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And

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PIAA polls its members on a regular basis, to keep up to date on the issues that matter most to the community. In our most recent survey, an old, but perennially important, topic was top of mind for many PIAA members: patient safety.

Patient safety has long been a central concern for everyone who is part of the Association. In fact, back in the 1970s, the founding companies that joined together to launch PIAA broke new ground, in many areas, when it came to developing a safer environment for healthcare. Innovative risk management and loss prevention initiatives comprised the foundation of these efforts, along with the analysis of MPL claims and cause-of-loss data.

Today, in light of the ongoing transformation of the healthcare system, and the intense focus on reducing the cost of healthcare while at the same time increasing its quality, patient welfare is arguably more central than ever for those in healthcare and in the MPL arena. The interests of healthcare professionals and their patients are squarely aligned when it comes to safety. Nobody in the chain of care is more focused on a positive outcome than the healthcare professional. So, in this instance, the interests of patients, healthcare professionals, and the MPL community truly are in sync.

For this reason, in this issue of Inside Medical Liability, our cover story examines the top ten patient safety concerns for healthcare organizations. It then goes on to provide details about three of these—care coordination, reporting test results, and drug shortages. The article can help healthcare organizations in determining where they can most usefully focus their patient safety efforts, and will assist them in selecting priorities and devising corrective action plans that can minimize adverse outcomes. You will also hear from two of your peers—PIAA member companies that offer some illustrative stories about what they've done to advance their progress in patient safety.

These are, of course, only two instances of the contributions that PIAA members have made to a safer healthcare environment. We hope that this discussion will serve as a springboard for a fruitful dialogue and the sharing of new ideas on patient safety. We urge you to keep us informed of your progress in this area.

It goes without saying that your feedback is the single most important driver in all that we do at PIAA. In the latest member survey, you told us about what you anticipate will be your most daunting challenges over the next three years: for example, the evolving healthcare landscape, the shifting MPL marketplace, operating and defense costs, and state regulation and legislation.

You also told us what we are doing best at this point: providing unique MPL data, leadership of the MPL community, offering exceptional continuing education for MPL professionals, and providing networking and relationship building opportunities, among others.

In addition, and perhaps most important, you helped us understand how we can assist you with your business, both now and in the future: we should sustain our focus on patient safety, provide cutting-edge information on loss prevention and risk management, expand our data collection and research capabilities, favorably influence legislators and public policy makers, and serve as a connecting point for the larger MPL community, to name a few.

We will keep all of this clearly in mind, in the months ahead, as we ensure that PIAA serves your needs to the best of our ability—and provides even greater value for each PIAA member. As your trade association, we endeavor to see for you, hear for you, and represent you whenever a need arises. Nothing is more important to us than meeting your needs.
Cover Story: Using PSO Data to Identify the Leading Patient Safety Concerns—and Lessons Learned
By Cynthia Wallace, CPHRM, and Karen P. Zimmer, MD, MPH, FAAP

Feature: The ‘Seven Deadly Sins’ of Large-Scale IT Project Management
By Martin Lippiett

Feature: Transparency: Changing the World We Live In, for the Better
By Kevin Bingham, Mark Bethke, Greg Chrin, and Josh Merck

Feature: Enterprise Risk Management for MPL Specialists
By Gerry Glombicki

Special Section
54 2014 PIAA Medical Liability Conference

"By collecting data from many providers, PSOs can spot problems and trends that an individual organization, with a limited pool of data, may be unable to detect."
—Cover story

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Medical Interactive's MiCapture™ Risk Assessment software features pre-generated and customizable assessment questions, templates, reports, and recommendations allowing Risk Managers to complete the entire assessment process on-site using a laptop or tablet.

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www.medicalinteractive.com    info@medicalinteractive.com    855.464.7475
“Common Complaints/Catastrophic Outcomes”

This is an essential topic for managing risk in every MPL enterprise: how to identify the common patient complaints in the ER that may signal a high-risk situation. Michael J. Gerardi, MD, FAAP, FACEP, President, American College of Emergency Physicians, will discuss what can go wrong in responding to symptoms such as abdominal pain, back pain, vomiting, headache, rash, syncope and more. He will then explain how risk management can lower, or even prevent, catastrophic outcomes in the ER.

“In the Courtroom, but Outside the Box”

You can also learn about the occasions when a successful outcome in the courtroom requires something novel—a nontraditional technique or strategy. In this session two experts will tell you when to use these, and how to deploy them to maximum effect, based on actual cases. Tracie M. Dorfman, Esq., Associate, Hancock, Daniel, Johnson & Nagle, P.C. and Richard L. Nagle, Esq., Director, Hancock, Daniel, Johnson & Nagle, P.C., will help you become more innovative in finding new approaches to persuading a jury.

“The Expanding Role of Advanced-Practice Nurses”

More of the tasks that were once restricted to physicians are now done by advanced-practice nurses. This raises important questions for MPL entities. Melissa Joy Roberts, JD, MSN, FNP-BC, Associate Dean, UMKC School of Nursing and Health Studies, will discuss the crucial issues with advanced-practice nursing for MPL. For example, how will states modify their scope-of-practice restrictions in response to physician shortages? As standalone nurse practitioner practices proliferate, what impact will that have on MPL exposures and rates?

“The da Vinci Robot: The Rest of the Story”

Physicians and patients are bombarded with advertisements promoting new medical technology like the da Vinci “robot.” In light of the volume of these procedures, it is time to examine their actual impact for MPL. Barry N. Gardiner, MD, will provide full coverage of this complex topic, including a roster of the surgical specialties that now use robotic surgery, rates of complications, and product defects. He will provide an insider’s view of the strategies that plaintiff’s attorneys use in claims of alleged harm from robot-assisted surgical procedures.
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How can you not love this one? Robots that shoot ultraviolet light onto room surfaces proved sufficiently powerful to drive down rates of the hospital-acquired infections (HAIs) that are caused by multidrug-resistant organisms or Clostridium difficile. The study confirming this happy fact was published in the venerable American Journal of Infection Control.

Ultraviolet disinfection (UVD) technology uses mercury bulb devices or pulsed-xenon bulbs. The pulsed-xenon devices were first used in May 2011, at a 643-bed New York hospital. Teams from several departments—infec-
tion prevention, environmental services, and performance management—monitored the results weekly.

More than 11,000 applications of UVD between July 2011 and April 2013 resulted in a 20% decrease in overall HAIs related to multidrug-resistant organisms, despite the fact that the researchers had missed nearly a quarter of the possible opportunities to use the technology.

Adult inpatient rooms at the hospital are routinely cleaned with sodium hypochlorite 0.55% disinfectants, and pediatric rooms are cleaned with a quaternary ammonium compound. During the study period, UVD was added to the regimen.

Study lead author Janet P. Haas, PhD, RN, director of infection prevention and control at Westchester Medical Center in Valhalla, New York, says that because UVD seems to work everywhere else in the hospital, it could plausibly do the same in operating rooms. However, she warns that the current clinical evidence for using UVD in the operating room is less compelling; more research is needed to fully assess how effective it might be in surgical care areas.

Despite their challenging financial circumstances, reinsurers have continued to report attractive results in recent quarters. Low catastrophe losses and positive reserve developments have helped. But can this be sustained? Not surprisingly, opinions differ.

The market, at any rate, has weighed in on the matter: reinsurance share prices have begun to slip as the abundant levels of traditional and alternative capital have exerted pressure on reinsurance rates.

Recently, presenters at a seminar sponsored by the Casualty Actuarial Society, in New York, offered their take on the relative extent of disruption in the reinsurance market resulting from the entry of new capital. Two of the analysts, Alan Zimmerman, managing director of Assured Research, and Matthew Mosher, SVP rating services at A.M. Best, suggested that the best option was to simply move on—to explore new opportunities. They noted that both insurers and reinsurers need to work hard to remain relevant—even if that means abandoning segments of the market to the new capital. There was a dissenting opinion from Meyer Shields, of Keefe, Bruyette and Woods. He suggested less drastic action, advising that insurers and reinsurers investigate the possibility of profitable niches within the affected market segments.

But it was Zimmerman who came up with the most memorable image for the market. He depicted the stark difference between the pre-Hurricane Andrew situation and today. Reinsurers in the prior era were like “huge, impregnable castles,” he said, with a broad base and underwriting depth. “Today,” he suggested, they seem more like “mobile homes,” with a greater number than ever before, and more competition.

Source: Artemis, June 24, 2013
Tacking against the headwinds of general consensus, University of Cincinnati College of Law professor Jim O'Reilly believes that the Affordable Care Act will actually transform MPL litigation into an uphill battle for the plaintiff's attorney. When the huge influx of new patients is fully in effect, O'Reilly says, we can expect to see a corresponding proliferation of telemedicine, as well as grocery and convenience store clinics that are staffed by nurses, not doctors.

“There will be errors and there will be compensation,” O'Reilly notes, “but it won’t be anything like what we’ve seen where patients win millions of dollars.” Speaking as a professor of future attorneys, he cautions, “For lawyers to better serve their patients, they need to understand that the system has changed. If they don’t know about it, their client loses.” Overall, O'Reilly predicts, there will be fewer and fewer cases where a patient goes to court directly against his family doctor.

The other big factor in the possible decline of MPL claims, he says, is the rise of large hospital-based accountable care organizations (ACOs). The thought of taking on a mega-hospitals cadre of lawyers may well be intimidating to a plaintiff’s attorney contemplating whether or not to take on a particular case.

The way out of this quandary? Well, this is America, where the answers to so many problems are revealed in a steady stream of brand-new publications. O’Reilly offers his: The New Medical Malpractice. Described by his employer, the University of Cincinnati, as “groundbreaking,” the book will supposedly help lawyers negotiate what O’Reilly sees as a whole new healthcare scenario, with a “more diverse set of defendants and a much more complicated decision for compensation.”

Source: Outpatient Surgery magazine, May 27, 2014

Let’s Shake on It: Ban the Handshake

Compliance with hand hygiene is an important goal in infection prevention. And yet the hand-to-hand transfer of infectious bacteria is still a common public health hazard. As draconian as it sounds, some clinicians are pushing to prohibit the familiar greeting, the handshake, between providers and patients.

According to a recent proposal published online in JAMA, hospitals, surgical centers, and office practices would be designated “handshake-free zones.” The authors, clinicians from the David Geffen School of Medicine in Los Angeles, propose some possible substitutes: open-handed waves, bowed heads, hands over the heart, and yoga-style “Namaste” gestures.

Department of Upbeat Predictions: In-Store Clinics, Telemedicine—and the Death of Windfall MPL Judgments

There is actually some research to back up the proposal. Last year, researchers from the University of West Virginia compared the infection-transfer potential of fist bumps vs. handshakes, and found that the fist bumps were less likely to pass on infecting agents.

The UCLA clinicians are quite insistent about the importance of the no-handshake policy. “Removing the handshake from the healthcare setting may ultimately become recognized as an important way to protect the health of patients and caregivers,” they say, “rather than a personal insult to whoever [sic] refused another’s hand.”

Source: Medical Xpress, May 22, 2014

Quiz Time! Students’ Concerns re MPL and Defensive Medicine

A recent report in the Western Journal of Emergency Medicine (William F. Johnson et al., Hackensack University Medical Center) noted the responses of third-year medical students to a series of statements about defensive medicine and their related medical liability concerns (MLC).

The study employed a five-point Likert scale, and their responses were tabulated as percentages, with a 95% confidence interval. Now it’s your turn. Match the statements in the first section with your guesses on the percentage of students who agreed, in the section below. The answers appear at the end of this article.

The statements

1. I rarely worry about being sued ____
2. The faculty are concerned about MPL ____
3. The faculty teach defensive medicine ____
4. My satisfaction as a doctor will be decreased by MLC and lawsuits ____
5. My choice of medical specialty will be influenced by MLC ____
6. My enjoyment of learning medicine is lessened by MLC ____
7. I worry about practicing and learning procedures because of MLC ____

Percentage of students who agreed

a. 51.0%  b. 32.4%  c. 21.6%  d. 85.3%  e. 16.7%  f. 55.9%  g. 23.5%

Answers: 1, d; 2, f; 3, b; 4, a; 5, c; 6, g; 7, e.
In conjunction with the cover story on page 22, Using PSO Data to Identify the Leading Patient Safety Concerns—and Lessons Learned, ECRI Institute ranked “retained devices and unretrieved fragments” as number seven on its 2014 Top 10 Patient Safety Concerns for Healthcare Organizations. A review of closed claims in the PIAA Data Sharing Project from 2008–2012 revealed “foreign body, surgical, left in patient during a procedure” as the fourth most prevalent patient outcome. This outcome is similar to “retained devices and unretrieved fragments” as identified in the previously named ECRI publication and also in ECRI’s 2014 Top 10 Health Technology Hazards. Among these claims, 28% totaled more than $20 million in indemnity payments. The claims had an average indemnity payment of $85,427.

The PIAA Data Sharing Project provides information on claim trends for the most recent ten-year period and other timeframes. For more information, please visit the PIAA website at www.piaa.us.

**MPL Data—Most Prevalent and Expensive Outcomes**

<table>
<thead>
<tr>
<th>MOST PREVALENT RESULTING MEDICAL CONDITIONS</th>
<th>Closed Claims</th>
<th>Paid Claims</th>
<th>% Paid-to-Closed</th>
<th>Total Indemnity</th>
<th>Average Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac-cardiorespiratory arrest</td>
<td>2,814</td>
<td>726</td>
<td>25.8</td>
<td>$252,065,722</td>
<td>$347,198</td>
</tr>
<tr>
<td>Postoperative infection</td>
<td>1,021</td>
<td>200</td>
<td>19.6</td>
<td>$54,810,736</td>
<td>$274,054</td>
</tr>
<tr>
<td>Emotional distress only</td>
<td>952</td>
<td>120</td>
<td>12.6</td>
<td>$14,286,539</td>
<td>$119,054</td>
</tr>
<tr>
<td>Foreign body, surgical, left in patient during a procedure</td>
<td>880</td>
<td>243</td>
<td>27.6</td>
<td>$20,758,861</td>
<td>$85,427</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>863</td>
<td>285</td>
<td>33.0</td>
<td>$132,015,648</td>
<td>$463,213</td>
</tr>
</tbody>
</table>

When compared to the most expensive outcomes, “foreign body, surgical, left in patient during a procedure” was not among the top five and was less than 1% of the total indemnity ($8.2 million) for all claims paid between 2008 and 2012; however, it’s critical to consider these claims as they impact areas for improvement in patient safety.

<table>
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<td>726</td>
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<td>$252,065,722</td>
<td>$347,198</td>
</tr>
<tr>
<td>Brain damaged infant</td>
<td>607</td>
<td>233</td>
<td>38.4</td>
<td>$172,109,686</td>
<td>$738,668</td>
</tr>
<tr>
<td>Birth trauma</td>
<td>590</td>
<td>246</td>
<td>41.7</td>
<td>$132,480,940</td>
<td>$538,540</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>863</td>
<td>285</td>
<td>33.0</td>
<td>$132,015,648</td>
<td>$463,213</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>650</td>
<td>231</td>
<td>35.5</td>
<td>$96,639,029</td>
<td>$418,351</td>
</tr>
</tbody>
</table>

The PIAA Data Sharing Project provides information on claim trends for the most recent ten-year period and other timeframes. For more information, please visit the PIAA website at www.piaa.us.
The world has changed. Information flow is faster than ever. Remaining at the top of your game requires focus, foresight and the ability to act quickly. We believe to keep moving forward, your team needs the best players: experienced investment professionals who combine sound judgment with innovation. Allow us to assist as you step onto your field.

Are you ready?

Joe Montgomery, Judy Halstead, Christine Stiles, TC Wilson, Bryce Lee, Robin Wilcox, Cathleen Duke, Kathryn Jenkins, Brian Moore, Loughan Campbell, Karen Hawkridge, Evan Francks, Vicki Smith and Brad Stewart
In a nutshell, AAU looks at these:

**Awareness.** The percentage of your target audience (customers or potential customers) who recognize your organization or its brand, either aided or unaided. It also measures how much knowledge the target audience has about your organization’s products and services. So, not only do you look to see if they know about you, you measure what they know about you.

**Attitudes.** This is a combination of what your target audience believes and how strongly they believe it. Measurements cover the target audience’s perceptions of quality, effectiveness, and value as they relate to your organization, and also cover intention to make a purchase or become involved with your cause.

**Usage.** This is simply the target audience’s self-reported behavior, as it relates to your organization.

So, how do you get this type of information? Here are two ideas.

But first, a caveat: make sure you specifically identify the target audience you want to measure. I can’t overemphasize the need for specificity in this step. Saying you want to measure awareness among the physician’s will not give you actionable data, because your organization probably doesn’t have the marketing budget for that large a study. Think specifically about the

---

If you ask 25 marketing professionals what a brand is, you’ll likely get 25 different answers. The best definition of a brand I’ve heard is this: “a promise held in the mind of the consumer, of an expected, consistent, and personal experience from a product, person, or organization.” But, despite the vast volume of words written about brands (Amazon has more than 5,000 books on the subject), it seems that many marketers today find it challenging to define their brand, let alone measure its impact.

The first brands were literally just that—names of companies burned into packing barrels, so they could be identified during the loading and unloading of ships in port. Some have said that the first brand to truly take root was that of the National Biscuit Company, which burned its abbreviated name—NABISCO—into these barrels to sort theirs from the other cargo more quickly.

More recently, however, branding fundamentally changed and became a marketing staple in the early 1980s, when Jack Trout and Al Ries published their seminal book, *Positioning: The Battle for Your Mind*. That simple paperback redefined the role of branding and put the business-customer relationship front and center in the purview of the marketing department, thereby sparking a whole new series of efforts meant to create specific associations and evoke positive feelings for brands in consumers’ minds.

**The challenge**

The challenge facing insurance marketers today is how to refresh our brands in a way that keeps them out of the general commodity market and viewed instead by the buyer and consumer as essential to their success. But how do you, as a marketer, know what that promise is—the one that is in the mind of the consumer? How do you unlock the power of your brand, if that power isn’t fundamentally yours to begin with?

The best place to start assessing your brand’s capabilities is with a simple metric designed to tell you how many people are aware of your brand, find out their attitudes about it, and reveal their behaviors in regard to your brand.

Typically referred to as AAU (“awareness,” “attitudes,” and “usage”), this metric is most useful when results are set against some form of comparator—that is, data from a prior term (e.g., year-over-year), different markets (e.g., geographic or demographic), or information from your competitor(s). An AAU metric by itself is meaningless, until you have a pivot point from which to demonstrate movement. In that light, several data sets are essential for identifying valid trends and movement in AAU.

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David Kinard is Vice President of Business Development at Physicians Insurance A Mutual Company, Seattle, Washington.
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LESS RISK.
THAT’S A WIN.
finite group you want to study, for example, radiologists in Arizona.

You can use surveys conducted by research organizations that know how to reach your target audience. These might be online, intercept, mail, or telephone surveys that ask a series of questions. Use the same set of questions over time, so you have data points to measure against.

Yes, you can administer a survey yourself if you’re measuring your internal constituents, but I’d still suggest that you employ a true researcher to help with the set-up, collection, and analysis. They’re the experts at this type of work—you’re likely not.

Or, you can scan discussion boards and social sites for first-hand comments and reviews. You can gather a wealth of knowledge just by becoming a quiet participant in user forums and sites that are talking about you. Resist the urge to defend and comment. Just listen and regularly monitor the tone of the posts, and the information shared.

Here are three kinds of data streams you might get and what to do about them.

- **High awareness, high attitude, low usage.** In essence, these people are saying, “I know about you, but I do not think highly of you and will not engage with you.”
  
  **How to respond.** These people may not know how to engage with your organization. Maybe your communications are unclear about your educational opportunities. Maybe your opportunities for learning are not what this audience wants. Go to them, find out how they want to engage with you, and then create the opportunities they’re looking for.

- **High awareness, low attitude, low usage.** These individuals may know about you, but they don’t think highly of you and will not engage with you.
  
  **How to respond.** These people should be left alone; instead, you should focus your energies on higher-yield opportunities. Seriously, the more you try to engage this population, the more likely you are to annoy them and create negative brand experiences.

- **Low awareness, low attitude, low usage.** Basically, these individuals don’t know you exist, and therefore do not engage with you.
  
  **How to respond.** An awareness campaign might move the members of this group into another, more fruitful category for your marketing efforts. But you’ll need to evaluate the cost of a program compelling enough to break through the noise in the market space as you compete for attention. Make sure you have a plan in place to engage with (or disengage from) these people once you do.

**Bottom line**

For many insurers, the commonly accepted idea is that if more people are aware of an organization, there will be more prospects and, ultimately, more buyers. These insurers equate awareness with moving the organization forward and enhancing success. Rather, the opportunity with branding is to create engagement, not awareness. Because if awareness were the name of the game, we’d all be shoveling pamphlets out of airplanes—from 30,000 feet.

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For related information, see www.phyins.com.
The Center for Quality Improvement in Radiology Interpretations offers two ways to improve outcomes in medical liability litigation

STRENGTHEN EXPERT TESTIMONY
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While regular readers of "Legislative Update" will recall previous articles about PIAA’s lobbying efforts in Washington, D.C., that represents only a portion of what it takes to advance the PIAA agenda and defend our companies from groups that oppose your interests. To be truly effective, advocacy efforts must include three components—grassroots, lobbying, and political fundraising. Unless we engage all three, it is nearly impossible to achieve legislative success in the nation’s capital.

Grassroots
In 2011, the Congressional Management Foundation (defined by them as an “organization founded to aid in management-related issues in Congress”) released a report on how well various types of advocacy efforts are perceived on Capitol Hill. Congressional staffers were nearly unanimous in saying that an in-person visit from a constituent had at least some influence over the Member of Congress. Compared with a meeting with a lobbyist (more on that later), nearly six times as many staffers said the constituent visit had “a lot of positive influence” on the legislator. Hill staffers also pay attention when an individual represents the views of multiple constituents. The same report noted that 96% of staffers said “contact from a constituent who represents other constituents” has an influence on the Member’s views.

With this information in mind, on September 15 and 16, PIAA will host a Capitol Hill Advocacy Day. The event will feature a networking dinner on the evening of the first day, so attendees can connect with their medical professional liability (MPL) colleagues from around the country. The next morning, participants will be briefed on the most pressing MPL issues facing Congress, and then meet with their elected legislators. Because the midterm elections will be less than two months away at that point, and many Congressmen will already be thinking about which issues they’ll need to deal with first during the anticipated post-election lame duck session, PIAA Advocacy Day will be perfectly timed to get Members of Congress thinking about important MPL issues.

To find out more information about this special event, or to learn how you can help even if you can’t come to Washington, D.C., see www.piaa.us.

Lobbying
Grassroots advocacy is critical, but PIAA knows you have many important things to do in keeping your company prosperous. This is why PIAA has a full-time Government Relations Department that connects with Congress and the Administration throughout the year. The lobbyist’s responsibility is to represent you and your interests when you cannot be there to represent yourself. In practical terms, this means meeting with Hill staff, Members of Congress, and officials from the Administration, to help shape policy.

Lobbyists’ efforts span a broad array of tasks, for example, working with a...
Congressional office to draft legislation, writing up talking points or questions for a Congressional hearing, developing strategy for advancing a particular piece of legislation (or to stop its progress), and explaining the impact of proposed regulation.

It is probably most accurate, however, to describe lobbyists as educators whose primary function is to ensure that government officials know as much about an issue as possible before they take action on it.

To many people, the lobbying process is somehow tainted, but in fact it’s a vital element in governing. For starters, no Member of Congress, Hill staffer, or regulator can know all the ramifications of a piece of legislation or proposed rule. In the case of Congress, legislators and their staffs are asked to consider literally thousands of bills over every two-year cycle, and there is simply not enough manpower on Capitol Hill to permit every office to have an expert on all possible issues. In addition, as noted above, you, as PIAA members, can’t be expected to serve as the resource for your Member of Congress on every issue of importance to you. You’ve got other things to do. Lobbyists ensure that your voice is heard and your issues are understood by the people who are making important policy decisions.

Campaigns

The third element in advocacy is political fundraising. While nearly every lobbyist I know would rather focus on his role as an educator, rather than spend time at campaign fundraising events, it is a sad truth that money is very often necessary to get access. That does not mean that money will necessarily influence a given official, however (more often than not, money is used to support a candidate who already holds a specific view, rather than in trying to convince that individual to change his mind). Instead, campaign contributions are used to pay for attendance at fundraising events, where you can focus a candidate’s attention on a key policy issue. These discussions are usually quite brief and superficial, but they can open the door for more in-depth conversations at some later point—and this was the actual objective of the initial discussion in the first place. Admittedly, this is not the ideal approach to getting things done, but overly zealous ethics “reforms” enacted several years ago banned many lobbying activities that were perfectly legitimate, leaving advocates with few options other than paying what may be large sums to attend fundraisers.

In this regard, PIAA maintains a political action committee (PIAAPAC) just for this purpose. Annual fundraising efforts from within the PIAA membership (federal law prohibits PIAAPAC from accepting funds from non-members and even a substantial number of individuals directly affiliated with a PIAA member company) provide the revenue needed to attend political fundraising events. To maximize the effectiveness of our extremely limited PAC dollars, PIAA focuses its attention on those candidates who sit on specific important committees or otherwise hold positions that will allow them to influence their colleagues. All funds given to campaigns from PIAAPAC are first approved by the PAC Board of Directors, and are donated without regard to the political affiliation of the candidate or their views on issues outside the scope of PIAA interests.

Conclusion

While PIAA is small compared with many other interest groups and associations, it strives to make the most of its resources. Utilizing grassroots advocacy, lobbying, and political contributions, PIAA has achieved remarkable success in recent years. Among these victories has been successfully defending MPL insurers from efforts to limit or eliminate limited antitrust exemptions for insurers and obtaining bipartisan support for efforts to prevent the misuse of federal guidelines/regulations in MPL lawsuits.

Advocacy is a key component of PIAA’s services to its membership—and one that PIAA takes very seriously. Only the strategic implementation of all three elements of our advocacy program will enable us to sustain our current success.
The Dental Professional Review and Evaluation Program, or D-PREP, was recently developed by the American Association of Dental Boards (AADB) as a tool for evaluating the competency of dental professionals. The program may be a good idea in theory; but a recent Massachusetts case highlights the serious legal issues and difficulties that its application poses for dental professionals and insurers alike.

D-PREP presents unique challenges for professional licensing defense. The sanction is so severe—and the results of it so unpredictable—that taking a matter to a hearing will likely prove more desirable than agreeing to D-PREP as a settlement term. Generally, going through a full adjudicatory hearing greatly increases the costs of defending an action. The D-PREP program itself is very expensive, however, and insurers and practitioners should be mindful of who will be stuck with the hefty fees associated with the program, should it be required.

This case note discusses the issues raised by D-PREP and offers some insights from our experience in successfully defending against it recently in Massachusetts.

What is D-PREP?

D-PREP was created by the AADB and modeled after the Physician Assessment and Clinical Education (PACE) program designed for physicians. D-PREP consists of the following six phases, with fees totaling nearly $20,000:

1. A dentist is referred by a licensing board and applies to the program at one of three host universities.
2. The dentist undergoes a full mental and physical examination, the results of which must be provided to the AADB.
review.

3. The AADB assembles all the information available about the dentist.

4. The dentist travels to one of the host universities, in Wisconsin, Louisiana, or Maryland. There, they undergo a full evaluation, including written and clinical testing, over the course of four to five days.

5. The reviewers write a comprehensive analysis of the dentist's competency for the referring dental board. The dentist will receive one of three grades: a pass, a pass with recommendations, or fail. A pass with recommendations will include suggested remediation. A fail is a determination that he cannot practice dentistry at a level of minimum patient safety, and in all likelihood will function as a complete revocation of the dentist's license.

6. The dentist completes the remediation recommended in the D-PREP evaluation once it has been approved by the board.

There is no appellate procedure or opportunity to obtain an appellate review at any stage of the program. The evaluation is final, and there is no mechanism for challenging the D-PREP report.

D-PREP is still in its relative infancy. As of January 2014, only approximately ten individuals had enrolled in D-PREP for serious issues that had cast doubt on their competency.

Legal implications of D-PREP

Generally, licensing boards are creatures of statute and must have a statutory grant of authority for any action they take. To order a dentist to undergo assessment by a third party. Compare this to the Massachusetts Board of Registration in Medicine's statute, which explicitly allows the board to utilize remediation programs like the Physician Assessment and Clinical Education Program (PACE), but even then, only on a voluntary basis.

Second, the D-PREP report is used by the board to determine whether a dentist will be able to retain his license. The evaluation is not limited to the issues that caused the case to be referred to D-PREP in the first place. Thus, a dentist enrolled in the D-PREP program risks losing his license completely for issues on which a hearing was never held and for which no appellate review was available.

This possibility flies directly in the face of traditional notions of due process and essentially outsources the hearing process to an unaccountable third party.

A case study

Our client dealt with a difficult patient population. He had received a series of patient complaints that, we believe, were motivated by a desire for free care, as the patients' insurance program had recently cut benefits substantially. In response to the complaints, the board conducted a thorough investigation, which included an unannounced compliance inspection of our client's office. Ultimately, the board did not move forward on the quality-of-care issues raised in the patient complaints, except for one allegation that involved an overfilled root canal. Instead, the board sought discipline for recordkeeping deficiencies and other issues discovered during the compliance inspection.

The board's proposed sanction, from the beginning, was to require that our client enroll in D-PREP. We viewed this as highly draconian; after all, our client was only being accused of a single clinical deficiency. D-PREP was designed for dentists with serious competency problems, not bad record keepers. Furthermore, if our client were to enroll in D-PREP, he would need to pay nearly $20,000 and spend a week away from his family. He would lose any type of control over the process, and also risked losing his ability to practice entirely, should the D-PREP assessment come back negative.

Keeping in mind that board cases rarely benefit from a full hearing, we sought to address the board's concerns by proposing that our client complete additional continuing education in the areas noted by the board. We also proposed to demonstrate that he had no physical or mental impairments that might impact his ability to practice. The board continued to insist on D-PREP, however, and, consequently, this became one of the rare cases where a hearing appeared the more attractive alternative to a negotiated resolution.

Our primary theory of the case was that D-PREP was not warranted under the facts. Nearly all the violations of which our client was accused were minor or entirely defensible. In particular, our expert was fully supportive of our client's treatment of the single overfilled root canal, which is a known complication of root canal therapy.

We also vigorously disputed the board's authority to order D-PREP as a sanction. There was evidence, developed through discovery, that tended to show that the board was not actually familiar with what D-PREP entailed. We attacked the board's position on both procedural and substantive grounds. Because we believed the board would go forward with its intention to order D-PREP, we thoroughly developed a number of issues for appeal.

In one final push, shortly before the hearing commenced, the case went back to the board for reconsideration. Our message was clear: this was not a case that warranted D-PREP, and we would challenge it. Should we prevail on appeal, the board risked losing D-PREP as an option in the future in cases where a D-PREP assessment might be a far more appropriate remedy. Ultimately, the Board relented and accepted our initial coun-
teroffer. This was only after substantial and intense efforts and expenditures needed to prepare the case and highlight the issues D-PREP raised, however.

**Insights and lessons**

Like outright revocation of a dental license, when D-PREP is proposed as a settlement term, taking the case through a full adjudicatory hearing may be the preferable option. The defense will be far more costly, but this approach does ensure some limitation in the scope of the issues considered, some level of due-process protection for the licensee, and appellate options not available with D-PREP.

If you are confronted with D-PREP as a settlement option, conduct a thorough evaluation and assessment of your client’s case. This is an extreme sanction, with wholly unpredictable, and possibly disastrous, consequences for your client. Your board’s enabling act may not authorize third-party assessments; your client may not be willing to sacrifice his substantive and procedural due process rights to the unknown individuals at the D-PREP centers; and you may obtain a more predictable result for your client through the established procedures of an adjudicatory hearing.

D-PREP may serve a suitable purpose for those whose clinical competency is in serious doubt, but it is likely not an appropriate option for practitioners facing more routine allegations.

D-PREP can be a useful tool for the boards, and offers an attractive alternative to revocation when the facts warrant it. The boards need to understand, however, that if they order it when it is not warranted and subsequently lose on appeal, they may foreclose the possibility of ever ordering it.

**Conclusion**

It remains to be seen how D-PREP will be utilized by the boards as the program matures and boards become more familiar with it. If, as in the Massachusetts case, the boards seek to require it for routine violations, it will impede the ability to reach negotiated resolution, and defense of professional licensure may become far more costly. If, however, the boards use it sparingly, and only where serious issues warrant it, the program could be an attractive alternative to the ultimate sanction of revocation.

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**For related information, see**


**References**

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Using PSO Data to Identify the Leading Patient Safety Concerns—and Lessons Learned

Patient safety is a top priority for every healthcare organization, but knowing where to direct patient safety initiatives can be daunting. To help organizations decide where to focus their patient safety efforts, ECRI Institute has developed a list of the top ten patient safety concerns confronting healthcare organizations (Figure 1).

*By Cynthia Wallace, CPHRM, and Karen P. Zimmer, MD, MPH, FAAP*
We’ve been collecting events since 2009, and with close to 400,000 events, we’re at a point where it’s important to share where we’re seeing recurring themes,” says Karen P. Zimmer, MD, MPH, FAAP, medical director of ECRI Institute’s patient safety, risk, and quality group and of ECRI Institute PSO.

The initiative underscores the intent of the Patient Safety and Quality Improvement Act of 2005, which laid the groundwork for providers to voluntarily report patient safety events and other information (e.g., root-cause analyses) to Patient Safety Organizations (PSOs) in a protected environment. The PSOs aggregate, analyze, and share findings and lessons learned. By collecting data from many providers, PSOs can spot problems and trends that an individual organization, with a limited pool of data, may be unable to detect.

**The list as a starting point**

The list, which highlights risks to patient safety that stem from issues with processes and systems, is not intended to be comprehensive, and not all of the patient safety concerns will be applicable at all healthcare facilities. “We encourage facilities to use the list as a starting point for patient safety discussions and for setting their patient safety priorities,” says Zimmer.
Although many of the organizations reporting to ECRI Institute PSO are hospitals, the list of patient safety concerns, such as drug shortages, mislabeled specimens, and care coordination, also applies to non-hospital settings, such as physician practices and long-term care settings.

This article highlights three of ECRI Institute’s 2014 Top 10: care coordination, test result reporting, and drug shortages.

**Where to find the full list**
The complete 2014 ECRI Institute Top 10 Patient Safety Concerns list, which ECRI Institute plans to update annually, is available for free download at https://www.ecri.org/Products/PatientSafetyQualityRiskManagement/Pages/Free-Reports-Advisories.aspx. It includes strategies for mitigating each of the ten concerns and is accompanied by a poster, PowerPoint presentation, and other tools.

**Care coordination**
Care coordination is a “shared responsibility” of all providers involved in a patient’s care, says Lorraine Possanza, DPM, JD, MBE, patient safety, risk, and quality analyst at ECRI Institute. However, events reported to ECRI Institute PSO reveal gaps in communication—between hospitals and providers, among providers, and between long-term care settings and hospitals or other providers. For example, in one event, an

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**“Walk This Way”: Impacting the Culture of Safety through Time and Example**

**By Missy Padoll**

On June 13, 2014, more than 200 patient safety advocates from across the country gathered to participate in a day-long symposium that was focused on how culture can progressively impact patient safety in healthcare organizations. Sponsored by CRICO, the goal was to gain a better understanding of the ways in which culture can enhance or inhibit safety improvements, and how organizations can affect their own environment by learning to “Walk This Way.”

In a unique opening segment, a skit comprising a series of acts depicted the evolution of smoking behavior in the hospital setting. Many of you may recall a time in the not so distant past when it was common practice for physicians to smoke on the wards, in the break room, and at nursing stations. This practice evolved—slowly, but surely—to remote smoking rooms at the end of the hallway, outside designated smoking areas, and finally, to present-day smoke-free campuses around the country.

Looking back, it’s difficult to believe we ever smoked on the ward, drove our children around without car seats, or allowed them to ride their bicycles helmet-free. However, through years of research, education, and persistence, all of these safety risks have indeed been recognized and changes introduced, and people have adapted. This premise segued to a robust program that captured an array of perspectives and impactful lessons for creating a stronger safety culture, including:

- **Paul McTague, Esq.: Culture as a Contributing Factor to Legal Defense**
  - Three “Cs” for MDs: be Competent, Confident, and Caring—in court and in practice.
  - Follow policies; it’s difficult to defend a claim when they’re not followed.
  - Document, as needed, to provide for good medical care, not what you think will protect you in court.

- **Asaf Bitton, MD: Envisioning Your Future Work Environment**
  - If we want to make drastic changes, we need to take drastic steps.
  - Imagine a patient-centered medical home that was designed for maximum teamwork and connected by robust IT systems.
  - Establish the goal of your culture through seven habits: co-location, huddles, warm handoffs, weekly meetings, staffing that matches the culture, work force development, and committed leadership.

- **Tracy Granzyk: What’s Your Story? The Power of Narrative**
  - Storytelling can change attitudes and beliefs, because it breaks down cognitive resistance.
  - Data helps us focus on “what” to fix; storytelling gives us the emotional connection to “why” it matters.
  - Honor patient and caregiver stories through actions respectful of their lesson.

**Jerry Hickson, MD: How to Recognize and Remove Obstacles**

- Establish an infrastructure that promotes reliability and professional accountability.
- Fix your faulty systems and promote professional behavior to set the right balance.
- Respond to every incident of unprofessional behavior with a consistent constructive response.

At lunch, attendees were asked to envision evolved cultural events five to ten years from now that may be as difficult to believe as the “smoking story.” The day wrapped up with a summary of the myriad submissions on the general topic: It’s hard to believe there was a time when:

- We did not always wash our hands before seeing a patient.
- We did not do formal timeouts for every surgery.
- We were afraid to report adverse events.
- We did not have efficient systems for tracking/follow-up on abnormal test results.
- We did not consider patients part of their own care team.

**Missy Padoll** is Director, Strategic Analysis and Communication, CRICO.

For related information, see www.rmf.harvard.edu.
infant’s discharge summary and follow-up care information were not provided to the patient’s primary care physician:

An infant who died from sudden infant death syndrome had previously been seen in the hospital for a life-threatening event. Because of abnormal findings on the patient’s CT scan, the patient’s discharge summary indicated the patient should have an MRI exam. The discharge summary was not sent to the patient’s primary physician. The patient did not undergo the MRI study.

While a best practice is for hospitals to send a patient’s discharge information to all the patient’s providers, staff can be overwhelmed trying to identify those providers. “It’s not only the hospital’s responsibility,” says Possanza, who previously had a podiatry practice and has experience with care coordination challenges. “It’s also on me as the patient’s provider to communicate with the patient’s other providers,” she says, recalling that in addition to communicating with patients’ providers as needed, she used to “touch base” with her patients’ other providers at least once a year “so they know I’ve been involved in the patient’s care.”

One “simple and basic” strategy to improve care coordination between hospitals and ambulatory settings is for practices to provide current contact information, such as phone and fax numbers, on their websites. Possanza adds: “Identify the providers in your practice. If the hospital needs to contact you, the information is right there.”

Linda C. Wallace, BSN, MSN, CPHRM, a consultant in aging services risk management at ECRI Institute, notes some of the strategies she has seen put in place to improve care coordination between hospitals and post-acute care providers. They include:

- Preadmission nurses from the postacute care setting evaluate the patient before discharge and prepare the post-acute care provider for meeting the patient’s needs.
- Hospital representatives visit the post-acute care organization to ensure an understanding of the services available there and to minimize the risk of transferring patients whose condition cannot be managed at that post-acute care facility.
- There are closer affiliations between hospitals and post-acute care providers, through accountable care organizations or other means.

Reporting test results
Breakdowns in reporting test results can occur for many reasons. Sometimes, the ordering provider never receives the results or receives them after a delay. Or, the reporting provider may be unavailable, and organizations may not have a backup plan for ensuring that results with important findings are communicated to someone else who can act on them. These breakdowns can contribute to “bigger issues of delays in patient care, as well as delays in diagnosing an acute condition,” says Christine M. Callahan, RN, MBA, physician practice management consultant for ECRI Institute.

Examples of test result reporting errors reported to ECRI Institute PSO include:

- A baby’s treatment with antibiotics was delayed because the test results confirming an infection were not reported promptly to the ordering clinician.
- Prompt management of a patient with C. difficile infection was hindered because of a delay in reporting test results confirming the infection.
- A patient’s seizure due to a low sodium level could have been avoided if blood chemistry results had been provided on a timely basis.

Callahan observes that breakdowns in test results reporting, particularly in physician practices, typically have one or more of three causes:

- Technology limitations, such as an inadequate interface between an electronic health record (EHR) system and a laboratory system that provides the results electronically
- Provider-to-provider communication gaps, such as those that occur when no backup plan is in place to designate a provider to review test results for another provider who is unavailable.
- Staffing and training failures, for example, requiring that a staff member periodically check an EHR system for test results but not informing him about the volume of test results he can expect to see.

As more healthcare organizations adopt EHR systems, Callahan warns against being lulled into thinking the systems can prevent test reporting failures. “It’s another tool,” she says. “It won’t improve test...”
results reporting if it's not used correctly.”

Whether test results are reported on paper, electronically, or in some combination of both, organizations must have policies and procedures to guide reporting of the results and must educate and train staff about the policies, says Debra Ann Maleski, MBA, senior associate with ECRI Institute’s Applied Solutions Group, which provides customized consulting. The policy should address key questions:

- Who gets the results?
- What is the process for reporting abnormal findings?
- Is there a designated backup provider to review the results if the ordering provider is unavailable or does not review the results within a specified time frame?
- What is the expected time frame for providers to review results?
- How are findings communicated to the patient?
- What is the policy for ensuring that information gets to the patient if that person is unavailable?

In addition, organizations must audit staff compliance, Maleski advises. “You may have a great policy, but if it’s not enacted or followed, the organization needs to be aware and implement corrective action.”

**Drug shortages**

The potential implications of drug shortages for patient care were highlighted when a hospital contacted ECRI Institute PSO about a severe shortage of emergency drugs. Unable to replenish its supply of injectable unit-dose medications stored on crash carts, the hospital wanted to know whether its remaining supply of expired drugs could be used instead.

“In the intervening months, the topic remained on our radar and showed an escalating level of interest from healthcare providers,” says Dr. Mary Gregg, senior vice president and chief medical officer of MagMutual, serves as president of the institute. Dr. Gregg previously served as medical director for quality and patient safety and vice president of medical affairs with Swedish Health Services in Seattle, one of the largest nonprofit health systems in the Pacific Northwest. She was also medical director for Clinical Outcomes Assessment and Performance (COAP) at the Foundation for Healthcare Quality (FHCQ), and medical director of clinical quality at Swedish Heart and Vascular Institute.

"Physicians appreciate the power of education and collaboration, and by tapping into our network of policyholders, we are taking our patient safety and quality efforts to new levels,” said Gregg. “We help them understand their areas of greatest risk, and then we design tools to help address them.”

So what are some of the key patient safety risks identified by the Institute so far? “Two of the most common of the many concerns we encounter are medication errors and issues with electronic medical records [EMRs],” explained Gregg. “Not only do physicians need to cross-check multiple lists of medications at every step of the prescribing and dispensing process; they also need to be more aware of drug interactions and side effects.”

"With regard to EMR issues, caregivers need to ensure that their system works for them. Technology can greatly enhance the quality of patient care, but there are risks as well. We encourage healthcare professionals who are prescribing and treating to take an active role in the formatting of order sets, progress notes, procedure notes, and care plans. Providers need to make the ‘right thing’ the easiest thing to do.”

"At the end of the day, our goal is to help our policyholders create a culture of safety characterized by transparency and trust, all grounded in the creation of a database that is focused on root causes,” added Gregg. “We are learning as we go, but we aspire to be the go-to organization for new ideas, solutions, and models that promote patient safety and mitigate risk, and to attract partners who are willing to pilot new processes.”

**MagMutual Patient Safety Institute Researches Safety Concerns**

**By Terrell McCollum**

With a supporting pledge of $50 million from MagMutual Insurance Company, the MagMutual Patient Safety Institute was established this past October, to facilitate in-depth study and analysis of patient safety issues confronting MagMutual policyholders. The institute endeavors to create evidence-based resources and practical tools to promote the adoption of best practices in order to improve safety among its policyholders and decrease their exposure to risk.

“We believe the best defense against medical error is to proactively assist physicians and other healthcare providers in the creation of environments conducive to optimal care and outcomes,” said Dr. Joe Wilson Jr., MagMutual’s chairman and chief executive officer. “Patient safety is one of the most pressing challenges in healthcare today.”

In addition to analyzing historical claims data, the institute facilitates risk assessments for the more than 19,000 physicians insured by MagMutual and its affiliate, Professional Security Insurance Company. This number includes solo practitioners as well as physicians employed by larger practices and hospitals. The data derived from these assessments serves as the basis for continuing medical education (CME), as well as specialty-specific and even practice-specific tools and resources.

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Terrell McCollum is Director, Marketing Communications, MagMutual Insurance Company.

For related information, see MagMutual.com/patient-safety/resource-library.
Patricia Neumann, RN, MS, patient safety analyst/consultant for ECRI Institute PSO. An event reported to ECRI Institute PSO shows the need for established policies that will guide pharmacists, nurses, and physicians on what to do when a drug is unavailable:

A patient in intensive care had a critical phosphate level. The physician ordered an intravenous sodium phosphate for the patient. The pharmacist could not fill the order because the drug was unavailable and did not tell the patient’s nurse or the ordering physician about the shortage. The patient had a seizure due to abnormally low phosphate levels in the blood.

Neumann advises healthcare organizations to develop a proactive plan for managing drug shortages. The plan should assign a task force to monitor impending shortages, she says. Two good resources for identifying potential drug shortages are the U.S. Food and Drug Administration’s (FDA) website on drug shortages, which provides a list of national shortages for which there are no substitutes, and the American Society of Health-System Pharmacists’ (ASHP) drug shortages website, which provides information on regional drug shortages.1

In addition to tracking shortages that can affect the organization’s supplies, the action plan should address these areas:

- Documenting drug shortages and approving alternatives to drugs that are unavailable or in short supply
- Monitoring adverse drug events to determine whether any may have been caused by shortages
- Keeping the quality improvement and pharmacy and therapeutics committees informed of any shortages
- Providing an annual report on shortages and their impact on the organization to its leaders.

Information about drugs in short supply or substitute drugs must be communicated to clinical staff. All ordering providers must know what drugs are in short supply; when regular distribution of them will resume; what alternatives or substitutes are available; and basic information on each alternative drug, including its current formulations, contraindications, and potential for error.

To keep clinical staff informed about any shortages and the organization’s planned response, it should consider posting updates on an Intranet site available to clinical staff at all times, suggests Neumann. In addition, it should ensure that a pharmacist is available to clinical staff to answer any questions. Components of the organization’s health IT system—EHR systems, electronic drug ordering, and electronic medication administration records—must be kept up-to-date as drug availabilities change. Although time-consuming, system updates are vital for preventing medication errors, says Neumann.

Reference

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The main news item, a few months ago, was the failure of the Affordable Care Act website to perform as intended. There were many reasons for this, and each failed project has its own story. But the following factors are almost always in play, to varying degrees, when the implementation of an enterprise-level system ends up in trouble.

By Martin Lippiett

Martin Lippiett is Vice President of Business Consulting, Delphi Technology, Inc.
Poor governance

This is probably the number-one reason why projects fail. The project is begun without an adequate and achievable plan with respect to requirements, budget, and resources. Then, as the work continues, control over changes in the plan is poorly managed, and mid-course corrections are made with politics, face-saving, extreme optimism, and other undesirable considerations assuming priority in decision-making.

The keys to effective project governance are these:
- It's critical to incorporate scenario modeling into the initial pre-project analysis, so that different options can be evaluated and the one that is most realistic—and shows optimal benefits—is selected. In other words, make sure the project you are planning in the first place is the right one for the business.
- Project criteria, roles, processes, and outcomes must be established early and then actively monitored to enhance project success. Have an escalation strategy in mind; nothing goes exactly as planned.
- Governance must be accepted and supported by all levels of management.
- Warning signs should be recognized and effective action taken early to avoid a snowballing failure.

Changes in scope and budget

If the content of the project can be easily changed, the rate of change will in time exceed the rate of progress. When this happens, the project managers have in effect abandoned the plan established at the outset, and the new plan will be compromised with short cuts, and expedient thinking, often done in a futile attempt to accomplish the impossible.

The work plan should be reviewed regularly, to track progress against time and budget. To do this effectively, on a project that has hundreds of tasks and dozens of participants, project planning and time tracking software is essential. Where there is slippage, the critical path must be identified, and corrective action should be taken as soon as possible.

These are some of the tell-tale signs of a project in trouble:
- There are small variances in schedule or budget that gradually get bigger over time; this is especially concerning in the early days.
- Activities noted as complete still are in fact being worked on.
- Team morale, quality, and service start to slide.
- Time allotted for quality control and project management gets cut back, to make up for lost ground.

Poor communication between business users and IT

A sustained focus on the value of the project to the company is essential, and any turf issues need to be put aside. The IT staff should remember to talk to the user community in business, not technical, terms. Project plans should be based on facts and business metrics, not opinions and assumptions, about the current status of the enterprise, as well as the objectives of the new project.

Gaining insight upfront from a variety of internal resources is essential for creating a project plan that encompasses all aspects of the business. Without that input, tools and processes may be developed that are incomplete or even unnecessary; also, the inclusion of users early on encourages buy-in to the project.

Unclear expectations

If expectations about the project are in any way ambiguous, what might start out as a minor piece of work could expand into a major
undertaking. Expectations not only define the final outcome; they also affect the process of getting there. If some of those working on a project worry that expectations will not be met, the project will become a lot harder to manage.

The first step in expectation-setting is to ensure that the project’s deliverables are actually going to meet the requirements of the project. Failure to do so means an unsuccessful project. But the need to manage stakeholder expectations goes beyond the delivery of specified requirements: It covers all aspects of a project’s work and the manner in which it’s accomplished. The next step is to map the expectations of the key stakeholders. This requires careful listening and the ability to decipher what’s meant, not just what’s said.

Expectations generally will fall into two groups—the realistic and the unrealistic. But even the realistic expectations need managing: they must be fulfilled, and the stakeholder must be made aware that they have been met. Communication requires delivering the right information to the right stakeholder in the right manner. Unrealistic expectations are obviously more difficult to manage, since they are unlikely to be met. Fortunately, expectations are not fixed, but fluid; they reside in a person’s mind, and they can be influenced or changed by fact-based communication.

Personnel issues
Project management is one of the most challenging tasks in the modern IT organization; the potential for payback makes it one of the most important functions. The project management function must be adequately staffed, and the individuals fulfilling that function must be adequately trained. A qualified person must also be allowed the time to do his work properly—the involvement of staff in major projects—not only the project manager, but also the users and developers. The amount of time required is often underestimated, and managers may not recognize the conflict that some team members face, between project work and their “everyday” duties.

In addition to selecting the right individual to lead the project, project managers should make sure that the staff engaged in it have the right credentials, with the required degree of expertise. Don’t forget that turnover during a project can have serious repercussions—one of many reasons for good documentation.

Inadequate attention to risk management
For most software development projects, the five main risk-impact areas are: (1) the use of new and unproven technologies, (2) software system requirements, (3) software system architecture, (4) software system performance, and (5) organizational and non-functional areas.

Risk management is generally not given as much attention as it should when planning a project—all too often it’s, “Trust the project manager,” and off we go. Risks to success should be identified early in the planning stage. For example, the use of an emerging technology might be a risk; there are others relating to the competence of the team, the availability of users to articulate requirements, the commitment to quality assurance (QA), the relative scalability of the solution, reliability of a vendor, business impact, and so on. Once risks have been identified, they should be prioritized, and the ownership of each should be assigned to a project team member.

Risks can be avoided, minimized (the most common case), or simply accepted. Not all risks will be identified ahead of time, but most can, and some preventive actions can be taken—or at least a possible response can be considered beforehand.

Inadequate QC and QA
When projects get into trouble, the most tempting areas for shortcuts are usually the ones that are related to the quality and integrity of the delivered software. “Hope for the best” thinking is a temptation when deadlines have to be met.

Quality control (QC) is used to verify the quality of the output; QA is the process of managing for quality. Achieving success in a project requires both QA and QC. If only QA is applied, then there is a set of processes that can be applied to ensure great quality in our delivered solution, but the delivered solution itself is never actually quality-checked. Likewise, if the sole focus is on QC, then tests are simply conducted without any clear vision for making them repeatable, for understanding and eliminating problems in testing, and for, generally, driving improvement into the vehicle used to deliver the new system.

Conclusion
Finally, here are some (potentially) comforting data, from a survey by IBM, of successes and failures in 1,500 large-scale projects:

- Only 40% of projects met schedule, budget, and quality goals.
- Biggest barriers to success were listed as these:
  - People factors: Changing mindsets and attitudes, 58%
  - Corporate culture, 49%
  - Lack of support from senior management, 32%.
- Underestimation of complexity was listed as a factor in 35% of projects.
Transparency:
Changing the World We Live In, for the Better

For consumers, this trend has financial, intellectual, health, and wellness benefits; we know much more about the price and quality of goods and services. Websites like Consumer Reports, Amazon, Zillow, IntellioQuote, and Carmax make it easy to comparison-shop for products and services.

These sources are widely known, and people use them in their day-to-day lives. For healthcare-related services, we believe that the transition to a more transparent future is gaining speed, especially in the wake of the Affordable Care Act (ACA), the American Recovery and Reinvestment Act of 2009/Health Information Technology for Economic and Clinical Health Act (HITECH), and new information posted on the Internet—for example, the Center for Medicare and
This article explains how transparency in healthcare may well transform our lives.

**Forces at work**
Achieving transparency in the healthcare market has been an uphill battle for consumers, for many years. Before the spike in numbers of high-deductible plans, most healthcare consumers in America probably didn’t pay much attention to the cost of visiting a doctor’s office or ambulatory care center. The small percentage of consumers who did try and figure it out were likely to be confused about how health services are priced and what they had actually paid for the diagnoses and treatments they received.

However, many Americans have switched to high-deductible plans, wherein a significant amount of first-dollar costs are born by patients. Consumers are learning that a visit to the doctor’s office or the emergency room can be quite expensive. Now, armed with apps/websites like Yelp, Healthgrades, myHealthcare Cost Estimator, Smart Patient, and state-sponsored sites like New Hampshire Health Cost, consumers are becoming savvy buyers of healthcare. Just as the availability of information changed the way we buy cars (i.e., transparency on price has replaced the “let me ask the manager” haggle), we believe that transparency in this market will, in time, transform the discussion between consumers and hospitals and physicians.

The ACA states: “(c) STANDARD HOSPITAL CHARGES—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.” We believe that this is definitely a step in the right direction!

**States taking action**
In the short term, we expect to see a gradual increase in both federal- and state-level efforts to enhance transparency. Some states have passed laws requiring that healthcare providers either report information to a central repository or be able to answer consumer queries about their prices, by procedure. The breadth, depth, and relative effectiveness of these laws vary, but there is no doubt that states are making strides toward a transparent future, in the name of reducing costs and improving patient outcomes.

One state, New Hampshire, has required that all providers report insurance-claim payments to an All Payer Claims Database. This database supplies the information for a website, NH Health Cost, where any consumer can search for costs by provider based on zip-code radius and procedure type (e.g., get a detailed cost estimate for outpatient arthroscopic knee surgery within 50 miles of Zip Code 03302).

In North Carolina, Section 131E-212.7 of the Health Care Cost Reduction and Transparency Act of 2013 addresses disclosure of prices for the most frequently reported Diagnostic Related Groups (DRG), Current Procedural Terminology (CPT), and Health Care Common Procedure Code System (HCPCS) codes. Beginning on June 30, 2014, and quarterly thereafter, each hospital must disclose, to the Department of Health and Human Services, the amount charged to a patient for each DRG, average negotiated settlements, Medicaid reimbursements for each DRG, etc. In addition, hospital and ambulatory surgical facilities must provide information on the total cost for the 20 most commonly performed surgical procedures and the 20 most commonly used imaging procedures, by volume, that are performed in hospital outpatient settings or in ambulatory surgical facilities, along with the related CPT and HCPCS codes.

In 2012, Massachusetts added a new Chapter 224 titled An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation, which became effective January 1, 2014. Section 206 of the law requires that all managed care health insurance carriers “establish a toll-free telephone number and website” so that insureds can find out the “estimated or maximum allowed amount or charge” and out-of-pocket cost that the insured member [consumer] shall be responsible to pay for a proposed admission, procedure, or service. Carriers are encouraged to do this in consumer-friendly ways and are generally expected to respond to patients’ queries within two business days.

**Hospitals taking the lead**
Some hospitals and healthcare providers have also been early adopters
of transparency.

In an article in The Blaze magazine, “Free Market at Work: Okla. City Hospital Causes Bidding War by Posting Surgery Prices Online,” we see what happens when people find out about the actual cost of surgery. For the past five years, the Surgery Center of Oklahoma has been posting surgery prices online. Since then, the center’s owners have noticed some interesting things about the market for surgical procedures: first, their costs were much lower than those of their competitors (e.g., one-sixth to one-eighth the cost); second, people were willing to travel a long way to get treatment at a lower price (e.g., from Canada); and third, they had had a deflationary effect on prices, as their competitors were forced to match the center’s prices.

There’s also been pressure on prices from outside the U.S., driven by lower-priced foreign hospitals and medical tourism. According to Patients Beyond Borders, it is estimated that 1.2 million Americans will travel to foreign countries for medical services each year. There are many issues involved in traveling outside the U.S. to get care, but the differences in costs are substantial enough that some patients are willing to deal with those issues. It is not uncommon to see magazine ads highlighting how Americans can save 50% to 80% on quality medical care in locations such as Mexico, the Bahamas, Costa Rica, India, Singapore, Thailand, and Jordan. Although many of us might prefer to be treated in the U.S., the new price transparency helps consumers make the best overall choice for themselves.

Evolution of quality metrics in risk-based contracting

The last several years have seen major advances in the field of quality metrics. With the emergence of the star quality-rating system for Medicare Advantage plans, which arose from the ACA, quality metrics now play a lead role in payer and provider contracting. The star quality-rating system was developed to educate consumers on healthcare quality and to make the data included in the metrics more transparent. Further, it provided quality bonuses to higher-scoring plans and also helps lower member premiums.

Then, CMS Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) developed their own set of quality metrics. To be eligible for CMS Shared Savings, an ACO must report on the 33 quality standards, and meet prescribed quality-performance thresholds for each of four quality domains:

- Patient/caregiver experience (seven measures)
- Care coordination/patient safety (six measures)
- Preventative health (eight measures)
- Measures for 12 at-risk populations (e.g., diabetes, hypertension, ischemic vascular disease, heart failure and coronary artery disease).

With Medicare taking the lead, it’s not surprising that quality metrics have become a more common feature in commercial payer/provider contracts that contain some form of gain and/or risk sharing of financial results. These quality metrics are often some variation of, or slight deviation from, those used in the STAR program for Medicare Advantage plans or the ACOs metrics. Organizations need to be able to track, report on, and exceed at these metrics, to become eligible for the financial savings they are striving for, and all of this adds an extra layer of administrative complexity and additional risk.

Conclusion

As healthcare providers become more transparent about costs, prices, and even outcomes, the demand for their various services will likely change as well. After the release of the first CABG mortality rates in New York, the hospitals reporting the worst mortality needed to do almost everything in their power to improve their performance in heart operations. For the hospital that had reported the 18% mortality rate, changes in their medical staff and internal review processes, over the years, ultimately decreased their observed mortality rate to less than 1%, based on 2009–2011 hospital and surgeon outcomes for isolated CABG data. That is 18 times lower than in their pre-reporting days, back when there was no transparency on outcomes after CABG procedures. Thus: the power of transparency at work!

As ACOs mature, the types of patients seen, the types of procedures performed, the use of defensive medicine, and even in what is used to reach their patients will evolve, as more information is made available to patients. Depending on whether healthcare providers lead from the front with transparency, or become late adopters because of necessity, the decision is in their hands. As we have observed in virtually every industry over time, the physicians, hospitals, and surgical centers that can provide the highest-quality service at the lowest price will eventually gain a competitive advantage, in a marketplace where information flows more freely. As Gary Hamel and C.K. Prahalad observed in Competing for the Future, “One doesn’t get to the future first by letting someone else blaze the trail.” Transparency is already all around us. It’s just a matter of making sure your organization is one of the trailblazers.

References
Enterprise Risk Management for MPL Specialists

Medical professional liability (MPL) insurers have enjoyed operating success over the last decade. However, accident-year results are beginning to deteriorate, and MPL specialists face a challenging operating environment that could lead to larger underwriting losses in the future, as well as an erosion of capital.

Primary threats to MPL underwriters include a persistently weak pricing environment that contrasts with the hardening market noted in the U.S. commercial lines market for the last three years and challenges in various states that would overturn legislative reforms that have helped stabilize loss severity over time. Also, with the implementation of the Affordable Care Act (ACA), healthcare providers are organizing their practices and obtaining liability coverage in new ways.

Property/casualty insurers continue to incorporate enterprise risk management (ERM) into their risk and strategic management practices. For MPL specialists, adopting a more disciplined approach to risk management and planning can provide benefits in assessing strategic options, preserving capital, and reducing volatility in performance.

What’s included in ERM

ERM is a process of systematically identifying, measuring, managing, controlling, and reporting on the various risks to which an organization is exposed. ERM emphasizes risk evaluation on an enterprise, or aggregate, level, rather than in isolated departments or business functions. Considering risks on an individual basis ignores the potential for interaction of risks that may seem unrelated but, in extreme events, may impact each other.

The ability to measure and assess risk is essential for effective management. For less quantifiable exposures, such as regulatory and reputational risks, insurers are utilizing risk dashboards more frequently, to consider the nature of the exposure and promote effective monitoring and risk mitigation. Assessment of operational risks can make it easier to develop contingency plans for recovery from natural disasters or information-systems failures. Stress-testing analysis is used to assess the potential impact of individual events, or a confluence of events, on capital.

Over time, more sophisticated risk measurement tools have developed for insurers. Economic capital models have become increas-
Economic capital models can provide unique insights into the key financial risks that an insurer faces and its ability to withstand an adverse confluence of events. These capital models look at all of the major risks in an integrated fashion, using a stochastic simulation process that weighs the interconnectedness of risks and gives weight to the impact of diversification.

The outcome of ERM activity provides insights that can help an organization in establishing risk limits and tolerances for its various operating areas and in allocating capital more efficiently. Over the longer term, information garnered from ERM processes may prompt adjustments in a company’s risk profile in several areas, including:

- Product terms
- Business mix
- Claims and reserving processes
- Asset allocation.

While the ultimate success of an ERM endeavor may prove difficult to measure, its essential worth hinges on limiting large losses and reducing volatility of earnings to boost risk-adjusted returns on capital.

**New requirements for risk reporting**

As insurance risk management practices evolve, so does the number of compliance and reporting requirements that insurers must deal with. The NAIC’s Solvency Modernization Initiative (SMI) includes the adoption of the Own Risk and Solvency Assessment (ORSA), which is management’s self-assessment of the insurer’s risk management and corporate governance framework.

Unlike historical regulatory reporting, ORSA represents an ongoing review of risk exposures and capital adequacy. Insurers must
describe the elements of their ERM framework and ORSA results in an annual “Summary Report.” Three key sections (1) describe an insurer’s risk management framework, (2) provide the insurer’s risk exposure assessment, and (3) show the company’s evaluation of its risk capital and future solvency.

Looming in the near future are more comprehensive risk-reporting requirements; these are spurring more insurers to embrace and expand their ERM practices. The first ORSA reports are required in 2015, but a number of insurers participated in 2013 pilot projects with them. The smaller MPL specialists will not be included in the initial ORSA reporting requirements, but it is likely that the ORSA mandate will expand over time.

MPL more volatile than other casualty segments

A review of multi-year results for assessing volatility, by business segment, in underwriting and loss reserves reveals that the MPL, claims-made, segment is the second-most-volatile major P/C product line (from the standpoint of underwriting profits/losses and reserves), exceeded only by product liability, occurrence and well ahead of other volatile segments, including workers’ compensation and other liability, occurrence (Figure 1).

A deeper look at historical industry accident-year underwriting experience in the MPL, claims made, line provides a vivid portrait of how volatile this business truly is (Figure 2), with periods of very strong underwriting profits, as well as severe and extended losses. From 1987–2011, the developed accident-year loss and loss adjustment expense (LAE) ratio ranged from 47% to 125%.

Loss reserve experience, as measured by the change in loss ratio from initial estimates to the latest reported estimate, reveals just how difficult it is to estimate claims costs in a long-tail line that has substantial litigation-related exposures. In the most extreme cases, from accident year 1987 to accident-year 2011, the P/C industry-reported incurred losses, for an individual underwriting period, were adjusted over ten years of development by 37%, favorably, and 25%, unfavorably.

Changes in risk selection, geographic mix, pricing, and underwriting practices and policy form may offer some opportunities...
for (marginally) reducing underwriting volatility. Likewise, reserve volatility may be reduced through better feedback and communication between claims, underwriting, and reserving functions or by ensuring greater consistency in case reserving processes. Still, the inherent volatility of the MPL line cannot be fully eliminated, so one important focus of MPL risk management lies in ensuring that the company’s capital is sufficient to withstand these inevitable bouts of volatility.

**Results: MPL specialists currently well capitalized**

Fitch’s Prism capital model was utilized for a cohort of 21 MPL specialists, using year-end 2012 statutory financial data, to assess the key financial risk exposures for these underwriters and to evaluate their capital adequacy. Summary results reveal that this group of MPL specialists is currently very well capitalized. Two-thirds of this universe has capital scores in the “Extremely Strong” and “Very Strong” categories; only one company scored at the “Somewhat Weak” level.

The current capital strength of MPL writers, as measured by stochastic capital models, is consistent with results from traditional measures of capital adequacy, including the NAIC’s factor-based Risk-Based Capital (RBC) and statutory net leverage (premiums plus liabilities/surplus (Figure 3).

MPL writers had considerably weaker capital positions a decade ago. Aggregating these ratios for the universe of 21 MPL writers for year-end 2012 reveals that the median RBC ratio was incredibly strong, at 628% of the company-action level, a 250% improvement over 2003. Over the same period, net leverage improved to 1.9X in 2012, as compared with 4.2X in 2003.

The analysis shows that the most significant risk exposures to capital for these MPL underwriters relate to loss reserve risks (47% of gross target capital) and underwriting exposures (24%), followed by investment exposures (11%). Risk factors that are more prominent for other, more diversified underwriters are not material for an MPL specialist, including natural catastrophe risk and latent liability exposures from asbestos or environmental claims (Figure 4).

For the P/C industry in aggregate, underwriting and catastrophe exposures combined comprise the most prominent contributor to target capital, followed by loss reserve risks. MPL writers have greater reserve risks due to the long-tail nature of MPL liabilities, and as-reported loss reserves typically represent a much larger exposure base relative to capital than current-period premium levels.

Analyzing the Prism score of this group of 21 MPL writers versus key risk parameters shows a strong relationship with operating leverage in various forms (Figure 5). Lower leverage reduces the marginal impact on capital from adverse underwriting or reserve outcomes. Entities with higher capital-adequacy scores gravitate toward lower reserve leverage (loss reserves/available capital) and lower reserve volatility. Similarly, from an underwriting perspective, lower underwriting volatility, coupled with lower underwriting leverage (premiums/available capital), translates into better capital scores.

**At a strategic crossroads**

Most MPL specialists are fortunate to be in a strong capital position that should enable them to endure a more challenging business environment. However, history shows that extended periods of volatile market conditions in this segment can lead to significant erosion of capital. Companies that most effectively manage core underwriting and loss reserve exposures are less vulnerable to the inevitable periods of adverse loss experience and better prepared to capitalize on shifts in the market cycle.

A comprehensive approach to risk management utilizing sophisticated modeling tools can prove helpful in reducing volatility and allocating capital. The same processes can be utilized to evaluate broader strategic actions as well. In a shrinking MPL market, lacking organic growth opportunities, insurers are more likely to consider other business opportunities, including acquisitions and product-line expansion to deploy their capital effectively.

Acquisitions within the MPL sector can expand the scale and geographic scope of a company, but there are also the new risks inherent in the effective integration of merged firms, possible overpayment for the acquired firm, and taking on the former competitor’s problems, which may not be immediately visible at the time of the deal.

Diversifying outside of the MPL market can provide the usual diversification benefits, but only if executed properly. If a company is poor at underwriting, no amount of diversification will help. History tells us that in prior soft markets, diversification efforts by MPL specialists did not fare well.

**Reference**

Don’t Miss the PIAA Fall Workshops!

Information and strategies that will help you succeed in MPL!

September 10–12, 2014
Technology, Human Resources, and Finance Workshop
Fairmont Olympic Hotel
Seattle, Washington

Visit sunny San Diego! It boasts a new city center, world-class museums, the world-famous San Diego Zoo, and more than 70 miles of beautiful coastline.

November 5–7, 2014
Claims and Patient Safety/Risk Management
Baltimore Marriott Waterfront Hotel
Baltimore, Maryland

Come to Baltimore and you will be charmed by Harbor East, a spectacular stretch of waterfront just east of Baltimore’s Inner Harbor that features dining, entertainment, great shopping, and more!

To view the complete agendas for any of these workshops, or to register online, go to www.piaa.us.
Q: How have captives traditionally gone about earning investment income?

A: Captives have traditionally earned their investment income through the acquisition of U.S. Treasury bonds. This type of investment is typically viewed as “safe,” provides a reasonable amount of return, and satisfies domicile regulations, since they are relatively easy to turn back into cash to pay claims, should the need arise. Unfortunately for these captives, recently, this investment strategy has not been providing the rate of return that has been expected or desired. Typical 10-year long-term Treasury rates have historically averaged around 6.5%; at the end of 2013, the rate of return (ROR) was less than 3%, and it has been projected to remain the same for the duration of 2014.

Q: Have you seen any changes in the way that captives have approached their investments, in light of this recent performance?

A: Given the low productivity of Treasury bonds, captives have been exploring alternate investment strategies, for example: intercompany loans (loan-backs), hedges, real estate trusts, etc. For captives, there is no one-size-fits-all investment strategy, as the investments depend on the size of the reserve fund, the risk appetite of the captive owner, and the minimum capital requirements of the domicile. Keep in mind that investments are approved by the domicile regulators to ensure that a loss of capital doesn’t negatively impact the captive’s ability to pay claims.

Q: Are there risks, for captives, in not achieving a stipulated rate of return on investments? Or, are returns sufficiently separated, as financial items, from insurance-related aspects like premiums and reserves, which are usually actuarially determined?

A: Well-managed captives have their premiums and associated reserves actuarially determined on an annual basis. A good captive manager should be able to put the necessary pieces in place to present a captive owner with multiple investment options that fit its appetite for risk and targeted ROR, all while working with the applicable regulators to ensure compliance with domicile requirements and the solvency of the captive.
income shouldn’t really factor in, because the premium is determined by the relative risk of the exposure, not the size of the reserve.

Since these items are sufficiently separated, the risks associated with underperforming returns are typically limited to the amount of the investment. This potential loss should be considered by the captive owner, as well as the regulator in the approval process of the investment: neither of these entities would want to put the captive in a position where it would be unable to remain solvent and pay claims.

**Q:** Are captives now moving into equities to any significant extent?

**A:** It is not unusual for a captive to make investments in equities. A typical captive portfolio might actually closely resemble that of an individual’s 401(k) investment: T-bonds, notes, higher-grade corporate bonds, and a small amount in stocks/equities. The size of the loss reserve, expected losses, and outstanding claims all play a part in the particular percentage of the portfolio that is made up of equity investments.

Keep in mind that a captive could need this money tomorrow, so the ratio of stocks/equities (particularly real estate) is going to be much lower than that of the dollars invested in a more stable vehicle. When dealing with money set aside to pay claims, the question isn’t only: “What happens if this investment fails?” More often, it is: “How quickly can we get the money back to pay claims?”

**Q:** I was struck by the idea of a captive entering the commercial lending space. Is this happening now? What factors would promote, or retard, this trend?

**A:** Captives have been players in this arena for quite a while now, just in a very limited capacity. It is a common practice (especially among the larger captives) to loan money to the captive’s insureds. This practice has a few additional complexities, investments by utilizing a portion of their loss reserves, which naturally reduces the funds available to pay claims. A regulator will examine the type of investment being proposed, and make a determination as to how that transfer of funds will negatively impact the claims-paying ability of the captive.

Some domiciles are well-versed in the language of alternative investment strategies because their domicile is home to a substantial population of massive captives with incredibly large loss reserves. The process for approval through other domiciles could be significantly more challenging, if they have not had this experience. It all comes down to how well the regulator understands the proposal and how comfortable he is with the ability of the captive to continue to pay claims.

Things can get very tricky quite quickly when the conversation turns from U.S. to international domiciles.

**Q:** You mentioned the fact that when compared with the other investment vehicles a captive might elect in addition to ensuring captive solvency, regulators also examine the interest rates and payment terms set forth in the proposed agreement between the two entities. The interest rates of these loans are typically slightly higher than fair market value rates, in order to avoid potential regulatory issues. This type of loan is attractive to the insureds, because the arrangements are not usually subject to the same level of restrictions that would be in place through a commercial lending institution.

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**A:** A captive is first and foremost an insurance company formed to protect the interests and assets of its insureds; the availability of the unpaid premium dollars as a source of investment funds is an ancillary benefit of proper captive operation. Find a domicile-neutral captive manager who offers more than an just an understanding of the liability side of captive—one who also has a solid grounding in best practices for the asset side, and how to apply them.

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lower than that of the dollars invested in a more stable vehicle. When dealing with money set aside to pay claims, the question isn’t only: “What happens if this investment fails?” More often, it is: “How quickly can we get the money back to pay claims?”

**Q:** I was struck by the idea of a captive entering the commercial lending space. Is this happening now? What factors would promote, or retard, this trend?

**A:** Captives have been players in this arena for quite a while now, just in a very limited capacity. It is a common practice (especially among the larger captives) to loan money to the captive’s insureds. This practice has a few additional complexities, investments by utilizing a portion of their loss reserves, which naturally reduces the funds available to pay claims. A regulator will examine the type of investment being proposed, and make a determination as to how that transfer of funds will negatively impact the claims-paying ability of the captive.

Some domiciles are well-versed in the language of alternative investment strategies because their domicile is home to a substantial population of massive captives with incredibly large loss reserves. The process for approval through other domiciles could be significantly more challenging, if they have not had this experience. It all comes down to how well the regulator understands the proposal and how comfortable he is with the ability of the captive to continue to pay claims.

Things can get very tricky quite quickly when the conversation turns from U.S. to international domiciles.

**Q:** You mentioned the fact that when compared with the other investment vehicles a captive might elect in addition to ensuring captive solvency, regulators also examine the interest rates and payment terms set forth in the proposed agreement between the two entities. The interest rates of these loans are typically slightly higher than fair market value rates, in order to avoid potential regulatory issues. This type of loan is attractive to the insureds, because the arrangements are not usually subject to the same level of restrictions that would be in place through a commercial lending institution.

**Q:** You mentioned the fact that domicile strategies because their domicile is home to a substantial population of massive captives with incredibly large loss reserves. The process for approval through other domiciles could be significantly more challenging, if they have not had this experience. It all comes down to how well the regulator understands the proposal and how comfortable he is with the ability of the captive to continue to pay claims.

**A:** A captive is first and foremost an insurance company formed to protect the interests and assets of its insureds; the availability of the unpaid premium dollars as a source of investment funds is an ancillary benefit of proper captive operation. Find a domicile-neutral captive manager who offers more than an just an understanding of the liability side of captive—one who also has a solid grounding in best practices for the asset side, and how to apply them.
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Maybe mobile tech *can* be helpful: case study

Supported by mobile technology, trained health coaches at Elder Services of Merrimack Valley (an Area Agency on Aging in Northeastern Massachusetts) visit recently discharged Medicare patients in their homes and monitored them via telephone to identify and address declines in health status that increase the risk of readmission. Administered in partnership with area hospitals, the four-week program begins with an in-hospital visit to determine the risk of readmission.

Patients at medium or high risk for readmission receive an in-home visit within 48 hours of discharge and a weekly phone call for each of the next three weeks. During each encounter, the coach uses a tablet-based application that provides suggested questions written in lay language based on the patient’s diagnoses, treatment, and overall risk profile. If the answers indicate a decline in health status, the system sends a real-time alert to a nurse care coordinator, who subsequently uses a different component of the software to help the patient and coach address the issue within 24 hours, including arranging for any needed services.

The use of health coaches supported by the tablet-based software significantly reduced readmissions among at-risk Medicare patients, as compared with use of health coaches without the software. This reduction generated substantial cost savings for partner hospitals and the healthcare system as a whole.

*Source: AHRQ’s “Innovations” newsletter, July 30, 2014*

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Although the overall rate of IRS examinations on corporations is at a three-year low, the focus on insurance companies, and particularly their deduction of loss reserves, seems to be intensifying. For most insurance companies, the tax deduction taken for loss reserves is one of the largest tax benefits on their income tax return. As a result, this is an area of focus for the IRS, once a company comes under scrutiny.

The rules
So what is the appropriate amount of tax loss deduction? IRS Code Section 832(b)(5) defines losses incurred as the losses paid plus the change in the discounted unpaid losses, less salvage/subrogation and reinsurance recoverable. Regulations Section 1.832-4(b) goes into more detail, adding that the taxpayer must provide support that the unpaid losses represent only actual unpaid losses. These losses must represent a "fair and reasonable" estimate of the amount the company will be required to pay. The regulations also state that, "[T]he district director may require an insurance company to submit detailed information with respect to its actual experience as is deemed necessary to establish the reasonableness of the deduction." The challenge to taxpayers is to determine what amount actually is "fair and reasonable." Most taxpayers rely on the amount of losses incurred as determined in their National Association of Insurance Commissioners (NAIC) Annual Statement, which is largely influenced by their annual actuarial report.

Brandy Vannoy is a Partner with Johnson Lambert LLP, and Derek Freihaut is a Principal and Consulting Actuary with Pinnacle Actuarial Resources, Inc.

Case study
In a recent tax court case, the IRS challenged this method. Fortunately for the taxpayer, the court ruled against the IRS. In September 2013, the U.S. Tax Court ruled in favor of Acuity Mutual Insurance Company ("Acuity"), a property/casualty insurer, concurring with the company that their loss reserve deduction was "fair and reasonable." In their 2006 income tax return, Acuity reported loss reserves of $660 million, which was within the acceptable range of the independent actuarial report. As required by IRS Section 846, this amount was then discounted to $622 million on the tax return.

The Tax Court relied on the 7th Circuit’s case law (the same circuit where this case was appealed) that the NAIC-approved annual statement should serve as the starting point for computing loss reserves. The IRS disagreed, stating that the annual statement controls only what is includable in loss reserves—but not the actual amount of the loss reserves themselves. The Tax Court held that the taxpayer deducted the appropriate amount of loss reserves, based on the rules established by NAIC and Actuarial Standards of Practice (ASOP), and asserted that they fell within a range of reasonable estimates determined by the company’s appointed outside actuary.

The victory in this case was not just for the taxpayer; it was also a win for insurance companies in general.
deemed “fair and reasonable.” Although the Acuity case is only a Memorandum Decision of the Tax Court, and is therefore limited in precedent value, it does give insurance companies some idea of the documentation and calculations needed, based on an independent actuarial report and NAIC and ASOP requirements, that would be needed to prevail against the IRS. Also, the case makes it more difficult for the IRS to assert that a company’s unpaid loss reserves include an “implicit margin” solely because the IRS’ actuaries determine a lower loss reserve amount.

The Acuity decision is significant in supporting a company’s ability to rely on its independent actuary. Acuity’s held reserves were within its own actuary’s reasonable range and were also within the reasonable ranges as calculated by two different independent consulting actuaries, who testified in the case on Acuity’s behalf. The IRS countered, in the case, with two other actuarial analyses that concluded that Acuity’s held reserves were outside of a reasonable range.

After giving significant weight to the fact that Acuity’s held reserves had been deemed reasonable by their independent actuaries, the Tax Court determined that Acuity had done enough to demonstrate that their held reserves were reasonable. After this determination, the court explicitly stated “our inquiry ends,” and so the validity of the IRS’s actuarial reports was no longer relevant.

This is a significant result: reserve estimates are inevitably full of uncertainty, and it is not uncommon to find varying results from different actuarial analyses. This decision allows a company to rely on its actuary’s reasonable range if the result is properly supported by the analysis and meets the appropriate standards of practice. This is a much more secure position to work from for a company; they do not have to be concerned about a potential duel between their actuary, and another opposing one, in court.

This decision also reinforces the importance, for a company’s reserve analysis, of proper documentation and adherence to the relevant ASOPs. While managers may not be able to determine if a report is meeting the necessary ASOPs, there are steps they can take to help ensure they are receiving a properly documented analysis. Any actuarial report the company receives should come from a credentialed actuary who is in good standing with his professional organizations and current with the requisite continuing education. Best practices require that the actuarial report be exposed to the company board, and it is recommended that the actuary be present in person, if possible. This gives management an opportunity to ask questions. Lastly, there are

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often opportunities for other actuaries to review a company’s reserve analysis. Leadership should request and review any report from a regulator or an auditor that offers an opinion on the company’s actuarial report. If these are not available, it is not uncommon to have an external peer review conducted by another independent actuary.

What the IRS will look for
Consider this scenario: you open your mail and find a notice from the IRS that your company is going to be examined. What can you expect the IRS will request in regard to loss reserves? On a typical insurance company exam, the IRS will request the actuarial report, Annual Statement (including Schedule F), and the calculation of discounting for tax purposes. As a standard request, they also ask for board minutes. They are checking to determine how the reserves were booked in relation to the independent actuary’s report. (We will discuss more later on looking to range or point.) As seen in the Acuity case, they are looking for any evidence that the loss reserves are higher than what is “fair and reasonable.” They will examine the historic evidence to see if the reserves have reversed and if the taxpayer has consistently booked to a higher estimate than actual.

In addition, they will look for trigger words in the board minutes or actuary reports, such as “redundant” or “excess.” If the IRS considered the reserves to be greater than an “estimate based on actual unpaid losses,” that estimate will likely be challenged.

The IRS has the advantage of hindsight when looking at these reserves. In cases and exams, we have seen taxpayers successfully argue that their reserve amounts were based on the best estimate available at the time, rather than with the intent of reporting an excess. Every exam and agent is different, but the important thing to be aware of is what they will be looking for in regard to loss reserves and the documentation needed to support the amounts claimed as your tax deductions.

Documentation
The amount of support necessary for a reserve estimate is detailed in the ASOPs. The general guiding principle for an actuary is provided in Section 3.2 of ASOP 41, “Actuarial Communications”:

In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work as presented in the actuarial report.

Not every company uses their actuary’s or actuarial reports in the same manner. ASOP 43, “Property/Casualty Unpaid Claims Estimates,” recognizes that it is appropriate for reserves to be provided “as a point estimate, a range of estimates, a point estimate with a margin for adverse deviation, or a probability distribution of the unpaid claim amount,” based on the intended purpose. If a company prefers to work with a point estimate or an estimate with a risk margin instead of a range, the opining actuary must still determine whether the held reserves make a reasonable provision for unpaid claims. It is this determination of reasonableness in the Statement of Actuarial Opinion that a company, an auditor, the IRS, or a Tax Court will look to first to determine if reserves are reasonable.

One of the documents that will be helpful during an IRS exam is support for how the loss reserves and losses incurred shown on the Annual Statement translate to the amount shown on the income tax return. The easiest way to achieve this documentation is to prepare a work paper in conjunction with the annual tax return that shows a reconciliation between the components of losses incurred (losses paid, change in losses unpaid) on the Annual Statement and the losses incurred that are deducted on the return. The main difference should be the discounting of the unpaid losses as required by Code Section 846, removal of any premium deficiency reserves, and any other loss reserve that is added in excess of the actuary’s reasonable range.

The important takeaway is to start thinking about the loss reserves your company is using in the calculation of taxable income and understand that this is a highly targeted area during an IRS examination. An understanding of what the calculation of losses incurred includes, Tax Court rulings on what is “fair and reasonable,” and what is needed for support if examined, will better prepare you in the event that the IRS does come calling.

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1. “Loss reserves” include unpaid losses and loss adjustment expenses.
3. Sears, Roebuck & Co. v. Commissioner, 972 F.2d 858, 866 (7th Cir. 1992)).
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Medical indemnifiers must accept that there will be a “next big thing.” All organizations experience periodic eruptions of systemic risk, and we need only look to past experiences for confirmation. We have all seen how the actions of individual practitioners, and also problems with technology, can affect large groups of patients.

Enhanced data collection, evolving risk management, and sophisticated claims analysis are reassuring developments. However, denying vulnerability to systemic risk, based on the premise that current methods of risk assessment and analysis of cases are better than ever, is inadvisable at best.

Developments within medicine continue to accelerate: staff roles, treatments, technologies, and protocols for managing patients may be rapidly introduced or changed. Within just a few months, a brand-new clinical approach to a certain medical condition may emerge. By contrast, within an insured line such as auto insurance, safety improvements such as the introduction of seatbelts, airbags, and improved car design have evolved over a much longer timescale. Medicine works on a weeks-to-months basis. In addition, medical professional liability suffers from the inherent time lag between incurred and reported events that one would not see in other insured areas.

Accordingly, the need to anticipate and manage systemic risk within medicine prospectively could not be greater. By the time the claims notifications begin to pour in, the events have long since taken place. At this stage, any steps to mitigate will be much less effective. But notwithstanding the financial liabilities for medical indemnifiers, there is also the obligation to anticipate and manage risk in the interests of patients themselves.

“Information is not knowledge”2

There is one happy coincidence in play here, though. The higher prevalence of clinical negligence litigation has emerged at the dawn of the digital age. The landscape of publicly accessible information is unrecognizable compared with what was available only a decade ago. However, the new sources are so extensive and widespread, it is now essential for medical indemnifiers to develop systematic methods of review. The data is not tidy. It is often qualitative and highly clinically based, a far cry from neat tables of claims data.

Magic is everywhere, if you know where to look

So where should medical indemnifiers look? Unhelpfully, the answer is “everywhere”: government and regulatory bodies, popular and medical press, the specialty-specific colleges, and clinicians themselves.
By way of example, the Medicines and Healthcare products Regulatory Agency (MHRA) is a U.K. governmental organization that regulates medicines, devices, medical equipment, and blood and other therapeutic products. In addition to licensing, the MHRA also reviews and monitors reports from healthcare providers, manufacturers, and patients. Of particular relevance are the rapid and regular medical device alerts published online alongside the agency’s regulatory guidance. The MHRA also administers the Yellow Card Scheme, which healthcare professionals use to report adverse drug reactions. The principle is wide dissemination of information, urgently if required, and the withdrawal or restriction of a product where deemed necessary. It allows healthcare staff on the front line to take action and indemnifiers to take stock early on about potential implications and, from that point, to take steps to mitigate their impact. In April 2010, the MHRA was the first regulatory agency worldwide to issue advice to doctors about the issues with metal-on-metal hips. This followed their establishment of an expert advisory group in 2008. They continue to provide updated advice about the matter.

Another example, the National Patient Safety Agency, provides a centralized adverse incident-reporting system. Anyone, healthcare staff and patients alike, can submit reports to the National Reporting and Learning System online. In turn, the agency releases rapid reports, safety alerts, and guidance on best practice.

Align with the responsible body
Healthcare providers now practice in an age of guidelines. In the U.K., these are published by a variety of respected organizations, ranging from national and governmental bodies, such as the National Institute for Health and Clinical Excellence, to the specialty-specific medical colleges. A key assessment of negligence is the “Bolam test,” i.e., whether a given clinician’s actions would be supported by a responsible body of practitioners. By definition, a guideline produced by one of these bodies represents the expected clinical management of the responsible body of practitioners. By adopting these guidelines in risk assessing and managing different areas of clinical work, indemnifiers may mitigate the vulnerability to successful litigation.

However, guidelines provide guidance and not rules. If patients with meningococcal meningitis routinely presented with a “text-book” set of symptoms, namely, severe headache, neck stiffness, photophobia, pyrexia, a positive Kernig’s sign, and a non-blanching rash, general practitioners would sleep more easily at night. It also remains the case that litigants tend to quote guidelines “to the letter” —as literal, obligatory instructions—in pursing cases. In fact, we know that it is important to respect the complexities of clinical practice, rather than using guidelines rigidly and inflexibly.

Growing comfortable with qualitative data
These are just a few examples of freely available information that can assist in our risk management processes. Medical indemnifiers are no strangers to monitoring data, principally in relation to claims trends, damages and legal costs, and membership, but they will now need to become comfortable in utilizing this sort of qualitative information, which does not easily lend itself to actuarial analysis. The local and national press, blogs, informal social media such as Twitter: any of these may contain that invaluable “heads up” about an emerging problem area.

Stay close to the profession
So if an underwriter diligently surveys the scene as suggested, how does he translate this into a meaningful approach to risk assessment and management? As medicine develops at breakneck speed, it is essential that medical indemnifiers stay close to the profession. Only by utilizing frontline clinicians can we expect to understand medical developments in real time. The Medical Defence Union, for example, maintains a large council of clinicians from all the specialty fields. They are an essential reference point, providing unparalleled insight into new treatments, areas of emerging concern, and individual case management.

But in an ideal world, we would want to know about problems with, for example, metal-on-metal hips, well in advance of 2010, or even 2008. Again, clinicians themselves are in the best position to alert us. Discussions with colleagues, presentations at meetings, murmurings at conferences, and clinical experience: these may provide the first indications of a problem, whether that risk lies with an individual clinician, device or a wider clinical area. Further, clinicians can offer practical

Man vs. Machine
New technologies, particularly automated clinical procedures and robotics, have the potential to improve patient safety by eliminating human error. However, if the original calibration is itself erroneous, the consequent repetition of error can be devastating. In the French town of Epinal, because of a calibration error in a new radiotherapy machine at the Jean Monnet Hospital, approximately 450 patients were subjected to radiation overdoses. Twelve patients died, and many were left suffering from urinary and digestive problems. Three of the doctors involved were convicted of manslaughter and imprisoned. Fundamentally, protocols attempt to standardize medical care and raise the quality of it, while also reducing the risk of errors. However, a single level mistake within a protocol, such as an erroneous medication dose or even an erroneous referral made by a computerized referral system, is quickly replicated in a large number of patients, with widespread implications. So it is more important than ever to front-load the risk management process—before an error is incorporated and then repeated hundreds or thousands of times.
advice in managing and mitigating the risk on the ground, which a risk manager can then incorporate into underwriting policy.

“To expect the unexpected shows a thoroughly modern intellect” 8

Unsurprisingly, there remains no quick solution for anticipating risk areas within medical indemnity. However, in terms of the information available to indemnifiers, the position has never been better.

Ultimately, there is no reason why the ghosts of the past will not revisit us. It is likely that implants and medical devices will come to the forefront again at some point. We have seen metal-on-metal hips and PIP breast implants and there have been recent concerns raised about vaginal mesh procedures.9,10 Non-therapeutic areas of medicine, such as cosmetic surgery, where patient expectations are high, will continue to be associated with high levels of litigation. There is an ever-increasing demand for novel cosmetic implants, such as pectoral and calf muscle prostheses. We have already been warned by the U.K. Department of Health about dermal fillers.11

Reviewing and making the best use of multiple, diverse sources of information will require that medical indemnifiers shift their approach, from the reactive to the proactive. The MHRA will not come knocking at our doors, and the professional colleges will not alert us when they publish new guidelines. Keeping up with these developments is a challenging and time-consuming task, but it is no longer optional. Medical indemnifiers must align themselves with the information available and then call upon the medical profession to make sense of it.

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These results could continue over the next several years if trends in reserve releases hold. This revelation is likely to give MPL insurers a brief reprieve from the impending market change, but it doesn’t alter the fact that insurers’ traditional business models will likely be tested over the next five years. Which companies will endure? Which will prosper?

For the past eight years, reserve releases have made MPL insurers the darlings of the property/casualty industry, driving down their combined ratio far below the industry’s breakeven point of 100%. The year 2013 was no exception, as MPL insurers posted a combined ratio of 85%—5 percentage points better than the previous year.

As in past years, overall profitability for calendar year 2013 was largely the result of reserve releases from prior policies, which, at $2 billion for the year, were in line with the previous five years. Over the past eight years, MPL insurers have released some $16 billion in reserves on policies written since the beginning of the 2000s (Figure 1). In 2013, reserve releases contributed nearly 25 percentage points of relief to the industry’s combined ratio (Figure 2). But even without the reserve releases, the MPL industry has likely experienced profitable results, even if this fact hasn’t yet been recognized in the financial statements of insurers. This is because the significant trends in reserve releases that have been recognized after the initial recorded results are expected to continue for the current policy year. And when all is said and done, we expect that calculations will show that current pricing has still been adequate to cover losses and associated expenses.

Many observers might breathe a sigh of relief at the likelihood of insurers’ continued profitability, especially in a fiercely competitive market, if it weren’t for the fact that it stems not from renewed pricing discipline but, rather, from an aberration in reported claim frequency—which happened a decade ago, when the number of claims received by insurers fell precipitously. Over the intervening years, MPL insurers have enjoyed the benefits of this sud-

Richard B. Lord, FCAS, MAAA, is a Principal and Consulting Actuary, and Stephen J. Koca, FCAS, MAAA, is a Principal and Actuary, Milliman.
The huge influx of insured individuals, which is expected to top 30 million by the time ACA is fully implemented in 2016, could lead to a shortage of physicians.

A tipping point
MPL insurers’ falling premiums have not yet converged with rising losses to an extent that could lead to real problems, in our estimation. But in this evolving healthcare environment, this situation could rapidly change.

The biggest question centers on the impact of the Affordable Care Act (ACA), which could shift MPL claim frequency and average claim cost (severity) trends in either direction. In the interest of time and space, let us just look at one in some detail—the introduction of accountable care organizations (ACOs). The goal of these organizations is to improve the quality and efficiency of care. As such, their risk-based compensation model is intended to encourage physicians, hos-

...den and somewhat unexplained drop in frequency. Loss trends, however, have continued to rise, but as of 2013 remain at levels that continue to yield profits for insurers, in our estimation.

The fact remains that MPL insurers’ loss trends are rising, and have been for the past ten years. And while the increase has admittedly been from a much lower starting point because of the unprecedented drop in frequency, loss trends have steadfastly continued their upward climb, while increasingly stiff competition has caused an erosion in rates and premium.

2013 was the seventh consecutive year that earned premiums declined. These year-over-year changes, in fact, constitute the longest stretch of premium declines of any in the past 30 years during which MPL results have been tracked. Since 2006, premiums have shrunk to $8.5 billion, and are now approximately 16% less than their 2006 level (Figure 3). At no other time over the past 30 years have premiums declined to this extent. Indeed, the exceptional decrease in premium happened for reasons that go beyond the sort of competition that perhaps defines most soft markets. Physician insurers have seen their markets shrivel as more physicians—faced with rising operating expenses and flagging revenues—have left private practice to become employed by hospitals or large medical groups. According to an Accenture study, the proportion of physicians in independent practice dropped from 57% in 2000 to 39% in 2012. The firm estimated we will likely find that this figure has slipped to 36% when the year-end 2013 data have been finalized.

With a growing number of physicians employed by large-group practices or hospital systems, many of which self-insure their MPL exposures, physician insurers have seen their exposure base contract, as more risks are removed from the primary commercial market. This trend has contributed to the prolonged decline in premium revenues and raises the possibility that expense problems could develop for some insurers that now confront a smaller premium base for spreading their costs.

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pitals, and other providers to coordinate patient care, in an effort to improve quality while slowing healthcare spending.

If ACOs work as intended and quality improves, it could follow that MPL insurers may see low claims frequency or severity. At this point, it is unclear whether the reduction in errors would be in the form of fewer incidental errors or fewer catastrophic errors. But the new risk-based compensation model might also prompt some providers to bypass ordering some diagnostic testing that they view as non-essential, which could lead to an increase in claims for failure to diagnose, in the event that a patient’s condition worsens. Frequency and severity could move in either direction, depending on the effectiveness of these organizations.

ACOs are only one of a great many of initiatives under the ACA that could reshape MPL insurers’ costs.

Treatment benchmarks and standards that are promulgated by the Patient-Centered Outcomes Research Institute (PCORI) may help to improve the quality of care—or they could be used as ammunition in a lawsuit.

Physician shortage?
The huge influx of insured individuals, which is expected to top 30 million by the time ACA is fully implemented in 2016, could lead to a shortage of physicians, who may turn over some of their duties to nurse practitioners or physician assistants. Lacking the same expertise as a physician, these providers may fail to diagnose or misdiagnose some condition. On the other hand, they may form more personal relations with patients, and that has been shown to reduce the likelihood of a lawsuit.

Under collateral-source payment rules, the ACA may result in lower awards, since the cost of future medical care would no longer be included in awards, thereby limiting MPL insurers’ exposure to the cost to future health insurance payments in an award, or it might have only a negligible impact, depending on how it is administered and the courts’ decisions.

These scenarios are actually less than a handful of the dozens of possibilities that can arise from the ACA. Any one of the ACA’s provisions is unlikely to upend MPL insurers’ cost structure, but in tandem, the layers and layers of issues stated or implied in the

ACO could tip costs in a direction that might prove difficult to absorb.

The ACA, however, is only one of the uncertainties facing MPL insurers.

The California question
In November, California voters will decide whether the state’s landmark statute, which caps non-economic MPL damages at $250,000, will remain intact, as written. Enacted nearly 40 years ago, California’s Medical Injury Compensation Reform Act (MICRA) has withstood a series of constitutional challenges, the last of which was in 1985.

Since then, MPL premiums in the state have moderated, averaging around 2.5 times their 1976 level—far less than the national average of nearly eight times 1976 levels. But MICRA is now being challenged in a ballot proposal that would raise the cap on non-economic damages to more than $1 million.

If enacted, the proposal would raise the cap on any claim that is outstanding as of January 1, 2015. MPL insurers and self-insured entities would see their liability increase for any unsettled claim on their books, as well as future claims. In all likelihood, claim severity would increase, but the frequency of claims would almost certainly rise if litigation were viewed as more attractive means of compensation than it now is.

This development has far-ranging consequences, given the size of the California market, but it could also signal a change in sentiment if other states decide to follow California’s lead—since California has long been a state that’s a bellwether for social and economic change.

According to the National Conference of State Legislatures, 35 states have some type of cap on medical professional awards. How many states might
again follow California’s lead and challenge reforms?

Time will shed more light on the answer, but the possibility that the longstanding tort reforms might evaporate over the next few years adds another layer of challenge to an already fluid market.

Perhaps the one certainty that emerges from all the current uncertainty is that traditional static business models that rely on what has worked in the past are highly unlikely to be up to the challenges of the future. These challenges require dynamic approaches that leverage existing expertise to judiciously expand or diversify into new markets. Companies that know how to build on their expertise, and do more than just manage rates, will be the insurers that endure and most likely prosper in the future.

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The 2014 Medical Liability Conference, May 14–16, in Toronto, Canada, brought together more than 500 insurance professionals, all looking to gain key insights on the global—and day-to-day—issues facing the medical professional liability (MPL) community. The meeting addressed the most important topics these professionals needed to learn about and discuss. All of the conference proceedings were set amid the vibrant, cosmopolitan city of Toronto.

Topics covered included finance, claims management, risk mitigation and patient safety, and government and regulatory policy. Of particular interest at this year’s conference were topics related to the notable changes in the healthcare market in the U.S., such as the rapidly increasing percentage of physicians who are employed. Attendees left the meeting with a clear perspective on the present and future of the MPL business, and with specific strategies for meeting the challenges of the evolving healthcare system, both in the U.S. and around the world.

Keynote Session
“Sustaining Cost-Effective, Patient-Centered Care in an Era of Transformation”

We are in an unprecedented world of consumer/patient-driven healthcare, said Reed V. Tuckson, MD, FACP, delivering the address in the Keynote Session. At the same time, he said, for medical professionals, healthcare is in a volatile, unstable market, filled with
risks. And yet, this disruption also makes possible new kinds of opportunities for innovation. In this sort of environment, he said, it is of critical importance that healthcare professionals sustain their traditional adherence to the Hippocratic Oath, and also preserve their autonomy.

Tuckson is Managing Director, Tuckson Health Connections, LLC; former Executive Vice President and Chief of Medical Affairs, UnitedHealth Group; and former Senior Vice President for Professional Standards, American Medical Association.

One example of the emerging opportunities, Dr. Tuckson said, pertains to “big data.” Now, it will be possible to aggregate the clinical information on large numbers of patients, and use techniques such as regression analysis to see which factors are truly relevant for rigorously evidence-based diagnosis and treatment. That information can then be applied to individual patients, to ensure that they get the care they need, while scrupulously avoiding unnecessary care. Other recent developments, such as mobile health apps, he pointed out, will also enhance the specificity of diagnostics and treatments for patients.

There are also some difficult issues for everyone in healthcare, Dr. Tuckson said. There is now a medicine for hepatitis C that cures the condition, rather than just treating the symptoms. But its cost is $84,000; adding to the complexity in deciding whether to use this treatment is the fact that hepatitis C occurs principally in addicts. There is also the new market in molecular diagnostics and genetic testing, expected to emerge as a $15 billion to $20 billion industry by 2021. But, he pointed out, we don’t yet know what to do with the vast amount of data generated by these analyses.

In the midst of the ongoing evolution in the U.S. healthcare system, Dr. Tuckson said, PIAA members should promote their work and all that it accomplishes. “You need to be much more public in your contribution to this discussion,” he said.

Peter Sweetland Award

James L. Weidner was named as the 2014 Peter Sweetland Award of Excellence recipient for his significant contributions and dedication to the MPL insurance industry and PIAA. Weidner has spent much of his extensive insurance career representing the interests of healthcare professionals and institutions through his work in the MPL industry. He is chief executive officer of the Cooperative of American Physicians, Inc. (CAP), located in Los Angeles, California.

Weidner has dedicated countless hours of service to PIAA. He is a past member and chair of the PIAA Board of Directors. He also has also served on numerous PIAA committees: Audit, Finance and Investment, Nominating, Strategic Planning, and Rating Agency Relations committees. In addition, Weidner continues to serve on the Data Sharing Advisory Committee and as the liaison to the PIAA Board Fellows program.

“We are honored to present Jim with our most prestigious award in recognition of his dedication and commitment to PIAA and those who provide healthcare,” said Ted J. Clarke, MD, chair of PIAA. “Jim has been a passionate advocate on behalf of the medical community and an unwavering supporter of PIAA.”

Brian K. Atchinson, president and CEO of PIAA, stated, “Jim is a great innovator and a true professional—and we are privileged to recognize his many accomplishments on behalf of both the medical community and PIAA. Through his work at both CAP and PIAA, Jim has been a driving force in bringing risk management and patient safety programs to healthcare professionals and in assisting them in addressing business challenges.”

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

The Peter Sweetland Award of Excellence, established in 1993 by PIAA’s Board of Directors, was created in honor of Peter Sweetland, one of PIAAs chief architects and ardent supporters. The Peter Sweetland Award of Excellence recognizes an individual who has provided great service to the industry and to PIAA, and who epitomizes the high ideals and ethics for which Peter Sweetland stood.
PIAA Leadership Awards
At the opening session, PIAA also presented its Leadership Awards for major contributions to the Association by volunteers from its member companies. This year, they included:
- Scott Diener, NORCAL Mutual Insurance Company, Data Sharing Advisory Committee
- Donald J. Fager, Medical Liability Mutual Insurance Company, Government Relations Committee
- Mary Hedin, Mutual Insurance Company of Arizona, Underwriting Section
- Gordon Ownby, Cooperative of American Physicians, Inc., Leadership Camp Section

Focus on a Session
“Hospital Employment: The Physician’s Changing Role”
The Affordable Care Act (ACA) and the establishment of accountable care organizations (ACOs), as well as similar contract arrangements, are clearly influencing the delivery of healthcare. Hospitals have been deploying their resources so as to maintain market share and visibility in the market, through the employment of physicians. The panel of physicians in this session discussed the evolving role of the physician in this new healthcare market and considered as well its impact on the MPL community.

Hayes V. Whiteside, MD, FACS, Chief Medical Officer, Senior Vice President, Risk Management, ProAssurance, pointed out an interesting aspect to the increasing employment of physicians: “Everything about the trend of hospitals employing physicians is consistently inconsistent.” The statistics might seem to indicate clear patterns. In 2012 and 2013 alone, he said, there was a 6% increase in physician employment and a corresponding 6% decrease in the ranks of solo practitioners. There was a 25% increase in physician employment between 2004 and 2011.

But there are many other factors that are inconsistent with this trend. For example, Medicare has been cracking down on services performed at hospitals that could be done more cheaply in the office. Hospital CFOs are expecting, at least in the short term, financial losses from acquiring physician practices. Smaller community hospitals, affected by cuts in Medicare and Medicaid, cannot compete for physician employees.

Physicians themselves may be uncertain about how they want to practice medicine. Dr. Whiteside noted that, among other considerations, physicians do like the freedom from dealing with business issues that employment offers, but at the same time, they hate having to follow the rules of others.

Doctors will need to decide what matters most to them in how they practice. If they do decide to opt for employment, they should consider what is happening in all
of the markets and competition in negotiating their terms of employment.

Luke Sato, MD, Senior Vice President and Chief Medical Officer, CRICO/RMF and Assistant Clinical Professor of Medicine, Harvard Medical School, offered the perspective of an academic medical captive insurer on the issue of physician employment.

There are several issues shared by all of these captives, he said, as a result of acquisition activity, and these include integrating risk management and patient safety programs, developing a strategy for non-employed/affiliated physicians, and resolving the cost disadvantage vs. the current commercial market.

Uniquely, these entities have issues that stem from structural program differences, such as separate physician limits in disparate MPL policies.

To deal with these issues, CRICO convened a working group to discuss the implications of acquisitions; one goal was to develop guidelines on underwriting, claims, and patient safety. To date, they have established underwriting risk mitigation and patient safety requirements for community hospitals. They are also developing a similar set of requirements for physicians practice groups (PPGs). They addressed the risk management and patient safety issues through a shared risk management structure, primary care risk interventions, and with that, a primary care incentive program. The next step, Dr. Sato said, is to establish a primary care risk reduction strategy, which will include data analytics on primary care risks.

Graham Billingham, MD, FACEP, Chief Medical Officer, Princeton Insurance Company, discussed some of the challenges that healthcare professionals, and U.S. healthcare as a whole, will have to confront in the coming years. Given the emerging imbalance between numbers of primary care providers—the ratio of such providers to patients is 1:10,000—Dr. Billingham envisions that what is done to compensate for the paucity of physicians, e.g., moving older, more complex patients faster through the system, ordering fewer tests and consults, and not readmitting them, will drive up frequency.

He also points out that one consequence of the ACA, White House officials have said, will be this: the healthcare system will evolve into one of two forms—organized around hospitals or organized around large physician groups. Physicians will face challenges in areas like loss of control and outcomes; hospital CEOs will face financial challenges and potential personnel shortages.

Employed physicians will also need to learn new skills in, for example, the fine points in navigating the Stark law provisions and compliance with new standards of care. They will likely play new roles, too. They will need to become tech- and politically savvy, adept at analytic skills and negotiation.

For traditional MPL carriers, some portion of their business is changing. In response, they will have to offer different layers of coverage and also pursue ongoing diversification of products and services. Amid all of the seismic change in healthcare, MPL companies will need to have “flexibility—but also be selective” about what they pursue.

PIAAPAC Luncheon Attendees Hear Expert Analysis on 2014 Congressional Races and More

Tom Bevan, co-founder and Executive Editor of RealClearPolitics, the popular website for all matters on politics and policy, spoke to a packed room at the PIAAPAC Luncheon, on May 15 at the Medical Liability Conference. Bevan provided attendees with an objective, non-partisan assessment of the 2014 Congressional races and what is in store for the nation’s capital once the elections are over. In searching for clues about the possible outcome of the elections, he advised the attendees to keep close tabs on the latest economic figures, as well as presidential approval numbers, as these will likely indicate whether one party will have national momentum or whether races will be decided more on local
issues. He also noted that state and local races may have an “up ballot” impact on some Congressional contests as well. Bevan concluded his presentation by fielding attendee questions about specific races around the country. To learn more about PIAAPAC, contact Mike Stinson at mstinson@piaa.us or visit www.piaa.us.

Focus on a Session
“From Obstacles to Opportunities: Using ERM as a Platform for Business Success”

This session was structured as a series of questions and answers—the ones that the speakers hear most often, and that are most important for keeping company finances, and company ratings, on a sound footing. This text offers a representative sample of what proved to be a very lively and engaging dialogue.

First Question: What is “enterprise risk management”?

Gerry Glombicki, CPA, a Director at Fitch Ratings, offered a broad definition. Enterprise risk management, he said, is “a set of business practices that supports a particular view of the world.” This encompasses all of the activities that are done with sufficient frequency to require control, and for which it is cost beneficial to exert such control. The key issue in thinking about ERM, he said, is what you hope to accomplish with your ERM system. It is important to have a clear objective in mind.

David Ingram, CERA, FRM, PRM, Executive Vice President at Willis Re, explained how ERM should be done. At the most fundamental level, he said, ERM can be understood as a control cycle. In an insurance company’s control cycle, management needs to first identify the key risks, and then determine the risk quantity they are willing to accept and retain. It is imperative, he said, that the entity monitor the risk taking throughout the year and react to actual situations that are revealed by the monitoring.

Second question: What are the rating agencies looking for in reviewing insurers’ ERM schemes?

Mark Stephens, Managing Director-Corporate Risk Advisory Services, Milliman, Inc. said that the rating agencies had in prior years been examining metrics like IRIS ratios; then the new item was risk-based capital; and most recently, it has been ERM. He noted that if every company did ERM well, we could expect to see a more shallow underwriting cycle.

Gerry Glombicki pointed out that although the ORSA [Own Risk and Solvency Assessment] is not yet required of smaller insurers, companies of all sizes have found it to be a very useful exercise for assessing and mitigating risk.

David Ingram asked if anyone had actually considered the risks involved in doing poor ERM. Had anyone actually measured the impact, in terms of declining revenues?

Third question: Are there common hurdles when companies first attempt ERM?

Mark Stephens said that companies tend to be good at estimating risks with underwriting and reserves, but other risks, like some operational risks, they can’t quite get their arms around easily. He also noted that companies may have difficulty in seeing the relationship among the various individual risks. He advice on introducing ERM: “Don’t do too much too soon.”

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What’s the Probability That You’ll Read This Column?

BY ERIC R. ANDERSON

If you turn on your morning radio program, and the show’s meteorologist tells you that the probability of precipitation is 80% for the day, you’ll probably grab your umbrella before you leave home. When it comes to the decisions healthcare professionals make, do they have the same sort of luxury in using statistical probability to help guide their diagnoses? Or, do they have to work with absolutes, making decisions on diagnoses or treatment regimens based purely on “yes” or “no” answers?

The real-world answer may lie somewhere in between. But the odds are good that in the courtroom, the concept of absolutes will reign supreme—and work against them.

Stepping away from clinicians for a moment, it is interesting to consider epidemiology. The cornerstone of public health, epidemiology includes investigations of all kinds of health-related conditions, to determine who is affected by them, why, and what can be done to treat and prevent them. Logic dictates epidemiologists would use statistically based results in detailing their findings.

But researchers have to navigate a great number of hurdles before they can establish the actual cause of a particular health outcome. Correlation is not causation, as they say: How strong is the link between event A and result B? Does A always take place after B? If A is changed, is B altered too, and to the same degree? The more frequently researchers can say “yes” to these sorts of questions, the closer they get to imputing causation between A and B. This is why epidemiologists are often so cautious when announcing their findings in anything but absolute terms.

Closer to home, in the MPL arena, probability is certainly a recurring theme in the delivery of healthcare. Quite likely, not a single day goes by when some healthcare professional returning home from a busy day at the office, clinic, or hospital suddenly has the uncomfortable sense that one or more of his diagnoses may turn out to be wrong, or that some of his recommended treatments may not produce the expected cure.

Encountering the unexpected is an occupational hazard in clinical practice. It’s been said that healthcare professionals, after some years of experience in their profession, begin to accept the simple fact that there is always some degree of uncertainty in any prognosis, and, at best, it can only be expressed as a probability in any particular case.

But, regardless of these realities, plaintiff’s attorneys attempt to persuade jurors to think only in black and white. They talk as if there were no middle ground in healthcare decisions. Any given decision is either wrong or right. But we know, after decades of study into the particular areas of medical care that give rise to MPL claims, that this is not the case. There are no guarantees. There are only informed decisions by healthcare experts—often the best and brightest in their respective specialties.

In a world with a judicial system that demands “yes” or “no” answers, and with the nearly countless pressures on healthcare professionals today, what can we do to help? For starters, we can continue to strive to provide them with the most up-to-date, comprehensive, and insightful patient-safety data—so they can learn from prior outcomes and continue to make the best decisions possible.

We can also hope that, at some point in the future, jurors will agree that on a day when the probability of precipitation was forecast at 80%, but skies happened to be sunny all day, a person who elected to take an umbrella made a prudent decision.
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