The keys to effectiveness of your professional liability program

by Jack Meyer

The new "claims-made" insurance calls for a new management approach.

Along with full-size luxury cars and grass playing fields, the "occurrence" form of professional liability insurance is becoming, for most, a romantic memory. Under a typical occurrence policy, the insured is protected for an unlimited period for claims that occurred during the policy period, as long as the reporting is timely. However, the volatile professional liability environment does not allow for the long-range forecasting necessary to provide the actuarial basis for this coverage. Occurrence insurance is being replaced by a more modern policy form that is cost effective, but complicated. In 1986, from coast to coast, many companies began offering professional liability insurance on a "claims made" basis in addition to, or in place of, the occurrence form.

For the medical group administrator, the claims-made form requires a different approach than does occurrence coverage. This difference extends beyond the mere obtaining of insurance for the group and into the realm of the group's contractual relationship with its member physicians. Occurrence coverage has traditionally been purchased and put on the shelf. Claims-made insurance must be managed.

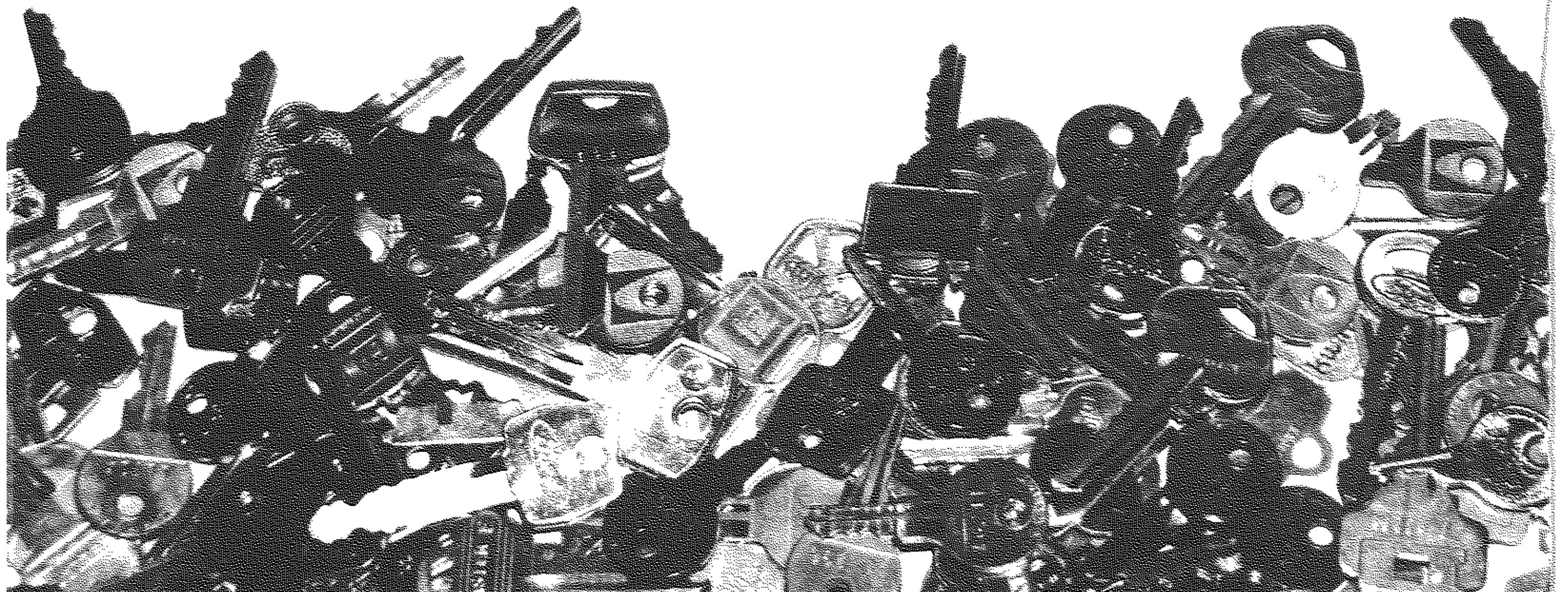
In form, claims-made coverage can be viewed as the "á la carte" version of occurrence insurance. The scope of the coverage is the same, but the period of coverage can vary depending on the needs of the physician and the group.

The claims-made premium is made up of three individually priced components:

1. the current year, which except for rate increases, stays the same;
2. the prior-covered-period, which starts at zero and increases in cost each year as the exposure to loss increases; and
3. the "tail," which accrues over the first few years, but is not due or payable until the medical group leaves the claims-made program.

Step increases

As shown in *Figure 1,* the premium for the first year of claims-made coverage is very low because the physician is being protected against claims reported in one year, based on professional services performed in year one. In year two, the premium increases significantly because protection must be purchased for the current year as well as for claims that may be reported in year



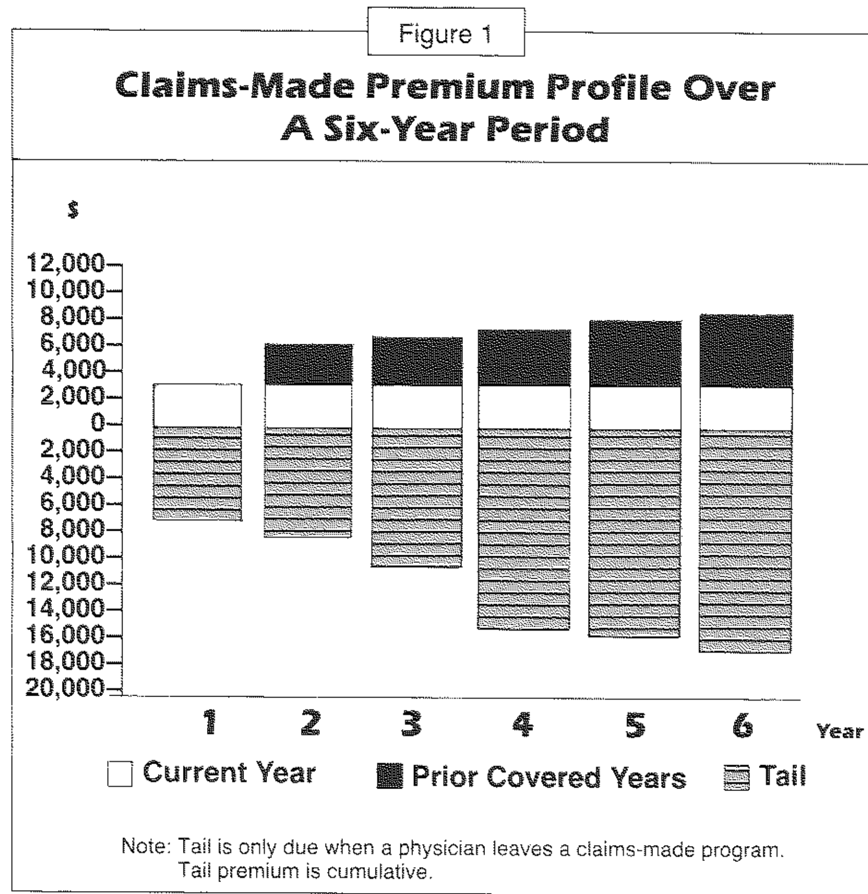
the contract must establish the group's responsibilities for the physician's past, present and future professional liability insurance needs.

From the insurer's view, a physician applicant falls into one of three categories: (1) he is new to practice, (2) he is new to claims-made coverage, or (3) he is continuing his claims-made coverage. The physician new to practice is seldom a problem. He begins at a first-year rate (often with a "new doctor discount"); then, year by year, he moves up the steps to a mature premium. A physician new to claims-made coverage also enters at the low first-year rate, since any previous exposure would be covered by occurrence coverage.

The third category of a physician applicant is one who was previously under claims-made insurance. This physician's coverage needs fall into one of two areas. If he paid the tail coverage for the previous claims-made period, he would begin at a first-year rate. If he had not purchased tail coverage, and the group is insured by the same company, he can continue with the same beginning date as his prior claims-made period. Or, if the group's coverage is with a different carrier, he can obtain prior-acts (nose) coverage with his new carrier, with a beginning date that includes his prior claims-made period.

Figure 1

Claims-Made Premium Profile Over A Six-Year Period



Note: Tail is only due when a physician leaves a claims-made program. Tail premium is cumulative.

Leaving the group

The medical group administrator has a number of alternatives with regard to departing physicians. The group can choose to buy the physician's tail, in which case the coverage for both group and physician are, in effect, converted to occurrence coverage.

An alternative available through some claims-made carriers is the purchase of tail coverage for the group's exposure only. This coverage is usually available at some percentage of the departing physician's premium and does not provide coverage for the physician. In this case, the physician would have the option of purchasing his own tail coverage, continuing coverage with the same carrier, or obtaining prior-acts coverage from another carrier. Whichever option the physician chooses, the group's exposure for the professional services rendered by the departed physician while he was with the group, is covered. Whichever option the group chooses, it is imperative that the group's obligation be clearly explained to the physician in writing at the time he joins the group.

Various groups approach the tail coverage options differently. Many groups pay the tail coverage for any physician who leaves the group. Other groups pay for tail coverage only if the physician stays until retirement, and retirement age varies among groups. Some groups have a policy of never paying for tail coverage. These administrators feel that the physicians should take responsibility for their own tail premium out of the compensation provided to them.

Changing medical specialties

There are anomalies in the claims-made program of which the administrator should be aware. One is the premium impact of changing specialties. Under occurrence insurance, if a physician changes his medical specialty, the premium will change immediately to reflect the change in risk. Under claims-made insurance, a physician medical specialty premium is made up of three individually rated parts: the current year, past year of claims-made coverage, and if applicable, the tail premium.

It takes years following the change for the physician's new specialty to become the dominant factor in the rating model. For example, a surgeon at a mature claims-made rate who gives up surgery will go to a lower base rate, but will have a premium that includes the exposure from his surgical specialty years. (From the insurer's point of view, the physician's total period of coverage still reflects a surgical risk.) Therefore, it behooves the medical group to have its physicians working full-time in their medical specialty. When a physician winds down his practice, the administrator must anticipate that the lowering of the premium will take some time.

Managing the program

There are a number of areas where an administrator can make his program more cost efficient and effective.

Splitting premiums. Some pro-

grams allow a medical group to carry different limits for different medical specialties. This allows the group to raise individual limits for physicians whose medical specialty constitutes a higher risk.

Raising limits. The claims-made form provides an advantage here. Under some claims-made insurance programs, when limits are raised, the effective date goes back to the beginning date of the coverage. Therefore, if it is decided that a group's limits are too low, limits can be increased for the entire period of the claims-made coverage.

"Loss leaders." When comparing premiums of claims-made insurance companies, it is important to look beyond first-year rates. The mature rate and the average rate increases over a five-year or six-year period indicate rate stability and should be factors in making a decision.

Slotting. In a "slot" program, physicians are not personally insured. They occupy insured slots that identify a medical specialty. As a physician leaves and is replaced, the new physician continues in the same slot that the former physician occupied. This arrangement has great attraction for groups with a high turnover. Over a long period, however, slotting can be a headache rather than a benefit, and it can work to the disadvantage of the departing physician, the new physician, and the group.

Medical society sponsorship. The programs sponsored by medical societies give the insurance buyer more access to the insurance carrier. Even if the physicians in a group are not society members, the society may provide an effective vehicle for obtaining prompt response to professional liability problems that occur.

Experience credits (dividends). Some physician-owned carriers are not-for-profit and are committed to returning unused premiums to policyholders. The medical group manager should inquire about the total credits returned by the program, and how many years the group must remain in the program to be eligible for these credits. Over time, premium credits can significantly reduce a group's overall insurance costs.

Surgicenter coverage. Special coverage for freestanding outpatient surgery centers is provided by some programs. The premium is charged based on the number and sometimes the type of procedures being performed. A minimum quarterly premium is usually charged.

Extended office hours coverage. Some programs offer coverage for walk-in clinics. The premium is usually charged on a per physician-hour basis, based on a 40-hour physician week. This coverage allows a group to use moonlighting residents or physicians insured by other companies to work at the extended-hours facility without having to pay the premium for a full-time physician.

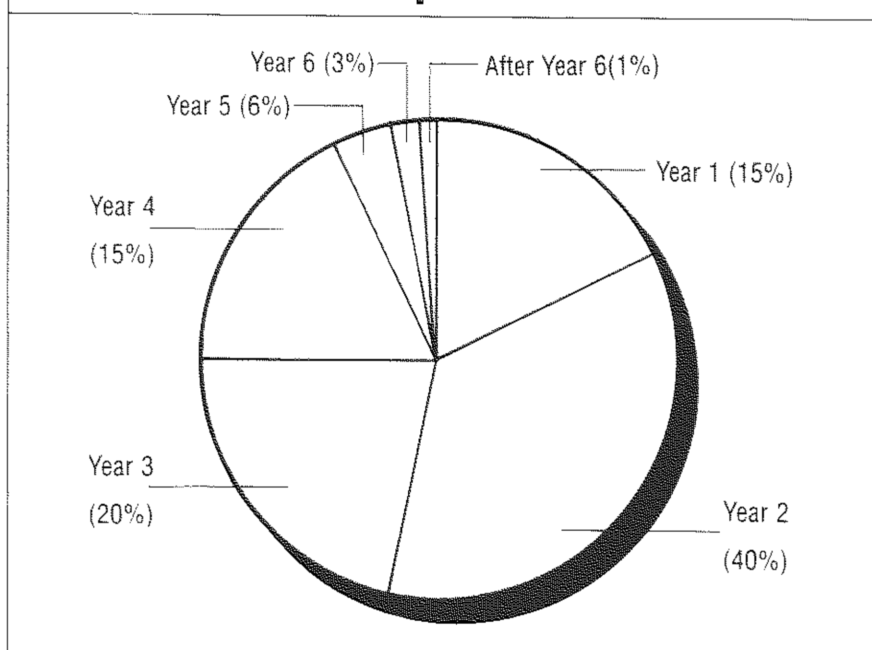
Loss control program. The successful claims-made carriers do more than just collect the premium and pay claims. Most use careful underwriting and frequent review of group claims patterns to ensure that a medical group does not represent an untoward risk. Over the long run, a carrier with an effective loss-control program can be very helpful to a group by being a partner in the group's quality control efforts.

The challenge

Effective managment of a claims-made insurance program is a challenge. As the focus of a medical group's activities changes, insurance needs may change also. Small changes in a practice can have a significant impact on insurance needs. Decisions regarding purchase of prior-acts coverage, as well as tail coverage, can have a significant impact on cash flow. Overall, however, depending on the time and skill with which the administrator manages the claims-made program, the benefits of this type of coverage can be maximized, and the unanticipated expense and anxiety that can result if the policy is thrown on the shelf to sit, forgotten until renewal, can be minimized. ■

Figure 2

Typical Reporting Patterns for Medical Malpractice Claims



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