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Celebrating 25 Years of Success Through Client Satisfaction!
After all of the ink and rhetoric that has been expended about the potential impact of the Affordable Care Act (ACA), major provisions of it will finally become effective on January 1, 2014. We will have a front-row seat to see how it will impact the U.S. healthcare system, possibly driving new and unanticipated changes. We do know that there will be a sustained focus on reducing costs, while at the same time an amplification of care quality. Lower costs will theoretically lead to greater access to care for more of the U.S. population. While a laudable goal, there are concerns about its impact on patient safety—a core tenet of PIAA throughout its history. Our members have always been at the vanguard of the patient safety and risk management movements, consistently innovative in developing best practices for safer care, and finding new ways to disseminate these practices to healthcare providers. It would be unfortunate if an unintended consequence of the ACA is a heightened concern about liability and, subsequently, an increase in the cost of healthcare from an expanded scope of liability applicable to physicians, nurses, hospitals, and other healthcare providers.

While we are keeping a watchful eye as the ACA story unfolds, we are also closely monitoring the state-level issues crucial to the health of the MPL sector. In California, one gold standard for effective tort reform, MICRA, is currently under siege. Oklahoma recently passed 23 tort reform bills, effectively overturning a state supreme court decision which struck down earlier reforms on a legislative technicality. PIAA endeavors to support local efforts to promote and sustain an equitable MPL environment throughout the United States.

PIAA also closely monitors the activities of state insurance regulators and the National Association of Insurance Commissioners. The NAIC’s “Own Risk and Solvency Assessment” or ORSA gets much of the current attention and headlines, but there is considerably more happening within state insurance departments and the NAIC that may impact PIAA members. We have been very engaged with the new NAIC Medical Professional Liability Working Group, which will study and report on the impact of the ACA “with particular attention to potential increases in such exposures as a result of provisions in the ACA that discourage the practice of defensive medicine.” This may result in new directives or public policy at the state level, and that is of great interest to PIAA and our members.

We scan the landscape for new protocols and controls, such as state regulations that are intended to apply to just one segment of the community. Many of these may seem harmless on the surface, but could prove capable of inflicting real damage to the MPL industry.

This issue of Inside Medical Liability reflects the range of activities conducted on your behalf by PIAA. For example, you will find an article by Bruce Fell and Stuart Hayes, “CFOs View NAIC’s New ORSA Regulation as a Strategic Tool.” In a survey of industry executives, the authors discovered that while the current requirement for the ORSA assessment pertains only to companies that write more than $500 million in gross written premium, a sizable number of smaller companies have recognized the benefits of ORSA for evaluating their capital and risk position.

The full scope of new risks associated with accountable care organizations is the subject of another feature article. Patient safety, in particular how PIAA companies can improve birth outcomes, is covered in a third feature. Finally, reflecting the diversity of PIAA members and their interests, there is an article about underwriting risks within an alternative risk transfer arrangement.

There is one other exciting development at PIAA that I want to share with you. The PIAA’s Data Sharing Project is on the cusp of incorporating data from hospitals and health systems. This will provide a more complete analysis of MPL costs and exposures, which will in turn help you in advancing patient safety and risk management.

I am proud to be part of such a vibrant and successful organization. I hope that you are, too. As always, I welcome your thoughts, questions, and suggestions.
Features
20  Cover Story: CFOs View NAIC’s New ORSA Regulation as a Strategic Tool
   By Bruce Fell and Stuart Hayes

24  Feature: How PIAA Member Companies Can Improve Birth Outcomes
   By Ruth Ryan

27  Feature: MPL Underwriting in Alternative Risk Transfers
   By Christina Kindstedt

30  Feature: The Transition to the ACO Model of Care: New Risks May Emerge
   Based on a report from Marsh & McLennan Companies

Up Front
1  Perspective
4  Events & Calendar
6  Observer
8  PIAA DSP Data Snapshot
   New Report: MPL Closed Claim Comparative

Departments
10  Marketing/Communications
   By Eric Morgenstern
14  Case and Comment
   Should Physicians Be Prepared to Appear in Opening Statements?
   By Kevin M. Smith
18  Legislative Update
35  International Perspective
   Openness in Action: Policy and Public Affairs at the Medical Protection Society
   By Gareth Gillespie
41  Insights on Accounting
   Insurance Contracts Exposure Draft Issued by the FASB
   By Dustin Partlow and Josh Partlow
45  The Asset Side
   Interest Rates and the Fed’s Playbook—Time for a Change?
   By Larry White
48  Last Word

“Sooner or later, though, it is likely that virtually all insurers, including small mono-line PIAA members, will be required to file an ORSA.”
—Cover story
MANAGING RISK ENSURES PROFITABLE GROWTH

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AMA President to Speak at 2014 Marketing Workshop

Ardis Hoven, MD, president of the American Medical Association, will be speaking at the 2014 Marketing Workshop in Chicago. Dr. Hoven, an internal medicine and infectious disease specialist in Lexington, Kentucky, became the 168th president of the American Medical Association in June 2013. Dr. Hoven has been a member of the AMA Board of Trustees since 2005.

As the leader of one of the largest organizations representing healthcare providers, Dr. Hoven will share her unique insights on the provision of healthcare in today’s landscape and the changing roles of physicians, allied healthcare providers, hospitals and facilities, and healthcare systems. She will discuss how she sees her constituents navigating through the new healthcare paradigm and identify some of the key demographic shifts that are occurring. She will also examine healthcare reform under the Affordable Care Act, how the ACA will impact healthcare delivery, today’s medical liability environment, and the role of PIAA members.

Dr. Hoven is a fellow of the American College of Physicians and the Infectious Disease Society of America. She has been the recipient of many awards, including the University of Kentucky College of Medicine Distinguished Alumnus Award and the Kentucky Medical Association Distinguished Service Award. In 2013, Dr. Hoven was named one of Modern Healthcare Magazine’s Top 25 Women in Healthcare.

April Dental Workshop to Feature Session on Strategic Leadership for Changing Times

Corporate dentistry may impact PIAA dental liability carriers as much as any other phenomenon over the next five years. The 2014 PIAA Dental Workshop in Chicago will examine corporate dentistry from a number of perspectives and help attendees understand the evolving environment as a result of the shift from solo dental practice to corporate dentistry.

Given the challenges that will likely arise as a result of these changes in the practice and delivery of dental and oral surgical care, PIAA companies will need to investigate, develop, and implement new strategies for the future. As former Director of Strategic Plans and Policy for the Joint Chiefs of Staff, Lt. General John F. Sattler understands change. He developed new strategy for the U.S. military, during a period of unprecedented change in the country’s basic approach to warfare. With more than 37 years of Marine Corps experience in leadership and strategic planning, Lt. General Sattler will speak to Dental Workshop attendees on the importance of communication and team buy-in during an era of new directions and planning. His session will focus on the optimal role of leaders in strategic planning during difficult times, and participants will understand the role they can play in successfully developing strategy in their own companies.

EVENTS & CALENDAR

COMING ATTRACTIONS

INSIDE MEDICAL LIABILITY 4 FOURTH QUARTER 2013

March 12–15, 2014
CEO/COO Meeting
Hyatt Regency at Gainey Ranch
Scottsdale, AZ

March 13–16, 2014
Board Governance Roundtable
Hyatt Regency at Gainey Ranch
Scottsdale, AZ

April 9–11, 2014
Marketing Workshop
The Peninsula
Chicago, IL

April 9–11, 2014
Dental Workshop
The Peninsula
Chicago, IL

May 14, 2014
Leadership Camp
Fairmont Royal York
Toronto, Canada

May 14–16, 2014
Medical Liability Conference
Fairmont Royal York, Toronto, Canada

September 10–12, 2014
THRF Workshop
Fairmont Olympic Hotel
Seattle, WA

September 30–October 1, 2014
Introduction to MPLI Workshop
Omni San Diego Hotel
San Diego, CA

October 1–3, 2014
Underwriting Workshop
Omni San Diego Hotel
San Diego, CA

October 16–17, 2014
Corporate Counsel Workshop
Fairmont Hotel Vancouver
Vancouver, Canada

November 5–7, 2014
Claims/Risk Management Workshop
Baltimore Marriott Waterfront Hotel
Baltimore, MD

Future Medical Liability Conference
May 13–15, 2015
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Las Vegas, NV
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OBSERVER

Dept. of Obfuscation:
NASA Toxicologist Pegs Adverse Event-Related Deaths at 440,000

The number was truly jaw-dropping. Picked up by newspapers, insurance e-newsletters, and on various websites on patient safety, it was hard to miss. Superseding by a factor of more than four the 1998 Institutes of Medicine estimate for deaths related to adverse events, 98,000, the new figure—440,000—left us puzzled. With so much evidence of enhancements in patient safety, and the corresponding drop in frequency of MPL claims, how could any valid calculation end up estimating adverse event-related deaths at a level that now puts it (noted prominently in headlines) as the third leading killer of Americans, right behind heart disease and cancer.

“Observer” decided to do a bit of investigating. What we found is that the new estimate in fact violates a good number of relatively standard requirements for scientific rigor.

First, the estimate is based on the work of just one researcher. John T. James is a toxicologist who works for NASA. (That fact alone was pretty intriguing, but we’d promised ourselves not to get distracted.) His study, “A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care,” appeared in the September 2013 issue of the Journal of Patient Safety.

Second, the methodology James selected seems arbitrary, even as described in his own article. He notes that his work is based on “4 limited studies,” which relied on the Institute for Healthcare Improvement’s Global Trigger Tool to zero in on evidence in medical records “which point to an adverse event that may have harmed a patient.” The choice of words here, as in “which point to” and “may indicate,” is clearly suggestive of “fudge factors” at work.

Now, dubious application of statistics: “Using a weighted average for the 4 studies, a lower limit of 210,000 deaths per year was associated with preventable harm in patients.”

And finally, a Great Leap Forward—to more than 400,000 deaths, annually. This step, a doubling of the previous result, was in turn purportedly based on the “limitations in the search capability of the Global Trigger Tool and the incompleteness of medical records on which the Tool depends.”

James admits that his personal experience was also a factor. He says, “Medical errors in the care of members of my family were common.” And there is even a degree of “secret sources” stuff: “Private conversations I had with highly-placed [?] physicians suggested that medical errors were far more common than the public recognized…” (from a posting by James on the Safe Patient Project website).

Corroboration, of a sort

The website www.opposingviews.com picked up the big number with nary a quibble about its reliability. The site has a tagline, “News. Views. Controversy.”—but there is no “about us” section, so it is difficult to tell what sort of preconceptions might be at work. However, there is an italic-type editorial comment, “In a sense, it does not matter whether the deaths of 100,000, 200,000 or 400,000 Americans each year are associated with patient safety events in hospitals. Any of the estimates demands assertive action of the part of providers, legislators, and people who will one day become patients.” Taking back its own assertion on the irrelevance of specific numbers several lines later, the text continues, “One must hope that the present, evidence-based estimate of 400,000+ deaths per year will foster an outcry…”

The investigative journalism website propublica.org also backed up James’s work, in this way: “ProPublica asked three prominent patient safety researchers to review James’ study, and all said his methods and findings were credible.” None of these researchers, or their affiliations, is named.

Asked about estimates like James’s, the American Hospital Association told Inside Medical Liability:

Keeping patients safe is a top priority for America’s hospitals. One adverse preventable event is one too many. For that reason, hospitals are focused on identifying specific causes of such events and rigorously implementing steps to prevent them in the future. While a national aggregate count of preventable adverse events may be helpful in prioritizing resources, there is not yet consensus that the tool upon which this study’s estimate is based on can be generalized to yield nationally representative results. The study does not adjust for hospital characteristics like service and patient mix. Moreover, the study cites a wide range of preventability of adverse events which underscores the need for further study. These methodological flaws undermine the credibility of the estimate.”

Is there a lesson here? Well, Observer notes that it is probably wise to keep a weather eye out for these sorts of potentially incendiary estimates. And then, to respond quickly and clearly when they do pop up.

Source: Journal of Patient Safety, September 2013
Sinai Hospital of Baltimore launched an inventive incentive program that quickly ran into trouble, because of patient safety concerns. The idea was to prompt nursing units to discharge 20% of their patients by noon. Each nurse on the unit who had racked up the highest number of early discharges would receive a $10 gift card.

Hospital officials were quick to respond that the goals of the program were taken out of context. They pointed out that while it is in fact doctors who decide if patients are ready for discharge, delays can occur because prescriptions or medical equipment hasn’t arrived. Other times, nurses can get backed up and prioritize sicker patients over those who are ready to leave.

Sinai Vice President of Marketing Debbie Hollenstein said that the new program is meant “to provide some sort of incentive for that to happen.” But hospital management’s position was compromised by what was sent out via one Sinai nurse, via Twitter. She tweeted a photo of a manager’s manual citing the program’s goals and rewards, with the message, “I kid you not,” adding in Twitter-ian lingo, “I’m sorry very sick patient not ready to go home, but I want a $10 gift card.” The hospital has noted that the nurse is still employed there.

Source: Baltimore Sun, August 30, 2013

In the course of a murder trial, the medical examiner Dr. Adele Lewis testified that the victim had been shot twice, once in the chest and once in the back of the head. Dr. Lewis stated that the victim could have survived the chest wound with proper medical attention, but not the head wound.

Shortly after the trial court had instructed the jury to begin their deliberation, after the medical expert witness testimony on the previous day, the trial judge got an e-mail from Dr. Lewis, saying that one of the jurors happened to know her and had sent her a Facebook message congratulating her on doing a “great job” during her testimony.

The trial court took no action, except informing the attorneys in the case about it. Insufficient, said the state supreme court. It sent the case back for an evidentiary hearing on the juror-expert witness communication. And now, for your edification, here it is.

Source: Eyewitness Guru, September 2013

Discharge Patients by Noon
Get a $10 gift card

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Source: Baltimore Sun, August 30, 2013

The Facebook message that overturned a conviction

I can’t send you actual copies of the emails since Facebook is blocked from my computer here at work, but here is a transcript:

Scott Mitchell: “A-adele! I thought you did a great job today on the witness stand … I was in the jury … not sure if you recognized me or not!! You really explained things so great!!”

Adele Maurer Lewis: “I was thinking that was you. There is a risk of a mistrial if that gets out.”

Scott Mitchell: “I know … I didn’t say anything about you … there are 3 of us on the jury from Wandy and one is a physician (cardiologist) so you may know him as well. It has been an interesting case to say the least.”

I regret responding to his email at all, but regardless I felt that this was a fairly serious violation of his responsibilities as a juror and that I needed to make you and General Miter aware. I did not recognize the above-referenced cardiologist or any other jurors.

Adele Lewis, MD

Source: Eyewitness Guru, September 2013

The Facebook message that overturned a conviction
NEW REPORT: MPL CLOSED CLAIM COMPARATIVE

PIAA is pleased to announce the release of its new “MPL Closed Claim Comparative” (MPL CCC). The MPL CCC replaces the “Claim Trend Analysis,” and provides information on claim trends for the most recent 5- and 10-year periods, as well as additional graphs and data on key MPL claim benchmarks. For more information, please visit the PIAA website at www.piaa.us.

10-YEAR SUMMARY (2012 DOLLARS)

- **$9 BILLION**
  Total indemnity paid in medical professional liability claims
- **$360,695**
  Average indemnity paid
- **$42,848**
  Average allocated loss adjustment expense
- **26%**
  Percentage of claims resulting in an indemnity payment
- **10%**
  Percentage of claims resulting in an indemnity payment ≥ $1M

AVERAGE INDEMNITY BY CAP LIMITS (2008–2012)

- **None**
- **$400,000**
- **$0**
- **<$300,000**
- **$300,000 – $499,999**
- **$≥$500,000**

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Stop Selling. Start Attracting. Get the Clients You Deserve.

The best sales calls are the ones where the prospect calls you. If you exude positive energy, positive things will happen. The law of attraction states that we attract whatever we think about, both good and bad. Take a moment and think about the reasons why customers or clients come to you. Are you dedicated to your clients? Do they see you as a “brand ambassador”? Do you have vast stores of expertise in your industry? These are just a few of the factors that can make you and your company attractive to others.

While many companies do have these qualities, the question remains: How do you get the phone to ring? The simple answer: attraction marketing.

Attraction marketing is a proactive marketing strategy designed to position your message so that it entices the right prospects to your business. Note that this approach is a long-term solution; it takes time and patience if you want to see results. But while it might take a lot of effort to get the ball rolling, once it's going, it just keeps on going.

At Morningstar Communications, we've seen, firsthand, the power of attraction marketing. Since the time when our company was founded, in 1997, some 94% of our new business has come from inbound calls. This is a proven approach for generating long-term, sustainable growth. Let's explore the essence of attraction marketing.
NO ONE IS BETTER PREPARED TO HELP YOU REACH THE TOP OF YOUR GAME.

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Be great at what you do

Take a strategic position that is based on excellence, not difference. It is crucial that you tell your story about the things that you do best for your clients and prospects, rather than about how you differentiate yourself from your competitors. Different isn’t necessarily better. Different is just that—different.

Own your position of excellence, and leave memorable impressions. Excellence is, after all, in the mind of the receiver.

I like to say, “Brands live in the six inches that lie between your ears.” We all know the UPS tagline, “What can Brown do for you?” or McDonald’s, “I’m lovin’ it!” It is a simple phrase that tells customers what they are excellent at. Your brand is, after all, “what the people who matter most say about you.”

Tell your story—clearly and persuasively

Tell your story using every possible marketing tool, on a systematic, ongoing, and proactive basis. Tap into all the channels that are relevant to your market. At Morningstar Communications, we use the Four-Channel Media Model, a strategic messaging platform comprised of paid media (advertisements), earned media (public relations), shared media (social media), and controlled media (collateral). Use these channels, in synchrony, to target your key messages to the people who matter most.

Remember to keep your message simple. We now live in an age when people don’t want to read between the lines. Today’s consumer hears and sees hundreds of messages every day. Don’t get lost in the clutter: stand apart with a clear and simple message. The key to creating a simple message is to think like your target audience. Do not tell them what they want to hear; tell them what they need to know. You owe it to your customers to create genuine experiences for them.

Take the time to foster important connections and improve brand awareness. Awareness, familiarity, consideration, and trust, together, make the phone ring.

Respond quickly

Stay engaged with your prospects at all times. Don’t let anything slip through the cracks. If someone is interested, make yourself available to him. Use relationship marketing, and continue to give your customer value by always being there for him.

Set “personal-networking stretch” goals for yourself. If there is a particular business leader I want to know, I reach out to him. And take the time to nurture your relationships. It is not who you know, it’s who knows you that leads to opportunity.

Be excellent at what you do. Tell your story proactively in a clear and compelling manner. And the right business will come to you. That’s our story, and we’re sticking to it.
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.

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American trial procedures offer attorneys two opportunities to speak directly to juries: opening statements and closing arguments. Even though neither is viewed as evidence, these twin opportunities to present the facts of a case in the most compelling manner and to explain how certain stories, themes, and facts will lead to the correct result cannot be understated, especially during opening statement when juries are the most attentive and keenly appreciative of any factual nugget that will help them make sense of the trial they are about to hear.

But what happens to this process when opposing counsel attempts to hijack opening statement and tell the plaintiff’s story via sound bites taken out of context from the videotaped deposition of the physician who has been sued for professional negligence? Such demonstrative evidence can be an incredibly powerful storytelling aid, as it tells juries what to think through a familiar medium.

Because jurors remember little to none of what they hear, but practically everything they see, a physician’s appearance by way of excerpts from his or her deposition can make or break the jury’s initial impression of the case and then color their approach to the facts throughout trial. Any elementary school teacher will tell you visual learning trumps the spoken word every time when teaching new concepts. With the increasing tendency of plaintiffs’ attorneys to videotape physicians’ depositions this is an eventuality.

Traditionally, trial courts did not view opening statement as a time for parties to present legal arguments or actual evidence. While some trial courts are holding the line of limiting opening statements to only a brief explanation of the facts, this traditional approach continues to evolve away from the spoken word and butcher paper on an easel to professionally edited “anything goes” multimedia presentations, designed for greater visual impact on a juror’s decision-making process.

The defense should now be prepared for trial judges who are willing to allow trial attorneys to push the envelope in their opening statements, especially when it involves items to be used as an aid in opening state-
ment which may be received in evidence during trial or are portrayed as fairly serving “a proper purpose.” This is no longer the liberal view of opening statements, but a clear trend in many jurisdictions where trial judges are more than willing to allow almost anything which will better help the jury analyze evidence that will be admitted during trial.

Examples of demonstrative evidence allowed in opening statements without triggering reversible error abound, ranging from the use of compelling photographs of crime victims to exhibition of a criminal defendant’s murder weapons. Once trial courts opened the door for playing tape recordings of an accused defendant’s confession to juries, the use of videotaped deposition testimony was not far behind. The illustrative use of an enlarged page from a preliminary hearing transcript during opening statement was allowed by the California Supreme Court 20 years ago, even where the transcript page had been highlighted to emphasize portions of testimony.

Only a limited number of courts have addressed whether videotaped depositions may be used in opening statements. In this respect it is worth noting Federal Rule of Civil Procedure 32 states that some types of depositions may be used “for any purpose.”

Creative trial lawyers will argue this includes opening statements. In one reported decision the trial judge allowed excerpts of videotaped depositions to be played during opening statement yet failed to offer any rationale behind his decision or respond to the arguments of either party on the issue: it just happened.”

This opportunity strips defense attorneys of the option of limiting juries to a preview during opening statement of what the live testimony of witnesses will be during trial, in favor of elevating the relevance of videotaped shreds of evidence over such live testimony on the witness stand with the apparent approval of the trial judge.

The safest course in such uncharted waters is to communicate with the trial judge prior to the commencement of trial regarding the boundaries of opening statements by way of pre-trial motions, objecting to the manner in which opposing counsel has chosen to cherry-pick only the low-lights of the defendant’s testimony. If the trial court is leaning toward allowing opposing counsel to use limited excerpts from a videotaped deposition in opening statement, demand equal time to show the portions of the videotaped deposition in order to place the selected excerpts back in their appropriate context.

But what happens if the trial court’s discretionary powers favor trying the defendant in a style more reminiscent of a 60 Minutes office-door ambush than the calm dignity of To Kill A Mockingbird? You may think that trial may be months or years away and it’s only a deposition, but will your physician be camera ready to be part of opposing counsel’s opening statement?

Lights, camera, action!

Keep in mind most jurors are totally unfamiliar with the deposition process, but readily identify with the witnesses being deposed (“There but for the grace of God, go I”) and not the lawyers asking questions. Juries favor those witnesses who can project grace under pressure and will stop listening to any witness who can add nothing new, fidgets, yawns, seems to be hiding something or is overly defensive.

Given the risk of having a physician’s appearance, demeanor, and attitude toward the pending action pushed under the spotlight of trial early on, deposition preparation should take on a heightened awareness of what the camera “sees” and how a physician sued for professional negligence wants to be seen. This means more interactive time in preparing for the deposition than ever before, which can’t be left for the day of the deposition itself.

Here are some general guidelines to offer to a physician who receives notice his upcoming deposition may be videotaped:

Appropriate dress. A deposition is not a fashion statement. Consider whether or not an expensive business suit is preferable to standard surgical scrubs or a white lab coat. What dress best says what you do and would inspire professional confidence on the part of a stranger?

Prepare for the video experience. Watch videotaped depositions until you are familiar with the process. Then practice being videotaped. Remember your audience. Review your practice deposition. Accept criticism.

Analyze nonverbal communication. You should look at the questioner straight on and answer in a direct manner. Avoid blank stares. Stop looking at your attorney. Stop looking around the room. You should be dispassionate, but not a robot. You are engaged, but not on edge.

Analyze verbal communication. Try answering each question yes or no. Only offer an explanation when it will make a response more clear. One-sentence responses always play best.

Craft a narrative. You are not your own expert witness. In most states you will not be asked to provide your view of the standard of care, but you should be familiar with the standard of care at issue and consider how you complied with it in order to better tell your story. Was the patient noncompliant? Was this an unforeseen complication? Was this a patient’s medical history withheld from you? These are the questions you should be asking yourself, even if they are not asked at your deposition.
Don’t be technical. Remember the exasperated jury foreman during the deliberations in the movie Philadelphia? “Why don’t you explain it to me like I’m 12 years old?” Explain medical terminology like the attorney asking questions is 12 years old.

Nothing is funny. Don’t laugh at dumb questions. Even if the attorney examining you is trying to provoke laughter or is making self-deprecating jokes at his own expense, do not smile or laugh appreciatively, as the most common follow-up question will be: “Do you think what happened to my client is funny?” This can be deadly stuff if it is caught on camera and played back for the jury at trial.

Get ready for the long haul. More than 100 years ago the world was captivated when Antarctic explorer Roald Amundsen raced Robert Scott to reach the South Pole. Even though Amundsen got there first, it was not a race with two teams of frenzied explorers whipping their sled dogs across vast expanses of ice in view of each other. The two men were barely aware of the other and more concerned about freezing to death. What is important to remember from their experience is it was just two tired men putting one foot in front of another across over 800 miles of rugged, unmapped land. Remember some depositions can be just that boring. You should approach your deposition with only one goal in mind: hearing the attorney deposing you say, “I have no further questions.” Let that be your South Pole.

A physician’s video deposition will be subject to endless editing to create a number of excerpts totaling something less than 15 minutes. Since your physician’s best testimony will always be left on the editing floor, it is best to leave nothing else on the deposition table for opposing counsel to use to impugn or attack your physician when you get up to go.

References
1. Los Angeles County Superior Court Rule 3.97 (effective July 1, 2011) still prohibits the use of graphic devices in opening statement, such as a videotaped depositions, absent leave from the court.

For related information, see www.professionals-law.com.

Once trial courts opened the door for playing tape recordings of an accused defendant’s confession to juries, the use of videotaped deposition testimony was not far behind.

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PIAA 4Q 2013 AFRONT _Layout 1 11/4/13 6:02 PM Page 17
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First came the traditional August recess for Capitol Hill, when Senators and Congressmen evacuate Washington, D.C., to get back to their states and districts. Then came the bickering over budget issues, which slowed congressional progress on all other legislation. Then came the federal government shutdown, which brought to a screeching halt a substantial proportion of activity in the nation’s capital. Nonetheless, PIAA’s Government Relations Department has been active on several fronts.

**NAIC**

As readers of *PIAA Newsbriefs* know, the National Association of Insurance Commissioners (NAIC) recently created an Affordable Care Act Medical Professional Liability Working Group. The specific objectives of the working group are still in development, but its general mission is to study the potential ramifications of the Affordable Care Act (ACA) for our nation’s medical professional liability (MPL) system. How the working group would go about studying that question, and exactly what it would focus on, however, remained an open question.

The working group is led by New Mexico Insurance Superintendent John Franchini, and consists of an additional seven state insurance leaders: Martin Hazen, Kansas; William Deal, Idaho; Kevin Dyke, Michigan; Andrew Boron, Illinois; Mike Chaney, Mississippi; Stephen Robertson, Indiana; and Scott Kipper, Nevada.

Soon after the working group was formed, PIAA reached out to NAIC staff, and some of the commissioners, to see how we could help with it. We suggested wording for the charge to the group and recommended specific issues on which to focus. As the working group came together, PIAA remained in touch with NAIC staff to be sure that we heard about everything they were planning. The result? PIAA was the first organization invited to address the working group on the issues it had opted to address.

The insurance commissioners convened the group’s first official in-person meeting in Indianapolis, at the NAIC’s Summer National Meeting. While the NAIC is familiar with PIAA because of our regular participation in NAIC meetings and frequent interaction with NAIC staff, PIAA President & CEO Brian Atchinson began his presentation by re-introducing PIAA and its members to the working group. He explained how the MPL insurance market has changed over the years, and how PIAA members have grown from modest startups to become the leading MPL writers in the U.S. He then discussed the changing healthcare system and what MPL insurers are doing to prepare for it.

He pointed out that much of what will ensue from the ACA is still up in the air, more than three years after it was enacted. For MPL insurers, significant questions remain about accountable care organizations (ACOs). In an integrated-care model, will responsibility, and therefore liability, rest with one or
many individuals? To what extent will federal efforts to rein in costs put financial concerns in conflict with healthcare decisions, and what are the liability ramifications of decisions based mainly on cost? Will providing coverage for 30 million more Americans translate to a proportional increase in liability lawsuits? Atchinson said that it is too early to answer these questions with any degree of certainty, but that anyone who understands MPL insurance should be concerned. He noted there is one area, however, where action is needed, now.

The issue: Standards of care. Atchinson stressed the importance of ensuring that new practice guidelines or recommendations do not create new negligence standards that would let federal bureaucrats decide what is, and is not, appropriate care. Fortunately, he informed the commissioners, federal legislation on this issue has already been introduced. The Standard of Care Protection Act (H.R. 1473) would clarify that nothing in the ACA, or for that matter, in any federal healthcare law, regulation, or guideline, should be interpreted as establishing the standard of care in an MPL lawsuit. The bill already passed the House Energy & Commerce Committee, by a unanimous vote, as part of legislation meant to fix the Medicare physician reimbursement formula. It now awaits action by the House Ways & Means Committee. Going forward, PIAA will encourage the NAIC to openly support efforts to move H.R. 1473 through the legislative process.

Next, the PIAA Regulatory Affairs Committee met to discuss comments it would submit to help determine the working group’s proposed work plan. The PIAA comment letter reiterated the need to support the Standard of Care Protection Act, and to learn more about potential liability risks associated with ACOs. PIAA will continue advocating these positions when the NAIC next meets in Washington, D.C., in December.

MICRA

MPL reform advocates like to cite California as the prime example of a more efficient and effective MPL system. Right now, however, the Golden State is the center of attention for a different reason, as reform advocates battle to save the centerpiece of their reform model—the $250,000 cap on non-economic damages.

In a recent meeting of the PIAA State Legislative Subcommittee, special guest Lisa Maas, Executive Director of Californians Allied for Patient Protection (CAPP), related the latest news on how MPL reform advocates are defending the nation’s preeminent reform law. The attack on MICRA, the Medical Injury Compensation Reform Act, began earlier this year, on two fronts. First, the personal injury bar targeted the state legislature, confident that supermajorities of Democrats in both chambers (Democrats hold a more than two-to-one advantage in both the Assembly and the Senate) would improve their odds of overturning the 30-plus-year-old caps on non-economic damages. To bolster their effort, they threatened a citizens’ initiative to overturn the caps if the legislators would not do so. They assumed that, given a choice between making changes to MICRA themselves, or having more extreme changes foisted upon them, the legislators would choose to act.

This was a miscalculation, however, as CAPP has had an extensive educational campaign for legislators for many years, thereby ensuring that they understood the true value of MICRA’s reforms and the potential harm of undoing them. California legislators are aware of the savings from MICRA, and were already inclined to keep the law in place, but now, they are more so than ever. As the state continues to try to implement the Affordable Care Act, lawmakers realized that they could not afford to risk rising healthcare costs at this time.

Having struck out after an extensive lobbying effort, the personal injury lawyers tried their second option—filing a citizens’ initiative. Hiding behind a father who lost two young children to an impaired driver, the backers of the initiative claim to focus on safety, in requiring doctors to consult a prescription database when writing prescriptions for certain controlled substances and submitting to mandatory random drug testing. But these provisions are only a transparent effort to mask the primary purpose of the initiative: raising MICRA’s cap to approximately $1.1 million and establishing an annual inflation adjustment going forward.

The personal injury bar has not yet started to collect signatures (they will need approximately 500,000 legal signatures to get the initiative on the ballot, which will require that an estimated 800,000 signatures be collected), although they may start at any time. Collecting signatures and coordinating a massive ad campaign will be extremely expensive, however, and could still deter the initiative from moving forward. In the meantime, however, MICRA proponents are actively organizing and preparing for what may be a pitched battle.

Much of the focus in California is currently on in-state fundraising, but PIAA remains in contact with our fellow reform advocates in the state, and has already provided data to help combat the personal injury bar’s distortions about damage caps. We stand ready to provide additional assistance as necessary and will certainly keep PIAA members informed about the ongoing efforts to protect MICRA.

Future efforts

PIAA remains committed to advancing the issues that matter the most to MPL insurers, in Congress, the federal bureaucracy, the NAIC, or the states. The future holds lots of new PIAA initiatives in store, as we look to expand our programs for members at both the federal and state levels. So stay tuned for news about what the PIAA Government Relations Department is doing to help meet your company’s needs in exciting new ways.
CFOs View NAIC’s New ORSA Regulation as a Strategic Tool

A recent survey uncovers tangible benefits from a regulation

The process known as the “Own Risk and Solvency Assessment” is a requirement for compliance with the NAIC. The ORSA integrates a company’s enterprise risk management efforts with its annual cycle of capital and business planning. Really big companies—with more than $500 million in gross annual premium—are working on ORSA. But some of the smaller companies are, too. Find out why.

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Beginning in 2015, large insurance companies in the U.S. will be required to file reports on their Own Risk and Solvency Assessment (ORSA), a new regulatory initiative from the National Association of Insurance Commissioners (NAIC), which requires insurance companies to perform risk and capital assessments, and then report the results to their state regulator.

The new ORSA requirement is an example of the natural evolution of improved solvency monitoring that is sweeping around the globe. Beginning with the Solvency II initiative in Europe, regulators have been working on enhanced solvency monitoring approaches to ensure that insurance entities are appropriately capitalized for the risks they support. Rating agencies have been following a similar path, placing significant emphasis on the importance of the enterprise risk management (ERM) efforts and capital modeling capabilities of the companies they rate.

While the ORSA will require that companies create or improve on their current internal capital modeling, it is not just about more modeling. A much more holistic and important purpose of the ORSA is to integrate an insurer’s ERM efforts with its annual cycle of capital and business planning. Further, this effort prompts companies to be more deliberate in evaluating the risks they take on, in light of the capital they have available. A well-designed ORSA aligns the board, executive management, and the business with the firm’s willingness to accept risk in pursuit of business objectives. It
demonstrates — quantitatively and qualitatively — that key risk exposures are aligned with, and supported by, the insurer’s assessment of its capital.

Recognizing the importance and potential impact of ORSA on financial planning, capital analysis, and ERM, Towers Watson used its semiannual CFO survey to take the pulse of insurance company CFOs on these topics. In general, the survey found:

\[\text{Many companies subject to the regulation are already well on their way to developing their ORSA processes, because of the requirements of other regulatory jurisdictions, or on their own initiative.}\]

\[\text{Many companies not subject to the regulation are also developing, or plan to develop, an ORSA process, even though they may not be required to do so.}\]

\[\text{Most important, many respondents recognize that the ORSA process could prove valuable as a strategic business tool.}\]

Who must file an ORSA?
The currently proposed regulation will require only large individual companies, those writing more than $500 million in gross annual premium or those that are part of a group with gross written premium in excess of $1 billion, to file ORSA reports. However, if the NAIC follows the path of other regulators, they might phase in and expand the requirement to include smaller companies in time.

This premise is supported by the finding that while less than half of the responding companies will initially be required to file reports related to their ORSA, three-quarters of the respondents said they were already working on one. When it comes to PIAA member companies, only a handful are large enough to be subject to the current regulation. Sooner or later, though, it is likely that virtually all insurers, including small mono-line PIAA members, will be required to file an ORSA.

However, insurance companies are building or planning to build their ORSA soon for several reasons.

According to the survey, 50% of the respondents said they viewed ORSA as a strategic exercise. They see the potential benefit in improving the evaluation of their risk and solvency position, regardless of whether or not the regulation will apply to them. Ultimately, the intent of ORSA is for management and board members to embrace and own their ERM process. It appears that CFOs are seeing a rare opportunity to put a best practice into place — and for good reason.

The survey found that only 22% of CFOs believe their current ERM processes are tightly linked to their company’s capital and strategic planning. However, 60% said they believe the ORSA process will ultimately improve that link. Improved linkage can enhance company returns and provide consistency in measuring those returns.

Another reason why companies are developing ORSAs even though they are not required to at present may be the recognition that building these capabilities requires significant investment in both time and resources. Indeed, more than half of the respondents said they thought enterprise-resource challenges would be significant barriers in designing and executing their ORSA process. Moreover, 45% of the respondents said they are unsure that their key personnel have a thorough understanding of ORSA or possess the relevant experience to implement it. That means that an educational element will be required to bring executives up the learning curve.

Challenges for the industry
When they actually get down to the task of designing their ORSAs, respondents foresee many challenges. First and foremost, 80% said finding and securing the resources necessary to conduct a proper ORSA will be either extremely or moderately challenging. The importance of this challenge is further emphasized by the finding that for nearly all tasks, the majority of respondents said they expected that their own internal resources would do almost all of the necessary work. Only in the case of capital model validation did a majority of respondents (53%) expect to look to outside resources.

CFOs also seem to have a reasonably good handle on how challenging the creation of an ORSA can be. For example, 53% said that identifying risks would be challenging, while more than 90% said they would be challenged by the task of quantifying risks. When it comes to developing assessments of risk appetite and tolerance, only 27% responded that it would not be difficult or only slightly challenging, while only 13% placed linking risk assessment and capital planning in these same “not challenging” categories. Sixty percent said developing the actual ORSA documentation would be moderately challenging; 27% said it would be difficult, while 13% said it would be easy.

When it comes to the capital models companies need to employ, they range from highly complex versions for large multiline companies to more basic ones for smaller companies. In the case of PIAA companies, which are for the most part smaller and limited in their types of products, spreadsheet models may suffice. However, more and more companies now favor third-party commercial economic capital modeling platforms. Among many advantages, these third-party models provide for better governance, allow better real-time feedback, and can grow with companies as they strive for continuous improvement, starting out simple and becoming more complex.

ORSA is as much about the risk management process as it is about models. If a company has good risk management practices in place, it can overcome shortcomings in a model. However, if a company does not have strong risk management processes, it will have trouble satisfying regulators regardless of how sophisticated its models may appear to be.
Continued resistance to ERM
While many of the CFOs questioned seemed positive about the new ORSA requirement—50% said they view ORSA as a strategic exercise—the survey found that 29% are somewhat skeptical, and look upon ORSA more as a tactical exercise that might influence some strategic decisions. The remaining 21% view the ORSA process strictly as a compliance chore—just another regulatory burden that will not create value.

Many senior executives remain skeptical about additional regulation linked with ERM, because they don’t want to “run their company according to a model.” Further, they have observed or experienced firsthand the significant costs related to Solvency II efforts in Europe. As insurance companies, they argue they are in the risk business and don’t feel that they need a formalized system. However, rating agencies and regulators don’t share this opinion.

In actual fact, ORSA is about risk management in a broader and more general sense. Unlike Solvency II, which demands highly specific metrics, the NAIC’s ORSA is not prescriptive. Rather, it offers companies a flexible and open-ended way to explain how they are implementing their ERM programs.

Developing a successful ORSA will require buy-in and support from the board of directors and senior management. Regulators will expect boards to demonstrate that they truly understand it and believe in it. Board ownership of ORSA may pose greater challenges for PIAA companies that have fewer professional insurance industry executives as board members. As a result, more education will be required to allow them to demonstrate familiarity, knowledge, and ultimately ownership of the company’s risk management.

Cultural change
As the survey demonstrates, most companies recognize the value of ORSA. Indeed, some have seized on the opportunity to implement it, even though it is not required. But even for those companies that look upon the proposed requirement as a tactical exercise or merely a compliance burden, it still offers an opportunity to do things with risk management that they haven’t done in the past.

For many companies, developing an effective ORSA will translate to a true shift in corporate culture; it will be considerably more than a simple response to a regulatory requirement. Those companies that embrace the change, and make the cultural shift, will be able to evaluate their business strategy through a new kind of risk-focused lens. The insurers will be well positioned to reap the benefits of an improved risk-adjusted return and will benefit from a clearer understanding of the risk-reward framework in which they operate.

For related information, see www.towerswatson.com.
How PIAA Member Companies Can Improve Birth Outcomes

And earn ACCME accreditation with commendation in the process

What would happen if the components in the healthcare system worked aggressively to persuade mothers to carry their babies to the full 10 months of pregnancy? Good things. The trick is to develop an educational program that can convince the providers to do the persuading.

Ruth Ryan is Senior Risk Management Educator, LAMMICO. LAMMICO earned accreditation with commendation from the ACCME in 2012.
Nine months of pregnancy” is a common phrase, but it’s actually incorrect. It contributes to the misunderstanding that a normal or term pregnancy is nine months, or 36 weeks. In reality, the 37th and 38th weeks of pregnancy are very important to the development of the baby’s brain, lungs, and gastrointestinal tract. The optimal time for delivery is during the 39th and 40th weeks, or 10 months. This is the period when complications for mother and baby are at their lowest rate (Figure 1).

Many have misconceptions about this. When asked in a major survey, “What is the earliest point when it is safe to deliver a baby?” more than half of the women responded, 34 to 36 weeks—which is actually premature for birth and is associated with lower birth weight and a higher rate of complications for the baby (Figure 2). Only about 7% of the women responded correctly, 39 to 40 weeks.

For many reasons, including convenience, women and their physicians have increasingly chosen to schedule induction and delivery, instead of waiting for natural labor to commence. But the results are in—elective induction and delivery prior to 39 weeks’ gestation without medical indication has led to higher rates of adverse outcomes. These adverse outcomes include respiratory complications, sepsis, and admissions to the newborn intensive care unit (NICU).

More than 30 years ago, the American College (now Congress) of Obstetricians and Gynecologists (ACOG) took a stand against non-medically-induced elective deliveries prior to 39 weeks’ gestation (ACOG Practice Bulletin 10). Yet, since that time, the rate of these inductions and elective early deliveries has multiplied (Figure 3).

Several national organizations have launched initiatives to reduce the number of elective inductions of delivery prior to 39 weeks’ gestation. These include the Institute for Healthcare Improvement, the Joint Commission, the March of Dimes, the Leapfrog group, several group health plans, and numerous statewide quality initiatives.

In 2011, the Louisiana Department of Health and Hospitals (DHH) Birth Outcomes Project launched a hospital initiative to reduce elective deliveries before 39 weeks. At baseline, rates of elective deliveries before 39 weeks in the 58 Louisiana hospitals ranged from under 1% to more than 57%.
The pledge
Dr. Kenneth Brown, Medical Director of Woman’s Hospital in Baton Rouge, assisted Dr. Rebekkah Gee, DHH Birth Outcomes Project Director, and other physician champions in enlisting leaders of all 58 birthing hospitals in the state to sign a pledge (the “39-week pledge”) to reduce the incidence of these deliveries in their institutions.

The education
Dr. Brown is a member of the Board of Directors of LAMMICO, a PIAA member company. He asked LAMMICO to assist him in creating an online educational activity for obstetricians and labor and delivery nurses to accompany this initiative, offering continuing medical education (CME) credit to physicians and nursing continuing education (CE) credit to nurses. The video CME activity titled “Reducing Elective Deliveries Before 39 Weeks’ Gestation” was filmed and posted online in June 2011, just in time for the DHH press conference announcing the kick-off of the 39 Week Pledge and campaign.


The hospitals promoted it to their obstetrical staffs. Patient education resources were provided by the March of Dimes.

Results of the pledge
One year after the launch of the pledge and the campaign, on July 18, 2012, the DHH issued a press release. An excerpt from the press release reports the following outcomes:

“Woman’s Hospital in Baton Rouge, the largest birthing hospital in Louisiana, has reported a 20% decrease in NICU admissions. . . . Ochsner Hospital reported a 28% decrease in NICU admissions. . . . Data reported through February 2012 show that 14 of the hospitals participating in the 39 Weeks Initiative decreased elective deliveries by 60 to 80%.”

Education outcomes
As of May 2013, a total of 359 physicians and 133 nurses and others completed the online education activity.

In a post-activity survey of the participants, subjects said that, as a result of this activity,

- “The number of elective deliveries before 39 weeks has been reduced in my facility,” 47.8%
- “We achieved a reduction prior to this activity and initiative,” 26.1%
- “We plan to do so in the future,” 4.4%
- “No change or not applicable,” 21.7%.

Here are some typical participant comments:

- “Excellent presentation. Convinced me that we actually have good evidence that this is an important consideration.”
- “Strong clinical content, backed up by well-presented statistical evidence.”
- “Very pertinent topic. Very well presented.”
- “Working in a pediatric practice, I see the effects firsthand on newly delivered term or preterm babies.”
- “The 39-week initiative has already been established in my practice and hospital. The information in this course reinforced that we are doing the right thing.”

Conclusions
First, the science was solid. Reducing elective early deliveries improves neonatal outcomes. Second, partnerships work. This initiative was a partnership between the DHH, the Louisiana March of Dimes, LAMMICO, and physician champions from many hospitals. Finally, we demonstrated that continuing education can be an effective tool for changing practice patterns and improving patient outcomes.

References
3. ACOG Practice Bulletin 10. Induction of Labor; Clinical Management Guidelines for Obstetrician-Gynecologists, 1999

Postscript: A Tip for PIAA Companies That Are CME Providers
The Accreditation Council on Continuing Medical Education (ACCME) awards national accreditation to successful applicants, permitting the applicants to be CME providers. Many PIAA companies provide CME under national accreditation with ACCME or through their respective state medical societies. They are able to award both CME credit and premium-discount credit for insured physicians who complete risk management education activities.

The ACCME requires that providers design CME activities so as to enhance physician competencies, performance, or outcomes. The most difficult one of the three is to demonstrate how educational activities have changed patient outcomes. This collaboration project provides an example of how this can be done. The partnerships and collaboration involved in this project have also helped to satisfy the ACCME Criteria 16-21, the “extra credit” criteria required to earn accreditation with commendation.
MPL Underwriting in Alternative Risk Transfers

BY CHRISTINA KINDSTEDT

Want to learn more about the inner workings of an ART? Read on to see how ARTs establish capital requirements, set financially sound premium rates, and differentiate hospital-employed physicians from those in private practice.

Historically, most of the entities and individuals with medical professional liability (MPL) risk exposure bought their insurance coverage from traditional insurance carriers. But then, when the MPL market began to harden at the dawn of the century, many insureds turned to alternative risk transfer (ARTs) arrangements, including, but not limited to, trusts, captives, and risk retention groups (RRGs).

While data for trusts and pure captives is not publicly available, because they are consolidated into their parent companies’ statements, data on RRGs is easily accessible, since they must submit the same regulatory filings as traditional carriers.

The number of MPL RRGs mushroomed from 18 in 2000 to 126 in 2012. Gross written premium (GWP) of the MPL RRGs...
reason, many ARTs choose to charge premiums at actuarial confidence levels that are higher than actually expected, in their early years. The extra premium funding flows into retained earnings, to build up capital. Then, as ARTs mature, and their reserves plateau after a few years, the pressure on capital adequacy subsides, and the need to charge premiums at higher confidence levels abates as well. Within ARTs, RRGs face challenges in how to allocate premium, because they have many members who share similar risks but not the same owners. It is not uncommon for larger-member hospitals or physician groups to incur smaller losses, while smaller members incur disproportionately more, and severer, losses. So the question arises: Should premiums be based on number of exposures—in which case, the larger members would pay more premium—or experience data, according to which the members with greater losses would pay more! 

One of the RRGs that we helped form in 2004 started out with a 50/50 ratio on experience vs. exposure, in premium allocation. Then, as the RRG grew, it transitioned to ratios of 60/40 and 70/30, finally settling on 80/20 for the experience/exposure split. But now, because the premium allocation tilts so heavily toward loss experience, a couple of large losses could have a major impact on a single member’s premium. That would defeat one key reason for joining an RRG in the first place: premium stability. So the RRG in question implemented a floor and ceiling for premium rates, to partially counter the effect of the 80/20 experience/exposure allocation. That is, any one member’s premium cannot increase beyond the ceiling, or decrease below the floor, in any single year. These two measures have kept the RRG’s owners content and collaborative.

Inequality among RRGs

Not all MPL RRGs are created equal. Some focus on physicians, regardless of their employment or contract affiliation, while others are owned by hospitals and physician groups. The former scrutinize physician applicants carefully during the underwriting process, because there is no prior relationship, only the current one, insurer and insured. The latter have already completed the requisite scrutiny and due diligence before the physician was hired or placed under contract. So, by the time the physician applies for insurance coverage under a hospital- or physician group-sponsored captive or RRG, the bulk of the work in the underwriting process has already been done: it is now more administrative than analytical. The latter rarely reject a physi-
Despite the captive ownership structure, ARTs still need to keep their rates and coverage options competitive, if they are to function as a viable option for their owners and insureds. Toward this end, ARTs have adopted many of the features that are available to insureds covered by commercial carriers. A prime example is death, disability, and retirement (DDR) coverage. Even though many captives and RRGs set up shop with a thin capital margin, and are really in no position to take on additional reserves, they do set aside DDR reserves. Insureds are granted free tail coverage when they meet the requirements for DDR.

ARTs typically have a lower general and administrative expense load than commercial carriers. To maintain this competitive advantage, ARTs streamline certain procedures, to simplify the administrative requirements for insurance. For example, when physicians purchase insurance from traditional (non-captive) carriers, they can choose from among various effective dates for the inception of coverage. This is a convenience for the insureds. ARTs, in contrast, typically enforce the same effective start dates for all insureds, after the insured’s first year, thereby simplifying the renewal process, and reducing the volume of communication that would otherwise be necessary for renewal, throughout the year. Because insureds still get the same coverage, but with a lower expense load, imposing identical effective and expiration dates has no tangible negative effect on the insureds.

Regardless of these differences, ARTs and traditional carriers in fact share more similarities than deviations in underwriting practices. To sustain profitability and to enjoy long-term success, both ARTs and traditional carriers have to apply prudent underwriting principles. So, the shift from traditional carriers to ARTs has not fundamentally altered what is done in MPL underwriting.

The other shift
But a lesser-known shift has been occurring in the MPL sector in the last five years: more and more traditional MPL carriers have set up their own MPL RRGs. It is still too early to tell how these MPL RRGs will affect MPL underwriting in general. For the time being, though, we can say that they seem to have adopted a set of underwriting procedures that are more commonly seen in traditional carriers than in the RRGs sponsored by hospitals, physician groups, and physicians. But market demands usually drive supplies, and ARTs have become ever more prevalent in the MPL marketplace, so some of the underwriting practices that are now unique to ARTs may well filter into these carrier-sponsored MPL RRGs.

One thing is for certain, though—the MPL marketplace will always be dynamic. New products and practices will doubtless emerge as time goes by.

Reference

The Transition to the ACO Model of Care: New Risks May Emerge

With more ACOs coming on line, companies that insure these entities need to take a more expansive view of risk. They may well need to consider (for example) new broad-based risk committees, risk assessments that include risk managers and quality managers, and the valuable exercise of risk mapping.
W hile accountable care organizations (ACOs) may be structured in several different forms, ranging from new standalone legal entities to loose alliances and networks, every organization that enters this market must be prepared for the emergence of new risks. Effective management of these risks may prove crucial to the success of the fledgling ACO enterprise.

These are some of the activities that may be linked with emerging risks.

- **The structure of the new ACO.** Every decision in this phase of the ACO startup may have its associated risks. In particular, it is essential to choose the organizations that will participate in the ACO carefully. Every aspect of the structure of the new ACO, whether a joint venture, a formal partnership, a series of alliances, a standalone entity, and how the payments and the expenses will be shared, can have corresponding risks. If there are errors in the provision of nonmedical services—and this includes the shared savings that are the principal distinction of an ACO—they may lead to antitrust allegations, contractual liabilities, and new kinds of lawsuits from patients, competitors, and regulators. In addition, there may be transactional risks in the event that the new network involves a merger and acquisition.

- **Contracts with payers.** Reimbursement agreements with providers can be a source of risks. There may be problems with the pricing of medical services or mismanagement of contracts for the member providers. The ACO may also incur medical expenses that exceed the agreed-upon levels of capitation.

- **The transition to the ACO.** By definition, an ACO involves coordination of each patient’s care, throughout the continuum of services provided. All of the patient’s health information should be shared seamlessly among all of the providers. In the long run, there is no doubt that this approach will benefit both providers and patients. But in the near future, the shake-up of personnel in each office coupled with the need to realign most of the other resources, determining new measures to track patient care and associated costs, and developing new processes and best practices may all increase the risk of errors in providing healthcare.

- **Risk of a data breach.** With more people sharing electronic medical records, including individuals who are not part of the formal ACO network, the chance of a data breach increases. Medical facilities that have been the subject of a data breach have had to absorb the costs associated with patient notification and possible government fines. These fines are specified in the HIPAA law and in the Health Information Technology for Economic and Clinical Health Act.

- **Integration of physicians.** Integrating and aligning the network’s physicians with hospitals—whether it is done through direct employment, a provider service agreement, or a loose affiliation—is a fundamental process in transitioning to an ACO. What happens will depend to some extent on the nature of the agreements with physicians, hospitals, and the ACOs noting that they may face new risks, and in particular, medical professional liability (MPL) risks.

And all this happens in a new world for healthcare, where patients can seek out information on hospitals and individual providers on any number of websites. Also, in light of the way they deliver care, ACOs may be more transparent to patients. Both trends render the ACO more vulnerable to damage in its reputation. In this sort of environment, just one error could inflict significant damage to an ACO’s reputation.

**A broader vision of risk**

Risk managers in healthcare, as in other industries, need to look beyond the mechanisms of risk transfer and the purchasing of insurance. In an Excellence in Management survey done by Marsh and the Risk and Insurance Management Society, 85% of respondents said that expectations for the risk management department have increased over the last three years. Fifty-seven percent said that what was most important for an effective program was a strategic view of the role of risk and risk management. A slightly lower percentage, 50%, said that an “intimate knowledge of the business and industry” was a top ability for a risk manager. Having “a broad-based operational perspective” ranked third, at 37%. But “insurance knowledge” was rated as important by only 28%.

Healthcare systems can foster closer integration between risk management and the organization’s strategic goals by involving everyone who participates in risk management in the early stages of strategic planning, improving communication between risk management and senior managers. There are also tools and exercises that risk managers can use to gain a more comprehensive sense of risk management, as they transition to an ACO:

- Broad-based risk committees that examine both current and emerging risk, which foster communications across the organization, and include representatives from various departments and functions.
- Risk assessments, using a collaborative approach involving risk managers and quality managers, to home in on financial, clinical, and operational risks, and think through how these risks might be mitigated.
- There is also risk mapping, an interactive exercise in which the current and emerging risks that will affect both the enterprise and the industry are plotted, in terms of likely frequency and severity.

**Assembling a new insurance program**

As the primary goal of the ACO model, close coordination of patient care, begins to be realized, many key exposures will likely decrease. However, during the transition period, there will no doubt be increases in exposures.

Note that directors and officers liability (D&O) coverage, which healthcare systems usually have in place already, provides significant coverage for many of the risks that ACOs confront—including litigation filed by shareholders and other parties, for any number of business decisions.

But some other useful options for coverage might include:

- **Managed care errors and omissions (E&O) coverage.** This protects the health plan, or the network coordinator, from claims insti-
gated by patients, competitors, and regulators. Any organization forming or joining an ACO should think about buying it.

- **Provider stop-loss (excess loss) insurance.** This protects the financial stability of a healthcare organization, by limiting its exposure to catastrophic individual health claims linked to services it has contracted to provide to managed care plan members.

- **Cyber/data privacy insurance.** This coverage protects the ACO or other entity from the consequences of data breaches, either intentional or unintentional, including the cost of notification to all of the individuals impacted by the breach.

- **MPL insurance.** Many healthcare organizations already purchase this insurance, while others set aside reserves, to draw upon in the event of a loss.

**Even with insurance in place, new questions**

Linked with the new ACO model of care are some new kinds of questions, even when all of the basic options for coverage have been purchased:

- While there may be a D&O policy in force, does it cover wrongful acts from building networks? Choosing care models? Negotiating payer contracts?

- Does the current managed care E&O coverage address establishing a network of providers, managing patient care, and distributing payments?

- Is there a provider excess program to protect at-risk managed care contracts?

- Does the present cyber/data privacy coverage address exposures for affiliated providers’ access to the same sources of patient data? Do affiliates have their own insurance for this exposure?

Underwriters haven't yet reached the point of demanding to review individual contracts that insureds have with other network participants. But they have shown a definite interest in ascertaining that the organizations they are insuring have well-defined plans for the transition to the ACO model of care.

Face-to-face meetings between risk manager and underwriters can help in finding a mutual understanding with any potential ambiguities and uncertainties, and also serve to ease possible doubts in the underwriters’ minds.

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Healthcare in the United Kingdom, as in many other countries, is a highly topical and emotive issue, which means the Medical Protection Society’s (MPS’s) work in the public affairs and policy arena has taken on extra significance.

MPS’s work in this field is driven by what we believe to be the best interests of our members. Although we have engaged with governments in countries such as Ireland, New Zealand, Hong Kong, and South Africa, the majority of our public affairs engagement is with the U.K. government, with additional work alongside the devolved administrations in Scotland, Wales, and Northern Ireland.

Policy in action
In practice, this involves monitoring and analyzing relevant policy and legislative changes that could impact our members’ practice or the MPS business model. From there, we develop detailed strategies to influence and engage with public policy developments.

We also actively seek opportunities to raise the profile of MPS among parliamentarians, opinion-formers, and key stakeholders. We do this by identifying and focusing on policy issues within our area of expertise, developing evidence-based policy positions and briefings, responding to consultations and legislative developments, and sharing our views with parliamentarians and others through a program of meetings and events.

These include roundtable discussions with senior representatives of the medical profession, and parliamentary briefings with health ministers and other stakeholders. In this sense, MPS differentiates itself from other organizations.

As already mentioned, healthcare in the U.K.—particularly in England—has rarely been out of the headlines over the past decade. While the fallout from the recent restructure of the NHS in England continues to sporadically feature in the news—principally focusing on the resource constraints that have resulted from efficiency savings—the main topic causing heated debate is the alleged cover-up of errors, poor standards of care, and the “gagging” of so-called whistle blowers.

A culture of secrecy
The high-profile scandal of Mid-Staffordshire NHS Trust—and the further allegations against the English health watchdog the Care Quality Commission (CQC)—has arguably put cover-ups, gagging clauses, and blame cultures firmly at the top of the healthcare political agenda.

The public inquiry into Mid-Staffordshire, chaired by Robert Francis QC, was prompted by reports of unusually high death rates at Stafford Hospital. The inquiry uncovered appalling standards of care, where patients were left in their own waste for days, were forced to drink from vases, and were given the wrong medication. One of the main criticisms was about how patients’ complaints were ignored, with senior managers accused of chasing targets and cutting costs, to the detriment of patient safety and basic standards of care.

Although the Francis Report recommended introducing a legally required “duty of candor”—making it a criminal offense to withhold information about poor care—comments by outgoing NHS chief executive Sir David Nicholson suggested that the problem lay more with the culture of the NHS: defensive attitudes to mistakes and failing to be open and honest with patients was something that was deeply embedded.

Sir David told the public...
administration committee (a group made up of MPs) that: “There is a very strong medical legal litigation culture in organizations and at that time, I know, the answer to any complaint was to deny—because of the potential litigation responsibilities for that. “So you have got a culture of that in the NHS which . . . you have got to tackle.”

Being open: the MPS campaign
Even before these high-profile events, MPS had already recognized the need to encourage a culture of openness in the NHS. Clear and honest communication is something that patients should—and rightly expect to—receive. In 2010, we formulated a campaign around this concept, and we have been pursuing it with health ministers and the media ever since. This includes taking an active role in a number of working groups.

In doing so, we have addressed a particular perception of medical defense organizations: that we seek to suppress openness because disclosure might prompt patients to pursue legal claims. In truth, we encourage openness because it is ethically and morally the right thing to do, and it can help to restore the relationship of trust between a patient and his doctor after something has gone wrong. In addition, an open approach reduces litigation; people are in fact more likely to sue if they believe that they are not being told the truth. Research shows that more claims arise because of poor communication than negligence.’

A key component of the campaign is our publication, A Culture of Openness: the MPS Perspective, which has been distributed at parliamentary briefings and at a number of other meetings and events. The booklet summarizes MPS’s stance on openness and lays down our argument for a culture change concerning a legal duty of candor. A principal concern is that such a duty would result in openness becoming merely a box-ticking exercise, which would fail to address the objective that communication about healthcare be personalized and sensitive to the patient’s needs.

We support this argument with a review of mandatory disclosure laws in the U.S., by Professor David Studdert, former of the Harvard School of Public Health, who describes how such attempts to regulate openness have fallen short, with a particular challenge being the “technical infeasibility of tracking compliance.”

In her preface, Dr. Stephanie Bown, MPS’s Director of Policy and Communications, accepts the supposition that it is harder to change culture than pass laws. But in a survey commissioned by MPS as part of the campaign, one doctor noted: “You cannot legislate to create either a change in culture or good behaviour. Only fearful behavior is created in this way.”

Fear is the key obstacle to openness—fear of litigation, fear of reputational damage, fear of
This year’s roundtable will focus on best practices in corporate governance. The National Association of Corporate Directors will deliver a dynamic program on many of the key topics of concern in today’s board-governance environment. These include the role of the board in corporate strategy and managing risk, succession planning for the board and key executives, the role of the director in crisis management, board room ethics, and much more.

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disciplinary action—and we argue that making openness a statutory obligation would do little to combat this tendency. By "normalizing" openness, and changing the experience of being honest and open about errors by removing the name, “blame, and shame” aspect, health services stand a much better chance of achieving this much-needed transparency. MPS would like to see the health service support doctors, understanding that error is an inevitable part of being human, and that the focus should be on getting the response to the error right.

On the campaign trail
Another aspect of the campaign includes doing more to promote the U.K.’s Compensation Act 2006, which clearly states that an apology is not an admission of liability. However, MPS would like to see this extended to including a definition of apology, as is the case in Australia, where the six states and two territories have each adopted their own apology protection laws.

MPS is also a joint signatory to a circular by the NHS Litigation Authority—which handles claims brought against doctors working in NHS hospitals—that was issued to NHS chief executives on apologies and explanations. In addition, we have contributed to the “Being Open” package from the National Patient Safety Agency (NPSA) (which has since been dissolved, with its patient safety duties transferred to the NHS Commissioning Board Special Health Authority), which is a set of tools and guidance for NHS trusts.

For many years, MPS has annually provided hundreds of communication skills workshops, free of charge, to members. The workshops teach practical skills in communicating openly and effectively, overcoming barriers to openness, and managing adverse outcomes.

Following the leader
The role of leadership in changing culture is something else that MPS has actively championed. Its importance is recognized by the regulatory body, the General Medical Council (GMC), in its guidance Leadership and Management for All Doctors in 2012.

There is often a gulf between clinicians and senior managers, but in our view, the starting point for creating a culture of openness lies with executive boards. It is important that staff on the frontline have the confidence that they are supported and empowered by management to fulfil their professional obligations in delivering quality patient-centered care.

Next steps
The latest large-scale review of the English health service was recently conducted by Professor Don Berwick, MD, who published his report in August. Dr. Berwick previously advised President Obama on his healthcare reforms. In his report, he cast doubts on the effectiveness of a legally required duty of candor, saying it would be a bureaucratic
strategy and, in any event, best reserved for serious incidents only. Dr. Berwick said that a culture of “no blame” was instead needed, to ensure that mistakes were reported in an honest and timely way.

He added: “In any organization, mistakes will happen and problems will arise, but we shouldn’t accept harm to patients as inevitable.

“By introducing an even more transparent culture, one where mistakes are learnt from, where the wonderful staff of the NHS are supported to learn and grow, the NHS will see real and lasting change.”

The challenge of engaging in health policy is greater than ever, because the arena is a particularly noisy one, now that the NHS is subject to such large-scale reforms and resource constraints. However, MPS has an important perspective to bring to the public discourse on these issues, and it is important for both MPS as an organization and our members that we continue in our endeavors to exert influence in our area of expertise. The government is due to respond to Dr. Berwick’s report at some point in the late autumn. As ever, MPS will follow such developments with interest.

Reference

Reading a Mammogram?
It’s Almost Never Easy

The majority of diagnostic errors by radiologists can be characterized as errors in either perception or interpretation, most often of mammographic findings. As long as humans participate in breast cancer detection and diagnosis, error cannot be entirely eliminated. New breast cancer imaging modalities promise opportunities for increased cancer detection, but may also open new avenues for medical professional liability claims. Having a high-quality systematic process for the performance and interpretation of all breast imaging examinations is essential to minimizing avoidable error.” —From: “Breast Cancer Study. MPL Cancer Claims Miniseries: Volume 1,” PIAA, November 2013

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The professionals who draft the U.S. Generally Accepted Accounting Principles (U.S. GAAP) have had to modify them on a regular basis, to keep pace with the ever-changing insurance landscape. In particular, the accounting standards must deal with the emerging changes in insurance contract terms and the increasing complexity of contract provisions. This is why we now have multiple different accounting models, each of which is linked to the nature of the underlying insurance contract. In addition, the application of U.S. GAAP guidance for insurance contracts is limited to insurance companies. So the accounting for two companies issuing similar contracts can be significantly different, if one is an insurance company and the other is not.

Many constituents had said that these areas of current U.S. GAAP were flawed. They also realized that the number of insurance companies that apply U.S. GAAP represents a significant proportion of the overall global insurance industry, the U.S. being a major presence in the global insurance scene. So when the idea of the Financial Accounting Standards Board (FASB) joining the International Accounting Standards Board (IASB) on a joint insurance project came up, most constituents were overwhelmingly in favor of the idea. Many believed that a joint project presented an excellent opportunity to correct some of the current flaws with U.S. GAAP accounting, and also to ensure that FASB would be actively involved in the development of the global accounting standards that govern insurance transactions. Given the significance of the U.S. in the global insurance industry, and the need for convergence of standards in the global marketplace, it seemed only natural that the U.S. would be a key contributor.

By October 2008, the members of the FASB had decided to proceed with the plan to work with the IASB on a joint insurance project. The Boards would collaborate in an effort to develop common, high-quality guidance that would establish principles for the recognition, measurement, presentation, and disclosure of insurance contracts and reinsurance contracts. In September 2010, FASB issued a Discussion Paper, “Preliminary Views on Insurance Contracts,” subsequent to its July 2010 Exposure Draft on insurance contracts. On July 27, 2013, after careful consideration of the comments received on the 2010 Discussion Paper and the 2010 IASB Exposure Draft, the FASB issued the highly anticipated proposed Accounting Standards Update, Insurance Contracts (Topic 834).

The new proposal will have a significant impact on every company that issues insurance contracts, but especially on those that issue life, annuity, and long-term health contracts. In accordance with the FASB proposal, companies will have to account for insurance contracts by applying one of two methods, which are based on the particular characteristics of the insurance contract under consideration: the premium allocation approach (PAA) or the building block approach (BBA).

The PAA will be primarily used for property, liability, and short-term health contracts, whereas the BBA will be applicable to most life, annuity, and long-term health insurance contracts. In addition, the new FASB proposal changes the definition of an insurance contract. Although the definition still requires that an entity must accept significant insurance risk, the definition of precisely what constitutes a “significant insurance risk” has been modified. Under current U.S. GAAP, an entity accepts significant insurance risk if it is reasonably possible that it could realize a significant loss; however, under the proposed guidance, an entity would accept insurance risk only if it is exposed to a signifi-
cant loss in any reasonable scenario. While this might seem like a subtle difference, we think that it’s going to make it considerably harder for contracts to qualify for insurance accounting under the proposed guidance.

**Premium allocation approach**
The PAA would be applied if the insurance contract’s coverage period is one year or less, or if, at the inception of the contract, it is unlikely that during the period before a claim is incurred there will be significant variability in the expected cash flows required to fulfill the contract.

- **Pre-claim liability.** A pre-claim liability would be recorded as it is in today’s accounting for the recording of an unearned premium.
- **Policy acquisition costs.** Costs could be expensed as incurred, or they could be netted with the pre-claim liability, which, under current accounting guidance, is referred to as unearned premiums, and is expensed ratably over the period of revenue recognition.
- **Post-claim liability.** A liability would be recorded on the balance sheet based on the present value of the unbiased, probability-weighted estimate (i.e., the mean) of the future cash outflows for claims that have been incurred. Discounting of the post-claim liability is not required if it is determined that the effects of discounting are immaterial or it is anticipated that the incurred claims will be paid within one year of the insured event.
- **Onerous contracts.** The pre-claim liability must include an additional amount representing the liability for any onerous contracts. (An “onerous contract” is one where the costs involved with fulfilling the terms and conditions of the contract are higher than the amount of economic benefit received.) The liability for onerous contracts is comparable to a premium deficiency reserve under current accounting guidance. However, as in the calculation of the post-claim liability mentioned previously, the calculation here to account for the liability of the onerous contract would be based on the unbiased, probability-weighted estimate of future cash flows.

Although the accounting used for a PAA contract is basically the same as it is under current U.S. GAAP, there are some key differences that will significantly affect any entity that issues property, liability, and short-term health insurance contracts. One of the most significant changes concerns the method used for establishing the liability for unpaid claims. Under current U.S. GAAP, the recorded reserves are based on management’s best estimate, which includes the estimated ultimate cost of settling the claims.

Many times, under current GAAP, the actuary provides the entity with a range of estimates; the entity has some leeway in working with this range, and applies its own judgment in recording the specific amount of reserves within the range. Under the FASB proposal, the liability for unpaid claims, or the post-claim liability, will be measured as the present value of the unbiased, probability-weighted estimate of the expected future cash outflows. The objective is to have the entity book reserves based on the statistical mean of the several possible scenarios that incorporate all of the relevant information. As such, under the new proposed standard, the actuary would provide the entity with a specif-
ic number for the mean, which the entity would then record on its books. The entity would no longer have a say in selecting a specific number, within the actuarial range reserves, to record in its accounts.

Some observers in the industry have declared that this standard will mean the “death of the range!” While this is true, it does not mean that a company doesn’t have any influence in determining actuarial reserving practices. Companies can, and should, work closely with their actuaries to ensure that the actuary’s assumptions and inputs accurately reflect management’s insights into the company’s outstanding exposures.

Another key difference relates to discounting loss reserves to present value. Under current U.S. GAAP, most entities do not discount loss reserves. Under the proposed guidance, the discount rate utilized at initial recognition should reflect the characteristics of the liability, and it will be used to reflect the initial expense for claims incurred. However, any subsequent changes to the discount rates will be captured within the accounting category, “other comprehensive income” (OCI), and will be recorded as a reversing entry as interest expense is recognized in net income.

Table 1 shows what a Statement of Comprehensive Income will look like under the PAA.

**Building block approach**

Under the BBA, a new methodology is introduced: companies must record earned premium for each reporting period during which the contract is in effect. The earned premium is equal to the value of coverage and other services provided on the contract, excluding any estimated return premium. Here are some of the material details in the accounting for a BAA contract:

- **Liability.** At each reporting date, a liability would be recorded as the present value of the unbiased, probability-weighted estimate of the future expected cash outflows, less the expected future inflows.

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outflows from the expected cash inflows. Any losses would be recognized immediately, whereas any gains would be deferred and earned ratably over the coverage and settlement periods. The margin would not be re-assessed at each reporting period.

■ Policy acquisition costs. The costs incurred would be applied as an offset to the margin, and recognized as an expense, in the same way as the margin.

Transition
The proposed update will need to be applied retrospectively. Companies will be forced to derecognize any existing deferred acquisition-cost balances related to insurance contracts, and will have to account for any qualifying acquisition costs, in accordance with the proposed update. Disclosures in company financial statements will need to include all of the information relevant to the prior period, retrospectively adjusted, with disclosure of the cumulative effect of the change on the various components of their equity portfolio, and disclosure of the indirect effects on the financial statements.

Even though the new proposed standard is still years away from becoming effective, it will have a significant impact if it is adopted. The proposed update will have a significant impact on insurance companies and a select group of other firms that issue product warranties, financial guarantees, performance bonds, or other contracts, as defined within the proposed guidance. Comments on the proposed update were due from constituents by October 28, 2013, and the final issuance date is still to be determined. However, current projections suggest the final standard will be issued at some point in 2015, but the effective date won’t come until 2018, at the earliest. Even though the new proposed standard is still years away from becoming effective, it will have a significant impact if it is adopted. So insurance companies and their actuaries should begin to consider how they might anticipate its consequences, and mitigate any negative impacts, today.
Much airtime has been dedicated (and advertising minutes sold) based on the prospect of the imminent resurrection of interest rates, from the low single-digits. This assumption is shared so universally that we have seen 10-year rates increase by 155 basis points (1.55%) since the summer of 2012. Well: is it over, or is this just a prelude to a prolonged period of inflation, stoked by an easy-monetary policy? And what to do? Just sit on cash, in anticipation of a further correction in fixed income markets?

We make the case here for staying the course, with a sprinkling of history, a bit of prevailing wisdom, some basic facts, and a projection developed by the Federal Open Market Committee (FOMC). Then, we’ll use math to fit the pieces together.

But first, we visit the opposing schools of thought.

**Why rates have the potential to rise**

Here are some reasons why interest rates might increase.

- **The Federal Reserve’s withdrawal of quantitative easing (QE).** Since the beginning of the financial crisis, the Federal Reserve has been employing unusual means to drive interest rates lower. More recently, and beginning in 2012, the Federal Reserve has been purchasing $45 billion of Treasuries, and $40 billion of agency-backed mortgages, every month. This artificial demand, intended to keep rates low and stimulate the economy, has just about run its course. Put in perspective, $45 billion in Treasury notes represents almost 90% of the U.S. monthly deficit. The removal of this demand (the Fed buying Treasuries) should drive rates up.

- **Seasoned investors remember inflation in the early 80s.** The Arab oil embargo of 1973, followed by the U.S. embargo of Iran in 1979, set the stage for the inflation of the early 80s. The price of oil nearly tripled in 1973, and then again in 1979, from $3 to $11 in 1973 and then up to $39.50 by 1980. Gas lines, shortages in general, and “Whip Inflation Now” buttons (“WIN”—get it?) led to a real inflation rate (measured by CPI) of almost 15% in March 1980. But even inflation is difficult to sustain. Market forces, and notably fuel efficiency, pulled inflation down to less than 2%—that we’re experiencing today.

As it turned out, the yield on the 10-year Treasury note was only 12.6% in March 1980, although it did ultimately peak at 15.8%, in September 1981.

And it has been downhill ever since. Since the mid-1980s, inflation rose to 6% just one time, and it hasn’t eclipsed 5% since the Clinton administration. But that hasn’t kept fixed income investors, especially those that lived through it, from waiting for the day when the opportunity of a lifetime wanders along once again.

- **Prevailing wisdom—it doesn’t take much effort to find some expert who will say that, “Rates must certainly rise.”**

Amazing: the power of suggestion driven by the media. That is, until the unexpected reminds us once again that the media does its best work in reporting the past. Their track record at predicting the future? Not so great. Y2K, anyone?

Economists, so adept at explaining why something happened in the past, don’t fare much better. A market adage becomes adage-worthy because it reveals some basic truth (for the most part). The veracity of one of our favorites, “Markets behave in such a way as to fool the greatest number of people,” is demonstrated repeatedly, because it is the unexpected that drives markets.

**Why rates will remain relatively low**

As of this writing, the 10-year Treasury yields 2.95%. Since July 2012, rates have risen by 155 basis points. It would be pretty easy to suggest that a correction has already occurred. Most measures of inflation remain at historic lows. It would seem that inflation, the driver of rates
in the late 70s and early 80s, at this point has no traction.

- The CPI (year over year) for July 2013 was 2%. (Figure 1).
- Capacity utilization, the percentage of our production infrastructure that we utilize, is directly correlated to inflation. In the 1980s, it was in the 80+% range and exceeded 90% by some measures. Recently, such utilization was at 77%.
- Unemployment rate and jobs growth remain stuck below the Fed’s stated target rate, 6.5%, as well as historical norms (Figure 2). Affected by factors like regulation (Affordable Care Act) and demographics (much of the population is retiring—and therefore, unemployed), the labor force participation rate stands at a 35-year low.

A projection from above—the Fed’s playbook

In January 2013, members of the FOMC were presented with a primer on the details and impact of quantitative easing, as well as projections on what would happen to rates when the Fed would ultimately begin to exit the markets and shrink its balance sheet. We present this as the most objective of the many forecasts available. The entire piece can be found on the FRB website at: http://www.federalreserve.gov/pubs/feds/2013/201301.

The Fed’s baseline projection (Table 1) shows the projections given to the FOMC members.

These projections take into account tapering (to conclude in early 2014), as well as the general principles that were outlined in the minutes of the June 2011 FOMC meeting, which are as follows:

1. Cease reinvesting some or all payments of principal on the securities holdings in the SOMA portfolio (the Fed’s portfolio).
2. Modify forward guidance on the path of the federal funds rate and initiate temporary reserve-draining operations aimed at supporting the implementation of an increase in the federal funds rate, when appropriate.
3. Raise the target federal funds rate.
4. Sell agency securities over a period of three to five years.
5. Once sales begin, normalize the size of the balance sheet, over two to three years.

Staying the course or time for a change? The mathematics of opportunity cost

Given what we believe to be a credible interest rate projection (provided courtesy of the people who have the tools to make it happen), we examine the opportunity cost of a fully invested strategy, versus that of holding cash over a period of five years. The cycle for rates typically lasts five years, and this includes the period from early 1977 to late 1981, when the 10-year Treasury rose from 6% to 16% (Figure 3).

Now, consider these two strategies in the context of the Fed’s projection (presented earlier):

1. Invest $1,000,000 at the federal funds...
Invest $1,000,000 in a 5-year Treasury note.

In order to price and calculate the value of the security in option 2, we projected market rates for a 5-year note purchased today, as it approaches maturity. These are shown in Table 2.

In Table 3, we compare the periodic market value of a 5-year note versus that of a deposit earning the projected federal funds rate.

In every year but 2019, Strategy 2—buying the 5-year security—outperforms the option of holding cash. This is based on a single projection; other projections can certainly suggest otherwise.

Understand, though, that as the curve steepens (5-year rate higher, compared with federal funds), this “carry trade” is even more profitable.

**In conclusion**

Expectations frequently preordain results, until market forces adjust to reflect reality. In this interest-rate cycle, the anticipated imminence of rising rates has already led to the evisceration of bond mutual funds and ETFs, and it has self-fulfilled at least part if not all of a continued rising-rate scenario. Traditional measures of inflation and employment do not yet support a rate spike like that of the early 1980s, which developed over a period of five years.

Considering such a horizon, remaining invested continues to be warranted for both the total return fund as well as more rate/margin sensitive insurance products. The opportunity cost of holding cash is significant under almost every scenario.

In either case, we are wise, as usual, to study history, lest we repeat it. That said, a market adage that’s used as a popular disclaimer still applies: *Past performance is no guarantee of future results.*

**Traditional measures of inflation and employment do not yet support a rate spike like that of the early 1980s, which developed over a period of five years.
It seems that hardly a day goes by without some reminder of the unbridled costs of healthcare. Apparently, this is for good reason. Consider the following: The U.S. spends a larger share of its gross domestic product (GDP) on healthcare than any other major industrialized country. Expenditures for healthcare account for nearly one-seventh of the nation’s GDP, and they persist as one of the fastest-growing components of the federal budget—estimated to consume a full 26% of the nation’s output in 2014.

For years, the underpinnings of spiraling healthcare costs—expenses associated with medical tests and treatments—may have been misunderstood by the very practitioners who provided care. Why? Because doctors in training have traditionally been shielded from details about the costs of the care they prescribe. For decades, this subject has been virtually taboo when professors and trainees discussed treatment decisions.

This trend, however, may be changing. U.S. medical schools are beginning to educate future doctors about the cost consequences of their medical decisions. According to the Accreditation Council for Graduate Medical Education, since 2007 U.S. residency programs have been required to teach doctors to “incorporate considerations of cost awareness” in caring for patients.

Nonetheless, medical students and resident doctors are still being taught to practice defensive medicine. Those of us who work with MPL know only too well why defensive medicine is so prevalent. But survey results also reveal some interesting insights.

In a 2010 national survey by Jackson Healthcare, 83% of doctors aged 25–34 reported that they were taught to practice defensive medicine in medical school or residency by an attending physician or mentor to protect themselves from being sued. In contrast, only 47% of doctors aged 45–54 gave the same answer, and the numbers dropped with increasing age, falling to 19% for physicians over 65. What this seems to point out is that, even as the burden on doctors to minimize costs grows, the conflicting pressure to do anything possible to help avoid a lawsuit is increasing even more rapidly.

Admittedly, concerns about liability fears aren’t the only reason for the overuse of healthcare resources. Doctors have to make hard choices in providing patient care. Patients often want answers to their problems, at any cost. The culture of medicine—based on the Hippocratic Oath—emphasizes the need to consider whatever might benefit the patient, irrespective of cost. Of course, on the other side of the ledger, this sometimes means denying treatments that patients may perceive—and may actually be—beneficial.

Reform of the current medical liability system would undoubtedly reduce the practice of defensive medicine and thereby help rein in healthcare costs. It would also help if doctors and patients would both realize that we just can’t afford to continue down the current path in spending ever-greater sums on healthcare.

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