Incident Reporting vs Written Demand for Damages

How do you define a claim? Different policies have different definitions of what constitutes a claim. In this regard, there are two basic kinds of policies. The first is an “incident report” trigger—where a doctor can report a negative outcome to the carrier as soon as it happens—without any need to wait for the threat of a lawsuit. And once the MLPI company has been informed of an ‘incident’, it remains the responsibility of the carrier to defend the insured against this event even if the insured doctor changes over to a different company. A tail policy is not required to be purchased for that event to be covered.

The other kind of policy is called a “demand trigger”, where the physician cannot report an adverse event to her carrier unless there is a written demand for money or an attorney letter requesting medical records or a lawsuit has been filed. This puts the insured physician in a very difficult situation with regard to changing insurers. She will no longer be covered for this event by her old carrier since she does not have insurance with them anymore and an MLPI company issuing
her a new claims made policy is not going to cover a claim that occurred under a prior insurer. In fact, they may not even cover an event that the doctor should have reasonably foreseen as a potential claim. Any retroactive coverage is only to cover completely unforeseeable claims at that point in time.

There are policies that may be more moderate than these two extremes. They may have an incident trigger for events for a short period of time, such as a couple of months, after they occur and a demand trigger outside of this time frame.

With a demand trigger policy, an insured doctor with a bad outcome that was reported to an insurance company, who thereafter switches to another company before a claim is made, is likely to find that any suit based on this bad outcome is not covered by either the old or new insurance company. It is not covered by the old insurance company because the insured is no longer covered by it and responsibility for this incident was not triggered before the insured switched companies.

There are hybrid versions of these two policy forms: policies that are incident trigger within a short window (30-60 days) after medical services were rendered, and demand trigger after that time; and, policies that are similar to demand trigger policies but are a little more liberal in defining what triggers coverage (e.g. a lawyer’s request for records).

This lawyer website recommends that whenever a physician has a choice (in some markets there may be no choice) between a demand and incident trigger policy, the incident trigger should be taken, no matter what the difference in price. He acknowledges it is a huge generalization but explains succinctly that rationale behind his advice.
This brings us to a difficult question: When is it appropriate to report a bad patient outcome to your MPLI company? As noted by the MedMal Insurance Blog, “The question is fraught with legal and practical issues: legal because there is a contractual duty to report matters that can lead to claims; and practical, because reporting bad outcomes can affect one’s insurability and qualification for claims free discounts.”

This is a grey zone because most insurers do want to know if a claim can be “reasonably expected”, but there is no definition of what constitutes “reasonable”. Also, the insured has a responsibility to cooperate in every way with her insurer so that they may defend her most effectively and it may be construed that any delay in reporting a significantly bad outcome to the insurer may hamper their ability to prepare for her defense.

On the other hand, treading with extreme caution and reporting every negative outcome you have may put you in the “high risk” category and seriously jeopardize your insurability since every new application for MLPI asks for a list of all incidents you have previously reported to your carrier.

Some general considerations:

-If an adverse event is routine or expected for a procedure or medical treatment, it need not be reported, unless more severe than usual or do not recover as expected.

-All requests for medical records do not need to be reported either, unless they explicitly state that the request is being made in light of negligence by the provider.
In this matter, asking for advice from your insurance agent/broker does not help because they can also be sued for negligence in case an incident does turn into a future claim and they recommended you do not report it. So, they will generally always recommend that you report the incident. If you think you need professional advice regarding a particular scenario, you should contact an attorney.

**Policy Exclusions**

Review policy exclusions carefully. Go through the list of procedures you will be performing and ensure that they are all included. Generally, procedures commonly performed by a specialty are not a problem but if you will be performing something that is not routinely performed by your specialty, make sure to keep your MPLI company informed.

**Medical Director Coverage**

Medical directorship of outpatient surgical centers, nursing homes, dialysis units have both patient-care related as well as administrative/non-patient-care related responsibilities. This exposes the medical director to potential litigation from their patients, employees or employers. Doctors are responsible for keeping their MLPI companies informed about any Medical Directorship positions they hold and always keep written records stating whether they are covered both for patient-related as well as non-patient-related activities that come with the territory. Usually, one’s standard MLPI policy does the cover the related patient-related activities but excludes the administrative responsibilities of Med Director. You may be able to negotiate extending coverage to such activities, hopefully without an increase in premium, but if not, at least with additional premium. Larger groups obviously have more bargaining power in this regard.
The MedMal Insurance Blog notes that “It is best to have the medical director exposure covered within one’s own medical malpractice policy because this reduces the likelihood of gaps in coverage that can occur when more than one policy provides coverage. If coverage cannot be secured through one’s own malpractice insurance policy, one should seek out the coverage either through a policy provided by the entity for which he or she is Medical Director or through a personal “Directors and Officers” policy.”

Cyber Liability Coverage

Healthcare providers and facilities are now routinely exposed to a wide array of potential sources of litigation due to EMR, electronic patient communication and increasing regulation by local and regional licensing and other authorities. In response to these new demands, MLPI carriers have begun to offer, usually at no additional charge, a package of cyber and regulatory coverages. It protects the insured from liability that comes from loss or wrongful transmission of electronic data, whether accidentally or as targets of cybercriminals and the costs associated with data recovery that follows. Unfortunately, most of the time, this included coverage proves insufficient if there is a real problem.

Hence, most insurers have the option of additional cyber/regulatory liability coverage with added premium. These often have some modest copay or deductible, after which limits are generally around $0.5M/$1M for cyber and regulatory coverages and $100k for license protection, which are generally sufficient. These limits will usually cost you between $1500- $3000 per provider, with per capita costs obviously demising as the size of the group increases. Here is
a more in-depth discussion on the different kinds of cyber, regulatory, and licensing liabilities.

Discounts

New To Practice

There is generally a new to practice discount for claims made policies because you have yet to accumulate a history of adverse events. These policies may start out at 25% of the mature premium rate for year 1, 50% for yr 2, and 75% for yr 3 until they mature at 4-5 yrs. When comparing policies by price, pay attention to the overall cost over this entire duration, rather than just the first year’s premium. Some companies may have a lower first year premium, but may be more expensive overall. Occurrence policies generally start with the mature rate and do not have a sliding discount in the first few years. As with most insurance, you get more bang for your buck with higher coverage amounts. For example, for $1M/$3M coverage, my 1st yr premium is $2766 - so, $1 of coverage costs me 0.2 cents. For $250,000/$750,000, my 1st yr premium is $1958 - or cost per dollar of coverage is 0.7 cents.

Part Time

You can also often get a part-time discount of around 50% if you work less than 20 hours a week. New to practice and part-time discounts cannot be combined.

Claims Free Discount

Just as StateFarm has accident forgiveness, there are claims free discounts for going 5/10/20 years without a claim. The size of the discount goes up as the claims free years add up, often as a percentage match: a 5% discount for a 5 yr claims-free period, 10% discount for 10 years and so on. How the insurance company defines a claim for this purpose varies with the insurer- the spectrum extending from receiving a mail summons to having to pay out indemnity.
Risk Management Discount

Some companies offer discounts of ~ 5% for participation in risk management seminars or webinars.

Board Certification

You can often get a discount for being board certified and increase your discount if you are a double/multi-boarded specialist.

Society Memberships

Check with your broker or your professional Association for discounts associated with membership.

Large Group Discount

As with health insurance companies, large practices can often negotiate better terms with their MLPI carriers.

Deductible

You may opt for a deductible that reduces the premium by a certain percentage. They are not common in MPLI policies in the standard market but are more common in the surplus lines market. The discount in premium is usually too low to be of significant value - but this is an area you may want to examine in your own situation since the ability/willingness to self-insure is very variable. Also, large groups may be able to negotiate a significant discount in their group policy with a sizable deductible.

Tort Law and Reforms

There is wide state to state variation not only in medical malpractice laws but also in culture. This excellent article in EPMonthly.com surmises that “state culture trumps state laws because the relation between tort reform, malpractice
costs, and medical liability environment favorability are complex and nonlinear. Sometimes, the legal culture in a state can overwhelm tort reform laws favoring physicians or can protect physicians despite the absence of meaningful laws.

Compare the hellhole known as South Florida with “nice” Minnesota to get a sense of the extremes. The best liability environment for a physician is one in which litigation and malpractice costs are both kept to a reasonable minimum. In an ideal environment, frivolous suits are minimal and meritorious cases are quickly identified.”

The states that have seen the greatest changes in recent times are Texas, Ohio, Pennsylvania, Mississippi, and North Carolina.

The reforms that have been known to have greatest impact are:

- a hard cap on non-economic damages without allowing too many exceptions or being too high to be meaningful
- a case certification mandate, which requires the plaintiff to attach a signed statement from a qualified expert
- a pre-litigation panel review process

Also, as part of the Affordable Care Act, there is now federal funding for tort reform alternatives. $50 million in grant money has been given to states for demonstration of viable options, some of which may include:

- Health Courts
- Early Offers
- Apology Programs
- Medical Review Panels
- No-fault system (patient compensation funds)

What do you think? What discounts did you get on your malpractice insurance? What do you think about tort reform? What would you like to see? Comment below!
“Claims made” vs “Occurrence” Policies

Claims made versus occurrence versus convertible claims-made is probably the most important feature of the insurance and the choice depends both on cost and your individual circumstances.

Claims-made policy is the commonest type of policy available to physicians. It covers events that occur while the policy is active, starting with the “retroactive date” - the first day the policy goes into effect; AND are also reported while the policy is still active.

Occurrence policies cover events that take place while the policy is active but may be reported even after the policy is no longer in-force. Because it is incredibly difficult to predict future claims costs in today’s medical malpractice environment—occurrence policies are rarely being offered by insurance companies these days. Berkshire-Hathaway-owned
Medical Protective (MedPro) is among the few companies who still do. The price of an occurrence policy is generally much higher than a similar claims-made policy since essentially the price of the tail is factored in.

**My Experience**

In my case, I obtained quotes for claims-made coverage from the 3 biggest (by volume) carriers in my state, which were all rated A or above: TDC, MedPro and MAGMutual. The two least expensive policies were within $1K of each other over 5 years. MedPro was almost $8K more expensive. Among these 3, only MedPro offers occurrence policies:

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Five Year Premium Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDC</td>
<td>$15.5K</td>
</tr>
<tr>
<td>MAGMutual</td>
<td>$16K</td>
</tr>
<tr>
<td>MedPro (claims made)</td>
<td>$23K</td>
</tr>
<tr>
<td>MedPro (occurrence)</td>
<td>$34K</td>
</tr>
</tbody>
</table>

[Editor’s Note: I am not sure what specialty this doc is in, but those sure look like one year totals to me, not five year totals! ]

Instead of going with the MedPro occurrence policy, if I went with the MAGMutual claims made policy and purchased a tail at the end of 5 yrs, it would cost me an additional $8K. This is still $10K less than the occurrence policy. Easy decision.

What was less easy was which to pick between TDC and MAGMutual. I chose the latter because I feel they have a bigger local presence and are more invested in my state. Hope I never have to find out!

A convertible claims made policy is the third and least common type of MPLI. As the name implies, you can convert your claims
made policy into an occurrence policy without paying for tail coverage. Calvin Sullivan of CM&F grp, an insurance brokerage, here provides more information on this:

“All you need to do is purchase and maintain the convertible claims made policy for three years, remaining claims-free in that time, and upon renewal the fourth year your entire policy back through your retroactive date will convert to Occurrence, meaning you no longer have to worry about Tail Coverage if you decide to leave your policy.

In order to purchase a convertible claims made policy, you’ll need proof of unbroken Professional Liability coverage back through your retroactive date, and you must have had your own individual limits of liability during that time. (Many group policies have shared limits.)”

**Level of Coverage**

Coverage is denoted by coverage limit per incident/annual aggregate limit. How much malpractice coverage is enough? This varies by state and specialty. States have minimum requirements for coverage. For example, Texas and Florida have lower than average minimum coverage requirements: TX: $200,000/$600,000 and FL: $250,000/$750,000 aggregate per year. On the other hand, New York is one of the states with a higher than average coverage requirement at $1.3M/$3.9 M. The most common MPLI coverage limit seen nationwide policy is $1M/$3M.

(Editor’s Note: When coverage limits are displayed like that the first number is the amount of coverage per occurrence and the second number is the amount of total coverage.)

If you increase your coverage limits with the same carrier, you have new retroactive date when the increased coverage begins. So, if you get sued for an event that occurred before you increased coverage, the lower limits of liability will apply. On the other hand, if you reduce your limits of
liability, your retroactive date reverts to the original date your policy took effect and your coverage will be covered by the lower limits regardless of when the event occurred.

Find out what kind of losses you are covered for—“pure losses” cover you only for amount due to plaintiff if you lose a case or have to settle. “Ultimate net losses” also cover you for defense costs, in addition to indemnity payment.

In this American College of Physicians article, Patrick Malloy gives some more practical advice:

“Know the extent of the insurer’s obligation to defend you. Will you be reimbursed for lost wages when in court? What services will be provided for you as part of your defense? How soon must you report a liability claim to the carrier in order to still be eligible for full coverage?”

Related Claims

When more than one claim arises from a group of related incidents, many carriers will consider them to be “related” claims and will cover only the amount covered by single-incident coverage limit (e.g., $1M in a $1M/3M policy).

This article in Medical Economics notes what happens if the claims reach the coverage limit? In most circumstances, the insurer simply tenders the defense of the claim back to the insured. This means that it is now the insured’s responsibility to hire attorneys to defend the claim. Some policies do provide that the insurer will continue to provide a defense even after coverage limit is reached.

Please note that Umbrella Insurance does NOT cover medical malpractice.

Assessable or Non-assessable

Most policies are non-assessable, implying that in case the
insurance company runs a loss, they cannot impose an assessment (levy extra payment) on policyholders. For example, an insurer in FL, FMMJUA, issues policies that are assessable. This carrier covers doctors with issues of insurability and they cannot deny coverage to anyone. Naturally, their premiums are 15-20% higher than comparable policies in the standard market. Of note, they have never issued an assessment but instead have returned dividends to policyholders since they are a “participating” carrier.

Nose and Tail Coverage

The next most important step to consider between policies you are comparing is to assess the Extended Reporting (“Tail”) Endorsements & Prior Acts (“Nose”) Coverage. Since a claims-made policy covers you only for events that both occur and are reported to the carrier while the policy is in effect, if you need/want to change coverage to a different insurer, you are not covered and therefore need to purchase coverage for events that occurred while the policy was in force but may be reported in the future.

If such coverage is purchased from your current/former carrier at the time you change to your new carrier, it is called “tail” coverage. If this coverage is purchased from your new malpractice carrier, it is referred to as “nose” or prior acts coverage.

Tail policies generally cover an unlimited duration and have the same limits of coverage as your policy with the insurer, unless you choose to carry lower limits of liability on your tail policy. Say, you had a $1M/3M policy and purchased a tail with the same coverage and then got sued for $1M- you have no
more coverage on your tail policy for any more events. Some carriers will refresh that limit ONCE per policy. So, in the above example, the insured is protected for another $1M claim but no more.

Tail policies generally cost about 1.5-2.5 times your annual premium. It is usually less expensive to buy prior acts coverage from your new carrier than tail from your former carrier.

State laws generally allow physicians about 30-60 days to purchase tail coverage. Most of the time, you have to pay the entire cost of the tail policy upfront (which can be a lot of money to cough up at one time), though there are some insurers, such as TDC, that offer financing. Please be careful to make all payments on time, otherwise your tail policy may be cancelled without refund.

Hence, when comparing prices between two equivalent claims made policies, it is important to include the price of tail coverage, especially in the current environment of greater mobility and higher turn-over. That is, unless you have negotiated “tail” be covered either by the practice you are joining as part of signing bonus or by your former practice who may want their business assets to be well-protected in case you are sued. This is usually accompanied by a restrictive covenant requiring you to practice outside of the area covered by your former practice.

This increased demand for tail policies has generated the development of “stand alone” tails. These are offered by companies willing to beat the prices that you have been quoted by your current insurer for the same coverage limits. may further reduce cost by offering the option of deductibles or limited-term tails- covering only a few years, such as a one-year or five year tail.

Free tail coverage is often provided by carriers as a courtesy
to physicians who have been insured by the same company over several years. The retirement age at which this is offered depends on how long you have continuously been insured by the carrier- >55 yrs at retirement if insured for at least 5 yrs and <55 yrs if insured for 10-15 yrs by the carrier- important for our FI-RE colleagues! Free tail coverage is also available in case of death or disability of the insured.

Consent to Settle Clause

Look for this in your policy. The insurance company’s interests are not always aligned with yours. Even if you think you are “right” and the case very is defensible, the insurance company may want to cut their costs and settle. The consent to settle clause in your policy ensures that the carrier needs your written permission before they can settle.

Some carriers may offer a waiver of this clause for a reduction in rate. For e.g., one carrier website stated a 5% reduction in annual premium with this waiver. Even with this significant saving, it is not wise foregoing this clause because every claim settled stays on your record, reducing your insurability in the future.

Defense Costs “Inside” or “Outside” Policy Limits

When a claim is being contested, the defense costs may either be part of your total liability limits or “outside” of these limits. For example, say you have a $1,000,000 (per occurrence)/$3,000,000 (yearly aggregate) policy and the defense costs for a claim is $200,000. A policy with defense costs “outside” of the limits of liability will have $1,000,000 to go towards paying the claim, whereas, if the defense costs are “inside” the policy limits, only $800,000 is left to cover the claim. Hence, a policy with defense costs “outside” of policy limits is preferable.
In Part 3 we’ll discuss discounts available and some the effects of tort law reforms. In the meantime, what do you think? Do you have an occurrence or claims-made policy? Who’s paying for the tail? Would you buy a policy without a consent to settle clause? Why or why not? Comment below!

How to Buy Medical Malpractice Insurance

[Editor’s Note: I’ve been running a guest post once a week for years now. Readers seem to enjoy them and it provides more voices, more experiences, and more expertise on the site than I personally possess. One of my favorite tactics for getting good guest posts is to ask readers who ask me a question I don’t have the answer for to do some research and send me a guest post when they know the answer. Another tactic is to ask someone who has done some unique research or done something new recently to write one. That second tactic is where this post came from. I figure if they just got done doing the research, why recreate the wheel? Dr. Sanghamitra Sadhu is the author, and we have no financial relationship. However, the original post as submitted ran over 5000 words, so I’m breaking it into three parts which we’ll run this week Tuesday to Thursday. Dr. Sadhu wishes to thank Steven Roylance, her insurance broker for assistance with this post. I have no financial relationship with him either.]

Most doctors do not have to go through the process of picking out their own Medical Malpractice Liability Insurance (MPLI) since it is almost always provided by the group/hospital
employing you. Unless you set up your own practice or, like in my case, work as an Independent Contractor, you may not have first-hand information of how to go about purchasing MPLI. Since I am planning to moonlight for other practices in town, I got my own malpractice insurance to give me the most flexibility to work with different groups. This is an account of what I learned going through the process recently.

Malpractice Crises

The medical malpractice insurance industry tends to go through cycles. In the early 1970s, several private underwriters left the segment due to increasing payouts and low premiums. This led to an availability crisis. In response to this dearth of availability, physicians across the nation turned to their state Professional Associations and formed their own malpractice insurance companies, jointly owned by them. These originally physician-owned MLPI companies now control half the market-share. Examples include The Doctors Company (TDC) from CA- that operates nationwide and MAGMutual from Georgia, which operates in 10 states of the SouthEast. These companies are mutually owned by policyholders and often return profits back to them in the form of dividends or rate cuts. For this reason, they are called “participating” carriers. As examples, in 2016 MAGMutual returned $25M to policyholders in the form of about 10-12% reduction in premiums (based on how long a policyholder has been with the company) and in 2015 TDC returned $28M in dividends to policyholders.

There was another crisis in the late 1990’s, leading to premiums peaking in 2002. Since then, they have gradually fallen and largely remained steady over the last decade or so. Coupled with the fact that the number of claims filed has been decreasing, premiums have fallen 20% since 2006.

Premises by Specialty and State
This map of the USA shows how average premiums of a primary care doctor varies from state to state. The states that are shown deeper in color have higher premiums than the lighter shade ones. (Image used with permission.)

Since 1991, Medical Liability Monitor has been publishing an annual rate survey for 3 specialties: Int Med, Gen surgery and Ob/Gyn (representing the broad spectrum of rates across specialties). Click here to see historical rates by state and specialty.

States with effective tort reform, such as caps on non-economic damages, have seen significant decrease in litigation followed by fall in average premiums. Some of these states are CA, CO, KS, TX, Alaska, NC and the Dakotas. Indiana has a process for pre-litigation screening by a panel, apart from a cap on total damages. Most of these states have seen among the lowest malpractice payouts per capita. Interestingly, many of these state legislatures have a physician in office.

At the other end of the spectrum are Illinois and a bunch of states in the North East- DC, PA, NY, NJ and Delaware. These states have no effective tort reform and see some of the highest malpractice payouts per capita. Here, litigation is commonplace and premiums are sky-high, sometimes more than six figures annually for high risk specialties such as surgery and OB. Here is a good summary of Malpractice Laws by state.

Malpractice insurers have had different experiences defending different specialties. As such, they develop a proficiency for better defending some specialties than others. It is important to research which carriers have had more success in defending claims in your specialty before you choose a carrier. This also results in you obtaining better premium rates within the context of your geographical region.

Choosing an Insurance Company
It is really important to choose the right insurer—one that has been around a good while, has developed a good reputation and is financially rock stable.

**Financial Strength**

With regard to financial strength, the principal rating system of the insurance world is [A.M. Best](https://www.ambest.com). I recommend you stay with a company with at least an A or better (A+, A++) rating unless you have a specific reason for your decision.

**Size of the insurance company**

There is strength in numbers. The biggest companies in the business are often also the most financially solid. The leading MPLI companies by volume written to physicians (amount of premiums they collect) on a national basis are (as of 4/15/16):

<table>
<thead>
<tr>
<th>MPLI Co.</th>
<th>Volume written to Physicians ($)</th>
<th>A. M. Best Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The Doctors Company (TDC)</td>
<td>620K</td>
<td>A</td>
</tr>
<tr>
<td>2 Medical Protective (Med Pro)</td>
<td>425K</td>
<td>A++</td>
</tr>
<tr>
<td>3 Medical Liability Mutual Insurance Co</td>
<td>376K</td>
<td>NR</td>
</tr>
<tr>
<td>4 Physicians’ Reciprocal Insurance</td>
<td>240K</td>
<td>NR</td>
</tr>
<tr>
<td>5 NORCAL Mutual Ins Co</td>
<td>235K</td>
<td>A</td>
</tr>
<tr>
<td>6 MAGMutual Ins Co</td>
<td>216K</td>
<td>A</td>
</tr>
</tbody>
</table>
Note that the first 5 companies write more than half the total volume according to annual statement data from SNL Financial as of 4/15/16.

**Use Local Defense attorneys**

If you get sued, that last thing you would want is to be defended by an attorney sitting halfway across the country from you. You want a really good, local lawyer by your side. Most MPLI companies do have a local network of attorneys but the density of the network will depend on how much they are invested in your state. For example, if there is a CA-based
insurer in FL, they may not have as rich a network of defense attorneys and other support staff based locally in each of the bigger cities in Florida than a company based in the Southeast. In that respect, MPLI is not just a commodity where price is the only consideration.

**Admitted or Surplus-Line Carriers**

Some insurance companies that are licensed and registered to the Dept to Insurance in your state are known “admitted” carriers for your state. They are more tightly regulated and also protected to some extent from insolvency by a “guarantee fund” (kind of FDIC for banks). Some doctors may have a hard time finding insurance in this market with strict underwriting rules if they have had difficult professional or personal issues- negative outcomes, disciplinary action, performing extremely high-risk procedures (like bariatric surgery, when it first evolved) or alcohol or drug dependence. They depend upon a secondary market of insurers- “non-admitted” or “surplus line” carriers. They are thus known because they are not regulated to the same extent nor covered by the state’s guarantee fund. Premiums in this market run significantly higher, often up to 30-50% more than usual and also carry hefty deductibles in the range of $5-10k per claim. Sometimes, your broker may be able to negotiate that the deductible go toward payout.

Now this alternate market is sometimes also available to regular, non-high risk providers, thereby providing them more choices, which helps to bring down costs. Be sure to pay attention to company ratings among these carriers, too.

**Getting Help**

It is possible for an informed physician to shop for malpractice insurance on her own. However, it makes sense to go with a knowledgeable and scrupulous independent broker who
is able to get you quotes from multiple carriers (as opposed to an agent who works exclusively with one insurance company). The broker is reimbursed by commission from the insurance carriers- so they do not directly charge you for their services. This carries with it the usual conflict of interest inherent in a commission-based model of reimbursement. However, the fee-based model may not save you money in this situation because insurers will charge you the same annual rate and you will get stuck also having to pay a fee to your broker.

Brokers do need licenses for the states they operate in but may be able to help out-of-state clients too, by working with other brokers in the client’s state of practice. Please remember, if you contact multiple brokers to obtain a quote from the same insurance companies, it hinders the process since the insurance carriers require additional paperwork from you and the brokers. In choosing a broker, ask the basic questions you would of any financial/insurance professional:

- How long they’ve done this
- How many clients they represent
- What percentage of their business comes from malpractice insurance
- How many insurance companies they can get you quotes from
- Why those companies
- How are those companies rated

In Part 2 we’ll continue with this series by looking at my personal experience buying. In the meantime, have you shopped for malpractice insurance? How did you decide on a company? Comment below!