REPORT OF THE
STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE ON

Medical Malpractice Insurance Tail Coverage

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 16

COMMONWEALTH OF VIRGINIA
RICHMOND
1990

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STATE CORPORATION COMMISSION

December 28, 1989

TO: The Honorable Gerald L. Baliles
Governor of Virginia
and
The General Assembly of Virginia

We are pleased to transmit this Report of the State Corporation Commission's Bureau of Insurance on Medical Malpractice Insurance Tail Coverage.

The study was initiated and the report prepared pursuant to Senate Joint Resolution 211 of the 1989 Session of the General Assembly of Virginia.

Respectfully submitted,

Thomas P. Harwood, Jr.
Chairman

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Executive Summary

The State Corporation Commission's Bureau of Insurance was requested by the 1989 Session of the General Assembly to study the reasonableness of medical malpractice insurance tail coverage and to determine whether it should be more stringently regulated or possibly prohibited. The findings of this study are summarized below:

1. Rates for tail coverage are subject to prior filing and actuarial review by the Commission pursuant to §38.2-1912 of the Code of Virginia.

2. Forms for tail coverage are subject to review by the Commission under §38.2-317. This section requires forms to be filed at least 30 days prior to their effective date. The Commission may disapprove a form if it does not comply with the provisions of §38.2-317.

3. Tail coverage extends the time to report claims resulting from incidents that occurred when a claims-made policy was in force. It is designed to eliminate gaps in coverage. The Bureau of Insurance requires tail coverage to be offered by the insurer of the expiring policy when (i) a claims-made policy is cancelled or non-renewed, (ii) the retroactive date is advanced, or (iii) a policy is renewed other than on a claims-made policy form. The insured must be given at least 30 days after termination to purchase tail coverage and the expiring policy's aggregate limits of liability must be reinstated at the time of purchase. The insured must also be offered "unlimited" tail coverage. This means that the extension of the reporting period cannot be limited in its duration. These requirements exceed the requirements of many other states.

4. The premiums charged for tail coverage vary from company to company, and some companies waive the additional premium for tail coverage if the insured retires, dies, or becomes totally and permanently disabled. Each company specifies the conditions which must be met in each of these situations.

5. A review of one company's rates on file with the Bureau of Insurance shows that over a 10-year, 15-year, or 20-year period a physician would pay less for coverage under a claims-made policy (including the purchase of tail coverage) than under an occurrence policy.

Based on these findings, the State Corporation Commission's Bureau of Insurance concludes that tail coverage for medical malpractice insurance is reasonable and that it should not be more stringently regulated nor should it be prohibited.

SENATE JOINT RESOLUTION NO. 211

Requesting the State Corporation Commission to study the reasonableness of "tail" coverage for medical malpractice insurance.

Agreed to by the Senate, February 6, 1989
Agreed to by the House of Delegates, February 17, 1989

WHEREAS, with malpractice insurance time lags exist between the occurrence of an incident and the date a claim is reported and its settlement; and

WHEREAS, in some cases many years may pass before final losses are known; and

WHEREAS, insurance coverage for claims that resulted from incidents occurring during periods when a previous policy was in force but are reported after a policy has expired is referred to as "tail coverage;" and

WHEREAS, the requirement that "tail" coverage be purchased from the insurer providing the new coverage virtually prohibits an insured from shopping for a better price with another company; and

WHEREAS, many feel that the absence of claims being made early in the coverage should off-set the claims made after the original coverage expires; and

WHEREAS, in some cases if there is a switch in insurance policies, general claims may not be covered at all or subject to duplicate coverage; and

WHEREAS, there is a need to determine if the "tail" coverage available is reasonable and meets the needs of those purchasing it; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the State Corporation Commission is hereby requested to study the reasonableness of "tail" coverage for medical malpractice insurance and whether such coverage should be more stringently regulated or possibly prohibited.

The Commission shall complete its work in time to submit its findings and recommendations to the Governor and 1990 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing of legislative documents.

Medical Malpractice Insurance
Tail Coverage

Introduction

The State Corporation Commission's Bureau of Insurance was requested by the 1989 Session of the General Assembly to study the reasonableness of medical malpractice insurance tail coverage and to determine whether it should be more stringently regulated or possibly prohibited. This study was requested by Senate Joint Resolution No. 211. According to the study resolution:

(1) In malpractice insurance, a time lag exists between the occurrence of an incident and the date a claim is reported and its settlement.
(2) In some cases many years may pass before final losses are known.
(3) There is a concern that insureds are prohibited from shopping for a better price for coverage because they are required to purchase tail coverage from the insurer providing new coverage.
(4) Many people feel that the absence of claims during the early years of coverage should off-set the claims made after the policy expires.
(5) There is a concern that if insureds switch insurance policies, claims may not be covered or there may be duplicate coverage.

Before determining whether medical malpractice insurance tail coverage is reasonable or whether it should be more stringently regulated or prohibited, it is necessary to understand why tail coverage is needed, when it is needed, and how it is marketed. It is also necessary to understand why medical professional liability insurance is different from many other lines of insurance and why a special policy form was developed to handle exposures of a "long-tail" nature.

Medical professional liability insurance, or medical malpractice insurance, is considered a "long tail" line of insurance; that is, claims can continue be to reported for many years after a policy is issued. The long tail nature of medical professional liability exposures arises out of the fact that it may take years for an incident of malpractice to be discovered, reported, and eventually adjudicated or settled. For example, if a surgeon leaves a foreign object in a patient's body during surgery, that object may not be discovered for several years or the bodily injury it causes may not become apparent until years later. In these cases, the claim might not be brought until after the surgeon's policy in effect at the time of the surgery has expired.[1]

According to Virginia Code, actions for personal injuries must be brought within two years after the cause of action accrues. There are certain exceptions to this, however. In cases where a foreign object has been left in a patient's body, the patient has one year from the date the object is discovered or reasonably should have been discovered to commence an action. The two-year statute of limitations is also extended in cases where an injury is prevented from being discovered because of fraud, concealment, or intentional misrepresentation. In these cases the action must be brought within one year from the date the injury is discovered or reasonably should have been discovered. Except for certain situations which toll the statute of limitations, the discovery rule does not extend the limitations period beyond ten years from the date the cause of action accrues. Minors under the age of eight have until their tenth birthday to commence an action; minors who are ten years of age or older have two years. The discovery rule applies to minors as well as to adults.

This "long tail" or extended period of liability creates a problem for insurers because of the uncertainty in determining what the final claim costs will be when a policy is first issued. Changes in inflation rates or in the tort system can also have an impact on the final costs of claims. All of these factors influence the prices charged by insurers and are taken into consideration when setting rates for medical professional liability insurance.[2]

Claims-Made Policies vs. Occurrence Policies

Medical professional liability policies are written either on an "occurrence" basis or on a "claims-made" basis. A policy written on an occurrence basis covers incidents that occur during the policy period, regardless of when the claim is reported to the insurance company (even if reported after the policy expires). A policy that is written on a claims-made basis covers only those claims reported during the policy period. Most claims-made policies provide coverage only for losses that occur after a "retroactive date" which is stated in the policy. This means that no claims will be covered if the incident occurred before the stated retroactive date. The retroactive date can either be the same as the inception date of the policy or it can be an earlier date specified in the policy. Usually, the retroactive date is the date the physician first becomes covered under the claims-made policy. If the retroactive date is advanced at any time, or if the claims-made policy is terminated, a gap in coverage is created, thus necessitating tail coverage. Tail coverage covers claims resulting from incidents which occurred while a claims-made policy was in force but which are reported after the policy has expired or after the retroactive date has been advanced.

Prior to the 1970's, most liability policies were written on an occurrence basis. The claims-made policy was developed in

response to the "long-tail" nature of liability exposures to better enable insurers to price their products. Claims-made pricing allows insurers to match today's premiums with today's losses in contrast to occurrence pricing which requires that the premiums collected in any one year pay for all future losses. It may take the company a number of years to determine whether the premiums collected in a given year were adequate for the claims paid under policies issued during that year.[3] The claims-made policy helps eliminate this pricing problem by covering only claims reported during the policy period. If an incident occurs during the policy period and the claim is not reported until after the policy has terminated, no coverage will apply, unless the policy is renewed or tail coverage has been purchased. Policies written on a claims-made basis thus enable insurers to better determine the extent of their losses at the end of each policy year and, therefore, enable them to more accurately price the coverage for their exposure the next year.

Claims-made policies offer certain advantages to policyholders too. Claims-made policies pay today's claims based on today's policy limits rather then paying today's claims using limits of liability that were purchased 15 or 20 years ago. An occurrence policy paying today's claim for an incident that occurred 15 or 20 years ago may have been purchased at limits of liability that were considered adequate for that time but by today's standards may be considered inadequate. The rising costs of health care and general living expenses that have occurred over the past two decades may not have been anticipated at the time the occurrence policy was purchased. Claims-made policies help policyholders keep up with inflationary trends.

Claims-Made Policy Rates vs. Occurrence Policy Rates

The rates for claims-made policies are substantially less than the rates for occurrence policies during the first few years of coverage. This is because coverage does not apply to occurrences prior to the retroactive date and it is usually a few years before any significant number of claims will be made. After a few years of coverage when the likelihood that claims will be made rises to a stable level, the claims-made rate matures, or levels, becoming fairly comparable to the rates for occurrence policies.[4]

The policyholder who changes from occurrence coverage to claims-made coverage may think he is continuing equivalent coverage at a discount particularly during the initial years of claims-made coverage. However, the reduced premium does not necessarily reflect a bargain but the fact that the accumulated exposure is less during the first years of coverage. The apparent savings may become reduced at any point when unlimited tail coverage must be purchased for an additional premium.[5] While most companies in Virginia write medical malpractice coverage for physicians and surgeons only on a claims-made basis, The Medical Protective Company also offers this coverage on an occurrence basis. The following chart compares The Medical

Protective Company's mature claims-made policy premiums with its occurrence policy premiums for five types of physicians using territory 1 (Northern Virginia) rates with limits of liability of $1,000,000/$1,000,000 effective 8/1/89. (Mature premiums are those which are applied to physicians with a certain number of year's cumulative exposure.)

Physician	Mature Claims-Made Policy Premiums	Occurrence Policy Premium
Allergist	$3,218	$3,498
Family Practitioner(minor surgery)	5,535	6,017
Emergency Room Physician	9,976	10,843
Anesthesiologist	18,554	20,166
OB/GYN Surgeon	39,653	43,100

In each of the cases shown above, the mature claims-made policy premium is less than the occurrence policy premium.

The following example compares The Medical Protective Company's claims-made policy premiums with its occurrence policy premiums over a 10-year period for a family practitioner who performs minor surgery in Territory 1 (Northern Virginia) using $1,000,000/$1,000,000 limits of liability and assuming the rates which are in effect as of 8-1-89 remain constant over the 10-year period. Tail coverage is purchased after the 10th year when the physician cancels the policy.

Claims-Made Policy Premiums		Occurrence Policy Premiums
1st year	$1,549	$6,017
2nd year	3,321	6,017
3rd year	4,981	6,017
4th year	5,259	6,017
5th year	5,535	6,017
6th year	5,535	6,017
7th year	5,535	6,017
8th year	5,535	6,017
9th year	5,535	6.017
10th year	5,535	6,017
Tail Coverage	$10,793	
Total	$59,113	Total $60,170

In this example, over a 10-year period the claims-made policy is $1,057 less than the occurrence policy.

In another example, an anesthesiologist who practices over a 15-year period and then cancels the policy would pay the following depending on whether he purchased a claims-made policy or an occurrence policy from The Medical Protective Company over the 15-period. (Again assume the rates are constant over the 15-year period, the limits of liability are $1,000,000/$1,000,000 and the physician practices in Territory 1.)

Claims-Made Policy Premiums		Occurrence Policy Premiums
1st year	$ 5,196	$20,166
2nd year	11,132	20,166
3rd year	16,698	20,166
4th year	17,626	20,166
5th year	18,554	20,166
6th year	18,554	20,166
7th year	18,554	20,166
8th year	18,554	20,166
9th year	18,554	20,166
10th year	18,554	20,166
11th year	18,554	20,166
12th year	18,554	20,166
13th year	18,554	20,166
14th year	18,554	20,166
15th year	18,554	20,166
Tail Coverage	$36,180	
Total	$290,926	Total $302,490

In this case, the claims-made policy is $11,564 less than th occurrence policy over a 15-year period.

If the same anesthesiologist remains insured with Th Medical Protective Company continuously for 20 years on a claims made policy, he is entitled to tail coverage at no extra charge The following chart compares the claims-made and occurrenc policy premiums.

Claims-Made Policy Premiums		Occurrence Policy Premiums
1st year	$ 5,196	$20,166
2nd year	11,132	20,166
3rd year	16,698	20,166
4th year	17,626	20,166
5th year	18,554	20,166
6th year	18,554	20,166
7th year	18,554	20,166
8th year	18,554	20,166
9th year	18,554	20,166
10th year	18,554	20,166
11th year	18,554	20,166
12th year	18,554	20,166
13th year	18,554	20,166
14th year	18,554	20,166
15th year	18,554	20,166
16th year	18,554	20,166
17th year	18,554	20,166
18th year	18,554	20,166
19th year	18,554	20,166
20th year	18,554	20,166
Tail Coverage	Free	
Total	$347,516	Total $403,320

In this example, the claims-made policy is $55,804 less than the occurrence policy over the 20-year period.

When Tail Coverage is Needed

Because claims-made policies cover claims reported during the policy period, certain gaps in coverage can occur. These gaps can occur when:

(1) A claims-made policy is replaced with an occurrence policy;
(2) A claims-made policy is cancelled or nonrenewed, such as when a person retires or changes insurance companies;
(3) A claims-made policy is renewed or re-written with an advanced (or later) retroactive date; or
(4) A claims-made policy is re-written on the condition that certain claims will be excluded from coverage.[6]

Tail coverage is designed to eliminate or reduce the gaps created by the above situations. This is done by extending the time within which a claim may be reported. The "tail" extends the coverage of the claims-made form to claims reported <u>after</u> the policy expires, provided the incident <u>occurred</u> before the policy terminated and after the policy's retroactive date, if any.[7] Tail coverage, also known as the extended reporting period, essentially converts claims-made coverage into occurrence coverage.[8] The extended reporting period or "tail" simply extends the time to report claims. It does not extend the time period during which medical malpractice incidents may occur.

In Virginia, medical malpractice insurers are required to offer what is called an "unlimited tail"; that is, insureds can purchase tail coverage which indefinitely extends the time a claim can be reported as long as the incident occurred when the claims-made policy was in force. This unlimited tail coverage cannot be cancelled as long as there are sufficient aggregate limits of liability remaining under the extended reporting period to cover future claims. (In Virginia, aggregate policy limits are required to be reinstated when tail coverage is purchased.)

Unlimited tail coverage can apply as excess insurance over any other valid and collectible insurance. If the insured has purchased another insurance policy, this other insurance policy will act as primary coverage and the tail coverage will be secondary.[9] This can happen if the new policy's retroactive date precedes its inception date and tail coverage has already been purchased.

> For example, assume that a claims-made policy is issued on January 1, 1988 which is also its retroactive date. After a one-year policy period, the policy is not renewed by the insurer and it appears that it will be difficult to find another insurer willing to handle the account. Even though

there are no unsettled claims related to known or reported occurrences, the insured purchases the "unlimited tail" coverage. The insured later finds an insurer that will provide a replacement claims-made policy during 1989 subject to a retroactive date coinciding with the inception of the insured's first claims-made policy in 1988. During the 1989 policy period, a claim is made because of bodily injury sustained by a third party in an occurrence that took place during the 1988 policy period. The 1989 claims-made form is triggered and applies to this claim because (1) the bodily injury occurred after that policy's retroactive date and (2) claim is now being made during the current policy period. The "unlimited tail" coverage also applies because (1) the bodily injury took place after the retroactive date and before the expiration of the first claims-made policy to which the unlimited tail endorsement applies and (2) the claim was made during the extended reporting period of the "unlimited tail" coverage. There is overlapping insurance, however, so the "unlimited tail" coverage will apply as excess protection.[10]

If the insured changes companies and his new policy's retroactive date is the same as the new policy's inception date, he will need to purchase tail coverage from his prior company for incidents occurring prior to the new policy's retroactive date. However, if the new policy is issued with the same retroactive date as the retroactive date of the old policy, no tail coverage is needed. In this case, the insured has purchased "prior acts" coverage. The insured would not have duplicate coverage nor would he ever be forced to purchase both tail coverage and prior acts coverage. Prior acts coverage is discussed later in this report.

How Tail Coverage Is Regulated in Virginia

Medical malpractice insurance rates, including tail coverage rates, are subject to "delayed effect" under §38.2-1912 of the Code of Virginia. This means they are subject to prior filing and actuarial review by the State Corporation Commission. Rates and all supplementary rating information must be filed with the Commission at least 60 days before they become effective. The Commission may extend the waiting period for 30 additional days by written notice to the filer before the first 60-day period expires. When the Commission has received all supporting data it deems necessary, a determination is made as to the actuarial soundness of the proposed rate change.

Medical malpractice policy forms and endorsements are also subject to state regulation under §38.2-317. These policy forms and endorsements must be filed with the Commission at least 30 days prior to their effective date. If they do not comply with

the provisions of §38.2-317, they are not approved for use in Virginia. One of the provisions of §38.2-317 allows the Commission to disapprove a policy form or endorsement if it "provides coverage of such a limited nature that it is contrary to the public interest of this Commonwealth."

Based on the provisions of §38.2-317, the State Corporation Commission's Bureau of Insurance requires the insurer of the expiring policy (not the new insurer) to offer tail coverage. Tail coverage is required to be offered (i) upon cancellation or non-renewal of any claims-made policy, (ii) upon advancement of any retroactive date, and (iii) upon renewal of a policy other than on a claims-made form. The Bureau of Insurance also requires the extended reporting period (tail coverage) to be provided for an unlimited time period if the insured elects to purchase the coverage. The insured must be given 30 days after the claims-made policy has terminated to purchase tail coverage. The Bureau of Insurance also requires the insured's aggregate policy limits to be reinstated. This means that the insured's original aggregate limits stated in the expired policy must be reinstated when the tail coverage is purchased. These aggregate limits apply separately to the extended reporting period and are not reduced by the amount of dollars previously paid by the insurer under the expired policy. (Aggregate limits of liability on a claims-made policy place a cap on the cumulative total an insurer is obligated to pay for claims reported during any one policy period.)

How Tail Coverage Is Regulated in Other States

The Bureau of Insurance conducted a survey among the other state insurance departments to determine how medical malpractice tail coverage is regulated in the other states. Out of 26 states that responded to our survey, all 26 indicated that they regulate policy forms for medical malpractice tail coverage. Twenty-five states regulate rates for medical malpractice tail coverage. In addition to Virginia, 10 states require the insurer to reinstate the policy's aggregate limits when tail coverage is purchased and, like Virginia, seven states require insurers to offer "unlimited" tail coverage when the claims-made policy expires. These states are as follows:

States Requiring Aggregate Limits to be Reinstated	States Requiring Insurers to Offer "Unlimited" Tail Coverage
Alabama	Alabama
Connecticut	Maine
Iowa	Nebraska
Maine	New York
Michigan	North Carolina
New Hampshire	South Carolina
New York	Texas
Pennsylvania	Virginia
Texas	
Virginia	
West Virginia	

Comparison of Tail Coverage Rates

A comparison was made of the tail coverage rates for four of the top writers of physicians' and surgeons' professional liability coverage in Virginia. The following chart is based on Territory 1 mature claims-made rates in effect as of 8/1/89 using limits of liability of $1,000,000/$1,000,000.

	Med.Prot.	TVIR	PHICO	St.Paul
Allergist	$ 6,275	$7,615	$4,099	$5,823
Family Practitioner (minor surgery)	10,793	13,104	8,745	10,470
Emergency Room Physician	19,453	23,593	16,396	17,112
Anesthesiologist	36,180	39,511	28,600	22,606
OB/GYN Surgeon	77,323	72,442	45,759	53,356

1989 House Document No. 33 contains a chart with additional premium comparisons using Territory 1 mature claims-made rates in effect as of 7/1/88 for a number of other provider specialty groups.

Premium Waivers for Death, Disability, or Retirement

Some companies waive the additional premium for tail coverage if the insured retires, dies, or becomes totally and permanently disabled. A survey of four of the top writers of physicians' and surgeons' professional liability insurance in Virginia was conducted to determine if each of these companies (St. Paul, The Virginia Insurance Reciprocal, PHICO, and The Medical Protective Company) offer such a waiver. The following information was obtained from each of the companies' manuals filed with the Bureau of Insurance.

TVIR (The Virginia Insurance Reciprocal)

TVIR issues tail coverage at no charge if the insured dies or becomes totally and permanently disabled, provided the insured:

(1) has been with TVIR for five consecutive years prior to death or disability; or
(2) is under the age of 65; or
(3) is over the age of 65 but has purchased an initial policy from TVIR prior to age 65.

Written notice of death or disability must be submitted to the company together with an application for tail coverage within 180 days after the policy has terminated. Proof of death or disability must also be given.

Tail coverage is issued at no charge if the insured completely retires from practice, provided the insured:

(1) is at least 65 years of age; and
(2) has been with TVIR for five consecutive years.

Physicians or surgeons who retire between the age of 62 and 65 are given a premium discount depending on their age and the number of years they have been insured with TVIR. Written proof of retirement must accompany the insured's written notice and application for tail coverage. This must be provided within 180 days after the physician retires.

PHICO

PHICO also waives the premium for the extended reported period (tail) coverage if the insured dies. If the insured becomes totally and permanently disabled, the premium will be returned to the insured after six months from the initial date of the disability. The company must receive certification of the disability from a mutually agreed upon physician. If the insured retires no earlier than age 65 and has been with PHICO continuously for four years, the premium will be waived.

The Medical Protective Company

The Medical Protective Company waives the premium for tail coverage if, after being continuously insured for a minimum of five years, the insured dies or becomes permanently, totally, and continuously disabled. The premium is also waived if the insured retires, providing he has reached the age of 65 and has been continuously insured by The Medical Protective Company on a claims-made basis for the previous 10 years. Aside from the premium waivers for death, disability, or retirement, tail coverage is also provided at no charge if the insured has been with the company continuously for 20 years on a claims-made policy.

St. Paul

St. Paul's manual indicates that the extended reporting endorsement will be provided at no cost if:

(1) the insured dies; or
(2) the insured retires after age 65 and has been continuously insured with St. Paul for the last five years under a claims-made policy; or
(3) the insured has been totally and continuously disabled for at least six months.

Proof of death, retirement, or disability must be provided to the company before the extended reporting endorsement is issued.

The Appendix at the back of this report contains a letter from the actuarial firm of Tillinghast explaining the rate loading for the waiver of tail coverage premiums and comparing the estimated rate loading factors for eight companies. The term "rate loading" means that there is a charge applied to the actuarial rate to cover the issuance of this "free" coverage. All policyholders pay for this coverage since it is factored into their rates. This enables companies to offer the coverage without an additional premium when the coverage goes into effect.

Other Coverages Offered

As mentioned earlier in this report,companies can also offer "prior acts" coverage. Prior acts coverage is similar to tail coverage, but it is provided by the insurer issuing the new policy. A physician who cancels his claims-made policy with one company and purchases a claims-made policy with another company may be able to buy prior acts coverage from the new insurer. This will eliminate the need to buy tail coverage from the old insurer. Rates for prior acts coverage are based on the retroactive date agreed upon by the policyholder and the insurer. In other words, the rates are based on how far back coverage will apply. An insured who wants 10 years of prior acts coverage, for example, will be rated according to the new company's mature claims-made rates. All other things being equal, this rate will be equivalent to a policyholder who has already been insured with the company for 10 years.

The charts below compare the premiums a physician will pay if he has been insured with TVIR for 10 years and then switches to The Medical Protective Company and remains with them for 10 years. In the first example, the insured buys tail coverage from TVIR. (Assume this physician is a family practitioner who performs minor surgery in Northern Virginia and asks for limits of liability of $1,000,000/$1,000,000; the rates in effect as of 8-1-89 remain constant.)

TVIR		Medical Protective	
		Tail coverage purchased from TVIR	$13,104
1st year	$1,734		1,549
2nd year	4,160		3,321
3rd year	6,240		4,981
4th year	6,587		5,259
5th year	6,934		5,535
6th year	6,934		5,535
7th year	6,934		5,535
8th year	6,934		5,535
9th year	6,934		5,535
10th year	6,934		5,535
Total	$60,325		$61,424

In this example, the physician has paid an extra $1,099 over the 10-year period because he switched companies and purchased tail coverage.

In the following example the physician does not buy tail coverage from TVIR, but instead buys prior acts coverage from The Medical Protective Company.

TVIR		Medical Protective
1st year	$1,734	$5,535
2nd year	4,160	5,535
3rd year	6,240	5,535
4th year	6,587	5,535
5th year	6,934	5,535
6th year	6,934	5,535
7th year	6,934	5,535
8th year	6,934	5,535
9th year	6,934	5,535
10th year	6,934	5,535
Total	$60,325	$55,350

In this case, the physician has saved $4,975 over the 10-year period by buying prior acts coverage from the new insurer instead of buying tail coverage from the old insurer.

Certain conditions usually apply to prior acts coverage. Contracts generally stipulate that coverage will not apply to any claim or incident that was already known to the insured when coverage went into effect or to any claim covered by a policy previously in effect. From an underwriting standpoint, companies generally will not provide prior acts coverage if there is a known incident or if there has been a gap in coverage some time prior to the inception of the new policy. According to a recent survey of St. Paul, TVIR, PHICO, The Medical Protective Company, The Doctors' Company and Continental Insurance Company, five out of the six companies write prior acts coverage. PHICO indicated that they do not offer this coverage at all. St. Paul indicated that they will write it under certain circumstances.

Conclusion

The State Corporation Commission's Bureau of Insurance concludes that tail coverage for medical malpractice insurance should not be more stringently regulated nor prohibited. Tail coverage is necessary in medical malpractice insurance when coverage that has been provided on a claims-made basis is terminated or when a retroactive date is advanced. In Virginia, insurers are required to offer "unlimited" tail coverage. This exceeds the requirements of many other states. Also, insurers in Virginia are required to provide limits equal to the expiring policy's aggregate limits when tail coverage is purchased. This also exceeds the requirements of many other states. Rates and

forms are subject to prior filing and review by the Commission and rates vary from company to company. The State Corporation Commission's Bureau of Insurance, therefore, finds that tail coverage for medical malpractice insurance is reasonable and that there is no need for additional regulatory authority.

End Notes

[1] C. Arthur Williams, Jr., et al., Principles of Risk Management and Insurance, Vol. I (Malvern, PA: American Institute for Property and Liability Underwriters, Inc., 1981), p. 112.

[2] State Board of Insurance, Medical Professional Liability Insurance in Texas: An Overview, (Austin, Texas: State Board of Insurance, 1981), p.2.

[3]Ibid., p.3.

[4] Ibid., p.4.

[5] Donald S. Malecki, et al., Commercial Liability Risk Management and Insurance, Vol.I (Malvern, PA: American Institute for Property and Liability Underwriters, Inc., 1986), p.345.

[6]Ibid., p.311.

[7]Ibid.

[8]State Board of Insurance, p.4.

[9]Malecki, p.329.

[10]Ibid, pp.329-330.

Appendix

THE MEDICAL SOCIETY OF VIRGINIA

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June 21, 1989

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Bureau of Insurance
State Corporation Commission
Commonwealth of Virginia
P.O. Box 1157
Richmond, VA 23209

Dear Bob:

As promised, I have enclosed a copy of a letter I received from Tillinghast describing various approaches taken by several medical malpractice insurance companies regarding payment, or the waiver thereof, of tail insurance premiums, and the estimated rate loading for each such approach.

Please do not hesitate to call if we can be of further assistance.

Sincerely yours,

Sandra L. Kramer

Enclosure:
cc: Ronald K. Davis, M.D.
James L. Ghaphery, M.D.
Alvin E. Conner, M.D.
Allen C. Goolsby, III, Esquire
James L. Moore, Jr.

cc Jo Anne Scott
Pat Worley

404 261-5420
Facsimile: 404 365-1662

Management Consultants
and Actuaries

Tillinghast
a Towers Perrin company

June 7, 1989

Ms. Sandy Kramer, Esquire
Medical Society of Virginia
General Counsel Office
700 East Main Street, Suite 1612
Richmond, Virginia 23219

Re: Death, Disability and Retirement Provisions (DD&R)

Dear Ms. Kramer:

At your request, we conducted a brief survey of the DD&R provisions of several physician insurers. Under the DD&R provision, a company will generally waive all, or part, of the extended reporting premium on cession of claims-made coverage for physicians meeting the eligibility requirements.

Responses were received from seven companies. Observations regarding the provisions follows:

1. All companies provide a reasonably consistent death and disability waiver benefit. Death, with reasonable notice, was always subject to premium waiver. Disability was generally defined as "totally and permanently disabled", some with a time requirement (e.g., six months) before issuance.

2. Retirement (defined as complete retirement from the practice of medicine) is usually, but not always, subject to two qualifying criteria - age and years with company. The table below summarizes survey results relative to these criteria. To date, we have not observed significantly different retirement frequencies among companies, despite a fairly wide range of qualifying criteria.

Company	Qualifying Criteria: Age	Qualifying Criteria: Years With Company	Estimated Rate Loading
1	65+	3	2.5%
2	60+	5	5.0%
3	None	None	4.0%
4	59+	5	5.0%
5	55+	5	6.3%
6	None	3	4.5%
	55-60	10	
	61	9	
	62	8	
7	63	7	3.0%
	64	6	
	65+	5	
St. Paul	65+	5	3.0%

3. The estimated rate loading appears reasonably consistent among the companies with the exceptions of companies 3 and 6. The loadings should reflect the age (and corresponding mortality/morbidity/retirement) characteristic of the individual companies. In most cases, the rat loading is intended to cover the issuance of free extended reporting coverage due to death, disability and/or qualifying retirement in the next year. Therefore, there is no "accrued" benefit (or liability) associated with free extended reporting coverage to be issued in subsequent periods.

4. The variation in the provisions has been increasing and the liberality of some gives an indication of the trend recently observed regarding this policy feature. St. Paul appears to be on the more conservative end of the range.

Hopefully, this will help in discussing this issue. Please call if you should have questions.

Sincerely,

James D. Hurley, ACAS, MAAA

JDH/km

THE MEDICAL SOCIETY OF VIRGINIA

GENERAL COUNSEL'S OFFICE
700 EAST MAIN STREET, SUITE 1612
RICHMOND, VIRGINIA 23219
TELEPHONE: (804) 643-2617

December 19, 1989

BY HAND

JoAnne Scott
Bureau of Insurance
1220 Bank St., 6th floor
Richmond, VA 23209

Dear Ms. Scott:

You have asked that the Medical Society provide a letter describing, in general terms, its perspective of problems or issues related to tail coverage for medical malpractice actions. It is my understanding that you are in the process of finalizing a report on tail coverage as it pertains to medical malpractice, and that Senator Robert Scott has asked for the input of the Medical Society of Virginia and of the Virginia Trial Lawyers Association.

According to Dr. Ronald K. Davis, the Chairman of the Medical Society's Professional Liability Committee, the primary issue relating to tail coverage for physicians concerns the need to purchase a tail upon retirement from practice. Some companies will provide tail coverage without charge if the physician practices to a certain age, retires permanently, and if he has been with that company a specified period of time. Such practices are obviously helpful in many instance, but can produce the untoward effect of encouraging physicians who should retire earlier for health or other reasons from doing so. If a physician should retire early, but would have to pay the high costs of tail coverage in a lump sum, he may defer retirement. There are physicians nearing retirement who literally cannot afford to retire, due to the high cost of tail coverage when paid as a lump sum at the end of their careers.

The second issue related to tail coverage of concern to physicians involves situations where they must change companies mid-practice. For example, if a physician leaves one group and begins practice with another that is insured by a different company, he may have to buy tail coverage. In some instances, the fees required are nearly prohibitive, particularly for a physician who has been in practice only a few years. Apparently the Virginia Insurance Reciprocal will accept a new physician

without requiring a tail if he has been insured under a claims made policy by a traditional insurance company, such as St. Paul. The Medical Society suggests that all commercial insurers writing medical malpractice coverage in Virginia on a claims made basis should be encouraged, or required, to adopt a similar policy.

A third, potential problem, related to tail coverage in the medical malpractice area concerns changing from a traditional commercial insurer to a risk retention group, or vice versa. The Society is uncertain whether traditional insurers will accept physicians previously insured through risk retention groups without requiring prior acts coverage or tail coverage. To the extent that large, lump sum amounts are required mid-practice to obtain such coverage, it will be difficult for many physicians to make such changes.

I hope that this letter is responsive to your request. Please Let me know if I can be of further assistance.

Sincerely yours,

Sandra Kramer

Sandra L. Kramer
General Counsel

cc: The Honorable Robert C. Scott
Ronald K. Davis, M.D.