Battling Mega-Verdicts

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With each passing year, we seem to have a whole new paradigm for medical professional liability (MPL). For everyone working in the MPL industry, prediction of new trends, of any sort, has become a daunting task. What you thought you knew in the past, and felt at least reasonably sure of, just doesn’t seem to necessarily apply anymore.

So-called “black swan events” aren’t quite so uncommon anymore. They’ve become more prevalent, though just as unpredictable in terms of both degree and timing. Similarly, what were once outliers have now, in many instances, entered the mainstream of news about property/casualty (non-life) insurance, and more specifically our line of business.

So what does this change mean for those of us working in MPL? What specific challenges do we face, and how can we best equip ourselves to cope with them?

This issue of Inside Medical Liability identifies a wide array of challenges. Consider one such predicament: many of the awards in verdicts in today’s MPL trials show a dispiriting lack of correlation between the actual damages suffered and the large amounts awarded. How does this come about?

There is a puzzling and inverse relationship between improvements in medicine, achieved through the application of evidence-based advancements in science and technology, and increasing liability. Changes in expectations may lie at the root of this phenomenon. For example, people now expect that everything will be perfect in the outcome of the labor and delivery of preterm infants—irrespective of what their individual risk factors, and self-care during pregnancy, may actually be. But as we know, medicine is not a perfect science. Despite the many advances in the field of obstetrics and the remarkable dedication of healthcare professionals, outcomes are not 100% predictable.

Additionally, people (jurors, in this instance) have become inured to the disproportional amounts earned by Wall Street titans, professional athletes, and entertainers. The authors of the article on runaway verdicts offer some useful insights about what may, in fact, be happening. They note that, “living the lifestyle of the rich and famous used to be just a dream. Now, though, through real-time videos of celebrities on private jets to selfies of movie stars with million-dollar sports cars, social media allows people, especially millennials, to experience what it’s like not having to worry about money.”

An article on page 26 surveys the full range of the financial issues now confronting MPL insurers. There is still considerable good news, and healthy results to be positive about. But there are other statistics, like the flat to declining premium rate trends, that give one pause for thought.

Five years ago, the winds of the healthcare and the MPL landscape were commonly perceived to be blowing in one direction. Now, those perceptions have changed. In every aspect of the business, including the clinical side, the market side, the insurance side, the financial side, one comes to realize that what you had presumed might not, at this point, be a solid basis for future decisions and planning.

So you can never stand pat in MPL, clinging to sound judgments of a mere half decade ago. Instead, you need to keep an eye closely focused on the shifting landscape. You need to be prepared to react to changing circumstances. And to the extent humanly possible, you need to be prescient about what may lie ahead.

In light of this new environment, some MPL insurers are giving fresh consideration to their risk appetite, to take account of the changes they may not have been able to see coming. In fact, every risk-bearing organization needs to make this sort of recalibration an ongoing practice. And every organization needs to bear in mind that what may have once been a well-founded given may not be sustained in 2019 and beyond.
“The outcome has been the infiltration of the “Rockstar” mindset into the jury box. Jurors are now conditioned to seeing million-dollar jackpot winners, celebrity assets, and CEO compensation on a daily basis.”

— Cover story
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## Events & Calendar

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
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<tbody>
<tr>
<td></td>
<td>4:00–5:00 p.m.</td>
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<td>Noted security expert Tom Patterson will leverage his decades fighting cyber criminals and foreign spies to take attendees on an insider’s tour through today’s cyber threats against the financial industry, giving a face to our enemies, and laying bare their sources and methods. This highly interactive presentation, Mr. Patterson will tell inside stories of current real world attacks that have made news headlines, dispel myths and misperceptions, and encourage active discussions on how, why, and what’s happening, and who is really behind it all. Armed with this information, he will then illuminate both mistakes and successes of industry peers, and highlight three specific keys to defense in this time of highly disruptive cyber attacks.</td>
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<tr>
<td>2019 MPL Association Conference—Concurrent Session</td>
<td>Friday, May 17</td>
<td>InterContinental Mark Hopkins, San Francisco, CA</td>
<td>MPL Implications of Precision Medicine</td>
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<td></td>
<td>10:45 a.m.–Noon</td>
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<td>With genetic and personalized therapies becoming more widely available, today's healthcare providers can become overwhelmed and challenged by the expectations of an ever-expanding knowledge base. Consider: does every healthcare professional breach the standard of care by not testing for all potential genetic biomarkers? Will this trend propel the next tidal wave of litigation? The “23 and me” consumerism mentality is taking off, and patients are going to begin approaching their healthcare providers with questions about genetic testing. MPL insurers must be prepared to provide the necessary clinician and patient education, best practices, policies, and protocols to deal with this potential exposure.</td>
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### Coming Attractions

- **February 27, 2019**
  - Webinar
- **March 13-16, 2019**
  - CEO/COO Meeting
    - Hyatt Regency at Gainey Ranch Scottsdale, AZ
- **March 14-16, 2019**
  - Board Governance Roundtable
    - Hyatt Regency at Gainey Ranch Scottsdale, AZ
- **April 3-5, 2019**
  - Marketing Workshop
    - Kimpton EPIC Hotel Miami, FL
- **April 5-9, 2019**
  - Dental Workshop
    - Kimpton EPIC Hotel Miami, FL
- **May 14, 2019**
  - Chief Medical Officer Roundtable (by invitation)
    - Marriott Portland Waterfront Portland, OR
- **May 15, 2019**
  - Leadership Forum
    - Marriott Portland Waterfront Portland, OR
- **May 15-17, 2019**
  - MPL Association Conference
    - Marriott Portland Waterfront Portland, OR
- **June 26, 2019**
  - Webinar
- **August 28, 2019**
  - Webinar
- **September 9-11, 2019**
  - Underwriting Workshop
    - InterContinental Mark Hopkins San Francisco, CA
- **September 11, 2019**
  - Chief Medical Officer Roundtable (by invitation)
    - InterContinental Mark Hopkins San Francisco, CA
- **September 11, 2019**
  - International Risk Management Seminar
    - InterContinental Mark Hopkins San Francisco, CA
- **September 11-13, 2019**
  - Claims and Risk Management/Patient Safety Workshop
    - InterContinental Mark Hopkins San Francisco, CA
- **September 25-27, 2019**
  - Technology, Human Resources, and Finance (THRF) Workshop
    - Fairmont Chicago Millennium Park Chicago, IL
- **October 24-25, 2019**
  - Corporate Counsel Workshop
    - The Mission Inn Hotel Riverside, CA
- **November 20, 2019**
  - Webinar
- **Future Conferences**
  - MPL Association Conference
    - May 6-8, 2020
      - Omni Shoreham Hotel Washington, D.C.
  - MPL Association International Conference
    - October 7-9, 2020
      - Ottawa, Canada
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Call and get to know us today.
The acquisition of GreatCall by Best Buy signals a few important things. First, we have another retail player entering health. Best Buy’s Geek Squad represents a great customer experience. Just wait until they outfit your home à la GreatCall, enabling aging in place. At ATA, [the American Telemedicine Association] we know the exam room of the future will be your home, thanks to the broad support of telehealth. “

So says Ann Mond Johnson, CEO of the ATA, with an inspiring vision of a bright new future wherein no one over 65 ever need leave the house. And what, exactly, is GreatCall? First, the new user selects a dedicated phone, from options that include the cutting-edge Jitterbug flip phone. Then, he chooses from a list of services; these include “daily health tips,” a “med coach,” and a daily “wellness call.”

The motivation for healthcare professionals to use GreatCall? According to the GreatCall website: “Expand your portfolio and market share. Accelerate your innovation strategy. Increase market access through innovative, scalable technology that drives down cost of care and creates positive member experiences.”

Can there be anyone whose days would be darkened by the demise of the fax machine? These machines, in fact, are very complicated pieces of equipment with delicate sensors, motors, and finely calibrated moving parts. All of which seem to serve the singular purpose of causing infuriating problems such as paper jams and unaccounted for major splotches in the received pages.

So there was little cause for mourning when the U.K.’s NHS was ordered to stop buying fax machines. Commented Rebecca McIntyre, a cognitive behavioral therapist, “Using fax machines makes it difficult to ensure that a patient’s information is actually sent to the right place.” She added, “We constantly receive faxes meant for other places in error, but this is never reported.”

The rationale for the ongoing presence of the fax, in the digital age, has been legal requirements. Only certain kinds of signatures can be accepted over e-mail. But the fax has been a legally valid method of sending a signed document.

Unambiguously backing the NHS’s decision to consign the fax to the wasteland of technological history, Richard Kerr, chair of the Royal College of Surgeons’ Commission on the Future of Surgery, noted, “Most other organizations scrapped fax machines in the early 2000s, and it is high time the NHS caught up.”

Brave New World Dept.—New Role in Medicine for Geek Squad (per Best Buy)

“...the acquisition of GreatCall by Best Buy signals a few important things. First, we have another retail player entering health. Best Buy’s Geek Squad represents a great customer experience. Just wait until they outfit your home à la GreatCall, enabling aging in place. At ATA, [the American Telemedicine Association] we know the exam room of the future will be your home, thanks to the broad support of telehealth.”

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The article title alone was singularly arresting: “Jaw-dropping, eye-popping malpractice suits in 2018,” as featured on the website mdlinx.com. Okay—that sounds like something of a challenge, doesn’t it? So let’s see what happens when you consider these cases.

First, there was the infamous surgeon who posted videos of herself dancing during operations. But that one was widely circulated. Also notable were these:

- The patient who sued a hospital for reviving her. Julie Sams, author of numerous spiritualist books, sues Santa Fe, NM, hospital Christus St. Vincent Regional Medical Center, asserting that the staff had revived her, despite her double “do not resuscitate” order, after she went into cardiac arrest during a visit in 2016.
- A patient who claimed that he was sent home from Providence St. Vincent Medical Center, Portland, Oregon, because he was too large to fit inside an MRI scanner has filed a $7 million lawsuit for medical negligence.
- Woman sues doctor who’s her secret sperm donor father. It would seem prudent to stop right there.

It’s the Beginning of a Year: Time for Those ‘Best of’ and ‘Worst of’ Lists

Or just plain outrageous

Okay, sure, the original pitch was for Christmas cash. But Presidents Day, and the myriad of opportunities for thoughtful gift giving that will soon be linked with it, is surely a happy occasion to avail yourself of this excellent resource for sure-fire funds.

Legal-Bay LLC tells us that, “If you have an active lawsuit and need legal funding, Legal-Bay may be able to help. Their pre-settlement funding programs are not a lawsuit loan or lawsuit loans as many clients may think. Funds do not have to be paid back if the case is lost.”

Adding, for everyone who may have encountered some pesky shortages around Christmas time, Legal-Bay noted that “We are happy to help answer the question, ‘How can I get some extra cash for the Christmas season?’”

The company points out that while motor vehicle accident cases “are typically approved within 24 hours,” similarly rapid-fire approval times are typical with slip-and-fall and (no real surprise here) MPL.

But thank heaven for Google, which brought us to the legal site, nolo.com. There we discover the disheartening truth: “The interest rates on lawsuit loans run between 27% and 60% a year—that are comparable to payday loans. On a $25,000 loan, the interest can cost you $12,500 or more in just one year.”

Source: Legal-Bay LLC, press release
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Of the 83,887 closed claims and lawsuits reported to the Data Sharing Project (DSP) between 2008 and 2017, 22% cited diagnostic error as the primary allegation.

- **Closed Claims**: 18,404
- **Paid Claims**: 5,897
- **Avg Indemnity**: $407K
- **Avg ALAE**: $53K

Average Indemnity Paid for Specialties with the Highest Number of Closed Claims:

- **Radiology**: $395,707
- **Internal Medicine**: $446,110
- **Family Medicine**: $366,366
- **Emergency Medicine**: $372,134
- **Ob/Gyn Surgery**: $525,172
- **General Surgery**: $433,497
- **Pediatrics**: $486,081
- **Orthopedic Surgery**: $401,871
- **Pathology**: $321,933
- **Neurology**: $511,610

Severity of Injury by Paid Claims:

- Death: 34%
- Severe: 32%
- Moderate: 25%
- Mild: 9%

Resolution by Closed Claims:

- Dropped, Withdrawn, or Dismissed: 61%
- Verdict-Defendant: 6%
- Verdict-Plaintiff: 1%
- ADR/Contract: 2%
- Settled: 29%
- Unknown: 1%

Contact for more information:
P. Divya Parikh, Vice President of Research & Education
dparikh@MPLassocation.org

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While there is no one right way to buy a new system, most likely you will go through most, if not all, of the following steps, whether you replace the entire enterprise system or just some of its modules.

Request for information (RFI)
The RFI is a usually brief three- or four-page questionnaire, designed with two purposes in mind:
- To gather cost information so that the project can be budgeted. License and maintenance costs can be obtained with reasonable accuracy, but the cost of the work needed to implement the software will generally be provided only as an estimate.
- To select the vendors that will receive your request for proposal (see below). It is easier to eliminate contenders than to select one that will be the best fit. The RFI should weed out those that do not offer the functionality required; that do not have the size, ownership, stability, experience, reputation, or the resources appropriate to work successfully as a long-term business partner; or have other issues that would eliminate them.

Request for proposal (RFP)
The RFP is sent to the vendors selected after an analysis of the information gathered during the RFI phase.

The functionality requested in the RFP is determined not only by current business needs, but also by the business plans within the company. Compared with the existing legacy software, a new system should be able to offer far more in terms of business functions—work-flow management, security, automated handling of business events, reporting, ease of maintainability, etc.

The RFI usually consists of narrative questions on technology, experience, costs, contracts, project management, and other matters, accompanied by a detailed functional checklist with answers about each function required in categories such as:
- **Supported out of the box.** This means that the function is inherent in the system and is available immediately after installation.
- **Supported after configuration.** Because the practices of insurance carriers can vary considerably depending on the lines of business they write, the distribution channels they use, how premium is calculated, the language on policy forms, and more, vendors generally provide a means to control the behavior of the software by configuration—that is, by altering the “settings” in the system to suit what is needed. Having most functions controlled in this way provides flexibility, and so it is usually considered beneficial.
- **Software changes needed.** This response is generally unfavorable, because it means that new programming work will be needed to make the function available. That will be costly and risky, and it may complicate your ability to receive new releases of the software in the future.
- **Not supported.** Unlike “software changes needed,” this implies a requirement that is well outside the scope and functionality of the vendor’s system, or is in an area that, for strategic or other reasons, he does not want to address. For example, if a vendor does not support multiple currencies, he would probably think that adding them to the system would not be something that he could propose in an implementation project. If the need is critical, it may be possible to find another vendor who can provide a solution to this need, and then integrate that within the new system.

Evaluate RFP responses
Based on the information gained from the RFPs it may be possible to eliminate some ven-
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dors—but not necessarily. Because the RFI should have whittled away those with a poor fit, it is likely that there will be pros and cons for each of the remaining vendors—but not enough to rule any of them definitively in or out.

So the next step is to request demonstrations of the software. This is an important, but time-consuming, element in due diligence. If possible, no more than three or four vendors would be invited. More than that may just result in too much choice, and lead to confusion.

**Arrange demonstrations**
The vendors should, ideally, present their systems on site, but remote demos would also be acceptable. Allow about four hours per demo, and no more than one per day.

The demos should be arranged within a short time of each other, so the comparative merits and issues presented in each will be fresh in the minds of the attendees when they are asked to rank the vendors. An evaluation sheet should be provided to the attendees, so they can focus on specific areas of the presentations. There may also be questions specific to each company that have arisen from the review of their RFPs—areas of particular interest or in instances where the information provided was not clear.

As well as what happens with day-to-day transactions, the demo should include some system administration functions like changing a rate table or a code in a drop-down.

**Select the best fit**
There is likely no one vendor that is ideal in every respect. Users may imagine some mix of what’s best from among everything they’ve seen, but that just doesn’t exist. Instead, the process of selection is based on choosing which of the systems presented is the best fit for the company. Since it is easier to rule out products than to rule them in, this is usually a process of elimination.

**Have an implementation assessment performed by the best-fit vendor**
The selected vendor should come on site to assess the company’s requirements; these are then used to develop a statement of work, and this will be attached to a contract for implementation services. A cost would also be provided, one that matches the scope of the work described. This type of engagement is generally billable, and it will take a few days on site, plus two or three weeks, to assimilate the information and draft the statement of work. This should be done before the company commits to the new software—it is a great tool for evaluating the vendor’s knowledge and overall approach to the job, before you make what is going to be a major commitment.

The report may also offer some alternative approaches to some requirements and may discuss a phased approach that is designed to bring some portion of the value of the new system to the company, as soon as possible. The report will need to be reviewed carefully to make sure that, on day one after cutover, at a minimum, the software will provide everything needed to keep the business operating.

**Contract negotiations**
There are three or four types of contracts that are usually associated with a new enterprise system:

- **License.** This describes the company’s rights and permitted use of the software. Licenses may be acquired via a one-time transaction, or they may be renewed annually. Areas of negotiation typically concern what would happen if the vendor discontinued support or went out of business, and whether license-fee payments are staged so as to be paid upon completion of certain deliveries and milestones. The license should also clearly define how additional license fees may be triggered in the future as the business changes.
- **A maintenance and support agreement.** This covers the services that are provided on a day-to-day basis to support the software—how defects are addressed, response times to issues, whether upgrades and new releases are provided, etc.
- **Implementation services agreement.** This will be the product of the analysis that was described previously. Typically, projects that involve the installation of an enterprise system last from six months to several years, in the case of large and complex implementations. The statement of work will be the critical piece of this agreement—the legal contract is generally designed to obligate the vendor to perform the work and for the licensee to pay for work done, based on some defined criteria that measure progress. A timeline and a high-level project plan should be included. The contract will also address the company’s obligations to provide a contact person for the duration of the project.
- **Hosting agreement.** If the vendor provides a hosting option, there may be a separate agreement that defines the terms and conditions including uptime, disaster recovery, back-ups, communications between the hosting site and the client, etc.

Bear in mind that the company is not simply buying shrink-wrapped software, so there will be some negotiation with all or most of these contracts.

At this point implementation can start, and the fun begins. These projects are a major undertaking in any company, because they will affect the efficiency of the business for years to come, and key staff have to find time to participate in them, in addition to their ongoing responsibilities.

The importance of the time and effort spent on the selection process cannot be overemphasized.
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As we kick off the new year, we find ourselves once again in the midst of a political environment that has changed substantially. Congressional Democrats scored huge victories on election night, not only recapturing control of the House of Representatives for the first time in nearly a decade, but also securing a solid 35-seat majority in the process. But their successes weren't limited to the southern side of Capitol Hill. Democrats scored significant victories on the state level as well, substantially altering the policy-making landscape in several states. The 2018 elections were not a total loss for Republicans, however. The Grand Old Party saw its numbers increase in the U.S. Senate, giving Majority Leader Mitch McConnell (R-KY) more flexibility in setting the policy agenda for that chamber. But what does all this mean for public policy going forward, especially as it relates to medical professional liability issues?

**Congress**

Obviously, the change in leadership in the House of Representatives means a significant change in that body’s agenda. While federal tort reforms passed the House during the previous Congress, any thoughts of moving similar legislation in the 116th ended on November 6. Despite the demonstrated benefits of medical liability reforms, including stabilized insurance markets, reduced healthcare costs, and increased access to healthcare, House Democratic leaders, including Speaker Nancy Pelosi (D-CA) and Majority Leader Steny Hoyer (D-MD), remain staunchly opposed to any federal tort reforms. In addition, the days of conservative “Blue Dog” Democrats bucking their party's leadership are also over, since they now make up only a small fraction of the party and they are not as ideologically different from the leadership as their predecessors were a decade ago. Thus, there is no realistic path forward for tort reform in the House.

Things are equally bleak in the U.S. Senate, where, despite the fact that political control of the chamber did not change, tort reform has no better prospects than it does in the House. Most notably, due to the retirement of Senate Finance Committee Chairman Orrin Hatch (R-UT), a series of dominoes fell whose end result was that Senator Lindsey Graham (R-SC) has assumed the helm as chair of the Judiciary Committee, which has jurisdiction over all matters related to the courts. Senator Graham, who was an attorney before beginning his political career, has been a long-time friend of the personal injury bar, and he will most certainly not allow tort reforms to move forward on his watch.

Does this mean that all hope is lost for 2019? Certainly not. It is important to remember that passing federal legislation is a long-term process, and major changes can occur in legislative bodies every two years. While tort reforms per se are off the table, it may be possible to pursue variations of reform (including incentive-based programs to encourage states to adopt more reforms or reforms that are narrowly applied to specific circumstances, such as the interstate provision of telemedicine).

While these concepts are highly unlikely to be included in legislation that passes during the 116th Congress, advocating for them now could lay the groundwork for success in future Congresses, when the political environment inevitably changes once again.

In addition, bipartisanship isn't completely out of the question, no matter how tumultuous the environment in Washington, D.C., appears to be. We had tremendous success in the House of Representatives last year with the Good Samaritan Health Professionals Act, and given that this legislation has no partisan opposition, it may be possible to expand on that success in the near term.
LEGISLATIVE UPDATE

States
Just like the federal government, several states saw significant changes in their partisan makeup. Democrats captured six legislative chambers last November, and lost only one. When combined with their pickup of six governorships (compared with only one for Republicans), a total of four additional states are now completely under control of the Democrats. So, starting in the beginning of 2019, Democrats have had complete governing control of 14 states, while Republicans control 22. Of the remaining 13 (Nebraska has a nonpartisan, unicameral legislature), eight states have a Republican legislature and Democratic governor, four have a Democratic legislature and Republican governor, and one (Minnesota) has a split legislature and a Democratic governor.

It’s hard to say at this point what this will mean in terms of government activity as it affects the MPL industry. What we do know, however, is that some activity is already well under way. As of this writing (in early January), we’ve already seen legislation introduced on expert witness reforms, judgment interest rates, and multiple bills requiring accuracy in the calculation of medical damages (so-called “phantom damages” legislation).

In South Carolina, the MPL Association is already working with multiple member companies to address pending legislation that would dramatically increase the burden on MPL insurers required to sustain the insolvent Joint Underwriting Association. The MPL Association is similarly engaged in Pennsylvania, where it is working with a coalition of member companies and other stakeholders to try and prevent the Commonwealth’s Civil Procedural Rules Committee, a creature of its Supreme Court, from nullifying rules that prevent venue shopping.

And, while we can’t say exactly where yet, it is all but certain that some states will see judicial challenges initiated by the personal injury bar intended to overturn liability reforms. These efforts will undoubtedly require the Association to file amicus briefs to defend those hard-earned reforms.

Conclusion
We know that the current governing environment will bring public policy challenges to MPL insurers. Hopefully, it will bring some opportunities as well. In either case, however, the MPL Association will be prepared. We will continue to monitor and track state legislation and provide grassroots advocacy capabilities to support both offensive and defensive policy efforts. We will continue to survey our members’ government relations needs and work with our member-led Government Relations Committee to keep our fingers on the pulse of the industry. We will continue to keep open lines of communication with all our members, so don’t forget that you may contact us if you ever need any assistance on public policy issues. Whatever the next year (or two) holds in store, the MPL Association will be there to defend and protect the industry’s interests.

It is important to remember that passing federal legislation is a long-term process, and major changes can occur in legislative bodies every two years.

WillisRe
The leading reinsurance expert in the medical professional liability industry
A patient, Mrs. Skounakis, died of a coronary artery occlusion after she had been prescribed an unusual combination of drugs (phendimetrazine and liothyronine) by Dr. Sotillo, for weight loss. Her husband sued Dr. Sotillo for medical malpractice. What makes this case interesting to those other than the parties involved is the claim Mrs. Skounakis’ husband also brought against Dr. G’s Franchising Companies LLC (“Dr. G”), which provided Dr. Sotillo with a proprietary software package that was said to have endorsed the combination of drugs alleged to have caused Mrs. Skounakis’s death.

The case was filed in the Superior Court of New Jersey, which held that the plaintiff’s expert witness was not qualified to render his opinions and accordingly granted summary judgment in favor of both Dr. G and Dr. Sotillo. But then, in March 2018, the Appellate Division reversed, holding that the trial court erred in excluding the plaintiff’s expert and hence erred in granting summary judgment to the defendants.

The plaintiff’s expert, Dr. Decter, a board-certified internist and cardiologist, opined that Dr. G’s program deviated from the standard of care by including a combination of phendimetrazine and liothyronine, because of the well-known adverse effects of these drugs when used in combination. The trial court held that he was not qualified to render this opinion because he was not a computer software expert.

We, however, find no reason to conclude Dr. Decter was unqualified to render an opinion regarding Dr. G’s program because he was not a computer software expert. The thrust of his concern about Dr. G’s program was its endorsement that [Mrs. Skounakis] take the combination of medications that he believed led to her death.

As framed in this appeal, the proposition that the appropriate expert to opine on the propriety of the medications recommended by Dr. G’s program.
propriety of medications prescribed to a patient is a physician is straightforward enough. That observation holds without regard to how or by whom the medications are identified, i.e. by a physician, a computerized decision-support tool such as that provided by Dr. G, clinical practice guidelines, standard order sets, or a textbook. But three related questions that go beyond this anodyne observation were not addressed in this appeal.

First, does a "standard of care" apply to a computer program operating as a clinical decision-support tool? It is one thing to opine—as did the plaintiff’s expert, Dr. Decter, in this case—that a particular combination of drugs was inappropriate for a specific patient and that the physician who prescribed them did not meet the applicable standard of care for physicians of that practice in that locality. As the Appellate Division held, those questions are medical ones that should be answered by a physician. But the question as to what degree of accuracy and precision can be reasonably expected from a computerized decision-support tool such as the one supplied by Dr. G here does not seem to be definitively a medical one that would be within the expertise of practicing physicians.

The differences between what is expected from physicians treating patients and computerized decision-support tools becomes particularly clear if one views the potential liability of the former through the lens of MPL and that of the latter through the lens of products liability.

Second, what is the required demonstration of causation for plaintiff’s claims against the supplier of a decision-support tool that provides its recommendations to a physician and not directly to the patient? Although not expressly stated in the Appellate Division’s decision, it appears that Dr. G's program recommended the combination of phendimetrazine and liothyronine to Dr. Sotillo, not to Mrs. Skounakis. But even if the recommendation had been conveyed directly to Mrs. Skounakis as part of Dr. G’s weight-loss program, both drugs are available only by prescription, and could not have been dispensed to her without a prescription from Dr. Sotillo. Regardless of the combination recommended by Dr. G’s program, by the warnings on the label. If Dr. G’s recommendations were accompanied by an instruction to consult the prescribing information for the recommended drugs for further information, Dr. Sotillo would have found (if she had checked the labels) these warnings. If she decided to proceed with prescribing the combination despite them, would the learned intermediary doctrine bar the plaintiff’s claim against Dr. G on the basis that even though its program recommended a potentially dangerous combination of drugs, it directed Dr. Sotillo to review the prescribing information that would have warned her of the potential danger?

Defense of a case like this may generate finger pointing between the treating physician and the supplier of the decision-support tool. The supplier would seek to minimize or extinguish its liability by arguing that the treating physician must exercise good medical judgment to avoid following recommendations that are not appropriate for a particular patient. The treating physician has a tougher choice: pointing the finger back at the supplier as the primary cause of the patient's injury could backfire if understood as an admission that the physician put undue reliance on the decision-support tool.

As medical protocols and treatment guidelines migrate from the familiar pocket reference guides stuffed into the lab coats of residents to programs that offer at least the appearance of individualized recommendations generated for specific patients based on their relevant characteristics, watch for more cases like this one. Also watch to see if differences develop between cases in which the patient had no knowledge that the physician was using a decision-support tool and cases (like this one) in which the supplier provided advertising and promotional material aimed directly at patients, thereby presenting itself as a type of specialist involved directly in patient care.

The differences between what is expected from physicians treating patients and computerized decision-support tools becomes particularly clear if one views the potential liability of the former through the lens of MPL and that of the latter through the lens of products liability.

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C O V E R  S T O R Y

Mega-Verdicts on the Rise

Rock Stars, Diversionary Tactics, and Lack of Willingness to Break from Traditional Defense Practices Sway the MPL Verdict Landscape

By John E. Hall, Jr., and E. Wayne Satterfield, Esq.

Over the past five years, the medical professional liability (MPL) arena has seen an increase in the severity of verdicts against healthcare providers. As shown in Figure 1, almost all of the common MPL categories have seen verdicts of more than $100 million.

John Hall, Jr., Esq., and E. Wayne Satterfield, Esq., are with Hall Booth Smith.

INSIDE MEDICAL LIABILITY 20 FIRST QUARTER 2019
While several drivers play a role in verdict amounts, there are three specific factors that defense attorneys need to be aware of to avoid a mega-verdict: (1) the “rock star juror” phenomenon, (2) periphery accelerants and (3) failing to defend damages.

**Jury box infiltration of ‘Rockstars’**

I’m going to trade this life for fortune and fame. I’d even cut my hair and change my name. Cause we all just wanna be big rock stars and live in hilltop houses, driving fifteen cars. –Nickelback.

Regardless of your opinion of Nickelback, their lyrics from “Rockstar” encompass the rich and lavish lifestyle that many people dream of at some point in life. However, living the lifestyle of the rich and famous used to be just that—a dream. Now, though, through real-time videos of celebrities on private jets to selfies of movie stars with million-dollar sports cars, social media allows people, especially millennials, to experience what it’s like not having to worry about money. On a daily basis, people can tune in to Facebook, Twitter, or Instagram and learn that Floyd Mayweather received $275 million for one boxing match or Taylor Swift earned $54 million in just five concerts. However, social media allows a user to go one step further and see how these celebrities spend their money or enjoy their time off. As a result, people want to be millionaires more than ever. It is no coincidence that the Mega Millions and PowerBall jackpots combined totaled an unheard of $2 billion just this past year.

The outcome has been the infiltration of the “Rockstar” mindset into the jury box. JURORS are now conditioned to seeing million-dollar jackpot winners, celebrity assets, and CEO compensation on a daily basis. Not only are they no longer offended by requests for multi-million-dollar verdicts; they have no problem awarding that amount of money if they feel negligence has occurred. Plaintiff’s attorneys now understand this and are using it to their advantage in several ways.

For example, plaintiff’s attorneys are now using celebrity, athlete, and executive salaries in closing arguments. By pointing to LeBron James’s $153 million contract with the Los Angeles Lakers, plaintiff’s attorneys are raising the minimum on what a jury might give. So even if a jury doesn’t believe that an amputation is preventing a plaintiff from becoming the next LeBron James, they may believe that a third of his contract—$51 million dollars—is reasonable.

This move can be successfully countered by an aggressive defense: using motions to exclude and also presenting real-life salaries and benefits. But mostly, what’s needed is recognition of the issue and a reasonable, aggressive response.

**Periphery accelerants**

A common driver in mega-verdicts is the “periphery accelerator” used by plaintiff’s attorneys to cast the defense in a negative light. Periphery accelerants are minor facts that can transform into the linchpin of the case, despite playing no role in the medical care. The most common accelerator is the missing or altered medical record. Others are former employees who’ve skipped town and money-focused policies and procedure. In most cases, the missing medical record or former employee plays little to no role in the care provided to a patient. However, plaintiff’s attorneys have begun using these accelerants as the themes for their cases, to take the focus away from the medicine.

Plaintiff’s attorneys will use the changed or missing medical record as evidence of spoliation. Most states have spoliation sanctions that can range from jury charges that allow juries to make every negative inference from the missing evidence to the striking of defenses from the record. Some states even have a separate cause of action for spoliation. A finding of spoliation increases the likelihood of a mega-verdict and will be the theme of the plaintiff’s case.

Another strategy is to paint the missing medical records as the consequence of a corporate cover-up. With MPL cases involving hundreds of medical records, most medical providers involved won’t be able to offer a reason for why a particular medical record is missing, nor do they understand its potential for sway a jury. Knowing this, plaintiff’s
attorneys will question each and every medical provider about the contents of the record and its whereabouts. Plaintiff’s attorneys then use inconsistent answers about the record from each provider to show that its absence must be the result of wrongdoing by someone with a monetary interest in the case—the corporation.

Similarly, a company’s policies and procedures are used to dehumanize the physicians and place the blame on the “executives” making them. By using video depositions of CEOs discussing the decision-making process behind policies and procedures, plaintiff’s attorneys shift the focus of blame away from physicians, whom jurors naturally like, to the “greedy” corporation.

But regardless of their specific form, accelerants need to be recognized and honestly dealt with. Millennials and others need us to show why this issue does not matter when it comes to care. Being unprepared for them can result in a mega-verdict.

Failing to defend damages

Lastly, mega-verbicts tend to come about in instances where the defense counsel fails to defend the damages the plaintiff has incurred. Defense attorneys often believe that if they acknowledge damages and suggest a value to award that they believe is reasonable, or counter a plaintiff’s life care planner with one of their own, they are conceding liability. However, jury studies show that when defendants have offered no testimony contesting the plaintiff’s damage estimate, jurors feel they have no choice but to rely on the plaintiff’s damage evidence, which is often inflated.

Traditionally, it’s the plaintiff who develops an itemization of the damages, and the defense is not involved in the early stages of development, because the focus is on challenging liability. However, defense attorneys need to begin defending damages at the outset of the case, by propounding the right discovery, obtaining the right experts, and identifying the right areas where value will be challenged. It is crucial that the defense aggressively establish its own number, as opposed to relying on plaintiff’s calculations, early in the litigation, regardless of liability.

Specifically, defense attorneys should be obtaining all medical bills early in discovery, to identify the special damages that the plaintiff will claim. In addition, they should research collateral-source rules that may allow them to argue for the offset of certain damages. Regarding experts, investigation into the plaintiff’s life care planner’s education and past testimony can often reveal bogus credentials or boilerplate life care plans. Moreover, the depositions of treating physicians should be considered; oftentimes, they may disagree with what a life care planner deems necessary for future care.

Overall, defending damages is crucial to eliminating the possibility of a mega-verdict. Defense attorneys should focus as much on damages as they do on liability, right at the outset of a case. Doing so allows the defense to establish its own value, and this number can be used as leverage in settlement negotiations, in addition to countering plaintiff’s request to the jury during the trial.

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The Alphabet of Asset Management.
Now imagine that all the parts are being played by one unlucky millennial…. How can you tell which part is being played at any one time? Who is speaking—a Montague or a Capulet?

Nationally, skilled nursing facilities (SNFs) contract with individual physicians—typically, a local internist or a family practitioner—to fill the role of medical director, in exchange for a monthly stipend. The physician is typically covered by a medical professional liability (MPL) policy, and the SNF is either similarly insured or operating under a self-insured/excess policy model. In almost every case, the medical director also serves as attending physician for half of the residents or more. In most instances, Romeo—the medical director, and Juliet—the attending physician, are performing sufficiently distinct duties to clearly identify their roles: O Romeo, Romeo, wherefore art thou Romeo?—easy enough. But lines quickly blur when lawyers put facts under a microscope and cram them into the mold most suitable to their clients.

**Regulatory background**

Under the Code of Federal Regulations, Medicare-participating SNFs must designate a physician to serve as medical director who is...
“responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.” In addition, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) and its implementing regulations require that medical directors be involved in the direct management and identification of potential quality improvement problems and plans, and should ensure implementation of existing law and regulations.

In contrast, attending physicians direct the care of individual patients and serve as the primary point of contact for the nursing staff charged with implementing orders and alerting the attending of significant changes in the patient’s condition. In this regard, the role of the attending in a nursing home is not drastically different than that of a physician on staff at an acute-care hospital. Attending physicians periodically see patients in the facility, frequently receive messages from nursing staff advising of changes in residents’ status, and issue orders for treatment and diagnostic testing.

Conflicting interests and legal implications

It all seems simple enough: The medical director handles the big-picture, facility-wide issues, and the attending handles issues dealing with individual residents. However, the apparent black-and-white dichotomy bleeds to grey when a medical negligence suit is filed against the facility—whether or not it names the physician as a party. Civil complaints are not required to identify exactly which role the physician played or every specific act or omission being criticized; rather, the rule in nearly every state is that a complaint need only contain “a short and plain statement of the claim showing that the pleader is entitled to relief.” The same standard is also used in slip-and-fall claims and toxic torts.

Typically, SNF cases allege specific injuries to the individual plaintiff (falls, fractures, infections, etc.) but make nebulous allegations as to the wrongful conduct, i.e., that deviations from the standard of care were “continuous and systematic” or that management practices created a “culture of noncompliance.” As such, when analyzing coverage issues that arise from these claims, a number of questions must be answered:

- Do the allegations implicate a medical director who acts solely within an administrative role?
- Is a physician who acts as director and attending physician liable in both roles?
- Does the policy at issue provide coverage for certain acts but not others?

A medical director charged with implementing and coordinating medical care at the facility may have exposure for care rendered to a patient he has never met. On the other hand, when the medical director also serves as the plaintiff’s attending physician, the situation escalates. The risk of liability exists in both roles. Attending physicians face liability under tort law for medical negligence, while medical directors face liability under allegations of negligent supervision, negligent credentialing, or regulatory compliance. Many times, unless specifically mentioned, insurance policies will not protect physicians fulfilling both roles.

The task of the underwriter requires a thorough understanding of these dual roles and the negotiated risk allocation between the SNF and the individual physician. In this way, coverage gaps can be identified and filled.

The consequences of a liability disconnect between the SNF and its medical director can be dire, as illustrated in one of the great cautionary tales of our time: the Dorothy Douglas verdict of 2011. The Douglas case involved allegations of neglect centered on the rapid decline in function and eventual death of an 87-year-old female resident admitted to a SNF for 19 days, during which time she went from walking with a walker, recognizing staff, and making her needs known to profound dehydration, unresponsiveness, and death within seven days of discharge. In addition to failure to provide sufficient fluids, the plaintiff alleged failure to properly budget, resulting in insufficient staffing and other administrative deficiencies.

The medical director was a principal witness at trial—for the plaintiff! During his testimony, he criticized both individual caregivers and certain facility policies. The medical director’s testimony added fuel to a very expensive fire. The plaintiff spent the rest of the case beating the drums of under-budgeting, poor staffing, and the familiar profits-over-people refrain. This conflict between facility and physician was likely not the sole cause of the $91.5 million verdict that was returned. It was, however, also symptomatic of a sour—or at least dysfunctional—facility/physician partnership.

Conclusion

In most ordinary situations, the fact that the medical director wears two hats rarely presents an issue, but those situations typically do not produce claims. It is the complex cases that implicate both patient care and policy implementation that can generate claims and potentially bad results. Squabbling staff, poor communication among departments, and failure of management to implement the quality assurance process produces bad results every time. In these rare instances, managing risk is complex, but spotting the issues is not.

Footnote

In aggregate, MPL insurance underwriters enjoyed a decade (2006-2015) of underwriting out-performance relative to the overall property/casualty (P/C) industry that included several years of sub-90% combined ratios.

But, that relationship has now reversed, following several years of gradually deteriorating MPL insurance results toward a segment underwriting loss. Shifting profit fundamentals have not led to visible pricing or underwriting adjustments. So, underwriting performance is likely to slip further before any market improvement is seen.

The previous extended period of success was fostered by a collective market response to previous large MPL insurance losses from 1999–2003 (average combined ratios approaching 140%), that included a major shakeout of underwriting capacity, steep premium rate increases, and the passage of litigation reforms in numerous jurisdictions.

Underwriters continue to benefit from relatively stable loss cost trends. However, effects of flat to moderately declining premium rate trends and changes in market fundamentals that reduce premium volume have led to a steady recent erosion in results toward 2016 and 2017 market underwriting losses.

From 2008-2017, the MPL insurance statutory combined ratio averaged 10 points better than the overall industry (92% versus 102%). More recently, MPL insurance results are even with the industry, at 101% from 2015-2017. Signs of further profit weakness in MPL insurance, coupled with modest improvement in broader industry conditions following inordinate 2017 catastrophe losses, point to more likely underperformance of MPL insurance versus other lines going forward. Barring adverse shifts in claims experience, underwriting results could moderately deteriorate to an estimated industry MPL insurance ratio ranging between 102% and 106% for the next two to three years.

Several key factors will influence profit opportunities in MPL insurance, going forward,
including elements that affect premium revenue trends. Segment statutory net written premium volume declined for the last 11 consecutive years, down in aggregate by 22% since 2006. This contrasts with the broader insurance market that is seeing better growth in premiums in an improving U.S. economy.

Declining underwriting exposures
Product demand in MPL insurance is affected by a key trend: individual medical providers are increasingly shifting toward employment in larger medical groups or hospital organizations. These larger entities have different insurance buying practices and are more inclined to self-insure and utilize captives and other alternative risk insurance programs.

These market changes reduce the aggregate MPL insurance exposure base and promote price competition, as insurers are more intensely focused on retaining existing policyholders. Several MPL insurance specialists are developing fee-based and service capabilities to attract business from larger medical groups, facilities, and captives, though smaller underwriters have more limited expertise and opportunities to reposition their business in this fashion.

Changing market fundamentals led to a lower proportion of premiums generated by physicians and hospitals. Physician coverage, the focus of many MPL insurance specialists still represented 57% of industry statutory MPL direct written premiums at year-end 2017, down from 62% in 2012. For the industry, direct written premiums for physicians and hospitals each declined by 15% and 8%, respectively, over the last five years. Conversely, premiums for coverage of other healthcare professionals grew by 10%, and of nonhospital medical facilities grew by 21%, over the same period.

A declining premium base puts pressure on expense levels. The industry MPL insurance expense ratio rose by 6.5 points over the last 10 years, as reduced premium volumes contributed to a higher burden from general operating and field expenses. Heightened technology-investment requirements, to improve operating efficiency and maintain competitiveness, are another contributor to higher expense ratios.

Catalyst for pricing improvement not evident
While recent underwriting losses have spurred a move towards premium rate increases in other commercial insurance segments recently, including automobile and property lines, abundant underwriting capacity in the MPL insurance market makes it unlikely that there will be material positive near-term rate increases. Insurance broker Willis Towers Watson’s latest Insurance Marketplace Realities 2019 report projected that physician MPL insurance renewal rate changes in 2019 would span a relatively wide range, from flat to -7%. The Council of Insurance Agents & Brokers’ quarterly Commercial Property/Casualty Market Index reveals that very flat MPL insurance pricing trends have existed for some time.

Favorable reserve experience abating
MPL insurance underwriting results benefited from extremely favorable loss reserve experience for more than a decade. Industry calendar-year favorable reserve development from 2008 to 2017 averaged 20% of annual earned premiums, which is unprecedented in magnitude and consistency compared with any other large P/C business line.

These results are indicative of inherent conservatism in MPL insurance reserving and relatively stable loss experience. However, reserve strength shows increasing signs of moderating.

The effect of reserve development on MPL insurance loss ratios declined for four consecutive years and moved to approximately 14% in 2017. While this result remains highly favorable, reserve experience is more likely to diminish further in the future.

Accident-year loss ratios have risen significantly in recent years due to this gradual erosion in profitability. For the claims made MPL underwriting segment, the reported industry loss ratio in 2017 (87%) is 30 points higher than 2008’s (57%). Favorable loss experience over time led to the 2008 loss ratio declining by 21 points from the original loss ratio estimate.

The most recent four accident years in MPL (2014-2017), which represent approximately 73% of all industry reserves, have seen considerably less favorable experience to date at similar periods of development from initial loss estimates relative to prior highly redundant years.

A review of loss payment patterns and incurred but not reported (IBNR) loss levels for these recent periods does not suggest that ultimate incurred loss development will measure up to that of prior years.

Future MPL Drivers
- Demand for coverage
- Market pricing
- Loss reserve strength
- Claims severity/litigation trends
- Specialty insurers’ capital management

MPLI vs. Industry Combined Ratios

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<th>Year</th>
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<td>105%</td>
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<tr>
<td>2017</td>
<td>104%</td>
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Source: SNL Financial.
Further declines in calendar year reserve development will add further pressure on MPL underwriting performance.

**Loss trends bear monitoring**
The greatest risk for unanticipated sharp increases in future underwriting losses lies with the potential for higher social inflation from rising legal settlements and jury verdicts. Signs of rising general and medical inflation in the U.S. economy and higher legal cost trends and more frequent large verdicts in other liability insurance segments bear further monitoring for a similar pattern in MPL insurance.

The potential for successful challenges of past reforms in various states that cap noneconomic damage payments or legal fees in MPL insurance cases is another source of periodic uncertainty that would promote higher claims costs.

**Specialty insurers’ capital deployment challenges**
More than 60% of MPL insurance market share is held by a large number of smaller specialty writers that tend to have limited product or geographic diversity. These organizations experienced highly favorable profitability and surplus growth in the prior hard market. In a steadily shrinking MPL insurance market, most of these companies have very strong balance sheets and risk-adjusted capital measures, but face limited opportunities to profitably deploy this capital.

A review of 40 MPL insurance specialists shows a group with combined policyholders’ surplus of more than $16 billion, net written premiums to surplus of less than 0.3x, and a median risk-based capital ratio of 526%. Underwriting fortunes have turned less favorable for this group in recent years, with the average combined ratio moving from 92% in the three-year period 2012–2014 to 100% from 2015–2017, and return on surplus moving from 10.0% to 5.4% over the same period.

Strategic options for MPL insurance specialists include: expanding into new markets or business lines for growth, executing mergers and acquisitions (M&As), or staying the course as an MPL insurance specialist. In prior soft markets, diversification efforts of MPL insurance specialists outside of their area of underwriting expertise were largely unsuccessful. Outside of utilizing existing relationships for growth in contiguous markets, MPL insurance writer diversification efforts are currently somewhat limited.

M&A transaction volume in the broader P/C market has accelerated recently. Transactions in the MPL insurance space are relatively few, but include two significant transactions. Berkshire Hathaway’s acquisition of New York-based MLMIC combined the first and fifth largest MPL insurance writers. The Doctors Company’s recently announced acquisition of Hospitals Insurance Company will combine the second and twelfth largest MPL writers.

Combinations among MPL insurance writers could add scale and geographic diversity to the book of business, promote expense efficiencies and technology investment, and foster a channel for utilizing...
excess capital. While there are numerous interested buyers of smaller MPL insurance specialists among larger players, there remain fewer willing sellers. As most MPL insurance specialists are structured as mutuals, reciprocals, or risk retention groups, the likelihood of successful unsolicited-acquisition approaches in the market is slim.

The lack of more widespread MPL insurance M&A activity is reflective of the current capital strength of MPL insurance specialty writers, as the large majority of underwriters remain positioned to absorb considerable adversity without seeking a strategic buyer.

The bulk of MPL insurance specialists have for some time opted for a stay-the-course approach and have largely maintained their focus on a narrow product, customer, and geographic footprint. Pursuit of a more active strategy may not be compelling until there is a larger market change that reduces capital levels.

More aggressive efforts to retain accounts in a shrinking market have a macro effect of further weakening pricing, creating a greater likelihood that excess capital is removed via underpriced insurance coverage and a return to reported operating losses. For related information, see www.fitchratings.com.
The Paradox of Prematurity: Why Have Improvements in the Care of Preterm Infants Led to More MPL Claims?

By Sean B. Maraynes
 Advances in maternal-fetal medicine and neonatology have dramatically increased survival rates for extremely premature infants, defined as infants born at fewer than 28 weeks’ gestation. One would think that medical advances that increase survivability would tend to lower the frequency and severity of medical professional liability (MPL) lawsuits.

We will examine here why, ironically, we’ve seen that medical advances related to the obstetrical and neonatal care of extremely premature infants have actually led to an uptick in high-exposure cases involving the birth of extremely premature infants. More important, this article will evaluate common plaintiff and defense strategies in MPL actions involving extreme prematurity.

Background
One of the driving factors behind the increased survival of extremely premature infants has been the use of antenatal steroids. After a 1994 National Institutes of Health (NIH) recommendation regarding the administration of antenatal corticosteroids, The American Congress of Obstetricians and Gynecologists (ACOG) followed with its own endorsement, leading to the administration of a course of antenatal corticosteroids in 70% to 90% of women who delivered at fewer than 34 weeks’ gestation. The use of antenatal steroids, coupled with the establishment of the modern neonatal intensive care unit, between the 1970s and 1990s, including the routine use of CPAP devices, mechanical ventilation and surfactant, has resulted in improved survival rates.

Much has been written about the societal costs associated with the delivery of extremely premature infants. A 2005 study found the annual economic burden for society at large associated with preterm birth in the United States was at least $26.2 billion, including special education services estimated at $1.1 billion. However, the impact of increasing preterm survival rates on the frequency and severity of related MPL actions is discussed less often.

Nevertheless, we’ve seen a deluge of cases that involve a defensible medical treatment that inexplicably results in an MPL claim. The crux of the problem faced by medical providers and their defense counsel is this: Although the use of antenatal steroids, modern neonatal care, and neuroprotective agents such as magnesium sulfate can sustain life and guard against cerebral palsy, they cannot make the fetal brain develop faster.

Litigation
The birth of an extremely premature infant with a poor neurodevelopmental prognosis creates an enticing opportunity for plaintiffs’ attorneys. Clearly, the cognitive dysfunction found in many extremely premature infants constitutes a high-exposure injury. In addition, the sheer number of medical decisions that must be made in the neonatal intensive care unit in order to keep the infant alive provides a plethora of opportunities for the plaintiff’s attorney to “Monday morning quarterback” the care rendered. These decisions in the intensive care unit can involve, among others, resuscitative efforts, ventilator settings, antibiotic coverage, and decisions related to feeding. Given the fragility of extremely premature infants, and given the fact that nearly any medical intervention can potentially cause serious injury, the number and complexity of the treatment decisions in this setting provide a wealth of opportunities for plaintiff’s attorneys.

Although every effort must be made to defend these claims on liability grounds, that can be challenging, given that plaintiff’s experts will attempt to link any injuries sustained by extremely fragile premature infants to medical interventions. For instance, a plaintiff’s expert may allege that an improper ventilator setting or use of a manual resuscitator caused an intraventricular bleed, a common occurrence in extremely premature infants. Given the seemingly endless potential for factual allegations that must be defended, in many cases the most viable defense theory is to focus on the science behind fetal brain development. This can provide a compelling causation defense as to why the infant’s neurodevelopmental delays were not caused by medical treatment rendered, but rather by a brain that never had the chance to fully develop. For instance, a 26-week infant has one-fifth of the brain volume of a 37-week infant. At 28 weeks, the cerebral cortex, perhaps the most important part of the brain in terms of cognitive function, has not fully formed, its neurons are not layered, and its synapses remain unformed.

Plaintiff’s attorneys may argue that some extremely premature infants can develop in the extra-uterine environment and live totally normal lives; therefore, but for the negligence of the providers, their client would have developed normally. Complicating the defense of this argument is the fact that, oftentimes, extremely premature infants...
who have permanent neurodevelopmental delays had stormier neonatal courses. As such, more medical decisions are made in the neonatal intensive care unit and, as discussed above, each of these decisions can lead to a potential allegation of MPL.

Mounting a defense
One possible response to the question of why some extremely premature infants develop normally, while others do not, is that in order for an extremely premature brain to continue to develop properly in an extrauterine environment, conditions must be “ideal.” Defense counsel must point to all the infant plaintiff’s difficulties during the neonatal course—such as respiratory distress, infection, or gastrointestinal problems—that were not caused by the medical providers but nevertheless led to increased stress on the infant and a diminished likelihood that the infant’s brain would develop normally. In addition, defense counsel must examine the quality of the intrauterine environment and point to complicating factors—such as intrauterine growth restriction or placental insufficiency—that would have made it less likely that the infant cited by the plaintiff would thrive once outside the womb.

In sum, when faced with the increasingly common claims involving extreme prematurity, it is helpful to assess the viability of the defense strategy from the outset, obtain experts who can support the theory, and use the neuroscience regarding fetal brain development to respond to the plaintiff’s efforts to link an infant’s injuries to medical treatment, as opposed to a tragic outcome that simply could not have been prevented by medical providers.

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The case emphasizes the importance of rigorous consent processes and a doctor’s duty to advise patients of their treatment options, particularly the material risks inherent in procedures and treatments, to enable them to make an informed decision about their treatment.

Case facts
A male long-distance bus driver in his late 40s was seen at a district hospital after rupturing his Achilles tendon. The rupture was managed conservatively: his leg was placed in a half-cast and he was referred to a major hospital. Several different doctors working at the referral hospital examined his leg on several occasions, and a new cast was put on. The doctors relied on their clinical examination and the patient's history, but they did not perform an ultrasound or other radiological examination in assessing the condition of the patient’s tendon. The facts were only briefly outlined in the notes on the decision, and further detail was not provided.

At no point did any of the doctors discuss the possibility of surgical repair of the tendon with the patient. On the patient’s second hospital visit, a doctor recorded that his tendon was “in continuity.” About two weeks later, another doctor recorded that the patient was a bus driver with an Achilles tendon rupture who had not been offered surgery, but surgery was not suggested then, and the nonsurgical treatment continued.

The patient’s leg healed with...
some tendon lengthening, which reduced his capacity to work as a bus driver.

The patient sued the state (which was legally responsible for the hospital and the doctors who worked there) for negligence. The patient argued that the hospital should have advised him of the two treatment options—nonsurgical and surgical—and explained the advantages and disadvantages of both options. In particular, the patient claimed that he should have been advised that nonsurgical treatment carried with it an increased risk that the tendon would heal in a lengthened position, possibly resulting in weakness of the plantar flexion, which could affect his capacity to perform certain activities relevant to his occupation as a bus driver.

The court originally found the hospital had breached its duty of care by failing to advise the patient of alternative surgical treatment and the advantages and disadvantages of nonsurgical and surgical treatment. He was awarded $81,515 (Australian) in compensation and his costs.

On appeal, the hospital unsuccessfully sought to overturn the findings of the original court based on the duty and standard of care owed and medical evidence. The Court of Appeal dismissed the appeal and instead awarded the bus driver a larger amount of compensation (A$215,955) for his injury.

**Duty to advise of the two treatment options**

There was some discussion in the case about whether or not the doctors had breached their duty of care in relying solely on clinical examination and medical history, instead of conducting further investigations, for example, with the use of ultrasound or radiology. Ultimately, this was deemed irrelevant to the main issue in the case, which was whether or not the hospital should have advised the patient about the advantages and disadvantages of the two acceptable treatment options—surgical versus nonsurgical.

The medical evidence from three experts was that while both nonsurgical and surgical treatment were appropriate forms of treatment for a ruptured Achilles tendon, nonsurgical treatment involved a greater risk of tendon lengthening.

Tendon lengthening was a particular problem for the bus driver because of his occupation, and the hospital had enough information from the history taken to be aware of this potential problem for him.

The court of appeal affirmed the findings in the lower courts that the hospital breached its duty of care in failing to advise the patient about the availability of surgical and nonsurgical treatment or about their respective advantages and disadvantages.

The court of appeal confirmed these legal principles, from earlier cases:

- The law recognizes the right of the patient to choose whether or not to undergo a proposed treatment, and the patient must be sufficiently informed to be able to make that choice.3
- Even if patients are not in the best position, on an objective basis, to decide whether to undergo a particular treatment, they nevertheless have the right to be sufficiently informed that they would be able to make an informed decision.2
INTERNATIONAL PERSPECTIVE

This decision is based only, in part, on the medical issues on which, plainly, the medical practitioner has a significant advantage.2

Whether the patient has been given all the relevant information needed to choose a treatment is not a question whose answer depends on medical standards or practices.7

An important aspect of the decision is the impact that the particular surgery or treatment will have on the particular patient’s life.2

This requires an understanding of the patient’s lifestyle, what is important to him, the strengths and weaknesses of the patient in coping with particular kinds of adversity.2

The court found that because of the patient’s employment and the need to recover in the shortest timeframe possible, if he had been advised about surgical treatment versus nonsurgical treatment, he would have chosen to have surgery which carried a lower risk of the injury he sustained.

Obtaining consent: risk discussions

This case highlights why it is so important for doctors to conduct rigorous consent processes with every patient. This discussion should include an explanation of the treatment options available and the risks, benefits, alternatives, and complications that may occur with a given procedure or treatment, to enable the patient to make a truly informed decision.

General and specific risks. All of the known risks should be discussed with the patient, including those that are general in nature, quite common, and involve only a minor detrimental effect, as well as the risks that are rare but whose outcome is severe. Risks specific to a particular procedure or treatment also need to be discussed.

Material risks. Doctors have an obligation to inform patients of the important or material risks inherent in a proposed procedure or treatment. The test for what is a material risk is patient-centered: it involves considering what is likely to be of significance to the patient in his particular circumstances. The emphasis is on the particular and the individual—what is material to one patient may not be to another.

The consent process is about engaging the patient in a discussion about his needs, priorities, and expectations and coming together to make a shared decision about his treatment. The patient’s perspective is important. The risks you need to discuss include those likely to be significant to the patient, which is why it is essential that you ask what is important to him.

The discussion needs to:

■ Consider the treatment and options from the patient’s perspective.
■ Explore with the patient what is most important to him—for example, being pain free, able to walk unassisted or live independently, or continue in his current line of work.
■ Explore what outcomes they are prepared to live with.
■ Talk to the patient about how he would manage a common outcome—for example, would he be able to take time off work to recuperate if necessary?
■ Consider the context of the patient’s life—in this case, what does tendon lengthening actually mean for him?

Key lessons

■ Inform patients of all the treatment options available, including the risks, benefits, alternatives, and complications of these treatments.
■ Discuss with the patient what outcomes are important to him.
■ Keep accurate, contemporaneous medical records of the discussion, document the patient’s consent, along with any written information you have handed out. MPL

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References

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If you aren’t asking the following questions, I would argue that you should be asking them, and perhaps many more, in your capacity as a board member.

- Have we documented our cybersecurity risk assessment?
- What is our risk appetite with respect to alternative investments?
- What key performance indicators is the management team using to monitor the operational performance of the organization?
- What is the health of our internal control environment?

Today’s business landscape, in the midst of a global economy, demands more from the individual board member than ever before. Board members are expected to be engaged, equipped, and educated on the issues facing the organization in order to fulfill their fiduciary responsibility.

The overall complexity of your fiduciary responsibility is greater now, because of competition in the marketplace, increased regulation, and the proliferation of external threats, including but not limited to: cyber matters, rating agency actions, and state regulators.

So, how do you arm yourself and remain abreast of such matters and their implications for your organization? What tools are you using to prepare yourself for the complex, fast-paced change and diversity of the current business environment? Finally, and most importantly, how do you get your arms around the full scope of risk in your organization?

In this article, I’d like to offer up some tips and tools that you can use to enhance your preparation and potentially increase the value that you bring to the boardroom discussion.

**Audited financial statements**

First, a great source of information that can be leveraged is the annual audited financial statements prepared by management and opined on by the independent auditors. These statements are significantly more streamlined than the annual statements filed with regulators and are generally consistent across organizations; there are defined and required footnote disclosures and an expectation of transparency to the stakeholders. Within the audited financial statements, I would point you to a few footnotes that provide some key information:

- Organization and nature of business, often the first footnote in the audited financial statements, is a great starting point. This footnote describes the organization, including the primary sources of revenue, and highlights for the reader any new lines of business, geographic expansion (i.e., licensing in new states), subsidiaries, and affiliates, and it includes subsequent-event matters that should be considered in evaluating the overall financial position of the organization.
- Significant accounting policies and their application; this describes the basis of accounting being used by the organization (generally, statutory accounting principles), including any principles of consolidation, and discusses the most significant accounting policies used by the organization in producing the financial statements. Reading this footnote can help you understand areas of significance, appreciate any differences in presentation or basis of accounting (i.e., statutory accounting or GAAP accounting), and learn about any significant upcoming changes in accounting standards and whether those are expected to have a significant impact on the financial position of the organization. In summary, the footnote gives context to the reader for interpreting the financial information.
- Insurance activity is generally covered in several different notes, but it includes significant information with respect to written and earned premium, reinsurance activity, and details on loss and loss adjustment expenses. In particular, the loss reserve roll-forward, a required disclosure, provides succinct details about the changes in the liability from prior years.
year to current year and highlights whether the reserves have developed favorably or adversely in the current year. Of note here is that the amount of reserve development shown in this roll-forward has a direct impact on operations for the period, and a reader can determine the impact of the reserve movement on current earnings. It may be important to you to be able to discern what is driving the earnings in your organization, whether it's underwriting results, investment performance, or other drivers such as reserve development.

Investment disclosures are lengthy, but contain important information that can help a reader isolate the specific risks in the investment portfolio. In addition, the disclosure includes valuation methodologies, a fair-value hierarchy, and detailed information regarding unrealized gains and losses in the portfolio. Much of this information is used in decision-making with respect to asset/liability matching, tax planning strategies, and overall investment management strategies.

Inside the boardroom
Second, a great place to create awareness, and provide strategic education, is within the boardroom itself. Often, strategic business advisors, such as investment managers, actuarial consultants, and independent auditors make annual and quarterly presentations. Most of these external specialists have experience with multiple companies throughout the industry. This is a great opportunity to measure how your organization operates compared with others in the industry and gather information on thought leadership and internal control environments and to gauge your organization’s readiness for confronting the industry’s ever-present risks.

Specifically, I would point you to the required internal control communication filed with the regulators. Your independent auditors issue an annual internal control letter addressing the health of the internal control environment. Whether there are matters to report or not, use this letter as a discussion point to understand what both management and the auditors are doing to assess the operating effectiveness of the key controls that both the management team, and ultimately, you the board member must rely on.
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3. Recognize and manage the risk associated with the absence of FDA regulation of genetic testing

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Imagine what typical people will do when they have a health concern. Upon noticing that something is wrong, they might hurry to a clinic to get a doctor’s opinion. Or, more likely, they will first rely on their own common sense, friends and relatives, or online resources to come up with a diagnosis.

Now, imagine these typical people as typical jurors. As they hear a medical liability case, they might suspend judgment and wait until they are able to hear a scientific expert’s testimony. Or, more likely, they will place their initial and strongest reliance on their own resources in order to form an impression that precedes the experts, and shapes their own conclusions about which expert to believe. Based on that process, the best medical science doesn’t always win medical liability cases. And even when the science is believed and used in assessing evidence, the standards that are used to gauge its validity will, in many instances, differ substantially from the standards that the scientific community adheres to.

As explained in a recent article in Popular Science, “The Problem with Taking Scientific Questions to Court,” the lack of agreement between what the scientific community says and what the jurors say can be traced to the differences between the standards of law and science. “What the legal system considers enough evidence to establish that exposure causes illness is different from the standards of science—and trying to fit the two together can be hazardous.” Of course, understanding that difference isn’t likely to satisfy medical liability litigants, who often have no choice but to bring science into the courtroom. At times, the defense will need jurors in the courtroom to think and act a bit more like they’re scientists working in a lab. In this article, I will take a closer look at the Popular Science piece and share a couple of thoughts on how to encourage jurors to adopt that mind-set.

Law vs. Science: 51% or 95%?
The legal standard is generally the familiar “preponderance of the evidence” standard of “more likely than not,” which plaintiffs often operationalize as equivalent to just slightly above the balanced midpoint: 51%, or nothing more than a feather placed on one side of the scale.

For scientists, of course, the standard is different. To reject the “null hypothesis” of “no relationship,” scientists need much more than 51%. The most commonly accepted error rate is usually expressed as equal or less than .05, meaning that there is a 95% or greater probability that the effect is caused by the phenomenon under study and a 5%, or less, chance that it is due to sampling error. When the observed relationship doesn’t reach that 95% threshold, the relationship isn’t “statistically significant,” meaning it could be an accident of sampling and not an actual relationship.

Of course, when that science makes it into court, jurors aren’t told they need to be 95% sure; they’re told that it only needs to be more likely than not. The result is that a lot of science that is in fact still quite uncertain can still end up being used, creating some uncertainty for juries. “One of the questions is, what are juries really sup-
posed to do?” asks Ed Cheng, who studies scientific and expert evidence at Vanderbilt Law School. “You have this sort of immature science out there, which isn’t clear. If you’re a juror, you really want to get it right, but what are you supposed to do when the numbers aren’t clear?”

**The response for defendants**

The best response for defendants is to give jurors the guidance they need to appreciate the difference between scientific and legal evidence. The side relying on the more questionable science might be happy to apply the more relaxed civil standard, but being true to science, while still staying within the law, can be frustrating for the other side. Here are a couple of ideas for handling this.

**Emphasize the frame**

How are you framing the trial and placing jurors in an appropriate role? For plaintiffs, the jury is likely framed as a voice for the injured and the powerless, with the verdict construed as a way to wrest popular justice from large and uncaring institutions. For defendants, the right frame might be to emphasize their role, not as dispensers of justice but as investigators of truth.

And when it comes to questions of science, approaching that truth requires a scientist’s commitment. It requires high standards, skepticism, and even doubt. Scientists begin by assuming that the null hypothesis is true, and then checking to see whether there is sufficient compelling evidence that allows one to be nearly certain in rejecting it. In that role, the jurors are serving as the gatekeepers, and their role is to prevent flawed or hasty assumptions from getting past that gate.

**Emphasize the threshold**

There’s a reasonable point to be made that, when the strength of an observed relationship is more than the law’s 51%, but less than the scientific standard of 95%, it is not a relationship with modest support; rather, it is in fact a relationship with no support. The reason for that is that scientists don’t typically like to think of their work as “tipping the scale slightly.” Instead, within their discipline, they are either rejecting the null hypothesis or they’re not. That means that a relationship with 70% reliability isn’t 70% supported; it is 0% supported. The science did not reach the requisite threshold, so science is not able to offer an answer to this question.

This, of course, can be asking a lot from jurors. It will still be easier to look at an anecdote, or look at a not-yet-reliable association and conclude that there must be a relationship. But we have found that jurors can be motivated to reject the easy way. Wanting to believe that they’re doing a good and thorough job, they can be encouraged to, in a small way, think like a scientist.
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The U.S. Federal Reserve should be in a similarly reflective mood after their ninth rate hike, taking the overnight lending rate to a range of 2.25%–2.50%. While the majority of these hikes were accompanied by a strong economic backdrop and an unrelenting rally in risk assets, the most recent hikes were followed by volatility and weakness. As we look out into 2019 and consider the future of Fed policy, market pricing indicates that the Fed is likely to hit the pause button on its rate-hiking campaign. This is a significant change from the end of third quarter 2018, when market pricing was assuming two to three hikes, and a departure from the Fed's current dot plot estimates, which are calling for two hikes in 2019 (Figure 1).

Much of the change in expectations for the Fed Funds rate can be attributed to the ongoing debate about the long-run neutral rate, or R*(r-star). Often referred to as just the neutral rate, R* is Fed parlance for policy setting that’s neither boosting nor slowing growth. Staying below neutral is the equivalent of stepping on the monetary accelerator, whereas going above it means applying the brakes. For most of 2018, Fed officials had been divided in their opinions about where the neutral rate should be, with some suggesting that we are already there, at 2.5%, and others calling for as many as four additional rate hikes in the coming year.

Fed Chairman Jerome Powell has also added to the uncertainty. As recently as October 3, 2018, he stated that the central bank still had a long way to go before it reached neutral. However, on November 28, Powell altered his position and said that the Fed was now nearing the range of estimates that represent a neutral setting. This ambiguity brought volatility to the markets, causing interest rates and market projections for Fed hikes in 2019 to plummet.

What's changed
To understand what is behind this rapid reversal in Powell’s assessment, it is important to remember that when the Fed estimates the neutral rate, it is akin to driving only by looking in the rearview mirror. This is because of the long lag time between Fed policy changes and their actual impact on the broad economy.

They must, therefore, rely on a set of real-time indicators to judge what type of impact their policy is having on the economy. During the fourth quarter of 2018, several of these indicators started to flash warnings signs.

The first warning sign to consider is inflation, which is one component of the Fed’s dual mandate (the other being employment). Though widely projected to increase, inflation has not shown convincing signs of moving higher. The Fed’s preferred measure, Core PCE, recently ticked down to 1.88% from its recent high of 2.04% in July.

The decline in energy prices since that time should exert further downward pressure on input prices. As a result, market-based measures of inflation expectations also fell significantly over the course of fourth quarter 2018, with rates for five-year inflation swaps falling from 2.35% to 2.01%. This is important to monitor, because the threat of escalating inflation has been the key driver for the Fed’s path of expected rate hikes. If inflation is, in fact, softening, there is less of a pressing need to slow the economy by using tighter monetary policy.

A second warning sign is the performance of the more interest rate-sensitive sectors of...
and close seven factories, worldwide, by the end of next year.

The Fed is also monitoring financial markets and asset prices, which helped trigger the past two recessions. The performance of risk assets during fourth quarter 2018, in particular, equities and high-yield bonds, has definitely caught their attention. And while the Fed has stated that it views financial stability concerns as moderate, they have also called out commercial real estate, corporate debt, and leveraged loans as potential problem areas to keep an eye on.

And finally, there is the yield curve, which continues to flatten and, potentially, invert. Recently, the spread between two-year and 10-year Treasury yields declined to the lowest level since 2007, offering only 12 basis points for the eight-year extension. The spread between three-year and five-year Treasury yields inverted by 2 basis points, signaling that the market is expecting the Fed to cut rates sometime between 2021 and 2023. The curve is an important indicator of the degree of Fed tightening relative to market interest rates. When the curve inverts, it means that the Fed is running a highly restrictive policy.

“Feeling your way”

These factors are important to monitor because if inflation is not accelerating, key rate-sensitive segments of the economy are rolling over and the yield curve is nearing inversion, making it difficult for the Fed to justify additional rate increases. This should lead them to the conclusion that we have reached the neutral rate. This type of decision would be what we might think of as a “dovish” shift, and would be received positively by the market, since it would imply, at minimum, a temporary pause in the Fed’s tightening campaign.

While the first nine rate hikes of this campaign, which began in 2015, were facilitated by a backdrop of economic growth and relative stability, future hikes will require greater contemplation and reflection. This potential new Fed strategy is perhaps best summarized by Fed Chairman Powell, who said during a November 14 appearance in Dallas that “when you’re walking through a room full of furniture and the lights go off, what do you do? You slow down. You stop, probably, and feel your way. So it’s not different with policy.”

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early nine out of 10 respondents from more than 450 insurance companies globally said that innovation was moderately to extremely critical to their organization’s success, according to results of a recent A.M. Best survey of its rated entities on this subject.

A.M. Best launched the survey in an effort to understand the innovation landscape within the insurance industry before considering a more explicit assessment of innovation within our rating process. A perception exists that the insurance industry has lagged in innovation, and so A.M. Best asked companies what they think about the overall industry’s adoption of innovation, as well as the strategies that are being employed to implement new and innovative ideas. The survey results are part of an extensive special report on innovation, titled “Insurers Agree Innovation Is Critical for Future Success.”

Breakthrough technologies such as artificial intelligence or internet of things may be driving many of the innovations we see today, but from A.M. Best’s perspective, being innovative does not equate to being high-tech or making financial outlays that have a significant impact on the expense ratio. A.M. Best defines innovation as “a multi-stage process by which ideas are transformed into new or significant improvements that ultimately have a measurable impact on the success of a company.” The paths companies can take to be innovative are numerous. Ultimately, innovation is about building a sustainable advantage through continuous organizational development.

Avoiding adverse selection
The survey revealed varied reasons for innovating, but most respondents said they wanted to better address customers’ needs (22%); gain a competitive advantage (21%); or realize operational efficiencies (16%). Companies are realizing that they need updated and modern systems and processes to understand and satisfy new and existing policyholders’ needs in a digital world. Without modernized IT systems and processes, retaining existing customers may prove challenging, to say nothing of reaching untapped markets. For smaller, budget-strapped companies lagging in this area, an insurtech partnership could prove challenging, to say nothing of reaching untapped markets. For smaller, budget-strapped companies lagging in this area, an insurtech partnership could prove beneficial. For example, in the private passenger and commercial automobile space, carriers are harnessing opportunities to collaborate with various telematics providers and thereby gain an ability to better price their risk.

Companies were also surveyed on the challenges innovation can help them overcome, as well as the technologies in which they expect to invest. For insurers operating in the property/casualty (P/C) segment, which includes medical professional liability, overcoming inefficient technology systems and processes was a top priority of survey respondents. Companies are also looking toward innovation to help provide strategic responses for emerging risks such as cyber threats, increasingly devastating natural catastrophes, and shifting customer demographics.

Risk selection increasingly is linked to profitability. If insurers have capabilities in big data, internet of things, predictive modeling, etc., they can better target a preferred customer base, better identify loss exposures, and better adjust pricing to be more commensurate with the risk.

Clare Finnegan is Criteria Analyst, and Sridhar Manyem is Director, Industry Research and Analytics, A.M. Best.

A.M. Best believes that innovation is becoming increasingly critical to the long-term financial strength of insurers, and in turn, a significant majority of insurers understand that innovation is becoming a differentiator in the global marketplace.
exposure. Those that do not innovate successfully may have to contend with adverse risk selection. Other challenges—such as significantly higher expense ratios than more innovative competitors, or lower growth because more innovative peers may have access to lower-risk customers—are distinct possibilities as well.

A business model game-changer for all segments
Technology is changing the risk profile of insurable interests. Consumer technology now interfaces with an increasingly connected world, and computer algorithms have infiltrated everyday life. The advent of smart devices, such as homes and cars, raises the question of what insurers will be insuring in the future, along with the security and privacy implications that accompany this development. That said, these advances also may allow insurance companies to focus more on risk prevention and move away from paying claims.

The impact of innovation in the insurance space is not limited to the P/C segment. Life/annuity writers need to be innovative to try to create attractive savings products and other life insurance products, particularly to penetrate the underserved middle market and millennials. In a “gig” economy where temporary, flexible jobs are more commonplace, health insurance companies are looking to make customer experiences more efficient, and at the same time, more affordable. The gap between insurers that have and have not embraced innovation will only get wider with time.

Insurance regulation does not evolve as quickly as technology, and so A.M. Best urges that any future action serve as a positive force on innovation, as opposed to a stranglehold. Insurance companies still need to act in consumers’ best interests without creating new amounts of systemic risk. As technology becomes a more dominant part of the insurance value chain, it becomes critical that regulators of communication talk with insurance regulators to create prudent oversight.

Innovation could impact financial strength, success
Increased competition, changing customer habits, and slow growth are just a few of the factors pushing the insurance industry to change its paradigm. The next step in A.M. Best’s innovation initiative is the development of a new criteria procedure focused on evaluating innovation. A.M. Best will also be reviewing where a more explicit assessment of innovation might be placed in its Best’s Credit Rating Methodology: this would highlight A.M. Best’s belief that the ability to innovate and respond to accelerating change through innovation is increasingly critical to long-term financial strength.

Innovation through existing and future breakthrough technologies will remain a key driver of change in the insurance industry, and no doubt this evolution will be accompanied by some degree of uncertainty and doubt. However, A.M. Best views these new technologies as an expansion of an insurer’s toolbox. It is ultimately up to management to decide which tools to use to gain a competitive advantage and remain relevant.

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What was it like, the last time you visited the doctor? Did the healthcare professional who saw you have enough time to discuss your situation in a deliberate, unhurried manner? Or did you feel more like an auto part on a faltering assembly line, as you were shuffled from the receptionist to the weight and blood pressure station, the exam room, and then, finally, to the payment window, with extended periods of waiting and only a few fleeting moments for the actual consultation?

Irrespective of the specifics of your personal encounter, the consensus of officials in the federal government, as well as a good number of private payers, seems to be that patient care will be notably improved with the advent of value-based care as an option, and eventually as a potential replacement, for fee-for-service reimbursement.

In fact, in an effort to foster restructuring of reimbursement for healthcare professionals, in recent years, the Centers for Medicare & Medicaid Services (CMS) has introduced several value-based care models, such as the Medicare Shared Savings Program and the Medicare & Medicaid Services (CMS) has introduced several value-based reimbursement. These are laudable steps. Because, in the end, irrespective of the particular reimbursement scheme in use, at the most basic level, healthcare professionals just want to provide good care. They took an oath to treat the ill to the best of their ability—and it is but a very few who don’t do everything in their power to live up to this commitment. So, it is incumbent upon all of us to make the system better, and to advocate for a fair balance in patient/provider interests and regulatory initiatives. That will go a long way toward improving outcomes for patients, while, at the same time, ensuring that healthcare professionals themselves can experience a wellness path of their own.
There are two good reasons to do something over and over: tradition...and habit.

The former creates value; the second saves you time. They key is to make sure you’re not doing what you’ve always done simply because you’ve done it before.

Like you, we’re staunch believers in tradition. But we also know that your best option isn’t necessarily what you’ve been doing the longest.

...That’s why it’s worth taking a good, hard look.

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