Analyzing Financial Strength Ratings

Adverse Verdicts on the Rise
Confidence

With the dynamic changes in the United States healthcare insurance market occurring at unprecedented speed, the only “certainty” we know is continued uncertainty. As the recognized industry leader in casualty reinsurance products and other risk transfer solutions, Guy Carpenter provides clients with the medical professional liability market intelligence and analytical expertise to help them face these times of uncertainty with confidence.

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In virtually every communication from an investment firm, the last words express a cautionary statement: “Past performance is not an indicator of future results.” These words also reflect what we know about most things in life. The future will be different from what came before—and quite possibly in very fundamental ways.

Some of the recent changes, like insurance and market cycles, have been relatively predictable. At the other end of the spectrum of predictability is the so-called “black swan” event, defined as one that deviates beyond what is normally expected of a situation and is extremely difficult to predict. But in between lies a sizable gray area, where we can discern some outlier results, but need to wait until more data or experience has accumulated before discussing whether there is a genuine sea change at hand—or just an anomaly.

The worlds of healthcare and MPL in 2008 were very different from the environment in 2018. Ten years ago, could anyone have predicted the dramatic changes in our healthcare delivery system or the significant increase in number of captive insurers as a common vehicle for risk transfer and financing?

As change continues to unfold, every organization needs to be vigilant, with a wide lens and open-minded perspective about what is occurring around it. Success will come to those equipped to think strategically and respond to shifting circumstances with initiatives that take advantage of new developments and evolving market dynamics. It is better to control one’s own destiny than to be merely reactive and buffeted by the prevailing winds.

For PIAA, this means evolving to address the changing MPL community and the needs of our diverse membership. For PIAA members, it means being prepared for the cyclical nature of the business and the ever-morphing practice of medicine and delivery of healthcare.

In this issue of Inside Medical Liability, one of the feature articles analyzes data related to a growing MPL concern: the increase in large adverse verdicts. According to the available data, 2017 established a record for awards of more than $10 million, and the year tied the record for verdicts of more than $25 million. The article reinforces the need to think strategically in order to counter this apparent trend.

Another article in this issue analyzes the recent trends in the financial strength ratings (FSRs) of MPL firms assigned by A.M. Best. In more recent years, an increasing number of MPL specialty companies have been receiving negative outlooks from Best. This raises numerous questions, including: Why the changes? Does this indicate a clear trend? If it is a “new” trend, does that mean that MPL specialty companies have reached a peak in terms of FSR?

Amid the transformation taking place in the world of healthcare and MPL, it is vital that PIAA also assess what it is as an organization of members, what it does and why it exists, and where it is going. Fortunately, the Association’s strategic plan adopted in 2017 by the Board of Directors has identified key areas of focus for the road ahead, including:

- To be recognized as the leading source for MPL information
- To ensure programs and content reflect evolving member needs and ongoing value
- To expand opportunities for members to communicate, collaborate, and network
- To focus on state and federal public policy issues of importance to our members
- To clarify, and strengthen, the PIAA brand
- To maintain a financial strategy that supports the sustainable operations of the organization.

We will accomplish these objectives with the needs and priorities of all our members in mind—the traditional mutual, reciprocal, and stock insurers and risk retention groups, as well as the hospital and healthcare system captives.

We pledge to you that we will work tirelessly on all of the vital elements in the new strategic plan. Your success is our objective, and we will remain agile and responsive to everything that impacts our members, their insureds, and the MPL community.
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“We would advise those decision makers to do what they believe is right: Run your own company.” —Cover story
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COMING ATTRACTIONS

EVENTS & CALENDAR

2018 Marketing and Dental Workshops—Keynote Session

It’s Not Personal, It’s Generational—
the Impact of Generational Differences in Healthcare

Thursday, April 12, 9:00–10:15 a.m.
Anna Liotta, CSP, MA, Author and Lead Consultant, Resultance, Inc.

For the first time in history, multiple generations are collaborating, competing, and all too often colliding in the workplace. When that happens, organizations can lose customers, valuable team members—and money. Learn “What Makes the Generations Tick and What Ticks Them Off” with author Anna Liotta in this fast-paced, highly interactive program that guides managers, leaders, and team members in new approaches for unlocking their full potential by discovering how to recognize the “generational codes” in action and transform them from obstacles to opportunities.

2018 Medical Liability Conference—Keynote Session

The Healthcare Trilemma: Access, Quality, and Innovation

Thursday, May 17, 9:15–10:15 a.m.
Amitabh Chandra, Professor of Public Policy, Director of Health Policy Research, Harvard Kennedy School of Government

Professor Chandra is a member of the Congressional Budget Office’s (CBO) Panel of Health Advisors, and is a Research Associate at the National Bureau of Economic Research. In addition to innovation and medical liability, his research focuses on cost-growth and racial disparities in healthcare.
Performance Art

Art / ārt / noun: Skill at doing a specified thing, typically one acquired through practice, (synonyms: skill, ability, know-how)

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Duck! That’s a Telemedicine-Delivering Drone Right over Your Head!

Some visionaries are now planning a futuristic strategy for deploying drones, in large numbers, as the ideal vehicle for transporting emergency telemedicine services. The drones can, proponents say, drop in on an accident, disaster site, or remote location with supplies, digital health tools, and a telehealth link to the outside world.

But we find ourselves a tad concerned about one aspect of drones. They seem to be yet another element in the transition from bio-forms-based labor to made-in-a-factory-based workers: “Drones are going to decrease the reliance on human beings that provide care and decrease the cost of assisting people,” says Jeremy Tucker, MD, Vice President of Patient Safety and Regional Medical Director of MEP Health. In a recent interview with Inside Unmanned Systems magazine, Tucker averred, “Being able to cross long distances at faster speeds to deliver blood products and lab samples also is a huge benefit.”

Continuing in an upbeat vein, Tucker adds, “Now, transporting blood products between hospitals, for example, involves vehicles on the ground that are prone to accidents and delays. Drones can help decrease those incidents.”

There’s been a hindrance to the widespread use of drones in the U.S., though. Current Federal Aviation Administration (FAA) regulations prohibit GPS-enabled drones from flying out of sight of the operator. But happily, there have already been exceptions for healthcare applications. And the drone optimists are convinced that the FAA will soon develop a liberating new policy for drones, later this year.

Source: mHealth Intelligence, December 27, 2017

Illinois Lawyer Offers 40 Things (Yes, 40) We Need to Know About the State’s MPL Law

Does anybody really want that much advice, especially when it comes with a hefty dose of the standard caveat, “You shouldn’t take any of this as legal advice.” (Then why read it, we ask?)

Some of the 40 items are fairly obvious. Consider Point Number 5, for instance: “A bad result doesn’t mean there is a case. Many procedures are very risky.”

And then there is happily encouraging general information. Point Number 12: “Cook County is the most plaintiff friendly place in Illinois to file a case.”

But this is balanced with cautionary notes like this one: “In some downstate counties, there has never been a medical malpractice trial [verdict] for a plaintiff.”

Finally, there is the just plain mean (one example, Point Number 19): “The honest truth is that it’s very hard to win a medical malpractice case for an elderly person no matter how bad the care was, as their life expectancy is so short that it limits damages.”

Source: Chicago Now, December 2017
Preventing Falls with ‘Smart’ Socks

“They’re comfortable. They’re warm. They don’t bind or roll.” That’s one patient’s review of her new “smart” socks. She’d been dangling her feet off the edge of the bed. But as soon as she touched her feet to the tile floor—even before she had a chance to shift all of her weight forward as if to stand—a nurse appeared in the room. The nurse was there to prevent a possible fall.

How did the nurse know what was happening? It’s another promising application of technology. The sock itself is made out of silk, knit with the tight fit of a high-end running sock. Woven into the foot of the socks are three sensors. They can send a signal through microfilaments in the fabric to a monitor attached to the leg shaft of one sock.

The monitor is a circuit board in a plastic case that is roughly 1 ¼ inches in diameter. Using a tablet computer, a nurse “tells” the monitor about the patient, including weight. When the socks detect the downward pressure past a certain threshold, the filaments in the fabric signal the monitor on the sock. This then alerts the three nurses closest to the patient.

The cost is approximately $350,000 to $450,000 a year, for a 100-bed facility. Chris Baker, Vice President of Palarum, maker of the socks, comments, “While our main objective is increasing patient safety, we honestly believe the hospital will save more money by reducing patient falls than what they pay for the system.”

Source: Cincinnati Enquirer, December 7, 2017

2017 Ranking of State Liability Systems: U.S. Chamber Institute for Legal Reform

The 2017 Lawsuit Climate Survey: Ranking the States that was conducted for the U.S. Chamber Institute for Legal Reform by Harris Poll documents just how fair and reasonable the various states’ liability systems are perceived to be by U.S. businesses.

Participants in the survey comprised a national sample of 1,321 in-house general counsel, senior litigators or attorneys, and other senior executives at companies with at least $100 million in annual revenues who indicated they are: (1) knowledgeable about litigation matters at companies; and (2) have firsthand, recent litigation experience in each state they evaluate.

Now, the results: the locales that the respondents deemed most miserable for those with a lingering fondness for jurisprudence—the “least fair and reasonable litigation environments”:

Chicago or Cook County IL 23%
Los Angeles, CA 18%
Jefferson County, TX 17%
New Orleans or Orleans Parish, LA 14%
San Francisco, CA 13%
Detroit, MI 13%
Miami or Dade County, FL 12%
New York, NY 11%
St. Louis, MO 10%
Washington, D.C. 10%
Philadelphia, PA 8%

But, surprise: There was good news here, too. The 2017 survey reveals that the overall average scores of the states are increasing, and senior attorneys and executives see the litigation environment improving generally.

Source: U.S. Chamber Institute for Legal Reform, 2017 Lawsuit Climate Survey.
Over time, a company’s business will inevitably have changed, and the software it uses may have reached a point where it can’t reasonably be adapted to accommodate the new functional requirements. And software technologies that were ubiquitous 10 years ago may no longer be the best choice as the infrastructure needed to support future development; worse yet, some of them may no longer be supported by their vendor.

Deciding that something has to be done is the easy part; the next question—determining what that “something” should be—is the hard part.

When we talk about software here, what we mean is the core enterprise system that manages policies, claims, billing, and related key functions. Satellite software like financial packages and document management is generally acquired from a vendor, so there isn’t any “repair” option; if there are issues with such software, there may be an upgrade that can address them. If not, another vendor’s software should be evaluated as a replacement.

What can be done under the “repair” option depends on who owns the software:

- If the system was developed by the insurance company and it owns the source code, it is freely able to do whatever it wants with it.
- If the system is licensed from a vendor, and assuming the most recent release is installed, the insurer will need to find out if the vendor can make the required changes, via configuration options, if possible, or through new projects that add the new functionality (at the client’s expense).

On the other hand, “replace” means looking for completely new software that can be written as a custom application or licensed from a vendor. In almost every case, the licensed approach will be the least expensive, and fastest, way to accomplish the project; building custom enterprise-wide insurance software that would rival the functionality of what is available from vendors would be far more risky and costly, and is not recommended.

So: How to proceed?

An evaluation process should define the problems and shortcomings of the installed software from multiple perspectives: business, technology, and any other impacted area of the company.
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The business evaluation
Here’s what you should consider in determining the various costs of repair versus replace. Start at a high level and look at the company’s direction: where it wants to be in the next five years. Any project—repair or replace—must strive to create a system that will not become obsolete soon after it is installed.

Next, review the current software, and inventory its functional weaknesses and deficiencies. For example, can it produce all the required reports? Does policy rating handle all coverages and can rate changes be made quickly? Does premium collection support the many payment options that have become expected in recent years? (In doing this evaluation, knowing the company’s business plan will be helpful.)

Determine the relative usability of the present system. Does performing work with it involve too many steps, repeating the entry of data already available? Is it hard to locate the records needed? Are the error messages insufficient?

In performing the business evaluation, consider how the enterprise software coexists with other software—are there opportunities for integration or interfaces that would enhance operations? For example, does the system exchange information with a financial package, with legal bill review services, bank lockboxes, etc.?

Are there products available that could address your discrete requirements, using a “best of breed” approach? For example, is a reporting package available to import insurance data and provide ad hoc reports? Is there portal software that could be easily customized to give agents and insureds online access? There are many such products available today, and vendors have designed them with features that permit easy integration using Web services and application program interfaces (APIs).

Technology
To assess your technology, you need to ask some essential questions.

First, if the system, at any level, uses technology that is no longer supported by its vendor, is there an upgrade path—for example, a newer release of the programming language, database engine, or the operating system? If a new release will work with your supported products, then the migration to the later release is generally straightforward. If that is not the case, I would strongly suggest to you that the repair option is off the table. Unsupported software will cause problems with security and maintenance, and as time goes on, it will be much harder to find IT tal-
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ent that can (or would want to) work on it.

Then, determine if the current system is unreliable—“wobbly.” For example, is data sometimes “lost”? Are there mysterious outages or system locking problems? Is there a regular issue with balancing reports? Does fixing a “simple” bug take far too long? **These are all symptoms of a poorly designed database and/or poorly written program code and suggest that the repair effort would be a lot more complex than it might otherwise be.** In other words, there is a weak foundation for supporting enhancements. The decision to repair may still be okay, but expect that a lot more work will be required.

Security and control are increasing concerns. There are three areas to consider:

- **External security.** Is the software safe from intrusion by outside parties? This is usually addressed outside of the application by means of firewalls, antivirus software, and good system-administration practices. Though very important, this is the simplest of the three concerns, because it is generally addressed independently of the enterprise software.

- **Internal security.** This is the ability to control what each person in the organization can see and to ensure that they can do only what is intended for them. This is something that must be addressed within the enterprise software. If internal security is found to be inadequate, the software will need to be enhanced, and, depending on the level and granularity of control required, this can be a complex matter.

- **Audit control.** This is the ability to trace activity on the system by user, time of day, record affected, changes made, etc. Again, this must be addressed in the enterprise software and, depending on the scope, it may not be simple to retrofit audit control into the application.

**Other concerns**

Then, there are issues that pertain to the company’s budget.

For small and medium-sized insurers, the cost of the “replace” option can be anywhere from $750,000 to several million, to cover the license fee and the services associated with implementation, such as configuration, project management, training, and data conversion. It may be possible to “rent” the software via an application services provider arrangement. But, with that option, although the ramifications for the entity’s cash flow are different, the cost would likely be close to that of licensing, over a five-year period. One advantage: the costs are generally agreed to, via an up-front contract, so that, barring changes in the scope of the project, they are unlikely to change.

Note that the “repair” option is not necessarily cheaper, and (as compared with assigning the project to a vendor) its success will depend far more on the capacity of the insurance company staff to direct and oversee the work that will be done, whether by their own IT department or by contractors. But repair projects can be done incrementally, to allow the spend to be based on the company’s budget over several years. Compared with a vendor who is installing his software for the nth time, the costs will be harder to fix; a repair of existing software inevitably involves some amount of discovery after the work has started. **And beware of underestimation—It projects are infamous for cost overruns and for not including the “soft” costs, such as the time business users will need to spend on defining requirements, testing the work, and other related project activities.**

Phasing and timing should be carefully planned. For “replace” projects, once the work starts it will generally continue without interruption until completion. There may be some phasing, but each phase will directly follow the other. Vendors generally do not want to drag out projects. They do not earn their full license fees, and do not start maintenance charges until the work is completed.

“Repair” projects can be developed in phases, but there is an important “if” with this. **Work should not start until a plan, including requirements definition and a budget, is developed and agreed to.** If the “to be completed” state is not clear at the start, there will be problems later; it would be like starting to build a house without a plan in place. With the end state clearly defined, it is possible, even desirable, to look at the dependencies among the various elements in the project, and returns on investment, and arrange for the work to be done in phases.

**Develop an inventory of the resources you will need.**

With the “replace” option, although there will be a good deal of client involvement, for the most part, it is up to the vendor to manage the resources needed.

With the “repair” option, it’s more complicated. If there is an IT staff, is it capable of moving from a maintenance role to working on a major project, probably with new technology? If outside contractors are used, will they stay the course for the full duration of the project, and will they deliver software that can be reasonably maintained by others?

**Making the decision**

Like most decisions, this one will come down to a mix of numbers and intuition, and every company facing this decision will have its own nuances. There is no one answer. **As a rule of thumb, though, if the repair option is estimated to cost more than 75% of the replace option, go with replace.** Whichever route is chosen, be sure to understand that it will take both time and money—as well as commitment—to reach your goal.
WE SEE OPPORTUNITIES OTHERS DON’T

Our deep specialist knowledge and extensive experience of both the reinsurance market and the medical professional liability industry enables us to ask smarter questions. We deliver outcomes to you that support your priorities and exceed your expectations.
GET YOUR TALENT STRATEGY RIGHT THE FIRST TIME.

FIND OUT WHAT THE INDUSTRY’S STAFFING OUTLOOK LOOKS LIKE.

For nine years, The Jacobson Group and Ward Group, a part of Aon Hewitt, a business unit of AON plc (NYSE: AON), have conducted an insurance labor outlook study. The data collected provides valuable insight into the labor market’s unprecedented challenges and allows insurers to strategically plan their talent acquisition and management to build and maintain a high-performing workforce.

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There are two key metrics that are often overlooked in today’s insurance company operations that have a significant impact on your ability to generate undiscounted revenue. And though these two metrics are of high importance, it’s more likely than not most medical professional liability (MPL) insurers are not measuring them. This provides you with an opportunity to gain invaluable insights, as well as a competitive advantage in the marketplace, by learning your own scores and acting on them.

The two metrics are actually two groups: Awareness/Attitudes/Understanding (AAU), and Satisfaction and Willingness to Recommend.

AAU is most beneficial when results are set against some form of comparator—that is, data from a prior term (e.g., year-over-year), different geographic or demographic markets, or with the competition. 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 to identify valid trends and movement in AAU. The second metric is customer satisfaction and willingness to recommend. Whether your customers are actual consumers of your product or service, influencers, or decision-makers, understanding what they feel about you—and how intense those feelings are—is an essential metric that you can use to improve your bottom line. Understandably, most customers who are really happy will tell you. The same goes for those who are not. It’s the great unwashed middle that you should be worrying about. They represent the part of your customer base most susceptible to the competition.

Getting to know you

The reason MPL carriers should care about AAU is that it helps in benchmarking your value propositions and provides a quantifiable measurement of the impact from advertising, exhibiting, and sponsorships. These commonly used marketing efforts are regularly undertaken without any data collection as to their effectiveness. Applying AAU measurements can fine-tune a promotional program and eliminate ineffective efforts and unproductive spending.

AAU looks at:

- **Awareness.** This is the percentage of your target audience (members or potential members) who recognize your company or its brand, from either an aided or unaided question. In other words, if I asked a practice man-

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**Customer Awareness and Satisfaction: The Missing Links in Your Business Strategy**

**David Kinard, MEd, PCM, is Senior Vice President at Physicians Insurance A Mutual Company.**
in your service area what MPL carriers were available to her, she would provide a list of those that come to mind—those responses are unaided. If I gave her a list and asked which she recalls, those would be aided responses. In this same way, you can also measure what knowledge the target audience has about your company’s products and services. So, not only do you look to see if they know about you, you also measure what about you they know.

**Attitudes.** This is a combination of what your target audience believes (good and bad) and how strongly they believe it. Measurements over the target audiences’ perceptions of quality, effectiveness, and value as they relate to your company, and can also measure intent-to-purchase.

**Usage.** This is simply the target audiences’ self-reported behavior as it relates to your company.

Getting at this type of information is relatively simple, but it is critical to specifically identify the target audience being measured. Saying simple, but it is critical to specifically identify the target audience being measured. Saying

High awareness, high attitude, low usage.

These administrators know about your company in still in the development phase, and efforts should be made to engage with them in ways that would positively shape your brand.

Low awareness, low attitude, low usage.

These administrators basically don’t know you exist and for that reason do not engage with you. Things to do: an awareness campaign might migrate administrators of this group into another category. You’ll need to evaluate the cost of what it takes to break through the noise in the market space as you compete for attention. Make sure you have a plan in place to access your target audience.

**Yes –** and we understand that no two insurance companies’ investment needs are alike.

**NEAM is fluent in the needs of the insurance industry.** Visit us at this year’s PIAA Medical Liability Conference to learn how we can act as your investment team down the hall.
Measuring satisfaction

Once you’ve used the AAU metrics to improve your campaigns and create new business, as you service those members over time, you’re going to want to measure their levels of satisfaction—from the point immediately after onboarding throughout their history with your company. So, how do you know if your members are happy? How do you know if they’re not? How do you figure out the intensity of their feelings?

Because satisfaction serves as a predictor of future success, it is one of the few forward measurements; most consumer-driven metrics are latent in nature. For example, let’s say I bought an MPL policy as well as a business owner’s policy (BOP) from your company five years ago when I opened my practice. A common assumption would be that because I bought two products from you I am a loyal customer or at least have some sort of “stickiness” with your organization. You might make projections, based on this purchase behavior, that I am likely to buy additional policies or services from your organization. But the problem with this sort of thinking is that you are looking backward at my behavior, not at the future behavior that my current level of satisfaction will drive.

In most instances, member satisfaction is generally measured on a five-point scale, allowing for two positive ratings, one neutral rating, and two negative ratings. Your survey asks if someone is “really satisfied, somewhat satisfied, neither satisfied or dissatisfied, somewhat dissatisfied, or really dissatisfied.” The inherent flaw in this scale is that satisfaction is better measured as an on/off, yes/no scale, lest we become misled by allowing a lesser degree of “somewhat satisfied” to give us a false sense of security.

What if you considered that your members are either satisfied or not? They can’t be half in love, or half anything for that matter, with regard to your company. As well, how do you meaningfully quantify the difference between what a score of 4 or 5 is in either direction of satisfied or unsatisfied? What does it mean to be a 4 and not a 5? And lastly, giving members a chance to select “neutral” only provides people with an opportunity to avoid really make a choice. That ambiguity doesn’t help you one bit. You should really want to know if they’re happy or not.

“Willingness to recommend” is another metric that serves in the same way as satisfaction, and is an indicator of the intensity of satisfaction. Some scales use an 11-point model (0–10) to rank the likelihood of someone’s recommending your company. Known as the Net Promoter Score, this method uses only the top two options (9 and 10) to indicate someone as satisfied and therefore likely to promote. Both metrics quantify an important dynamic: when your company has satisfied customers, you’re more likely to gain positive word-of-mouth marketing, which is arguably more effective than any brochure you can stick in the mail.

However you choose to ask the question, “How satisfied are you with your experience?” be sure to find out what the reasons are for either a yes or no answer. You will want to fix any problems you discover, and also strengthen the elements that are working right. Then, for both the yes and no respondents, ask the willingness-to-recommend question. This gives you the insight as to how deeply they feel about you. In asking this question, you might use a three-point scale: No, Maybe, Yes. If you set up your survey correctly, you should be able to do some cross-tabulations to see how many unsatisfied people answered yes, no, and maybe, and how many satisfied people chose those same options.

Here is an example of what the data might mean to your company. If you get a bunch of satisfied members who say they are not willing to recommend you, then your problem could be that although you’re meeting expectations, you’re not very exciting or inspirational, or you’re seen merely as an undifferentiated commodity. Basically, it means there is no energy behind your brand. In another example, if you have a bunch of unsatisfied members who may be willing to recommend you, then you have a major opportunity to fix something and generate a bunch of advocates for your organization.

Bottom-line results

It’s a common assumption that if more consumers are aware of your company, then there will be more buyers of your products. But this is a misperception, equating awareness with action and intent-to-buy. Your efforts should be focused on creating awareness as well as action. Ultimately, while quantifying AAU will tell you a lot about your target audience, it does not fully measure their willingness to act on your behalf.

That’s why the additional measure of satisfaction scores is a must. Collecting and analyzing the data over time will help in identifying trends that are critical, not only to your competitive success, but also to your ability to identify problems and fix them before they become serious problems. Measuring your audience’s willingness to recommend your organization, or products, is a great tool for identifying action plans to retain customers, while also growing your base of grassroots evangelists.

For related information, see www.phyins.com.
Providing expertise and resources to support strategic decision making beyond the reinsurance transaction
American humorist, and legend, Will Rogers once wrote, “This country has come to feel the same when Congress is in session as when the baby gets hold of a hammer,” and many feel the same way today. It’s not exactly news to say that Congress has been dysfunctional in recent years. The partisan rancor seems to escalate on a regular basis and the result is a seemingly perpetual inability to address major issues.

PIAA continues to engage with Congress on many issues, but since moving something through the federal legislative process is more difficult than ever, we have shifted the focus of our overall advocacy strategies. As noted in the previous Legislative Update (“PIAA Public Policy: It’s Not All about Congress,” Inside Medical Liability, Fourth Quarter 2017, p. 17), the result has been an expanded focus on other policy arenas including state legislation.

While Congress remains gridlocked, state legislatures (although certainly not without their own political problems) have been a source of more regular activity. While our member companies have traditionally handled this arena on their own, the changing nature of the MPL insurance industry has opened up opportunities for PIAA to assist members in these efforts.

State bill tracking
Through our own research, consultation with civil justice reform organizations, and reports from our members, PIAA has compiled information on important bills as they progressed through state legislative chambers for years. For 2018, however, we wanted to go further, bringing you even more up-to-date information, and ensuring that you have cost-effective access to the legislative information that is most important for you and your company.

With this in mind, we are proud to announce our new “Pending State Legislation” tracker. Located on the PIAA website (www.piaa.us), this new service is available at no cost to PIAA members. Through an online tool, you can view up-to-date information on the status of legislation pending in any state. Our map of the U.S. highlights which states have active MPL-related legislation. Want to know what is happening in a specific state? Simply click on the appropriate spot on the map, and you’ll immediately see a list of summaries of relevant legislation. Prefer to see what states are
considering bills on a specific topic? Just scroll over the “Select an Issue” box, click on the issue of your choosing (see sidebar for list of available issue areas), and you’ll get a list of every state with active legislation on that subject.

We don’t stop with high-level overviews of these bills, though. If you find a bill that piques your interest, just click on the bill number and a veritable treasure trove of information appears. You’ll see where the bill stands in the legislative process, the names of its sponsors/cosponsors, what committees have jurisdiction, and, most important, the full text of the bill (including amendments). This information will help you determine what state legislation requires your attention, when you should engage in advocacy to influence that legislation, and how many of your resources to focus on specific bills.

You’ll find all this with just a few simple clicks on the State Legislation section of the PIAA website. We hope you’ll give it a test-drive, to see how it can help you in your state legislative advocacy efforts.

Grassroots advocacy
Suppose you find a bill that requires your company’s attention. What can PIAA do to help you then?

I’m glad you asked. As I’ve said many times, lobbyists are an important part of any legislative advocacy effort. They are your eyes and ears in state capitals (just as we are your eyes and ears in Washington, D.C.), and they can quickly secure the information that may be crucial to your advocacy strategies. But they don’t have a big impact on the one thing that elected officials worry about the most: votes. Knowing that a sizable number of voters (i.e., the grassroots) care about a bill can and does have a significant influence on a legislator’s voting decisions. That’s where PIAA can be of assistance.

Through our grassroots initiative, we can help you mobilize your colleagues, your insureds, even your family and friends, to contact key state elected officials. Based on your needs, we’ll establish an advocacy campaign aimed at achieving your specific goals. Collaborating with your company, we’ll put together a Web page that defines the issue for your stakeholders, helps them identify their elected officials, and even provides a prewritten e-mail that they can send to those legislators, all with just a few simple clicks. We can even set the page up to include your logo, so that everyone visiting the site will see it as your company’s initiative. All you need to do is distribute the PIAA-provided Web page link as far and wide as you choose, and then watch the e-mails start flowing to your elected officials. We’ve even got tracking tools that will let you see how many people are responding to your campaign, what actions they’ve taken, and which officials have been contacted.

To establish a grassroots campaign of your own, or to just find out more about how you can leverage this new tool, contact us at GovernmentRelations@piaa.us.

Model legislation
Looking for “different” legislation to propose to your state elected officials? PIAA has that covered for you as well. On our State Legislation Web page you will find model acts addressing important topics such as standards of care, apology protections, and so-called “phantom damages.” These model bills have been assembled through careful analysis of other legislative initiatives on these issues and reviewed by PIAA’s Government Relations Committee, to ensure that they won’t result in any unintended consequences. While all our model bills may need to be tailored to meet a specific state’s legislative drafting criteria, they can serve as a solid base for building an expanded state legislative agenda.

In the coming months, we’ll be analyzing the latest legislative trends to see if new issues are coming to the forefront in the states, and then determining if we need to add model legislation on those issues as well. In addition, we are always happy to help member companies in crafting any other new legislation they may be considering.

Conclusion
Whether or not the legislative logjam in Washington, D.C. eventually breaks, PIAA will continue to look for innovative ways to assist our members with their state advocacy efforts. We hope that you’ll find our new state legislative tracking and grassroots initiatives helpful, and that you’ll make them a significant addition to your own state advocacy programs.
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Every state has its own statute of limitations applicable to medical professional liability (MPL) actions that restricts the time by which a plaintiff must file a lawsuit. The deadline imposed provides certainty to potential defendant healthcare providers, as well as their insurance carriers, that after a set period of time, it is unlikely that they may be sued for allegedly negligent care rendered to a patient.

The New York statute of limitations for MPL cases, codified under Civil Practice Law and Rules (CPLR) §214-a, provides that “an action for medical, dental or podiatric malpractice must be commenced within two years and six months of the act, omission or failure complained of...” In other words, unless an exception, such as tolling, applies, a prospective plaintiff has 2.5 years from the date of care at issue to file a lawsuit against a defendant-physician. The current statute of limitations is based on the longstanding principle that a cause of action for negligence arises at the time of the alleged wrongdoing.

It appears likely, however, that the law in New York is about to undergo a substantial change due to an anticipated amendment to the statute of limitations that is awaiting the Governor’s signature. This amendment, now widely known as “Lavern’s Law,” will extend the limitations period for MPL cases involving a claimed failure to diagnose cancer.

Editor’s Note: The last issue’s Case and Comment discussed claims expiration periods/statutes of limitations in general; in this issue, the authors take a closer look at one state’s potential change as it relates to misdiagnosis of cancer.

Underlying facts
On February 2, 2010, Lavern Wilkinson, a then-38-year-old single mother of an autistic child, presented to the hospital and reported chest pain. A medical workup, including a chest x-ray, was performed to evaluate her complaint. The radiologist who interpreted the chest x-ray identified and reported a 2-cm mass in the right lung. However, the patient was never informed of this critical finding prior to her discharge from the hospital.

Wilkinson returned to the hospital in May 2012 for evaluation of a chronic cough, at which time she was diagnosed with lung cancer. During this admission, she was advised of the findings of the February 2010...
retroactive window for bringing cases that posed "discovery rule," but also a one-year period so that plaintiffs could revive old cases, the bill that finally passed did not include such a provision.

Although the bill has not been passed into law as of the writing of this article, it is expected to be signed by Governor Andrew Cuomo in the near future.

Impact of legislation
The extension of the statute of limitations in cancer cases under Lavern's Law will undoubtedly result in an increase in the number of such lawsuits being filed. A plaintiff, whose claim under the current law would be barred by the statute of limitations, would be able to argue under Lavern's Law that they only recently discovered that the malpractice had occurred. It has been suggested that the overall costs secondary to the proposed amendment will result in an approximate 10% to 15% increase in MPL insurance premiums. One hospital system estimated its own direct cost increase in MPL insurance premiums. One hospital system estimated its own direct cost would increase by $8 to $9 million per year.

With that said, a plaintiff will still have to prove that the alleged delay in diagnosis of the malignancy proximately caused a worse outcome. Given that the majority of cancers progress over time, some more virulent than others, the impact of the extension of the statute of limitations may be limited as it will be argued that the "reasonable person" should have known that malpractice may have occurred based on a progression of symptoms. However, there are indolent forms of cancer that do not cause symptoms early on and it is those plaintiffs' cases that may benefit.

Communicating Diagnostic Uncertainty

Diagnostic uncertainty is widespread in clinical practice, and guidelines generally recommend that doctors explain the degree of uncertainty associated with their diagnosis. However, how exactly doctors should communicate uncertainty is a matter of debate. This communication can possibly lower visit satisfaction, decrease adherence to doctor instructions, lessen trust, and decrease confidence in the doctor.

The researchers [at Baylor] surveyed parents of pediatric patients who hypothetically received a diagnosis with an element of uncertainty. The uncertainty in the diagnosis was communicated in one of three ways: either with an explicit expression of uncertainty (such as "I'm not sure which disease this is"), an implicit expression of uncertainty using broad differential diagnoses (such as "it could be this disease or this other disease") or another implicit expression of uncertainty (such as "it is most likely this disease").

Researchers found that explicit expressions of uncertainty were associated with lower perceived technical competence of the doctor, less trust and confidence, and less willingness to adhere to doctors' advice.

— Press release, Baylor College of Medicine, Houston
the most from the extension of the statute of limitations.

In addition to an increase in cases being filed, the litigation cost for each individual lawsuit will be higher. The question of when the plaintiff actually knew that the claimed malpractice occurred, and when the proverbial “reasonable person” should have known that it occurred, will be a costly issue to litigate. Given that this is often viewed as a factual issue to be decided by a jury, the entire case may have to be tried before the statute-of-limitations defense can be litigated.

It has also been argued that the bill’s drafting is ambiguous, and its language could be interpreted to extend the statute of limitations for non-cancer cases as well. Opponents of the bill have argued that these drafting errors can lead to years of costly litigation.

The new “discovery rule” for failure to diagnose cancer cases will result in lawsuits being brought up to seven years (or more where there is “continuous treatment”) after the treatment at issue was rendered. With the passage of time, memories of the events fade, witnesses become unavailable, and records are lost or destroyed. The move towards electronic records may minimize the potential for lost or discarded medical records, but ancillary evidence, such as older non-digital films or software programs used to interpret imaging, may not be available years later.

Given the potential for having to defend a case years later under Lavern’s Law—when it may be impossible to recall the rationale chosen for the course of treatment recommended—physicians should make sure that their contemporaneous documentation is sufficiently detailed to allow them to reconstruct their medical judgments years later. As New York State law only requires medical records to be maintained for six years from the last date of treatment, the claimed malpractice.

Footnotes
1. Although the statute of limitations in New York State is 2.5 years, this limitations period is shortened to 15 months for cases brought against municipal hospitals. See, New York General Municipal Law § 50-i.
2. New York is one of only six states that do not have a “discovery rule” by which the statute of limitations begins to run; the other states are Idaho, South Dakota, Minnesota, Maine, and Arkansas. 3. Bill A8516/S.6800.
4. Under New York’s “continuous treatment doctrine,” the current 2.5-year statute of limitations is tolled until the last date of treatment, provided that there has been continuous treatment for the same illness, injury, or condition which gave rise to the claimed malpractice.
6. Id.
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- Paralegal – “Wow, thank you.”

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In this article, we examine the A.M. Best financial strength ratings (FSR) as well as A.M. Best’s outlook for MPL specialty insurers. Recent history shows a generally upward trend in ratings, but also a more recent trend that has left an increasing number of MPL specialty insurers with a negative outlook. We explore the reasons behind these negative outlooks and what they may presage for the industry as a whole, going forward. At issue is the potential for an FSR downgrade, which, given the soft state of the MPL market, may result in lost business. (Note that we were only able to review high-level, publicly available financial data, as compiled by SNL Financial, for these MPL specialty companies and have not reviewed the companies in the same degree of detail as A.M. Best.)

Balance sheet strength results in rating upgrades
The profitability experienced by the industry since the mid-2000s, and the resulting strengthening of balance sheets, has not gone unnoticed by A.M. Best. As seen in Figure 1, an increasing number of MPL specialty companies have been receiving A ratings over the past five years. This is an expected outcome, given that A.M. Best’s definition of an FSR is: “an independent opinion of an insurer’s financial strength and...”

Has The MPL Specialty Industry Reached Its Peak in Financial Strength Ratings?

The medical professional liability (MPL) insurance industry as a whole has been riding a wave of positive results for the past decade. This run of profitability has led to strong balance sheets across much of the industry, specifically as measured by surplus and Best’s Capital Adequacy Ratio model (BCAR). As one might expect, these trends have led to generally higher ratings from A.M. Best across the MPL industry.
ability to meet its ongoing insurance policy and contract obligations. The surplus accumulated over the industry's long profitable stretch supports these changes.

**Rating increases give way to negative outlooks**

In more recent years, however, an increasing number of MPL specialty companies have been receiving negative outlooks from A.M. Best (Figure 2). This new trend prompts questions regarding whether MPL specialty companies have reached a peak in terms of FSR. It also begs the question, what about these companies, relative to the other MPL specialty companies, is driving the negative outlook? Milliman examined the financial information of approximately 40 MPL specialty companies rated by A.M. Best. We compared the companies that had received a negative outlook with all of the other companies, using several relevant metrics to assess the differences between these two cohorts.

**Why the negative outlooks?**

We first explored the changing balance sheets of these companies to determine whether significant deterioration had occurred. To measure this phenomenon, we collected the historical BCAR scores for each company and averaged them by group, as shown in Figure 3. While there has been some deterioration for the negative-outlook companies, the BCAR scores for them remain near 300. (Under this methodology, a BCAR score of 175 or more implies an A++ balance sheet strength.)

Second, we explored the geographic diversification of these MPL specialty insurers. In past years, A.M. Best has expressed some concerns about mono-line, mono-state companies, since their lack of diversification meant that a single legal, legislative, or other event could have an undue impact on the company. Since each of the companies we looked at is primarily a mono-line entity, we did investigate whether the MPL specialty companies that had received negative outlooks were also mono-state. However, the negative-outlook companies represented a wide range of geographic coverage, from writing in just one state to writing in all 50 states, so geographic diversification does not appear to be the driver of these negative outlooks.

The income statement, on the other hand, shows noticeable differences between these cohorts. Figures 4 and 5 display the operating ratio and combined ratio, respectively, over the last five years. These ratios are generally worse for the negative-outlook companies and are largely trending away from profitability. Interestingly, the gap between the cohorts is wider from an operating perspective. The implication here is this: not only are the negative-outlook companies performing worse from an underwriting standpoint; they are also lagging behind in investment income.

In addition, Figure 6 shows the one-year loss reserve development history, which has steadily deteriorated for the negative-outlook companies, declining from favorable development to adverse development. The remaining companies also appear to be trending in the wrong direction in recent years, but this group continues to produce favorable development on prior years.

**Strong balance sheets but weak income statements—recipe for a negative outlook**

As displayed in Figures 4 and 5, the income statement appears to be driving the negative outlooks for these MPL specialty companies. While we agree that these negative results will give rise to balance sheet deterioration, we believe that these potential rating decreases may be premature. As mentioned previously, the FSR is A.M. Best's opinion of an insurer's financial strength and ability to meet its ongoing obligations. It is not clear how long and under what accounting basis the insurer must be able to meet these obligations. However, given that A.M. Best performs annual reviews of its clients and the BCAR model itself relies...
on statutory data, one might assume that the obligations to be met might well be short- to medium-term on a run-off basis. Generally speaking, given the balance sheet strength of these companies relative to their poor income statements, their balance sheets will continue to look strong for many years.

This surmise is exacerbated to some extent by the fact that most observers highlight the fact that exposures are exiting the individual and small-group market and moving to coverage from captives or self-insurance instead. Although that challenge is a significant one for the MPL industry, from the perspective of a deteriorating income statement and its impact on the balance sheet, it simply means that fewer dollars of potential losses will be able to negatively impact the balance sheet. In other words, the impact of the income statement on the balance sheet, all else being equal, will decline as fewer exposures are insured.

What’s next?
If A.M. Best is truly focused on income statement strength, companies looking to maintain their rating will need to increase rates or reduce expenses. But if they do that, the companies may lose market share. On the other hand, they have such strong balance sheets that executives and company boards have multiple options for deploying their surplus. We would advise those decision makers to do what they believe is right: Run your own company. In the late 1990s, when A.M. Best had similar issues with MPL specialty companies, it recommended diversification of the insured portfolio, which for most companies meant writing business in more states. The MPL industry subsequently experienced a hard market: Many companies lost money, and that, ultimately, resulted in weaker balance sheets.

Finally, note that an additional wrinkle was added to this picture on October 13, 2017, when A.M. Best officially began to employ its new stochastic BCAR model and new Best’s Credit Rating Methodology (BCRM), which created a “building block” approach to ratings. The stated position from A.M. Best was that the new methodology included no change to the rating process, and that the intent of its use was simply to increase transparency. However, a number of companies were placed under review at that time for likely rating changes within the six-month period after the date of its release. It is unclear at this time what, if any, impact the new BCRM will have on the MPL specialty industry as a whole in the coming years, but the recent increase in negative outlooks remains a key issue for the industry and a pressure point for several companies in particular.

For related information, see www.milliman.com.

Footnotes
1. Best’s Credit Rating Methodology, draft, October 13, 2017, p. 46.
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Can Captive Insurance Help in a World of Disruptive Healthcare Innovation?

Are we moving toward “Star Trek” or “The Jetsons”? As a child of the 1970s, today’s technological advances seem to continually blur to images from my youth. The disruptive innovation that is dramatically influencing the delivery of healthcare has major implications in the area of risk.

While some risks are dramatically reduced, other risks can newly emerge or materially increase. These new risks can delay or even prevent the implementation of valuable new technology. Captive insurance companies are proven risk-financing tools that provide flexible and creative solutions for evolving risks, and they will continue to play a key role in the future.

Let’s start by defining the term, “disruptive innovation.” A disruptive innovation is a development that creates a new market and value network (customers, users, partners, stakeholders, suppliers, etc.), significantly unsettling an existing market and value network, and displacing established market-leading firms, products, and alliances. Disruptive innovation is nothing new. Consider the Erie Canal, lamplighters, or ice delivery men. New technology, namely trains, electric lights, and refrigerator-freezers made better products available, made entire industries obsolete, and caused a reallocation of whole segments of the workforce out of old industries into new ones.

The healthcare industry has seen similar seismic shifts. For example, imaging using x-rays, then magnetic resonance (MRI), then ultrasound, and in the near future, proton beams, have each built on the advances that came before and fundamentally changed healthcare. Similarly, advancements in laparoscopic surgery displaced many surgical procedures and not only improved treatments, but also dramatically reduced negative patient outcomes.

These innovations, and many others, led to substantial shifts in healthcare delivery and substantially disrupted existing systems. Rather than focusing on shorter-term healthcare insurance trends such as provider consolidation or cyber liability, I’ll focus on bigger, longer-term trends that are impacting healthcare risk.

Based on these examples and countless others, it is clear that disruptive innovation is nothing new. But as the rate of change increases, it challenges society’s ability to keep up. A 2013 study by researchers at the University of Oxford examined 702 detailed occupations to assess their susceptibility to computerization. The study found that about 47% of total U.S. employment is at high risk (greater than 70% chance) of computerization.

At first blush, many of the jobs deemed most likely to become obsolete make a lot of sense. Cashiers, motion picture projectionists, and telephone operators all seem destined to join the ranks of the ice delivery men and lamplighters sooner rather than later. The tasks involved are largely manual and repetitive.

A closer review of the list also shows that, in addition, insurance underwriters, medical records technicians, lab and pharmacy technicians, and receptionists are all at least 90% likely to find their work computerized. The reason is simple—these jobs are cognitively rote and are also easily computerized. Is the healthcare industry ready for a world with no medical records technicians and robotic lab techs and pharmacy techs? Are patients?

Disruption in healthcare: Risky robots?

So what are the next disruptive innovations that will change healthcare and healthcare delivery? Well, let me ask you this: How much time do you have? Following innovation websites, blogs, and social media provides a stunning, awe-inspiring, overwhelming, and somewhat terrifying array of new healthcare innovations. I’ll categorize some of the most interesting into broad categories: artificial intelligence (AI), robotics and 3-D printing, nanotechnology, and genetic engineering. All of these prospective innovations present not only amazing poten-
Enter: captives

What does all of this have to do with captives? For decades, captive insurance companies have consistently been able to: (1) insure health-care risks that the traditional insurance market was unwilling or unable to insure, and (2) reward entrepreneurial healthcare providers who effectively manage their own innovative risks. Captives were among the first to provide coverage for managed care organizations, allied health professionals with expanding roles, cyber liability, and numerous other coverages. Many high-risk specialties, such as cardiologists, obstetrics, bariatric surgeons, emergency medicine, and others, are extensively insured by captive insurance. When the use of locum tenens staff increased, captives were among the leaders in providing affordable premiums. Captives have also enabled providers to reap the benefits of reduced claims costs when they have implemented loss prevention and control tools such as physician apology programs and pre-procedure patient education initiatives. Today, healthcare providers using advanced medical technology sometimes have the opportunity to provide patients with warranties assuring the effectiveness of the technology through captive insurance programs.

As the size and risk-management sophistication of both hospital-owned and large physician group-owned captive insurance companies continue to grow, their risk appetite has shown no signs of abating. These captives are continuously evaluating their enterprise-wide risk profiles for new coverages that they can add to their rosters. In recent years, we have seen captive insurers add countless new and innovative risks such as infant kidney and ransom, spoilage of chemotherapy treatments, pre-paid countersuit of experts involved in frivolous claims, medical tourism exposures, and loss of income due to the breakdown of sophisticated medical equipment. These types of forward-thinking coverages highlight how nimble and entrepreneurial captive insurance can be. This will be essential as the pace of innovation continues to accelerate.

The future

All of these innovations only scratch the surface of what we could see in the coming decades. In his book, Homo Deus: A Brief History of Tomorrow, author Yuval Noah Harari suggests that famine, disease, and war are no longer worthy adversaries for humankind. He provides compelling evidence that these three issues the Homo sapiens species has fought against for millennia are under more control than at any point in human history. He goes on to suggest that the two new foes will be mortality and the search for happiness.

In fact, Harari posits that an individual with enough money and in good enough health by 2050 will live in an era when medical advancements will outpace the ongoing deterioration in the human body, allowing humans to strive for immortality. Others, including Dr. Aubrey De Grey, suggest that the first human to live to the age of 150 has already been born. Even in the age of Dubai’s autonomous air taxis (whose resemblance to George Jetson’s car is unnerving) and handheld devices that have most of the functions of “Star Trek” communicators and tricorders, captive insurance will continue to be an essential risk-financing tool. Beam me up Scotty, indeed.

Reference
Some risks are simply more complex

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- And many more!
As we closed 2017, we were in many respects on ground that was even less firm as compared with where we were one year prior, whether this relates to the continued debate over the future of the ACA, or if H.R. 1215 or subsequent tort reform measures will be instituted, or what the impact of continued mergers and acquisitions within the healthcare space will be going forward.

But there is one observation we can make with certainty: 2017 was a year that saw significant upticks in adverse (for the defense) medical professional liability (MPL) verdict activity.

As many readers are aware, as a reinsurer with a longstanding and significant presence within the MPL community in literally every jurisdiction, Transatlantic has a broad perspective when it comes to MPL verdict activity. What we saw in 2017 was an increase in adverse MPL verdicts, via basically every dynamic that we measure. From a gross statistical average of the 50 largest MPL verdicts in our repository, 2017 marked the third consecutive year in which average verdicts increased, and end-of-year statistics may show the second-highest average, as measured over the past 10 years.
Dissecting the data

Turning the data on its side and assessing specific “cuts,” which would eliminate potential skewing of “average” verdict size, what we saw was even more enlightening. Within the top 50 verdicts each year, we segment out where the tenth, twenty-fifth, and fiftieth largest verdicts are placed, as well as how many verdicts are coming at specific levels, such as XS of $10 million, XS of $25 million, and so on. In this fashion, one gets a different perspective, as compared with a gross statistical average.

A noteworthy observation: The PLAA membership certainly recognizes that MPL claim frequency has significantly diminished over the past 10 to 12 years or so, whether due to tort reform efforts or other variables. This has been one factor as far as the overall population of claims that are even available to try to verdict, but beyond that, generally speaking, feedback we have from within the MPL community seems to clearly point to the fact that we are seeing fewer and fewer MPL claims actually tried to verdict—yet the results below suggest “verdict severity” is something that cannot be ignored.

Recognizing that there is no one single source which captures all MPL verdict data, TransRe secures verdict information from multiple sources, including our own claims data, local and national verdict subscription services, national defense counsel contacts, as well as certain data from those individual states who specifically monitor MPL statistics, which can include verdicts. While some of these sources contain more results than others in a given territory, taken in totality, the pooled verdict data, year over year, consistently pulls from the same sources.

With that caveat in mind, here’s what we saw in 2017:

- By every measure (average verdict, verdicts above $25 million, verdicts above $10 million, tenth, twenty-fifth, and fiftieth largest)—2017 has seen a significant uptick in adverse MPL verdict activity.
- Over the 18 years the data has been tracked, 2017 has set a record for awards of more than $10 million, and has tied the record for verdicts of more than $25 million.
- 2017 was the third consecutive year that verdicts of more than $10 million have increased, and that total is more than double the number we saw in 2014.
- We saw seven MPL verdicts of $40 million or greater in 2017, whereas we saw only eight such verdicts over the past three years, combined.
The past year was the third consecutive year in which the number of verdicts of more than $25 million increased and in 2017, there were more than three times the number of verdicts of more than $25 million than there were in 2014.

Looking at this via a "cross section" (10th/25th/50th largest verdicts), we set a record in 2017 for where the twentieth largest came in ($6.8M, only the fourth year of the past 18 where twentieth largest was at least $6 million)

2017 also tied the 18-year record for twenty-fifth largest ($15 million, from back in 2003)

We saw the second highest result for the tenth largest, at $28.9 million, just barely inside of $30 million, which was posted in 2004.

Why is this happening?
What is the cause of this phenomenon, and what can be done by the PIAA base to turn the tide? There are no simple solutions; however, we can make some observations and then provide our best guidance on what can be done.

First, no longer can we assume that historically conservative venues will continue to be "defense-friendly" going forward. Indeed, we have seen numerous "record" verdicts being returned in such venues, even if those verdicts may not have achieved national attention.

Second, now is the time for the defense community to revisit its historically embedded positions when it comes to how "damages" are defended. This goes far beyond what has been generally characterized as "ACA" arguments and gets specifically to strategies focused on "reasonable valuation" of damages as well as "anchoring" of damage assessments. The long-held belief that "we don't want to set a floor for the jury" and/or "it will signal that we are conceding liability" is one that we are continually seeing as in need of reconsideration.

Third, there must be some form of coordination of effort to make accountable the exorbitant life-care plans that we see and that often exceed the mid-eight figure range, if not even higher. Part of this may involve the "damages" strategies mentioned above, but beyond that, we need to put our respective heads together to rein in what has largely become a runaway train with respect to life-care plans.

Refining our strategies
In addition, we need greater coordination and refinement of our defense strategies, not just within the PIAA community, but more important, with those outside of PIAA as well, whether these entities are hospitals, risk retention groups, or "commercial" insurers, who typically have major areas of policy limits exposed.

As a reinsurer that touches all corners of the industry, we are encouraged that we see some truly innovative and cutting-edge ideas being developed. Unfortunately, all too often we don't see the level of collaboration that would advance these ideas for the benefit of all.

Too often, we are seeing a lack of cohesive defenses, if not outright adversarial relationships across defendants and counsel. This serves no purpose; it merely plays into the hands of the plaintiff's bar.

The homework
With that, we all have our assignment, as it were, and if there is going to be meaningful improvement in MPL results for the industry as a whole, there is no better place to start than with PIAA.

What TransRe pledges to do: act as a conduit, wherever possible, to facilitate meaningful discussion within and amongst all segments of the MPL arena and to promote collaborative efforts aimed at improving MPL results.
The promise of a better tomorrow through predictive analytics related to underwriting or developing algorithms to help insurers improve their marketing prowess is now a focus of the executive suite, in much the same way that the decision to adopt a mainframe computing system was during the original technology revolution. Then, as is true today, the decision to invest in new technology required a flexible workforce that could lead the implementation of data storage, system conversions, and training around the new way of doing business.

As leaders face the challenge of an evolving workforce, it can be tough to understand what the next generation of change will bring to the insurance community. Historically, the landscape of insurance company personnel has been dominated by actuarial, accounting, and distribution talent that helps sell, price, predict, and measure all things related to the business. While these professions will remain cornerstones of insurance companies, there is an emerging need within the insurance profession to develop data scientists and “master orchestrators.” But it

Capturing Efficiency, Profitability, and Predictability Through Big Data

By John Roberts

In a modern world of rapidly evolving technology and constant innovation, we often hear that using “big data” helps companies become more effective, efficient, and profitable, while at the same time reducing volatility and increasing predictability.

John Roberts is Managing Partner–Client Services, Dixon Hughes Goodman LLP.
would be inappropriate to make a statement like this without providing a framework outlining what these jobs actually entail.

In recent Forbes articles, definitions of a “data scientist” have continued to evolve, but they all tend to include words like “sexy” and the “hottest job” in the marketplace. In reality, most common definitions, including those in Forbes, specify characteristics that describe a savvy mathematician with product-development acumen who is an inquisitive detective with an engineering or programming mindset. This skill set helps him identify trends in data that tell the emerging story of a business. For instance, we can learn not just the frequency with which a mistake in surgery happens, but in addition, the most common day of the week, the time of day, and geographic areas where it occurs. We can dig deeper to determine whether it occurs with specific types of patients, equipment, or lighting. We can dig even further to determine if the types of gloves worn, the number of assistants in the room, the manufacturer of the dressing for the wound, or the time spent in recovery had any statistical significance.

If all of this sounds a bit far-fetched, consider the other data we can potentially obtain: Was the surgeon right-handed or left-handed, what color eyes did she have, what was her height, did she drink coffee that morning, how long before the procedure did she arrive at the facility, and how many hours of rest did she get the night before? While you might think that the answers would be tough to find, a simple search of a driver’s license record, a quick scan of banking receipts, an upload of Fitbit activity, and the use of an access badge would give us almost everything we need to know.

Identifying the useful data

As you can see, there is an unlimited amount of data we could collect. The question we must ask ourselves is whether or not that data is useful to our understanding of the business. The issue we must tackle is whether or not our own personal bias would rule out some of the data as being unnecessary. This is why data scientists must be detectives. They must be allowed to troll the data, identify trends, and present findings that may at first seem irrelevant but might in fact lead to breakthroughs in risk mitigation, best practices, or even underwriting exclusions. Many of us may dismiss some of these characteristics, but when we are allowed to explore freely, the scientific logic of discovery can lead to answers that might otherwise remain buried in the nuances of the data.

To facilitate the cultivation of data in a manner in which it can be understood, many entities should consider finding what Forbes terms “a master orchestrator.” These are people who draw meaning from large data sets and, based on that, create action plans. They may review the data set in the above example and find that right-handed surgeons have a higher failure rate than left-handed ones. They may also conclude that a surgeon shorter than 5 feet 6 inches has a greater risk of a mistake in the procedure. Then, after combining the two populations, they may note that petite, right-handed surgeons are struggling with the procedure.

A true master orchestrator then prepares a plan of action. He might use the data provided by the data scientist to recommend changes such as lowering the surgical bed to a height of 32 inches for surgeons less than 5 feet 6 inches tall and requesting that the surgical-instrument manufacturers make smaller handles for petite, right-handed surgeons.

And then, the hard part...

This is where the hard part comes in for these unique individuals. Once a path is set, they must return the evaluation to the data scientists to remeasure, reevaluate, and reassess the success of the solution. Did they miss something in the data? Was another common link overlooked? Could LED lighting be the real issue, or have they in fact made a statistically significant improvement in the process? It is this relentlessly pursuit of culling out data that does not impact processes or outcomes, while searching for new sources of data that can reveal new discoveries that leads to continual improvements in the understanding of business operations and processes.

The simple fact is that data exists to help us achieve a deeper understanding and develop improved outcomes for ourselves and our customers, while also improving safety and profitability. If we continue to rely on the traditional hires of the past, we will fail to cultivate data appropriately. Just as choosing to ignore technological change has rendered the taxi industry obsolete, so here we must invest in understanding our data through these new professional groups, to ensure our survival.

If not, competitors may find information that gives them a competitive advantage or a meaningful relationship that drastically improves their profitability or, even worse, might threaten your customer base or long-term ability to compete. Just as there were for the early adopters of mainframes, there will be challenges. Some of the investment will not yield the efficiencies we dream of, and ultimately some of the people we hire will not be as valuable as we had hoped.

Yet, unless we make the investment and experiment with information we do have and the data we can cultivate, we will be missing out on the next evolution of what an industry leader will in fact require. Welcome to the new age of data and to the day when data scientists and master orchestrators are much more than just one part of your information technology department; instead, they are a critical component of your management team and your decision-making process as well.
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Medical Liability and Sepsis: Accelerating Interventions with Predictive Analytics and Prescriptive Alerts

BY SEAN BENSON

The speed at which sepsis is diagnosed, and appropriate treatment initiated, can make the difference between a rapid, uneventful recovery and a lengthy stay in the critical care unit (CCU), resulting in lifelong side-effects—and even death. The margin for error in terms of time-to-diagnosis is razor-thin; each hour that passes without treatment increases the likelihood of death from sepsis by 8%. However, several factors hinder clinicians’ efforts to make that rapid diagnosis. First, the initial symptoms mimic several common illnesses. There are also challenges in aggregating and analyzing siloed data to identify at-risk patients and then with communicating actionable recommendations to the frontline clinicians.

Together, these issues make it clear why sepsis has been a frequent target of medical professional liability (MPL) claims, many resulting in multi-million-dollar judgments and settlements for patients whose lives have been forever altered—or taken—by this physically, emotionally, and financially devastating condition. Among the most recent is the award of more than $20 million to the family of a Minnesota woman who died of sepsis less than a week after giving birth. The jury sided with the family, who claimed that an emergency room nurse practitioner ignored the lab results that pointed to sepsis. Less than 12 hours after she was sent home, the woman returned to the hospital and succumbed to sepsis a short time later. In another case, a $32 million settlement was awarded to an 8-year-old girl who underwent a quadruple amputation...
sepsis “sniffer” algorithm (SSA), a predictive analytics tool developed at WOlters Kluwer (POC Advisor®), has scientifically demonstrated its ability to reduce sepsis-associated mortality, length-of-stay, and 30-day readmissions.

Technology and sepsis

The nature of sepsis and the challenges it presents make it a prime target for a technological intervention. In fact, in its report “Untapped Opportunities for Saving Millions,” The Advisory Board recommended preventing treatment delays by embedding screening tools into the triage process and simplifying the complex sepsis protocol into a four-step bundle.

This has led to a growing interest among hospitals and health systems in third-party solutions designed to aid in the early detection and treatment of sepsis through real-time screening and alerting, and by making it easier for providers to track and improve internal compliance. According to KLAS Research, approximately 20% of healthcare organizations interviewed for its 2017 sepsis surveillance report were utilizing third-party sepsis solutions.

Yet, not all of these offerings are created equally. For sepsis, solutions that achieve both high sensitivity (minimizing missed cases of true sepsis) and specificity (minimizing false positive alerts) will have the greatest impact on outcomes, alert fatigue, and user attrition. It’s a difficult balance to achieve, due in part to the use of the systemic inflammatory response syndrome (SIRS) criteria to identify sepsis cases. This results in far more false-positive than true-positive alerts, because they are present in many hospitalized patients, including those who never develop the condition.

When SIRS criteria are the primary factors in triggering alerts for potentially septic patients, the system will have high sensitivity but poor specificity, resulting in many false alerts. One study, published in the American Journal of Respiratory Critical Care Medicine, found that a typical system has 95% sensitivity but specificity of only 15%. With specificity that low, if 1,000 patients had a sepsis incidence rate of 10%, a false alert would be fired for 765 of the 900 patients who actually did not have sepsis.

Striking the balance: what works in practice

Most sepsis solutions have delivered results that are marginal at best, due to difficulty delivering both high sensitivity and specificity. But not all have failed to achieve meaningful and measurable outcomes. For instance, a sepsis “sniffer” algorithm (SSA), a predictive analytics tool developed at the Mayo Clinic, has been useful in helping clinicians identify high-risk patients more quickly and accurately than manual methodologies. See: Sepsis “Sniffer” Brings Predictive Analytics to Patient Safety https://healthitanalytics.com/news/sepsis-sniffer-brings-predictive-analytics-to-patient-safety.

POC Advisor is another tool, which has been able to drive significant reductions in mortality. This was demonstrated in a peer-reviewed study published in 2016 in the Journal of the American Medical Informatics Association (JAMIA), in which POC Advisor achieved sensitivity and specificity rates of 95% and 82%, respectively, resulting in a 53% reduction in sepsis mortality and a 30% decline in sepsis-related 30-day readmissions.

The JAMIA study highlighted the experience with POC Advisor at Huntsville Hospital in Alabama. There, the platform leveraged existing electronic health record (EHR) technology and patient data that was aggregated and normalized from disparate clinical systems. A predictive algorithm then ran the data against several hundred patient-specific sepsis rules that were coupled with the latest medical evidence and recommended treatment advice. The prescriptive rules engine accounted for comorbidities, medication abnormalities, and chronic diseases. Lab and vital sign values were also adjusted, based on the specific patient population.

If sepsis was indicated, three separate alerts were sent to clinicians’ mobile devices and clinical portals. The diagnosis alert identifies cases of SIRS, sepsis, severe sepsis, severe sepsis with hypotension, and septic shock. Treatment advice alerts are designed to account for comorbidities and medications based on the latest medical advice and the guidance issued by the Institute for Healthcare Improvement. Reminder alerts ensure that clinicians “close the loop” and acknowledge the signal by either accepting or dismissing the alert.

More recently, POC Advisor has been deployed at Halifax Health, where it has been integrated with the health system’s EHR, existing sepsis screening tool, and Vocera communication system. It’s an approach that allows for accelerated diagnoses, more precise alerts, and more timely delivery of actionable, evidence-based recommendations to clinicians at the point of care.

At Halifax Health, POC Advisor leverages an HL7 interface to continuously aggregate and analyze real-time data from the existing EHR and to integrate with the Vocera badges worn by nurses throughout the hospital, including the emergency department (ED), where most cases of sepsis first present. This broad interoperability enables the platform to aggregate and analyze EHR data, account for lab abnormalities created by co-morbidities, adjust the analysis as appropriate, and fire patient-specific alerts to the ED nurses’ badges—all in less than 60 seconds.

Ultimately, POC Advisor provides one solution to the challenges of firing alerts the right time, in the right place, to the right provider, and with the right information. Doing so accelerates diagnosis and treatment, reducing sepsis severity and mortality rates, while also mitigating the risk of MPL claims.

For related information, see www.pocadvisor.com.
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Commitment Beyond Numbers
Analyzing the Current Status of the Reinsurance Market: What Does It Mean for MPL Writers?

The reinsurance market is integral to the operations of organizations that operate in the medical professional liability (MPL) space.

Inside Medical Liability recently sat down with brokers from Guy Carpenter to discuss some of the key issues and events that are having an impact on the global reinsurance market and, by extension, affecting the cost and availability of cover for MPL writers.

It is important to note that much of the discussion pertains to 2017 property/catastrophe (P/C) events and their broad effect on all reinsurance lines of business across the globe. While not specific to MPL, the events of 2017 were highly significant for multiline reinsurers of MPL who write other products, and hence there is a potential crossover impact. However, more restrictive pricing and higher charges for coverage expansion in the MPL reinsurance sector are not necessarily singularly tied to the P/C losses of 2017.

Inside Medical Liability: In light of the recent catastrophes, notably hurricanes Harvey, Irma, and Maria, the Mexico earthquake and California wild fires, what was the impact on the reinsurance market?

Guy Carpenter: Swiss Re’s sigma research offers a preliminary estimate of global catastrophe insured losses of approximately $136 billion for 2017, the third highest on record behind 2005 and 2011. The United States was hit hardest by Hurricanes Harvey, Irma, and Maria, which contributed to making 2017 the second costliest U.S. hurricane season on record after 2005 (Hurricanes Katrina, Rita, and Wilma). The three category 4+ hurricanes generated all but roughly 30.0% of the 2017 insured loss, with current estimates indicating reinsurers will absorb close to half this amount. Reinsurers, in turn, transferred approximately $20 to $25 billion on to their retrocessionaires (reinsurance purchased by reinsurers to protect their net risk/loss). Guy Carpenter’s current 2017 catastrophe loss estimate, reflecting recent decreases in public estimates and excluding National Flood Insurance Plan losses, which do not notably impact reinsurance capital levels or pricing, is closer to $111 billion. Whether the true number is closer to $136 billion or $111 billion, 2017 generated a substantial amount of catastrophe loss that largely halted the continued decline in reinsurance pricing.

For the nine months ending September 30, 2017, reinsurers in the Guy Carpenter Global Reinsurance Composite (a representa-
Reinsurance pricing?

Were the events of 2017 severe enough to finally bring about a “tipping point” in reinsurance pricing?

While 2017 was a challenging year for catastrophe business, by nature this line can have significant volatility, and weighted average ROAE over the past 10 years, including 2017, is still 8.1%, despite the inclusion of two of the three costliest catastrophe years on record.

Were the events of 2017 severe enough to finally bring about a “tipping point” in reinsurance pricing?

At the January 1, 2018 renewal, reinsurers did not obtain the large, wholesale upturn in pricing that some sought. Retrocession covers, programs with unattractive margins and loss-affected accounts saw pricing increase, but pricing shifts were focused and tailored. Accounts that were not impacted by losses typically saw only modest price increases, with renewals flat to up 5% on a risk-adjusted basis. Whether this is seen as a tipping point is debatable if you consider that the reinsurance rate declines of the last several years ended.

For many years, experts who closely track reinsurance financial capital of all types have been wondering what amount of catastrophic loss to the reinsurance market would prompt some level of reinsurance market disruption and higher prices. Were the events of 2017 enough to do it? At this time, the answer appears to be “no.” The extraordinary levels of excess financial capital at work in the global reinsurance sector have long been considered the cause of “oversupply” market dynamics that are pressuring reinsurer margins.

Some observers see the reinsurance industry evolving toward one with fewer radical price swings. For example, Kevin O’Donnell, President and CEO, Renaissance Re, made such comments in the November 13, 2017 edition of Reinsurance News. What is your assessment?

GC: Historically, significant market pricing corrections have been driven by two things: an imbalance in supply and demand and a change in the perception of risk.

Neither of these factors is currently present to any significant degree, and it is unlikely that the industry will see dramatic price swings in the future without a measurable decrease in supply or a significant increase in demand.

The development of the 2017 losses did not differ dramatically from what reinsurers had been pricing for, although there are likely to be local impacts; the high loss total was driven more by the accumulation of events rather than a very large, unexpected loss.

However, casualty and other underperforming business is no longer being supported by good property catastrophe results, so reinsurers must focus on how to write this business on its own. This, more than any lack of capacity, led to some general firming of prices. While reinsurers point to “expected” returns that are reaching unacceptable levels, actual returns have been fairly good, even with the 2017 results.

In the wake of a catastrophic 2017, reinsurance costs rose for those insurers who incurred significant loss and in turn ceded significant losses to the reinsurance markets. But there are many more insurance companies whose reinsurance costs did not rise at all at January 1, 2018. Reinsurance renewals were widely described as “orderly”; in most instances where reinsurance rate increases happened there were clear justifications for this, and did not happen if a particular insurer’s risk profile and loss experience were unaffected by events in 2017.

What is the current capital status of the P/C reinsurance sector?

GC: Guy Carpenter’s reinsurance composite saw a modest capital decline of 3% for the first nine months of 2017, which is expected to hold true for the full year as well. Industrywide, some companies experienced decreases in capital as losses, dividends, and share buybacks exceeded earnings, while others continued to report modest growth. Guy Carpenter’s estimate of dedicated reinsurance capital from traditional sources, completed in conjunction with A.M. Best Company at year-end 2017, is approximately $427 billion, up 2% from 2016. While traditional capital is flat, convergent capital grew by 9% to $82 billion, after replacing lost or trapped capital. Guy Carpenter and A.M. Best’s estimate is calculated using A.M. Best’s proprietary capital model (BCAR) results as well as line of business allocations. Reinsurance capital through 2018 is expected to be flat (Figure 3).

The reinsurance industry’s capitalization has long been considered strong and even excessive. That perspective persists. For the
last several years, A.M. Best has assigned a negative outlook to the reinsurance sector and continues to do so, but not because it believes the quantity or quality of reinsurance capital is in question. In fact, quite the opposite. A.M. Best and many other experts think there is significant pressure on reinsurer margins and profits due to soft pricing sustained by excess capital levels, and despite the current plateau there is no strong evidence of this changing in the foreseeable future.

**IML**: Will reinsurers cut back on the exposures they choose to reinsure?

**GC**: While some reinsurers cut back on exposures, notably flood, most kept to their business profile and continued to provide reinsurance coverage in line with previous years. Market capacity in place seems sufficient to allow companies that are willing and able to fill any voids and do so quickly. For example, as respects MPL specifically at July 1, 2017 and for renewals at January 1, 2018, some reinsurers cut back their appetite for MPL risk. However, other reinsurers viewed this as an opportunity to get on accounts they found attractive, taking advantage of the timing. Also of note, many MPL insurance companies offered their balance sheet strength and capacity as reinsurance for other smaller MPL insurers as an expansion strategy, particularly in the risk retention group niche. In some instances, this offered capacity, in the form of reinsurance, was very significant. In short, while reinsurers exercised greater caution in deploying capital at January 1, there was no indication they would cease supporting the sector.

**IML**: What role has the participation of alternative capital played in the dynamics of the reinsurance market? Has it served as a buffer against the impact of the year’s catastrophes?

**GC**: In recent years, reinsurers have increased their use of retrocession. This can be seen in cession rates and the higher growth in gross premiums as compared with net premiums (Figure 4). It also shows up in the reduction in reported probable maximum losses over the last few years. Retrocession has most certainly acted as a buffer for 2017 losses, with current estimates indicating that retrocession markets absorbed about half of reinsurers’ losses. The majority of retrocession cover was provided by the alternative markets.

There is no question that the level of alternative capital coming into the reinsurance sector over the last decade has been significant. It is now a major element in the reinsurance market and a contributing factor to the over-abundance of reinsurance capital mentioned earlier. Most experts agree that this form of capital performed well in the catastrophe environment of 2017, especially in the retrocession market, and responded nicely to the niche areas it targets as a diversification strategy to other investments. It is expected that this form of capital will remain an integral part of (re)insurers’ risk management strategies.

**IML**: Have most buyers resigned themselves to the fact of upcoming price increases—along with some tightening of terms and conditions?

**GC**: In general, buyers have resigned themselves to the fact that reinsurance pricing has bottomed out, with modest price increases expected in 2018. But 2019 could go either way, modestly up or down, depending on final 2017 loss adjustment, new events, or other factors.

It is a given that PIAA companies and other specialty MPL insurers are not engaged in property catastrophe insurance in the primary market. However, all of the reinsurers that have become familiar to PIAA reinsurance buyers over the years are very much...
engaged in supporting risks and perils that go far beyond stand-alone MPL risks. Therefore, significant events to the broader market can impact MPL reinsurers. However, price tightening and a slowing of coverage enhancements in the MPL sector are not necessarily tied to the catastrophic property events of 2017. Reinsurance pricing for MPL business, and the coverage enhancements offered, have encouraged a buyers’ market for years. Reinsurers are trying to stop that trend.

Many buyers of MPL reinsurance will not experience reinsurance price increases, but some will, and generally there is a good rationale supporting this. Hospital professional liability loss experience has been especially severe in some areas, and we are seeing reinsurance price increases in these instances.

There were also examples of attempts to add specific coverage enhancements to MPL reinsurance placements, at no added cost, at January 1, 2018. The reinsurance market often declined such initiatives, suggesting for the first time in many years that there must be an added charge for these types of coverage enhancements. Systemic risk coverage would be one such example; cyber risk, another.

**IML:** How should MPL writers optimally engage in the reinsurance market in light of these developments?

**GC:** A prospective cedent’s data quality is a very significant factor when trying to quantify or justify a particular reinsurance goal. In those instances at January 1, 2018 where we achieved a reduction in reinsurance cost, we were able to do so because our client’s data could be used to clearly show a decreased severity or frequency trend to a reinsurance cover and/or perhaps a significant reduction in exposure of the profile of the book of business to be reinsured. The case for a reinsurance price reduction was “provable.”

However, this does not mean the desired result will come easily, if at all. Therefore, price decreases and free enhancements to coverage will not be the “norm.” Also, depending on any one particular reinsurer’s response to a reinsurance placement, MPL entities may need to come to terms with the potential that there could be a turnover in their panel of reinsurers; some established reinsurers may come off the placement, with some new ones coming on.

For example, assume a company decides to embark on a new or renewed initiative to insure hospitals, and the reinsurance placement must accommodate this business. Such a program will receive heightened scrutiny from the reinsurance market. Everything from the qualifications and experience of the underwriter to marketing strategies, rate filings, experience rating plans, use of credits, capacity needs, covered jurisdictions, policy forms, and coverages offered will be intensely reviewed by reinsurers. The case for a reinsurance price reduction was “provable.”

However, this does not mean the desired result will come easily, if at all. Therefore, price decreases and free enhancements to coverage will not be the “norm.” Also, depending on any one particular reinsurer’s response to a reinsurance placement, MPL entities may need to come to terms with the potential that there could be a turnover in their panel of reinsurers; some established reinsurers may come off the placement, with some new ones coming on.

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The connection between doctors who are not coping in the workplace and poor patient outcomes has long been identified. The Australian Health Practitioner Regulatory Agency (AHPRA) requires that health practitioners, their employers, and training providers notify the agency when they reasonably believe the conduct of a health practitioner places the public at risk of substantial harm because of an impairment (health issue). Fear of this “big stick” approach can add to the stress and anxiety felt by a doctor who is not coping and who may feel professionally isolated.

Barriers to a doctor’s seeking professional help can be:

- **Personality based.** Traits such as stoicism, self-sacrificing, dedication, and limited experience with personal failure can inhibit openness.
- **Systemic.** Poor organizational structures for supporting doctors who are unwell, no budgets for managing personal leave and allowing for backfill, concerns about gossip and lack of confidentiality in seeking help, competition for training spots encouraging an “always available” and “no complaints” attitude where stress or anxiety is not normalized.

The positive news is that there is a focus on doctors’ health at a national level.

**Support from MIGA**

There is also good support being offered at a local grassroots level. MIGA is an Australian medical defense organization established by doctors, for doctors, more than 117 years ago. Apart from providing professional indemnity insurance, advice, and legal support in the event of a claim for compensation or a disciplinary matter, MIGA has a strong focus on preventative risk management education. The education program raises awareness among the doctor members about the areas of medico-legal vulnerability and provides strategies for managing the risk of an adverse outcome for the patient and for the doctor. The personal health risks of doctors comprise...
a recent area of focus for MIGA, recognising that:

■ Poor practitioner health can be a contributing factor to patient outcomes

■ Broader education within the profession can help to build a more supportive environment, encourage individuals to seek help earlier, and promote ways doctors can appropriately manage their health.

There is mounting evidence that a significant number of doctors don’t have their own general practitioner or family physician, with common barriers such as embarrassment, fear of notification, and confidentiality contributing to self-investigation and self-treatment.

MIGA has developed the following tools for doctors:

■ Interactive small-group workshops on the topic “Caring for our Colleagues.” This workshop helps doctors, through case studies and role play, to identify the warning signs that a colleague is not coping. Strategies for addressing the issue and assisting the impaired doctor are also covered in the workshop.

■ A Doctors’ Health Assessment. Guidelines and resources have been developed to assist a doctor in initiating a comprehensive health assessment with a family physician or with a health clinic that is dedicated and trained in the nuances of treating health professionals.

■ A Doctors’ Health eBook that contains video case studies, tips, resources, and links to support agencies that can be shared within the medical community.

■ The MIGA Practitioners’ Support Service, which provides a doctor, who is caught up in litigation, a coronial investigation, or disciplinary proceedings, access to support from peers and other professionals on a confidential basis.

Doctors who complete the Risk Management Program each year receive a premium discount in the next policy year. Doctors who attend a Workshop and undertake a Doctors’ Health assessment will complete the Program and qualify for the discount.

Information on these resources can be found in the Education section of the MIGA website at www.miga.com.au.

Footnotes
3. BeyondBlue—Doctors’ Mental Health Program established following the 2013 report into the national mental health of doctors; Australian Medical Association (AMA) National Forum on reducing the risk of suicide in the medical profession (14 September 2017); Australian Doctors’ Health Conference (ADHC) 15 September 2017.
4. The Australasian Doctors’ Health Network (ADHN) provides contact information on the doctors’ health advisory services in each state of Australia. Doctor-only health clinics are available in some States, such as Doctors’ Health SA (DHSA) in South Australia.
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Professional indemnity for doctors originated at the end of the nineteenth century in the U.K., when medics realized that they were operating in an increasingly difficult professional environment. They had to deal with accusations of medical professional liability (MPL) by patients. In the 1880s, a number of high-profile negligence and criminal cases made headlines, and it soon became clear that medical professionals needed proper representation and support when facing patients’ allegations.

**2017 PIAA International Conference, London**

“Change and Disruption: Strategies for Managing the Evolution of Medical Liability”

Professional indemnity for doctors is now a global concern, but it was fitting that PIAA held its International Conference in London this year to discuss the MPL issues currently facing the healthcare sector. Not only is the City of London the birthplace of modern professional indemnity; it is also at the center of the insurance and reinsurance industry.

Joint hosts for the event, October 4-6, 2017, were the Medical Defence Union (MDU) and the Medical Protection Society (MPS). The MDU is the world’s oldest mutual defense organization, which has been providing doctors with medico-legal advice and indemnity since 1885. MPS, the world’s leading protection organization, was founded in 1892 and now supports more than 300,000 professional interests of members in the U.K. and overseas.

Attendees from around the world gathered at the Grange St. Paul’s Hotel, right in the heart of the City of London, to exchange ideas and hear expert insights from speakers in the MPL insurance, healthcare, and technology sectors. The title of this year’s conference was “Change and Disruption: Strategies for Managing the Evolution of Medical Liability,” a highly relevant theme in the context of the challenges that healthcare systems face worldwide.

**Welcome address**

In his welcome address, PIAA Chair Dr. Richard Anderson summed up the spirit and purpose of the event: “The PIAA Conference is a unique event for the global medical professional liability community and the sharing of knowledge and information is key to our success.”

The conference’s first session addressed new paradigms in medicine and MPL, with two speakers discussing areas of change and continuity in patient safety and liability insurance.

The keynote speaker was Derek Feeley, President and CEO of the Institute for Healthcare Improvement, an independent, not-for-profit organization that explores inventive ways to improve the health of individuals and populations. Speaking on the theme of “New Horizons for Safety and Quality,” he considered five promising trends in healthcare improvement, including positive and proactive ways of thinking about patient safety, prioritizing systems improvement rather than piecemeal interventions, and an emphasis on nurturing a safety culture rather than a blame culture.

He was followed by William Stancil (Stan) Starnes, JD, Esq.,...
Chairman and CEO of ProAssurance Corporation. Starnes considered some of the global trends in MPL around the world, from the U.K. government’s scheme for employed doctors to the no-fault compensation systems in countries such as France, New Zealand, and Sweden. However, he concluded that political realities make it unlikely that the U.S. will adopt a government-sanctioned and funded compensation system.

Dr. Rhona Mahony, Master of National Maternity Hospital in Dublin, Ireland, spoke on the nationalization of clinical risk in Ireland. The cost of clinical negligence in Ireland was €1.6 billion in 2016; Dr. Mahony further explained that “claims in Ireland are at an all-time high and morale is at an all-time low.” Maternity services were the subject of the highest number of clinical claims by the State Claims Agency in 2014.

James Rakow, of Actuarial and Advanced Analytics in Deloitte’s London office, discussed the economic costs of catastrophic injuries. In the U.K., the personal injury discount rate (PIDR or “Ogden rate”) recently changed from 2.5% to -0.75%—a decision that substantially increased the cost of settling large clinical negligence claims. The medical defense organisations in the U.K. have been unanimously vocal about the impact of this change to the PIDR, as it poses a real risk to the cost of clinical negligence, which may now become unsustainable for the healthcare sector.

The second-day sessions

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Dr. Kevin Fong, a Consultant Anaesthetist who has also worked with NASA’s human space flight program in Houston, spoke about understanding risk and learning from error. His NASA experience allows him to draw interesting parallels between the ways that different types of industry sectors—aviation and healthcare—approach risk management. Under the title, “Life, Death and Mistakes,” Dr. Fong examined teamwork and decision-making under extreme pressure, with reference to two events: the 1986 Challenger disaster and subsequent investigation and what happened with U.S. Airways Flight 1549, when the pilot averted catastrophe by making a forced landing in the Hudson River. For Dr. Fong, a key difference was that the flight crew were fully prepared to take control of decision-making in an emergency situation. By contrast, repeated concerns had been expressed about the component that caused the NASA tragedy, but they were not taken seriously by mission leaders.

The conference also heard how solutions can be engineered to address known patient safety risks. Dr. Maryanne Mariyaselvam, a Clinical Research Fellow at Queen Elizabeth Hospital, Kings Lynn and Cambridge University, spoke about the fascinating work she and her colleagues have been doing to make medical devices safer by design, while still practical and convenient for doctors to use.

The parallel sessions, under the rubrics of “Professional” and “Commercial” tracks, complemented the conference plenary talks. The “Professional” track featured discussions about emerging models of care, the benefits and potential risks of technology in healthcare, and the purpose of compensation, which contrasted the theory with the reality of escalating litigation. Attendees heard about the different experiences of the U.K., where compensation costs continue to rise at an unsustainable rate, and, in contrast, in Australia, where claims and litigation are down by 60% 15 years after the Australian government introduced tort reforms. The “Commercial” track covered a range of topics, from data security risks to the application of big data in investment and reinsurance strategies.

By the end of the two-day conference, feedback on the conference from attendees was very positive. Many also attended the social programs to network and enjoyed a unique evening event at St. Paul’s Cathedral in the heart of the City.

Conclusions
Concluding the event, in light of the commonalities noted in the sessions, the chief executives of MDU and MPS shared their reflections.

MDU Chief Executive, Dr. Christine Tomkins, concluded the conference stating:
Our self-interest lies in having healthcare governance systems and accountability systems that are fair and appropriate. It lies in taking care of our healthcare professionals and in defending the defensible. If we don’t do these things, access to healthcare will suffer. It’s our PIAA mission to ensure access to high-quality, reliable healthcare, and meetings like this one, which bring us together from 24 different countries to share ideas, is a great way to help us all make that happen.

MPS Chief Executive, Simon Kayll, said:
The fantastic collection of speakers at the PIAA conference contributed to our understanding of the medico-legal climate that exists in other parts of the world, and how we can emulate changes that led to a better healthcare outcome for both professionals and patients alike. MPS’s experience in serving members around the world has shown that while there are differences in how jurisdictions work, the issues facing healthcare professionals are similar.

Left to right: Dr. Richard Anderson, PIAA Chair and Chairman and CEO, The Doctors Company; Brian Atchinson, President, PIAA; Christine Tomkins, Chief Executive, MDU; and Simon Kayll, Chief Executive, MPS.
If every physician has good reason to worry about a lawsuit, emergency physicians have particular cause for feeling vulnerable. At least 75% of them will be cited in a medical professional liability (MPL) lawsuit at some point in their career. The percentage rises to a staggering 95% if they stay at work until they’re 65.

Emergency room providers and surgeons are in a comparable position vis-à-vis claims. For those surgeons who have weathered an active lawsuit in the prior two years, it is 1.64 times more likely that they will consider suicide in a later year. And those who contemplate suicide are in fact 3.4 times more likely to report a self-perceived medical error.

In fact, emergency physicians, much like surgeons, must work within what they perceive as “a culture that, like it or not, honors self-denial, prizes impervious resilience, and tends to interpret imperfection as failure” (Archives of Surgery, 2011, volume 146, p. 62-63).

So what are emergency physicians to do? What might seem like the most fruitful response would be to rigorously analyze existing claims to identify the most frequent risk factors linked with claims, and do what can be done to minimize these factors. In a go-with article, published in same issue of Annals of Emergency Medicine as the piece by Dr. Sachs, A. Venkat et al. report on their work in attempting to moderate the negative climate within which emergency physicians must practice by decreasing the risk of MPL claims.

Prior work on this issue has been compromised by methodological weaknesses. For example, using a series of claims cases, studies were limited to the variables in the numerator—cases with lawsuits—and failed to include the denominator—all of the patients treated during the time and location that has generated the cases.

In contrast, the Venkat study uses data from both numerator and denominator, thus allowing differentiation of the factors that were associated with higher risk from the compilation of all emergency department encounters.

Venkat et al. focused on a lengthy roster of MPL risk factors that has been identified by previous researchers. They included years in prac-
But only two of these factors were found to have a statistical association with the risk of a lawsuit: increased patient volume and number of years in clinical practice. While some studies have suggested that physician behavior may be at work in increasing risk, this study renders that notion moot.

So what’s the next best move for mitigating risk? One option might be to examine more variables, such as handoffs and volume of tests ordered, on larger data sets.

But maybe what’s called for is a whole new line of investigation. Instead of looking for ever-more provider and practice factors, it may be that the variables most predictive of claims are linked with patient plaintiff lawyer combinations, or the characteristics of the plaintiffs’ attorney within a given geographic area, as it does with the physicians located there.

There may also be associations with, for example, the amount of a medical bill that a patient is responsible for, the type of health insurance coverage of the patient, and the number, and years of experience, of local attorneys who take on MPL cases.

And what if the demographics of the patients turned out to have a significant influence on the probability of claims? The likely consequence of that finding would be a sense of animosity, which would quite possibly have a negative impact on physicians’ relationships with their patients.

“The most important information learned from the formative research by Venkat et al. on malpractice risk,” says Dr. Sachs, “is that it’s a crapshoot.”

She adds, “We know that physicians who treat more patients are slightly more likely to be sued than colleagues who consistently treat fewer patients over the years.” The simple arithmetic here is that if a doctor practices a sufficient number of years, he will be sued.

The good news is that becoming the subject of a suit does not mean that the provider is a bad physician. Further, Dr. Sachs says, “Continued exploration into provider factors associated with lawsuits merely reinforces our own extreme self-blame and perfectionist ideals.”

Dr. Sachs advises, “It is time that we teach the truth about this to our students, residents, and fellow emergency physicians. We need to cease pretending that a specific course, degree, or charting tip will prevent lawsuits.”

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Fed Tightening Cycles and Their Impact on Treasury Rates

By Peter Cramer, CFA

The Federal Reserve recently completed its third rate hike of 2017 and is committed to further tightening over the course of 2018. As discussed in our previous article (Inside Medical Liability, Fourth Quarter 2017, p. 61), it is very important to monitor this shift from easing to tightening given the magnitude of the stimulus that is being removed.

For this article, however, we will focus on the anatomy of past Fed tightening cycles, and attempt to identify any similarities that could be used to forecast how the current cycle will play out.

One important fact to keep in mind when analyzing rising rate environments is that a higher fed funds target rate does not necessarily imply higher rates across the curve. This is because central banks can only directly control short-term interest rates; long-term rates are influenced by their own unique set of factors that do not always coincide with the movement of short-term rates. Occasionally, the two will unexpectedly diverge, a phenomenon that Alan Greenspan referred to as “a conundrum,” and his successor, Ben Bernanke, blamed on “a global savings glut.”

For evidence of this fact, let us consider the three most recent Fed hiking cycles in the U.S. As illustrated in Table 1, while all three cycles saw the Fed Funds rate rise by an average of 300 basis points (bps), the impact on longer rates was more muted, with 2-year and 10-year rates rising by 192 bps and 67 bps, respectively.

In the first hiking cycle, which spanned from January 1994 until February 1995, the 10-year Treasury rate increased by roughly half of the amount of the front-end rates. During the next cycle, from June 1999 until June 2000, the 10-year Treasury rate moved by just 40 bps (and soon after, in early 2001, fell well below its starting level as the Dot–Com bubble began to burst). And finally, during the hiking cycle that preceded the Great Recession, the 10-year Treasury rate was unchanged.

An important observation regarding the table is that during all three hiking cycles, the yield curve materially flattened. The yield curve is an important indicator, as it reflects

<table>
<thead>
<tr>
<th>Cycle</th>
<th>Change in Rate (Basis Points - bps)</th>
<th>2/10th Curve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fed Funds</td>
<td>2-year Treasury</td>
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<tr>
<td>1994-1995</td>
<td>300</td>
<td>265</td>
</tr>
<tr>
<td>2004-2006</td>
<td>425</td>
<td>215</td>
</tr>
<tr>
<td>Average</td>
<td>300</td>
<td>192</td>
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<tr>
<td>Current</td>
<td>125</td>
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Table 1. Fed Hiking Cycles

Peter Cramer, CFA, is an Investment Strategist with Prime Advisors, Inc.
where markets expect Fed policy to head. In theory, the Treasury curve should simply be the chained average of expected future overnight Treasury rates, since the “risk free” U.S. Government poses no greater threat of default in 10 years than it does today. But long-term rates also include a “term premium,” which compensates investors for locking their money away over long time horizons. A large portion of this term premium is compensation for inflation risk. This is because, as inflation increases, bondholders’ returns are reduced, and they are unable to redeploy that money into the rising short-term rates that inflation typically provokes.

A flatter yield curve is somewhat to be expected over the course of a hiking cycle. This is because the Fed typically raises rates in response to high levels of inflation, with the goal of cooling the economy and slowing price appreciation. If they are successful, and inflation begins to fall, the term premium embedded into long-term rates also moves lower, resulting in a flatter yield curve. A flattening yield curve is, therefore, not particularly surprising; as it is, in many ways, a direct result of the Fed’s actions.

What is alarming, however, is when the curve inverts—meaning that longer rates fall below shorter rates. An inverted Treasury curve can be a bad omen for the economy, as it has occurred just before each of the past seven recessions. Since the curve inverted in each of the two most recent cycles, any signs that the curve is heading closer to inversion in the current cycle should be closely monitored.

Armed with the knowledge from this analysis of past Fed hiking cycles, we can now examine how rates have moved, thus far, in the current cycle (Figure 1), and can see if we identify any similarities.-

As the graph demonstrates, short-term rates have increased in response to the higher Fed funds rate, while long-term rates remain unchanged. The 10-year Treasury rate has increased by a mere 20 bps, while the 30-year Treasury rate is actually 20 bps lower than it was when the Fed started hiking rates. This has resulted in a much flatter curve where the spread between 10-year and 2-year Treasury rates has fallen to a post-recession low of 60 bps. Putting all this together, we can see that the current cycle bears some resemblance to the two most recent hiking cycles of 1999–2000 and 2004–2006. Since both cycles led to an inverted yield curve, and ultimately recessions, it’s worth exploring what’s behind the flattening of the curve in the current hiking cycle.

Much of the flattening in today’s yield curve can be explained by falling inflation. Even though unemployment has dropped to 4.1%, wage inflation remains stubbornly low, with Average Hourly Earnings showing growth of just 2.5%. The 10-year breakeven inflation rate has fallen to 1.90%, from a high of 2% at the beginning of 2017. The Fed’s preferred measure, Core PCE Inflation, is running at a mere 1.3%, and has consistently undershot its target of 2%. Heightened expectations for the passage of tax reform into law could also offer some explanation for the flatter curve. Tax cuts can provide a short-term boost to the economy, but are unlikely to trigger a long-term boost to inflation that would drive long-dated yields higher.

As the Fed continues to express confidence that inflation will return to its target once the multitude of temporary factors are removed, the markets appear to be losing confidence in the Fed’s ability to raise rates without driving inflation even lower. The impending change in leadership at the Fed, from Yellen to Powell, could precipitate a shift away from a focus on theory-driven approaches to inflation and put more emphasis on realized inflation data and indicators. It is therefore critical to monitor the pace of inflation, which is likely to dictate the future path of Treasury rates. Continued weakness in inflation could lead to further curve flattening, and possibly even curve inversion, which would increase the odds that a recession is lurking, in the not-too-distant future.™

Figure 1. Current Hiking Cycle

| Rate (bps) | 1M | 6M | 1Y | 2Y | 3Y | 5Y | 10Y | 20Y | 30Y
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<tbody>
<tr>
<td>2015</td>
<td>1.5</td>
<td>1.0</td>
<td>2.5</td>
<td>3.0</td>
<td>3.5</td>
<td>4.0</td>
<td>4.5</td>
<td>5.0</td>
<td>5.5</td>
</tr>
<tr>
<td>2017</td>
<td>0.5</td>
<td>0.5</td>
<td>1.0</td>
<td>1.5</td>
<td>2.0</td>
<td>2.5</td>
<td>3.0</td>
<td>3.5</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Source: Bloomberg. Date: 12/15/2017

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TRUCKERS HAVE WORK LIMITS—SHOULD MEDICAL RESIDENTS?

How long should a first-year medical resident work during a single shift? This is an age-old, hotly debated question in healthcare and in medical education circles as well. It can seem as if this issue will never be resolved. Worse, it's just becoming more contentious.

Last July, the Accreditation Council for Graduate Medical Education (ACGME)—the professional body charged with overseeing physician training in the U.S.—eliminated the 16-hour limit on work shifts for first-year resident physicians (interns) that it had itself implemented in 2011. Instead, the new rules extended residents' shifts to 28 hours—which mirror those in place for second- and third-year doctors.

This is the latest development in a longtime effort by the medical profession to balance the need for rigorous education with the possibility of a bad outcome as a result of patient care that is provided by inexperienced, and potentially sleep-deprived, physicians—clearly an unenviable task.

According to Thomas J. Nasca, ACGME chief executive, the goal is to “improve the coordination of clinical care by the interns and residents in the teaching environment.”

ACGME leaders have the backing of other key players in the medical community. Some surgeons had been critical of the 16-hour limits, saying that there have been occasions when interns were forced to leave the surgical team during an operation to avoid breaking the rules. In addition, some physicians point out that the limits have compromised patient care by increasing the required number of handoffs, as each intern’s shift ends sooner.

But I’m not sure that lengthening the maximum number of working hours will improve the situation. Truck drivers, pilots, and flight attendants can work only so many hours because there are safety issues involved. Should student doctors, who are already under stress, work for a full 24 hours without restrictions?

Admittedly, first-year physicians do not perform solo surgeries, but they do interact with patients, take vital signs, and give medications. These situations require them to be at their best, both mentally and physically. Maybe the answer is to revert to the previous shift limitations and, at the same time, increase the overall duration of residencies.

This may not be the best solution. But, given the potential that an alleged error by an exhausted intern could be the driver for a medical liability claim, it may be time for the MPL community to weigh in on this discussion.

Eric R. Anderson is Vice President of Marketing and Communications at PIAA; eanderson@piaa.us.
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