30 Years and Counting

The Amazing Versatility of the PIAA Data Sharing Project

AND

Annual ‘Industry Update’
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To learn more about our medical professional liability expertise and our Commitment Beyond Numbers, visit us at pinnacleactuaries.com.

Meet Pinnacle at the PIAA Medical Liability Conference
Booth #19

Commitment Beyond Numbers

Medical Professional Liability
Rate Analysis
Alternative Markets
Enterprise Risk Management
Legislative Costing
Litigation Support
Loss Reserving
**Big Data: Revolutionizing Healthcare and Medical Professional Liability**

"Big data" is a topic that crosses all boundaries; it is ubiquitous these days. It now serves as the basis for much of what we do in healthcare and in business. W. Edwards Deming, the famous quality guru once remarked, "If you can't measure it, you can't manage it," and that statement has never been more relevant.

This year marks the fifteenth anniversary of the Institute of Medicine's publication, "To Err Is Human." We have seen significant changes in medical professional liability (MPL) since 1999 and this report. Notably, there have been major gains in patient safety, achieved through a broad range of initiatives such as the widespread adoption of root cause analysis practices throughout much of the nation's healthcare system. However, it is important to remember that the IOM report was based on data from the 1990s, a time when the desktop computer was far from universal.

Recently, there has been a fundamental change in the way we look at and use data. With the recent development of enhanced quality measures and standards for healthcare professionals, there is now the ability to quantify and conduct analyses in new and inventive ways, revolutionizing the healthcare and MPL industries.

As we contemplate these dramatic changes, we are pleased to offer you two important and timely articles in this issue of *Inside Medical Liability*. The cover story, "PIAA Data Sharing Project: In the Vanguard of 21st Century Data Analytics," celebrates the 30 years of uninterrupted excellence of the PIAA Data Sharing Project. It now houses more than 280,000 closed claims, and has proved over the years to be a nimble tool for analyses that assist PIAA members in critical business functions, such as detecting claim trends, assessing performance as compared with peers, and providing the basis for new risk management and patient safety programs.

The second article, "Counting Mouse Clicks in Clinical Practice with an EHR: Comparing Time Spent Before a Computer versus Time with Patients," addresses another, less fortunate, aspect of the data revolution: the need to compile and store data sometimes robbing both physicians and patients of the most important aspect of a patient visit: time well spent, in speaking and listening with full attention.

At the 2015 Medical Liability Conference, we have sessions to help you navigate the brave new data-driven world. One of these is "Big Data’s Big Impact on Healthcare and the MPL Industry." You will hear new strategies for turning data into knowledge and knowledge into intelligence—how to use real-time operational intelligence to drive key performance indicators, and methods to predict and monitor outcomes and results. There will also be coverage of new sources of data for making decisions in underwriting, rating, and pricing.

This year’s keynote speaker James E. Orlikoff, National Advisor on Governance and Leadership to the American Hospital Association, will explore the rapidly changing hospital marketplace and discuss new data that raises serious issues: depressed hospital volumes and margins, declining reimbursement, mergers and acquisitions that lead to super systems, and new models for providing care, like ACOs. He will explain how healthcare leaders need to adapt in order to be effective within today’s complex systems, positioning their organizations as something radically different from their past operational models.

If you think it is difficult now to predict the future of our healthcare and MPL systems, this challenge will only become more complex as we consider the data on the emerging millennial generation. Today’s young adults constitute the largest living generation, so the MPL community will need to understand how this emerging group sees the world. To assist with this challenge, we offer a presentation by Scott Hess, who has been studying the Millennials for the past 15 years. With his guidance, you can learn how to connect with Millennials as clients and colleagues.

PIAA strives, through its varied projects and publications, to provide a rich variety of information and perspectives on the newest and most significant issues affecting our members and the MPL community. We hope you take advantage of all PIAA has to offer.
“As compared with databases solely comprised of paid claims, the DSP data enables comparisons of closed claims vs. paid claims, thus providing a critical metric for assessing the current status of the MPL sector: the paid to close ratio.”

—Cover story
IN TODAY’S COMPETITIVE MARKET, ARE YOU STAYING AHEAD OF YOUR COMPETITION?

Delphi Technology is the only solution provider that gives you all the tools you need... a seamlessly integrated suite of business solutions, more than 20 years of industry knowledge and business expertise, and an innovative technology solution.

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• Flexible product definition workbench
• Highly-configurable interface, business rules and workflow
• Highly-configurable dynamic intelligent web portal services platform
• Industry-leading data warehouse, data cubes and OLAP / predictive analytics

Let Delphi Technology show you how its fully-integrated medical professional liability solution will transform your critical business challenges into measurable business results.
## 2015 Technology, Human Resources, and Finance Workshop

**Strategic Leadership for Changing Times**

As former Director of Strategic Plans and Policy for the Joint Chiefs of Staff, Lieutenant General John F. Sattler, United States Marine Corps (Retired), understands change. He developed strategy for the U.S. military during one of the greatest times of change in the history of warfare. With more than 37 years of Marine Corps experience in leadership and strategic planning, Lt. Gen. Sattler will speak on the importance of communication and team buy-in during an era marked by new directions and planning. He will also speak about the optimal role of leaders in strategic planning during challenging times. Participants will understand the role they can play in successfully developing strategy for effecting change in their own companies.

## 2015 Underwriting Workshop

**The Enterprise Risk Management Approach for Telemedicine and Telehealth Underwriting**

Fay A. Rozovsky, JD, MPH, President, The Rozovsky Group, Inc., is an experienced risk management consultant who has worked in Australia, Canada, and the U.S., with trade associations, governments, hospitals, long-term care organizations, home health agencies, and physician practices. Rozovsky will relate how telemedicine and telehealth are transforming healthcare delivery. Now including remote diagnostic imaging, pathology, dermatology, cardiology, and psychiatry, as well as patient-generated telehealth data, this technology can potentially foster efficient, effective, and safe care. But what are the underwriting exposures? Rozovsky will show how an enterprise risk management approach can be used to identify the most important issues, from an underwriting perspective. Renowned as an educator in healthcare risk management and patient safety, Rozovsky pioneered “live to air” risk management education in Canada, first via satellite radio uplink to remote nursing outposts and then on television throughout Atlantic Canada.

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**Events & Calendar**

### Coming Attractions

- **May 13, 2015**
  - Leadership Camp
  - Caesars Palace
  - Las Vegas, NV

- **May 13–15, 2015**
  - Medical Liability Conference
  - Caesars Palace
  - Las Vegas, NV

- **September 16–18, 2015**
  - Technology, Human Resources, and Finance Workshop
  - Omni Providence Hotel
  - Providence, RI

- **October 7–9, 2015**
  - Underwriting Workshop
  - The Mayflower Renaissance
  - Washington, D.C.

- **October 22–23, 2015**
  - Corporate Counsel Workshop
  - Casa Monica Hotel
  - St. Augustine, FL

- **November 4–6, 2015**
  - Claims and Patient Safety/Risk Management Workshop
  - The Roosevelt
  - New Orleans, LA

Future PIAA Medical Liability Conferences:

- **May 11–13, 2016**
  - Washington, D.C.

- **May 17–19, 2017**
  - Colorado Springs, CO
Beyond breach response, your cyber liability coverage from NAS is designed to help you swiftly recover from the incident and restore your operations.

More than insurance, we provide the essential services to restore your practice with confidence.
That’s Resilience.

For more information about our cyber liability solutions, visit:

nasinsurance.com/resilience
Healthcare professionals know that the switch to ICD-10 on October 1 means a major change in how they input billing and diagnostic codes. The sheer number of codes will increase by thousands. To help explain the changes to doctors and consumers, the Centers for Medicare & Medicaid Services has taken to the Web, creating a series of animated videos that explain the changes in an easy-to-understand format.

When a brief article on the animation was featured in the February 23, 2015, edition of Healthcare Finance News, there was only one comment. But it was more than enough. According to one Stanley Beekman (not otherwise specified):

“The video says that ‘doctors will capture much more information, meaning they can better understand important details about a patient’s health than with ICD-9.’ Coding is done after a patient is seen, and is sent to an insurance company. There is no way that a doctor captures more information. The only thing that will be captured is the doctor’s time in trying to figure out this nonsense and his time dealing with audits based on inevitable miscoding.”

Now, if you’re kind enough to send us your review of one of the videos, we promise to include it in the very next Observer. Stay tuned.


Should Patients Be Allowed to Record Visits with Doctors?

Well, should they? A pretty long list of pros and cons comes quickly to mind. Pros: a recording of a visit could help patients remember all the details of a diagnosis, medication, treatment, and follow-up discussions, and also help caregivers who might not have been present at the visit.

But on the other hand, attorney and risk management consultant Lee J. Johnson warns that doctors have every right to worry that such a recording may become evidence in a medical professional liability lawsuit. Only a handful of states require that both parties in a conversation must consent for a conversation to be legally recorded. In most states, only one party needs to consent. If a recording is made surreptitiously, it’s still legal, irrespective of how it will be used later.

Physicians had responded to a prior article on patients’ recording of visits with a decided lack of enthusiasm. One family physician said, “Always refuse! Patient/physician action is confidential. Recording the visit opens up the possibility for all kinds of misuse and abuse.”

There was one dissenter, though. He said, “I believe that a patient has the right to record communications with his or her physician. What does a physician have to fear if he or she is practicing medicine in good faith?”

What indeed?

Source: Medscape, February 17, 2015
Aussie Taxpayers Have Spent More than $1 Billion on a Digital Health Record Doctors Don’t Use

The concept looked good on paper: a “Personally Controlled e-Health Record” for every Australian. But while it has been in operation for three years now, only one in ten Australians (2.1 million people) currently has one. Physicians haven’t been using them much either. They have uploaded only 41,998 shared health summaries onto these records. This means that most of the more than 2 million health records are... empty.

But the scheme has cost more than $1 billion, or almost $24,000 per shared health summary. That equates to a hip replacement, knee replacement, or removal of brain tumor (though consumers were not in fact offered these additional options).

The digital records were launched by the previous Labor government in July 2012, and the system was meant to include an electronic health summary, a list of allergies and medications, and eventually, x-rays and test results. The new Abbott Government called for a review of the scheme just after taking office, but failed to act on its recommendations for more than 14 months.

Australian Health Minister Susan Ley has been talking with doctors about their experiences with the e-health system, and has concluded that, “Unfortunately, Labor has left a complex, expensive mess behind and this is not an easy overnight fix, but we’re continuing to put the time and effort into getting the right outcome for all involved.”

Australian Medical Association president Professor Brian Owler says that the scheme “remains in limbo, and to have spent that much money and still not have anything of widespread value is terrible.”

More specifically, he notes, “They tried to roll it out with general practitioners and missed the specialists, and it ended up being GPs talking to themselves, when it was meant to be about integrating healthcare.”

Still: no mention about issues with “interoperability.” Every nation, it seems, has its own singular set of issues, EHR-wise.

Source: news.com.au, February 27, 2015

Surprise: Mississippi Is a Leader in Telemedicine

The state has some grim numbers in its rankings in population health: worst infant mortality and the most children born with low birth weight, second highest rate of obesity and cancer deaths, and second to last in diabetes outcomes.

But the state has a pretty nifty telemedicine system. The state’s sole academic hospital has remote connections to 165 sites, and provides specialized services to some of the state’s most far-flung medically deprived cities and towns. In fact, Mississippi’s telemedicine system is ranked among the seven best in the nation. It has prompted neighboring Arkansas to take bigger steps in this area, too.

So, is more widespread use of telemedicine the answer the nation’s increasing doctor shortage? Mississippi will certainly provide us with a good pilot study to find out. They have the worst doctor shortage in the country. Massachusetts has roughly 2½ times more doctors per capita. For specialists, the ratio climbs to 3 to 1.

The University of Mississippi Medical Center’s Center for Telehealth has put in place an impressive range of networks that makes doctors’ reach go farther. It provides 8,000 telemedicine visits per month and 100,000 a year across the state. Services are as varied as diabetes counseling and robots examining premature babies.

But even with all of this innovation and integration, a doctor’s time can only be stretched so far. It might be wise to keep tabs on this experiment in Mississippi, to see what happens in the MPL domain. Observer thinks of this as something akin to “extreme telemedicine,” and would not be at all surprised to discover that there were some unintended consequences.

Source: Politico, February 26, 2015

Aussie Taxpayers Have Spent More than $1 Billion on a Digital Health Record Doctors Don’t Use

$1,000,000,000!
PIAA Data Sharing Project
2009–2013 MPL FACTS (2013 Dollars)

AWARDED
$342,384
AVERAGE INDEMNITY PAID
9.5% of indemnity payments were greater than or equal to $1M.

PAID
27%
OF ALL CLAIMS AND LAWSUITS
Conversely, 73% received no monetary award, but cost $40,650 to defend.

COST
$50,766
AVERAGE EXPENSE TO DEFEND
80% of claims result in a lawsuit, of which 10% were resolved by a verdict with 91% in favor of the defendant.

Highest Average Indemnity Payment by Healthcare Specialties

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>$467,221</td>
</tr>
<tr>
<td>Neurology</td>
<td>$443,353</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>$438,218</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$421,326</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>$388,097</td>
</tr>
</tbody>
</table>

Highest Payment Ratio by Healthcare Specialties

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Payment Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>57%</td>
</tr>
<tr>
<td>Neurology</td>
<td>45%</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>39%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>34%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>32%</td>
</tr>
</tbody>
</table>

Total Defense Expenses (ALAE) by Healthcare Specialties—in Millions

The ten specific healthcare specialties listed above absorbed approximately 75% of the total ALAE reported to the DSP.
Getting at the heart of the markets

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Or contact Dennis Klimes at Dennis.Klimes@primeadvisors.com
People frequently ask me why it is that PIAA—a recognized leader in the medical professional liability (MPL) insurance community—is such a dynamic and resolute organization. I believe that several notable factors are involved in this achievement.

At the core is our membership—a group of steadfast MPL organizations dedicated to providing stable, dependable professional liability coverage. These organizations are also at the cutting edge of advances in patient safety and risk management, continually finding new ways to minimize adverse outcomes.

We have access to the best and brightest minds in MPL, and we are fortunate to have so many of them on our Committees and Sections. They donate their time and insights, so that we can bring you the most informative programs in the MPL field. Expanding knowledge is a hallmark of PIAA. It wouldn’t happen without the contributions of these dedicated individuals.

Perhaps most important is PIAA’s legacy of physician involvement. The founders of PIAA had the foresight to envision a new business model, which would combine the medical expertise and unwavering pledge to quality of physicians with the knowledge of insurance professionals. PIAA’s founders also felt passionately that empowering physicians with the tools and information they needed to understand loss data—at the time, a unique vision—would advance the caliber of patient care in a way never seen before.

Over the years, because of this approach, PIAA and its members have achieved an unparalleled understanding of MPL and the essential elements for the provision of quality healthcare.

As we enter 2015, and the close of my first year as PIAA Chair, I am proud of our achievements. Our evolved mission—to promote, protect, educate, and connect MPL insurers who support the quality delivery of healthcare—has positioned the Association to preserve the intent of our founders, while adding a broader diversity of members, via an enhanced membership structure.

Your Board of Directors, comprised of a majority of physicians, developed an innovative strategic plan for the Association that reflects the new realities in healthcare. This calibration of PIAA’s strategic direction has paid off in many ways. For example, we established the Fellows Leadership Program to identify and engage healthcare professionals serving in member companies’ senior management and Board positions, to help them prepare for future participation in PIAA and industry leadership. Our first class of Fellows graduates this month, and we congratulate them on this achievement.

We also brought you a new event to promote the importance of diversity in the MPL workplace. This program is of particular importance to me as the first female chair of PIAA—and I look forward to its ongoing success.

And, as we celebrate the 30th anniversary of the PIAA Data Sharing Project (DSP), we are proud of the evolution of this unique resource. Expansion to include hospital and health system data, transformation to ICD-10 coding, and the development of new analytical reports are just some of the more recent enhancements to the DSP.

In looking to the future, I am committed to ensuring that PIAA remains an indispensable resource for every group with a commitment to quality healthcare and a stake in MPL. I know that your Board of Directors is as well, and I believe we are on the right track to continued success.
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Visit us at the 2015 PIAA Medical Liability Conference, May 13-15 in Booth #23 & 24 for a demo of MiCapture and to learn more about our comprehensive collection of Risk Management resources.
Customer Segmentation: A Path to Profitability

Not all customers are created equal. This is a fundamental truth in business that isn't commonly accepted. Rather, medical professional liability (MPL) insurers go after any warm-bodied, breathing physician practice in order to meet the quarterly or annual sales goals. Solo practices, single and multispecialty independent groups, even hospitals or systems—all are targets in our efforts to increase premium and expand market share.

Yet savvy companies around the world know that there is a better way—and it's time for the MPL industry to catch up. MPL carriers need to start value-scoring their prospects and quantifying the value of their various customer populations, in terms of cost of acquisition, customer lifetime value, and profitability. The first step in this strategic process is to create appropriate and sustainable segments that match both the insurer's long-term strategy with specific performance metrics and its goals for each segment (and even targets within those segments).

"Segmentation is about the profitable satisfaction of customer needs," say Paul Hague and Matthew Harrison of B2B International. "It is designed to be a practical tool, balancing idealism with practicality and coming up with a solution that maximizes profit." In other words, segmenting your market should not be an academic exercise.

David Kinard, MEd, PCM, is Vice President of Business Development at Physicians Insurance A Mutual Company, Seattle, Washington.

Rather, market segmentation is a process of unlocking consumer insight in order to drive profitability.

Fundamentals of segmentation
Let's start with a few definitions, to ensure a basic level of understanding about the segmentation discipline. A "segment" is a group of prospects and customers that are mostly homogenous, have definable boundaries in regard to other segments, and whose member base is relatively stable and sustainable over time. A segment's value should be quantifiable in terms of revenue, expenses, and profitability. And, lastly, the segment's members should be reachable by the company and respond similarly to any given market stimulus or promotion.

Within each definable and separate segment there are "targets." These are subgroups within a particular segment that may pivot off of a particular variable. Unlike a segment that should only change when the insurer's core strategy and value proposition changes, a target is a temporarily defined audience group that may be pursued for a particular season of time with specialized messaging, pricing, or services.

What does this look like in the real world? Let's say an insurer has a segment of solo practitioners. Within that segment, however, there are many possible targets, such as family practitioners (or any other specialty). Or perhaps the insurer wants to reach out to solo practitioners within a specific geography (state or region); that would be another example of the segment/target model.

How to segment your audience
As previously noted, a segment is a definable...
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Are you ready?

Joe Montgomery, Judy Halstead, Christine Stiles, TC Wilson, Bryce Lee, Robin Wilcox, Cathleen Duke, Kathryn Jenkins, Brian Moore, Loughan Campbell, Karen Hawkridge, Vicki Smith and Brad Stewart
group of prospects and customers that are mostly homogenous. Uncovering the critical factors that make a widely diverse universe of prospects and customers mostly homogenous is both an art and a skill. The process is both analytical and intuitive, so using a team to work through the various scenarios and to represent multiple perspectives (numbers and relationships) is critically important. The litmus test for an effective and sustainable segmentation model for your organization is to find the golden thread—a key insight—that your model can pivot from, some theme or idea that naturally brings your audiences together.

To find this golden thread, you will need a lot of data: financials, demographics, purchasing approaches, operating variables, situational factors such as trends/industry changes/regulation, supplier variables, employee data, competitor data—basically, any and all information should be considered when you first get started. Editing information and data points from the mix will emerge as you refine your segment models, but not having it at the beginning can limit the scope of your outcomes.

Some examples of segment models that other have used—and keep in mind these worked for those companies because the segment model linked to their strategy—include a price-focused segment, a brand/quality-focused segment, a service-focused segment, and a partnership-focused segment. Each segment was identified based on customer needs, what the customer was looking for and wanting. Another example was a segmentation that considered years of experience as the defining factor, creating new-to-practice, mid-career, and seasoned-expert segments. Again, in each segment there are many ways to target more specific audiences on a varying basis, but in all cases the segments themselves remained stable.

In most successful efforts, the end result is about four to six segments. Anything less runs the risk of not being sufficiently definitive to create meaningful discriminations between prospect and customer needs. On the other hand, having more than six segments can mean that your process was too discriminating, resulting in a model that consumes unnecessary resources.

Lastly, once your organization has landed on a segmentation model, it is important to “personify” those segments, so they can be clearly envisioned by the rest of the company. Many successful companies will create personas that represent the segments, naming them, using photography and other visuals, and describing them in enough detail that employees can envision them as individual people, for whom they are working to create value and provide excellent service. Without this step, the segmentation models run the risk of being impersonal to employees, and that discourages engagement with the segment strategies and goals.

Pursuing profitability

As noted earlier, the ultimate goal of segmentation is to unlock consumer insights to drive profitability. Not all customers are created equal; they consume services differently and contribute different profit margins to the insurer. They may buy the same MPL policy as their peers in other segments, but their needs are not always the same. An insurer’s

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ability to recognize the differences in the
needs of each segment, and deliver value
appropriate to that segment, is the first step in
increasing profitability and efficacy in cus-
tomer relationships.

One key factor to know about your
newly defined customer segments is the cost
of acquisition associated with each. For sure,
there are different costs for acquiring a solo
practitioner account than for pursuing and
landing a large multispecialty clinic account.
These costs could include marketing, sales
(direct/indirect/telemarketing/in-person),
loss-leader services/promotions, and costs to
underwrite and sign on a new account. Other
factors to know are the discounts that the seg-
ment is typically provided and the costs of
servicing them, or perhaps the loss ratios for
that segment. Conversely, you want to also be
able to evaluate the segment in terms of total
revenue and profitability.

Just think about what this process could
mean for your organization: You do your
homework and realize that your new-to-prac-
tice physician market represents 15% of your
overall premium, with a 30% profit margin.

Yet your mid-career physician segment repre-
sents 48% of your overall premium, but only
17% of your profit. With this information, you
can make strategic decisions about your mar-
ketin
and sales plans, quantifying those
efforts in ways that will help you reduce your
ongoing/acquisition expense and thus add
more to your bottom line.

Resonate or retreat
Some of the more common pitfalls to avoid as
you segment your market include hubris, fast-
forgetting, and impatience. Each of these
shares one fundamental quality: the inability
of the organization to realize that the old way
of doing things is no longer effective, and that
the better practice is to adopt a segmentation
discipline. This discipline must become an
integral element in the organization’s culture,
where all conversations about customers link
back to segment strategies and goals, and
where decisions are made by considering the
segments’ needs (present and future).

Mostly important, the process of adopt-
ing a segmentation discipline isn’t one that
can be rushed. There is no set schedule
that your organization needs to follow in
developing its first segment model iteration.
But an appropriate amount of time should be
dedicated to discovery, analysis, debate, syn-
thesis, testing, and adoption. Rushing this
process will only lead to a thin and unstable
segmentation model that yields substandard
results.

The fundamentals of any good business
are the same for the segmentation discipline:
have an intimate knowledge of who your cus-
tomers are, what their needs are, and what
challenges they face, and then create a prod-
uct, and wraparound services, that solve those
problems. It’s the clearest path to understand-
ing what value proposition your audiences
want and need, and it also increases your
competitiveness by enhancing your ability to
resonate with your audiences. Gone are the
days of one-size-fits all approaches for MPL
carriers. The companies that embrace a seg-
mentation discipline will be those that
increase revenues, profitability, and market
share. Those that attempt to overlook this new
discipline will, not too slowly, retreat into
obsolescence.

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depth of technical expertise and an exceptional level of service
focused on our clients’ specific needs.
For many years, when legislators, lobbyists, and bureaucrats in Washington, D.C., thought of PIAA, the first—and only—thing that came to mind was tort reform, and with good reason. PIAA has been the leading voice for effective, time-proven medical professional liability (MPL) reform in the nation’s capital for many years. We have testified at Congressional hearings on the issue, provided data to numerous Congressional allies, and been tasked with running the only coalition in Washington, D.C., dedicated to enacting such reforms.

Times, however, have changed. While tort reform is still very much at the heart of what we do, PIAA has expanded its legislative agenda to include additional reforms that will benefit the MPL community. And, happily, some of those reforms are gaining traction.

Why change?
Has PIAA abandoned its longstanding support for MPL reforms, such as reasonable limits on non-economic damages, collateral source rule reform, and guarantees that plaintiffs won’t find that legal bills have consumed most of their settlement or award? Certainly not. These reforms have proved their worth over time, and we are still very much committed to their enactment at the federal level.

The focus of our energies has changed, however, by necessity. The impact of the MPL crisis of the early 2000s has faded, and with it, so has the attention of Congress. The reality is that without the threat that doctors might be unable to obtain MPL coverage, and the diminished access to care that would result, many members of Congress simply don’t see the need to address the issue. In addition, a vocal minority of dedicated states’ rights activists in Congress has depleted the ranks of our prior support.

As a result, the likelihood of enacting true MPL reforms diminished. To remain relevant, and to set the stage for a bigger push for MPL reforms when the timing is right, PIAA Initiatives Off to a Quick Start in Congress

Two bills backed by PIAA have already been introduced, and could well go much further

Michael C. Stinson
is Director of Government Relations at PIAA;
mstinson@piaa.us.

Michael C. Stinson

Insider Medical Liability 16 Second Quarter 2015
PIAA had to find other issues that we could use to connect with federal legislators. Fortunately, we have identified these issues, and they have made it possible for us to engage in a way that has expanded our advocacy role in Congress.

Good Samaritan Health Professionals Act
Following the devastation of Hurricane Katrina, PIAA heard about physicians who went to the affected states to aid the victims of the disaster, but were unable to do so because of questions raised about liability for healthcare providers. As a result, PIAA developed the first drafts of what was to become the Good Samaritan Health Professionals Act. First introduced in 2011 by Congressmen Cliff Stearns (R-FL) and Jim Matheson (D-UT), the bill granted immunity from liability for volunteer healthcare providers who treat victims of federally declared disasters. The bill also stated that protections would not be granted in cases of gross negligence or criminal misconduct, and that nothing in the bill would alter state tort laws. With Congressman Stearns’s leadership, the bill eventually made it to the House floor as an amendment to another healthcare bill, where it passed in a bipartisan vote of 251-157. Unfortunately, the bill was never considered in the Senate.

Hoping to build on that success, the Good Samaritan Health Professionals Act has been introduced in subsequent Congresses. Most recently, Congressmen Marsha Blackburn (R-TN) and David Scott (D-GA) teamed up to advance the bill in the 114th Congress. The latest version of the bill (H.R. 865) is identical to that of 2011, and already has nine additional cosponsors (as of this writing) from all corners of the nation. Given the previous bipartisan vote on the bill, we believe that we may see legislative action on the bill, in this Congress, especially as members seek out some opportunity to reach across the aisle for legislative success.

Standard of Care Protection Act
The Standard of Care Protection Act came as a direct result of concerns about provisions of the Affordable Care Act and Medicare reimbursement policies. Congressman Henry Cuellar (D-TX) teamed up with Congressman Phil Gingrey, MD (R-GA) and introduced the Standard of Care Protection Act to ensure that no federal regulation or guideline could be used to establish the standard of care in an MPL lawsuit. Eventually, the bill was incorporated into a larger legislative package to repeal Medicare’s Sustainable Growth
Rate (SGR) formula last year. Unfortunately, while the proposal garnered broad, bipartisan support, it was not enacted because of budgetary concerns about the underlying SGR package.

Having come so close to success last year, advocates for the Standard of Care Protection Act began lobbying efforts promptly in 2015. The result was a new partnership, this time between Congressman Cuellar and Congressman Larry Bucshon, MD (R-IN), to take the lead on the legislation. The new bill is identical to the previous bill that had been negotiated among PIAA, the trial bar, and key committee staff, and thus it starts off with the same crucial support it had previously. Because it is now extremely difficult to secure passage of standalone legislation in the current environment, we are once again focusing our efforts on inclusion of the bill as part of an SGR package. In that regard, we are concentrating our lobbying efforts on members of the House Ways & Means and Energy & Commerce committees, as well as the Senate Finance Committee, the key committees that have jurisdiction over Medicare issues. Like last year, the major stumbling block may not be the legislation itself, but rather, funding for the SGR fix as a whole.

**Conclusion**

PIAA has worked diligently in recent years to develop and promote legislation that not only would establish sound public policy, but would also allow us to expand our roster of important contacts and our influence on Capitol Hill. This year, we have the potential to make significant progress with not just one, but two, of our priorities. Please lend a hand by contacting your senators and representatives to tell them that their support for these bills is important, and that they will be held accountable if they fail to support them.

To aid you in this effort, PIAA has placed some helpful information on the Government Relations section of its website, including contact information for your members of Congress, and talking points you can use in letters, e-mails, and phone calls. Please visit www.piaa.us and click on “Advocacy” to learn more. In addition, keep an eye out for PIAA Newsbriefs, our Advocacy Update newsletter, and the Inside Government Relations webcasts, for more information on the progress of each bill, and what you can do to keep both of them advancing through the legislative process. With your help, this might well be the year that victory is achieved.

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By now, most healthcare professionals are well aware of the civil and criminal penalties they can incur if they disclose individually identifiable patient health information in violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Notwithstanding potential penalties, inadvertent disclosure by healthcare providers can still occur during pre-litigation and pending litigation matters. Disclosing a patient’s medical record in response to a defective HIPAA authorization, or, in response to a proper HIPAA authorization, providing a copy of a plaintiff’s medical record containing another patient’s diagnostic reports, are but two examples. And now there is a new area of potential professional liability exposure for inadvertent disclosures: recent decisions in state courts have made it possible for individuals to bring private causes of action for negligent disclosure of protected health information.

HIPAA’s “Privacy Rule” regulates the disclosure of “protected health information” (PHI) by “covered entities” and their “business associates,” including health insurers, physicians, healthcare providers, their independent contractors, and others. Under the law, an individual who believes that his PHI was disclosed improperly could file a complaint with the Department of Justice, eventually resulting in the imposition of penalties, sometimes amounting to millions of dollars. However, does not provide for individuals instituting their own lawsuits against healthcare providers who have violated its regulations. It has been proposed that absent any financial incentive for an individual to bring a HIPAA violation to the government’s attention, some percentage of violations go unreported. However, a series of more contemporary decisions may well lead to a resolution of these concerns, and also provide a mechanism for awarding damages to the aggrieved patient.

Recently, the Connecticut Supreme Court
ruled that an individual plaintiff was permitted to bring a private cause of action under state law for negligent disclosure of protected health information. In Byrne v. Avery Center for Obstetrics and Gynecology, P.C., the plaintiff brought an action against the defendant medical practice for negligently disclosing her obstetrical records pursuant to a subpoena issued by a local family court. Plaintiff, who received obstetrical and gynecological care from the practice, explicitly instructed it not to disclose her records to a specific individual. A paternity suit was brought against her by the same individual, who then served the defendant practice with a subpoena for disclosure of her obstetrical records. Without notification to the patient, and likely without seeking legal counsel, the practice sent her records to family court, where they were subsequently reviewed by the individual to whom she had explicitly prohibited disclosure. When the plaintiff learned that her records had been disclosed, she successfully filed legal papers to seal her records, though the damage had already been done.

Although the plaintiff argued that the defendant practice negligently disclosed her PHI and violated her privacy, defense counsel raised a valid legal argument that such claims must be dismissed because they were preempted by federal law, as HIPAA does not permit private causes of action. Although the Connecticut lower court agreed with the defense position and dismissed the claims, the Connecticut Supreme Court held, on appeal, that the plaintiff’s lawsuit was viable. The Court reasoned that the claims were not preempted, because they were brought under state negligence law, not HIPAA, and Connecticut’s privacy law was not “contrary” to HIPAA. Importantly, the Connecticut Supreme Court determined that the plaintiff can use HIPAA to establish the “standard of care” for her negligence claim involving the handling of medical records.

Although this appears to be the first time that a state’s highest court has ruled on the issue, Connecticut is not the first state that has allowed a plaintiff to bring a lawsuit against a healthcare provider for breaches of privacy and confidentiality involving medical records. An Indiana jury verdict of $1.44 million was upheld on appeal; the plaintiff in the case claimed that a Walgreens pharmacist had accessed the medication records of her husband’s former girlfriend to find out if she was at risk of a sexually transmitted disease. Other states that have also permitted these types of lawsuits—and rejected the argument that they are preempted by HIPAA—include

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Missouri, Minnesota, North Carolina, West Virginia, and Maine. Although courts in Delaware and Kentucky have refused to permit private causes of action stemming from HIPAA violations, the number of states looking to HIPAA for guidance in establishing a standard of care in actions for negligent disclosure of a patient's PHI is growing. Whether such a lawsuit will be permitted will vary from state to state, but other state courts may look to the ruling by the Connecticut Supreme Court in Byrne for guidance or as precedent.

Given the significant exposure that inadvertent PHI disclosure may pose to a physician within his state, healthcare providers must establish office and staff protocols to prevent it from occurring. If they are uncertain as to whether such policies or staff education is both compliant and fully effective for avoiding HIPAA violations, as well as potential state court civil actions, providers should consider training in compliance and consultation with a law firm with expertise in this area of the law.

For related information, see www.mcblaw.com.

References
3. 102 A.3d 32 (Conn. 2014.
5. I.S. v. Washington University, 2011 WL 2433585 (E.D. Mo. 2011)(permitting plaintiff to bring a claim for “negligence per se” for negligent disclosure of complete medical records to the plaintiff’s employer where plaintiff only authorized certain dates of treatment to be disclosed).
7. Acosta v. Byram, 638 S.E.2d 246 (N.C. Ct. App. 2006)(holding that private cause of action against psychiatrist for negligent infliction of emotional distress was not preempted by HIPAA where defendant negligently disclosed access code for medical records to office staff).
9. Bonney v. Stephens Memorial Hospital, 17 A.3d 123 (Me. 2011)(dismissing cause of action brought under HIPAA, but noting that HIPAA may be admissible to demonstrate standard of care in support of state court claim for negligent disclosure of medical information).
10. Faneau v. Rite Aid Corp., 984 A.2d 812 (Del. Super Ct. 2009)(dismissing civil claim for negligence per se predicated on HIPAA violation on the basis that there is no private cause of action under HIPAA).
11. Young v. Carran, 289 S.W.3d 586 (Ky. Ct. App. 2008)(rejecting plaintiff’s attempt to use HIPAA as foundation for damages claim under state “negligence per se” statute, but observing that federal statutes may inform standard of care in common law negligence actions).
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The PIAA Data Sharing Project (DSP) has, in its 30-year life span, been the engine for an ever-increasing roster of applications for getting a clear picture of national trends in medical professional liability (MPL) claims and their associated costs. It has at the same time emerged as a powerful tool for learning about the potential vulnerabilities in health-care practice and, from that, developing new safeguards for protecting patients. It also provides PIAA and its members with unimpeachable information that serves as a foundation for key policy initiatives that promote the success of these organizations, and the healthcare professionals they serve. The PIAA DSP is a success story in data analytics. And a walk through this multifaceted tool shows just how valuable it can be.

DSP background
PIAA members insure more than two-thirds of America’s private practicing physicians, as well as dentists, nurses and nurse practitioners, and other healthcare providers. All told, they provide insurance and other services to more than 2 million healthcare professionals around the world. PIAA members also insure more than 2,000 hospitals and 5,000 medical facilities.

At present, there are 20 participants in the DSP—PIAA member companies that provide data on their company’s MPL claims. These companies make up 40% of the PIAA domestic membership and represent 50% of PIAA member company domestic MPL market share and 40% of the U.S. MPL market share, as reported by A.M. Best.

Rapid growth
Initially, the DSP was primarily employed as a tool for tracking metrics that related to the financial health of PIAA companies, e.g., numbers of claims and ratio of claims filed to claims with a payment. After a decade of operation, more than 100,000 claims and lawsuits had been reported, of which 32% represented $4.9 million of total indemnity paid. Today, data on approximately 286,000 claims and lawsuits are contained in the DSP; $18.9 billion dollars of indemnity and $7.2 billion dollars of defense expenses related to these claims have been paid.

P Divya Parikh is Director of Research & Risk Management at PIAA; dparikh@piaa.us.
DNA of DSP
Participants submit data semi-annually in a codified format. Each data file sent by participants to the DSP contains 50 data fields. With such a rich trove of information, the DSP data can be combined, and then analyzed, in a wide range of ways, to answer a broad range of study questions. The DSP data fields are divided into seven sections, with these headings:
1. “General Information”
2. “Patient Demographics”
3. “Insured Demographics”
4. “Location of Loss”
5. “Loss Description and Causation”
6. “Resolution.”

The section “Loss Description and Causation” historically captured the claimant’s conditions and procedures that are coded according to the International Classification of Diseases, Clinical Manifestation (ICD-9-CM), as well as unique PIAA created codes. However, in light of CMS’s new reporting requirements in ICD-10 coding format as of October 1, 2015, the DSP has been mapped to allow ICD-10 coding as part of the database. A major advantage of this will be additional detail to medical conditions reported within the database.

In the past, the data records have primarily captured physician MPL data. But more recently, as part of an initiative driven by new ICD-10 coding and mapping, the DSP expanded the fields further to include hospital/health system liability claims data as well. The addition of fields to include entity data is a reflection of PIAA’s expanding membership.

The Association’s membership once consisted predominantly of traditional—mutual and reciprocal—medical liability carriers that primarily write physician risks. However, over time, the membership has evolved and today includes captives, risk retention groups, trusts, and health systems with risks that vary from healthcare clinics and institutions to allied healthcare, dental, and oral surgical professionals.

As compared with databases solely comprised of paid claims, the DSP data enables comparisons of closed claims vs. paid claims, thus providing a critical metric for assessing the current status of the MPL sector: the paid to close ratio. In 2013, seven out of ten claims and lawsuits reported no monetary award, but did incur an average defense cost of $40,650 (in 2013 dollars).

DSP and financial metrics
The DSP enables participating companies to track their performance against other participating PIAA members, overall, in measures such as the number of claims in a specific specialty, and in the number and size of awards. Its compilation of data also gives participating companies a concise picture of what is happening with MPL claims, nationwide, over an unbroken span of years beginning in 1985.

Here is one example, which compares data for the two five-year

The Abiding Value of the PIAA Data Sharing Project
Darrell Ranum, JD, CPHRM, is Vice President, Patient Safety & Risk Management, The Doctors Company.

Inside Medical Liability: What has your company gained by participating in the Data Sharing Project?
Ranum: Participation in the DSP is extremely useful for companies. Even as the nation’s largest physician-owned medical professional liability insurer writing business in almost every state, there is tremendous value in sharing what the participants in the DSP are learning, particularly as it relates to improving patient safety. Sharing data from across the experience of thousands of physicians has much more value, because of the insights that we gain.

Also, collaborating through PIAA using our shared data has enabled effective industry representation in Washington, D.C., and around the country. Data has an impact on decision-making and is very influential in promoting change.

IML: Which of the metrics calculated using the DSP data are most useful for your company?
Ranum: We use the different metrics in the DSP in many ways. Our staff members present educational programs across the country. DSP data helps us identify areas of medical practice that represent the greatest risk to patients. It is also useful for identifying the types of patient injuries. And information on loss description and causation offers hints about where interventions would be most beneficial.

The other part of this is more concrete—looking at our data and then at the aggregated PIAA data and determining whether we are managing our claims in a similar manner and whether our patient safety initiatives are having any impact. Then too, it is of great value in all of the financial discussions, such as, for example, are we collecting adequate amounts of premium, based on what we see trended across this many companies?

IML: What would you say to other companies to encourage them to participate in the DSP?
Ranum: Participating in the DSP has helped our company become better at sharing information, discussing the interpretations of information, and collaborating on future directions. Now, we are working across departments to evaluate how we can become more effective in utilizing the data that is available to us from our company and from PIAA.
Risk management and patient safety applications

Over the years, there have been many PIAA DSP reports published on a wide range of topics of material importance for MPL and healthcare professionals, including breast cancer, aortic claims, telemedicine, and electronic health records (EHRs). These publications, which were developed in collaboration with medical specialty societies, elucidate specific areas where DSP data indicated some aspect of medical practice in which vulnerability to adverse events was indicated by increasing numbers of MPL suits. These reports became important components of preparation of risk management and patient safety guidance by PIAA members and others.

Risk management information from the DSP, for these and many other topics, is presented in a wide variety of media, for example, electronic media (on the PIAA website, e-mail alerts), industry (MPL and healthcare) presentations, and direct response/guidance to member requests.

Spotlight on meningitis. Here is one example of the comprehensive studies conducted by the DSP. In 2012, the DSP completed a study on pediatric meningitis claims. Even with timely and appropriate care, bacterial meningitis in children can progress so rapidly that the outcome is catastrophic. Either death or the requirements for lifetime care for an individual with severe neurological injuries can lead to high payments for plaintiffs alleging medical error in the treatment of meningitis.

With the powerful tool of the DSP data, it was possible to develop sound measures for risk management. For example, telephone triage protocols and pediatric discharge instructions are needed. Also, non-clinical staff (e.g., receptionists and nurse aides) should be told not to provide clinical advice to parents and caregivers—especially not

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over the phone. Communication problems contribute to the liability for meningitis claims, for example, poor communications with parents or caregivers, and failure to give a referral or consulting physician a thorough account of medical findings and history to date and to inform them of problems with critical test results. Documentation problems, such as failure to record relevant negative findings, can be another issue.

Examining telemedicine. The DSP also studied the issue of claims related to the use of telemedicine. For the period 2004 to 2013, there were 94,228 total claims in the DSP (24,793 were paid claims), of which 196 involved telephone treatment (56 paid claims). The total indemnity for the total DSP claims was $8.2 billion (average indemnity, $328,825), and for the telephone treatment claims it was $17 million ($303,691). Total ALAE for the full complement of DSP claims was $3.9 billion; for telephone treatment, it was $10 million.

Considering the chief medical factors for telephone treatment, errors in diagnosis were linked with the most closed claims, medical errors with the most paid claims, and failure to properly respond with the highest total and average indemnity.

Liability considerations include privacy issues, self-reporting considerations, in-person visit advantages, and the need for contingency plans. In addition, those who use telephone treatment should use secure computer network systems and protocols for webcams and Web-based portals.

Investigating risks associated with EHRs. Another important topic analyzed is the ongoing story of the risks associated with the use of EHRs. In January 2012, PIAAs Claims and Risk Management section members conducted a survey, which was completed by 43 PIAA members. The survey measured the exposure to EHRs, the impact for ALAE, ways to prevent pitfalls, and the best way to provide education on this topic.

Trends in allegation reveal, for example, that plaintiffs are asserting that providers have had insufficient training in the use of EHRs or that there has been a breach in the EHR system.

Examples of major issues identified by the survey participants include drop down boxes that are too limited or provide the wrong selections, and the high probability of erroneous entries with the auto-population feature. Also, the cut and paste feature is likely to be abused, leading to improper notation, or inadequate information being entered into the system.

The Abiding Value of the PIAA Data Sharing Project

Mary-Elizabeth Knox is Vice President-Claims, Medical Mutual Insurance Company of Maine.

Inside Medical Liability: What has your company gained by participating in the Data Sharing Project?

Knox: By participating in the DSP, we at Medical Mutual feel that we have a voice at the table, on national issues. The DSP data is used extensively for legislative matters both nationally and in the various states.

As a small company, we don’t always follow the national trends. It is important that our physicians know what the emerging trends are. There may be some initiative that our risk management staff can take, through education and outreach, that will allow us to stop a trend before it starts, here in northern New England.

IML: How does your company use the DSP data and reports?

Knox: We use the Specialty Specific reports, particularly when we are talking to groups that we insure, and when we speak at medical society meetings, where everyone in the room is (for instance) a neurologist. Because of our small size, we don’t necessarily have as wide a range of claims to talk about for every specialty. It’s very helpful to be able to show them what is happening throughout the country.

We use the comparative data in the reports to describe how often a given specialty is sued compared with others, and talk about the data that is trending, in terms of indemnity payments, or loss payments—not just what a particular case was about, but what we’re seeing as one part of a complex national puzzle. This gives physicians a more well-rounded feeling for the subject.

We are excited about the new data reporting for hospitals. We have written coverage for hospitals since the early 1980s. That has been an area where we’ve been able to show only our own company’s data; there hasn’t been a national dataset for hospitals like the DSP dataset for physicians. Within a few years, we hope, there will be enough data in the DSP to allow us to run some type of analytics on our hospital claims, and compare those to the aggregate of hospital data through PIAA.

Compared with other sources, I prefer the PIAA data. I know how the PIAA gathers data—and how reliable it is.

IML: What would you say to encourage other companies to participate in the DSP?

Knox: It can be somewhat daunting to take on yet another reporting obligation. But really, in my experience, in doing this, it is really fairly easy. Our claims adjustors can pretty much fill out the whole PIAA claims form, sitting at their desk, based on their knowledge of the claim, without referring to a lot of other documentation.
DSP support of public policy initiatives

The wide range of information captured in the DSP combined with the statistical power conveyed by the sheer number of claims in it, makes it possible for PIAA to speak as the recognized expert on policy issues that matter most to its members.

Assessing the impact of state MPL caps. Several states have enacted tort reform measures, by implementing caps on medical liability damages. The DSP investigated differences in claims trends in states with, versus those without, such caps. The data was further evaluated to summarize claim payments by cap limit categories ($<300,000; $300,000–$499,999; ≥ $500,000; and none).

DSP analysis revealed that claims occurring in a state lacking tort reform resulted in the higher average indemnity payment of $416,634, compared to states with tort reform. For claims with cap limits, the highest average indemnity payment ($334,226) occurred where limits were in the $300,000–$499,999 category versus states with higher caps ($248,922).

Claims resulting in a verdict for the plaintiff resulted in the highest average indemnity payments across all disposition types and cap limit categories. Claims with a cap limit of greater than or equal to $500,000 resulted in the topmost average indemnity payment of $973,187, exceeding average payments in states without caps ($722,182).

Advocating before Congress. The PIAA Government Relations Department has relayed DSP data to federal legislators in a number of ways. In testimony provided before Congressional committees, DSP data have been used to convey statistics on how PIAA can improve the DSP in order to enhance participation and use of the captured data. The DSAC consists of individuals from the claims, risk management, IT, and general management disciplines. The committee efforts assist in ensuring the quality and value of the research materials that the Association provides to its members. Committee members advise the PIAA research staff regarding special areas of interest for focused studies. Participation on the DSAC currently involves biannual in-person meetings at PIAA headquarters in Rockville, Maryland.

DSP data in underwriting

The data contained in the DSP, in particular a number of specific ratios, are used in providing guidance to underwriters. The DSP provides comparative healthcare professional MPL data by specialty, close years, loss causation, demographics, and resolution.

The largest indemnity payment among all specialties over the lifetime of the DSP is in Ob/Gyn. In 2013 dollars, neurosurgery, Ob/Gyn, neurology, and pediatrics had average indemnity payments greater than or equal to $400,000. The average indemnity payment among all specialties was $361,340.

The DSP also identifies new procedures and conditions as emerging areas of risk in specialties as well as changes in the location—i.e., outpatient, etc.—of loss. The identification of these key trends provide valuable guidance for underwriters.

A look at the future

The conversion to ICD-10, and other new enhancements to the database, will facilitate collaborations with PIAA’s international members, as well as make possible more detailed information on conditions and procedures.

Over the years, the DSP has also kept pace with technological innovations. Data was first collected through paper records; then, delimited files were used, and a desktop application was created for validation. Now, the data are collected via a Web-based application. PIAA members will have novel access to the information including real-time analytics via interactive dashboards that will allow companies to compare their own individual data to the national aggregate for individual medical specialties, resolution data, financial data, chief medical factors leading to claims, and more.

With such a powerful and multidimensional tool as the DSP, we can expect to see the scope and depth of its applications continue to expand in the coming years. As the healthcare system and PIAA member needs evolve, with new challenges, the DSP, PIAA is confident, will prove up to the task.
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In 2013, MPL specialty companies released $1.4 billion in prior year’s reserves, bringing the total release over the past decade to $11.4 billion. For an industry with approximately $10 billion in written premium, these capital movements are meaningful. These changing market dynamics, along with a decade of profitability, have led to M&A activity, with the prospect of even more significant consolidation in the near future. Yet, while the need for capital has decreased, in theory, the availability of capital has never been greater.

For many PIAA companies, re-leveraging the balance sheet, by declaring a series of cash dividends and utilizing available reinsurance capacity, would be a more efficient use of capital than allowing the funds to build up unencumbered.

In general, primary rate levels in the medical professional liability (MPL) insurance market continue to fall. This trend in rates certainly makes sense: MPL insurers continue to achieve favorable results, with historically low loss frequency, only moderately increasing loss severity, and prior year’s loss reserve releases.

Capital Structure Management: Is a New Approach Warranted?

Steven M. Schafer, FCAS, CFA, is Co-Head of Medical Professional Liability Practice Group, Aon Benfield.
Recent historical results
The period of the early 2000s was a seminal moment for many of the PIAA carriers currently in operation. With a difficult tort environment, low absolute primary rates, and thin capital bases, many in the industry were facing dire financial straits, if not outright collapse. But then, well-documented rate increases, better risk management, a turnaround in the legal environment, and a host of other factors enabled the segment to regain its footing and then some. As Figure 1 depicts, the specialty MPL carriers (which excludes commercial lines companies) have experienced eight years in a row of favorable combined ratios, in line with the MPL results from the past decade, which show that the claims-made and occurrence lines combined are as profitable as any annual-statement line of business. While some modest headwinds are beginning to develop, certainly the expectation is that PIAA carriers will show similar results in 2014 and 2015, if not even further into the future.

As such, the typical PIAA company now faces a much different set of challenges than a decade ago. As noted in Figure 2, total direct written premium volume for the industry, in aggregate, has declined from its peak in 2006. Yet, despite dire prognostications about the complete evaporation of premium, this segment still has roughly $9 billion to $10 billion in premium, which represents a doubling in volume in just 15 years.

Against this backdrop, what is of particular interest is the changing leverage ratio of the PIAA segment. Taking the simple metric of premium/surplus, PIAA companies had a total of $8 billion in premium in 2004 versus $5 billion in surplus. By 2013, these figures had grown to $7 billion and $13.5 billion, respectively. Thus, the leverage ratio had moved from 1.6/1.0 to 0.5/1.0 over the last decade, a rather startling change. Given this movement, it is not surprising that the use of reinsurance has decreased in lockstep with the increase in surplus, with ceded premium declining from slightly more than 20% of written premium to, now, slightly less than 10% of written premium.

Supply of capital
This decrease in demand for capital by PIAA companies is occurring at the same time that a record surge in supply is entering the market, from both traditional and nontraditional sources. Presently, this supply is in the form of reinsurance capital, but as favorable results continue to be posted, larger commercial carriers are increasing their footprint in this space. When we look at the typical PIAA company, it is worth noting that the value proposition of reinsurance to them—the combination of quality and price—has likely never been higher.

Commercial facultative insurers and treaty reinsurers have continued to perform well, leading to further competition for high-attaching excess-of-loss business. The price of traditional reinsurance on lower layers has fallen in response to favorable experience, as well as in response to disruptive alternative capital that has grown in influence: it has become a price maker, rather than a price taker. Likewise, the quality of the financial security provided by insurers and reinsurers is equally as high. And while alternative capital to this point has focused on accepting property risk, it seems only a matter of time before it begins to accept casualty risk as well.

In aggregate, global reinsurance capital continued to increase in 2014, up by more than $35 billion (or 6%) since year-end 2013. As Figure 3 illustrates, there are now more “traditional” reinsurance funds chasing reinsurance transactions, a circumstance that favors cedents in their purchase decisions.

Traditional reinsurers have reached the end of a 15-year journey
featuring chronological stages of alternative capital’s insignificance, competition, and now, finally, disruption. Nontraditional capacity increased by more than $12 billion through 2014, an increase of almost 25% to $62 billion over 2013, which keeps it on track to reach our prediction of $150 billion by 2018. We expect these trends to continue through the 2015 and 2016 renewal cycles. Buyers now have the widest selection of high-quality offerings for accretive underwriting capital that we can recall.

The end result for PIAA companies is that reinsurance pricing for January 2015 placements decreased further from both July 1, 2014 and last year’s January 1, on an exposure- and experience-neutral basis. And the capacity and resulting support is truly global at this point, with reinsurers in the United States, London, Bermuda, and Europe all active in the space. Ceding company demand continues to increase for catastrophe/contingency-type reinsurance coverage, while demand for working layer coverage has been stable. In the near term, the reinsurance market outlook is favorable for ceding companies, as reinsurers are receptive to creative structures and competitive pricing.

**Better utilization of capital**

It has been a good, stable, and consistent market for both insurers and reinsurers. While the future is always unknowable, it is relatively easy to foresee that the future may not be as bright as the most recent past. Over the past few years, we have seen a definite increase in severity, particularly with batch losses and systemic-type losses. Additionally, any uptick in frequency would change market results quickly and potentially significantly.

In reviewing numerous MPL carriers’ balance sheets, it’s clear to us that current operating profits are coming from reserve takedowns, as opposed to accident-year operating results. Thus, it is not hard to predict that challenging times are ahead, not only in pricing, claims, and healthcare consolidations, but also with new and evolving risks and burdensome/costly administrative and regulatory requirements.

From an opportunistic standpoint, utilizing attractive reinsurance, as part of an overall risk management strategy, seems like an ideal hedge if the market may be moving toward a potentially more volatile period.

A more radical, yet seemingly more astute strategy for the long-run health of companies in the PIAA segment would be to transform their balance sheets and optimize the premium-to-surplus ratio, to align themselves more closely with the current market environment. While it is difficult to make bold pronouncements, it is not hard to argue that many PIAA companies should consider continuing to return surplus back to policyholders. A leverage ratio of 0.5 to 1.0 (or even lower, in some cases) may not be necessary to support the risk inherent in this line of business.

Many PIAA companies have engaged in dividend programs in the recent past. And how capital is returned (as a one-time payout or a series of dividends), who is eligible, and to what magnitude—these are all operational issues that are best decided by each PIAA firm, in conjunction with its advisors. But at a time when opportunities for organic growth are modestly shrinking and reinsurance capital is ever more plentiful, it is an option that is at least worth exploring.

No one would suggest going back to the capitalization levels of the early 2000s, but as the bottom line of the balance sheets becomes ever larger, the MPL segment risks cannibalizing itself through foolish price competition, poorly thought-out mergers, or misguided expansion ambitions. While it may be conceptually accurate that the typical PIAA company does not have a profit motive, these entities still need to remain profitable, to ensure regulators, insureds, and their own employees that they have a long-run sustainable business model. Some of the more recent actions by the PIAA community would appear to be compromising this future.
Counting Mouse Clicks in Clinical Practice with an EHR

By Alan Lembitz, MD

Comparing Time Spent Before a Computer versus Time with Patients

How many mouse clicks does an emergency department (ED) physician perform in a typical ten-hour shift? That’s the question a study1 in the American Journal of Emergency Medicine examined. The study, “4,000 Clicks: A Productivity Analysis of Electronic Medical Records in a Community Hospital ED,” observed an ED physician over a normal shift and noted the changes in the workflow dynamics related to the adoption of electronic health records (EHRs).
as its title tells us, the study found that the ED physician actually exercised 4,000 mouse clicks during her ten-hour shift. But more important was the observation that only 28% of her time involved face-to-face, direct patient contact. Most of the shift was spent doing data entry, reviewing tests and records, and having discussions with colleagues.

Unfortunately, the patient is blind to all but the face-to-face time, and when the outcome is adverse (and costs are substantial), there may be the perception that the physician spent only a few minutes and never actually examined the patient. If the outcome was unexpected and when the outcome is adverse (and costs are substantial), there may be the perception that the physician spent only a few minutes and never actually examined the patient. If the outcome was unexpected from the patient's perspective, the 28% “face time” may be conducive to an adversarial legal environment.

Furthermore, as demand for access to care increases with the Affordable Care Act, supply may not increase accordingly, at least in the near term. Patient volumes for primary care and emergency medicine physicians are projected to increase. Thorough documentation is required for justifying billing codes, meaningful use attestation, and protection against subsequent allegations involving quality or liability. As a result, the needs and usage of EHRs will not be decreasing. The net effect of increased volumes of patient encounters and expanded requirements for EHR documentation will likely contribute to less “face time” with patients. And when we sacrifice the most valuable portion of the physician-patient interaction, there may be a negative influence on provider and patient satisfaction.

These observations are not unique to the ED setting; national estimates now indicate that more than 70% of office-based practices use an EHR. The national data on hospitals reveals a similar level of use, and the trend is currently accelerating, expected to reach 100% adoption. It is not the intent of this article to debate whether the impact of these changes is good or bad for patient safety and medical liability, but rather, to look at this issue in relation to patient interactions.

PIAA member companies continue to hear about new theories of liability stemming from EHRs. These issues are a high priority for education in patient safety, risk management, and claims. Topics related to EHR usage and patient interactions are common on the agendas of conferences nowadays, but it’s hard to believe that our company first presented on this topic with a seminar titled “The Good, the Bad, and the Ugly of EHRs in Liability” nearly a decade ago.

Areas of frustration

The benefits of EHRs are undeniable; most notably, they provide a standardized tool for entering information, sharing that information with other clinicians, and extracting data and determining best practices. EHRs also assist in involving the patient and his family in very difficult decisions, by transparently providing all the necessary information. The legibility issue has obviously been remedied in the electronic world. Yet, the unintended consequences of EHRs for two main areas of healthcare are dramatically exposed in this study: the patient experience and the clinician’s workflow demands.

Some practical suggestions for physicians

1. Recognize that the patient’s experience is the quality metric. From his perspective, how attentive and involved are you? Does he think of you as caring and listening? Does he believe you are asking questions about him and his concerns, or are you just “collecting data”?

2. Ask yourself, as you move into the 72% of the necessary care that is invisible to the patient, what parts of this can I do in collaboration with the patient? Patients ultimately have access to all of their medical records, so involving them in the production of these can build rapport, improve accuracy, and improve compliance with the shared decision-making model of medicine. Can you connect with the patient and still be entering data in the EHR?

3. How many mouse clicks are necessary for the physician, and how many can be entered by someone else? Can an assistant improve workflow, and will that extra productivity cover the salary of the assistant? There is an ever-expanding number of data fields that have to be entered for payers, governmental overseers, and quality analysts. Can you design the system so that the information in it is at the necessary level of expertise? Otherwise, you will have burned out your physicians as they click on mundane (but mandatory) fields, well past the time allotted for the patient, and thinking that they have had to do so in order to do their duty. Patients want time with their physicians, and physicians find their work rewarding in direct correlation with the amount of face-to-face contact they have with patients.

4. If your keyboard and screen configuration puts your back to the patient, change the room layout. Hospitals are paid or not paid according to their HCAHPS scores, and this change will yield a huge ROI.

Alan Lembitz, MD, is Chief Medical Officer, COPIC.
5. The beginning of the medical interview sets the stage for trust. Abolish every barrier that might compromise that trust. Do you let the data entry device get in the way of setting the stage for a listening, caring interaction? In light of the fact that nonverbal communication can be critical in establishing trust, how can you build that trust in spite of the inherent barriers that are unavoidable with the EHR and the need to keep entering more data?

6. Recognize the history of how we got to where we are, and the multiple parties with an interest in EHRs. The payers require many elements in order to justify a code, so the systems prompt one to complete them, even if the information doesn’t really enter into clinical decision-making. The EHR vendors are trying to meet the government’s meaningful use stipulations, and so additional fields are required. The federal government is trying to gather some data for analyses of population health and, some might skeptically say, to advance politically motivated policy.

7. Finally, there is the difficulty of setting alarm thresholds so that one doesn’t need to click away “less important” prompts, but still needs to be highly aware of the important alerts. In an American Medical News article, the researchers identified several common themes in relation to alert fatigue. (1) Providers are often uncertain as to why an alert is generated. (2) Alerts were designed by pharmacists, despite the fact that a physician or nurse practitioner is doing the prescribing. (3) Alerts may be overridden because they aren’t specific to a particular patient.

**Conclusion**

Approximately 4,000 clicks—or 72% of a physician’s time—may be spent away from the patient, with a significant impact on his perceptions of how well they interact, and also on the physician’s own reasons why he decided to become a healer. Physicians need to ask themselves how EHRs can better support patient interactions, acknowledge it as a tool that can be used well or poorly, and learn new ways to improve their workflow schedule moving forward, given the fact EHRs are not going away.

**References**

The delivery of healthcare is undergoing profound change. New regulations, shifting business models and evolving client needs require timely market and industry intelligence to maintain competitive advantage. This, coupled with the reality of a protracted soft market insurance cycle, poses both a threat and an opportunity for MPL insurers.

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Electronic health record (EHR) systems have become the norm in U.S. healthcare. As their presence has expanded, there has been increasing interest in their impact on various aspects of medical legal risk, medical risk insurance, medical professional liability (MPL) claims, and on the reliability of EHRs for assuring the authenticity of records. The legal profession has a number of contexts for evaluating the impact of digital records systems in their professional domain, but there are few opportunities for subject matter experts from both clinical and legal domains to meet and confer on EHRs.

One notable recent event was held as a joint clinical and legal subject matter expert workshop, “Foundations of Digital Records in Medicine and Law: Reliability and Authenticity,” which took place in October 2014, at the Johns Hopkins University Division for Health Sciences Informatics. It is clear that clinicians, informaticists, policymakers, the judiciary, academics, researchers, EHR developers, EHR implementers, and lawyers (attendees) are all describing obstacles in the use of EHRs, but also using key terms about the attributes of EHRs in different ways. The goal of this proceeding was to find common ground about an essential set of expectations about the veracity of EHR content for both primary (clinical) and secondary (analysis/legal*) purposes. This article is a brief description of those proceedings, its results, and opportunities for future endeavors.

Background
After long-running discussions on the divergent and conflicting uses of key terms and concepts within the HL7 EHR Standards/Records Management and Evidentiary Support community, a presentation for the American Bar Association’s January 2013 e-Discovery and Information Governance National Institute at Stetson Law School in Tampa, Florida, sparked interest among prominent digital records authorities and thought leaders. The panel, entitled, “Managing ESI Within Health Information Systems Riddled With Landmines,” led to a call for a number of next steps, including a joint clinical and legal workshop on healthcare digital records systems.

The latter initiative was introduced to the Johns Hopkins University Division for Health Sciences Informatics in spring 2014.
which quickly became the October workshop event. Attendees were selected for invitation by the workshop planners from subject matter experts. The proceedings began with level-setting presentations in analysis/legal and clinical concepts of EHR system reliability and record authenticity by nationally recognized authorities, including Judge John Facciola, George Paul, Esq., and Harold Lehmann, MD. Attendees, with one observer, were then divided into four groups, each with different compositions and charges for the morning and afternoon discussions. The assignments to each were to achieve group plurality in identifying "issues or concerns" statements about digital data in EHRs in the morning, and then prioritizing the resulting issues statements in the afternoon.

The four morning groups’ issues/concerns domains were designated as:
1. Clinical reliability of source systems (more specifically, for patient care, not for secondary or tertiary uses [research, quality, administration/payment, defense])
2. Clinical record authenticity
3. Analysis/legal reliability of source systems
4. Analysis/legal authenticity of records.

In the afternoon discussions, attendees were reassigned, so that each of the four discussion groups included different distributions of individuals and expertise. A top rank-weighted subset of the morning discussion group concerns was used as the basis for collective summary prioritization during the afternoon discussions. Subsequently, all sources of comments and priorities were reviewed by the workshop planners. Given the diversity and the collective expertise of the attendees, the discussions were permitted to range widely.

**Collated concerns and priorities**
The comments and concerns captured were grouped into subsets. The subsets were then ranked by multidisciplinary panels in the afternoon. The end result of the day is summarized in Tables 1 and 2, with ordinal ranking 0–10, color-coded: red is highest in that column, orange is second, yellow is third).

**Potential for consensus and differences**
As Tables 1 and 2 indicate, there was substantial crossover among attending subject matter experts in recognizing key themes of importance to both. While all the issues were high priority from the morning sessions, the topics noted above drew the most combined attention among eight priority subsets. Thus, among the attendees, these indicate that all attendees ranked statements attributed to these subsets as of primary importance for uses of digital data in and from an EHR system.

**General conclusions**
In sum, based on the discussions during the day and the rankings, the attendees demonstrated that the most important three things that a reliable EHR's outputs must authentically support are:
1. Users of EHR outputs must have reason to trust that the patient care information record represents what the clinician actually intended it to represent.
2. Users of EHR outputs must have reason to trust that the patient care information record represents data in a manner that supports the end-users' ability to assess the comparability of data from different systems and sources.
3. Users of EHR outputs support the importance of information governance regimes that assure items 1 and 2. Information governance entails an organization's plan to support both the reliability and authenticity of its data.

There are also some areas of substantial differences or disconnects depending on the perspective of the attendees. For example, Appropriate Syntax and Context was far more important to Reliability of the data than to Authenticity of the data.
Interestingly, attendees considered Temporal Information far more important to Clinical Purposes than for Analysis/Legal purposes.

The takeaway
As noted, three topics gained significant consensus across the clinical and analysis/legal perspectives represented, and were considered a necessary assurance of system reliability and record and data authenticity. Substantial consensus also emerged that testing EHRs will be key to evaluating their utility and speeding their improvement.

The experimental and loosely structured aspects of the event commend the results as more qualitatively than quantitatively significant. The workshop planners are currently seeking support for follow-on projects and initiatives and invite inquiries, especially from those interested in supporting a formal research and development initiative. In particular, insofar as there was nearly uniform agreement among attendees that, in all instances, system testing will be a critical step in addressing the topics and concerns identified in the workshop, there is an unmet need for joint clinical and legal guidance on field or end-user testing of digital records systems.

From an MPL perspective, mere use of an EHR alone does not seem to greatly reduce or increase liability exposure. As a matter of risk management, clinicians should be encouraged to review the product of EHR documentation on a routine basis, to verify that they understand how it is representing their patient interactions to the outside world. In larger institutions, testability of data and information governance are key concepts that should be addressed by the organization as a measure to reduce risk relative to EHRs.

Acknowledgment
The workshop planners greatly appreciate the support by Johns Hopkins University Division for Health Sciences Informatics, specifically Kersti Winny, Joe Warren, and LaShawn Johnson.

References and Footnotes

*In order to avoid the connotations that the word “legal” might have to participants, the workshop planners chose “analysis/legal” to represent non-clinical purposes of EHR data.

**The exact numbers calculated have been converted to ordinal rankings for the purposes of this article, since the ranking and weighting methodologies are omitted here. These will be available in a subsequent report.
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MPL Claims in Australia: Mediation Emerging as the Most Common Route to Resolving a Claim

In Australia, in 2000, the country was on a “post-Olympics high,” but that turned out to be short-lived. Just around the corner, in 2001, a number of factors had come together to create a “perfect storm” for MPL.

There had been, for several years, concerns about the increasing numbers of MPL claims, and the size of the payments made for them. But then, a series of shock waves hit the industry. First there was a high-profile case, in which a young woman sued her mother’s obstetrician for the damage that had occurred during her birth. The result was a $14 million (Australian dollars) payout, double the highest prior amount for a cerebral palsy case. While the actuaries were still trying to get their heads around the consequences of a $14 million claim for their portfolios, a second shock wave hit. Australia’s second-largest insurer, HIH Insurance, which had had 40% of the market in public liability coverage, collapsed, forcing many organizations to run for cover, literally.

And as if that wasn’t enough, in one year, the largest MPL insurer—United Medical Protection, which is now Avant—went into provisional liquidation.

Premiums for many specialties had skyrocketed. Obstetricians were telling their patients they might not be around to deliver their babies. They had been paying premiums of $100 per year in 1980; by 2001, it was up to $35,000, and for some, up to $150,000. The media gave this lack of accessible, affordable insurance extensive coverage.

These developments, not just in medicine, but also in the cancellation of sports and public events like school festivals, forced the government to step in, and intervene. If any of these things had happened in isolation, there may not have been the reforms that ensued. The government had realized that a stable insurance environment was vital to communities; there was a fear that “Australia is becoming just like America,” with its highly litigious environment.

So the government did two things. It set up insurance funds to assist medical defense insurers in dealing with their high-cost claims. Now, the government underwrites 50% of awards in excess of $300,000. They also pick up the cost of runoff coverage for retired physicians. And there is a blue-sky scheme for doctors who exceed their indemnity level of $20 million.

The second thing the government did was to commission a report on tort reform—“the Ipp Report,” which was issued in 2002. It recommended that widespread uniform reform be enacted throughout Australia. It should be noted that Australia is a nation of 25 million, spread out over six states and two territories. It is rare to get things done in a uniform manner.

But many changes in regard to torts were made that were relatively similar. Doctors, in particular, had been concerned that the pendulum had swung too far in favor of plaintiffs. A lot of doctors had lost faith in the judiciary. The response from the government was establishment of a standard of care, which would serve as a statutory defense—basically, a modification of the U.K.’s Bolam test. There was also a standard in regard to causation—common law was replaced with a two-
step inquiry, and there was new protection for Good Samaritans.

Liability insurers in Australia had been concerned, on the one hand, with the proliferation of small claims, in the medical and also the public liability arena. To limit these, thresholds have been put in place.

In New South Wales, for example, you cannot get general damages unless you can show that you have at least 15% of the damages in the most extreme case.

On the other hand, in response to the fear of uncapped high awards, like the one for $14 million, in some states a cap was established for economic loss: in New South Wales it is three times the average weekly earnings.

For general damages, there are thresholds, sliding scales, and caps. Also, importantly, the discount rate was increased from 3% to 5%, with some variations—the opposite to what has happened in the U.K. The limitation period was reduced to three years. Limits were put on costs. In New South Wales, for example, for any claim under $100,000, costs are limited to $10,000 (plus disbursements). Expert evidence is now often provided in court by "conclaves of experts."

### Impact of tort reform

In the intervening years, the impact of tort reform has been impressive. For New South Wales, MPL civil claims peaked in 2001, at almost 60 claims per 1,000 members of Avant; this number declined gradually in 2005, and then stabilized, to 20 claims per 2,000 members, in 2014. There were similar trends in disciplinary claims.

In the post-tort reform period, a breakdown of primary incident/allegation type in a national study of indemnity claims showed that "procedure" accounted for 24.1%; "diagnosis," for 17.4%; and "treatment" 17.1% of claims. General-practice physicians were linked with 23% of claims with general surgery and Ob/Gyn in second and third place, with only 8% of claims, each.

In terms of size of awards, post-reform, 79.1% of awards were in the range of $1 to $50,000; 13.4% were $50,000 to <$250,000; 4.2%, $250,000 to <$500,000; and 3.4%, $500,000 or more.

There has been a concomitant decrease in the time required to resolve a claim. Forty-four percent are resolved in year 1, 37% in year 2, and 13% in year 3.

But tort reform has not been the only factor that has led to fewer claims, Gillman said. There has also been "more rigorous case management," for example.

There is virtually no legal aid, and it is largely a "no-win/no-fee" system for funding of claims. There have been restrictions placed on advertising by plaintiff’s firms, and consolidation of these firms as well, and as a result, "much more due diligence" in the plaintiffs’ selection of the claims that they do take on.

When the PIP implant issue blew up, there was an expectation of lots of claims. But that did not happen. And then it was discovered that many of the firms that had handled these kinds of claims had been burnt in the 80s and 90s, and would not touch them now. Further, they had found that the company selling these implants was not insured.

As in other countries, risk management programs have had a positive impact.

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Mediation increasing
Where might the winds of claims trends blow in the future? Gillman said that there has been a cultural shift in Australia. Some years ago, she said, a barrister had told her that you could never mediate a medical negligence case, because they were too complicated. But in Australia now, she said, “Mediation is the norm.” Only about 4% of cases go to trial, and Gillman does not foresee that this will change.

Also, the Australian states have had mainly Conservative governments for a while now, and there has not been any movement to rescind the current reforms in any drastic form.

There is also a new National Disability Insurance scheme, currently in a trial project now. It is a non-means-tested scheme, intended to provide support for any baby born with a disability who is diagnosed with cerebral palsy. Parents can apply to this scheme for immediate care and support—early intervention. The aim was to reduce the reliance on litigation in these cases. But because it is an insurance scheme, its CEO has a right to require that the family affected pursue any legal right of compensation, and it can also pursue the case itself, in the name of the family, if necessary. So it remains to be seen what will happen if the scheme is rolled out as intended in 2019, given its cost.

There is also the issue of claims in class actions against regulators. The first class action of this sort was filed in 2014—a claim against the Australian health professions regulatory agency. One Dr. Peters, an anesthetist, who was working in an abortion clinic and habitually injected himself with Fentanyl, infected 55 women with hepatitis. He is in jail, and he did not have MPL coverage. So the women looked to see if they could recover from the regulatory agency, since this was not the first time that Dr. Peters had had a problem. He had undergone regular drug tests, but had passed them, since Fentanyl was not one of the drugs included in the tests. The claim alleged that the regulator had failed in ensuring safe care, as required under the regulations.

And this is an example of the claims becoming more common now, as plaintiff’s attorneys look for ways to circumvent the tort reforms, by recourse to intentional torts, for example.

The case concerns a worker who incurred minor injury to his front teeth on the job. The dentist he consulted, Dr. Phung, managed to treat all 28 teeth, over 53 consultations, at a total cost of more than $73,000. The dentist admitted negligence, but denied trespass. The case proceeded based on the premise that he was liable for an intentional act. Under the law in New South Wales, if a defendant is found guilty of an intentional act, all of those caps discussed above go out the window, and don’t apply. Further, the plaintiff is entitled to exemplary damages. That is what happened in this case. The court was satisfied that Dr. Phung knew that his treatment was not reasonably necessary.

MPL companies in Australia are now seeing additional pleadings come in, asserting intentional tort and trespass. So they are watching that area closely.

In short, MPL in Australia weathered a storm in the early 2000s, and has emerged stronger for it. Claim numbers seem to have stabilized. But concern remains about the increase in discipline claims, which could well be a common concern across the world.

For related information, see www.avant.org.au.

Prevalence of Defensive Medicine from a National Survey
Orthopedic and trauma surgeons as well as radiologists from public hospitals in Austria were invited to complete a study questionnaire on patient contacts and defensive requests in a typical month.

The prevalence of defensive medicine was found to be 97.7%. The average orthopedic or trauma surgeon requests 19.6 tests per month for defensive reasons, which represents 28% of all diagnostic examinations. Survey respondents stated that they were confronted with 1.4 liability claims per month. During the treatment of high-risk patients, 81% of doctors request additional diagnostic procedures for defensive considerations. Expenditure of time for defensive practice amounts to 9.2 hours/month in radiology and to 17% and 18% of total working time, respectively, in orthopedic and trauma surgery.

The Web-based Physician Litigation Resource Center was established ten years ago, so that any physician who experiences an adverse event and, in many instances, a subsequent lawsuit, does not have to endure it alone. Since that time, the need to support physicians in this regard has increased dramatically; they now face lower reimbursements, increased regulation (some of which are directly tied to reimbursement), maintenance of certification (MOC) requirements, and the continuing transformation of their work environment. The number of articles in the medical literature related to “second victims,” physician burnout, physician suicide, and occupational stress has increased correspondingly.

Against this background, the Physician Litigation Stress Advisory Group has implemented a major update in the content and delivery of its online resource. The new enhancements reinforce the belief that emotional responses are perfectly normal and acceptable reactions to such events and that, given sufficient resources, physicians can help themselves to cope more effectively. They can function as safe physicians and confident defendants as they traverse a difficult passage that may in fact last many years.

Website enhancements
Mobile capability. In an effort to make the site more accessible, a mobile device version is now available, from anywhere, at any time. Shortly after its introduction, more than one-fourth of all the users of the site took advantage of this feature.

Video. The home page features a 3-minute video (narrated by Sara Charles, MD) that serves as an introduction to the reality of being sued. It suggests that physicians may experience new and unexpected feelings and reactions in response to a suit, and that these may or may not interfere with their personal and professional life. The page also has drop down menus with links to a wide range of articles, many of which can be downloaded, on topics such as:

- What to expect after being sued
- What defendants can talk about, and with whom, after an adverse event
- Symptoms to watch for, and when a consultation might be appropriate
- A list of online resources that may be helpful.

Database. The literature search feature has been completely overhauled. It is now more user-friendly and compatible with other, similar search engines. It is updated monthly with newly published books and recent PubMed listings on topics related to litigation stress, disclosure after adverse events, recent developments in tort reform, and trends on other topics related to medical professional liability (MPL).

Blog. There is a new blog on the site, too. Some of the posts are written by members of the advisory group, and others are authored by invited guests. Brian Whitelaw, a Grand Rapids, Michigan, MPL defense attorney who has more than 30 years’ experience contributed a three-part article addressing the three-way relationship among physicians, their defense counsel, and the insurance carrier. Laurie Drill-Mellum, MD, an emergency medicine physician and the chief medical officer at MMIC, recently offered “Tips for Living through the Cloud of Litigation.”

A data analysis on the first six months’ use of the blogs revealed that the top three subjects for viewers were:

- “Relationships . . . with My Spouse or Significant Other”
- “Can I Talk to Anyone about My Lawsuit?”
- “Relationships . . . with Our Fellow Professionals.”

Posts on these topics were among the first published, so users’ priorities may shift, as more articles on a broader range of subjects are offered.

Key topics
As demonstrated by the data on the blog, ques-
tions about the appropriate parties for discussing a lawsuit continue to be a central concern for defendants. Here is the guiding philosophy for the website:

Accepting the discipline demanded by legal counsel, we can still talk with trustworthy and understanding confidants about our reactions without going into details of the event. Some of the event’s context will naturally emerge—it is difficult to talk about an auto accident without talking about whether it involved a car or a truck—yet the focus is on how we feel about being involved rather than on the explicit details of the event.

In fact there are a several individuals physicians can turn to as potential confidants. Since medical work is gradually transforming into institutional, large clinic- and/or hospital-based practice, physicians in leadership positions have become an increasingly important resource—for example, the department chairman, chief of staff, or some other administrator who may have had some personal experience of adverse events and/or MPL litigation. Frequently, they take the initiative and take the first step in offering support and a sense of perspective for the doctor who has just been informed of a claim.

It is the rare physician who does not experience some symptoms of distress—anger, anxiety, insomnia, appetite changes, and other disruptive emotions—at some point during the aftermath of these critical events. Fortunately, most physicians are resilient, and their symptoms diminish within a reasonable period of time, although they are subject to the vagaries of the lengthy process of investigation and litigation. The website provides a self-assessment tool, a symptom checklist, as well as descriptions of common emotional and physical symptoms, some of which may persist beyond a reasonable period of time. When that happens, professional consultation with a personal physician, psychiatrist, or other mental health professional may be helpful and, in some instances, imperative. As stated on the site, no specific legal or psychological advice is offered, because this is the role and responsibility of the physician’s personal attorney, physician, and/or mental health professional.

Modus operandi
The site is now being managed by a new vendor, and it serves approximately 350 users a month, most of whom identify themselves as physicians.

Originally established by an advisory group of five volunteers (two physicians, two lawyers, and a nurse/insurance company risk manager) and funded by a foundation and private donations, the website is currently housed as a “donor restricted fund” within the Oregon Medical Education Foundation, a 503(c)(3) organization that administers the site and serves as a receptacle and reporting mechanism for monies donated. The following MPL insurers, in response to earlier and more recent solicitations, have donated in support of the site: Cooperative of American Physicians, Inc., Coverys, The Doctors Company, ISMIE Mutual Insurance Company, MagMutual, Medical Insurance Exchange of California, Medical Interactive, Ophthalmic Mutual Insurance Company, and Physicians’ Reciprocal Insurers. These companies, whose logos are posted on a separate donors’ page, receive biannual financial and website activity reports, and several of them include a link to the site from their company site, for the use of their insureds.

Additional companies who may wish to join their colleagues in support of this endeavor are welcome.

A final caveat
In the report on website performance for the last six months of 2014, the landing page with the topic, “Online Sources of Support: Insurance Companies,” ranked fourth among the five top landing pages for users. The developers of this website strive for a comprehensive list of available resources, and clearly, users are looking for this information. Some companies offer content on litigation-related stress, or support via videos, that are accessible to nonmembers; other companies’ resources are available to members only. Writing in December 2014, one of our physician users, however, underscored the work yet to be done:

Thanks for doing this. In searching for information on this subject online, I have been rather surprised and dismayed to find how few resources there are for physicians in this situation. My state and regional medical society websites, and the website of my insurer, make no mention of it—as if any doctor sued for malpractice was not worthy of support.”

Here is a simple, although admittedly only partial, solution to this doctor’s plea: insurance companies, and specialty and general medical societies, can provide on their websites a link to the “Physician Litigation Stress” website for their members’ use. That alone would be an acknowledgment, and recognition, of the added stress for the many physicians who have become a “second victim” and, in many instances, a defendant in the aftermath of a medical misadventure.

To establish a link, just go to the homepage, www.physicianlitigationstress.org, click on “link to our site” at the bottom of the page, and follow the instructions. All companies are welcome, whether or not they choose to financially support the site, to create the link for the benefit of their policyholders.

Acknowledgment
The following volunteers serve on the advisory group: Dower Azizi, MHA, RN, BSN; Paul R. Frisch, JD; Gerri Donohue MSN, AFRN, ARM; Theodore Pavuladas, JD, IBRM; Larry Veltman, MD; and Sara Charles, MD. This group meets regularly via conference call, to oversee the content and administration of the site, and each member contributes in many ways to the overall functionality of the site.
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The Universal Protocol is a three-step process aimed at eradicating wrong site surgery. The steps include these interventions, in the pre-operative and operating room settings: (1) pre-procedure verification, (2) marking the operative site, and (3) a Time Out or final verification, performed immediately before the start of the procedure.1

As the granddaddy of preventable patient harm, wrong site surgery invariably occupies the top position on any sentinel or “never events” list and, in the public’s mind, is the most vivid example of preventable patient harm—a rare, but egregious event, often with catastrophic consequences. Preventing such catastrophes requires vigilance, commitment to patient safety, and the full deployment of all available safeguards.

The question on most everyone’s mind, when reconciling current incident rates for wrong site surgery with an arsenal of interventions, is—How could this problem possibly persist? Yet the Joint Commission estimates that wrong site surgery occurs at an alarming rate—nearly 40 times per week (that’s 2,000 times per year). Other questions follow: What are the root causes of these failures? Are there any common factors in these events? And why haven’t trusted interventions, such as the Universal Protocol or Time Out, been effective?

As researchers from the Joint Commission Center for Transforming Health Care recently discovered in identifying the risks of wrong site surgery across various settings, the problem just might reside in the way we approach patient safety problems, in general. Whether it’s a wrong site surgery, a medication error, or a mislabeled specimen, reliability experts will tell you that there is never a single root cause for any given adverse event; rather, there are multiple root causes and, often, these causes originate at various points in space and time, and then perpetuate, undetected, culminating in the eventual “perfect storm.” Joint Commission research identifies the common cultural and systemic issues at work in wrong site surgery, and offers insight into how we can approach patient safety problems, in general.

From silo to systems thinking: the error cascade
Partnering with eight healthcare facilities, researchers from the Joint Commission Center for Transforming Healthcare sought to understand the specific process vulnerabilities and root causes of what has proven to be one of healthcare’s most intractable problems. They evaluated the risks for wrong site surgery at every step along the entire surgical continuum, from initial scheduling to start time.

The results of this panoramic assessment were enlightening. The researchers determined that, in 39% of the cases evaluated, risks for wrong site surgery were introduced at a very early point in the surgical
continuum—in the outpatient setting. Colleen Smith, RN, High Reliability Initiatives Director for the Center, describes errors that originate in this setting, escape detection, and then somehow persist with the tenacity of a drug-resistant organism, “[In the surgeon’s office] there could be a simple error, where a right or a left is written as an R or L, and that subsequent letter is misinterpreted and ends up on the surgery schedule as—the opposite.” To mitigate risks at this stage, Smith recommends improving legibility, eliminating unapproved abbreviations, performing read-back when imparting information, and providing supporting documentation whenever scheduling surgeries by telephone.

Looking next into the hustle and bustle of pre-op, the researchers found that 52% of cases showed risks associated with the absence of primary paperwork, incomplete or ambiguous documentation, and last-minute changes in procedure, in the absence of appropriate notification of staff. Pressures for productivity in the pre-op setting often prevent staff from fully investigating any discrepancies that arise. Additionally, Smith notes that whenever anesthesia providers decide to “go it alone” for procedures like regional anesthesia blocks, and fail to enlist a third party to conduct a procedurally correct Time Out, risk exposure increases dramatically.

Moving on into the OR, the researchers noted that 59% of evaluated cases showed additional risks; the predominant defect was team inattention during the Time Out. Additionally, the use of unauthorized pens whose ink fades after prepchange, resulting in site markings that were neither visible nor verified—is another risk. Researchers also noted that in several cases, x-ray films needed to confirm the correct site were inaccessible to the team. As Mark Chassin, MD, President of The Joint Commission, commented, “There are about 300 ways Time Outs can fail, from not having everyone stop what they’re doing and pay attention, to having a bad safety culture where someone knows something is wrong but is too scared to speak up.”

Patient safety thought leaders, including Lucian Leape, MD, of the Harvard School of Public Health, have long attributed the relatively slow progress of the patient safety movement to defects in culture—especially the risks created by a rigid hierarchy) wherein staff would rather keep silent about their safety concerns than risk ridicule or belittlement.

In summary, Joint Commission research reinforces two crucial concepts: that we are only as safe as (1) the integrity of our systems and (2) the quality of our culture. The fact that problems from a previous setting can trespass into other environments, encourages “big picture thinking,” inter-departmental collaboration, and an engineering-type approach to process improvement, including detailed process mapping of the entire surgical continuum—perhaps utilizing a favorite tool that is used in engineering, the Failure Modes and Effects Analysis (FMEA) to outline, in great detail, each step in the process we use to detect and prioritize risk. Knowing about this error cascade, perhaps we will be more questioning about the information in front of us. And perhaps we will be much less tolerant of ambiguity, missing information, or deviations from safe practice.

### Changing attitudes

Researchers understand that the mere presence of the observer can influence the behavior being observed. This “Hawthorne effect” likely holds true for impromptu observations of Time Outs in hospitals, where members of surgical teams often seem to be on their best behavior in the presence of the Joint Commission surveyors or hospital risk managers. Although the actual Time Out process may be less technically perfect in real life, less easy to conceal are team members’ attitudes toward the Time Out. In many respects, these observations provide the perfect window into the local culture and attitudes toward safety that may undermine performance. From the reluctant assignee inaudibly reciting checklist answers, to the half-hearted, ritualized mumbles of a distracted team, to more assertive devaluations suggesting that the Time Out is a nuisance hampering productivity. The way a team enacts a Time Out is telling.

While it’s easy to blame professional hubris (and sometimes, that is the cause) or any of the other less appealing aspects of human nature, believers in the “Just Culture” concept know that, in the majority of cases, complacency and disengagement are rooted in a lack of awareness about the true importance of the safety practices we require. As the Institute for Safe Medication Practices has astutely noted, in evaluating compliance challenges with independent double checks for high-risk medications, it’s often difficult to commit to a safety practice that seems to result in catching anything only rarely.

Patient safety officers, risk managers, and administrators are thus challenged to dispel complacency through robust education, discussion of their near misses, and frequent debriefings on incidents that happen locally as well as nationally. And of course, they should be offering team training that teaches what has been an historically autonomous group of individuals, how to respect each other and work together.

Additionally, simple changes can have a huge impact. For example, assigning to each team member a distinct role in the Time Out and phrasing the Time Out checklist as a series of questions—thereby requiring actual thought rather than just parroting back rote answers—may work to increase attention and active engagement. The objective is to change culture and reinforce belief: “This is how we do it, each and every time, and the patient in front of us deserves our complete attention and best effort!”
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Straight through processing (STP) makes it possible for companies to process business transactions without the need for re-keying or manual intervention, subject to their specified business rules and restrictions. It requires a single system, or tightly integrated components, that control the workflow from the “point of sale” to the “back office.”

In contrast, traditional operations require multiple steps involving human intervention, which slows down processing, and introduces the possibility of errors. STP promises to improve timeliness, service levels, efficiency, scalability, and cost. A recent IBM study estimated that eight cents of each dollar of premium is spent on redundant or non-value-added activities. And a recent Celent study on STP indicated that some carriers who have adopted it have reduced cycle times by up to 80%, decreased workload by up to 75%, and cut paper costs by up to 40%.

Since alternating hard and soft markets have made the control of profitability through pricing very difficult, the expense control (and service improvement) opportunities from STP should be of keen interest to insurance companies. And although it’s true to say that “volume” lines like personal auto and workers compensation seem better suited than medical professional liability to STP, there is still plenty of opportunity.

Obviously, the goal shouldn’t be to automate every transaction in every process—there will always be complex types of business that require the expertise of a skilled individual. Complicated risks like E&S for a large hospital system, or some reinsurance transactions, will always need to be processed mainly “by hand.”

For less complex processing, the goal should be to identify what can be automated, versus what the exceptions should be. For example, if renewal cycle processing is being considered, you may be able to gain a good measure of efficiency by automatically renewing, say, 40% of your renewals that fall within certain guidelines, taking into account premium size, medical specialty, number of risks, type of policy, loss experience, or any of a number of other criteria that come to mind.

Start conservatively, and then refine the criteria to include more policies over time, if your experience indicates that this is possible.

Working with current software

Unless a company is building its IT infrastructure and business processes from scratch—hardly ever the case—STP has to be considered within the context of the software that is currently installed. That makes implementation more challenging. There is no quick off-the-shelf solution, and the effort required will depend on what technologies are available. That’s the bad news; the good news is that STP is very amenable to incremental adoption. The end game can be accomplished through successive “mini-projects” that are relatively easy to manage, deliver value more quickly, and can act as a proof-of-concept for the organization.

Martin Lippiett is Vice President of Business Consulting, Delphi Technology, Inc.
The major workflows in any insurance carrier are:
- Business acquisition—applications, quoting, and booking new business
- Policy changes—endorsements, cancellations, and reinstatements
- Renewal processing—verifying information, possibly providing quotes, and creating the renewal policy
- New claim notifications—verifying coverage for new claims, creating the claim records, and assignments
- Claim payments and reserve maintenance
- Cash processing—application to receivables and resolving queries.

All of these can be broken down into steps, and each can be attacked incrementally, generally, without affecting what happens with the others.

Here is one approach for transitioning to STP.

- Decide where to start. Most managers will, intuitively, have a good idea of the problem areas in processing their business: What takes the most time, and what tasks or transactions are done most often? Be selective—don't attempt to address “everything” in the organization.
- Document—and measure—cost. After you have selected an area to focus on, perform an audit of the workflow in it. For each task or step, measure the cost associated with it—labor, processing costs, printing, mailing, travel—anything and everything that is a part of completing the work; if it can't be measured, it can't be managed. The documentation should specify how exceptions are processed, and, where human intervention is required, identify the best individual to deal with it.
- Evaluate other factors in the workflow. For example, the error rate, and the specific type of error most often encountered, delays that are a concern from the perspective of service, apparent redundancies in the work being done, and so on. Also ask whether the current workflow is still relevant to the business. For example, if the company decided to ask for a new application at every renewal several years ago, perhaps this could be changed, and requested on alternate years, or at every renewal only if other criteria are present.
- Pick your battles. From these three steps, if done thoughtfully and thoroughly, the areas that will benefit the most from your attention will probably be obvious. In addition, you will have developed metrics that can be used later to quantify the process improvements.

- Consult your IT group. Because the adoption of STP involves automation, share your plan with your IT staff, to get their input. You will want to leverage what you have; they will be able to advise you about the level of effort that will be needed to make changes, and perhaps suggest the low-hanging fruit: where you might be able to reap a major improvement with a minimum of effort in software development.
- Make a plan. At this point, it should be possible to make a plan for implementation, which would include the changes to be made in the company software and a cost-benefit analysis.

There is nothing really revolutionary in the concept of STP, and the decades-long adoption of automation by the insurance industry has been driven by the same motivations: accuracy, timeliness, cost effectiveness, and service. But it has been slow to move forward. Systems in use today are not all that different, in regard to automated workflow, from those in use ten years ago—a long time in the tech world.

However, it seems that STP is now a solidly emerging trend that has been facilitated by:
- The advent of workflow engines that are embedded in some insurance products. Document management (imaging) systems were pioneer advances in this.
- New technology standards—Web services and service-oriented architecture that make the integration of software far easier.
- A new family of software products—business process management systems from Oracle, Software AG, and others that are directed at overlaying business rules on existing systems.
- Data standards like ACORD are also a key STP enabler, particularly when workflows involve both in-house and business partner activity.

The imaging vendors’ lead in workflow management focused on document-based activity. Less common are workflows that depend on events or data, for example, the automatic creation and assignment of a “review” task for claims that have been inactive for six months, or quotes that have not had a response from customers for more than a week. But we will soon see the event/data based-business rules catch up and become as important as the more familiar paper-based business rules.

With the promised payback from the investment in time and effort, new technology, ramped-up competition, and the appealing option to move along the workflow path incrementally, we may, in 2020, look back at 2015 and see it as the year when STP really kicked in.
Before we dig into the details, consider the following:

**Enhanced Short-Term Insurance Contract Disclosures—Imminent?**

**By Magali Welch**

Your financial statements may be getting much thicker, if the Federal Accounting Standards Board (FASB) has its way! Although the joint insurance project between the FASB and International Accounting Standards Board (IASB) is officially dead, the FASB has been diligently working to develop enhanced and expanded loss disclosures for short-term insurance contracts.

U.S. constituents made it loud and clear that they really like the current accounting model used now for short-term insurance contracts; it works well, so why switch to the FASB and IASB’s proposed models? The investor community concurred, but suggested that additional disclosures could be helpful in their decision-making process.

So the FASB listened and drafted a paper that leaves the accounting model intact, but enhances and expands the required disclosures for short-term insurance contracts. If issued, the new disclosures will be effective December 2015, for public companies, and one year later (2016) for all others.

**A taste of the proposed disclosures**

Tables 1-3 will give you some sense of what’s in store. The disclosures need to be aggregated or disaggregated, based on how management utilizes the information in decision-making (by type of coverage, geography, claim duration, etc.). So be prepared to have as many tables as you have internal categories, for each of the proposed disclosures.

Other required disclosures include additional information about discounted losses, material changes in judgments in determining the liability, and more.

**What’s next?**

The FASB initially intended to have some of its constituents conduct a “fatal flaw” review of the paper. However, they have hit a little bit of a roadblock. Other parties have come forward with concerns and questions about some of the disclosures, which include:

- Claim counts accessibility
- Coming up with claim counts net of reinsurance
- Users’ misinterpretation of aggregation/disaggregation of data
- Distortions in the claims paid table, resulting from unusual events
- Determining whether to use pure IBNR, versus pure IBNR plus expected development, on reported claims.

So, what will the FASB do? Stay tuned.

Magali L. Welch, CPA, CA, AIAF, is a Partner, Johnson Lambert LLP.
### Table 1  Incurred claim development table, net of reinsurance, by accident year (going back to the earliest accident year, but not to exceed ten years), claim counts and IBNR

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### Table 2  Paid claim development table, net of reinsurance, by accident year

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### Table 3  Expected claims payout

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<th>Y1</th>
<th>Y2</th>
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<th>Y4</th>
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<th>Y6</th>
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<td>30.3%</td>
<td>9.2%</td>
<td>8.8%</td>
<td>13.3%</td>
<td>7.5%</td>
<td>8.2%</td>
<td>8.5%</td>
<td>1.7%</td>
<td>3.3%</td>
<td>1.7%</td>
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</tbody>
</table>
M y last article, “Why Can’t My Personal Investment Portfolio Do That?” (Inside Medical Liability, Fourth Quarter 2014) distinguished between the investments in an insurance company’s portfolio and the personal investments held in vehicles such as 401k plans, IRAs, and trusts. It explained the philosophical and conceptual differences, including time horizon, risk posture, revenue sources, regulatory constraints, and accounting challenges.

But there was one similarity: asset class exposure. For the longest time, there were many asset classes that were accessible only to institutional investors, such as insurance companies. However, markets and opportunities have evolved to the point where many of the investment opportunities that were available only to institutions are now accessible to individuals. This also works the other way; that is, many of the nontraditional investments (at least for insurers) that you may have invested in personally are starting to show up as opportunities for insurance companies, as regulators and investment committees, and you (as fiduciaries) learn to appreciate risk mitigation benefits that come from prudent diversification.

Given the current environment, with elevated valuations of U.S. equities and record low interest rates, both institutions and individuals are asking themselves, “Where do I invest now?” This article will take a look at the reasons why institutional and individual investors are anxious about the go-to asset classes like U.S. large-cap stocks (S&P 500 Index) and U.S. investment grade bonds (Barclays Aggregate) and the asset classes they are considering now, to hedge against an equity market correction and/or a spike in interest rates.

**Figure 1  2014 Total Return (12/31/13–12/31/14)**

*Indices used include S&P 500 Index, Barclays US High Yield Index, JP Morgan Emerging Market Bond Index, MSCI Asia Index, MSCI ACWI ex-US, MSCI Europe Index, BofA Merrill Lynch 10-Year Treasury Bond Index, MSCI Emerging Markets Index, Citigroup World Government non-U.S. Index, S&P GSCI Gold Index. Broad-based securities indices are unmanaged and are not subject to fees and expenses typically associated with managed accounts or investment funds. Investments cannot be made directly in an index. Charts are for illustrative purposes only.*

**Figure 2  Six-Year Cumulative Return (12/31/08–12/31/14)**

*Indices used include S&P 500 Index, Barclays US High Yield Index, JP Morgan Emerging Market Bond Index, MSCI Asia Index, MSCI ACWI ex-US, MSCI Europe Index, BofA Merrill Lynch 10-Year Treasury Bond Index, MSCI Emerging Markets Index, Citigroup World Government non-U.S. Index, S&P GSCI Gold Index. Broad-based securities indices are unmanaged and are not subject to fees and expenses typically associated with managed accounts or investment funds. Investments cannot be made directly in an index. Charts are for illustrative purposes only.*

_T.C. Wilson_ is Managing Director-Investments and Institutional Consulting Director, The Optimal Service Group of Wells Fargo Advisors.
Calendar year 2014 reinforced the assumptions that many investors have settled into as the norm following the 2008 crisis—you can't beat the U.S., nothing is better than the S&P 500 Index, and investment grade bonds, while not providing the yield they used to, have been generating sufficient total return. Figure 1 illustrates the total returns for calendar year 2014 of some broad asset classes in which you or your company may invest. The S&P 500 Index led the way, with a 14% total return, and was one of only five broad measures to record positive results for the year. Of particular note is the 17% outperformance of the S&P 500 over non-U.S. stocks, as measured by the MSCI ACWI ex-U.S. Index.

If one year is too short a duration for you to believe that the S&P 500 has dominated the markets, then let's look at the past six years (post-“Great Recession” of 2008). Figure 2 illustrates the returns of the same asset classes from December 31, 2008, through December 31, 2014. Over this period, the S&P 500 has risen a cumulative 159%, or an annualized 17.2%, which is more than twice its historical annual average. U.S. high yield and Asia ex-Japan are the only other broad measures that have doubled since 2008.

How soon we forget. It has been easy to get caught up in the hype and euphoria that institutions and individuals have enjoyed—especially those that have invested a majority of their funds in the S&P 500 and U.S. investment grade bond market since 2008. What seems to be forgotten by investors is the “lost decade” that spanned 2000-2009. It seems like a long time now since investors were complaining that the U.S. stock market had done nothing for them for ten years. Figure 3 provides a look at the same asset classes for the ten-year period from December 31, 1999—December 31, 2009 . . . the “Lost Decade.” The S&P 500 Index declined 9% on a cumulative basis, with only Japanese stocks (as measured by MSCI Japan Index) recording a lower ten-year cumulative result.

So, what does this all mean? It appears that investors have recently lost focus on the long-term benefits of diversification, given the recent dominance of just a few asset classes. Institutional and individual investors are positioned to chase the proverbial “hot dot,” which usually leads to unwanted volatility. Both your company and you, as fiduciaries and individual investors, should consider a broader set of asset classes, to help mitigate the portfolio’s risk. As mentioned in the previous article, you can take on the risk in your personal portfolio, but as a fiduciary, you are legally required to spread the risk exposure across complementary strategies, to dampen the impending volatility that is inevitably involved with a more-limited portfolio.

Figures 4 and 5 depict the cycles of the U.S. stock market during the past 20 years, as well as the troubling trend of record-low interest rates since the year they peaked—1980. These figures could be interpreted as indicating that U.S. stock prices are set to generate low, single-digit returns at best for the near-term and that bond total returns could be even less.

If these assumptions are true, then which asset classes should you consider? Where are the opportunities for you and your company to think about, given the concerns generated by the figures.
above? Many investors are looking for income, a component of all insurance portfolios that is paramount for better predictions of income streams. With recent record low rates on the 30-year treasuries and near-record lows on 10-year treasuries, yield-hungry investors are turning to non-traditional investments as income sources. Figure 6 shows the yields of various asset classes that insurance companies and individual investors are turning to now. They are doing this not just to capture greater income. They are also looking to implement an investment strategy whose objective is to enhance their portfolio’s potential for better overall absolute and risk-adjusted returns, should we experience a sharp correction in the U.S. equity market and/or a sudden spike in U.S. interest rates.

The asset classes listed in Figure 6 appear to be getting increasingly attractive lately, to both institutional and individual investors. It was not too long ago that many of these were not accessible by individuals, because there were no vehicles (i.e., mutual funds, exchange-traded funds, separate accounts) with sufficiently low minimums to make them feasible investments for individuals. They were used strictly by institutions. Despite this, insurance companies have lagged behind in securing exposure in these investments, due to state regulations, lack of understanding of them, accounting challenges, and software that was incapable of synchronizing information on these securities in a timely manner during the annual reporting process.

Now, 2015 brings a new opportunity for all types of investors, in a time when diversification is not only possible, but also logical, given the current environment of lofty domestic equity valuations and low interest rates. With the rapid expansion of exchange-traded funds (ETFs) and the creation of SEC-registered pooled vehicles with minimums as low as $1,000, each of the asset classes listed above, and many more, can now be accessed by just about any type of investor. While larger investment amounts typically get access to lower-fee vehicles, we believe it is worth the additional cost to consider expanding the mix and reducing the volatility that is looming for less-diversified portfolios. As fiduciaries, your legal responsibility requires you to evaluate the diversification benefits of considering these asset classes. As individuals, you owe it to yourself to better preserve what you have worked so hard to earn.

For related information, see www.wellsfargo.com

**Figure 5** Equities versus Fixed Income

<table>
<thead>
<tr>
<th>Period</th>
<th>Equities Returns</th>
<th>Fixed Income Returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1954 – August 1981</td>
<td>After 5% inflation: Equities: 5%</td>
<td>Fixed Income: -1%</td>
</tr>
<tr>
<td>September 1981 – December 2012</td>
<td>Returns after 3% inflation: Equities: 8%</td>
<td>Fixed Income: 6%</td>
</tr>
</tbody>
</table>

The future of: Stocks: Interest rate trend may no longer support expanding P/E ratios. Bonds: Interest rate trends may no longer support price appreciation. Portfolio Construction: Interest rate trends may no longer support strong risk-adjusted returns

Source: www.treasury.gov
Past performance is no guarantee of future results. Securities and insurance products are not FDIC insured, are not bank guaranteed and may lose value.

**Figure 6** Asset Class Yields as of 12/31/14

<table>
<thead>
<tr>
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<th>Yield</th>
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<tbody>
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<td>High Yield</td>
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<tr>
<td>MLP</td>
<td>6%</td>
</tr>
<tr>
<td>Eng. Mkt. Debt</td>
<td>6%</td>
</tr>
<tr>
<td>Eng. Mkt. Corp. Debt</td>
<td>6%</td>
</tr>
<tr>
<td>Bank Loans</td>
<td>5%</td>
</tr>
<tr>
<td>REITs</td>
<td>3%</td>
</tr>
<tr>
<td>US Large-Cap Stocks</td>
<td>2%</td>
</tr>
</tbody>
</table>

High yield refers to Barclays High Yield Index, MLP refers to Alerian MLP Index, EM Debt refers to Barclays Emerging Markets USD Aggregate Index, EM Corporate Debt refers to Barclays Emerging Markets International Corporate Index, Bank Loans refers to Barclays US High Yield Loan Index, REITs refer to the Dow Jones US Select Real Estate Index, US Large-Cap refers to the S&P 500 Index. Broad-based securities indices are unmanaged and are not subject to fees and expenses typically associated with managed accounts or investment funds. Investments cannot be made directly in an index.
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Profitability Continues to Decline from Peak Levels; Reserve Releases Fund Dividends while Surplus Stabilizes

BY SUSAN J. FORRAY AND CHAD C. KARLS

The year 2014 was a year of financial stability for the medical professional liability (MPL) insurance industry, despite a continued decline in profitability. While the industry’s operating ratio remains below 100%, it increased by several points over the prior year, as it has for each year since 2010. Insurers continued to experience a decline in reserve releases, increased expenses, and diminished investment income.

Despite this decline in profitability, the MPL industry again returned a substantial portion of its income as dividends to policyholders. Surplus grew slightly in 2014, leaving the MPL industry in a financial position roughly consistent with where it has been since year-end 2011.

The increased capitalization and favorable operating ratios in the MPL industry of late have had one primary cause—the release of prior-year reserves. In 2014 in particular, reserve releases contributed 25 points to the industry’s operating ratio. Even without these reserve releases, though, the industry would have been profitable. These reserve releases represent a decline relative to each of the years 2008 through 2013, during which reserve releases contributed an average of 31 points to the industry’s operating ratio each year.

Rates continue to fall for many writers, as evidenced by the declining premium volume of the industry as a whole. Certain markets have seen a cumulative decline in rate levels in excess of 20% over the past several years. It is not uncommon for companies to see certain of their competitors writing at rates perceived to be inadequate, in some cases forcing companies to choose between losing market share and writing at rate levels they themselves believe are inadequate.

At the same time, the industry’s pattern of declining frequency has ended, and we have seen the reporting of claim counts stabilize for most companies. Indemnity severity trends have remained manageable, although trends in defense costs continue to remain in the range

Susan J. Forray, FCAS, MAAA, and Chad C. Karls, FCAS, MAAA, are Principals and Consulting Actuaries in the Milwaukee office of Milliman.
of 5% to 8% per annum. While rate levels generally remain adequate for most companies in the MPL industry, a continued pattern of declining rate level combined with eventual increases in claim costs would work, over time, to impact the industry’s rate adequacy.

In certain states, MPL insurers are facing challenges to the tort system itself. As of this writing, bills have been filed in several state legislatures that would remove MPL claims from the tort system, creating what these bills term a “patient compensation system” (PCS; see Inside Medical Liability, First Quarter 2014, pages 28–31). If passed, these bills would create a formulaic approach to determining compensation for MPL claims and, depending on the particular language of the state’s bill, would significantly expand the number of claims eligible for compensation, fundamentally altering the landscape for MPL insurers. In addition, caps on damages continue to be challenged in various states, typically in the courtroom. On a favorable note for the industry, advocacy groups failed in their challenge to MICRA at the ballot box in California last November, although many expect California to face a similar proposition again soon.

The overturn of tort reform can be expected to lead not only to direct increases in claim severity, but also, indirectly, to increases in the number of claims as well. Absent a functional cap on damages, there is additional financial motivation for plaintiff’s attorneys to accept cases. A plaintiff with a less meritorious case will have a better chance of obtaining representation if the plaintiff’s attorney believes that the lesser likelihood of a plaintiff verdict is offset by a greater potential for a damages award.

MPL insurers also continue to face declining market share due to the continued acquisition of physician practices by hospitals and healthcare systems, as well as the preference of newly trained physicians to join these larger systems rather than enter into independent practice. Healthcare reform has only recently begun to impact the landscape of patient care. Once they have become more fully operational, we expect that the long-predicted decline in the availability of healthcare providers will become accelerated, due to the increased demand in services from a more fully insured population. Presumably, such an outcome could only impact MPL writers negatively, as patients begin to experience greater frustration with their providers.

To get a more detailed picture of the state of the MPL industry today, we have analyzed the financial results of a composite of 38 of the largest specialty writers of MPL coverage (“the composite”). Using statutory data obtained from SNL Financial, we have compiled various financial metrics for the industry, categorized by:

- Written premium
- Overall operating results
- Reserve releases
- Capitalization
- Policyholder dividends.

In viewing the financial results discussed below, it is important to consider that the 38 companies included here are all established MPL specialty writers. They exclude most of the relatively recent startup writers and any MPL specialty writer that has become insolvent or otherwise left the market, as well as the multi-line commercial writers of MPL coverage. The companies in each of these three excluded categories are generally less well capitalized than the 38 companies included here. In addition, while the underwriting results of the startup companies have typically been comparable to those of the composite, the underwriting results of the multi-line commercial writers have generally been somewhat less profitable. This was, of course, also true for the writers that became insolvent. Thus, the results presented below reflect the experience of the established specialty writers, which is inherently more favorable than a view of the industry as a whole.

**Written premium**

Last year, 2014, marked the eighth straight year of decreases in direct written MPL premium for our composite (Figure 1). Cumulatively, premium has decreased by more than $1.1 billion since 2006—almost 25% of the premium written in that year. To put that in perspective, consider: in the 30-year history of the MPL industry, no other period of decreasing premiums has lasted longer than two years, and the greatest consecutive-year premium reduction was 7%. On the surface, this would suggest that the circumstances of the current market are much worse than those of the previous soft market, of the mid- to late 1990s through early 2000s.

Yet the current market has some characteristics that distinguish it from the previous...
soft market. Both have shown decreasing rate levels, but similar evidence of rate inadequacy has not been manifest in the current soft market, versus the previous soft market. During this prior time period, rate deficiencies—including those documented in rate filings—ultimately culminated in adverse financial results. The reduction in frequency for MPL writers means that their rates are in a much better position now than they were a decade ago. However, we are beginning to see aggressive rate action in certain markets, exemplified by double-digit rate decreases filed by certain carriers.

Overall operating results
As measured by the composite operating ratio, the industry appears to have reached its peak profitability during 2010. During that year, the composite posted an operating ratio of 56%, which has risen to 74% since that time (Figure 2). The increase has been driven by the decline in reserve releases beginning in 2012, but also by an increase in underwriting expenses and continued lower levels of investment returns. The 2014 combined ratio for the industry was 96%, up from a low of 76% in 2008 (Figure 3).

The investment gain ratio of 22% in 2014 is similar to other recent years, but it represents a decline from the ten-year high of 27% in 2010. Investment gains, as split between investment income and capital gains in 2014, differed noticeably from prior years as the result of the accounting by one larger carrier of its investment in its affiliates. Thus, the industry’s capital gains ratio reached 6% (up from 2% in 2013) for the first time since the 1990s, while the investment income ratio declined from 19% in 2013 to 16% in 2014. If this one instance of an accounting treatment is set aside, we believe results indicate that investment income for the industry as a whole maintained a similar pattern in 2014 as was observed in 2013. The calendar-year loss and loss adjustment expense (LAE) ratio for 2014, 69%, is higher than in any year since 2006, and represents an increase of more than 12 points since 2008, when the ratio was less than 53%. The increase has been driven largely by the decline in reserve releases noted earlier, and is discussed further below. The loss and LAE ratio carried for the 2014 coverage year is 90%, the same as the loss and LAE ratio carried for the 2013 coverage year, as of year-end 2013, and only a five-point increase over the 2008 starting loss and LAE ratio of 85%. In light of the rate decreases during this time period in virtually every locale, a greater increase in the initial loss and LAE ratio would be expected. Thus, this modest increase suggests that the 2014 coverage year is starting out from a weaker, or perhaps less strong, position than other recent coverage years.

Reserve releases
As discussed above, the composite released close to $900 million in reserves during 2014, a decline from the almost $1.1 billion released in each of 2012 and 2013 and the $1.2 billion released each year between 2008 and 2011 (Figure 4). Despite the decline, the reserve releases remain material. Yet, they should be put in the context of the reserves carried by the composite, which for net loss and LAE totaled almost $9.9 billion as of year-end 2013. The release of reserves was driven by
the ongoing impact of a lower frequency, combined, for many companies, with a relatively benign indemnity severity trend during the past several calendar years.

It is important to recognize that a history of favorable calendar-year reserve development is not necessarily indicative of redundant reserves currently. In fact, a review of calendar-year development segregated by coverage year shows that favorable calendar-year reserve development has historically continued two to three years past the point when reserves were subsequently found to be adequate. Thus, if the industry is currently at a level where reserves are theoretically exactly adequate, history would suggest that we will see favorable reserve development, on a calendar-year basis, through 2016 or 2017. This would then be followed by adverse development (at least for the older coverage years) in subsequent calendar years.

Finally, as we have mentioned several times now, the industry has seen a dramatic decrease in reported frequency over the past decade. However, for many companies, frequency (on a per-physician basis) has stabilized. Other companies have continued to see small declines in frequency, while for some writers, frequency has turned slightly upward again.

Given the rate decreases of the past several years, frequency has of course increased more relative to premium than to the number of insured physicians. Frequency per $1 million of gross earned premium reached its lowest point for the industry in 2006. Reported frequency has increased each year since this time, although there have been small declines in both 2013 and 2014. Thus, for every claim reported, fewer premium dollars have been available to defend or settle the claims than was the case several years ago. Cumulatively, reported claim frequency (measured relative to premium) has increased by about 25% since the 2006 year. This increase is largely the result of rate decreases (mostly in the form of greater premium credits, as opposed to manual rate changes), although some writers have seen modest increases in “true” frequency—i.e., claims per insured physician.

**Capitalization**

The industry’s surplus increased just slightly during 2014, from $12.2 billion to $12.5 billion, a growth rate of 2% (Figure 5). While net income for the industry exceeded $800 million, a large portion of this income was returned to policyholders in the form of dividends, discussed further below. The industry’s growth in surplus during 2014 represents a noticeable decline from the double-digit growth rate seen during most of the prior decade.

To put the industry’s capitalization level in a broader context, consider the Risk-Based Capital (RBC) ratio for the industry. This metric provides a comparison of a company’s actual surplus to the minimum amount needed from a regulatory perspective (although, from a practical perspective, given market fluctuations, many would consider the actual amount of capital needed to be well in excess of this regulatory minimum). The RBC ratio of our MPL composite declined in 2014 for the first time in over ten years, from 1,140% to about 1,120% and now sits at a level comparable to 2012. However, individual RBC ratios
In light of the industry’s fundamentals, we expect a continuation of the current soft market into the foreseeable future.

Policyholder dividends

The stabilization of the industry’s capitalization level is in part due to the significant amount of policyholder dividends that MPL writers have continued to pay. In 2014, the composite writers paid $2.5 billion in policyholder dividends, representing almost 9% of the carried net reserves, which implies a redundancy for our composite of $900 million. Thus, continued reserve releases can be expected to mask deteriorating underwriting results on current business, both prolonging the soft market and increasing the risk that rates may become inadequate. Insurers face other risks to the bottom line as well: possible increases in frequency and severity, including the threats to the tort system and tort laws in various states, the potential for a decline in asset values, the continued impact of healthcare reform, and a decline in market size, as hospitals continue to acquire physician practices, among others factors.

In light of the industry’s fundamentals, we expect a continuation of the current soft market into the foreseeable future. This will exert further pressure on the industry’s rate adequacy, and profitability will continue to slowly erode, albeit from a relatively strong position. The appropriate use of capital will become an increasingly common topic of conversation, as the industry’s capital continues to reach record levels.

More of the same to come

In its most recent “Review & Preview” report, A.M. Best estimated a net total reserve redundancy of $2.5 billion for the MPL line of business as a whole. This is approximately 9% of the carried net reserves, which implies a redundancy for our composite of $900 million. Thus, continued reserve releases can be expected to mask deteriorating underwriting pattern of policyholder dividends is very similar to that of reserve development. Thus, a large portion of the after-tax income resulting from reserve releases has been returned to policyholders.

Typically, these dividends are paid to all renewing policyholders as a percentage of premium. Thus, on a dollar basis, the dividends have provided greater benefit to those physicians who have historically paid higher premiums. We expect that policyholder dividends will continue for several more years, given their historically cyclical behavior and the composite’s strong balance sheet.

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Connecting Devices for Better Patient Care

By Eric R. Anderson

As I typed in the following words, I realized that I’ve seen them so many times before, I’m not sure I can stand to see them even one more time. But, still, here they are: Every day, those who participate in the healthcare delivery system face a multitude of challenges that impact their ability to safely deliver care. There, I’ve said it. And I’ve wondered, what ever happened to the days when healthcare professionals could simply worry about caring for patients? The halcyon times of Marcus Welby, MD, Doogie Howser, and even the prickly Dr. House seem lost forever.

Today’s challenges are formidable, as we know, ranging from a lack of resources, financial and otherwise, to patient overcrowding, to the volatile and unpredictable system of jurisprudence for medical liability. Here at PIAA, and in each of our member companies, we do everything we can as advocates for those who deliver healthcare to think of better ways to overcome these hurdles. Fortunately, technology has been one solid rock amid the stormy healthcare seas. Or, come to think of it—has it?

As technology continues to evolve, those of us who support healthcare professionals confront a daunting technical challenge: How can we advance the effectiveness and safety of connectivity for the wide and increasingly diverse scope of medical and information technology that has become an essential tool in so many healthcare settings?

Interoperability—the capacity to share health information seamlessly across a multitude of medical devices and systems—is now the essential ingredient for improving the coordination and delivery of care across a multitude of medical devices and systems—is now the essential ingredient for improving the coordination and delivery of care within the automated, connected, and coordinated future that we can all envision.

What do healthcare professionals have to say about the current status of medical device interoperability? Opinions, it would seem, are decidedly gloomy. The West Health Institute, a medical research nonprofit that works to come up with new, more effective ways of delivering care, recently conducted a nationwide survey of professionals on the frontlines of healthcare, asking about their personal experiences with medical devices and related technology.

Of the registered nurses who responded, roughly 60% said that medical errors could be decreased if hospital medical devices were coordinated and interoperable. And 46% of the RN respondents noted that if manual transcription from one device to another has to be done, an error is “extremely” or “very likely” to occur. These statistics are critical for medical liability—especially when you recall that it may take as many as ten devices to monitor or treat a patient in an intensive care unit.

We share the collective goal of safe and high-quality healthcare. So what can we—as the medical liability community—do to fix this problem?

For one thing, we can take an active part in discussions about interoperability, bearing in mind that the challenges inherent in this technology are not the exclusive domain of professionals in the IT field. We will no doubt discover that the solutions lie in the interaction between people and technology, in the context of healthcare processes, environments, and organizations. People who know technology—and people like us who know about the delivery of care—must collaborate to foster better connectivity.

We can also help by spreading the word that the principal goals of healthcare—do no harm, and do some good for the patient—require not just information, but in addition a deep understanding of many, and many different kinds, of variables. IT captures data, but smoothly interoperable systems can make it possible to capture even more, and that will be a major boost to achieving these goals.

So, the bottom line here: Interoperability matters because it impacts patient safety. If we can work together, with patience and imagination, to get it right, we will contribute to sound clinical decisions and positive patient outcomes, and also serve to protect the healthcare professionals we work for.

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

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