits of Liability – The maximum amount an insurer will pay out under the terms of a policy. Professional liability policies typically specify both a ‘per occurrence’ limit and an aggregate limit for all claims incurred during the term of a contract.

Litigation – The process of resolving a dispute in a court of law to determine factual and legal issues and the rights and duties between the parties to the controversy and to award damages or other relief.

Medical Professional Services – The rendering of the usual and customary service directly related to the practice of medicine

Motion – A written or oral court plea requesting that a judge make an order or ruling affecting the lawsuit.

Mutual Insurance Company – A company organized as “cooperative” activity by a group of person, whereby all participants share the losses and profits of the business. A mutual company has no formal stockholder or capital stock.

Negligence – A tort that is proved by showing:

1. The existence of a duty owed to the plaintiff
2. breach of the duty by defendant
3. an injury that was caused by the breach.

No fault compensation – A method for compensating person injured during the course of medical treatment, regardless of whether the injury was caused by the negligence or fault of a health care provider.

Nose Coverage - Known as retroactive coverage, this insurance is purchased from a new insurance carrier to provide coverage to the insured during the time when the previously held policy expired or was canceled by the policyholder.

Occurrence – Any incident or event that happens, especially one that is not designed or expected.

Occurrence Policy - Policy written on an occurrence basis covers claims transpiring within the specified policy period regardless of the date a claim was filed.

Off-Shore Insurance – Insurance provided by an insurer whose place of doing business (domicile) is located outside the United States.

Patient Compensation – A fund established by law in a few states that pays benefits to patients injured in the course of medical treatment. Benefits may be awarded on either a fault basis or no-fault basis, depending on the state. The fund's benefits may either supplement the payment made by a defendant in a medical malpractice claim or be the primary compensation, again depending on the state.

Periodic Payments – Damages paid over a period of time instead of in a lump sum. Periodic payments may be mandated when damages exceed a certain amount. Some periodic payment awards cease upon the death of the plaintiff.

Plaintiff – The party who initiates a lawsuit by filing the complaint; the claimant.

Pleadings – First phase of a lawsuit, consisting of the complaint, the answer, and any affirmative defenses or counterclaims, during which the issues in dispute are identified and clarified.

Policy – The contractual agreement between an insurance company and its insureds. The policy sets forth the rights and obligations of both parties to the agreement.

Policyholder – The insured.

Preferred Risk – A risk that an insurer finds favorable.

Premium Credit – A reduction in premium that acknowledges an expected reduction in risk due to claims history, completion of a risk management course, or a variety of other factors.

Premium – The amount of money an insured pays for an insurance policy. The premium is calculated by the insurance company's underwriters to bring in enough money to establish reserves for future losses; pay current losses; cover the company's operation expenses, including the cost of defending claims; and, if the company is organized as a profit-making business, generate profit.

Primary Insurance – The first layer of insurance coverage that will afford a "first-dollar" payment with regard to any loss covered under the policy.

Prior Acts – Incidents that may have occurred, but have not yet been filed as claims, prior to the onset of the company-insured relationship. Companies typically require a new insured to purchase supplemental coverage to protect against claims arising from prior acts.

Prior Acts Coverage – A supplement to a claims-made insurance policy that may be purchased from a new carrier when a physician changes carriers and had claims-made coverage with the previous carrier. A prior acts policy, also known as nose coverage, covers incidents that occurred prior to the beginning of the new insurance relationship but for which no claim has yet been made. Prior acts coverage is an alternative to an extended reporting endorsement, also known as tail coverage, which is purchased from the original carrier when a change in carriers is made.

Proximate Cause – An act or omission that is uninterrupted by an intervening cause, produces an injury. Proximate causation is one of the four elements that a plaintiff must prove in a negligence claim. In a medical malpractice case, a plaintiff must prove that failure to adhere to the standard of care was the proximate cause of the injury to the patient.

Rate - The basis or classification upon which the premium is based; often used as a synonym for premium.

Reciprocal Insurance Company – A company organized as a cooperative activity in which an attorney-in-fact operates on behalf of the policy holders, who agree to share each other's losses. Like a mutual company, a reciprocal company has no stockholders or capital stock.

Reinsurance – An insurer, who in consideration of a premium paid by another insurer assumes all of some of the risk of that insurer. The reinsurer agrees to indemnify another insurer for a percentage of the losses sustained under the insurance policy issued by that primary insurer.

Release – A statement signed by one party relinquishing a legal claim against another party, usually in exchange for a money payment

Reporting Requirement – The contractual obligation of an insured to report promptly to the carrier any claim for damages asserted against the insured. What constitutes a claim that must be reported varies from company to company but is always defined in the policy.

Reservation of Rights – An insurance term that refers to the situation arising when there is a question as to whether a given incident is covered. Typically, an insurer is obligated to defend a claim during the time the coverage issue between insurer and policyholder is being resolved.

Reserve – Money set aside and invested by an insurance company to pay estimated future losses. A company's claims department typically specifies a reserve amount for every claim that is filed, which may be modified as the claim proceeds in the courts.

Respondeat Superior – A legal doctrine that holds an employer liable for the actions of employees acting within the scope of their employment.

Retroactive Date – The date on which a policy's coverage begins.

Rider – See endorsement

Risk Classification – A classification based on the number and size of losses that can be predicted from a physician’s specialty and procedures. A physician’s specialty and procedures. A physician’s risk classification is used in determining his or her premium.

Risk Pool – A group of individuals or organizations who purchase insurance whereby the policy limits and risks are shared by the members comprising the pool

Risk Purchasing Group (RPG) – A group of similarly situated persons or entities that are permitted under federal law to organize across state lines to buy insurance. The carrier that sells insurance to the group must be licensed in at least one state but need not be licensed in every state where a member of the group resides.

Risk Retention Group (RRG) – A group of similarly situated persons or entities that are permitted under federal law to organize across state lines for the purpose of pooling their liability risk and self-insuring. If the group is licensed in one state, it is permitted to solicit business and sell insurance nationwide without fulfilling each state’s licensure requirements.

Schedule – The component of an insurance policy that lists the limits of liability.

Self-insurance – A direct assumption of the risk of liability

Settlement – An agreement between opposing parties in which the claimant accepts “consideration” usually a money payment, in exchange for a release of any legal right against the party upon whose behalf the payment is made.

Severity of Claims – Also known as claim magnitude, severity is the dollar value of a claim as determined by jury verdict or settlement agreement. The frequency and average severity of claims are the principal variable used in determining insurance premiums.

Standard of Care – A term used in the legal definition of medical malpractice. A physician is required to adhere to the standards of practice of reasonably competent physicians in the same or similar circumstances, with comparable training and experience.

Standard Risk – An insured who is entitled to coverage without additional charges or restrictions according to the insurer’s underwriting standards.

Statute of Limitations – The time period established by laws during which a plaintiff may file a lawsuit. Once this period expires, the plaintiff’s lawsuit can be barred.

Statutory Law – Laws enacted by a legislature, as opposed to case law.

Stipulation – An agreement made by both parties to a case, proceeding, or trial that regulates some matter related to the litigation.

Stock Insurance Company – An insurance company that is a for-profit corporation, with stockholders who have invested capital in the company and are entitled to its profits.

Structured Settlement – A settlement agreement between the parties to a lawsuit or a claim in which the damages are paid to the plaintiff over a period of time (periodic payments) instead of in a lump sum.

Subpoena – A court order requiring a witness to appear at a certain proceeding to give testimony or produce documents.

Suit – see case

Summary Judgment – A judgment in favor of either party that is made prior to trial. Summary judgment is only granted when there is no material fact in dispute and one of the parties is entitled to judgment as a matter of law.

Summons – A legal document that is attached to the complaint in a lawsuit and must be served on the defendant. It orders the defendant or the defendant's attorney to file an answer within a specified period of time.

Surplus – The amount by which an insurer's assets exceed its liabilities.

Surplus-Lines Insurers – Insurers that are regulated for solvency but not for policy provisions or premium rates.

Syndicate Insurance Company – A company organized by groups of entities that each agree to share in selling insurance to the syndicates' policyholders and pledge their personal assets to cover the losses of the policyholders.

Tail Coverage – Also known as extended reporting endorsement this policy is a supplement to a claims-made policy that provides extended protection to the insured for any incident that occurred while the insurance was in effect, but had not been brought as a claim by the time the insurer-policyholder relationship terminated. It covers the time from when the previously held policy has expired or was canceled by the policyholder into a specified period of time in the future. The insured typically purchases the extended reporting endorsement from the former insurer prior to changing to a subsequent claims-made policy.

Testimony – Oral evidence taken under oath and presented during a judicial proceeding to prove a fact.

Tort – A civil wrong for which an action can be filed in court to recover damages for personal injury or property damage resulting from negligent acts or intentional misconduct.

Tort Reform – A term used to describe collectively a number of legislative and judicial modifications to traditional tort law.

Trial Court – The court of first jurisdiction, where pleadings are filed, witnesses appear, testimony is taken, and judgments are entered: also referred to as the lower court.

Umbrella Coverage – A policy that provides broader coverage than a primary policy.

Underwriting – The process by which a company evaluates and classifies risks and measures and calculates the cost of protection, within the framework of the rules, rates and coverage forms that are permitted by law in a particular state.

Unearned Premium – That part of a premium that applies to the time that an insurance policy has yet to run.

Verdict – A formal decision or finding made by a jury or judge. A verdict is made in favor of either the plaintiff or the defendant. Damages may be awarded when a verdict is made in favor of the plaintiff.