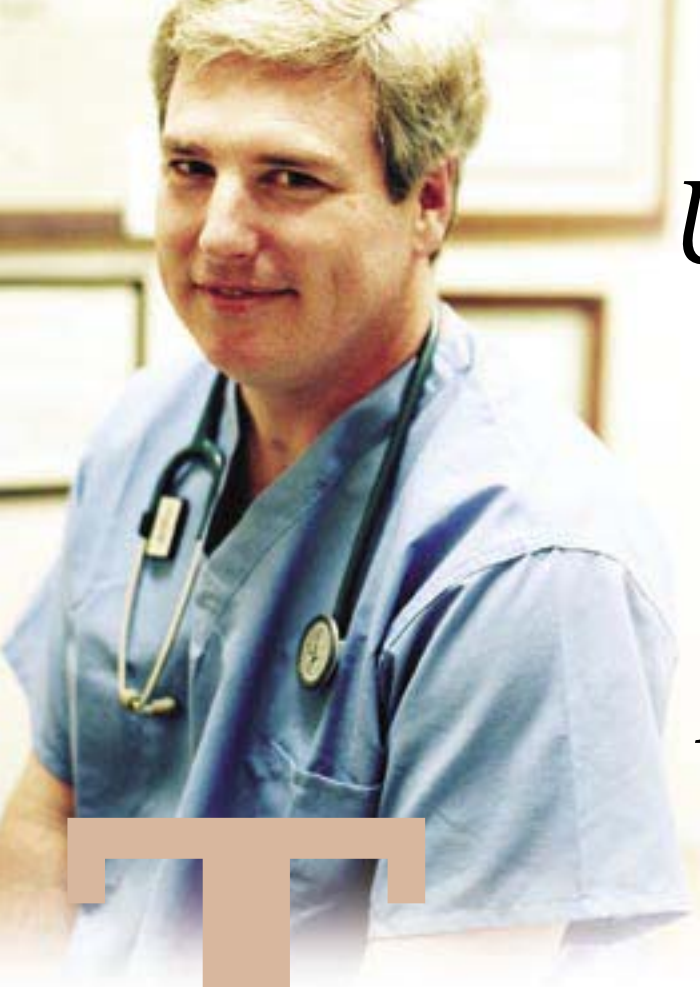

Understanding Your Medical Professional Liability Insurance Policy

A GUIDE TO THE BASICS – PART I

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Taking the time to learn about your medical professional liability insurance ("malpractice") is one of those tasks no one likes to do. Often, this task is accomplished too late, when a claim or lawsuit drives the healthcare provider to seek greater understanding of the policy and its implications on the individual practitioner.

It is always amazing how often I ask physicians who their insurer is and what type of policy they have – claims made or occurrence; and they cannot tell me who the company is, nor can they tell me which type of policy they have, or the difference between the two. Without such knowlege, how can practitioners understand even the basics of their policy? Yet the basics are important for every healthcare provider to understand, because there are implications from your policy that ultimately affect you when a claim arises. Since there are so many basics to cover, this guide will be split into two, with additional basics to be covered in the following issue.

There are two types of malpractice policies – claims made and occurrence. An occurrence policy protects the insured for any claim arising from an event that occurs during the policy period, regardless of when the claim is reported or when in the future it may be paid. This means that as long as your policy was in effect at the time of the incident which results in a claim, you will have coverage. While it is great to think that you are forever protected for the time when your occurrence policy was in place, it is only good so long as that insurance company is still around to defend you and pay out your claim. Occurrence policies are now virtually extinct due to rules regarding how the company must reserve assets for future claims. Where occurrence policies are available, the premium is typically more than 100% of a mature claims made policy.

Beyond understanding the basic types of policies, it is important for physicians to understand the differences between the two types of insurance markets that offer malpractice.

More common are claims made

policies. A claims made policy covers any claim arising from an event that occurs on or after the "retroactive date" and that is reported during the active policy period. When a physician secures a claims made policy without insuring any prior period exposure, the retroactive date and the effective date are the same (i.e., 1/1/07 to 1/1/08 effective period, 1/1/07 retroactive date). At renewal for the second policy year, the effective date is one year after the retroactive date (i.e., 1/1/08 to 1/1/09 effective period, 1/1/07 retroactive date). The retroactive date thus is the date for which the current policy is responsible for the patients treated on and after that particular date. In most cases, this date is prior to the effective date of the current policy. In essence, this gives the physician two years worth of coverage for the example above. This date is most often transferred from one policy to the next. When this transfer occurs, we say the policy is including coverage for the "prior acts" of that physician. There is no time limit as to how far into the past the retroactive date can be.

The non-standard insurance carriers are not sub-standard. In fact, of the top four financially rated insurance companies, three are surplus carriers.

What is essential to understand about a claims made policy is that when the expiration date comes and the policy is not renewed, whether due to the insured or the insurance company, there are two ways to maintain coverage on the past. The first would be to obtain a new policy that includes prior acts coverage by matching the retroactive date on the expiring policy. The second option is to purchase an extended reporting period, commonly referred to as "tail coverage." The tail coverage provides an additional period of time after the expiration of a claims made policy in which to report a claim from an event that arose during the period covered by the policy retroactive date and the expiration date. This may require an additional premium. Tail coverage is purchased when a claims made policy ends and the new policy does not pick up prior acts. If neither of these two options is implemented, there will be a time period which does not have coverage, also called a "gap" in your insurance coverage. This creates a time period for which you are "bare" and in essence have no malpractice insurance in place.

Beyond understanding the basic types of policies, it is important for physicians to understand the differences between the two types of insurance markets that offer malpractice – the standard ("admitted") insurance carriers and the non-standard ("surplus" or "non-admitted") carriers. A standard malpractice carrier is an insurance company that is licensed and regulated by a State's Department of Insurance, thus an "admitted" carrier of that particular state. A standard carrier must get State approval for its physician classifications, policy forms, rules, and premiums. Standard carriers are required to stay within their pre-approved parameters. Admitted carriers target the 90% of the marketplace that possess the "standard" characteristics and fit into the pre-defined parameters. The

traditional physician's malpractice insurance is secured through the standard market. Since premium rates are pre-determined, the underwriter can only accept or decline an application. The standard carrier has a limited ability to "create" coverage at a price to match a non-standard risk.

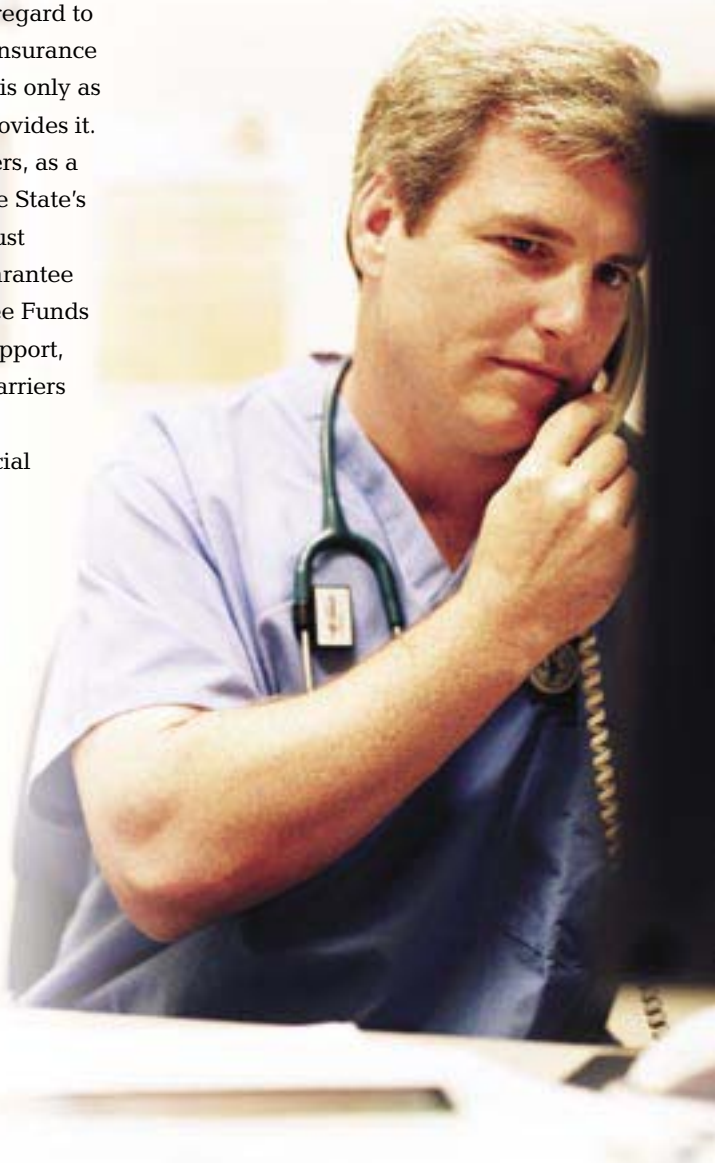
Physicians who cannot secure coverage through the standard market must look to the non-standard market for their coverage. Such is the case for many physicians who are not plastic surgeons or dermatologists by specialty, and who begin to incorporate aesthetic procedures into their practices. The same often applies to physicians who open medical spas who are not plastic surgeons or dermatologists. The standard carriers are not able to provide coverage since such procedures are not included within the pre-approved parameters that have been set.

The non-standard insurance carriers are not sub-standard. In fact, of the top four financially rated insurance companies, three are surplus carriers. Issues that may move a physician to the non-admitted market include the specialty or type of practice, types of treatment and procedures offered, a history of claims, license issues, or non-board certification. While non-admitted markets are not regulated by the State's Department of Insurance, they must be approved by individual State's Department of Insurance. Surplus carriers have almost unlimited flexibility to create coverage and develop price to make the risk acceptable. Therefore, almost any risk can secure coverage.

Why is it important to understand this difference between types of carriers? Too often physicians who have a policy from a standard carrier and expand into the aesthetic medical area do not understand why they cannot simply secure coverage from their standard insurance carrier. As all providers have concerns over premiums, physicians who must secure coverage through the surplus market all too often seek out policies with low premiums without regard to the financial stability of the insurance carrier. An insurance policy is only as good as the company that provides it.

Standard insurance carriers, as a part of their regulation by the State's Department of Insurance, must participate in the State's Guarantee Fund. These State Guarantee Funds provide back-up financial support, should one of the standard carriers become financially insolvent and unable to meet its financial obligations, such as paying out claims. Surplus carriers do not participate in the State's Guarantee Fund. It is of utmost importance to make sure that the surplus carrier is a financially stable company. Rating companies such as A.M. Best and Standard & Poor's provide a basis for which insureds can learn about the financial stability of the carrier.

In addition to understanding the carriers and types of policies, it is crucial to have basic knowledge of your policy. There are implications from your policy that ultimately will come into play when a claim is brought against you. Price is only one element of the policy; and because price is easy to understand, many policies are purchased without understanding other features of the coverage. This can lead to unpleasant surprises resulting simply from lack of education and knowledge. Every policy is made of several components:



declarations page, definitions, insuring agreement, exclusions, conditions, and endorsements. The declarations page is the first page of the policy that includes the essentials. It defines who the insured is (including name and address), the policy period, the retroactive date (for claims made), the limits of liability, the deductible (if applicable), the coverage provided, the premium, and the percentage for tail coverage (for claims made).

We have already covered the policy period and the importance of the retroactive date for claims made policies. Limits of liability state the maximum amount that the carrier will pay out on behalf of the insured if a claim is made against the insured. The most common limit of liability is $1 million per claim / $3 million per aggregate. Individual states and/or healthcare organizations, such as hospitals, may require a higher or lower limit level. Defense costs, sometimes referred to as "claims expenses," are required for the investigation into the claim and legal counsel to defend the insured. Defense costs can be included within or outside the limits of liability. If included within the limits of liability, the amount of defense costs reduce the amount the carrier can pay out in damages. For physicians who have experienced large judgments and required payouts, a policy with defense costs outside the limits of liability is worth the additional premium that may be required so that the full limit per claim can be paid out in damages.

Limits of liability can also be reduced by more than one individual sharing the limit.

Limits of liability may also be reduced by more than one individual sharing the limit. If two physicians are named on one policy with one shared set of limits, the maximum payout would be the limit of liability per claim, not per individual physician. There is also an implied shared limit of liability for employees of a physician, even if those employees are not named as insureds on the policy. If, for example, Dr. Smith's employed nurse has a negligent act which results in a claim made against both parties, Dr. Smith's policy limits will cover both individuals: Dr. Smith as the named insured and his nurse as one of his employees. This will ultimately reduce the amount payable for any future claims against Dr. Smith for that particular policy period.

It should be clear, so far, why understanding the basics of your policy is important so that you know what to expect when a claim is made against you. In segment two, we will expand on this basic guide to your malpractice policy to cover premium amounts, deductibles, minimum earned premiums, coverage triggers, consent to settle clauses, exclusions and endorsements, and much more.

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