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RESOURCE PACKET:
PROFESSIONAL LIABILITY RESOURCE PACKET

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PROFESSIONAL LIABILITY RESOURCE PACKET

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Disclaimer

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Introduction

In March/April 2001, ACNM members read in *Quickening* about a new malpractice crisis brewing. "As malpractice premium rise and availability of coverage recedes, the solid foundation the College has laid with ACNM Insurance Services will provide midwives a port in the storm." A year later, the storm was raging and more and more midwives were becoming aware of the crisis as they were affected by policies not renewed or premiums multiplying almost beyond belief.

ACNM Insurances Services has, indeed, proved to be that port in the storm. For over 15 years the American College of Nurse-Midwives (ACNM) has kept its promise to avoid the professional liability disaster our profession faced in the mid 1980s. At that time, the association was not actively involved in procuring liability coverage for our members. Premiums were relatively inexpensive and members had more than one option for coverage. Carriers were making minimal distinctions between nurses and nurse-midwives and our focus was on many other barriers to practice. When the professional liablity market went into a tail spin, based on an alarming increase in the number of suits, especially in obstetrics, our members found themselves, not with exorbitant premiums, but with non-renewal notices. As each month passed, more and more services closed because coverage was not available. We not only lost jobs, but it took a long time to bring new members and consumers back to the profession that many thought had disappeared.

As would be expected, the ACNM Board of Directors and staff, worked long hours in response to the 1980s disaster. Their goal was to negotiate a new, nation wide program that would offer coverage to nurse-midwives across the country. ACNM does not own a company, but we do endorse a specific policy that is offered to members only through our administrator, ACNM Insurance Services. Through the years the College has focused our successful efforts on building a close relationship with our plan administrator, developing an active risk management program, carefully monitoring the industry, and negotiating for a policy that reflects an understanding of midwifery practice.

We clearly recognize that when the market for professional liability coverage is favorable, our members will have a number of options to chose from. Some will have to go with their employers option and some will chose strictly on price. Others will consider loyalty to a program that is heavily influenced by leaders in the profession. With a vision built on an understanding of the market and lessons learned, we have kept a policy alive when most of our members went elsewhere for coverage.

Thus, our blessings are mixed as we face this latest crisis. The exorbitant rise in premiums being experienced by virtually all health care professionals is a terrible shock. Even worse would be a return to the 1980s when coverage could not be purchased at any price.

The Professional Liability Section of the ACNM Division of Standards and Practice and the national office staff in the Department of Professional Services have put together this Resource

Packet in response to the latest concerns regarding professional liability insurance. The packet has been organized in several parts to allow members to access the information they need:

Part 1: Professional Liability Primer – provides basic information about the insurance industry, reviews options for obtaining insurance, answers the most frequently asked questions (the infamous "tail") and provides advice on purchasing your own policy, as well negotiating a policy as an employment benefit.

Part 2: Physician Surcharge – is written for midwives and consulting physicians who have faced the imposition of a surcharge on a physician who collaborates with midwives

Part 3: Legislative and Policy Initiatives – provides the background and tools midwives need to take a proactive approach in addressing the professional liability crisis with legislative and policy initiatives.

We expect to add information and update the packet as needed.

Professional Liability in the News

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Summers Lisa. "They're Baaaack: The Physician Surcharge" Quickening September/October 2002, 33(6):12.

PART 1: PROFESSIONAL LIABILITY PRIMER

Background: Insurance Industry

Casualty insurance is protection purchased against unforeseen incidents. People insure themselves against losses from fires, theft, and car accidents by making regular payments into pools of funds that are used to support the few who actually experience losses. Professional liability insurance follows the same principle: regular payments are made into a pool to protect those who have claims made against their practice. The insurance company assumes the monetary risk. Professionals of all kinds purchase liability insurance: engineers, nurses, attorneys, and accountants for example. Certified nurse-midwives/ certified midwives (CNM/CMs), as educated professionals, can be held personally liable for a professional breach of duty. Purchased liability insurance is a cost of doing business as a professional.

Medical Malpractice Insurance vs. Professional Liability Insurance

Medical malpractice insurance is often used synonymously with professional liability insurance; however, they are not the same.

Professional liability is the obligation to compensate others for negligent injury (not just bodily injury), specifically resulting from the performance of professional services. Medical malpractice is the act of causing such injury to a patient, which results in professional liability for those injuries.

When used in insurance "medical malpractice" implies coverage for injury to a patient, while the broader term "professional liability" provides additional coverage for other allegations, like slandering a doctor, inadequately training a subordinate, etc. In short, professional liability covers acts, errors and omissions in the performance of professional services (including injury to patients), while medical malpractice insurance covers only the bodily injury to patients. In spite of this, even insurance providers often use the terms interchangeably.

Midwives must be willing to protect their assets against liability claims or face severe financial loss when a jury finds a breech of duty has occurred.

Midwives have several routes for purchasing liability insurance, which are reviewed throughout this chapter. Regardless of the source of liability insurance, the midwife has the responsibility to know the type of professional liability coverage she has and that her premiums are paid and up to date.

Availability and *affordability* of professional liability insurance are affected by a number of factors, including changes in American insurance markets, numbers of claims, cost of settlements, fluctuations in stock markets, and legal changes in the insurance industry. Understanding these factors prepares you to understand insurance industry business cycles and the importance of maintaining liability protection.

A Cyclic Industry

The casualty insurance industry is strongly cyclical in nature. The cycle becomes familiar to experienced professionals but can be puzzling and frightening to new midwives. The course is as follows: Liability coverage is sold at some market determined price. As money flows in from purchase of insurance (in the form of premiums), it is invested by the insurance company. The combination of premiums collected (capital) and the interest earned (investment income) allows the insurance company to experience losses greater than the premiums collected (100% of capital). The investment

income may cover losses greater than premiums collected or it may become profit to the insurance company.

For an insurance company to be competitive, it must price premiums as low as possible, balancing anticipated losses and risk against anticipated income. Since there is a considerable lag between the filing of liability claims and eventual pay-outs through settlements or jury awards, the insurance company must hold hefty reserves for eventual payouts.

Some insurance company capital is invested in the stock and bond market. Generally, when interest rates are high, premiums fall and competition increases for policy holders. When value in the stock market and/or bond interest falls (as it did in 2001 and 2002), insurance companies earn less income on their invested capital. To maintain payment reserves, the insurance companies must increase the price of premiums.

If a company experiences more payouts than anticipated, capital will be drained. Insurance companies protect themselves and their insured against risk by attempting to attract many policy holders. A large pool of policy holders reduces the chance that capital will be depleted. A large premium pool can sustain more loss than a small pool. Insurers also attempt to limit loss by screening out poor quality practice. This might be accomplished by refusing to insure practitioners who have prior claims or limiting the actions a practitioner can perform. For example, an insurance company might refuse to insure use of a vacuum extractor by a midwife.

There was a well-publicized professional liability insurance crisis for physicians in the 1970s. It was a crisis of ***availability*** as insurance companies suddenly experienced a surge in claims unprecedented in the history of insuring health care providers. Jury awards were at their highest recorded levels Many companies, knowing that medical liability coverage was their least profitable line of insurance, stopped writing professional liability policies. That left many physicians and hospital without coverage.

The availability crisis drew a strong response from physicians, hospitals, and their professional organizations, as well as state legislatures. More than 500 state statutes were passed to deal with the crisis. Tort laws and the circumstances under which people could sue were changed. Some states, such as Florida, established patient compensation funds (PCFs). State insurance laws were changed to allow for the formation of new insurance corporations thereby increasing competition with older insurers. Many of these new companies were physician owned. Premiums were kept artificially low to attract new insured. Insurers were able to sustain low premiums because stock and bond market interest returns were high and covered losses.

During the 1980s, interest rates fell sharply as the number of liability claims rose. Initially, this new crisis was an *affordability* crisis. Insurance companies raised premiums hundreds of percentages, trying to recoup dollars lost through liability claims and sagging investment income. There were 13.6 million civil lawsuits filed in 1984, one for every seventeen American. Physicians had paid a collective total of $2.5 billion for professional liability coverage in 1983. They paid $4.7 billion in 1985, effectively a 100% increase in premiums (ACOG, 1988, personal communication; Best's Insurance Reports).

During this crisis, many physicians practiced "bare," or without coverage, risking their personal and professional assets. Approximately 15% of physicians have practiced bare at some time or another (ACOG studies 1983; 1985; 1988; 1999). Most physicians managed to obtain insurance, many through the newly formed physician owned or physician sponsored companies.

Midwifery care traditionally was attractive to clients and employers because of the increased time midwives spent with patients and the lowered cost to provide care. Lower educational costs than physicians and lower liability insurance premiums were the foundation of this cost competitiveness. As liability premiums rose in the 1980s, midwives had to increase practice revenue by seeing increasing numbers of clients. While this increased the ability to pay higher liability premiums, it decreased the attractiveness of midwifery care based on length of visits. Midwives also increased the defensiveness of their practice. The increasing cost of midwifery care strained relationships with physicians, hospitals, and other health care colleagues.

In 1985, the ACNM was notified that the group policy offered to members would not be renewed. This availability crisis was not a reflection of poor claims data but was tied to general problems in the insurance industry, specifically to the lack of reinsurance (most companies underwrite only a portion of the limits of a policy and purchase excess coverage from a reinsurance company). ACNM Insurance Services is an outgrowth of the efforts on the part of the ACNM Board of Directors and staff to ensure the availability of coverage.

A Re-emerging Crisis

In the 1990s, liability premium costs remained artificially low. Many insurers did not adjust premiums for inflation because capital interest earnings were high. Insurance inflation includes both the cost of doing business and increases in liability claims awards. Keeping premiums low made policies attractive and increased the pools of insurers. If a company did not adjust for inflation, and insurance inflation averaged 6% a year, in just 5 years, the company would have to increase premiums by 30% to break even.

The insurance industry sustained massive losses following September 11, 2001. As value on the stock market fell, interest on invested capital fell. At the same time, the United States experienced another surge in claims against physicians and midwives. Insurance companies had to raise premiums to cover potential losses.

Some insured received premium notices with increases of 30 to 50%. Dade County, Florida, the metropolitan Miami area, is an example of one of highest premium markets in the United States. In 2002, obstetricians paid $150,000 per year for $1,000,000 of coverage. Physicians with poor claim histories were denied coverage or paid even higher rates. Some south Florida midwives received premium notices for $25,000 per year for $1,000,000 coverage. As Florida liability premiums rose, many obstetricians again left obstetrics and limited practice to gynecology. Many employers questioned the cost effectiveness of midwifery care as premiums rose.

The Insurance Policy

First and foremost, and insurance policy is a contract. It is a contract between the insurance company (called the insurer) and the person the insurance is protecting (called the insured).

Through the insurance policy, the insurer assumes a defined financial risk on behalf of the insured. The insurer agrees to make payments on behalf of the insured regarding claims of bodily injury as a result of negligence, even if the claims are groundless. In exchange for claims payment, the insurer receives payment from the insured (this payment is called the premium).

The insurance contract covers a limited amount of time specified in the policy. The time covered, also known as the time the policy is *in force* or the policy period, is generally one year. Insurance policies cover only the time period of the policy, as defined by each policy.

The insurer is responsible for the expenses related to defending a CNM/CM against a professional liability claim. Some of these expenses include:

- Investigation costs
- Attorney fees
- Expert witness fees

If a claimant is successful in alleging malpractice against a CNM/CM, the insurer pays the claim against the midwife. The claim is called a settlement if an agreement is made before a trial. It is called a judgment when awarded by a judge or jury after a trial. Settlements and judgments are both called indemnity payments.

Sources of Professional Liability Coverage
Depending on the state you live in and your practice setting, you may have more than one option for obtaining professional liability coverage.

ACNM Insurance Services. ACNM Insurance Services is an outgrowth of the insurance crisis of the 1980s. The ACNM Board of Directors and staff have worked over the years to negotiate a nation wide program that offers coverage tailored to CNMs and CMs. Though ACNM does not "own" ACNM Insurance Services, it is the only program endorsed by ACNM and we work very closely with our plan administrator to develop an active risk management program and to negotiate a policy that reflects and understanding of midwifery practice. The more good midwives and collaborating physicians we have in our plan, the more effective we can be in offering the most cost effective coverage. ACNM Insurance Services maintains a toll-free number, 800-950-2366, where you can speak with representatives about the program, and you can also obtain information on the ACNM Web site, *www.midwife.org*. If you have questions or concerns that cannot be addressed by the staff at ACNM Insurance Services, phone or e-mail the Professional Services staff in the ACNM national office.

Self insurance. If you are employed by a large hospital, university or health maintenance organization, you may be offered coverage through your employers self-insurance program. Self-insured organizations set aside money to pay future claims, invest the capital themselves, and

earn sufficient investment income to pay future claims. Self-insurance is not simply saving enough money to pay claims, rather, it is the joining together of similarly situated individuals and institutions to purchase insurance coverage uniquely tailored to their circumstances. Others who are not part of their group are not allowed into the risk pool. Self-insuring through hospitals and large group practices generally results in strong administration, risk-limiting oversight, and close scrutiny of practice guidelines.

Joint Underwriting Associations (JUAs). You may live in a state where insurance is available through a Joint Underwriting Association (JUA). JUAs are chartered to provide insurance when insurance is unobtainable from other sources. They are collectives of commercial companies compelled by states to offer insurance coverage with one company administering the JUA plan. A central problem to JUAs is their lack of a central corporate identity. No one company within the JUA has an identifiable stake in reducing claims or injuries. State JUAs may provide other insurances in addition to liability insurance, such as catastrophic home owner's insurance. The Florida JUA sustained record losses from hurricane damage during the 1990s, adding to the cost of midwifery liability premiums.

"Going Bare"

"Going bare" refers to practicing without professional liability insurance. This is not an option in some states (some states require that midwives show evidence of liability insurance before a license to practice is issued).

Where it is a possibility, going bare raises the ethical question of whether professionals should be financially responsible for their professional work. Though some states have formed patient compensation funds, American society as a whole still depends on liability insurance to pay for the care of injured persons. In going without coverage, the midwife makes the assumption that the value of her personal assets is too low to be an attractive claim target.

Consider the following questions before making a choice to go without coverage:

1. How will the injured patient be compensated?

2. How will I pay for my defense in court or before a state licensing board?

3. Can the patient sue me for my personal worth?

Physician-owned/sponsored companies**.** Some midwives enjoy access to coverage through association with physicians who are covered by one of the physician-owned insurance carriers. Some of these carriers have chosen to levy a surcharge for physicians who employ or serve as consultants for midwives, though there is no actuarial data to support such a surcharge. This issue is addressed in detail in the ACNM Resource Packet, Physician Surcharge, available free of charge from ACNM Department of Professional Services.

Federal Tort Claims Act. Midwives employed at federal community health centers and government installations (ie Indian Health Service hospitals and military hospitals) may have liability coverage through the Federal Tort Claims Act. For more information see *http://bphc.hrsa.gov/programs/FTCAProgramInfo.htm*

Types of Insurance Policies

There are two very different types of professional liability insurance, 1) occurrence and 2) claims made policies. For most midwives, claims made is the only type of insurance still available.

Occurrence Policy
Occurrence is the simpler of the two types of insurance but is rarely available for midwifery and obstetrical providers today. Occurrence policies cover alleged malpractice events that occur during the policy period. Events are covered regardless of the date of discovery or when the claim is filed.

Practice Profile

Consider this case an example of occurrence coverage. A CNM/CM had an occurrence policy with a policy period covering 1/1/00 through 12/31/00. The midwife attended a birth complicated by a shoulder dystocia on November 14, 2000. The infant's ongoing Erb's Palsy did not respond to physical therapy and the parents filed a claim in March of 2002. The policy period expired in December of 2000, however, the incident occurred during the policy period and was, therefore, a covered incident.

Claims Made Policy
A claims made policy covers a claim if the incident occurs between the retroactive date and the end of the policy period, and, only if the claim is made during the policy period. Claims-made policies are generally less expensive in the first year of coverage. In the first few years of coverage, the premiums increase each year toward a future year when the policy "matures." When the policy matures, the yearly premiums are standard for all insured. A midwife in the first year of claims made coverage will pay less than a colleague in the third year of coverage. Midwives need to know what the policy premium increases will be per year and plan for that increased cost of practice.

Some claims are filed years after the incident, especially in obstetrics. What happens when a CNM/CM retires or changes jobs and no longer continues the claims made policy, since claims must be made during the policy period for the insurer to cover the midwife? When a professional ends a claims made policy, the insurer offers an Extending Reporting Period (ERP) endorsement to the insured. This endorsement, commonly referred to as a "tail", allows additional time to report claims that occurred during the policy period. Usually, the ERP must be elected within 30 days after coverage has ended.

Extended Reporting Periods vary between insurance companies. Some companies offer tails that provide only 5 years of extended coverage. Some states allow liability claims related to birth to be filed as long as 18 years after the birth. A tail limited to 5 years would leave the midwife without coverage for another 13 years. Some insurers offer an unlimited tail. When a midwife

buys an unlimited extended reporting period, incidents that occurred during the policy period are forever covered.

The low premiums of the first year of claims made coverage are attractive to new midwives. However, midwives must consider both the cost of premium increases as the policy matures and the cost of tail coverage to have a complete idea of the total costs of coverage. The cost of the extended reporting period endorsement is based on the premium paid in the final year or years of the policy. It may be up to 200% of the claims made policy's annual premium. For a claim's made policy that currently costs the midwife $12,000 per year, the cost of the tail would be $24,000. The ERP must often be paid in a lump sum.

The time limitations of claims made coverage and the cost of tail coverage are worrisome in a profession where practices may be unstable and new graduates change positions often. Midwives need to plan for the actual expenses of maturing premiums and tail coverage when they start a claims made policy. Because tail coverage is vital to a midwife's financial security, the CNM/CM should request an unlimited ERP and request that its premium be part of the written insurance quotation. Once the policy is issued, the midwife must review the policy to be sure that this option is included in the written policy.

Practice Profile

This case illustrates a claims made policy. Two midwives were employed by a busy group practice that attended more than 60 births per month. The practice purchased claims made insurance for the midwives. The midwives took 24 hour call duty in the hospital and changed rotations every morning after antepartum and postpartum rounds. On the morning of August 14, 2000, one midwife attended a birth on labor and delivery as the second midwife was coming onto the labor and delivery ward. Severe fetal bradycardia occurred just prior to crowning. The first midwife paged for STAT help. The second midwife entered the room and assisted the first with the birth while the nursing staff page the physician to come to the hospital. The fetus was asphyxiated and 18 months later was profoundly developmentally delayed.

The group practice split in December of 2000 and the midwives were let go. The first midwife was later employed at another group practice across the state. This new group paid her liability insurance and she did not give tail coverage for her prior practice a thought. The second midwife accepted a position with a self-insured health maintenance organization. She borrowed money to pay for tail coverage for the insurance from the former practice. In February of 2001, the parents of the developmentally delayed newborn filed a liability claim against both midwives and the physician on call for August 14, 2000. The second midwife was covered through her tail coverage. The first midwife found herself uninsured. The cost of a malpractice attorney, court costs, and the final judgment were hers alone.

Limits of Policy Liability

Professional liability policies have two sets of limits: 1) a per claim or incident dollar limit on the amount that the company will pay for each claim, and 2) the aggregate dollar limit that the insurer will pay during the policy period. The per occurrence limit and the aggregate limit are often indicated as two dollar amounts divided by a slash. Therefore, limits stated as $250,000/$750,000 mean that the company will pay no more than $250,000 for a single claim and no more than a total of $750,000 during the policy period.

The per claim or incident limit and the aggregate limit are often indicated as two dollar amounts divided by a slash.

The two common sets of liability limitations for health care providers are: $250,000/$750,000 and $1,000,000/$3,000,000. State law and /or hospital bylaws may dictate the limits you are required to carry.

1) The per occurrence limit or claim limit, is the most an insurer will pay for a claim. If there is settlement for $100,000 on a claim, the insurer will pay the entire amount. However, if there is a judgment of $300,000 awarded on a claim, the insurer will pay only the claim limit, $250,000. The midwife will be responsible for the additional $50,000.

2) The aggregate limit, is the total amount an insurer will pay for all claims paid during the policy period, usually one year. The aggregate limit applies to the policy period is which the claim is paid out, not the policy period in which the incident occurred. If the policy has a $750,000 aggregate limit, and one claim is settled for $500,000 and a second for $65,000, the insured ends the policy period with $185,000 remaining toward the aggregate limit. However, unawarded aggregate dollars are not rolled over or credited to the next policy period. If the insured sustains claims of $430,000 and $390,000 ($820,000 total) during the policy period and the aggregate limit is $750,000, the insurance company will only pay out $750,000. The midwife will be responsible for the remaining $120,000.

There are two common sets of liability limitations for health care providers: $250,000/$750,000 (in Florida only) and $1,000,000/$3,000,000. State law may dictate the limits a provider is required to carry. Some hospital medical staff bylaws require minimum limits for physicians and midwives to have hospital privileges. The midwife needs to know these requirements before purchasing a liability insurance policy.

Some states have special plans that provide “excess coverage” above the midwife’s policy limits. The insurance agent should know whether these plans exist, whether participation is voluntary or state mandated, and the benefits or disadvantages of the excess coverage. In some states, for example, electing to participate in the excess plan can limit the maximum amount a court can award an injured party (sometimes called a statutory cap). If the midwife does not participate in the excess coverage, the amount of potential malpractice awards is technically unlimited.

Another limit placed on liability coverage is the work covered. Many liability policies cover only specified employers or work places. A liability policy covering a midwife in private practice may

not cover midwifery care provided as a charity at a local free clinic. A midwife moonlighting with a second practice may need to purchase separate liability insurance to cover that work. The cost of additional liability insurance may be more than the earnings from moonlighting.

Insurance policies may also limit actions that the insurer sees as risky. Examples of some policy exclusions include home birth and the use of recording or photographic equipment in the birth suite.

Purchasing Your Own Policy

Midwives who obtain professional liability insurance through ACNM Insurance Services benefit from the work of the ACNM Board of Directors and staff. On behalf of members, ACNM leadership and staff have worked over many years to develop a close relationship with our plan administrator, carefully monitor the industry (warning of the latest crisis!), and continually negotiate for a policy that reflects an understanding of midwifery practice. If you chose to shop elsewhere for professional liability insurance, consider carefully your choice of agent and company.

The Insurance Agent

Insurance agents are typically independent distributors of insurance services, usually representing more than one insurance company and selling more than one type of insurance. The choice of agent is one of the most important factors to consider when purchasing professional liability insurance. You will rely on the agent's knowledge of liability protection products and state laws regarding liability insurance.

Select an experienced agent who specializes in professional liability insurance for healthcare providers. Professional liability coverage is more complicated than car or homeowners insurance. An agent who has experience with providing professional liability insurance to midwives is most preferable. Agents earn commissions off sales and premiums. In the best scenario, the midwife has two or more agents experienced with professional liability insurance and receives written premium quotations from each.

The Insurance Company

Considering several points will help you select a sound insurer. First, select an insurer that is admitted to do business in your state. To be "admitted," an insurance company's policies and premiums must be approved by the state's Department of Insurance. In some circumstances, states allow non-admitted insurers to do business within the state. Unless there are no other options, always choose an admitted insurer. The agent knows if the insurer is admitted or not.

Second, examine the financial stability of the insurer. This information also can be provided by the agent. One source of information on insurance companies is Best's Insurance Reports. Best's was the first insurance rating organization and is still recognized as the industry rating leader. Best's is an independent organization and receives no funding from insurance companies.

Best's rates insurers on the basis of their perceived financial ability to pay claims. These are the Best's ratings that indicate a secure insurer:

- Superior A++, A+
- Excellent A, A-
- Very Good B++, B+

Ratings change with changes in the industry as well as with changes in a particular company. In 2002, a superior rating is virtually unheard of in the professional liability market. Be wary, however, of selecting an insurer with a Best's rating lower than very good. Insurers without sufficient capital and investment income to pay out claims may go out of business, leaving you without coverage or the possibility of buying tail coverage.

A consideration related to the insurer's financial stability is the length of time the insurer has been providing professional liability coverage. The company should be committed to providing liability coverage, not a company that has recently entered the market because conditions are favorable and profits are likely. An experienced insurance company is more likely to weather an insurance crisis than a start-up with low capital reserves.

Premium Rate Setting

Malpractice premiums are calculated from several pieces of information, some which are related to you as the midwife applicant and some which are more related to the insurer and the industry. The factors that go into determining a rate include:

"Because of the need to review each midwife's characteristics, the insurance plan is no longer "cookie-cutter." We structure terms of coverage for each midwife. This makes it all the more important to submit applications for insurance (including those currently in the ACNM plan) well in advance of the current policy expiration date so that we have time to evaluate your practice characteristics and offer a unique plan of coverage just for you. This may require some personal dialogue with you to make sure we have all the facts. Allow at least 30 days for this process[1]."

- Gary McCammon, *President, ACNM Insurance Services Inc.* "Quality Insurance for Quality Practices," Quickening; 30(5): 2000

- The state in which you practice. Many states have multiple rating territories, particularly those with large urban areas. Generally, premiums will be higher in densely populated urban areas because the incidence of real or perceived injury is higher
- Your practice setting (site of birth, type of hospital) and scope of practice. Practices providing obstetrical care pay higher premiums than those limiting their services to gynecology. Your number of years in practice and your malpractice history.
- Your longevity with the insurer. Some insurers offer lower premiums to midwives who have participated in the insurance plan for years without claims (The ACNM plan is one of these contracts).
  - Your former coverage;
  - The frequency and severity of claims against the company's insured;
  - The administrative and marketing expenses of running a business in a;

competitive field;
- Investment income on the insurer's capital;
- Corporate taxes;
- Corporate profits;
- The amount and nature of state insurance regulations; and
- The amount and nature of insurance competition.

Reviewing this long and complicated list makes it clear why an insurance company is likely to ask you to fill out an application *before* being able to quote a rate (Asking for a price quote over the phone is like being asked to make a diagnosis before you can take a history and do a physical exam).

Once the premium is set, a discount may be available. The ACNM plan offers a discount to midwives who participate in risk management education provided by the plan.

Most midwives have limited options in choosing more affordable premiums. Calculate carefully the immediate and long term costs of any insurance product.

Employer Provided Insurance

It is important to discuss professional liability insurance during your interview and contract negotiations. Once employment has started, bargaining power is lost. Regardless of the type of coverage, you should be able to answer these questions:

- Will you be covered under your employer's policy or will your employer pay the premium for an individual policy?

- Is there an insurance company or is the employer self-insured? Does the self-insured organization have sufficient capital to cover claims? If there is an insurance company, what is its Best's rating? How long has the insurer been in business?

- Is the policy claims made or occurrence?

- If you leave employment and have been covered by a claims made policy, will the employer pay for tail coverage? Will the employer promise this in a written contract? If the employer will not purchase the tail, will you have that option? What will the cost of tail coverage be?

- Is the employer willing to provide a copy of the Certificate of Insurance to you? If the employer is unwilling to provide written proof of insurance, it may not exist.

- Does your employer's coverage provide you with separate limits of liability or do you share in group liability limits? Other group members may exhaust liability limits leaving no coverage available for claims against the midwife.

- If there is a claim, will the employer's coverage provide legal counsel representing your individual interests? In claims made against multiple members of the same group, may individual midwives and physicians have different attorneys to represent their individual interests?

- Will the employer advise employees before settlement offers are made to suing claimants? Will you have the ability to approve or reject a settlement offer before it is made?

- Will the liability policy cover all midwifery work done during the policy period or will the policy cover only work done for the employer?

Purchasing Additional Coverage

Proper and adequate professional liability insurance is crucial to your career. The coverage provided by an employer may not be sufficient in either scope or limits of liability. Even if you are covered by your employer, you might want to consider purchasing individual coverage. There are a number of factors you might want to consider in deciding whether and how much coverage to purchase:

The policy will list exception or exclusions. For example, ACNM Insurance Services offers coverage for midwives offering home birth services, but the policy excludes coverage for "after the onset of sustained labor leading to delivery, any nonvertex fetal presentation, unless delivery is imminent within 30 minutes.

- Consider the scope of practice and independence in decision making in the practice. The more independence in decision making a midwife has, the greater the potential exposure for liability claims.

- Consider the frequency of claims in the rating territory, current settlement and judgment amounts, and your existing financial resources. If your employment provides liability insurance at $250,000/$750,000 limits, you might consider paying additional premiums or purchasing another policy to provide coverage to $1,000,000/$3,000,000.

- Are you moonlighting or working outside the direct and defined scope of employment? You may need to purchase an individual policy to provide coverage for that work.

Read the Policy Contract

Many professionals who carry professional liability insurance do not truly understand their obligations and respective rights and responsibilities under the contract — until they have a claim filed against them. ***If you have not already done so, get a copy of your liability policy contract and carefully review its provisions.*** If you have questions about coverage and conditions, get answers from the company.

The critical elements of the liability contract include not only the named insureds, definitions, exclusions, and other limitations of coverage, but also matters related to reporting of claims or incidents, record keeping, cooperation in claims management and alternative insurance coverages. Most insurance contracts are brief, yet they contain numerous provisions that may be confusing or misleading to one who reads the contract casually.

Specific areas outlined in the critical elements of the contract include the coverage limits, the stated duties of the company and the insured midwife concerning their respective obligations. The policy will list the exceptions to when coverage will be extended. You must be aware of the circumstances in which practice falls outside the bounds of contract coverage. Some insurers limit policy coverage when the midwife has other insurance that would also cover the claim.

There may be special requirements in the contract that the company be notified of claims within a certain period of time. If the insurer is not notified according to its contract specifications, it may deny the claim. Some companies require notification of incidents that might lead might lead to a claim, such as a difficult birth where the newborn is transferred to a neonatal intensive care unit. Contract details vary from policy to policy. Carefully review the policy duties, requirements, limits and conditions. If you don't have a clear understanding of the provisions, the insurance company will answer questions.

Coverage for collaborating physicians

ACNM Insurance Services is now offering coverage to physicians who collaborate with CNMs/CMs. Each physician who applies to ACNM Insurance Services must first be collaborating with an ACNM member who is also insured by ACNM Insurance Services. The physician will be asked to complete an application. Acceptance of the application and the cost of the premiums will be based on many of the same factors that are used when making those decisions for CNMs/CMs.

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Glossary of Terms

Claims made insurance coverage - a contract that covers a claim when both the incident occurs and the claim is made during the policy period.

Duty - an obligation recognized by law

Extended reporting period - a contract that extends the coverage of a claims made policy into the future to cover all claims after the basic claims made coverage period (also known as tail coverage)

Indemnity - compensation provided to a claimant in a malpractice case

Joint Underwriting Associations (JUA) - a consortium of insurance companies mandated by law in some states to underwrite malpractice insurance to assure its availability

Malpractice - professional negligence, including those acts that involve a departure from the prevailing standard of care

Negligence - a legal principle that establishes liability for one who breaches a duty owed to another when that breach of duty causes a compensable injury

Occurrence insurance coverage - a contract that covers all claims, whenever filed, arising out of care rendered during the policy period

Standard of practice or standard of care – the degree of care a resonably prudent person, with the same qualifications, should exercise under the same or similar circumstances. This is often based on the prevailing set of professional performance expectations established by published standards, the consensus of published literature and the content of expert testimony

Statute of limitations – a state law which sets a time limit in years from the date of an alleged injury after which a civil lawsuit may be filed

Tail coverage - see extended reporting period

Tort - a wrong or injury.

PART 2: PHYSICIAN SURCHARGE

Introduction

In the 1980s, the number of professional liability claims against health care professionals grew exponentially. Though only a small proportion of the claims were upheld in court against the health professional, professional liability insurance companies claimed that the cost of litigation had become a major financial burden. The resulting "insurance crisis" had a direct impact on midwives in three ways: 1) professional liability coverage was unavailable to some nurse-midwives for a period of time; 2) premiums were increased; 3) surcharges were imposed on physicians who worked with nurse-midwives.

The ACNM worked quickly to develop an insurance consortium that was able to provide professional liability coverage to nurse-midwives. Though this "crisis" was resolved, premiums were significantly higher and the imposition of physician surcharges posed a significant barrier to nurse-midwifery practice (1).

The surcharge is an additional premium paid as a set amount or a specified percentage of the physician's premium. In theory, it is justified based on the allegation that the physician is at increased risk for malpractice actions because of a professional association with a midwife.[1] **Some surcharges were quite low, while others were much more costly, with the charge levied ranging from less than 1% to 25% of the physician's annual premium.**

A survey carried out in 1988 showed that in fourteen states and the District of Columbia, midwifery practices were affected by surcharges levied on physicians who worked with nurse-midwives. These surcharges ranged from $94 to $23,000 per midwife per year, and were responsible for the closing of over 14% of affected practices and for fee increases in an additional 26%.

In 1991, ACNM published the first "Physician Surcharge Resource Packet," compiled by Nancy Fleming, CNM, PhD and the Professional Liability Committee, to assist members facing this problem. The packet contained background information and details about the successful challenge that was mounted by CNMs in Illinois in 1985-86. Nurse-midwives in Washington, DC also mounted a highly publicized and successful challenge to physician surcharges.

In the years following publication of that Resource Packet, there was evidence that the physician surcharge problem was abating. The 1988 ACNM survey was not repeated, but the volume of calls to the ACNM national office regarding physician surcharges diminished greatly for a few years. A downward trend was also seen in the American College of Obstetricians and Gynecologists (ACOG) Survey of Professional Liability: 60% of the 1992 survey respondents who employed a nurse-midwife reported an insurance carrier surcharge for such a position; by 1996, the percentage reporting a surcharge dropped to 32%.

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[1] *CNMs/CMs and midwives as used herein refer to those midwifery practitioners who are certified by the American College of Nurse-Midwives (ACNM) or the ACNM Certification Council, Inc.; midwifery refers to the profession as practiced in accordance with the standards promulgated by the ACNM.*

With the re-emerging malpractice insurance crisis, the volume of calls to the national office regarding surcharges has once again increased, and the material has been included as Part 2 of the Professional Liability Resource Packet.

The ACNM Department of Professional Services is interested in hearing from members who continue to face a problem with physician surcharges. We are interested in knowing if the information provided in this resource packet is helpful, and we will update it based on feedback from members. Please contact Lisa Summers, CNM, DrPH at 202-728-9892, or lsummers@acnm.org.

Acknowledgements

Nancy Fleming, CNM, PhD, working with the Professional Liability Committee, was largely responsible for the first edition of this resource packet and Suzanne M. Smith, CNM, MS, MPH and the Professional Liability Section of the Division of Standards and Practice reviewed the revisions. The second edition was developed by Lisa Summers, CNM, DrPH, in consultation with Alyson Reed, MA, and Karen Fennell, RN, MS, and Marion McCartney, CNM of the ACNM Professional Services staff, Arthur Lerner, JD, for the law firm of Michaels & Bonner, P.C., and Gary McCammon with Professional Risk Advisors, Inc. The sample letter to an insurance company was developed using excerpts of actual correspondence by Susan Jenkins, JD, former ACNM General Counsel.

Central Issues

The central issues related to physician surcharge are:

1) Can placing a liability surcharge on physicians who work with midwives be supported by actuarial data?
2) If surcharges can be substantiated by actuarial data, are the surcharges excessive or unfairly discriminatory?
3) Are surcharges being used to restrain the practice of midwives or physician/midwife practices?
4) Can surcharges validly be placed on physician/midwife relationships that are not employer/employee relationships?

The following sections examine each of these central issues more closely:

Can placing a liability surcharge on physicians who work with midwives be supported by actuarial data?
The insurance company's basis for levying an additional premium is the presumption that the insured is at increased risk for professional liability action. This has been done in cases were there have been several successful malpractice actions against a specific physician, and thus the insurance company assesses a higher premium than required for other specialists in the same class and the geographical location **based on documented past experiences**.

In the other instances, certain physicians are deemed to be a higher risk because of the nature or the location of their practices. For instance, malpractice actions are more frequent in urban areas, and therefore physicians who practice in certain urban or suburban locales are assessed a surcharge **based on documented expectations of occurrence.**

The question as it relates to midwives is whether physicians who employ **CNMs/CMs** are **REALLY** at higher risk for liability actions **because of the CNM/CM association** ("vicarious liability")? In other words, for a liability surcharge to be legally levied on the physician employer of a certified nurse-midwife, the insurance company MUST be able to show statistics that document either: a) such physicians or individuals have been shown in the past to have sustained an increased number of malpractice actions, or b) that the physician-colleagues of certified nurse-midwives as a group can be anticipated to have more malpractice actions based on documented expectations.

The statistics regarding past claims that are used as a basis for future claims (and therefore future risk) are called "actuarial data," and these statistics become a very important part of the case for any nurse-midwife challenging physician surcharges.

For a surcharge to be assessed accurately, the statistics not only must document this increased risk for malpractice actions for the physician's colleagues, but also must document that these

increased risks are **because of the physician's professional association with a midwife.** If a surcharge has been levied prior to the association with the midwife, it is doubtful that it could be challenged successfully under these guidelines, since arguably such a pre-existing surcharge was placed for other indications of "increased risk." However, if it is not stated but is temporally associated with the commencement of the physician/midwife professional agreement, good grounds exist for questioning the insurance company's apparent assumption of increased risk based solely on the physician/midwife professional association.

At this time, the ACNM has not been provided with any actuarial data to support a surcharge. In fact, we have data from ACOG which undermines the surcharge assumption.

If surcharges can be substantiated by actuarial data, are the surcharges excessive or unfairly discriminatory?

The prohibition on "excessive or unfairly discriminatory" rates (or wording of a similar nature) can be found in many state insurance department[2] codes addressing the cost and availability of insurance. The department of insurance is charged with overseeing the insurance industry and examining actuarial data to see whether premiums are impartially levied and set at an equitable rate. It is this body to whom a challenge of a physician surcharge must ultimately be made. A challenge is most often initiated by the physician, because s/he is the one protesting the unfairness of the surcharge levied against him or her.

If surcharges are levied, this department may be asked to examine them to determine whether the actuarial data indeed exists that permit the surcharge assessments, and if so, whether the surcharges are excessive or unfairly discriminatory. There are instances in which physician surcharges are levied that are nominal in nature and the practices involved have chosen to pay the additional premiums rather than challenge them.

There are several major problems to consider in this area. State insurance codes vary in the scope of authority provided to the department of insurance to regulate the fairness or basis for malpractice liability premiums and the resources of the various states' insurance department also vary. All states, however, have some official body that deals with insurance disputes, and it is to this body that challenges must be directed. The ACNM State Policy Analyst maintains a State Policy Resources listing for each state, including the state insurance department contact[3].

Second, such a challenge almost always necessitates engaging knowledgeable legal counsel. While challenges may be brought directly to the state department of insurance, state law and insurance structures differ vastly, so legal expertise is usually vital to success. The Illinois midwives were fortunate to benefit from pro bono legal counsel in their challenge.

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[2] *All states have a regulatory body which deals with insurance. It may be called a department, division, bureau or commission. For the sake of simplicity, we refer in this document to the state insurance departments or "the department of insurance".*

[2] *The State Policy Resources are available on the ACNM Web site at www.midwife.org/prof/spr_indx.htm.*

Third, practices are often asked to provide actuarial data related to their rates of professional liability actions. We are fortunate that ACOG has added questions to their 1992 and 1996 Surveys on Professional Liability and are able to provide us with some information. Their data show that the number of physicians who employ nurse-midwives has increased, from 7.7% of respondents in 1992 to 12.6% of respondents in 1996. During the same time period, the number of respondents reporting a nurse-midwife named as a co-defendant has decreased, from 2.4% in 1992 to 1.1% in 1996.

Are surcharges being used to restrain the practice of midwives or physician/midwife practices?

In recent years, an increasing number of ACNM members have called the national office requesting assistance with a problem they view as an antitrust violation or restraint of trade. The most common problems relate to hospital credentials and supervision requirements, but if physician surcharges cannot be supported by actuarial data as being fair and reasonable, the question arises, "do surcharges constitute restraint of trade?" and can they be challenged on that basis?

The ACNM has responded to these questions regarding restraint of trade in a number of ways. An *Antitrust and Restraint of Trade Resource Packet* has been developed and is made available to members free of charge[4]. The packet (written with a minimum of legalese) contains an overview of antitrust issues, advice about evaluating your case, and options for responding to a possible antitrust case.

It is important to remember that while a company or organization may indeed engage in activities that are unfair and restrictive and cause significant problems for a midwife, those activities may not necessarily meet the federal or state antitrust standards and definitions. To assert an antitrust claim, a private plaintiff is required, as a threshold matter, to make allegations that satisfy three "standing" requirements:

1) A violation of the antitrust laws;
2) injury to business or property, or, in the case of injunctions, threatened loss or damage; and
3) a causal relationship between the antitrust violation and the injury.

On the merits, proof of an antitrust violation in this context will require evidence of an unlawful conspiracy. In one successful antitrust suit brought by a nurse anesthetist against a hospital and its anesthesiology staff, the judge delineated the conditions that must be met in order to prove a conspiracy in restraint of trade.[5] As stated in this opinion, "A claimant must initially prove three elements:

1) an agreement or conspiracy among two or more persons or distinct business entities;
2) by which the persons or entities intend to harm or restrain competition;

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[3] *Contact the Senior Assistant in Professional Services at the ACNM: 202-728-4713 or e-mail a request to info@acnm.org*

[4] *Oltz v. St. Peter's Community Hospital, 861 F.2d 1440 (9th Cir. 1988)*

3) which actually injures competition."

In order to succeed in court, the CNM/CM must prove (show evidence) that all these things occurred. Where an insurance company acts on its own, and is not controlled or coerced by physicians, no conspiracy will be found, so antitrust will not provide a remedy even if the rating practice involved lacks justification and harms competition.

The *Antitrust and Restraint of Trade Resource Packet* contains summaries of relevant cases. Even if your circumstances sound similar to cases that have been won, there are no guarantees. As the judge also noted in the opinion quoted above, each case is unique: "The rule of reason requires the evaluation of each challenged restraint in light of the special circumstances involved. That the analysis will differ from case to case is the essence of the rule."

Can surcharges validly be placed on MD/CNM relationships that are not employer/ employee relationships?
Some legal experts are of the opinion that when a midwife in an independent practice hires and pays a physician as her/his medical collaborator, this NON-EMPLOYER physician cannot be assessed a surcharge for additional liability exposure. Based on this opinion, some collaborative practices have quite successfully changed employer/employee relationship to circumvent the surcharge.

Another practice pattern that seems to have avoided the surcharge is that of the hospital-employed CNM where the CNM is covered by the hospital policy. There are, of course, other advantages and disadvantages to consider with regard to these relationships.

Responding to the Problem of Physician Surcharge

There are a number of actions you might consider and the best course depends on your individual situation. Regardless of how you proceed, it is critical to begin with accurate information.

Gather evidence; Ask for Documentation
It is not uncommon for midwives and physicians to be told of decisions regarding credentialing requirements, changes in regulations, the imposition of surcharges, etc., when decisions have, in fact, not been made or changed. It is important to ask those you speak with to put what they say in writing. Request that the insurer send a copy of the proposal (or quotation) detailing the additional cost to the physician. Also request a copy of the insurer's "rates and rules" upon which the additional cost is based. In most cases, these rates and rules have been filed with and approved by your state's department of insurance.

Use a telephone log to document your calls. Summarize conversations and follow-up in writing with requests for confirmation.

Date

Dear _____:

Thank you so much for taking time to meet/speak with me yesterday to discuss...(your company's consideration of surcharges for physicians who provide consultation for nurse-midwives). I am glad...was able to join us. I understand that you will...(research the questions of actuarial data to support such a surcharge)...

You suggested that I need to.... (or)
I hope you will reconsider your position that... (or)
As suggested by you, I will...(or)
It is my understanding that .. (should there be no evidence to support such a surcharge, you will reverse you decision of)...(or)
I am looking forward to hearing from you... (or)
It is my understanding that you will provide me with...

If I do not hear from you to the contrary, this will confirm your agreement with the above.

Sincerely,

Educate and Question

The insurance carrier, particularly one that has not previously covered midwives, may be acting out of ignorance. Put together a packet of information that describes midwifery practice and stresses the quality and safety of midwifery care. Present a professional image by packaging the information in the ACNM's two pocket folder or similar holder.[6] Consider including:

- Today's CNM brochure;[7]
- Standards for the Practice of Nurse-Midwifery;[8]
- State Fact Sheet for your state;
- Resources & Bibliography: Quality and Effectiveness of Nurse-Midwifery Practice;[9]
- Evidence-Based Health Care brochure reprint of one or more studies from the effectiveness literature reprint of: Jenkins S. The myth of vicarious liability. JNM 1994;39:98-106;
- Your resume; and
- Your practice brochure.

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[6] *Available from the ACNM Resource Catalog, Stock ID #309.*
[7] *Available from the ACNM Resource Catalog, Stock ID #201*
[8] *Available from the ACNM Resource Catalog, Stock ID #901, or from the ACNM Web site, or Fax on Demand, Item #2004*
[9] *Available on the ACNM Web site.*

Send the packet with a cover letter. Refer to whatever documentation of the physician surcharge you have been provided. Inform the carrier that neither you nor ACNM is aware of any actuarial data to support a surcharge. Offer to meet in person and follow up with a letter. Depending on the nature of your relationship with the physician(s) involved, you may wish to write a letter/ meet jointly with the carrier. In some instances, this action alone has resulted in the dropping of a physician surcharge.

Seek advice from ACNM Insurance Services
ACNM Insurance Services (800-950-2366) may be helpful to you in analyzing the additional cost to your physician's insurance coverage and providing options. Most helpful to them would be your procurement of:

- The proposal (or quotation) from the insurer to the physician detailing the additional cost. The physician involved should be able to supply this.
- A copy of the physician's current policy, the most recent application for coverage and the most recent proposal of coverage terms (usually described as the renewal quotation).
- The exact name of the insurer (if not specified in the proposal or if you cannot obtain a copy of the policy). Some insurers operate several different companies; it will assist in research to know the specific company involved. You will have to ask the insurer for this unless it is identified in the above documents.
- A copy of the insurer's "rates and rules" upon which the additional cost is based. In most cases, these rates and rules have been filed with and approved by your state's department of insurance. You will have to ask the insurer for this.
- A specimen of the form (called an "endorsement") that will be added to the physician's policy to recognize the additional premium charged. You will have to ask the insurer for this.

Work through the department of insurance
It is possible to work directly with the state insurance department in protesting a surcharge. In some states, an appeal to the department of insurance or a request for a hearing has brought prompt, supportive responses.

If this approach is used, the possible favorable effect of political pressure should not be overlooked. Sympathetic legislators may be willing to write letters of inquiry to the state insurance commissioner. Letters from supportive physicians, patients, and friends may be helpful in promoting the midwife's cause. Media coverage may also be beneficial. (See Appendix for sample letter to a state insurance commission.) As noted earlier, the ACNM State Policy Resources listing for each state includes the state insurance department contact.

Challenge the surcharge with a letter from legal counsel
It is important to realize that a threat of legal action (even a hint of legal action) can have important personal and political ramifications for the midwife and physician involved. Midwives are involved in many situations where personal contacts and support are particularly important, e.g., issues of hospital credentialing, changing state practice acts, advancing legislative agendas. Consider the possibility that those personal contacts and support may be affected by the involvement of legal counsel. Instead of the discussion you were accustomed to, you might now hear,

"Have your lawyer talk to my lawyer." Such letters have, however, been successful for some midwives and physicians. (See Appendix for sample letter.)

Pursue legal action
This is costly, time-consuming, and may not result in a favorable decision. In general, it's always best to stay out of court, and to keep conversations serious while allowing others to change their minds and still "save face." For antitrust-based claims, refer to the *Antitrust and Restraint of Trade Resource Packet.* You could also explore the possibility of a claim based on the carrier's alleged violation of state insurance law.

References

1. Sinquefield G. Physician surcharge: another barrier to practice. J Nurse Midwifery 1989; 34:1-2.

2. Jenkins SM. The myth of vicarious liability: impact on barriers to nurse-midwifery practice. J Nurse Midwifery 1994; 39:98-106.
APPENDIX A

Glossary of Terms

Physician surcharge — an additional professional liability premium charged to physicians working with midwives.

Vicarious liability — indirect legal responsibility, such as an employer for the acts of an employee
(This is addressed in great detail in the referenced article.)

Actuarial data – information compiled as a result of statistical calculations related to insurance risks; used to establish premiums and reserves.

Department of Insurance/Insurance Commission – though their names vary, each state has a regulatory body charged with overseeing insurance practices within the state. The ACNM State Policy Analyst maintains a State Policy Resources listing for each state, including the state insurance department contact. The listing is available on the ACNM Web site at *www.midwife.org/prof/spr_indx.htm.*

Antitrust/Restraint of trade actions – legal complaints charging that the purpose and/or effect of certain practices is to curtail competition. State and Federal laws exist to protect trade and commerce from unlawful restraints, price discrimination, price fixing and monopolies.

Appendix A:

Sample Letter to State Department of Insurance

Director, Department of Insurance
State of Illinois
320 W. Washington
Springfield, Illinois 62767

Dear

I wish to make a formal request for a hearing by the Illinois Department of Insurance into action taken by the Illinois Medical Society Insurance Exchange (ISMIE) which adversely affect my practice as an obstetrician employing two Certified Nurse-Midwives (CNMs). The action is inherently unfair and cannot be justified by any actuarial data.

There are approximately 120 CNMs working with obstetrician/gynecologists in Illinois. Ninety percent of them work in hospitals or for institutions which provide professional liability coverage for them. The remaining ten percent work in private practice settings or for an HMO where they must carry their own liability coverage. Until this year, there were several sources of coverage available for CNMs, but, as you may be aware, as of December, 1986 there are no firm insurers.

Until last August, the Illinois CNMs who needed professional liability coverage could purchase it through ISMIE for a premium of approximately $2,000 per year. Then, abruptly ISMIE issued a statement saying they would no longer offer coverage for CNMs, although communications with Mr. X and Mr. Y of ISMIE failed to identify any reason for the action other than the generally poor liability climate nationwide. Investigation by the Illinois chapter of the American College of Nurse-Midwives shows that the litigation record involving CNMs in Illinois over the last ten years has been extremely good, and both the CNMs and their physician employers are puzzled as to how the ISMIE can justify dropping CNM coverage while continuing to cover all other nurse-practitioners (including nurse-anesthetists) statewide.

At the same time that it dropped CNM coverage, ISMIE levied a 15% surcharge to the annual premium of every physician who has employed a CNM on a <u>per midwife</u> basis, irrespective of the number of deliveries done, or the full-time vs. part-time status of the terms of employment. While it was stated that this surcharge was due to "additional vicarious liability" incurred by working with CNMs, no evidence documenting this allegation was ever introduced, and those of us who have been practicing in team relationships with CNMs are firmly convinced we are actually at <u>decreased</u> risk because of the various benefits the CNMs bring to our practices.

When one adds the cost of this vicarious liability surcharge (currently almost $6,400 for me for each of my CNMs performing deliveries) to the insurance premium the CNM will be required to pay for her own coverage should such become available (estimated at between $2,000 and $4,000 yearly), it becomes immediately evident how cost-prohibitive this surcharge is.

There are two additional problems I wish to bring to your attention. First, ISMIE presently will not insure physicians who work with CNMs unless each CNM carries her own professional liability coverage at the $1 million level. This is the same level of coverage ISMIE requires of its high-risk physician specialists, and yet the CNMs do not manage high-risk patients independently, do not perform surgery, and work within a medical framework that provides for physician consultation. This is an unrealistically and unfairly high level of coverage to demand, and should a CNM self-insurance program or other means of obtaining liability coverage become available through other sources, it almost certainly would not be at the ISMIE-required level.

Lastly, there is a problem with an unnecessarily restrictive ISMIE interpretation of the term "physician supervision" for CNM deliveries. ISMIE has stated it will not cover an ob/gyn who hires more than one CNM, despite a part-time status in the terms of employment for the CNM. For a solo practitioner such as myself, this is extremely restrictive and seems to be without rationale since I have made arrangements with six other obstetricians who have indicated willingness to provide supervision for one of my two CNMs should the situation of simultaneous deliveries ever develop. I do not quarrel with the one-supervising-physician-able-to-respond-immediately-to-an-emergency-at-delivery concept; rather it is ISMIE's restrictive interpretation of how that concept must be operationalized that is most unfair.

Taken as a whole, these four ISMIE requirements have had a most adverse effect on my ability to practice medicine as an ISMIE-insured physician. While there are many sources documenting the safety of CNM/physician team care, and my practice has grown due to the popularity of the option of CNM birth care, I am facing the curtailment of my ability to utilize the services of my CNM employees.

I would also like to point out that I see an unfairness in the ISMIE policy related to obstetricians who practice with nurse-practitioners (CNMs) versus those physicians in other specialties (such as anaesthesiologists) whose nurse-practitioners are covered by ISMIE policies, and for whom there is no vicarious liability surcharge.

Finally I must point out what probably seems very clear to you, and that is the enormous increase in a malpractice litigation situation where two practitioners have cared for a patient and yet have different insurance carriers. The splitting of insurance coverage and competing counsel representation for health care providers who work together as a team merely increases the cost and decreases the chances for a successful defense.

Time is critically important to those of us whose practices involve employment relationships with CNMs. I understand those of us who have requested this hearing will need legal counsel if the matter proceeds, and we shall plan accordingly.

Sincerely,

William Jones, MD

used with permission

Appendix B:

Sample Letter to Insurance Company (Adapted from letter in ACNM files)

Date

Underwriting Manager
Docs Insurance Company
4000 Cold Hwy.
Anchorage, Alaska

Re: Certified Nurse-Midwives

Dear Mr. :

The Alaska Chapter of the American College of Nurse-Midwives (ACNM) has contacted me for assistance regarding Doc's imposition of a surcharge upon those of its insured physicians who act on a consultant or referral basis with CNMs. The Alaska nurse-midwives are also concerned about a number of restrictive endorsements that Doc's imposes, such as in-person "supervision" of the CNM by the physician and refusal to provide coverage for the MD if the CNM provides home birthing services.

The endorsement limitations and premium surcharge, which cannot be justified by actuarial data or standards, have had the effect of restricting CNM practice in Alaska. For these reasons, Doc's should, therefore, immediately notify the State Insurance Commission and its physician insureds that Doc's is rescinding the restrictions and rolling back the surcharges. I believe that the following legal principles may be relevant to Doc's decision:

State nurse-midwifery practice law: The Alaska nurse-midwifery practice statute (Alaska Stat. Section 08.68.010 et seq.) does not require physician *supervision* or *direction* of nurse-midwives. In fact, CNMs are no longer required to provide proof of a collaborative relationship with a physician to the Board of Nursing. Rather, the CNM must simply have created written procedures for *consultation* with other health professionals, as well as a method for quality assurance. Alaska law specifically looks to ACNM's practice statements for a determination of nurse-midwives' scope of practice and has adopted ACNM's definitions. As you can see from the enclosed document, ACNM's *Standards of Practice for Nurse-Midwifery,* CNM have consultation and referral relationships with physicians, rather than supervision or direction, which is fully in accord with Alaska law. This scope of practice would satisfy JCAHO standards for determining whether CNMs would be considered independent practitioners under state law, as set forth in its current medical staff standards (1994 *Accreditation Manual for Hospitals*). Alaska nurse-midwives bill independently (Alaska Stat. section 21.42.355) and have prescriptive rights (Alaska Administrative Code, Title 12, Section 44.440). Clearly, the State of Alaska has deter-

mined that CNMs are legally capable of practicing independently, without physician supervision or direction.

Malpractice Law. Doc's surcharge implies an assumption that, regardless of the actual relationship between a nurse-midwife and a physician, that physician will bear vicarious liability if the nurse-midwife is negligent. Such an assumption is not supported by either legal precedent or existing actuarial data. Although a physician who *employs* a CNM will be liable under the respondeat superior theory, no reported cases exist which support the presumption of liability where no employment relationship exists. As we all know, plaintiffs in malpractice actions tend to sue every institution and professional who had any involvement, but this does not mean that all defendants will be found liable. Most will be dismissed on motion. Doc's does not surcharge physicians who consult with or refer patients to other physicians, even though both might be named in a lawsuit if one is negligent. Similarly, there is no legal basis to impose a surcharge on physicians who are willing to consult with or accept referrals from nurse-midwives. The attached article from the Journal of Nurse-Midwifery on the topic of vicarious liability provides additional information.

I understand that Mary Smith, CNM, has already provided you with a copy of the NCRIC decision of the D.C. Superintendent of Insurance. You and your attorneys have thus had an opportunity to review that decision, including the Superintendent's finding that a surcharge under these circumstances amounted to "double dipping." The actuary expert witness in that case, who recognized the significance of statistics which supported the double dipping charge, was Robert Hunter, now the Insurance Commissioner of Texas, whose opinions are likely to be considered with deference. As NCRIC admitted in that case, no actuarial data exist to support the imposition of a surcharge because the data regarding claims against OBs are neither reported nor retained under separate categories of direct or vicarious liability. Neither the insurance industry in general nor the national association of physician-controlled insurers has any data whatsoever which differentiates between direct and vicarious liability claims against obstetricians. Thus, the rates paid by all OBs in Alaska reflect whatever claims — direct or vicarious — underlie your total risk exposure. Doc's has no basis for surcharging for a hypothetical risk of loss which, if it exists at all, is already underwritten by the direct liability premium.

Antitrust Law. I have been informed that the decision to impose a surcharge resulted from the input of Alaska physicians, either on Doc's board of directors or an advisory board. I wonder if you or your attorneys are aware of the Federal Trade Commission's case against State Volunteer Mutual Insurance Company ("SVMIC"), the physician-controlled malpractice insurer in Tennessee. SVMIC refused to cover physicians who consulted with independent nurse-midwives and, following a Congressional hearing and the institution of the FTC's action, agreed to a consent decree that barred it from such action in the future. A number of federal courts view such refusals to deal as falling under the boycott exception to the McCarran-Ferguson insurance antitrust exemption.

Similarly, the practice restrictions imposed by Doc's, a physician-controlled insurance company, are similar to the anticompetitive standards imposed in American Society of Mechanical Engineers v. Hydrolevel Corp., 456 U.S. 556 (1982), a Supreme Court decision which held a profes-

sional association liable for the actions of certain of its members and employees, who conspired to create product standards which adversely affected competitors of those members. Doc's "standards" (in-person supervision, no home births) make it difficult if not impossible for CNMs and their consulting physicians to compete effectively with other obstetricians. This result appears to have been the purpose of these restrictions since no clinical or actuarial basis can be found for them.

Finally, your requirement that the CNM also purchase her direct liability coverage from Doc's, even though better insurance at a lower cost is available to her from MMI, would appear to constitute a tying arrangement, tying the availability of insurance to a physician upon the purchase of insurance for the CNM, a practice which would also violate antitrust laws.

Finally, it is only fair to let you know that ACNM Alaska Chapter considers the imposition of surcharges upon physicians who consult with or accept referrals from CNMs to be a serious anticompetitive barrier to the practice of its members, and it is our policy to refer all such cases to the appropriate state and federal officials. Please feel free to call me to discuss these matters or to obtain additional information.

Very truly yours,

Nancy Jones
General Counsel

Enclosures

PART 3: LEGISLATION AND POLICY

Introduction

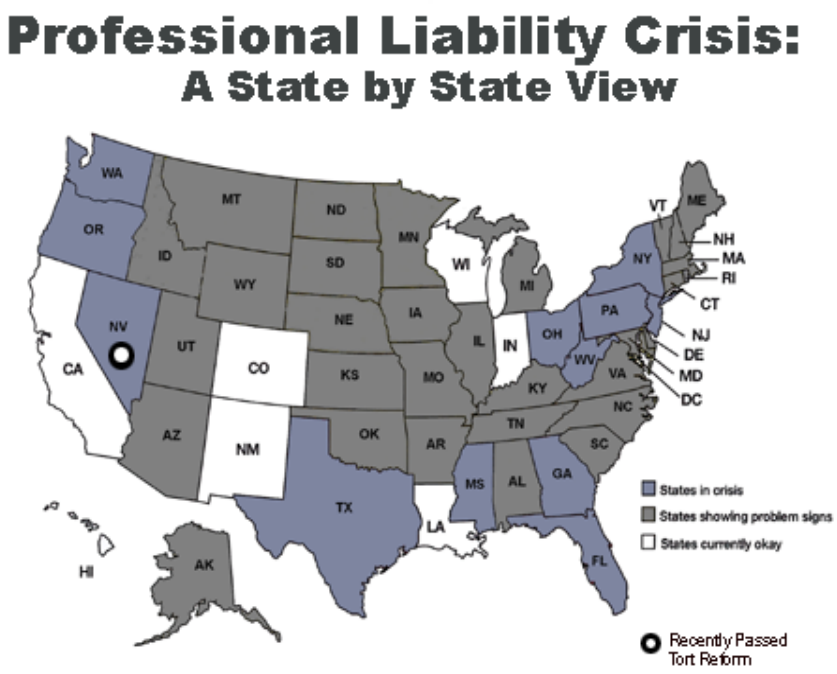
Part 3 of the Professional Liability Resource Packet will provide you with the necessary information to implement legislative changes to improve the professional liability insurance issues impacting your practice. This type of legislative change is called tort reform.

Tort reform has been proposed on both the federal and the state level; both are important. State legislation typically occurs faster than federal legislation. Federal legislation, however, has the potential for more comprehensive reform than might be possible at the state level.

It can be confusing to keep up with the latest in tort reform. On both the federal and state level, bills are frequently introduced and may be amended and debated (and generate a lot of press) but not passed. In this packet, we have provided a brief overview and some tools; watch the ACNM web site for up-to-date information.

State Legislation

Effective tort reform that includes midwives in the language has been passed in several states, including California's MICRA law which is considered the 'gold standard'. State legislation, which typically occurs faster than federal legislation, has the potential to significantly impact the premiums of your professional liability insurance by decreasing rates and thus ensuring continued access to your health care services by your patients.



Who has been impacted?

- Florida, Indiana, Mississippi, Pennsylvania, Tennessee, Texas, and West Virginia have experienced large liability insurance rate increases. *(Source: USA Today, December 4, 2001, Soaring Malpractice Premiums Stun Many Doctors)*
- In 2001, eight states saw two or more liability insurers raise rates by at least 30% and more than a dozen states saw one or more insurers raise rates by 25% or higher since 2000. *(Source: AMA News, January 7, 2002, Professional Liability Insurance Rates Go Up; Doctors Go Away)*
- Pennsylvania's Attorney General, Mike Fisher, wrote "…Insurers have requested increases for 2002 as high as 20 percent on the heels of 20 to 60 percent hikes in 2001." *(Source: NMLRC Testimony to Committee on Judiciary US House of Representatives)*
- The Mississippi State Medical Society stated the premiums for pregnancy-related care liability insurance has risen from 20% to 400%. *(Source: NMLRC Testimony to Committee on Judiciary US House of Representatives)*
- In rural Arizona, after 4 out of 6 physicians stopped attending births due to skyrocketing premiums, women were force to travel over 35 miles to the next hospital. *(Source: AMA Testimony to Committee on Judiciary US House of Representatives)*
- In the past two years, Philadelphia, PA, has lost seven out of its 39 maternity units, with the most recent being at Methodist Hospital and Mercy Hospital. This was directly related to increases in malpractice premiums. *(Source: McCullough, Philadelphia Inquirer, 7/7/02)*
- New York and Florida obstetricians, gynecologists, and surgeons routinely pay $100,000 to $200,000 a year for $1 million in coverage. *(Source: BNA Vol.10, No.25)*

Access to Health Care for Women is at Risk

Every midwife needs to take a proactive approach in addressing the professional liability crisis and *now* is the time to communicate the message to your community leaders and elected officials. Any statement given, whether testimony, letters to your legislator/governor/insurance commissioner, letters to the editor of your newspaper, or face-to-face conversations should focus on the issue of limited access to health care. Specify how this crisis has impacted access for women to health care services and providers; give lots of examples. Your public officials need to know how this issue is impacting their constituents as an entire population. It is also important to include recommendations for resolving the problem. The following ideas should be included in your statements.

Recommendations

- **Inclusion of advanced practice nurses, certified nurse-midwives, and certified midwives in all legislative and regulatory changes,**
- **Establishment of limits on non-economic damages,**
- **Mandating offsets for collateral sources,**
- **Limitations on contingency fees,**
- **Creation of periodic payment of future damages,**
- **Reduction of the statute of limitations, and**
- **Establishment of alternative dispute resolutions.**

Resources

The ACNM policy staff has developed a number of resources to facilitate your efforts:

- **Action Alert.** For those who need assistance in developing a statement, you can access a pre-formatted letter to send to your legislators on ACNM's Web site at *www.midwife.org/speakout*. The letter can be revised to reflect the specifics of your practice and state. The Web site will automatically identify your elected officials after entering your zip code.

- **ACNM Position Letter on Professional Liability.** The ACNM has developed a letter that can be sent at your request from Deanne Williams, Executive Director to policy makers such as state legislators, the governor, licensing board, insurance commissioner, etc. Contact Jennifer Moore at *jmoore@acnm.org* or 202-728-9890.

- **Sample Consumer Letter.** This sample letter in Appendix B (available on the ACNM Web site as well) can be altered to reflect the specifics of your practice and state.

- **Talking Points.** Talking points are included in Appendix C

- **Web Sites.** Check the ACNM Web site frequently for updates on the professional liability crisis, tort reform, and a host of other issues of importance to you. The following Web sites are also recommended for information about tort reform.
  - Health Care Liability Alliance: *www.hcla.org*.
  - The Doctor's Company: *www.thedoctors.com/Advocacy/legislative/IndexStatePA.htm*.
  - Californians Allied for Patient Protection: *www.micra.org*.

- Texas Alliance for Patient Access: *www.tapa.info*.
- American Tort Reform Association: *www.atra.org/show/7338* (Please be aware that the charts on this Web site are outdated. Current charts are available in the Professional Liability Strategy Packet that has been sent to all Chapter Chairs and State Legislative Contacts).

Federal Legislation

The ACNM is an active member of the National Medical Liability Reform Coalition. This coalition is a broad-based group of organizations gathered for the purpose of promoting medical liability reform.

The National Medical Liability Reform Coalition believes that Congress should enact effective medical liability reform. Cost containment and health access objectives of comprehensive health system reform cannot be achieved without effective medical liability reform. The coalition supports strengthened patient safety efforts, alternative dispute resolution mechanisms, and demonstration projects to test the effectiveness of developing practice parameters for quality of care and use as an affirmative defense. The coalition strongly supports the adoption of the following tort reforms:

- Periodic payment of future damages over $100,000
- Limit on non-economic damages
- Mandatory offsets for collateral sources
- Plaintiff lawyer fees limited by sliding scale
- Proportionate liability among all parties
  - Each defendant is liable for the percentage of damages that he or she caused
- Statute of limitations
  - Two year "reasonable discovery" rule with 4 year statute of repose
  - Special exception to statute of limitations for minors, which would allow up to 4 years for children under 6 to initiate claims
- Special obstetrics rule for drop-in patients
  - If a health professional has not previously treated a patient for pregnancy, burden of proof is "clear and convincing evidence"
- Expert Affidavit
  - Any claim filed in court or an ADR proceeding must be accompanied by an affidavit from an individual qualified to be an expert witness asserting that the claim has merit
- Federal preemption of state law
  - These federal tort reform provisions preempt corresponding provisions of state law unless the latter are more effective
- Scope of Reform
  - Reforms should apply to any claim arising from health care services offered by health care professionals or institutional providers in any state or territory

- All claims arising from the delivery of blood services should be included in this reform legislation; suppliers of blood services should be included in defini tion of health care providers
- Reforms do not create a federal cause of action or otherwise alter federal court jurisdiction or state choice of law and venue

H.R. 4600: Help Efficient, Accessible, Low-cost, and Timely Healthcare Act of 2002" (the HEALTH Act)

We expect the focus of our work in the 108th Congress to focus on H.R. 4600. The HEALTH Act is modeled after California's quarter-century old and highly successful health care litigation reforms, addresses the current crisis and will make health care delivery more accessible and cost-effective.

California's Medical Injury Compensation Reform Act ("MICRA") went into effect in 1976 and has proved immensely successful in increasing access to affordable medical care. MICRA's reforms include a $250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge, authorization for defendants to introduce evidence showing the plaintiff received compensation for losses from outside sources (to prevent double recoveries); and authorization for courts to require periodic payments for future damages instead of lump sum awards that prevent bankruptcies in which plaintiff's would receive only pennies on the dollar. The HEALTH Act includes provisions creating a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault, and reasonable guidelines – but not caps – on the award of punitive damages. Finally, the HEALTH Act will accomplish reform without in any way limiting compensation for 100% of plaintiffs' economic losses, their medical costs, their lost wages, their future lost wages, rehabilitation costs, an any other economic out of pocket loss suffered as the result of health care injury. The HEALTH Act also does not preempt any State law that otherwise caps damages.

Appendix A:

Sample Consumer Professional Liability Letter

Feel free to alter this letter to reflect the specifics or your practice and state.

DATE

Legislator's or Governor's Name and Address

Dear _____,

Currently, I receive care from _____, a certified nurse-midwife (CNM)/certified midwife (CM) at _____ in CITY, STATE. SHE/HE receives reimbursement from Medicaid, Medicare, _____, _____, _____, and_____. The CNM currently collaborates with Dr. _____ who is available for consultation, collaboration, and transfer of care if needed.

As a woman, I value the philosophy and access to care that I receive from _____. However, I fear that the current crisis involving professional liability insurance for health care providers will decrease, if not eliminate, my access to women's health care and my choice to obtain services from a nurse-midwife. As a resident of (CITY), (STATE), and your constituent, I am requesting that you ensure that my access to health care will not be compromised by enacting effective tort reform. My needs as a women are at stake.

_____, CNM/CM is a highly trained licensed professional who is experienced in providing clinical care for low-risk women, health education, and follow-up for mothers and their families. My care from a midwife is a safe, cost-effective and patient-responsive health care alternative that produces good outcomes and high levels of patient satisfaction. The costs associated with midwifery care are lower as a result of fewer technological interventions, fewer cesarean sections and other surgical procedures, and shorter hospital stays. I do not want to lose my access to cost-effective health care.

I know that you are committed to ensuring that my needs as a woman are accessible to high quality, cost-effective care. It is my belief that tort reform is essential to secure my needs today and in the future. Your immediate attention to this issue is appreciated.

Sincerely,

Your name, address, and phone number here.

CC: Your midwife and their collaborating physician.

Appendix B:

Quick Reference: Talking Points

Please feel free to alter this document to reflect the specifics of your practice and state when speaking to community leaders and policy makers.

Background

- Since the 1970's obstetrical and gynecological health care professionals have been faced with increasing overhead costs, decreasing reimbursement for services, and decreasing availability and affordability of liability insurance. Thus many professionals have been forced to move to states with effective malpractice reform or retire early. As a result, many women are left without access to health care services and professionals.

- Dramatic jury awards and frivolous lawsuits have pushed the insurance industry to drive up premiums to unaffordable levels.

- To stabilize risk pools, insurers have significantly increased premiums or have refused to cover high-risk specialties like obstetrics.

- The consequences of the professional liability crisis are limiting access for women to needed services.

What YOU can do

- Enact professional liability legislation (tort reform) that promotes women's access to high-quality, cost-effective midwifery and obstetrical and gynecological care.

- Ensure that patients affected by professional negligence have an opportunity to be compensated.

- In addition, we recommend the following for all legislative and regulatory initiatives:

  - Inclusion of all licensed health care professionals, including certified nurse-midwives, certified midwives, and advanced practice nurses.
  - Establish limits on non-economic damages for pain and aguish.
  - Mandate offsets for collateral sources of compensation for injuries.

  - Limit contingency fees.
  - Create periodic payment of future damages.
  - Reduce the statute of limitations to sue in the field of midwifery, obstetrics and gynecology.
  - Establish alternative dispute resolution.