

A Glossary

of Common

Insurance & Legal Terms



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A Glossary *of Common* Insurance & Legal Terms

As part of MLMIC's ongoing commitment to educate health care professionals through participatory programs, educational lectures and seminars, advisory opinions, and written resources, we have developed this handy guide for your reference. It includes some common insurance and legal terms you may encounter related to your professional liability coverage.



Abandonment—The termination of a professional doctor/patient relationship by a health care professional without reasonable notice to the patient and without an opportunity for the patient to acquire alternative medical care, thereby resulting in injury to the patient.

Ad Damnum—A demand for relief (i.e. monetary damages) in a legal pleading, complaint, counterclaim, cross-claim, interpleader complaint, or third-party complaint, to which the pleader deems himself/herself entitled. In a medical malpractice action, the demand should not state the dollar amount of damages sought.

Arbitration—A form of informal dispute resolution almost wholly independent of the Court system. In arbitration, the dispute is given to a private person or persons agreed upon by the involved parties in order to arrive at a private and practical determination with maximum dispatch and minimum expense.



Bill of Particulars—An amplification of a pleading, which supplies more information and detail, thereby giving the defendant a more specific picture of the claim(s) against him/her.

Cancellation—Termination of a policy before its stated expiration date, either by the insurer or the insured. Two types of cancellation are: *Pro Rata*—cancellation by an insurance company whereby the unearned premium (the portion of the premium for the remaining time period that the policy will not be in force) is returned to the policyholder. *Short Rate*—cancellation by the insured whereby the unearned premium returned to the insured may be diminished by administrative costs incurred when the insurance company wrote the policy.

Certificate of Insurance—A document issued to another party by an insurance company on behalf of a policyholder, confirming the coverage that is in effect. In the event of any material change in, cancellation of, or non-renewal of said coverage, the certificate holder is notified by the insurance company.

Certificate of Merit—Certification in a medical malpractice action supplied (along with a complaint) by the plaintiff's attorney certifying that he/she has reviewed the facts of the case, has consulted with at least one physician (or dentist), and has concluded that there is a reasonable basis for the action.

Claim—A report by an insured to his/her insurance company, based on notification by a patient, the patient's representative, or the patient's attorney, of an event out of which malpractice has been alleged.

Claims Made Policy—The type of professional liability insurance coverage that protects a physician, surgeon, or dentist for alleged acts of malpractice which both occur and are reported to the insurance company while his/her claims made policy is in continuous force. The premiums for claims made policies are considerably less expensive initially when compared to those for occurrence policies; however, claims made premiums increase annually, rising rapidly until they level off at the mature claims made rate.

Claims made policyholders may purchase "Reporting Endorsement" (*Tail*) coverage upon termination of the policy to protect themselves for claims arising from professional services rendered during the policy period, but which are reported after the policy has been terminated.



Classification—The placement of a physician in a premium category based on the types of procedures performed within a medical specialty or a general practice. These classifications form the basis for establishing statistical experience data and determining rates.

Co-insurer—An insured who, in accordance with the terms of the policy, participates with an insurer in personally bearing a portion of losses covered by his/her policy.

Collateral Source—Source of compensation for injury other than the defendant's resources in a tort action, including worker's compensation, health insurance policies, etc. In New York, the collateral source rule allows these sources to be put in evidence, and damages are reduced by the amount paid by these sources.

Common Law—Laws developed through judicial decision rather than through legislation.

Comparative Negligence—A method of measuring negligence among the participants in a lawsuit, that is, both defendant and plaintiff, in terms of percentages of culpability. Damages are then diminished in proportion to the amount of negligence attributable to the complaining party.

Concurrent Insurance—Two or more separate policies providing similar or identical coverage for the same risk.

Confidentiality—see *Privileged Communications*.

Consent to Settle—A contractual right of a physician or surgeon policyholder to maintain that no claim against him/her is settled without his/her unconditional consent. This right is contained in all standard physician policies and may be waived in exchange for a modest reduction in premium.

Contingency Fee—A contract between a plaintiff's attorney and his/her client whereby the attorney agrees to represent the client in exchange for compensation calculated as a percentage of the amount recovered.

Contractual Liability Coverage—Insurance coverage provided by MLMIC to a physician, surgeon, or dentist, at no additional cost, for vicarious liability attributable to a person or organization, such as an HMO, assumed by a contract or agreement exclusively for the professional acts or omissions of the policyholder or his/her employees. This type

of coverage does not cover the direct acts of the other person or organization.

Court Costs—Compensation paid to the winner for the trouble and expense of litigation theoretically engendered by an adversary's failure to deal with him/her fairly. These costs do not include attorney's fees, and the dollar amounts are prescribed by statute and are minimal.

Coverage—The extent of protection provided for acts or omissions that are insured by the policy.

Credentialing—A process whereby a hospital evaluates health care providers for employment status or for appointment/reappointment to the medical staff. Criteria to be considered in the evaluation process include character, competence, training, experience, judgment, and physical and mental capabilities. By statute in New York, information such as prior history of credentialing, claims, and misconduct must also be considered.

Damages—Compensation for both tangible (e.g. medical expenses; lost earnings) and intangible (e.g. pain and suffering) losses.

Deductible—A fixed amount of loss per claim for which an insured is personally responsible before an insurance company will make payment.

Defense Attorney—The lawyer representing the person who is being sued (the defendant).

Deposition—See *Examination-Before-Trial*.

Discovery—Typically, that period of a lawsuit beginning with the service of summons and complaint and concluding (unless otherwise ordered by the Court) with the filing of a Note of Issue. During discovery, all evidence, material and necessary in the prosecution or defense of an action, is produced and exchanged by the parties or as ordered by the Court.

Endorsement—A written amendment, added to and made part of an insured's policy, reflecting a change in the original contract.

An endorsement takes precedence over the original policy provision.

Event (or 'Incident')—An occurrence which may potentially lead to a formal claim or malpractice suit that is reported by a physician or dentist policyholder to his/her insurance company.

Examination-Before-Trial (EBT or Deposition)—A method of obtaining, by way of sworn testimony, a disclosure of information which is material and necessary to the underlying lawsuit. EBTs usually take place during the Discovery phase of litigation.

Excess Insurance—Coverage that provides limits of liability above those in the basic or primary policy. These additional limits may also apply after a policyholder's primary limits have been exhausted.

Exclusions—Provisions listed in an insurance policy, or on an endorsement to it, which indicate what is not covered by the policy.



Expert Medical Witness—

A physician qualified, by virtue of his skill, knowledge, education, experience, or training, to testify regarding his/her opinion of the degree of care rendered and the cause of injury claimed. The sufficiency of the witness' qualifications to testify in a medical malpractice action, as well as the scope of the testimony, rests in the discretion of the trial court.

Freedom of Information Law (FOIL)—Under this statute and in accordance with its published rules, each government agency shall make their records available for public inspection and copying. Public documents requested by plaintiffs concerning physicians, dentists, and hospitals may be useful in gathering information to make or strengthen a plaintiff's case.

Frivolous Suit—A lawsuit, counterclaim, defense, or cross claim deemed by the court

to be either commenced, used, or continued in bad faith, solely to delay or prolong the resolution of the litigation or to harass or maliciously injure another. Also, a lawsuit commenced or continued in bad faith without any reasonable basis in law or fact and one that could not be supported by a good faith argument for an extension, modification, or reversal of existing law.

General Liability Insurance—Coverage for negligent acts and/or omissions, excluding medical malpractice, that result in bodily injury and/or property damage on the premises of a business (e.g. slips and falls). Also, coverage for injuries sustained by an individual as a result of using a product manufactured or distributed by a business, or in the general operation of a business.

Good Samaritan Doctrine—In New York, this statute states that liability for ordinary negligence shall not ensue when rendered for first aid emergency treatment “voluntarily and without the expectation of monetary compensation at the scene of an accident or other emergency, outside a hospital, doctor’s office, or any other place having proper and necessary medical equipment,” unless the injuries are alleged to have been worsened by the result of gross negligence on the part of the acting physician.



Hold Harmless Agreement—An agreement or contract in which one party agrees not to hold the other party responsible for damages or other liability arising out of a transaction (i.e. the rendering of patient care).

Incident Report—A form used by a hospital to record the facility’s adverse occurrences. A comprehensive Incident Reporting System can identify potential events, claims, and lawsuits.

Indemnity Agreement—An agreement to pay, on behalf of the insured, all sums which the insured shall become legally

obligated to pay as damages for activities covered under the policy, subject to policy terms, limits and conditions.

Informed Consent—The legal doctrine affirming a patient's rights to determine and control the course of his/her own medical treatment. This doctrine obliges physicians and dentists to provide information and explanations, in language that lay persons can understand, to assist patients in their decision-making process. In New York State, the physician or dentist providing the treatment or diagnosis must disclose to the patient the alternatives, the reasonably foreseeable risks, and the benefits of having, or electing not to have, a particular treatment or procedure, so that the patient has an opportunity to evaluate the information, before making a decision to consent to or refuse the treatment or procedure.

Inherent Risk—A risk of complication which occurs in the absence of any negligence on the part of the physician, but which is commonly associated with a specific procedure or treatment.

Insurance Department—The department within the state government with the authority to administer state laws regulating insurance and to license insurance companies and its agents.

Insuring Agreement—The section of an insurance policy that describes the coverage and generally outlines the responsibilities of the insurance company in the event of a claim.

Joint and Several Liability—A rule whereby each tortfeasor (that is, an individual found to have committed a tort) is responsible not only for that portion of the assessed damages which he/she caused, but also for those portions attributable to the other culpable tortfeasors. If one of the defendants is able to pay the entire judgment (either through insurance coverage or with personal assets), even though he/she is not responsible for the entire amount based on his/her percentage of culpability, the plaintiff can

collect the entire amount from that individual. That financially solvent defendant can then, in turn, seek reimbursement from the other defendants based on their percentage of shared guilt. In New York State, the rule of joint and several liability was amended in late 1986. In narrow circumstances and with many exceptions, 'joint' liability of certain tortfeasors is now reduced, making them responsible to the plaintiff for only their own percentage of liability and not the percentage of liability attributed to others.

Joint Defense—

The representation of more than one defendant by one attorney in the same lawsuit (e.g. one lawyer simultaneously representing a doctor and a hospital, or two or more doctors).



Joint Underwriting Association

(JUA)—Created by legislative mandate, this organization requires all carriers authorized to write direct personal injury liability insurance in the State to provide a market for medical malpractice insurance.

Lawsuit—A legal process instituted by one party to compel another to do him/her justice.

Limits of Liability—The maximum amount an insurance company agrees to pay in the event of a loss (e.g. \$1,000,000/\$3,000,000). The first amount is the *per person aggregate*, the maximum amount of damages payable by the insurance company as a result of an injury or death sustained by any one person. The second amount is the *annual aggregate*, the maximum amount of damages payable by the insurance company for all claims during any one policy year.

Locum Tenens—Literally meaning 'taking or holding a place for,' this term frequently refers to a New York State licensed health care professional who temporarily

substitutes for another professional (e.g. during his/her vacation period, sabbatical, illness, or training period).

Loss Reserves—Estimated amounts an insurer sets aside in anticipation of payments for reported and incurred-but-not-reported (IBNR) claims. This includes consideration for loss adjustment expenses (e.g. attorney's fees) as well.

Malpractice—Professional negligence in which a physician, surgeon, or dentist deviates from the approved and accepted standards of practice within a given specialty, thereby causing an injury or damage to a patient.

Merit Rating Plan—A plan designed to identify and surcharge any physician policyholder whose conduct or method of practice does not meet accepted professional standards of care, or whose claims experience predicts the likelihood of future claims, in excess of the norm for his/her specialty and territory, thereby making insuring him/her at base rates an unreasonable burden to other policyholders.

Minor—A person under legal age. In New York State, children under the age of 18 are considered minors.

Mutual Insurance Company—An insurance company that is owned and directed by its policyholders. As owners, policyholders are entitled to share in the company's profits, if any, in the form of dividends or reductions in future premiums. In contrast, a 'stock insurance company' is owned by its stockholders, and they are generally the recipients of any distributed dividends.

Negligence—The failure to use the same degree of care a reasonably prudent and careful person would use under the same or similar circumstances.

New Doctor Discount—An insurance premium discount offered to physicians, surgeons, and dentists who enter private practice (solo or group) immediately following the completion of their training.

Nose Coverage—See *Prior Acts Coverage*.

Note of Issue—A form which, together

with a Certificate of Readiness, must be filed with the Court by the plaintiff (usually) in order to get a case placed on the trial calendar. These documents certify that the case is ready for trial and that the 'discovery' period has concluded, that is, all required pleadings and bills of particulars have been served, all required disclosure completed, and any applicable court orders complied with.

Occurrence Policy—The type of professional liability insurance coverage that protects a policyholder for alleged acts of malpractice which occur while his/her policy is in force, no matter when a claim against the policyholder is instituted by or on behalf of a patient.

Part-time Discount—An insurance premium discount offered to physicians and surgeons who practice medicine no more than 20 hours per week and to dentists who practice dentistry no more than 16 hours per week.

Plaintiff's Attorney—The lawyer representing the person who is suing (the plaintiff).

Pleadings—The documents by which both the plaintiff(s) and the defendant(s) give the Court and parties in a lawsuit notice of the transactions, occurrences, or series of transactions or occurrences, intended to be proved and the material elements of each cause of action or defense.

Policy Period (Effective Date & Termination Date)—The period of time for which the insurance coverage is in force, as described by the effective date and termination date which appear on the policy's Facts page.

Premium—The sum of money a policyholder pays in return for coverage under his/her policy. For a MLMIC insured, the variables which principally determine the premium rates for his/her professional liability policy are: (1) medical/surgical specialty (if applicable), (2) practice location, (3) the limits of liability selected, and (4) prior claims experience. The authority to set rates

for professional liability insurance premiums rests with the Superintendent of Insurance, and, as a rule, these rates are subject to change effective at the beginning of each policy year (July 1st).

Prior Acts (“Nose”) Coverage—A vehicle for insuring after-reported claims when a policyholder wishes to transfer, uninterrupted, his/her claims made coverage from one carrier to another. Like tail coverage, nose coverage provides protection for claims that are reported after the cancellation of a policyholder’s prior claims made policy. However, unlike a tail, which can be very expensive and is purchased from the insurer the doctor is leaving, nose coverage is secured through the insurer to which he/she is going and, usually, requires no initial expenditure.

The policyholder simply begins paying premiums at the claims made rate commensurate with the amount of time the claims made policy had been in effect with the prior carrier.



Privileged Communications—Information acquired by an authorized, licensed health care professional when attending a patient, which is necessary to enable him/her to act in that professional capacity. Such information is considered ‘privileged,’ and shall not be disclosed unless that patient waives the privilege.

Professional Entity Coverage—Additional limits of liability provided by MLMIC, at no additional cost, to a qualified professional service corporation or partnership.

Professional Liability (“Malpractice”) Insurance—Insurance provided through a contractual relationship between the insured and the insurer, whereby the insurer, in return for a premium, agrees to pay damages to others as a result of the insured’s negligence. There are two types of professional liability coverage: occurrence and claims made.

Professional Medical Liability Insurance and Defense Board—A physician peer review

board begun in 1946 under the auspices of the Medical Society of the State of New York (MSSNY). With the assistance of its specialty committees, the Defense Board: (1) reviews the claims experience, conduct, and methods of practice of MLMIC insureds who are members of MSSNY; (2) recommends changes in policy provisions; (3) resolves questions of classification; and, (4) considers special problems related to medical malpractice.

Property and Casualty Insurance Security Fund—This fund, established by New York Insurance Law, protects policy-holders in the event their insurance company becomes unable to pay claims due to insolvency.

The Fund is maintained by contributions from New York State licensed insurance companies in direct proportion to the amount of business they write within the State.



Pro Se—A person appearing on his/her own behalf, without an attorney, as a litigant in a lawsuit.

Quality Assurance—A process which reviews a hospital's activities to enhance the quality of patient care and prevent medical and/or dental malpractice. This process includes identifying and investigating potential problems, developing recommended courses of action to address and correct the problems, and implementing and evaluating corrective action.

Reciprocal Insurance Company— Also called an Inter-Insurance Exchange, this is a company in which persons holding insurance policies join together and exchange their policies, thereby 'inter-insuring' each other. A management company called an attorney-in-fact performs administrative operations of the Exchange.

Reinsurance—A form of insurance bought by insurance companies for their own

protection. This 'sharing of insurance' allows an insurer to reduce its maximum loss on either an individual risk or on a large number of risks by giving a portion of its liability to another insurance company (the reinsurer).

Reporting Endorsement ('Tail')

Coverage—Coverage for incidents that occurred while an insured's policy was in force, but which are reported after he/she cancels the policy. Like the premium for the claims made policy itself, the cost of the tail is determined by the doctor's territory and specialty, as well as by the number of years his/her coverage was in continuous force. It makes sense... the further back in time the tail must reach, the greater the liability risk assumed by the insurer and, therefore, the more expensive it is to purchase.

It should be noted that the premium for tail coverage will be waived if any of the following conditions apply: that is, in the event of the insured's death, disability, or permanent and total retirement from the practice of medicine or dentistry after he/she attains the age of 65 or older and has been insured on a claims made basis by an authorized insurer for 5 or more consecutive years; or, after he/she attains the age of 55 or older and has been insured on a claims made basis by an authorized insurer for 10 or more consecutive years.

Res Ipsa Loquitur—"The thing speaks for itself." A doctrine of law with reference to cases in which mere proof that an occurrence took place is sufficient under the circumstances to shift the burden of proof to the defendant, making it necessary for him/her to prove that it was not due to his/her negligence.

Retroactive Date—A provision found in professional liability claims made policies that limits coverage to losses occurring on or after a specified date. Ordinarily, the retroactive date represents the effective date of the first claims made policy.

Risk Management—A process that

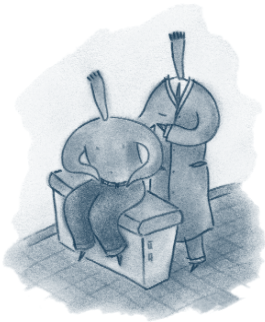
emphasizes the prevention of adverse patient occurrences through the gathering of data and its utilization to reduce the risk of a specific loss. A typical risk management program includes the identification and assessment of loss potential; the development of loss prevention programs; the development and maintenance of loss funding and risk financing programs; and the development, maintenance, and coordination of claims control.

Risk Management Discount—

A discount offered to physician, surgeon, and dentist policyholders who successfully complete approved Risk Management Programs.

Service of Process—The procedural methods by which certain legal pleadings (e.g. complaints and subpoenas) are delivered. The purpose of these procedural methods is to assure that the parties have the proper notice of pending actions and defenses. Once the procedural methods are satisfied, then the Court has jurisdiction to bind the parties to its determinations.

Short-term Policy—A policy written for a term of less than one year. Insurers generally charge higher proportionate rates for short-term policies than for longer term insurance because of the need to recoup relatively fixed administrative and processing costs over a shorter policy life. A *locum tenens* is considered to be a short-term policy.



Standard of

Care—The degree of care maintained by a reasonable physician, surgeon, or dentist under the same or similar circumstances.

Statute of Limitations—The period of time in which a plaintiff may bring a lawsuit after an incident has occurred. In New York

State, the statute of limitations in a medical malpractice action generally is two years and six months from the last date of treatment. In cases involving infants, the statute of limitations is 10 years or the age of majority plus 2-1/2 years, whichever occurs first.

Structured Settlements—A method for periodic payment of damage awards or settlements.

Subpoena—“Under penalty.” The judicial process whereby a witness is subjected to the jurisdiction of the Court and required to give relevant information subject to the penalty of contempt for disobedience.

Summons—A document issued by the plaintiff’s attorney which, when properly delivered, commences a legal action.

Surcharge—An amount of premium relating to substandard conduct, methods of practice, or claims experience, that is in excess of the standard premium rate applicable to a physician or dentist.

Tail Coverage—See *Reporting Endorsement Coverage*.

Tort—A civil wrong.

Umbrella Insurance—A form of liability insurance protecting policyholders for claims in excess of the limits of their primary policies.

Underwriting—The process of examining, accepting, or rejecting insurance risks, and then classifying and rating those selected to determine the proper premium for each. The purpose of underwriting is to spread the risk among a pool of insureds in an equitable manner.

Vicarious Liability—The imposition of liability on a person for the acts of another, based solely on the relationship between the two persons. For example, as an employer, a physician or dentist could be vicariously liable for the acts of the physicians or dentists employed in his/her office.

Voluntary Attending Physician (VAP)—A physician or surgeon, insured for primary professional liability coverage by MLMIC, whose hospital of principal

affiliation is also insured by MLMIC. A VAP receives a discount on his/her individual premium if he/she participates in a Risk Management Program and agrees to a joint defense.

Wrongful Death Action—An action to recover damages for a tort, such as negligence or malpractice, which caused a decedent's death, that is brought about by the decedent's duly appointed personal representative. Such an action is brought against a person who would have been liable to the decedent by reason of such wrongful conduct if death had not ensued.



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