Claim Costs: Is the Sky the Limit?

AND

Big Data without the Dogma
Leading the Way

With more than 30 years of healthcare experience, our dedicated team combines advanced analytics with trusted market relationships to effectively protect and allocate your capital, and help minimize your exposure to risk. To learn more about how BMS provides specialized solutions to PIAA companies, visit us at bmsgroup.com.

Contact: Mike Hollenbach, Executive Vice President
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Tony Hill, Director
+44 20 7374 5907 Anthony.Hill@bmsgroup.com
PIAA is excited and proud to celebrate the 30-year track record of its one-of-a-kind Data Sharing Project (DSP). Now housing more than 265,000 closed claims, the DSP continues to be an invaluable resource for investigating and understanding the key trends in healthcare delivery and the impact on the liability of the medical professionals and institutions providing care.

Back in 1985, the visionary leaders of PIAA realized the potential benefits of compiling the claims data collected by each of its member companies. The aggregated information could be analyzed to develop a national overview of claim trends, and to identify areas of healthcare practice most vulnerable to assertions about liability. In addition, a database of this magnitude provided a statistically powerful basis for attempting to determine the true cost of claims—and also bolstered the defense against the burgeoning number of non-meritorious claims.

Since then, the scope of applications of the DSP, and the spectrum of the uniquely valuable products provided to member companies from it, has steadily expanded. In past years, valuable studies, such as the Breast Cancer Study and the Aortic Disease Claims Study, have been published to provide an overview of the current issues in the diagnosis and treatment of these maladies, with a particular focus on how they impact medical professional liability (MPL) claims. More recently, we have debuted the “Closed Claims Comparative,” which provides key information on claim trends for the most recent 5 and 10 years and the “Specialty Specific Series,” which features key medical specialty specific claims information. Both of these unique publications offer unmatched insights into what is happening in MPL, and offer promising areas of focus for patient safety and risk management initiatives.

Also in recent years, receipt of requests for individual analyses from PIAA members has become a common occurrence for our Research Department team. In order to make this even more user friendly, the DSP will soon introduce dashboards that offer a real-time user interface for DSP participating members, allowing them to see a snapshot of their own current data juxtaposed with industry trends. Participants will have the power to interact and create personalized data visualizations when these new dashboards become available later this year.

The staff members who shepherd the DSP are also working on the transition from ICD-9 to ICD-10 that is finally expected to take place in the U.S. in 2015. It is a daunting undertaking, but the new manual, with nearly 69,000 diagnosis codes (vs. roughly 13,000 in ICD-9) may well make possible new analyses that provide greater insights into the impetus behind claims and how best to resolve them. And given that MPL has become a global enterprise (we learned just how true this is during the October 2014 PIAA International Section Conference in Amsterdam), implementing ICD-10 will facilitate our ability to share and compare data with our international PIAA members.

Also, data from hospitals and healthcare systems will soon be included in the DSP. This puts the DSP in the vanguard of harnessing liability and claims data for every type of entity involved with healthcare delivery.

It is therefore appropriate that this issue of Inside Medical Liability features two articles whose central focus is on data. Our cover story, “The Changing Dynamic of MPL Claims,” examines the recent data within MPL, combined with external developments expected to impact significantly upon it, to provide insights into what may be some challenging months ahead for the MPL sector. Every innovation in healthcare, such as expanded use of telemedicine, seems to be potentially linked with new kinds of risk.

In another feature, “Big Data without the Dogma—Analytics for Better Decisions and Predicting Behavior,” the author sorts through the various kinds of hype that surround the term “big data,” and suggests a strategy for using it wisely.

As an organization that is uniquely built on the unimpeachable foundation of a vast compilation of individual data, PIAA remains focused on the major issues of importance to the MPL community, and on how we can best protect your interests in them. We will continue to explore new ways to utilize this data to advance and protect the interests of individual healthcare professionals, hospitals, health systems, and anyone with an interest in the safe and quality delivery of medicine.
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By Milka Kirova, Patricia Marzella-Graubart, and Ginger Turner

25  Feature: Big Data without the Dogma—Analytics for Better Decisions and Predicting Behavior
By James Guszcza

30  Feature: Bariatric Surgery: A Special Case for Patient Engagement
By James W. Saxton, Esq., Amanda R. Budak, RN, CBN, PhD, and Theresa A. Folino, Esq.

35  Feature: Interplay between State Board Actions and MPL: Shared Risk and Potential Implications
By Michael J. Schoppmann

“In the coming years, an economic rebound and ever-evolving regulatory and technological changes will likely drive up the number and severity of MPL claims.”
—Cover story

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Special Section
39  2014 PIAA International Conference
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Let Delphi Technology show you how its fully-integrated medical professional liability solution will transform your critical business challenges into measurable business results.
COMING ATTRACTIONS

EVENTS & CALENDAR

Special Luncheon Event!  
(This luncheon is part of the PIAA Leadership Camp.  
All registered attendees of the PIAA Medical Liability  
Conference are also invited to attend.*)

Wednesday, May 13, 11:30 a.m.–1:30 p.m.  
The Business Case for Board of Directors and  
Senior Management Team Diversity

Speakers:
Scott C. Syphax, President & Chief Executive Officer,  
The Nehemiah Companies; Director, NORCAL  
Mutual Insurance Company
Dave Jones, California Insurance Commissioner
Aeisha Mastagni, Investment Officer, CalSTRS;  
Board of Directors, International Corporate  
Governance Network

PIAA will continue its Diversity Series in 2015 with a  
moderated discussion that features distinguished  
speakers from the healthcare and insurance indus- 
tries. The panelists will discuss the economic and  
professional advantages of employing a diverse board  
of directors and senior management team. The  
Speakers will challenge the status quo of corporate  
America based on first-hand experience and personal  
success stories that grew into long-term business  
strategies that proved effective in engaging and enlist- 
ing diversity in their organizations’ management.

*PIAA Leadership Camp is a one-day meeting that takes  
place immediately before the 2015 PIAA Medical Liability  
Conference. It provides attendees with the critical insights and understanding they  
need to serve with confidence as strong contributing members of a senior leadership  
team, or on a board or committee.

2015 Medical Liability Conference—  
Keynote Session

Seeing Beyond Reform: A Leadership Guide to the  
Emerging New Normal in Healthcare

James E. Orlikoff, President, Orlikoff & Associates,  
Inc.; National Advisor on Governance and  
Leadership to the American Hospital Association

The “new normal” of healthcare is here! In today’s  
landscape, we see depressed hospital volumes and  
Margins, declining reimbursement, mergers and  
new affiliations creating super-systems, disruptive  
innovations like ACOs emerging daily, and much  
more. The challenges facing both leaders and individual healthcare pro- 
fessionals are daunting—but they can be overcome. First, leaders need to  
recognize that the changes in healthcare really are transformational—  
not just transactional.

Leaders need to position their organizations so they become something  
radically different. They need to work on the system, not just in it. And  
they need to work on themselves as well, to leverage leadership best  
practices at all levels. In this presentation, Mr. Orlikoff, author of the  
award-winning book,  
Board Work: Governing Health Care Organizations,  
and the primary author of  
Malpractice Prevention and Liability  
Control for Hospitals, will discuss the macro forces driving  
revolutionary change in healthcare, and their probable repercussions.  
He will also suggest approaches to effective transformative leadership,  
based on more than 25 years’ experience in consulting for healthcare  
systems in six countries.  

April 8–10, 2015  
Marketing Workshop  
The Ritz Carlton  
Charlotte, NC

April 8–10, 2015  
Dental Workshop  
The Ritz Carlton  
Charlotte, NC

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

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

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

October 6–7, 2015  
Introduction to Medical  
Professional Liability  
Insurance Workshop  
The Mayflower Renaissance  
Washington, D.C.

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

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

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

Future PIAA Medical Liability  
Conferences:

May 11–13, 2016  
Washington, D.C.

May 17–19, 2017  
Colorado Springs, CO

Scott C. Syphax  
Dave Jones  
Aeisha Mastagni  
James E. Orlikoff  

December 8–10, 2016  
Professional Liability  
Conference  
The Roosevelt  
New Orleans, LA

April 8–10, 2017  
Marketing Workshop  
The Westin Kierland Resort & Spa  
Scottsdale, AZ

April 8–10, 2017  
Dental Workshop  
The Westin Kierland Resort & Spa  
Scottsdale, AZ

May 13, 2017  
Leadership Camp  
Caesars Palace  
Las Vegas, NV

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Safety/Risk Management  
Workshop  
The Roosevelt  
New Orleans, LA

Future PIAA Medical Liability  
Conferences:

May 11–13, 2018  
Washington, D.C.

May 17–19, 2019  
Colorado Springs, CO
In a world of risks and costly claims, you can be a hero to your insureds.

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Google Glass: Half Full—or Half Empty?

The idea that wearing Google Glass while, say, performing surgery has obvious appeal, especially in the academic setting for training new surgeons. Glass can capture and transmit a vast amount of data with immense teaching value. But then, the obvious problems come to mind. The tough nut to crack with this device is privacy protection. A spokesman for IT security consultant Wisegate, Elden Nelson, cautions that any doctor using Google Glass “will have to be absolutely certain that they don’t use an out-of-the-box Glass device, have it paired with a phone, and wind up having it video streamed to a Google server. That would be a monstrous and massive violation of the HIPAA rules.”

He adds, “There are very few tools so far that essentially restrict data collection to local servers and keep those rules and regulations intact. So they’re using the hardware of Google Glass, but not being able to use it in its pure consumer version of all the hardware that is allowed.”

So the challenge, as Nelson sees it, is to come up with practical and effective policies for the best use of Google Glass in hospital settings. And with the rapid proliferation of all sorts of devices in the healthcare setting, policies will need to be extensible, he advised, to smartphones, tablets—any device a physician might bring with him to work.

And there is another issue: Might the data captured in devices like Google Glass become discoverable in the event of a medical professional liability claim? It has been a tortuous process sorting through the discoverability of e-mail. This could well be the next New Frontier in contentions about discovery. But then, maybe a data record like this could just as easily afford a physician a measure of protection, indicating clearly that the proper standard of care was followed.

Observer will make no predictions, on that score.

Source: Fierce Mobile IT, January 8, 2015

New Jersey Physicians with Bleak View of Current Situation: Just Ride This One Out?

According to a recent survey by the law firm Brach Eichler, physicians in New Jersey are quite unhappy about their current lot. Fully 90% believe that the current healthcare environment has negatively impacted their role as a physician. What’s making life hard? Well, more than 86% report increased administrative burdens, and 60% say they are spending less time with patients and more money on technology.

John D. Fanburg, chair of the health law practice at Brach Eichler, notes that he is not surprised at the survey results. “What we’ve seen in the transactional area is a lot of activity, frustration, and fear. He adds, “We have doctors doing one of four things: selling their practice to a hospital; joining a large multi-specialty group; joining or forming a single specialty group”; or making no changes and instead “just trying to ride it out until the next phase of healthcare reform kicks in.”

Becoming part of an accountable care organization doesn’t seem to have helped matters, either. While 29% of respondents now belong to an ACO, only 5% report gaining any benefits from it.

Linda Schimmer, vice president of New Jersey Health Care Quality Institute, comments, “The survey results are interesting and are evidence of just how hard it is to transform healthcare.”

Source: NJBIZ, January 7, 2015
Here it is: “Win a Fishing Trip with President Jimmy Carter by Committing to ZERO Preventable Patient Deaths by 2020.”

But perhaps you’d like more details. If so, here is the venue for the outing: “the exclusive Brigadoon Lodge in the North Georgia mountains.”

Know that you will have to do more than merely express a commitment to greater patient safety. According to the competition’s sponsor, the Patient Safety Movement foundation, “The winners of the trip will be the top three healthcare institutions that measurably demonstrate the most lives saved through commitments to implementing Actionable Patient Safety Solutions. Each will get two spots on the exclusive trip.”

But the Foundation itself, it seems, has something of a checkered past. It is the creation of Masimo Corporation president Joe Kiani. Masimo manufactures medical devices, and is one of the leading makers of pulse oximeters. In this regard, on October 6, 2014, National Public Radio reported that, “An inspection by the Food and Drug Administration last year found Masimo didn’t adequately investigate dozens of reports that its devices may have malfunctioned.”

When Kiani was asked how the FDA findings might reflect on the ideals put forth by his nonprofit effort, Kiani said that he never claimed to be perfect: “I’m just trying to do my best and get my other colleagues to do their best.”

Maybe, the Headline Is All You Need

Researchers, prompted by some motivation not explicitly identified, analyzed Wikipedia page views of disease-related articles, and then compared these with official reports of disease incidence. What they found was an increase in page views of a certain infectious disease that popped up a full four weeks before health offices declared an outbreak.

The researchers concluded, “We have established the utility of Wikipedia access logs for global disease monitoring and forecasting.” Seems like rather a big leap here, extrapolation-wise.

Source: Becker’s Hospital Review, November 24, 2014

Using the (Unimpeachable) Wikipedia to Monitor Infectious Disease Outbreaks

Source: Becker’s Hospital Review, November 24, 2014

Source: Insurance Journal, January 8, 2015

Source: Market Wired, December 19, 2014

The 2014 Insurance Regulations Report Card

Each December brings the annual “Judicial Hellholes” report. And then in January, we get the yearly “Insurance Regulation Report Card.” The former is far more exciting than the latter, and they have that neat website with the flames of hell burning everywhere (www.judicialhellholes.org).

But the R Street Institute, which issues the Report Card, certainly gets points for thoroughness. There are 12 broad performance categories considered in evaluating the states, including how well they monitor insurer solvency, how efficiently they spend the insurance taxes and fees they collect, and the extent of transparency and politicization of insurance regulation in the state.

Vermont, at the head of the class, received an A+. Not far behind, with a grade of A, were Virginia, Illinois, and Iowa. An A- was awarded to Maine, Utah, Ohio, and Kentucky.

At the other end of scale were the 12 states that got a “D” or “F” grade: California (F), North Carolina (F), Montana (D-), Hawaii (D), New York (D), Michigan (D), Washington, Mississippi, and Florida each received the vaguely oxymoronic grade of D+.

The remaining states fell nicely under the mid sections of the bell curve.

R Street Institute cautions that a high (or low) grade is not necessarily the result of what is happening in a state’s insurance department. They note that state legislatures, more than regulators, often control the conditions in the most heavily weighted variables considered in the report.

Source: Insurance Journal, January 8, 2015
PIAA MPL Specialty Specific Series
MPL Highlights 2009–2013

Average Indemnity (2013 Dollars)

<table>
<thead>
<tr>
<th>Period</th>
<th>Indemnity Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004–2008</td>
<td>$381,585</td>
</tr>
<tr>
<td>2009–2013</td>
<td>$342,384</td>
</tr>
</tbody>
</table>

27% resulted in an indemnity payment

2004–2008 vs 2009–2013:
- Decreased 10%

Top Chief Medical Factors
1. Improper performance
2. Errors in diagnosis
3. No medical misadventure
4. Failure to supervise or monitor case
5. Failure to recognize a complication of treatment

Top Outcomes
1. Cardiac or cardiorespiratory arrest
2. Postoperative infection
3. Emotional distress only
4. Surgical foreign body left in patient during a procedure
5. Accidental puncture or laceration during procedure

Average Defense Expenses (2013 Dollars)

<table>
<thead>
<tr>
<th>Period</th>
<th>Defense Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004–2008</td>
<td>$39,078</td>
</tr>
<tr>
<td>2009–2013</td>
<td>$50,766</td>
</tr>
</tbody>
</table>

2004–2008 vs 2009–2013:
- Increased 30%

Resolution
- 64.5% Dropped, Withdrawn, or Dismissed
- 24.5% Settled
- 7.1% Defendant Verdict
- 0.7% Plaintiff Verdict
- 2.3% ADR/Contract
- 0.9% Not Specified

Check out the new PIAA MPL Specialty Specific Series; MPL highlights provided for each specialty. Reports are available at www.piaa.us.

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The intent of the PIAA Data Sharing Project (DSP), begun in 1985, was to discover what could be learned by compiling the data stored by its member companies. PIAA endeavored to measure the true cost of medical professional liability (MPL) claims and to provide statistics in support of the argument that the majority of MPL claims filed are non-meritorious. The DSP also collected and analyzed these member-company data to develop a national overview of claim trends, and to identify areas of healthcare most vulnerable to liability.

In turn, the synergies between the PIAA DSP and the PIAA participating members have given them validity in areas where they wouldn’t necessarily have their own specific loss information, thereby making it possible for them to identify emerging areas of MPL risk and develop new educational programs. As well, the DSP serves as the basis for doing large, nationwide studies, such as those on breast cancer, colorectal cancer, and aortic disease. As the largest ongoing database of its kind in the U.S., the DSP is PIAA’s in-house source to provide unimpeachable evidence for advancing the priorities on PIAA’s public policy agenda.

Over the years, the DSP has also kept pace with technological innovations. Data was first collected through paper records; then, delimited files were used, and a desktop application was created for validation. In 2015, the data will be collected via a Web application and reported through dashboards. Data capture in the DSP relies on a complex code system incorporating the International Classification of Diseases, 9th Clinical Modification (ICD-9). But it is progressing towards utilizing ICD-10 codes, beginning this year. It uses the codes to identify medical conditions and treatments, and also incorporates other systems of specialized codes, to account for key medico-legal issues.

Importantly, it does not identify individual practitioners.
ALL THAT’S FIT TO PRINT

NEWSLETTERS ARE A GREAT WAY TO STAY IN TOUCH WITH CUSTOMERS, PROSPECTS, AND THE OTHER INFLUENCERS OF YOUR BUSINESS. THE NEWSLETTER IS A DYNAMIC TOOL THAT CAN BE INFORMATIVE, AND ALSO SERVE AS A SALES TOOL AND A LOYALTY BUILDER. HOWEVER, NEWSLETTERS ARE FREQUENTLY HANDLED HAPHAZARDLY BY MANY ORGANIZATIONS, WHICH FALL TO PLAN, DEVELOP, AND IMPLEMENT THEM APPROPRIATELY. IN FACT, MANY NEWSLETTERS ARE SIMPLY THROWN TOGETHER EACH TIME, INCLUDING ANY ODDS AND ENDS THAT THE ORGANIZATION HAS IN HAND AT THE TIME OF PUBLICATION.

WITH HUNDREDS OF THOUSANDS OF NEWSLETTERS IN CIRCULATION EVERY MONTH, IT IS CRITICAL TO CREATE A NEWSLETTER THAT COMMUNICATES AND DELIVERS VALUE IN EVERY EDITION. THIS IS THE MOST IMPORTANT GOAL OF ANY NEWSLETTER. WHETHER IT IS DELIVERED VIA FAX, MAIL, E-MAIL, OR WEBSITE, EVERY SUCCESSFUL NEWSLETTER HAS A SINGLE GOAL IN MIND—DELIVERING ADDED VALUE TO THE READER.

FOUR KEY POINTS

NEWSLETTERS CAN BE INFORMATIVE AND COVER A WIDE VARIETY OF TOPICS. OFTEN, HOWEVER, NEWSLETTERS ARE HAMPERED BY DISTRACTING DESIGN, POOR SPACE PLANNING, AND TOO MUCH COPY. AS A KEY COMMUNICATION PIECE FOR YOUR ORGANIZATION, A NEWSLETTER CAN MAKE A HUGE IMPACT ON THE READERS’ PERCEPTION OF THE QUALITY AND EXCELLENCE THAT YOUR ORGANIZATION OFFERS. SO IT IS IMPORTANT TO KEEP IN MIND THE FOLLOWING FOUR POINTS.

START WITH A STRATEGY

THIS IS THE STEP MOST ORGANIZATIONS AND INDIVIDUALS SKIP WHEN THEY FIRST LAUNCH THEIR NEWSLETTER. THEY JUST START WRITING AND COLLECTING TIDBITS OF INFORMATION TO INCLUDE. INSTEAD, IT IS IMPORTANT TO THINK ABOUT THE LONG-TERM STRATEGY OF YOUR NEWSLETTER. WHAT DO YOU WANT IT TO DO? HOW OFTEN WILL YOU PUBLISH IT? WHAT TYPES OF INFORMATION ARE VALUE-ADDED FOR YOUR PROSPECTIVE READERS?

THINK ABOUT YOUR TARGET AUDIENCE FOR THE NEWSLETTER. WHAT ARE THEY ALREADY RECEIVING FROM OTHER SOURCES? HOW CAN YOU MAKE YOUR CONTENT RICH AND SUFICIENTLY UNIQUE THAT PEOPLE WILL CONSIDER IT AN ESSENTIAL RESOURCE?

DETERMINE THE ORGANIZATIONAL IDENTITY YOU WANT TO PROJECT TO YOUR READERS THROUGH YOUR NEWSLETTER. SHOULD IT BE FRIENDLY, PROFESSIONAL, HIGH-CLASS, TECHNICAL, EXPERIENTIAL, AUTHORITATIVE?

THEN, THERE ARE SOME OTHER ISSUES YOU’LL WANT TO CONSIDER. FOR EXAMPLE, SHOULD YOUR NEWSLETTER CONTAIN RELATED ADVERTISING? AND IF SO, SHOULD YOU CHARGE FOR IT? HOW WILL PEOPLE SUBSCRIBE AND UNSUBSCRIBE? WHAT IS YOUR BUDGET FOR PRODUCING IT? HOW WILL YOUR SUBSCRIPTION DATABASE BE MANAGED AND UPDATED?

AND THE ULTIMATE QUESTION YOU NEED TO ASK IS THIS: IS THIS NEWSLETTER A BRAND-BUILDING OR A BUSINESS-BUILDING EFFORT? A BRAND-BUILDING EFFORT FOCUSES ON GAINING EXPOSURE AND INCREASING THE FAVORABILITY OF YOUR PRODUCT OR SERVICE IN THE CONSUMER’S MIND. A BUSINESS-BUILDING EFFORT FOCUSES ON DRIVING SALES TO YOUR BOTTOM LINE.

DESIGN AND LAYOUT

WHILE THERE ARE A LOT OF SHORTCUTS AVAILABLE HERE, IT IS IMPERATIVE THAT YOU ENSURE THAT...
Cyber liability insurance from NAS provides state-of-the-art coverage and an expert breach response team to help you handle the crisis efficiently and thoroughly.

With experienced claims staff, legal experts, and our nationwide network of data breach response specialists at your side, we’re here to help you get your business back on track. Quickly.

For more information about our Cyber Liability Solutions, visit nasinsurance.com/cyber
your design and layout are consistent with your other published materials. A consistent and integrated look will increase recognition when your newsletter arrives from your organization. It is amazing to see how many newsletters are sent out from organizations that don’t look anything like the other materials they produce. Be careful not to create a visual disconnect between your newsletter and the rest of your organization.

Also, design is more than just eye-candy. Type, photos, illustrations, graphic elements (like boxes, charts, lines, and grids) are the four basic building blocks you can use to help communicate your ideas. Thoughtfully gathering, manipulating, and placing these elements will create a stronger newsletter.

If you don’t have an experienced graphic designer on your staff who can design your newsletter, it may be wise to consider hiring an outside vendor to help you. Professional designers generally have significant training in both design and the computer applications needed to translate your desired look and feel onto paper. If you’re budget-conscious, you can always have the designer create templates for you that you can print in large quantities. Then, you can use this “stock” as a frame for your content throughout the year(s).

Content management
There are different types of newsletters. Some are informational, some are motivational, and some are designed to give you a little bit of information and then drive you to other fee-based resources. It is important, whatever type of newsletter you choose, to plan your content for the full year. This practice alone helps to ensure the relevance of content to your readers, and it also gives you sufficient time to prepare for any required research.

If you plan on accepting outside article submissions to your newsletter (which is usually a good idea), be sure to set up some writers’ guidelines. These are the rules and specifications a prospective writer will follow when submitting his materials to you. You may want to specify a minimum or maximum length (in words), preferred format for submission (fax, e-mail), whether an author photo is needed, submission deadlines, and some details about your review process. If you do accept outside contributions, it is always nice to send the author a few free copies of your newsletter as a thank you. They’ll often use it in their own marketing, thereby providing you with exposure to additional audiences.

Reader relevance
This is likely the second most important part of any newsletter strategy. (The first is to have a strategy to begin with.) As noted above, there are hundreds of thousands of newsletters in circulation every month. Yours must compete for the attention of an already overwhelmed and busy audience. To achieve relevance, make sure you identify your goals for your newsletter and clearly identify what your typical reader will want in terms of content.

You can verify your readers’ interest by conducting a reader survey on your current newsletter. If this hasn’t happened within the last three years, you should do a targeted evaluative assessment, to generate ideas for improvement, right away. Remember, the newsletter is only as good its relevance to its reader’s needs. Find out what their needs are.

New! From the PIAA Data Sharing Project:

PIAA MPL Specialty Specific Series

The MPL Specialty Specific Series is an all-new publication designed especially for every individual who works on medical professional liability (MPL) claims, risk management, and patient safety, as well as other professionals with an interest in MPL claims and lawsuits. The MPL Specialty Specific Series identifies MPL trends for 24 medical specialties, ranging from surgery to primary care. Features include:

- Specialty-specific and combined specialty data for making key comparisons
- Top medical conditions involved, procedures, allegations, resolutions, and costs
- Special note: PIAA Data Sharing Project participants receive individualized reports, so they can compare their data with nationally aggregated information

Go to www.piaa.us to purchase this and other essential PIAA research publications!
And, how many subscribers you have shouldn’t be the sole measure of the success of your newsletter. You also need to consider retention and content penetration. Retention refers to the length of an average subscription. Do people hang around for only one or two issues, or for years, before they end their subscription? Also, content penetration refers to how much of the newsletter they are reading—only certain parts, or do they devour the whole thing? Is only part of your newsletter of value?

**Fit to print**

If you have a company newsletter, whether internal or external, online or off, take a few minutes today to review it, and then begin to develop a continuous improvement plan. If you don’t have a newsletter, call some of your customers today and see what information they need that they’re not getting now from any other source. This is a good first step to creating a newsletter that is fit to print.

---

**The Promise of Precision Medicine**

“Ultimately, we will need to evaluate the most promising approaches in much larger numbers of people over longer periods. Toward this end, we envisage assembling over time a longitudinal ‘cohort’ of 1 million or more Americans who have volunteered to participate in research. Participants will be asked to give consent for extensive characterization of biologic specimens (cell populations, proteins, metabolites, RNA, and DNA—including whole-genome sequencing, when costs permit) and behavioral data, all linked to their electronic health records.”


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**Who Do You Want at Your Table?**

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For the fourth time in the last five nationwide elections, we’ve seen a wave, with one party clearly dominant. Congressional Republicans picked up 14 new seats. Now the GOP has its largest majority in the House of Representatives since 1930. In the Senate, Republicans gained nine seats, and they are back in the majority for the first time since 2006. At the state level, Republicans saw gains, netting two governorships, and the GOP now has control in 31 states. The GOP also captured 68 of the 99 legislative chambers in the nation.

**Makeup of Congress**
The 114th Congress is not only the most Republican we’ve seen in many years, it’s also been touted as the most diverse Congress ever. Women make up 104 of the 535 legislative officials in Washington, D.C., exceeding the century mark for the first time in Congressional history. A racial breakdown of the new Congress reveals that 46 blacks now serve (the most since Reconstruction), along with 33 Hispanics, 12 Asian-Americans, and two Native Americans.

In terms of background, more than half of the federal lawmakers previously served in an elective office (most in state legislatures), and more than one-third of those in Congress previously worked as lawyers. Ninety-eight have prior military experience, and 27 have some prior experience in the healthcare field.

So: What does the change in control of Congress, with greater diversity among its members, mean for the medical professional liability (MPL) community? The answer isn’t simple; actually, it depends on several other factors.

**Policy strategies**
While Congressional Republicans certainly intend to propose a positive agenda in 2015 and 2016, they don’t seem to be in a mood to negotiate with the President to get that agenda enacted. The increase in the GOP majority in the House may give Speaker Boehner (R-OH) more room for compromise with the Democrats, and Majority Leader McConnell (R-KY) will have to compromise with at least a few Democrats to prevent filibusters on his priorities. Few observers anticipate, however, the sort of negotiations that occurred the last time a Democratic President took on a completely Republican Congress (during the Clinton Administration). Instead, the Republican leaders seem content to pass their priority legislation, and then let President Obama veto anything he doesn’t like. The upshot may be that only a few bills will be enacted, but this strategy will serve to highlight the differences between the two parties.

At the other end of Pennsylvania Avenue, President Obama doesn’t seem all that interested in compromise either. Since
The drubbing he took on election night, he has become more adamant about advancing his own agenda and has talked about some new policies he knows the GOP will never accept.

The impact for MPL
How will all this affect the interests of MPL insurers? At the moment, it appears that the path forward for our primary legislative objectives remains unchanged. **Standard-of-care legislation** narrowly missed enactment last year because of budgetary issues that arose from the proposed repeal of Medicare’s Sustainable Growth Rate (SGR) reimbursement mechanism. The **Standard of Care Protection Act** is once again on the table, however, and is already being considered by Congress. It should be included as one part of the new SGR package under development, and it will likely pass if the aforementioned budget issues can be resolved. If not, some other piece of healthcare legislation may provide another vehicle for its enactment.

It is unlikely that we will see **federal tort reforms**, in light of ongoing concerns about states’ rights. The current environment, however, may provide an opportunity to finally resolve that issue. That is the upside of Congressional leaders’ reluctance to advance tort reform legislation at present: It gives them time for more methodical discussion of the states’ right issue, so that the matter can be addressed before any votes are scheduled to take place.

PIAA is also considering other areas where there could be incremental change in Washington. **Early-resolution programs** may be one possibility, and there has been increasing interest in reforming the National Practitioner Data Bank. These issues are not inherently partisan, and as such, they might have more potential for advancement in a divided government.

Conclusion
With both parties committed to emphasizing their political differences, it is unlikely that major legislative proposals will advance during the 114th Congress. At the same time, however, it’s not likely that either party wants to look like complete obstructionists as we head into the 2016 elections. For this reason, this could be an occasion for advancing modest, nonpartisan legislation (the kind that garners scant media attention) in the coming months.

As we begin to see what will actually happen in Congress, PIAA will focus on what we can gain, in terms of legislative or even regulatory victories for you, by capitalizing on the new political realities in the nation’s capital. We’ll be closely monitoring the situation, leveraging every opportunity we discern. 

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Eighteen months later, he leaves, and within the next year you find yourself named as a defendant in more than 20 medical professional liability (MPL) lawsuits, filed by patients you never treated. What went wrong, and just as important, how could you have protected yourself?

‘Respondeat superior’
The legal doctrine of “respondeat superior” (literally “the master answers”) has its roots in English common law. It is based on the idea that if an employee (or, in the past, a “servant”) harms a third party in the course of performing duties for an employer (or “master”), the employer should be held responsible, along with the employee. In theory, such a concept is logical. The employee would not have caused the harm if he had not been working for the employer, who ultimately has control over his duties. The California Supreme Court has identified three public policy reasons for applying the doctrine of respondeat superior: “(1) to prevent recurrence of the tortious conduct; (2) to give greater assurance of compensation for the victim; and (3) to ensure that the victim’s losses will be equitably borne by those who benefit from the enterprise that gave rise to the injury.” (Mary M. v. City of Los Angeles (1991) 54 Cal.3d 202, 209.)

Generally speaking, for the principle to be applied, three conditions must be satisfied:
The employee’s wrongful act must occur while the employee is “on the clock”; the wrongful act must be related to a benefit derived by the employer; and, the act must be related to a benefit derived by the employer.
employer. Under respondeat superior, an employer may even be responsible for an employee’s criminal activity. In *Lisa M. v. Henry Mayo Newhall Memorial Hospital* (1995) 12 Cal.4th 291, the California Supreme Court held a hospital liable for the sexual molestation of a patient by an ultrasound technician. But how far should that liability extend when a physician employs another physician in his practice?

**Respondeat superior and MPL**

A neurosurgeon in California was faced with a catastrophic dilemma after hiring a young doctor to join his practice. This new doctor had outstanding references and had been trained in one of the best neurosurgery programs in the country. An employment contract identifying the doctor as an employee was drafted and signed. (The contract was revised after the first year, changing the “employee” designation to “independent contractor,” although the rest of the contract language remained the same.) He was granted provisional privileges by the local community hospital after his successful completion of proctoring. Soon, he was receiving referrals and performing “cutting-edge” procedures that no other local surgeons performed. By all outward appearances things were going well, but before the end of the first year the hospital noticed his infection rate was higher than anticipated. An investigation was initiated, and measures were undertaken to remedy the infection issue.

Shortly thereafter, it was discovered that his complication and readmission rates were high, and in addition, his record-keeping appeared to be poor and even intentionally false. He was terminated by his employer, and his hospital privileges were suspended. Throughout his employment, he did not disclose any issues with his employer, and when asked, denied that there were any unusual problems. Of course, his employer had not routinely reviewed any of his charts, in light of patient privacy laws. For this same reason, other physicians did not advise the employer of their awareness of patient care concerns.

Within a year of his departure, the employer was named as a defendant in 25 MPL lawsuits arising from the patient care that was provided during the 18 months the surgeon was employed, all on the basis of respondeat superior. While the employee carried his own MPL coverage, his limits were insufficient to satisfy the volume of claims that ensued, and so the employer’s policy contributed to settlement of most of the claims.

If the three public policy considerations expressed by the California Supreme Court are considered, there are valid arguments for exempting physician employers from respondeat superior liability in this and many other situations.

(1) Preventing recurrence of the tortious conduct. Our neurosurgeon/employer spoke regularly with his new hire, discussing

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**THE DOCTOR’S PERSPECTIVE**

In 2009, my professional corporation hired a neurosurgeon, with the help of a reputable national recruiting firm. He was thoroughly vetted, and his exemplary letters of recommendation were personally verified. He started working as an employee of my professional corporation as a neurosurgeon when he finished his residency. Unfortunately, he was a “bad hire,” and I fired him less than 18 months later, when I became aware of information justifying his firing.

Regrettably, during this short period, he caused a great deal of harm: a total of 29 MPL lawsuits were filed against him. My professional corporation was named in 25 of these suits. Respondeat superior liability was invoked, each time.

I maintain that the differences between a regular employee and a professional employee, in this case a neurosurgeon, are so significant that anyone with common sense would quickly come to the conclusion that this legal theory should not, and does not, apply in my cases.

**Consider the facts**

A neurosurgeon was licensed by the state to practice medicine; had a medical degree from an established university, and a certificate of completion of training at a reputable neurosurgical training program; he was given the appropriate recommendations and was properly vetted before being hired as a surgeon; he had his own privileges at a local hospital (granted by the hospital and not by his employer), and the hospital had released him from protorship.

Add to that the fact that privacy laws, spelled out quite restrictively in HIPAA, prohibit one physician from looking at another physician’s patients’ charts, even if the first physician is the employer. And yes, the penalties are stiff. If I were to look into my employee’s patients’ charts without the express consent of the patients, I’d be in significant violation of the HIPAA rules. In this case, I was only able to review some of the charts after I had fired him, and when the patients in question had asked me to evaluate them as my own patients.

So is it logical for me to be held responsible for the act of a professional who has all the appropriate credentials? Is it appropriate that I be held responsible for the acts of a professional who acted unprofessionally and who was proven to have lied repeatedly to his employer? There is no question that some laws were designed with good intentions, but we often suffer because of their unintended consequences. Changing such laws should be a priority, to better protect patients and hold the real offenders more accountable.

Employers do share some extent of responsibility, but somehow that should be commensurate with their actual ability to manage their employees; obstacles put in effect by laws such as HIPAA should be taken into consideration.
cases and work in general terms. The employee did not disclose the problems that were discovered later, and denied any problems when asked. After becoming aware of the infection issue, the employer instituted regular meetings to review cases (anonymously). The employer was prohibited from randomly reviewing patient charts because of privacy laws, and no information could be shared by the other consulting physicians for the same reason. Making a physician employer responsible would therefore have no impact on his ability to prevent the employee’s wrongful acts.

(2) Providing greater assurance of compensation for the victim. The employee carried his own MPL coverage, and was well paid for his work. Although in this case the employer’s policy contributed to many of the settlements, in almost every other circumstance, funds from an employer’s liability policy should not be necessary to assure adequate compensation.

(3) Ensuring that the victim’s losses will be equitably borne by those who benefited from the enterprise that gave rise to the injury. In the present situation, the employment contract (and the subsequent “independent contractor” agreement) tied compensation to performance. All billing was handled by the employer, who received the payment for the employee’s work. The employee was paid a base salary plus a percentage of the billing. Arguably, this factor favors employer liability in the current circumstances, but other compensation arrangements, such as an overhead/cost-sharing model, could be explored.

Conclusion
The basic concept of respondeat superior liability requires that an employer, who controls an employee’s duties and performance thereof, be ultimately responsible for any harm caused by his employees. In the context of physician employment, this concept is not easily applied, because a physician must be independent of that control to effectively practice medicine. When physicians complete their residency, they are deemed to be fully trained and free to practice independently. Privacy laws inhibit an employer from conducting an independent performance review, and making the employer responsible has little impact on protecting patients from harm.

To minimize the risk of respondeat superior liability, we recommend that written contracts with new physicians clearly define the relationship as one of an independent contractor, with control over how the work is to be performed, including the selection of patients, specifically delegated to the new physician. Careful consideration should be given to the compensation arrangement, recognizing that any financial benefit realized by the hiring physician (or group) may result in an argument for respondeat superior liability. Finally, to avoid ostensible agency arguments, patients should be advised that these physicians are independent contractors and not employees, by posting signage in the office and by specifying that this is the case in any patient medical-service agreement.

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MEDICAL INTERACTIVE COMMUNITY
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In the last decade, the number of medical professional liability (MPL) claims has dropped considerably below its historical average. In 2013, MPL net claims amounted to 0.03% of GDP, compared to 0.08% in 2003 (Figure 1). Many MPL insurers wonder if this is just a temporary dip, or if this might be a “new normal.”
In fact, according to Swiss Re’s sigma research report, “Liability claims trends: emerging risks and rebounding economic drivers,” claims are likely to increase in the next few years. The study indicates that the decline in inflation-adjusted claims between 2004 and 2012 was largely due to reserve releases, which reduced claims incurred, as well as to tort reform and a slowdown in healthcare expenditures in the mid-2000s. In the coming years, an economic rebound and ever-evolving regulatory and technological changes will likely drive up the number and severity of MPL claims.

In response to an aging population and the changes in U.S. healthcare promulgated under the Affordable Care Act (ACA), increased usage of medical services will test the capacity of the healthcare system, and that may result in more MPL claims. Facing continued pressure to overturn tort reforms, many state courts or legislatures could remove caps on non-economic damages. Meanwhile, rapid advances in medical and communication technology will introduce new risks, as hospitals, physicians, and insurers alike are compelled to continuously adapt to new ways of administering care.

The ACA
The ACA has fundamentally altered the landscape of access to healthcare insurance coverage in the U.S. Starting in 2014, it has expanded the number of insured people, through both private coverage in the new exchange marketplaces and Medicaid. As a result of the expansion of Medicaid and the subsidies for purchasing individual coverage offered through the exchanges, the government is now funding a greater share of

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national health expenditures. Increasing involvement in healthcare financing, combined with the need to put federal spending on a sustainable long-term path, provides powerful incentives for the government to curb medical-cost escalation.

One of the goals of the ACA is to introduce and test new healthcare delivery and payment systems. Through the promotion of Accountable Care Organizations (ACOs), the ACA encourages a transition from the fee-for-service payment system to new delivery and reimbursement systems that encourage providers to deliver more cost-effective care, through financial incentives. Commercial insurers are also putting more emphasis on cost-effective delivery of care, by introducing incentives that prompt hospitals and physicians to achieve quality and cost targets.

These changes are affecting all of the participants in the healthcare sector. A number of hospitals have acquired physician practices, because collaboration between the different care providers—such as primary care physicians, specialists, and hospitals—is seen as an important factor for reducing system costs and overutilization of medical services. Moreover, the lines between providers, administrators, and insurance companies are becoming increasingly blurred, with health insurers acquiring medical groups, and large hospital systems acquiring insurance companies. While payer-provider integration creates a closer alignment of the economic incentives of the various stakeholders involved in the delivery of healthcare, it may also create potential conflicts of interest.

While the impact of the ACA on MPL exposures is uncertain, not least because of political opposition to the reform and delays to some key provisions, there are several reasons to expect that the adjustments in care standards and practices could increase MPL claims. First, a growing number of people with health insurance will lead to higher utilization of medical services and increased MPL activity. Second, the movement of many physicians from private practice to hospital systems, along with the growing number of ACOs, will increase enterprise-level liability exposure, and could increase the complexity of claims defense, because there will be many more co-defendants. It could also motivate more severe damage settlements because the hospitals’ higher-limit liability programs could become involved. In addition, potential allegations that financial incentives to achieve cost targets have distorted medical-necessity decisions could lead to increased MPL claims.

Resource constraints and cost containment measures will likely result in more work that was traditionally done by physicians being delegated to ancillary providers, such as physician assistants, nurse practitioners, and midwives. State scope-of-practice requirements for ancillary providers differ, and they are continuously evolving to keep up with expanding needs and evolving standards of care. For example, nurse practitioners can act without physician supervision in some states, but not in others. As a result, changes in roles and procedures may create communication challenges and uncertainty concerning MPL risks.

A recent study by the RAND Corporation, a nonprofit research organization, attempted to quantify the impact of the ACA on MPL insurance in the U.S. national healthcare system. Uncertainty as to the full extent of the impact remains, but this study estimates that the ACA could cause a potential 2.4% ($120 million) increase in MPL costs.
Tort reform
In the wake of the tort reform movement that spanned the 2000s, approximately 35 states have legislation limiting non-economic, or total, damages in MPL claims. While tort reform has largely been at the state level, there have also been efforts to limit mass tort litigation at the federal level, such as the “Class Action Fairness Act” of 2003, which reduced the scope of “forum shopping” by plaintiffs’ attorneys looking to transfer high-ticket interstate class-action lawsuits to federal courts.

Many early studies concluded that tort reforms were effective in reducing MPL. However, some of these caps have been overturned by state supreme courts or legislatures, as in Missouri and Illinois, and in many other states, there is pressure to overturn or weaken tort reforms. While some laws contain a built-in inflation adjustment clause, or specify different thresholds for each type of claim, others are more general or open to regular evaluation. For instance, a recent proposition in California sought to adjust the punitive damages cap from $250,000 to $1.1 million, though it was rejected by two thirds of voters. Furthermore, judicial decisions remain a wild card, as many state judges have the authority to set precedents for higher damage awards.

Technological change
Development of new medical technology creates exciting possibilities for care, but also gives rise to emerging risks that challenge previous MPL standards. With mobile phone apps, patients are able to monitor and record their own vital statistics, such as blood sugar, and physicians can interpret scans and track patient data. Remote sensors can also improve care: for example, hospital mattresses can monitor patient status, and digestible monitors can collect data internally from the body. While aiming to consolidate physician workloads, reduce human error, and give individuals more control over their healthcare, such advances may increase the liability for doctors, who are now asked to be responsible for large volumes of real-time information.

Telemedicine lets patients interact with their doctors via mobile video, thereby expanding availability and reducing the costs of care, especially for remote or immobile patients. Some U.S. providers have even outsourced scan-reading to data analysts in other countries, such as India. Thus, the role of care providers becomes more complex, as they strive to maintain a relationship with patients, and treat individuals, rather than numbers. For instance, some states, such as Georgia, now require that doctors see most patients in person before they can provide remote services. As interconnected technology enables physicians to combine ancillary providers, outsourcing, and telemedicine across multiple geographic locations, licensing credentials in each jurisdiction will inevitably become more complicated.

Cyber risks create privacy and theft concerns in the MPL community. According to a 2013 survey, the healthcare sector contributed the most cyber claims of any sector, with 29% of all cyber claims worldwide. Health systems are a prime target for data theft, as medical records are a more permanent source of identification than financial records and are therefore easily monetized. Furthermore, with the computerization of medical devices and the increasing use of robotics in medical procedures, either hacking or human error that disrupts electronic systems could present a physical safety risk. As technology continues to evolve at lightning speed, both insurers and providers must continue to update their systems, based on concerns about from privacy, security, and MPL.

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Bias in the System

Decision-making is at the heart of business, medicine, and public affairs, and there is now widespread recognition that data-driven decision-making initiatives can yield appreciable benefits. Anecdotal evidence abounds. Thanks to a predictive model, the fraction of city building inspections in New York City that resulted in vacate orders rose from 13% to 70%. During the 2012 U.S. presidential election, the data journalist Nate Silver exemplified, with considerable flair, the superiority of rigorous data analysis and statistical thinking over unaided expert judgment in forecasting election results. Netflix decided to produce its hit
Series *House of Cards* in the light of an analysis of fine-grained subscriber viewing patterns. This cursory list could be extended for pages.

Academic research is beginning to corroborate the abundant anecdotal evidence. For example, Erik Brynjolfsson and his collaborators at MIT estimated that firms engaging in data-driven decision-making enjoy 5% to 6% higher output and productivity than they would otherwise.

This story, itself hardly over a decade old, has lately been complicated by the emergence of "big data" as a dominant theme of discussion. Big data is routinely discussed in transformative terms as a source for innovation. "Data is the new oil," the saying goes, and it will enable scientific breakthroughs, new business models, and societal transformations. A zeitgeist-capturing book's subtitle declares that it is a "revolution that will transform the way we live, work and think." The Cornell computer scientist Jon Kleinberg judiciously declared that, "The term itself is vague, but it is getting at something that is real ... big data is a tagline for a process that has the potential to transform everything."

While there is little doubt that the topic is important, its newness, combined with the vagueness of the term, has led to misconceptions that, if left unchecked, can lead to expensive strategic errors. One major misconception is that big data is necessary for analytics to provide big value. Not only is this false, it obscures the fact that the economic value of analytics projects often has as much to do with the psychology of de-biasing decisions, and the sociology of corporate culture change, as it does with the volumes and varieties of data involved.

The second misconception is the fallacy that more bytes yield more benefits. This is an example of what philosophers call a "category error." Decisions are not based on raw data; they are based on relevant information. And data volume is at best a rough proxy for the value and relevance of the underlying information.

An implication of the first point is that, rather than wait for mastery of big data, it is typically possible—and indeed advisable—to pursue near-term applications of analytics that involve readily available data sources. An implication of the second point is that "big data" is probably not the most useful concept for organizing our strategic thinking. Big data does represent something new and important in the world, but not for the reasons most commonly discussed.

"It is time to draw a practical conclusion."

There are hundreds of examples, accumulated over many decades, in which analyzing and acting upon traditionally underutilized data sources outperforms traditional modes of decision-making. Our own consulting work has given us many such examples. For example, we have built and implemented models that predict:

- Which physicians are more likely to be sued for malpractice
- Which insurance claims are likely to exceed a monetary threshold
- Which individuals are at highest risk of contracting such lifestyle diseases as diabetes and hypertension
- Which workplaces pose the greatest safety risks
- Which divorced parents are most likely to fall behind on their child support payments
- Which university applicants are most likely to succeed in their coursework
- Which job applicants are most likely to succeed as employees, and which successful employees have the highest risk of leaving the firm.

Each case, and any number of analogous cases, involves "sorting" or "prioritization" decisions that (a) are central to an organization's operations (b) are made repeatedly, typically by experts relying on professional judgment in varying degrees; and (c) incorporate quantifiable information that is readily available, yet commonly used only in informal or limited ways.

And furthermore: it turns out that in each case a straightforward predictive scoring equation can be counted on to outperform unaided professional judgment. Michael Lewis' *Moneyball* is now the classic example: a cash-strapped baseball team began to analyze, and act upon, readily available data sources in making scouting decisions. Because the scouting industry was largely judgment-driven at the time, the market for talent was inefficient: the "price" (salary) of the "asset" (players) simply did not reflect important publicly available information. Because of this market inefficiency, "better management was able to run circles around taller piles of cash."
More data is typically better, and adding new dimensions from innovative data sources is better still. But we repeatedly see notable economic benefits result from more effective use of readily available data sources, harnessed using statistical methodology, together with domain knowledge and a dash of creativity.

Not only are such results well established, they are explained by research done in the academic psychology community for many decades. In the mid-1950s, the pioneering psychologist Paul Meehl began to study the surprising degree to which even simple predictive models can regularly outperform the unaided judgment of highly trained experts. Meehl’s work influenced a young Daniel Kahneman, whose work in uncovering the biased mental heuristics that affect so many of our decisions sheds considerable light on Meehl’s findings: Simple equations can help experts, not just because the equations are so good, but also because expert judgment is so predictably biased.

Near the end of his career, surveying the field he initiated three decades earlier, Meehl wrote:

_There is no controversy in social science which shows such a large body of quantitatively diverse studies coming out so uniformly in the same direction as this one. When you are pushing over 100 investigations, predicting everything from the outcome of football games to the diagnosis of liver disease, and when you can hardly come up with half a dozen studies showing even a weak tendency in favor of the clinician, it is time to draw a practical conclusion._

Astonishingly, Meehl wrote these prescient words decades before business analytics became mainstream. It is hard to overstate the importance of Meehl’s “practical conclusion” in our age of cheap computing power and open-source statistical analysis software. His lesson—routinely echoed in case studies ranging from baseball scouting to evidence-based medicine to risk management—is that in virtually any domain where routine judgment-driven decision making is the norm, statistical analysis can likely be used to drive better expert decisions.

The reason why this is so has nothing to do with data volume, and everything to do with human psychology. Even when only traditional data sources are brought to the table, predictive models and analytically derived business decision rules provide value, by warding off inefficient or biased decisions. In such applications, models have something like a prosthetic character: they serve as “eyeglasses” for myopic human minds.

**B is for “behavioral”: The promise of big data**

This view of business analytics lets a bit of air out of the big data bubble, but does not burst it entirely. It is worth noting that most “big data” consists of the streams of digital exhaust each of us generates as we go about our increasingly digitally mediated lives. At the same time, some of the most useful applications of data analytics—particularly in such domains as insurance, behavioral health, and patient safety—involve predicting various aspects of human behavior.

_Behavioral data_ would therefore be a more useful strategic organizing principle than big data. Anyone who has worked with large volumes of behavioral data knows that past behavior is often predictive of future behavior, and often in surprising ways. For example, personal credit information not only predicts who is likely to default on a loan; it is also strongly predictive of which individuals are more or less likely to experience an auto accident. Marketing and lifestyle data can be used not only to predict future purchase behavior, but also to identify the presence of such lifestyle diseases as diabetes and hypertension. Recorded conversational patterns (tone of voice, interruptions, turn-taking, for instance) can help predict the “collective intelligence” of teams. Position in one’s social network is believed to affect one’s likelihood of taking up smoking and becoming overweight.

The computational social scientist Alex “Sandy” Pentland forcefully articulates the point:

_I believe that the power of Big Data is that it is information about people’s behavior instead of information about their beliefs. . . . This sort of Big Data comes from things like location data off of your cell phone or credit card: It’s the little data breadcrumbs that you leave behind you as you move around in the world._

_What those breadcrumbs tell is the story of your life. . . . Who you actually_
ally are is determined by where you spend time, and which things you buy. Big data is increasingly about real behavior, and by analyzing this sort of data, scientists can tell an enormous amount about you. They can tell whether you are the sort of person who will pay back loans. They can tell you if you’re likely to get diabetes.

Reframing the discussion from “big data” to behavioral data helps focus attention on why certain varieties of big data are sources of innovation. Behavioral data often provides a sort of “window into the soul” in the sense of helping quantify behavioral traits that are typically hidden from view. Such traits are highly predictive of future health, risk, compliance, purchase, and occupational behavior. Clearly, this raises very real concerns about privacy and data ownership that must be confronted head on. Still, one can imagine opt-in, socially constructive uses of behavioral data: people at risk of chronic lifestyle diseases, for example, can be given early-warning signals, advice, and perhaps behavioral nudges prompting healthier lifestyles. Physicians’ communications styles and bedside manner characteristics can be quantified. Behavioral data-driven approaches can be used to hire and match health coaches to clients.

So say goodbye, two dogmas of big data. First, analytics projects can yield material economic benefits without petabyte-class data. Second, the behavioral content of big data, not its volume or supposed completeness, is often what accounts for its potential for innovation.

This article was adapted from the essay “Two Dogmas of Big Data: Understanding the Power of Analytics for Predicting Human Behavior,” by James Guszcza and Bryan Richardson, Deloitte Review 15, and is accessible at: http://dupress.com/articles/behavioral-data-driven-decision-making/.

References
2. In an election-day blog, New York Times columnist Timothy Egan memorably characterized judgment-driven political forecasting writing, “In the last days of the election, Peggy Noonan had a ‘feel’ that things were moving Mitt Romney’s way. George Will was more cerebral: his brain told him it would be Romney in a rout. And Michael Barone, who used to have a good divining rod to go along with an encyclopedic knowledge for all numbers political, also predicted a Romney landslide: What they had in common, aside from putting up a brick Tuesday that completely missed the electoral net, was a last-hurrah push for the old-fashioned prediction by gut, “available at http://campaignstops.blogs.nytimes.com/2012/11/06/e-day/#Beeson.
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Bariatric Surgery
A Special Case for Patient Engagement

Increasingly, quality and safety provide the cornerstone for reimbursement and safety initiatives. The Affordable Care Act (ACA) and related regulations encourage Medicare, Medicaid, and plans participating in exchanges to broaden implementation of performance-based payment, by tying reimbursement to quality outcomes, including the patient experience, using new approaches to payment, rewards, incentives, and penalties.
This is a paradigm shift in patient care and reimbursement (from volume to value), which provides healthcare professionals with an incentive to implement the most effective possible processes, to enhance both the patient experience and outcomes. Bariatric surgery has unique implications related to quality and safety, due to increasing support for the return-on-investment debate and the high incidence of self-pay patients. Bariatric surgery continues to be a safe process and, as the technique has become more refined and surgeons gain greater experience with it, the mortality rate has fallen from 3% to 0.2%.

However, complications do happen. From a claims point of view, frequently, it is not the complication per se that leads to a claim, but the response to the complication. The causes of bariatric claims can be split into clinical and nonclinical risk factors. A review of 100 consecutive bariatric lawsuits revealed the most common adverse events initiating litigation were intestinal leak (53%), intra-abdominal abscess (33%), bowel obstruction (18%), major airway event (18%), organ injury (10%), and pulmonary embolism (8%). The nonclinical factors include physician-patient communication, failure to meet patients’ expectations as well as a patient’s failure to follow up with the surgeon, after surgery, due to lack of satisfaction with the surgeon and/or the procedure.

To address both, a surgeon can mitigate the risk of litigation by truly engaging with the patient, educating patients as well as documenting the same by using the bariatric surgery second-generation informed consent form. Critically, also, he should aggressively address complications when they do occur.

This article will identify strategies to help mitigate the risk of a claim resulting from a serious complication.

Building a patient relationship
To engage a patient, a strong patient relationship must be built. The relationship with a bariatric surgery patient begins in an atypical fashion, via referrals from other specialists. In most instances, bariatric patients “shop around” for their surgeon. Often, patients will attend multiple informational seminars and support groups, and speak with current patients to find the surgeon and bariatric program that is the right fit. Patients invest time and energy in selecting a program that sets a precedent for high expectations. The patient presenting for bariatric surgery has battled obesity, and its health and social consequences, for years. The decision to proceed with surgery for many is viewed as a last resort. The elective nature, and consumerism, creates an environment wherein excellent care, superior customer service, and optimal clinical outcomes are expected. A poor physician-patient relationship is a prevalent theme in bariatric medical professional liability (MPL) claims, and reflects a lack of understanding of the patient’s perspective.

Having a positive physician-patient relationship is necessary because bariatric surgery is more of a service business than many other surgical specialties. Patients go to bariatric surgeons with a combination of emotional and physical issues and then undergo a structured approach to medical, and potentially surgical, weight management. Educating bariatric patients includes education on the risk of complications, and the implications and severity of the complications, as well as their need to comply with the postoperative diet. Patients also need to learn about the signs and symptoms to watch for after surgery that may indicate a possible complication, and what to do when they occur.

A positive patient experience is not enough. It is essential that bariatric patients be engaged. True patient engagement occurs when a patient, and the family, is fully involved in their own care. The patient must be willing to take responsibility for their health. The surgeon must also support and welcome the patient as a full participant in the healthcare team.

To engage a patient, there should be active involvement in the development of a care plan; then, the patient will be more likely to adhere to it. In bariatric surgery, having a patient who takes responsibility for their health can mean the difference between successful surgery and an unfortunate outcome.

The bariatric-specific second-generation informed consent form is for both the patient and the physician, and will aid in patient engagement. While informed consent is “verified” through signature on a document, informed consent is not just a document; rather, it is a process. The informed consent process in bariatric surgery begins with the initial encounter with a patient. Typically, bariatric surgery patients enter a bariatric surgery program through an informational seminar, and then proceed through a process of preoperative evaluation and work-up that is fairly extensive.

Even with extensive education on the risks of complications and the need for lifestyle changes in lifestyle, many patients do not remember that there is a real risk of postoperative complications. In one study of post-operative bariatric surgery patients, only 29% of patients reported that a leak was a potential complication of the procedure. As

James W. Saxton, Esq., Amanda R. Budak, RN, CBN, PhD, and Theresa A. Folino, Esq., are with Stevens & Lee.
BARIATRIC SURGERY

What's in the consent form
A procedure-specific informed consent form has three critical elements: (1) a new introductory paragraph, (2) procedure-specific risks, and (3) a true witness. The introductory section is important: it tells the patient not to sign the form unless he has read and fully understands what is in it. The introductory paragraph sets the tone for the process. Then, the section on risks details the procedure-specific risks. This section must be reviewed and updated regularly by content experts. The procedure-specific risks provide another benefit—when presented as a list, each can be reviewed in a stepwise fashion; the patient should initial the page once it has been reviewed.

Finally, having a true witness to the process closes the circle on it. Three key questions are asked, and the witness may not check the boxes, unless and until the patient says yes to each question. It is the rare case when a patient denies the validity of a signature. More often, they state that they did not read—or understand—the form, or that they had unanswered questions. Documentation of the patient's responses to these questions is a powerful tool.

On the day of the procedure, there are additional opportunities to engage with patients and provide guidance. While the patient is in the holding area, meet with him to give an opportunity for any final questions. Finally, even after the procedure, the informed consent process provides a roadmap for disclosure in the event of an adverse outcome.

If a complication happens
You have engaged your patient, and provided appropriate education through your informed consent process. Now, a complication occurs. Patients, even well-educated, loyal patients, are not only surprised, but emotionally devastated as well when a complication occurs. Physically, a complication from bariatric surgery can mean an extended stay in the critical care unit, or even death for some patients. Emotions cloud rational judgment, especially in a situation of uncertainty about recovery from a serious complication. That simple reality of human behavior makes the “how” of disclosing an adverse event all more significant. A related issue is “what” information is to be provided and how the communication should be handled. It is clear that complications and errors must not just be disclosed, but discussed. Toward that end, the bariatric surgery informed consent form tells patients they should come back to the surgeon in the event of a complication.

Disclosure can prevent many claims and, if appropriate, fast-track claims for resolution before a lawsuit is initiated. Disclosure is becoming more of an accepted concept than ever before, although confusion persists about what is involved among doctors, lawyers, and even patients. As of October 23, 2013, the number of states with some form of “apology law” totaled 38, when a Pennsylvania law was signed that lets healthcare providers express a “benevolent gesture,” which cannot be used against them in the courtroom (under certain circumstances).

Footnote
1. We thank Surgi-Protect, a new bariatric surgery safety and insurance program, for the information about the second-generation, procedure-specific consent forms and process.
The delivery of healthcare is undergoing profound change. New regulations, shifting business models and evolving client needs require timely market and industry intelligence to maintain competitive advantage. This, coupled with the reality of a protracted soft market insurance cycle, poses both a threat and an opportunity for MPL insurers.

Guy Carpenter’s Healthcare & Life Specialty Practice is dedicated to assisting our clients in addressing these challenges. We invite insurers to learn how our dedicated team of specialists leverages our industry experience, market insights and analytical expertise to customize solutions that meet their unique needs.

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Interplay between State Board Actions and MPL

Shared Risk and Potential Implications

There is an extensive list of government entities and laws that can potentially harm physicians. Better known by their acronyms, these include: BOM, IRS, CMS, MEC, OSHA, HMOs, FTC, CLIA, EMTALA, DEA, HIPAA, OIG, FBI, AG, and FCA (Figure 1).

The National Practitioner Data Bank (NPDB) collects information on healthcare practitioners including medical professional liability (MPL) actions, hospital actions, and licensing actions, as well as information from insurance companies and managed care companies. This data is managed by the Bureau of Health Professions, Health Resources and Services Administrations, U.S. Department of Health and Human Services, under a legal notion of “informed consent.” All the acronyms listed previously have access to both the NPDB and your state’s Department of Health (DOH) Profile, reiterating the importance of physicians’ compliance with the NPDB and the DOH.

MPL is interwoven into every adverse action. In the past, the review of medical records was done according to this procedure: patient, hospital, and government actions were filtered through state boards, which were consequently interlaced with reviews by the U.S. attorney (fraud and abuse), the attorney general (licensing actions), and the district attorney (criminal charges).

But now, medical records go through review by the hospital, patient, and insurance company. At this point, state boards and their components (district attorney, U.S. attorney, and the attorney general) are in charge of compliance and regulation.

It is important to note the threshold differences between what is done in MPL lawsuits vs. what is done by state boards. With the state boards, there are no rules of evidence, no advance notice of issues under review, no advance disclosure of complaint or complainant, no statute of limitations, and no damages are required. In addition, physicians are often denied access to records, and the same agency that decided a physician’s fate at a hearing decides the appeal.

To better illustrate the role of the Federation of State Medical Boards (FSMB) in the total number of actions initiated by state
boards, I would like to reference the FSMB’s 2014 report, “U.S. Medical Regulatory Trends and Actions” (Table 1). In 2012, a total of 14,487 disciplinary alerts were issued by the FSMB to state boards; of these, 9,219 state board actions were initiated as a result of the FSMB alerts. The results of these board actions ranged from license restrictions (most often) to license suspension to license denial (less often).

State board actions are an increasing trend; the numbers of actions initiated, reprimands, license restrictions, probation, surrender of license, and revocation of same from 2008 and 2012 are shown in Table 2.

**Information sources**
State boards gather their complaints from diverse sources, including patients, documents from MPL actions, hospital actions, and other state licensing actions; and insurance companies and managed care companies. The tactics that state boards use in order to obtain these complaints include investigations of employee contacts, comprehensive record reviews, queries to physician witnesses, pharmacy sweeps, and hospital staff-file reviews.

This state board process begins with a request for medical records. At this point, they begin the information-gathering process, including a demand for a written reply to all allegations. A notice of investigative hearing is sent, at which point a preliminary evaluation committee is set in place. The committee is in charge of determining what, if any, action to take, based on the recent trends of the committee in working on other, recent cases. Unless charges are filed or the case is settled, the investigation remains confidential. Otherwise, if charges are filed, this information will become public. Sample forms for the documentation of “professional misconduct” that led to actions include failing to show “cultural sensitivity,” “disruptive” behavior, errors created by office staff, failure to wear an identification tag, poor documentation or treatment—even if rendered by another physician.

**Beware of the state board**
The issue of possible dire effects from state board materials, during an MPL case, should be addressed by carefully considering and avoiding any “state board” admissions in pleadings, as well as in letters to the court, depositions, and trial testimony. In addition, during this interplay between an MPL action and the state board and state DOH, it is wise to challenge any request for information or documents, because state board investigations are confidential, the fact that an investigation is neither an action nor a disciplinary proceeding, and, lastly, the fact the physician’s quality assurance file is typically not discoverable.

Subsequent to any interaction with the state board after the MPL case, it is advised that your legal counsel review the client’s physician profile obligations, advise the physician to contact his or her insurance provider if any type of state board investigation is begun, and preserve any information and evidence that was inadmissible or not used at trial but may be useful before a state board.

In addition to consolidating the NPDB and the Healthcare Integrity and Protection Data Bank, by Section 6403, the Affordable Care Act is better known for providing insurance for previously uninsured people. The mere presence of more insureds will increase the number of MPL claims. These newly insured individuals, who are largely unfamiliar with the healthcare system, will likely give rise to an increase in state board actions as well. Accordingly, there may be a disproportionately higher increase in state board than in MPL actions.

**The Golden Rule** I would like physicians to take away from all this is: Never speak to any media representative, investigator, and—especially—to some other attorney who is not your direct legal counsel.

### Table 1 State Medical Board Actions, 2012

<table>
<thead>
<tr>
<th>State Medical Board Actions</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total state medical board actions</td>
<td>9,219</td>
</tr>
<tr>
<td>Board actions by category*</td>
<td></td>
</tr>
<tr>
<td>License restricted</td>
<td>1,480</td>
</tr>
<tr>
<td>Reprimand</td>
<td>1,224</td>
</tr>
<tr>
<td>Fine</td>
<td>995</td>
</tr>
<tr>
<td>Administrative action</td>
<td>949</td>
</tr>
<tr>
<td>Probation</td>
<td>913</td>
</tr>
<tr>
<td>License suspended</td>
<td>907</td>
</tr>
<tr>
<td>CME required</td>
<td>819</td>
</tr>
<tr>
<td>License surrendered</td>
<td>511</td>
</tr>
<tr>
<td>Conditions imposed</td>
<td>485</td>
</tr>
<tr>
<td>License revoked</td>
<td>299</td>
</tr>
<tr>
<td>License denied</td>
<td>170</td>
</tr>
<tr>
<td>Other</td>
<td>487</td>
</tr>
<tr>
<td>Reciprocal actions taken by state boards</td>
<td>1,306</td>
</tr>
<tr>
<td>Number of disciplinary alerts issued by the FSMB</td>
<td>14,487</td>
</tr>
<tr>
<td>Number of physicians disciplined</td>
<td>4,479</td>
</tr>
<tr>
<td>Physicians put on probation</td>
<td>857</td>
</tr>
<tr>
<td>Physicians with a license suspension</td>
<td>739</td>
</tr>
<tr>
<td>Physicians with a license revocation</td>
<td>275</td>
</tr>
</tbody>
</table>

*Note: The total number of board actions is higher than the total number of disciplined physicians because physicians may have had more than one action taken against them.

### Table 2 State Board Actions, 2007/2008 and 2012*

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions initiated (total)</td>
<td>8,222</td>
<td>9,219</td>
</tr>
<tr>
<td>Breakdown of actions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reprimands</td>
<td>892</td>
<td>1,067</td>
</tr>
<tr>
<td>License restrictions</td>
<td>859</td>
<td>1,012</td>
</tr>
<tr>
<td>Probation</td>
<td>785</td>
<td>913</td>
</tr>
<tr>
<td>Surrender of license</td>
<td>377</td>
<td>511</td>
</tr>
<tr>
<td>Revocation of license</td>
<td>256</td>
<td>299</td>
</tr>
</tbody>
</table>

*Note: The total here compares 2007 and 2012; the breakdown of numbers compares 2008 and 2012.*
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The 2014 PIAA International Conference took place on October 8-10, 2014, at the Marriott Renaissance Hotel Amsterdam in the Netherlands. The conference, which was open to the public, served as the preeminent international educational and networking event for every stakeholder in medical liability.

The conference was titled “The Good, the Bad, and the Ugly,” and its subtitle explained how the famous Sergio Leone movie was relevant to medical professional liability (MPL): “How Threats Can Become Opportunities in Medical Liability.”

Leaders from medical liability insurance companies and indemnifiers, legal professionals, reinsurers, healthcare professionals, and others from around the world convened to meet and discuss pressing issues.

The 2014 PIAA International Conference was co-hosted by PIAA member VvAA Group and its subsidiary, MediRisk.

The Conference program was developed by members of the PIAA International Section. The companies that make up the PIAA International Section are based in six nations and provide MPL insurance and indemnification and related services to healthcare professionals around the world.

“We were excited to welcome all of the diverse medical liability professionals to Amsterdam for the 2014 PIAA International Conference,” said PIAA President and CEO Brian K. Atchinson. “This event provided participants from around the world with a unique opportunity to gain invaluable insights on the global and day-to-day issues of common concern to every organization involved in medical liability.”

Atchinson noted that those who work in MPL now face a new set of challenges, as the transformation of healthcare continues at an unprecedented pace around the world. “This unique gathering has helped attendees find pragmatic solutions for optimizing performance in these rapidly evolving times,” he said.

The keynote speaker for the Conference was Martin Bromiley, founder and chair of the Clinical Human Factors Group, a broad coalition of healthcare professionals, managers, and users of services who have partnered with experts in human factors from...
healthcare and other high-risk industries to campaign for change in the United Kingdom’s National Health Service.

Serial claims, class action lawsuits, and the many other types of systemic risks can be a major concern for physicians, nurses, and other healthcare professionals, hospitals, health systems, and MPL insurers and indemnifiers. An international panel provided attendees with the critical intelligence they need to understand the actual scope of these threats, and take proactive steps to minimize their likelihood.

The conference also featured a session on the diverse causes of failure to render a timely and accurate diagnosis, and its many impacts for each of the parties involved in healthcare. One source for this session was data from PIAA’s Data Sharing Project, which provided a claims-based foundation for illuminating the prevalence of failure to diagnose, and its consequences for healthcare providers and MPL insurance and indemnification organizations.


Featured below are highlights from one conference session, to provide some sense of the richness of the discussions in Amsterdam.

Sample Session: “High-Severity Claims: Is the Sky Really the Limit?”

David Franklyn, Technical Claims Controller, the Medical Defence Union, said that recently in the United Kingdom, the cost estimate for lifetime care of a cerebral palsy patient was estimated at £11.4 million pounds. Just five years ago, he pointed out, we were expressing surprise at claims valued at £7 million to £8 million pounds. What, he asked, has happened during this time period? And can MPL insurers ignore the trend toward rising claims, regardless of what is happening in the rest of society? In the U.K., he said, awards are made for compensatory damages. The general aim of an award of damages in tort is to put the injured party in the same position as he would have been in if the tort had not occurred. There are also aggregated damages, which may be awarded in unusual cases—for assault, for example. But they generally only add a small sum.

Decisions made by the U.K. courts have led, indirectly or indirectly, to higher total rewards. For example, one contributing factor in the higher awards has come from trends in the discount rate used. Until recently, it was assumed that awardees would invest in a certain way, like a regular investor. But claimants asserted that they needed a different approach to investment allocation, because they are totally reliant on the sum of their damages for support. The government determined that these claimants were in fact special cases, necessitating the security afforded by fixed-income investments, with their lower rate of return. The ensuing discount rate was 2.5%, which meant that higher original awards were required for compensatory damages.

Another example: In 2005, pure payment orders (PPOs) were introduced, under which the defendant pays what the claimant needs for care, for the remainder of his life. In 2009, a claimant’s right to choose private care was upheld, in a case of a patient who had been housed in a public healthcare facility. This dramatically increased the cost of care required under the PPO.

Which healthcare professionals are at risk? In the NHS, it is the general practitioners, although the numbers of high-value claims against them remain relatively small. There are instances of high-severity claims, however, in particular for childhood sepsis and meningitis. The symptoms of both are relatively easy to miss, though their onset can have devastating consequences.

So, is the sky the limit? As it stands now, Pranklyn said, the answer is yes. However, the Medical Defence Union has launched a campaign to make the government, and the public, aware of the high costs at stake that must be assumed by the taxpayers, in consequence of the high-value awards, especially in regard to the amounts provided for future care and loss of earnings.

Conclusion

At the PIAA International Section Conference, participants learned a great deal from hearing how other countries are confronting similar realities in the shifting healthcare market, and MPL as well. There were multiple lessons learned, and a wealth of new perspectives gained.

Dr. Richard E. Anderson, Chairman and CEO, The Doctors Company, discussed the pervasive nature, and cost, of defensive medicine in the U.S., for comparison to what is happening in other countries.

Martin Bromiley, Founder and Chair, Clinical Human Factors Group, opened the conference with a keynote address on human factors from his perspective and their role in healthcare, patient safety, and medical liability.
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Healthcare is often used as the poster child for “change” these days—change arising out of legislation, demographics, and transformation in the healthcare delivery system. Medical professional liability (MPL) companies have certainly had to adapt to these market changes, but what has not changed very much is rating—the process used for calculating premiums. Many companies now offer cyber coverage in response to the expanding adoption of electronic medical records, the use of deductibles has increased, rating on a patient-visit exposure basis has been introduced, and insurers have begun to grapple with the risk implications of accountable care organizations, telemedicine, and multi-state practitioners. But the rating process per se remains much the same as it has been since the advent of claims-made coverage in the 1980s.

In comparing physicians’ MPL to other lines of business, one notable difference in the calculation of premium is the relatively minor consideration of loss experience in determining the cost of the coverage. MPL insurance covers liability based on tort actions. These address and provide remedies for civil wrongdoings that are not linked to contractual obligations. A person who suffers injuries from medical care may be able to use tort law to receive compensation from someone who is legally responsible, or liable, for those injuries. Tort law, in general, has two purposes. The first is to compensate the victim; the second is to deter harmful activities. MPL may do a good job in compensating the patient, but is it as successful as a deterrent to harmful activities? In thinking about deterrence, the first thing that comes to mind is risk management. This takes many forms, from educational events to “office visits” by MPL carriers to check on safe practices, peer review, and the gathering and analysis of data on incidents and claims. All MPL carriers practice risk management in various forms, and to varying degrees, as a tool to contain losses. But what of loss experience? Most lines of business use prior losses not just as an underwriting tool but also in calculating the premium for individual applicants. If you insure your car, the more losses you have, the higher your premium—which in turn should motivate you to drive more carefully. And the number of accidents you have (frequency) counts for more than the cost of the claim (severity). Workers compensation is another line of business where the insured’s experience is an important factor in the calculation of the premium charged.

In comparison, MPL—except for hospital business—doesn’t put the same kind of emphasis on experience as a rating factor, and therefore it would seem that it cannot play much of a role in improving the behavior of the individual insured. Rates are based on specialty groups and practice location and, while the base premiums increase dramatically with the additional risk for certain kinds of medicine, and for certain territories, there is not much difference in the premium charged to an individual in a given specialty and territory, irrespective of whether he is loss-free or has had several claims.

Why loss experience should matter
Consider the following:

- About 90% of losses in some high-risk specialties are incurred by fewer than 10% of the insured doctors.
- A practitioner’s loss experience surcharge accounts for between 1% and 2% of total MPL premium across all medical specialties.
- Less than 2% of doctors incur surcharges for adverse loss experience—but credits for few, or no, losses are used more often.
- In even the worst cases, surcharges never exceed twice the amount of the base premium.

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

If you insure your car, the more losses you have, the higher your premium—which in turn should motivate you to drive more carefully.
Experience rating plans are often discretionary, and subject to a review by a physician panel.

Where experience rating is used, there is generally more emphasis on severity than frequency, despite the fact that frequency is generally believed to be the better predictor of future losses, and is the factor that is more easily controlled by the insured.

The database used for the calculation of experience is usually limited in some way—by time span; by the inclusion of only recent or open claims; by type of claim, for example, excluding claims that were closed with no indemnity payment; capping the dollar amount of claims to be included, etc.

And, although they represent a declining share of the market today, and their base rates reflect higher risk, joint underwriting associations, designed to provide an insurance market of last resort to any doctor regardless of experience, serve to illustrate the extreme example of disregard for individual loss experience.

It is a practical proposition, with today’s ready access to information, to analyze claim data at renewal and provide the underwriter with actual loss experience. So why does this factor not play a bigger role in determining the premium for a given doctor?

Perhaps, in comparison to workers compensation or personal auto, MPL is considered a low-frequency line, and therefore it is assumed that it is not amenable to the use of experience as a factor in underwriting. Perhaps it is due to the traditional form of governance of MPL entities: most mutuals were started by medical societies and are still controlled by boards made up mostly of physicians, who may prefer to look at risk in the aggregate rather than by individual. Perhaps, given the high number of frivolous claims, there is a feeling that loss experience shouldn’t mean a higher premium for claims that have no merit— even though every claim, frivolous or not, has a cost to the insurer. Perhaps doctors are unaware of the concentration of losses among just a few of insureds, not considering that the “good” are subsidizing the “bad.” Perhaps this is just inertia: “No one else is doing it.” And there may be some concern that a plan based on loss experience might dissuade physicians from early notification of incidents, and that doctors would resist settlement of claims if the consequence was a severe increase in premium.

Change inevitable?

But as more doctors transition to employment by hospitals that are self-insured, they will become experience-rated by default; for hospitals, loss history in the aggregate is already an important determinant of premiums. And as doctors increasingly come to practice in groups, with the size of the groups increasing, it may be possible to experience-rate at the group level. This would be analogous to what is done with workers compensation: the claims of all of the employees are factored into the experience rating of the employer and the premium he pays. And once the current soft market for MPL turns, that will likely come, as before, with a tightening of both pricing and underwriting standards. We shall see.
Online Physician Reviews: Strategies for Success

By Tracy Murphy

While websites that enable patients to review their physicians’ performance have been commonplace in the United States for some time, these sites are comparatively new in Canada. They allow patients to view physician profiles, share patient experiences, rate doctors on a number of different factors, and comment on individual doctors and their medical practices.

Patients may use the sites to comment on their physicians’ communication skills, timeliness for appointments, follow-up of test results, and their office staff and practice procedures. The posted information can also be used by patients to share information about a particular physician, prepare for a referral visit to a different doctor, or learn more when looking for a new physician.

While some physicians would prefer to wish these sites away, the fact is, they are here to stay. For this reason, doctors everywhere should consider monitoring what is being said about them, and take measured steps to deal with their patients’ reviews, when necessary.

Managing online reviews

While many physicians may be worried about, or reluctant to search for, comments about themselves, doing so can be valuable. Physicians may want to occasionally monitor what is being said about them and pay particular attention to physician-rating sites. These sites are generally not intended to harm physicians’ reputations. Most physician-rating sites let doctors update and correct their profile information, and many have terms of use stipulating that only truthful, non-libelous, and relevant postings can be made. Some sites also allow physicians to respond to comments, if they choose.

When a physician’s online reviews are largely positive—and most are—this is a sign that patients are generally satisfied with the care and service received. In these situations, physicians should reflect on the feedback, build on what works well in their practice, and continue to provide quality care to patients. Physicians should place less emphasis on numerical ratings. When negative online reviews and comments are encountered, it may be appropriate to pause and assess the feedback as objectively as possible. Online reviews may provide important insights for doctors.

Physicians should generally not reply online to specific patients, even if they feel certain about which patient provided the comment or review, nor should they post any specific comments online. Where appropriate, face-to-face conversations are preferred, and it is best for physicians to listen to patients’ comments and constructive feedback, and then respond calmly and with compassion.

“I feel very fortunate to have Dr. X as my physician. She is knowledgeable and experienced and truly listens. She always follows up.”

“...not to be recommended. ...Dr. Y is always in a frenzy and is inattentive. ...I always feel rushed and intimidated from asking questions, because he seems so hurried.”

“...this doctor is amazing. ...He sure knows his medicine. ...He listens, cares, and makes you feel comfortable. Unfortunately, the receptionist takes pleasure in being difficult and making life miserable whenever you deal with her. ...Rather than being pleasant, she always makes you feel like you are interrupting and bothering her.”

Tracy Murphy is Senior Policy Analyst, Canadian Medical Protective Association.
Six practical steps
1. Foster a positive patient experience in your medical office or practice. Many online complaints relate to medical office issues such as wait times, staff interactions with patients, continuity of care, and technology. Physicians should review these complaints with an eye to improving patient experience and satisfaction.

2. Encourage an open dialogue with patients. Ideally, patients should feel comfortable discussing their concerns directly with physicians. Fostering honest and open communication can have a positive effect on the physician-patient relationship, improve patient satisfaction, and reduce the potential for negative Internet comments.

3. Develop formal mechanisms to obtain and measure patient feedback. Formal feedback or complaint mechanisms can be an effective way for physicians to hear from patients. Patient satisfaction surveys may help physicians identify areas for improvement within their practice. Doctors who ask for patient feedback through this mechanism should try to follow through on any relevant suggestions.

4. Identify and make improvements based on online comments. Similar comments from multiple patients may be indicative of a problem that needs to be addressed. For example, a physician who receives multiple complaints about rushing patients may want to analyze the factors that could be contributing to this perception. In light of heightened patient expectations and growth in the use of social media, patients expect that physicians will listen to and consider their comments.

5. Respond appropriately. While the source of online comments may be apparent, physicians should never assume that a specific patient made a posting. Similarly, physicians should not ask patients to provide positive online reviews or sign agreements indicating that they will not write negative Internet reviews. When responding to patient complaints, it is best to listen actively, remain professional, and follow through as needed.

6. Protect privacy of patients. Physicians must always be aware of their obligation to patient confidentiality and privacy. Responding to online reviews too quickly, or in anger, may escalate a situation unnecessarily or give rise to additional medico-legal issues, such as breaches of physician-patient confidentiality.

The bottom line
Honest comments on physician-rating sites can provide important information for both patients and physicians. While it can be difficult to accept criticism—particularly when caring for patients is one’s life’s work—most patients comment on their doctors to provide positive feedback or to help them improve. Patients, ultimately, want their physicians to take action to enhance the quality of their care.

Doctors with concerns or questions about online reviews would benefit from speaking to their medical professional liability provider or to their own legal counsel. When faced with patient reviews that contain false or defamatory comments, physicians should consider requesting that the ratings website remove these comments.
HEALTHCARE PROVIDER CAPTIVES: AN ALTERNATIVE APPROACH TO EVOLVING COVERAGES

BY ROBERT J. WALLING, III

Major changes in the delivery of healthcare are creating new—and increasing—insurance exposures for providers. Loss exposures related to electronic health records, billing audits, and accountable care organizations (ACOs), for example, all give rise to a greater likelihood of claims.

For many years, healthcare professionals have participated in captive insurance companies as one approach to financing their medical professional liability (MPL) insurance. As a result, they are quite familiar with how captives operate and the risks and opportunities they present. We have seen that these captive insurers can respond quickly to emerging and changing loss exposures.

As a result, one of the fastest-growing applications of captive insurance companies is this: small captives that provide coverage for low-frequency, high-severity insurance exposures to healthcare providers.

A number of healthcare professionals are expanding their adoption of captives to address the ever-evolving healthcare delivery environment and the related insurance exposures they face.

Challenges and a solution

Healthcare providers are now confronting new kinds of insurable risks, beyond those covered by traditional MPL. Electronic medical records requirements create substantial cyber liability exposures. In the wake of significant regulatory actions related to HIPAA, the Food and Drug Administration, and other oversight organizations, there is a new need for coverage insuring both defense costs and penalties. Billing audits from both Medicare and healthcare insurers are linked with a real risk of defense costs and penalties from the insurer.

In addition, as group practices become more prevalent for healthcare delivery, there is a greater need for coverages that protect the corporate entity and the business from the economic impact of the loss of a key physician and/or loss of referrals from a hospital. This is particularly true of physician groups that join the new ACOs.

Similarly, the growing number of physicians who are opting to become hospital employees face challenges when they combine their current MPL insurance coverage with that of the hospital. A captive insurance company is one approach that physicians can take to finance these complex and evolving risks.

Captives serve many important purposes in the insurance industry. Key among them are:

- Providing innovative or emerging coverages
- Enabling an insured to fund coverage that is currently unavailable or not affordable in the commercial insurance market
- Developing innovative insurance coverages before they are commercially available
- Allowing insureds to retain for themselves the overhead expense, profit, and contingency margins used by admitted insurers in setting their rates
- Providing a mechanism to finance insurable exposures, especially those with a low frequency of occurring and a high-average-claim severity.

All of these factors make a captive an attractive solution for...
addressing many of the emerging and evolving loss exposures that healthcare providers now confront.

Captive design and formation

Healthcare provider-owned captives have a myriad of potential coverages they can consider providing. Common coverage selections include:

- **Cyber liability and related coverages**—a greatly increased risk for providers due to electronic health record (EHR) requirements
- **Regulatory actions**—especially HIPAA and FDA actions
- **Billing and HIPAA audit expenses**—significant and growing expense items for healthcare providers
- **Contingent business income**—loss of income from causes of loss such as the loss of hospital privileges or the loss of referrals
- **Reputational risk**—to fund efforts to restore a provider’s reputation after a covered incident
- **Loss of key personnel**—to insure loss of income (e.g., lost profits and fixed expenses) in the event of the departure of a key staff member
- **Professional liability gap coverage**—to address exclusions in current commercial coverage
- **Professional misconduct**—this coverage is commonly excluded from most MPL insurance policies.

Commercial insurance coverages, such as employment practices liability insurance, directors and officers liability, fiduciary liability, and employee theft and dishonesty, are now common coverages that are included in physician captive policies. These captives can also provide deductible reimbursement for traditional coverages such as property, general liability, workers compensation, and others, in instances where maintaining the current commercial insurance policies may be required by law or desired by the healthcare provider. The captives may also provide deductible reimbursement coverage for MPL insurance and/or “gap” coverage, to ensure events excluded by the commercial insurance coverage.

A wide range of captive types lend themselves to physicians looking to establish a captive. The choice depends mainly on the size of the insured population, the coverages included in the program, the need—or lack thereof—for risk pooling mechanisms, the domicile selected for the captive, and the ownership structure of the captive. Series LLC captives, segregated cell or portfolio captives, pure/single parent captives, and group captives have all been successfully established for innovative healthcare provider captives.

Onshore domiciles, including Vermont, South Carolina, Hawaii, and Tennessee, and offshore locations such as Bermuda, the Cayman Islands, and the British Virgin Islands, and others, are all available for this new group of captives.

Pricing approaches

It is imperative that the premiums for any captive be actuarially sound, neither inadequate nor excessive. Actuaries use several techniques to ensure that a captive’s premiums meet these criteria. Common pricing approaches include:

- **Market pricing**—based on one or more quotes from admitted insurers for the captive’s insured(s) or similar risks and adjusted for differences in expenses and risk margins
- **Benchmark pricing**—based on industry rate bureaus such as the Insurance Services Office, Inc. and others
- **Frequency and severity models**—based on assumed claim frequency rates and claim sizes
- **Rate on line**—based on the number of years’ worth of premium required to pay off one full-coverage-limit’s loss (a common reinsurance pricing tool)

These exposure rating techniques can also be modified to reflect actual prior insured experience for the covered risks, whether these are insured at the time or not. These approaches, and others, allow the actuary to form the basis for actuarially sound premiums for the captive.

The “T” word

In the current captive insurance environment, it has become almost taboo to say the word “tax.” As previously stated, a captive must first, foremost, and always be an insurance company. However, to ignore the tax benefits of a captive insurance company for healthcare providers is to fail to identify a major benefit of these insurance companies.

Assume that the captive is designed in such a way that it is first and foremost an insurance company, meeting all of the IRS and captive insurance regulatory requirements, such as those for risk transfer and risk distribution. Further assume that the pricing is actuarially sound, that is neither excessive nor inadequate. If these assumptions are true, then the captive may have multiple significant tax advantages.

1. The premiums paid to the captive by the healthcare provider may be tax deductible when they are paid. This could be a significant benefit compared to the covered losses only being tax deductible when they are paid if the risk is not insured.
2. If the captive qualifies for, and chooses to make, the 831(b) election, the captive’s underwriting profits—i.e., the difference between premiums and losses plus expenses—are exempt from federal income taxes.
3. If the captive is owned by certain forms of trusts, some tax advantages for estate planning may be available when retained earnings in the captive are paid out in dividends to the owner.

All of these opportunities require the assistance of a sophisticated tax professional. Neither I, nor my firm, is qualified to provide tax advice, and the information presented here should be recognized...
Benefits and risks
Captives providing healthcare providers with the types of coverages described earlier provide many benefits. These include:
- Control of currently uninsured or underinsured risks, such as billing audit liability
- Good flexibility in coverage design
- Cost certainty for coverages that could dramatically reduce income if uninsured, such as loss of hospital privileges or referrals
- Flexibility for meeting evolving insurance needs, such as professional misconduct coverage
- The ability to build up retained earnings in order to assume larger amounts of risk within the captive
- Efficient financing for low-frequency, high-severity risks that can threaten a healthcare provider's practice.

It is also worth noting that captives tend to have much less capital than traditional insurance companies. In addition, the same coverage and forms flexibility can result in unexpected claims due to differences in coverage interpretation. There is also a greater commitment of time in being a captive owner than with most commercial insureds. Many of the leading physician-owned medical professional insurers are developing captive solutions for their customers, including but not limited to partnering with risk retention groups to have some of the earlier benefits available to their customers.

Conclusion
Captive insurance has proven to be a nimble means of addressing insurance needs in evolving markets for sophisticated insureds, including healthcare providers. In the past, captives have functioned principally as a safety valve for manufacturers that need product liability coverage, healthcare providers and hospitals that have been unable to find MPL at any price, and businesses that need property insurance in areas subject to natural catastrophes.

Today, captives are meeting the changing needs of healthcare providers with innovative coverages and captive designs that allow them to take control of their risks, reduce the volatility in their balance sheets, and better protect their businesses from new and evolving insurable risks.

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AS A MATTER OF FACTA... An Introduction to the Foreign Account Tax Compliance Act

BY SARAH STUBBS, ALLAN AUTRY, AND CHRIS PITTMAN

In recent years, the U.S. Department of the Treasury has been increasingly focused on regulating U.S. taxpayers who attempt to avoid U.S. tax obligations by conducting business with certain foreign entities. The enactment of the Foreign Account Tax Compliance Act (FATCA) forces U.S. taxpayers, and certain foreign entities that conduct business with U.S. taxpayers, to make a choice: comply with the new documentation and reporting standards or face a 30% withholding tax.

Before we dig into the details, consider the following simplified example. ABC Company (ABC), a U.S. taxpayer, makes withholdable payments to XYZ Company (XYZ) a foreign entity. (The concept of “withholdable payments” will be explained later.) Under FATCA, ABC must request documentation from XYZ of XYZ’s FATCA status. If XYZ produces, and ABC maintains, such documentation, the process is complete. However, if XYZ fails to provide the documentation, ABC is required to withhold 30% of its future withholdable payments to XYZ. If ABC fails to comply with the documentation or withholding requirements, it may face a 30% penalty.

To comply, taxpayers must understand the two types of foreign entities to which FATCA applies: foreign financial institutions (FFIs) and non-financial foreign entities (NFFEs).

Foreign financial institutions
An FFI is any entity that is a non-U.S.-resident located in a country that either:
1. Has an intergovernmental agreement (IGA) in effect, under which the entity meets the definition of a financial institution, or
2. Does not have an IGA in effect, but the entity meets the definition of a financial institution.

An IGA is an agreement between the Treasury or IRS and a foreign government or agency that allows the partnering countries to share financial information to ease compliance with FATCA. When an entity meets...
the FFI requirements, it should register with the IRS to certify its status as an FFI (IGA is in effect) or register with the IRS and agree to comply with the terms of an FFI agreement (IGA is not in effect).

Under the FFI agreement, the FFI agrees to report information on its U.S. account holders such as name, address, tax identification number, account number, etc. Further, the FFI agrees to serve as a withholding agent and collect a 30% withholding tax on U.S.-sourced withholdable payments made to:

- An entity that has not registered with the IRS and agreed to comply with the terms of an FFI agreement
- Account holders that fail to prove they are not U.S. taxpayers
- Foreign entities that fail to prove its owners are not U.S. taxpayers.

Entities that may qualify as an FFI include:

- Depository institutions (e.g., banks)
- Custodial institutions (e.g., mutual funds)
- Investment entities (e.g., hedge funds)
- Certain types of insurance companies that have cash-value products or annuities.

Withholdable payments are fixed, determinable, annual, or periodic payments from a U.S. taxpayer to an FFI. Examples include:

- Insurance premiums
- Bank, brokerage, and investment advisor fees
- Custodial fees
- Interest and other payments connected to lending transactions
- Dividend payments on U.S. equities.

The rules related to withholding taxes on such withholdable payments are being phased in as follows:

- July 1, 2014—FFIs are required to withhold the 30% tax on withholdable payments. Failure to make the required disclosures to the IRS under FATCA could result in fines of 30% of the withholdable payments.
- January 1, 2015—The IRS will begin penalizing FFIs for compliance failures. As of this date, FFIs are required to begin withholding on proceeds from sales of investment property that generated interest or dividends that are taxable in the U.S.
- January 1, 2017—Reporting and withholding on pass-through payments from other FFIs is required.

**Non-financial foreign entities**

An entity may be subject to FATCA even if it does not qualify as an FFI, in effect making it an NFFE. NFFEs are classified as active or passive, depending on the extent to which they earn passive income and/or hold assets that generate investment income. Active NFFEs are NFFEs in which 50% of the assets are passive assets and less than 50% of the calendar-year gross income is passive income. Active NFFEs are exempt from FATCA. All other NFFEs are considered passive.

A passive NFFE is required to disclose its substantial U.S. owners or certify that there are no substantial owners. A substantial U.S. owner is defined as a U.S. citizen who owns, directly or indirectly, more than 10% of the stock of the entity. If a passive NFFE fails to disclose its substantial U.S. owners, the 30% tax penalty applies to U.S.-sourced withholdable payments received by the NFFE.

Most foreign property/casualty (P/C) insurance companies will be classified as passive NFFEs, unless they write cash-value contracts or annuities, because it is likely that more than 50% of their assets consist of cash and/or cash equivalents.

**FATCA status documentation**

FFIs and NFFEs may provide one of the following documents in support of their FATCA status:

- Form W-8BEN-E, Certificate of Status of Beneficial Owner for United States Tax Withholding and Reporting (Entities)
- Form W-8BEN, Certificate of Status of Beneficial Owner for United States Tax Withholding and Reporting (Individuals)
- Form W-9, Request for Taxpayer Identification Number and Certification.

Form W-9 is to be completed by foreign insurance and reinsurance companies that elect to be treated as U.S. taxpayers under IRC § 953(d).

**How does FATCA apply to P/C insurance companies?**

A U.S.-domiciled P/C insurance or reinsurance entity (domestic entity) may have a reinsurance or retrocession agreement in place with a foreign-domiciled P/C insurance or reinsurance entity (foreign insurance entity) that meets the qualifications for an FFI or NFFE. As such, the domestic entity is required to obtain a completed Form W-8BEN-E or W-9 from the foreign entity. If the foreign entity does not provide such documentation, the domestic entity is required to withhold 30% of the premium payment to the foreign entity.

A domestic entity may invest in, or with, a foreign depository or custodial institution or an investment entity (foreign investment entity). The reporting and withholding requirements are the same as
those described in the paragraph above. However, the domestic entity’s investment manager may serve as the withholding agent and could request the FATCA documentation on behalf of the domestic entity.

Regardless of which party serves as the withholding agent, if that party fails to comply with the documentation and withholding requirements, it is subject to the 30% penalty, plus interest. In addition, the following penalties may be assessed for noncompliance:

- 2% for compliance failures of 5 days or less
- 10% for compliance failures of more than 15 days
- 15% for compliance failure penalties not paid within 10 days from the date of the delinquency notice.

If the foreign entity meets the qualifications for an FFI or NFFE, it should immediately determine whether it needs to register with the IRS in order to avoid the 30% tax on the U.S.-sourced withholdable payments it receives.

**Best practices**

Because FATCA compliance is achieved by requesting, and then maintaining, proper documentation, domestic and foreign entities should ensure that they are adhering to the documentation and/or withholding requirements, as applicable. For this reason, consider implementing the following steps in your process and procedures:

- Ensure that withholdable payments have been analyzed and that the withholding agent has requested the foreign entities’ FATCA status documentation. Simplify the process by requesting FACTA status documentation, rather than a particular form, to avoid confusion.
- Ensure that withholding agents have received Form W-8BEN-E or W-9 and have not imposed the 30% withholding tax.

P/C insurance companies should be able to transition into the FATCA-compliance environment without incurring any significant administrative burden or punitive assessments from the IRS, if they follow these steps.


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**INSIGHTS ON ACCOUNTING**

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Joe Montgomery, Judy Halstead, Christine Stiles, TC Wilson, Bryce Lee, Robin Wilcox, Cathleen Duke, Kathryn Jenkins, Brian Moore, Loughan Campbell, Karen Hawkridge, Vicki Smith and Brad Stewart
Two recent studies seemed to show that defensive medicine in fact plays but a minor role in U.S. healthcare costs. The authors of the report in the New England Journal of Medicine (October 16, 2014) concluded that raising the threshold for culpability for emergency room (ER) doctors did not measurably change practice patterns. Another study (JAMA Internal Medicine, November 2014), in which physicians rated tests according to a “defensiveness score,” found that although defensive orders were not uncommon, completely defensive orders were. What is your assessment of the relative worth of this research?

**Farmer:** Extensive survey and anecdotal data support the idea that physicians commonly practice so-called defensive medicine. When practice patterns are examined in the context of a major shift in medical professional liability (MPL) risk (as in Texas, Georgia, and South Carolina), the effects of tort reform on practice have been mixed. There are a number of potential explanations for this phenomenon. First, some of the prior work on the effects of tort reform has examined a very limited time horizon, while practice changes are likely to evolve over time.

Second, when physician interview comments are scrutinized, it is found that they often conflate MPL risk with risk of a poor outcome. Tort reform changes the likelihood of a successful lawsuit, but presumably has little bearing on the likelihood of a poor outcome (at least as it relates to “defensiveness”).

Third, physicians have often been extensively trained in a culture that promotes intensive testing as a “standard of care.” Altering perceived MPL risk does not necessarily change the perception of “standard practices.”

Finally, physicians have multiple motivations. These may include direct or indirect financial incentives, among other factors. The Waxman study uses an empirically reasonable design and a long time horizon, which should be adequate to capture lagged effects (delays in practice changes). The researchers have examined clinical actions, which should be sensitive to MPL risk if physicians are indeed practicing
defensively. However, like much of the prior work, the analysis is unidimensional; it examines the MPL concept in isolation.

**IML:** In light of that appraisal, what, in general terms, needs to be done to untangle the many motives that may prompt a doctor to order particular tests?

**Farmer:** We argue in our proposal that a multi-dimensional study design, with a long time horizon, is needed. We account for varied reforms in more U.S. states and account for their relative stringency. We have data on adjudicated lawsuits at the county level in three states and can therefore show variations both within and between states. Finally, we examine both financial incentives and tort reforms both independently and together.

**IML:** How, specifically, will the design of your research clarify the impact of financial and other incentives in orders for cardiac testing? Why was five years chosen as the duration of the research?

**Farmer:** We first examine the effects of tort reforms, then the effects of major reimbursement changes, and then both together, on the prevalence of cardiac testing. The study examines data between 1999 and 2015. The project will be completed over a five-year time horizon because that is how NIH grants are organized.

**IML:** Tell us about the different types of professionals who will be part of your study team.

**Farmer:** Many prior studies on tort reform have included only economists. My research team incorporates input from a broad range of investigators. I am a non-invasive cardiologist. We also have two attorneys, one anesthesiologist, one emergency physician, three economists (with various specializations), a health policy expert, an epidemiologist, and a biostatistician.

**IML:** Do you have any hypotheses, at this point, on what you may find?

**Farmer:** The nature of MPL risk is likely to differ, depending on the financial circumstances of the testing. We hypothesize that fee-for-service medicine has often aligned with “defensive medicine” to promote high-intensity testing practices. If testing is profitable, it may continue at a high rate regardless of MPL risk. If testing is not profitable, testing may fall to unacceptably low levels in states with limited MPL liability.
If ever there was a conundrum, the post-hospitalization discharge, with its often intricate and difficult problems, certainly qualifies as one. So many stakeholders, so much information, so many opportunities for ineffective communication—all of these can promote and multiply the threats to patient safety, and increase the risk of medical professional liability (MPL) lawsuits, during the patient’s transition from one setting to another. At any age and in any group—but especially among the elderly and the very young—chronic illness with multiple comorbidities, critical illness, cognitive impairment, a lack of health literacy, a first language other than English, can all increase the risk to patient, physician, and staff.

The Affordable Care Act, the implementation of Current Procedural Terminology (CPT) codes for managing transition of care, and the CMS’s penalty for hospital readmissions within 30 days of discharge have increased the pressure for finding workable solutions to the post-hospitalization conundrum. Responsibility, accountability, liability, and defensibility are the watchwords for those who are responsible for achieving smooth transitions, for patients, physicians, and staff. The recent history of research, analysis, and program development to achieve effective care transitions confirms what we have learned anecdotally: we need to have a system and use it relentlessly.

If we are to “promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another,” as described by Mary T. Naylor in her March 23, 2011, presentation for the Avoid Readmissions Through Collaboration group, we must broaden our view of the who, what, and how involved in achieving effective transitions of care. There are multiple descriptions and definitions of the phrase “transition of care,” and there is a wide variety of models designed to improve the process. These models may include, unless limited by their state code of practice, non-physician practitioners, physicians assistants, clinical nurse specialists, and certified nurse midwives, who are eligible to bill using the CPT’s transitional care management codes.

Naylor and her colleagues define transition of care as “…a broad range of time-limited services designed to ensure healthcare continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another.”

The Agency for Healthcare Research and Quality’s patient safety culture survey assesses staff perceptions of patient safety in more than 1,000 hospitals nationwide. In 2012, handoffs and transitions comprised the second-lowest scoring area—another area, non-punitive response to error, was 1% lower. More than 50% of staff responding agreed that:

- “Things ‘fall between the cracks’ when transferring patients from one unit to another.”
- “Important patient care information is often lost during shift change.”
- “Problems often occur in the exchange of information across hospital units.”
- “Shift changes are problematic for patients in this hospital.”

Accepting that these perceptions are accurate when the patient stays within the same organization and physical setting, we have to consider how much more likely is it that important patient information will be lost upon discharge.

The National Transitions of Care Coalition (NTOCC) was founded in 2006 to define solutions by addressing the gaps that impact...
safety and quality of care for transitioning patients. The NTOCC has seven recommendations for improving transitions of care:

1. Improve communication
2. Establish accountability
3. Integrate information technology
4. Expand pharmacists' roles
5. Develop quality measures
6. Increase use of case management
7. Align payment systems and incentives.

Outcomes after intervention

Richard Balaban et al., in their 2008 study, measured four undesirable outcomes after hospital discharge: (1) no outpatient follow-up within 21 days; (2) readmission within 31 days; (3) emergency department visit within 30 days; and (4) failure by the primary care provider to complete the outpatient workup that had been recommended by the hospital doctors.

In response, the hospital instituted an intervention designed to promptly reconnect patients to their medical home after hospital discharge. The intervention patients received was a standardized, user-friendly patient discharge form. Upon their arrival at home, there was a phone call outreach to them from a nurse at their primary care site. The study found:

- Only 25.5% of intervention patients had one or more undesirable outcomes, compared with 55% of the concurrent and historic controls
- About 15% of the intervention patients failed to obtain physician follow-up within 21 days, compared with 41% of the concurrent and 35% of the historic controls
- Only 12% of recommended outpatient workups were incomplete, versus 31% in the concurrent and historical controls.

In 2009, the Picker Institute launched an initiative to improve the patient experience by identifying those things that are so important to patients and families that they should occur in every healthcare interaction, for every patient, every time. The institute moved from “Never Events” to “Always Events,” a significant change in thinking, to include not just the patient’s experience, but the physician and staff experience as well. (In 2013, the Picker Institute’s Always Events initiative was transferred to the Institute for Healthcare Improvement, where the initiative's materials and references can now be found.) The Always Events Healthcare Solutions Book offers information and tools to improve coordination and integration of care, to help avoid the frustrating, expensive and even life-threatening consequences of poor transitions of care.

Anne Arundel Medical Center (AAMC) in Annapolis, MD, received a grant from the Picker Institute and put it to work to develop the SMART Discharge Protocol. The SMART discharge process helps to ensure that key information is consistently discussed and understood. A SMART discharge includes communication about:

- S—Symptoms
- M—Medications
- A—Appointments
- R—Results
- T—Talk with me.

Available materials for reference include the SMART Discharge Worksheet, FAQs, the SMART Discharge Self-Learning Packet for staff, and the SMART Discharge Training Presentation. AAMC reported a decrease in visits to the emergency department and inpatient hospital utilization, as well as an increase in the percentage of patients who had seen the correct physician after the transition.

The Lahey Clinic Palliative Care Services and the Middlesex East VNA/Hospital in Massachusetts also received a grant and developed “Partnering with Patients and Families to Reduce Readmissions.” The commitment is to sustaining an active partnership with patients and families through use of transitions, liaisons, and personalized educational tools. Available tools include:

- Transitions of care partnership project overview
- Transitions of care management call and questionnaire
- Case management initial assessment and readmission 30-day assessment
- Patient medical journal templates.

The “patient medical journal” provides a single place where patients and families can record and organize their healthcare information. Among patients using the journal, the Lahey Clinic reported a decreased readmission rate, an increase in the number of patients who...
reported that they felt ready to go home, and an increase in the number of patients reporting that they understood their medications at time of discharge. Caregivers have said that the medical journal is an effective tool for communicating with the family.

From the medical literature
A search of the medical literature indicates that there have been 46 articles describing 24 handoff mnemonics published since 1987, most of them appearing since 2006. Our job is to identify the at-risk populations we encounter, and the information, tools and behaviors we need to mobilize to seal the cracks and effectively transfer patient information among all of the members of the patient's healthcare team.

In practical terms, at every step in the healthcare experience of the patient and family, there is the opportunity to get everyone on the same page. At every step, there is the opportunity to build trust and alleviate anxiety. The patient, family, physician, and staff all have a stake in ensuring continuity of care, reducing the likelihood of error, and creating the trust and confidence that makes everyone feel that the job has been well done. No matter what we call it, the safe and timely movement of patients among providers and organizations contributes to becoming the provider and place of choice.

If we ever have to answer the question, “And you never saw the patient again?”, we need to be able to demonstrate that we have policies, processes, and procedures in place that engineer an active partnership with patients and families, physician colleagues, and staff, to optimize patient safety through effective transitions of care, especially in the post-hospitalization discharge period.

References
5. Hayward M, Endo JA, and Rutherford P."A Focus on 'Always Events'."

Additional Reading

New Questions about Corporate Wellness Programs
Until corporate wellness programs demonstrate ROI, many companies have to consider whether there are other ways to improve the health of their employees and the country.

The backlash against corporate wellness programs has reached a crescendo with lawsuits by the Equal Opportunity Employment Commission on behalf of workers who feel coerced to complete health risk assessment programs as a condition of receiving healthcare insurance.

The backlash has been long simmering, and in the summer of 2013 came to a boil in central Pennsylvania when Penn State University professors and staff successfully revolted against a proposal to require physical exams and health risk assessment and impose a $100 per month premium surcharge for opting out.

—Healthcare Payer News, January 2015

For related information, see www.cappphysicians.com.
PIAAPAC Declares Victory

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PIAAPAC is the recognized voice of the medical professional liability community in the political arena. To learn more about the PAC, contact PIAAPAC Assistant Treasurer Mike Stinson at mstinson@piaa.us.
In light of today's litigious society, combined with the sometimes insidious nature of personal injury lawyers, healthcare professionals have plenty to worry about when it comes to liability. So it's disheartening to consider that there is now among us a newly emerging—and rapidly proliferating—risk: data breach.

Every day, we see alarming headlines about another data breach in a healthcare facility. Hospitals, clinics, and physician practices have been prime targets for sophisticated computer hackers looking to pilfer patient data. Most recently, Anthem, Inc., the nation's second-largest health insurance company, was the victim of a truly massive data breach.

According to the company, as many as 80 million Anthem customers had their account information stolen. The hackers gained access to Anthem's computer system, and stole personal details that included names, birthdays, medical identifications, Social Security numbers, street addresses, e-mail addresses, and employment information, including income data.

Why is patient data so tantalizing to hackers? According to some experts, patient information is one-stop shopping for hackers, since it usually contains everything they need to establish a new identity. However, even more worrying, it's the actual medical data that is considered the real prize in breaches, because people without health insurance can potentially get treatment by using the medical data compiled on one of the hacking victims. Also, the information can be used to file fraudulent claims.

A medical record can be worth anywhere from $50 to $250 to the right customer—which is much more than what's typically paid on the black market for a credit card number, or the pennies paid for just a user name and password.

Here's the silver lining in this particular cloud: As longtime and stalwart supporters of professionals and institutions that provide healthcare, PIAA member companies have an excellent opportunity to strengthen their bonds with policyholders by helping them understand the critical importance of protecting patient data and by providing education and tips on data security.

Moreover, so healthcare professionals can protect themselves from catastrophic loss if they are hit with a data breach, PIAA companies can offer coverage for this risk, or help their insureds find high-quality policies for it. Today's sophisticated cyber risk insurance can help hospitals or medical practices handle the costly aftermath of a data breach; the myriad of costs associated with a data breach can be daunting to contemplate. Just a partial list would include notifying patients that their private data has been leaked or in some way compromised, supplying credit-monitoring services for everyone affected by the cyber attack, and managing public relations so as to conserve the healthcare professional's reputation.

PIAA and its members have always worked on behalf of the best interests of healthcare professionals and institutions. As the crime of data breach continues to flourish, we can take a key role in helping to provide the best possible protection for all of the patients our providers care for.
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