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Assuring Quality in the Provision of Healthcare:
The Role of Medical Malpractice Underwriting

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I. Introduction

Tort reform is often mentioned as a way to limit health care costs. Since California put a cap on non-economic medical malpractice damages in 1976, other states have either added caps or considered them. Significant reductions in liability, however, would reduce resources allocated to underwriting. Another policy option, no-fault insurance, would do away with medical malpractice underwriting entirely. In both cases, it is important to consider what will be lost. In this paper I describe ways in which the medical malpractice industry promotes physician quality and benefits consumers.

Lists of mechanisms to assure physician quality commonly include state medical board oversight, state and national databases that track adverse claims and board actions, and private efforts to credential by specialty boards, professional associations, hospitals, and health maintenance organizations. The incentives for quality care generated by the private medical professional liability (medical malpractice) insurance industry are seldom mentioned. In this paper, I explain how the medical malpractice market currently functions. Although the belief that medical malpractice insurance is not experience rated is widespread, it is not true.¹ Not only does experience play a significant role in determining premiums, rewarding physicians who work to manage risk, but the medical malpractice industry offers a number of other incentives in the form of premium credits, benefits and financial penalties that promote risk management and protect consumers.

The policy implications of these findings extend beyond tort reform. In the concluding section I address implications for tort reform but also for state medical licensing. The merits of three related public policy options are also discussed: state laws that require physicians to carry malpractice insurance, state efforts to act as an insurer of last resort when physicians are denied coverage, and laws that grant malpractice immunity to physicians who work for federal, state or local government providers.

II. Background

There are several sources of medical professional liability insurance for physicians. Since the mid 1970s, traditional for-profit commercial multi-line property-casualty insurers have seen their share of the medical malpractice market fall as not-for-profit physician-owned insurers have grown. Other risk transfer entities include captives and risk retention groups which provide insurance to medical societies or other groups of physicians. Risk retention groups are comprised of similar businesses that join together to create an insurance company to self insure. Captives also self insure the risk of their owners, but are not restricted to insure similar risks (for example, not restricted to insure medical malpractice). Most commonly, captives insure the risks of a parent company or a group of companies (Hillman & Cluff, 2005).

Physicians purchase insurance from either admitted or surplus lines carriers. The admitted market is comprised of carriers approved by the state department of insurance. Admitted companies must demonstrate financial stability and adhere to state regulations. They must seek approval of their rates and forms from the state department of insurance. When damages are awarded, consumers are protected against the insolvency of an insurer by state guarantee funds. Physicians who have lost hospital privileges, have a history of
claims or drug or alcohol abuse, or have been sanctioned by their state medical board are likely to be denied coverage by admitted carriers. These physicians turn to surplus lines insurers.\(^2\) Medicare or Medicaid fraud can also be a ticket to the surplus lines market (Pillsbury, 1995). Not all physicians covered by surplus lines insurers have problematic records. Doctors with clean clinical records may be in the surplus lines market because they practice in more than one state, have gaps in their insurance coverage, or because they are using a new procedure, recently approved, but not yet widely in use (this is discussed below).

For the most part, surplus lines companies are not as heavily regulated as admitted carriers nor backed by a state guarantee fund.\(^3\) State laws attempt to keep surplus lines companies from competing with admitted carriers; in many states, physicians must be denied coverage from admitted carriers before they may turn to a surplus lines company. Because they are not required to file forms and rates, surplus lines insurers have greater flexibility in pricing. This allows them to design insurance products for nonstandard risks (Boone, 2002; Martin, 2002; Morse, 2009; Schwartz and Mendelson 1989a).

The number of physicians in the surplus lines market depends on the medical malpractice insurance cycle (Boone, 2002; Davies, 2009; France, 2005, 2007; Mello, 2006; Nibbe, 2009; Vermont Medical Malpractice Study Committee, 2005). In a buyers’ market, the so-called soft market, admitted companies take on more risky physicians. Today, an aging soft market has led many admitted companies to expand the set of physicians they will cover, crowding out the surplus lines market. Vlazny (2009)

\(^2\) For example, see http://www.generalstar.com/mpl_spnsplp.php (Retrieved July 31, 2009)

\(^3\) There are exceptions. PULIC is a surplus lines carrier admitted in California. In New Jersey, surplus lines policies are covered by the New Jersey Surplus Lines Guaranty Fund, offering protection should insurance companies become insolvent. Many of the surplus lines companies doing business as non-admitted carriers in one state are admitted and regulated in another.
estimates that the share of premium attributed to doctors in the surplus lines market can be as low as one percent in a soft market and as high as ten percent in a hard market.

III. Medical Malpractice Insurance and Physician Quality

This section describes aspects of medical malpractice underwriting and contracts that benefit consumers. They include keeping a watchful eye on physicians, sanctions for substandard care, incentives to consider the risk associated with practice patterns, practice limitations to protect consumers and reduce risk, limiting the risk associated with the introduction of innovative medical treatments, improving tort results, and providing health professional credentialing agencies and boards and healthcare providers with valuable information about physicians.

Oversight

Medical professional liability insurance underwriters perform an important oversight function. When physicians apply for insurance and as long as their policies are in place, physicians are subject to monitoring by medical professional liability underwriters. Physicians are evaluated annually. On the application form for insurance, physicians are asked questions about their practice profile, including whether they perform or assist with surgery, the type of medicine they practice, practice volume, specific medical techniques and procedures they use, and where they practice.4

Applicants report their educational history and a list of hospitals where they are permitted

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to practice. Applicants are asked if they have ever been denied status as a medical student, a license to practice medicine, a license to prescribe narcotics, hospital privileges, membership in a professional society, or medical professional liability insurance. They are asked if any one of these has ever been restricted, suspended, revoked or voluntarily surrendered. Physicians are asked if they are specialty board certified and if they have ever failed the specialty board certification test or been denied certification by a specialty board. As part of the application process, physicians must complete a form for every claim filed against them (including information about damages paid and defense costs to their insurer at the time) and they are asked about any claims they expect to be filed. Physicians are asked about alcoholism, mental illness or narcotics addiction and their criminal history. The policy serves as a warranty. Lying on one’s application is grounds for denial of a claim (Dow, 2009; O’Connell, 2009).

Insurance underwriters verify all the information in a physician’s application. Vlazny (2009) explained that their job is to “verify, verify, verify.” According to Dow (2009), preferred companies, those with the strictest underwriting guidelines, go so far as to search county records. In this way they can be aware of claims even before they are reported to public databanks. Surplus lines carriers who work with hard-to-place physicians require applicants for insurance to produce loss runs for every company with which they have been insured (Dow, 2009; Vlazny, 2009). Loss runs document claims, damages, defense costs and some incidents that are not be reported to the National Practitioner Data Bank. For example, if a physician personally pays damages on a claim, that claim is exempt from NPDB reporting requirements. Yet underwriters would pick it up as part of their comprehensive monitoring and oversight activities.
On occasion, underwriters review the type of equipment a physician is using. For example, a clinician may have had problems with claims in the past, but if he or she has adopted newer techniques or purchased state of the art equipment, that may allow the physician to secure a policy with a lower premium (Allen, 2009).

Some insurance underwriters have access to information about physicians that is not publicly available. For example, underwriters might obtain private information about physicians from a managed care company negotiating for a lower rate. Managed care companies have information about physicians that others do not have. They see physician-specific utilization reports and know what tests are being ordered. With this information, underwriting is more robust (Allen, 2009).

Underwriters’ incentives are to accurately assess risk to maintain the solvency of their company. They have an incentive to look for evidence of negligence or substandard care. They have an incentive to evaluate the type of care provided and whether the equipment a physician is using is out of date. This puts them in a position to contribute to the detection of any aspects of a physician’s practice that might result in higher than normal risk. As will be described below, this information is used to modify the practice patterns of physicians.

Medical malpractice underwriters also offer consumers protection from risk retention group insolvency. Self-insured risk retention groups mushroomed in the hard malpractice market of 2000-2004 (Hillman & Cluff, 2005). The Liability Risk Retention Act (1981, amended 1986) facilitated the formation of risk retention groups by preempting state insurance law. Physicians were attracted to the self-insured groups by the promise of freedom from the cycles of the private medical malpractice market.
Some medical professional liability risk retention groups are poorly capitalized and fail. A 2005 report published by the U.S. Government Accountability Office (Hillman & Cluff, 2005) argued for additional regulation. However the malpractice insurance industry has come up with a solution. Observing the failure of some risk retention groups and worried about the risk to consumers of an undercapitalized insurer, some hospitals denied physicians insured by risk retention groups practice privileges. The solution has been for risk retention groups and captives to pay an admitted company to “rent their paper” (their name). The company that fronts the policy is said to be “hanging paper.” In this case, the admitted company vouches for the financial stability of the risk retention group or captive. The fronting company gets a flat fee but takes on risk for any damages beyond what the group can cover. This gives the fronting company an incentive to undertake an in-depth actuarial study to be sure the group risk is securitized by the assets of those insured. The fronting company wants to be sure the ceding carrier is fully collateralized in order to minimize the fronting company’s exposure (Vlazny, 2009).

In this situation, the incentives are correctly lined up to provide oversight by underwriters at admitted companies. The admitted companies bear the risk if their assessment of how much capital is needed is wrong. Hospitals rely on the fronting admitted carrier for assurance that a risk retention group is fully collateralized, so that patients are protected should damages be awarded in a claim against one of their physicians.

*Companies Specialize to Assess Risk*

The medical malpractice insurance market is stratified by risk. The result is that physicians end up paying premiums, even in the admitted market, that reflect the risk
they bring to their practices. This rewards risk management efforts which ultimately benefit consumers. In California, the Cooperative of American Physicians, Inc. provides coverage through Mutual Protective Trust, a company with very strict underwriting guidelines (Davies, 2009). The company’s web page says, “MPT…protects more than 10,000 of the state’s finest physicians.”

Preferred Physicians Medical Risk Retention Group (owned by its policyholders) insures only “high quality anesthesia practices” in over 30 states. Its web page notes that “selective underwriting is the key” to its success. General Star offers three professional liability programs to serve the “risk profile needs encountered by the physician community.”

Its Physicians Advantage Program insures only those physicians with a good loss history, specialty board certification and no practice impairments.

There is stratification of risk in the surplus lines market as well. Some firms will offer coverage to nearly every physician at a price (Davies, 2009; O’Connell, 2009).

Others will not. Shaw (1998) noted that there were only a very few companies with the expertise to underwrite physicians in the extreme risk category. CNA targets only those physicians who over time show the potential for returning to the admitted market (Morse, 2009). Clearly, firms specialize and that determines their appetite for risk. The result is that physicians are offered premiums that reflect their risk. Attempts to reduce risk are rewarded.

Darwin National Insurance Company specializes in underwriting “gray docs.” These physicians don’t have bad claims records, but are in the surplus lines market.

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because they need more underwriting than the standard market is comfortable with. They may have gaps in coverage, practice in two or more states (as with a radiologist involved in telemedicine), have a large claim that is relatively old, or be involved in clinical research (Allen, 2009). In this case, specialization allows underwriters to address the needs of the specific physicians they insure.

*Forcing Explicit Consideration of Risk in Practice Patterns*

Decisions about practice patterns are best made with information about the magnitude of the underlying risk to patients. In the surplus lines market, malpractice insurance underwriters convey this information to physicians through their brokers in the form of pricing options for insurance (Vlazny, 2009). For example, a carrier may make several offers. One may include surgical coverage while another option, with a lower premium, would not cover surgery. This is especially important for new procedures (discussed below). From an economic point of view this creates appropriate incentive for physicians to consider the risk associated with their practice patterns.

*Sanctions for Negligence and Substandard Care*

Physicians with a history of negligence or substandard care pay higher premiums and take on more risk. Few physicians fall into this category, but for those that do, the consequences can be severe. As a first step, a standard lines insurer may impose a premium surcharge on a physician whose claims history does not meet their standards. My review of medical malpractice insurance rate filings in California found experience rating provisions, including surcharges (or debits) and credits, to be widely incorporated in rate manuals.8 Filing surcharges gives insurance companies the flexibility to use them

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8 In addition, schedule rating plans sometimes overlap with experience rating by including credits and/or debits based on claims (as in Allianz, 2000 and Zurich, 2000).
as they see fit. However, rather than surcharge a physician, it is more common for physicians with a claims history to be denied coverage, cancelled or not renewed (Freedman & Priddy, 2009). In 2008, The Doctors Company rate filing to cover standard physicians in California noted that “Only a small percentage of insureds have surcharges at any given time.” For new business, the blunt tool of denying coverage is more common (discussed below). Table 1 lists experience rating provisions found in the most recent California rate filings. The dates show the last filing that made any changes to experience rating provisions.  

** **Insert Table 1 here ** **

These filings are similar to those in Florida. A filing by the Florida Doctors Insurance Company (2008), the second largest insurer in Florida, with 25 percent of premium written, reveals filed surcharges between 50 and 500 percent of standard premiums based on a physician’s seven-year claim history.  

Many states limit surcharges to 25 or 40 percent (Allen, 2009; Freedman & Priddy, 2009). Even where larger surcharges are allowed, some smaller companies are unwilling to take on the exposure associated with an individual physician whose claims history is bumpy. Rather than surcharge much above 25 percent, they will either fail to renew a physician’s policy or impose reductions in coverage upon renewal (Morse, 2009).

** **Insert Table 2 here ** **

Just as surcharges punish poor risk management, claims free credits reward physicians who take steps to reduce risk. Almost all of the companies’ California filings

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9 Perr&Knight’s proprietary RateFilings.com is the source of all California filings viewed. Some Florida filings were also reviewed. They are similar. For manageability, only the California filings are summarized in Table 1. Appendix Table 1A lists the top ten medical malpractice insurance companies in California in 2008; all of these company filings were reviewed, plus others.

10 Florida filings are available on the Florida Department of Financial Services web page.
include claims-free credits. They range from five to twenty five percent of a physician’s base premium. Table 2 lists the various claims-free credits listed in California rate filings.

Most physicians qualify for a claims free credit. Often the size of the credit is a function of how long a physician has been claims free. A Florida rate filing for The Medical Protective Company (2008) reports that only 3.1 percent of the company’s premiums were paid by physicians who did not qualify for any type of claims-free credit. Physicians insured from 1989 to 2008 in Florida by First Professional Insurance Company (2008) earned an average claims free credit of 12 percent on their premiums. Longevity credits also reward good claims experience. CNA Underwriting Companies (1996) offered a five percent credit to physicians insured for five or more consecutive years. These credits are lost as claims are made providing incentives for risk management that benefit consumers.

A 2005 survey of Vermont companies confirms the California findings are not unique to California (Vermont Medical Malpractice Study Committee, 2005). Reported underwriting tools included claims-free discounts, declining or not renewing coverage, involuntary deductibles, and surcharges for physicians with high claim frequency. Respondents reported credits as large as 20 percent per credit and surcharges as high as 400 percent.

Surcharges are often couched in terms of a substitute for non-renewal or cancellation of a policy (Norcal, 2005; The Doctors Company, 2008; Zurich, 2000). An admitted company might surcharge a physician with the intention that continuing education and enrollment in risk management seminars would allow the company to “ride a physician back down” to where the admitted market is comfortable (Allen, 2009). If the required surcharge would be very large, the company is most likely to reject a physician’s
application, refuse to renew a policy, or terminate coverage. After checking with other admitted companies, the physician or his/her broker would turn to a surplus lines broker or company. Premiums in the surplus lines market are generally between 150 to 500 percent of those in standard markets (Davies, 2009; Dow, 2009; Freedman & Priddy, 2009; Morse, 2009; Nibbe, 2009; Swicker, 2009). A physician paying $10,000-15,000 in the admitted market might pay $25,000-$50,000 in the surplus lines market if s/he has been sued many times (Nibbe, 2009). Vlazny (2009) calculates that premiums in the surplus lines market average twice the level of those in admitted markets in the hard part of the medical malpractice cycle and average 1.25 times the admitted rate in a soft market.

In the surplus lines market, it is common to see required deductibles between $5,000 to $25,000 per claim (Davies, 2009; Dow, 2009; Morse, 2009; Nibbe, 2009; PULIC, 2004). This means that physicians are bearing the first dollar of damage costs (Boone, 2002). Higher deductibles are not required as it is difficult for many physicians in the surplus lines market to collateralize their deductibles; concern about the ability to collect keeps these deductibles lower than they might be if this were not an issue (Freedman & Priddy, 2009; Morse, 2009). O’Connell (2009) described deductibles in the surplus lines market as “a form of risk management;” a tool for motivating desired behavior on the part of physicians. Similarly, Davies (2009) pointed out that, sometimes, if a physician has a history of claims experience, they may want him or her to share in the cost “to help rehabilitate them.” Freedman and Priddy (2009) note it is a way to make sure physicians have “some skin in the game.” These are various ways of saying that the deductible creates incentives for physicians to manage their risk.
Physicians denied or dropped by admitted companies not only pay higher premiums and bear more risk, but when they retire or are disabled, they have to pay substantially more for Extended Reporting Period (tail) coverage.\(^\text{11}\) When a physician is disabled or retires or dies after many years with an admitted company, the physician is offered tail coverage at no charge or at a significantly reduced premium (Alliance, 2002; CNA, 1996; Zurich, 2000; Norcal, 2005; Northwest Physicians Mutual Insurance Company, 2002; and The Doctors Company; 2008). This is a valuable asset. In contrast, physicians retiring from the surplus lines market find tail coverage expensive. Premiums may range from 125 percent of the physicians previous year’s premium for one year of coverage to 500 percent for five years of coverage. Not only is this costly, but it leaves the physician carrying the risk for claims related to events in prior years that are not covered (Dow, 2009, O’Connell, 2009). This added expense is one more cost associated with being dropped from the admitted market.

The Doctors Company Tribute Plan provides an additional penalty for substandard care; physicians dropped from by an admitted carrier lose access to their Tribute Plan balance. Marketing materials for the program say that, in fifteen years, a physician with an annual medical professional liability premium of $25,000 could expect a retirement payment of $30,000.\(^\text{12}\)

For many, being placed in the surplus lines market is a “major wake up call” (Swicker, 2009). Physicians know they are at the end of the line; if their surplus lines

\(^{11}\) Under claims-made policies, insurance covers claims made during the period the physician is insured. In contrast, occurrence policies cover any claim made at any time that results from an event during the period the physician was insured. As this left insurance companies with uncertain liabilities, most med mal companies switched to claims-made policies with tails as necessary. Tail coverage offers protection against claims arising from past behavior.

insurance is not renewed they are out of business (Freedman & Priddy, 2009). Once in the surplus lines market, physicians are motivated to take steps that will reduce their perceived risk so that they can return to the admitted market (Boone 2002). Most doctors covered in the surplus lines market return to the admitted market after showing that their problems have been resolved (Pillsbury, 1995). For some, the passage of time suffices to demonstrate to the admitted market that they bring with them no unusual risk (Morse, 2009). Often specific remedial actions are required (Karls, 2008). A number of physicians resolve drug or alcohol issues under state board stipulations requiring rehabilitation (Davies, 2009). Some surplus lines companies offer risk management services on a case-by-case basis (Boone, 2002). For example, MedPro/Frontier’s program for high risk physicians included “specialized risk management designed to ‘rehabilitate’ those physicians and return them to the standard market.” (Levin, 1997, Appendix 1, P. 28). Conventus Inter-Insurance Exchange announced a program of oversight designed to get marginal physicians back in the admitted market:

…we will provide a full suite of…risk management services including a practice assessment…[providing] specific guidelines and steps the practice must take, and standards the practice must meet, in order to quality for a transfer from this program into Conventus.” (Business Wire, 2007)

In addition to higher prices and deductibles, the following statement, in a 1996 rate filing in California by The Doctors Company, illustrates the discomfort some physicians feel being in the surplus lines market:

The purpose of this filing is to establish a new program at The Doctors’ Company (TDC) for writing nonstandard medical professional liability coverage…TDC has adopted the rating methodology of PULIC, an affiliated company…The reason TDC is developing this new program is…that PULIC is well known in the medical community as a nonstandard insurance provider and many potential insureds are unwilling to seek coverage from PULIC for this reason. (P. 42)
Rarely, in the very worst cases, physicians will be denied coverage in the surplus lines market. It may be because there is no practice restriction that would make sense because the physician is a danger to the public. Even if the state board allows him or her to practice, the surplus lines insurer may decline to offer coverage (Freedman & Priddy, 2009). Or, it may be that the individual has engaged in such egregious behavior (e.g., child molestation) that no surplus lines insurance company would be willing to insure him or her (Davies, 2009; Swicker, 2009).

All of this protects consumers. From an economic perspective, the potential for surcharges or non-renewal or cancellation of standard policies and the higher cost of obtaining insurance in the surplus lines market create incentives for physicians to practice care that meets medical community standards. In general, physicians want to avoid being in the higher priced surplus lines market and, once they are there, many proactively take steps to manage risk or to comply with state medical board stipulations. When state boards or other credentialing organizations (such as hospitals) fail to sanction a physician who should not be practicing medicine, the surplus lines market will give the physician the choice of ending their practice or practicing without insurance—precluding affiliations with most hospitals and other provider organizations.

Oversight for Innovative Procedures

Not all physicians in the admitted market are there because they have gotten in trouble. Some are there because they perform fairly unique or risky procedures that companies in the admitted market do not have the expertise to underwrite. The surplus lines market plays a major role when there is a new procedure and doctors are just getting experience with the procedure (Davies, 2009; Nibbe, 2009). If there are numerous claims,
policies issued through the admitted market start including exclusions for cutting edge procedures and physicians must turn to the surplus lines market. As examples, Davies mentioned laparoscopic gallbladder surgery (cholecystectomy), bariatric procedures (including gastric bypass and lap band), the da Vinci prostatectomy (a minimally invasive, robotic assisted surgical procedure for prostate cancer), and the first lasik eye surgeries to correct vision. When new procedures are introduced, the surplus lines industry keeps an eye on claims and verifies a physician’s training to be sure it is adequate (Freedman & Priddy, 2009). The ability of the surplus lines market to adjust premiums and policy restrictions quickly is an advantage. In this way, the surplus lines industry facilitates and, to some extent, manages the risk associated with the introduction of new medical procedures, benefiting consumers.

*Reinforcing State Medical Board Sanctions*

A physician sanctioned by the state board is likely to be denied coverage in the standard market, raising the penalty associated with state board sanctions. A substantial number of physicians in the surplus lines markets are in this category. At CNA HealthPro, Vlazny (2009) reports that, between 2004 and 2009, 22.6 percent of hard-to-place physicians reviewed had a board action at least one time in their career. Davies (2009) and Dow (2009) estimated that half the nonstandard physicians they deal with have state board sanctions in effect.

It is general practice in the surplus lines industry to write any state medical board stipulations that restrict the practice patterns of physicians into a physician’s professional liability insurance contract. (Davies, 2009: Nibbe, 2009; O’Connell, 2009; Vlazny, 2009). If a board limits a physician’s practice, that limit will be reflected in his or her insurance
contract. If a physician is sanctioned by a state medical board for drug or alcohol abuse, the physician’s policy could include an endorsement form requiring notification if drug or alcohol use resumes. The physician may be monitored to insure participation in a diversion program (Boone, 2002). In this way, actions of the medical professional liability industry put teeth into state medical board sanctions to protect consumers.

*Better Tort Results*

Tort law objectives are best served by penalties for malfeasance that reflect the true underlying risk of behavior. One common criticism of the tort system with respect to medical malpractice is that the efficiency of the system depends on the accuracy of court judgments and awards (Beider and Hagen, 2004). To the extent that valid claims against a physician are isolated from those that are not, the system functions better in providing physicians with incentives for appropriate practice patterns. Since the mid-1970s, the growth of physician owned and operated professional liability insurance companies has resulted in greater use of peer review to isolate valid claims from those that are not (Danzon, 1985; Schwartz and Mendelson, 1989b). These companies advertise that they will defend physicians against invalid claims—cases where peer review indicates that adverse outcomes are not the result of physician negligence (PIAA, 2009).

Traditional commercial insurers tend not to use internal peer review but rely on expert witnesses and experienced malpractice attorneys to judge whether a claim involved physician negligence or substandard care (Morse, 2009; Vlazny, 2009). Darwin National Assurance Company relies on registered nurses (some of whom are also lawyers) to assess the validity of claims (Allen, 2009).
Some malpractice insurance companies underwrite more extensively than others. O’Connell (2009) described surplus lines insurer Evanston as an “underwriting company.” In contrast, Davies (2009) explained that, for RSUI, a “claim is a claim.” Of course, a physician with a history of invalid claims would seek insurance from a firm that does extensive underwriting and review. Whether through peer review or reliance on knowledgeable medical professionals and malpractice attorneys, efforts to assess the validity of claims by medical malpractice insurance carriers not only work to preserve the reputation of a physician falsely accused of negligence, but push the entire malpractice system toward more accurate penalties for negligence or substandard care.

Risk Management

Most medical professional liability insurance companies offer incentives to physicians who engage in risk management activities. Among California medical professional liability insurers filing rates and forms with the state department of insurance, CNA (2002), GE Global (2007), Norcal (2005) and Zurich (2000) offer a five percent credit to physicians who attend a company approved risk management/loss prevention workshop. PHICO (1995) offers up to five percent credit to physicians who comply with federal regulations regarding mammography testing, on-site laboratory testing, and employee exposure to blood-borne pathogens. One of the largest malpractice insurers in the U.S., The Doctors Company, offers moderate discounts for physicians who participate in risk management activities or comply with specialty-based risk management program requirements.\(^\text{13}\) By doing this, insurance underwriters improve the

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\(^{13}\) TDC’s Rules and Rates Manual is online at: http://www.thedoctors.com/ecm/groups/public/@tdc/@web/documents/web_content/con_id_001996.pdf (Retrieved August 12, 2009)
odds that individuals engaged in high risk procedures are appropriately trained and prepared to avoid adverse outcomes.

Furthermore, peer review efforts have led to the development of risk management programs, adding a significant benefit for consumers (Hillman and Cluff, 2003; PIAA, 2009; USGAO, 1997). When Congress enacted the Federally Supported Health Centers Assistance Act of 1992, which extended medical malpractice insurance coverage to community and migrant health centers under the Federal Tort Claims Act, many of the health centers were reluctant to cancel their private insurance because they would lose the tailored risk management services the private carriers supplied (GAO, 1997).

As part of risk management, claims tracking and analysis identifies clinical practices, facilities and practitioners that pose a risk to patients (GAO, 1997). The Physicians Insurers Association of America (PIAA) Data Sharing Project produces information that alerts insurance companies to areas of practice where the incidence of claims or suits is relatively high.¹⁴ PIAA closed claim data reviews are one of the most valuable sources of trends and claim activity (Allen, 2009). The PIAA data help hospitals and other healthcare providers identify and focus on patterns of practice where malpractice risk is substantial. Another example is CNA’s Physical Therapy Claims Study which offers risk management suggestions for physical therapists based on CNA’s review of closed claims.¹⁵

Practice Constraints Protect Consumers

Unlike state licensure, which does not restrict a physician’s practice to a particular specialty or area, medical professional liability insurance companies sometimes exclude

¹⁴ http://www.piaa.us/research/research.htm (Viewed September 7, 2009)
¹⁵ http://www.cna.com/vcm_content/CNA/internet/Static%20File%20for%20Download/Risk%20Control/Medical%20Services/Physical_Therapy_Claims_Study.pdf (Viewed September 30, 2009)
coverage for certain types of procedures. Companies may add exclusion forms to policies to limit the company’s liability. For example, AIG’s (1999) California rate filing includes forms to limit the scope of duties and another which can be used to exclude liability associated with assisting with or performing surgery, administering anesthesia, or treating pregnancy. California rate filings by CNA (1996) and Zurich (2000) include forms to exclude one or more specified medical procedures from coverage.

In some cases, insurance policies dictate very specific evidence-based standards of care that must be used for coverage to apply. Due to the much celebrated advancements in safety controls associated with delivering anesthesia, some medical professional liability insurers dictate conditions for administering anesthesia. For example, MIEC’s Anesthesia Restrictive Endorsement (MIEC, 2006) insists that the physician be physically present in the operating room or either a physician trained in anesthesiology or certified registered nurse anesthetist must replace the insured physician. The MIEC endorsement includes detail on the specific equipment that must be available during anesthesia and dictates mandatory monitoring procedures. The Doctors Company (2005) has a similar endorsement form. Physicians who fail to comply are financially liable to pay any related malpractice claims, creating incentives to follow the guidelines laid out in insurance policies.

Some companies exclude risky procedures entirely, forcing them into the surplus lines market where there is more oversight. For example, The Doctors Company (2005) Exclusion of Medical Procedures form includes an option to exclude internet medicine. Guadagnino (2002) reported that GE Medical Protective had a national policy of declining coverage for procedures failing to meet accepted standards of care or
procedures not performed regularly. General surgeons branching out to do gastric bypass surgeries on morbidly obese people or ENTs offering tummy tucks would have been declined coverage (Guadagnino, 2002).

Once in the surplus lines market, companies commonly place restrictions on a physician’s practice, laying out what the physician can and can’t do (Freedman & Priddy, 2009; Shaw, 1998). Because they are not regulated, surplus lines companies can raise rates or change policy terms as conditions warrant; admitted insurance companies can only change rates once a year (Freedman & Priddy: 2009). Underwriters follow up on policy restrictions to be sure a physician adheres to the restrictions set out in his or her policy. Underwriters review physician’s annual renewal applications for statements that suggest patterns of practice inconsistent with policy exclusions. Other sources of information may be the doctor’s website or advertisements aimed at consumers.

Procedural restrictions can also be put in place by means of lower limits on coverage. A physician with a policy limit of $100,000 per claim for most procedures might be offered a policy with a lower, or even zero, limit for certain specified surgical procedures.

Brokers negotiate with carriers on the behalf of physicians regarding coverage and pricing (Vlazny, 2009). Decisions have to be made with respect to trading off price and coverage. The result is that physicians are faced with a premium that reflects the risk of their actions. This gives physicians the incentive to consider the risk of their actions, to the benefit of consumers.

Insurance imposed restrictions sometimes mimic the types of rules formalized in state regulation. MIEC (2003) limits physicians to supervising no more than four certified registered nurse anesthetists. A state legislature would be ground zero for a turf war
between physicians and certified registered nurse anesthetists if it were to attempt to set a similar guideline. With special interests fighting for control, the outcome might not be the best for consumers (in terms of cost, access to care, and quality of services). An advantage of having these rules in the domain of insurance underwriters is that the restrictions reflect risk—as best as it can be determined. Another advantage is that, as conditions change, insurance rules are more amenable to change than state regulations.

Privileging and Credentialing Bodies Rely on Medical Malpractice Oversight

Just as medical malpractice underwriters rely on private privileging and credentialing organizations for information, these organizations rely on medical malpractice insurers to raise a flag when they have information not available to the credentialing boards. For example, a physician denied coverage or dropped by the admitted market or one with a fairly current retroactive policy date warrants particular attention by a hospital credentialing board. Board members might ask why a physician is insured in the surplus lines market or why the retroactive date on his or her policy is fairly recent (O’Connell, 2009).

Healthcare Providers Rely on Medical Malpractice Oversight

Concerned about the risk they are exposed to, many hospitals and health maintenance organizations require their physicians to demonstrate evidence of insurance. Although this behavior is widely reported, a measure of the number of providers that require physicians to be insured is not available. The legal issues related to requiring malpractice insurance of physicians are summarized by Hollowell and Smith (2007).

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16 Hollowell and Smith (2007) report a 1977 survey by the American Hospital Association of U.S. community hospitals found 26 percent required physicians to have a minimum level of malpractice insurance. The AHA does not currently collect this information (email communication with the author, August 21, 2009).
Courts have ruled that hospitals and health maintenance organizations may require physicians to purchase medical malpractice insurance as long as the requirement is not deemed arbitrary and capricious. If physicians receive prior notice and are afforded procedural due process, several state courts have ruled in favor of hospitals in challenges by physicians (Hollowell and Smith, 2007). Some physicians secure a certificate but let their coverage drop (Dow, 2009). Because this is not unheard of, at least one Southern California hospital has gone so far as to check malpractice coverage monthly (Rubino, 2009).  

**IV. Policy Options**

These findings have implications for a number of public policy issues. They include tort reform, the value of state medical licensing, joint underwriting associations, and government employee immunity from malpractice suits, and the merit of state laws that require physicians to purchase medical professional liability insurance.

*Tort Reform – Damage Caps and No-Fault Insurance Plans*

Tort reform is a major topic in current discussions of health care reform. Many observers have argued for caps on medical malpractice damage payments to reduce the cost of medical malpractice insurance. However, caps on medical malpractice payments are likely to have the unintended consequence of reducing private efforts to evaluate physicians. The lower the potential loss, the less effort private insurance companies would be expected to make to investigate risk characteristics of individuals they insure. Although caps on legal damages have been lauded for reducing claims payouts, evidence

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17 Conversation with Louis Rubino, Ph.D., Fellow of the American College of Healthcare Executives, Associate Professor, Health Sciences, California State University, Northridge, July 21, 2009. Dr. Rubino serves as a governing board member at St. Francis Medical Center in Lynwood, California, and is Chair of their Quality and Patient Safety Subcommittee.
of the effect on premiums is mixed (Ambrose & Carroll, 2007). If they do not reduce premiums and if caps reduce the incentive to spend resources on underwriting physician risk, on net, caps would be detrimental to consumers. The same consideration applies to discussions of the benefits of switching to a no-fault insurance system. A switch to no-fault insurance would eliminate private underwriting and restrictions on practice altogether. Certainly this cost must be weighed against any benefits of switching to a no-fault system.

One concern is that existing damage caps are falling in real terms. For example, California’s Medical Injury Compensation Reform Act set the cap on non-economic damages in medical malpractice cases at $250,000 in 1975. Since that time, the cap has not been adjusted for inflation. Using the GDP deflator to adjust for inflation, in 2009 the California cap is about 30 percent of the level originally intended. If $250,000 made sense in 1975, were legislators counting on inflation reducing the real cap on non-economic damages over time or did they fail to include an appropriate adjustment for inflation? In states where caps apply to total damages, this is an even more serious issue, as total damages dwarf non-economic damages.

State Medical Board Licensing and Discipline

Elsewhere I have questioned the value of state medical boards. They unnecessarily limit entry, competition and access to services with politically influenced scope-of-practice constraints on non-physician clinicians and with increasingly costly education requirements for non-physician clinicians. In addition, state disciplinary actions arguably protect physicians more than consumers. Given the high cost of proving substandard care and fears of hurting a physician’s career, boards often settle claims

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confidentially, so that no information about the claim is ever made public. Meanwhile, consumers have a false sense of security, as evidenced by the observation that brand name, which protects consumers in other markets, is rarely used in the market for clinician services. Given the many market generated protections for consumers, including private medical professional credentialing, specialty board certification, hospital medical staff oversight (granting privileges to practice and peer review), and medical malpractice underwriting, and the potential for brand name to play a greater role in quality assurance in the market for physician services, it seems reasonable to ask why we persist with the existing system of licensure which makes health care more expensive and limits access to care (Svorny, 2008).

When I asked insurance industry professionals about the value of state licensing they argued that the two—medical malpractice underwriting and state board disciplinary efforts and sanctions—go hand-in-hand (Davies, 2009; Dow, 2009). Allen (2009) is of the view that the state’s ability to pull a license is an important protection for consumers, keeping them out of the market. The real question is whether these same physicians would be identified to consumers if state boards were not in place. Given that state boards only revoke the licenses of the very worst physicians (Svorny, 2008), it seems doubtful that, given their serious practice issues, these physicians would have access to insurance.

To assist consumers, states could list physicians with malpractice coverage and list any constraints on their practice included in their policies. This would improve the level of information consumers have to judge clinician quality.

One industry professional pointed out that state boards provide cover for physicians with substance abuse problems, encouraging them to voluntarily participate in
rehabilitation programs. These physicians are allowed to practice while they seek help. The advantage is that they receive assistance with their substance abuse problem. It is useful to compare this outcome to what would be observed were there no state board. The situation would still be the same. A physician could similarly voluntarily enter a substance abuse program. In either case, the physician would have to report the substance abuse problem on his or her medical malpractice insurance renewal application and would generally only find malpractice insurance coverage in the higher priced surplus lines market. In either case, the malpractice underwriters would include a policy clause requiring the physician to report any resumption of drug or alcohol use, an action that would terminate their insurance policy. If information about malpractice insurance coverage were available to consumers, as suggested above, they would be equally or better protected.

I tried to get some idea of the number of physicians that would not be identified by malpractice underwriters were it not for state board sanctions. Vlazny (2009) calculates that only eight percent of physicians reviewed by CNA in the last five years for surplus lines coverage had no claims history that would raise a flag. This eight percent likely includes a subset of individuals who would have been identified as nonstandard by the private medical malpractice market on its own due to loss of hospital privileges, actions taken against them by a provider they work for, being dismissed from their physician group, gaps in coverage, or the nature of their practice (engaging in new procedures). If the CNA data are representative, the vast majority of malfeasant physicians would face higher premiums or limited malpractice insurance coverage even if state boards did not exist. The most troubled physicians, even some who state licensing
boards overlook, are denied medical professional liability insurance (Freedman and Priddy, 2009). Given the resources of the medical professional liability industry, its detailed efforts to identify physicians at risk of hurting consumers, and the financial incentives imbedded in the structure of malpractice premiums, state laws requiring physicians to secure medical professional liability insurance might do more to protect consumers than state board actions.

Arguably, one valuable function of state licensing boards is making information on individual physicians public by posting it to the web. State postings give malpractice insurers convenient access to information they would not find elsewhere. Of course, giving malpractice underwriters and consumers access to the National Practitioner Data Bank would make much of the same information public. Efforts to open the NPDB to the public have failed multiple times.

State Requirements for Medical Malpractice Insurance

Seven states require physicians to purchase professional liability insurance. Another seven states require it as a condition to qualify for caps on damages or to participate in a state compensation fund. Table 3 lists the states with requirements and describes the relevant state laws.

*** Insert Table 3 here ***

It is likely that the political objective is to assure compensation for patients who are harmed. A perhaps unanticipated consequence is that these states take advantage of the private sector’s profit motive to monitor, identify and restrict the practice of risky physicians. Opponents of mandated insurance may fear some physicians would be denied coverage or priced out of the market. Some would be denied coverage or priced out of the
market because they have not met established standards of care. Others would be priced out of the market because they are engaged in risky procedures that patients, when faced with higher prices, would find less attractive. In one case consumers are clearly better protected. In the other the high price reveals the risk associated with the procedure, providing information to help consumers make better decisions about care. Of course mandating medical malpractice insurance requires states to eliminate laws that limit what insurance companies may charge.

*Government Employee Immunity for Physicians*

Physicians employed by the government are protected against medical malpractice claims though the 1946 Federal Tort Claims Act (FTCA).\(^19\) The federal government is responsible for defending federal agency employees when malpractice claims arise. Medical professionals who work for the Department of Veterans Affairs, the Indian Health Service, the Department of Defense, and other federal agencies are covered by the FTCA (GAO, 1997). As noted above, the Federally Supported Health Centers Assistance Act of 1992 extended FTCA medical malpractice insurance coverage to community and migrant health centers. The goal in this case was to allow the health centers to shift the money they would have been spent on medical malpractice insurance to expanding patient treatment (GAO, 1997).

From the perspective of the information provided in this paper, this assumption of liability by the government is problematic. If medical professionals are not required to purchase private liability insurance, they are not subject to private market underwriting and oversight. Federal agencies take on this oversight. For example, the Department of

\[^{19}\text{Thanks to Linda Gorman, Senior Fellow and Director of the Health Care Policy Center at the Independence Institute, for pointing this out.}\]
Defense and the Indian Health Services have risk management programs in place. But in some cases, as with the community and migrant health centers, the oversight organization—the Health Resources and Services Administration—was not equipped to provide the risk management activities provided by private insurers (GAO, 1997). Of course, private companies have more at stake in risk management than do federal agencies, making the assumption of risk and risk management efforts by any government agency problematic.

*Joint Underwriting Associations*

It is rare that a physician is denied coverage in private markets (Davies, 2009; Dow, 2009; O’Connell, 2009; Swicker, 2009; Vlazny, 2009). However, the cost of the policy may be so high that a physician retires early or limits his or her practice. In some states, physicians faced with high premiums in the private market can turn to the state Joint Underwriting Association. JUAs are state-sponsored risk-sharing pools that act as insurers of last resort, providing coverage to individuals faced with high premiums or to those individuals who are unable to purchase insurance in private markets (Ambrose & Carroll, 2007). The structure varies by state but generally all insurers authorized to write liability insurance must participate. Although JUAs set premiums with the objective of covering their costs, the participating companies are liable for losses based on their share of premiums written in the state. Many states have the statutory authority to activate a medical malpractice JUA, but have chosen not to or have shuttered their JUAs (Virginia

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20 New York’s assigned-risk pool is a variant of a JUA. With state imposed premium surcharge limits, the state’s medical malpractice insurers share in insuring those physicians whose expected risk exceeds the premium they pay.

State Corporation Commission, 1988). In 2007, Ambrose and Carroll reported JUAs were operational in thirteen states.22  

Because there are JUAs, some bad doctors remain in practice. Following an investigation into the possibility of shutting down New York’s JUA in the mid-1990s, the Department of Insurance (DOI) concluded “…there is a possibility that some physicians with truly disastrous loss histories would be uninsurable.” (Levin, 1997, P. 23). In some cases, there seems an unwillingness to use medical malpractice underwriting to price bad doctors out of the market. When Massachusetts’ JUA was prohibited from denying coverage, Sloan, Bovbjerg, and Githens (1991) wrote, “A merit rating plan is not intended to be used to remove poor doctors by pricing them out of business.” (P. 172) One has to ask, why not? Clearly, getting very dangerous physicians or those with truly disastrous loss histories out of the market has to benefit consumers. It is troublesome to think that they are protected by state joint underwriting associations (JUAs), putting consumers at risk.  

Consumers lose important protections when government regulated, insurance industry funded associations act as insurers of last resort for physicians facing high premiums in private markets. JUAs were first established to protect consumer access to care by giving physicians affordable insurance. Given the competition in private surplus lines markets, the value of offering high risk physicians subsidized premiums through state joint underwriting associations must be questioned. To the extent that the private market cannot perfectly assess risk, some physicians may be priced out of the market when they shouldn’t be. Competition in the surplus lines markets makes this very

22 In some states, such as South Carolina, the JUA insures the majority of physicians in the state. http://www.scjua.com/why_choose_scjua.shtml (Retrieved August 13, 2008)
unlikely, but not impossible. The alternative is having JUAs which put patients at risk by protecting physicians who should only practice with restrictions or who should not practice medicine at all.

V. Conclusion

Clearly, the oversight, surcharges and penalties (including higher premiums and deductibles), and policy exclusions on practice described above could be expected to improve safety in the provision of medical care. Physicians who choose to practice outside standard parameters share in the financial risk associated with adverse outcomes. By setting up these incentives for physicians, medical professional liability insurance can be viewed as contributing to consumer protection in the market for physician services.

It would be optimal if medical malpractice insurance generated penalties “…large enough to serve as a meaningful financial incentive…to make a tangible impact on the incidence of patient injuries.” (Weiler et al., 1993, P. 115). This is impossible to assess as many factors influence physician behavior besides the penalties created by the medical professional liability insurance industry, including the implicit costs associated with negligence—loss of reputation, time in court, etc. (Danzon, 1985). However, clearing up misconceptions about the extent of medical professional liability experience rating and highlighting the positive externalities that result from the actions of the medical malpractice industry are surely important to the debate over the public policy role of medical malpractice insurance and the tort system in protecting consumers.

I found it interesting that, when asked about the value to consumers of medical professional liability insurance, all the industry professionals I talked with only mentioned patient compensation. When damages are awarded by a court or in a
settlement, the insurance company insures that the injured individual will be compensated. However, the level of oversight and penalties for negligence and questionable behavior outlined here suggest much more is at work in terms of consumer protection. Malpractice underwriters review physicians annually. They evaluate each physician’s claims history individually. They investigate any loss of hospital privileges, substance abuse, and loss of specialty board certification. They observe whether a physician is using up-to-date equipment and techniques and whether the physician has sufficient training to engage in new procedures. The medical malpractice industry penalizes malfeasant physicians with surcharges or higher premiums and rewards claim-free physicians with premium credits. These financial arrangements create incentives among all physicians for risk management. Beyond that, companies spread information as to how to reduce practice risk and physicians who engage in risk management activities are rewarded with premium credits. Aggregate closed claims data are used by health care providers to avoid situations that systematically have resulted in bad outcomes for patients. In many cases, medical malpractice insurance companies offer consumers protection from risk retention group insolvency. In the United States, healthcare consumers are protected by an interdependent system of physician evaluation, penalties and oversight that includes private credentialing activities and relies heavily on the medical malpractice insurance industry.
Table 1: Experience Rating Provisions in California Rate Filings

<table>
<thead>
<tr>
<th>Rate filing reference</th>
<th>Credit or Debit/Surcharge to Base Premium</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allianz (2000)</td>
<td>Debit to 94.5 percent, credit to 30 percent</td>
<td>Based on number of years since claim(s) made and total amount paid in indemnity and expense. Physicians with more than five claims or total payments and/or reserve(s) exceeding $150,000 are set aside for special underwriting review.</td>
</tr>
<tr>
<td>AIG (1999)</td>
<td>± 25 percent</td>
<td>Applicable to those insured who, in the opinion of the Company, uniquely qualify due to factors not contemplated in the filed rate structure of the Company. A debit or credit of up to 15% may apply based on the claims experience. Additional debit or credit for loss history.</td>
</tr>
<tr>
<td>Chubb Group (1999)</td>
<td>Credit to 25 percent; surcharge to 75 percent</td>
<td>Compares actual to expected loss ratio to determine credit or surcharge.</td>
</tr>
<tr>
<td>CNA Insurance Companies (1996)</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>First Professionals Insurance Company (2001)</td>
<td>Maximum credit of .50 of premium and maximum debit of 200 percent</td>
<td>Only applies to risks with five full time physician exposures and an annual basic limits manual premium of $100,000 or more.</td>
</tr>
<tr>
<td>GE Global/MedPro (2007)</td>
<td>± 25 percent to maximum debit of 200 percent</td>
<td>Under the Schedule Rating Plan, ± 25 percent maximum modification to recognize risk characteristics that are not reflected in the otherwise applicable premium. Considerations include unusual frequency or severity of claims, cumulative years of patient experience, and other measures not related to experience rating. In addition, there is a Non-Discretionary Debit Rating Rule which assigns debits based on history of loss payments on claims and the number of claims pending against the physician. The highest debit rating, 200 percent, would apply to a physician who, in the past five years, had at least one loss payment in the $100,000 - $250,000 range and another in the $250,000 - $500,000 range.</td>
</tr>
</tbody>
</table>
### Table 1 (Cont.): Experience Rating Provisions in California Rate Filings

<table>
<thead>
<tr>
<th>Rate filing reference</th>
<th>Credit or Debit/Surcharge to Base Premium</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Insurance Exchange of California (2006)</td>
<td>Surcharge up to 100 percent</td>
<td>In those individual situations where the risk of loss is materially higher than contemplated by the standard classification and rate because of unusually high loss frequency or severity, unusually hazardous practice pattern, or failure to comply with risk management/loss prevention recommendations.</td>
</tr>
<tr>
<td>Northwest Physicians Mutual Insurance Company (2002)</td>
<td>Surcharge of 10 to 25 percent</td>
<td>Allows NPM to recognize, through the use of a surcharge, a physician…whose claims experience is below the norm of the Company and allows NPM to charge a lower premium to those physicians with a superior claims history. Looks at 36 month history of claims. Surcharge kicks in with 3 claims (open or closed without payment) or paid claims totaling $100,000. With paid claims totaling over $750,000, the surcharge is 25 percent.</td>
</tr>
<tr>
<td>PHICO (1995)</td>
<td>± 15 percent</td>
<td>Based on history of incurred loses.</td>
</tr>
<tr>
<td>The Doctors Company (2008)</td>
<td>Surcharge up to 400 percent; beyond that “Nonrenew”</td>
<td>In lieu of declining or not renewing a risk. Considers frequency and severity of claims, drug or alcohol impairment, government agency actions (public reprimand, fine, citations, failure to report investigation, criminal and civil indictments/convictions, Medicare/Medicaid investigation, loss of M/M privileges, inappropriate patient contact, privileges, gaps in practice, payment history and other characteristics. Some points go to characteristics that are not experience rating, such as not being board certified. The Florida rate filing (07-07147) in 2007 looks the same.</td>
</tr>
<tr>
<td>Zurich (2000)</td>
<td>Surcharge up to 60 percent</td>
<td>Factors that may be used in determining the surcharge include adverse claims frequency and severity, loss of hospital privileges, performance of a procedure outside of standards, and weak or non-implemented credential procedures.</td>
</tr>
</tbody>
</table>
Table 2: Claim-free Credits in California Rate Filings

<table>
<thead>
<tr>
<th>Rate filing reference</th>
<th>Claim-free credit</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>GE Global/Med Pro (2007)</td>
<td>5 to 20 percent</td>
<td>Offers a claim-free credit of five percent at three years, ten percent at five years and twenty percent at ten years. In a 2008 Florida rate filing, Med Pro revised its claim free credit, bringing the maximum to 25 percent for ten years (The Medical Protective Company, 2008).</td>
</tr>
<tr>
<td>CNA (1996)</td>
<td>5 percent</td>
<td>Applies when physicians have had no claims with an incurred indemnity amount greater than $5,000 in the past three years.</td>
</tr>
<tr>
<td>First Professionals Insurance Company (2001)</td>
<td>10 to 20 percent</td>
<td>Offers a claims free discount of 10% with five to nine loss free years; 20 percent with 15 or more loss free years.</td>
</tr>
<tr>
<td>Northwest Physicians Mutual Insurance Company (2002)</td>
<td>5 percent</td>
<td>For physicians with three years of claim-free history.</td>
</tr>
<tr>
<td>The Doctors Company (2008)</td>
<td>12.5 percent; 17.5 percent</td>
<td>TDC offers a claims-free discount of 12.5 percent for policyholders who have been with the company for at least three years, whose cumulative outstanding claim reserves fall below $20,000 and whose three-year cumulative claim payments are less than $10,000. Surgical specialties qualify for a 17.5 percent claim-free discount.</td>
</tr>
<tr>
<td>Zurich (2000)</td>
<td>10 percent</td>
<td>For physicians with five years claim free, no incurred indemnity or expense amount greater than $5,000 and an aggregate incurred indemnity for all claims reported less than $5000.</td>
</tr>
</tbody>
</table>
Table 3: States that Mandate Minimum Levels of Professional Liability Insurance for Physicians

Required in these states:

<table>
<thead>
<tr>
<th>State</th>
<th>Rule (The first number is required coverage per incident or claim, the second number is required coverage for all claims in a year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>$500,000/$1,500,000 or equivalent bond</td>
</tr>
<tr>
<td>Connecticut</td>
<td>$500,000/$1,500,000</td>
</tr>
<tr>
<td>Kansas</td>
<td>$200,000/$600,000</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$100,000/$300,000 or equivalent bond</td>
</tr>
<tr>
<td>New Jersey</td>
<td>$1,000,000/$3,000,000; if you don’t have extended reporting endorsement coverage (tail coverage) a $500,000 letter of credit is required</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$1,000,000/$3,000,000</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$1,000,000/$3,000,000</td>
</tr>
</tbody>
</table>

Not mandatory:

<table>
<thead>
<tr>
<th>State</th>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>To participate in the state Patient Compensation Fund (a system of excess insurance): 250,000/$750,000 in coverage.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>To qualify for caps on damages: $100,000 coverage per claim or equivalent bond</td>
</tr>
<tr>
<td>Missouri</td>
<td>Physicians on the medical staff of a hospital in a county with a population over 75,000 and not employed by the hospital: $500,000 in coverage</td>
</tr>
<tr>
<td>Nebraska</td>
<td>To qualify for cap on damages: $500,000/$1,000,000</td>
</tr>
<tr>
<td>New Mexico</td>
<td>To qualify for cap on damages: $200,000 per occurrence or $600,000 bond; must buy “occurrence-made” rather than “claims-made” policy.</td>
</tr>
<tr>
<td>New York</td>
<td>To participate in the excess liability pool: $1.3 million/$3.9 million</td>
</tr>
<tr>
<td>Wyoming</td>
<td>To participate in the state Medical Malpractice Compensation Fund (a system of excess insurance): $50,000 per occurrence</td>
</tr>
</tbody>
</table>

References


Freedman, Stephen and Cheri A. Priddy. (2009). Conversation with author. September 10, 2009. Freedman directs the operations of Professional Underwriters Liability Insurance Company and PULIC Insurance Services, in the surplus lines market. Freedman is senior vice president; Priddy is vice president of underwriting. Each has over 20 years experience in the medical professional liability insurance industry.


Morse, Timothy R. (2009). Conversation with author. August 26, 2009. Morse is Senior Vice President - Health Care Professional Liability, at CNA HealthPro. Morse is on the Board of Directors of the National Patient Safety Foundation. CNA is, among other things, the sponsored carrier (sponsored by the state medical society) for individual medical professional liability insurance for physicians in Oregon and Idaho.


Pillsbury, Dennis H. (1995) Where do you turn if one of your physician insureds has claims problems? Rough Notes, 138(3):50 (2 pages)


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Vlazny, Timothy. (2009). Conversation with author. September 2, 2009. Vlazny is Underwriting Director, CNA HealthPro. Vlazny has more than 10 years experience in the hard to place physician market, before that he insured standard doctors, allied facilities, and other professional (attorneys, etc.).


Appendix Table A1: 2008 California Market Shares for Medical Malpractice Insurers Top Ten by Written Premium

Source: California Department of Insurance, Rate Specialist Bureau, 4/30/2009

<table>
<thead>
<tr>
<th>Group/Company Name</th>
<th>Notes</th>
<th>Written Premium</th>
<th>Market Share</th>
<th>Cumulative Market Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Norcal Mutual Insurance Company</td>
<td></td>
<td>$163,317,374</td>
<td>26.8%</td>
<td>26.8%</td>
</tr>
<tr>
<td>2 The Doctors Company</td>
<td></td>
<td>$151,261,024</td>
<td>24.8%</td>
<td>51.5%</td>
</tr>
<tr>
<td>3 SCPIE Indemnity Company</td>
<td>SCPIE was purchased by The Doctors Company in 2007</td>
<td>$87,751,988</td>
<td>14.4%</td>
<td>65.9%</td>
</tr>
<tr>
<td>4 Medical Insurance Exchange of California</td>
<td></td>
<td>$37,864,332</td>
<td>6.2%</td>
<td>72.1%</td>
</tr>
<tr>
<td>5 Dentists Insurance Company*</td>
<td>Dentists</td>
<td>$28,532,495</td>
<td>4.7%</td>
<td>76.8%</td>
</tr>
<tr>
<td>6 Medical Protective Company</td>
<td></td>
<td>$28,123,839</td>
<td>4.6%</td>
<td>81.4%</td>
</tr>
<tr>
<td>7 American Healthcare Indemnity Company (SCPIE Group)</td>
<td>Acquired by SCPIE in 1996; insurance for non-California physicians</td>
<td>$25,983,208</td>
<td>4.3%</td>
<td>85.6%</td>
</tr>
<tr>
<td>8 National Union Fire Insurance Company of Pittsburg (AIG Group)</td>
<td></td>
<td>$16,378,872</td>
<td>2.7%</td>
<td>88.3%</td>
</tr>
<tr>
<td>9 American Casualty Company of Reading PA (CNA Group)</td>
<td></td>
<td>$14,923,219</td>
<td>2.4%</td>
<td>90.8%</td>
</tr>
<tr>
<td>10 Professional Underwriters Liability Insurance Company</td>
<td>Surplus lines insurance only; wholly owned subsidiary of The Doctors Company</td>
<td>$10,799,148</td>
<td>1.8%</td>
<td>92.5%</td>
</tr>
</tbody>
</table>

* Rate filings for this company were not reviewed for this paper as only Dentists are insured.