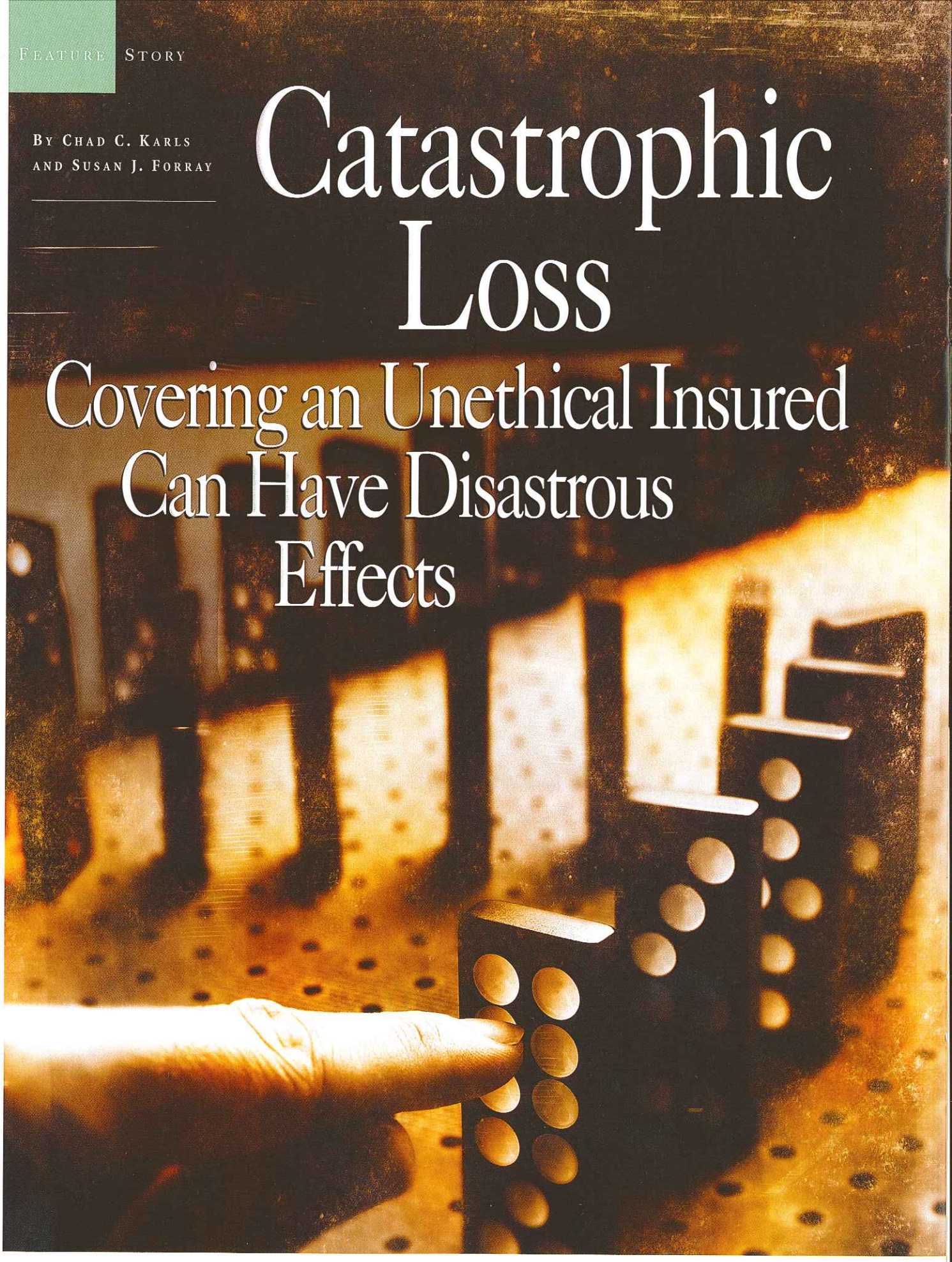
By Chad C. Karls
and Susan J. Forray

Catastrophic Loss

Covering an Unethical Insured Can Have Disastrous Effects



In July 2007, William Hurwitz was sentenced to nearly five years in prison on 16 counts of drug trafficking. But Hurwitz is not your typical convicted drug felon. He was a pain-management specialist with a practice in McLean, Virginia. And he is not the only former physician behind bars today.

- James Graves, a Florida doctor, was convicted in 2002 of manslaughter in connection with the deaths of four patients who overdosed on drugs he had prescribed.
- Ronald McIver, formerly a pain management specialist in South Carolina, was convicted and sentenced in 2005 to 30 years in prison, on multiple counts of narcotics distribution, and for the death of one of his patients from an overdose of drugs he had prescribed.
- Daniel Maynard, a Texas physician, lost his license in 2003 and, law enforcement officials alleged, was responsible for as many as 11 deaths resulting from drugs he had prescribed.
- Frank Fisher, a general practitioner in Shasta County, California, served five months in jail in 1999 before it was discovered that the patients with whose deaths he was charged had in fact all died from accidents or other causes, not the drugs he had prescribed for them.

As the case of Dr. Fisher shows, well-meaning physicians guilty of no crime have also been caught in what some see as a trend: prosecutions of doctors accused of overprescribing pain medication. Dr. Hurwitz also has many defenders, among them his own patients and other pain-management specialists, who allege that he is the victim of an overzealous effort by the Drug Enforcement Administration to step between doctors and their patients.

A recent survey of state medical board members, published in *The Journal of Pain,* found that a significant majority believe that prosecutions of physicians for alleged overprescription are increasing.

The impact on medical professional liability (MPL) carriers can be significant. Once a physician has been convicted of criminal charges, it is much easier to successfully bring a civil case, whose proof threshold is lower. Criminal charges can also have the effect of extending the time period of discovery in a related civil case, leading to higher defense costs. We are aware of one case in which an MPL insurer found itself without medical records to use in defending its insured physician, after these records were seized by federal agents. The insurer was left with little more than the word of the physician as its method of defense. In addition, a criminal conviction can alter the dynamic of a lawsuit: a plaintiff whose case might otherwise appear to be wholly without merit can emerge as a sympathetic figure.

Take Dr. McIver, for example. After his conviction, he was sued by a number of former patients, who alleged that he had overprescribed addictive medication. These claimants include some who had testified in his criminal case that they lied about, or exaggerated, their pain to obtain drugs to which they were addicted. One claimant testified that he lied to Dr. McIver in saying that he had spilled the liquid painkiller prescribed for him (he later testified that he had in fact injected it), and that he had once altered a prescription the doctor had written. Another claimant testified that she had resold most of the drugs the doctor prescribed for her.

While such cases are extreme and very rare within the medical profession, they can have (and have had) a sizable adverse effect on an MPL insurer's finances. With dozens of lawsuits, each of which could cost an insurer hundreds of thousands of dollars to settle or defend, having the misfortune to have insured such a physician can end up costing an MPL insurer several million dollars. Table 1 displays the actual costs that an MPL insurer incurred to defend and settle a series of cases attributable to a single physician. Table 2 provides a summary of the actual costs incurred by various MPL insurers, in total, for claims of this sort.

Table 1

Claim Number	Indemnity and Expense Paid	Estimated Cost in 2009 Dollars
1	$194,000	$222,000
2	2,000	3,000
3	182,000	208,000. . .
. . . 63	4,000	5,000
64	359,000	411,000
65	4,000	6,000
Total	**$5,432,000**	**$6,234,000**

Table 2

Policyholder	Number of Claims	Total Indemnity and Expense Incurred Estimated	Cost in 2009 Dollars
1	39	$364,000	$455,000
2	29	1,760,000	2,321,000
3	21	2,255,000	2,878,000
4	65	5,432,000	6,234,000

Source: Proprietary client data; used with permission.

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Overprescription not the only allegation

Overprescription is not the only allegation that can result in multiple claims against a single healthcare provider. Robert Courtney, a pharmacist in Kansas City, Missouri, was sentenced to more than 30 years in prison for diluting the medications he provided to his customers. It is estimated that Courtney's actions affected more than 4,200 patients, and more than 400 lawsuits were filed against him. In downgrading Pharmacists Mutual in 2005, A.M. Best cited the $6 million (net of reinsurance) paid by the company in 2003 to settle the claims against Courtney for which it had liability. Subsequently, Eli Lilly & Company and Bristol-Myers Squibb settled more than 300 lawsuits against them, alleging that they knew Courtney had been diluting drugs as long as three years before his arrest, although the terms of the settlement were not disclosed.

Criminal and civil cases are currently pending against Mark Weinberger, a former otolaryngologist with a practice in Indiana. The civil cases allege that Dr. Weinberger gave all claimants (and there are more than 350 of them) essentially the same diagnosis (deviated septums and nasal polyps), and sedated some of them without performing the procedures that patients believed they would undergo. The criminal charges allege that he then billed some of his patients' health insurers for these procedures. Dr. Weinberger has not surfaced since a vacation in Greece in 2004.

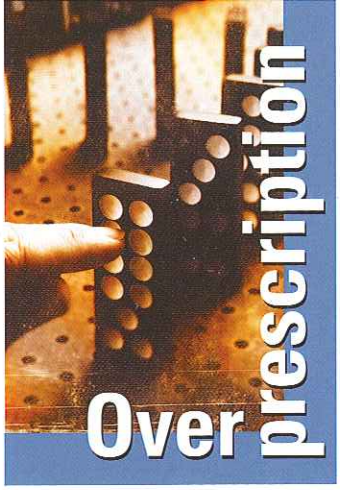
The cases against Dr. Weinberger are far from resolved: the issue of defense coverage is currently being disputed. Dr. Weinberger's MPL carrier has filed an action in federal court arguing that it has no responsibility to defend him, since he is not participating in his own defense. If the carrier is successful, this may be an interesting precedent.

Managing the risk

While the costs and consequences of being liable to events like these can be severe, there are a few ways that MPL insurers can manage this risk. Beyond the fundamental underwriting and risk management techniques that insurers would already typically employ, there are several ways to manage the exposures described above:

- Including the criminal-acts exclusion in policies
- Limiting the size of aggregate policy limits offerings
- Writing exclusively claims-made coverage
- Using additional reinsurance.

The criminal-acts exclusion provides somewhat narrow protection against claims that involve criminal charges or convictions. Typically, the allegation of criminal activity must be proven in a court of law for the exclusion to apply. Even when a criminal conviction has occurred, typical MPL allegations, such as failure



to diagnose, would not be considered part of the criminal activity and, consequently, would not fall under the criminal acts exclusion. However, while this standard exclusion may only offer limited protection, it should be viewed as the first, and most basic, way to manage this risk.

Limiting the size of aggregate policy limits offered also offers limited protection for insurers. Claims of this nature may be incurred across various policy years, particularly if occurrence coverage was written; this limits the effectiveness of aggregate policy limits, regardless of their magnitude. Further, the standard policy includes a provision that defense costs be covered outside of the policy limit.

While not writing occurrence coverage certainly couldn't hurt in avoiding such a situation, a claims-made policy form is no guarantee of protection. A claims-made policy is indeed preferable—but only because it allows for a single aggregate limit on any claims yet to be reported as of the policy-cancellation date. As mentioned above, if an occurrence policy were written, separate aggregate limits would be in effect for each covered occurrence year.

Traditional excess-of-loss reinsurance coverage will likely offer only limited protection in the situations described above. Most reinsurance contracts do not allow for the aggregation of claims, as described above, in determining excess-of-loss coverage. Consequently, for most insurers, the impact of claims like these would go straight to the bottom line.

However, within the past few years, we have seen the emergence of reinsurance treaties that take situations like these into account. Referred to as common loss coverage or systemic coverage (and discussed in more detail in an article in the Third Quarter 2008 issue of *Physician Insurer*, entitled "Systemic Loss"), these treaties allow for the aggregation of losses associated with an individual insured in determining the loss cessions. This type of coverage is relatively new, and consequently there are currently various definitions in place within these treaties concerning what constitutes a "common loss."

As this coverage is generally considered an enhancement to traditional excess-of-loss coverage, rather than its replacement, companies can expect a premium surcharge for these additional cessions. Companies can also expect that this surcharge will vary, depending on how broadly or specifically the term "common loss" is defined. Given the potential for a loss that be as high as eight figures, the price of coverage may well be worth it. PIAA