Medical Malpractice Insurance: Read the Fine Print

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Our emergency medicine group was informed that a new corporate mandate will force us to nearly double our malpractice coverage from $1 million for each occurrence and $3 million in yearly aggregate ($1M/$3M) to $2M/$4M. This mandate came despite our group's low malpractice claims history, a higher burden of proof for plaintiffs in the state where we practice, and a very "doctor-friendly" malpractice environment in our county. To my knowledge, there has never been an emergency medicine case in our jurisdiction that has exceeded the $1M policy limits.

Logic notwithstanding, it was a mandate and thus, we were forced to comply. Some members of our group wanted to pursue joining our system's self-insured policy. On the surface, this makes some sense until one starts reading the fine print. This article will review a number of "gotchas" of which to be aware when negotiating malpractice insurance.

Joining Forces with a Health System

A large percentage of providers in the United States purchase medical malpractice insurance through companies that are admitted to write policies in their particular state. To be admitted, these carriers must comply with a number of strict financial and reporting requirements. In some states, if the carrier becomes insolvent, the state will guarantee at least some level of coverage.

Today, many providers are joining large health system-sponsored physician groups. These health systems often elect to self-insure in lieu of using a med mal carrier admitted to the state. One downside to this is that if the health plan becomes insolvent and declares bankruptcy, the state guaranty not step into guarantee coverage. In New York, when St. Vincent's Hospital declared bankruptcy in 2010, the physicians were left holding the bag. Before blindly signing on, make an effort to gauge to financial health of the fund and the sponsoring entity.

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Another challenge that I have witnessed is that once providers sign on, they lose the ability to determine their own fate. The contracts I have reviewed all give the system a unilateral consent to settle the case on behalf of the physician. I have seen the following situation all too often. A frivolous medical malpractice case is filed. The self-insured determines that the cost of defense (discovery, experts and trial) would likely exceed $75,000 and makes the purely economic decision to settle a defendable case, thereby throwing the physician under the bus. This triggers a report to the National Practitioners Data Bank and at least in my state, a medical board investigation. A veritable trifecta of abuse is heaped upon the provider solely based on economics. Once an amount is paid, it makes it that much harder for a provider to join other systems or med mal carriers, be admitted to additional states to practice medicine, or to join other organizations.

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the event of a malpractice action, the provider should stay vigilant for assessing what could become an inherent conflict of interest. An attorney representing a provider who is employed by or on retainer to the system has an inherent conflict, inasmuch as he or she is defending the provider yet being paid by the system. In such cases, the provider may want to retain counsel of his or her own who has been prospectively vetted by the plan.

In additional, many medical malpractice policies cover providers in peer review actions, medical board complaints, and other formal hearings. Providers who are terminated by the very system that provides coverage would be better served to find their own representation, but that likely will be very expensive.

The take-home point is to make sure you understand your rights under a health system's self-insured policy. Before signing the contract, a provider can negotiate with the system about certain terms in the employment and medical malpractice agreement and consider continuing his or her own coverage in the event that it's not possible to reach a reasonable compromise.

Hammer Clause

There are certainly times when settling a malpractice case is the smartest decision. With a consent-to-settle clause, the provider gets to make the final decision. Today, most carriers have a consent-to-settle clause but are tacking on "hammer" clause, which makes the consent clause nearly worthless. A hammer clause essentially compels a provider to settle against his or her will even with a consent-to-settle provision by making it financially hazardous to reject the insurance company's recommendations.

With a hammer clause, if a provider refuses a settlement offer recommended by the insurance carrier, the carrier's exposure is capped at the amount of the proposed settlement offer.

For example, let's say that an insurance company wants to settle a med mal case for $50,000. The provider refuses because he or she knows that the case is easily winnable and that a settlement would mean significant additional exposure. If the case goes to court and is lost, the carrier will pay only $50,000 regardless of the final decision. If the judgment is $150,000, the provider will end up being responsible the other $100,000.

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A modified hammer clause limits the carrier's liability to a percentage of the verdict in excess of the proposed settlement. For example, it may set a 50% limit. In the above case, the insurance company would pay the amount of the offered settlement ($25,000) plus one half of the amount over that figure ($50,000). The provider remains liable for the final $75,000.

Here is a worrisome scenario under a policy (like ours) with higher limits. Our emergency medicine group's policy contains a limit of $2 million per occurrence, meaning that there would likely be no uninsured exposure concerns for a typical claim with a maximum value of $1 million. However, despite paying the significantly higher premiums, what if our insurer invoked the hammer clause after our refusal to consent to a settlement of $250,000? We could face potential liability for all legal expenses incurred after the refusal, as well as potential liability for the amount of any judgment in excess of the recommended $250,000. Essentially, the carrier has morphed our $2 million policy into a $250,000 policy.

You won't find the term "hammer clause" in your insurance contract. Typically, the clause is buried in the Defense and Settlement section, using somewhat ambiguous phraseology. For example:

> *If the Insured refuses to consent to a settlement recommended by the Insurer and elects to contest a Claim, the Insurer's liability shall not exceed the amount for which the Insured would have been liable for loss if the Claim had been so settled when and as recommended, and the Insurer shall have the right to withdraw from the further defense of the Claim by tendering control of the defense thereof to the Insured.*

The bottom line is that if you are not sure, carefully read your policy. If you are still not completely sure, call your broker or agent or the carrier. This is not an area in which you can afford to assume anything. ■