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It may be more than a little ironic—in this era of Big Data, the likelihood of achieving hard numbers for something as important as medical errors is minimal. It is now the fifteenth anniversary of the Institute of Medicine report *To Err Is Human*, which estimated that every year 98,000 people die from medical errors. More recently, an article in the September 2009 *Journal of Patient Safety* increased that estimate by more than fourfold.

These numbers make for gripping headlines. Of course, if even one person is the victim of a medical error, that is too many. But there is little coverage, or none at all, of the methods—the data gathering techniques and the statistical tests—used to produce them. Peeling back the layers of the onion can reveal some extraordinarily unrealistic assumptions and mathematical theories that fail to convince. The Fourth Quarter 2013 *Inside Medical Liability* (page 6) dissected the *Journal of Patient Safety* number, noting that it was admittedly based on “four limited studies.”

Yet, amid all the confusion about precise numbers, PIAA and its member companies are steadfast in their commitment to advancing patient safety.

Toward that end, this issue of *Inside Medical Liability* features an article by a retired physician that provides a scientific approach to error reduction via an expansion in the use of simple tools like checklists, which are easy to implement and have been proven effective in multiple care settings.

It can be equally difficult to arrive at the truth in a medical professional liability (MPL) lawsuit. A 1996 Harvard study found no correlation between the presence or absence of medical negligence and the outcome of malpractice litigation. To shed some light on the process, this issue also includes an article that explains what juries are looking for in reaching a verdict.

Interpreting the multitude of data on the health of the MPL industry can be another type of challenge in the search for truth. There is much information, and it can be presented in a wide array of formats and ratios, so this issue provides some assistance.

“Survival: It’s More than a Numbers Game” highlights the critical data for indicating what is happening in MPL now, and explains what these numbers suggest about the best choices for the future.

Finally, there is the difficult issue of what is, versus what is not, truth in today’s healthcare system. Despite diligent efforts, the shift from inpatient to outpatient care has proved resistant to many of the initiatives undertaken to make it seamless. This quarter, our risk management feature, “Transition from Inpatient to Outpatient: How to Reduce Risk,” details an approach that can effectively minimize the likelihood that some essential element of this process will slip through the cracks.

Additionally, you will find some sobering truths about healthcare in our interview with James Orlikoff, keynote speaker at the 2015 Medical Liability Conference, along with other fascinating highlights in our coverage of select sessions from the Las Vegas event. I hope you find this information stimulating and you will make plans to join us in Washington, D.C. next May for the 2016 Medical Liability Conference.

In philosophical arguments, and equally so in the realm of numbers, predicting the future will always be elusive. But at PIAA we endeavor to provide you with the resources and tools you need to plan for tomorrow.
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Lawyers have a fundamental problem in society—they are paid to speak for others, not for themselves, and juries believe that they will say and do just about anything to win cases.

—Cover story
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## Events & Calendar

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

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

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

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

### March 9–12, 2016
**CEO/COO Meeting**
The Westin Kierland Resort
Scottsdale, AZ

### March 10–12, 2016
**Board Governance Roundtable**
The Westin Kierland Resort
Scottsdale, AZ

### April 6–8, 2016
**Marketing Workshop**
Delano
Las Vegas, NV

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

### May 11–13, 2016
**Medical Liability Conference**
JW Marriott
Washington, D.C.

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**2015 Underwriting Workshop**

**Healthcare Is Going Retail—New Opportunities and New Risks**

Angela Patterson, FNP-BC, Chief Nurse Practitioner Officer, CVS Minute Clinic, will provide a comprehensive overview of the origin, and recent developments in care delivery, in a retail practice setting. Patterson will explain the drivers that are influencing the growth of the retail healthcare model, and describe the current characteristics, performance, and future directions for care in this setting. The session will also include a special emphasis on how CVS, in particular, is utilizing telemedicine. In rural areas, for example, MinuteClinic staffs clinics with a licensed practical nurse or licensed vocational nurse (LVN). The LVN takes patient vitals, and then connects the patient via video to a nurse practitioner at a distant MinuteClinic site, who then diagnoses the patient and creates a treatment plan.

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**PIAA Claims and Risk Management/Patient Safety Workshop**

**Social Media, Telemedicine, and Other Emerging Technology MPL Risks**

From the perspective of a practicing physician who is also an attorney, medical expert, and noted author, Richard E. Moses, DO, JD, will examine some significant new risk issues for MPL. In social media, the line between good communication and professional treatment tends to become blurred, and this can lead to risks for both patients and physicians. We have arrived at the point where telemedicine is emerging as a powerful and evolving method of patient assessment, but many people may not be aware of its treatment limitations, or of the rapidly changing laws and regulations surrounding its use in diagnosis and prescribing. Emerging technologies, such as the use of multiple devices by physicians and patients, are linked to some emerging risks that every insurer should be aware of.
STAY AHEAD
BE PREPARED FOR THE NEW REALITY

The delivery of healthcare is undergoing profound change. New regulations, shifting business models and evolving client needs require timely market and industry intelligence to maintain competitive advantage. This, coupled with the reality of a protracted soft market insurance cycle, poses both a threat and an opportunity for MPL insurers.

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Let us put our intellectual capital to work for you. Please contact Steve Underdal at (952) 820.1030 or steve.underdal@guycarp.com for more information.
It may not affect the property/casualty sector immediately, but this development will likely affect the P/C business in the not too distant future. Led by Mutual of Omaha, we now see banks that are carrier-owned, and the company has a chain of more than 40 banks. In the past, it was banks that had attempted to cross sell, offering insurance products. But they didn’t fully understand that with insurance, there is risk; the underwriter assumes the risk.

Pundits of P/C insurance (and yes, there are actually quite a few) say this will be a “game-changer.” The diversity of products offered by agents will have to broaden to include a new set of investment products. In particular, it is anticipated that the monoline carrier that writes only a certain type of coverage will be heavily affected.

The vision of this Brand New World can be truly breathtaking. John Sarich, for example, writing in PropertyCasualty360, effused thus: “In order to survive, insurance agents will have to be able to sell all kinds of products, helping customers take care of all their household needs.”

All, John, really? Pet-sitting included? Well, hey, thanks a bunch!

According to the findings from a recent survey by U.K. firm PA Consulting Group, 46% of senior executives, from among an international group of 750 of them, describe their innovation experience as a “costly failure,” with 50% of organizations seeing a brilliant idea fail for reasons they think could have been avoided.

Perhaps what’s needed is a better business model. In redesigning healthcare in particular, Nilesh Chandra of Health Data Management suggests that “perhaps there is something to learn from Elon Musk, one of the true radical innovators of our time."

Musk, he says, “upended a traditional business model in mature industries through the successful use of technology and innovation. And the healthcare industry, as it strives to transform itself, has much to learn from them.”

Case in point—before the advent of SpaceX, designing rockets was a costly business because each rocket was custom designed. In contrast, SpaceX takes a modular approach, with reusable components.

To Chandra, this principle can be nicely applied to the care of patients with “complex, chronic conditions.” He tells us, “Taking an evidence-based approach to designing care programs of reusable components will help reduce complexity and cost in delivering care.”

(Confession here—some uncertainty about what a “reusable component” in medicine might actually, physically, be.)

But there is an important overall mindset that healthcare entities should adopt, Chandra says: “Healthcare organizations need to embed innovation in their DNA.” They are advised to “rapidly scale up successful ideas, refine them, and push for continuous improvement.”

It would probably be a tad tasteless, at this point, to mention the rather alarming footage of the SpaceX Falcon-9 rocket exploding in midflight.

Source: Health Data Management, June 21, 2015

Source: PropertyCasualty360, June 15, 2015

Insurance Companies Enter the Banking Sphere

It Is Rocket Science (Maybe)
Joe White, the former CFO of Shelby Regional Medical Center, in Center, Texas, has been sentenced to 23 months in federal prison. The crime? He had attested to successful meaningful use of an electronic health record, even though his facility had not in fact met the requirements.

And there was a hefty fine as well: $4.5 million in restitution. But the yield for false attestation was $17 million. Now that would have been a pretty tidy profit for Mr. White—assuming he was allowed to keep the difference.

Source: Becker’s Hospital Review, June 18, 2015


**PIAA Data Sharing Project**

**MPL Resolution 1989-2013**

![Diagram showing the distribution of indemnity payments and claims resolution methods.](image)

Approximately 73% of claims and lawsuits that closed between 2009 and 2013 received no monetary award, but incurred defense costs. Conversely, 27% were resolved with an indemnity payment by settlement, verdict, or alternative dispute resolution/contract.

### Average Indemnity Paid

(2013 Dollars)

<table>
<thead>
<tr>
<th>Close Year Interval</th>
<th>Settled</th>
<th>Verdict-Plaintiff</th>
<th>ADR/Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989-1993</td>
<td>$265,240</td>
<td>$510,027</td>
<td>$227,737</td>
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<tr>
<td>2004-2008</td>
<td>$373,232</td>
<td>$742,091</td>
<td>$330,572</td>
</tr>
<tr>
<td>2009-2013</td>
<td>$333,840</td>
<td>$763,285</td>
<td>$293,963</td>
</tr>
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</table>

### Average Defense Cost

(2013 Dollars)

<table>
<thead>
<tr>
<th>Close Year Interval</th>
<th>Dropped, Withdrawn, or Dismissed</th>
<th>Verdict-Defendant</th>
<th>Settled</th>
<th>Verdict-Plaintiff</th>
<th>ADR/Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989-1993</td>
<td>$14,815</td>
<td>$80,232</td>
<td>$35,742</td>
<td>$105,176</td>
<td>$46,865</td>
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<tr>
<td>1994-1998</td>
<td>$14,979</td>
<td>$90,806</td>
<td>$43,208</td>
<td>$122,129</td>
<td>$47,718</td>
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<tr>
<td>2004-2008</td>
<td>$21,856</td>
<td>$115,710</td>
<td>$61,840</td>
<td>$180,480</td>
<td>$87,060</td>
</tr>
<tr>
<td>2009-2013</td>
<td>$28,933</td>
<td>$144,776</td>
<td>$71,074</td>
<td>$230,214</td>
<td>$105,782</td>
</tr>
</tbody>
</table>

Check out the MPL Closed Claim Comparative for other MPL facts. Reports are available at www.piaa.us.

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Every insurance company has a website providing corporate and “product” information. Fewer companies have a portal. A website is not a portal; portals provide the users—policyholders and agents—with customized information, transaction processing, and channels of communication with the insurer. Though there are exceptions, where companies have provided a full range of functions via the Internet, it’s still true that in the adoption of e-commerce, insurance lags behind. Think of brokerages, banks, travel companies, and retailers—these are the leaders in using the Web to drive customer satisfaction, efficiency, and service and to distinguish themselves from their competitors. They have proved that even in the instance of quite complex transactions, it’s possible to design a successful experience for the user.

Perhaps insurance has lagged behind because most of the policyholders’ interaction with their carrier happens only once a year—at renewal. Perhaps certain lines of insurance—like MPL—are considered too “difficult” for the use of the Web to be appropriate. Perhaps there is some concern about security, as there should be. But if other industries can deal with this, there is no excuse for insurers. However, expectations are changing. Would you even ask a bank or brokerage that you were considering for your business whether they had a portal? Also, two changes in the MPL market have rendered use of the Web more of an imperative:

- Far more business among the PIAA companies is done via agents than was the case a few years ago. Agents might be expected to have daily or weekly interaction with the company, so the use of a well-designed Web portal that can deliver 24/7 services makes sense for both parties. Companies that have deployed a Web portal have found that portals are used much more frequently by agents than by insureds.
- With more doctors practicing in ever-larger groups, there are fewer, but “larger,” policies, and as with the agents, there is likely to be some weekly or monthly activity, particularly with larger groups.

The benefits

Portals can help insurers realize a number of important benefits:

- **User satisfaction.** Customer retention can be improved by providing convenient access to services and information. A well-designed portal can be an important and highly visible tool for giving the company a competitive edge.
- **Operational efficiency.** A single channel of communication for all aspects of the company’s relationship with external parties will improve efficiency and data accuracy, and also serve to speed up decision making.
- **Cost saving.** Providing self-service options for external parties will reduce the amount of work to be done within the company. Ready access to up-to-date information should reduce inquiries to the call center, and offer the user the ability to make some changes and transactions. For example, the capacity to make address updates, premium payments, or requests for certificates of insurance will reduce the company’s workload.

**Revenue generation.** A Web presence will appeal to new prospects, as well as provide the ability to cross-sell to existing policyholders. Opinion is divided on the subject of online quoting; without underwriting, the premium amount generated may not represent the company’s “best offer,” and in consequence, the business may be lost.

**Considerations in designing a Web portal**

- **Design for each user class.** In the information that is provided, and in the transactional options offered, the portal design should consider the needs and abilities of each user class. Agents, insureds, and group administrators could be three basic classes of users, and there could be others, like risk managers. The login process should ask the individual to identify the class of user, and the portal should then respond with different options.
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data and functions.

**The extent of data to be available.** There is a conflict between, on the one hand, simplicity and ease of use and, on the other hand, providing the most information possible. Too much information may make the portal hard to use, and it may generate questions rather than help the user. The information available for an agent (all of “his” policies) would be different from the insured (who would see his own policy only). An agent would likely want information on commissions and upcoming renewals.

**The extent of transaction processing to be available.** Most portals offer the ability to make payments, to change demographic data like name and address, phone numbers, etc. But how far should the user be allowed to go in making changes that affect his policy? Should an agent be able to do more than a policyholder? What if an address change moves the risk to a different rating territory—how would that be handled?

**Technology flexibility.** The software should be able to run on any Web browser, and increasingly, a mobile version of the software for smart phones and tablets should be considered. The architecture should use Web services to communicate with the company’s enterprise systems so that maintenance is as efficient as possible. For example, if a quoting capability is to be offered on the portal, the rating tables and rating engine already in the “back-end” software should be used. Also consider that a portal will need to be changed as a result of business changes, as well as user experience feedback. The technology selection process should include this as an important priority. And performance matters, too. The portal should be lean and fast if it is to leave a positive impression.

**Ergonomics and screen design.** The look and feel of the portal represents the “brand” of the company, so the choice of graphics, colors, font, and style needs to be made carefully. The placement of elements like buttons and controls should be consistent. Users will be expected to work in the portal without any training so the layout should be as intuitive as possible, with easy navigation and minimal scrolling. Help should be available, as well as a print option that lets users reformat certain pages to make them printer friendly. Password-changing and password reminder functions should be provided. Users should have the ability to customize screen content to suit their preferences.

**Security.** This has two dimensions. The design of the software must ensure that the information presented to the user is what is intended. For instance, Agent A cannot see Agent B’s business. In addition, the technical infrastructure needs to be “hack proofed” to avoid intrusion.

**Engage real users in the process.** Getting the input of a small group of the people that will be using the portal is a good idea. They can offer suggestions based on real-world concerns. Further, when the project is complete, give this group of users some time to work with the portal before you make it generally available. It can take a long time to recover from a badly launched project.

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**TECH TALK**

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While proven and effective reforms, such as caps on non-economic damages, collateral source rule reform, and periodic payment of damages, continue to stand the test of time, some people can’t resist the siren call of new “reforms” that promise to solve all the problems of our current MPL system with one simple change.

Several years ago, health courts were all the rage. Lately, Capitol Hill has focused on “safe harbors,” government-approved medical guidelines that could be used as a defense against MPL claims. Most recently, yet another proposal has begun to crop up in state legislatures; this one threatens a dramatic change to the way MPL insurers interact with their insureds.

There are several different names for these schemes—no fault, medical injury compensation systems, and more frequently, patient compensation systems (PCS)—but the basic concept behind them is the same. Rather than compensate patients who have been injured by medical negligence, these proposals would compensate for any suboptimal medical outcome, regardless of whether negligence was involved. In effect, then, the PCS concept would replace the current MPL system with a workers’ compensation-type program. While the individual proposals differ from state to state, the proponents of all of them claim that they will provide funds to patients who would otherwise not receive compensation, speed up the claims resolution process, and dramatically reduce the practice of defensive medicine.

Unlike prior alternative “reforms” such as health courts (whose enactment was never really a serious threat) and safe harbors (which are getting a good deal of attention, though there doesn’t seem to be enough momentum behind them for enactment), the support for PCS appears to be increasing. PCS (or related) legislation has been introduced in six states, as of this writing. As such, MPL insurers in every state need to know what, and who, is behind these proposals, and what can be done to stop them.
Background
The sole advocacy group promoting PCS is Patients for Fair Compensation (PFC), based out of Atlanta, Georgia. Founded by Richard Jackson, Chairman and Chief Executive Officer of Jackson Healthcare, a health professional staffing company, PFC is the driving force (financially and politically) behind most, if not all, of the efforts to get PCS enacted at the state level.

Originally targeting their efforts in Georgia and Florida, PFC now acknowledges that it is involved in legislative discussions in Tennessee as well. Its fingerprints are also on similar legislative efforts in Montana, Maine, and Ohio.

According to its website, PFC’s motivation is to (1) drive down the costs associated with defensive medicine, (2) speed up the process by which injured patients are compensated, and (3) compensate more patients than the current system. But while its intent may be laudable, its proposal is anything but. In its efforts to achieve “reform,” the organization proposes a system that is, in reality, unworkable, and it makes some highly questionable claims about the benefits that such a system would supposedly provide.

Why are people so interested in what is, in fact, an unproven and untested concept? Primarily, the appeal lies in PFC’s promises about how it will work and who will benefit. Initially, advocates tugged on people’s heartstrings by claiming that their scheme would make it possible to compensate more people and provide them with more money than the current MPL system, without increasing anyone’s costs.

In light of the fiscal impossibility of these claims, PFC in time toned down their assertion to a simple promise to provide compensation to people who otherwise would be unable to get legal representation because their claims aren’t worth enough to a lawyer to take them. Who could argue with the idea of doing more for people who suffered a bad outcome after a medical procedure?

Then, in targeting healthcare professionals, PFC stated that their proposal would ensure “that doctors’ [names] are never . . . submitted to the Data Bank.” They also claim that physicians will never have to appear in court, under their plan, or be identified in any way in association with a patient compensation claim. Clearly, avoiding the litigation system entirely would be attractive to any healthcare professional.

So, are these promises too good to be true? PIAA believes they are.

Reality check
How should insurers respond when they’re faced with these claims? Fortunately, just confronting what PFC claims with the basic
facts should be sufficient.

Regarding PFC’s claim that more people will be compensated under a PCS system, you just need to point out that for that to happen, something will have to give. If people who suffer bad outcomes, which are not the result of negligence, are now to be compensated, where will the money come from? An early version of the proposal seemed to indicate that the savings achieved by reducing “defensive medicine” would be sufficient. But money that is not paid for healthcare services wouldn’t suddenly become available to pay medical injury claims—not unless health insurers or healthcare professionals were subjected to hefty taxes.

More recently, the PCS proposals have included a provision that would cap total annual payments for medical injuries. But if more people are to be paid under the system, either the most severely injured will not be fully compensated, some patients will have to forego compensation when the money runs out, or, more likely, the cap will have to be raised, with insurers or taxpayers left to pay the increased costs. None of these are acceptable alternatives to the current MPL system.

While the “no reporting” aspect of PCS proposals is very attractive to physicians, who have for many years had issues with the National Practitioner Data Bank (NPDB), it is not that simple to avoid the federal reporting requirement. As established by many years of court precedent, federal law supersedes conflicting state law. If state law says reports do not have to be filed, and federal law says they do, then they do. Furthermore, while PCS advocates claim that physicians can circumvent the reporting requirement by not addressing the issue of fault, that is not the criterion that triggers an NPDB report. As clarified in a recent memo from the U.S. Department of Health and Human Services, any payment on behalf of a healthcare provider that stems from a written demand (i.e., the filing of a claim for compensation), regardless of whether fault is determined, is reportable to the NPDB. The memo also stated that “the NPDB has no history of allowing states to define requirements for reporting,” and clearly indicated that it had no intention of changing that policy.

What’s next
If no one has introduced the PCS concept in your state yet, consider yourself lucky. Don’t assume, however, that it won’t pop up in your legislature at some point. But if and when it does, you should be aware that there are many resources available to fight it. PIAA has assembled a series of one-pagers (available at www.piaa.us) to address the various issues involved in the PCS concept. In addition, some of your colleagues throughout the nation have gained substantial expertise on this issue, and they would be happy to share their experiences in developing the best strategies for fending off these proposals. If you need to learn more about the kinds of resources that are available, and how to prepare your defense against PCS legislation, just contact the PIAA Government Relations Department, and we will be happy to help out.

Clearly, avoiding the litigation system entirely would be attractive to any healthcare professional.

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A U.S. district court allowed the production of an audit trail over defense objections about peer review privilege and the work product doctrine earlier this year. The unreported decision, of no binding precedent even in its federal jurisdiction, is still useful for illustrating a general principle and also offers a word of caution. The general principle is this: once a type of electronic health record (EHR) data (or metadata) is created, it may be very difficult to claim that it should somehow be kept out of a legal inquiry, even when it should. Some sources have suggested an aggressive use of EHR metadata to look far beyond the cases in controversy to determine a clinician’s habits and routine.

This should serve as a cautionary tale, because the federal government is in the midst of affirmatively mandating EHR implementations to create new classes of data, including audit trail reporting. The end result is that healthcare institutions will be footing the bill for increasing demands by litigants who want access to the data, metadata, and the original displays of data as originally viewed by the clinicians. Those demands come with significant technical, administrative, and legal expenses, which are born solely by the parties in healthcare.

The Hall v. Flannery case stands for no binding law, but is typical of how many trial judges handle discovery requests involving EHR data. In essence, in what appeared to be a medical liability matter, the plaintiff, among other demands, brought a demand for the production of an audit trail for the defendant’s EPIC EHR software. The plaintiff’s request for the audit trail was prompted when two different versions of the printed EHR were produced to the plaintiff. On the sole basis of the two different printed versions of the record, the plaintiff asserted that the medical record had been altered. By accessing the audit trail, which contained fields for the date, time, user ID, and action taken, the plaintiff believed she could prove an alteration of the record.

The defendant hospital raised two privileges: peer review protections (which vary by state) and the work product doctrine, a subset of the attorney-client privilege.

**But what is an EHR?**
Part of the court’s decision rests in the fact that those who work in healthcare are themselves confused about what an EHR actually is. The court describes EPIC as “the software...
used to create an electronic medical chart.” Most in the legal world envision the “electronic medical chart” as the end product of the EHR software, like the printed term paper that is produced by word processing software.

In truth, the EHR digital data is the electronic medical chart. It does not exist to create anything in printed form; it is meant to remain electronic. It can create a printed paper or electronic image display (such as PDF or TIFF) of a subset of its data, but that representation will always be imperfect, incomplete, limited, and subject to change as time goes on. A printout of the record is an afterthought to the EHR vendor; they want us to forget paper.

What do we mean now when we say a “medical chart” in an EHR? Is it a printed, hard copy approximation of what we could hold in our hands in the paper chart paradigm? Or is it the underlying data, metadata, and functionality of a true electronic health record that only resides in the EHR servers and is usable only with unique, proprietary software, but useless outside that environment?

The answer to these questions can have a profound impact on litigation and a disruptive impact on litigation costs. To explain, let’s turn back to the case in Flannery. The precipitating event to further discovery was the production of two printed versions of one patient chart. One explanation of a different printed version of the record was evidentiary tampering. At present, the potential technical reasons for differences in exports of the EHR chart are many, however. It’s an imperfect process.

For example, if the software in question underwent patches or version changes between the time of the two printouts, that alone could account for changes in how the data is produced on paper. Let’s assume the latter for argument’s sake. In every case in which there is more than one version of the exported record produced for discovery purposes, the healthcare institution will be subjected to a costly forensic battle about whether or not it tampered with the record after the fact. Those costly forensic battles are driven in part by our expectations that the EHR should create a replica of a paper chart. As long as the underlying data has not been modified, however, how it prints out is irrelevant.

Treating the EHR as what it in fact is, however, is no less costly. EHRs are not marketed or designed with evidentiary or discovery purposes in mind. They are designed to be fluid, constantly updating, and supported by undocumented functionality that does not exist in paper charts (such as clinical decision support). In part, they are designed to do what a paper record cannot do, based on the belief that digital patient data will lead to more connected and smarter care. EHR data is not meant to be used outside its native environment and home systems. Sharing the true form of the EHR is an enormously expensive undertaking and often practically impossible, at present. And much of EHR data and functionality will be misunderstood if considered out of the context of its home environment.

For example, audit trails themselves are often not self-explanatory. They are dependent on technical conventions created by the system’s software developers and are, by nature, idiosyncratic. Interpreting them correctly often requires technical expertise that is specific to that implementation of the software. To the untrained reviewer, audit trails may be no better than reading tea leaves.

This is why there was considerable debate at the federal level about whether patients should be allowed to access full audit trail reports.¹ Current requirements for the accounting of disclosures intentionally leave out the internal uses inherent in more robust audit trail reporting.² Much of the concern related to the expense, the technical feasibility, and the confusion that likely would ensue. For instance, one transaction within an audit trail might give rise to more than 100 separate system entries during that same second. As a lay observer, what real conclusions can you draw about what occurred during that one second? That there were a 100 different logins to your record? Someone with technical expertise and experience with that system might see nothing out of the ordinary based on how that software functions and how it draws together different data elements in a process that seems integrated and simple to the lay end user.

In any event, once a court decides that an EHR creates a medical chart in the same way that word processing software creates a printed term paper, then assuming the audit trail is an additional product is a logical progression. But this is a fundamental misassumption. The truth is that an audit trail is a report generated using the EHR data and metadata. It is not automatically generated; an administrator must create the report. Sometimes the report is not generated internally within the software but through the use of external third-party software. If the audit trail is created in the face of discovery demands, it would be by definition created solely for litigation purposes. It is not a report that is typically run or even used by clinicians. Most clinicians are not familiar with how to interpret one. There are a variety of reports that software administrators can run, but that doesn’t mean the reports exist absent a court order compelling their production.

Moreover, quality assurance processes sometimes lead to minor alterations of the data or metadata. In one case, the plaintiff was convinced there had been an alteration of the record when what had occurred was that the hospital’s director of quality assurance had gone into the record and inserted tags to help identify what had happened for quality purposes.³

The court’s analysis in Flannery concludes that there is negligible harm in producing audit trail reporting to plaintiffs, despite privilege claims of peer review and attorney client privilege, because it will only display the names of persons who accessed the records, identify the documents reviewed, time/date, and what was done to the record. If this type of information was truly considered to be of negligible harm, then consider whether any court would require

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plaintiff’s attorneys to keep a time-stamped track of any time when their clients, experts, and their own office accessed records related to the legal proceeding and produce them to the defendants.

Could detailing the sequence of records, dates reviewed, and amount of time spent with different notations reveal something about how the defendant might construct defenses? If the plaintiff is not expected to keep such logs, why should healthcare defendants be forced to create similar logs for the plaintiff’s benefit? Surely the intent of the federal government’s requirement for having the ability to log all healthcare operations disclosures of EHR patient data was not to provide potential plaintiffs with an uneven advantage in proceedings against healthcare institutions and create additional costs. But the interaction of federal law and actions of trial court judges may be doing exactly that.

In any event, the decision making in Flannery is not unusual, for decisions like it are being made at the trial court level all across the U.S. These are everyday decisions that never find their way into supreme courts or casebooks, but they have a powerful practical effect on how far litigants can go in pressing for more, no matter how much it may cost those in healthcare to respond. As a result, healthcare institutions should be very careful about when they allow privilege holders, such as attorneys, litigants, and the peer review committee, to access the EHR directly, because their activity may be reproduced in exquisite detail later. Such activity may be revealed by a court order, and then, in addition, be subject to a lay misinterpretation by an adversarial party. The truth is that an audit trail is a report generated using the EHR data and metadata. 

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A high percentage of healthcare professionals in this country can expect to be sued during their career. Despite the presumption that juries are biased in favor of the plaintiff, the data points in the other direction, and yet, the common perception about how people actually decide cases is filled with misconceptions.

With healthcare professionals’ and organizations’ reputations—and large sums of money—hanging in the balance, it is helpful to know that what actually happens when juries decide these cases is highly predictable. What is the bottom line? It is that the witnesses you present, specifically the defendants, and the way they are perceived, are the keys to winning your case.

The four questions jurors ask
First, let’s consider how juries think. They ask a hierarchy of four questions: (1) Who can I trust in this lawsuit? (2) If I was in medical crisis, would I be in “safe” hands with this provider? (3) Under the circumstances of the case, did the provider do the best he could? (4) Did the provider make the right medical decision?

In Part Two of this article, I will discuss the variables at work in jurors’ perceptions of the evidence presented in a case, and then suggest some techniques for effective preparation of witnesses.
1. Who can I trust in this lawsuit?

Trust is the basis of all relationships, but the legal system is more complicated than many other situations, given the participants.

**Attorneys.** Lawyers have a fundamental problem in society—they are paid to speak for others, not for themselves, and juries believe that they will say and do just about anything to win cases. The research consistently finds one thing. Attorneys receive low marks for trustworthiness. A survey of federal jurors found that—after the trial was over—less than one-third of them believed that either side's attorneys cared at all about truth or justice. Advocating for others’ positions is the attorney’s job. People know they aren't there to say what they personally believe but, instead, what other people need them to say. The result is that people don’t trust what they say is the truth.

To make matters worse, attorneys are not especially accurate in their own perceptions about how they come across in the courtroom. Another study found that there was no correlation between the number of trials attorneys had done or their years in practice and jurors’ opinions about their rapport, enthusiasm, or articulateness. In fact, the longer an attorney had been in practice, the more likely it was he would underestimate how nervous he was and overestimate how
PREPARING WITNESSES

with the best experts wins. Not so. The “hired gun” perception is alive less than the lawyers: the experts. Many people believe that the side the one with testimony that was easy to understand and a low compensation was deemed least trustworthy. The most trustworthy expert was, again, and complexity of the testimony. The high-complexity/high-pay expert annoying. The researchers also tested for the effects of compensation 

The plaintiff. Contrary to popular opinion among many healthcare professionals, jurors are not particularly sympathetic to the typical plaintiff. Indeed, there is such a strong presumption of sympathy toward the plaintiff that the Federation of Insurance Corporate Counsel made a videotape, “Handling Sympathy in Jury Trials.” The tape suggested strategies for “counteracting the natural compassion that jurors feel for severely injured plaintiffs.” However, consistently in our research and that of others, this presumption has proved to be completely false. Indeed, jurors actually have a bias against plaintiffs. As Valerie Hans found in her research, “Jurors’ suspicions about plaintiff’s claims led them in most cases to dissect the personal behavior of plaintiffs, with seemingly no limits. Jurors criticized plaintiffs who did not act or appear as injured as they claimed, those who did not appear deserving, and those with pre-existing or complicated medical conditions. The state of their marriages, their treatment of their children and coworkers, and their financial status were all subject to close examination.”

Jurors ask themselves whether attorneys urge plaintiffs to lie or exaggerate their injuries. They, and the public at large, believe that there is much too much litigation in the U.S., that there has been a “litigation explosion.” Surprisingly, this opinion was also held by patients who had actually filed lawsuits themselves. Of those who did file, about 70% agreed with the position that there are too many medical professional liability (MPL) lawsuits filed each year. Jurors are suspicious of individuals who are asking for compensation in a situation where they (the juror) may have had a similar experience, but did not take action, referring to the plaintiff as “money hungry.” To a great

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The jury must believe that the healthcare professionals can be trusted, their patients are in safe hands, and they are motivated to do the best for their patients.

extent, plaintiffs come into the courtroom with the deck stacked against them, which is just the opposite of what the defendants may presume.

The defendant. The most important testimony in the case comes from the healthcare professionals testifying for the defense. Only rarely do actual jurors report they thought that the defense witnesses lied or exaggerated. Indeed, those in the medical field continue to be the most trusted people in the country. So it is vitally important that the defendants themselves be present during the trial. Jurors look at individuals. And frankly, they report to us that they draw negative inferences from a defendant’s absence. It is difficult to trust, let alone answer the other questions noted at the beginning of this article, if there is no one there to identify with. Only the defendants themselves can make that connection.

2. If I was in medical crisis, would I be in safe hands with this healthcare professional?

All MPL cases revolve around questions of safety and a sense of “abandonment” by the healthcare professional. Was he competent for the task at hand? In their professional capacity, there is no question that healthcare professionals are held to a higher standard than others in assessments of the quality of their decisions. Persons and organizations who are in positions of authority are, and we might argue should be, held to a higher level of responsibility. Patients and jurors need to feel reassured that they would be in safe hands in the defendant’s care, since their lives might well depend on it.

That is why credentials are not particularly important to jurors. In our research, only about 25% of the competency issue was decided on the basis of credentials, and that was focused primarily on experience, not education and training. Jurors believe that the more experience a healthcare professional has, the more competent he is. But the most important element for jurors in determining safety is a belief that the healthcare professional uses good judgment. Jurors want careful, thoughtful healthcare professionals. In actuality, they want the worries the whole concept of worry is linked to the notion of rumination (thinking something through very carefully), and that dovetails with Question 3.

3. Under the circumstances, did the healthcare professional do the best he could?

The number one thing jurors say to us when defendants win is, “They did the best they could.” Jurors talk in human terms. When they speak well of an organization, they speak in terms of individuals as well. Jurors understand that motivation makes a difference in the decisions a provider makes. They want a provider who has a personal stake in those he cares for. That is why the concept of worry is such an interesting one. Jurors understand that you don’t worry if you don’t care. They do believe that a provider who cares about patients makes better judgments.

Tell a jury what motivates people and organizations, and then they will decide whether hindsight bias will apply. Of course, by the time the case comes to trial, there has clearly been some sort of bad outcome. Once they learn about that, people have a tendency to exaggerate their capacity to predict the inevitability of the outcome. That works against defendants. People sitting on the jury already know that the patient had a problem, sometimes a fatal one. This is the “creeping determinism” or the “knew-it-all-along effect.” The only way a defendant can overcome this is to prove to the jury that he was careful, thoughtful, and, beyond that, had the best interests of the specific patient in mind—that his motivations were pure.

4. Did the healthcare professional make the right medical decision?

Why are the facts of the actual case the last thing that jurors decide? Because, in order to choose which side’s version of the evidence they will gravitate to, they must have made a basic decision already: “This is the party I am leaning toward.” This is especially true in cases, such as MPL cases, where experts testify virtually 100% of the time. The experts present completely opposite views of the medicine involved in the case. The jury can’t believe both of them, so they have to choose whom to listen to. First, they decide about the party in the case they will favor; then, they decide about the experts. And what matters to juries in evaluating experts? What counts is an ability to be truly helpful, to explain things in nontechnical, lay terms. Such experts are generally described as good teachers, with sound credentials and acceptable motives. The goal of witness presentation is to convince the jury that our view of the medicine is the right one by convincing them that those who testify meet the test of character.

This is the usual way people make decisions: If they don’t buy the messenger, they won’t buy the message. First, the jury must believe that the healthcare professionals can be trusted, their patients are in safe hands, and they are motivated to do the best for their patients. In short, people want healthcare professionals who exhibit character—whether in the examining room, the operating room, or in a deposition or courtroom. In the law, we call it credibility. If decision makers don’t answer yes to the first three questions here—the ones that are the foundation for credibility—juries won’t give us the benefit of the doubt on the medicine.

Editor’s note: Look for part two in the Fourth Quarter 2015 issue of Inside Medical Liability.
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17. Hans VP. Supra at fn 8.


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A.M. Best Company’s review of an insurer starts with an assessment of its balance sheet strength, operating performance, and business profile. Enterprise risk management is important too, since it impacts all three of these categories. Then, they look at country risk and the potential lift or drag from affiliates.

A.M. Best’s New Model for Its BCAR Metric
Rating agency to refine tool for use in financial ratings

How does Best’s Capital Adequacy Ratio (BCAR) fit within the general rating process? It is the ratio of adjusted surplus to net required capital. It is one element in the analysis of a balance sheet, but this assessment also includes considerations of asset quality, liquidity, cash flow, financial flexibility, asset liability matching, and reserve adequacy. Within the category of company performance, Best will look at items like financial statements and company forecasts, and compare that with A.M. Best projections. Finally, under the heading of business profile are items such as lines of business the company writes, management team, growth, distribution channels, and the geographic spread of the company’s exposures.

Additional metrics are based on the company’s risk profile, including event risk, risk appetite, and risk tolerance. How a company uses reinsurance is assessed as well.

Within this overall assessment, BCAR serves as an analytical tool used to evaluate current balance sheet strength and in making pro forma projections and “what if” scenario testing. These tests consider, for example, possible changes in the reinsurance structure, business...
acquisition or disposition, and changes in the asset (or liability) mix.

In the current structure of BCAR for property/casualty (P/C) companies, this ratio is expressed as adjusted surplus versus what a company needs in required capital. Adjusted surplus is calculated using factors such as equity adjustments (e.g., assets, loss reserves, and unearned premiums), debt adjustments (e.g., surplus notes and debt service requirements), and other adjustments (e.g., future dividends and future operating losses). To determine the net required capital, Best considers these risk categories in the gross required capital:

- Fixed income securities
- Equity securities
- Interest rate
- Credit
- Loss and LAE reserves
- Net premiums written
- Off-balance sheet.

Since it is assumed to be unlikely that all of these negative impacts will occur at the same time, Best adds a covariance adjustment.

**Rationale for the new BCAR model**

One of the principal drivers of improvement in BCAR is advances in the processes that underlie the ratio. More sophisticated and faster software is available, which makes it possible to use probability curves and thousands of simulations off of those probability curves. Best can utilize economic scenario generator (ESG) software to apply thousands of simulations of future paths of where the economy might go.

With software that is stronger and more sophisticated, Best can do a better job in calculating diversification credit than before. Instead of applying a straight formula, they can program in some correlation matrices and use those to calculate diversification benefits.

Best can also now incorporate more specific details in the annual statement. They can capture more information on assets and reinsurer credit risk—individually, by reinsurer. There is also more information on profitability and the volatility of loss development, and the impact on reserves.

They have also looked at some metrics that are better understood and used by the P/C industry, versus expected policyholder deficit (EPD) which is used in BCAR. One of these is tail value at risk (TVaR). This allows them to look at more of the probability curve. TVaR is an average of all losses beyond a given threshold, where the threshold is a percentile (e.g., 99%). It considers size of losses beyond that given threshold (financial strength). Another commonly used ratio is value at risk (VAR), or probability of default, the probability that a loss will exceed a given threshold. Also, it is now possible to use one consistent confidence interval across a multitude of different risks.

And all of these risks can be situated on a consistent time horizon. If they select “runoff to ultimate” as the basis, they can incorporate that in all of the risk categories. But some risks will need to include other areas of the balance sheet, such as duration of liabilities, as the indicator of ultimate risk. That would be the indicator of that ultimate time horizon. For bonds, Best can look at the duration of bonds, assuming that the bond portfolio is matched to the liabilities. For common stocks, it’s a little bit different in terms of volatility; the volatility cone around those market prices would get wider and wider, over time, so they consider a one-year time line, in concert with the annual review of insurers.

In short, the intent with the new model is not to change the underlying view of the risks or the main structure of the model. Instead, the goal is to generate risk factors using stochastic simulations to generate those underlying risk factors.

**Phase 1: Updates to metrics for bonds and common stocks**

A.M. Best is currently in Phase 1 of its work on updating BCAR (Figure 1). In the instance of bonds (Figure 2), the company will use the ESG in updating bond default risk factors to reflect the following:

- Duration of company’s bond portfolio
- Asset quality of company’s bond portfolio
- Volatility in bond default assumptions (stochastic portion—tied to ESG)
- Recovery on defaults (varying by rating)

**Figure 1: Overview of Proposed Changes & Work to Date Phase 1—Bonds**

- Use Economic Scenario Generator
- Update bond default risk factors
  - Reflect duration of company’s bond portfolio (SRQ)
  - Reflect asset quality of company’s bond portfolio (SRQ)
  - Reflect volatility in bond default assumptions (stochastic portion—tied to ESG)
  - Can offset default with recovery on defaults (vary by rating?)
  - TVaR metric (currently 5 year, 5% probability of ruin)
  - VaR metric?
TVaR metric vs. five-year, 5% probability of ruin metric
- VaR metric as alternative to TVaR metric.

This insurer information is captured in the supplemental rating questionnaire, “Bond Quality and Maturity” (Figure 2).

The analysis of common stocks, again, uses the ESG, which generates thousands of potential paths that the stock market might take. For these investments, Best’s supplemental rating questionnaire asks for a “Common Stock Beta,” requiring the beta and R-squared values for stocks, by country (U.S., Canada, U.K., Japan, and “Other”) (Figure 3). This indicates how the company’s portfolio will move, relative to the S&P 500. The VaR metric may be included in this analysis, too.

**Updates to metrics for reinsurance**

The credit risk factors for reinsurance will be updated as well, to:
- Reflect type of recoverable (paid, unpaid, unearned premium revenue)
- Reflect rating of each reinsurer (Schedule F/S and ratings data)
- Reflect duration of recoverables

Partial recovery when reinsurance defaults.
Best will be simulating 10,000 scenarios for each reinsurer, and the model will also reflect concentration risk. If an insurer uses a single reinsurer, there is a greater risk than with multiple reinsurers.

From these simulations, Best may use a TVaR metric or a VaR metric as part of determining balance sheet strength.

**Updates to metrics for premium risk**

P/C premium risk factors are being updated as well. Best has created four underwriting-loss probability curves for each line of business (schedule P), based on one of four net premiums written (NPW) size categories, resulting in 84 industry probability curves for premiums. The company NPW size is used to a select industry probability curve; the company profitability is used to adjust the curve. A company that is profitable has a greater profit margin built in to their pricing, and so can withstand greater downside loss, so they can be charged a lower capital requirement.

Best simulates 10,000 underwriting profit/loss scenarios on the adjusted curve for that company, for each line. Diversification across...
lines is captured, using one of four industry correlation matrices, based on the size of company's total NPW (VS,S,M,L).

Risk factors could be based on the TVaR metric (currently, 1% expected policyholder deficit, on an ultimate basis) or perhaps the VaR metric.

**Updates for reserve risk**

There are also updates to the P/C reserve risks. Best created probability curves for industry unanticipated adverse development for 21 Schedule P lines and four reserve size categories (VS,S,M,L). There are 84 industry probability curves for reserves.

The company reserve size is used to select industry probability curve; the company volatility is utilized to adjust the curve. A total of 10,000 simulated reserve development scenarios are applied to each line. Diversification across lines is included in the model using one of four industry correlation matrices, based on the size of company's total net reserves (VS,S,M,L).

Risk factors could be based on the TVaR metric (currently, 1% expected policyholder deficit, to ultimate). The VaR metric may be used instead.

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**Conclusion**

In the upcoming Phase 2, BCAR will include updated metrics for the remaining asset classes, and also for life and annuity risks. A.M. Best will also address the square root rule that is used to recognize diversification across the various risk categories and may consider a correlation-matrix approach instead.

For bonds, the new BCAR may indicate that there is greater risk for certain categories. The current construct of the model is just too narrow to reflect the risks within each of the current NAIC classes. A.M. Best plans on using a much broader approach that recognizes shifts in the bond portfolios by rating and by length of maturities. “A-” 20-year bond, for instance, have a much different risk profile than, say, “AAA” 20-year bonds. Also, a “BBB-” 20-year bond, in NAIC Class 2, will have a much different risk profile than a “BBB+” five-year bond. So, there will be more differentiation in terms of the bond portfolio evaluation.

In short, the goal of the new BCAR, by incorporating greater detail on a company’s financial metrics, and a more sophisticated analysis, is to provide a different picture of a given company’s balance sheet strength.
Errors in Medicine: Do Something Now?

Robert M. Bell, MD

Despite a plethora of data indicating progress in patient safety, some experts in the field think that the situation in regard to medical misadventure is not improving. For example, in January 2015, the Centers for Disease Control issued its annual report on hospital-acquired infections. It said while dramatic progress in reducing infections in hospitals had been made, the results failed to reach the national goals set in 2009.
Dr. Peter Pronovost undertook a study at Johns Hopkins that, in turn, led to a multi-center study in Michigan using his five-point checklist to ensure proper, sterile insertion of central venous catheters. The study was immensely successful: 1,800 lives and $100 million were saved during the 18 months of the study.

Dr. 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. Further, he says that in order to make this happen, we will need to understand disease biology, discover effective therapies, and ensure that those therapies are delivered effectively.

It would seem that the success achieved by Dr. Pronovost could well be reproduced in other areas of medicine, if the desire to do so was similarly motivated.

Of course, getting a full understanding of the complexities of medicine, and all the nuances associated with preventing errors in medicine, is a Herculean task that will probably require completely new approaches to patient interaction, diagnosis, training, and error-prevention strategies. If this is to be done properly, it will require greater national attention, robust funding, and a greater understanding of all of the elements in healthcare delivery—all supported by computer programs and systems far in excess of anything we have now.

However, one could start today by listing what needs to be done, and then asking interested groups and organizations to focus on the elements in the overall problem that they feel they can undertake right now. In this way, the ball will start to move—the Pronovost way!

Tasks that need to be addressed
The three lists below are by no means intended to be complete. But they may give some idea of the issues that need to be tackled. Further, it would seem like a good idea to introduce first those things that seem like common sense and then, if possible, evaluate and analyze all initiatives, and work toward ensuring that any change made is evidence-based.

The less difficult tasks
- Extension of the use of simple lists, similar to Dr. Pronovost’s ideas, to other areas of medicine
- Timeouts currently used, e.g., with surgery and, as appropriate, in other areas of healthcare practice
- Standards on methods for organizing thoughts
- Patient visit agendas/passports
- Providing lists of the most commonly made errors in the various sub-specialties
- Diagnostic “pearls of wisdom,” and recommendations to help in distinguishing the more serious diagnostic situations
- Learning the fundamentals of situational awareness, attention to detail, and consequential/critical thinking
- Focusing on prediction, prevention, detection, and correction
- Improving accuracy and reducing errors in healthcare professionals’ (HCP) offices that can readily become transferred to the hospital environment. Most office-based errors may appear innocuous, but via the so-called Swiss cheese phenomenon, wherein many small errors become additive, the outcome could be serious or even fatal.

The more difficult tasks
- Adoption of team concepts among all HCPs, patients, and local communities.
- Coordinated communication within and among healthcare facilities
- Reviewing what is working in the U.S. and the rest of the world to evaluate what could be introduced generally in the U.S.
- Finding sound approaches to overcoming language difficulties
- Hand-washing compliance
- Medical and allied professional education to embrace safety in each and every aspect of teaching
- Obviating pharmacy errors via bar coding and eliminating confusing abbreviations
- Introducing proven strategies to minimize laboratory and radiology errors
- Addressing electronic health record issues
- Optimizing the functionality (and privacy) of patient/HCP portals
- Adopting community prevention programs
- Systematic collection and storage of safety data
- Maximizing what can be learned from the airline and other industries
- Recommend that every HCP private office has the equivalent of a safety officer, who collects data on error incidents and regularly conveys that to the HCP and other office staff on a periodic basis for handling/correcting.

The very difficult tasks
- An accurate nationwide data-collecting system for errors in medicine
Simulator training

Countering the widespread problem of owing some measure of allegiance to a code of silence, commonly coupled with a strong desire to resist change

Correlating root cause analyses and failure modes effects analyses results with patient safety initiatives, and assessing the resulting reduction in errors

Overcoming a lack of transparency

Finding strategies to tackle the relative sense of the unimportance of prevention in medicine

An appreciation that in complex systems, changes to one part of a system can significantly affect other parts

Finding solutions to the current challenges to telemedicine

Securing the requisite data to obtain an accurate overview of the national situation

Harnessing advanced computers to help in case management and in reducing diagnostic errors

Securing sufficient funding to make all of this happen.

While there are multiple organizations participating in preventing errors in medicine, what seems to be missing is a collective and coordinated, nationwide approach to the various elements of the problem. The concept of a consortium of interested parties that would drive the process would be well worthwhile investigating. Such a consortium could become a bottom-up endeavor, passing from one group of HCPs to another. This is important, since there does not seem to be the political will in the U.S. to make this a top-down initiative.

Such a dedicated conference should have a well-defined purpose and goal, with a focus on patients. Interested patient safety organizations and specialty societies, as well as the insurance and hospital industries and other stakeholders could take on the aspects of the challenge that they, within their budgetary restraints, feel comfortable in handling. It might just be one or two small tasks or studies that an organization would be comfortable undertaking—but every small initiative would be contributing to the whole.

It would be best if each participating group could organize and fund its own projects, with any studies undertaken being done with the cooperation of hospitals and academic institutions, when and where necessary. General funding would help move the process forward, but this is not absolutely necessary to get things started and underway.

Consider: If we can put a man on the moon and are now planning to send humans to Mars, surely we can do something on a national scale that could improve patient safety.

The Institute of Medicine is, in 2015, to issue a report on errors in diagnosis (estimated now to be about one-third of all errors in medicine). The 64th Annual Scientific Session of the American College of Cardiology was held in Southern California in March 2015. The meeting, it was said, was designed to be innovative, interactive, and informative, and would leverage the entrepreneurial environment of Southern California to inspire registrants. What an invitation to attend!

So much could be done toward the goal of preventing errors in medicine with the right leadership, inspiration, and the willing cooperation of many.

Reference

The growth in innovative coverages found in these captives must be accompanied by innovative actuarial solutions, so that the actuarial findings are reasonable, justifiable to auditors and regulators, and in compliance with actuarial professional standards of practice.

Business owners are exposed to a diverse and ever-expanding array of financial risks. Many healthcare providers have been insuring a subset of these risks through captives for reasons documented in many other articles. Several of the coverages common in the new breed of healthcare provider captives differ substantially from coverages available from commercial carriers and older healthcare captives in one important dimension—availability of claim data.

**The spectrum of claim data availability**

Claims for property/casualty coverages range from those with high frequency and low severity to those with low frequency and high severity. For example, a coverage such as automobile physical damage (APD) typically experiences many claims, but few large claims. We can use this as a representation of one end of the spectrum. Ask an actuary to develop a pricing (or “funding”) estimate for APD and what will he do? Most likely, he will ask you for loss runs, exposure information, and details about the program and the layer of loss that is covered. This will form the basis of his funding estimate, and actuaries with the req-

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**Actuarial Creativity Required for Healthcare Provider Captives**

By Aaron N. Hillebrandt, FCAS, MAAA, CPCU, is a Consulting Actuary with Pinnacle Actuarial Resources, Inc.

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Reading an actuarial report typically brings a few adjectives to mind, but “creative” isn’t a common one. However, actuarial creativity is exactly what is needed when developing captive insurance companies (captives) for healthcare providers.
uisite experience can do this reasonably well. We can call this, generally, a traditional experience-based rating method.

Moving toward the other end of the spectrum, consider medical professional liability (MPL). We would expect MPL to experience fewer claims than APD but, on average, anticipate that the claims would be more severe. The traditional method may continue to work reasonably well for larger MPL risks, although some differences are common. (We won't go into detail in this article, because healthcare providers have insured MPL through captives for many years.)

If we continue on our path toward the far end of the spectrum, we begin to encounter coverages for risks that are new or evolving, or ones that healthcare providers haven't traditionally insured. These coverages may include, but are not limited to:

- Cyber liability, including electronic medical records
- Defense costs related to the Health Insurance Portability and Accountability Act (HIPAA) reviews and/or actions of oversight organizations
- Defense costs and penalties related to billing audits from the Centers for Medicare & Medicaid Services or healthcare insurers
- Contingent business interruption related to losing key drivers of income (key personnel, referrals, practice privileges, etc.)

What these coverages have in common is that there is typically little or no historical claim data for deriving a funding estimate. This situation is not your run-of-the-mill actuarial exercise, so what's an actuary to do?

**Actuarial creativity**

The answer lies in actuarial creativity, which becomes a necessity for developing reasonable funding estimates in this situation. The actuary must think critically and creatively about what data is or may be available in order to select one or more actuarial methodologies appropriate to each of the coverages under consideration. The right solution isn't always apparent or straightforward. Beyond just complying with actuarial standards of practice, the actuary must also be prepared to justify the reasonableness of his funding estimates to auditors and regulators.

Healthcare captive owners and managers need to be sure they have chosen an actuary who has more than just experience in healthcare; he should also have the creativity and judgment necessary to perform these services successfully. One component of this evaluation may be the amount of discussion and questions between the actuary, captive manager, and captive owner throughout the entire captive feasibility study. The more time the actuary spends gathering information about the insured(s) and the coverages being offered to them, the more likely it is that the result of the actuary's work will be reasonable.

The discussion and questioning should go in both directions. Captive managers and owners should be comfortable questioning their actuary about his analysis and models. For example, data used, significant assumptions, how the methods and assumptions used reflect the insurance coverages offered, and past scrutiny of the actuary's models by auditors and regulators are all items that should be covered to maximize the captive manager's and owner's comfort level with the premium estimates.

**Is it worth it?**

Now, let's pause for a moment to consider whether these new types of coverage that have little or no historical claim data are really worth the time and expense of insuring through a captive. Perhaps they should be considered as just one part of the overall cost of doing business?

The risk of data breach can serve as an example. The Identity Theft Resource Center reports that not only are the annual number of data breaches increasing, but data breaches to the healthcare/medical sector are becoming a greater proportion of the total (Figure 1).

Part of this increase is the result of the mandatory reporting of protected health information (PHI) breaches to the U.S. Department of Health & Human Services (HHS), as required by the 2009 HITECH Act.

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**Figure 1** Number of Data Breaches by Sector

**Figure 2** Number of PHI Breaches by Individuals Affected
Act. However, the key driver is the growing use of electronic medical records, which may be more vulnerable to a breach due to the technology involved. If we look specifically at the HHS database, which includes breaches affecting 500 or more individuals, we find that about a third of recent PHI breaches affect 5,000 or more individuals (Figure 2).

This tells us that a substantial portion of such breaches could lead to higher-severity losses. In fact, 2015 has already seen the two largest incidents in the history of the HHS database, both involving hacking of a health plan’s network server. In the breach affecting Premera Blue Cross, 11 million individuals were impacted; in the breach affecting Anthem, 79 million individuals were impacted. Potentially severe breaches can also happen to providers, as evidenced by the 2013 Advocate Medical Group breach, caused by a theft of computers, which affected more than 4 million individuals.

An additional source of uncertainty comes from the potential dollar impact of a breach, even when the number of affected individuals is known. As shown in Figure 3, there is no evident relationship between the number of individuals affected by a breach and the ultimate HIPAA settlement. Figure 4 focuses on HIPAA cases with settlements under $2 million with fewer than 10,000 affected individuals.

The cost of a breach can extend far beyond any HIPAA settlement that may potentially be involved, including the costs of investigating the cause of the breach, identifying and communicating with affected individuals, legal defense fees, and data security improvements. Also, a provider may experience fewer new patients and a loss of existing patients after the breach becomes publicized.

Based on this cyber liability example, it is clear that given the significant uncertainty and potential for severe losses, retaining this exposure as just another business risk may be imprudent for many healthcare providers. As a result, healthcare providers in increasing numbers have been placing coverage for risks such as this in captives.

Once the coverage is being considered for a captive, the actuary is charged with translating the exposure into a reasonable funding estimate. Because of the significant uncertainty involved, coupled with the lack of historical claim data, the methodology the actuary should employ is not obvious. Actuarial creativity becomes key.

**Conclusion**

An analysis like the one above could be completed for a variety of new and emerging coverages to illustrate why they are commonly being found in the new breed of healthcare provider captives. As innovative coverages are increasingly being written by captives, innovative actuarial solutions must go hand in hand.

It is vital that the actuary performing a funding analysis for a new coverage has the experience and judgment necessary to successfully arrive at a reasonable result while simultaneously satisfying actuarial professional standards of practice. Captive managers and owners should actively engage with, and evaluate, their actuary in this regard to ensure that the calculated premiums are appropriate for the level of exposure being assumed by the captive. This will help satisfy auditors and regulators, and more importantly, it will help safeguard the long-term financial health of the captive.
The 2015 Medical Liability Conference, in Las Vegas, Nevada, brought together more than 500 insurance professionals, all looking to gain key insights into the global—and day-to-day—issues facing the medical professional liability (MPL) community. The meeting addressed the most important topics these professionals needed to learn about and discuss. All of the conference proceedings were set amid the perennially exciting city of Las Vegas.

The 2015 PIAA Medical Liability Conference

Topics covered included finance, new applications of simulation, the impact of big data on healthcare and MPL, and the likely fallout from the ongoing rollout of the Affordable Care Act (ACA). Attendees left the meeting with a clearer perspective on the present and future of the MPL business, and with specific strategies for meeting the challenges of the evolving healthcare system, both in the U.S. and around the world.

Keynote address

The big changes we’re seeing in healthcare are not being driven by developments like the ACA or regulations, noted keynote speaker James E. Orlikoff. Rather, he said, these are just symptoms. The real drivers are several mega-trends that have converged on the country all at the same time. These include the steady increase in globalization and the concomitant decrease in the U.S. capacity to control what happens or compete. In addition, we’re experiencing a major change in demographics, a flipping of the pyramid in size of the population of aged versus young.

Also the percentage of the gross domestic product (GDP) consumed by spending on
healthcare keeps increasing at an alarming rate. In 1970, 7.2% of the GDP was allocated to healthcare, versus 17.9% in 2009 and 2010. But now, Orlikoff said, we are actually on the edge of the cliff, with 18.9% of the economy consumed by healthcare. There are some easily evident negative impacts from this misallocation. Healthcare is now the biggest employer in the U.S. Yet clearly, someone has to be making the stuff we need.

Orlikoff knows whereof he speaks. He is a National Advisor on Governance and Leadership to the American Hospital Association. He is concerned that the "medical industrial complex" will destroy the U.S. economy, since $3 trillion was spent on healthcare in 2014. In contrast, only 4% of the federal budget was spent on defense.

The phrase “bending the cost curve,” Orlikoff said, has become popular in recent years. But, he noted, we are past the point where incremental change is sufficient. Instead, what we have to do is break the cost curve.

There has been a recent decrease in the rate of increase in healthcare spending. This is probably a result of trends like the expansion of the cost shifting that is built into high-deductible plans. Only 4% of insureds were in such plans in 2005 as compared with 31% in 2011. With high-deductible plans, people tend to postpone care or seek lower-cost retail clinics.

When they have to pay for it themselves, healthcare ranks about fifth in the order of priorities for household spending. People are now asking new questions, namely, why do I need this treatment, and what happens if I don’t get it? In fact, Orlikoff points out, there are dozens of entities waiting in the wings to grab healthcare dollars. Google, Intel, and Microsoft, as well as CVS and Walmart, will all be selling healthcare apps that will significantly disrupt the market. They will drive change, especially in imaging and clinical laboratories. Walmart will install an MRI in each store and charge a flat rate of $800 per scan.

In addition to the costs of care, patients will be focusing more on safety, Orlikoff said. They will be asking to see the safety statistics for providers and hospitals.

How can those in healthcare, and MPL entities, best react to this newly transformed environment? They should encourage experimentation and develop a healthy tolerance for risk and uncertainty. They should ask themselves about ways to play new roles in this consumerist market.

Peter Sweetland Award
Victor T. Adamo was named as the recipient of the 2015 PIAA Award of Excellence in Honor of Peter Sweetland. Adamo was honored for his significant contributions and steadfast dedication to the MPL insurance community and PIAA.
Focus on a Session
“Patient Safety Organizations: Today’s Landscape and Tomorrow’s Implications”

A Patient Safety Organization (PSO) can be formally defined as an entity or a component of another organization that is listed by the Agency for Healthcare Research and Quality, based upon a self-attestation by the entity or component organization that it meets certain criteria established by the agency. The primary activity of an entity or component organization seeking to be listed as a PSO must be to conduct activities to improve patient safety and healthcare quality.

But why would an entity want to take on the role and requirements of a PSO? Three presenters considered this question, and provided some interesting answers.

Scott D. Geromette, Esq., of Honigman Miller Schwartz and Cohn LLP, noted that, among other benefits, a PSO fosters a culture of safety and creates a secure environment where providers can collect, aggregate, and analyze data, and identify and reduce the risks and hazards associated with patient care. They can thereby improve both the processes of care and its outcomes.

The information included under the PSO umbrella includes “data, reports, records, memoranda, analyses or written or oral statements that are assembled by a provider for reporting to a patient safety organization” (Patient Safety and Quality Improvement Act, 2005). Subject to some limitations, this information is not discoverable and may not be used in criminal, civil, or disciplinary proceedings.

Cathy Pusey, RN, Manager, Clinical Analysts, ECRI Institute PSO spoke about the potential challenges in forming a PSO. Security is a prime issue, and effective security must be in place for all aspects of the PSO database, including access, storage, and transmission. Then, there is a need for a fully qualified staff for the project. A third, perhaps more basic, challenge is that there is no designated funding available for PSOs.

But Pusey feels that what is gained, such as the learning and sharing that take place, and the federal legal and confidentiality protection a PSO confers, are well worth the effort and investment.

Finally, D. Scott Jones, CHC, Health Providers Insurance Exchange, noted that although PSO participation was linked in the ACA to payment, making it essentially mandatory, the new deadline for participation is January 1, 2017—so that PSOs have more time to grow and develop processes. Specifically, there is meant to be sufficient time “to include standards around hospitals and PSOs, healthcare providers, and healthcare quality mechanisms.”

One-on-One with a Speaker: Luke Sato, MD
During the conference session “Simulation Is Safety: Perspectives from Aerospace, Human Factors, and Healthcare,” one speaker was Luke Sato, MD, Senior Medical Officer, CRICO.

Inside Medical Liability: In considering the possible applications of simulation, surgery seems like the obvious candidate. But are there others?

Sato: Yes, and the way we use it falls into two general categories. One is technique-based simulation, and the other is
what we’re calling team-based care simulation.

The other area where we’re using simulation is in team-based care improvement—communication among the team. This type of simulation involves a whole group of individuals, working, as a team, on scenarios. The entire process is videotaped, and then the videos are used as a basis for debriefing on how well the team communicated with each other.

**IML:** You were trained in computer science as well as in neurology. Do you think simulations will become more sophisticated—including more of the variables needed to replicate human physiology?

**Sato:** Absolutely. Think about technology moving to a point where bandwidth becomes less and less expensive, and more readily available; that’s what has been happening. With this new capacity, simulations are becoming startlingly real.

As simulation becomes more sophisticated, maybe, in the future, you’ll be able to do things pretty much the same as in reality. That’s a science fiction vision come true.

**IML:** That will change what companies will need from a risk management point of view.

**Sato:** Right. I think simulation will help in identifying the individuals more likely to practice in a riskier way versus those less likely to take risks.

There are also tools that let you measure the riskiness of an environment. If it’s an emergency department, for instance, people say that if it’s crowded and chaotic, it tends to be an environment. If it’s an emergency department, for instance, people say that if it’s crowded and chaotic, it tends to be an area of high risk. If you combine the measures for riskiness of the environment with the measures of the riskiness of an individual, you can see what the outcome might be.

You can use this to evaluate—or even predict—risk.

**PIAAPAC Breakfast Attendees Hear Expert Analysis on 2016 Presidential Race and More**

**Tom Bevan,** co-founder and Executive Editor of RealClearPolitics, the popular website for all matters related to politics and policy, who had addressed a packed room at the PIAAPAC luncheon in 2014, was back by popular demand at this year’s MLC.

“You have two distinctly different views about the efficacy of the ACA, whether it’s good or bad,” said Bevan. “I’m trying to think of what the latest polls show: I think people like it better now, but I think that if you keep a running average on whether the public is for or against the president’s healthcare law, it’s been negative since its inception. That ACA was under water since before it was even a law.”

Bevan noted that the new Senate leadership was focused on a variety of policy goals and on accomplishing several solid achievements early in the Congressional session.

“Republicans now want to show that they can get stuff done, that they can govern,” stated Bevan. “That’s been one of the things that they’ve been hit with—that there are right-wing, anti-government folks who want to see the government go away. But as we get deeper into the race, everything sort of takes on that 2016 filter.”

Bevan wouldn’t make any specific predictions for the 2016 presidential contest, given the number of potential candidates in the race, but he did opine on some of the more interesting Senate contests. He also noted that while every race is different, the presidential race could have a huge impact on some of the down-ballot contests, especially in states like Illinois, Nevada, and Florida.

**Focus on a Session**

“Hard Lessons Learned with Systemic Risk: Defense and Plaintiff Counsel Perspective”

In systemic risk, multiple claims involving one or many defendants, entities, or insureds are based on a common cause or theory, said Thomas J. Donnelly, Esq., Donnelly Nelson Depo & Murray. They usually involve product liability, medical procedures, medical practitioners, hospital practices, HIPAA, data breaches, and electronic medical records.

One example of systemic risk from a medical device that has received significant press coverage is the morcellator. First approved in the mid-1990s, power morcellators are widely used in minimally invasive (laparoscopic) hysterectomies and uterine fibroid removal procedures. Every year, 600,000 women undergo hysterectomy or fibroid removal. At the same time, one in every 350 women who undergoes these procedures has an occult undiagnosed or undiagnosable tumor. If a morcellator is used in these women, and detectable cancer ensues, the upshot may well be a lawsuit.
The 2016 Medical Liability Conference will be held in Washington, D.C. Don’t miss the premiere conference for the MPL community. Make plans now to attend next year’s event!

Inside Medical Liability: Do you foresee new legal risks from genetic testing?
Marchant: Yes, absolutely. Patients will get this kind of information through direct-to-consumer channels or from their healthcare provider. But they may not be clear about it—what it means or what its implications are.

But then, at some point down the road, if they have a bad outcome, they’ll want to talk to a lawyer about a lawsuit. And then, hindsight bias may come into play.

Doctors will be subject to a tremendous amount of second-guessing about information after the fact that, at the time, was either very unclear or the patient didn’t have the requisite education or tools to deal with.

And there will be new kinds of duties for doctors. For example, when doctors get the results of a genetic test, or even a whole genome sequence, they may not know what it means.

But then, two or three years down the road, we find that a particular marker does in fact have a significant risk, does a doctor have a duty to go back to the patient—find him—even if he is no longer working with him, and notify him about it?

This is completely uncharted territory. If you throw this question to a jury, you never know what you will get out of it in the end.

IML: Are plaintiff’s attorneys trolling for these kinds of cases?
Marchant: Yes. We have already found several websites where plaintiff’s attorneys are advertising as genetic malpractice specialists, and that they’re looking for new clients.

IML: Is there anything the MPL community can do to advance the understanding of this issue with the providers—to help educate them?
Marchant: I think there is a definite role here for provider education from MPL entities, to help providers understand this new science. The other thing doctors need is clear standards. If they comply with the current state of the art, they should be protected from being sued.
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n the Australian health system, the general practitioner (family physician) is a broadly trained, accessible, affordable point-of-first-contact and referral for patients. Eighty-seven percent of Australians have a family physician, but only 50% of Australian doctors have one, with surgeons being the least likely to have a family physician.1

This year, the new Medical Board of Australia2 has sought to reduce the incidence of health-related complaints by allocating $2 million dollars annually from medical registration fees ($20 per doctor) to independent local, state, and territory doctors’ health service providers. These will offer educational and clinical support, in addition to the phone advisory services already in place for doctors and medical students.

This small but nevertheless important investment can leverage the capital and human resources within the profession for the common good, especially if there are complimentary efforts by the medical defense organizations.

Why doctors avoid the doctor
We understand two basic precepts, that “prevention is better than cure” and patients will be healthier if they have their own doctor. While these are sound value propositions, doctors can be reluctant to apply them to their own personal circumstances. There are many factors that contribute to this mindset, including:

- The competitive culture of medicine
- Fear of discovery and its consequences
- Hostile, competitive working environments
- Career jeopardy
- Unsatisfactory doctor-doctor consultations that are not patient-centric3
- Convenience and privacy of self-treatment
- Poor recognition of illness in oneself
- Reluctance to assist an unwell colleague
- Absent income protection insurance
- The occupational health risks of drugs in the workplace
- A catastrophic view of mandatory notification as a career-ending event.4

How unwell doctors behave
These barriers encourage a whole spectrum of help-seeking behavior, ranging from risky self-treatment for everything, on the one hand, to formal consultations with the family physician on the other. Doctors commonly opt for a blend of the two.2

Doctors may be reluctant to access formal healthcare to avoid the “waiting room experience” and the significant opportunity cost of in-hours attendance.

It is not surprising, therefore, to find that a busy doctor has opted to take a drug sample for an incorrectly self-diagnosed problem and
then proceeded to hastily run it past a polite but dismissive or disinterested colleague in the corridor!

**Impairment progression**

Doctors can appear to function professionally while imperceptibly drifting along a pathway from wellness through illness to impairment. Efforts to conceal symptoms may intensify as impairment progresses.

Recognition of illness and impairment is less likely among mentally unwell doctors who lack sufficient insight and judgement and are frightened of what’s happening. This is significantly compounded when the doctor is junior, female, remote, high-profile, solo, culturally inhibited, or professionally disconnected.

Warning signs of “impairment progression” can be missed by busy colleagues or deliberately masked by wary doctors who, cognizant of the potentially catastrophic cost of discovery, are trying to resolve their health issues privately, in their own way.

Warning signs of mental illness include:

- Poor interpersonal behavior, disruption, or irritability
- Risk-taking with boundaries, reputation, career, billing, notation, clinical scope of practice, and guidelines
- Absenteeism or working excessively long hours
- Overt use of alcohol or drugs
- Cynicism and a focus on income
- “Compassion fatigue”
- A dismissive and trivializing attitude to patients. In particular, risk-taking can be a symptom of depression.

Such behavior can trigger significant patient dissatisfaction and a complaint when expectations are not met. South Australian experience suggests that complaints derive from four common categories of unmet need. These are the “4 Ts”:

- **Time**: lack of time, excessive waiting time, tardiness of a clinical response, delayed decision-making
- **Talent**: exceeding one’s scope of practice, lack of clinical skill contributing to a poor medical or surgical outcome, diagnostic errors
- **Trust**: misleading information, suboptimal consent, failure to follow-up or recall
- **TLC** (tender loving care): lack of concern or empathy, dismissive attitude, desertion, and insistence on payment despite a bad outcome.

While many internal and external factors may be involved, the contribution from a doctor’s illness cannot be ignored. Consider a patient’s reaction to being treated by a:

- Depressed doctor who lacks energy, concentration, empathy and thoroughness
- Burnt-out doctor who is dismissive, lacking compassion, and is instead cynical about medicine and focused on income
- Anxious, hesitant, or obsessional doctor with poor time management skills
- Exhausted, lonely, overworked, and estranged doctor who seeks comfort in the arms of an appreciative, dependent patient.

Further exacerbating the unhealthy situation are workplaces that expect doctors to:

- Work when hungry, dehydrated, unwell, sleep deprived or fatigued
Complete detailed documentation in time-poor and under-resourced departments and clinics with little time for detailed clinical handover

Perform flawlessly during prolonged unrelieved periods of stress.

These are unhealthy workplaces that sow the seeds of illness in doctors and discontent in their patient.

**The potential role of medical indemnifiers in doctors’ health**

The few organizations in Australia that have 100% coverage of doctors and students are in a unique position to influence the health of the profession as a whole.

The Medical Board of Australia has optimized its contribution, within its statutory constraints, but there is now an opportunity for Australia’s four medical indemnity organizations, MIGA, MDA National, MIPS, and Avant, to mitigate health-related MPL risk through a preventative health approach that detects impairment progression as early as possible.

This requires a culture change that encourages every doctor and student to accept preventive health checks as a professional responsibility.

Check-ups are widely accepted by the profession as worthwhile. Providing support for them can significantly increase participation and induce doctors who have not previously seen another doctor to do so.

**Risk management strategies that indemnity providers can implement**

MIGA has invested in doctors’ health as a risk-mitigation strategy and supported the health of its doctor members with:

- A significant annual 10% premium discount for doctors who undertake a comprehensive, evidence-based medical check-up and participate in an interactive workshop or activity
- Quality face-to-face and online risk management education that focuses on the health and wellness of doctors
- 24-hour support for medico-legal duress
- Collaboration with existing doctors’ health service providers to access a personal physician.

Doctors’ Health SA (DHSA) is one such provider in South Australia that offers:

- A 24-hour colleague-to-colleague phone advisory service
- An after-hours medical clinic for doctors and medical students in the Adelaide capital central business district
- Website links and online appointments
- Education and training
- A network of trained doctor-friendly family physicians across the state.

DHSA will soon introduce resiliency training for junior doctors and telemedicine consultations for rural doctors.

MIGA has worked with DHSA to promote doctors’ health to all of its members across Australia.

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**What others are doing— the corporate approach**

The medical profession can learn from the corporate approach to employee health and well-being, which demonstrates a return on investment through recruitment and retention, loyalty, productivity, creativity, innovation, and staff morale.

Corporations know the value of executive health checks, employee fitness programs, and the provision of opportunistic health screening and immunization in the workplace.

Prevention is better than cure, and suboptimal doctor health is a modifiable risk factor that can be mitigated through a bolder, more corporate approach to the health of the profession on the part of medical indemnity organizations.

It is in everyone’s interests to do so. 

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**Ten Key Points**

1. Healthy doctors practice better medicine and promote their positive lifestyle habits to their patients.
2. Doctors are healthier if they have their own doctor.
3. Unwell doctors can become patients without a doctor.
4. Sick doctors are at risk of not meeting the needs of patients for time, trust, talent, and TLC.
5. Self-treatment is very common.
6. There are multiple barriers that prevent doctors from seeking help.
7. Mental illness is twice as common among female as compared to male doctors.
8. Clear and confidential pathways of care for doctors are needed.
10. Doctors are least satisfied with life at 40.7 years of age.

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**References**

James E. Orlikoff was the keynote speaker at this year’s Medical Liability Conference. He is President, Orlikoff & Associates, Inc., and National Advisor on Governance and Leadership to the American Hospital Association. Following the keynote address, Inside Medical Liability sat down with Mr. Orlikoff for a conversation about his vision of the future of healthcare—and how medical professional liability (MPL) fits into that.

Inside Medical Liability: What metrics should we be using to assess the value of healthcare dollars?

Orlikoff: The real question is, what is the purpose of healthcare? We understand now that you can’t do everything, for everybody—so what are we actually trying to accomplish? Is it to add years to life? Is it to add life to years? Is it to make sick individuals healthy? Is it to keep populations healthy?

What we do know—clear as a bell—is that you can’t do all of that. So the real question isn’t, what are the metrics going to be, the real question is, what should the metrics be? What is our health system designed to accomplish?

One of the great problems that we are facing is that the overriding objective now is to lower healthcare costs—even if that yields worse health outcomes.

So an assessment of healthcare pretty much depends on the metrics—what we decide as a society that we are going to be looking at.

Orlikoff: No, and if we don’t have that conversation, the default metric will be reduction in healthcare costs. Look at the consequences. Right now, because of antibiotic resistance, we’re seeing the return of diseases we thought we’d vanquished.

Here’s something people can’t get their minds around: is it possible for healthcare to get worse? They think it has to get better. But look around: is public education getting better or worse? The answer is, it’s getting worse. Infrastructure, roads, electrical transmission grids—better or worse?

So why do we think healthcare can’t get worse? If we’re not careful, we’ll see the same forces that hit these other sectors are going to hit healthcare, and instead of an ascending curve of quality and innovation, we’ll see a descending curve.

Orlikoff: It is. And it is the only area where we still have it. Most people don’t expect public schools or roads to be as good as they once were. They’ve acclimated to it, and now that same acclimation is likely to come to healthcare. See, that’s part of the problem: people still expect—cure me, come up with a new miracle, and less and less of that is going to be happening.

Will MPL have to change in tandem?

Orlikoff: They should change ahead of it. Because the risk you run is that risk management goes away—becomes subsumed—by patient safety. Patient safety goes away—becomes subsumed as an integral part of the value proposition. You cannot provide cost-efficient care and you cannot provide quality care unless it is safe care.

So if in fact we reduce the number of medically related patient injuries in this country, which we are going to have to do in order for providers who have assumed risk to stay in business, you begin to obviate the need for the risk management function. You begin to obviate the need for the patient safety function.

And ultimately, when you get to a full-risk environment, you begin to obviate the need for traditional medical professional liability (MPL) risk products. That doesn’t mean that the need goes away. But
that's the great challenge for this industry—to figure out how it can make itself relevant to changes that the customers are trying to make themselves relevant to. And many of the customers don't know what they're doing. So it's tough, it's very tough to do.

You can say that the providers are feeling these new forces first. But you provide services like insurance to the providers. You really need to be thinking about what pressures your customers are under, and how they are changing, so you can help them make this change. Before they understand what they need, you can be already giving them what they need, and helping them through the transition.

If you wait till they come to a rational conclusion, you will go out of business. Because they may not come to that rational conclusion. So it's a very challenging time for providers of services to the actual deliverers of healthcare—which is what the insurance industry basically is.

**IML:** Do we know if people will bring different standards to purchases like an MRI from, say, Walmart?

**Orlikoff:** We do know that. When you pay cash for something, you expect something very different. At a minimum, you expect transparent pricing. And you don't expect to wait around for two hours. So yes, there are very different expectations.

This is what the acute care providers are struggling with. If I'm paying cash out of pocket, and you treat me like a Medicaid patient, I'll go somewhere else. It's just like any other market.

For years in healthcare, we called ourselves patient-centric, but in fact we were the most provider-centric business you could imagine. You had to make yourself relevant to us, come at a time that was convenient for us, and we'd keep you waiting, charge you outrageous amounts of money, and not tell you what the costs were—and at the same time, provide a poor quality of care. And then act like we were saviors of the world. This is one of the reasons we saw the malpractice problem emerge—because we weren't providing good care, and because we lied about it.

So in fact, malpractice, the willingness of individuals to sue for malpractice, was an expression of an anti-consumerist sentiment by the providers. All the research shows that you need to make sure that you do what you say you're going to do, and get more involved in the decision. If we did that right, and we treat the people not as patients but as partners, there is a very good chance that we could fundamentally change the dynamic of traditional malpractice insurance.

**IML:** So this period is something like a shakedown cruise?

**Orlikoff:** Maybe, but the problem with the shakedown cruise concept is that it implies that you've got a margin for error and that you've got time to practice. This is a shakedown cruise without a net (to mix metaphors). This is shakedown cruise where there are submarines in the water. You need to know that if you make too many mistakes while you're learning, you're going to get torpedoed. There is no submarine net to protect you.

**IML:** So our member companies really need to keep up with the evolving market?

**Orlikoff:** No. They need to stay ahead. They really need to be thinking, what are the threats to our business model? And not, how do we keep doing what we've been doing and just fight a delaying action? We need to ask how do we change what we're doing, and make ourselves relevant to our traditional customer base, in ways they didn't realize.

The pressure that your association, and your members are under, is number one, all of these forces are going to force a consolidation in the traditional and most lucrative customer base. So there will be fewer customers.

Also, the risk exposure for the retail market will be very different. And so the CVS's and the TheraNo's and the video chats aren't going to be your customers. So you have not only fewer customers, they will also have less money. And more of the disruptive players will not be the traditional customers of medical professional liability programs.

Then, the traditional customers that have gotten big will start to say, we need to take so many functions that we used to pay money for, and we've got to bring them internally. There is the risk that they may say, let's have our own captive insurance company.

Then there is the risk that when they start really assuming risk for health of a population, they're going to recognize that integrating risk with the malpractice risk will give them more control over the ability to both provide higher-quality care at lower cost and also to minimize MPL exposure.

Just as there is a very real question, will we need hospitals in the future, so there is the question, will we need MPL insurers in the future.

**IML:** Don't say that.

**Orlikoff:** No, this is real, and the leaders who don't ask this question are the ones that won't be here in the future. The surviving leaders will say, I don't like that; let's think about why I don't like that; and let's honestly examine that question and see what we can do to make sure that the answer is that we are really necessary.

**IML:** But many of our companies are in exciting new kinds of endeavors, they're not sticking their heads in the sand.

**Orlikoff:** No, and I think that's wonderful. But I think the question is, at what point does the provider not need you because they can do it themselves? When I become really good at predictive analytics in terms of delivering care, how much harder is it to become good at predictive analytics for minimizing MPL risk? So what are the firewalls—what is the value? How does the value that you bring change the pressures that I face change? At a minimum, you have to stay abreast. You have to know more about what is confronting your customers than they do, you have to stay ahead of this, so you can be seen as a resource to your customers, as a partner in figuring out new products.

You never want to be in a position where your customer says, "Yes, I'll use you, but you're next on my list to cut out." That's what a lot of these systems are thinking about, as they internalize more and more functions.
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This article will review the reimbursement issues first, since they are a major topic in conversations about transitions of care. Unfortunately, it is the reimbursement penalties that are driving the discussion at this point and not the quality issues. So the article will then focus on how medical professional liability (MPL) companies can influence the redesign of transitions in care, specifically the discharge process, for both hospitals and physicians.

Consequence of readmission
In a survey conducted by HealthLeaders Media Council in September 2013, senior hospital leaders indicated that 85% were addressing the CMS 30-day readmission penalty in their current business plan. The survey also revealed that hospital leaders were working with other healthcare providers to identify strategies for reducing preventable readmissions.

Now in its third year, the Centers for Medicare & Medicaid Services (CMS) Hospital Readmissions Reduction Program (HRRP) is applying the maximum penalty, 3%, for readmissions. The list of conditions considered in assessing the penalties now includes total knee and hip replacements and chronic obstructive pulmonary disorders. The purpose of these penalties is to prompt improvements in quality and to decrease the cost of healthcare by reducing readmission rates and, ultimately, decreasing adverse events.

A change in culture
Readmissions that incur penalties typically indicate gaps in quality that can result in MPL claims. A common theme in any discussion on readmissions is how to improve the discharge process or care continuum. But this is not a simple matter; it involves time, staff hours, and a targeted analysis and evaluation of the facility’s discharge process, readmission, and post-acute adverse event statistics.

Hospitals are facing a substantive challenge in motivating physicians to participate in identifying the specific nature of the problems they face and asking them to help in defining solutions. Because physicians are busy and are not currently affected by the CMS readmission penalties, their participation is limited and sometimes absent completely. Another challenge all hospitals face, but in particular small hospitals, is the cost of completely redesigning the program and capturing data absent physician participation or buy-in.

As the era of healthcare reform continues, hospitals and facilities are busy collecting data, redesigning processes, and identifying lapses in the quality of care by their staffs and physicians. The challenge for most healthcare providers is to identify and implement high-reliability systems and processes to optimize patient care transitions, and thereby prevent medical error and also avert the costly new penalties associated with Medicare readmissions.

Ann F. Whitehead, RN, JD, is Vice-President Risk Management & Patient Safety at the Cooperative of American Physicians, Inc.
MPL carriers are in a unique position to influence change and reduce adverse events, readmission penalties, and potential liability for their insureds by providing guidance and risk services in regard to transitions in care and discharge plan development. To start the conversation, I will discuss what you should consider in the redesign of a hospital discharge program and what hospitalists and primary care providers (PCP) can do.

**Hospital discharge plans**

Discharging patients from the hospital is a complex and comprehensive process. The focus of any new discharge program should be to move patients safely out of the hospital to their next site of care, whether it is at the patient’s home or a skilled nursing or rehabilitation facility, in a manner that prevents unnecessary readmissions and adverse events, such as medication errors and errors related to lack of follow-up. This requires a transfer of all of the relevant medical information from healthcare clinicians to the patient and his family or the new facility’s staff.

The patient discharge process should be more patient-centered and also more consistent. Unfortunately, there is no standardized patient discharge protocol. Therefore, it is important for acute care facilities to choose a protocol that is aligned with the culture of the organization and the providers using it, focusing on reducing administrative burden and clinical time.

An important factor, with any system redesign, is to identify the high-risk patients early in their acute-care stay—when they are admitted. Discharge planning should begin on admission for these patients. Special attention should be given to community and family support, and on what services will be needed and if they are currently available.

The discharge process should include both pre-discharge and post-discharge procedures. Before discharge, the patient’s discharge team, which may include hospital staff, hospitalists, PCPs, nursing and rehab centers, home health agencies, family members—and last, but not least, the patients themselves—must be on the “same page” to ensure compliance with these other important processes. Transitions are frequently linked with adverse events, especially medication errors and lack of follow-up appointments, and these may well lead to readmissions. So be sure the patient is given:

- Comprehensive written discharge instructions
- Complete medication list, instruction and side effects
- Date of scheduled follow-up appointments

- Healthcare provider contact information for questions.

After discharge, hospital staff should continue to provide support to patients through follow-up, telephone consultations, assessing patient compliance with medications, evaluating further care needs, and arranging necessary future appointments.

**Physicians and the discharge process: hospitalists and PCPs**

Good communication between hospitalists and PCPs at the time of discharge is critical to patient safety and to the reduction of risk. Historically, this communication has been “one-way,” in the form of a discharge summary. Studies have pointed out the insufficiency of this approach:

“[F]ollowing hospital discharges nearly half (49 percent) of hospitalized patients experience at least one medical error in medication continuity, diagnostic workup, or test follow-up.”

The following risk reduction strategies will focus on the transition of a patient from an inpatient to resuming life at home. But many of the strategies below can be applied to transitions to skilled nursing facilities and acute rehabilitation facilities. These strategies include timely delivery, improved content and formatting of the discharge summary, and ways to improve communication between hospitalists and PCPs.

**Discharge summaries**

- Only 12% to 33% of discharge summaries were available to the PCP at time of first visit. With the addition of hospitalists, discharge summaries have become a mechanism for conveying information and transferring responsibility from the inpatient physician to the outpatient physician. The discharge summary should tell the PCP about what happened during the patient’s hospitalization and should include, at a minimum, the diagnosis, discharge medications, results of procedures, follow-up needs, and pending test results. Discharge summaries should be structured with subheadings, be thoughtfully organized, and highlight the most important information. Also, if the discharge summary is to be useful, the information in it must be up-to-date, and it should be received before the patient’s first visit with his PCP.

**Pending results and follow-up of abnormal test results**

- Only 25% of discharge summaries mentioned some of the pending tests, and only 13% mentioned all of the pending test results.
About 25% of all medical liability lawsuits arise from failure to follow-up. Many patients are discharged with pending test results or abnormal test results that require follow-up that PCPs are not aware of. There is a risk to patient safety when no one takes responsibility for pending results or the follow-up of an abnormal test. The old adage “if you ordered it, you own it” is still a good place to begin in determining who should take responsibility for pending tests. Hospitalists, who order tests, are ultimately responsible for follow-up of the results from those tests. Facilities need to develop a system that notifies the hospitalist of any test results that come in after the patient has been discharged. The system also should provide a method for transmitting the results to the PCP. Lastly, abnormal test results that require follow-up should be documented in the discharge summary.

Communication

At discharge from the hospital, only 3% to 20% of the time is there direct communication from the hospitalist to the PCP. More than half of all preventable adverse events that occur soon after discharge can be traced to poor communication. The gold standard in communication is direct physician-to-physician communication at the time when a patient is discharged from the inpatient setting. However, limited time on both ends makes this system impractical. Some other suggestions include telephone follow-up by the discharging hospitalist, a phone message with a name and contact information for questions, or electronic delivery, through a health information exchange, of the complete and accurate discharge summary. Irrespective of the system that is used for communicating patient information between physicians, it should be routinely assessed for deficiencies, timeliness, and completeness by all parties to minimize the risk of liability and improve patient safety.

Conclusion

No matter what strategies are used and how they are applied, it is irrefutable that the rapidly evolving healthcare environment requires that each facility take a second, third, or even fourth look at its patient discharge process, and also review its data on overall admission rates, emergency department visits, and readmission rates. Decreasing the rate of hospital readmissions and associated adverse events should be a high priority for every healthcare facility and its physician staff.

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Nothing great is ever achieved without assuming risk.
Most metrics last year only inched up or down from their previous year's marks, providing little hint of what lies ahead. The sector's strong, some would say enviable, financial results have buffered insurers from the ongoing upheaval, and for some insurers they are providing the wherewithal to overcome whatever may befall them in the future.

While financial strength will still be important, the forces now sweeping through the healthcare market will also call for agility and diversification. It's a call that MPL insurers have heard before, but this time the call is fueled by market forces that go beyond mere prompts to diversify.

Last year, MPL insurers extended their run of profitability, ending the year with a combined ratio of 92% and marking the ninth consecutive year when the metric was less than insurers' theoretical break-even point of 100%. Only a few points worse than the previous year's result, the ratio remains in line with results of the past five years.

During this time, the ratio bounced around, after bottoming just below 80% in 2008 but then rising to, and hovering in, the high 80s to low 90s since then.

The 92% combined ratio gave insurers a profit of $0.08 before investment income for every dollar of coverage they wrote. But as in years past, this profit stemmed from releases of reserves for prior accident years, which have offset companies' current estimates of losses on policies written in 2014.

Without the reserve releases, which accounted for approximately 20 points, insurers' aggregate combined ratio would have been 112%, a figure that is fairly consistent with the past four to five years (Figure 1). Compared with the broader property and casualty insurance industry—which has posted combined ratios in the range of 96% to 108% in recent years, including a two- to three-point boost from reserve releases—ratios in the MPL segment are, comparatively, much better.

**Hard to ignore**

And while profitability has been considerably better for MPL insurers when compared with the broader property and casualty market, premiums have been under severe pressure for nearly a decade. Last year, premiums fell 4.5% from the 2013 level, the largest year-over-year decrease in the past eight years. Over this time, premiums have withered to $8.2 billion and are at their lowest point since 2002, the advent of the last hard market (Figure 2).

The nearly decade-long decline in premiums is the longest stretch of year-over-year declines in the past 30 years and far exceeds its closest rival, which petered out after only two years in the late 90s. At that time, rates quickly became inadequate, prompting the market to harden. But even now, after eight years of waning premiums, there is only spotty evidence that rates are inadequate. This is because of the huge reduction in frequency that took place during the early to mid-2000s and left insurers in an advantageous position, and the fact that premium is leaving the commercial insurance marketplace as physicians continue to leave private practice to affiliate with hospitals and large medical groups.

But the insurers' reprieve isn't going to last forever. Over the past 10 years, physician insurers have seen their markets dwindle, as more physicians shutter the doors of their independent practices and seek employment at hospitals or large medical groups, in an attempt to

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Medical professional liability (MPL) insurers are in the midst of enormous change in the healthcare market, but there has been little more than a ripple in insurers' financial results over the past several years. And 2014 was no exception.

**Survival: It's More Than a Numbers Game**

**BY RICHARD B. LORD AND STEPHEN J. KOCA**

Richard B. Lord, FCAS, MAAA, and Stephen J. Koca, FCAS, MAAA, are Principals and Consulting Actuaries in the Los Angeles office of Milliman.
stave off the rising operating costs and flagging incomes.

With the implementation of the Patient Protection and Affordable Care Act (ACA) and its renewed focus on lowering healthcare costs while improving quality, the exodus of physicians from independent practices is likely to continue, if not accelerate, and cause a further contraction in the physician-insurers' traditional exposure base.

This trend is fairly well defined, but the ground is still shifting for MPL insurers in ways both foreseen and unforeseen. One example is the influx of individuals into the healthcare system, which has been in line with many estimates, but their demand—or, rather, their lack of demand—for the services of primary care physicians has been somewhat unexpected. Many had speculated that as individuals became insured, they would seek the services of primary care physicians, potentially increasing their exposures.

In reality, primary care physicians haven’t felt the severe crunch for services; instead, hospitals have observed an increase in emergency room (ER) visits. The reason may stem from the payment structure of many individual policies, which have copays for primary care visits or require full payment because of deductibles but do pay for ER visits. This unforeseen demand for ER services could increase hospitals’ exposures while leaving physicians’ exposures relatively unchanged.

What one hand taketh away, the other giveth

The ACA has indeed triggered a contraction in the MPL market, but it may also offer MPL insurers that are willing and able to adjust to the new landscape a way out of the impending cutthroat competition that is likely to ensue as the soft market deepens.

One dominant feature of the new landscape is the accountable care organization (ACO), a network of doctors, hospitals, and other healthcare providers charged with coordinating patient care in an effort to improve quality, while also reducing costs. Like health maintenance organizations (HMO), a primary care physician is at the heart of the patient’s care with ACOs.

While ACOs are far from a new concept, their numbers have ballooned since the ACA, climbing from 164 a year and a half after the enactment of the law to slightly more than 606, as of 2014.

Despite this growth, their success is far from assured. This is because the current healthcare system is highly fragmented, and treatment protocols are largely decided by independent-minded physicians who have considerable leeway in managing a disease. Now they must adapt to a new system whose processes are being reconfigured to conform to the goals of ACOs. Under ACOs, healthcare providers will be expected to coordinate care and adhere more closely to quality standards.

As part of this transition, physicians will most likely need informational tools that help them in safely integrating services across the spectrum of care, while also keeping up to date on best practices. This development opens the door for MPL insurers that, until now, have only provided continuing education. Now they can step in to bridge the risk-information gap. This strategy would allow them to maintain or, in some cases, to establish relationships with physicians who are now employed at hospitals or working in large medical groups.

Forward-looking MPL insurers can also partner with self-insured hospitals or large medical groups that do not have expertise in underwriting MPL for physicians. Some have started to focus on providing risk or claims management services for physician risk as a way of establishing or maintaining client relationships. Whether the services involve preventing a claim against a physician or devising strategies to defend against a claim, insurers have started to redeploy their expertise and target hospital systems or large medical groups that have not had the resources or desire to develop these specialized skills, which can contain claims costs and help to solidify the hospital’s relationship with its physicians.

By unbundling services, MPL insurers have started to shift their focus from providing risk transfer mechanisms, whose results can often be volatile, to risk-related services whose revenue streams are

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**Figure 1** Combined Ratios, Before and After Reserve Releases

<table>
<thead>
<tr>
<th>Ratio to Net Earned Premium</th>
<th>Calendar Year</th>
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<tr>
<td>2009</td>
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<td>2010</td>
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<td>2011</td>
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<td>2013</td>
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<tr>
<td>2014</td>
<td>100%</td>
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- **Loss, LAE, and Underwriting Expenses**
- **Policyholder Dividends**
- **Prior Year Reserve Releases**

Source: SNL Data: Medical Professional Liability. All companies excluding Swiss Re
likely to be more predictable. This shift may be only the first step in insurers' transformation, which could involve developing products and services that are more relevant to the changing healthcare landscape.

As an alternative, some MPL insurers may also choose to pursue more traditional options that involve streamlining processes for providing fronting arrangements to institutions in states that require coverage placement with a licensed insurer, or providing excess MPL coverage to hospital systems or large medical groups.

A storied past
And while the road ahead is uncertain, fortune has indeed shone on MPL insurers since 2003, when insurers first began to see a decrease in claims frequency. It took another four years before they realized the change wasn’t an anomaly but, instead, a sea change in their baseline frequency. Over the intervening years, insurers have benefited from this sudden, unprecedented, and unexpected plunge in frequency, which resulted from the confluence of several factors and has underpinned insurers’ abilities to release reserves for the past nine years.

At the same time, severity of losses has risen steadily, though not precipitously. The combination of somewhat predictable increases in severity and a much lower baseline for frequency has paved the way for MPL insurers’ long run of profitability. Recently, however, there has been increased activity in very large claims, which has raised some concern, but the still relatively low numbers of claims of this magnitude make it difficult to determine if the observed jump in mega-awards is an aberration or a developing trend.

One conspicuous source that might provide an explanation is a weakening of tort reforms, but reversals for the most part haven’t happened. Of the 32 states that have enacted caps on noneconomic damages, more than two-thirds remain in place or have had only minor alterations. And the plaintiff lawyers’ challenge to California’s landmark tort reform, enacted some 40 years ago and a bellwether for reform in other states, was rebuffed this past November in a voter referendum. One point of interest, however, is that even states with traditionally strong tort reform laws have not been entirely shielded from an increase in claims severity, because many of the large awards are often the result of anticipated high costs for future medical care or other related items that typically do not fall within the scope of the damage caps.

Even so, the continual pressure on claims severity, MPL insurers’ relentless decline in premium, and ongoing changes in the broader healthcare market have made for decidedly unsettled times. Standing in place goes against the grain of a rapidly changing market and ignores the opportunities that lie ahead. Survival, indeed the future, is likely to go to those insurers that not only have the financial resources to weather the transition, but also the foresight and the agility to develop the products that support the next generation of healthcare providers. Unlike prior calls for diversification, this time market forces are driving change. Agility as much as financial strength may define who will survive.

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You wake up in the morning with a stuffy nose, headache, chills, and maybe a fever, too. The first thing that comes to mind is that you should probably stay home from work. Or is it? If you’re like most people, your response is precisely the opposite—you’ll try and find some way to soldier on.

In fact, more than one in four American workers surveyed during last year’s flu season said that they show up to work while they’re ill, even though they could very well make their colleagues sick. The survey, conducted by a public-health testing group in Michigan, found that employees worry about getting behind in their daily workload, possible recriminations from their supervisor, or loss of a day’s pay, if they take a sick day.

It isn’t surprising, then, that the healthcare professionals we work so hard to protect feel the same way—actually, maybe more so. JAMA Pediatrics recently came out with a study that revealed that three-quarters of the medical practitioner respondents admitted to working while they were sick—despite the potential risk to their patients.

Why do they do this? Healthcare professionals cited reasons that ranged from preserving the continuity of care and not wanting to let their patients down, to concerns that enough staff would be available.

In addition, interestingly, some survey respondents reported that they keep the fact that they’re sick to themselves, for fear of professional ostracism for continuing to work when they know that they probably shouldn’t.

In our efforts to support physicians, surgeons, doctors, and advanced practice clinicians, we need to find ways to help break this chain. One way could be to provide some helpful guidance in the design of new staffing systems in physician practices, clinics, surgi-centers, hospitals, and other facilities. Or, we could develop support services or other resources that would make it possible for healthcare professionals to make the right choice to keep their patients and co-workers free from infectious illness, while at the same time taking better care of themselves.

The statics reveal that our work is cut out for us. The JAMA Pediatrics survey found that 95% of the physicians polled believed that working while you’re sick puts patients at risk; but 83% had nonetheless worked at least once during the previous year while they were ill.

The ramifications for potential liability, not to mention the ethical considerations of such practices, are considerable. So we owe it to our doctors, nurses, and every other healthcare professional, and their patients, to develop some innovative variation on the proverbial “doctor’s note” for them—and encourage them to use it whenever they need it.

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