Inside Medical Liability

2017 Second Quarter

The Genetic Test That Wasn’t Done

Annual ‘Industry Update’
The United States healthcare insurance market is undergoing rapid and profound change. In fact, the only “certainty” we know is continued uncertainty. Will the American Healthcare Act repeal and replace the Affordable Care Act? Will the relatively benign medical professional liability claims environment continue in the near term? What healthcare exposures will be the next target of the plaintiffs’ bar?

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For more information, please contact: Steve Underdal at +1(952) 820-1030 or steve.underdal@guycarp.com
A wise person once said, “Knowledge must be shared to have value.” This has been the essence of PIAA’s purpose since its inception and continues to be core to our mission as reflected in our recent survey of members. As a membership organization, it’s important that we periodically ask our members about their priorities and how PIAA can continue to remain an important component of their success through the sharing of knowledge, experience, data, and much more. In recent months, we have heard from PIAA members in the United States and around the world that the opportunities to meet, exchange information, and establish relationships are among the most valuable benefits to being a member of the PIAA community.

For this reason, PIAA is continually exploring new ways to enhance our range of programs and the opportunities for members to benefit from collective wisdom. Our in-person events held throughout the year provide the medical and healthcare professional liability (MPL/HPL) insurance community with unique forums for collaboration, communication, and networking. These enriching experiences can be found in Colorado Springs at the Medical Liability Conference, at one of our many workshops, or this autumn in London, at the 2017 PIAA International Conference. At each of these programs, you will find that the schedules are structured to maximize opportunities for knowledge-sharing. You can learn from your peers and from the many acclaimed speakers on a diverse range of MPL/HPL topics.

The seismic changes taking place in the healthcare environment—and the resulting challenges for those providing MPL/HPL coverage—make it vital that leaders take advantage of the best opportunities to expand their knowledge and explore new ways of doing business. This issue of Inside Medical Liability illustrates the wide breadth of critical issues confronting the leaders of today.

For example, our cover story analyzes the thorny issue of determining when genetic testing should be considered. The article suggests that decisions to forgo the use of this tool in some instances could become the impetus for a new wave of MPL/HPL lawsuits.

There is also a timely article that examines the changing role of physician clinical practice guidelines under the federal Medicare Access & CHIP Reauthorization Act, now being phased in following its 2015 passage. In addition, you will find an article that explores the best methodologies for optimizing labor and delivery for neonatal safety. This work of the authors aims to apply the tenets of process engineering to patient safety.

These topics and the others covered in this issue merely scratch the surface of the long list of challenges those in MPL/HPL need to be aware of to stay up to date.

For this reason, there is no better way to gain the knowledge required for sustained success than interacting with your peers, colleagues, and thought leaders throughout the MPL/HPL community. Our goal is to find ways to provide you with more of these opportunities.

PIAA is proud to be a unique and valued forum for the exchange of ideas serving a network of leaders at the forefront of change. Globally connected professionals within the PIAA community represent the combined intelligence of thousands of minds working to meet the challenges facing those who operate at the intersection of law, medicine and risk.

Knowledge is the currency of a successful community and network—and fruitful relationships are built through a mutual exchange of knowledge. Share when you can—because it pays to pay it forward.
features
30  cover story: failure to recommend genetic testing: the next wave of medical professional liability lawsuits?
   by victor r. cotton, md, jd, and douglas h. kirkpatrick, md

33  feature: proactive blindness: the allure (and costs) of reaction
   by robert j. latino

37  feature: optimizing labor and delivery for maternal and neonatal safety
   by louis p. halamek, md, faap, and henry c. lee, md, faap

40  feature: clinical practice guidelines and medical professional liability under macra. part one. how did we get here?
   by richard e. moses, do, jd, michelle moses chaitt, esq., and d. scott jones

43  feature: informed consent: ensuring it really is informed

“to limit the financial risk posed by the millions of women who meet the criteria for such testing but have not been tested, mpl/hpl organizations can educate their insureds about the relevant guidelines, the importance of maintaining a current family history of cancers, and the risks posed by both managed care restrictions and the lack of fda oversight.”
—cover story

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The current environment for medical and healthcare professional liability (MPL/HPL) insurers is a difficult one. There are the challenges of a soft market, familiar yet serious, but today uniquely intertwined with consolidation of the healthcare delivery system. This process continues at an unprecedented pace, and is exceptionally unlikely to be reversed. Add to this the uncertainty surrounding the Affordable Care Act and the outcome of the “Repeal and Replace” process now underway in Washington. The kaleidoscopic environment produces new opportunities, but it also portends new risks and liability exposures. While some of these are already becoming clear, there will undoubtedly be more that are unanticipated.

The challenges are not just in the United States. In nearly every country around the world where PIAA members operate, economic and political uncertainties are combining with a rising tide of American-style MPL litigation.

It was probably inevitable that an industry as large as American healthcare (18% of our GDP) would face economic rationalization. The great tradition of our medical practice is that the physician is the relentless advocate for the patient, but at the same time modern healthcare is far too complicated to remain essentially a cottage industry. It is incumbent on us to adapt to the emerging needs of the medical profession to control risk, and to advocate for a level playing field in legislative, judicial, and regulatory venues. For more than 40 years, PIAA has played a pivotal role in supporting the MPL/HPL community. We provide claims data and analyses through the Data Sharing Project (DSP); advocate on behalf of our members to protect hard-won reforms and create new ones; and we offer some of the best education and training available for MPL/HPL professionals. PIAA has always endeavored to meet your needs.

But just as MPL/HPL organizations face a changing environment, so too does PIAA. Association and its members, the PIAA Board of Directors has undertaken a formal process to recalibrate our mission, goals, and strategic priorities. We have completed a detailed survey of our membership and compiled feedback from key constituencies to help us orient our compass. We are evaluating a number of strategic initiatives and we will report to you what we’ve learned this May, at the Annual Meeting of Members in Colorado Springs.

There are a number of issues to consider. For example, today’s PIAA has become even more diversified than in the past. Formerly known primarily as an organization of physicians insuring physicians, we have come to welcome additional members of the MPL/HPL community into PIAA. Today, our members include mutuals, reciprocals, risk retention groups, captives, trusts, stock companies, and others. In addition, an impressive list of hospitals and health systems have joined our ranks. Our international membership is also growing significantly.

This is an exciting, and challenging, time in the MPL/HPL marketplace. As PIAA expands to match the new arena of healthcare, we are finding that greater inclusiveness makes us stronger and we discover how much there is to learn from each other.

The PIAA Board of Directors is committed to ensuring your organization continues to meet your needs. The bottom line is this: PIAA will continue to be the preeminent source of information for MPL/HPL organizations. Our dedication to our core values and services, and to the value of the services our members themselves provide, is inviolable.
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2017 Underwriting Workshop
The Nines, Portland, OR
Buckle Up: Bumpy Ride for Mass Torts
July 27, 2017, 3:00–4:00 p.m.

Mass torts present a major risk to medical and healthcare professional liability (MPL/HPL) insurers, indemnifiers, and reinsurers. Sometimes called batch claims, or systemic risks, in mass torts insurers are subjected to a high frequency of claims that result from a series of related incidents. Recent high-profile examples include (1) cardiologists who allegedly implanted unnecessary stents; and (2) pain management specialists who injected tainted steroids. When presented with a mass tort, an insurer may face tens or even hundreds of interrelated claims, which significantly increase the complexities of claims handling. This informative session will examine mass torts from the perspective of the defense attorney, as well as the several perspectives of claims specialists, from both the insurer and reinsurer markets. Attendees will learn about these potential damaging claims in which allocated loss adjustment expenses may be severe, and aggregate limits of liability may be exhausted.

Future PIAA Medical Liability Conferences
May 16-18, 2018
Waldorf Astoria/Hilton Bonnet Creek
Orlando, FL

May 15-17, 2019
Marriott Portland Waterfront
Portland, OR

May 6-8, 2020
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Department of Tough Decisions: Was MPL Involved in a MedExpress West Virginia lawsuit?

Enterprising attempt to circumvent MPL cap

The facts: A 71-year-old man, Andrew Minnich, fell while attempting to get on an examination table at a MedExpress in South Charleston, West Virginia, and subsequently died from the injuries he sustained.

The plaintiff’s (the patient’s wife’s) case: This is not an MPL case (subject to a cap in non-economic damages) but instead a suit against the facility for inadequate maintenance of its examination tables.

What the lower court said: This is in fact an MPL suit; you can’t circumvent the limitations that govern MPL by filing a complaint based on contentions about the physical facility used by the MedExpress.

The West Virginia Supreme Court’s decision, following an appeal by Mrs. Minnich was, yes, this is an MPL case:

“Upon our examination of these contentions, we conclude that a ‘health care provider,’ as defined by the MPLA, did in fact provide ‘health care’ related services to Mr. Minnich prior to his fall.”

Source: Charleston Gazette-Mail, February 23, 2017

Once Again, MPL Is a Sure-Fire Source for Great Literature

In the First Quarter issue of Inside Medical Liability, we informed you about Justice for the Deserving, Steve Clark’s brand-new novel, purported to be an “action-packed thriller.” No doubt, you have finished that by now, and are yearning for more MPL-focused literature.

Happily, your wishes are granted. Robert S. Goodman and Louis Kraft have just given us The Discovery. It is a tale of a young ob/gyn who in 1952 delivers a premature baby after attending a dinner party.

The child survives the delivery, but complications lead to an MPL suit, 20 years later.

Is the doctor prepared for a possible negative verdict? His attorney advises him that the policy he bought in 1952 will not cover even a fraction of the multimillion dollar lawsuit.

It is at this point that our author really dials up the melodrama. To quote from the publisher’s press release on the book, “The stress and uncertainty of the case, along with the accusation of fraud, breaks the doctor, leading him down a road of depression and alcohol dependence.”

And then, things get darker: “As the doctor’s wife, Helen, watches her husband deteriorate, she makes an unthinkable choice to put an end to the plaintiff’s case.”

So, what is it, MPL mavens? Does she murder the defendant? Murders the judge and/or jury?

Find out by buying the book: $17.99, paperback. Reviews on Amazon showed two five-star appraisals. What’s not to like?

Source: Global Press Release Distributors, February 20, 2017
Patient Jose Carmen Bernal was admitted for gallbladder surgery. He was told he would be released on the following day. Instead, he ended up spending months in the hospital, and nearly died. During that time, he suffered a punctured lung, lost 70% of his intestines, and had a leg amputated.

The attending physician commented to Bernal’s wife that her husband had simply “suffered bad luck,” adding, “Medicine is not a science, and it never will be.”

The insurance giant Aviva will soon be asking its 16,000 employees two daunting questions: Do you think a robot could do your job better? And then, if yes, would you admit it to your boss? The employees who say yes to both will be retrained for another position at the company.

The rapidly expanding scope of capability of robots has become a topline issue for bosses all over the world. Robots have already replaced tens of thousands of workers in many areas of manufacturing, notably, in the automobile industry. And experts have warned that entire professions now dominated by middle-class workers—such as accountancy—could be pushed to the brink of extinction, as developments in computers proceed.

The Bank of England governor has warned that 15 million Britons, almost half of the total workforce of 31.8 million in the U.K., will see their livelihoods annihilated by the technological revolution.

Helpfully, Oxford University has compiled a list of jobs most in danger of automation. Unfortunately, underwriters were at the top of the list. But dentists and doctors have less than a 1% chance of being replaced by robots. It would appear that no one has told the researchers at Oxford about the happy capabilities of artificial intelligence.

The Endoscopy Center of Southeast Texas was recently hit with an MPL lawsuit. This time the malevolent item was a wheelchair.

The plaintiff was under the care of the Endoscopy Center. She was awakened after a colonoscopy, placed in a wheelchair, and then rolled out to the rear exit of the building. She was told to ring a bell when her ride arrived, and was left alone; she fell asleep. But when she woke up, she found that she’d fallen out of the wheelchair, and had landed on her shoulder. As a result, she injured her shoulder and also suffered a head injury. She is suing for $1 million, for past and future pain, mental anguish, impairment, disfigurement, and lost wages, plus attorney’s fees.

No word, as of yet, on the status of the wheelchair.
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INTERNAL MEDICINE & SUBSPECIALTIES

INTERNAL MEDICINE
9,735 internal medicine (IM) claims were closed between 2006 and 2015. Of these, 24% resulted in payments to claimants/plaintiffs averaging $354,831. The top five IM subspecialties,* by number of closed claims, were cardiovascular disease, gastroenterology, pulmonary disease, nephrology, and oncology.

Cardiovascular Disease
2,179 closed claims, of which 27% resulted in an average indemnity payment of $248,590.

Gastroenterology
1,879 closed claims, of which 20% resulted in an average indemnity payment of $336,182.

Pulmonary Disease
1,129 closed claims, of which 15% resulted in an average indemnity payment of $327,432.

Nephrology
506 closed claims, of which 14% resulted in an average indemnity payment of $236,921.

Oncology
412 closed claims, of which 19% resulted in an average indemnity payment of $321,846.

*IM subspecialties are based on the American College of Physicians classifications.

For more detailed information, see the PIAA MPL Specialty Specific Series for Internal Medicine, Cardiovascular Disease, or Gastroenterology or contact P. Divya Parikh at dparikh@piaa.us.

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cybercrime has been a regular headline item in the national news lately, with high-profile victims as diverse as political parties, the IRS, Yahoo, Sony, and Target.

Forbes estimates that total cybercrime costs worldwide could exceed $2 trillion by 2019. It is a form of criminal activity where the returns are great, and the risks and costs are low.

What has spurred the growth of cybercrime? Aside from the obvious fact that the internet is “everywhere” and is used for “everything,” there are two reasons:

■ The degree of overlap between cybercrime and organized crime has increased greatly, and that trend is likely to continue. Years ago, the cyber criminals were geeks, cranks, or people with a grudge who made mischief for fun, for their ego, or for revenge—generally, on a fairly small scale. Now these hackers and vandals are vastly outnumbered by professional criminals. Today, there is criminal intent in the hacks, and organizations have been set up specifically to profit from the data that is stolen.

■ The “internet of things” (IOT) has made cybercrime a lot easier. Years ago, protecting against cybercrime was limited to desktop PCs and the servers they were connected to. But now, anything with internet access and a hard drive can be hacked. This includes laptops, cellphones, routers, and more unlikely products like insulin pumps, iPhone cameras, and patient monitoring equipment.

In healthcare, the advent of electronic medical records that need to be accessed by providers, payers, and the patients themselves has resulted in new opportunities for the criminals. And because of the intensity of compliance and regulations in this niche, the costs per breach in healthcare top those of all other industry groups. In 2012, 34% of data breaches in the U.S. occurred in the healthcare/medical industry; in 2013, the number had increased to 48%.

In looking at cybercrime, to borrow the vernacular of actuaries, we see a frequency and a severity problem: More and bigger attacks are commonplace, and the expectation is that this trend will continue.

So let’s examine cybercrime as a risk management challenge. In that light, consider the following equation: Risk = threat X vulnerability X cost.

The threat
Cybercrime can take many forms, too numerous to mention here. It is estimated that more than a million malware threats are distributed each day, and that 34% of computers have been subject to cyber intrusion attempts (not all successfully).

The five methods of cybercrime that are apparently used most often are:

■ Phishing. This is where an e-mail is sent from a seemingly legitimate source (like your boss, or a UPS tracking e-mail), but when it is opened, it provides criminals with access to the network for whatever purpose they have in mind. Phishing e-mails are particularly hard to detect by software. Defense against them relies on users who have been trained to look critically at their incoming mail before it is opened and notify their IT department of anything suspicious. Between October 2015 and March 2016, incidence of phishing attacks rose by 250%.

■ Ransomware. Here, after the criminals have hacked into the organization’s servers, they encrypt the computer data stored there; without the key needed to de-encrypt it, the data becomes unusable. A ransom is then demanded for rendering the data readable again. Having good backups to the system may make it possible to recover most of the...
data, if the problem is detected quickly, but this is not always the case. In February 2016, Hollywood Presbyterian Hospital in Los Angeles paid $17,000 to have hackers decrypt its data—an amount not so large as to create difficulty in paying it, and probably calculated to seem like a small enough price for putting the intrusion quickly behind it.

■ Denial of service. In this stratagem, the target servers are inundated, such that they shut down and are unable to provide normal service. Like ransomware, the plan here is to obtain a payment in exchange for removing the culprit malware.

■ Lost, stolen, and dispersed devices. Lost phones, laptops, and tablets are a potential source of access to digital data. (According to the Transportation Security Administration, almost 50% of devices lost at airports are never claimed!) Computers donated to organizations that have not been “scrubbed” of data are another source of access. JPMorgan Chase, Sony, and Target were each hacked by using compromised credentials (username and password) of an employee; this method escapes intrusion detection software because the hackers looked like valid users. Once logged in, they were then able to pivot and access the majority of servers on the network.

■ Compromising servers. Software can be installed on servers that will cause them to malfunction. Or, having penetrated the server security, the objective may be the theft of data. InfoWorld recently reported that “…hackers sold access to over 170,000 compromised servers since 2014, a third of them in the U.S…for as little as $6,” acting as “wholesalers” to other criminals.

The vulnerability

■ The internet of things. The proliferation of connected devices, for a host of uses, that are scattered throughout the organization, including mobile devices that can be lost or stolen, has added to the exposure. Gartner technology research predicts that the number of “things” connected to the Internet will grow from 6.4 billion in 2016 to 21 billion by 2020. And while security should be a part of deploying PCs, these devices are often put into service with the default settings left in place.

■ Lack of preparedness. In a survey conducted by Ernst and Young, 91% of executives said that being prepared for a cyber-attack was essential. But 75% of those same executives, by their own admission, said they were not prepared, and 55% said they lacked sufficient awareness, analysis, and assessment of the situation in their organizations.

■ Human error. There are many examples: users not trained to watch for phishing e-mails, system administrators placing devices into service with the login left at the default “admin/admin,” and users jotting down their access credentials on a sticky note and attaching it to their computer. Software bugs can create security holes. And lost devices also come under this heading.

The cost

According to a survey conducted by the Ponemon Institute of Cyber Crime, the average cost of a data breach rose from $3.79 million to $4 million between 2015 and 2016. Each record lost because of a “malicious or criminal attack” cost an average of $236. In addition to the direct costs of the fix, there are obvious consequential recovery costs.
Five key actions to address cybercrime

Cybercrime is a new issue and one that, all too often, can make managers’ eyes glaze over. They don’t understand the technology or the implications, and so they let “others” take care of it. While the technology and the methods are indeed complex, from a management perspective, C-level executives should understand the five high-level key actions that they need to enforce in talking about cybercrime to their IT staff, who will serve as their subject matter experts in this area.

■ **Count.** This is the first step for any organization. Inventory all authorized and unauthorized hardware and software assets that are connected to the internet. Many companies do this for PCs and laptops but don’t extend the effort to the growing number of connected devices that are used by their employees.

■ **Configure.** Hardware as it leaves the factory is designed for ease of access. It is for the buyer to implement security as it is deployed. The Sony servers that were hacked had the user name and password as “admin” and “admin!”. In addition, there is a fast-growing industry in anti-cybercrime software—it has become such a large segment of the industry that there is an exchange-traded fund (symbol: HACK) for it, which rose 19% in 2016. These early detection products track the users with access to the network, detect viruses, and monitor networks.

■ **Patch.** Cybercrime prevention is a moving target. The bad guys come up with new threats every day. Applying patches to software as rapidly as possible is a critical part of the risk management plan.

■ **Control.** Administrative privileges need to be restricted to the extent possible. Password change enforcement needs to be in place. Access to the network should be mapped for each user according to his needs—not left open. And network security should be challenged and penetration tested; there are outside vendors who can provide this service. Also, the use of cybercrime prevention software to detect intrusions, or intrusion attempts, is one element in control.

■ **Repeat.** Most important, these steps are not processes in a one-time project. They need to be ongoing and monitored.

**Cybercrime and insurance**

PIAA members have two distinct interests in cybercrime: protection of their own digital resources, and increasingly, providing cyber coverage for their clients.

If the increase in cybercrime currently predicted come to pass, providing cyber coverage will become more complex compared to what it is today: Usually a low, flat-rate premium is charged, or the coverage is provided “free.” However, the policy language will need to be adapted as exposures change, and inevitably, cyber coverage will become a greater focus for risk management, and the underwriting process will need to be applied to it.
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A new Congress is sworn in every two years, and with it come new opportunities and challenges. Whether the party currently in control is strengthened or tossed out, however, strategies, and sometimes even priorities, must change.

For this reason, PIAA reaches out to its members via a Government Relations survey shortly before each new Congress begins. Just as circumstances change in Washington, D.C., periodically, they also change for the medical and healthcare professional liability (MPL/HPL) community. By surveying your organization, we can determine whether our focus will need to change to meet your most pressing legislative and regulatory needs.

2017 survey
The Government Relations survey focuses on four key areas of PIAA interaction with several levels of government: federal legislative, state legislative, federal regulatory, and state regulatory. Each time we conduct the survey, we add new questions, and delete old ones, from each of these categories to ensure that we are only asking about the most important issues. We also ask how we can best communicate about what is happening inside the various levels of government. All this information allows us to tailor our approach to government relations in a way that best serves the broadest possible range of PIAA members.

Federal
Our federal legislative advocacy program has consistently ranked as the most important thing we do—and results from the 2017 survey were no different.

Overall, PIAA members indicate that their highest federal legislative priority is ensuring that bills detrimental to MPL/HPL do not move forward. PIAA monitors for such activity closely, and we acted recently in this regard. A bill to strip the McCarran-Ferguson limited antitrust exemption from health insurers was advanced in the House of Representatives. Because of previous PIAA advocacy, the bill already contained specific language excluding property/casualty insurers from the proposal. When an amendment was offered to include MPL/HPL insurers in with health insurers, PIAA collaborated with other industry associations to block the effort; as a result, the bill was not changed.

Regarding specific issues of concern, the survey indicated that telemedicine and pro-
protections for healthcare volunteers are the top (non-tort reform) priorities for members. I’m pleased to report that PIAA is already actively engaged on both the issues. The Good Samaritan Health Professionals Act, which provides limited immunity for uncompensated healthcare providers serving victims of federal disasters, remains a top priority. Most recently, we negotiated a minor amendment to the bill to help secure additional medical community support. We also lobbied extensively to get the bill reintroduced in both the House and Senate, and to secure bipartisan co-sponsorship in both chambers. As a result, we are well positioned to advance the bill during the 115th Congress.

Telemedicine presents some different challenges. While our members are most concerned about the liability implications of expanding telemedicine, many on Capitol Hill and within the medical community are focused on other aspects of this growing technology. For this reason, PIAA has reached out to connect with telemedicine thought leaders and advocates to educate them on our liability concerns. We’ve also contacted the Members of Congress doing the most work on this issue. There is no consensus yet about how to address telemedicine liability issues, but we have secured a seat at that table as this issue moves forward.

Considering the federal regulatory front, members also prioritized proactive efforts to prevent regulations harmful to MPL/HPL from moving forward. Among their specific concerns are the potential for federal regulation of insurance, Medicare reporting requirements, and National Practitioner Data Bank (NPDB) guidelines. Once again, PIAA is already working on all of these issues.

As part of our outreach efforts to the Administration, regardless of who is in charge, we’ve focused heavily on the Federal Insurance Office (FIO) and its Federal Advisory Committee on Insurance (FACI). While neither has any regulatory authority over the industry, FIO is the most likely pathway where such an effort might start. This is why we have established relationships within FIO, and attend every FACI meeting, to ensure that we are up to date on their current and future plans.

Medicare and NPDB reporting have long been areas of focus for us as well. We have well-established ties to the NPDB leadership, and regularly communicate with them about diverse issues of concern to the MPL/HPL community. Medicare reporting provides an even more recent example of PIAA engagement. As part of its obligations for renewing that reporting requirement, the Centers for Medicare & Medicaid Services sought public comments about the program. PIAA was the only organization to respond, submitting formal comments on ways reporting guidelines could be reinterpreted to prevent interference with informal patient assistance programs.

State
The most significant focus at the state level, survey responses indicated, was the National Association of Insurance Commissioners (NAIC). Members stated emphatically that PIAA should continually monitor and report on NAIC actions, especially those of the Affordable Care Act-Medical Professional Liability (ACA-MPL) Working Group and the Cybersecurity Task Force. As our members already know, we’ve been very engaged with both entities for some time.

Most recently, PIAA weighed in on the ACA-MPL Working Group’s 2017 work plans, recommending a study of what claims data is already being collected and how it is currently used. As we noted in our letter to the Chair, Superintendent Franchini of New Mexico, “Knowing exactly what information is available, and whether or not it has clear utility, should be the Working Group’s first step” in determining what, if any, NAIC action is appropriate regarding MPL closed-claim data collection.

The Association has also submitted formal comment letters to the Cybersecurity Task Force and been a participant in its conference calls. All along, PIAA has emphasized that any cybersecurity standards must not lead to conflicts with standards with which MPL/HPL insurers are already in compliance (most notably, HIPAA). PIAA has also recommended that the standards consider the resources available to insurers for implementing data protection, that insurers not be held accountable for the actions of third-party vendors, and that breach notification notices not be subject to prior approval of every state where a potentially affected individual may live. Our efforts to shape the NAIC’s cybersecurity standards are ongoing.

We realize that many companies already have well-established state legislative lobbying activities in place. The survey indicates, however, that one area where some members could use help is in developing new legislation for state use. Thus, PIAA has several model bills already available on its website and more are in the works.

Communications
Another area covered by the survey was communications—both ours with you and yours
continued on page 26
Providing expertise and resources to support strategic decision making beyond the reinsurance transaction
A hospital is generally immune from liability for the alleged negligence of physicians who are not in its employ. However, a recent Connecticut Supreme Court decision has broadened a hospital’s exposure such that it now includes vicarious liability for alleged negligent acts committed by non-employed physicians, based on the theory of apparent agency. This decision affirmed that apparent agency applies in tort cases including medical professional liability (MPL) lawsuits. The court discussed two standards (one of which is new) for holding a hospital vicariously liable.

Underlying facts
In June 2016, the Connecticut Supreme Court decided an appeal involving an MPL action brought by plaintiff patient against multiple defendant medical providers, including a surgeon, his medical practice, and the hospital where a gastric bypass surgery was performed. The patient alleged that the surgeon negligently failed to remove a surgical sponge from her abdominal cavity. The patient further asserted that the hospital was directly liable and vicariously liable for the surgeon’s negligence, based on the theory that the surgeon was an agent or employee of that hospital. To this end, the patient asserted that she had assumed the surgeon was an employee of the hospital, because he maintained privileges there and because she had relied on that supposition in choosing that hospital as the site for her surgery.

The patient argued that she chose to consult with this surgeon after her research had indicated that he was the “best” Connecticut physician for gastric bypass surgery. She also knew about the particular surgeon because he had successfully performed the same procedure on her partner’s mother. Before she was accepted as a patient, she attended a series of informational seminars at the hospital conducted by the surgeon and his staff. The patient was also given a pamphlet prepared by the hospital, which specifically stated that the healthcare team would provide necessary information and care before and after the procedure.

The patient underwent the gastric bypass procedure on December 8, 2003. Six years later, on August 6, 2009, a foreign material was seen on a CT scan (performed after a
breast cancer diagnosis). On September 9, 2009, the patient consulted with the surgeon who had performed her gastric bypass procedure in 2003, and he informed her that the foreign material was a surgical sponge that had been retained from the gastric bypass.

Court decision
At the trial court level, the defendant hospital moved for summary judgment, arguing that the hospital could not be held vicariously liable for the surgeon because he was not its actual agent or employee, and stating that the doctrine of apparent agency could not be applied to impose liability in Connecticut tort actions. In opposition, the patient argued that the doctrine of apparent agency was recognized in Connecticut. The patient asserted that there was a genuine issue of material fact (which must be established to warrant the denial of a motion for summary judgment) as to whether the hospital held out the surgeon as its agent or employee, and whether the patient had relied on that representation. The trial court granted the hospital’s motion, holding that Connecticut did not recognize the doctrine of apparent agency in tort cases. Plaintiff appealed, and the appellate court affirmed.

The Connecticut Supreme Court then agreed to review the issue of whether the appellate court had properly concluded that the doctrine of apparent authority is inapplicable in tort actions. The court reversed the lower court decisions and remanded the matter, after establishing a new standard for the application of the doctrine of apparent agency in tort actions, a standard that encompasses MPL lawsuits.

The court acknowledged a distinction between apparent authority and apparent agency by explaining that “…the doctrine of apparent authority expands the authority of an actual agent, while the doctrine of apparent agency creates an agency relationship that would not otherwise exist.” Despite this distinction, the court held that the two terms can be used interchangeably and noted that both terms apply in tort actions. This holding may significantly impact MPL risk, as explained below.

The court ruled that two tests could be used to determine whether there is apparent agency in tort cases. The first test requires the plaintiff to establish that: (1) the principal held itself out as providing services, (2) plaintiff selected the principal based on the principal’s representations, and (3) plaintiff relied on the principal in selecting the specific person who performed the services, which resulted in harm. This test can apply when the hospital chooses a provider to treat the potential plaintiff.

The second test, which established a new standard, requires that: (1) the principal held the agent or employee out to the public as possessing authority to engage in the conduct at issue (or knowingly permitted the agent/employee to act as if he had such authority), (2) plaintiff knew of such acts by the principal and actually and reasonably believed that the agent/employee had authority, and (3) plaintiff detrimentally relied on the principal’s acts. The requirement of detrimental reliance limits the scope of this new standard, by requiring the plaintiff to prove that she would not have used the services of the agent/employee if she knew that the agent/employee was not the principal’s agent/employee. Importantly, the court acknowledged that only rare tort actions would fulfill this new standard involving detrimental reliance, which was traditionally a contract, not a tort, theory.

The Supreme Court remanded this action to the trial court to give the plaintiff patient an opportunity to “set forth facts and evidence capable of raising a reasonable inference that she would not have allowed [the surgeon] to perform the surgery if she had known that he was not [the hospital’s] agent or employee.”

Significance of the decision
This decision opens up an expanded scope for hospital MPL risk. Although it appears that the court intended that the theory of apparent agency be applied narrowly in tort cases going forward, plaintiffs will no doubt attempt to tailor the evidence and testimony in their case to meet the criteria in the court’s ruling. The new standard is essentially a further expansion of the principle in which hospitals are held vicariously liable under the doctrine of respondeat superior, which holds an employer vicariously liable for acts of an employee that occurred within the scope of employment.

In addition, although the court did not emphasize the distinction between apparent authority and apparent agency, its further explanation of the difference may be significant, since it appears to justify the creation of the new standard. The court expressed that the doctrine of apparent authority holds a principal vicariously liable for an actual agent who acted within an expanded scope of authority. This highlights a more traditional interpretation of vicarious liability in which, for example, a hospital is held vicariously liable for the acts of a provider who was selected by the hospital to treat the patient.

The court’s comparison with the doctrine of apparent agency seemingly broadened the scope of vicarious liability significantly, by indicating that an agency relationship may be created or discerned where it
would not ordinarily exist. This interpretation is what may now be used to hold a hospital vicariously liable for a non-employed physician, an individual who plaintiff argues appeared to be an agent but was not nor intended to be. Still, it appears that the court intended that the latter new standard be applied narrowly: It requires that the specific aforementioned tests be fulfilled. Hopefully, the limited intent will prevent the further expansion of MPL risk. The true extent of increased risk will remain unclear until further decisions that rely on this new standard have been rendered.

While the implementation of the new standard remains to be seen, it may be beneficial for hospitals to be aware of the following circumstances that may give rise to greater risk of vicarious liability under the apparent agency doctrine. Hospitals that use non-employed physicians to staff departments and on-call positions may have heightened risk, since current practices may create a facade that a given physician is an agent or employee. Hospitals may also have increased exposure when they arrange services for admitted patients with privately employed physician specialists or other rehabilitation or nursing home facilities. These situations inherently involve reliance on individuals who may appear to be agents or employees of the hospital but are not.

So it may be advantageous for hospitals to assess their protocols in light of this new decision. Hospitals might also consider modifying marketing plans for non-employees, admission forms, MPL insurance policies, and other materials that may create opportunities for inadvertent misrepresentations of agency/employment relations. It is not yet clear if posting signs or disclaimers will be held to reduce or limit potential liability, but initiating such practices may be good measures for demonstrating to the court what is being done in an effort to do so. The institution of new hospital procedures and practices may help limit or prevent increased liability risk stemming from any inadvertent representation of physicians as agents or employees until the courts establish clearer precedent based on the new standard.

Hospitals may also have increased exposure when they arrange services for admitted patients with privately employed physician specialists or other rehabilitation or nursing home facilities. These situations inherently involve reliance on individuals who may appear to be agents or employees of the hospital but are not.

For related information, see www.mcbiew.com.

References
2. Id. at 772.

LEGISLATIVE UPDATE CONTINUED FROM PAGE 22

Changes is the introduction of a new “grassroots” feature. This will allow you to quickly send comments to your Member of Congress or Senators regarding pending federal legislation. In addition, you can use it to enhance your own state advocacy efforts. Coordinating with you, PIAA will be able to create a grassroots campaign dedicated to a specific legislative issue in a given state. All you need do is share the appropriate link with anyone you like, and they can send a message to their state legislator at the click of a button. For those members without their own grassroots operation, this feature will greatly expand the capacity to influence state legislators. For those with an operation already in place, this feature could save significant sums if they choose to utilize the PIAA-supplied service instead of using an outside vendor. For more details, contact the PIAA Government Relations Department, governmentrelations@piaa.us.

Conclusion
The biannual Government Relations survey is a very useful tool for PIAA: It helps us stay on track in representing your needs. The latest survey let us know that we are already targeting your most significant priorities, and told about some additional issues of concern to you. But it is not our only tool. We also have monthly town hall conference calls that are open to all PIAA members, and quarterly meetings of our Government Relations Committee, to help in establishing priorities. Of course, we are also available, by e-mail or phone, any time you need to contact us. Whether you took the survey, joined a town hall call, or simply sent us a note with your thoughts, we greatly appreciate your feedback.
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**Delphi Reporting & Analytics**

Delphi Reporting & Analytics is designed to enable all levels of users to create and maintain reports of varying complexity based on the data from Delphi Policy, Delphi Claims, Delphi Billing, or from other data sources.
A 44-year-old woman was under the care of an obstetrician-gynecologist. She had no active medical problems and three children, ages 13, 11, and 9. Her maternal grandmother had died of breast cancer at age 64, and her mother had been treated for ovarian cancer.

Based on her family history, she had undergone yearly mammography for the past four years. The mammograms showed increased breast density, but were interpreted as negative for disease. Then, approximately nine months after her most recent mammogram, she discovered a lump in her left breast. She was diagnosed as having breast cancer; she underwent surgery, radiation therapy, and chemotherapy, but subsequently died of her disease, three years after diagnosis.

Her spouse filed a medical professional liability (MPL) lawsuit against the patient’s obstetrician-gynecologist and the radiologist who had interpreted the mammograms, alleging a delay in diagnosis. At trial, the plaintiff’s expert witness pointed to an anomaly on the patient’s most recent mammogram that was located in the area where the cancer arose and testified that the mammogram had been misinterpreted. He also testified that the patient should have undergone genetic testing to determine if she had a BRCA mutation. The jury found against both physicians and awarded the family $4 million.
Delay in diagnosis of breast cancer is one of the most common, and most expensive, types of MPL lawsuits. According to PIAA data, although most patients who develop breast cancer are over the age of 50, most breast cancer-related lawsuits are filed by women who are under age 50. This apparent paradox is explained by two factors. First, the disease is often more aggressive (and therefore more likely to be fatal) in younger patients. Second, plaintiff’s attorneys prefer cases in which juries are likely to award large sums of money, as commonly happens when a case involves young children who lose a parent. Because the outcome of these lawsuits often hinges on the retrospective analysis of a mammogram, they can be very difficult to defend.

Although mammography is a useful screening tool, it is far from perfect. Mammographic sensitivity (the capacity of mammography to visualize cancer) is approximately 80% among women with predominately fatty breasts, but only 40% in women who have extremely dense breasts. Because dense breast tissue is more common in younger women, mammography is least reliable in the patients who pose the greatest potential risk for an MPL claim.

To address this shortcoming, mammography is sometimes supplemented with sonography or MRI. Although these measures can help in detecting additional cancers, they may also reveal areas of concern that are not cancer but that necessitate additional imaging studies or biopsy, and thereby expose healthy patients to additional risks.

A potential solution is to change the nature of our approach in a fundamental way. Rather than waiting for a cancer to develop and then trying to detect it with sufficient time to successfully treat it, a much more effective approach would be to identify those patients who are likely to develop breast cancer and intervene before they do so. This is the promise of genetic testing.

Although most breast cancers are not related to the BRCA genes, patients who possess a pathogenic BRCA mutation have a 50% risk of developing breast cancer by age 50 and an approximate 85% risk of developing breast cancer in their lifetimes. In terms of improving patient care and also reducing MPL exposure, it is imperative that these patients be identified.

To facilitate this, genetic testing for BRCA mutations is currently recommended by numerous entities, including the American College of Obstetricians and Gynecologists and the National Comprehensive Cancer Network. Because BRCA mutations are relatively rare (affecting approximately 1 out of 400 people in the general population), testing should be limited to patients who have positive family histories.

The basic criteria are summarized in Table 1.

<table>
<thead>
<tr>
<th>Table 1. National Comprehensive Cancer Network: Basic Criteria for BRCA Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>One first- or second-degree relative diagnosed with breast cancer at or under age 45</td>
</tr>
<tr>
<td>One first- or second-degree relative diagnosed with ovarian cancer</td>
</tr>
<tr>
<td>Two breast cancers on the same side of the family, one diagnosed in an individual under age 50</td>
</tr>
<tr>
<td>Three breast cancers on the same side of the family, diagnosed in persons of any age</td>
</tr>
<tr>
<td>One first- or second-degree relative diagnosed with triple-negative breast cancer at or under age 60</td>
</tr>
<tr>
<td>Three relatives on the same side of the family with any combination of breast, ovarian, pancreatic, or prostate cancer</td>
</tr>
<tr>
<td>Known BRCA mutation within the family.</td>
</tr>
</tbody>
</table>

Discrepancies in genetic tests

Although genetic testing holds great promise, it also raises several MPL concerns. First, it has been estimated that up to 14 million women in the U.S. meet the criteria listed in Table 1, of which only 1 million have been tested for BRCA. This is problematic, because many of these women are BRCA positive, at high risk of developing cancer, and do not know it. Should they remain untested and untreated, develop cancer, and then file an MPL lawsuit, their cases will be nearly indefensible.

This was the situation in a Connecticut case from 2012; the case summary at the beginning of this article is based on it. Given the risks to both patient and physician, it is imperative that patients who

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GENETIC TESTING

and the case was settled for $2 million.8

BRCA
outside laboratory determined that she did not have a
both tested negative. The patient then underwent repeat testing, and an
breasts, uterus, and ovaries removed. When the patient's parents were
ing that they can simply follow the insurer's directive to use an inferior
insurer's lab is of high quality, this is neither a medical nor a legal
that lab is less expensive. As long as the physician is satisfied that the
is sent to a lab of the insurer's choosing—typically selected because
insurance company may not cover
in making this determination are listed in Table 2.
they use are capable of producing accurate results. Factors to consider
burden is (unfortunately) on clinicians to ensure that the laboratories
structure that would standardize genetic testing. In the interim, the

Table 2. Factors to Consider in Evaluating Laboratory Quality

- Percentage of the gene evaluated
- Depth of the intron sequenced
- Database and algorithms used to interpret variants
- Analytical sensitivity and specificity
- Operating history, supporting data, and quality control measures
- Commitment to variant reclassification when new information is discovered
- Communication of both the initial result and any follow-up results

In an Ohio case, a 48-year-old woman underwent genetic testing
at a local lab, and the result was positive for a BRCA mutation.
Believing that she was at high risk of cancer, the patient had her
breasts, uterus, and ovaries removed. When the patient's parents were
tested to determine which side of the family carried the mutation, they
both tested negative. The patient then underwent repeat testing, and an
outside laboratory determined that she did not have a BRCA mutation,
meaning that her surgeries had been unnecessary. She filed a lawsuit,
and the case was settled for $2 million.9

Due to the significant variation in test results, and consequent
potential for patient harm, the FDA is contemplating a regulatory
structure that would standardize genetic testing. In the interim, the
burden is (unfortunately) on clinicians to ensure that the laboratories
they use are capable of producing accurate results. Factors to consider
in making this determination are listed in Table 2.

The final concern of import for MPL is that the patient's health
insurance company may not cover BRCA testing unless the specimen
is sent to a lab of the insurer's choosing—typically selected because
that lab is less expensive. As long as the physician is satisfied that the
insurer's lab is of high quality, this is neither a medical nor a legal
problem. However, physicians should not fall into the trap of presuming
that they can simply follow the insurer's directive to use an inferior
lab and that the insurer is the party that will be held liable for any

harm that results. While there are certainly situations where a health
insurer could be liable, a physician is never relieved of his duty to
advocate on behalf of the patient.

As a result, when faced with a managed-care restriction that com-
promises patient care, physicians should weigh the degree of risk and
assess the alternatives—and then make a reasonable effort to over-
come the restriction, documenting their efforts. In some situations, the
risk will be so minimal that no effort is required, while in others it will
be great, and a significant effort required.

With respect to BRCA testing, an incorrect result is likely to cause
devastating consequences (a false-positive, leading to unnecessary sur-
gery; and a false-negative, leading to incorrect assurances that the patient
is not at increased risk of cancer). Given the degree of risk for both patient
and healthcare professional, it would be imprudent for a physician to sim-
ply follow a managed care company's directive and use an inferior lab.

Instead, physicians should either request permission to use
another lab, find out whether the patient can cover the cost herself, or
delay testing until the patient can make alternate arrangements. If
none of these are viable, then using the insurer's lab may be the only
choice. Although this would increase the risk of an incorrect result that
compromises patient care and quite possibly leads to litigation, the
physician would be in a highly defensible position, provided he has
documented the efforts that were made.

Conclusion

“Failure to diagnose” genetic mutations that predispose patients to
developing cancer are poised to become the next wave of MPL law-
suits. In order to limit the financial risk posed by the millions of
women who meet the criteria for such testing but have not been tested,
MPL/HPL organizations can educate their insureds about the relevant
guidelines, the importance of maintaining a current family history of
cancers, and the risks posed by both managed care restrictions and the
lack of FDA oversight. This education should target both obstetrician-
gynecologists and primary care physicians, as the latter provide some
20% to 30% of women's healthcare.  

For related information, see

Law and Medicine has created a complimentary online CME activity,

References

2. FDA Approves First Breast Ultrasound Imaging System for Dense Breast Tissue. FDA, September 18, 2012.
Proactive Blindness: The Allure (and Costs) of Reaction

BY ROBERT J. LATINO

The allure of an effective reaction to an adverse event derives from the fact that when it happens, there is adrenaline pumping and, eventually, recognition for a job well done.

Lives could have been lost, as well as significant financial losses via claims and other related costs. However, a paradigm shift is necessary to recognize the greater benefits of “proaction,” a new approach that obviates the need to react in the first place. To make this happen, proaction must become a priority, and incentives will be needed to persuade people to become part of this new type of culture.

Figure 1 indicates how the candidates for root cause analysis (RCA) are selected in the reactive, versus the proactive, paradigm. There are two proactive, analytical tools discussed here: (1)

Robert J. Latino is CEO, Reliability Center, Inc.
failure modes and effects analysis (FMEA) and (2) opportunity analysis (OA). Clinicians on the front lines can use these to make a business case for proaction.

FMEA and OA are field-tested tools, in essence, two approaches to risk assessment and prioritization. They identify things that could go wrong, and they assign quantitative values to those potential. This will be a measure of risk. At some point in this type of analysis, we will draw a line and say everything above that point is an unacceptable risk, and below it, is a risk we are willing to live with and mitigate if possible.

**FMEA vs OA: What’s the Difference?**

FMEA is not a foreign concept to high-hazard industries; it has been a regulatory requirement to formally assess risk for more than five decades. The requirements are quite rigid in the high-hazard industries and a critical step in any reliability and environment, health, and safety strategy.

While variations of FMEA exist, Figure 2 is intended to express the basic concept. The universal measure of Risk is Severity (S) x Probability (P) = Criticality (or Risk Prioritization Number [RPN] in healthcare). Different industries use different value tables to measure these parameters. Regardless, they end up quantifying risk.

An FMEA is a tool that puts a magnifying glass on a “process flow” (either new or already in place) and analyzes what could go wrong within each process step. It lets us determine the impact on the overall process if a given failure mode were to occur. After that, it becomes a subjective evaluation on the Probability (P) the failure mode will occur and its Severity (S) if it were to occur. As Figure 2 indicates, it lets us look into a crystal ball and predict what might happen in the future. Certainly, our experiences in the past will play into that subjective evaluation of the future.

An FMEA can be applied to any business in any industry; the framework is applied in the same way. Every organization is a “system” (inputs > transformation > outputs), so where FMEA is applied is not of significance.

When such an analysis is completed, the analyst can sort the items in the “criticality” column from highest to lowest. One way of “drawing the line” between acceptable versus unacceptable risk, is to figure the sum for the criticality column, and multiply it by .80. Then, we can add up how many of the top failure modes (rows) it takes to equal or exceed the 80% number totaled in the “criticality” column.

Wherever this point falls, the identified risks above the line are deemed “unacceptable” and will require further, deep-drill analysis using tools like RCA to determine why the risks are so high. This is truly a proactive application of RCA: no failure has yet occurred. We are using the RCA to minimize the risk that such potential failures will actually occur.

Let’s contrast this procedure to an OA, as seen in Figure 3. While an OA is typically not a regulatory requirement, it may be deemed a recommended best practice. This is the reason why most people likely have never heard of this tool. It is a sister analysis to the FMEA, but instead of predicting the future, it relies on looking in the rearview mirror to see what has happened, not what might happen.

Notice that the calculation in this case is
based on failures that have occurred (usually in the past 12 months) that have met some predetermined definition of failure. Samples of these include:

- Any event or condition that has resulted in a claim paid due to a surgical misadventure
- Any event or condition that has resulted in an adverse drug event (ADE)
- Any event or condition that has resulted in a blood redraw in the ER.

Defining what constitutes a “failure” in the process analyzed establishes the scope for the entire analysis. This is necessary in order to maintain our focus on what is important to us, at the time.

In these cases, the analysis teams (usually made up of those closest to the work) identify events they have encountered in their daily work that have met the definition of failure in each process step. The facilitator will simply ask, “How often does that happen in a year?” And then, every time it does happen, “How long does it take to get back to normal operations and what costs are incurred during this interval?”

Notice in these examples how the frequency factor sheds new light on the true cost of seemingly insignificant chronic failures. When these happen one at a time, no one usually cares because personnel were not hurt and the costs of each event were minor. They are hidden in plain sight in our budgets. The blood redraw line item is a classic case of a chronic failure that is perceived as a normal cost of doing business and therefore considered acceptable.

This type of analysis will provide the raw data to be able to determine the cost of inefficient labor (because they had to react and could not be doing more productive work), the costs of extended lengths of stay (or what we call “lost profit opportunities”), and the costs of any materials that were used to get back to where we were before. If claims were paid in such cases, they were paid in addition to the costs just described, which normally go unnoticed. The simple calculation here is Frequency/Year x Sum of the Impacts/Occurrence = Total Annual Loss (TAL).

Then the lead analyst does the same sorting as he did with the FMEA, summing up the TAL column in this case, and arriving at the 80% number. Usually 20% or less of the Failure Modes (rows) will equal or be greater than 80% or more of the TAL (the Pareto Split in Figure 4). In an OA (and FMEA), these are now the quantified and qualified candidates for a thorough RCA.

### Figure 3. OA Basic Spreadsheet

<table>
<thead>
<tr>
<th>Sub System</th>
<th>Event Mode</th>
<th>Frequency</th>
<th>Impact/Occurrence or Severity</th>
<th>Total Annual Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis, Interview, Evaluation or Consultation*</td>
<td>Claim Paid</td>
<td>Diagnosis Related Error</td>
<td>13</td>
<td>$234,038</td>
</tr>
<tr>
<td>Patient Oversight*</td>
<td>Claim Paid</td>
<td>Failure to Supv/ Monitor Case</td>
<td>8</td>
<td>$237,500</td>
</tr>
<tr>
<td>Prescriptions of Medications*</td>
<td>Claim Paid</td>
<td>Medication Errors</td>
<td>7</td>
<td>$299,826</td>
</tr>
<tr>
<td>Blood Drawing in ER</td>
<td>Excessive Blood Redraw Costs</td>
<td>Blood Culture Contamination</td>
<td>480</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

*ELOS=Extended Length of Stay

### Figure 4. Determining the “Significant Few” The Pareto Split

<table>
<thead>
<tr>
<th>Sub system</th>
<th>Event Mode</th>
<th>Frequency</th>
<th>Impact Per Occurrence or Severity</th>
<th>Total Loss/Yr</th>
</tr>
</thead>
</table>

The Pareto Split

80 / 20 (or less)

% 35% 65

% EVENTS

Grand Total = $1000

Pareto Cost = x $50

Significant Few = $ 800

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**OA case study results**

In the explanation of the OA tool shown in Figure 3, we cited a few line items to demonstrate how to fill in the blanks with relevant data. The blood redraw line item was actually the subject of a published case study that is quite persuasive in demonstrating the OAs’ capacity to express astounding returns on investment (ROIs)* that result from the identification of chronic failures in a process.

Figure 5 shows the summarized results of this case study: blood redraws in the ER were costing more than $3 million annually. Here, the OA was done because they wanted to do it, not because a regulation compelled them to do it. After this analysis, redraws became a candidate for RCA; before, they were not.

To me, the OA is the more valuable tool, because it makes it easy."
to determine ROI rapidly. The “Frequency/Year” column is what allows the chronic failures to bubble up to the top and catch the eye of CFO types (and other Cs). These chronic failures are eating our lunch and are typically contributing factors/root causes in more serious events that occur, ones that frequently result in claims (and claims paid). So conducting this sort of proactive analysis is indeed an effective approach to preventing unnecessary liability, and thus claims as well, in the future.

Summary
To summarize (Figure 6), the OA is historical and deals with factual evidence (because these events have occurred). The reason we still call it “proactive” is because the chronic nature of the failures it identifies are failures that are generally viewed as acceptable because we have learned to compensate for them.

The FMEA on the other hand is truly proactive as it looks to tomorrow and seeks to identify unacceptable risks before they materialize.

Using both of these tools together, as part of an overall reliability strategy, is key to shifting from a reactive culture to a proactive one. This will allow us to “control the fix, instead of the fix controlling us.” High reliability organizations have an obsession with “failure,” whether they are sporadic/acute in nature or repetitive and chronic.

Business case tools like these make it easier to correlate the impact of failures in our work flows to our financials. Since we are usually seeking funds from our budgets to pursue these opportunities, we need to speak the language of finance so they can see the potential returns. These tools also allow us to show the cost of inaction.

Tools like OA and FMEA help us view healthcare as a system and a science. They also allow us to take action right now, in order to make a quantum difference not only in patient safety, but on our bottom lines as well. Dr. Peter Pronovost says that the fundamental problem with the quality of American medicine is that we’ve failed to view the delivery of healthcare as a science.1

Unfortunately, if we don’t use these types of analytical tools, it is nearly impossible to find and quantify these opportunities. There is no line item on our balance sheet or income statements for the specific annual costs of chronic failures or the cost of not acting on a high risk.

Remember, “We NEVER seem to have the time and budget to do things right, but we ALW AY S seem to have the time and budget to do them again.” Together, using these basic tools, we can defeat this paradigm and make a difference to our patients now.

For related information, see www.reliability.com.

References
“Birth is a blessed event…”

As neonatologists, we are acutely aware of what the birth of a premature or critically ill full-term newborn means for that patient, the patient’s parents, and the extended family. Our colleagues in obstetrics, maternal-fetal medicine, anesthesia, and nursing share in this awareness, as pregnant women can also experience adverse outcomes of their own. Somehow, that comforting, private delivery room environment must also support, often at a moment’s notice, the human and technical resources that are needed when the life of the newborn or of the mother is at stake.

Taking a cue from professionals working in the fields of human factors/ergonomics and systems engineering, we have embarked on a project to design the labor and delivery room of the future, a space that not only meets the needs of healthy mothers and newborns but also facilitates the performance of healthcare professionals who must respond in times of crisis. This work is funded by a grant from the Agency for Healthcare Research and Quality, the federal agency

Optimizing Labor and Delivery for Maternal and Neonatal Safety

The birth of a child should be a time of great joy for every parent, and tremendous efforts have been made to make the hospital delivery room an environment that is as comforting and private as possible for the mother, partner, and newborn. While most of the time, healthy babies are born to healthy mothers, in a small number of situations this ideal circumstance does not occur.

By Louis P. Halamek, MD, FAAP, and Henry C. Lee, MD, FAAP

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charged with supporting research that enhances the quality of patient care and improves patient safety. This funding has allowed us to assemble a multidisciplinary team of professionals possessing a diverse range of valuable skills; this team includes, but is not limited to, physicians, nurses, industrial design specialists, architects, and sociologists. Together, we are examining all aspects of the delivery experience, from the perspectives of everyone involved, including the patients.

The process that we have undertaken from the beginning is relatively simple. We start by describing the tasks that need to be carried out to facilitate a safe birth. Once we have described a particular task, we develop a list of the human and system resources required to successfully accomplish that task. We have developed an extensive understanding of the current state-of-the-art in labor and delivery design by conducting site visits at multiple California hospitals, and we have found that there are a number of aspects of caring for pregnant women and their newborns that have eluded efforts to optimize the patient experience while simultaneously maximizing the ability of the healthcare professionals to provide safe, efficient, and effective care under any and all circumstances.

As we refine ideas, we build prototypes of environments or devices and test those at the Center for Advanced Pediatric and Perinatal Education (CAPE), our simulation center that is dedicated to the obstetric and pediatric sciences. CAPE replicates an actual delivery room with a high degree of realism, including the medical equipment, supplies, patients, and healthcare professionals necessary to effectively simulate labor, vaginal birth, cesarean delivery, and neonatal resuscitation and stabilization. CAPE is equipped with numerous high-definition, pan-tilt, remote control cameras and sensitive, adjustable-gain microphones that allow us to create an audiovisual record of how healthcare professionals interact with the patients, devices, and other aspects of the labor and delivery environment. This record, along with other data sources, can then be used to drive the design of additional iterations of the prototype. This process is facilitating the design of both new products for which we are currently seeking patent protection and new spaces, including a labor and delivery room, an operative delivery (cesarean section) room, and a fetal transition suite.

Design, then simulation
Intense discussion and iterative design, followed by realistic simulation, allow us to “fail quickly” and effectively troubleshoot small problems before they can become big complications. We believe that our ongoing emphasis on patient safety throughout this process will produce innovative designs and novel technologies that will greatly enhance human and system performance. By examining the process of birth from many different viewpoints, we believe that we can achieve the goal of designing an environment that is not only comforting to families, but also conducive to optimal human and system performance, particularly during emergencies.

Although our process is simple, that does not mean that it is easy. Many of us on the investigative team have worked in and around labor and delivery for decades. While beneficial in some ways, this experience can also make it difficult to recognize when our thinking is being restricted by the limitations of the facilities in which we have worked, some of which were designed more than three decades ago and are now inadequate for the delivery of state-of-the-art care. Only by being vigilant as we listen to each other and willing to challenge any failure to discriminate fact from opinion can we accomplish truly innovative design.

One of the most challenging aspects of work in this area is designing an environment that accommodates the needs of women giving birth during a normal labor as well as those who experience...
complications that affect either their newborns or themselves. An example of this is the area provided for the neonatal resuscitation team to care for a newborn in distress. In many hospitals, women experience labor and delivery in the same room. When a healthy newborn can be given to the mother to hold at the time of delivery, there is little need for additional space to accommodate the newborn’s needs, as those needs are met, for the most part, in the mother’s arms. But when a newborn is delivered and requires resuscitation, additional space is required for the healthcare professionals, equipment, and supplies that are necessary to save the newborn’s life.

During the most complex neonatal resuscitations, the newborn requires placement of an artificial airway (intubation), chest compressions, intravascular access (umbilical vein cannulation, intravenous needle placement), and vasoactive drug and fluid volume administration. Performing these procedures in a timely manner typically requires five or more healthcare professionals just for the newborn, in addition to those present who are delivering care to the mother. Based on our observations of various units (including our own), in many instances this aspect of neonatal care does not receive sufficient attention in the design of labor and delivery units.

Work products
The work products that we expect to produce by the end of this study include:

■ Baseline ergonomic data as to how human beings interface with the various physical structures and medical devices in the typical delivery room
■ A list of evidence-based, innovative approaches to design, validated through the use of highly realistic simulation, that not only meets the needs of the patients but also facilitates optimal human performance by the healthcare professionals caring for those patients
■ Ideas for improving the function and integration of the various subsystems in the modern labor and delivery unit
■ Novel medical devices
■ Architectural plans and models for a vaginal delivery room, a cesarean section room, and a fetal transition suite.

What will be the ultimate outcome of these efforts? We believe that this work will produce environments and a technical infrastructure populated with medical devices that will allow healthcare professionals to deliver safer, more efficient, and more effective care, while at the same time meeting the physical and psychological needs of pregnant women and their newborns.

Disclaimer
This project was supported by grant number P30HS023506 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.
Clinical Practice Guidelines and Medical Professional Liability under MACRA

Part One. How Did We Get Here?

The Patient Protection and Affordable Care Act (PPACA)
set the stage for subsequent legislation that has led to the upheaval of the healthcare system in the U.S. Changes in the approach to delivering healthcare are ongoing. Many of the changes, such as the infiltration of clinical practice guidelines (CPGs) into medical practice, are laying a foundation for new medical professional liability (MPL) actions, but this fact has not yet been widely recognized.

This is the first of a two-part article discussing the role and need for understanding CPGs in the context of MPL litigation in the evolving healthcare delivery system. Part One will track the legislation that has mandated these changes and put into perspective the variation among the several CPGs and some of the shortcomings for patient care delivery. Part Two will discuss CPGs with regard to the unrealized risks that are developing, as their role becomes increasingly significant in patient care, to substantiate the reimbursement of physicians and other healthcare professionals. It will also put CPGs into perspective concerning their use in MPL litigation, so they can be properly interpreted by a medical expert.

The changing healthcare system: focusing on “quality”
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was initially passed on March 26, 2015, by the U.S. House of Representatives, and then by the Senate on April 14 by an overwhelming majority vote. MACRA was officially signed into law by President Obama on April 16, 2015.

This bipartisan legislation made radical changes in the procedures for reimbursing physicians for their services under Medicare. The law repealed the Medicare Sustainable Growth Rate (SGR) methodology for updates to the Physician Fee Schedule (PFS). Among other initiatives, MACRA requires the Centers for Medicare & Medicaid Services (CMS) to...
implement a two-track payment system for physicians and other eligible healthcare providers (EPs) that replaces the current fee-for-service (FFS) reimbursement system. EPs currently include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and groups that include these healthcare professionals.

The new payment system will be known as the Quality Payment Program (QPP). The proposed regulations for implementing the QPP were issued by CMS on April 27, 2016, with the final rule published on October 14, 2016. Interestingly, a recent Deloitte survey showed that only a minority of physicians and healthcare providers are aware of, much less understand, the sweeping changes expected to come over the next few years. It is imperative that healthcare professionals understand the financial dynamics that are being used to enforce reporting of quality measures and drive improvements in perceived quality of care.

The QPP is intended to reward the delivery of high-quality healthcare, instead of basing reimbursement on the roster of services provided. There are two reimbursement tracks available. EPs will need to choose either the Advanced Payment Model (APM) or the Merit-based Incentive Payment System (MIPS).

APMs are payment approaches developed in partnership with the clinical community that create incentives for physicians to participate. The goal is to move the Medicare program from a FFS model to a payment system tied to outcomes and population health. MACRA requires that APMs meet certain criteria. An APM must require the use of certified electronic healthcare records (EHRs), provide payment based on quality measures comparable to those used in the MIPS quality category, and assume financial risk for more than a nominal amount of monetary loss, or be set up as a medical home that meets certain criteria. Advanced APM providers are required to refund Medicare if their spending for healthcare services under the model exceeds a projected amount.

MIPS is based on the FFS model, and is believed to be the reimbursement model that most EPs will choose. It directly ties Physician Fee Schedule (PFS) payment, and any adjustments to those payments, to measured quality performance. Beginning January 1, 2019, MIPS becomes the default payment system for EPs; however, with several options, data collection began on January 1, 2017. MIPS consolidates three existing pay-for-performance and reporting programs. The current programs are: Physician Quality Reporting System (PQRS), Physician Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program. The consolidation of these programs into MIPS will continue to focus on cost, quality, and the use of certified EHR technology (CEHRT) in a program that avoids redundancies. The final rule has rebranded this terminology. EPs will be assessed in the MIPS under four categories: quality, resource use, clinical practice improvement activities, and advancing care information (ACI).

**CPGs: overview**

As a consequence of the requirements set forth by the QPP, CPGs will assume greater significance for future reimbursement. They will, therefore, have a potentially greater role in MLP litigation.

The National Institutes of Health database of biomedical literature, PubMed, generated 8,299 references for the term “CPGs” in English as of 2016. There is no one standard grading system that is used in developing a CPG. In fact, many exist, and they are used by different organizations and in different countries. The variation in the usability, reliability, and most importantly scientific validity among the various CPGs has led to a call for a “standardization of standards,” to the point that some have attempted to formalize the procedure for CPG development and reporting. As thousands of CPGs already exist, they have been used for sundry reasons, including MPL litigation, on both the defense and plaintiff sides, for more than 50 years. Medical associations, medical colleges, and health systems are currently very active in developing CPGs to be used for MIPS quality reporting. From the standpoint of a healthcare reimbursement, attaining the QPP parameters of each selected guideline for a particular healthcare service will determine whether an EP is granted a bonus or penalized financially for not attaining the parameters in a particular CPG.

The National Academy of Medicine (NAM), formerly the Institute of Medicine, defined CPGs as “systematically developed statements that include recommendations, intended to optimize patient care, that are informed by systemic review of evidence and an assessment of the benefits and harms of alternative care options.” Contemporary CPGs are essentially consensus statements utilizing evidence-based medicine that guides the model under which medical decisions and practice are based on the best available evidence.

Based on the NAM definition, a CPG for a given condition has two parts: (1) the foundation, a systemic review of the research evidence bearing on a clinical question, focused on the strength of the evidence on which the clinical decision-making for that condition is based, and (2) a set of recommendations comprising both the evidence and value judgments regarding the benefits and harms of alternative care options. The AGREE Collaboration, Development and Validation of an International Appraisal Instrument for Assessing the Quality of Clinical Practice Guidelines: The AGREE Project, 12 Quality Safety Health Care 2003;12:18-23. 8. Mello MM. Of shields and swords: The role of clinical practice guidelines in medical malpractice litigation. Univ PA Law Review 2001;149:645-710. 9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4458582.

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“Common factors cited by plaintiffs for pursuing litigation included dissatisfaction with cosmetic outcomes and perceived deficits in informed consent. These factors reinforce the importance of a comprehensive, preoperative informed consent process in which the specific potential risks and outcomes are presented by the surgeon to the patient to limit or avoid postsurgical allegations.”

— “Analysis of Factors Associated With Rhytidectomy Malpractice Litigation Cases,” by A. Kandinov et al., JAMA Facial Plastic Surgery, February 9, 2017

Informed Consent: Ensuring It Really Is Informed

The issue of informed consent comes up frequently in medical professional liability (MPL) lawsuits—but in a tricky way. The suit will cite a major claim, “medical malpractice,” and it will list the facts making up that claim. Or it will assert “professional negligence.” You don’t usually see cases where there is a formal allegation of “failure to obtain informed consent.”

However, if you read through the full text of complaints, you will find something related to informed consent almost every time: often, the patient is angry about something that happened that he hadn’t expected. Or he may be upset about some kind of
miscommunication—he didn't understand what he should be watching for, or understand all of what could possibly go wrong.

Emily Clegg, risk consultant with UMIA Insurance, Inc. (UMIA) works with healthcare professionals to reframe informed consent as a process of communicating, rather than as a form. Here is some guidance about what can be done to address this issue. But first, an illustrative example of what can go wrong.

Case study. A middle-aged man, David Cobbs, is suffering from abdominal pain and nausea. He goes to see his family physician, who diagnoses a stomach ulcer. The doctor brings in a surgeon, and both doctors recommend surgery. On the morning of the procedure, Cobbs is given a stack of forms and told to complete them. He signs them, and then goes into the procedure. It goes well and recovery is uneventful.

But then, Cobbs begins to feel severe pain in his abdomen. He goes back to the hospital, and the physicians there discover that he is suffering from internal bleeding due to a severed artery that arises from his spleen. Because of the seriousness of this event, he goes back into surgery for repair of the artery.

Subsequently, this becomes an MPL case. When the case went to trial, the defense said that the severed artery is a risk in his type of surgery, even though doctors of course try to avoid it.

The patient countered, "No one told me that." A month later, patient Cobbs again begins to feel pain, and a second stomach ulcer was diagnosed, and a third surgical procedure is done. He again recovers uneventfully. But internal bleeding again ensues; the cause is discovered to be absorption of a suture.

At trial, the provider explains that this can happen sometimes; doctors don't want it to happen but it does. And once again, the patient counters, "But nobody told me." In this case, all of the care was done well, and the patient was treated appropriately; but there was an unfortunate chain of events. What is lacking here is communication with the patient about what could have happened. And there is a lack of respect for the patient in not telling him what to watch for, what could happen.

From this case, Clegg draws out three "lenses" for examining informed consent. The first is the patient safety lens: Are we being careful in patient selection? Can a better informed-consent process reveal that a given procedure isn't right for a particular patient? And every patient needs to understand what's going on—what to watch for, and what to do if he is feeling that something is wrong when he gets home.

The second lens pertains to the physicians' ethical duty. They have an ethical obligation to communicate with patients about what's happening to their bodies, and their health, and their lifestyle. Considering the patient in the case study above, did he know the full plan for his care and all of its implications? Did he know what life would look like after it was done?

Did the care team fulfill its ethical duty to communicate with him?

The third lens is risk mitigation. Many lawsuits stem from breakdowns in communication: A patient was unhappy, or perhaps had unrealistic expectations or experienced an unexpected outcome, or had lingering questions that were never answered.

Focusing more attention might help avoid these issues. In regard to the patient in the case above, he should have been monitored for complications all along the way; he should have been told what the team would be watching for next, what the team would be worried about, and the possibilities for what could happen in each phase. With that, he might have not ended up filing a lawsuit.

The cycle of informed consent

Clegg coaches providers about reframing informed consent as a cycle. There's a reason why she calls it a "cycle." Informed consent is not an end point; it's not a check box; it's not a result. Informed consent is actually a cycle of back-and-forth communications, possibly over several conversations. Note that this does not pertain to the minor, routine encounters in medicine, and we're not talking about emergency care. Don't start thinking about the cycle in an emergency situation—just care for the patient.

But it is critical to think about informed consent whenever there is a chance of a complication, or a reaction—or if the treatment the physician is giving will mean a life style change for the patient. These are the kinds of things that should make a doctor think about informed consent.

Clegg explains that it would be a lot easier if the legal world would give healthcare professionals a checklist of the informed consent procedures needed. But unfortunately, that doesn't exist. It's more of a professional judgment issue that a physician needs to think through—if there are life or life-style changes involved or a chance of some sort of reaction.

For the first step in the informed consent cycle, physicians need to consider if a particular patient has the capacity to make an informed consent decision at all.

The second part of the cycle is communication. Providers should consider, what do I need to say? What is important to this patient and his or her life going forward? Clegg advises that a reasonable, patient-centered approach will serve providers better than worrying about...
what a court will think later.

The third part is comprehension: does the patient understand everything—are we getting everything through? How can we be sure? How can we check that the patient understands?

Finally, we reach consent. But consent is much more significant than a signature on a form. Consent is an agreement that we have communicated, explored questions, shared mutual expectations, and we reached a plan together.

Focus on the form misses the point

A common question from facilities focuses on the informed consent form: Does it look good? Does it cover everything I need? But in fact, focusing on the form per se is missing the point, which is the conversations you need to have with the patient.

Consider the basic time line of a surgical patient: pre-op visit, signing of forms, the procedure, post-op period in the hospital, discharge, and post-op visit to a clinic. Where should the informed consent conversations happen? They should happen at every step along the way.

As Clegg advises, informed consent starts at the initial visit, where the physician asks: How do you feel about this plan? What questions do you have? Then, at the pre-op visit, ask, what questions do you have now? Has anything changed? How are you feeling at this point, and do you understand what is about to happen?

It's not just one moment in time, remember; it's an ongoing cycle. But note that during the post-op period, the conversation changes slightly. If the doctor has done a good job of informed consent upfront, and communicated well, he can start by saying “Remember we talked about this; remember we were worried about this; we were watching for this.”

This article is based on a webinar presented by Emily Clegg (eclegg@umia.com) for UMIA and MMIC, February 8, 2017, “Informed Consent: More than a signature,” and is continued on the PIAA website. Please visit www.piaa.us to read the complete article. To view the webinar, visit UMIA.com or MMICGroup.com.
The year 2016 manifested continued declining profitability for the medical professional liability (MPL) insurance industry. While on a downward trend, movement in the industry's profitability has occurred at a relatively slow pace. In 2016 the industry's operating ratio increased slightly to 81%, just 1 point over the prior year. Meanwhile, insurers continued to experience a significant decline in reserve releases, compounded by both lower rate levels and increased expense ratios.

Some would observe that the industry’s 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 2016, leaving the MPL industry in a financial position roughly consistent with where it has been for the past half-decade.

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 2016, reserve releases contributed 18 points to the industry’s operating ratio. However, this is a noticeable decline from the reserve releases of 2015, as well as those of prior years. In the decade preceding 2016, reserve releases contributed an average of 27 points to the industry’s operating ratio each year. Yet despite this decline in reserve releases, without them, the industry would have remained profitable in 2016, albeit by the slimmest of margins.

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 common for companies to see certain of their competitors writing at rates perceived to be inadequate, forcing companies to choose between losing market share and writing at levels they themselves believe are unprofitable. MPL insurers have seen increased caps on damages in some states and, in others, challenges to the tort system itself in the form of “Patient Compensation System” legislation (see “Patient Compensation Systems Evolve—But Are No Less Worrisome” available online at: https://www.piaa.us/docs/OnlineExtra/2017_Online_Extra_Patient_Compensation_System.pdf).

At the same time, the industry’s one-time pattern of declining frequency ended several years ago. We have seen the reporting of claim counts stabilize for most companies, with some volatility evidenced for certain writers. Indemnity severity trends have
remained manageable, although trends in defense costs remain in the range of 4% to 6% per annum. We have seen rate levels vary by state and industry segment, remaining adequate in most locales but deficient in some.

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 only served to accelerate the trend in physician employment that was already well underway. Whatever reversals to healthcare reform lie in the short-term or long-term future, it is unlikely that any such changes would reverse or even slow the trend in physician employment—change and uncertainty are hardly an encouragement to independent physician practices.

We have written previously that under healthcare reform we expected that the long-predicted decline in the availability of healthcare professionals would 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 would begin to experience greater frustration with their professionals. This frustration might even be exacerbated under any reversals to healthcare reform, as segments of the populace may be tempted to blame healthcare providers for changes in healthcare availability. Regardless of their understanding of the reasons for such changes, it is unlikely that these events would contribute positively to the patient-provider relationship.

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 S&P Global Market Intelligence, 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 any MPL specialty writer that has become 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, 2016, marked the tenth straight year of decreases in direct written MPL premium for our composite (Figure 1). Cumulatively, premium has decreased by over $1.1 billion since 2006—more than 25% of the premium written in that year. To put that in perspective, consider: in the close-to-40-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 timeframe have been driven only in part by declining rate levels. An additional 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 healthcare system acquisitions of both hospitals and 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 inadequate rate levels, but to a lesser level and in fewer locales 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 dramatic reduction in frequency since the early 2000s...
means that MPL rates are in a much better position now than they were 20 years ago. However, we continue to see aggressive rate action in certain markets and have observed significant premium reductions on non-renewed, large accounts.

Overall operating results
As measured by the composite operating ratio, the industry 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. The 2016 combined ratio for the industry was 101%, up from a low of 76% in 2008 (Figure 3). This represents the first time since 2004 that the industry's combined ratio exceeded 100%, meaning that the industry would have been unprofitable in 2016 without its investment income.

The investment gain ratio of 19% in 2016, while up slightly from the 2015 investment gain ratio of 16%, represents a noticeable decline from the previous six years, in which the investment gain ratio ranged from 21% to 27%. In large part, the lower investment gain ratios of the past two years have been 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 slightly negative amounts in both 2015 and 2016. The investment income ratio increased from 17% in 2015 to 19% in 2016.

The calendar-year loss and loss adjustment expense (LAE) ratio for 2016, 70%, is higher than in any year since 2005, and represents an increase of 17 points since 2008. The increase has been driven largely by the decline in reserve releases noted earlier, which is discussed further below. Also contributing to the increase in the calendar year loss and LAE ratio has been an increase in the starting loss and LAE ratio for the most recent corresponding coverage year.

However, the starting loss and LAE ratio for the composite fell for the first time in 10 years, to 88%, in 2016. Information from the composite on the development of its 2016 coverage year to date, such as claim frequency, would not suggest that the 2016 coverage year will outperform its predecessors. This implies that the 2016 coverage year is starting from a weaker position than other recent coverage years.

Finally, as noted previously, the industry saw a dramatic decrease in reported frequency since the early 2000s. 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 decade, 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 increased significantly leading into 2012, although increases have been smaller since then. Thus, for every claim reported, fewer premium dollars have been available to defend or settle the claims than was the case at the beginning of this time frame. Cumulatively, reported claim frequency (measured relative to premium) has increased by...
almost 40% since 2007. 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
The composite released $640 million in reserves during 2016, a decline from the $1.1 to $1.2 billion released in each of the years 2008 through 2013 and the $900 million released in each of 2014 and 2015 (Figure 4). Despite this 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 $9.5 billion as of year-end 2015. 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 2018 or 2019. This would then be followed by adverse development (at least for the older coverage years) in subsequent calendar years.

Capitalization
The composite’s surplus increased modestly during 2016, from $12.6 billion to $13.1 billion, a growth rate of 4% (Figure 5). While net income for the composite was close to $600 million, a large portion of this income was returned to policyholders in the form of dividends, discussed further below. The industry’s growth in surplus during 2016 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 practical minimum amount of capital needed to be well in excess of this regulatory minimum). The RBC ratio of our MPL composite was 1150% in 2016, approximately its same level since 2012. However, individual RBC ratios vary considerably within the composite, from a low of 650% to a high of more than 3000%.

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 2016, the composite writers paid slightly more than $200 million in policyholder dividends, representing close to 6% of net earned premium (Figure 5). Cumulatively, the composite has paid more than $2.5 billion in policyholder dividends since 2005.
pattern of policyholder dividend payments, despite a decline in the reserve releases that have historically been used to fund these dividends. In 2015 and 2016, policyholder dividends were approximately 35% of net income in each year. This represented an increase from an average of approximately 25% of net income in each of the preceding eight 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 $3.0 billion for the MPL line of business as a whole. This is approximately 11% of the carried net reserves, which implies a redundancy for our composite of $1.0 billion. Thus, continued reserve releases can be expected to mask deteriorating underwriting results on current business, both prolonging the soft market and possibly increasing the risk of rate inadequacy. 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, the continued impact of healthcare reform or its reversal, and a decline in market size, among others.

We expect that further pressure will be exerted on the industry’s rate adequacy as the soft market continues, and that profitability will continue its slow erosion as a result. Yet capital remains strong, and we expect that discussion of its appropriate deployment will continue to be a common topic of conversation. Any “pleasant surprise” that comes to the industry, or to us as arguable pessimists, will take the form only of declines in profitability that are less than expected, or a longer time period during which current capital levels are maintained, prior to declining.

If you have been reading this annual series of articles for several years, you will know that for some time we have seen the soft market extending further and further into the future. We have attempted to speculate on when the market might harden, knowing not much more than that the market will harden only when it is done softening. In an industry that remains consistently, but decliningly, profitable, we expect that it will be at least several years before we can begin to speak of the hard market in the present tense again.
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The 2017 PIAA International Conference will focus on what we can do to manage the ongoing evolution of medical and healthcare professional liability (MPL/HPL).

Featuring a range of high-profile speakers, the event, titled “Change and Disruption: Strategies for Managing the Evolution of Medical Liability,” will be held at Grange St Paul’s Hotel, London, from October 4 to October 6. This is a fantastic location, next to St. Paul’s Cathedral, with a view over the River Thames.

The conference is hosted jointly by the Medical Protection Society and The Medical Defence Union. It will bring together more than 250 global indemnification, insurance, and risk professionals, to network and share key developments and insights on the macro, as well as the day-to-day, issues facing MPL/HPL.

Derek Feeley, President and CEO of the Institute for Healthcare Improvement, will be a keynote speaker for the conference. He said: “I’ll be focusing on new ways for health systems, doctors, and MPL/HPL organizations to think about safety. My talk will stress the importance of learning from all events, of systems and of culture. The best way to mitigate liability risks lies in proactivity and risk mitigation. I’ll also stress the importance of dignity and respect.”

The conference aims to provide guidance for attendees on new practices that they can adopt to mitigate risks in MPL/HPL. They can expect to leave with a fresh outlook they can take home and apply in their workplace.

Feeley told us he hopes that everyone who attends will be challenged by what they hear. “We want to tackle entrenched mind sets, along with the persistence of fear about medical misadventures and the ongoing tendency to focus on judgment rather than on learning,” he said.

“In fact,” said Feeley, “there are new ways to think about safety and new ways to learn. We should try and keep an open mind, so we can learn from both different countries and different industries.”

Something for everyone
The Conference program will cover a wide variety of topics. Take high-value claims, for example: James Rakow, partner at Deloitte, will share his actuarial and analytical expertise to explore the true economic cost of catastrophic injury.
example: Mark Doepel, Chairman of Lloyds Australia and Associate Professor of Law at the University of Notre Dame, will discuss the healthcare litigation crisis in Australia and explain how tort reform is being used to bring this crisis under control.

MPL/HPL entities must have sufficient funds to pay the costs of future claims, and prudent investment of the company’s funds is one element in preparing to pay such costs. And who would be better to advise on investment strategy than Patrick Liedtke, Managing Director at BlackRock? He has authored more than 150 papers on insurance, finance, and economics. He is also an Honorary Visiting Professor at the Cass Business School in London.

Patient safety will also be explored at the Conference. World-renowned healthcare safety expert Dr Jim Bagian of the University of Michigan will be another keynote speaker. Not many people can put the titles of doctor, engineer, and astronaut on their CV; Dr Bagian’s experiences in all three roles combine to give him unique insights for designing safety into systems in the workplace.

In addition to the practical sessions described above, there is also the opportunity to consider the bigger picture: what compensation is meant to achieve, and whether it accomplishes that goal. This session is chaired by Sir Robert Francis QC, distinguished barrister, President of the Patient’s Association, and Chair of the public inquiry into the deficiencies at the U.K.’s Stafford Hospital. Also speaking will be Professor Deborah Bowman, Professor of Bioethics, Clinical Ethics and Medical Law at the University of London.

Here are some of the other exciting topics, which serve to illustrate the many commonalities shared by MPL/HPL organizations, worldwide:

- Emerging models of care— the use of non-medical professionals
- Underwriting privacy and data security risks
- Telemedicine: Benefits, risks and pitfalls—who carries the liability?

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One of his current research projects is a collaboration with the American College of Surgeons (ACS). This initiative, the AHRQ Safety Program for Enhanced Recovery After Surgery (ERAS), seeks to improve surgical patient outcomes by increasing the implementation of ERAS practices in participating hospitals through the use of an adoption of AHRQ’s Comprehensive Unit-based Safety Program (CUSP). The current goal is to recruit 750 hospitals to participate in the program.

The AHRQ ERAS program will be implemented as an integrated combination of clinical and hospital-team cultural interventions in all participating hospitals. Originally introduced and successfully used in European hospitals, ERAS is a compilation of preoperative, intraoperative, and postoperative practices that have been shown to decrease surgical patients’ complications and speed their recovery, as shown through numerous published reports in the medical literature.

ERAS strategies are employed throughout a patient’s entire care process—from the time a surgeon decides to operate to after a patient is discharged following a procedure. Protocols include patient and family engagement, avoiding prolonged fasting periods, prescribing and using opioids sparingly, and incorporating multiple methods to control pain. ERAS brings a collaborative care approach, involving close teamwork among surgeons, anesthesia providers, and nurses.

**Inside Medical Liability:** How will the collaboration between Johns Hopkins and the American College of Surgeons work?

**Rosen:** There are many components, but the biggest division of labor happens between ACS’s core expertise around the content—the specific clinical protocols, the guidance on what the surgeons and other providers should be doing, as well as the measuring piece, for measuring surgical quality and safety. The Armstrong Institute will focus on implementation strategy, change management, safety culture, leadership, and team building.

**IML:** How long has it taken to put all this together?

**Rosen:** We’re still in the process. Our first launch will happen this summer, but there will be months of lead-up for us until that time. We started in August 2016, and we were working right through the end of last year. There were multiple systematic reviews of both the implementation process and the clinical protocols, and time was also devoted to developing tools and the program curriculum.

**IML:** What is contained in the ERAS protocols, and what were the sources for developing them?
**Rosen:** The clinical protocols themselves differ to some extent, based on surgical specialty. We are rolling protocols out in five specialty areas. We started with one for colorectal, and followed that with protocols for orthopedic and bariatric specialties. The specifics will be a bit different, but the focus is on things like use of anesthetic agents and pain management, patient education, antibiotic use, and physical therapy and early mobility.

**IML:** Is this a whole new way of doing things, or is it just tying things together in a novel way?

**Rosen:** Many of the components have been around for a while, so a lot of it is integration. Versions of this program have been implemented already, primarily in Europe. The basic approach is not new; it has been implemented and had a dramatic effect in hospitals and systems in the U.S.—we have implemented here at The Johns Hopkins Hospital. So the components are not what is new. It’s the tying of them all together.

That’s what’s great about it, but that’s also what’s tough about it. Because it required change, all the way from clinic visits and the preoperative decision-making all throughout the continuum of care. There are things that need to happen in lots of different places, so it’s complex trying to get all the pieces functioning correctly.

**IML:** And then to sustain it, I would think.

**Rosen:** Yes, exactly. That is the challenge with any of these programs, or any of these changes.

**IML:** How do the protocols promote patient safety?

**Rosen:** They are based on best practice, so we know that these practices are linked to reductions in complications, linked to a quality of care. Most of these things are focused more on quality of care, such as making sure people are receiving the appropriate therapies, than safety itself. But there’s a gray line here. So if you give them the best therapy and interventions possible—that reduces the risk for complications they would have gotten but in the past, people would just say, “The patient was sick, he had a complication—those things happen.” But in reality, they are preventable by implementing best practices.

**IML:** What do you hope will be the end result of all this?

**Rosen:** We hope to see better outcomes, like shorter length of stay, reduced readmissions, reduced complications, fewer infections—and also returning people to their normal quality of life faster, with a more positive perception of their experience of care, so people are satisfied with their care. Doing a lot of these things, we hope, will drive down costs too.

So there’s a lot going on. Some of it may sound too good to be true. But the existing evidence really shows that a lot of these things work; it’s a really powerful intervention.

**IML:** So there is work on this already published in the medical literature?

**Rosen:** Yes, mostly from Europe. They have been the leaders in this work. So there is a good amount of literature showing that these methods are very effective. There is a lot of buy-in from the surgeons and other people that this is going to be a useful intervention.

**IML:** Do you think this can be replicated in various sizes of facilities?

**Rosen:** Yes, absolutely. So we are recruiting all different sizes and type of hospitals, community hospitals to big academic medical centers—some of which haven’t had this type of intervention before.

The process is flexible enough that people can adapt all of these guidelines and recommendations to their unique setting, and it integrates them into the way they do business.

**IML:** What are the next steps?

**Rosen:** We’re getting ready to do the recruitment in the next month or so. We’re working with our partners to make that happen. We expect to have our kickoff this summer, in June.

Editor’s note: Facilities interested in participating in the ERAS initiative should contact: enhancedrecovery@facs.org.

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**Another Perspective: American College of Surgeons**

**From:** Clifford Y. Ko, MD, FACS, Director of the Division of Research and Optimal Patient Care, American College of Surgeons.

**Inside Medical Liability:** How will the collaboration between JHU and the American College of Surgeons (ACS) work?

**Ko:** Johns Hopkins will help lead the culture/CUSP items; the ACS will lead the clinical issues of the project.

**IML:** What is contained on the ERAS protocols, and what were the sources for developing them?

**Ko:** The ERAS protocols will contain multidisciplinary clinical protocols that will address important things to do across the spectrum of care, from preoperative to intraoperative to postoperative phases of care. The sources include the published medical literature.

**IML:** How do the protocols promote patient safety?

**Ko:** The protocols align with quality and safety results.

**IML:** What do you hope will be the end result of this research project?

**Ko:** We hope the result will be that clinical care for these surgical patients will be improved such that there is higher quality, more efficiency, better satisfaction, and improved safety. Our pilot studies have demonstrated that these results should be achievable.
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Well, it turns out many insurers aren’t capitalizing on this opportunity, as they fail to notice one area of their website that, with just a minor change, could result in more conversions. This change would vastly improve the frequently arduous task of working with the insurer’s forms, the ones that customers need to fill out.

Although this may sound trivial, we’ve noticed natural language forms are making significant improvements in conversion rates and also boosting the website user experience (UX).

Forms—they are incredibly useful for businesses trying to gather information about their clients. Yet, they are also incredibly tedious for customers. And let’s be honest, no one particularly enjoys filling in forms.

They are one of the longstanding issues UX designers have and the Web challenge they need to master for the insurance industry.

So why not spice up forms and entice people to fill them in more willingly by using natural language forms?

It gets especially difficult when designing insurance-purchase processes that have a requirement for gathering a large amount of data. When a client asks for many fields, UX designers become concerned. How am I going to make this a pleasure to use—without the forms giving the appearance that they’ve suddenly been empowered to get as much information from the user as possible?

The first thing to ask yourself is: “Do I really need this information?” If the answer is yes, the second question to ask is: “Why do you need it, and how is this going to benefit the user?” This helps to reinforce the notion of risk, but also helps explain to the user the benefit they will get if they go the extra mile in giving that information.

Customers will be more likely to disclose information if they understand the need for it.

It’s true, though, that despite asking those questions and adding appealing distractions like calculators, sliders, and inline validation, the form may still feel uninviting.

That’s why I’m so intrigued by the idea of using natural language forms and how likely they are to improve the user experience of completing insurance applications. Natural language forms differ from the traditional input formats of web forms; instead, they consist of input fields that are contained in full sentences.

In insurance terms, the user is in effect...
completing a "statement of fact" in a natural way.

A good example of this comes from the U.S.-based health insurance provider Oscar. The form reveals itself as the user fills in each field; dropdowns show up to help only when they do help, and then they are accompanied by an enjoyable animation.

While they are still relatively rare, we are noticing natural language forms increasingly appearing on financial websites. The site www.MoneySuperMarket.com includes a criteria search that is another recent example.

Research on natural language forms

The power of natural language forms is supported by research. Luke Wroblewski tested a natural language form and found that it increased conversion by 25-40%. And you can find other reports of improved user experience on the Web. For instance, Scott Sharp tested a natural language form for Embrace Pet Insurance and shared his results on GoodUI.org. His results suggest an increase of 3.3% in conversions (measured as visits to the second step of the quote process).

Of course, there is no guarantee that they will always work. But it’s probably a good bet for usability or A/B testing with your users.

In particular, this will be the trend as the insurance space continues its shift in attitude toward embracing technology and innovation. Within the last 12 months, with innovation labs, rapid prototyping, and user testing, as well as an adoption of agile practices, the technical advances among insurers are on the rise, among the companies that are the most “switched-on.”

So insurers should be on the lookout for the design solutions that will engage their users and also be easy to use, while at the same time delivering the business outcomes they are looking for.

As the industry faces some disruption with insurtech startups, its companies should keep an eye out for simple but effective changes that will serve to enhance their customers’ experience, especially as we welcome a new generation of customers with a host of new demands and expectations from insurers.

So the question is, will you take a chance on natural language forms and find out if they can make a difference for your business?
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It is also a good time to take a fresh look at the investment landscape, as many things changed over the course of 2016. The election of a new president has driven an unexpected rally in risk assets, the dollar has appreciated, oil has recovered from its lows in early 2016, and the Fed once again appears poised to raise rates in the latter half of 2017. With all of these moving parts, it can be difficult to forecast how the coming year will unfold. However, one useful analysis is a comparison of the various sectors that make up the fixed-income market.

In order to compare different sectors of the market, it is helpful to look at the spreads of those sectors, as opposed to the yields. The yield of a bond can be broken down into two elements: a risk-free rate and a spread. The risk-free rate is typically the rate of a Treasury bond whose maturity date is similar to that of the bond in question. The spread therefore represents the additional yield that investors are being offered above what they could get for holding a comparable Treasury security. The most common measure of spreads when comparing different sectors is the option adjusted spread (OAS). The OAS measure attempts to remove the elements of total spread that come from prepayment optionality, which is found in mortgage bonds as well as callable bonds. It is therefore a better way to compare sectors with more optionality (mortgage-backed securities [MBS]) with sectors that are more like bullet bonds (corporates; a debt instrument whose entire principal value is paid all at once on the maturity date).

Figure 1 shows how the OAS of the main sectors of the fixed-income market have changed over the past year. The dramatic spread widening (risk off) move in the beginning of the year was followed by a steady rally throughout the rest of the year. Spreads are now trending back towards their all-time

**Figure 1. Sector OAS**

Peter Cramer, CFA, is Senior Portfolio Manager, Prime Advisors, Inc.
highs, as optimism for tax stimulus- and infrastructure-funded growth reigns supreme.

By looking at Figure 1, one could draw a number of conclusions. The sectors that offer the highest spreads are the ones with the most “credit” risk, meaning risk of default. Those are the corporate sectors (expressed in this chart as their major components, Financials, Industrials, and Utilities) and taxable municipals. The higher-quality Asset-Backed Securities (ABS), MBS, and Agency sectors offer significantly lower spreads. There also seems to be more volatility in the spreads of the corporate sectors: The spread lines oscillate more than the lines of the ABS or Agency sectors.

This brings up an important element for assessing relative value across sectors: Spreads alone do not tell us the whole story. This is because not all sectors are created equally, and they have different risks that are not captured in spread alone. Some of these additional risks include credit quality, duration, extension, and volatility. In order to get a better picture of the value offered by a sector, we must therefore look at spread offered per unit of risk.

**Spread and risk**

While there are several methods for normalizing spreads (looking at spread per unit of risk), one of the most practical is to adjust for duration. Duration is defined as the sensitivity of a bond’s price to changes in interest rates, and it is expressed in years. For example, a typical 10-year bullet maturity bond will carry a duration of 8-8.5 years. Using duration, we can look at normalized spreads across sectors by dividing a sector’s OAS by its duration. This will show us the amount of spread that sector offers per unit of duration risk (Table 1).

Table 1 shows the spread per unit of duration for each sector, as well as the average, high, low, and Z-Score1 for each using a three-year time horizon. Using this lens, the ABS and Financial sectors jump out as offering compelling value, compared to the other sectors. This is due in large part to the shorter duration of most ABS vehicles; this is also true for the majority of the bonds in the Financial sector. The ABS sector spread per unit of duration is also slightly above its three-year average, as indicated by the positive Z-score of 0.1, compared to all other values, which are negative.

While duration is a widely used measure of risk in the fixed-income market, it is not the only one. Another way to measure risk is to look at the volatility of a data series (Table 2). In the case of fixed-income sectors, the volatility of spreads can also be a useful indicator of risk. If we again look at the OAS for each sector, and calculate the standard deviation (using the rolling past one-year daily data set) for each series, we can come up with a volatility-adjusted spread number, which shows the spread per unit of volatility.

After accounting for the differences in volatility across sectors, the taxable municipal sector stands out as attractive, offering 44% more spread per unit of volatility than the next closest sector (Agencies). Looking just at the corporate sectors, it is interesting to note that Utilities, which offered the lowest spread per unit of duration as shown in the previous table, now offer the highest spread per unit of volatility. This is evidence of the relatively low volatility in Utility spreads, compared to Industrials and Financials.

These examples are just a few of the ways to incorporate risk management into your analysis of fixed income. Having a solid understanding of the risks currently in your portfolio helps you to become a more informed investor. This will ensure that you are taking the risks that you intend to take, that you are being adequately compensated for bearing those risks, and that your exposure is in fact a prudently diversified combination of risks.

**Table 1. Duration-Adjusted Spreads (Three-Year Time Period)**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Current</th>
<th>Average</th>
<th>High</th>
<th>Low</th>
<th>Z-Score</th>
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<td>18</td>
<td>31</td>
<td>13</td>
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</tr>
<tr>
<td>UTE</td>
<td>12</td>
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<td>17</td>
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<td>17</td>
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<td>-.2</td>
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<tr>
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<td>25</td>
<td>32</td>
<td>-32</td>
<td>.1</td>
</tr>
<tr>
<td>MBS</td>
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<td>6</td>
<td>13</td>
<td>3</td>
<td>-1.0</td>
</tr>
<tr>
<td>AGCY</td>
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<td>5</td>
<td>7</td>
<td>3</td>
<td>-.3</td>
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</table>

**Table 2. Volatility-Adjusted Spreads**

<table>
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<td>9</td>
<td>14</td>
<td>4</td>
<td>-.1</td>
</tr>
</tbody>
</table>

Reference

1. The Z-score is a method used for assessing how far above or below a value is from its historical average. Z-score is calculated as the difference between the most recent value and the average, divided by the standard deviation of the series. A negative value indicates that the current value is below its average.

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ARE COMPUTERS BECOMING TOO SMART?

BY ERIC R. ANDERSON

Man vs. machine is often depicted as a battle between two divergent forces. We, as humans, never seem to be on the same side as the machines. Consider Arnold Schwarzenegger in the “The Terminator” relentlessly pursuing Sarah Connor. Or Keanu Reeves, playing Thomas Anderson in “The Matrix,” who becomes a victim of a massive artificial intelligence system that has tapped into people’s minds.

At this point, you’re probably wondering if you’ve stumbled across a review from the “Rotten Tomatoes” website. Let me assure you that this is still Inside Medical Liability. But it may come as a surprise (or maybe not) that the tension of man vs. machine has reached the insurance industry. Earlier this year, a Tokyo-based insurance company announced that it will soon replace the workers in its claims department with an artificial intelligence (AI) system based on IBM’s Watson. Fukoku Mutual Life is hopeful that the new cyber claim adjuster will be 30% more productive than 34 employees.

This raises a compelling question: Are machines better than humans at making decisions in the realm of insurance?

You may think machines have an advantage if you agree with this principle for the big-data age formulated by Andrew McAfee of the Harvard Business Review: “As the amount of data goes up, the importance of human judgment should go down.” McAfee has concluded, after considering studies on algorithms versus human judgment, that we should turn many of our decisions—both the trivial and the consequential—over to the algorithms. Score one for the machine.

On the other hand, Kate Crawford of Microsoft Research warns that “Numbers can’t speak for themselves, and data sets—no matter their scale—are still objects of human design.” She believes that biases and blind spots crop up in big data just as they do in individual perceptions and experiences. Man is on the scoreboard!

Like many difficult questions, the true answer is probably somewhere in between. The power of AI seems to reside largely in its scalability. To deviate from insurance for a moment, consider medicine. Watson can do something no human can do: It can read every medical book, journal article, and medical blog—and will then emerge as an expert diagnostician and medical consultant that has read everything.

But: this doesn’t necessarily mean that a computer, even Watson, can become a great doctor. What it does mean is that a computer can serve as an excellent medical assistant.

Fortunately, for insurance professionals, while there is an understandable fear that the advent of AI may result in an increasingly automated world, Fukoku Mutual Life aside, this possibility may be considerably more remote than one might imagine. According to a recent survey of insurance executives, the majority view AI as a way of providing additional support to human decision-making, rather than as a tool for reducing the workforce.

Over the centuries, technological advancement has introduced virtually constant change into human society, eliminating some categories of jobs, while giving rise to new (and more skilled) ones to replace them. We will need to keep a close eye on AI in insurance, to ensure that it doesn’t disrupt that natural process, by eliminating some jobs and failing to create new ones to replace them.

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

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Eric R. Anderson

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TOP 400
FINANCIAL ADVISORS

Rankings are based on data provided by investment firms. Factors include assets under management, experience, industry certifications and compliance record. Investment performance and financial advisor production are not explicit components.

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has been recognized as one of the

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FORBES
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Ranking algorithm based on industry experience, interviews, compliance records, assets under management, revenue and other criteria by SHOOK Research, LLC, which does not receive compensation from the advisors or their firms in exchange for placement on a ranking. Investment performance is not a criterion.

The Optimal Service Group of Wells Fargo Advisors

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Barron’s Top 100: The rankings are based on data provided by thousands of advisors and their teams. Factors included in the rankings were assets under management, revenue produced for the firm, regulatory record and client retention.

Barron’s Top 30 Institutional Consultants: The teams in the ranking were evaluated on a range of criteria, including institutional investment assets overseen by the team, the revenue generated by those assets, the number of clients served by the team, and the number of team members and their regulatory records. Also considered were the advanced professional designations and accomplishments represented on the team.

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