Healthcare professionals are in a constant race to keep up with regulatory changes and technological innovation. So make sure your professional liability insurance programs have the strength and stamina to not only keep up, but stay a step ahead.

From MEDEFENSE™ Plus for regulatory risks, to e-MD™ cyber liability, to custom-tailored EPLI programs, we provide the supplemental coverages that keep you and your insureds fit, confident, and running strong.

For more information about our innovative reinsurance programs, call us at 818.808.4465 or visit us online at www.nasinsurance.com
Earlier this year, at the annual PIAA Medical Liability Conference, we told you that we would be introducing additional elements of the PIAA rebranding project in the coming months. Now, we are pleased to present to you yet another important piece of that effort: our flagship publication, Inside Medical Liability. We have changed the title of the magazine, from Physician Insurer, to reflect the wide array of changes taking place in both the healthcare arena and in the business of medical professional liability (MPL) coverage.

Recently, one of the nation’s largest health insurers announced that it will double the amount of its provider payments, to $50 billion, that are tied to quality and cost efficiency measures, in the next five years. This is just one example of the evidence highlighting the trend away from fee-for-service healthcare to arrangements such as accountable care organizations. Meanwhile, the state of Missouri recently made news, announcing a new law that makes physician assistants virtually independent practitioners.

PIAA’s new brand, and Inside Medical Liability as prime evidence of it, recognizes this seismic shift in the healthcare environment. In addition, the publication will now include material on the wide variety and number of risk-bearing entities in today’s market that offer healthcare providers protection against MPL claims. In this issue, for example, you will find “Alternative Medical Liability Insurance Programs—Establishing the Reserve,” by Charles Mitchell and Brad Parker. The article details the special issues that should be considered in establishing reserves when the entity providing coverage is not a traditional carrier.

But note that this change in the purview of what is included in Inside Medical Liability is additive to what we have presented in the past—not a subtraction—or even a substitution. Our objective is to cover the relevant issues in MPL from all perspectives. By offering comprehensive coverage from more angles, we will provide you with a better and more complete picture on the issues that may impact you and the healthcare providers and institutions that you protect.

So many of the key processes employed in the sound management of a risk-bearing MPL entity are common to all of them, that we have very much to learn from each other: in risk management and patient safety; underwriting, claims handling, finance, and more.

We have also added a new standing column, “Global Perspective,” to present information on how MPL organizations outside of the U.S. deal with key issues. We believe that this column will offer valuable insights for best practices in every MPL entity, regardless of its size, structure, or geographic location. The “Global Perspective” article in this issue titled “I Knew It All Along,” by Dr. Pierre Campbell, head of underwriting at the Medical Defence Union, discusses the factors that may contribute to a delayed diagnosis or misdiagnosis. Articles of this caliber are convincing evidence that including diverse voices on key topics offers a richer, fuller take on how best to deal with difficult issues.

Of course, we hope you have noticed that the design of the magazine has been updated, too. Like the new name of the magazine, we think that this redesign reflects the wider scope of PIAA membership, and the broader spectrum of issues that matter for the Association and the MPL community in which we serve.

Please let us know what you think about this “new” PIAA publication, Inside Medical Liability. Any comments you might have on either content or design will be gratefully accepted. Should you wish to suggest a topic for coverage here, that too will be welcome. And best of all, should you raise your hand to say you are willing to write an article for the magazine, we will be pleased to hear from you. Just let us know.

Do not forget that this is your magazine, a place to deliberate and debate what is most important for today’s MPL participants—for the full range of business structures and types of healthcare professionals now striving to uphold the highest possible standards of care, in an environment that keeps shifting, perceptibly or not, beneath them.
Inside Medical Liability

features

22 Cover Story: ACO Development—Managing Evolving Physician Liability Risks
By James W. Saxton and Stephanie C. Sher

25 Feature: Your Reinsurance Program: Is It in Step with MPL Loss Exposures and Changes in Healthcare Delivery?
By Stephen M. Underdal

29 Feature: Alternative Medical Liability Insurance Programs—Establishing the Reserve
By Charles Mitchell and Brad Parker

32 Feature: Expanding Health Insurance Coverage—What Will It Mean for MPL?
By J. Bradley Karl and Patricia Born

special section

36 2013 PIAA Medical Liability Conference

up front

1 Perspective
4 Events & Calendar
6 Observer
8 MPL Data Snapshot

departments

10 Marketing/Communications
Eric Morgenstern

14 Case and Comment
Non-Party Treating Physicians: Protection of Patient Confidentiality
By Linda J. Hay, Anne M. Oldenberg, and Anthony G. Joseph

18 Legislative Update

41 Insights

43 Toolkit
Challenging EMR Complacency
By Missy Padoll

46 International Perspective
"I Knew It All Along"
By Dr. Pierre Campbell

50 Interview With an Expert
With Leonard D. Schaeffer, Founding Chairman and Past Chief Executive Officer, Wellpoint; and Judge Robert Maclay Widney Chair and Professor, University of Southern California

54 The Asset Side
Private Placement Securities: A Defensive Option for MPL Insurers
By Scott Sell and Jason Gingerich

57 By the Numbers
The Big Countdown
By Stephen J. Koca and Richard B. Lord

60 Last Word
Looking for an investment strategy designed exclusively to satisfy the unique needs of your insurance company?

Prime Advisors, Inc.

Patrick Tuohy, SVP
860.331.3050
patrick.tuohy@primeadvisors.com

We Hear You!

Celebrating 25 Years of Success Through Client Satisfaction!
CEO of The Joint Commission to Speak at Claims/Risk Management Workshop

Mark R. Chassin, MD, FACP, MPP, MPH, president and chief executive officer of The Joint Commission, will be speaking at the 2013 Claims/Risk Management Workshop in Seattle. The Joint Commission is the nation’s predominant standards-setting and accrediting body in healthcare. Dr. Chassin is also president of the Joint Commission’s Center for Transforming Healthcare, which works to address healthcare’s most challenging safety and quality issues.

His career has combined high-level positions in both health policy and patient safety, giving him unique insights into both. He served as the Edmond A. Guggenheim Professor of Health Policy and founding Chairman of the Department of Health Policy at the Mount Sinai School of Medicine, New York. He was Executive Vice President for Excellence in Patient Care at The Mount Sinai Medical Center, and a former Commissioner of the New York State Department of Health.

Dr. Chassin is also a board-certified internist and practiced emergency medicine for 12 years.

Dr. Chassin will be speaking in two sessions at the 2013 Claims/Risk Management Workshop. In “Making Tangible Progress Toward Zero Patient Harm,” he’ll talk about The Joint Commission’s role in promoting high reliability as an essential goal for healthcare organizations. And he’ll offer some specific examples of what The Joint Commission’s Center for Transforming Healthcare has been doing recently to develop solutions that will become integral to the processes of high-reliability care.

In a second presentation, Dr. Chassin will explore the thorny issues that are almost unavoidable in patient handoffs.

October Underwriting Workshop to Explore Emerging Risks in Emergency Medicine

There was a time when after-hours care was confined to emergency rooms. Then, urgent care centers entered the scene. And then came the hospitalists, who might be working multiple shifts on varied days. By now, the whole emergency-care scene is a complex mix of specialists, healthcare settings, and categories of patients. And it isn’t just emergency care that is being provided. There are evening-hours options for patients who are simply too busy to come in for a daytime appointment.

To do the best possible job as an underwriter, you need to know what risks in after-hours care are emerging, in which settings, and with which kinds of medical specialists.

Damian F. McHugh, MD, FACEP is the presenter for this Underwriting Workshop session, “Emerging Risks in Emergency Medicine.” Dr. McHugh works in the Emergency Department of the Raleigh, NC, Rex Hospital. He has published numerous articles on the clinical aspects of emergency care, so he knows medicine firsthand. But he has also been watching the new kinds of risks that are emerging in emergency care, in the ever-mutating practice of medicine.

You need to know what Dr. McHugh knows. Come and listen at the PIAA Underwriting Workshop in Charlotte on October 2–4.
Helping physicians across the country to better prepare for the new health care environment.

Now more than ever, health care providers are facing a variety of risks that challenge their sustainability and growth. At the heart of each is how to improve safety and quality of care while reducing the cost of care and creating “value.”

In combination with partner companies SE Healthcare Quality Consulting and OB Consult, Stevens & Lee brings together professionals skilled in internal medicine, practice transformation, safety, quality and risk management with lawyers and leading clinicians, including recognized experts in obstetrics and gynecology, trauma, gastroenterology, and bariatric and general surgery. This unique blend of multidisciplinary expertise allows us to provide comprehensive services to assist physician practices transform and thrive in this new and challenging environment.

Stevens & Lee is part of the Stevens & Lee/Griffin family of companies. For more information, please contact James W. Saxton at 717.399.6639 or jws@stevenslee.com.
In the first week of July, the Department of Health and Human Services announced that significant staff and budget cuts were going to be needed, and that this downsizing would of necessity impact the scope of its Recovery Audit Contractor (RAC) program.

In a Senate Finance Committee hearing held on July 1, there was rare accord among politicians that this was one program whose cutback would occasion very little in the way of mourning. Witnesses from health systems around the country concurred that the administrative burdens of the audits can be horrific.

But yes, the RAC group does indeed have its champion, dubbed the “American Coalition for Healthcare Claims Integrity.” And this is how they see themselves (direct quote):

“The importance of preserving healthcare integrity programs has never been greater. The loss of dedicated personnel and resources is bound to expose new challenges in the fight against healthcare waste, fraud, and abuse. But as funds dwindle, federal lawmakers can rely on Recovery Audit Contractors combating improper payments, while returning billions to the Medicare Trust Fund.”

Now: cue background footage of gently undulating flag and rousing music.

What would it take to attain the dizzying achievement of Stage 6 in an ascending ladder of electronic health record (EHR) adoption? (While it is admittedly bad form to pause this early in a brief article, we note that this ladder is the one from the Health Information Management and Systems Society—HIMSS—which has only a nodding acquaintance with the federal government’s Meaningful Use program.)

But an impressive 539 hospitals have reached Stage 6, defined by HIMSS as one where “full physician documentation with structured templates and discrete data is implemented for at least one inpatient care service area…”

Here is a telling example of the software acquisitions needed for Stage 6. Virtua Health System, of Marlton, New Jersey, structured as an accountable care organization, comprises four hospitals and employs 250 physicians. The company’s shopping list included:

- Siemens (inpatient); NextGen (ambulatory)
- McKesson (document management)
- Cerner (lab); GE (PACS)
- Allscripts (home care)
- Compudata (nursing home)
- Caradigm (data warehouse).

But it wasn’t over yet. To support these programs and tools, Virtua needed even more tools. The health system also bought IT for:

- A private health information exchange
- A clinical decision support and analytics application
- A care coordination documentation system
- Some 500 home monitoring devices to track blood clotting remotely and feed data back via health information exchanges.

Virtua’s chief medical information officer, Jim Gamble, MD, comments on all of his company’s recent acquisitions: “While the technology package may seem staggering, IT is the easiest part. The ACO model changes the way practices operate. Even though we’re automated, we are used to taking care of one patient at a time. In this model, you still take care of patients one at a time, but now we are asking practices to manage patient populations.”

Source: Health Data Management, July 8, 2013

Benjamin Lansky, the superintendent of New York’s Department of Financial Services, has said that many states are letting domiciled companies use risky collateral in what he describes as “a regulatory race to the bottom.” Lansky claims that captives are an example of what he terms “shadow insurance.” His department’s June report on the topic, dramatically titled, “Shining a Light on Shadow Insurance,” asserts: “The fact that certain insurers [none are specifically named in the report] are inappropriately using shell games to hide risk and loosen reserve requirements is greatly troubling.” And, “Shadow insurance allows companies to divert reserves for other purposes besides paying policyholder claims.”

The potential failings of the shadow insurers, the report says, could well spill over to the rest of the economy, noting that, “Shadow insurance also could potentially put the stability of the broader financial system at greater risk.”

As one remedy, the report calls for the NAIC to “develop enhanced disclosure requirements for shadow insurance across the country.” The NAIC demurred. Association president Jim Donelon commented, “I don’t see a need for such a moratorium. We are doing what we need to do in a thoughtful, deliberative way.”

New York State Wary of Captives’ Financial Status
In expansionist grab for national influence, NY calls for country-wide halt on captive insurance deals

“Big data” has become the focus, by our count, of at least half of the recent offerings among webinars for insurers. But just how extensive is insurers’ application of big data? The insurance consulting firm Novarica set out to investigate, surveying the 55 members of its Insurance Technology Research Council.

“When it comes to big data, insurers are engaging in a limited manner, most commonly leveraging consumer, business, and geospatial data for benefits in underwriting, actuarial, and product development,” says Martina Conlon, principal at Novarica.

Overall, the percentage of insurers with big data initiatives underway was right around 35% in all areas except service, which fell below 30%.

For actuarial/product modeling, 18% of insurers said they had derived significant value from big data. Thirteen percent reported “some business value,” while another 24% reported that they had plans to use big data in the next 12 months. Only 4% said that the value of big data was “unclear.”

Marketing is another area where insurers are planning to use big data in the next 12 months—24%—followed by underwriting—18%—and then claims and service (both around 15%).

Why aren’t more insurers jumping on the big-data bandwagon sooner? The most commonly cited reason is that they are deploying resources elsewhere, on items like “core systems replacement projects.”

We note the decided irony in a survey on big data that is, in itself, based on a total sample size of 55.

Role of ‘Big Data’? For Insurers, It’s Sort of Big, but Getting Bigger
Not surprisingly, most initiatives focus on modeling

This story, which appeared on the technology website cnet.com, elicited 11 pages of responses. Among them was a roster of some rather interesting equivalents for what you could buy with $23 million:

- 46 very respectable homes
- 2,631 Tesla Model S performance cars
- 57,500 PlayStation 4s
- 3 golf courses (initial development)
- 52 Lamborghini Aventadors
- Support for 5,750 children in Africa.

The writer of the comment concludes, “You could not, however, purchase a new brain, unfortunately.”
Foreight

So, while reserves are not nearly as redundant now as they were five years ago, we do still feel that there is a bit of redundancy remaining.

Breast cancer and lung cancer were among the top ten resulting medical conditions that resulted in an indemnity payment to the claimant. Colorectal, prostate, and brain cancer followed within the top resulting medical conditions reported. The average indemnity and paid-to-closed ratio for these cancers are provided below. Breast cancer had the highest number of closed and paid claims; however, prostate cancer had the highest average indemnity and paid-to-closed ratio.

Average Indemnity and % Paid-to-Closed by Top Resulting Cancers (2002–2011)

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Average Indemnity</th>
<th>% Paid-to-Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>$433,709</td>
<td>33.6</td>
</tr>
<tr>
<td>Lung</td>
<td>$360,810</td>
<td>30.2</td>
</tr>
<tr>
<td>Colorectal</td>
<td>$418,834</td>
<td>36.6</td>
</tr>
<tr>
<td>Prostate</td>
<td>$454,202</td>
<td>43.5</td>
</tr>
<tr>
<td>Brain</td>
<td>$433,278</td>
<td>30.7</td>
</tr>
</tbody>
</table>

Top Resulting Medical Conditions by Paid Claims (2002–2011)

1. Cardiac or cardiorespiratory arrest
2. Brain damaged infant
3. Breast cancer
4. Birth trauma
5. Acute myocardial infarction
6. Surgical foreign body left in patient
7. Postoperative infection
8. Accidental puncture / laceration during a procedure
9. Lung cancer
10. Dyschromia

Top Resulting Medical Conditions Involving Diagnostic Error (2002–2011)

1. Breast cancer
2. Cardiac or cardiorespiratory arrest
3. Lung cancer
4. Acute myocardial infarction
5. Colorectal cancer
6. Appendicitis
7. Pulmonary embolism
8. Lymph node cancer
9. Aortic aneurysm
10. Paraplegia

Note: Cancers of the breast, lung, colorectal, and lymph node were among the top paid claims naming diagnostic error as the chief medical factor.

As breast cancer continues to have a high incidence among MPL claims in the DSP, the PIAA will be publishing the 2013 Breast Cancer MPL Claim Study later this year. This study will highlight breast cancer data from the DSP from 2002–2011. For more information, contact Stella Lee, PIAA Research Analyst, at slec@piaa.us.
Medical interactive’s MiCapture™ Risk Management software features pre-generated and customizable assessment questions, templates, reports, and recommendations allowing Risk Managers to complete the entire assessment process on-site using a laptop or tablet PC. Increase Risk Managers’ productivity and reduce Risk Management expenses with MiCapture™.

Contact us for more information or to schedule a demo of MiCapture™.
When it comes to the notion of “culture,” many different definitions and meanings may come to mind. Cultures can be expansive or circumscribed, old or new, simple or complex. Cultures can shape personalities, create common ground between people, or even cause conflict. How a person was raised, or currently lives, can have a profound impact on his views, beliefs, and actions.

Typically, when we think of culture, we think of a group’s associated geographic area or perhaps a religion it collectively follows. We may hear people make assertions such as, “Family is very important in their culture,” or, “This culture focuses a lot on personal well-being.” Each culture has its own distinct set of characteristics that are defined internally, but can also be recognized externally.

In this article, I focus on company culture. This intangible concept can be difficult to define, but understanding it is vital for creating a healthy work environment. It tells a company’s story—which attracts and retains both happy employees and loyal customers.

In order to grow your business, you’ll need to master the following elements for strengthening your company’s culture.

First, define it
A business’s personality is initially defined from the employee’s perspective. Happy employees translate into a happy workplace, and it shows. Outsiders see it, and then they’re drawn in. Although culture is guided by the company’s mission, values, ethics, expectations, and goals, it is driven more by emotion than by logic. An emotional connection keeps employees and customers coming back for more.

From an internal perspective, if a company places a high priority on meeting ambitious sales objectives each month, and rewards those who earn the highest, its culture might be defined as “competitive” or “aggressive.” Meanwhile, a company that provides sales quotas and works to provide its employees with the tools they need to reach them may be called “supportive” or “nurturing.” Determine how your employees define the culture, and ensure that the definition aligns with the company’s values.
What’s slowing you down?

Technology alone isn’t the answer. Delphi Technology is the only solution provider that gives you all the tools you need to win the race... an innovative technology solution AND more than 20 years of industry knowledge and business expertise.

- Policy Management
- Financial Management
- Reinsurance
- Advanced Workflow
- Physician eLearning
- Incident Management
- Advanced Business Analytics
- Claims Management
- Risk Management
- Document Management
- Policy Holder Services
- Online Applications
- Data Warehouse & Reporting
- Predictive Analytics

Our fully-integrated medical professional liability solution will transform your critical business challenges into measurable business results.

Delphi Technology
470 Atlantic Avenue, Suite 702
Boston, MA 02210
617-259-1200
www.Delphi-Tech.com
Shifting to an external focus, you realize that company culture is also important to potential clients. Satisfied employees are much more likely to provide valuable customer service and retain clients longer. Additionally, customers who see a company treating their employees well may be more inclined to want to work with them, instead of with a company that clearly does not invest in company culture. Like I always say, “Companies have a culture no matter what. It’s up to leadership to make sure it’s a good one.” All companies have a culture, and clients pick up on it.

Embrace it

The Business Dictionary defines culture as “the values and behaviors that contribute to the unique social and psychological environment of an organization.” A unique environment is often determined by factors such as how an organization treats employees, clients, and the community, as well as the freedom given to employees regarding decisions, ideas, and expressions. Once a company figures out its identity, it should do all that it can to embrace it, so it can deliver consistent messages to all of the people that matter most.

Cultures inevitably vary, because what works within one organizational structure may be completely ineffective in another. The key is to find what works for your specific company. This might require a few trial runs, but you will eventually satisfy current employees and give potential employees a better understanding of what to expect.

Forbes recently delivered several tips to help companies define and embrace their own company culture. Included in the list were communicating company values, as well as showing employees that they care about them professionally and personally. I have found these strategies especially useful in my experience with company culture. When you learn to define and embrace your special culture, it is easier to find and retain employees who are the right fit.

Understand its importance

A strong company culture is significant because it essentially determines the talent that a business attracts. The best companies build culture from the inside out. If a company culture appeals to potential employees, they will be more inclined to accept an offer, stay longer, and work harder.

Company culture is so fundamental to employees that it was ranked as “important” and “very important” by 93% of respondents in a survey by the Society for Human Resource Management. It also plays a huge role in overall employee satisfaction, which is critical to a company’s bottom line.

Overall, culture is an investment. When you invest in culture, you invest in your employees. And when you invest in your employees, you invest in your company’s success.

For related information, visit www.morningstarcomm.com.
The world has changed. Information flow is faster than ever. Remaining at the top of your game requires focus, foresight and the ability to act quickly. We believe to keep moving forward, your team needs the best players: experienced investment professionals who combine sound judgment with innovation. Allow us to assist as you step onto your field.

Are you ready?

Joe Montgomery, Judy Halstead, Christine Stiles, TC Wilson, Bryce Lee, Robin Wilcox, Cathleen Duke, Kathryn Jenkins, Brian Moore, Loughan Campbell, Karen Hawkridge, Evan Francks, Vicki Smith and Brad Stewart
Patient confidentiality is a topic that is an important consideration in nearly every aspect of healthcare, and its scope continues to expand every day. Expansion became exponential with the inception of HIPAA, and this pace has continued with the explosion in the frequency of electronic transmissions of healthcare records and communications. One particular area of concern to litigators, healthcare entities, practitioners, and the companies that provide coverage for practitioners and healthcare entities is that of the communications between defense counsel and treating practitioners in a litigated case. Various jurisdictions have widely varying theories as to whether these communications are prohibited, discouraged, narrowly restricted, or allowed freely. Some jurisdictions address the issue by virtue of common law, some by way of statutory law, and some by a statement on ethics.

Every attorney who defends healthcare professionals has pondered whether he is allowed to speak to the plaintiff’s subsequent treating medical doctor or dentist, ex parte, i.e., without notice or involvement of the opposing party. The answer is not a simple yes or no. Rather, it depends on the state where the lawsuit was filed and, even then, it may still depend on the specific facts in the particular case. A national review shows that, generally, states can be grouped into one of three separate categories: states that allow ex parte communications, states that do not allow ex parte communications, and states that do not allow ex parte communications unless certain criteria and/or conditions are met.

**States that allow ex parte communications**
Multiple states, including Alabama, Alaska, Colorado, Delaware, Iowa, Kentucky, New York, Rhode Island, and Wisconsin allow the defense counsel to communicate with the plaintiff’s prior or subsequent treating dentist.
and/or doctor regarding the care and treatment that the particular practitioner rendered to the plaintiff. These states permit the communications to occur under common law or pursuant to a specific statute. The overriding rationale supporting this position is a waiver of the physician-patient privilege. In addition, some states have recognized that allowing defense counsel to interview medical providers promotes judicial efficiency, by eliminating non-essential witnesses from the litigation process.

In Delaware, the court went so far as to state that there is no specific public policy to support either ex parte disclosure or ex parte nondisclosure, once litigation ensues. Citing rules of evidence, the court noted that there is no privilege that would attach to communications that are relevant to an issue of the physical, mental, or emotional condition of the patient that is being claimed as damages or that may support the defense of the claim. Despite this position, the court did recognize that a physician could opt to refuse a request to communicate with a defense counsel. If this happens, defense counsel would have to resort to formal discovery requests under the applicable rules of civil procedure.

**States that do not allow ex parte communications**

Multiple states, including Arizona, Idaho, Indiana, Illinois, Florida, New Hampshire, New Mexico, Tennessee, Utah, and Washington do not allow a defense counsel to communicate with the plaintiff’s prior/subsequent treating dentist and/or doctor regarding the care and treatment that a particular doctor rendered to the plaintiff. The courts in these jurisdictions cite numerous reasons for barring the ex parte communications. These reasons include the violation of the sanctity of the physician-patient privilege and a concern that privileged information that does not pertain to the medical treatment at issue in the lawsuit will be disclosed. These jurisdictions expressly prohibit ex parte communications between the attorney for the defendants and the plaintiff’s physician.

As is true for the states that do allow such communications, the position of the states that forbid it is supported by both common law and statues. For example, Arizona has enacted a very specific statute, which states:

“In a civil action a physician or surgeon shall not, without the consent of his patient, or the conservator or guardian of the patient, be examined as to any communication made by his patient with reference to any physical or mental disease or disorder or supposed physical or mental disease or disorder or as to any such knowledge obtained by personal examination of the patient.” A.R.S. §12-2235

As such, a physician cannot engage in ex parte communications with the legal adversary of the patient.

Recently, the Supreme Court of Florida expanded the prohibition beyond the scope of the defense attorney. In the case of Hasan v. Garvar, DMD, the court held that a non-party treating healthcare provider could not be represented at deposition by counsel retained by the medical professional liability (MPL) insurance company of the defendant provider. Both doctors were insured by the same company. When he was subpoenaed to testify, the non-party treating physician was provided with counsel to assist him with the deposition. The court determined that in providing independent counsel to the non-party treating physician, the physician-patient confidentiality protections were breached. The court found that the insurance company’s retention of counsel would “foster an environment conducive to inadvertent disclosures of privileged information.” To date, this is the most far-reaching extension of the prohibition and has serious implications for non-party treaters and insurance companies.

Regardless of the nature of the law supporting the position, attorneys should be mindful of the ramifications of violations of the rule. Many jurisdictions will bar evidence obtained through inappropriate contact with the treating healthcare professionals. Such a barring of evidence could jeopardize the entire defense of the case.

**States that do not allow ex parte communications unless certain conditions are met**

There are also a plethora of other states that do not allow defense counsel to communicate with the plaintiff’s prior/subsequent treating practitioner about the treatment that particular doctor rendered to the plaintiff unless very specific conditions are met. The conditions oftentimes focus on obtaining the plaintiff’s consent—but, in reality, this happens only in rare instances. You will find a detailed guide to the specific requirements for each of these states on the PIAA website, www.piaa.us.

**General considerations: caveat**

Overall, in the jurisdictions that prohibit ex parte communications between defense counsel and the plaintiff’s treating physicians who are not named as a party in the suit, important consideration should be given to whether or not the requirements have been met, to ascertain that the defense counsel can in fact conduct ex parte communications. If all of the requirements have not been met, or cannot be met, formal discovery methods, as outlined in the rules of civil procedure in each state, should be followed.

In some states, such as Missouri, if a physician engages in an ex parte conference absent a waiver or discloses information
beyond the scope of the waiver, there may be exposure to that physician or counsel, as the patient can file a lawsuit for damages against that particular physician or lawyer.

It is important for insurance carriers, defense counsel, and physicians to be familiar with the particular rules of their jurisdictions. In those states that have specific mechanisms to obtain a waiver and proceed with communications, protocols should be established to dispel any potential argument that the patient’s rights were not protected.

Documentation of the entire process with full disclosure to all parties will protect both the defense counsel and the physician.

References

For related information, see www.illinois-law.com
KEEPING DOCTORS IN MALPRACTICE.

For nearly a century, Thuillez, Ford, Gold, Butler & Monroe, LLP has been the law firm doctors, hospitals and nursing homes have called to their defense.

We have a proven track record in complex, multimillion dollar lawsuits for negligence, medical malpractice and wrongful death. Our dedication to litigation is well known in the industry, and it’s because of this that we’re able to maintain a network of experts with outstanding credentials in every medical specialty.


Thuillez, Ford, Gold, Butler & Monroe, LLP. Keeping the healthcare industry alive and well for 100 years.

Thuillez, Ford, Gold, Butler & Monroe, LLP
ATTORNEYS AT LAW

20 Corporate Woods Boulevard  •  Albany  •  NY 12211
P 518.455.9952  •  F 518.462.4031

Prior results do not guarantee a similar outcome.
Attorney Advertising.
In the last edition of “Legislative Update” we told you about PIAA’s numerous legislative initiatives that were then making good progress through Congress. I am pleased to report in this edition that progress continues, and one bill, in particular, is rapidly gaining the momentum needed to (potentially) reach the finish line.

The Standard of Care Protection Act (H.R. 1473), as you may recall, was written to ensure that the standards of care used in a medical professional liability (MPL) lawsuit cannot be based on federal healthcare guidelines. With new guidelines emanating from the Affordable Care Act, and the ongoing threat that Medicare payment rules on hospital-acquired conditions might be used as “evidence” of negligence, the need for a clarification of the law is crucial.

In developing a strategy for advocating on behalf of H.R. 1473, PIAA focused on gaining bipartisan support for the legislation, rather than merely increasing support among the majority in the Republican-controlled U.S. House of Representatives. Working closely with the bill’s sponsors, Congressmen Phil Gingrey, MD (R-GA) and Henry Cuellar (D-TX), we began outreach efforts to influential Democrats, including representatives who had not been supporters of PIAA in our initiatives on behalf of MPL reform. Bolstered by advocacy work by The Doctors Company, NORCAL Mutual Insurance, Cooperative of American Physicians, and Texas Medical Liability Trust, this strategy has paid off in significant dividends.

As of mid-July, a bipartisan coalition of eight Members of Congress had signed on to the legislation, including Shelley Moore Capito (R-WV), Michael Burgess, MD (R-TX), David Scott (D-GA), Beto O’Rourke (D-TX), Raul Ruiz, MD (D-CA), and Steve Stivers (R-OH). This support has been significant, but passing any individual piece of legislation is difficult, especially when partisan division in the House seems to get worse with every passing day. So, advocates on and off Capitol Hill decided that the best approach for passing the Standard of Care Protection Act would be to add it to some other piece of healthcare legislation that Congress has a substantial interest in enacting.

The benefit of this approach became increasingly obvious after the release of a “discussion draft” of legislation meant to replace Medicare’s outdated Sustainable

Clarifying Standards of Care
One Step Closer to Reality

Michael C. Stinson
is Director of Government Relations at PIAA.
Growth Rate (SGR) formula with a new payment structure. Drafters of the proposal, which nearly everyone agrees must be enacted during the current Congress, embraced the concept of basing payments on “quality measurements.” This approach rendered H.R. 1473 relevant to the SGR discussion, and also provided the perfect “vehicle” for attaching our legislation.

AAJ weighs in

Now focusing on the SGR bill, we began to wonder about what the American Association of Justice (AAJ) might be contemplating. In discussions with Democrats about the standards-of-care issue, one question inevitably arose: “Where are the trial lawyers on this?” With the help of some friends on Capitol Hill, the proponents of H.R. 1473 were able to learn that the AAJ was not opposed to the proposal, and would not stand in the way of passage. At this point, PIAA began an all-out effort to ensure that the bill would be included in the SGR fix legislation.

PIAA reached out to legislators beyond the group already advocating for the bill, targeting, primarily, national healthcare associations, to unify the entire healthcare sector in support of our efforts. The first step was to issue a formal comment to the House Energy & Commerce Committee, to express our support for including the Standard of Care Protection Act in the SGR fix bill. While some
organizations were concerned about the ramifications of adding any additional issues to the proposed reform package, instead preferring a “clean” SGR fix bill, eventually, 16 organizations signed our letter endorsing the standards-of-care proposal.

**Educating House staff**

Working with staff from the Energy & Commerce Committee, we soon made significant strides. PIAA discussed with them the critical importance of including the standard-of-care language, and explained why this provision was so important to the overall SGR proposal. Eventually, AAJ made some suggestions for editing the standard-of-care language—suggestions that, it turned out, clarify some issues and improved the underlying concept. With the AAJ now expressing its acceptance of the proposal, a major hurdle had been cleared, and committee staff began negotiations for including the standard-of-care language in the text of the pending SGR draft.

With a potential victory so close at hand, we pulled out all the stops. PIAA organized another group letter of support, this one to every member of the Subcommittee on Health, the first subcommittee that would vote on the SGR replacement package. This time, the letter garnered the support of 19 organizations. The day after the letter was sent, the Energy & Commerce Committee released another “discussion draft,” which now had the full support of committee leaders from both sides of the aisle. And this version included the standards-of-care language.

With any threat of opposition from the AAJ out of the way, and with bipartisan support from committee leaders like Michael Burgess (R-TX), Frank Pallone (D-NJ), Fred Upton (R-MI), Henry Waxman (D-CA), Joe Pitts (R-PA), and John Dingell (D-MI), it would seem that the way is open for passage of the Standard of Care Protection Act. This may have been proven in late July when the Subcommittee on Health approved the entire SGR package without a dissenting vote.

That said, bear in mind that much work remains to be done. The full Energy & Commerce Committee still needs to act on the SGR fix, as does the House Committee on Ways and Means, which also has jurisdiction over this legislation. After that, we will have to await a vote by the full House of Representatives, followed by committee and then floor consideration in the Senate, and eventually, negotiations by a conference committee to reconcile any differences between the House and Senate versions of the bill.

If all of this sounds daunting, it should: The legislative process can be a quagmire, where even legislation with bipartisan backing can be shot down. But, through its strenuous efforts, PIAA and our allies have already overcome significant odds, to put this key bill on solid footing toward enactment.

Look for the latest breaking information on the Standard of Care Protection Act in Newsbriefs and on the PIAA website at www.piaa.us.

---

**Toward a Rational Approach to Allocation of Care**

In a fascinating article, featuring a well-thought-out strategy for pushing new medical knowledge from the research journal to the bedside, James B. Jones (Geisinger Center for Health Research) and colleagues explain how to determine which sort of healthcare provider should provide which level of care.

“...[W]here there is strong evidence for when and for whom a care process or treatment (e.g., pneumovax in older patients) should be done, it may be sensible to simply automate the task so that it occurs 100% of the time [81]. For example, all Type-II diabetics without a recent HbA1c should have this laboratory test completed at appropriate intervals, but neither the decision nor the completion of the test requires the involvement of the physician. In this example, CPGs could be structured to recommend a link between the HbA1c level, the importance of other covariates (e.g., liver function tests, kidney function test), who should manage the patient (i.e., nurse, primary care physician, endocrinologist), and the ongoing need for care (i.e., automate decision about next scheduled visit).

Thus, where evidence about what to do is robust and understandable (e.g., management of hypertension, hyperlipidemia, etc.), risks are low, and within the limits of common sense, as much control as possible should be shifted to others. Where the risk of confusion and of making the “wrong decision” increase (e.g., as decision complexity increases), decision support tools may become increasingly important and useful for both the provider and others involved in the care processes. In addition, patient guidance and preferences are likely to be important in a shared decision approach to care. Future development of CPGs may consider the extent to which care processes and decisions can be assumed by others and where patient preference is important.

Source: BMC Medical Informatics and Decision Making 2013, 13:47.
MANAGING RISK ENSURES PROFITABLE GROWTH

GUY CARPENTER LOOKS AHEAD

Let’s make it happen
ACO Development—Managing Evolving Physician Liability Risks

The risk mitigation strategies needed to work within the newer models of care can actually enhance financial performance—and that’s a powerful combination. This alignment of safety and economics provides a strong incentive for physicians and hospitals to look for resources that will help them take risk management activity to the next level.

James W. Saxton, Esq., and Stephanie C. Sher, Esq., are with Stevens & Lee.
The number of accountable care organizations (ACOs) is proliferating, in both the public and private sectors. According to a recent report, there are 428 ACOs in 49 states and the District of Columbia. This number includes more than 250 Medicare ACOs, with the latest group of 106 approved by the Centers for Medicare & Medicaid Services in January 2013. It is estimated that between 25 and 31 million Americans now receive their care through an "ACO." This does not include the numerous ACO-type arrangements being discussed by multiple payers in almost every market. Many are small and intentionally meant to be a first step in the process of learning how to "practice" in a different fashion. The shift from pay-for-volume to pay-for-value will not happen overnight, but it will (and already is) occur incrementally.

Physicians have been very active in forming ACOs, with physicians now leading more than 200 of them, followed by hospitals and health insurers. Specialty care providers and pharmacies have also been aggressive in the development of ACOs. Each of these models has a different approach to achieving savings, enhancing quality, and managing its patient population. However, all must refocus on balancing the need to reduce costs while maintaining excellence in outcomes and the all-important "patient experience." Many will use the patient-centered medical home with the corresponding medical neighborhood, while others will focus on the "principal care provider," who helps to coordinate care and receives additional compensation. Many will look for ways to engage the patient in a more effective way, as this is the fundamental principle of the ACO. The overlapping concept here is the need to better coordinate and manage the care and, importantly, to build in incentives to do so.

These new care delivery systems are (unintentionally) prompting a shift in what we call the "3Ws" of care. New pairings of providers are emerging, revising how we think of "who" is providing care. Today's patient may well be discharged from the hospital into the care of a nurse practitioner, who provides follow-up care, monitors recovery, tracks medication usage, and refers to needed specialists and therapies; the patient never has to see his family physician, relying, perhaps to a great extent, on telemonitoring.

Care settings are also evolving, changing the "where" of care delivery. Preventive and maintenance care is now routinely available in retail locations, and urgent-care centers are siphoning patients away from both emergency departments and primary care offices. Emergency departments may well be admitting patients to a different setting than a hospital. Similarly, at times, the emergency department may be discharging patients to a new setting to further stabilize the patient and for ongoing observation of his condition, before he returns to his home or a nursing home. Hospitals are adopting new ways of providing care and, perhaps in the future, will be assuming a different role.

Economics continues to play a greater role in the provision of care, and efforts to increase value and efficiency are also changing the "what" of care. The "Choosing Wisely" campaign, for example, is viewed by some as potentially redefining the standard of care, by identifying certain diagnostic and therapeutic modalities as unnecessary in certain circumstances. This campaign has great promise and should be monitored carefully. However, guidelines such as these, developed by professional medical organizations and formerly considered "suggestions" rather than "mandates," could come to be viewed as required care, and, if the guidelines are not followed, that could be deemed "evidence" of inappropriate care. At least one state, Georgia, has enacted legislative protection for providers, prohibiting care standards from being used as evidence of negligence, and federal legislation to accomplish this same objective has been introduced. This could be an important development, and we need to be prepared to fight some evidential legal battles along these lines.

New delivery models, combined with changes in the 3Ws, make transitions of care especially challenging. We have known for many years that some patients are discharged from the hospital with pending test results that the primary care provider may not know about. Discharge summaries, traditionally the vehicle for communicating information about a hospital stay, often fail to provide adequate information for a safe transition of care from the inpatient to the outpatient setting. Some studies have shown that only 12% to 33% of discharge summaries...
maries were available to the primary care providers at the time of the first office visit. And, while the use of hospitalists and advanced-practice providers has been shown to increase efficiency and quality, it has also created a discontinuity between inpatient and outpatient settings and a fragmentation of care management. All of these transition-risk issues could intensify in an environment in which the system is put under greater stress, in terms of volume, and also in terms of pressures to create a more efficient process.

These changes are real, and they rely on technology, as well as a novel deployment of the personnel needed to make them happen. During the period of “transition” to new care models, we must concurrently evaluate and mitigate the risk to medical professional liability (MPL) claims. We can do this by focusing on reducing the number of adverse clinical outcomes (the root cause of claims).

One can map out where that potential lies and put in place a safety net to help reduce the probability that it will actually happen. We also need to strengthen our documentation systems, to capture important new topics such as patient engagement and responsibility—communication and patient experience. Electronic transition tools need to be deployed to prevent fragmentation of communication and documentation. Even our EMRs need to be a focus of our attention, and our EMR audit tools need to be used so as to maximize effective transitions and documentation.

Opportunities for MPL insurers
MPL insurers can help healthcare providers by becoming a platform and a resource center for this transformation. Consider some of the following tools and strategies that are being developed:

- New care pathways, by specialty, to articulate responsibility for ordering and follow-up on tests. These can fill the gap that results from incomplete discharge summaries or delays in receiving test results.
- Protocols specifying medication usage, direction, and follow-up. Medication coordination between primary care providers and specialists can avoid medication errors and improve outcomes.
- The second-generation supervisory strategy tool, which helps advanced practice providers, patient navigators, care coordinators, and other non-physician members of the care team to coordinate effectively. Making this work will require changes in policy and training.
- New patient-engagement tools assist providers in involving patients as active participants in their own care, making them full members of the care team. There should be concurrent documentation that this is happening.
- The new EMR risk audit tool can be used to improve documentation, enhance effective EMR use, and obviate “alert fatigue” and other “work-arounds.”
- EMR capabilities should be evaluated to maximize inter-communication and to facilitate “neighborhood” collaboration.
- Patient portal protocols can be put in place to ensure appropriate usage, timely responses, and clarity of communication, and important-

Economics of risk mitigation
The bottom line? One in four physicians is either in an ACO or plans to be in one in the coming year. That number will grow. So, quite soon, the majority of physicians will be involved in these new models of care and the risk associated with them. We need to get ahead of the wave of “transitional liability” that could come with it. MPL insurers have a vested interest in mitigating this risk, but they can now do so in a true “value-added” fashion for their physicians and hospitals.

The fact that the same risk mitigation strategies can enhance financial performance is a powerful combination. This alignment of safety and economics provides a strong incentive for physicians and hospitals to look for resources that will help them take this activity to the next level. For MPL insurers, this is an enormous opportunity to provide unusual value during a time of great need.

References
By Stephen M. Underdal

Your Reinsurance Program:

Is It in Step with MPL Loss Exposures and Changes in Healthcare Delivery?

The MPL insurance industry will undergo significant change in the years to come, requiring proactivity and nimbleness on the part of insurers. Some advice to MPL insurers: abide by the motto of the Boy Scouts of America: “Be Prepared.”

The medical professional liability (MPL) insurance market continues to post operating profits, in spite of the protracted soft market cycle and negligible investment returns. While MPL insurers are currently experiencing a state of market equilibrium, they are at the same time witnessing undercurrents of rapid change.

Several insurance dynamics remained consistent in the market during 2012:

- **Underwriting profitability continues.** The MPL insurance industry posted a combined ratio of 93.8% during 2012, which is a record seventh consecutive year of underwriting profit (Table 1).
- **Policyholder retention is strong.** In spite of stiffening price competition and continued provider consolidation, insurers have generally experienced record soft market retention levels, with percentages in the low to high 90s.
- **Insureds are rewarded with dividend and customer loyalty programs.** Several MPL insurers paid robust policyholder dividends to promote continuity with their insureds, with dividends contributing more than five points of the industry combined ratio in 2012. Customer loyalty programs, which offer financial incentives such as subscriber sav-
ings accounts for longstanding policyholders, are also in vogue.

- **Claims frequency remains at record lows.** Our tracking of nationwide claims frequency for physicians yields an average frequency of approximately seven to eight claims per 100 doctors, which is a significant reduction from the market “norm” of 15 claims per 100 doctors in the early 2000s.

- **Loss redundancies continue.** In the aggregate, the MPL industry continues its pattern of loss reserve redundancy, even in recent accident years. The year-over-year total industry redundancy was reduced by almost 50% at December 31, 2012, which could be a troubling sign (Table 2).

**But there are storm clouds**

While the MPL class continues to outperform all other commercial lines of insurance, there are, arguably, storm clouds gathering on the horizon:

- **Industry premiums continue to decline.** Average premium per exposure unit fell again in 2012, fueled by rate decreases and greater utilization of rating credits. According to A.M. Best, MPL industry direct written premiums declined by another 2.4% in 2012, driven by pricing reductions and business lost through consolidation.

- **Is claims frequency on the rise?** While we do not have direct evidence of nationwide or regional increases in claims frequency, a minority of clients have experienced some “noise” in their frequency numbers thus far in 2013.

- **Will claims severity spike in 2013?** The pendulum of justice has arguably swung back in favor of the plaintiffs’ bar in several jurisdictions. Although claims severity ostensibly continues its moderate, upward march, there were a number of massive verdicts in the MPL space during 2012 (Table 3).

The MPL industry has also been hit with several large jury verdicts in 2013 (Table 4).

- **The Affordable Care Act (ACA).** We are on the doorstep of major implementation of the ACA, during 2014. The ACA has a dizzying array of rules, regulations, and mandates, with several of the important decisions already delayed. How will the adoption of the ACA affect the MPL insurance industry?

While we do not yet know the answer to that question, we do know that the MPL insurance industry will undergo significant change in the years to come, requiring proactivity and nimbleness on the part of insurers. Our advice to MPL insurers is to abide by the motto of the Boy Scouts of America: “Be Prepared.” As such, we believe insurers should carefully review their reinsurance programs to ensure that they are in sync with current MPL loss exposures and changes in the delivery of healthcare.

**Does your current reinsurance program protect against unanticipated increases in claims severity?**

As mentioned, there were a number of large jury verdicts in 2012 that impacted MPL insurers. Figure 1 shows that the average of the 50 largest MPL jury verdicts “spiked” to nearly $28 million, easily outpacing the mean results of prior years.
In addition to their recent success in attaining large jury awards in the MPL space, the plaintiffs’ bar have become increasingly aggressive in pursuing bad faith claims against MPL insurers. Jurisdictions such as Florida present attorneys with a fertile environment for bad faith actions that may involve, for example, low policy limits, high damage potential, or time-sensitive demands to settle.

There were several sizeable bad faith awards and settlements sustained by MPL insurers during 2012.

We believe that it is prudent for MPL insurers to consider purchasing reinsurance coverage designed to protect against large jury awards (that are often in excess of the MPL carrier’s policy limits) and bad faith claims. Reinsurers offer MPL insurers a variety of coverage options (e.g., excess casualty catastrophe or “awards made” alternatives) at favorable terms and pricing.

We also recommend considering aggregate stop loss reinsurance coverage to protect against an unexpected frequency of moderately severe claims within net retentions. Reinsurers are generally willing to offer comprehensive, risk-transfer coverage solutions to MPL insurers.

**Does your existing reinsurance program offer coverage for MPL “batch claims”?**

Batch claims are a series of related MPL losses arising from the same thread of causation. These claims involve multiple plaintiffs who allege a common source of loss, often spanning several policy years. Recent examples of batch claims include:

- Unnecessary medical procedures done for financial gain
- Improperly calibrated medical equipment
- Products liability actions
- Infection/sterilization claims
- Negligent compounding of medicine
- “Shorting” of medical prescriptions for financial reward.

There have been several massive settlements for batch claims within the MPL space in the past few years.

We strongly recommend that MPL insurers explore reinsurance coverage alternatives for batch claims. Reinsurers offer a variety of creative, comprehensive, and cost-effective reinsurance options for this cover.

Here are some of the coverage considerations that MPL insurers should consider in exploring reinsurance protection for batch claims:

- Is the reinsurance limit adequate?
- Allocated loss adjustment expenses (ALAE) often comprise the majority of losses for MPL batch claims. We encourage MPL insurers to procure reinsurance protection that includes ALAE coverage within the ultimate net loss provision.

- The reinsurance coverage trigger should allow for the grouping of related batch claims, spanning several policy years, as a single event.
- Is the reinsurance coverage “named peril” or “all risk”?
- Is the reinsurer willing to offer a “no claims bonus” for favorable loss experience?

**Does your current reinsurance program contemplate exposures emanating from the ACA?**

The implementation of the ACA will impact the MPL industry in the years to come. Will your reinsurance program be responsive to changes in the delivery of healthcare?

- Electronic health records (EHRs). The ACA mandates the adoption of EHRs by medical providers, with deadlines for establishment of “meaningful use.” In recognition of the transformation of healthcare data to an EHR format, MPL insurers may have potential exposure to...
cyber liability claims resulting from the breach of protected health information.

- Accountable care organizations (ACOs). ACOs are another critical feature of the ACA. MPL insurers should explore ACO reinsurance coverage with existing treaty reinsurers, as well as with insurance or reinsurance market facilities. To date, ACO coverage has not gained meaningful traction.

- Provider consolidation. The ACA, together with market forces, have fueled significant consolidation among physician groups and hospitals. In light of this trend, several physician insurers have elected to form “strategic partnerships” with hospital professional liability (HPL) carriers, or have elected to insure the HPL exposure themselves.

For those insurers who are new entrants to the HPL game, the following questions come to mind:

- Does the carrier have HPL underwriting expertise?
- Does the insurer have sufficient HPL claims handling experience to contemplate the “deep pocket” policy limits and ostensible agency/vicarious liability exposures?
- What are the insurer’s competitive advantages in the marketplace, other than price?

- Employed physicians. In view of the tremendous number of physicians that have been employed by hospital groups over the past few years, does the HPL rating formula provide an adequate premium for the employed physician exposure?

- Healthcare “extenders.” The delivery of healthcare, driven in part by the shortage of primary care physicians, will be increasingly provided by healthcare “extenders,” such as nurse practitioners and physician assistants. Is this exposure properly addressed in your existing reinsurance program? As an aside, we have witnessed a wide disparity in pricing for healthcare extenders within the MPL insurance community, so we encourage carriers to revisit their pricing and underwriting approaches for this growing exposure.

- Provider stop loss. In an effort to “bend the cost curve” and promote pay for performance, the ACA stipulates that healthcare providers be reimbursed on a bundled basis in the future. To protect the reimbursement flow to their insureds, MPL insurers can secure provider stop loss reinsurance coverage from reinsurers.

Conclusion

The MPL insurance market will undergo profound change in the years to come. To prepare for these contingencies, we believe it is wise for MPL insurers to ensure that their reinsurance programs dovetail with loss exposures and changes in the market.
Alternative Medical Liability Insurance Programs—Establishing the Reserve

By Charles Mitchell and Brad Parker

The success of an alternative insurance program could well depend on the decisions that are made when the program is first set up. What follows is a discussion of what you’ll need to consider in establishing reserves for the new entity.

Medical professional liability (MPL) risk has historically been managed through the purchase of traditional insurance coverage that is offered by either stock or mutual insurance companies. But then, in the early 2000s, the periodic hardening of the MPL insurance market meant higher costs and limited availability of traditional insurance coverage in some markets. In response, the MPL market has seen a dramatic shift toward alternative insurance entities, including self-insurance, risk retention groups (RRGs), and other captive MPL insurance vehicles.

Charles Mitchell, FCAS, MAAA, and Brad Parker, ACAS, MAAA, are consulting actuaries with Milliman.
Based on data from SNL Financial, Figure 1 illustrates the sizeable growth, since 2000, in the number of alternative programs relative to the growth of MPL companies with traditional ownership structures. The majority of the RRG growth materialized during the period from 2002 to 2005.

This figure reflects only companies that file statutory financial statements. There are also a significant number of captive insurance programs for which information is not publicly available, because they do not file statutory statements. Today, there are more than 100 captive domiciles internationally, as well as at least 30 and counting in the United States.

In addition, the MPL insurance market continues to transform, as consolidation of the U.S. healthcare delivery system proceeds, toward the various forms of accountable care organizations (ACOs). The result will be the creation of larger healthcare organizations, which has led, and will continue to lead, to a greater reliance on self-insurance, captives, and group practice insurance models.

As the market transforms itself to include a larger share of these alternative insurance entities, it will demand a more diverse set of procedures and considerations for establishing unpaid claim liability reserves. In the paragraphs that follow, we discuss a number of issues that should be carefully considered when establishing unpaid claim reserves for these alternative risk transfer vehicles. These considerations are particularly important during the period of transition to a new insurance program. Some examples of these issues include:

- Regulatory differences between domiciles
- Coverage and accounting differences
- Lack of historical claims experience
- Discounting of reserves
- Risk margins
- Differences in the Statement of Actuarial Opinion

Regulatory domicile differences

The states or countries under which these alternative entities are domiciled have varying requirements for establishing the unpaid claim liability reserves or for issuing the Statements of Actuarial Opinion. Reserve differences might pertain to the requirements for discounting of reserves or risk margins, both of which are discussed below. Different domiciles may require alternative or refined language for the Statement of Actuarial Opinion—particularly in the case of off-shore captives, since most U.S.-based domiciles will require that entities follow guidelines established by the National Association of Insurance Commissioners (NAIC) model opinion. The deadline for filing financial statements or the actuarial opinion may also vary according to the legal structure or domicile of the insurance vehicle.

Coverage and accounting differences

The prevalence of claims-made coverage within the MPL market will also give rise to potential challenges. This is particularly true when considering the tail exposures for a newly acquired physician group. Independent physicians currently insured under a claims-made form will have extended reporting (tail) exposures for claims not yet reported on past incidents. If a large healthcare system provides claims-made coverage to employed physicians, through self-insurance or commercial insurance, it will, presumably, be required to establish a reserve for these tail exposures. Whether the system is required to set up this reserve or not may depend on what is specified about tail coverage in the physicians’ employment agreement. Unless accounted for in some other fashion, this reserve is normally carried on the balance sheet of the healthcare system.

In addition, insurers that provide claims-made coverage to individual physicians will frequently offer a premium waiver for tail coverage in the case of death, disability, or retirement (DDR). These insurers are required to establish a reserve for the cost of these future benefits. However, a self-insured healthcare system providing occurrence coverage would not need to provide DDR tail benefits for employed physicians, because the system is already responsible for these tail benefits and will have already established a reserve for them.

Lack of historical loss experience

As mentioned above, as a consequence of the continued consolidation of the U.S. healthcare delivery system, more and more physicians will be employed by healthcare organizations. These healthcare organizations may want to insure their employed physicians through an existing self-insurance or captive professional liability program. However, it may not be easy to obtain the past claims experience associated with these physicians. Furthermore, the historical data may not be an accurate reflection of the new conditions under an alternative program—for example, how
claims are handled or risk management is done. If there is no historical loss experience, the actuary would need to rely more on industry information in estimating unpaid claim liabilities. In turn, this would add to the inherent uncertainty in the estimates of the unpaid claim liabilities.

Discounting
A self-insured entity is frequently allowed to discount its unpaid claim liabilities, to reflect the investment income earned on its supporting assets, until such time that the claims are fully paid. The particular form, and amount, of the allowance for discounting might depend on the legal structure or the domicile of the self-insurance vehicle. For example, a captive insurance company that files a U.S. statutory financial statement is not permitted to discount its unpaid claim liabilities. However, foreign domiciles often allow or require discounting. The requirement to discount or not to discount may change in future years, as we see progress from the current efforts to merge U.S. and international accounting standards.

Risk margins
Depending on the structure and domicile, a self-insured entity might incorporate a risk margin into its booked reserve. The risk margin is included in addition to the actuarial expected value of the unpaid claims liability, to provide a buffer against adverse claims development. Risk margins can be estimated by stochastic actuarial reserving methods that make it possible to analyze the degree of variability in an entity’s unpaid claim liabilities. This practice may become more common if some of the proposals for accounting standards are implemented.

Statement of Actuarial Opinion differences
For example, some foreign domiciles require that the actuary opine on whether the established reserves are “adequate,” instead of the NAIC requirement that the actuary state whether the reserves are “reasonable.” While both terms are admittedly somewhat vague, the “adequate” standard is generally perceived as more conservative than the “reasonable” standard. The deadline for filing financial statements and the Statement of Actuarial Opinion may also differ, based on domicile or whether GAAP or Statutory accounting is used.

In conclusion, there are a variety of issues related to unpaid claim reserves and the Statement of Actuarial Opinion that need to be considered in using alternatives to traditional MPL insurance programs. Requirements vary by regulatory jurisdiction, applicable accounting principles, and the legal structure of the insurance vehicle. These issues are particularly important to assess during the transition to a new program or in adding new exposures to an existing program, for example, insuring newly employed physicians within an existing healthcare system captive. There are many domiciles and legal structures to contemplate, and the success of an alternative insurance program could well depend on the decisions that are made when the program is first set up.

For related information, see www.milliman.com.
Expanding Health Insurance Coverage—What Will It Mean for MPL?

Surprise! One new study, at odds with the typical analysis on the impact of the ACA, indicates that the higher levels of health insurance claims that will ensue after the ACA is in force may in fact lead to a lower rate of MPL claims, despite the additional risk exposure.

J. Bradley Karl, PhD, is with East Carolina University, and Patricia Born, PhD, is with Florida State University, College of Business, Department of Risk Management/Insurance, Real Estate and Legal Studies; pborn@cob.fsu.edu.
While rising healthcare costs keep the U.S. healthcare industry in the public policy spotlight, the markets for health insurance and medical professional liability (MPL) insurance remain targets for reform. Although these two markets serve essentially different buyers and sellers, they are interrelated through the healthcare system. Performance in each of these insurance markets depends, at least to some extent, on the performance of the other, because activities in either market are likely to affect the performance of the healthcare system. For example, the health insurance market can be the target of regulations intended to expand coverage (e.g., benefit mandates), which leads to additional use of medical services and, consequently, an increase in the risk of an MPL lawsuit.

Prior research has not examined the effect of changes in the health insurance market on the market for MPL insurance. In particular, it is not clear how specific changes, such as expanding health insurance coverage to a larger population, ultimately play out in the MPL market. Understanding the potential direct and indirect consequences of such a change is especially important as new regulations, notably the Patient Protection and Affordable Care Act of 2010 (ACA), contain several provisions designed to extend health insurance coverage to more individuals.

Changes in the health insurance industry, such as an expansion of people covered, can alter the general nature of provider-patient interactions. We note that prior research suggests health insurance coverage has a positive effect on the utilization of healthcare services, largely because patients with insurance face a lower cost of obtaining healthcare services than those with no coverage. Likewise, expanding the scope of covered services encourages increased utilization. In any case, we propose that an expansion in coverage will subsequently affect providers’ liability exposure.

However, it is not clear whether the liability exposure will increase or decrease. One possibility is that increased insurance coverage, which leads to increased use of healthcare services, creates an increase in MPL events, simply because there are more opportunities for adverse events. On the other hand, an increase in health insurance coverage may facilitate greater continuity in the provision of services and a higher quality of care and, hence, a reduction in MPL events. We seek here to determine which of these effects dominates, and then provide a more detailed explanation of our theory and empirical test, below.

We consider the potential effects that changes in health insurance markets have on MPL insurance markets in the following way. First, insurance contracts offered by health insurers are subject to state health insurance regulation and will reflect the characteristics of the state population. The scope of coverage and policy provisions have the subsequent effect of influencing healthcare utilization decisions, which reflect the interactions between the patient and providers. Further, it follows that if the frequency and/or intensity of provider-patient encounters is affected by a change in health insurance coverage, patient health outcomes might also be affected.

When levels of patient utilization and treatments increase, the adverse event rate may rise, because providers have more occasions to
render poor medicine to patients, commit a medical error, or simply be charged with some form of medical negligence. Then, we would expect that as health insurance claims increase, we would note an increase in MPL claims. On the other hand, providers’ liability might be reduced when these encounters reflect an increase in preventative procedures that reduce the number of cases of high-risk, complicated procedures. As noted above, it is unclear whether the change in encounters necessarily increases or reduces MPL risk. The answer hinges on the degree to which the frequency and type of services rendered to patients tend, in the aggregate, to increase or mitigate medical errors.

In our research, we go a step further and posit a bidirectional relationship between the health insurance market and the MPL insurance market. This naturally follows if a change in providers’ liability exposure, whether real or perceived, leads to changes in the behavior of the provider. Thus, it may be that MPL insurance markets affect the way that providers interact with patients, in terms of the frequency or types of services rendered, which ultimately translates into an effect on health insurance markets. For example, providers worried about the MPL risk could provide additional services to obviate the likelihood of a lawsuit. They might also react by avoiding high-risk patients or procedures. Again, while both behaviors are likely to occur when we view patients on a case-by-case basis, we seek to determine which behavior dominates in the aggregate.

Data source
We use data on insurance company financial operations from the National Association of Insurance Commissioners (NAIC) to evaluate this relationship. Our measures of interest are the state per-capita MPL insurance losses and the state per-capita health insurance losses incurred. We also control for a wide range of factors that may influence insurance claims in these two markets. These state-level measures include the total premiums earned in each market, median income, the percentage of population in metropolitan areas, the presence of a non-economic damages cap, the presence of a mandate to purchase MPL insurance, the statute of limitations duration, and per-capita measures of the number of specialists, hospital admissions, liability claims of more than $1 million, persons enrolled in an HMO, persons under the age of 19, and persons above age 65. These data are drawn from the U.S. Census Bureau, the U.S. Bureau of Labor and Statistics, and the Centers for Disease Control.

We use a two-stage regression model to estimate the bidirectional relationship between health insurance claims per capita and MPL.
claims per capita. While controlling for the state measures listed above and including additional state and year fixed effects, our results indicate that higher levels of health insurer claims per capita are associated with significantly lower levels of MPL insurer claims per capita. Specifically, an increase in health insurance losses per capita of $1 is associated with a reduction in MPL insurance losses per capita of approximately $.058. At the mean, the results suggest that a 1% increase in health insurance losses per capita is equal to a 2.59% decrease in MPL insurance losses per capita.

We perform a variety of checks for robustness, and get similar results. Thus, we conclude that the liability mitigating effects of higher levels of health insurance claims appear to prevail over the effect of increasing MPL claims due to additional risk exposure. In our counterpart equation, we find that higher MPL claims are associated with lower health insurance claims. This finding supports the idea that providers respond to the medical liability risk by providing fewer services, not more. While defensive procedures are most certainly applied in practice, the net effects estimated here support the idea that insured patients receive higher-quality care, which results in fewer MPL events.

While our analysis reveals much about the relationship between health insurance markets and MPL insurance markets, additional research on this subject would be valuable. For example, the way in which changes in health insurance coverage influences provider-patient encounters remains unclear. Further, we cannot anticipate changes in the composition of the insured population. If health insurance coverage is extended to more high-risk types than average, or to more litigious individuals, the effects here cannot be generalized.

Given the current state of health insurance reform in the United States, the analysis presented here is especially important, because it suggests that increases in health insurance coverage rates are associated with lower rates of MPL insurance loss. From a broad perspective, the finding of a statistically significant bidirectional relation between health insurance markets and MPL insurance markets provides valuable insight into the structure, conduct, and performance of these related markets.

References
The 2013 PIAA Medical Liability Conference, May 15–17, in Palm Desert, California, brought together more than 450 insurance professionals, all looking to gain key insights on the global—and day-to-day—issues facing the medical professional liability (MPL) community. The meeting addressed the most important topics these professionals needed to learn about, and discuss. All of the conference proceedings were set against the scenic background of Palm Desert.

Topics covered included finance, claims management, risk mitigation and patient safety, and government and regulatory policy. Of particular interest at this year’s conference were topics that relate in some critical way to the seismic changes in the healthcare market, notably, the Affordable Care Act, and how these may impact the MPL insurance sector. Attendees left the meeting with a clearer perspective on the present and future of the MPL business, and with specific strategies for meeting the challenges of the evolving healthcare system, and emerging economic conditions, both in the U.S. and around the world.

For PIAA: A Brand-New Brand
The conference provided the perfect showcase for launching the rebranding of PIAA. The changes support and build on the PIAA’s leadership role in the MPL community. They also reflect the impact that the changing landscape in the delivery of healthcare has had on MPL. On May 16, the organization began doing business as simply “PIAA.” To accompany
the new name, PIAA introduced a new tagline: “Our expertise is medical liability. Our passion is quality healthcare.” The organization also unveiled a new logo that reflects its expanding role in the MPL arena.

A redesigned website, www.piaa.us, was launched as well. Ted J. Clarke, MD, chair of PIAA and chairman and CEO of COPIC Companies, commented, “Speaking on behalf of the PIAA Board, I am excited about the new brand, and where it will take the organization in the ensuing months and years. I am confident that these actions will keep us on target for meeting the needs of the MPL community.”

PIAA President and CEO Brian K. Atchinson commented, “PIAA was once identified as an association of physicians insuring physicians—a perception that clearly set us apart and an important aspect of our heritage. Today, in addition to insuring more than two-thirds of America’s private practicing physicians, our members provide MPL coverage for more than 3,000 hospitals, as well as other healthcare providers. Our new brand reflects who we have become over the years—and it represents our mission to promote, protect, educate, and connect the diverse kinds of MPL entities that all support the quality delivery of healthcare and practice of medicine.”

“We are committed to ensuring that PIAA remains an indispensable resource for every group with a stake in MPL regardless of structure—mutual, reciprocal, RRG, captive, or trust,” Atchinson continued. “And PIAA will continue to offer programs and services tailored to meet the needs of all types of healthcare providers and healthcare systems covered—physicians, hospitals, nurses and nurse practitioners, dentists, or others.”

Keynote Session
“Healthcare Reform: Change Is the Only Constant”

If U.S. healthcare costs continue to rise at today’s relentless pace, Keynote speaker Leonard D. Schaeffer warned, these costs will consume such a substantial chunk of the GDP that congressional budget hawks will join with the national security hawks to force draconian cuts in government payments to healthcare. Even now, he said, rising healthcare costs could threaten the economy and drive deficits.

Schaeffer is Founding Chairman and Past Chief Executive Officer, Wellpoint; and Judge Robert Maclay Widney Chair and Professor, University of Southern California.

Under the ACA, Schaeffer pointed out, healthcare spending will rise more quickly, according to the CMS actuaries’ estimate. In 2014, costs for physician services are expected to increase by 8.9%; without the ACA, that figure would be substantially lower, 5.8%.

One promising development, for both costs and healthcare quality, Schaeffer said, is the evolution of new models for both care and payments. Both health insurers and providers are consolidating, forming new ACOs, investing in new data capabilities, and implementing novel payment reforms.

For the MPL sector, the risk profile is inevitably changing in tandem. These insurers can support the positive trends in healthcare by emphasizing evidence-based medicine, promoting team-based care, and encouraging patient-centered care.

There is an in-depth interview with Leonard Schaeffer in this issue of Inside Medical Liability, on page 50.

Peter Sweetland Award

James F. Carland, III, MD, was named as the 2013 Peter Sweetland Award of Excellence recipient, for his significant contributions and dedication to the MPL insurance industry and PIAA. Dr. Carland is president and chief executive officer and chairman of the Board of the Mutual Insurance Company of Arizona (MICA). He has spent many years representing the interests of the medical community, through his work in both the MPL and healthcare industries.

His service to PIAA includes serving as both a member and chair of the Board of Directors and on the Association’s Continuing Education Advisory Committee, Government Relations Committee, Membership and Bylaws Committee, Nominating Committee, and Rating Agency Relations Committee.

Prior to joining MICA in 1997, Dr. Carland practiced pediatrics in Arizona.

“Jim has been an outspoken advocate on behalf of the medical profession and a tireless supporter of PIAA,” said Ted
J. Clarke, MD, PIAA chair. “We are honored to present him with this award in recognition of his dedication and commitment to PIAA and the industry.”

Brian K. Atchinson, president and CEO of PIAA, stated, “The Peter Sweetland Award was created to recognize an individual from our ranks who has provided great leadership and has served as an inspiration to others in the industry. Jim truly embodies the spirit of this award, and we thank him for his hard work and years of service.”

The Peter Sweetland Award of Excellence, established in 1993 by the Association’s Board of Directors, was created in honor of Peter Sweetland, one of PIAA’s chief architects and ardent supporters. The Peter Sweetland Award of Excellence recognizes an individual who has provided great service to the industry and to PIAA, and it epitomizes the high ideals and ethics for which Peter Sweetland stood.

PIAA Leadership Awards
At the opening session, PIAA also presented its Leadership Awards for major contributions to the organization from volunteers from its member companies. This year, they included: Sheila Anzuoni, Eastern Dentists Insurance Company; Paul Gabel, NORCAL Mutual Insurance Company; John E. Gray, MD, CCFP, FCFP, The Canadian Medical Protective Association; Philip Hinderberger, Esq., NORCAL Mutual Insurance Company (retired); Fred Kirchgraber, Louisiana Medical Mutual Insurance Company; Debra Udey, OMS National Insurance Company, RRG; and Deborah Willis, State Volunteer Medical Insurance Company.

Focus on a Session
“Healthcare Information Technology: Friend or Foe?”

Sol Lizerbram, MD, Chairman, HealthFusion, Inc., explained how a well-designed electronic health record (EHR) system can reduce medical errors. Paul E. Smolke, Industry Managing Director, Worldwide Health, Microsoft Corporation, talked about the emerging privacy and security issues with EHRs, and what can be done to resolve them.

Sol Lizerbram, MD
A recent article in the New England Journal of Medicine notes a trend toward fewer medical errors with the use of EHRs, but the article also identified some issues that the designers of these systems need to focus on. Dr. Lizerbram highlighted some of these, and suggested several useful EHR features, which providers should look for in purchasing a system.

EHRs have greatly simplified many areas of record-keeping on patients. Before EHRs, lab results would come to the office via fax, and would then have to be sorted, compiled, and inserted into individual patient charts. Abnormal results might be flagged via some sort of notation, but the physician may not have seen these. In contrast, with EHRs, the doctor looks at all of the test results, and the flags on abnormal findings remain, until she has reviewed them and considered them in the context of the full patient record.

A well-designed EHR can also include reminders for any necessary screening procedures such as mammograms, and it can store a lengthy series of lab results such as blood glucose levels. The latter can be linked to specific doses of (for example) insulin to monitor an ongoing dose-response effect. A good EHR will also include the metrics needed for Medicare’s Patient Quality Reporting System, which then builds the...
reporting requirements into the regular work flow of the practice, including examination, diagnosis, and treatment.

Asked about interoperability of EHRs, Dr. Lizerbram said that it is getting better, though still not perfect. EHRs for physicians’ offices may require some extent of customization, he said, since many were originally designed for hospitals, where the work flow is obviously different from that of an individual practice.

Paul Smolke
Data breaches involving medical patients’ information have been getting major headlines of late, Paul Smolke noted: there may at least one such breach every day. Trends such as “BYOD”—bring your own device—into work can be risky, if the information is not encrypted and password-protected. Smolke asked: Can your IT people wipe the devices clean, remotely, in the event that they are lost or stolen? This should be a basic requirement for the use of EHRs on personal devices, he said.

Smolke described three basic aspects of preserving the privacy of patient data: purpose and control (who has access to the information), transparency (what the vendor has done in regard to HIPAA compliance), and accountability. Any party who will be able to view the patient information, he said, should sign a formal business associate agreement beforehand. Vendors of EHRs, prior to sale, should explain how they will keep their products current to maintain security, and challenged about any risks to security that seem inherent in the design.

MPL carriers can reduce security risks with EHRs, he advised, by bearing in mind that the EHR technology will always be evolving, whereas the users may well be a little bit behind.

The issue of “cut and paste,” wherein information is copied in several screens of the EHR, is one that can be resolved by encouraging insureds to use the “cut and paste” function thoughtfully. It can be a good tool, for example, if providers use it to bring forward information that was recorded in a prior visit, and then modify it to suit the current situation.

Like Dr. Lizerbram, Smolke acknowledged that there is still work to be done in designing EHRs: Many software architects have never been in a room with an actual patient. Systems designed in collaboration with physicians are much easier to use. Soon, EHRs may be able to “think like a doctor” and offer only the relevant assistance—for instance, instead of listing every possible drug interaction, citing only the salient ones for the particular patient.

Cong. Cardoza Speaks at PIAA PAC Event
On May 15, the PIAA Political Action Committee (PIAA PAC) held its second annual fundraiser, in conjunction with the 2013 PIAA Medical Liability Conference. The politically engaged crowd enjoyed libations, spirited conversation, and an insider’s perspectives on the workings of Congress.

The evening’s featured speaker was the Honorable Dennis Cardoza (D-CA), a former Member of Congress who recently retired, having represented the people of the 18th Congressional District for a decade. Congressman Cardoza spoke about why he had decided to seek political office, how his wife (a physician) had strengthened his support for medical professional liability (MPL) reform, and what it was like to be one of a handful of pro-tort reform Democrats in the U.S. House of Representatives. He also offered sage advice for medical liability reform advocates, urging them to find new ways to present the benefits of MPL reform, as a means of countering the anecdotes often recounted by the personal injury bar.
Focus on a Session
“Healthcare Reform: New Developments and Long-Term Implications”
Bruce A. Johnson, JD, Shareholder, Polsinelli, Shughart, PC, and Donn H. Herring, Partner, Lathrop & Gage LLP, gave a joint presentation on the consequences and emerging opportunities for MPL insurers, from the transition from volume-based to value-based reimbursement and the trend toward new models of care such as ACOs.

They described the emerging economic climate for healthcare practice, noting that hospital employment has increased greatly since the year 2000. At the same time, reimbursement will be provided for outcomes, not for services, based on how well hospitals and healthcare systems perform on measures like the CMS’ value-based payment model, which specifies a composite score for preventable hospital admissions for heart failure, COPD, diabetes, dehydration, urinary tract infections, bacterial pneumonia, and hospital readmissions.

For MPL insurers, these changes have meant a smaller customer base. But they can increase their market by building on a base of independent practice physicians, but partnering with them in new ways. Or, they can diversify their service mix and customer base. MPL insurers need to bear in mind the stresses and pressures that physicians are undergoing at this point. Providers are anxious about lower reimbursement, higher operating costs, and scarce capital. They are looking for security.

More specifically, MPL companies can work with physician practices in new ways: in reinsurance for ACOs, meeting the capital needs of physicians, assisting with EHRs, consulting for group formation and clinical integration, collaborating on captives, advising on data management and driving the quality agenda, and providing assistance with data systems and support.

Or, they can diversify their service mix and customer base. ACOs and physician-hospitals can become new customers. MPL insurers can in fact consider anything that is at the “intersection of capital, quality, risk management, and culture,” including standardization and process improvement, clinical practice standards and guidelines, insurance law as it applies to ACOs, patient handoffs, and the optimum role of physicians.

SAVE THE DATE!

2014 PIAA Medical Liability Conference • May 14-16 • Fairmont Royal York, Toronto, Canada

The 2014 Medical Liability Conference will be held in Toronto, Canada. At this conference, PIAA will continue to offer content that meets the needs of its ever-expanding membership. Make plans now to attend next year’s event!
Reflecting on the Conundrum of Healthcare

Laura P. Jacobs is Executive Vice President, The Camden Group. A featured luncheon speaker at the 2013 PIAA Medical Liability Conference, in Palm Desert, California, Ms. Jacobs has particular expertise in formulating strategies for physicians to succeed in group practice. Here are some of the insights she shared during a brief conversation with Inside Medical Liability.

On the benefits of joining an accountable care organization (ACO)—at this point:
The opportunity for physicians is this: if they can participate in an ACO that’s successful, they can make, in the case of Medicare, more than fee-for-service Medicare.

Physicians can enter the ACOs that are coming out today, from the Medicare Shared Savings Program, with no downside risk. They’re not going to take money away from you, if you blow through your budget. It’s not capitation.

On how to evaluate an ACO:
In considering whether to become part of an ACO, a provider should investigate several key factors. For instance, how robust is their information technology? And, what kinds of reports am I going to be getting? Do they have the ability to take the data that’s coming from the payer, whether it’s Medicare or Blue Cross or whoever, and give me input on how I’m doing? How am I doing in managing my patient population, how am I doing on all my quality metrics?

The other piece of that is, what else is the ACO going to do? Because if it’s just organized for Medicare, then the question I would ask is, do you have plans to do direct employer contracting? Do you have plans to directly contract with a commercial carrier? Because that’s where the growth is, that’s where the ongoing opportunity is.

On advocacy for physicians in today’s turbulent healthcare environment:
Doctors have not had good advocates who are progressive. They have had advocates who know how to say no—we don’t want that. But now we are starting to see some more cooperative reactions—yes, we get it, we know we need to change, and here’s an opportunity. You are starting to see that in some of the organized medical group associations, like MGMA and AMGA.

The problem you do have is that the solo practice is basically outnumbered.

On the pivotal role of PIAA, as advocate:
Yes, having PIAA serve as advocate on physicians’ behalf would be potentially advantageous, as these loosely knit networks of physicians come together into an ACO or an integrated network. They could use an organization that could speak for them.

I think the focus would have to be on making the migration of change smoother. It can’t be, “We can’t change.” That was the criticism of the old AMA.

On new roles that PIAA members can play:
When you think about all of the different things that physicians are doing that are new, that could potentially create more risk—for example, using nurse practitioners or using even an LPN in a new way: I may want them to go through my disease registry and help with the diabetes patients. Carriers may want to provide services to assist with these risks.

So to me, I think the carriers could help out by checking to see if there is staff training, and suggesting ways to use their staff in more efficient ways, and provide patient education tools.

They could offer both materials and training, especially in the area of finding new ways to provide information—via websites, or tools for tracking results in, say, blood pressure.

On assuming a leading role in addressing new risks.

On pathways for reinvention, for MPL carriers:
Companies have to help providers adjust to a whole new way of delivering care: are they using technology appropriately? How do you optimize the use of e-health and EHRs? How can you help doctors learn how to do it right?
Don’t Miss the PIAA Fall Workshops!

Information and strategies that will help you succeed in MPL!

**September 11–13, 2013**
Technology, Human Resources, and Finance Workshop

Hutton Hotel
Nashville, Tennessee

- **Featured speakers:**
  - Jenny R. Susser, PhD, Performance Coach, Human Performance Institute
  - Debra Magnuson, CPCC, Vice President of Talent Management, CPI Twin Cities

- **General session:** Strengths-Based Leadership

- **Other sessions include:**
  - Information Technology: SaaS Arrangements: Pitfalls, Perspectives, and Pointers
  - Finance: Economic Outlook
  - Human Resources: Variable Compensation—Getting It Right

**October 2–4, 2013**
Underwriting Workshop

The Ritz-Carlton
Charlotte, North Carolina

- **Featured speakers:**
  - Hal C. Lawrence, III, MD, FACOG, Executive Vice President, American Congress of Obstetrics & Gynecology
  - Grace E. Terrell, MD, MMM, FACP, FAAP, President/CFO, Cornerstone Health Care, PA

- **Other sessions include:**
  - Healthcare Through the Eyes of a Plaintiff’s Attorney
  - Emergency Medicine: Present and Emerging Risks

**November 6–8, 2013**
Claims/Risk Management Workshop

The Westin Seattle
Seattle, Washington

- **Featured speakers:**
  - Mark R. Chassin, MD, FACP, MIP, MPH, President and Chief Executive Officer, The Joint Commission
  - Daniel O’Connell, PhD, Consulting Psychologist

- **Other sessions include:**
  - Claims: Insuring Hospitals and Physicians—A Balancing Act
  - Risk Management: Passing the Baton—Reducing Medico-legal Risk in Handoffs

Visit the International Gateway to the South! Charlotte has the buzz of a major city, but it’s also sustained its tradition of southern hospitality.

To view the complete agendas for any of these workshops, or to register online, go to www.piaa.us.
CRICO has produced a new video that embodies a vision of the future: it shows how electronic medical records (EMRs) might be embedded into the physician workflow in a way that would improve healthcare delivery.

CRICO, a group of companies owned by and serving the Harvard medical community, provides medical professional liability (MPL) coverage, claims management, and patient safety resources to its members. The dramatization represented in this 10-minute film, “Better, Safer Care: Imagining a Medical Record of the Future,” is based on real MPL cases. Through combined analysis of how harm can come to patients from flawed encounters with providers using EMRs, and conversations with medical and technological visionaries across the country, the video integrates various scenarios into an idealized patient/physician encounter.

Hearing significant frustration from physicians about their experiences with EMRs, CRICO was inspired to envision a way in which these soon-to-be-required tools might be better integrated into the clinical workflow. This would allow the EMR to offer some relief to physicians and nurses who face seemingly insurmountable challenges in managing time and data.

Everyone who works in a clinical setting, or has ever been treated in one, probably has an opinion about EMRs.

CRICO was inspired to envision a way in which these soon-to-be-required tools might be better integrated into the clinical workflow. This would allow the EMR to offer some relief to physicians and nurses who face seemingly insurmountable challenges in managing time and data.

Everyone who works in a clinical setting, or has ever been treated in one, probably has an opinion about EMRs.

Everyone who works in a clinical setting, or has ever been treated in one, probably has an opinion about EMRs.

Harvard medical community, provides medical professional liability (MPL) coverage, claims management, and patient safety resources to its members. The dramatization represented in this 10-minute film, “Better, Safer Care: Imagining a Medical Record of the Future,” is based on real MPL cases. Through combined analysis of how harm can come to patients from flawed encounters with providers using EMRs, and conversations with medical and technological visionaries across the country, the video integrates various scenarios into an idealized patient/physician encounter.

Hearing significant frustration from physicians about their experiences with EMRs, CRICO was inspired to envision a way in which these soon-to-be-required tools might be better integrated into the clinical workflow. This would allow the EMR to offer some relief to physicians and nurses who face seemingly insurmountable challenges in managing time and data.

Everyone who works in a clinical setting, or has ever been treated in one, probably has an opinion about EMRs.

CRICO was inspired to envision a way in which these soon-to-be-required tools might be better integrated into the clinical workflow. This would allow the EMR to offer some relief to physicians and nurses who face seemingly insurmountable challenges in managing time and data.

Everyone who works in a clinical setting, or has ever been treated in one, probably has an opinion about EMRs.

Everyone who works in a clinical setting, or has ever been treated in one, probably has an opinion about EMRs.

In a recently released video, CRICO offers a vision of how EMRs of the future might improve healthcare safety for both patient and physician.

To get a better sense of the risks that the healthcare industry is facing in this area, CRICO conducted a pilot analysis of MPL claims in which the EMR was cited as a contributing factor to the error or adverse event. The claims analysis involving an EMR found that many involved a missed and delayed diagnosis by a primary care physician. The pilot identified 42 related cases,
There are myriad articles, videos, and social media posts in the healthcare industry about EMRs. Despite abundant discussion, there is no concerted effort to design the next generation of EMRs with the physician in mind. In addition to a need for standards across systems, the need for manual data entry with today’s EMRs adds to the burden of already time-pressed physicians.

This film was created as a collaborative effort between CRICO’s Luke Sato, MD, and David Ting, MD, associate medical director for information systems at Massachusetts General Physicians Organization, who acted as an expert resource for script development and video production. Ting said, “The actual purpose of the video is to ask whether we might intelligently prioritize today’s choices to move our institutions toward improved patient care and improve provider and practice work-life experience.”

“Better, Safer Care” presents a vision for a streamlined and integrated clinical experience, one where physician, patient, and EMR work as a team to provide a significantly automated, safer, and more efficient experience. CRICO’s depiction of a patient-physician encounter in the video is meant as a launching pad to begin the conversation about how new technologies might be better leveraged. Most of the technical solutions presented in this film are currently available. So why, for example, don’t all EMRs use voice recognition software to capture automated dictation of patient encounters?

Dr. Ting explains it this way: “We inundate our physicians with so much data and so much work and so many tasks and tell them that all of this is priority one and it all has to be handled now. That is a recipe for airplanes crashing out of the sky. From a risk perspective, it’s a huge risk, because the human brain can only do one thing at a time.”

The head-on approach to these issues has elicited emotional reactions from those who have seen the film, ranging from “cool, efficient, saves time, and improves outcomes” to “I don’t want voices interfering with my patient interactions.” Regardless of a positive or negative reaction, the film is, ultimately, catalyzing discussion and challenging the norm.

Through broad dissemination of “Better, Safer Care: Imagining a Medical Record of the Future,” we hope to prompt conversation and initiate action by healthcare leaders poised to implement change. Ideas abound. We know ours is not the only vision. We invite all who need to interact with EMRs to watch our film and share your reactions. The video is available for viewing on the CRICO website, www.rmf.harvard.edu/EMR, or through the CRICO Video channel on YouTube.
At National Document Services, the pursuit of flawless execution is a way of life.
That’s why we respond to every customer with energy and intelligence. And why we’ve invested in a proprietary, web-based document retrieval system.

Unlike others, we craft document management solutions tailored exclusively for medical professional liability insurance carriers and law firms. Whether it’s record retrieval, indexing and organizing, or secure online hosting, we have a solution that will meet your requirements.

NDS ensures peace of mind while saving you time and money.

For more information, visit our website at www.national-docs.com.

See what our tools, technology, and service can do for you!
With the benefit of hindsight, clinical errors that were not apparent at the time of the incident may seem obvious to an expert who reviews the case. In this article, Dr. Pierre Campbell, head of underwriting at the Medical Defence Union, debates the potential for unwitting bias in medico-legal reporting.

When doctors are the subject of litigation, the clinical sequence of events and their actions are typically assessed by medical experts who are acting on behalf of the court. In short, doctors are judged by their peers.

In England and Wales, this principle is well founded in case law, and the standard by which a doctor’s actions are judged is known as the Bolam test.

The Bolam test refers to an English tort law case dating back to 1957. The case established a number of important principles that doctors still apply today. The most important of these is that a doctor is deemed not negligent if he or she acts in accordance with a “responsible body of medical opinion.”

In practice, in England and Wales the medical practitioners who function as expert witnesses provide an opinion on the standard of care of other doctors. In contrast with other jurisdictions (where an expert may act on behalf of a particular party), the duty of an expert in England and Wales is unequivocal: it is to the court.

Experts in England and Wales are expected to be totally impartial. Part 35.3 of the Civil Procedure Rules states:

“(1) It is the duty of experts to help the court on matters within their expertise.
(2) This duty overrides any obligation to the person from whom experts have received instructions or by whom they are paid.”

Clearly, bias has no place in medico-legal reporting, but research seems to indicate that unconscious bias may sometimes tinge the expert’s opinion.

**Hindsight bias**

Hindsight bias (a term often used interchangeably with outcome bias) is a form of cognitive bias that affects us all. It is easy to assume that if an expert is being instructed, something wrong must have happened in the first place.

Dr. Hugh’s radiology experiment

The following experiment was conducted in Australia by a consultant surgeon, Dr. Thomas Hugh. Dr. Hugh obtained a copy of an x-ray that was the focus of an Australian clinical negligence
The radiologist was being sued for failing to diagnose an impacted fracture of the neck of the femur in a patient. The x-ray showed evidence of marked osteoarthritis of the hip joint. There was also a very faint line representing a fracture in the neck of the femur. This was incredibly difficult to discern. Dr. Hugh explained that the experts for the claimant had all commented that they could clearly see the fracture.

In his experiment, Dr. Hugh first showed the x-ray to a conference of radiologists. He added it to a series of x-rays that were also known to have abnormalities. When he did so, six out of 10 of the radiologists reported that they could see the fracture. The other four did not spot the injury. Dr. Hugh then sent the x-ray for standard reporting. Only two out of 10 radiologists who assessed the x-ray saw the fracture.

Dr. Hugh concluded that this was a case of hindsight bias. When the radiologists knew that there was something abnormal on the x-ray, they would look carefully, to see what had been missed, rather than reporting the x-ray in the standard manner, as they would have done on any other day.

Testing hindsight bias in court
In 2000, Berlin described a radiological clinical negligence claim in the U.S. illustrating how hindsight bias can play a role in the determination reached by the court.5

The case involved a 66-year-old man who had had a routine posteroanterior and lateral chest radiographs as part of a medical examination. The findings on the x-rays were reported by the radiologist as normal.

Three-and-a-half years later, the investigation was repeated.
Experience bias may come into play if there is a difference in the amount of experience between the reporting expert and the defendant—when a specialist comments on an intern’s management of a patient, for example—or when the expert comments on colleagues from a different specialty.

time, as that would make it possible for any reviewing radiologist expert to know exactly where to look on the original film. The defense stated that the abnormality on the original chest x-ray was so subtle that failing to identify it was not unreasonable.

This case eventually proceeded to a jury trial, and, ultimately, the jury was not convinced by the arguments put forward by the defense. On this occasion, the claimant was successful.

Other potential biases

There are several other forms of bias that may influence medical experts in their medico-legal work.

**Instruction bias.** This commonly occurs in adversarial legal systems in which unilateral expert instructions are commonplace. An expert could produce a report that is (or is seen to be) more favorable to the party instructing him. In the U.K., experts must bear in mind the guidance issued by the medical regulator, the General Medical Council, which states:

> ...you have a duty to the court and this overrides any obligation to the person who is instructing or paying you.

**Empathy bias.** This potential source of bias relates to the circumstances of a case. For example, in a case in which a young child has been severely disabled from an alleged delay in the diagnosis of meningitis, empathy for the patient may cause an expert to subconsciously produce a more favorable report. The MDU reminds experts that they are commenting on how well the physician managed the case at the time of the incident, rather than on the date of instruction.

**Experience bias.** Experience bias may come into play if there is a difference in the amount of experience between the reporting expert and the defendant—when a specialist comments on an intern’s management of a patient, for example—or when the expert comments on colleagues from a different specialty. The MDU always reminds experts not to stray beyond their sphere of expertise.

**Conflict of interest.** This may occur when an expert has prior knowledge of the case or the doctor involved. If at all possible, experts should not accept instructions if there is a personal or professional connection between the defendant and themselves. If unavoidable, conflicts of interest must be declared.

How can bias be mitigated?

MDU claims handlers and solicitors work to identify and guard against potential bias in medico-legal reporting. The MDU will check the medical credentials and experience of the experts it instructs on behalf of members, and asks experts to ensure that there is no conflict in accepting an instruction.

Hindsight bias in particular is difficult to mitigate; it is an unconscious mechanism that affects us all. It is easy to assume that if an expert is being instructed, something wrong must have happened in the first place. Experts may be challenged and asked whether their evidence, or the evidence of others, has been affected by hindsight or other forms of bias.

The MDU will continue to study the implications of hindsight bias on expert reporting and to explore related areas as well, for the benefit of its members.

References

1. Bolam v Friern Hospital Management Committee [Queen’s Bench Division (McNair J), February 20, 21, 22, 25, 26 1957] — all England law reports [1957] 2 All E.R.
International Conference
8-11 October 2014
Amsterdam, the Netherlands

Medical Liability:
The Good – Reducing Risk
The Bad – New Losses
The Ugly – The Unknown

Registration Now Open
www.piaa2014.com
Leonard D. Schaeffer, who spoke at the Keynote Session of the PIAA Medical Liability Conference, May 15-17, 2013, Palm Desert, California, is Founding Chairman and Past Chief Executive Officer, Wellpoint; and Judge Robert Maclay Widney Chair and Professor, University of Southern California. He is widely known as an eminent thought leader on healthcare and healthcare systems.

**IML:** Are you optimistic that the newer forms of healthcare systems will be any more adept at “bending the cost curve” than the structures we have seen in the past? The only factor that has proved potent in the past in that regard was the recent financial meltdown.

**Schaeffer:** As I mentioned in my talk, the healthcare system is changing, and there are new models of care delivery and payment that are being tested in the marketplace. And I think we should be hopeful that some of them will work. I think one of the problems, though, is that the ACA creates ACO and other structures that may result in increasing market power for physicians in hospitals. Traditionally—there is a lot of research about this—when you have increased market power, you have increased prices.

I’m not terribly optimistic that the slowdown that’s occurred is going to continue. Historically, healthcare costs have rebounded. Every time we’ve gone down, we’ve gone back up. If you want to talk about this, there are three new studies that have come out about it. I’m with the Kaiser study which says that 77% of the slowdown is from the economic situation. You know, when you expand benefits that dramatically, you’re going to expand utilization, and costs are going to go up.

I also think you’re going to see a greater enrollment in Medicaid. Now, that pays providers less on a per-unit-of-service basis, but there’s going to be a big increase in the number of services.

**IML:** So overall, gross numbers will go up, no matter how you slice and dice it?

**Schaeffer:** Oh, yes. I think it is safe to say that healthcare costs will continue to increase, as a percent of the GDP. The question is, at what rate?

The problem is, healthcare costs drive the federal deficit. There is nothing wrong with deficits, every once in a while. But we have a huge accumulated debt. Every deficit adds to the debt. The debt becomes both an economic challenge and a national security challenge.

And that’s what’s going to turn things around. At some point, there will be an unholy alliance between the national security guys and the deficit hawks. And we’ll see, I think, arbitrary cuts in healthcare. That’s down the road a bit.

**IML:** What role are the new health insurance exchanges playing?

**Schaeffer:** The United States is one of the few countries on earth that has left the healthcare delivery system in the market economy. Every other developed...
country in the world has taken it out, and made it some kind of government, or heavily regulated, part of the economy.

It’s in the market economy in the United States, and we like to believe that patients can be good consumers. That isn’t usually true, for several reasons.

First, if you’re insured, it’s not your money. So there is a sense—both on the provider side and on the patient side—it’s not your money, it’s the insurance company’s money, so we might as well do whatever the incremental thing is.

I don’t think this is theft or fraud. But the notion that healthcare is in the market economy just doesn’t work.

Equally important, from an economist’s point of view, we don’t know the prices—and it’s very difficult to find them—but more importantly, we don’t know what we need. If you go to buy a car, you have a pretty good idea about what you want. You go to see the doctor, and he tells you you’re going to need this intervention, or that test, what are you going to say—“no?”

So even if you had transparency—which we don’t—you don’t really have empowered consumers in healthcare. So these notions are not terribly helpful.

**IML:** Will we ever see a resurgence of HMOs?

**Schaeffer:** Oddly enough, many sophisticated physicians and organized delivery systems are now advocates of capitation. It’s really interesting; it’s the doctors who are interested. Because in those delivery systems, they have figured out ways of managing patients and managing care, and they do very well in a capitated environment.

**IML:** That’s a shift, though, isn’t it?

**Schaeffer:** Oh, yes. I’m not saying that it’s all doctors. I’m just saying that the physicians I know who are managing large delivery systems prefer capitation, because they have a fixed amount of money; they can move it around for different things, and they can help their physician colleagues in managing their delivery systems.

What they worry about, as I mentioned before, are arbitrary cuts in reimbursement levels. Sequestration is a good example—a 2% cut, across the board. Politically, that’s popular; your benefits aren’t going to change. That means I get re-elected. But your reimbursement is going to be cut 2%. Everybody is going to be cut 2%, so it’s considered “fair.” That doesn’t change the delivery system. It doesn’t increase quality or lower costs. And if you can do it this year, you can do it next year, and next year after that.

That would be my fear for the healthcare system—in order to avoid economic and national security problems, we’ll get this every year: cuts in reimbursement levels. That’s different from saying we’re going to improve the healthcare delivery system.

**IML:** Is there in fact a magic answer—if we could just make it happen?
Schoeffer: No, this stuff is real hard. There are three things that every healthcare system is trying to maximize: high quality of care, availability to all people, and affordable cost. Nobody’s got all three. And we’ve barely got one.

IML: In an interview you did several years ago, in 2006, you noted that a substantial percent of care is not evidence-based. Has there been any improvement?

Schoeffer: One would hope that there has been improvement. But I was referring to a RAND study, a very good one, peer reviewed, and it said that 45% of the time, if you’re an adult, you don’t get evidence-based care for the 12 most common diagnoses. And it’s worse for kids—55% of the time, they don’t get evidence-based care.

One would hope it’s improved. But to my knowledge, there haven’t been any follow-up studies.

IML: Is the change in the dynamic of the way healthcare is delivered, to increasing use of nurse practitioners and other allied health professionals, going to alter the healthcare system as we now know it? This is a big issue for PIAA companies, in terms of the focus of their market share. But there is also a patient safety angle here, too.

Schoeffer: Yes. It’s a huge liability issue. Speaking personally, let me tell you what I know about California. There, a licensed physician assistant, which is a three-year course of study after a bachelor’s degree, one year of which is an internship, can do anything a physician can do—provided they are supervised by an M.D. What does “supervision” mean? In the law, supervision means that a doctor reviews 10% of the charts. That’s it.

Now, if you think about other parts of our economy, the most highly trained, highly paid person is up the chain of command and supervises less highly trained, less highly paid people.

In healthcare, it’s the reverse. The doctor is at the bottom of the chain, in a hierarchical sense, and what these nurse practitioners and physician assistants are about is making healthcare work more like the rest of the economy. The problem is, the physicians aren’t trained to do the management and the supervision.

Doctors prefer to do what they were educated to do. Also, until very recently, that would be a very labor-intensive process, with all the charts and other documents. Now, though, with electronic medical records, you could conceive of ways that physicians could be trained—and be very good at—supervising not just one, but seven or eight staff, even large teams.

I was at dinner last night with some doctors who said that the proliferation of allied health professionals is bad for care. But I said, How much of what you do, doctor, could be done by someone who’s not an M.D.—what percent? Some said 80%. So I said, Think how that would free you up to do other things.

So I think it is a good idea in that it works in other parts of the economy. The question is, can physicians be trained and be...
comfortable in managing other people, as opposed to doing 100% of the patient-related work, and all of the other stuff too.

**IML:** Do you think that the policymakers understand this? In my state [Maryland], they just passed legislation that lets allied professionals work without any supervision. It must be a result of lobbying pressure.

**Schaeffer:** Yes, you have to understand this. The politics of healthcare have very little to do with healthcare. Most of the discussion about healthcare is really about three things. First, there is the role of government. "Single payer is terrible!" "Single payer is the answer!" That difference is not about healthcare.

Second, it's about economics and cost. Hospitals are extremely powerful in healthcare politics, but not because they are hospitals. It has nothing to do what happens in them. They're powerful because of jobs, and community pride. Nobody wants to close the local hospital.

So that is what the politicians are thinking about—jobs and community pride.

The third set of things—and this is most complicated—are all kinds of moral, and ethical, and religious issues. We can't start the conversation about healthcare without talking about issues like abortion, even though that doesn't come up all that often in actual practice.

**IML:** Is there a good bit of synergy between PIAA companies and the health insurers? Our members have so much data on patient outcomes that could be useful to them.

**Schaeffer:** In theory, in healthcare, you wouldn't pay for process, you'd pay for outcomes. Most insurance companies are interested in finding ways to do that. The difficulty is that most of them don't have the kind of data PIAA has. And everybody is worried about litigation—so they are worried about privacy issues, about doctors saying they are being manipulated. And there aren't the kind of clear-cut standards you would like.

What I'd hope is that you could work with insurance companies, and with academic institutions, to define just how you measure outcomes—and then help to define its value. The problem we always have with outcomes is, "My patients are sicker than your patients, and that's why my outcomes aren't as good."

So there is a commonality of interest. The problem is, this is not an easy problem. This is really complicated stuff. Our medical system was created to treat acute conditions, to find a treatment and a cure. But now, it's about chronic conditions—not about cures, not about complete episodes of care. It's about how to keep someone going over a long period of time when most Americans will fall prey to an almost predictable series of chronic conditions. The first one will be managed, so you can live long enough to get the third one, and then the one after that. Our health system just isn't set up to deal with that.

---

**Johnson Lambert**

Nation's Largest Insurance-Focused CPA Firm

Johnson Lambert's specialized practice and vast expertise in your industry translates to a more efficient service to you. With our industry-specific knowledge, we offer customized solutions to address your business needs.

- Financial Statement Audits
- Internal Control Reviews
- Tax Compliance & Consultation
- Regulatory Services
- Business Advisory Services
- SOC 1, 2, and 3 Reports
- Enterprise Risk Management

www.johnsonlambert.com
The yields on bonds remain at or near all-time lows. Many market participants expected bond yields to move considerably higher as the economy slowly recovered after the financial crisis. Fears of inflation were also widespread, as some expected that the Federal Reserve’s unprecedented actions would lead to higher bond yields as a result of price inflation.

More than half a decade has now passed since the collapse of Bear Stearns, which, in the spring of 2008, heralded the approach of the global financial crisis, and yields have not reacted as most expected. In response to the low level of yields on fixed income investments, investors are considering alternative assets, in an attempt to generate sufficient investment income from their portfolios.

In their search for return, many insurers are purchasing riskier assets or letting their current risky assets increase, letting market returns accumulate without rebalancing their portfolios. An analysis of PIAA member companies’ portfolios at the end of 2012 (Figure 1) shows that MPL insurer allocations to common stock are nearly twice as high as they were four years ago. This shift in asset allocation increases the volatility of their investment portfolios, and has the potential to result in greater losses, if the equity market declines from its recent all-time highs.

Risks in the fixed-income portion of the portfolio are increasing as well, as companies take on greater credit risks in their search for yield. The allocation to bonds carrying BBB ratings (the lowest investment grade bond rating) has increased by nearly 50% in just the past two years.1

Some observers are encouraging companies to invest in assets outside of the more traditional markets; these include emerging-market debt, high-yield bank loans, and collateralized debt obligations. The resurgence of interest in some of these products echoes some of the decisions made in 2006 and 2007, when many investors sought to increase returns by significantly increasing the credit and structural risks in their portfolios. Taking on these additional credit risks didn’t work out so well for investors in the past, when they saw the value of these assets plummet in the latter half of 2008.

Risky assets have produced attractive returns over the past several years, as the U.S. economy has slowly recovered, and asset prices have rebounded strongly from their dislocated values of 2008 and 2009. It is important to be aware, however, of the risks that lie ahead, and investment returns are not likely to repeat the robust performance of the past four years.

In this situation, it makes sense for insurers to invest a portion of their portfolios in assets that can offer incremental return above that of traditional fixed income securities, but that do so in a manner that attempts to reduce rather than increase risk. An attractive investment opportunity for those who want to pursue this strategy is fixed income private placement securities (“privates”). Here, we describe the market for private placements in some detail, and explain how insurance companies can benefit from a minor allocation of their portfolio to this market.

What are private placements?
Private placements are negotiated sales in which securities are sold directly to investors, rather than through broker dealers via a public offering. They are exempt from registration with the Securities and Exchange Commission (SEC), under Regulation D of the Securities Act of 1933. These securities are open to larger investment institutions that meet the standards that allow their purchase under this SEC exemption. Privately placed debt encompasses a wide variety of fixed income structures; these include secured and unsecured corporate obligations, lease-related financing for real property (real estate investment trusts and pass-through obligations), lease-related financing on other property and equipment (rail cars, aircraft, machinery, and inventory),

Scott Sell is Vice President and Jason Gingerich, CFA, FSA, MAAA, is Senior Investment Strategist, Prime Advisors, Inc.
A main catalyst of the recent economic crisis was the collapse of private placements remained relatively healthy, compared with even the safe world of municipal bonds has had its issues, such as the sovereign debt crisis in Europe has damaged both the price of liquidity to capture yield and structural protections.

Typically, it is advantageous to use a buy-and-hold strategy for private placements, forfeiting some degree of liquidity in the secondary market. Typically, it is advantageous to use a buy-and-hold strategy for private placements, forfeiting some degree of liquidity to capture yield and structural protections.

Why private placements?

This asset class offers financial covenant protection, which is a promise by a borrower (or guarantor) relating to the business or condition of the borrower. Covenants minimize the risk that the loan will not be repaid, by assuring the continued creditworthiness of the borrower. Private placements have higher recovery values under distressed conditions. Because private placements are less liquid, the sellers offer excess spread, as compared with public debt securities.

Some of the top institutions in the U.S. are active purchasers of traditional private placements. Berkshire Hathaway, Pacific Life, and GE all have concentrations in traditional private placements. Major insurance companies such as Met, Prudential, NY Life, Northwestern, Allstate, Nationwide, State Farm, Travelers, and The Hartford are industry-leading private buyers. More recently, those who oversee state and institutional pension funds, and other money managers, have become involved in this asset class.

Authorities in several areas hold favorable opinions of them. The U.S. Society of Actuaries, the American Council of Life Insurers, Moody’s, and Fitch have studied the asset class over long periods of time and have concluded that privates have less downside risk than similar corporate bonds.

During the 2008/2009 liquidity crisis and economic downturn, liquidity in the private placement market was affected less than it was in the public market. The volume decline in the private market resulted, to a considerable extent, because the large public insurance companies needed to rebuild capital, and thus declined to participate at the same level as before the crisis, and corporate borrowers did not want to issue placements in the wider-spread environment. During 2009, three new secondary trading firms were created, and the secondary traders who had been at Lehman moved to Barclays, thereby improving the liquidity of the secondary market.

Comparison to other asset classes

Each asset class has its roster of safest investments—and its riskier choices. Here are some examples of recent problems in other asset classes that were largely avoided by the traditional private placement market.

- A main catalyst of the recent economic crisis was the collapse of sub-prime residential mortgages and structure products. Our firm does not participate in structured product private placements and, generally, private placements have limited involvement in structured products.
- Corporate bonds have been linked with liquidity issues in the financial sector. There were problems involving government agencies, failing banks/investment banks, and insurance companies that needed to raise capital because the value of their assets had declined. In the past, corporate bonds have been hit by highly visible fraud problems; names such as Enron and WorldCom come to mind. Recent equity-friendly actions and mergers have hurt the ratings on this asset class. Financial sector private placements are generally less than 5% of annual offerings and have not been associated with recent bankruptcy and fraud problems.
- The sovereign debt crisis in Europe has damaged both the price and the ratings of foreign government bonds. Private placements are not part of the sovereign market.
- Even the safe world of municipal bonds has had its issues, such as budget constraints, overspending on projects, poor investment choices, etc. These problems became more pronounced as a result of the decline in the credit quality of the monoline companies that insured these bonds. We avoid deals that are dependent on the strength of “monoline insurance wraps.” Privates have a very limited role in municipal financing.
- Private placements remained relatively healthy, compared with other asset classes, during the most recent down economic cycle. If operational problems arise, the possible violations of covenants will prompt the company to meet with its lenders early on, so a solution can be found. Private placements also became a more common funding source when bank liquidity dried up.
Key characteristics
There are three important considerations in underwriting a private placement bond.

1. Credit quality. The issuing company is analyzed and approved based on financial and market analysis, industry comparisons, and a review of its management. Those who purchase privates have greater access to management via pre-purchase call/question sessions and a due diligence meeting that is held afterward. Private placement lenders may also get confidential information on (for example) financial projections, market share, and marginal costs on a divisional or product-line basis, and they are provided with details on planned acquisitions. These items are crucial for reviewing a company’s financial health.

2. Structure. Deals will have a comprehensive protection package with tests on income, leverage, cash flow, change of control, etc.; they may also offer collateral protection. Outside counsel is hired to represent the lenders. Discussions of “worst” case scenarios are done, to help demonstrate the value of these instruments in tough times. Covenant protections explain why private placements have lower default rates and higher recoveries. Counsel also prepares and files the necessary documents to protect the lenders’ rights.

3. Price. Does the deal offer value? Illiquidity is mentioned as the principal negative point for this asset class. It is true that the total market size is smaller than the public market (new issuance totals roughly $25 billion to $58 billion each year) and fewer institutions purchase privates than purchase publicly traded corporate bonds. These factors tend to cause the bid/ask spreads to be wider than they are for other investment opportunities; however, there is a small but active secondary market for them. Helping to bolster this market is the supply/demand dynamic, since demand is greater than supply. In every asset class, distressed securities may require price concessions to sell, and privates are no different.

Caveat
Bear in mind that it may take relatively longer for settlement of a private placement, due to the complexity of the documentation required. Typically, settlement happens several weeks after the closing of the deal. Some issuers may request a settlement of one to three months after closing, to coincide with their planning for the use of the funds received. Also, price discovery is less transparent with privates, because the secondary market is smaller. It also costs more to administer and underwrite private placement deals.

In light of the intricacies of the private placement market, it is essential to hire an experienced investment team, with a disciplined underwriting and monitoring process, if you plan to invest in them.

References
2. Source: Bank of America.
Over the past seven years, reserve releases from previous years’ policy writings have been a mainstay of the medical professional liability (MPL) market, contributing to insurer’s profits in the early years and, more recently, buoying results. But they’ve also been the engine of competition, undercutting price levels at a time when insurers have seen their client base shrink. The apparent convergence of these two forces—a runoff of reserves and consolidation within the healthcare industry—raises the question: Could their intersection cause the market to harden, quite suddenly?

Competition, spurred by a massive buildup in reserves, is nothing new to MPL insurers. But unlike other soft market cycles, the present competition is not the only reason for insurers’ pricing woes. Over the past 10 to 15 years, MPL insurers have seen their market shrink as physicians, faced with stagnating or declining revenues and rising costs, have sought employment with hospitals or large group practices. According to the American Hospital Association, the number of physicians employed by hospitals increased 32% from 2000 through 2010.

This trend has only accelerated in recent years with the prospect of implementation of the Patient Protection and Affordable Care Act (ACA), which, among its other provisions, gave new impetus to physicians to partner with hospitals or large groups that may be better able to manage the evolving risk-based compensation models of the new healthcare landscape. Hospitals or integrated delivery systems now employ more than half of the practicing physicians in the United States.1

As more and more physicians seek employment in hospitals or large group practices that often rely on self-insurance or other alternative risk management mechanisms for MPL protection, primary MPL insurers have been forced to compete for business in a shrinking market.

The impact of consolidation within the healthcare market may already be reflected to some degree in the unprecedented decline in earned premium, which has fallen nearly 15%, to well below $9 billion over the past six years (Figure 1). And while it is difficult to conclude with absolute certainty that consolidation has contributed to the decline, this type of premium shortfall hasn’t happened in more than 30 years, a period that included two soft markets.

What may be an even more direct consequence of consolidation in the healthcare market and competition within the industry is the upswing in merger and acquisition activity among insurers.

A time of reckoning?

Some insurers have been able to shrug off the competition of the past few years, largely because of the trove of reserves amassed during the hard market.

Since then, insurers have released some $14 billion in reserves on policies written during the first half of the 2000s, when prices jumped in steep increments and claims frequency fell at an unprecedented rate. The combined impact of fewer claims and higher prices made it possible for insurers to build up massive loss reserves on these policies, which have bolstered results for the past seven years.

As more and more physicians seek employment in hospitals or large group practices that often rely on self-insurance or other alternative risk management mechanisms for MPL protection, primary MPL insurers have been forced to compete for business in a shrinking market.

The impact of consolidation within the healthcare market may already be reflected to some degree in the unprecedented decline in earned premium, which has fallen nearly 15%, to well below $9 billion over the past six years (Figure 1). And while it is difficult to conclude with absolute certainty that consolidation has contributed to the decline, this type of premium shortfall hasn’t happened in more than 30 years, a period that included two soft markets.

What may be an even more direct consequence of consolidation in the healthcare market and competition within the industry is the upswing in merger and acquisition activity among insurers.

A time of reckoning?

Some insurers have been able to shrug off the competition of the past few years, largely because of the trove of reserves amassed during the hard market.

Since then, insurers have released some $14 billion in reserves on policies written during the first half of the 2000s, when prices jumped in steep increments and claims frequency fell at an unprecedented rate. The combined impact of fewer claims and higher prices made it possible for insurers to build up massive loss reserves on these policies, which have bolstered results for the past seven years.

A time of reckoning, however, may be ahead. Last year, insurers posted a combined ratio of 90% on a calendar-year basis, 5 percentage points worse than the 2011 result, but still well below insurers’ break-even point of 100%. The concern is that, much like the previous six years, a considerable part of insurers’ 2012 profitability has come not from their current-year operations but rather from policies written during the hard market.

Without the $1.8 billion in reserves released last year, for example, insurers’ combined ratio for their current 2012-year policies, or what actuaries call policy-year results, would have been 115%. This type of disparity between calendar-year and policy-year results has been more or less the case for the past six years, during which reserve releases have accounted for between 20 and 25 percentage points of the insurers’ combined ratio (Figure 2).

Reserve releases were hardly a concern in the earlier years, when the policy-year combined ratio hovered at slightly more than 100%, and...
investment income could offset most, if not all, of insurers’ pricing shortfalls. But in recent years, the policy-year combined ratio has climbed to the mid- to high teens—a level that puts profitability, on a policy-year basis, beyond the reach of insurers’ investment income.

At around 20% of earned premium, reserve releases are only modestly less than the previous year’s levels, which might mistakenly lead some to conclude that insurers still have a wellspring of reserves (Figure 3). But insurers are now in their eighth year of reserve releases, and they have likely exhausted the majority of their stockpiles. Without the reserve cushion provided by policies written during the hard market, insurers will need to depend much more heavily on the performance of underpriced policies written in recent years. How unsustainable the pricing on these policies turns out to be will determine whether future prices will explode—or rise rationally.

The big question for some insurers is not so much when the market will start to firm—though that is an important issue—but rather, how rapidly the momentum in price increases will build. This is because some smaller MPL insurers with relatively modest capital resources may reach a point where they need to increase prices sooner and more rapidly than their larger competitors, many of which still have massive capital reserves, despite the competition of the past years. If larger insurers were to move slowly on raising prices, smaller insurers could be forced to accept prices that generate less than sufficient revenue. This situation could bring about further consolidation within the MPL industry.

How quickly the market will turn, however, will likely be up for grabs, especially if frequency were to jump sharply. And while a sudden increase would be an anomaly, based on historical experience, the possibility is plausible, in light of the steep decreases in frequency that began more than 10 years ago and have only been partially explained by past tort reform initiatives, healthcare providers’ increased attention to risk management, and the advent of “I’m sorry” laws, among other theories.

Despite these well-thought-out explanations, no definitive answer has surfaced. Without a clear understanding of the forces that caused a steep decrease in frequency, the reverse could happen just as easily.

Healthcare reform: challenge or opportunity?

The uncertainty surrounding future trends in claims is only compounded by enactment of the ACA. With its implementation, 14 million people are expected to gain access to healthcare services through insurance exchanges and expansion of Medicaid in 2014. This figure is expected to increase to 30 million in the coming decade.

Increased utilization is expected to shift the demand curve for services to higher medical-cost levels. As one of the main drivers of MPL claims costs, these higher medical costs could cause claims severity to balloon, at least in the short term. And with increased use of the healthcare system, claims frequency could also rise, all things being equal. But all things are not equal.

ACA’s focus on coordinated, integrated care could improve efficiency and quality of care and thereby reduce medical errors. But should this come to pass, it is unclear whether the reduction in medical errors would come in the form of fewer incidental medical errors, which might lower claims frequency, or fewer catastrophic errors, which might reduce claims severity, or both.

The focus of accountable care organizations (ACOs) on cost control might also lead to a reduction of noncritical procedures, including fewer diagnostic tests. They may yield savings on the side of cost of care, but these reductions could result in more claims related to failure to diagnose.

The management structure of an ACO could precipitate a shift in the composition of claims costs. For example, hospital-dominated ACOs might seek to settle claims early rather than endure a long costly defense. Coordinated defense strategies among defendants might also be more easily achieved in an ACO environment, which could reduce the indemnity portion of liability claims.

The countless twists and turns that the trajectory of insurers’ claims could take is indeed a daunting puzzle, but it is not a challenge...
insurers should shirk.

Now, more than ever, attention to the movement of current pricing and calendar- and policy-year results can help insurers unravel the complexities of the healthcare market and navigate the impending changes. This assessment is certainly critical in understanding current market pressures, which continue to indicate that pricing levels are inadequate.

References
SELF-DIAGNOSIS IN THE TWENTY-FIRST CENTURY

By Eric R. Anderson

When it comes to healthcare in the twenty-first century, thanks to advances in technology, patients have access to an unprecedented amount of information. But is this really a good thing for patient safety? Moreover, what does expanded access to information mean for healthcare providers; does it in fact increase potential liability?

Irrespective of healthcare providers’ opinions about self-diagnosis, the reality is that patients are increasingly acting as their own diagnostician when they think they have a health issue, merely by consulting the Internet.

Consider in this regard some recent survey results that reveal the patient’s perspective on this issue. When queried by Royal Philips Electronics, U.S. consumers expressed confidence that Web-enabled mHealth and mobile apps are a crucial element in healthcare and a key resource for a long and healthy life. For example, one in 10 Americans polled in the survey stated that, were it not for Web-based health information, “…they might already be dead or severely incapacitated.” In addition, one-quarter of those surveyed said they rely on “symptom-checker” websites or home-based diagnosis technology as much as on visits to the doctor. Forty-one percent said they were “comfortable” using websites to check on their health symptoms.

Learning about public opinion on symptom-checkers may have sounded a warning for healthcare providers. So some have found ways to make this technology a useful part of a treatment regimen. These providers are directing their patients to state-of-the-art symptom-checkers that make it easy for them to research their condition, find reliable information about a potential diagnosis, and even connect directly to online medical advice.

Eric R. Anderson is Director of Public Relations and Marketing at PIAA; eanderson@piaa.us.

Still, some thorny medical liability issues may be lurking in all this. For example, a symptom-checker built into a doctor’s website or electronic medical record software might mislead him, resulting in a misdiagnosis. In the medical professional liability arena, we are all too familiar with the potential ramifications of this sort of situation.

In regard to patient safety, this trend could be dangerous for patients if they don’t follow up and get medical advice for a problem, after they’ve mistakenly concluded that they really don’t need to talk with a healthcare provider.

Of course, there are economic ramifications as well. Would a patient spend less on healthcare because he uses a symptom-checker? Conversely—and far more likely—might symptom-checkers lead to more, and more costly, testing as a result of patient demands?

What about the benefits of symptom-checkers? As healthcare providers incorporate these tools into their practices, they are in this way encouraging patients to use them prior to office visits, to save time and make consultations more productive. This might improve a doctor-patient relationship, with both parties more engaged in the processes of care. In addition, the information provided by a symptom-checker could help a healthcare provider identify a new condition or come up with a diagnosis he hadn’t previously considered.

For many years now, PIAA members have been at the forefront of the patient safety movement, exploring possible new risk management strategies for ensuring the best outcomes for the patients their policyholders care for. As the adoption of symptom-checkers by patients and healthcare providers expands, we have another opportunity to gather the requisite data needed to get out ahead of the curve—to discover the inherent problems with symptom-checkers, and devise practicable solutions for dealing with them.
MEDICAL PROFESSIONAL LIABILITY REINSURANCE

PROTECTING YOU,
PROTECTING HEALTHCARE

Leading the industry by keeping our clients in front

To find out more please contact:

Email: healthcarepractice@willisre.com, Tel: 952-841-6614

www.willisre.com
Looking for education on MPLI for your staff? Look no further!

Introduction to Medical Professional Liability Insurance Workshop

October 1-2, 2013
The Ritz-Carlton
Charlotte, North Carolina

Your staffers will learn the essentials—what every team member needs to know—about the medical professional liability enterprise. The presentations will cover the diverse departments, and types of work, that make up a successful MPL company.

**Introduction to MPLI is designed for:**
- PIAA company employees in the first years of their insurance careers
- Longer-term professionals who have not yet worked with the full range of insurance processes
- Physicians or other directors new to the insurer governance processes
- PIAA affiliate member employees who want to learn more about the companies they service

**Program topics include:**
- Claims administration
- Underwriting
- Risk management and patient safety
- Rate-making and reserves
- Understanding reinsurance

To see the complete agenda, or to download a registration form, visit our website at www.piaa.us.