Healthcare Risk
ADVISORS

HealthCare Risk Advisors, LLC

Glossary

A

Absolute Liability
Liability regardless of fault.

Adjudication
The act of determining an issue or settling a dispute in court.

Admitted Assets
See Assets.

Allocated Loss Adjustment Expense (ALAE)
Expenses directly attributable to specific claims. Include payments for defense attorneys, medical evaluation of patients, expert medical reviews and witnesses, investigation, and record copying.

Annual Aggregate Limit
For claims-made carriers, the annual aggregate limit is the maximum amount the carrier will pay for all claims arising from incidents that occurred and were reported during a given policy year. For occurrence carriers, the annual aggregate limit refers to the maximum amount the carrier will pay for all claims arising from incidents that occurred during a given year of insurance.

Assessability
An obligation of policyholders to pay additional money, in excess of premium amounts, to cover past insurance company losses for which reserves have proven to be inadequate.

Arbitration
An alternative method for resolving disputes that allows the parties to define the process.

Assets
The property and financial resources owned by an insurance company. Admitted assets are those that can be liquidated to raise cash to pay claims. Nonadmitted assets are assets, such as real estate (other than home office), furniture, and other equipment that are not recognized for solvency purposes by state insurance laws or insurance department regulations.

Assumed Premium
The consideration or payment an insurance company receives for providing reinsurance for another company.

Attorney-in-fact
The entity that manages an interinsurance or reciprocal exchange and to whom each subscriber (policyholder or owner) gives authority to exchange insurance among subscribers.

B

Best's Rating
A rating given to insurance companies by the A.M. Best Company, an insurance industry ratings agency. The ratings range from A++ (Superior) to D (below minimum standards). Ratings of E and F are given to companies under state supervision or in liquidation. The ratings reflect A.M. Best's evaluation of an insurance company's financial strength and operating performance relative to the norms of the property and casualty insurance industry.

C

Captive
In its simplest form, a captive is a wholly owned insurance company that is formed by a noninsurance entity or group to insure or reinsure some or all of the risks of its parent. A captive is usually administered by specialized consultants.

Claim
A written notice, demand, lawsuit, arbitration proceeding, or screening panel in which a demand is made for money or a bill reduction, and which alleges Injury, disability, sickness, disease, or death of a patient arising from the physician's rendering or failing to render professional services.

Claims-made Insurance
Claims-made is a form of insurance in which coverage is limited to liability for those claims that arise from incidents or events that occur and are reported to the insurance company while the policy is in force. As premiums for claims-made insurance reflect ongoing claims experience, they can be readily adjusted as experience changes.

Claims-paid Coverage
Under a claims-paid policy, premiums are based only on those claims settled during the previous year or those projected to be settled in the coming year. Many claims-paid policies are assessable for a number of years, or even indefinitely, after a physician has terminated the policy. When leaving a claims-paid carrier, physicians often have difficulty obtaining retroactive (prior acts) coverage from their new carriers, and they may be forced to purchase tail coverage from the claims-paid carrier.

Claims Reserves
Under a claims-made policy, claims reserves are funds set aside to satisfy those claims that have been reported to the company but have not yet been resolved or paid. Under an occurrence policy, an additional reserve must be set aside for incidents that occurred but were not formally reported during the policy year and are expected to be reported after the

close of the policy year. A company that underestimates its claims reserves may face future financial difficulties. A company that overestimates its reserves could be charging unnecessarily high premiums.

Credentialing Report
Provides up-to-date information on a physician's policy and claims experience.

D

Date of Incident
The date on which a situation of alleged malpractice took place. It can also be called the date of occurrence.

Date of Reporting
The date on which an incident was reported to the insurance company. The shorter the time between the date of incident and the date of reporting (i.e., if the insured promptly reports the incident or claim), the easier it is for the insurer to investigate the case and handle the insured's defense.

Declaration
Also called Declarations Page, this portion of an insurance policy states information such as the name and address of the insured, the policy period, the amount of insurance coverage, premiums due for the policy period, and any coverage restrictions.

Deductible
There are two types of deductibles:

A voluntary deductible allows the insured to pay an amount of the "first dollars" of a claim payment and to pay a lower premium for assuming this risk.

An involuntary deductible is imposed by the insurance company because of the adverse risk characteristics of an insured. Involuntary deductibles do not include a premium reduction.

Deductibles may take one of two forms:
A straight deductible provides that all loss payments are reduced by the amount of the underlying deductible with no other considerations.

A franchise or quota share deductible provides that the insured and the insurance company share costs within the deductible amount.

Deductibles may apply to indemnity only or to both indemnity and allocated loss adjustment expense (ALAE). In the latter situation, the insured pays, up to the total amount of the deductible, for claims in which allocatable expenses (such as legal fees) have been incurred, even if no indemnity is ever paid. If the deductible applies to indemnity only, the insured pays only if indemnity is paid. A limit on the total number of claims or total amount paid in a given year may be specified. (Aggregate Deductible)

Direct Written Premium
A carrier's gross premium written, adjusted for cancellations, before deducting any premiums paid or ceded to a reinsurer.

Dividend
A partial return of premium to policyholders. In an interinsurance exchange, the company's governing board would normally declare a dividend to be disbursed for a particular state or specialty if the company's claims and financial experience for one or more past years resulted in funds exceeding those needed to pay the claims for that year or prior years.

Domicile or Country
Refers to the state in which an insurance company receives a license to operate. The company is then regulated by that state's department of insurance.

E

Earned Premium
The portion of premium that applies to an actual coverage period. Insureds usually pay a calendar quarter or more in advance of the actual coverage period; the advance payment is initially unearned and becomes earned incrementally during the ensuing coverage period.

Economic Damages
Out-of-pocket expenses, such as medical bills incurred, lost wages, etc.

Endorsement
An amendment, sometimes referred to as a rider, added in writing to an insurance contract or policy.

Excess Insurance
A separate insurance policy with limits above the primary (or "first dollar") policy.

Exemplary Damages
See Punitive Damages.

Experience Rating
A system of pricing insurance in which the future premium reflects the actual past loss experience of the insured.

Extended Reporting Coverage
See Tail Coverage.

I

Incident
An occurrence that the plaintiff claims has led to culpable injury.

Incurred But Not Reported Losses (IBNR)
An estimate of losses for incidents that have occurred during a policy period (usually one year), but have not yet been reported to the company. Mainly applicable to occurrence policies, these apply to claims-made policies only when extended reporting endorsements (tail coverage policies) are in effect.

Incurred Losses
These losses include both paid and unpaid (reserved) losses.

Indemnity
Payment to a plaintiff in settlement or adjudication of a claim.

Indemnity Reserves
Claims reserves that are set aside to pay the portion of claims costs paid directly to claimants.

J

Joint Underwriting Associations
Joint Underwriting Associations (JUAs) are state-sponsored insurance vehicles for physicians who do not have access to other sources of professional liability insurance. Insureds of some JUAs bear infinite assessability for losses incurred by the organization during prior years of insurance activity. In some states in which JUAs operate, all casualty insurers in the state are assessable. In others, only the insured doctors are assessable. In those instances in which only the insureds of the JUA are assessable, ultimate financial obligations are unpredictable and can be significant.

L

Limit
The maximum amount paid under the terms of a policy. A professional liability insurance policy usually has two limits, a per-claim limit and an annual aggregate limit. (See Annual Aggregate Limit.)

Loss Ratio
The result of losses incurred (indemnity and ALAE) divided by net earned premium.

Loss Reserves
The amount set aside to pay for reported and unreported claims. For an individual claim, a case reserve or estimate of the expected loss is set aside.

Loss Reserves-to-surplus Ratio
See Reserves-to-surplus Ratio.

M

Malpractice
Professional negligence—an abrogation of a duty owed by a healthcare provider to the patient; it is the failure to exercise the degree of care used by reasonably careful practitioners of like qualifications in the same or similar circumstances. For a plaintiff to collect damages in a court of law, the plaintiff's attorney must show that the provider owed the patient a duty and that the provider's violation of the standards of practice caused the patient's injury.

N

Net Earned Premium
Net written premium (plus assumed premium for reinsuring risk) less unearned premium.

Net Written Premium
Direct written premium less payments to reinsurers.

Nonassessable
A condition under which an insurance company is sufficiently sound to free policyholders of any obligation to pay additional money for past losses for which reserves are inadequate.

Noneconomic Damages
Pain, suffering, inconvenience, loss of consortium, physical impairment, disfigurement, and other nonpecuniary damages.

Nose Coverage
Also called retroactive or prior acts coverage, nose coverage extends the effective date of claims-made policies to a prior date. See also Retroactive (Prior Acts) Coverage.

O

Occurrence Insurance
A type of policy in which the insured is covered for any incident that occurs (or that did occur) while the policy is (or was) in force, regardless of when the incident is reported or when it becomes a claim.

P

Paid Losses
The amount paid in losses during a specified time period.

Policy
The contract between an insurance company and its insured. The policy defines what the company agrees to cover for what period of time, and it describes the obligations and responsibilities of the insured.

Policy Term
The length of time for which a policy is written.

Premium
The amount of money a policyholder pays for insurance protection. The amount is deemed necessary to pay current losses, to set aside reserves for anticipated losses, and to pay expenses and taxes necessary to operate the company during the time period for which the policies are in force. Premiums allow the company to generate a reasonable profit that reinforces future solvency and contributes to the company's growth. In the case of a reciprocal insurer, the premiums allow the company to offer insurance to new applicants without the need for additional capital contributions.

Premium Credits
A credit included in the premium computation that recognizes a reduction in hazard, which makes the account a better risk.

Premium-to-surplus Ratio (P/S)
The ratio of net written premium to surplus. This ratio reflects a company's financial strength and future solvency.

Profit or Loss
Underwriting results are combined with investment income, expenses, and taxes to calculate profit or loss. Actual profit results from underwriting profit plus investment income that exceeds losses, expenses, and taxes or from investment income that offsets the underwriting loss, expenses, and taxes. Actual loss results if the investment income does not offset the underwriting loss, expenses, and taxes. Actual losses must be offset by drawing on the company's surplus. Companies offering assessable policies can impose payments on their policyholders to amend the loss. (See also Underwriting Results.)

Punitive Damages
Also called exemplary damages. Optionally covered by professional liability insurers. A few states require that punitive damages be covered. Other state laws prohibit insurance companies from covering punitive damages because such damages are intended to punish the defendant for willful, fraudulent, oppressive, malicious, or otherwise outrageous behavior that should not be covered by insurance.

R

Rate Maturation
In the early period of claims made coverage (typically the first four to seven years), claims-made insurance rates rise annually until they are considered mature. Increasing the premium is necessary because the longer the physician is insured, the greater the potential for a claim. That is because of the delay between incidents occurring and patients filing claims from those past incidents.

Reinsurance
An agreement between insurance companies under which one accepts all or part of a risk or loss of the other. Most primary companies insure only part of the risk on any given policy. The amount varies among carriers. The remainder of the policy limits is covered by reinsurance entities. The less primary risk that a company insures, the more premium it has to pay to the reinsurer to cover the remaining policy limits. In general, smaller companies are able to cover only a relatively small proportion of the liability limit. This results in large premium payments to reinsurers. Larger companies can safely cover a large proportion, thus reducing the payments they must cede to reinsurers, which indirectly reduces the cost of insurance to their policyholders.

Reserves
See Claims Reserves.

Reserves-to-surplus Ratio (R/S)
Measures a company's financial ability to pay claims if reserves prove to be inadequate. Such payments must come from the insurer's surplus.

Retroactive (Prior Acts) Coverage
Under a claims-made policy, retroactive coverage provides insurance for claims arising from incidents that occurred while a previous claims-made policy

or policies were in effect, but that were not reported until that policy (or the last in a succession of policies) was terminated. With retroactive coverage, the new policy covers such claims. With retroactive coverage, purchase of tail coverage from the previous carrier is not necessary. (See also Tail Coverage.)

Retrospective Rating
A formula of premium calculation that reviews the previous loss experience and, after the policy year ends, adjusts the premium based on the loss experience. Some plans provide a guaranteed maximum cost; some guarantee that the premium will not exceed the standard premiums otherwise applicable.

Reunderwriting
The process by which a company re-evaluates policyholders and imposes surcharges, deductibles, or nonrenewal as necessary in cases where the policyholder's claims history or other experience presents a consistent pattern that creates an undue liability risk.

Risk Classifications
A risk classification is based on the number and amount of losses that can be expected from a physician's specialty and procedures.

Risk Management
A systematic approach used to identify, evaluate, and reduce or eliminate the possibility of an unfavorable deviation from the expected outcome of medical treatment and thus prevent the injury of patients as a result of negligence and the loss of financial assets resulting from such injury.

Risk Purchasing Group
Risk purchasing groups (RPGs) came into existence as a result of the federal Risk Retention Act of 1986. Unlike a risk retention group (RRG), an RPG is not an insurance company but an association of insurance buyers with a common identity (e.g., a medical specialty society) who form an organization to purchase liability insurance on a group basis. Since an RPG purchases coverage from an insurance carrier, no capital contributions are required in order to join. The company from which the RPG purchases insurance need not be licensed in every state. The purchasing group's insurer must indicate how much premium was generated by the purchasing group in each state on its National Association of Insurance Commissioners' annual statement. Physicians considering purchasing insurance through an RPG should inquire about the strength of the insurance company that provides coverage to the purchasing group.

Risk Retention Group
Risk retention groups (RRGs) came into existence as a result of the federal Risk Retention Act of 1986. That act allows an RRG to form as an insurance company and requires that it follow the insurance laws of at least one state. When first joining an RRG, a physician is typically required to pay a capital contribution in addition to the annual insurance premium.

An RRG is governed by the regulations of the state in which it is domiciled. If an RRG is appropriately capitalized and operated, it can be a viable insurance alternative. As there is less regulatory scrutiny in some states, however, some RRGs are inadequately capitalized and charge inadequate premiums. As a result, insolvencies that imperil the coverage of the insureds have occurred among RRGs.

An RRG must file an annual financial statement with its chartering state and all other states in which it operates. Doctors considering purchasing insurance from an RRG should review that statement. They should also carefully evaluate the degree to which the state in which the RRG is domiciled requires them to meet the high standards of solvency and effective management necessary to ensure that the company is able to fulfill its insurance obligations.

S

Standard Risk
A person who, by the company's underwriting standards, is eligible for insurance without restrictions or surcharges.

Substandard Risk
A person or entity that must pay higher premiums and is subject to special coverage restrictions based on underwriting standards.

Surplus
The amount by which a company's assets exceed its liabilities. A company's surplus allows it to take on risk and serves as a cushion in the event that the losses from that risk exceed the premiums intended to cover the risk. Stated another way, surplus can be used to make up for deficiencies in loss reserves that were set aside from earned premiums. Surplus thus serves to provide strength and to maintain fiscal integrity in the face of adverse loss experience that was not actuarially anticipated.

Surplus Contributed and Surplus Earned
Surplus contributed is the amount of capital that insureds must provide for a mutual company or reciprocal exchange during the early years of the company's operation. Surplus earned represents the earnings of the company after losses, expenses, and taxes. As the company stabilizes and grows in financial strength, earned surplus from profits is added to the contributed surplus, and the contributed surplus can be returned to the early policyholders.

T

Tail Coverage (Extended Reporting Coverage)
Coverage that protects the physician against all claims that arise from professional services performed while the claims-made policy was in effect, but which were reported after the termination of the policy. Some insurers offer this feature free of charge for retiring doctors who meet certain requirements.

Trusts
An alternative to insurance companies. In some states, trusts are not regulated by state insurance departments nor are they protected by state guarantee funds in the event of insolvency. Trusts frequently require capital contributions in order to join, and trust members are retroactively assessable if assets prove insufficient to pay losses. Typically, coverage through trusts is provided on a claims-paid basis. Some trusts stop defending and paying open claims for members who go elsewhere for coverage if the members do not agree to remain assessable or do not purchase tail coverage from the trust.

If considering coverage through a trust, RRG, or RPG, a physician should carefully investigate all aspects of the policy, rules regarding assessability, tail coverage requirements, and the financial solvency of the organization.

U

Unallocated Loss Adjustment Expenses (ULAE)
Claims expenses of a general nature that are not directly attributable to specific claims. They include the salaries of claims personnel and the other costs of maintaining a claims department.

Underwriting Results
The profit or loss of the insurance company, calculated by subtracting from earned premium those amounts paid out and reserved for losses and expenses. Any residual amount is called an underwriting profit. If deductions exceed earned premium, it is called an underwriting loss. Underwriting results do not include investment income. (See also Profit or Loss.)

Unearned Premium
That portion of a premium that is paid in advance of a coverage period. Insureds usually pay a calendar quarter or more in advance of an actual coverage period; the advance payment is initially unearned and starts to become earned on the first day of the coverage period and incrementally thereafter during the ensuing coverage period.

V

Vicarious Liability
Liability for the acts of someone else.

W

Written Premium-to-surplus Ratio
See Premium-to-surplus Ratio.