

SERFF Tracking Number: DCTR-126042978 State: District of Columbia
Filing Company: The Doctors Company, an Interinsurance Exchange State Tracking Number:
Exchange
Company Tracking Number: 2009-DC-01
TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations
Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
Project Name/Number: District of Columbia Rule Revision/

Filing at a Glance

Company: The Doctors Company, an Interinsurance Exchange

Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
SERFF Tr Num: DCTR-126042978 State: District of Columbia

TOI: 11.2 Med Mal-Claims Made Only SERFF Status: Closed-APPROVED State Tr Num:

Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations Co Tr Num: 2009-DC-01 State Status:

Filing Type: Rule

Reviewer(s): Robert Nkojo

Author: Michael O'Donohue

Disposition Date: 07/23/2009

Date Submitted: 02/23/2009

Disposition Status: APPROVED

Effective Date Requested (New): 07/01/2009

Effective Date (New):

Effective Date Requested (Renewal): 07/01/2009

Effective Date (Renewal):

State Filing Description:

General Information

Project Name: District of Columbia Rule Revision

Status of Filing in Domicile: Not Filed

Project Number:

Domicile Status Comments: rates and rules vary by state/jurisdiction

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 07/23/2009

State Status Changed:

Deemer Date:

Created By: Michael O'Donohue

Submitted By: Michael O'Donohue

Corresponding Filing Tracking Number: DCTR-126043066 (2009-DC-MPL01)

Filing Description:

THE DOCTORS COMPANY, AN INTERINSURANCE EXCHANGE

PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE PROGRAM

RULE REVISION

We are submitting a rule revision for the captioned program. Based on TDC's current book of business, there is no rate

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level impact resulting from this revision. This revision consists of the following changes:

- 1) extended reporting period coverage rules for death, disability and retirement have been revised (See Section 1-Pages GR-4 and GR-5 of Countrywide Rules and Rates Manual). An appropriate amendatory policy endorsement reflecting this change has been submitted concurrently in SERFF Filing Number DCTR-126043066(2009-DC-MPL01).
- 2) minimum premium for Surgicenters has been revised (See Section 1-Page GR-7 of Countrywide Rules and Rates Manual).
- 3) shared business entity coverage premium charge has been revised (See Section 1-Page GR-8 of Countrywide Rules and Rates Manual)
- 4) minimum premium for auxiliary healthcare professional coverage has been introduced (See Section 1-Page GR-9 of Countrywide Rules and Rates Manual)
- 5) risk management discount rule has been introduced (See Section 1-Page GR-12 of Countrywide Rules and Rates Manual).
- 6) deductible discounts have been revised (See Section 2-Page DC-E-1 of Countrywide Rules and Rates Manual)
- 7) Schedule Rating Plan modification factors have been revised (See Section 2-Pages DC-E-1 and DC-E-2 of Countrywide Rules and Rates Manual)
- 8) other changes of an editorial nature only have been made to current rating rules

The rates and rules included in this revision replace all currently filed rates and rules. Due to a significant change in the format of the new rates and rules manual, a "side-by side" comparison of current and revised rates is not practical.

We have enclosed a Rule Change Explanatory Memorandum.

Company and Contact

Filing Contact Information

Michael O'Donohue, Vice President-Regulatory modonohue@thedoctors.com

Compliance

185 Greenwood Road 800-421-2368 [Phone] 1318 [Ext]

P. O. Box 2900 707-226-0162 [FAX]

Napa, CA 94558

Filing Company Information

The Doctors Company, an Interinsurance CoCode: 34495 State of Domicile: California

Exchange

185 Greenwood Road Group Code: 831 Company Type: Property & Casualty

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 P.O. Box 2900 Group Name: Doctors Company State ID Number:
 Insurance
 Napa, CA 94558 FEIN Number: 95-3014772
 (800) 421-2368 ext. 1318[Phone]

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Doctors Company, an Interinsurance Exchange	\$0.00		

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	Robert Nkojo	07/23/2009	07/23/2009

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Disposition

Disposition Date: 07/23/2009
 Effective Date (New):
 Effective Date (Renewal):
 Status: APPROVED
 Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
The Doctors Company, an Interinsurance Exchange	0.000%	0.000%	\$0	69	\$2,467,574	0.000%	0.000%
Percent Change Approved:							
	Minimum:	%	Maximum:	%	Weighted Average:		%

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Cover Letter All Filings		Yes
Supporting Document	Consulting Authorization		Yes
Supporting Document	Actuarial Certification (P&C)		Yes
Supporting Document	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)		Yes
Supporting Document	District of Columbia and Countrywide Loss Ratio Analysis (P&C)		Yes
Supporting Document	Rule Change Explanatory Memorandum		Yes
Rate	Countrywide General Rules		Yes
Rate	District of Columbia Rules Exception Pages		Yes
Rate	District of Columbia Rate Pages		Yes

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Rate Information

Rate data applies to filing.

Filing Method: File and Use
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: -1.800%
Effective Date of Last Rate Revision: 06/01/2008
Filing Method of Last Filing: File and Use

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
The Doctors Company, an Interinsurance Exchange	N/A	0.000%	0.000%	\$0	69	\$2,467,574	0.000%	0.000%

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Rate/Rule Schedule

Schedule Item Status:	Exhibit Name:	Rule # or Page #:	Rate Action	Previous State Filing Number:	Attachments
	Countrywide General Rules	Pages GR-1 to GR-13 (1/09)	Replacement	DCTR-125460884 (2008-DC-01)	Countrywide General Rules Pages (1-09).pdf
	District of Columbia Rules Exception Pages	Pages DC-E-1 to DC-E-2 (7/09)	Replacement	DCTR-125460884 (2008-DC-01)	District of Columbia General Rules Exception Pages (7-09).pdf
	District of Columbia Rate Pages	Pages DC-R-1 to DC-R-2 (7/09)	Replacement	DCTR-125460884 (2008-DC-01)	District of Columbia Rate Pages (7-09).pdf

**THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS**

COUNTRYWIDE RULES AND RATES MANUAL

TABLE OF CONTENTS

<u>SECTION 1 GENERAL RULES</u>	<u>PAGE NUMBER</u>
<u>I. GENERAL GUIDELINES</u>	
A. Application of Manual	GR-1
B. Application of General Rules	GR-1
C. Prior Acts Coverage	GR-1
D. Suspension of Insurance	GR-1
E. Policy Changes	GR-2
F. Cancellation/Nonrenewal	GR-3
G. Extended Reporting Period Coverage	GR-3
<u>II. RATING GUIDELINES</u>	
A. Premium Calculation	GR-6
B. Sizable Risk Rating	GR-6
C. Rating Factors	GR-6
D. Minimum Premium-Surgicenters	GR-7
<u>III. ADDITIONAL COVERAGES</u>	
A. Ancillary Healthcare Professionals	GR-8
B. Entities	GR-8
C. Slot Positions	GR-8
D. Auxiliary Healthcare Professional Coverage	GR-9
E. MediGuard Coverage	GR-9
F. Punitive Damages Coverage	GR-10
<u>IV. DISCOUNTS/SURCHARGES</u>	
A. Claims Free Discount	GR-11
B. Prep Discount	GR-11
C. Part Time/Quarter Time Discount	GR-12
D. Risk Management Discount	GR-12
E. Deductible Discount	GR-12
F. Defense Within Limits of Liability Discount	GR-12
G. Waiver of Consent to Settle Discount	GR-12
H. Imposed Surcharges	GR-12
I. Schedule Rating Plan	GR-13

SECTION 2 STATE GENERAL RULES EXCEPTION PAGES

General Rules modified in accordance with state requirements.

SECTION 3 STATE RATE PAGES

**THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS**

SECTION 1- GENERAL RULES

I. GENERAL GUIDELINES

A. Application of Manual

This manual provides the rates, rules, classifications and territories for writing Healthcare Professional Liability Insurance for The Doctors Company (“the Company”).

B. Application of General Rules

These rules apply to all Sections of this manual. Any exceptions to these rules are contained in the State General Rules Exception Pages in Section 2 of this manual.

C. Prior Acts Coverage

Prior Acts Coverage (retroactive/nose coverage) provides coverage for those claims arising from incidents that take place after the retroactive date and prior to the date the insured's policy became effective with the Company. The initial retroactive date will impact the rating of a policy based on the years of claims-made policy maturity. Once established the retroactive coverage date can only be advanced at the request or written knowledge of the insured.

If the limits of liability on policies carried by an applicant in the Prior Acts Coverage period are lower than those the applicant requests from the Company, then the policy will be endorsed to provide the lower limits of liability for Prior Acts Coverage. The premium is computed using the Blended Rate methodology (See I. General Guidelines, E. Policy Changes).

D. Suspension of Insurance

An insured may request temporary suspension of insurance, due to a disability, military duty, pregnancy, family leave, or sabbatical leave for training. Suspension allows for cessation of practice without the need to purchase Extended Reporting Period coverage, and then restart the claims-made maturation process when practice is resumed. The insured may report claims during the period of suspension which arise from incidents that take place after the retroactive date, but not incidents that take place during the period of suspension.

1. No premium is charged during the period of suspension. When the period of suspension commences for a policy covering only one Named Insured, any unearned premium will be refunded to the Named Insured on a pro-rata basis. For group policies, any unearned premium for the applicable suspended Named Insured will be credited on a pro-rata basis toward the group premium.
2. Normal maturation of the policy continues during the period of suspension.
3. If a insured's coverage is suspended because of temporary disability, and he or she does not return to the practice of medicine due to permanent and total disability, the Company will waive the premium for Extended Reporting Period Coverage (as described in part G of this Section), issued retroactively to the first day of the period of suspension. Cancellation will be on the same date of the suspension if cancellation is at the insured's request. If the Company cancels the policy, the

Company will send advance notice of cancellation or nonrenewal in accordance with state requirements.

4. If a insured's coverage is suspended for reasons other than disability, and he or she does not return to the practice of medicine after the period of suspension, the Company will cancel the policy, and calculate the premium for the Extended Reporting Period Endorsement effective on the first day of the period of suspension. Premium is calculated based on the rates and rules in effect on the inception date listed in the Coverage Summary. Cancellation will be on the same date of the suspension if cancellation is at the insured's request. If the Company cancels the policy, the Company will send advance notice of cancellation or nonrenewal in accordance with state requirements.

E. Policy Changes

1. Changes in Territory

If a Named Insured moves to a different territory, the premium adjustment (if appropriate) is billed or refunded effective the date of the change. This change is computed as a Blended Rate as discussed below.

2. Changes in Limits of Liability

The Company requires a written request for changes in limits of liability and a "no known loss" disclaimer signed by each Named Insured under the policy. Increases in limits of liability are made at renewal and are not backdated. Decreases in limits of liability are made effective immediately.

3. Changes in Specialty/Rate

Changes in specialty occur when a physician adds or drops certain procedures, such as obstetrics. Changes in rate occur when the status of the physician changes, such as from full-time to part-time.

The new premium after a change in specialty/rate is computed at either the standard rate of the new coverage (a "Straight Change") or a mixed rate that is partially based on the specialty/rate of the previous coverage (a "Blended Rate").

a. Straight Change

A straight change is made:

1. If the period of coverage preceding the change is six months or less (eighteen months or less for a "Prep" physician).
2. If the change is by Company election, such as a general rate change for a specialty, the change is only done at the renewal date with required notification, if any.
3. If the insured has been continuously insured by the Company for at least five complete years and the change is based on semi-retirement.

In all other cases, the territory and specialty/rate changes are Blended Rates.

b. Blended Rate

When an insured is reclassified as a result of a territory, specialty/rate or other change, a "blended rate" computation is done to cover the previous exposure.

In the computation of a Blended Rate, the following variables are used:

1. The rate for each previous and new scope of coverage.
2. The effective date, the retroactive date, and the effective date of each subsequent change.
3. The period of coverage to be considered (usually over a five-year period).

Computing a Blended Rate involves:

1. Determining the mature claims-made annual premium for the "old" and "new" classifications.
2. Application of a pro-rata factor to compute how much "old" premium and "new" premium applies within each calendar year considered.
3. After the Blended Rate has been computed, any additional charges or discounts on the policy are applied.

F. Cancellation/Nonrenewal

The policy can be cancelled by written request of the First Named Insured and stating a prospective effective date of cancellation. Any unearned premium will be refunded, less the customary short rate fee.

The Company may cancel or nonrenew a policy in accordance with state requirements. A pro-rata refund is made of any unearned premium.

G. Extended Reporting Period Coverage

When Extended Reporting Period Coverage is purchased, the aggregate limit provided under the expiring policy will be reinstated. This aggregate limit applies to the entire Extended Reporting Period Coverage period and is reduced by all amounts the Company pays for damages for claims reported during the entire Extended Reporting Period Coverage period.

1. Premium Calculation and Payment

The premium for the Extended Reporting Period Coverage is calculated as follows:

- a. If the retroactive date is five or more years before the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the undiscounted annual premium in effect on the termination date of the coverage.
- b. If the retroactive date is less than five years, but more than nine months prior to the termination date, the premium for the Extended Reporting Period Coverage will be 230% ("incident" basis) or 285% ("demand" basis) of the undiscounted annual premium in effect on the termination date of the coverage, which has been based on premium over the last twelve months factored pro rata with regard to maturity.

- c. If the retroactive date is nine months or less prior to the termination date, the premium for the Extended Reporting Period Coverage will be 230% (“incident” basis) or 285% (“demand” basis) of the undiscounted annual premium in effect on the termination date of the coverage, which has been multiplied by the factor corresponding to the length of time the coverage was in effect:
- | | |
|-------------------|------|
| i. One to 30 days | .090 |
| ii. 31-91 days | .276 |
| iii. 92-182 days | .520 |
| iv. 182-273 days | .760 |
- d. The Extended Reporting Period Coverage must be requested and appropriate payment received within thirty days of the termination date of the coverage.

Payment of the premium for the Extended Reporting Period Coverage is due prior to the issuance of the Extended Reporting Period Endorsement.

As described in (2) and (3) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

2. Retirement

The Company will waive the premium for Extended Reporting Period Coverage if a Named Insured:

- a. has permanently and completely retired from the practice of medicine; and
- b. has been continuously insured with the Company or one of its subsidiaries for at least five years.

If the Named Insured returns to the practice of medicine, he or she may reapply to the Company. If the Company agrees to offer coverage, the premium for the Extended Reporting Period Coverage is reinstated and due in full. However, if such return is within two years of the date of retirement, coverage will be retroactively suspended, Extended Reporting Period Coverage canceled and active coverage reinstated without additional charge, subject to underwriting of the risk.

If the Named Insured returns to the practice of medicine more than two years after the date of retirement, the Named Insured will pay a prorated Extended Reporting Period Coverage premium based on the length of time since the date of retirement. However, such Named Insureds are not eligible for a second waiver of Extended Reporting Period Coverage premium upon subsequent retirement from the practice medicine.

If the Named Insured returns to the practice of medicine more than one year after the date of retirement, and purchases active coverage from another company, the premium will be prorated based on the length of time since the date of retirement.

3. Death or Disability

The Company will waive the premium for Extended Reporting Period Coverage in the event of:

- a. the death of the Named Insured while his/her policy is in force; or
- b. the total and permanent disability of the Named Insured when the disability commences while the policy is in force.

If the Named Insured returns to the practice of medicine after disability, he or she may reapply to the Company. If the Company agrees to offer coverage, the premium for the Extended Reporting Period Coverage is reinstated and due in full. However, if such return is within two years of the date of disability, coverage will be retroactively suspended, Extended Reporting Period Coverage canceled and active coverage reinstated without additional charge, subject to underwriting of the risk.

If the Named Insured returns to the practice of medicine more than two years after the date of disability, the Named Insured will pay a prorated Extended Reporting Period Coverage premium based on the length of time since the date of disability. However, such Named Insured is not eligible for a second waiver of Extended Reporting Period Coverage premium upon subsequent disability or retirement from the practice medicine.

If the Named Insured returns to the practice of medicine more than one year after the date of disability, and purchases active coverage from another company, the premium will be prorated based on the length of time since the date of disability.

If a Named Insured dies during the Extended Reporting Period, any remaining premium is waived.

II. RATING GUIDELINES

A. Premium Calculation

Premium is calculated in consideration of the following:

1. State and territory in which the insured practices,
2. Medical specialty,
3. Limits of liability,
4. Policy maturation based on the retroactive date.

All changes requiring additional premium or return premium are computed on a prorated basis. Premium calculations are rounded to the nearest dollar.

B. Sizable Risk Rating

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least \$100,000 at \$1,000,000/\$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, the Company must maintain complete files of how it modified the applicable rates, rules and coverages for the risk and make these files available to the Department of Insurance upon request.

C. Rating Factors

Policies are rated under the following calculation using the factors detailed below.

Manual Base Premium = Manual Base Rate x Increased Limit Factor x Claims-Made Maturity Year
Factor

The manual base premium may be adjusted to reflect applicable discounts/surcharges set forth in this manual.

1. Manual Base Rate

The manual base rate is the 1M/3M claims-made mature rate based on specialty. See State Rate Pages for applicable manual base rates.

2. Increased Limits Factors

For all specialties except Chiropractic, the Company offers the following limits of liability: 0.5M/1.5M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

For Chiropractic only, the Company also offers the following limits of liability: 0.1M/0.3M, 0.2M/0.6M and 0.25M/0.75M.

The applicable increased limits factors are shown on the State Rate Pages.

3. Claims-Made Maturity Year

Claims-made maturation is the process of the policy aging. The policy attains maturity through premium increases occurring on the anniversary of the retroactive date. The policy is mature upon the completion of five consecutive years of claims-made coverage.

The claims-made maturity factors are as follows:

<u>Claims-Made Maturity Year</u>	<u>"Incident" Basis Factor</u>	<u>"Demand" Basis Factor</u>
Year 1	0.35	0.21
Year 2	0.60	0.45
Year 3	0.80	0.72
Year 4	0.92	0.88
Year 5	1.00	1.00

D. Minimum Premium-Surgicenters

Surgicenters are rated on a per procedure basis and are subject to a minimum premium of \$10,000. See State Rate Pages for applicable manual base rates.

III. ADDITIONAL COVERAGES

A. Ancillary Healthcare Professionals

Ancillary healthcare professionals include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists, Perfusionists and Psychologists. These ancillaries share limits of liability with a Named Insured. Coverage is provided at no additional charge, except for the following ratable ancillaries:

Physicians Assistant
Surgeons Assistant
Certified Nurse Practitioner
Certified Nurse Midwife
Certified Registered Nurse Anesthetist
Optometrist

The ancillary healthcare professional may purchase his/her own separate limits of liability. See State Rate Pages for applicable rates. Shared limit coverage is available for 25% less than the separate limits of liability rate. The supervising physician/surgeon may purchase vicariously liability only coverage for 10% of the applicable physician's/surgeon's premium.

B. Entities

Entity coverage is available when a group of two or more physicians have formed a business organization. The entity coverage also covers nonratable employees of the entity. Shared or separate limits of liability coverage may be provided to the entity:

Separate Limits of Liability Coverage = 10% of each physician's/surgeon's premium

Shared Limits of Liability Coverage = up to 2% of each physician's/surgeon's premium. The shared limits of liability charge is dependent upon the exposure presented by the entity.

C. Slot Positions

Slotting of coverage allows for the adding and deleting of healthcare professionals in the same specialty without the need to purchase Extended Reporting Period (ERP) Coverage. Healthcare professionals are insured one at a time under the slot position rather than adding each new healthcare professional as a Named Insured and canceling each deleted healthcare professional with the option to purchase ERP Coverage. Since the slot is continuous, the ERP Coverage for any deleted healthcare professionals is "built-in". The slot matures based on the effective date of coverage of the first healthcare professional in the position. A slot will be active and billed premium even when not occupied by a healthcare professional. Only one active healthcare professional at a time can occupy a slot. Slot occupants share the Limits of Liability of the slot.

Slots when unoccupied are designated as "open slots". When the group cancels a slot, payment of the ERP Coverage premium provides ERP coverage for all the occupants of that slot position. The ERP Coverage premium for a canceled slot position is calculated in the same manner as any canceled coverage.

D. Auxiliary Healthcare Professional Coverage

Auxiliary Healthcare Professional Coverage is available for certain types of risks and is rated on an hourly basis. This coverage is subject to a minimum premium of \$750 per quarter.

Hourly Rate: 0.0625% of the rate based on the medical specialty of the Auxiliary healthcare professional. See State Rate Pages for applicable manual base rates.

E. MediGuard Coverage

Basic Limits Coverage – Included as part of the medical professional liability premium - \$25,000 Per Disciplinary Proceeding/\$25,000 Annual Maximum for all Disciplinary Proceedings/\$1,000 Deductible Per Disciplinary Proceeding.

Optional Excess Limits Coverage – Basic limits coverage of \$25,000/\$25,000 may be optionally increased to either: \$50,000/\$50,000, \$75,000/\$75,000, or \$100,000/\$100,000 for the following additional charges:

- \$50,000/\$50,000 Excess: \$300 per person
- \$75,000/\$75,000 Excess: \$550 per person
- \$100,000/\$100,000 Excess: \$800 per person

These optional excess limits may also be purchased by an entity at the applicable per person charge provided that the limits for the entity do not exceed the lowest limits purchased by any one person insured under the endorsement.

Group Aggregate Limits for Medicare/Medicaid only – This applies to groups only. Depending on the group size (number of Named Insureds) and the total limits selected, i.e., basic limit plus optional excess for the lowest total limits amount selected among all of the group members, the following Maximum Aggregate Limit automatically applies with respect to the group as a whole for Medicare/Medicaid only:

<u>Group Size</u>	<u>Selected Limits</u>	<u>Maximum Group Aggregate Limit for All Medicare/Medicaid Proceedings</u>
2 - 4	\$ 25,000/\$ 25,000	\$50,000
	\$ 50,000/\$ 50,000	\$100,000
	\$ 75,000/\$ 75,000	\$125,000
	\$100,000/\$100,000	\$175,000
5 - 9	\$ 25,000/\$ 25,000	\$100,000
	\$ 50,000/\$ 50,000	\$150,000
	\$ 75,000/\$ 75,000	\$175,000
	\$100,000/\$100,000	\$225,000
10 - 25	\$ 25,000/\$ 25,000	\$150,000
	\$ 50,000/\$ 50,000	\$250,000
	\$ 75,000/\$ 75,000	\$375,000
	\$100,000/\$100,000	\$500,000
26+	\$ 25,000/\$ 25,000	\$250,000
	\$ 50,000/\$ 50,000	\$500,000
	\$ 75,000/\$ 75,000	\$750,000
	\$100,000/\$100,000	\$1,000,000

If a group has mixed limits of liability, the lowest limits of the group drive the Group Coverage Aggregate Limit available. For example, in a group of 5-9 Named Insureds with mixed limits of liability such as four with the basic limits of \$25,000/\$25,000, three with \$50,000/\$50,000, and two with \$100,000/\$100,000, the Group coverage Aggregate Limit available will be that associated with the \$25,000/\$25,000 limits, or \$100,000.

F. Punitive Damages Coverage

A Named Insured may elect to include punitive damages coverage. When a Named Insured makes such an election, a 5% additional charge shall be applied to the Named Insured's premium.

IV. DISCOUNTS/SURCHARGES

A. Claims-Free Discount

A 17.5% or 12.5% claims-free discount shall be applied on the effective date of the policy for each Named Insured meeting all of the following criteria:

1. Named Insured is an insured with the Company for at least three full years immediately preceding the effective dates of the policy.
2. Cumulative outstanding claims reserves (indemnity and allocated loss adjustment expenses) less than \$20,000.
3. Cumulative claim payments (indemnity and allocated loss adjustment expenses) less than \$10,000 in the last three full years immediately preceding the effective dates of the policy.

If the Named Insured is an insured with the Company less than three full years, the claims-free discount shall also be available if the insured has cumulative outstanding claim reserves less than \$20,000 (including no outstanding claims reserves with previous carriers and cumulative claim payments less than \$10,000 in the last three full years immediately preceding the effective date of the policy. In order to receive the discount, the insured must submit acceptable documentation of "claims-free" experience from its previous insurance carriers.

A 17.5% claims-free discount applies for General Surgery (All Other), General Surgery (Bariatric), Neurosurgery, Obstetrics & Gynecology, Orthopedic Surgery (No Spinal), Orthopedic Surgery (With Spinal), Plastic Surgery, and Thoracic/Cardiovascular Surgery.

A claims-free discount shall NOT apply to:

- any Named Insured with an imposed surcharge
- part time/quarter time, prep, slotted and auxiliary healthcare professionals
- ancillary healthcare providers (e.g. Physician Assistant, Certified Nurse Practitioner, etc.) that share limits with any Named Insured
- healthcare professionals rated on a "per procedure" basis

B. Prep Discount

A "prep" or new to practice discount may be requested by an insured who purchases a claims-made policy and is entering private practice for the first time within two years of completing his/her: internship, residency program, military service, HMO or Veteran Administration employment, volunteer/county/government work, or teaching position. Prep rate may also apply to a physician who decided to change his or her specialty by completing a new residency training program. No additional discounts will apply.

First year	50%
Second year	25%
Third year	0%

C. Part Time/Quarter Time Discount

A part time discount is available for non-surgical medical specialties based upon hours worked per week or days worked per year subject to underwriting. No additional discounts will apply.

1. Part Time: 50%

20 hours or less per week or who work 26 weeks or less per year. Anesthesiologists must work 20 hours or less per week (15 billable hours and five hours administrative).

2. Quarter Time: 75%

10 hours or less per week and have been in practice for at least three years with loss history of no more than one claim with no severity.

D. Risk Management Discount

1. A risk management discount of up to 5% shall be applied for all Named Insureds that participate in risk management activities through a Company approved national, state or local medical association.
2. A risk management discount of up to 10% shall be applied for all Named Insureds that comply with Company approved specialty-based risk management program requirements within a 12 month period.
3. A risk management discount of up to 5% shall be applied for all Named Insureds that participate in any other risk management program approved by the Company.

E. Deductible Discount

A Named Insured can elect that a deductible apply on a per claim basis. The two deductible options are:

- a. \$5,000 deductible per claim-4% premium discount
- b. \$10,000 deductible per claim-7.5% premium discount

Regardless of limits of liability purchased, the actual deductible dollar discount shall be calculated based on the \$1,000,000/\$3,000,000 rate reflecting all applicable discounts/surcharges including schedule rating credits/debits.

The deductible is subject to an annual aggregate equal to three times the per claim amount. The deductible applies to damages and claims expenses. A physician/surgeon may not increase, decrease or cancel his/her deductible during the course of one policy year.

F. Defense Within Limits of Liability Discount

A Named Insured may elect coverage that includes payment of defense expenses within the limits of liability. A 4.5% discount shall be applied to the Named Insured's premium.

G. Waiver of Consent to Settle Discount

A Named Insured may elect to waive his or her right to consent to settle a claim and give the Company the sole right to investigate, negotiate and settle. A 5% discount shall be applied the Named Insured's premium.

H. Imposed Surcharges

Surcharges represent an alternative to cancellation/nonrenewal/declination and are accepted as such by an insured. Surcharges are imposed as a percentage of premium. The primary purpose of a surcharge is to address extraordinary claims frequency or claims severity. Only a small percentage of insureds have surcharges at any given time.

I. Schedule Rating Plan

This plan applies to all risks. The following characteristics are used in determining overall schedule rating plan credits/debits:

<u>Modification Factors</u>	<u>Range of Modifications–Credit/Debit</u>
1) Claims Management	40% to 40%
• Internal Review Procedures	
• Commitment to Loss Prevention	
• Incident/Claim Reporting Procedures	
• Other Claims Management Characteristics	
2) Risk Management	40% to 40%
• Credentialing/Peer Review	
• Medical Record/Consent Form Documentation	
• Quality Assurance Procedures	
• Employee Selection, Training and Supervision	
• Participation in Risk Management Programs (other than those approved by the Company)	
• Other Risk Management Characteristics	
3) General Factors	40% to 40%
• Geographic Location	
• Loss Experience/History	
• Hospital Staff Privileges	
• Managed Care Network Participation	
• Practice Profile	
• Other Factors	
Maximum Credit/Debit for all factors:	40% to 40%

**THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS**

SECTION 2-DISTRICT OF COLUMBIA GENERAL RULES EXCEPTION PAGES

II. RATING GUIDELINES

Rule B. Sizable Risk Rating is deleted and replaced with the following:

B. Sizable Risk Rating

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least \$100,000 at \$1,000,000/\$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, the Company must file the rate for this risk for approval with the District of Columbia Insurance Administration within 30 days after the policy effective date. The filing must include an explanation of the factors used in determining the rate for the risk.

III. ADDITIONAL COVERAGES

Rule F. Punitive Damages Coverage is deleted.

IV. DISCOUNTS/SURCHARGES

Rule E. Deductible Discount is revised by deleting and replacing the first paragraph with the following:

A Named Insured can elect that a deductible apply on a per claim basis. The two deductible options are:

- a. \$5,000 deductible per claim-1.5% premium discount
- b. \$10,000 deductible per claim-3.0% premium discount

Rule I. Schedule Rating Plan is deleted and replaced with the following:

I. Schedule Rating Plan

This plan applies to all risks. The following characteristics are used in determining overall schedule rating plan credits/debits:

<u>Modification Factors</u>	<u>Range of Modifications–Credit/Debit</u>
1) Claims Management <ul style="list-style-type: none">• Internal Review Procedures• Commitment to Loss Prevention• Incident/Claim Reporting Procedures• Other Claims Management Characteristics	25% to 25%

- 2) Risk Management 25% to 25%
- Credentialing/Peer Review
 - Medical Record/Consent Form Documentation
 - Quality Assurance Procedures
 - Employee Selection, Training and Supervision
 - Participation in Risk Management Programs (other than those approved by the Company)
 - Other Risk Management Characteristics

- 3) General Factors 25% to 25%
- Geographic Location
 - Loss Experience/History
 - Hospital Staff Privileges
 - Managed Care Network Participation
 - Practice Profile
 - Other Factors

Maximum Credit/Debit for all factors: 25% to 25%

**THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS**

SECTION 3- DISTRICT OF COLUMBIA RATE PAGES

A. MANUAL BASE RATES

TERRITORIES

Territory A = Entire District

\$1M/\$3M LIMITS OF LIABILITY MATURE CLAIMS-MADE COVERAGE

<u>Physicians/Surgeons Specialties</u>	<u>Territory</u>
	<u>A</u>
Administrative Medicine	9,476
Allergy/Immunology	10,205
Anesthesiology	32,074
Anesthesiology-Pain Management	38,781
Cardiology (Invasive)	43,738
Colon & Rectal Surgery (Minor Surgery Limited to Anal Ring)	58,317
Dermatology	17,495
Dermatology (With Liposuction)	67,064
Diagnostic Radiology	42,863
Emergency Medicine	61,233
Family General Practice (No Surgery-Hospital Care)	23,618
Family General Practice (Minor Surgery-No Obstetrics)	33,241
Family General Practice (Restricted Major Surgery-No Obstetrics)	42,280
Family General Practice (With Obstetrics)	57,734
Gastroenterology	33,241
General Medicine (Restricted)	20,411
General Surgery (All Other)	108,032
General Surgery (Bariatric)	145,792
Gynecology (Major Surgery)	61,233
Gynecology (With In-Vitro Fertilization)	91,849
Hand & Foot Surgery	35,427
Internal Medicine	29,158
Internal Medicine Subspecialties (see Note A)	24,785
Neonatology	40,822
Neurology	41,551
Neurosurgery	226,269
Nuclear Medicine	13,121
Obstetrics & Gynecology	125,964
Occupational Medicine	8,748
Ophthalmology (No Surgery)	8,748
Ophthalmology (Minor Surgery)	17,349
Ophthalmology (Major Surgery)	27,263
Orthopedic Surgery (No Spinal)	77,416
Orthopedic Surgery (With Spinal)	88,933
Otolaryngology (Major With No Facial Plastic)	51,319
Otolaryngology (Major With Facial Plastic)	61,233
Pathology	26,826
Pediatrics	29,158
Physical Medicine & Rehabilitation	17,495
Physical Medicine & Rehabilitation-Pain Management (Minor Procedures)	23,327
Physical Medicine & Rehabilitation-Pain Management (Major Procedures)	38,781

Note A: Internal Medicine Subspecialties include Non-Invasive Cardiology, Endocrinology, Hematology, Infectious Disease, Nephrology, Oncology and Rheumatology.

Territory**Physicians/Surgeons Specialties (Continued)****A**

Plastic Surgery	64,440
Psychiatry	11,080
Pulmonary Medicine	34,990
Surgical Specialty (Office with Minor Surgery)	41,405
Therapeutic Radiology	17,495
Thoracic/Cardiovascular Surgery	102,054
Urology	45,779

Per Procedure Rates

Surgicenter	18.81
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Other Healthcare Professionals

Chiropractic	4,374
Dental (Local Anesthesia and Nitrous Only)	5,832
Dental (Sedation)	11,663
Oral Surgeons	34,990
Dental Anesthesiologists	40,821
Podiatry	18,953

B. LIMITS OF LIABILITY**All Specialties Except Chiropractic****Chiropractic**

<u>Per Claim/Aggregate</u> <u>Limits of Liability</u>	<u>Factor</u>	<u>Per Claim/Aggregate</u> <u>Limits of Liability</u>	<u>Factor</u>
.1M/.3M	Not Available	.1M/.3M	0.526
.2M/.6M	Not Available	.2M/.6M	0.684
.25M/.75M	Not Available	.25M/.75M	0.737
.5M/1.5M	0.810	.5M/1.5M	0.842
1M/3M	1.000	1M/3M	1.000
2M/5M	1.350	2M/5M	1.350
3M/6M	1.554	3M/6M	1.554
4M/7M	1.673	4M/7M	1.673
5M/8M	1.742	5M/8M	1.742
6M/9M	1.798	6M/9M	1.798
7M/10M	1.843	7M/10M	1.843
8M/11M	1.884	8M/11M	1.884
9M/12M	1.916	9M/12M	1.916
10M/13M	1.946	10M/13M	1.946
11M/14M	1.976	11M/14M	1.976

For each \$1,000,000 increase in the annual aggregate limit, add 0.005 to the applicable increased limits factor.

For each \$1,000,000 decrease in the annual aggregate limit, subtract 0.005 from the appropriate increased limits factor.

C. ANCILLARY HEALTHCARE PROFESSIONALS

<u>Ancillary Healthcare Professional</u>	<u>Separate Limits Rate</u>
Physician Assistant	19% of Family/General Practice (No Surgery-Hospital Care) rate or otherwise applicable physician/surgeon rate
Surgeon Assistant	19% of Family/General Practice (No Surgery-Hospital Care) rate or otherwise applicable physician/surgeon rate
Certified Nurse Practitioner	19% of Family/General Practice (No Surgery-Hospital Care) rate or otherwise applicable physician/surgeon rate
Certified Nurse Midwife (Direct Supervision)	11% of Obstetrics & Gynecology rate
Certified Nurse Midwife (Indirect Supervision)	22% of Obstetrics & Gynecology rate
Certified Registered Nurse Anesthetist (Supervised by Anesthesiologist)	19% of Anesthesiology rate
Certified Registered Nurse Anesthetist (Supervised by Surgeon)	34% of Anesthesiology rate
Optometrist	12% of Internal Medicine rate

SERFF Tracking Number: DCTR-126042978 State: District of Columbia
 Filing Company: The Doctors Company, an Interinsurance State Tracking Number:
 Exchange
 Company Tracking Number: 2009-DC-01
 TOI: 11.2 Med Mal-Claims Made Only Sub-TOI: 11.2000 Med Mal Sub-TOI Combinations
 Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
 Project Name/Number: District of Columbia Rule Revision/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Cover Letter All Filings		
Comments:		
Attachment: 2 23 09 cover letter.pdf		

	Item Status:	Status Date:
Bypassed - Item: Consulting Authorization		
Bypass Reason: Not Applicable		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Actuarial Certification (P&C)		
Bypass Reason: See Rule Change Explanatory Memorandum		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: District of Columbia and Countrywide Experience for the Last 5 Years (P&C)		
Bypass Reason: See Rule Change Explanatory Memorandum		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: District of Columbia and Countrywide Loss Ratio Analysis		

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Project Name/Number: District of Columbia Rule Revision/
(P&C)

Bypass Reason: See Rule Change Explanatory Memorandum

Comments:

Item Status:

Status

Date:

Satisfied - Item: Rule Change Explanatory
Memorandum

Comments:

Attachment:

Rule Change Explanatory Memorandum.pdf



THIS FILING WAS SUBMITTED VIA SERFF

February 23, 2009

Honorable Thomas E. Hampton
Commissioner
Department of Insurance, Securities and Banking (DISB)
810 First Street North East - Suite 701
Washington, D.C. 20002-4227

Attn.: Mr. Clark Simcock

RE: The Doctors Company, an Interinsurance Exchange
NAIC Number 831-34495
Physicians, Surgeons and Ancillary Healthcare Providers Professional
Liability Insurance Program
Rule Revision
Effective Date: July 1, 2009-New Business
July 1, 2009-Renewal Business
District of Columbia
Filing Number 2009-DC-01

Dear Mr. Simcock:

On behalf of The Doctors Company, an Interinsurance Exchange (TDC), we are submitting a rule revision for the captioned program. Based on TDC's current book of business, there is no rate level impact resulting from any of these changes.

This revision consists of the following changes:

- extended reporting period coverage rules for death, disability and retirement have been revised (See Section 1-Pages GR-4 and GR-5 of Countrywide Rules and Rates Manual). An appropriate amendatory policy endorsement reflecting this change has been submitted concurrently in SERFF Filing Number DCTR-126043066 (2009-DC-MPL01).
- minimum premium for Surgicenters has been revised (See Section 1-Page GR-7 of Countrywide Rules and Rates Manual)
- shared business entity coverage premium charge has been revised (See Section 1-Page GR-8 of Countrywide Rules and Rates Manual)
- quarterly minimum premium for auxiliary healthcare professional coverage has been introduced (See Section 1-Page GR-9 of Countrywide Rules and Rates Manual)
- risk management discount rule has been introduced (See Section 1-Page GR-12 of Countrywide Rules and Rates Manual)

Mr. Clark Simcock
February 23, 2009
Page 2

- deductible discounts have been revised (See Section 2-Page DC-E-1 of Countrywide Rules and Rates Manual)
- Schedule Rating Plan modification factors have been revised (See Section 2-Pages DC-E-1 and DC-E-2 of Countrywide Rules and Rates Manual)
- other changes of an editorial nature only have been made to current rating rules

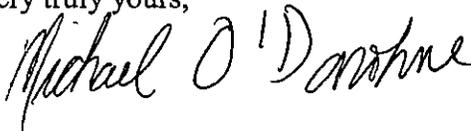
The rates and rules included in this revision replace all currently filed rates and rules. Due to a significant change in the format of the new rates and rules manual, a "side-by side" comparison of current and revised rates is not practical.

We have enclosed a Rule Changes Explanatory Memorandum.

This revision will apply to all new and renewal policies effective on or after July 1, 2009.

If you have any questions or if I may be of further assistance, please contact me at (800) 421-2368 Ext. 1318 or email me at modonohue@thedoctors.com.

Very truly yours,

A handwritten signature in black ink that reads "Michael O'Donohue". The signature is written in a cursive style with a large, prominent "M" and "O".

Michael O'Donohue
Vice President
Regulatory Compliance

The Doctors Company, an Interinsurance Exchange
Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability

Rule Change Explanatory Memorandum

This filing proposes the following changes to current District of Columbia rating rules for physicians, surgeons and ancillary healthcare providers professional liability. Based on TDC's current book of business, there is no rate level impact resulting from any of these changes.

- extended reporting period coverage rules for death, disability and retirement have been revised (See Section 1-Pages GR-4 and GR-5 of Countrywide Rules and Rates Manual). An appropriate amendatory policy endorsement reflecting this change has been submitted in a separate filing.

The free Extended Reporting Period Coverage retirement benefit may now be exercised by an insured at any age upon 5 continuous years of coverage with TDC or its subsidiary companies. Our previous rules allowed free retirement benefits at age 55. We have also incorporated new rules addressing how the free Extended Reporting Period Coverage retirement benefit is impacted if the insured returns to the practice of medicine after retiring or being on permanent disability

- minimum premium for Surgicenters has been revised (See Section 1-Page GR-7 of Countrywide Rules and Rates Manual).

This change was made based on underwriting judgment. The previous minimum of \$1,800 was insufficient for the cost of issuance and maintenance and, as a consequence, TDC has written very few surgicenters. SCPIE Indemnity Company, a recent acquisition of TDC writes a larger number of such facilities, and has a minimum premium of \$20,000. As a compromise between the rules of the two companies, \$10,000 was selected. TDC currently writes no Surgicenters in the District of Columbia.

- shared business entity coverage premium charge has been revised (See Section 1-Page GR-8 of Countrywide Rules and Rates Manual).

We have replaced the current 2% charge with an "up to 2%" charge. This change rule provides the Company with flexibility to apply a charge commensurate with the exposure presented by the individual entity.

- quarterly minimum premium of \$750 for auxiliary healthcare professional coverage has been introduced (See Section 1-Page GR-9 of Countrywide Rules and Rates Manual).

This change was made based on underwriting judgment. The auxiliary physician product feature is used for rating physician exposure on an hourly basis. Without a minimum, the rating can result in a premium that is insufficient for the cost of issuance and maintenance. Since the average premium for all specialties is in the

range of \$12,000, it was felt that a minimum premium of \$3,000 was reasonable. TDC currently writes no auxiliary healthcare professionals in District of Columbia.

- risk management discount rule has been introduced (See Section 1-Page GR-12 of Countrywide Rules and Rates Manual).
- deductible discounts have been revised (See Section 2-Page DC-E-1 of Countrywide Rules and Rates Manual).
- Schedule Rating Plan modification factors revised (See Section 2-Pages DC-E-1 and DC-E-2 of Countrywide Rules and Rates Manual).

Practice profile has been added as a risk characteristic under General Factors.

- All other rating rule changes are strictly of an editorial nature with no intended substantive change.