FRONTLINE

MEDICAL MALPRACTICE INSURANCE NEWS

RICK'S CORNER

The Worst Is Over, For Most...

By Rick Mortimer

Here's some good news! The medical malpractice insurance hard market is officially over. How can I tell? It's simple. The policy renewals we've been negotiating for the past several months are coming in at premium levels that are either flat or a little lower than the expiring policy. Few have been bumped up just because the carrier has increased its rates. I'm comfortable that, at a minimum, we have reached the top of the hard market three year cycle.

Even better news is that an abundance of new capital has flowed into the market because investors believe they can earn higher returns on their underwriting activities than they can from buying stocks, bonds, T bills and other interest bearing instruments. In order to put their capital to work, carriers are now looking for new policyholders. As competition for market share increases, buyers can expect to see a new cycle of lower prices.

An exception we expect to see is that tight underwriting standards will hold a bit longer for Ob-Gyn, Emergency Physicians, Tele-Medicine, Nursing Homes, and a few other special risk classes. These special risks are relying on RRG's, for protection. A word of caution: Most RRGs are not rated by AM Best. If you are tempted to participate in an RRG, be sure to carefully examine its financial statement and ask about its reinsurance.

While all this bodes well for the present, no one can tell how long this new phase, let's call it "softened" market phase, of the ever revolving cycle of market changes will last. Looking back at the past 50 years, it's clear that within a few years from now, maybe 5 or 10, we can expect the cycle to revolve back to hard times. If competition again drives rates below the levels needed to pay claims and realize expected rates of return on capital, (and history shows it always does) the perfume of the premium will be overwhelmed by the stench of the losses and the hard market cycle will return.

The motor that drives most insurance market cycles, regardless of the type of insurance involved, is price. Underwriters would like you to believe that the premiums they charge are based upon rates determined by actuarial analysis of a wide range of data viewed retrospectively and trended prospectively. The fact is, if policy sales aren't growing fast enough, prices are artificially lowered to attract new applicants. This places pressure on underwriters to select the better than average risks from the pool of applicants in the hopes of at least breaking even if they operate as a mutual, or to make some margin of profit if they're a Wall Street company. When prices drop well below the cost of risk, and losses start

continued on page 2

QUOTABLES

There is no conversation more boring than one where everybody agrees.

~ Michel De Montaigne

Issue 9
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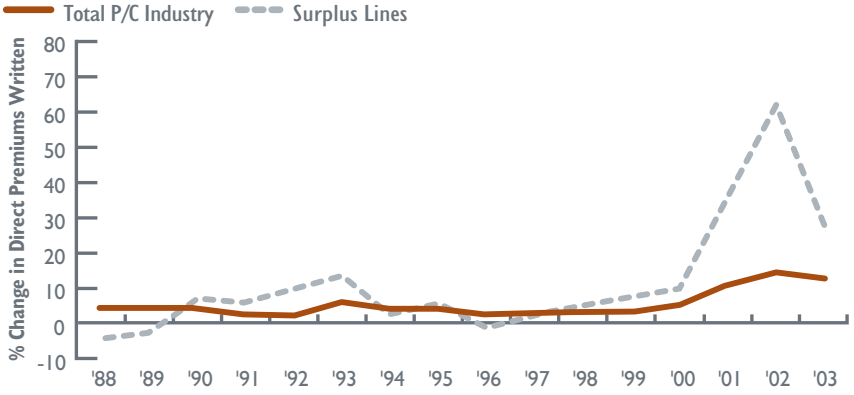
continued from page 1

to mount, the cycle will inevitably begin to revolve into a hard market phase as prices begin to rise. Most well established and financially sound carriers are able to survive the financial chaos that results from years of discounted prices. For example, St. Paul and CNA suffered huge financial losses during the peak of the hard market cycle and survived financially. Many however, including St. Paul, accelerate the hard market cycle by either voluntarily withdrawing their facilities or being forced out due to insolvency. As supply diminishes and prices are driven higher, buyers have little choice but to go along for the ride.

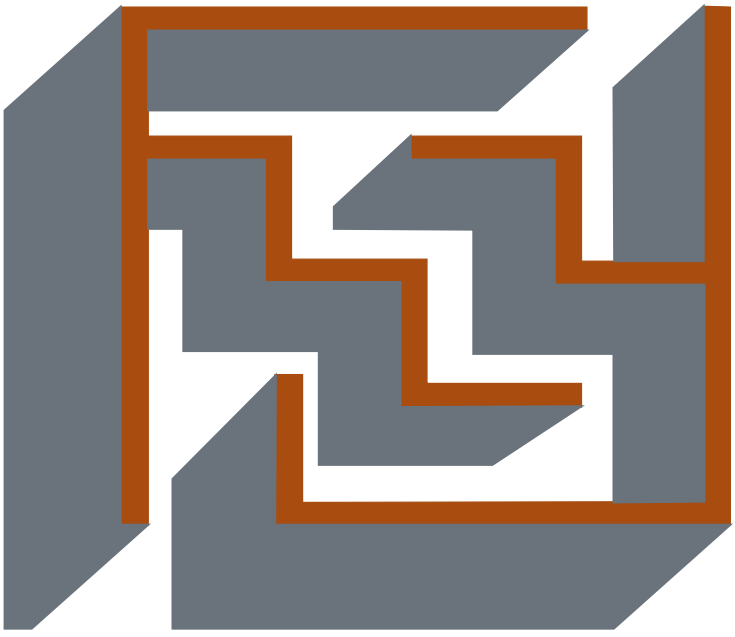
Premium Growth: Surplus Lines vs. Total Industry



Source: A.M. Best Co.

Many insurance analysts believed that the PIAA carriers (mostly doctor owned and managed mutual and reciprocal carriers) could avoid the cycles by stabilizing rates and offering "at cost" pricing as opposed to their "for-profit" competitors. But PIE Mutual, MIIX, and other "non-profit" carriers allowed themselves to be sucked into the bidding wars of the 1990s that drove premiums down while loss frequency and severity were on the rise. As we have discussed in previous Front Line articles, we know that state regulators have an impact on whether carriers can raise their rates and how much and when. Depending upon the influence asserted by doctors and other health care providers, regulatory mandates generally cause more havoc than relief. How you might ask: If regulators succumb to social pressure to keep the cost of health care down and prevent provider owned companies (ones who are already essentially non profit) from raising their rates, they are left with only one choice. They have to tighten their underwriting standards and clean their houses of existing policyholders that no longer meet their new standards. The lesson learned from the last hard market cycle is that moratoriums on new submissions, the imposition of choking underwriting standards, and unreasonably high increases in premium hurts more than it helps to heal market ills.

> *"Insurance, and more particularly medical malpractice insurance, should never be purchased as a commodity based solely on price."*



A word of advice to underwriters. Whether you're a not-for-profit provider owned company or a commercial carrier, you must not ignore the cost of risk or the basic cost of running a business. From the perspective of your health care provider insureds, insurance is never cheap or a cost they relish paying. Insurance is part of the overhead of every business. As long as we enjoy the privilege of a free market, you must act responsibly as good enterprise citizens and avoid the temptation to chase market share by under pricing your policies. The "market share at any price" strategy inevitably produces a flood of red ink that triggers a chain reaction that adversely affects your policyholders and the community at large.

During my 25 years of specializing in the programming of medical malpractice insurance and the related lines of cover-

age for the healthcare industry, my clients consistently ask how can they minimize, or possibly avoid all together, the financial hardship imposed by hard market cycles. I tell them it's really quite simple. The best way is to pick a single "A" or better rated carrier and stick with them through thick and thin; even during times when they may be tempted to change carriers when a lower price has been offered by a competing carrier. Sounds easy, but it rarely works. The low bid is just too tempting to resist making a change, and so the price wars start again and inevitably, a hard market cycle will follow. It's only a matter of when.

In other cases, depending upon individual needs and circumstances, I sometimes suggest that my clients consider exiting the commercial insurance market and adopt a suitable alternative risk funding plan. Prudence dictates that these plans include the use of some form of stop-loss or reinsurance mechanism to limit the self-assumed losses. Unless the election is to go completely bare, participants are at the mercy of the stop-loss and reinsurance market and its cyclical swings.

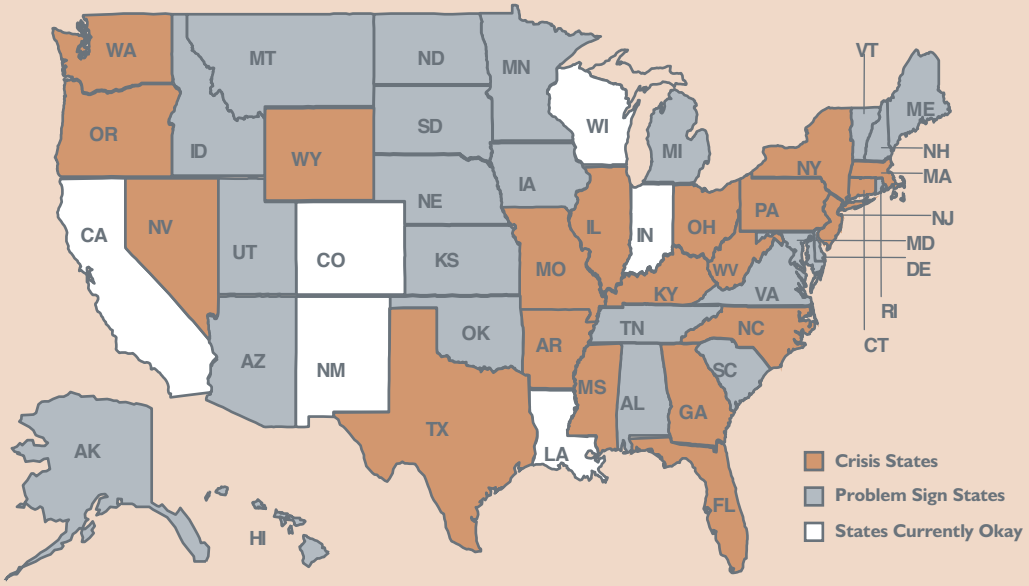
My point? Insurance, and more particularly medical malpractice insurance, should never be purchased as a commodity based solely on price. That's why you need a malpractice specialist to guide you through the maze. This is my third market cycle, certainly not my last. History is a good teacher and we here at Brown & Brown's HealthCare industry division do our very best each and every day to help our clients though each cycle and prepare for the next. ◆

ONE INSURANCE COMPANY'S OUTLOOK ON THE STATE CLAIM CLIMATE

March 4, 2004

BETTER THAN AVERAGE	AVERAGE	WORSE THAN AVERAGE
Colorado	California	Arkansas
Indiana	Connecticut	Alabama
Kentucky	Delaware	Arizona
Minnesota	Georgia	Washington DC
North Carolina	Idaho	Florida
North Dakota	Illinois (except Chicago)	Hawaii
South Carolina	Maine	Iowa
South Dakota	Montana	Illinois (Chicago)
Tennessee	Nebraska	Louisiana
Virginia	New Hampshire	Massachusetts
Vermont	New Mexico	Maryland
	New York (not NYC)	Michigan
	Oregon	Missouri
	Rhode Island	Mississippi
	Utah	Nevada
	Texas	New Jersey
	Wyoming	New York (NYC)
		Ohio
		Oklahoma
		Pennsylvania
		Washington
		West Virginia

America's Medical Liability Crisis: A National View



Source: American Medical Association July 2004

Unlicensed MedMal Insurer Cited in Maryland

"Caveat Emptor"

Medical Liability Monitor, September 2004, Volume 29, NO 9

Maryland's Insurance Commissioner has issued a cease and desist order against Unimed Insurance Company and its affiliates, Professional Liability Insurance Co. (PLIC), Ledee and Associates, LLC, Professional Liability Insurance Co., PLIC Claims Management Inc., Crowne Global Group LTD, Medical Risk Associates, RPG, LTD and Physical Malpractice Analysts, Inc. The Maryland action comes after the Washington state insurance commissioner ordered the company to stop doing business in the state in July.

The companies have also been charged with unlicensed sales by insurance departments in Alabama, Florida, Illinois, Mississippi, Nevada, Pennsylvania and Texas.

AM BEST'S RATING GUIDE

A++, A+ . . . . . Superior
A, A- . . . . . Excellent
B++, B+ . . . . . Very Good
B, B- . . . . . Fair
C++, C+ . . . . . Marginal
C, C- . . . . . Weak
D . . . . . Poor
E . . . . . Under Regulatory Supervision
F . . . . . In liquidation
s . . . . . Rating Suspended
u . . . . . under review
NR-1 . . . . . Insufficient Data
NR-2 . . . . . Insufficient Size/Operation Expense
NR-3 . . . . . Rating Procedure Inappropriate
NR-4 . . . . . Company Request
NR-5 . . . . . Not formally followed

"'Round and 'Round the Cycle Goes, Where it Stops Nobody Knows"

According to Ken A. Crerar, President of The Council of Insurance Agents & Brokers, "Terms and conditions are still tight, but we are seeing accelerated decreases in premium rates and a return of competition to the market."

- Insurance Journal-National, N10, August 9, 2004

"Soft Market Ahead?"

The RIMS (Risk and Insurance Management Society) survey indicates that price declines outpaced price gains in every major category except workers compensation, where 50% of all renewals were priced an average of 14% higher and an additional 7% remained at the same level.

Rough Notes, pg 168, September 04

MEDICAL MALPRACTICE: 2003

	BEST RATING	MARKET SHARE	2003 RANK	2002 RANK	(003) DIRECT PREMIUMS	2003 ADJUSTED LOSS RATIO
MLMIC Group	NR-5	9.4	1	1	$950,000	112.4
GE Global Ins Group	A-	9.1	2	3	927,516	84.2
Amer Intl Group, Inc	A++	9.0	3	2	910,586	69.1
ProAssurance Group	A-	5.2	4	4	523,891	40.0
Doctors Co Ins Group	B++	4.6	5	6	464,199	56.2
CNA Ins Cos	A	4.0	6	8	403,693	74.4
Health Care Indemnity, Inc	A-	3.7	7	7	379,172	76.5
ISMIE Mutual Group	B+	3.7	8	10	375,502	78.2
Zurich/Farmers Group	A	3.2	9	5	327,364	148.3
FPIC Ins Group, Inc	B++	2.9	10	9	294,060	72.2
Mag Mutual Group	A-	2.8	11	13	282,096	72.0
Norcal Group	A	2.7	12	11	277,271	56.8
ProMutual Group	A-	2.2	13	17	219,718	89.1
State Volunteer Mutual Ins Co	A	2.1	14	20	212,487	41.6
Physicians' Reciprocal Insurers	NR-4	2.0	15	16	203,782	119.2
Markel Corp Group	A	2.0	16	15	202,893	48.7
APCapital Group	NR-5	1.9	17	19	191,733	88.1
Allianz of America, Inc	A	1.5	18	14	156,662	91
SCPIE Cos	B	1.4	19	21	144,591	57
Fairfax Finl Hldgs Ltd	NR-5	1.3	20	18	129,763	65.6
Mutual Ins Co of AZ	A-	1.3	21	22	128,272	78.5
Medical Mutual Group (MD)	A-	1.2	22	23	118,846	93.6
Chubb Group of Ins Cos	A++	1.1	23	25	113,163	59.0
Physicians Ins Mutual Group	B++	1.1	24	-	106,843	68.0
Everest Re US Group	A+	1.0	25	-	102,747	44.8
Top 25 Writers		**80.3**			**$8,146,852**	**79.3**
Total U.S. P/C Industry		**100.0**			**$10,142,575**	**81.1**

Source: A.M. Best Co. State/Line Fall 2004

Surplus Line Carriers First Responders

Michael Rozenberg, the chief operating officer of Markel subsidiary Shand, Morahan & Co, cited as evidence the medical malpractice line, from which about 20 carriers have withdrawn in the last several years. Almost 70 percent of those firms "are no longer even in business," he added. "These types of results have kept large amounts of new capital from entering the market, and accordingly we anticipate rates to remain firm in the near term for carriers who are still able to write these risks for their clients.

Insurance Journal – National, N9, September 20, 2004

Some key statistics in the national medical-malpractice tort reform debate

Percentage of malpractice trials involving claims of permanent injury: 57 percent
Percentage of trials involving death: 33 percent
Overall win rate for plaintiffs in large counties: 27 percent
Percentage of medical-malpractice payments resulting from jury verdicts: 4 percent
Amount of health-care spending accounted for by malpractice costs: 2 percent
Median payment for damages on behalf of physicians: $150,000

Sources: U.S. Department of Justice; Government Accountability Office; Congressional Budget Office; National Practitioner Data Bank

Leading Writers By Line 2003-2002

2002

	MARKET SHARE	2002 RANK	2001 RANK	(000) DIRECT PREMIUMS	2002 ADJUSTED LOSS RATIO
MLMIC Group	10.7	1	1	958,842	149.8
American Intl Group	7.2	2	11	642,410	100.1
GE Global Ins Group	7.1	3	3	633,229	76.8
ProAssurance Group	5.0	4	4	443,275	63.8
Zurich/Farmers Group	4.7	5	5	416,496	149.3
Doctors Co Ins Group	4.5	6	7	404,949	67.6
Healthcare Indemnity	3.8	7	6	340,927	82.9
CNA Ins Cos	3.7	8	8	329,422	82.1
FPIC Ins Group	3.3	9	14	291,530	63.3
ISMIE Mutual Ins Co	2.9	10	13	260,757	109.2
Norcal Group	2.8	11	9	246,744	61.9
St Paul Cos	2.4	12	2	217,997	138.3
MAG Mutual Ins Co	2.4	13	20	212,654	111.3
Allianz of America	2.3	14	10	207,381	112.2
Markel Corp Group\ Evanston	2.1	15	u	186,205	55.0
Physicians Reciprocal Insurers	2.1	16	16	185,332	9.0
ProMutual Group	.0	17	18	179,791	107.7
Fairfax Finl (US) Group	2.0	18	u	177,194	139.9
AP Capital Group	2.0	19	17	176,627	78.8
State Voulunteer Mutual	1.8	20	u	163,859	84.1
SCPIE Cos\ AHI	1.8	21	15	159,767	78.1
Mutual Ins Arizona	1.2	22	u	107,230	69.9
Medical Mutual Group (MD)	1.1	23	u	100,155	77.6
MIIX Group	1.1	24	12	95,700	155.7
Chubb Group of Ins. Cos	1.0	25	u	93,385	81.8
Top 25 Writers	**81.0**			**7,231,858**	**99.1**
Total U.S. Writers	**100.0**			**8,928,252**	**95.1**

As Reported by A.M. BEST CO Fall 2002

Converging Conditions Create Current Cycle

2000 We got hit from multiple fronts:
- A. Stock Market Slump
- B. Severity of Claims Continue to Rise
- C. Carriers Fail and many others abandon medical malpractice line all together
- D. World Trade Center Terrorist Attack
- E. Four Hurricanes in weeks

1990 The driving force "winds of Hurricane Andrew" (but the 1990's were relatively calm. A buyers' market.)

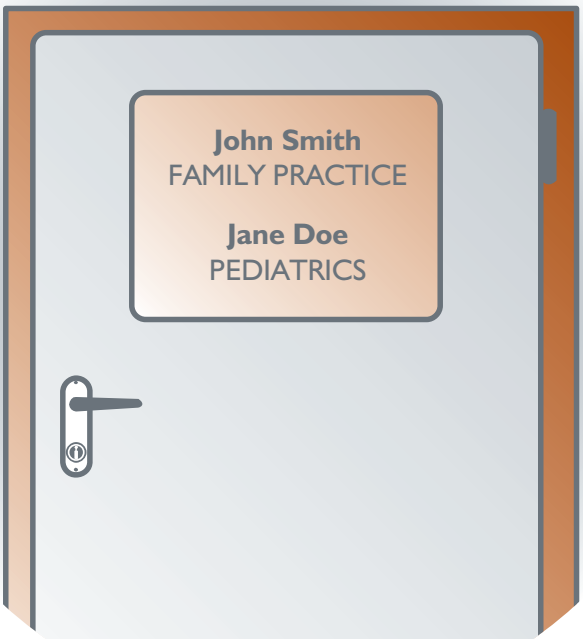
1980 Mini Hard Market – Sky Rocketing Liability Claims

1970 Stock Market Decline

This decade has tested the insurance industry, some say as never before. Higher prices and tighter underwriting continues to lead. For some, prices have peaked, but for those with less than average risk profiles, tight underwriting may keep them out of the flat or reduced pricing a bit longer. ◆

VICARIOUS LIABILITY

It would seem perfectly logical to assume that your liability as a physician begins and ends with the standard of medical care you deliver to your patients. After all, the rigorous practice of good medicine should provide you some universal guarantee of protection, shouldn't it? But the truth is that practicing even textbook medicine won't protect you against liabilities stemming from the clinical and business relationships you establish with other physicians and health care professionals. Generally referred to as "vicarious liability," these direct and indirect liability exposures can crop up in the most surprising and unexpected places. In fact, just placing your name on an office door next to another physician's name may entitle a patient to sue you for that physician's alleged negligence. But we're getting ahead of ourselves. Let's begin with the basics.



What is vicarious liability?

Under the general principles of tort law, a partner may be held liable for the acts of another within the context of their joint undertaking of the practice of medicine. This is true not only in instances where a formal partnership agreement exists, but also in instances where a plaintiff's attorney can prove the existence of an "ostensible" partnership. "Ostensible" basically means "apparent" or "perceived" – it also means "superficial." Don't feel bad if this concerns you. It should. There are a handful of common actions or shared resources that indicate that you might be involved in an ostensible partnership with another physician (listed in order of significance):

- Using common letterhead and billing statements
- Seeing each other's patients on a regular basis
- Sharing overhead expenses
- Sharing professional employees, such as RNs and technicians
- Placing both your name and the other physician's name on an office door.

If the commonalities include only office space and overhead expenses, and every other practice feature is separate, then your practice presents very little potential for vicarious liability. However, there are exceptions to every rule (as many exceptions as there are attorneys to dream them up). Of course, explicit contractual relationships almost always create the potential for shared liability. Also, a medical corporation (and indirectly its directors, shareholders, and all physician employees) may be held liable for the acts of a single physician employee acting within the scope of his or her authority as an employee of the corporation.

Why is vicarious liability bad?

Aside from the obvious answer to this question, being that you could be subject to direct financial liability for an act you did not perform; vicarious liability becomes complicated when different people in the vicarious liability "chain" carry different medical liability insurance limits. (These are referred to as "deep pocket" scenarios.) For example, if you share resources and office space with another physician who carries $1 million/$3 million limits of liability, and you carry $2 million/ $4 million limits, a patient dissatisfied with the care provided by the other physician could choose to sue you because you represent a "deeper pocket" so to speak.

Vicarious Liability can also create a situation whereby two or more physicians, each represented by a different medical liability insurer, are named as defendants in a single claim. When this occurs, your insurer's ability to control both the direction and quality of your defense is seriously compromised because there may be competing – and even conflicting – interests in the case. ◆

These are excerpts from an article written by **By Barron Bixler**
Sonoma Medicine Winter 2004

Risky Business . . . Part 2

By: Sharyn O'Mara, CPHRM

While the healthcare industry and the practice of medicine prepared to survive the storm of medical malpractice rate increases and non-renewals, as insurance carriers left the market and reassessed the exposures they were willing to cover, the hurricanes hit the business of healthcare – "Enterprise Liability". The business of medicine has outgrown its private practice roots with advances in technology and evidence-based care models expanding its reach to the physician involvement in extended or unrelated entity care models. The plaintiff bar discovered opportunities for action beyond the insurance industry's focus on the underwriting exposures specific to the scope of care related to the practice of medicine.

> *"Risk exists from what you do, not necessarily how well you perform."*

The assets of your "Enterprise", the business of medicine, are at risk if not adequately protected. Risk management is the discipline that when applied to business operations allows for assessment, management and protection of assets. The assessment process defines all operations involved – risk exists from what you do, not necessarily how well you perform. Only when appropriately defined can the risks be adequately treated through the application of management and insurance/risk financing techniques.

"Professional Liability" exposures are associated with your medical professional job, assignment, tasks or undertakings related directly to the practice of medicine. Professional liability insurance coverage is underwritten specific to your declared scope of practice. Medical Malpractice Tort Reform at the State level has assisted in limiting total loss costs in certain jurisdictions, and the need for Federal Tort Reform has been proven yet debates continue.

"Enterprise Liability" exposures are associated with all other ventures, projects, endeavors and schemes, and include risks related to contracts, net income, endorsement and oversight of unrelated entity operations. The trial attorneys, to escape potential limits in awards, specifically represent enterprise liability actions as outside of the medical malpractice arena. Additional management and insurance/risk financing techniques are required to protect assets.

Prepare Asset Protection! It's not too late to retrofit your risk management and insurance plan, and preserve assets. How? Up-date your risk profile to include all activities, ventures, and practices. Just as audited financials promote fiscal health, review of agreements made and endeavors undertaken each year will reduce surprises and conserve assets. Your broker and risk management professionals are there to help.

Risk Profile Contents:

- ✔ Patient/client served and outcomes of care
- ✔ Patient satisfaction, grievance and claims experience
- ✔ Health care team qualification and competency, all those in contact with your client population, in all settings, whether employed, contracted or support service.
- ✔ Services, advise and counseling provided by diagnosis, treatment, procedure, at all locations, for all entities.
- ✔ Operational protocols, policies and procedures managing potential risk, all settings
- ✔ Patient care equipment, pharmaceuticals and supplies, in all locations, used directly or use directed
- ✔ Regulatory compliance, clinical correlation of medical record documentation and billing practices, HIPPA
- ✔ Continuum of patient care referrals, monitoring and case management
- ✔ Contracts, appointments and decision positions served
- ✔ Consent, of all kinds, especially INFORMED CONSENT – avoid battery allegations!
- ✔ Inventory of loss exposures and insurance program coverage details, all lines.

It is all about your scope of medical practice AND your business(s) in healthcare/medicine! ◆

FRONTLINE

This newsletter is for general informational purposes only. It is intended to provide a limited overview of the market and to provide thought provoking ideas for our readership to consider when arranging for risk transferal programs and insurance.

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HealthCare Professionals' Insurance Services
"Risk Finance Consulting & Insurance"
475 S. State College Blvd.
P.O. Box 9699
Brea, CA 92822-9699

CONTACT US
Telephone:
714.990.4430
Fax:
714.255.0872
Email:
info@bbbrea.com
Internet:
www.HCPinsurance.com

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