Underwriting for Telehealth: New Risks, New Strategies

Annual ‘Industry Update’
Johnson Lambert LLP is a niche-focused CPA firm that provides audit, tax, and advisory services to 500 insurance entities nationwide, including dozens of Medical Professional Liability clients.
Telehealth is becoming woven into the fabric of healthcare delivery, and very rapidly. Virtual patient visits—which become more common every day—have the potential to improve care, reduce costs, and at the same time meet the ever-expanding demands for greater access to healthcare professionals.

But there may well be some important liability issues in using telehealth. This is why PIAA has devoted time and resources on this issue, to ensure that your interests and those of your policyholders are protected.

Our Government Relations team has been engaging with a coalition of organizations and stakeholder groups with a shared interest in telehealth. We are working to develop innovative approaches for addressing our concerns about telemedicine—especially the potential for liability in the provision of telehealth services. There are many new and profound issues that may arise—such as the venue that will be recognized if a lawsuit is filed, and, correspondingly, the state's laws and standard of care that will apply—when insuring healthcare providers that utilize telehealth. We are also speaking with key policy makers in Washington, D.C., to make certain that they know about these liability issues and take them into consideration whenever new legislation or regulations regarding telemedicine are drafted.

But our work doesn't stop there. PIAA is also partnering with the American Telemedicine Association and others to explore the potential for using telemedicine in chronic care management. The project, underwritten by the Kaiser Permanente Institute for Health Policy, involves some of the best minds and most prominent voices working on today’s healthcare issues. Several PIAA member companies have joined us and are participating in the development of a white paper that will synthesize the available evidence about the effectiveness, and economic implications, of telehealth interventions in the management of chronic and other conditions. We look forward to sharing this study with you when it is released later this year.

In light of our current activity on the topic of telehealth, as well as the significant interest expressed by PIAA members about this issue, it is appropriate that this quarter’s lead story takes a close look at the benefits of using an enterprise risk management (ERM) approach for telemedicine and telehealth underwriting. As you will learn, the challenge for today’s medical and healthcare professional liability (MPL/HPL) underwriters is to identify all of the potential risk exposures and then apply sound underwriting principles to them while working within this rapidly changing area of healthcare.

Also in this issue, you’ll read about the impact of recent reinsurance dynamics on MPL/HPL. Like all markets, the reinsurance market responds to changes in supply and demand. But today’s market is especially dynamic because there have been so many fundamental shifts in both of those forces.

In addition, there is a thoughtful article on the steps that healthcare professionals can take to enhance patient safety: “Paying Attention to the Signals: Understanding Healthcare’s Most Critical Patient Safety Vulnerabilities.” The author uses as an example the approach taken by the nuclear power industry to present some innovative and constructive ideas about what the healthcare industry and those who advocate on behalf of healthcare professionals can implement to prompt measurable progress in the safe delivery of healthcare.

As we come together for the 2016 Medical Liability Conference, it seems eminently appropriate that our meeting site is Washington, D.C. As you know, it is our pledge that PIAA members will always have a seat at the table, irrespective of whether the issue at hand is pending before Congress, a federal agency, or a regulatory body, and regardless of the issue—telehealth, patient care, or any other challenge that we must confront as a community. Our objective is to stay focused on the matters that are most important to you, and whenever possible, deliver meaningful results that make a real difference to your organization.
Inside Medical Liability

Contents

Features

28 Cover Story: Using an ERM Approach for Telemedicine and Telehealth Underwriting
By Fay A. Rozovskiy, JD, MPH

32 Feature: Paying Attention to the Signals: Understanding Healthcare’s Most Critical Patient Safety Vulnerabilities
By Robert Hanscom, JD

37 Feature: Reinsurance Dynamics Impact Medical Professional Liability: It’s a Buyers’ Market—But with Natural Limits
By Todd Mockler

41 Feature: The Evolution of the Chief Medical Officer Role in MPL

Up Front

1 Perspective
4 Events & Calendar
6 Observer
9 PIAA DSP Data Snapshot
12 Letter from the Chair

Departments

14 Tech Talk
Underwriting Errors—Causes and Remedies
By Martin Lippiett

17 Legislative Update

21 Case and Comment
Parents May Be Waking Up to Sedation Risks
By Kyle Sweet, Esq., Vanessa Hicks, Esq., and Brian Blackstock, Esq.

45 International Perspective
2017 PIAA International Conference
By Dr. Michael Devlin and Dr. John Tiernan

49 The Asset Side
Is the Bond Market Smarter than the Stock Market?
By Jason Gingerich

53 Toolkit
Add Another Tool to the Defense Toolkit—Courtesy of the ACA
By James W. Saxton, Esq., and Darlene K. King, Esq.

56 Commentary
Is it Possible to Predict Physicians Prone to MPL Claims?
By Richard E. Moses, DO, JD, Michelle Moses Chaitt, Esq., and Scott Jones

66 2016 Medical Liability Conference
Sponsors and Exhibitors

68 Last Word

Special Section

61 Industry Update
By Chad Karls and Susan Forray

“By implementing an ERM approach in underwriting, there is a framework for effective engagement with healthcare prospects moving aggressively into telemedicine.”
—Cover story

Inside Medical Liability 2016 Second Quarter
IN TODAY'S COMPETITIVE MARKET, ARE YOU STAYING AHEAD OF YOUR COMPETITION?

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

- Thin-client browser-based web application
- Extensible SOA web services
- Highly-scalable architecture well-adapted for virtualization
- Efficient modular design
- Flexible product definition workbench
- Highly-configurable interface, business rules and workflow
- Highly-configurable dynamic intelligent web portal services platform
- Industry-leading data warehouse, data cubes and OLAP / predictive analytics

Let Delphi Technology show you how its fully-integrated medical professional liability solution will transform your critical business challenges into measurable business results.
COMING ATTRACTIONS

EVENTS & CALENDAR

May 11, 2016
Leadership Camp
JW Marriott
Washington, D.C.

May 11-13, 2016
Medical Liability Conference
JW Marriott
Washington, D.C.

July 27-29, 2016
Underwriting Workshop
Omni Interlocken Hotel
Denver, CO

September 7-9, 2016
Claims and Risk Management/Patient Safety Workshop
Loews Santa Monica Beach Hotel
Santa Monica, CA

September 27-28, 2016
Introduction to Medical Professional Liability Insurance Workshop
Royal Sonesta
New Orleans, LA

October 20-21, 2016
Corporate Counsel Workshop
La Posada de Santa Fe
Santa Fe, NM

Future PIAA Medical Liability Conferences

May 17-19, 2017
The Broadmoor Hotel
Colorado Springs, CO

May 16-18, 2018
Waldorf Astoria/Hilton Bonnet Creek
Orlando, FL

■ 2016 Underwriting Workshop

Radiology Revolution: The Shifting Landscape Following Two Decades of Digital Transformation
Friday, July 29, 9:00–10:00 a.m.
Matthew J. Fleishman, MD, MMM, FACR

Over the last two decades, the changes in both medicine and technology have driven significant changes in the role that the radiologist plays in the healthcare system. The traditional image of the radiologist as a physician who sits in a dark room interpreting films and generating reports has become outdated, if not obsolete.

This presentation will focus on the evolving practice of radiology and what medical and healthcare professional liability (MPL/HPL) underwriters need to know about the changes, and the corresponding underwriting risks. Participants will learn about the impact of the digital transformation of radiology practice, as this change impacts underwriting. Dr. Fleishman will review the underwriting challenges that are implicit in the new practice paradigm for radiology groups. He will also explain the changing pattern of risks, as radiology practices expand and consolidate.

■ 2016 Introduction to Medical Professional Liability Insurance Workshop

Don’t miss the return of this popular PIAA workshop in 2016!

September 27–28, 2016 – Royal Sonesta, New Orleans

The “Introduction to Medical Professional Liability Insurance Workshop” is back in 2016, and it will be held at the Royal Sonesta in New Orleans, just prior to the first day of the 2016 PIAA Technology, Human Resources, and Finance Workshop. This unique educational program gives attendees a comprehensive overview of the most important fundamentals and dynamics in MPL—knowledge that is invaluable for becoming a major contributor to an MPL insurer.

In one workshop, your staff members can learn about every aspect of the MPL business including claims administration, underwriting, rate-making and reserves, reinsurance, and more! This innovative program is designed for: employees in the early phase of their insurance career; longer-term employees with relatively less experience in some of the disciplines or departmental procedures that comprise an insurance operation; and physicians or other directors who are new to insurance governance. The workshop also provides valuable information for the employees of companies that provide goods and services to the MPL community and who need to learn more about the inner workings of the enterprises they work with.
The United States healthcare insurance market is undergoing rapid and profound change. Guy Carpenter is focused on this evolving and specialized market. As the recognized industry leader in casualty catastrophe reinsurance products and other risk transfer solutions, we are uniquely positioned to offer clients seamless and innovative coverage solutions that respond to both known and emerging exposures.

We invite you to learn how our dedicated team of specialists leverages our industry experience, market intelligence and analytical expertise to customize solutions that can meet the unique strategic and reinsurance needs of the medical professional liability insurance market.

Let us put our intellectual capital to work for you. Please contact Steve Underdal at (952) 820-1030 or steve.underdal@guycarp.com for more information.

To learn more, please visit guycarp.com
**Why (Some) Doctors Buy Bigger Homes than Lawyers**

It's an intuitive conclusion: physicians in states with unlimited homestead exceptions might want to use their homes as a way to shelter their life's savings in their residence, in the event of an MPL award that exceeds their policy limits. But now, this has become the subject of a formal study, published in February 2016 in the *National Review of Economic Research*.

In states with the exemption, physicians bought homes that cost, on average, 13% more than they would without the exemption. Lawyers and business executives who made comparable salaries didn't buy bigger homes in those states.

But dentists, also vulnerable to lawsuits, did.

One of the study's authors, Anupan Jena, associate professor of health care policy at Harvard Medical School, says the house-purchase phenomenon indicates that fear of lawsuits is a major force in physicians' lives.

Jena comments, "If you've ever talked to a physician who has been sued, it's a really dramatic thing. People will rank it just below losing a loved one. We have been interested in understanding how does that pervasive aspect of a physician's career influence the decisions they make—whether it means they practice more defensive medicine, quit their jobs earlier, or invest more in houses to protect themselves against liability."

Bottom line: tort reform, on a nationwide scale, can't come soon enough, can it?


---

**Solvency II: “We’ve Only Just Begun”**

While it is distinctly unlikely that The Carpenters had some future vision of Solvency II in mind when they recorded their hit tune, many experts in Europe think this is what's happening with the Solvency II regime.

Solvency II totally changes the framework in which insurers operate. In the old, pre-Solvency II days, assets had to match liabilities. Now, the issue of capital charges dictates, somewhat, the asset allocation in an insurer's portfolio. This is clearly not an easy change to bring about.

Sweden, it turns out, is at the head of the pack in implementing Solvency II. But even there, says Ashley Smith, senior vice president of development at Silverfinch (described on the Web, confusingly to Observer, as a "secure fund data utility"), "There is little sign of any common approach among businesses."

*Source: Global Reinsurance, February 2016*
Financial Innovation, Scary Dept.: Loans for Medical Procedures
And then those get bundled together, and securitized

Is this reminding you of anything yet? How about “The Big Short”? The new loan concept is the brainchild of MIT Sloan Professor Andrew Lo and colleagues. They see this period as a time that offers major breakthroughs in medicine—but with correspondingly major price tags.

These treatments are financially out of reach, says Lo, for many patients. In research published in Science Translational Medicine, and he offers a remedy: securitized consumer healthcare loans (HCLs).

HCLs, the equivalent of mortgages for large healthcare expenses, spread the cost of drugs and therapies over many years, making them more affordable to the people who need them. Financing HCLs through securitization—pooling loans and converting them into securities—would allow more patients to have access to the therapies, while at the same time generating attractive returns to investors, the research team contends.

“This is an instance where financial engineering could benefit the entire ecosystem,” said Lo in the study. “It helps patients by providing them with affordable access to therapeutic drugs and cures. It helps bio-pharmaceutical companies by enabling them to get paid back for the substantial investments in (research and development) they make to develop the therapies in the first place. And it helps insurance companies by linking payment to ongoing benefit.”

Securitized HCLs may in fact be profitable investments, the researchers claim. Based on numerical simulations and statistical models, a large, diversified fund of HCLs generated hypothetical annual returns of 12% [Observer wants in!].

Lo and his co-authors do acknowledge that using financial engineering techniques in healthcare is not without risk—especially as securitization was chief among the techniques that precipitated the recent global financial crisis.

Training for a healthy organization...

How agile are you?

With an ever-evolving industry, your business must be nimble enough to adjust to whatever the market throws your way. With our proven expertise and superior suite of software, you'll deliver the right products to cover all the bases and best serve the needs of the medical professional liability insurance market, on-premise or through Duck Creek On-Demand, our Software as a Service model accessed via the cloud.

For more information on how our suite provides modernization that is attainable and affordable and gives you a competitive advantage, visit our website at www.duckcreek.com.
PIAA Data Sharing Project


- Average indemnity payments for the recent five-year period.
  - $354,524 in 2010
  - $344,361 in 2012
  - $361,128 in 2013
  - $333,101 in 2014

- More than $4.4 billion in total indemnity was paid in claims and lawsuits. The median indemnity payment was $200,000.

- Average indemnity paid: $346,451
- Average defense cost: $51,333

- 65% of claims were dropped, withdrawn, or dismissed (DWD) with no indemnity payment but incurred an average defense cost of $30,000.

- The percentage of claims and lawsuits resulting in an indemnity payment. Of these, 10% had indemnity payments greater than or equal to $1 million.

- Average defense cost for a claim with an indemnity payment is $79,884. Average defense cost with no indemnity payment is $41,050.

- Defense costs are up while indemnity is down when comparing averages between the two recent five-year intervals (2005-2009 and 2010-2014).

Contact P. Divya Parikh at dparikh@piaa.us for more information.

© 2016 PIAA. All rights reserved. This page may not be reproduced or distributed without express written consent from PIAA.
NO TWO CLIENTS ARE ALIKE

For over 25 years, Prime Advisors, Inc. has specialized in developing unique investment portfolios, customized to each client’s individual needs and objectives.
Focused
Bringing a disciplined approach to managing every client portfolio in the pursuit of investment performance that adds value above our clients’ investment benchmarks.

Customized
Medical professional liability companies need to strike a proper balance between generating investment income and protecting the security of policyholders. At Prime, we understand that no single approach, or one set of guidelines, applies to every company.

Experienced
Since 1988, Prime has been striving for Success Through Client Satisfaction. Our company has developed an investment management approach that utilizes dynamic financial analytical models and performance measurement systems to optimize performance.

Stop by booth #22 at the PIAA Medical Liability Conference to learn more about Prime’s customized portfolio management solutions.

Dennis Klimes, SVP
425-202-2075
www.primeadvisors.com
Sustaining a Vital Legacy

It takes broad shoulders to steward a legacy. I’m reminded of this every time I reflect on the founders of PIAA and what they achieved. Nearly four decades ago, a group of far-seeing, passionate doctors, collaborating with some very astute, innovative insurance professionals, and assisted by several state medical societies, started PIAA. Their goal was to establish an organization that would serve as an information-sharing forum for all of the new companies working to ensure a stable, predictable medical professional liability insurance marketplace. They also focused on a closely related objective: to help in optimizing the safe delivery of medical care.

These visionaries achieved the objectives they set out to accomplish. And, thanks to the leadership and dedication of the many individuals—both doctors and insurance professionals—who followed in their footsteps, PIAA is thriving, sustaining the important legacy initiated so many years ago.

In addition to the guiding principles established by our founders, there are several other factors that have been crucial to PIAA’s ongoing success. Clearly, the continued input and participation of clinicians in PIAA’s leadership and governance, the “true north” for the Association, has played a major role in our success.

Glória H. Everett
President & Chief Executive Officer, The Mutual Risk Retention Group, and Chair of the PIAA Board of Directors

Those who are well versed in their PIAA history know that we used to be characterized as an association of physicians insuring physicians—and this undoubtedly distinguished us, as an essential element in our heritage. To meet the changing needs of medical practices and healthcare, over the years, PIAA has evolved to embrace within its ranks professional liability carriers that insure hospitals, clinics, and a diversity of healthcare specialists, including dentists, podiatrists, and many others.

Over time, PIAA, to fulfill its mission and be relevant to the future of healthcare, also welcomed the new types of business structures adopted by some carriers. In the early days of membership, the Association was comprised predominantly of mutuals and reciprocals. My company, a risk retention group (RRG), at one time did not fit the PIAA membership criteria. With further expansion, trusts, RRGs, and international MPL indemnifiers joined the ranks of PIAA. The Association has become more dynamic, and much the richer, for this growth in its membership.

Today, more than 60 organizations—located throughout the U.S. and around the world—of all sorts of structures and sizes constitute the PIAA membership. They are unique: Not only are they unsurpassed in the knowledge required to administer medical and healthcare professional liability coverage; they are also staunchly committed to improving the delivery of healthcare.

As we embark on a new year, and the close of my tenure as PIAA Chair, I feel confident in stating that we have made significant strides in our efforts to serve as an indispensable resource for every group with a commitment to quality healthcare and a stake in medical and healthcare liability, regardless of structure—reciprocal, mutual, RRG, trust, stock, or captive.

Our value proposition is now stronger than ever. We are dedicated to helping you become more successful, by serving you in key areas: advocating for favorable federal legislation, public policy, and regulation; providing education and training for your staff; advancing patient safety by aggregating and analyzing data on medical and healthcare claims; and serving as the leading forum where you can meet, network, and exchange ideas.

Our strategic plan, which reflects the new realities in healthcare, provides a roadmap for further progress in meeting the needs of the medical and healthcare professional liability community.

In closing, I’d like to thank every member of the Board of Directors for their dedication, wisdom, and contributions to the Association. I would also like to recognize you, the PIAA members, for your unwavering support. Thanks to you, we are able to carry on the good work of our founders.
Bringing a connected perspective across talent, assets and ideas to unlock your full potential
It’s difficult to know how errors that happen in the underwriting process affect a company’s results, because the errors that aren’t detected can’t be counted or their impact measured—and many, if not most, are never discovered. Errors come in many shapes and sizes, and a single error can be due to more than one cause.

Because of this, the economic impact of errors is hard to measure. But as the saying goes, to err is human—so as nebulous as this topic is, it’s perfectly clear that errors are made and that they have an adverse effect on the finances and services of a company.

So let’s try and classify the various sorts of underwriting errors and explore how they might be mitigated.

**Errors of judgment on the part of the underwriter**

Here is an example: a failure to carefully consider an application and making an uninformed decision by accepting an unsuitable risk—or (the opportunity cost of) not accepting a good risk. A less serious example would be to apply debits or credits to the insured inappropriately, resulting in a premium that is too low to adequately fund the risk, or too high to win the business.

Leaving aside the obvious humans relations issues regarding staff selection and training, what can be done? First, underwriting guidelines have to be clear and specific, with set limits and, where appropriate, an escalation process for authorization of deviations from the limits. And let’s go for simplicity. Does having lots of options and rules really improve business outcomes? The software used should embed the rules into the data entry and rating process. With specific criteria, automated underwriting should be possible on at least some of the book of business—for dentists, individuals, and small groups. Perhaps, some 80% of renewals should flow through the system, with the other 20% flagged by the software for human interven-
Relational edits should be used, to the extent possible, to enforce underwriting rules. For example, if the company does not write certain specialties in certain states, the system should prevent such entries.

Business rules should be automated, as much as possible. For example, if a new doctor discount lasts three years, and the percentage is reduced each year, the system should preclude the user from reducing it. Transactions should be held in a "pending" status, so that the user can check the forms and the premium generated before finalizing the changes. If a chiropractor was classified as a neurosurgeon, the resulting premium should raise a question!

A specific level of authority could be established for each user, based on his experience and ability. Assuming that an error with a large premium is more critical than on a smaller amount, in instances where a transaction exceeds the underwriter’s level of authority (usually measured by dollar amount but also, possibly, on the demographics of the policy), the transaction should be kept in a “hold” status, and a supervisor automatically alerted to review it before it can be accepted.

Out-of-range reporting can be used to catch errors—but after the fact. These reports look for characteristics of a transaction, such as a deviation from the base premium by more than some pre-established limit, x%.

Errors due to system defects

Errors in the software can have a host of causes, and as software has become increasingly complex, the chance of error increases accordingly.

Here are some examples of possible causes of software errors:

- Relational edits should be used, to the extent possible, to enforce underwriting rules. For example, if the company does not write certain specialties in certain states, the system should prevent such entries.
- Business rules should be automated, as much as possible. For example, if a new doctor discount lasts three years, and the percentage is reduced each year, the system should allow the user to set it up once, at the time the new business is acquired; after that, the renewal process for the policy should do the work of reducing the discount and ultimately removing it.
- Transactions should be held in a "pending" status, so that the user can check the forms and the premium generated before finalizing the change. If a chiropractor was classified as a neurosurgeon, the resulting premium should raise a question!
- A specific level of authority could be established for each user, based on his experience and ability. Assuming that an error with a large premium is more critical than on a smaller amount, in instances where a transaction exceeds the underwriter’s level of authority (usually measured by dollar amount but also, possibly, on the demographics of the policy), the transaction should be kept in a “hold” status, and a supervisor automatically alerted to review it before it can be accepted.
- Out-of-range reporting can be used to catch errors—but after the fact. These reports look for characteristics of a transaction, such as a deviation from the base premium by more than some pre-established limit, x%.

Valid but incorrect entries

Here is one example: misclassification that happens because the wrong healthcare specialty was selected from a list, the wrong dollar amount for a risk management credit was entered, etc. Hopefully, we can assume that the system in use today will, at minimum, be designed to validate data and reduce the work of entry by offering for selection only valid options. However, there is a difference between “valid” and “correct.”

These errors are the hardest to catch, but there are some techniques that will help the user:

- Relational edits should be used, to the extent possible, to enforce underwriting rules. For example, if the company does not write certain specialties in certain states, the system should prevent such entries.
- Business rules should be automated, as much as possible. For example, if a new doctor discount lasts three years, and the percentage is reduced each year, the system should allow the user to set it up once, at the time the new business is acquired; after that, the renewal process for the policy should do the work of reducing the discount and ultimately removing it.
- Transactions should be held in a "pending" status, so that the user can check the forms and the premium generated before finalizing the change. If a chiropractor was classified as a neurosurgeon, the resulting premium should raise a question!
- A specific level of authority could be established for each user, based on his experience and ability. Assuming that an error with a large premium is more critical than on a smaller amount, in instances where a transaction exceeds the underwriter’s level of authority (usually measured by dollar amount but also, possibly, on the demographics of the policy), the transaction should be kept in a “hold” status, and a supervisor automatically alerted to review it before it can be accepted.
- Out-of-range reporting can be used to catch errors—but after the fact. These reports look for characteristics of a transaction, such as a deviation from the base premium by more than some pre-established limit, x%.

Errors due to system defects

Errors in the software can have a host of causes, and as software has become increasingly complex, the chance of error increases accordingly.

Here are some examples of possible causes of software errors:

- Human factors—like trying to meet a deadline at the expense of quality, or accepting “last minute” changes without proper planning
- Communication error—the programmer did not fully understand the business requirement
- Poor design logic—improper or incomplete logic in a calculation or decision step, or poor coding techniques
- Lack of version control—allowing some changes to the software to overwrite others
- Bugs in third-party tools—software relies on an operating system, a database, and most likely some third-party tools like HTML editors, compilers, dynamic link libraries, etc., some of which may have bugs that affect the performance of the software being written to use them.

That is not a complete list—but there’s probably enough here to make the point.

Ideally, you should have software development standards and documentation that are designed to prevent errors, but since that will never work 100% of the time, the catch-all for errors, whatever the cause, is testing, and that is a topic unto itself.

The short story is that nothing should be moved into production without being rigorously tested by the software development organization’s QA team, followed by a review by the user who is best able to understand and comment on the performance of the new code, as measured against what the business expects of it.

Aside from defects, the other issue is whether the functionality of the system adheres to the best practices of software design. Is the degree of automated support as high as it could be? For example, is duplication entry eliminated—does application data flow into a quote without having to be reentered? Are steps in the workflow monitored by the software? Is there “intelligence” applied to processes like application review—does the system prompt that the applicant has a prior history with the company? Can indication quotes be fully automated without user intervention? Are electronic interfaces used to avoid manual processes—for example, a lockbox for payments? These, and many more features, as well as increasing efficiency, can serve to reduce errors, improve service, and assure quality.

At I noted at the outset, while errors are a given, it’s difficult to determine their impact. But difficult or not, it’s still a good question to ask.
Investing for insurers is a whole different breed of cat.

That's why Conning focuses on innovative investment solutions involving non-traditional or alternative asset classes that meet the specific needs of insurance companies.

Conning develops customized solutions for insurers that are designed to enhance risk-adjusted returns and portfolio diversification while addressing concerns about risk-based capital treatment, income and earnings volatility, liquidity, taxes and fees. Our deep understanding of the needs of insurance companies, our expertise in a wide range of asset classes, and extensive experience in strategic asset allocation help us to provide innovative strategies to meet the unique needs of our clients.

Visit us at PIAA’s Medical Liability Conference, Booth #27

CONNect with Conning for customized investment solutions at connect@conning.com
Already, the 2016 election has emerged as one of the most memorable in a generation—and the primaries aren’t even officially over. The traditional playbooks for a presidential campaign have been tossed out the window, with many prognosticators and strategists left scratching their heads and asking, “What just happened—and how exactly did it happen?” Despite the chaos and confusion surrounding the presidential campaign, the down-ballot contests are playing out just as many observers had anticipated. And these races are poised to exert a significant impact on PIAA’s policy objectives in 2017 and beyond. So what is PIAA doing to position itself after the election? Answer: We’re utilizing our political action committee (PIAAPAC) more aggressively than ever before.

Narrowing the field
Not long after the previous election ended, we began work on a careful review of all the significant congressional races, looking for opportunities to support our friends and oppose those who would side with our adversaries. As part of this process, PIAAPAC has analyzed the records of congressional candidates to find out who shares PIAA’s views on issues such as reform of the legal system and regulation of the insurance industry. While tort reform is clearly an important issue in considering whom to support, a candidate’s views on issues such as antitrust reform and patient safety also influence the PAC’s decisions on providing financial support. Other factors that we consider are the candidate’s commitment to the financial health of the insurance industry, his ability to influence the legislative process if elected, and his relative viability as a candidate.

After compiling this information, PIAAPAC takes its analysis to the PIAAPAC Board of Directors (comprising seven individuals who represent a diverse array of PIAA’s membership), which then reviews the information and decides how it will allocate the PAC’s limited campaign dollars. It is important to note that in so doing, the Board adheres closely to PIAAPAC policy: to remain a voluntary, non-partisan political organization. As such, its leaders make every effort to support a bipartisan slate of candidates. Once the candidates who will receive contributions have been selected, PIAA’s Government Relations team

The fundraising process is difficult—but is it worth it? The answer, most certainly, is “Yes!” For starters, money generates attention.
uses those contributions to gain access to political fundraising events, where we can engage in the all-important discussions about our issues directly with the candidate.

Following the rules
Before we can decide which candidates to support, however, PIAA confronts a series of hurdles that simply do not apply to many of its counterparts. As a trade association made up of companies (rather than an individual-member association), we cannot reach out directly to individuals to ask for their support. Also, we can’t accept corporate funds for political purposes or any contributions from the general public. To raise money, we have to contact each of our member companies annually, to (1) get their permission to ask for contributions from the company’s employees that the law allows us to solicit, or (2) confirm the names of the persons we are allowed to solicit if the company has given us permission to do so in the past. Under federal campaign law, individuals who can legally be solicited make up what is known as the “restricted class” or “eligible class,” which consists of salaried executive and administrative personnel and/or paid board members of PIAA and its member companies.

If a member company has granted us permission, we still have to go back to those companies to get the contact information for every individual in the eligible class for that company. It is illegal for us to seek a contribution from anyone until both of these conditions have been met. Clearly, these are onerous requirements, but PIAAPAC is determined that they will not hinder our efforts to represent PIAA members in the political arena.

Does the PAC help?
The fundraising process is difficult—but is it worth it? The answer, most certainly, is “Yes!” For starters, money generates attention. The political fundraising process is a key tool to ensuring that elected officials are aware of who we are and what we do. Furthermore, PIAAPAC is the only political entity in Washington, D.C., that is committed solely to the interests of the medical/healthcare professional liability community. Without it, our message would more than likely get lost amid all of the other groups advocating on other healthcare issues.

So, how do we make a small PAC, and one that is hampered by a Byzantine bureaucratic system, effective? By selectively targeting our political contributions, we leverage the limited funds we are able to raise in a way that magnifies their impact beyond what many might assume. While we can’t donate to every candidate who may agree with us on the issues, we can focus on those incumbents on key committees, or in formal or informal leadership roles, where they may be able to exert considerable influence on their fellow lawmakers. Conversely, we may also target challengers taking on candidates we deem to be working on behalf of our opponents.

Getting the attention of certain specific members may be all we need to get our message across, and thereby dramatically increase our likelihood of success.

Without PIAAPAC, our opportunities to achieve positive results would be significantly diminished.

Especially now, with so many competitive races for the U.S. House and Senate underway, maintaining a viable and effective PAC is essential to any organization’s lobbying efforts. With the help of PIAAPAC, PIAA remains committed to playing a significant role in the legislative process, for our members as well as the healthcare professionals they insure.
OUR TEAM IS READY TO HELP YOU REACH THE TOP OF YOUR GAME.

The world has changed. Information flow is faster than ever. Remaining at the top of your game requires focus, foresight and the ability to act quickly. We believe to keep moving forward, your team needs the best players: experienced investment professionals who combine sound judgment with innovation. Allow us to assist as you step onto your field.

Are you ready?

THE OPTIMAL SERVICE GROUP of Wells Fargo Advisors

428 McLaws Circle, Suite 100 Williamsburg, Virginia 23185
757-220-1782 · 888-465-8422 www.osg.wfadv.com

Joe Montgomery, Judy Halstead, Christine Stiles, TC Wilson, Bryce Lee, Robin Wilcox, Cathleen Dillon, Kathryn Jenkins, Brian Moore, Loughan Campbell, Karen Hawkridge, Vicki Smith, Brad Stewart and James Johnson
Think BMS...

BMS – Delivering what you need to succeed

With more than 30 years of healthcare experience, we are a responsive, independent and stable partner. Our dedicated teams combine advanced analytics with an extensive range of trusted market relationships, allowing us to access the best solutions 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

Connect with BMS at: www.bmsgroup.com
Use of in-office sedation has been increasing in a variety of healthcare settings, including dental offices. In addition to avoiding difficulties in scheduling hospital admissions, advancements in sedation techniques have led to increased safety, easier administration, and lower cost to patients.

Other factors have led to increased demand in dental offices where children are treated. The prevalence of early-childhood caries means more children require extensive dental work at younger ages. According to a joint publication by the American Academy of Pediatrics (AAP) and American Association of Pediatric Dentistry (AAPD), children younger than 6 years and those with developmental delay often require deep levels of sedation for controlling their behavior. Parents of anxious or noncompliant children with dental disease have limited options if their insurance plan does not cover general anesthesia. As a result, more than 70% of board-certified pediatric dentists in the U.S. provide some form of sedation in their offices.

Parental acceptance
Sedation hasn't always been a popular treatment option among parents. According to a study published by the AAPD, sedation and general anesthesia were among the least accepted forms of behavior management during the mid-1980s. Two decades later, a new study showed that sedation and general anesthesia were the second and third most accepted behavior management techniques. Parental familiarity with sedation and general anesthesia in the outpatient setting may be the reason, at least in part, for this shift.

Negative publicity
In recent years, the increase in use of sedation has been accompanied by publicity of sedation-related hospitalizations and deaths. Recently, the Dallas Morning News published a series of articles under the title “Deadly Dentistry.” This publication followed an 18-month, nationwide investigation of dental-related injuries and deaths, some of which involved young children who had undergone in-office sedation procedures. Sedation-related injuries and deaths garner media attention due to the public perception that no one should die from a visit to the dentist. Such negative pub-
licity may lead to a reversal of parental acceptance of sedation as a form of behavior management, as well as an increase in the potential for dental professional liability claims.

Potential adverse outcomes
Sedation is typically safe and uneventful, but the risks of adverse outcomes are greater when the patients are young children. Children are particularly vulnerable to sedation’s effects on respiratory drive, patency of the airway, and the body’s protective reflexes. Sedation of pediatric patients poses risks of hypoventilation, apnea, airway obstruction, laryngospasm, and in rarer cases, cardiopulmonary impairment. Youn a children are especially susceptible to falling into deeper levels of sedation than the provider intended.

Practical considerations
Recognizing the trend of increasing numbers of in-office sedation procedures and the associated risks, the AAP and the AAPD jointly published guidelines for management of pediatric patients during and following sedation. The practices advocated in these guidelines reflect the issues we have encountered when defending dentists in litigation involving children treated under sedation. In these cases, experts supported the care provided by our dentists. Nonetheless, it may be possible to avoid some criticisms by taking precautionary steps.

Informed consent. We have defended dentists nationally in multi-plaintiff corporate dentistry cases, in which the adequacy of informed consent is frequently a focal point. Criticism arises in instances where consent forms are not in the parent’s native language, an assistant or office staff obtained consent, or consent was not accompanied by an oral discussion with the provider. Regardless of likelihood, providers should inform parents of all possible risks associated with sedation, including the risk of death.

Patient choice. We defended a dentist in a case involving injury to a developmentally disabled state ward that occurred after an in-office sedation procedure. The plaintiff alleged the dentist and nurse anesthetist had failed to thoroughly review large binders of medical records brought by the patient’s state-employee caregivers. Plaintiff claimed these records revealed a family history of anesthesia-related complications, which should have led to additional precautions.

Obtaining an accurate patient history is difficult, even when parents are present. Providers should avoid a one-size-fits-all medication regimen for their patients, by considering unique patient characteristics. Pre-proce-
WE’VE GOT YOU

Keais is your partner for fast, organized records retrieval.

WWW.KEAIS.COM

YOU CAN DEPEND ON US

★ Fastest Delivery of Organized Records
★ Nationwide Coverage
★ Litigated and Pre-Litigated Expertise
★ Serving Over 50 Insurance Carriers

WWW.KEAIS.COM • 1 (800) 467-9181
Accredited CME for physicians
Online and Hardcopy
Educating physicians since 1991

- Over 50 different courses for physicians!
- Straightforward approach with no “legalese”!
- 14 specialty specific courses including:
  - Ambulatory care
  - Anesthesiology
  - Neurology
  - OB GYN
  - Ophthalmology
  - Orthopedics
  - Pain management
  - Pathology
  - Pediatrics
  - Psychiatry
  - Surgery

- General interest courses include:
  - CRM and teamwork
  - Cultural competence
  - Managing difficult patient relationships
  - Disruptive physician behavior
  - Documentation
  - Failure to diagnose
  - Medical and surgical system failures
  - Avoiding “never” events
  - Informed consent
  - Low health literacy
  - Common missed diagnoses and errors

- And many more!

For further information visit www.medrisk.com or contact:
Christine Nash Long 800 633 7475
chris@medrisk.com
dure evaluations should document the patient’s baseline condition and assess the potential for adverse reactions. The assessment should include underlying medical conditions, allergies, sedation or anesthesia history, cardiopulmonary function, and anatomical abnormalities in the airway. Consultation with a pediatrician or anesthesiologist may be necessary for patients with special needs.2

Pre-procedure and post-procedure instructions. Our firm was involved in a case discussed in the Dallas Morning News investigation, where a 4-year-old girl was rushed to a hospital hours after waking from sedation. On a hot August day, the patient and her 17-year-old stepmother were driving home in a car with a broken air-conditioner. About two hours after leaving the clinic, the stepmother called 911 when she noticed the girl was struggling to breathe. The child later died in the hospital. Despite a determination that heatstroke was the official cause of death, the plaintiffs criticized the dentist for not using a longer post-procedure observation period and for giving release instructions that fluid intake should be restricted for two hours.

Providers should instruct parents on the intra-operative and post-operative effects of sedation. When applicable, affirmation of adherence to pre-procedure fasting should be documented. Warnings on car safety, potential airway obstruction, and observation periods should be given before parents leave the office.2 Post-operative instructions should include a 24-hour emergency contact for the practitioner or their associates. Instructions on any limitations on activities or dietary precautions should be included.

Monitoring. The Dallas Morning News investigative piece also discusses a case of a 4-year-old child who died following a sedation procedure.1 The pulse oximeter had fallen off the patient’s finger during treatment.1 When it was reconnected, the monitor showed falling oxygen saturation levels and no pulse.1 A delay in rescue of a pediatric patient can be especially harmful due to the vulnerability of a child’s brain to even brief periods of oxygen deprivation.1

During a sedation procedure, a staff member who is not directly involved in treatment should monitor vital signs, including oxygen saturation, pulse, blood pressure, temperature, and respiratory rate.1 This individual should also monitor for potential airways restriction. Recording vitals throughout the procedure helps to spot trends and creates a record of sedation’s effect on the patient. Any adverse events and interventions should also be documented. Monitoring should begin pre-operatively to establish a baseline and continue during recovery to ensure that the discharge criteria have been met.

Rescue. The case we defended involving the developmentally disabled child who was a state ward also included an allegation of delay in resuscitation. In defending the actions of the dentist and nurse anesthetist, documentary evidence of the personnel involved, timing of actions taken, medication administered, assistance requested, EMS activation, and vital signs was critical to show that every possible intervention was executed promptly. For the average juror, it is difficult to imagine having to remain calm during a situation where there are incessant code alarms and a patient in need of life support. Demonstrating the professionalism of the providers during a life-threatening situation can greatly impact a juror’s impression of the care provided.

Professional associations vary in their guidelines on the extent of training required for in-office sedation, but all require education in basic life support training.2 Many associations require advanced cardiac life support training as well.2 When treating children, providers should have training and re-certification in pediatric advanced life support or other approved programs.2

Members of the team, and even office staff, should have some level of life support training. The office emergency protocol should be documented and regularly rehearsed by all office personnel. Crash carts should be easily accessible, with a regularly inspected supply of rescue medications. Equipment should be the appropriate size for the age of patients being treated. Rescue also entails bringing a patient back from a deeper level of sedation than intended.

Conclusion
Adherence to the practices outlined here may prove essential in defending a case alleging negligence during a sedation procedure. Even when all precautions are taken, there is no guarantee against adverse outcomes when using sedation. While the chance of an adverse outcome is rare, these outcomes are generally more severe than those associated with other behavior management techniques. Publicity of in-office sedation procedures that may have precipitated injury or death will undoubtedly raise parental awareness of the associated risks. As parents weigh the risks and benefits of sedation, they may come to decide against approval of sedation as a behavior management technique for their children.

For related information, see www.sweetlawfirm.com.

References
BE BOLD.
BE STRONG.

State-of-the-art insurance coverage
plus expert risk management and
breach response services to protect
your practice and your reputation.
That’s Cyber Strong.

nasinsurance.com/cyber
For underwriters the challenge is to identify these potential risk exposures and then apply sound underwriting principles in this rapidly changing area of healthcare. An enterprise risk management (ERM) approach offers a disciplined framework for underwriting healthcare applications in TTS. In doing so, it is useful to define “telemedicine” and “telehealth” and then discuss both current and projected uses of the technology in the delivery of healthcare services, across the continuum of care.

Defining “telemedicine” and “telehealth”

The American Telemedicine Association, a key player in the industry, describes “telemedicine” as:

“...the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status.”

The Health Research and Services Administration (HRSA) defines “telehealth” as:

“the use of technology to deliver health care, health information or health education at a distance.”

For its part, the Agency for Health Research and Quality (AHRQ), defines “telehealth” as:

“the use of information and telecommunications technologies to support health care delivery and administration, as well as health education.” Also: “All telehealth applications require health information technology (IT), but not every use of health IT can be called telehealth. Stand-alone systems like Electronic Health Records (EHRs) or Computerized Decision Support (CDS) are types of health IT that are not typically thought of as telehealth applications.”

Is there really a difference? The answer is yes, especially in regard to the legal-regulatory requirements and how these services are reimbursed. To add to the confusion, as the number of service applications increase, it may be a real challenge for regulators to define what is, versus what is not, a covered service. The same will be true for private payers.

For underwriters, having a good understanding of the future directions for telemedicine and telehealth can translate into developing and using appropriate underwriting principles for this evolving area of healthcare services.

Underwriting risk exposures

Like other areas of healthcare innovation, TTS involve a number of risk exposures that can impact underwriting decisions. Some key risks include the following:
Negligence. A broad topic area, negligence in the TTS context includes negligent diagnosis and missed diagnosis, as well as negligent treatment.

Credentialing and privileging. Medicare has an explicit regulation for credentialing and privileging for telemedicine that raises serious concerns from a liability perspective. For example, absent is an updated roster at the distant location for credentialed and privileged care providers. To its detriment, the facility where the patient is receiving care may be relying on inaccurate credentialing and privileging information.

Delays in care. Technology-dependent resources can be impacted adversely by denials in service (DNS), slowed transmissions, software incapability, and more. For care providers waiting for reports, delays in care can result in serious consequences for patients.

Consent. Some state laws set forth requirements for informed consent in telemedicine and telehealth. Other laws are not as specific, and care providers might ask, “Do I really need to obtain a consent for telemedicine and telehealth services?” The answer is yes. There is a liability risk exposure when a care provider fails to obtain a patient’s consent for TTS. There is also a negligent-consent risk exposure when a care provider fails to engage the patient in a two-way discussion about benefits, risks, alternatives, and the consequences of refusing to utilize TTS.

That a private payer may not “cover” such services may be a key factor for a patient deciding to seek in-person care. That there may be limitations in diagnosis or treatment capability with telemedicine is also important information for a patient to consider. Knowing who is involved in providing the service may be a consideration for some patients. Hence, the consent communication process, and related documentation, reflects potential risks in the use of TTS.

Scope of practice and delegation of care. One reason why telemedicine is an attractive healthcare delivery service stems from the shortage of specialists in many areas of the country. However, specialists do not work in isolation. Who is the “on the ground” provider who is offering services for the patient? Is he working in a clinic? In an ICU? Do any of the services at the patient’s location require a physician? In other words, are such services barred from delegation to a midlevel provider? Exceeding scope of practice places a healthcare provider in the position of a professional-licensure risk exposure. If a patient is injured in this context, the healthcare facility could encounter the risk of vicarious liability for employed care providers the organization knows, or ought to know, are exceeding the scope of practice or using an unauthorized delegation of care.
TELEMEDICINE AND TELEHEALTH

Documentación practices. Using the services of remote-care providers in telemedicine may involve transmission of reports across multiple time zones. The receipt of a report that is time and date stamped seemingly a day before or a day after the patient presented for care can raise credibility issues about the document and the medical record. The lack of a standardized documentation protocol can be another risk for attending providers who must take steps to confer with the telemedicine specialist whose report is uncertain.

Data privacy and security. Implicit in utilization of TTS is the transmission of protected health information (PHI). The potential for a data breach, unauthorized use of PHI, and lack of security practices in handling health information are definite liability risk exposures.

Billing and coding. Medicare is very clear about who can submit claims for telemedicine services: “Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States. For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India.”

The failure to follow this policy could trigger significant regulatory risk exposure.

Legal-regulatory risk exposure
Aside from clinical risks, TTS can trigger specific legal-regulatory exposures. Corporate liability, enterprise liability, and violations of applicable laws dealing with fraud and abuse all are within the ambit of legal-regulatory risk.

The delivery of TTS is based on contractual arrangements. The precision with which these agreements are written will be pivotal when dealing with allegations of contractual breach.

Underwriting—an enterprise risk perspective
TTS involve risk exposures that extend well beyond the traditional underwriting considerations that are linked to clinical care. As such, TTS merit the type of comprehensive approach found in enterprise risk management (ERM).

Various organizations have published definitions of ERM. One that is widely recognized comes from the American Health Lawyers Association, which defines ERM as:

"An ongoing decision-making process instituted and supported by the healthcare organization’s board of directors, executive administration, and medical staff leadership … across the continuum of care … to reduce uncertainty and process variability, promote patient safety, and maximize the return on investment (ROI) through asset preservation, value creation, and the recognition of actionable risk opportunities.”

As underwriters have observed, healthcare organizations increasingly incorporate ERM into their strategic planning and daily management. Using a disciplined, business analytical approach, healthcare organizations can make choices that help reduce uncertainty and process variation, while at the same time maintain and enhance assets. In real terms, ERM helps promote patient safety and also augments the possibility of a measurable return on investment in technology, including TTS.

When an organization takes a “360” perspective in its decision-making process, it suggests a thoughtful, comprehensive evaluation of the full panoply of risks and business opportunities. Just like healthcare organizations, underwriting professionals can incorporate ERM in their work.

ERM explores risks and opportunities by aggregating information into domains. The risks found in one domain may also be found in another. There is no hard-and-fast rule on how many domains should be applied; much depends on the needs of the organization. However, it is common practice to include domains for human capital, hazards, operations, technology, financial, legal-regulatory, and reputational risk.

Risks can be identified using several tools, including self-assessment surveys, group brainstorming sessions, and interviews. Once identified, risks are analyzed using such techniques as failure mode and effect analysis (FMEA); strength, weakness, opportunity, and threat analysis (SWOT); gap analysis; and root cause analysis (RCA). After the findings from the analysis have been compiled, the next step is to evaluate the treatment of the risk or opportunity. With the organization’s risk tolerance and the total cost of risk as known assumptions, the evaluation may yield a recommendation to avoid risk, take steps to mitigate a risk, reduce the potential frequency of harm, or diminish the severity of a risk.

For underwriters, a similar approach can be used to decide if a given organization is a good risk. For example, an applicant for coverage presents a stellar submission that reflects a thoughtful, comprehensive risk-and-opportunity assessment that incorporates controls for variability and risk exposure. For underwriting the organization is a...
good risk. By comparison risk controls are mediocre leaving underwriting to ask whether the applicant is willing to incorporate improvements in its TTS plan to make it a more acceptable insurance risk.

By implementing an ERM approach in underwriting, there is a framework for effective engagement with healthcare prospects moving aggressively into TTS. Indeed, the same ERM principles can be used throughout underwriting for a variety of prospects along the continuum of the healthcare industry. It can foster better communication and understanding with brokers and insureds in areas of rapid change like TTS that are heavily impacted by external industry and legal-regulatory changes. The growth in patient-generated and -directed telehealth data should be monitored carefully, to determine how risks exposures can best be managed, and this should include specifics on who has access to the information, how it is disseminated, and how to use the information in a timely manner for patient care. Using an ERM approach, underwriters will be in a good position to see the risks and opportunities associated with it, and assist the industry in taking appropriate steps to adjust risk.

Conclusion: practical approach for ERM
Underwriting professionals should not be deterred by the terminology and tools of ERM. There are many professional education programs that will help them get started with ERM. It is also important to learn how healthcare organizations are using ERM and what it means from an underwriting perspective.

When applying ERM in the underwriting context, it may be helpful to use a consistent checklist as a tool for identifying the current, emerging, and projected risks associated with TTS. The goal is to make informed underwriting determinations, taking stock of pertinent risk domain information and evaluating data in light of the insurer’s philosophy for dealing with new and emerging opportunities like TTS.

References
6. Medicare Beneficiary Policy Manual (Rev. 198, 11-06-14) 60 - Services Not Provided Within United States (Rev. 102; Issued: 02-13-09; Effective/Implementation Date: 03-13-09).
A sentinel moment in the world of risk management and healthcare quality was the 1999 release of the first Institute of Medicine (IOM) report, “To Err is Human.”

Without question, the report’s pronouncements—particularly the one estimating that there were up to 98,000 preventable healthcare deaths per year—ignited global attention to problems that had not been completely remediated, despite persistent efforts by medical professional liability (MPL) companies.

That report gave major impetus to the modern-day patient safety movement. In the first few months after the IOM report was published, many of the right steps were taken. The attention on improving healthcare safety was unwavering, and it became generally accepted that those in healthcare could not fix this alone. While “fragmentation and decentralization” of the healthcare system was identified as a key factor, it was also recognized that (1) licensing and accreditation had been lax, (2) third-party purchasers were offering little incentive for healthcare organizations and providers to improve safety and quality, and (3) the medical professional liability (MPL) system was frequently impeding efforts that would allow providers to learn from error.

To accelerate progress, a number of steps were taken on a national scale. The Agency for Healthcare Research and Quality (AHRQ) created its Patient Safety Center, and there was a national impetus for both mandatory and voluntary reporting systems. External groups such as

Robert Hanscom, JD is Vice President, Business Analytics, Coverys.
the Joint Commission and Leapfrog increased the pressure—and accountability—for better outcomes and improved quality. A new emphasis emerged on achieving a higher degree of reliability in both processes and systems in support of safer care. And finally, the preponderance of the MPL defense industry also came on board—albeit, somewhat reluctantly—in supporting disclosure and apology as “the right thing to do.”

That was in 1999–2001. Fast forward to 15 years later, today, and there are legitimate questions about whether the patient safety movement has in fact accomplished what it set out to do. A review of the literature highlights some progress being made, but the list of achievement seems to vary by author. Generally speaking, however, there has been uniform agreement about the categories where the delivery of care has improved. There have been reductions in:

- Central-line bloodstream infections
- Early elective deliveries
- Post-operative venous thromboembolisms
- Catheter-assisted urinary tract infections
- Surgical-site infections
- Hospital-acquired infections
- Adverse drug events
- All-cause 30-day readmissions.

While we can applaud the efforts to improve patient safety in these categories, the list is missing some notable categories. The vulnerabilities in the delivery of healthcare that were not well represented have resulted in some of the most tragic of outcomes, and they include:

- Missed/delayed cancer diagnosis
- Poor surgical outcomes related to skill, communication, and clinical judgment
- Obstetrical tragedies.

These are areas that have been detected for many years by those collecting and analyzing MPL claims data. The root causes of many of these are factors that evade reporting in hospital-based adverse event systems, and intelligence as to why these events have occurred has frequently been scant. In fact, there has been little or no knowledge that a diagnosis even occurred in the missed or delayed diagnosis category.

What happened?

There are three primary elements involved in explaining why the patient safety movement has failed to make more of an impact:

- A pervasive notion that the patient safety movement would best flourish and succeed if the initial work was focused on “low-hanging fruit.” In other words, there was a widespread belief that it was important to go after the least complicated scenarios first, and then tackle the more challenging and complex initiatives later.

- A deeply rooted apprehension continued to exist that standardization would never be accepted—or tolerated—by physicians.

- An inability to sort through the onslaught of healthcare data to determine the patient safety priorities. Stated another way, we have failed to identify which data sets provide the best signals indicating where healthcare delivery is most at risk.

The response within the healthcare community to the first IOM report was vastly different from the responses in several other industries that found themselves in crisis over safety-related events, e.g., nuclear power, the NASA space program, and aviation. In each of those industries, the approach taken was to identify what data (and sources) were most critical in identifying the root causes of serious problems. Once this analysis was done, there was an assessment to determine whether the issues were still in play. If that was confirmed, carefully thought out steps were taken to design, then assure universal adherence to, basic processes that were deemed paramount in achieving safety. For example, in the nuclear power industry, a “defense-in-depth” approach was developed according to which all nuclear plants in the western world were—and still are—to function.
Real-time vulnerabilities in healthcare delivery - process, skills, communication, behavior...

function. The key aspects of this approach included:

- High-quality design and construction
- Equipment that prevents operational disturbances or human failures/errors developing into problems
- Comprehensive monitoring and regular testing to detect both equipment and/or operator failures
- Redundant and diverse systems to control and contain damage, if it does occur.

Essentially, the approach taken by the nuclear power industry can be summed up in four words: detect, prevent, monitor, and (if necessary) mitigate.

This is where healthcare has parted ways from those other industries. While some may argue that the delivery of medicine is significantly more complex than nuclear power, aviation, car manufacturing, and other industries where safety has been an issue, there has never been a successful effort in healthcare to identify “signal data” that alerts hospitals, practices, and providers about precisely where the greatest vulnerabilities lie. In turn, the failure to do this has prevented healthcare from pinpointing what the true patient safety priorities are, establishing standardization where uniformity and consistency are critically necessary, and then implementing models that have the greatest impact on measurably improving patient safety.

Of course, healthcare professionals have always had at their disposal at least three, if not four, sets of "signal data" that they should have been watching much more closely:

- Findings and lessons learned from root-cause analyses, which historically had to remain within the walls of a hospital but now, thanks to the advent of Patient Safety Organizations (PSOs), can be shared across organizations.
- Patient complaints provide an opportunity to benefit from the voice of the patient. In order to capture what's really important, and to separate the substantive issues from the total compilation of complaints, text-mining tools are essential.
- Themes from deeply analyzed MPL cases should be studied—not just the headlines from these cases (e.g., the allegations or the "case type")—but rather, the true causal factors that were involved. We need to know the "why" behind each of these cases.
- Finally, "near miss" data has the potential for providing some critical signals to organizations by indicating at which points healthcare delivery is vulnerable. But, for a variety of reasons, this sort of "intelligence" is not routinely gathered at most institutions.

What is analyzed via MPL data has long been described as "the tip of the iceberg" (Figure 1). Despite its limitations (e.g., it is always looking backward, to past claims, it is not statistically significant, and it often reflects a one-time convergence of factors), it is still one of the best collections of signal data that differ from any other industry. First and foremost, unlike nuclear power or aviation, there is really no central industry organization that can compel uniform application of best practices. If that were the case, many of the issues related to high-severity injury risks would probably have been solved decades ago. Second, healthcare is a discipline that values the expertise, the decision-making, and the skills of individuals—so much so that it leans heavily toward allowing them to perform all aspects of care in the way they consider best. This has led to puzzling, and often unacceptable, degrees of variability in how medicine is delivered. That variability shows up in differences from organization to organization, and even within organizations.

Paradoxically, healthcare professionals have always had at their disposal at least three, if not four, sets of "signal data" that they should have been watching much more closely:

- Findings and lessons learned from root-cause analyses, which historically had to remain within the walls of a hospital but now, thanks to the advent of Patient Safety Organizations (PSOs), can be shared across organizations.
- Patient complaints provide an opportunity to benefit from the voice of the patient. In order to capture what's really important, and to separate the substantive issues from the total compilation of complaints, text-mining tools are essential.
- Themes from deeply analyzed MPL cases should be studied—not just the headlines from these cases (e.g., the allegations or the “case type”)—but rather, the true causal factors that were involved. We need to know the “why” behind each of these cases.
- Finally, “near miss” data has the potential for providing some critical signals to organizations by indicating at which points healthcare delivery is vulnerable. But, for a variety of reasons, this sort of “intelligence” is not routinely gathered at most institutions.

What is analyzed via MPL data has long been described as “the tip of the iceberg” (Figure 1). Despite its limitations (e.g., it is always looking backward, to past claims, it is not statistically significant, and it often reflects a one-time convergence of factors), it is still one of the best collections of signal data.
data available to those in healthcare. Whether the signals are weak, moderate, or strong, it can help in effectively posing the appropriate question: “Here’s where [system, skill, behavior, communication] issues happened in the past. Are they likely to recur?”

In a way, MPL data can act like a sort of “divining rod” for patient safety. Risk is everywhere. Risk could fill up a vast storeroom with data. It is overwhelming. Without some means to work one’s way through it, there is a strong probability that the right things will not be prioritized.

As an example, taking a significant risk area—surgery—and viewing it through the lens of the MPL risk signals, here are the elements of the surgical experience that would warrant greater focus:
- Patient selection
- Optimizing the patient’s medical condition prior to performing the procedure
- Determining if the procedure is medically necessary (e.g., are there physical therapy programs that could obviate the need for surgery?)
- Shared decision-making/education before the procedure
- Systems to ensure the highest quality of sterile techniques in and out of the OR
- Technology that can minimize the potential for human error
- Communication between services and teams, particularly as the patient transitions between the OR, Post Anesthesia Care Unit, and the ICU
- Oversight of trainees

- Close coordination among members of the OR team
- Minimizing or eliminating distractions in the OR.

The MPL “tip of the iceberg” is filled with surgical claims and lawsuits in which the signals are not just present but strong, indicating that these vulnerabilities are present. And yet, this unique collection of intelligence is routinely shrugged off. Many of these problems are historic and yet continue to remain in today’s operating rooms.

Patients and their families—the consumers of healthcare—are beginning to lose patience with an industry that never seems to solve its most serious problems. Fee-for-service care is slowly vanishing, being replaced by value-based care. That is happening because payers finally realized that providers should not be paid for poor quality. Perhaps this is finally the moment in time when the emerging alignment between revenue and quality can prompt some real and measurable progress.

The signals are here for the taking—and the time to act is now.

---

**For related information, see www.coverys.com.**

This article is based on a presentation made at the 2015 PIAA Claims/Risk Management and Patient Safety Workshop in New Orleans: “How the ‘Right Data’ Will Revolutionize Healthcare Integration of Risk Intelligence into the Delivery of Care.”
The rules have changed.
So have the risks.

Risk managers need to juggle issues across the continuum of care.

You need resources from an independent organization that understands that managing risk in a hospital or aging services facility is not the same as a physician practice.

Join the many medical professional liability insurance carriers, captives, and risk retention groups who rely on ECRI Institute for unbiased advice and proven patient safety and risk reduction strategies.

Let ECRI Institute be your trusted source for:

- Online guidance and tools
- Evidence-based best practices
- Patient Safety Organization participation
- Risk assessment services
- Online CME and education programs
- Healthcare technology decision support

Align yourself with our reputation for excellence and help your insureds juggle their risk management and patient safety initiatives.

Visit www.ecri.org/insurance
Reinsurance Dynamics Impact Medical Professional Liability: It’s a Buyers’ Market—But with Natural Limits

By Todd Mockler

Like all markets, the reinsurance market responds to changes in supply and demand. Today’s market is especially dynamic because of numerous fundamental shifts in both of those forces.

Todd Mockler is Managing Director, Guy Carpenter & Company, LLC.
Reinsurers are also insurers and, simultaneously, investment vehicles. They have to generate an acceptable return on the capital they deploy or there is no incentive for them to be in the market. Their investors can put their money anywhere, so the market still has to be attractive relative to other investments. In the current interest-rate environment, that is not a high bar, but rising returns will put significant pressure on capacity deployed at rock-bottom pricing.

Second, recall the assertion that risk is not fungible. Providers and insurers are taking on more risk, but are doing so in a measured way: good data and other risk management practices help limit their exposure. After retaining the most predictable risks for themselves, which risks are they ceding to the market? These, the most unpredictable and volatile risks that MPL can generate:

- Extra-contractual cases that can culminate in a result and cost well beyond the intention of the original policy coverage and the policy limit
- Claims stemming from policy limits greater than $1 million, especially those that are linked with the higher-severity medical specialties such as Ob/Gyn
- Higher limits for hospitals
- "Clash" events—loss events involving a single patient but numerous policy limits

Insurance ROEs also impact capacity—heavy asset owners such as pension funds need to invest in higher-performing assets and have found that reinsurance fits in their portfolio very well, as a diversification strategy. The end result is convergence in the insurance and financial markets. This flow of “convergent capital” has kept capacity abundant, outpacing demand and keeping prices relatively low. However, abundant capacity does not always translate to lower prices in all situations; money is fungible, but risk is not.

For now, reinsurers have the edge in understanding risk dynamics and creating new products, but the gap will shrink quickly as fund investors gain experience. Reinsurers are responding with a broad search for new opportunities for profitable growth. For some reinsurers, this has come in the form of expanding into developing economies overseas, where they perceive a potential growth in demand. Others seek scale through strategic merger or acquisitions. Still other reinsurers have built both an insurance and reinsurance business platform, which, today, often includes significant investment in the Lloyd’s of London market.

At the same time, (re)insurers are also focusing on developing and offering improvements in the structure and efficiency of reinsurance programs and incorporating more refined capital-management goals. New technology and sophisticated data analytics present opportunities for customized pricing and distribution strategies.

**Impact on MPL**

What do these reinsurance market changes mean for medical professional liability (MPL) insurers? The broad market forces, together with recent MPL claim trends, create an environment where capacity is abundant. Reinsurers, looking for growth and yield by expanding into new lines of business, have found MPL extremely attractive.

There are, of course, certain venues and specialties that have not performed as well as others, but overall, the MPL business has outperformed virtually all other lines of insurance for more than a decade. As a result, traditional players will need to be more aggressive to grow or even maintain their market share, while new players look for ways to break through. The MPL market is attracting many in both the insurer and reinsurer markets. For those who have been involved in the MPL niche for any significant period of time, these results are an extraordinary turn of events.

Against this wealth of capacity, there are two behemoth competitors to consider, both of which have tremendous advantages over all other players—medical providers’ own risk captives and insurers’ collective retentions. The outsized returns for MPL reinsurers are evident to both insurers and provider groups. They want a share, and they can achieve that by driving pricing down or by simply retaining more risk. MPL insurers that operated with a $500,000 reinsurance retention ten years ago might today operate with a retention of $2 million—a quadrupling of the level of self-retained risk they manage. Trying to keep these forces at bay, reinsurers offer terms and pricing that have improved significantly over the past five years.

**The factors in play**

A host of factors are coming into play. Convergent capital is eyeing the performance of MPL reinsurance; traditional reinsurers are looking to grow; medical provider groups are utilizing more captives; and MPL insurers are comfortable assuming more risk, if needed. With these factors in play, do these insurers have complete leverage over the reinsurance market? The factors certainly translate to a buyers’ market, but there are natural limits that no amount of competition and capacity can overcome.

First, reinsurers are also insurers and, simultaneously, investment vehicles. They have to generate an acceptable return on the capital they deploy or there is no incentive for them to be in the market. Their investors can put their money anywhere, so the market still has to be attractive relative to other investments. In the current interest-rate environment, that is not a high bar, but rising returns will put significant pressure on capacity deployed at rock-bottom pricing.

Second, recall the assertion that risk is not fungible. Providers and insurers are taking on more risk, but are doing so in a measured way: good data and other risk management practices help limit their exposure. After retaining the most predictable risks for themselves, which risks are they ceding to the market? These, the most unpredictable and volatile risks that MPL can generate:
Aggregate claim scenarios, where a physician or physician group has numerous claims in the same policy year

Significant loss adjustment expense associated with high-severity claim events and systemic claim events ("batch" claims), which can sometimes take on the status of class action lawsuits.

For a reinsurer, these risks have the least amount of actuarial useable-loss data associated with them and the absolutely highest degree of severity. That can be a challenging combination, considering that when a reinsurer signs on to a reinsurance treaty, it is essentially investing in the performance of the underlying risk, be it good or bad. The reinsurer in effect agrees to follow and support the insurer's management team, underwriting and pricing, claims handling, loss reserves, and other operational aspects of the insurer or cedent. This may even extend to the current or future political environments in any of the venues where the insurer operates, or any future outcomes of jury verdicts, for example.

Absent control over any of these operational risks, many reinsurers and convergent capital investors cannot make the leap from a comfortable amount of data to nonexistent data and the potential for a high-severity loss. When they do, they still have to adhere to disciplined underwriting, and the cover is necessarily more expensive than the cost of the retained risk. In these more extreme cases, a key component in executing a successful deal is a strong, transparent commercial relationship between insurer and reinsurer.

This illustrates why reinsurance, though it shares many of their characteristics, remains fundamentally different from other investment vehicles. Even as market forces and better data are lined up to commoditize the MPL reinsurance market, relationship—colloquially, the "R" in reinsurance—still matters very much. As an example, reinsurers that have strong relationships with cedents may be more likely to offer support for expansion into new lines of business or new geographic areas, and these are frequently the circumstances when reinsurance support is most needed.

For related information, see www.guycarp.com.
THE INSURANCE TALENT SOLUTION

PROFESSIONALS FOR ALL YOUR MEDICAL LIABILITY NEEDS

As the leading global provider of talent to the insurance industry, The Jacobson Group is dedicated to connecting companies with the highest caliber of insurance professionals. For more than 45 years, we have been providing a variety of talent solutions including executive search, professional recruiting, emerging talent, temporary staffing, subject matter experts, RPO, onsite and work-at-home operations support.

Visit jacobsononline.com/PIAA to learn how Jacobson can solve your insurance talent needs.

Contact Us  
+1 (800) 466-1578
He acts as a liaison between the CEO, governing boards, medical staff, and department heads, and integrates the activities of all departments to ensure maximum operational efficiency. Within professional liability risk-bearing entities, however, the CMO may play a slightly different role than his counterpart in a traditional hospital. Since any enterprise addressing liability issues comprises medical, legal, and insurance functions, either internally or through a consultant, the CMO typically must work, in some capacity, in all three areas.

Graham Billingham, MD, FACEP, FAAEM, Chief Medical Officer at Medical Protective, speaks to the integrative role of CMOs, among the many departments and functions in his MPL entity: “The CMOs in MPL companies have both insurance and medical knowledge. So I find myself working as a translator, if you will, to be able to explain to clinicians the insurance side of things. But I also bring clinical knowledge back into the insurance company.”

Here, we discuss the typical role of the CMO within a professional liability enterprise. CMOs describe the factors that led to the creation of the CMO position, the roles that an MPL CMO commonly plays, and how the CMO role has adapted, and evolved, over time.

Impetus for the CMO position

“Except for brief periods, since its inception, my company has always had a medical director,” says Gerry Ann Houston, MD, CMO at the Medical Assurance Company of Mississippi.

Other CMOs trace a more gradual realization that a CMO-type role would be invaluable to a company’s success. Mark Spiro, MD, CMO at The Mutual Risk Retention Group, explains: “As the industry progressed and became more complex, these companies wisely graduated managing the companies.” But then, he says, “Our company and others like ours found they were starting to lose the physician perspective.” He notes that though he “stepped into this new role to help our company with claims and risk, I found that adding a doc’s perspective on other management issues helped us come up with more well-rounded solutions.”

In fact, one theme that emerges, in many of the discussions of the rationale for the CMO position, is that, like Dr. Billingham, many CMOs were needed to coordinate the various functions of an MPL enterprise. At Avant, in Australia, Dr. Penny Browne says that in her capacity as CMO, she provides “medical leadership for the Advocacy division, coordination of the medical voice at Avant, and medical/member input directly at the executive level, to ensure member perspective is considered at the executive level.”

Kevin Klauer, DO, EJD, FACEP, Chief Medical Officer, Emergency Medicine, and Chief Risk Officer, TEAMHealth Holdings, Inc., comments on the vital interrelationship between risk mitigation and care, which can best be facilitated by a CMO: “Risk cannot be mitigated without impacting clinical care, and clinical care cannot be impacted in a meaningful and actionable way without an intricate and detailed understanding of the intersection of risk and the delivery of clinical care.” He adds, “In addition, a direct colleague-to-colleague interaction is essential to
“The initial expectation and role was to help the company understand the large claims, and to help them work with their insureds to come to the resolution of these claims.”

Mark Spiro, MD

invoking change that is both clinically applicable and credible.”

Key roles: original expectations

“The initial expectation and role,” Dr. Spiro explains, “was to help the company understand the large claims, and to help them work with their insureds to come to the resolution of these claims.” There was also a risk management focus: “I was charged to work with the risk team to look at both our trends and industry rates,” with a goal of “developing strategies to reduce claims for improved patient care.”

Like many other CMOs, he highlights his contribution to education, “Another related role was to assist the company’s educational development for our insureds.”

CMOs may be asked to work with every department of the company: “One of my major responsibilities,” says Dr. Houston, “is to be available.” There are queries from “underwriters, risk managers, claims reps, and administrators.” A quick response may be important: “They like to be able to get answers back to the insureds promptly. I am always available to answer questions, offer recommendations, or call physicians.”

Some companies made allowance for the likely need for evolution in the CMO position job description. “MedPro built flexibility into the CMO position,” says Dr. Billingham. “When I accepted the position, it was a new role. Both the organization and I realized that the position would evolve and expand as new opportunities and challenges arose.” He offers an example: “I was given a good deal of freedom in designing and structuring MedPro’s Specialty Advisory Board Program.”

This approach has been a win-win, for MedPro and Dr. Billingham: “Over the years,” he says, “my position has continued to evolve, allowing me to expand my knowledge and more broadly offer my expertise.”

On the job: initial focus

For Laurie Drill-Mellum, MD, MPH, Chief Medical Officer, MMIC Group, the initial focus was on patient safety. “The first thing I noticed,” she says, “is that we needed more data to inform the patient safety work that we do. We needed to get a better understanding of which factors were driving our losses.” The company had already developed a data warehouse, she notes, “and this was very helpful in aiding our understanding of where our losses were the greatest.”

Dr. Browne says that she has had multiple roles in coordinating relationships within Avant, and outside the company as well. She was charged with “developing a trusting relationship with our major stakeholders,” and “improving our regulatory complaints processes and relationship with regulators.” It was also her job to “review our member-based committees,” and “coordinate the voice of our internal medical advisors.” Like many CMOs, she also assists insureds in the event of a

In Contrast: CMPA

There is no CMO position per se in the Canadian Medical Protective Association, says Dr. Douglas Bell, its Associate Executive Director. Instead, there are two positions. The first is the Managing Director of Safe Medical Care, and three departments report to him: Practice Improvement, System Stakeholder engagement, and Medical Care Analytics. Initially focused on the education of individual physicians, Dr. Bell notes that, “Over the years, the position has evolved to place more emphasis on prevention of harm and improving the system.”

The other position that fulfills a CMO role is the Managing Director of Physician services, who is a physician. He is responsible for CMPA’s assistance model, wherein “member physicians call the CMPA and are assisted in medical legal matters by a physician.” Dr. Bell says that CMPA is “now moving to an approach where assistance is focused more on a career basis, as opposed to the individual case.”
lawsuit: “We also work with the doctors’ health groups and regulators to increase awareness if the impact on doctors’ well-being when involved in a complaint or claim.”

For Luke Sato, MD, Senior Vice President and Chief Medical Officer, CRICO, one of the important responsibilities of CMOs “is drawing on their understanding of the clinicians’ ‘pain points’—what keeps them up at night. What we as CMOs are trying to do is to make sure, from a holistic perspective, that we’re addressing the clinicians’ concerns, and that we will be able to represent that to a very high level of the leadership.”

How the CMO role has evolved

“Two things happened that helped me grow in the CMO role,” says Dr. Spiro. “One was attending PIAA educational seminars.” He points out what he’s gained from this participation: “It not only increased my ability to speak the same language as the rest of the management team, but also allowed me to meet many talented individuals from other companies that were facing the same issues.”

Secondly, he found that having a physician with a physical presence in the office “made it much easier for others in the office to spontaneously come to me as a resource to better understand the medicine, and the physician perspectives.” He adds, “I did not expect such expansion of this role,” and explains, “As I became more knowledgeable in the insurance field, I believe my role was becoming more valuable in assessing management issues, be it claim related, underwriting questions, or the business in general.”

Dr. Browne also notes the company-wide role that she now plays at Avant: “I have realized that the CMO can have a positive role for the organization, in growth, underwriting, risk education, and the approach to management of doctors involved in claims.”

Dr. Klauer says that his work as CMO has, over time, deepened and strengthened his relationships with his colleagues. “Although I knew many of my colleagues prior to joining TEAMHealth, our prior interactions were outside the organization. Establishing and earning the trust of others has been important to any relationship, including that of nurses they serve.”

What they’re (particularly) proud of

Dr. Browne says that one major contribution she’s made is “bringing the medical voice to the Avant management team.” She adds, “I have also been successful in continuing to keep the internal focus on the impact of doctors being involved in a complaint or claims.” And like several of the other CMOs, she is proud of her abilities “in coordinating the medical voice of Avant in many aspects of the business.”

Dr. Drill-Mellum asked her CEO about what he considered to be her greatest contribution. “He said that he believes that my greatest contribution thus far has been in leading our re-created patient safety solutions department.” And she then echoes an idea of several other CMOs: “My most important contribution is bringing the voice and experience of the doctor into the day-to-day work of the company.”

That, and serving as a bridge—a liaison—between the several functional areas of an MPL enterprise. Dr. Klauer sums it up nicely: “Avoiding a fragmented organizational approach to risk management has been key. Planning initiatives to improve our practice environments, patient safety and quality of care, while reducing professional liability exposure should be coordinated and not conflict with other organization goals.”

Alan Lembitz, MD, Chief Medical Officer for COPIC, highlights the personal role that an individual CMO can play in an MPL organization: “The CMO serves a critical role in establishing connections. Those connections are what makes a successful company more than just a nameless, faceless commodity. The strength of the connections internally allows the breadth of knowledge and experience contained in such departments as claims, underwriting, patient safety and risk management to be applied to a unified service company.”

This role in creating connections serves the MPL enterprise in multiple ways, says Lembitz: “The CMO can develop materials and serve as the face of the physician understanding—that helps marketing. The CMO can serve senior leadership in its communication with the BOD. Externally, the CMO can make connections to organized medicine, selected legislative arenas, and national organizations involved in quality, patient safety, and medical liability.”

“Except for brief periods, since its inception, my company has always had a medical director.”
GOING BEYOND BROKING TO ENSURE YOUR SUCCESS

At StoneHill, our experienced leaders stay on top of the constantly changing reinsurance market so you don’t have to.

To start the conversation contact:
Dan Koshiol
612.444.7544
dan.koshiol@StoneHillRe.com
StoneHillRe.com
You can probably think of a million reasons to visit London, but in 2017 there will be yet one more, when the Medical Defence Union (MDU) and Medical Protection Society (MPS), together with PIAA, host the triennial PIAA International Conference. The conference will be held right in the heart of one of the world’s great cities, making it easy to combine the educational program with networking opportunities—and still have the chance to enjoy London’s historic and cultural offerings. The London 2017 conference will build on the success and energy of the conference in Amsterdam 2014. And the countdown to October 4–6, 2017 begins now.

Destination London

London, the birthplace of insurance, is a fitting location for the PIAA International Conference. More than 325 years ago, Edward Lloyd began selling marine insurance out of his coffee house, and Lloyd’s was well established by the time of the American Revolution of the 1770s and the Napoleonic Wars of the 1800s. Those wars saw shipping losses on a large scale, highlighting a need for effective insurance. Lloyd’s, the world’s specialist insurance market, was born.

Today, London endures as one of...
the most important cities globally for insurance and reinsurance.

But our focus is not on history; it is on the future. The medical and healthcare professional liability (MPL/HPL) market is evolving at breakneck speed. Technological innovation, shifting social norms, increasing patient expectations, economic considerations, and the changing relationship between private and public healthcare all have an impact on MPL/HPL—and the potential to disrupt the market.

Be part of the debate at PIAA 2017

PIAA 2017’s theme is “Change and Disruption” and it is firmly international in its scope. The program will provide you with an overview of emerging trends and what they mean for the MPL/HPL market. The sessions will focus on both technical and commercial challenges that are impacting the MPL/HPL industry and also help you develop an understanding of strategies for how best to innovate, adapt, and respond to the changes.

The conference is designed to be engaging and dynamic. Between the thought-provoking sessions, there will be plenty of opportunities to network with colleagues from the PIAA International Section member companies, as well as PIAA companies based in the U.S. During the sessions, you can participate in stimulating discussions with your fellow insurance professionals and company board members on topics as diverse as medical tourism and cyber liability. You can contribute to the debate on where the MPL/HPL market is heading, and what that means for patient safety.

The program: “Change and Disruption”

Some of the program highlights will include:

■ The changing medical market, and its impact on liability
  Listen to accounts of the rapidly changing healthcare environment in other countries—including the legal and regulatory landscapes—and see how your experience compares.

■ Economies of market disruption
  This session will put a spotlight on financial liability and products and strategies in the marketplace. What do best practice medical tourism models look like? How does provider contract liability work to incentivize healthcare professionals not to order tests, or to admit or readmit patients?

■ Compensation versus deterrence
  Join the debate about the evolving role of lawyers in the changing MPL/HPL market. Hear the latest strategies for managing payments to attorneys, and find out how the regulation of contingency fees could change the market.

■ Patient safety—emerging liability issues
  ■ Cyber security and liability
  ■ Data: Risks, Uses, and Methods
  ■ Legal Tactics
  ■ Investment Strategies
  ■ Reinsurance Strategies
  ■ Patient Safety—Emerging Liability Issues
  ■ Lessons Learned from around the World

Relax and enjoy your time in London

The PIAA International Conference 2017 also includes a full social program, including a welcome reception on Wednesday, and a conference dinner on Thursday evening. Both events will let you soak up London’s unique historic yet vibrant atmosphere. They will also whet your appetite for what else London has to offer.

Those with a fondness for English literature will doubtless be familiar with Samuel Johnson’s maxim: “When a man is tired of London, he is tired of life; for there is in London all that life can afford.”

So when you are not participating in a conference activity, or if you have the chance to stay an extra day or two, why not see if Johnson was right? If it’s history you want to imbibe, why not take in the classical landmarks: Buckingham Palace, the Mall, Horse Guards Parade and Downing Street, the Houses of Parliament, Tower of London, and the iconic Tower Bridge.
Alternatively, you might like London's modern side: Canary Wharf, the Shard, the Gherkin, the Tate Modern, and the London Eye. Lovers of culture will not be disappointed with the number and quality of London's art galleries and museums, the majority of which are open to the public without charge.

If you prefer to be entertained, book a show in one of London's West End theaters or take in a movie in the buzzing atmosphere of Piccadilly Circus. Indulge yourself with tea at the Ritz, followed by dinner at one of more than 60 Michelin-starred restaurants in London. Or perhaps taste traditional fare with fish and chips (out of a newspaper, naturally), or if more adventurous you might try “pie and mash” and jellied eels. It is worth finding time for a “swift half” in one of London’s many and varied pubs (and these days they will serve coffee and tea too, if warm brown beer is not your thing).

If time and energy permit, particularly if you need a souvenir or two, try Oxford Street and Regent’s Street, or take a trip to Knightsbridge and visit Harrods. If you need to escape the hustle and bustle, you won’t have far to travel to a green space, such as Kensington Gardens, Hyde Park, Green Park or the wonderfully gentrified Regent’s Park.

**London awaits—get on board**

We are excited having an opportunity to bring the 2017 PIAA International Conference to London—please save the date!

For more information, visit www.piaa2017.com. We look forward to welcoming you to London in 2017! 🇬🇧

---

**During the sessions, you can participate in stimulating discussions with your fellow insurance professionals and company board members on topics as diverse as medical tourism and cyber liability.**
That flash of brilliance you see?
It's doctors and health care innovators uniting as a powerful source for good.

Here, the dream of healing the sick is as pure as it ever was. Here, the champions of the healers know they, too, have a champion. Constellation is a growing partnership of mutual liability insurers and health service companies. Together we're stronger. And together we're embarking on a mission to change the future of health care.
To learn more about our vision, visit ConstellationMutual.com.
Risk assets have had a rough start in 2016. Volatility has returned to financial markets, and many asset prices have weathered sharp declines in the beginning of the year. In the first few weeks of trading, the Dow Jones Industrial Average (DJIA) fell to 15,450. This was 2,000 points lower than its year-end close, and 3,000 points (or nearly 16%) below the high point of 2015.

In 19 of the first 34 trading days, the DJIA rose or fell by more than 200 points. In periods of normal volatility, changes of more than 200 points would have been roughly half as likely. The NASDAQ index has fallen further than the Dow, down 20% from its 2015 high. The declines haven’t been limited to the U.S.: Global equity markets have also suffered. Broad indices of stock markets in developed countries outside the U.S. have fallen 20% from their intraday highs, and emerging markets have lost more than 30% of their value since April of 2015. But the declines in the equity markets seem relatively minor compared with the 75% drop in the price of crude oil, in a little more than two years.

As riskier assets have suffered, the beneficiaries of the volatility have been the safer assets, such as Treasury bonds and high-quality, investment-grade fixed income (with the exception of those in the energy sector.) Investment-grade fixed-income was up by 2.25% by mid-February, with long-duration Treasury bonds posting a return of more than 10%, in just six weeks.1

In advance of this swift—and painful—decline in the equity markets, many commentators and market prognosticators had been predicting a continued advance in stock prices. The average prediction from Wall Street brokerage houses was an 8% return in 2016. This is still possible, but the market declines of the early weeks of trading have put a major hurdle on the path to achieving that sort of return.

While many market observers and participants did not predict the turmoil we have seen thus far in 2016, a portion of the bond market clearly signaled that trouble lay ahead. The high-yield bond market commenced its downward turn in late spring of 2015, well before the percentage decline in equity prices reached double digits. Prices in this market fell steadily throughout the rest of the year, with the decline accelerating in late fall, as fears about the equity markets continued to grow.

Risk and return in bonds and equities
It may be useful at this point to quickly recap the relationship between investment-grade bonds, high-yield bonds, and equities. Both investment-grade and high-yield bonds are debt instruments; they are essentially loans made from the investor to the issuing company, and they contain a promise to pay back the loan principal amount in full, along with interest. Investment-grade bonds are those issued by companies with the four highest credit ratings (as determined by national ratings organizations such as Moody’s and Standard & Poor’s), including AAA, AA, A, and BBB. High-yield bonds are those rated BB, B, and CCC. These lower ratings indicate that there’s a higher probability that the issuing companies will default on their loans, because of the greater uncertainty in their business and the higher levels of debt, relative to their cash flows.

Equity securities, in contrast, contain no specific promise to pay anything to the investor. They are, instead, a small share of ownership in a business; the investor profits by receiving dividends (if any are paid) and because they may be able to sell the shares for a higher price if the business is successful. If a company issues both debt and equity, the debt is privileged over the equity in the capital structure. This means that investors in the debt (bondholders) must be paid what they are contractually owed before the stockholders receive any dividend.

So if a company faces financial troubles, the equity will very likely decline in value by more than the debt, even if the debt is in the lower rating (high-yield) category. In the extreme event of default, the equity securities become essentially worthless, while the bonds may possess some residual value, as the company is restructured or potentially broken up and

Jason Gingerich, CFA, is with Prime Advisors, Inc.
sold in pieces to pay to bondholders whatever value can be salvaged.

This discussion explains why equities are a riskier asset class than bonds, including high-yield bonds. This premise is substantiated by the historical returns and volatilities of these asset classes. Looking back 25 years to 1990, we can calculate the return, volatility, and Sharpe Ratio (a ratio of return versus risk) for investment-grade, high-yield, and equities (Table 1).

We can see that the average return, standard deviation, and Sharpe Ratio statistics for the high-yield bond market all fall between those of investment-grade bonds and equities. This is exactly what we would expect for the asset class, since it occupies the space between bonds and stocks on the risk spectrum.

The bond market signal
As discussed earlier, the high-yield bond market experienced a downturn several months before the one that hit the stock market. A key metric for this bond market selloff is the option-adjusted spread (OAS) of the Barclays U.S. Corporate High Yield Index, which covers the universe of fixed-rate, non-investment-grade debt rated BB, B, and CCC. OAS tells us the amount of additional yield earned on high-yield bonds compared to a U.S. Treasury bond with a similar duration. When the OAS is increasing, it means bond prices are decreasing relative to Treasury bonds, because the market is demanding more compensation for owning bonds that have a higher risk of default. The additional yield provided by the OAS must be sufficient to compensate the investor in the event that some bonds default and do not repay their full principal and interest as contracted.

The median OAS for the high-yield bond market over the past 22 years has been 465 basis points (bps), or 4.65%. This indicates that a

Table 1. Three Asset Classes: Returns and Volatilities

<table>
<thead>
<tr>
<th></th>
<th>Average Return</th>
<th>Standard Deviation</th>
<th>Sharpe Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment Grade Bonds</td>
<td>6.08%</td>
<td>3.61%</td>
<td>0.27</td>
</tr>
<tr>
<td>High-Yield Bonds</td>
<td>9.17%</td>
<td>8.71%</td>
<td>0.21</td>
</tr>
<tr>
<td>U.S. Large-Cap Equities</td>
<td>10.55%</td>
<td>14.44%</td>
<td>0.16</td>
</tr>
</tbody>
</table>


The bond market focuses primarily on a company’s ability to pay its outstanding debt.
high-yield bond would earn an annual stated yield (prior to any losses due to default) of 4.65% more than Treasury bonds. Annual default losses of 1.50% to 2.00% could be expected, using projected default and recovery rates.

After reaching lows that approached 300 bps (meaning very high bond prices/low-risk premiums) in the summer of 2014, the OAS began to rise significantly, as high-yield bond prices fell. Stocks continued to rise, despite this clear sign of trouble in the financial markets; even after two sharp selloffs of less than 10%, equities quickly recovered, while the bond spreads continued to increase. After the OAS moved steadily above 600 bps in late 2015, equities finally fell in line with the signal from the bond market, and began their sharp decline, which has persisted into early 2016.

Figure 2 compares the high-yield OAS with the level of the S&P 500 index.

In the last two equity bear markets (which began in 2007 and 2000), the OAS on the high-yield index also rose above 600 bps before the equity selloffs reached bear-market levels. Market historians will recall the events that occurred prior to the Great Recession of 2008. High-yield bonds at that time had also become very expensive, with the index OAS falling to 233 bps in May of 2007. As bond spreads then marched higher throughout the summer, stocks rose to new highs that October, in defiance of the deep problems that were revealed by the actions of bond investors. Bond spreads finally broke through the 600 bps level in January of 2008, and stocks began a tumble that would eventually see their prices fall by more than 50% by early 2009.

If we were to go back even further in time, we could make very similar statements about bond spreads preceding the 2000–2002 bear market, which took the DJIA from nearly 12,000 to below 7,200.

What should investors learn from this?
Given the consistent pattern of the bond market in providing indicators of trouble and responding to it prior to declines in the stock market, it can be valuable for investors to be aware of what is occurring in the various asset classes. The bond market focuses primarily on a company’s ability to pay its outstanding debt, rather than its ability to generate extensive profits (which is the hope of the stock market investor). For this reason, the bond market would seem to offer a better indicator for detecting and responding to financial stresses, before the equity market. Given the losses that could be avoided by following early-warning signals, equity investors would be well advised to pay close attention to the messages that the bond market is sending.

Reference
1. Sources for price changes are Yahoo Finance and Barclays, as of 2/23/2016.
For nearly a century, Thuillez, Ford, Gold, Butler & Monroe, LLP has been the law firm doctors, hospitals and nursing homes have called to their defense.

We have a proven track record in complex, multimillion dollar lawsuits for negligence, medical malpractice and wrongful death. Our dedication to litigation is well known in the industry, and it’s because of this that we’re able to maintain a network of experts with outstanding credentials in every medical specialty.


Thuillez, Ford, Gold, Butler & Monroe, LLP.
Keeping the healthcare industry alive and well for 100 years.

Thuillez, Ford, Gold, Butler & Monroe, LLP
ATTORNEYS AT LAW

Prior results do not guarantee a similar outcome.
Attorney Advertising.
The Affordable Care Act (ACA) ushered in an era in which “patient engagement” and “patient experience” are common catchphrases. Effective patient engagement strategies clearly create opportunities for improving clinical outcomes. But there has been little discussion, to date, of how we might use those same strategies to support and defend physicians when medical professional liability (MPL) actions are filed against them.

Studies show that involving patients in decision-making promotes greater adherence to medical advice and better health and functional status.1 “Satisfied” patients are more likely to adhere to treatment plans, continue using health services, remain loyal to their physicians, and recommend services to others.2

The HHS National Strategy for Quality Improvement in Health Care, promulgated in the implementation of the ACA, included “engaging people and families as partners in care” within its six initial priority areas.3 The ACA itself encourages engagement through several of its provisions, for example, by prompting patients to get preventive care by eliminating co-pays for recommended preventative services, and by providing Medicare coverage for annual wellness visits.4 But this is only the beginning; patient involvement will inevitably become a critical success factor in the private market as well.

In 2013, a study by the Center for Advancing Health (CFAH) found that key healthcare leaders considered patient engagement as an “essential strategy for improving health outcomes and the quality of health care experiences, and in some cases for reducing health care costs.”5 The intent of patient engagement strategies and tools is to involve the patient in the decision-making process, and to encourage patients to assume an appropriate level of responsibility for their own care. There is a scientific basis for changing the old pattern wherein the physician alone was responsible for care to joint responsibility between physician and patient. The data shows that when the balance of accountability is altered, the patient does better.

As part of the new economics of medicine, physicians are being measured on the success of their efforts to satisfy patients, and there are new tools for measuring engagement. A key component of the reporting requirements under the ACA is public reporting on physician performance that includes patient experience measures.6 The collection and reporting of a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Physician Quality Reporting fulfills this requirement. The Clinician and Group Survey is commonly known as CG-CAHPS.

Importantly, patient engagement has been described as a strategy to achieve the “Triple Aim” of (1) improved health outcomes, (2) better patient care, and (3) lower costs.7 As a result, physicians are now expected to take action to engage their patients: the government is encouraging it, and payers are increasingly demanding it. Correlating with this national push toward patient engagement, healthcare providers have an unprecedented opportunity to utilize easy-to-use patient engagement documents and tools to show the engagement efforts the physician has made, as well as the patient’s adherence (or not) to what’s needed to fulfill his own important responsibilities.8

Reduce risk and build compelling defense

A core element in patient-centered care is the sharing of power and responsibility between the physician and patient. Traditional views of the physician-patient relationship tended to place responsibility for patient compliance on the shoulders of physicians. Patients passively relied on physician-directed advice, reminders, and decision-making. But even with the best treatment plans, it is the patient...
recognizes that patients are actu-
emphasis on patient engagement
them. Now, however, the greater
expect their doctor to remind
jury were also patients who also
situation because of a missed
least partially responsible for his
litigation, it was risky to point
event or unexpected outcome led
MPL defense toolkit.
So information about engage-
ment is a powerful tool to add to
the MPL defense toolkit.
In the past, if an adverse
event or unexpected outcome led
to litigation, it was risky to point
to a sick or injured patient as at
least partially responsible for his
situation because of a missed
appointment or neglected follow-
up care. After all, the judge and
jury were also patients who also
expect their doctor to remind
them. Now, however, the greater
emphasis on patient engagement
recognizes that patients are actu-
ally essential partners with their
physicians in optimizing their
healthcare. When patients miss
appointments, neglect follow-up
testing, or ignore physician rec-
ommendations, they, in effect,
make the choice to put their own
health at risk. Research has
shown that sometimes patients
may make a conscious choice to
skip or delay care because they
don’t want to incur the co-pay-
ment or their plan includes a
large deductible; they have been
forced to make a difficult finan-
cial decision.10 Or, the pace of
their schedule and daily obliga-
tions compel them to delay fol-
low-up care. Many busy profes-
sionals are months (or years)
behind in their screenings, yearly
physicals, or blood tests. So
although there could be legiti-
mate, sensible reasons for the
decision to postpone or forego
treatment, the key is that it is their
choice.
If the patient suffers an
adverse event related to the
missed appointment or test, and a
suit is filed against the doctor
who recommended the test, the
issue becomes: who should be

L. Gregory Pawlson, MD, M.P.H., Former Executive Vice President National
Committee for Quality Assurance (NCQA); Senior Medical Consultant, Saxton &
Stump, LLC, says:
“Given the growing complexity of healthcare, we sometimes need to remind our-
sehves that our patients are the central focus of all of our efforts. Because more
and more healthcare decisions carry major risks as well as benefits, patients
must become more engaged with us in the process of healthcare.
He adds, “An engaged and informed patient is more helpful in choosing care that
is right for him, in following through with treatment offered, and in working with
his healthcare team in producing the best outcomes. While physicians and other
healthcare providers have a very critical role in informing and supporting patient
decisions, in the end, it is the patient, or his proxy, who must make the choice of
which course of treatment”

THE UNITED STATES HEALTHCARE INSURANCE MARKET IS UNDERGOING RAPID AND
PROFOUND CHANGE. GUY CARPENTER IS FOCUSED ON THIS EVOLVING AND
SPECIALIZED MARKET. AS THE RECOGNIZED INDUSTRY LEADER IN CASUALTY CATASPRE INSURANCE
PRODUCTS AND OTHER RISK TRANSFER SOLUTIONS, WE ARE UNIQUELY POSITIONED TO OFFER
CLIENTS SEAMLESS AND INNOVATIVE COVERAGE SOLUTIONS THAT RESPOND TO BOTH KNOWN AND
EMERGING EXPOSURES.

WE INVITE YOU TO LEARN HOW OUR DEDICATED TEAM OF SPECIALISTS LEVERAGES OUR
INDUSTRY EXPERIENCE, MARKET INTELLIGENCE AND ANALYTICAL EXPERTISE TO
CUSTOMIZE SOLUTIONS THAT CAN MEET THE UNIQUE STRATEGIC AND REINSURANCE NEEDS OF THE MEDICAL PROFESSIONAL LIABILITY INSURANCE MARKET.

LET US PUT OUR INTELLECTUAL CAPITAL TO WORK FOR YOU. PLEASE CONTACT STEVE UNDERDAL (952) 820-1030 OR STEVE.UNDERDAL@GUYCARP.COM FOR MORE INFORMATION.

TO LEARN MORE, PLEASE VISIT GUYCARP.COM
held accountable for the delayed diagnosis? Clinical leaders and health policy experts such as L. Gregory Pawlon, MD (see inset), based in part on the research cited above, point out that it is clearly reasonable to expect patients to take responsibility for certain well-defined aspects of their care. They point out that the goals of healthcare reform cannot possibly be achieved unless the patient is not only a member of the team, but a fully engaged member as well. We have consulted with experts who appropriately emphasize that engagement is a key critical success factor for patient health and is their (the patient’s) responsibility.

Evolving focus on defining responsibility in the courtroom

So what does this mean to a physician faced with defending against an MPL claim? While patient engagement puts a greater degree of responsibility on the shoulders of patients (which is obviously beneficial to their health), the concept of accountability for care may also be applied to the professional negligence arena.

The key is new, careful, but appropriate, documentation and the use of specific patient engagement tools that enable healthcare professionals to educate their patients more thoroughly, and thereby also (appropriately) shift more responsibility for care to patients and to document what was done. Many practices are already utilizing effective patient engagement tools, including second-generation specialty-specific informed consent forms or at-risk letters. Effective engagement strategies such as these will lend crucial support to those physicians, if the patient decides at some later point to claim negligence. The documents, importantly, also drive home the negative health implications if patients do not engage in their care as they have been told to. As it turns out, this is one of the turning points in the courtroom.

The legal term for this idea of shared responsibility for negligence is “comparative negligence.” The concept is a recognition that accountability for an unfortunate outcome may not be the result of the conduct of just one individual, but instead, may be traced to decision-making among several people, including the patient. So the patient/plaintiff’s actions are held to the standard of a reasonable patient acting under similar circumstances, just as the physician’s actions are judged against the standard of a reasonable physician acting under similar circumstances.11

This defense can be strengthened dramatically if the record reflects that the physician specifically documented the shared-decision making process including:

■ Introducing specific choices, describing options, and providing written educational information about those options
■ Helping the patient to explore and understand preferences and make decisions
■ Using procedure-specific informed consent forms
■ Documenting clearly explained follow-up care and discharge instructions.

Again, this information needs to include the implications of not being engaged. This often motivates patient involvement and makes it clear that the patient made his choice based on full information. Effective language highlights the fact that the patient is aware of what he needs to do—and also understands the implications of not doing so. This type of documentation will only become even more important as the cultural shift toward personal responsibility for care of one’s health takes hold.

Benefits of clearer roles and responsibilities

The extent of patient satisfaction and engagement is strongly correlated with MPL risk.12 Thoughtfully implementing strategies to improve relationships with patients and purposefully involve them in decisions about their care provides an opportunity to improve outcomes, deliver better patient care and lower costs. These engagement strategies offer the added benefit of reducing liability risk and, if a suit is filed, in supporting an effective defense.

Adopting an effective patient engagement strategy is essential for physicians and their patients, to maximize healthcare delivery in our evolving world.

As is so often the case, the process begins with education of our physicians, who have tended to default to the assumption that “it’s my responsibility.” Then, physicians must incorporate specific tools for documenting patient engagement and perhaps add some novel education strategies. Some should be Web or portal based; others, paper and electronic. It needs not be, in fact should not be, either complicated or resource-intensive. We must stay focused on the fact that positive patient outcomes are the goal. If, at the same time, we can better clarify and document relative responsibilities, we have moved the ball a good way down the field. The last component may turn out to be the most important. We need to measure in order to assure the use of these tools and strategies. Measurement helps ensure change, and that may well be our biggest obstacle.

References

6. Affordable Care Act §10331: 42 USCS §1395w-5(a)(1).
8. We appreciate the contributions of SE Quality Healthcare Consulting to this article. http://www.sequalityhealthcare-qualityconsulting.com/.
IS IT POSSIBLE TO PREDICT PHYSICIANS PRONE TO MPL CLAIMS?

BY RICHARD E. MOSES, DO, JD, MICHELLE MOSES CHAITT, ESQ., AND SCOTT JONES

Interest in predicting potential medical professional liability (MPL) claims is not a new trend. Preventing or mitigating a negative medical outcome benefits patients, physicians, the health system, and MPL insurers. Researchers in the area of MPL and patient safety have historically equated MPL claims with substandard care, but many cases filed against providers do not in fact involve treatment below the standard of care, regardless of the severity of the injury.

There is a subgroup of physicians who have been sued two or more times. Individuals in this group have been referred to as “claim-prone” physicians. Attempts have been made to find the factors that would identify this group of physicians for more than 25 years, with limited success. Studies in the 1970s utilizing data from single insurers or states have identified a number of variables, including claim and complaint history, age, sex, training and certification, specialty, claim and complaint history, and quality-of-care.

And now, Studdert et al. have published a study using national data. They sought to characterize the distribution of paid MPL claims among physicians in the entire U.S. and analyze the physician characteristics associated with incurring multiple paid claims over a recent ten-year period, January 1, 2005 through December 31, 2014. The study used data from the National Practitioner Data Bank (NPDB), the confidential data repository created by Congress in 1986, and data on the total number of active physicians in the U.S., according to specialty and year, from the American Medical Association Physician Masterfile. Finally, data based on additional variables by special application to the Health Resources and Services Administration was utilized.

The authors’ complex statistical multivariable recurrent-event survival analysis was based on the information from these sources. While their analysis is comprehensive and does help in identifying certain characteristics that may contribute to lawsuits, further analysis is necessary to ensure that the likelihood of suit is not related to the type of specialty chosen rather than the individual physician being analyzed. NPDB data used would include all indemnity payments resulting from a written claim or judgment, according to the NPDB Guidebook. Claims paid with a “nuisance value” (low) or because the demand is less than the anticipated legal expenses, are included. In addition, many MPL payments do not result in disclosure to the NPDB, and not all MPL claims resulting in verdicts are the result of “bad medicine.”

There are other significant factors that need to be explored for a better understanding of NPDB reporting.

Study results: general overview

A review of the entire study is beyond the scope of our discussion. Of interest, 84% of physicians with paid claims had just one paid claim, 16% had at least two paid claims, 4% of the group had at least three paid claims, and 1% of this limited class had at least four paid claims. Studdert’s results show that about 1% of all physicians accounted for one-third of the total paid claims.

Physicians’ risk of future claims varied exponentially across specialties. Compared to the risk of recurrence among internal medicine physicians, neurosurgeons had double the risk of recurrence, followed by orthopedic surgeons, general surgeons, plastic surgeons, and obstetrician-gynecologists. Psychiatrists and pediatricians had the lowest risks of recurrence. Residents had a lower risk than nonresidents, and allopathic physicians had a lower risk than osteopathic physicians.

MPL claims data has been tracked by PIHA, through its Data Sharing Project (DSP), since 1985. This data indicates that a higher number of...
claims are reported in certain medical specialties with a higher frequency of patients seen (as in internal medicine), and higher severity is linked with physicians who are involved in higher-risk invasive procedures, or where patients have a high expectation of successful outcomes (surgical specialties, or Ob/Gyn).8

In the study by Studdert et al., physicians who had seen a third paid claim had a 24% chance of another paid claim within two years and a 37% likelihood of another claim in four years. A small group of physicians experienced a sixth paid claim. This group had a 62% chance of another claim in two years and a 79% chance of another claim in four years. The data of Studdert et al. also suggests that physicians with three or more previous paid claims bear a greater risk of incurring additional claims in the year after a payment was made, and thereafter declined.

Discussion
In this retrospective ten-year study, a relatively small group of U.S. physicians accounted for a disproportionately large share of paid MPL claims.

Research reports, to date, have not been convincing in stating that a specific set of variables has been identified that will help, proactively, in preventing recurrent MPL claims involving a single physician. The physician's specialty in particular does seem to be a strong determinant of claim incidence.9 The current Studdert paper utilized data on the total number of active physicians in the U.S., according to specialty and year. There is inherent inaccuracy when defining "active physicians," as many in this group maintain an active medical license but may not see patients. Physicians have moved into executive and business positions over the past five to ten years, especially after the Affordable Care Act (ACA).10

As the study notes, some MPL payments are not reported to the NPDB. The extent of under-reporting, an unknown variable, creates an under-reporting bias. Some physicians are shielded through settlements made in the name of the institutional codefendant. As our healthcare delivery system becomes more integrated, more physicians will become healthcare system employees, and there is a chance that the employer will be held liable for its employee-physician's actions, especially since the physicians and their employers are generally insured by the same insurance, creating a potential of "shielding" individual doctors, as recognized by Studdert.

The number of solo and private-practice physicians has shown a decreasing trend over at least the past five years. Currently, more than 60% of physicians are employees, and the numbers keep increasing.11 Finally, many physicians wishing to remain in private practice are merging with larger groups in the same or different medical specialties.

Variables such as volume of patients treated, hours worked, practice structure, case mix index, and use (or not) of electronic medical records (EMRs) were not included in the Studdert analysis. These are important considerations. Further, there are physicians who, as a result of an MPL claim, retire early, stop treating patients, or have their medical license suspended or revoked. All of these factors have a propensity to influence the information being analyzed.

In addition, the data used is based on claim count, not severity of claim. Because the study is not severity-adjusted to account for nuisance-value claims, or those paid primarily to avoid the uncertainty of jury trial, claims that have a low-severity value are counted with the same weight as those with high severity.
Unfortunately, most MPL insurers do not prospectively intervene with practitioners who are potentially at high risk for future claims. The insurers’ approach is usually to offer premium discounts when the physician has a clean loss history and/or completes educational programs. These discounts are offered across the board to the insurance pool. For physicians who have multiple plaintiff verdicts or settlement payments, insurers generally enforce an insurance surcharge on premium, or simply terminate coverage of the claim-ridden physicians. These strategies are costly for the physician and the insurer, because they do not correct the fundamental issues leading to many claims.

The U.S. healthcare system is undergoing a radical change as a result of the ACA and, most recently, the Medicare Access and CHIP Reauthorization Act of 2015. Rapid change is creating additional and new stresses on physicians and other healthcare providers with regard to patient care, thereby increasing the potential risk of error. For example, while it was believed that use of EMRs would decrease the risk of error, it now appears that the opposite may be true. Other post-ACA variables to consider in evaluating MPL data include the more prevalent use of non-physician clinicians (advanced practice providers), the requirements for quality and outcomes data, incorporation of clinical practice guidelines into patient care, public reporting of data in the public domain that might be misunderstood or utilized out-of-context, electronic communications with patients, and social media, among others.

Studdert et al. suggest that the ability to identify risk of future claims would be extremely useful, given that a minority of physicians account for the majority of MPL paid claims. Once identified, they say, these high-risk physicians could be targeted with educational and other interventional efforts. This could potentially mitigate the risk of future claims involving this small subset of physicians. While we agree with this contention, we do not think that the current approach to dealing with MPL claims and educational prevention should undergo a drastic change, based solely on this study. More investigation is necessary before concrete conclusions can be drawn from this one retrospective analysis.

Risk Avoidance
Medical students do not receive specific or extensive training in MPL risk prevention. This education is principally the responsibility of the MPL carrier, once students transition into medical practice. A robust medical educational program is needed to educate student physicians before they begin post-medical school training careers.

Yet student educational programming is certainly not enough to resolve the current dilemma. What additional steps should be undertaken to help anticipate, mitigate, and/or prevent recurrent claims against claim-prone physicians? The medical and surgical specialties at risk for recurrent claims seem to be well-defined. Once a physician in one of these particular specialties has had an MPL claim, an educational program should be presented, with particular attention to the specialty area of practice.

This program should clearly define the issues that prompted the claim, and clearly outline what can be done to prevent the same issues from recurring. Mentoring is also necessary. Finally, specialty-specific educational programs should be developed based on the most frequent causes of actions brought against that particular specialty. This of course is in addition to generalized education involving more “routine” risks, such as those entailed in using EHRs.

There is no quick-fix to preventing multiple MPL claims against an individual physician. As more data pertaining to MPL and patient safety becomes available and the health system evolves, so should our educational approaches.

References
3. Danzon, PM. The frequency and severity of medical malpractice claims: new evidence. 49 Law and Contemporary Problems No. 2, 57-84.
32. PIAA, Data Sharing Project, https://www.piaa.us/.
Lower Risk and Improve Patient Safety!

Offer the Value-Added Benefit of Online CME/CNE and MOC to Your Insured Medical Professionals

- 100+ online courses emphasizing patient safety and risk management solutions to reduce liability
- Comprehensive catalogue of Obstetrical CME, CNE and MOC courses
- Largest collection of Diagnostic Error courses approved for MOC Part II credits available in the industry
- Extensive library of specialty-approved MOC courses across 28 specialties

Contact Us:
855.464.7475
info@medicalinteractive.com
www.medicalinteractive.com
CHANGE IS COMING

Do you have the right tools to successfully make the leap?

Technology alone isn’t the answer. Delphi Technology is the only solution provider that gives you all the tools you need... an innovative technology solution AND more than 20 years of industry knowledge and business expertise.

* Policy Management
* Financial Management
* Incident Management
* Advanced Workflow
* Physician eLearning
* Reporting & Analytics

* Claims Management
* Risk Management
* Document Management
* Policy Holder Services
* Online Applications
* Advanced Business Analytics

Our fully-integrated medical professional liability solution will transform your critical business challenges into measurable business results.

470 Atlantic Avenue, Suite 702
Boston, MA 02210

617-259-1200
www.Delphi-Tech.com
The year 2015 manifest continued declining profitability for the medical professional liability (MPL) insurance industry. For those who had grown accustomed to operating ratios below 70%, the industry’s most recent results might seem like a glass half empty. The industry’s operating ratio increased to 81%, 7 points over the prior year, a larger increase than what was seen in any recent year except 2012.

Meanwhile, insurers continued to experience a decline in reserve releases, lower rate levels, increased expense ratios, and diminished investment gains.

Yet others would observe that the operating ratio remains well below 100%. Despite the decline in profitability, the MPL industry again returned a substantial portion of its income as dividends to policyholders. Surplus grew slightly in 2015, leaving the MPL industry in a financial position roughly consistent with where it has been since year-end 2011. Is the glass half full?

The increased capitalization and favorable operating ratios in the MPL industry of late have had one primary cause—the release of prior-year reserves. In 2015 in particular, reserve releases contributed 24 points to the industry’s operating ratio. The reserve releases are similar to those during 2014 and represent a decline relative to each of the years 2008 through 2013, during which reserve releases contributed an average of 31 points to the industry’s operating ratio each year. Yet despite this decline in reserve releases, without them, the industry would have been unprofitable for the first time since 2003.

Rates continue to fall for many writers, as evidenced by the declining premium volume of the industry as a whole. Certain markets have seen a cumulative decline in rate levels in excess of 25% over the past several years. It is not uncommon for companies to see certain of their competitors writing at rates perceived to be inadequate, in some cases forcing companies to choose between losing market share and writing at levels they
themselves believe are unprofitable.

At the same time, the industry’s pattern of declining frequency has ended, and we have seen the reporting of claim counts stabilize for most companies. Indemnity severity trends have remained manageable, although trends in defense costs remain in the range of 5% to 8% per annum. While rate levels generally remain adequate for most companies in the MPL industry, a continued pattern of declining rate level, combined with eventual increases in claim costs, would work, over time, to impact the industry’s rate adequacy.

MPL insurers have seen increased caps on damages in some states and, in others, challenges to the tort system itself. MPL insurers in several states face legislative bills that, if passed, would remove MPL claims from the tort system, creating what these bills term “a patient compensation system.” If passed, these bills would create a formulaic approach to determining compensation for MPL claims and, depending on the particular language of the state’s bill, would significantly expand the number of claims eligible for compensation, fundamentally altering the landscape for MPL insurers.

MPL insurers also continue to face declining market share because of the ongoing acquisition of physician practices by hospitals and healthcare systems, and because many newly trained physicians have opted to join these larger systems rather than enter into independent practice. Healthcare reform has only served to accelerate the trend in physician employment that was already well underway. In addition, we expect that the long-predicted decline in the availability of healthcare professionals will become accelerated, due to the increased demand in services from a more fully insured population. Presumably, such an outcome could only impact MPL writers negatively, as patients begin to experience greater frustration with their professionals.

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

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

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

Written premium

Last year, 2015, marked the ninth straight year of decreases in direct written MPL premium for our composite (Figure 1). Cumulatively, premium has decreased by almost $1.2 billion since 2006—more than 25% of the premium written in that year. To put that in perspective, consider: in the 30-year history of the MPL industry, no other period of decreasing premiums has lasted longer than two years, and the greatest consecutive-year premium reduction was 7%.

Premium decreases during this time frame have been driven only in part by declining rate levels. An additional—and perhaps primary—driving factor behind the lower level of premium has been the loss of business to self-insurance mechanisms. Throughout this timeframe, PIAA companies have been losing business due to hospital acquisitions of physician practices. In earlier years—through about 2008—companies also frequently lost business due to the formation of new captives.

This is a distinct difference between the current market and the previous soft market, of the mid- to late 1990s through the early 2000s. Both the current and prior soft markets have shown decreasing rate levels, but a comparable level of rate inadequacy has not been manifest in this current soft market, as compared with the previous soft market. During this prior time period, rate deficiencies—including those documented in rate filings—ultimately culminated in adverse financial results. The reduction in frequency for MPL writers means that their rates are in a much better position now than they were 15
years ago. However, we continue to see aggressive rate action in certain markets, exemplified by double-digit rate decreases filed by certain carriers.

Overall operating results
As measured by the composite operating ratio, the industry appears to have reached its peak profitability during 2010. During that year, the composite posted an operating ratio of 56%, which has risen to 81% since that time (Figure 2). The increase has been driven by the decline in reserve releases beginning in 2012, but also by an increase in underwriting expenses and ongoing lower levels of investment returns. Several points of the increase have also been driven by an increase in the initial carried loss and the loss adjustment expense (LAE) ratio for the most recent coverage year, which has increased from 82% in 2007 to 89% in 2015. The 2015 combined ratio for the industry was 97%, up from a low of 76% in 2008 (Figure 3).

The investment gain ratio of 16% in 2015 represents a noticeable decline from the previous six years, in which the investment gain ratio ranged from 21% to 27%. In large part, this was due to the accounting treatment by one larger carrier of its investment in its affiliates. Thus, the industry’s capital gains ratio declined from 6% in 2014 to negative 1% in 2015, the first time the capital gains ratio has been negative since 2008. The investment income ratio increased from 16% in 2014 to 18% in 2015, although this remains less than any year since 2005. Even absent this one instance of an accounting treatment, the industry’s capital gains ratio would nonetheless have decreased by approximately 4 points in 2015, and the investment gain ratio by about 3 points.

The calendar-year loss and LAE ratio for 2015, 65%, is higher than in any year since 2006, and represents an increase of almost 13 points since 2008. The increase has been driven largely by the decline in reserve releases noted earlier, and is discussed further below. The loss and LAE ratio carried for the 2015 coverage year is 89%, only a 4-point increase over the 2008 starting loss and LAE ratio of 85%. In light of the rate decreases during this time period in virtually every locale, a greater increase in the initial loss and LAE ratio would be expected. Thus, this modest increase suggests that the 2015 coverage year is starting out from a weaker position than other recent coverage years.

Finally, as noted previously, the industry saw a dramatic decrease in reported frequency over the decade following 2001. However, for most companies, frequency (on a per-physician basis) has since stabilized. Other companies have continued to see small declines in frequency, while for some writers, frequency has turned slightly upward again. Given the rate decreases of the past several years, frequency has of course increased more relative to premium than to the number of insured physicians. Reported frequency per $1 million of direct earned premium has increased year-over-year since 2006, although there were small declines in both 2013 and 2014. Thus, for every claim reported, fewer premium dollars have been available to defend or settle the claims than was the case several years ago. Cumulatively, reported claim frequency (measured relative to premium) has increased by more than 25% since the 2006 year. This increase is largely the result of rate decreases (mostly in the form of greater premium credits, as opposed to manual rate changes), although some writers have
seen modest increases in “true” frequency—i.e., claims per insured physician.

**Reserve releases**

As discussed above, the composite released $800 million in reserves during 2015, a decline from the $1.2 billion released in each of the years 2008 through 2011 and the $900 million to $1.0 billion released each year subsequently (Figure 4). Despite the decline, the reserve releases remain material. Yet, they should be put in the context of the reserves carried by the composite, which for net loss and LAE totaled $9.7 billion as of year-end 2014. The release of reserves was driven by the ongoing impact of a lower frequency, combined, for many companies, with a relatively benign trend in indemnity severity during the past several calendar years.

It is important to recognize that a history of favorable calendar-year reserve development is not necessarily indicative of redundant reserves currently. In fact, a review of calendar-year development segregated by coverage year shows that favorable calendar-year reserve development has historically continued two to three years past the point when reserves were subsequently found to be adequate. Thus, if the industry is currently at a level where reserves are theoretically exactly adequate, history would suggest that we will see favorable reserve development, on a calendar-year basis, through 2017 or 2018. This would then be followed by adverse development (at least for the older coverage years) in subsequent calendar years.

**Capitalization**

The industry’s surplus increased just slightly during 2015, from $12.5 billion to $12.7 billion, a growth rate of 2% (Figure 5). While net income for the industry was close to $600 million, a major portion of this income was returned to policyholders in the form of dividends, discussed further below. The industry’s growth in surplus during 2015 represents a noticeable decline from the double-digit growth rate seen during most of the prior decade.

To put the industry’s capitalization level in a broader context, consider the risk-based capital (RBC) ratio for the industry. This metric provides a comparison of a company’s actual surplus to the minimum amount needed from a regulatory perspective (although, from a practical perspective, given market fluctuations, many would consider the actual amount of capital needed to be well in excess of this regulatory minimum). The RBC ratio of our MPL composite increased to 1215% in 2015, although this appears to be due largely to the effect of the accounting treatment for several acquisitions. However, individual RBC ratios vary considerably within the composite, from a low of 625% to a high of nearly 5000%.

**Policyholder dividends**

The stabilization of the industry’s capitalization level is in part due to the significant amount of policyholder dividends that MPL writers have continued to pay. In 2015, the composite writers paid $214 million in policyholder dividends, representing more than 6% of net earned premium (Figure 3). Cumulatively, the composite has paid $2.4 billion in policyholder dividends since 2005.

MPL writers have sustained a similar pattern of policyholder dividend payments, despite a decline in the reserve releases that have historically been used to fund these dividends. In 2015, policyholder dividends
increased to 37% of net income from approximately 30% in 2013 and 2014. Policyholder dividends were roughly 20% to 25% of net income in the preceding several years. Typically, these dividends are paid to all renewing policyholders as a percentage of premium. Thus, on a dollar basis, the dividends have provided greater benefit to those physicians who have historically paid higher premiums. We expect that policyholder dividends will continue for several more years, given their historically cyclical behavior and the composite’s strong balance sheet.

**Profitability expected to continue—but so is its decline**

In its most recent “Review & Preview” report, A.M. Best estimated a net total reserve redundancy of $3.3 billion for the MPL line of business as a whole. This is approximately 12% of the carried net reserves, which implies a redundancy for our composite of $700 million. Thus, continued reserve releases can be expected to mask deteriorating underwriting results on current business, both prolonging the soft market and increasing the risk that rates may become inadequate. Insurers face other risks to the bottom line as well: possible increases in frequency and severity, including the threats to the tort system and tort laws in various states, among others factors.

For related information, see www.milliman.com.

**Cloud-Based Hospital and MPL Software**

Covering Policy and Claims

- Provider Management
- Physician Portal
- Education Tracking
- Claims Administration
- Rating
- Policy Issuance
- Certificates

978.729.7530 • www.davidcorp.com

Visit us at GO.DAVIDCORP.COM/PIAA_MPL and booth #18.
PIAA thanks all sponsors of the 2016 Medical Liability Conference. Many contributors are longtime supporters of the Association, and we gratefully acknowledge their participation. We are also pleased to welcome our new supporters. Thank you to one and all—your commitment is an integral part of our continued success.

Sponsors

Platinum

Delphi Technology, Inc.
www.delphi-tech.com

Prime Advisors, Inc.
www.primeadvisors.com

GOLD

Duck Creek Technologies
www.duckcreek.com

Guy Carpenter & Company, LLC
www.guycarp.com

Johnson Lambert LLP
www.johnsonlambert.com

SILVER

Milliman, Inc.
www.milliman.com

Willis Re
www.willisre.com

OnBase, by Hyland Software
www.onbase.com

LANYARDS
A.M. Best Company
www.ambest.com

CONFERENCE FOLDERS
Constellation
www.constellationmutual.com

REFRESHMENT BREAKS
Imperial PFS
www.ipfs.com

Wi Fi/Mobile App
OnBase, by
Hyland Software
www.onbase.com

INSIDE MEDICAL LIABILITY 66 SECOND QUARTER 2016
## Exhibitors

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Booth Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>CapVisor Associates, LLC</td>
<td>#5</td>
</tr>
<tr>
<td>Cincom</td>
<td>#1</td>
</tr>
<tr>
<td>Cleareview, Inc.</td>
<td>#12</td>
</tr>
<tr>
<td>Conning</td>
<td>#27</td>
</tr>
<tr>
<td>DAVID Corporation</td>
<td>#18</td>
</tr>
<tr>
<td>Dephi Technology, Inc.</td>
<td>#7 &amp; 8</td>
</tr>
<tr>
<td>Duck Creek Technologies</td>
<td>#15</td>
</tr>
<tr>
<td>ECRI Institute</td>
<td>#26</td>
</tr>
<tr>
<td>Empathetics, Inc.</td>
<td>#10</td>
</tr>
<tr>
<td>EthosCE LMS</td>
<td>#25</td>
</tr>
<tr>
<td>Fitch Ratings</td>
<td>#21</td>
</tr>
<tr>
<td>Imperial PFS</td>
<td>#11</td>
</tr>
<tr>
<td>Johnson Lambert LLP</td>
<td>#28</td>
</tr>
<tr>
<td>LifeGuard</td>
<td>#16</td>
</tr>
<tr>
<td>MedFax</td>
<td>#2</td>
</tr>
<tr>
<td>Medical Interactive Community</td>
<td>#14</td>
</tr>
<tr>
<td>MedTunnel</td>
<td>#3</td>
</tr>
<tr>
<td>MRM Group, LLC</td>
<td>#4</td>
</tr>
<tr>
<td>NAMIC Insurance Company, Inc.</td>
<td>#20</td>
</tr>
<tr>
<td>New England Asset Management, Inc.</td>
<td>#13</td>
</tr>
<tr>
<td>Perinatal Quality Foundation</td>
<td>#17</td>
</tr>
<tr>
<td>PIAA International Conference</td>
<td>#19</td>
</tr>
<tr>
<td>Pinnacle Actuarial Resources, Inc.</td>
<td>#23</td>
</tr>
<tr>
<td>Prime Advisors, Inc.</td>
<td>#22</td>
</tr>
<tr>
<td>The Risk Authority Stanford</td>
<td>#6</td>
</tr>
<tr>
<td>Swiss Re</td>
<td>#24</td>
</tr>
<tr>
<td>Vermont Captive Insurance Association</td>
<td>#9</td>
</tr>
</tbody>
</table>
ICD-10 Ignites Anxiety—and Maybe a Bit of Levity

By Eric R. Anderson

ICD-10 codes are by now an inescapable element in the daily life of a healthcare professional in the U.S. ICD-10, of course, is the acronym for the 10th iteration of the “International Classification of Diseases.”

There’s been a great deal of turmoil among healthcare providers and lawmakers alike over the implementation of ICD-10. In fact, bring up the phrase “ICD-anything” to a healthcare professional, and what you are likely to see is an icy stare or a chagrined shrug. Or, if you are particularly unlucky, you’ll be on the receiving end of a diatribe on the shortcomings of this entire coding system.

Why does this topic strike a nerve in healthcare professionals? Some experts have estimated that for average doctors, the ICD-10 system will require as much as an additional hour, every day, spent in finding the correct codes. This extra time is not exactly easy to find for today’s doctors. More concerning, according to cardiologist Ira Nash, is the fact that, “clinicians believe that they can achieve the fundamental goals of clinical documentation without the constraints and complexity of ICD-10 coding.” As Nash sees it, doctors and hospitals have accepted a system that documents their work so that they can be compensated—but the language chosen for that exchange and hospitals have accepted a system that documents their work so that they can be compensated—but the language chosen for that exchange and what you are likely to see is an icy stare or a chagrined shrug. Or, if you are particularly unlucky, you’ll be on the receiving end of a diatribe on the shortcomings of this entire coding system.

Why does this topic strike a nerve in healthcare professionals? Some experts have estimated that for the average doctor, the ICD-10 system will require as much as an additional hour, every day, spent in finding the correct codes. This extra time is not exactly easy to find for today’s doctors. More concerning, according to cardiologist Ira Nash, is the fact that, “clinicians believe that they can achieve the fundamental goals of clinical documentation without the constraints and complexity of ICD-10 coding.” As Nash sees it, doctors and hospitals have accepted a system that documents their work so that they can be compensated—but the language chosen for that exchange and what you are likely to see is an icy stare or a chagrined shrug. Or, if you are particularly unlucky, you’ll be on the receiving end of a diatribe on the shortcomings of this entire coding system.

But regardless of what people think about it, the ICD system is most likely here to stay. And, to add insult to injury, the Centers for Medicare & Medicaid Services recently announced that this fall another 5,500 codes will be added to the current ICD-10

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

diagnostic library. This comes only 12 months after ICD-10 and its 70,000 codes replaced the dated, and more compact, ICD-9 code set.

Amid all of this angst, it seems only right to have a chuckle at the expense of the people who developed this torturous system. The robustness of ICD-10 includes things that I would like to believe no clear-thinking individual would ever contemplate. Here are some examples:

■ Struck by turtle (W59.22XA): Described as “the Art gallery as the place of occurrence of the external cause (Y92.250):
■ Burn due to water-skis on fire, initial encounter (V91.07XA):

Why does this topic strike a nerve in healthcare professionals? Some experts have estimated that for average doctors, the ICD-10 system will require as much as an additional hour, every day, spent in finding the correct codes. This extra time is not exactly easy to find for today’s doctors. More concerning, according to cardiologist Ira Nash, is the fact that, “clinicians believe that they can achieve the fundamental goals of clinical documentation without the constraints and complexity of ICD-10 coding.” As Nash sees it, doctors and hospitals have accepted a system that documents their work so that they can be compensated—but the language chosen for that exchange and what you are likely to see is an icy stare or a chagrined shrug. Or, if you are particularly unlucky, you’ll be on the receiving end of a diatribe on the shortcomings of this entire coding system.

But regardless of what people think about it, the ICD system is most likely here to stay. And, to add insult to injury, the Centers for Medicare & Medicaid Services recently announced that this fall another 5,500 codes will be added to the current ICD-10

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

diagnostic library. This comes only 12 months after ICD-10 and its 70,000 codes replaced the dated, and more compact, ICD-9 code set.

Amid all of this angst, it seems only right to have a chuckle at the expense of the people who developed this torturous system. The robustness of ICD-10 includes things that I would like to believe no clear-thinking individual would ever contemplate. Here are some examples:

■ Struck by turtle (W59.22XA): Described as “the Art gallery as the place of occurrence of the external cause (Y92.250):
■ Burn due to water-skis on fire, initial encounter (V91.07XA):

Why does this topic strike a nerve in healthcare professionals? Some experts have estimated that for average doctors, the ICD-10 system will require as much as an additional hour, every day, spent in finding the correct codes. This extra time is not exactly easy to find for today’s doctors. More concerning, according to cardiologist Ira Nash, is the fact that, “clinicians believe that they can achieve the fundamental goals of clinical documentation without the constraints and complexity of ICD-10 coding.” As Nash sees it, doctors and hospitals have accepted a system that documents their work so that they can be compensated—but the language chosen for that exchange and what you are likely to see is an icy stare or a chagrined shrug. Or, if you are particularly unlucky, you’ll be on the receiving end of a diatribe on the shortcomings of this entire coding system.

But regardless of what people think about it, the ICD system is most likely here to stay. And, to add insult to injury, the Centers for Medicare & Medicaid Services recently announced that this fall another 5,500 codes will be added to the current ICD-10

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

diagnostic library. This comes only 12 months after ICD-10 and its 70,000 codes replaced the dated, and more compact, ICD-9 code set.

Amid all of this angst, it seems only right to have a chuckle at the expense of the people who developed this torturous system. The robustness of ICD-10 includes things that I would like to believe no clear-thinking individual would ever contemplate. Here are some examples:

■ Struck by turtle (W59.22XA): Described as “the Art gallery as the place of occurrence of the external cause (Y92.250):
■ Burn due to water-skis on fire, initial encounter (V91.07XA):

Why does this topic strike a nerve in healthcare professionals? Some experts have estimated that for average doctors, the ICD-10 system will require as much as an additional hour, every day, spent in finding the correct codes. This extra time is not exactly easy to find for today’s doctors. More concerning, according to cardiologist Ira Nash, is the fact that, “clinicians believe that they can achieve the fundamental goals of clinical documentation without the constraints and complexity of ICD-10 coding.” As Nash sees it, doctors and hospitals have accepted a system that documents their work so that they can be compensated—but the language chosen for that exchange and what you are likely to see is an icy stare or a chagrined shrug. Or, if you are particularly unlucky, you’ll be on the receiving end of a diatribe on the shortcomings of this entire coding system.

But regardless of what people think about it, the ICD system is most likely here to stay. And, to add insult to injury, the Centers for Medicare & Medicaid Services recently announced that this fall another 5,500 codes will be added to the current ICD-10

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

diagnostic library. This comes only 12 months after ICD-10 and its 70,000 codes replaced the dated, and more compact, ICD-9 code set.

Amid all of this angst, it seems only right to have a chuckle at the expense of the people who developed this torturous system. The robustness of ICD-10 includes things that I would like to believe no clear-thinking individual would ever contemplate. Here are some examples:

■ Struck by turtle (W59.22XA): Described as “the Art gallery as the place of occurrence of the external cause (Y92.250):
■ Burn due to water-skis on fire, initial encounter (V91.07XA):

Why does this topic strike a nerve in healthcare professionals? Some experts have estimated that for average doctors, the ICD-10 system will require as much as an additional hour, every day, spent in finding the correct codes. This extra time is not exactly easy to find for today’s doctors. More concerning, according to cardiologist Ira Nash, is the fact that, “clinicians believe that they can achieve the fundamental goals of clinical documentation without the constraints and complexity of ICD-10 coding.” As Nash sees it, doctors and hospitals have accepted a system that documents their work so that they can be compensated—but the language chosen for that exchange and what you are likely to see is an icy stare or a chagrined shrug. Or, if you are particularly unlucky, you’ll be on the receiving end of a diatribe on the shortcomings of this entire coding system.

But regardless of what people think about it, the ICD system is most likely here to stay. And, to add insult to injury, the Centers for Medicare & Medicaid Services recently announced that this fall another 5,500 codes will be added to the current ICD-10

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

diagnostic library. This comes only 12 months after ICD-10 and its 70,000 codes replaced the dated, and more compact, ICD-9 code set.

Amid all of this angst, it seems only right to have a chuckle at the expense of the people who developed this torturous system. The robustness of ICD-10 includes things that I would like to believe no clear-thinking individual would ever contemplate. Here are some examples:

■ Struck by turtle (W59.22XA): Described as “the Art gallery as the place of occurrence of the external cause (Y92.250):
■ Burn due to water-skis on fire, initial encounter (V91.07XA):

Why does this topic strike a nerve in healthcare professionals? Some experts have estimated that for average doctors, the ICD-10 system will require as much as an additional hour, every day, spent in finding the correct codes. This extra time is not exactly easy to find for today’s doctors. More concerning, according to cardiologist Ira Nash, is the fact that, “clinicians believe that they can achieve the fundamental goals of clinical documentation without the constraints and complexity of ICD-10 coding.” As Nash sees it, doctors and hospitals have accepted a system that documents their work so that they can be compensated—but the language chosen for that exchange and what you are likely to see is an icy stare or a chagrined shrug. Or, if you are particularly unlucky, you’ll be on the receiving end of a diatribe on the shortcomings of this entire coding system.

But regardless of what people think about it, the ICD system is most likely here to stay. And, to add insult to injury, the Centers for Medicare & Medicaid Services recently announced that this fall another 5,500 codes will be added to the current ICD-10

Eric R. Anderson is Vice President of Marketing and Communications at PIAA; eanderson@piaa.us.
The medical professional liability system presents constant challenges to healthcare providers and other industry stakeholders. Accurate, timely and quantitative information, from indicated loss reserves and funding estimates to the impact of proposed legislation, is vital. Our experts understand the inherent risks of delivering healthcare services in today’s litigious and ever-evolving environment.

Pinnacle Actuarial Resources, Inc. provides actuarial consulting services for every aspect of the medical professional liability insurance industry at the local, state and national levels. Our wealth of experience drives our strategic solutions to manage your healthcare-related liability exposures. We deal with the unique issues of all specialties and insurance programs, including traditional, alternative and government.

To learn more about our medical professional liability expertise and our Commitment Beyond Numbers, visit us at pinnacleactuaries.com.
Get on board
Register your interest now!

PIAA
International Conference 2017
www.piaa2017.com

Change & Disruption
Strategies for managing the evolution of medical liability

LONDON
4-6 OCTOBER 2017
GRANGE ST PAUL’S

Hosted by
MDU MPS