Using Data—and Science—to Limit Defense Costs

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It is very gratifying that in 2015, there is an important discussion taking place in the United States and around the world about patient safety and safe medical care. For years, in discussing the topic of patient safety, the media has painted an unflattering picture of healthcare professionals. The publication of the Institute of Medicine’s (IOM) To Err Is Human in 1999 has been the genesis for much of this negative coverage. A widely publicized statement in the report noted that at least 44,000 and possibly as many as 98,000 Americans die each year due to medical errors. This credibility of this report, however, is far from flawless. The statistics for patient deaths that were cited in To Err Is Human came from a Harvard Medical Practice Study, which used 1984 data from New York and 1992 data from Colorado and Utah. Of course, the resulting media attention and perpetual recitation of the report’s findings have obscured the fact that these statistics were not credible as they were extracted from undersized samples. For instance, the finding of 98,000 deaths nationally was magnified from an analysis of only 180 deaths that occurred among 30,000 patients.

In the months and years after the publication of To Err Is Human, a steady stream of scientific articles set forth rigorous critiques of the estimates in the report. But little, if any, of this work has ever been cited by the popular media.

The fact is, there has been enormous progress in patient safety since the 1999 IOM report was issued. Leveraging big data in ways that promote patient safety is one important new tool. Another is root cause analysis, which can reveal with precision the factors that led to a particular medical misadventure.

There is also some excellent work being done on patient safety by organizations with a global focus. Two excellent examples are the programs undertaken by the World Health Organization and the Organization for Economic Cooperation and Development.

We in the MPL community have witnessed the exciting proliferation of programs like Patient Safety Organizations. PSOs aggregating event-level data are poised for breakthroughs in understanding patient safety. And in more immediate terms, most of us have witnessed the steady decrease in MPL claims over the last 15 years in the U.S. and other parts of the world.

Despite this well-documented headway, some in the media still depict a healthcare environment fundamentally unchanged since 1999 in regard to patient safety. Furthermore, in most media coverage of complex healthcare issues, no context is provided, there is a tendency to focus on the negative, and to ignore the granular data that provides the specifics and which often doesn’t support the broad generalizations in the media.

But the tide may be changing. Earlier this fall, a new study was issued by the IOM titled Improving Diagnosis in Health Care. This IOM report notes that, frequently, diagnostic errors are not the result of negligence, but instead, of failings in the health system as a whole. It highlights the need to improve communications between healthcare professionals, and between those professionals and their patients, acknowledges that inappropriately applied health IT can contribute to errors, and criticizes our legal system for focusing on punishment rather than addressing the causes of diagnostic errors. Most notably, the report calls for state and federal action to address our broken medical liability system.

Progress to ensure that the reality about healthcare is published may be slow—but it is progress nonetheless. And you can be sure that PIAA will continue to serve the interests of our members and those you insure—and to counter negative publicity about patient safety with that most powerful of counterarguments: the facts.
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“The big data analytics is quickly becoming an essential tool for MPL insurance companies trying to get a handle on their ballooning defense costs.”
—Cover story
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**COMING ATTRACTIONS**

**EVENTS & CALENDAR**

- **2016 Marketing Workshop**
  - *Tribal Leadership: Creating a Culture of Excellence*
  - The culture within an organization is one of its core elements, with a direct impact on quality, satisfaction, and financial outcomes. So it is important to know how to characterize the current culture in your organization, and how to improve it using techniques derived from the latest research. During this session, Halee Fischer-Wright, MD, President and CEO, Medical Group Management Association (MGMA), will discuss how to assess your current culture, and then explain how to align it, based on shared values and the role of team excellence. Dr. Fischer-Wright, a nationally recognized healthcare executive and physician leader, started her own successful medical practice early in her career, and then spent time as a management consultant. She also served as president of Rose Medical Group in Denver, a 680-physician PHO/MSO for 12 years. She co-authored the *New York Times* bestselling book, *Tribal Leadership*, and is a nationally recognized speaker. Dr. Fischer-Wright will help attendees understand how culture affects organizations, the leverage points best suited for improving culture, and how to create high-performance teams.

- **2016 Dental Workshop**
  - *The Science of Dentistry and a Glimpse into the Future*
  - Dentistry, like many other healthcare professions, has evolved at a breakneck pace over the last few decades. Advances in the field include changes in technology, techniques, treatments and modalities, care settings, and patient interaction. These changes present challenges, as well as opportunities, for dental professional liability insurance carriers and for the dental professionals whom they insure. Daniel M. Meyer, DDS, Chief Science Officer, American Dental Association (ADA), will discuss the evolution of dentistry over the past decade and the likely future landscape of clinical practice and patient care. Dr. Meyer, an endodontist who has been with the ADA for more than 20 years, directs the Association’s scientific activities, including the ADA’s Evidence Based Dentistry Center and the Council on Scientific Affairs. He has also been a scientific advisor to the World Health Organization and the Centers for Disease Control and Prevention. Dr. Meyer will present an overview of the most important dental research, practice trends, and environmental factors that have influenced dentistry in recent years. In addition, he will help attendees gain an understanding of the triggers (regulatory, environmental, scientific) influencing changes in dental practice and their relevance to clinical care. Dr. Meyer will also offer a perspective on the evolution of dental practice models and the delivery of clinical care.

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**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

**March 9-12, 2016**
**March 10-12, 2016**
**April 6-8, 2016**
**April 6-8, 2016**
**April 6-8, 2016**
**May 11, 2016**
**May 11-13, 2016**
**July 27-29, 2016**
**October 20-21, 2016**
**May 17-19, 2017**
**May 16-18, 2018**

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

**April 6-8, 2016**
**Dental 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.

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

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

**September 28-30, 2016**
**Technology, Human Resources & Finance (THRF) Workshop**
Royal Sonesta
New Orleans, LA

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

**Future PIAA Medical Liability Conferences**

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

**May 16-18, 2018**
**Waldorf Astoria/Hilton Bonnet Creek**
Orlando, FL
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Insurance Networking News thinks you can. The publication holds regular “Innovation Roundtable” discussions in New York, where innovators from insurers and banks can (according to one facilitator) “come out of their day-to-day battles, take a tactical pause, and share their knowledge.”

The September 18 session was focused on the Internet of Things (their initial caps, not Observer’s) in insurance. The view from the roundtable was nothing short of dizzying. One participant summed up the discussion thusly: “We have been doing the business of insurance according to ‘effects analysis’ for 300 years. That is, actuaries and underwriters have been looking backwards and projecting what contract terms should be going forward.”

IoT, he said, will displace all of that out-of-date machinery with something called “casual analysis.” Using this approach, insurers will discover the true causes of loss—and how to avoid them.

Among the manifest benefits of this new way of analyzing present and future business, roundtable participants note, is that IoT is changing “the profile of the skills required in insurance.” In particular, “Actuarial science is giving way to data science, as more predictive techniques and more non-traditional data sources are used.”

The next step, according to roundtable attendees, is to form a consortium of insurers that will partner with NYC-area universities to establish an “insurance data scientist training program.”

But how is this new professional actuarily much different from an actuary? At the Observer desk, we’ll be waiting patiently to find out.

Some recently reported metrics might make you think that ACOs are indeed providing some benefit. According to one recent study, the Medicare Pioneer ACO program, in its initial year, was linked with “modest reductions” in low-value services that provide minimal clinical benefit to patients.

Writing in the online publication JAMA Internal Medicine, J. Michael McWilliams, MD, PhD, and Aaron Schwartz, PhD, of Harvard Medical School studied the use of 31 low-value care services before and after the ACO program began. These services included certain cancer screenings, preoperative testing, and cardiovascular testing.

Here’s what they found: a reduction of 0.8 low-value services per 100 beneficiaries, which translated to a 1.9% reduction in service quantity and a 4.5% reduction in spending on these services.

Okay—maybe a 4.5% decrease in cost is worth mentioning. But the “0.8” decrease in low-value services? That would seem to stretch the adjective “modest” to some new limit.

Noting the challenges inherent in prompting physicians to think about their work in a new way, Arnold Milstein, MD, MPH, of Stanford University comments, “Although adjusting practices to lower costs is a stretch from physicians’ traditional role, the well-being of their patients and their communities now depend on it.”

Source: Medical Express, September 21, 2015
Solvency II: Watchdogs Caution on ‘Ridiculous’ Levels of Capital

Senior European watchdogs are cautioning insurers that they may be holding too much capital, in the advance of Solvency II rules that will come into play on January 1, 2016.

“There is a lack of understanding of how the [Solvency II] regime works,” said Gabriel Bernardino, chairman of the European Insurance and Occupational Pensions Authority (EIOPA).

Insurers seem to be publicizing their capital strength—as measured by their Solvency II ratios—well above the target requirement, says Karel Van Hulle, a former European Commission official, frequently dubbed the “father” of Solvency II.

At a press conference on September 8, Van Hulle said, “Some (national) supervisors expect some companies not (only) to be in conformity with the solvency capital [SGR] requirement, but have an SGR that is 100% higher, which is ridiculous.”

He added, “I hear stories from the market that supervisors are trying to behave like that, which I do not like.”

The idea here is to have insurers publish SGRs and risk sensitivities that will make it possible for analysts to make sound comparisons among companies. He warns that the companies that have opted not to carry excess capital “should not be penalized from a capital perspective and a cost of capital perspective because they are more transparent and are publishing numbers that are more risk-based.”

Source: Property Casualty 360, June 22, 2015

Plaintiff’s Firm to Reward Students for ‘Medical Malpractice Videos’
We are not making this up. Honest.

The Eisen Law Firm, of Cleveland, recently launched a ground-breaking new project. It is a contest targeted to two groups of students: high schoolers, and everyone else. The challenge is to create a video (no longer than two minutes) to increase public awareness of medical malpractice and to advocate for its victims.

More specifically, the videos must address one of two prompts, notes Eisen Law:

1. Medical malpractice lawyers are often the butt of jokes. Tell us your favorite lawyer joke. Then tell us why it isn’t funny.

2. In Shakespeare’s “Henry VI,” Dick the Butcher says, “The first thing we do, let’s kill all the lawyers.” Why might that be a bad idea for the future quality of health care?

Speaking about his new pet project, Larry Eisen of The Eisen Law firm says, “I am passionate about eliminating preventable medical mistakes. By educating teens and young adults about the dangers of malpractice, I hope our firm can spark the same passion in a younger generation.”

The deadline for submitting videos is January 15, 2016. But why not get started on the storyboarding right now?

Source: Blackbird PR News, September 21, 2015
WHERE IS YOUR DATA?

The PIAA Data Sharing Project (DSP) is evolving with new features for DSP participants. Listed below are just some of the benefits that come from participating in the DSP. Are you ready to share?

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

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Let's start with some numbers.

- From 2005 to 2014 the expense ratio at medical professional liability (MPL) companies rose from 16.4% to 24.0%. That's compared to the property/casualty (P/C) industry as a whole: the expense ratio increased from 25.5% to 28.0% in the same period. MPL companies' expenses have increased three times faster than those of P/C insurance carriers as a group.

- Conning Research's report, "Property/Casualty Expense Management: Trends and Guiding Principles for Holistic Benchmarking" indicated that insurers' expense ratios have recently peaked to a 40-year high.

- A recent benchmarking study by Novarica found that 50% of IT budgets were spent on running the businesses, 30% on growing the business, and just 20% on transforming the business.

The main components of the expense ratio are staff costs, agents' commissions, and administrative expenses—everything from office space to IT. Without question, some of the increase in MPL companies' expenses over these nine years has been due to the increased use of agencies, as companies moved into new states and group sizes increased.

But that can't be the full story. A company's ability to effectively track and control expenses is critical to its survival, especially in a soft market. With salary and employee-based costs high on the list of growing expenses, enhancing efficiency through investment in technology is something that every insurer should pay close attention to.

If only 20% of the IT budget is available for "transforming the business," that's a problem. It speaks to an environment that is too high-maintenance—80% of the IT dollars are spent on keeping the ship afloat. The 20%/80% ratio needs to be changed if a company wants to get the best from technology. This may lead to an increase in costs in the short term, because of the components that are consuming the resources that need to be replaced, but it is a necessary step in becoming an efficient operation. Depending on the situation, some improvements can be made incrementally, but in other cases, a complete replacement of the legacy infrastructure is needed. Regardless of the particular situation, the application of new technology will fall under four main headings.

Automating key processes
Technology has already (or should have!) replaced the tasks done by raters, typists, billing clerks, and many other functions, allowing staff to be used for more high-value roles. But often, more can be done; here are some examples:

- Document management systems offer a quick return on investment, by migrating the company to a paperless environment—there is no need for paper files, and staff have instant access to documents.

- Business rule and workflow engines allow computer systems to monitor activity and keep track of critical activities in all areas of the business, thereby increasing efficiency and improving service.

- Integration of software components also offers major benefits. There is no longer any excuse for having to re-key the same data in different systems. Application data should flow into a quote without having to be re-entered; payments through a lock box should be imported electronically, and so on.

- Elimination of off-line processes is essential too. It's a sure sign of weakness in systems when some functions are being handled offline using spreadsheets or manual records. This is usually a Band-Aid approach—not the most efficient way of doing business.
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**Improving responsiveness to business change**

If a change in the computer systems, in response to new business initiatives, happens too slowly, that points to a software architecture that is not easily adaptable. This is serious, because it generally means that significant re-engineering—or replacement—of the current systems is needed. There can be workarounds—for example, quoting can be done on a standalone basis, and that may be acceptable if the quote is then integrated into the legacy back end. But generally, it will not be ideal.

If this is an issue, the solution may be long term and costly.

**Leveraging data**

Transactional systems of necessity gather a great deal of data in order to handle the operational needs of the company, including rating, issuing the policy, handling claims, collecting premium, and so on. This data is an important asset to the company—provided it can be accessed efficiently. Modern data warehouses allow for this. A non-technically-savvy user should be able to create his own reports using drag and drop tools, so that ad hoc queries can be done to test hypotheses about the business; for example, what is the relationship between the deductibles and the loss ratio, comparing the performance of selected specialties, exploring the demographics of new business to see where growth is coming from, etc. The information gained from the data can be converted into actionable changes to the way the company does business.

There is another, quite different, use of data that is emerging in MPL. Predictive modeling and analytics have evolved in commercial and personal lines of business, and they are now widely used, unlike 10 years ago.

One new initiative in the MPL industry has combined IT and actuarial expertise to apply predictive analytics to MPL. Data on some 60,000 physicians over 10 years was used to test about 500 variables to reveal the correlations between each variable and actual results. Then, the number of variables was pared down, and the analysis continued by looking at the combined effect of several variables together, to finally arrive at a working model that stood up to the test of applying it to historical data. Predictive analytics now offers a tested new tool to supplement the expertise of the underwriter.

**Opportunities for self-service**

Self-service means having policyholders and agents use facilities provided by the carrier via the Internet to accomplish certain tasks. Some examples:

- Requesting a certificate of insurance and passing it electronically to the certificate holder
- Making a premium payment
- Obtaining a credentialing letter
- Processing an address change
- Getting copies of policy documents
- Enrolling in various payment options

The agent might have additional or different functions in regard to policyholders:

- Running expiration lists
- Obtaining loss histories
- Doing indication quotes
- Processing policy changes subject to authority rules that can be automated
- Getting copies of billing statements
- Viewing commissions.

The ability to offload these tasks is a win-win situation. Agents and insureds generally see the ability to do these things 24/7 as a matter of convenience and service. The company benefits by not having to allocate its staff to do the work. Both parties benefit from improved timeliness.

Obviously, security and privacy, as well as ease of use, are key concerns in exposing company functions to the outside world, but given the far deeper penetration of self-service with banks and brokerages, there is no question that this is feasible. The use of business rules at the back end to track what is happening and to intercept certain activities lets the carrier automatically monitor what is happening: for example, a policyholder processing an address change might be referred to an underwriter in case it involved a change in rating territory.

**Conclusion**

Unless the insurer is already on board with using IT to gain competitive advantage, there are many opportunities to drive efficiency with better IT. In exchange for an investment driven by the direction of the business, there should be both tangible and intangible long-term gains.

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Congressional races will also have a significant impact on the governing environment. While it is highly unlikely that party control of the House of Representatives will change, Republicans will have an uphill battle to increase, or even maintain, their historically high numbers in that chamber. Republicans in the Senate are in a more tenuous position. They are attempting to hold on to 24 seats, while their Democrat colleagues are defending only ten. Furthermore, Republicans are trying to retain more seats in “hostile territory” (i.e., traditionally “blue” states) than Democrats need to defend in “red” states. Since Democrats must capture only five seats currently held by Republicans (four, if they retain control of the White House) to take control of that chamber, the people responsible for establishing policy priorities for the parties will have to support more than just the goals of their presidential nominee; they will also need to balance those goals with the needs of endangered incumbents whose states may not favor those positions.

Don’t forget that many state races will be in play too in 2016, and the outcome of these could affect policies at that level of government as well. Republicans control 69 of the 99 state legislative bodies, but many of these are, from the GOP perspective, tenuous at best. Another “wave” election like we’ve seen in several recent elections could shift the balance of power substantially. Demonstrating more stability, however, are the upcoming gubernatorial races. Only 12 governorships will be up for grabs next year, and very few of them will likely end up as truly competitive races. You can expect to see little change in the governors’ offices, regardless of how the states’ legislative bodies look after Election Day.

Federal issues

So: how will this political activity affect federal policies on medical professional liability (MPL) insurance during the coming year? That depends on the specific issue you consider. Let’s begin by looking at some of PIAA’s legislative priorities: Good Samaritan legislation, telemedicine liability, and federal tort...
reform. There is some promise for the Good Samaritan Health Professionals Act in 2016. Recently, in response to stepped-up lobbying efforts by PIAA, more Members of Congress are expressing their support for this legislation that would protect volunteer health professionals from liability in treating victims of federal disasters. As we head into 2016, it may be possible to leverage the emerging political environment into even more support for the bill. During election season, legislators like to find some bipartisan legislation they can endorse, to show that they’re looking to actually get something done in D.C., rather than just play partisan games. Legislation to provide better access to healthcare for disaster victims gives them a pretext for doing just that.

Interest in expanded use of telemedicine also seems to cross partisan lines, and so it may be another issue area that could move forward in 2016. Thus far, those leading the charge on telemedicine in Congress have largely ignored the issue of interstate liability for these services. PIAA is looking to step into that gap by developing legislation that will provide clarity on this issue. We are looking for input from a diversity of stakeholders, to develop unanimity among interested parties on the best approach to take.

Telemedicine, with its focus on expanding access to healthcare services, may provide another bipartisan issue upon which Congress is willing to act, even as the partisan environment heats up. If PIAA is successful in creating a consensus on related liability issues, we may see a significant opportunity to tackle this issue.

Federal tort reform has some potential for consideration too, but for very different reasons and in very different ways. PIAA is working diligently to make improvements to the federal tort reform legislation we’ve endorsed in the past. We are also being realistic about the potential response to this legislation in Congress. Even if the Association is completely successful in tackling the states’ rights issue (the biggest current stumbling block), it is unlikely that bipartisan support will develop for the bill. It may, however, consolidate the bipartisan support for the bill, and that will increase its political value for Congressional leadership. As elections get closer, congressional leaders will be looking for causes that will let them make a clearer distinction between the two parties. Federal tort reform provides that opportunity, by presenting a clear divide on an issue, i.e., doctors vs. lawyers. So, while federal tort reform will not likely be enacted in 2016, it may appear on the legislative agenda if the opportunity arises.

Other MPL issues discussed in recent years include supplemental reforms (e.g., cooling-off periods, apology protections, etc.) and safe harbors/medical guidelines. Neither of these proposals will likely benefit from the upcoming elections. Quite simply, while both have a certain level of support, the demand for either is not large enough, nor the political benefits of acting strong enough, to generate congressional action at this time.

Washington, D.C., doesn’t just focus on legislation, though. Federal regulations and proposals from the Executive Branch will be coming out in the months ahead, and they may be influenced by the political environment as well. Here’s an example: one recent issue entails a proposed rule that would limit the use of binding arbitration agreements by nursing...
homes. While not directly relevant to MPL insurers, it does establish a potentially dangerous precedent that should not be ignored. As with every Administration nearing its end, the Obama White House will push to achieve its regulatory priorities before the next President assumes office. If limits on binding arbitration are successfully implemented for nursing homes, it is not inconceivable that additional limits on the use of arbitration may be preferred in the coming months, as this has been a priority for the President’s base for many years. Additional regulations that would benefit the plaintiffs’ bar are not out of the question, and PIAA will closely monitor federal regulatory activity in 2016 to make sure nothing slips through the cracks.

**State issues**

For PIAA, state issues mean state legislation and the National Association of Insurance Commissioners (NAIC). In recent years, we’ve seen an expanded legislative focus on litigation lending (loans provided to plaintiffs that are only repayable if the plaintiff wins), phantom damages (healthcare expenses billed versus those actually paid), and early communication and resolution programs, and it looks like these will still be the major issues in 2016. Litigation lending bills can be expected irrespective of the partisan makeup of the legislature, because both MPL insurers and the plaintiffs’ bar find the issue disruptive to the claims resolution process. Phantom damages bills, on the other hand, are unlikely to appear in any state whose legislature is friendly to personal injury lawyers, but may be considered in states more favorable to business (including those whose pro-business majority may be in jeopardy). Early communication and resolution legislation could potentially arise in any state, since there seems to have been some extent of collaboration between healthcare providers and lawyers in drafting these proposals in states where they have already been enacted.

One additional legislative issue, no-fault proposals for MPL (so-called “patient compensation systems”), appears to favor a more partisan environment: only one state where it has been introduced so far (Maine) did not have complete Republican control of the legislative branch. Thus, we can probably conclude that states with “blue” legislatures, and those where the GOP has more tenuous control, are less likely to see this proposal emerge in 2016.

Fortunately, the NAIC is not subject to the same sort of political cycle as the state legislatures. In light of the nature of this body, and the lengthy interval before any new proposal is approved, it is highly unlikely that any changes to its current course of action will occur in response to the coming elections.

**Overall**

As elected officials—or those hoping to become elected officials—look to establish their bona fides with their constituencies, we will see them take up those proposals that have substantial political appeal to one or more interest groups. The months leading up to the 2016 elections will see some predictable actions, just as we’ve seen in the past: in pending elections, political posturing frequently takes precedence over substantive policy discussions. Still, these months can present both new opportunities and new challenges for everyone working in advocacy, and PIAA stands ready to seize those moments when they arise.
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The principles and strategy espoused by co-authors Don Keenan and David Ball in *Reptile* have infiltrated courtrooms across the country, as plaintiffs' attorneys attempt to frame lawsuits in a way that portrays the defendant as a threat to the safety of the community. According to *Reptile*, when the issue is framed in this manner, the jury vicariously experiences the conduct in a way that connects with the reptilian part of the brain. The plaintiff's attorney's job is to convince the jury to view the defendant's allegedly tortious conduct as a threat to the safety of the jurors—on a personal level as well as to the community at large. According to Keenan and Ball, once this issue framing has been achieved, jurors will view a plaintiff's verdict as a means of defending themselves and the community.

**Reptile and medical professional liability**

When *Reptile* principles are utilized in medical professional liability (MPL) cases, plaintiffs' attorneys attempt to portray the actions of the defendant physician that are at issue in the litigation as violations of safety rules. The plaintiff's attorney disregards nuance in favor of an easily understandable black-and-white rule. The goal is to attribute the plaintiff's injury to a specific decision that the defendant physician made at some point in the care and treatment of the plaintiff. The jury is led to believe that this decision deviated from the standard of care, and that it is what caused the plaintiff's injury. Furthermore, the plaintiff's attorney then attempts to impress upon the jury the concern that if the defendant physician is not stopped by way of a plaintiff's verdict, then the defendant physician will continue to violate safety rules and will pose a further risk to the community. The plaintiff's attorney wants the jury to feel threatened, while simultaneously giving them a sense of empowerment because they can give a plaintiff's verdict that will serve as a means of protecting themselves and their community from the danger posed by the defendant physician.

The plaintiffs' attorneys' use of the term "safety rules" in this regard can infect the litigation as early as initial pleadings, but can also arise during depositions or upon the filing and serving of an expert disclosure. Use of the term "safety rules" at any point in litigation prior to trial offers the defense counsel a window into the plaintiff's upcoming trial strategy. If the plaintiff's attorney references safety rules in pleadings or discovery, at the time of trial, he will most likely look to frame the defendant physician's alleged injury causing conduct as a violation of safety rules. It is the
plaintiff’s attorney’s goal to convince the jury that the defendant physician violated a safety rule and thereby placed the plaintiff in danger and further, that any individual in the community could have been in the plaintiff’s position. In other words, the jury is meant to conclude that the defendant physician poses a risk to the community and that a verdict for the plaintiff is a way to protect against future injury.

Reptile in the courtroom
This was the exact situation that occurred in Majid v. Cheon-Lee. The plaintiff was a middle-aged woman who had undergone an open abdominal hysterectomy after a pre-operative diagnosis of chronic pelvic pain and recurrent endometriosis. The surgical team noted an obliterated cul-de-sac and dense adhesions throughout the abdominal cavity, which complicated the surgery. At some point during the surgical procedure or shortly thereafter, the plaintiff suffered an injury to her left ureter. The injury was exacerbated by the fact that it was not discovered right away. The ureter injury caused kidney damage that resulted in minimal function in the plaintiff’s left kidney.

Ultimately, the plaintiff required a nephrectomy.

The plaintiff and the defendants had competing theories about how the plaintiff’s ureter was injured. Central to the plaintiff’s attorney’s theory was that the failure to dissect out and identify the ureters was a deviation from the standard of care. According to him, the failure to identify the ureters was a deviation because failing to identify the ureters prior to transecting, clamping, and suture-ligating the infundibulopelvic ligament in the course of a hysterectomy needlessly placed the plaintiff’s ureters in danger of injury. This reasoning aimed to frame adherence to the standard of care as adherence to a safety rule. According to the plaintiff’s attorney, the plaintiff’s safety mandated that the defendant physician identify the ureters prior to performing the open abdominal hysterectomy. In accordance with Reptile instruction, the plaintiff was attempting to have the jury view the standard of care as a safety rule.

Exposure to reptilian tactics began early in the trial when, during jury selection, the plaintiff’s attorney began speaking to prospective jurors about the importance of adhering to traffic laws and asking the prospective jurors if they believed that it was imperative that everyone obey traffic laws. The plaintiff’s attorney’s objective was to have the members of the jury start to think of medical malpractice as something as simple as breaking a rule established from the standard of care.
for the safety of patients, i.e., a safety rule.
Then, he asked the prospective jurors if they believed that rules should be applied to everyone, including doctors. The plaintiff’s attorney was laying a foundation for the jurors to think of the standard of care as a rule, and he wanted the jurors to be comfortable punishing doctors who violated that rule.

In an effort to impede the plaintiff’s attorney’s attempt to improperly define the standard of care as a safety rule in front of and to the jury, the defense made an objection on the grounds that the court, i.e., the judge, was the only one allowed to issue legal definitions to the jury. The defense argued that calling the standard of care a “safety rule” was tantamount to defining the term, which when done by one of the parties in the case was improper. The judge sustained the defense’s objection.

As a result, the plaintiff was no longer able to obfuscate or alter the legal definition of “standard of care.” From that point forward in jury selection, the plaintiff’s attorney was not able to reference safety rules in front of the potential jurors. The defense’s timely objection, on the grounds that plaintiff’s attorney was improperly defining the term “standard of care,” prevented the plaintiff’s attorney from framing the defendant physician’s conduct as the violation of a safety rule.

Conclusion
Given the proliferation of Reptile tactics in MPL litigation, defense attorneys should familiarize themselves with the goals and strategies of plaintiffs’ attorneys who utilize these methods. In addition, after recognizing the motives behind the use of the term “safety rules,” defense attorneys should move to object at the earliest possible time. If the term “safety rule” is seen prior to trial, defense attorneys should consider filing and serving a motion in limine to stop the plaintiff from defining the term “standard of care” as a safety rule. Defense counsel should also make every effort to keep the plaintiff’s attorney from defining the standard of care as a simplified black-and-white safety rule free from any nuance or circumstantial context. By taking action at the earliest juncture, defense counsel can ensure that they do not have to combat such reptilian tactics throughout trial.

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Big Data Analytics
A Practical Application for MPL Insurers

Defense costs for medical professional liability (MPL) insurers have risen dramatically since the start of the century. Fifteen years ago, litigation expenditures were approximately one-third of the total cost of managing, defending, and paying MPL claims, with indemnity payments to claimants comprising the other two-thirds. Since then, defense cost trends have significantly outpaced indemnity trends to the point where, for many companies, defense costs have become their single largest expenditure.

Making matters even more challenging for the industry is the fact that these increasing defense costs are happening during a period with significant top-line pressures as a result of the competitive rate environment and the ongoing consolidation in healthcare. As a result, many companies have undertaken a critical review of their operations in an effort to control their increasing expense ratios. No department or functional area is immune to these discussions. No outlay is overlooked—“How much value do we get out of that sponsorship?” No cost is too small—“Should we give away golf balls or pens at our booth?”

Yet, ironically, the single largest expense category for the industry, loss adjustment expenses, is frequently subject to the least scrutiny. The reasons for this are twofold: (1) the same level of detail companies have for other categories is not available for review of this category, and
Advances in the science of “big data” analysis offer MPL insurers something they’ve never had before—an opportunity to bring science to the art of claims handling.

(2) the art of handling individual claims, each with its own unique circumstances, does not lend itself to analysis. Or so it seems, anyway.

So how do the industry’s rising defense costs fit into the broader discussion regarding big data analytics? In addressing this question, it is helpful to first define this relatively new and still evolving science.

“Big data”—what is it?
“Big data” is big in more ways than one. A Google search for the term garners 777,000,000 hits in 0.33 seconds. Compare that to 485,000,000 hits in 0.53 seconds for the term “baseball,” a concept so revered in this country it has been dubbed our “national pastime.”

But what is it, exactly?
The term “big data” refers to the expanding capability of computational techniques and technologies, enabling the almost instantaneous processing of enormous amounts of data that were, until recently, unmanageable due to their vast size and complexity.

But the value of big data analytics has as much to do with the size of the data sets as it does with the astonishing speeds with which new technologies can now analyze large pools of data. Vitally important to these analyses is the precision with which sophisticated algorithms can instantly troll the data and extract patterns or trends from these data sets; valuable nuggets of hidden knowledge that would otherwise be overlooked are revealed.

A white paper from the Software & Information Industry Association notes that the value of big data analytics is its “ability to capture, comingle, store, verify and analyze relevant data, and then integrate the results into established processes to derive innovative practical outcomes.”

It is the last part of this definition that is the most important—deriving innovative and practical outcomes from the data. Innovation that can be applied within an entity’s operations has long been a hallmark of successful organizations, whether in the military, business, or baseball.

The book, and later film, Moneyball dramatizes an early example of how innovation through analytics can provide a measurable competitive advantage in an industry that, until that point, was managed almost exclusively by experience and judgment. The film shows how the Oakland Athletics baseball team brought science to what was previously considered the “art” of baseball management, by employing big data analytics to find and sign the most cost-effective professional baseball players.

They did so by listening to what the data was telling them in terms of what new metrics were important for winning baseball games. Then, they built their strategies and roster with the assistance of those metrics. The result was that the As, and their modest payroll, made it to the post-season far more often than one would have predicted if they had used traditional experience and judgment alone.

Big data analytics is already being used to drive retail sales, by matching individual customer preferences with precisely targeted advertising. It is being employed to unsnarl traffic in big cities, reduce operating costs for businesses and nonprofits, predict the frequency and severity of big storms, and—most noteworthy for the purposes of this article—big data analytics is quickly becoming an essential tool for MPL insurance companies trying to get a handle on their ballooning defense costs.
Do MPL defense costs qualify as big data?
To their credit, MPL defense firms provide their clients with very detailed descriptions of their activities as reflected in their invoices, showing exactly how much time and money has been spent on each individual task within the litigation process. These descriptions are so detailed, in fact, that the information quickly becomes overwhelming for any person, or persons, to review.

How massive is the amount of information law firms provide to their MPL clients? We estimate that if one were to print out and stack up all of the defense attorney invoices an average PIAA insurer receives in a single year, the pile of those bills would be taller than a three-story building (32 feet), and weigh as much as the average adult Alaskan brown bear—almost 900 pounds (Figure 1).

The fact is that while insurers employ entire departments dedicated to managing and mitigating indemnity payments, relatively few resources are committed to understanding, managing, and ultimately developing data-driven best practices in regard to the $25 million the average-sized PIAA company typically spends every year in defense costs. This is not because insurers don’t want that information, but rather, because there has been no reliable method they could use to extract it from that 32-foot-high mountain of data points—until now.

Bringing science to the art of claims handling
The new and rapidly advancing science of big data analytics offers MPL insurers the opportunity to absorb the massive amount of legal invoice data as it is being reported, take a deep dive into it, and—with the help of sophisticated algorithms—quickly derive valuable insights that can be used to better understand and manage the claims process.

The result is precise, actionable information that insurers can utilize to evaluate and manage their defense strategies—even as cases are progressing from discovery to depositions, from the expert witness prep phase to trial and beyond.

The algorithms are really a means to an end. They are the computer code that turns “information into data.” In data-mining parlance, they bring structure to unstructured data, in this case by normalizing the many varied ways in which the same activities of the litigation process for MPL claims are described (e.g., deposition of the defendant). Once these same activities of the litigation process are referenced identically—that is, have been normalized or structured—we can then begin to analyze and report on them effectively.

So, once this data has been properly prepared and constructed, an MPL insurer is in a position to investigate the efficacy of its claims-handling strategies. Rather than relying on just intuition and judgment, which are often biased by one’s outlier and/or most recent experiences, we can allow the data to inform our strategies. We can answer questions like these:

- Is it an effective strategy to file a motion for summary judgment (MSJ) in a particular venue or with a particular judge, given our historical success rate?
- How much does it cost to file an MSJ?
- What is the average cost of an expert deposition and are we taking more of
them now, or has the average cost per deposition increased, or both?

■ What is the optimal lag between preparing our defendant for his or her deposition and the deposition itself, if any? (Figure 2 shows hypothetical data illustrating how this question might be analyzed.)

■ Do we tend to get a better outcome when the lead attorney’s hours represent at least X% of the total hours spent on the case?

■ How much does it cost to have our defense firms comply with our 90-day claim summary report, and does the compliance rate correlate with the outcome of the claim?

■ Can we develop a more cost-effective strategy for our record retrieval and court reporting costs?

These, and many more, are the types of questions to which the answers reside in the three stories and 900 pounds of information that, heretofore, the industry has conducted at most a cursory review of for payment purposes only, and then simply shredded.

This is only the beginning; the possibilities are endless, because big data analysis often reveals not only the information we are looking for but the information we did not even know that we should be looking for.

Conclusion—still a place for human intuition?

In the film Moneyball, some of the major league baseball scouts felt they were being displaced by the team’s increasing reliance on analytics. Will big data and algorithms make claims adjusters irrelevant?

Well, major league baseball still relies heavily on the instincts of its scouts, and the same will undoubtedly be the case for MPL insurers. What big data and algorithms do is offer claims departments a powerful new tool, one that will allow them to leverage their experience and judgement even more effectively by supplementing their instincts with data.

As in Moneyball, big data analytics is about science supporting something that has always been considered an instinctive art. We are never going to replace the wisdom and instincts of the claims department—their judgement and experience—we can’t. But we can supplement their instincts with reliable evidence.

In business and baseball, knowledge is power. The A’s lost their competitive advantage only because every major league team followed suit, and today they all use analytics in devising their strategies and building their rosters. MPL insurers have that same opportunity available to them for the first time—using data and science to better manage their largest expense and develop effective defense strategies that are informed by the data.

For related information, see http://us.milliman.com/Solutions/Products/Milliman-Datalytics-Defense.

References

You go to a doctor—you check in on Foursquare. You go on vacation—you post pictures of your trip on Instagram. You have a bad experience at a doctor’s office—you Tweet about it on Twitter. And, of course, you provide constant updates on your whole life on Facebook, sharing every detail with friends and family.

Social Media
Best Practices for Investigation in Claims Handling, and Considerations for Possible Litigation
This is the social media world we live in. This is the same social media world that claimants, who become litigants, also live in. But, very often, these claimants care more about their social media presence than they do about their case or potential case.

As claims handlers, we realize that a great deal of information may be discovered about a claimant before a case becomes a lawsuit. Claimants are most active in the social media world before they have retained a lawyer, or before they’ve even considered, or decided, to pursue litigation.\(^1\)

From a claims perspective, it is important to develop and follow good practices to investigate the good, the bad, and the ugly that you may find in the social media world. It is also important to understand how that material could be used, and if necessary, the limits of its admissibility if a case were to ever reach trial.

**What to check on**

“Google it.” A basic search on Google will reveal a great deal about a claimant, or an insured. If anything has been reported in the press, the articles could show up in the “News” tab. Many public records will also turn up in a Google search. Typically, however, Google is only a starting point. Be sure to go to the secondary sources, once you discover what they might be from a Google search, and always consider the reliability of any source.

Next, check the social media accounts.

**Facebook.** Determine if the claimant has a publicly-accessible Facebook account, and check for any posts that were made post-incident. Do not assume, however, that just because something was posted post-incident, that is when it occurred. Also, ethics rules may make it impermissible to attempt to “friend” a claimant merely to review his or her Facebook account.

Best practices dictate printing all of the pages that contain potentially helpful information, including any photographs and videos. It is even better to ask a third party, such as an investigator, to do so. He should sign an affidavit indicating which pages (URLs) were visited, on what dates, and at what time, and attach the pages as exhibits. There may still be admissibility issues with the material, but it could serve other purposes, as discussed below.

It is also important to review the publicly accessible pages of the claimant’s “friends” on Facebook. Perhaps a claimant was the subject of a video taken by someone else? You may want to speak to that person, or take his deposition.

**Other accounts.** Don’t forget to search other types of accounts, too, such as Twitter, Instagram, YouTube, and LinkedIn. These may be publicly accessible, even if the Facebook account has been kept private.

**Investigate and advise your clients appropriately**

Once a lawyer is retained, he may counsel a client not to discuss the case on social media. The lawyer may tell a client to, in the future, avoid posting photographs or videos of physical activity that could compromise a case. Indeed, it is good practice for a lawyer to advise a client as much. However, if there is any reason to believe that something has already been posted that speaks to the claim, there are potential problems in telling a client to delete that content.\(^2\)

Thus, it is also good practice to investigate your own client. Do not rely upon his representations about what may be posted in the social media world. Indeed, in the case of a business or a doctor, the client may not know what is posted online. There are many websites where patients or clients may post independently; and once something is posted, it is very hard to remove it. So, best practices dictate reviewing these types of sites (such as WebMD or Healthgrades) on a fairly regular basis.

**Considerations for potential litigation**

As defense counsel, I have two concerns when considering social media as evidence: (1) can the material be authenticated, and (2) will the court allow the material to be admitted into evidence?

I frequently receive claims that have already been investigated. But, often the claims handler or investigator has not taken the necessary steps to preserve social media material appropriately so that the material may be used as evidence.

The following facts provide a good example of ways to use best practices to avoid such problems in litigation. A claimant puts a carrier on notice that he has been injured from a fall down a stairway. Upon receipt, the claims handler goes onto Facebook, which is accessible to the public, and reviews the claimant’s posts. The handler makes notations in the claims file that the claimant had posted numerous videos and photographs in which she was both “twerking” and pole-dancing. The handler writes that this appears to be the claimant’s occupation.

These posts were made after the alleged accident, but before the claimant underwent surgery to her lower back (a lumbar spine fusion). The claimant also claims she can no longer work, and has not worked

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**Tara C. Fappiano, Esq.,** is with Hawkins, Rosenfeld, Ritzert & Varriale, LLP.
since the accident, in any capacity. The handler, however, does not print any of the pages or download any of the videos. A year passes, the claimant files suit, and defense counsel is assigned. By this time, the plaintiff has changed the settings on her Facebook account so it is now private.

Certainly, being aware of this material, defense counsel might serve the plaintiff with discovery demands seeking the photographs or videos. In New York, where this case was filed, most courts are erring on the side of a party seeking discovery being able to show that the demand is not a “fishing expedition,” and the demand will yield information that is “material and necessary.” The court’s decision will focus on whether the demand is tailored specifically to obtain information that is likely to be relevant to the claim. So here, knowing there was such material at some point in time helps in these efforts.

In this case, defense counsel does a further search of social media, and discovers that the plaintiff has posted a “twerking” video on YouTube. The video is downloaded. Counsel shows the video to the plaintiff at her deposition. She testifies that the video is, in fact, one of her dancing. But, she claims the video was not taken after the accident. She just posted it to her YouTube channel after the accident date. Of course, this creates an issue for trial. There may be a problem proving the video shows activities after the accident date, in which case the court will not allow the video into evidence. In New York, to use a photo or video to provide a material fact, it must be shown to be an accurate representation of the fact, or the video must be identified. That is, there must be direct testimony to prove that the video or photograph depicts what you say it does. Here, that most likely requires finding the person who took the video, and having him testify that the video was in fact taken after the accident date. 

At the deposition, however, the plaintiff is also asked, and admits, that her YouTube channel was set up to promote her occupation as a dancer. So, the argument is that the plaintiff had to have worked after the accident. If not, there would be no reason to post the video onto her YouTube channel after the accident date. But, given the information brought out at this deposition, the plaintiff and her attorney are now eager to try to resolve the case. They suggest mediation—and at mediation, rules of evidence do not apply. Thus, defense counsel may show the video to the neutral mediator and, hopefully, use it to achieve a more favorable settlement.

It is clear, therefore, that investigating social media from the moment that there is knowledge of a claim, which may in time evolve into a lawsuit, is necessary to achieving a successful outcome. References

1. ABA’s Model Rules of Professional Conduct, Rule 1.1, states “a lawyer… must keep abreast of changes in law and its practice, including the benefits and risks associated with relevant technology.” As such, there is responsibility on lawyers to be aware of the benefits and risks of using social media in prosecuting and defending claims.

2. See Lester v. Allied Concrete, No. CL 08-150 (Circuit Ct., Charlottesville, NC 2011) (attorney fined over $700,000 for instructing a client to delete certain Facebook posts and photographs that might be detrimental to her claim). 3. N.Y. CPLR § 3101; see also Romano v. Steelcase, 30 Misc.3d 426 (N.Y. Sup. Ct. 2010) (discussing test of usefulness and reason, with a focus on sharpening issues and reducing delay; court allowed disclosure of historical Facebook and Myspace pages, including deleted information, because of claim of “loss of enjoyment of life”).

4. See generally Taylor v. New York City Transit Auth., 48 N.Y.2d 903 (1979); compare with Federal Rule of Evidence, 901, which outlines ways to authenticate evidence, the majority of which are either not applicable to, or difficult to achieve with, social media (testimony of witness with knowledge, distinctive characteristics, opinion about a voice).

5. There are other options as well, but not necessarily to use this particular video. Consider going to the club where the plaintiff may be working and see if it has its own surveillance. Or take surveillance footage of the plaintiff now to show she is able to work as a dancer. Then, have the investigator come to court to authenticate that video.
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Evaluating Downside Investment Risk—Filtering Through the Background Noise

By Chris Myers

Not All (T)VARs Are Created Equal

Designed to provide perspective on the impact of significant downside-risk scenarios, both value at risk (VAR) and tail value of risk (TVAR) are important measures to consider in any portfolio management process.

Chris Myers is an Enterprise Risk and Capital Management Professional with GR-NEAM, Ltd.
While VARs articulate a percentage of loss that is not to be exceeded at a certain level of confidence, TVARs estimate the expected loss if that VAR threshold is indeed exceeded (Figure 1). These two metrics are jointly referred to as (T)VARs.

Understanding downside risk and the related capital implications are part of an Own Risk Solvency Assessment (ORSA), which is becoming a requirement within regulator-inspired solvency modernization initiatives in the United States, Europe, and other regions. Rating agencies are also noting the importance of ORSAs in their discussions of enterprise risk management (ERM).

Economic capital models are useful in supporting an ORSA and ERM, and the outputs of these models are often expressed as (T)VARs. Indeed, these are useful metrics for understanding and targeting a risk profile when they are used appropriately. However, these measures are far from perfect, with inherent "noise" due to the vast array of assumptions and model structures that (T)VARs are dependent upon.

Often, three methods are used to calculate these measures. One is a parametric approach wherein the key assumptions are the mean, standard deviation, and distribution shape of a portfolio’s returns. The second is a Monte Carlo approach that simulates thousands of scenarios predicated on certain assumptions and parameters. The third is a historic approach: you rank-order past returns and identify the worst of these over certain periods. Each method has its benefits and limitations, and potentially each can produce different results for the same portfolio.

It is critical that management understand—and be prepared to challenge—any risk estimates and recognize how some of the underlying assumptions can impact those estimates. There are several approaches and parameter settings to choose from when modelling VARs and TVARs. Four elements central to (T)VARs include: (1) correlations, including tail risk correlations, (2) returns, (3) volatilities, and (4) shape of the distribution. These can be developed by assessing historic data, by establishing forward looks developed from fundamental analysis or simulations, or by some combination of these approaches.

**Structure and scope**

Another consideration for management is how the (T)VAR was developed and the scope of risk it’s meant to capture. There may be a top-down or a bottom-up structure. These are different means to the same end goal, and, as with other elements mentioned regarding the construction of (T)VARs, there are advantages and disadvantages to each. The scope reflects the types of risks that are included. For an investment portfolio, this might include risk associated with interest rates, credit (spread risk volatility versus defaults), equity volatility, currency, and the potential.

![Figure 1. Distribution of Portfolio Returns](source: GR-NEAM)

Figure 1 illustrates value at risk and tail value of risk as two different aspects of a distribution of returns. The far-left tail of this distribution shows severe downside portfolio returns, but at very low probabilities. (T)VARs are estimates of what those downside risks would look like for a portfolio at particular probability levels.
call optionality that are associated with certain structured securities.

A bottom-up approach will evaluate these different risk sources separately and then overlay some presumed explicit correlation or covariance calculation to link and aggregate them. The net result forms the portfolio (T)VAR.

In a top-down approach, the overall return characteristics of the portfolio are evaluated first, to measure (T)VAR at the portfolio level. Then, each risk area is isolated and measured individually, and, finally, they are summed. The difference between the portfolio (T)VAR and the total of the isolated (T)VAR components provides an implied correlation (Figure 2).

GR-NEAM follows a top-down approach based on observable prices. In contrast, the risk-based capital models put forth by regulators and rating agencies utilize a bottom-up approach. In our view, an approach based on observable prices improves transparency and reduces the number of assumptions necessary to measure risk. With bottom-up approaches typical of rating agencies and regulators, where risk factors are applied to holdings, it is not always clear how factors or

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**Figure 2. Bottom-up and top-down approaches for calculating portfolio (T)VAR.**

**Figure 3. Portfolio correlations and volatilities**

Figure 2 is an illustration of the bottom-up and top-down approaches for calculating portfolio (T)VAR. A bottom-up approach measures risks by applying predetermined risk factors and correlations to a portfolio. A top-down approach decomposes the portfolio into different risks and implied correlations.

Figure 3 shows how portfolio correlations and volatilities evolved prior, during, and after the 2008 financial crisis for the U.S. property/casualty industry. The shaded area highlights where correlations (blue line) decreased during the financial crisis, while volatility (yellow line) increased during this period.
Investment risk tolerance is specific to each organization.

(T)VARs are one way to express it. For perspective, we calculated the (T)VARs for 30 of the largest PIAA member insurers and the overall property/casualty industry as a whole.

Correlations were developed. This elevates the possibility of bias within risk estimates.

Normal or not

In GR-NEAM’s experience most insurers using (T)V AR metrics follow a stochastic-path-independent process, either parametrically or via simulations. These stochastic (T)V AR estimates may assume that the potential range of returns follows a normal distribution. This assumption can expedite or simplify the modeling framework, but there is some risk of oversimplifying. One rationale for downside risk measures is to gain perspective on the economic capital at risk that the organization may be exposed to during extreme and stressful market periods. During these stress scenarios, assumptions based on normal conditions are easily challenged. Significant loss outcomes would be expected to occur with a very low probability under normal distribution assumptions, but they can have a greater probability of occurring when markets exhibit non-normal return characteristics. This potential for “fat tails” highlights the prudence of stress and scenario testing.

Risk and finance managers are concerned about unexpected outcomes. Processes to assess pricing, to select risk, and to set reserves can be impaired when unanticipated events occur. GR-NEAM will often consider different measures of (T)V AR using different return distribution assumptions. This provides insight into how an enterprise’s risk profile might look under normal or extreme market conditions. More informed views of appropriate risk tolerance ranges and risk budgets are a result.

Good practice also includes stressing the parameters that were used in the modeling process. This exposes the inputs to which model is most sensitive. For example, correlations and volatilities are key factors in risk models. Historical time-series data may provide a good starting point for estimating these factors, but a manager relying on history alone might have a misinformed view of how things

Figure 4. A portfolio’s one-year daily return series

Figure 4 is an illustration of a portfolio’s one-year daily return series, showing that during the year there was an extreme intra-period loss of -19.7%. A singular focus on the end-of-period loss of 1.6% could provide an incomplete view of the risk of the portfolio.

Figure 5. Asset vs. 99.5% TVAR (Annual) (Intersect @ Industry Median)

Figure 5 lists invested assets to surplus, return on invested assets (ROA), ROA VAR, and ROA TVAR for 30 of the largest members of PIAA as measured by year-end 2014 total assets. Investment portfolio characteristics use 2014 year-end holdings per statutory filings, and use the annualized historic volatilities implied by those holdings. Blue dots represent various property/casualty insurers. The yellow dots represent the 30 PIAA member insurers used in our sample.
DOWNSIDE RISK

val using historic investment return volatilities as of year-end 2014. We
industry as a whole. These were calibrated to a 99.5% confidence inter-

one way to express it. For perspective, we calculated the (T)V ARs for 30
Investment risk tolerance is specific to each organization. (T)V ARs are

drawdowns that can accumulate over the course of 12 months (Figure 4).
(T)V AR that considers the daily volatility of returns and the potential

of the portfolio or enterprise, creating additional uncertainty for the deci-
of-period (T)V AR measure can understate the actual risk characteristics

months from now for economic capital purposes. The latter is more
may be a daily view for portfolio trading purposes, or one day at 12

point in the future. The view is based on an end-of-period estimate. This

During this period the volatility of all asset classes increased, but for
different reasons. Some investors were looking for high-quality assets.

Hence, demand increased for high-rated bonds and treasuries, while
lower-rated bonds, equities, and other risk assets were deemed less attrac-
tive. Credit spreads widened, treasuries and high-grade bond prices
increased, and equity prices fell. Since insurers tend to hold large alloca-
tions to higher-quality fixed income assets, some benefited from the rally
in treasuries and other very-high-grade securities, while simultaneously
experiencing depressed values in their equity positions. These disparate
directional moves influenced the fall in correlation highlighted in
Figure 3.

Intra-period or end of period

Embryonic (T)V ARs traditionally consider downside risk at a certain
point in the future. The view is based on an end-of-period estimate. This

may be a daily view for portfolio trading purposes, or one day at 12
months from now for economic capital purposes. The latter is more
appropriate for longer-term strategic decisions. That being said, an end-
of-period (T)V AR measure can understand the actual risk characteristics
of the portfolio or enterprise, creating additional uncertainty for the deci-

dison-making process. GR-NEAM embraces an intra-period one-year
(T)V AR that considers the daily volatility of returns and the potential
drawdowns that can accumulate over the course of 12 months (Figure 4).

Industry comparisons

Investment risk tolerance is specific to each organization. (T)V ARs are
one way to express it. For perspective, we calculated the (T)V ARs for 30
of the largest PIAA member insurers and the overall property/casualty
industry as a whole. These were calibrated to a 99.5% confidence inter-
val using historic investment return volatilities as of year-end 2014. We
also tracked duration and credit quality for that year.

PIAA firms are also generating slightly higher returns on average, which suggests that they are being rewarded for some of the higher tail risk associated with their risk profile.

There is no perfect investment (T)V AR for a PIAA insurer, nor is there one for the insurance industry as a whole. However, there are some notable characteristics worth highlighting. As Figure 5 shows, generally PIAA firms have higher risk tolerances, as implied by their average VAR and TVAR compared with the industry as a whole. This is in part due to the relatively higher allocation to equities. Duration and credit quality are about the same.

However, PIAA firms are also generating slightly higher returns on average, which suggests that they are being rewarded for some of the higher tail risk associated with their risk profile.

Final thoughts

An enterprise’s capital and risk management process should serve as a
foundation for its risk-based decision-making. This can be used in
developing an investment strategy or in determining broader operational
choices. Risk measures such as VAR and TVAR are designed to support that process by estimating the potentially severe downside risk potential of a portfolio. These metrics are useful guides and estimates, but prior to their utilization management should be prepared with the proper background so that they understand their meaning and can challenge their results. Risk estimation should improve accordingly.

There are some common attributes of (T)V AR metrics and the
different ways that these are developed. Indeed, they are becoming the
standard means for articulating risk positions internally to manage-
ment and externally to regulators and rating agencies. However, a mis-
understood or misapplied understanding of downside risk is clouded
by noise. Being mindful of what is behind that noise will make us bet-
ter risk managers and better decision makers in the process. TPIAA

References
1 See also “Benchmarking Capital Charges: A Top-Down Observable Price
Approach,” in GR-NEAM’s General ReView, September 2014, Issue 64. This article
provides additional insight on how GR-NEAM’s top-down observable price
methodology compares to bottom-up derived risk-based capital models.
2 See also “The (Ir)relevance of VAR: An Oxymoron,” in GR-NEAM’s General
ReView, April 2010, Issue 47. This article discusses VAR estimation in more
detail. It provides insight on “normal” market VAR estimates, which may under-
state tail risk, and how they compare to “extreme” market VAR estimates based
on a heavy tail distribution.
The digital world we live in today is one that is expanding at an unprecedented pace. This revolution has provided great opportunities for business to develop and deploy innovative products and services and to connect with their customers in ways previously unimagined.

But this explosive growth has also made it possible for criminals to attack and exploit businesses for significant financial or intellectual gain. The presence of criminals in cyberspace is not a new phenomenon. However, the organized criminal and government-directed actors that operate in cyberspace today are specialized groups, with sophisticated engineering and organizational capabilities. The anonymity and complexity offered on the Internet often lets these organizations operate without resistance from law enforcement. Cyberspace today can seem much like American West in the 1860s and 1870s: law enforcement was present, but was many times powerless to stop those with superior numbers and firepower.

For businesses that hold protected or sensitive information, this can be an extremely frightening landscape. Keeping data secure has become an increasingly difficult, yet critical, operation. The challenge begins with discovering an attack, as in the “needle in the stack of needles” metaphor. Finding the attacker amid the sea of information generated by today’s Internet-connected devices can be quite difficult. That challenge is only compounded by the rapid emergence of new technologies.
software vulnerabilities, the persistence of these attackers in altering their methods, the pervasive mobility of company data, and the speed required to execute business in the twenty-first century. Facing these sorts of challenges, many businesses wonder how they can successfully protect their sensitive data.

The defense
While no organization is 100% secure, deploying a defense strategy that makes use of both practical and technical safeguards can significantly blunt the impact of an attacker. Note that technology alone does not solve the security problem. As I discuss below, human nature is often the weakest link in cyber security. But combining prudent technology investments, a culture of cyber security awareness, practical access controls, and appropriate insurance can go a long way toward decreasing the impact of an outside attacker.

Using technology solutions to secure data assets is a critical element in an in-depth defense strategy. Many organizations have already deployed the standard set of security tools to protect their organization. This standard set includes firewalls, intrusion detection/prevention appliances, enterprise antivirus, and encryption. In no terms is that an exhaustive list of security tools; it is simply a starting point for most organizations. While it’s easy to think that implementing these tools is a “set it and forget it” activity, the reality is that these tools require constant maintenance and tuning to keep your data assets safe.

Phishing and spear phishing
Even with these technologies in place, many organizations still find themselves vulnerable to attack from cyber criminals that target individuals, not systems, as their way in. Phishing and spear phishing campaigns have proved wildly successful for cyber criminals seeking access to corporate systems. Phishing e-mails are crafted to look like legitimate communications from organizations that require action or some sort of other a response from an individual.

Some of the most famous and prevalent e-mail phishing campaigns have come from e-mail addresses that look like they originate at the IRS or the Better Business Bureau. These messages contain legitimate looking links and/or attachments that prompt the recipient to click or download their malicious payload. Once those malicious links and/or attachments have been executed, malware is installed on the local machine, giving the attacker access to that machine and, potentially, the corporate network.

Spear phishing campaigns are focused efforts that target specific individuals at an organization, the ones the attackers have identified as either vulnerable or as having access to the systems they want to invade. These spear phishing campaigns are typically perpetrated by the most advanced of cyber criminals. These criminals do extensive research on their targets and deploy expertly crafted e-mail content, making it look as though it is coming from a legitimate sender.

A spear phishing campaign was what caused the compromise in the White House unclassified network systems. A compromised e-mail account from the State Department sent an e-mail to a recipient in the White House. The message had all the right content and context, but it contained malicious elements. The attackers had monitored the e-mail communications of a specific user at the State Department and crafted an e-mail from that individual that had looked legitimate to its recipient at the White House. They used that malicious e-mail to compromise an account at the White House, thereby gaining access to the unclassified network.

As evidenced by the example above, the people within an organization can be the weakest link in its security. But they can also be one of its best defenses. Developing a culture of cyber security awareness within an organization can offer excellent protection against these types of threats.

A security-based culture should best be demonstrated, and communicated, from the top down. When the leaders in an organization demonstrate that they take data security seriously, it sets the tone for the organization as a whole. This means that the leaders of an organization need to understand fully the security elements that their organization has implemented, and consider them as welcome protections, rather than annoying hindrances.

A key element for a thriving security culture is continuous training and discussion about data security policies and best practices. I will add that training must not stop once new employees enter the door. Training must be an ongoing endeavor. Some organizations have begun running phishing campaigns that randomly target people in their organizations. These campaigns send simulated phishing mes-
sages to employees to gauge the employees’ practical knowledge on phishing. Those in the organization who click on the content in the phishing messages are then redirected to a training program to educate them on their mistake. These campaigns target the most vulnerable employees and work to educate them, while keeping the more tech-savvy employees sharp. Practical training like this is, for many organizations, more effective than traditional webinar- or classroom-based trainings.

A well-educated workforce in an organization that has developed a culture of cyber security awareness, and implemented technology solutions to protect their data, offers a formidable defense to cyber criminals. Even so, no organization is invulnerable to attack. The pace at which vulnerabilities are discovered and exploited, and the determination of attackers to penetrate a network mean that it’s not a matter of if your company will be compromised but when.

Understanding this inevitably shifts the conversation from what we can do to prevent cybercriminals from gaining access to our systems to what do we do once they have gotten access.

Developing and implementing proper access controls to sensitive data, an incident response plan, as well as investing in cyber liability insurance and/or remediation agreements can reduce the impact and cost of a cyber attack.

Controlling access to sensitive data is critical to mitigate the impact of a cyber attack. By enumerating and restricting access to sensitive data in their environment, organizations can significantly constrict the ability of attackers to capture data. While it is impossible to restrict all access to sensitive data, following best practices that prevent blanket access to sensitive data can help prevent an attack from spreading. This is accomplished by only providing employees and vendors with access to sensitive data that they need to complete their job function. This is a complex and time-consuming process. However, the long-term benefits associated with proper access controls outweigh the risks of an environment without access control restrictions. It is important to note that this applies not only to employees within an organization, but vendors that an organization uses must also be a part of the access control evaluation process. Vendors are often a cyber criminal’s way into an organization, so properly managing vendor access is imperative to properly securing your data. Access controls must be constantly monitored and tested to ensure that they are applied correctly across an organization. Testing these controls to confirm their effectiveness is just as important as imposing the controls themselves.

Many organizations have decided to test these controls as a part of their incident response plan. Developing and testing your incident response plan is critical to effectively handling a cyber attack or data breach. These incident response plans often test internal and external communications within the organization, and test the assigned roles within the organization in the response process. Knowing who in the organization is going to handle each part of the process, and having prepared communications ready for clients, employees, and vendors is important to ensure your company’s response is cogent and controlled.

Moreover, practicing what to do when a cyber attack has breached sensitive data helps your organization identify gaps in your proposed response.

Part of an organization’s incident response plan should include coordinating communications with its insurance carrier. One way organizations that handle sensitive data have chosen to offset some of their risk is by investing in cyber insurance policies. These policies will insure organizations beyond their general insurance against business disruption and damage from a cyber attack. While these insurance policies do not protect against cyber attack, they help organizations respond and recover from a cyber security incident. Many policies also cover the costs associated with remediation of the security incident, not just notification expenses. This is important, as exfiltrating an attacker from your network can be an expensive and time-consuming task.

The understanding that no matter how many technical safeguards are in place, or how well your organization has been trained, your organization still remains vulnerable to attack is the mindset needed in today’s digital economy. Conversely, not doing the items outlined above can be viewed as negligent and can cost an organization more in the long run than implementing these items today. The long-term trust associated with a breach are not just short term. Long-term trust associated with an organization can be eroded if a breach is not handled properly, or if general safeguards are not followed. This makes preparation and avoidance critical to long-term organizational success.

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Effective Witness Preparation

Part One, published in the Third Quarter 2015 issue of Inside Medical Liability, examined the juror’s perspective in assessing witnesses. They seek to determine who they can trust in the lawsuit, and whether they feel they would be in safe hands with the defendant physician if they were themselves in a medical crisis. Now, Part Two considers what is required for effective preparation of witnesses.

Based on what the research tells us and my own work with witnesses over the past 27 years, I’ve found that witnesses are most effective at deposition and trial when they go through the following six-step process.

Inform. The defendant is educated about the decision-making process in medical professional liability (MPL) cases. He learns that what he says is extremely important and that the jury wants to believe him. He learns about the people who make up his defense team and their commitment to him and the case. And the defendant learns about the expertise of defense attorneys, including his own, who are among the most skilled lawyers in the United States.

Instruct. The defendant learns that the courtroom is a very visual experience for jurors. He learns the proper way to answer questions and conduct himself throughout the trial. This is critical because the courtroom experience is based on the law of first impressions. Since up to 85% of what people remember is what they see, how the defendant presents himself is often more important than what he actually says.

Integrate. The defendant learns how to view his role in the case. He learns that he is crucial to a successful outcome, because he is the individual that the jury is depending on. Indeed, jurors want to hear from the people they consider the best experts—those who have personal knowledge of the events. If the defendant is comfortable in the courtroom, jurors are more willing to believe him. This is why it behooves the defense attorney to allow the defendant to testify freely. Attention to small details, things that only someone with personal knowledge and interest would know, makes for a more credible—and more

By Linda S. Crawford, JD

Linda S. Crawford, JD, is Principal, Linda Crawford and Associates.
The defense has to live with the basic facts of the case, whatever they are. Fortunately, while the facts are important, the jury is also attuned to another factor. They are very concerned about what kind of person the defendant/witness is.

The jurors ask themselves, “Do I trust the provider?” “If I was in medical crisis, would I be in safe hands with this provider?” “Under the circumstances, did the provider do the best he could?” “Did the provider make the right medical decision?” No question, the cases that go to trial are not the cases that are cut and dried. They often are the cases that are more ambiguous—and thus are the cases where the jurors’ feelings about the defendant will sway their decision one way or the other.

The educator may need to reframe how the defendant thinks about himself. The person must conclude that whoever he is, is good enough. The educator must be able to relate to the defendant in a way that builds and sustains his self-confidence, so he can focus on what he needs to do at deposition and in the courtroom. Research and experience both show that if you focus on witness presentation skills, you increase your chances of winning the lawsuit.

The good news is that, at the end of the day, healthcare providers continue to be the most successful of all professionals in the courtroom—when they meet the test of character. The challenge is to be that person, within a foreign and hostile environment: the legal system.

**References**

HOW MEDICAL MALPRACTICE INSURERS MAY IMPROVE INVESTMENT EFFICACY

Mark Whitford
Senior Insurance Investment Risk Strategist Lead,
Insurance Risk Advisory Practice
Franklin Templeton Institutional
mark.whitford@franklintempleton.com

ENTERPRISE RISK MANAGEMENT CAN PROVIDE A MORE COMPLETE PICTURE

Medical malpractice insurance providers are under intense pressure to maintain profitability in the face of increasing competition, changes in claim frequency and severity, regulatory changes, and low interest rates. Enterprise Risk Management (ERM) analysis may offer medical malpractice insurance providers the ability to improve the efficacy of their investments by providing in-depth analyses of risk on the liability and asset sides of the balance sheet. Unfortunately, greater investment income generally involves increased exposure to investment risk, particularly in today’s interest-rate environment. While a medical malpractice insurer’s investment portfolio may be a significant part of their income, liquidity risk must be carefully evaluated prior to setting any strategy.

Our ERM analysis finds important differences based on the size of a medical malpractice insurer. As the size of an insurer increases, we see a drop in the amount of margin built in claim reserves (based on reported-loss-development claim triangles); smaller RBC ratios; lower combined ratios; and larger capital and surplus ratios. ERM analysis can provide other useful insights, including the observation that larger companies have a greater level of investment income as a percent of premium.

The analysis of assets concentrates on the risks inherent in investment portfolios, including liquidity and credit characteristics, as well as the composition of the invested asset base. Concern about managing liquidity is justified as approximately 50% of claims are paid out within the first two years, while the liability duration tends to follow a normal distribution pattern with some tail risk.1

Again, our ERM analysis reveals important differences based on company size. Larger medical malpractice companies appear to have a greater tolerance for holding more illiquid and riskier asset.1

IN SEARCH OF YIELD

Our ERM analysis of medical malpractice insurance companies leads us to believe that an opportunity exists to potentially increase investment income. If bond yields remain low, attempts to increase investment income will require a re-evaluation of risk tolerance levels and credit quality adjustments to investment portfolios. We believe that medical malpractice insurers may benefit from a shift in asset allocation to high-yield corporate and municipal bonds, bank loans, select opportunities within mortgage-backed securities (MBS), equity strategies (REITs, infrastructure, high-dividend strategies) or NAIC-rated funds.

CONCLUSION

As companies rely more on income from investments, we expect the need for proper evaluation of the composition and risk level of investment portfolios to become more urgent. In skilled hands, ERM has the potential to support the evolving needs of growing companies, particularly in a dynamic financial and regulatory environment. We believe companies in the medical malpractice insurance industry should consider ERM as they seek to meet the competitive, financial and regulatory challenges that lie ahead.

To read the full topic paper, please visit www.ftinstitutional.com/iam.

1. Our analysis of risk tolerance levels related to liquidity showed that larger companies tend to have lower current liquidity ratios (calculated as cash and liquid assets as a percent of liabilities) than smaller companies.

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Repercussions can include distress for the patient who believes he has experienced poor care, the clinician who has to face the challenge to his professionalism or expertise, or the financial cost to the healthcare system. Poor doctor-patient communication often contributes to patients’ willingness to complain about, or take action against, their physicians.

How to address the fact that a small number of physicians generate a disproportionate number of patient actions is a challenge for indemnity organizations and the wider profession. Research has identified the characteristics of clinicians who are the subject of more complaints or claims than their peers. The presence of a pre-existing complaint has been reliably found to be a predictor for future complaints. Importantly, Bismark recently found that the risk of subsequent complaint was directly related to the number of previous complaints. However, there is little published evidence on the effectiveness of educational interventions for established physicians to address this phenomenon.

In 2005, MPS, in partnership with the Cognitive Institute (CI), an Australian-based clinical communication skills and risk management organization (and now a wholly owned subsidiary of MPS), launched a program for the identification and educational remediation of members who have a significantly adverse risk profile. The results of a detailed study of one of these interventions, the Clinical Communication Programme (CCP) developed by CI, was presented at the PIAA International Conference in Amsterdam in October 2014 and at the PIAA Claims and Risk Management/Patient Safety Workshop in Baltimore in November 2014.

Who was selected?

MPS members with a history of complaints and claims that placed them far above the mean of their peers were identified through a membership governance system. The claims and complaints of these members were analyzed, and those with issues related to patient communication or for whom inter-professional interaction had contributed to their risk were asked to participate in the Clinical Communication Program (CCP) as a continuing requirement of membership. The CCP is now offered to doctors in the United Kingdom, Republic of Ireland, Australia, New Zealand, Singapore, Hong Kong, and South Africa.

The study examined the progress of 58 physicians practicing in the United Kingdom in a range of specialties, with approximately one-half in family practice and the other half in hospital practice as specialists. Twenty-six were graduates of British medical schools. The age range of the doctors was 32 to 70 years, with a median age of 46.

The most frequently reported behaviours for the doctors referred to the CCP were concerns about:

- Teamwork
- Communication
- Professional behavior
- Personal behavior, manner, and attitude
- Clinical performance.

Many of the doctors had multiple factors reported in the complaints and claims made against them.

What is the nature of the intervention?

The CCP program is conducted over 24 weeks and involves a total of 24 hours of face-to-face contact, as well as a minimum of five sessions of
telephone mentoring (30 to 60 minutes each) and at least six hours of reflective activities. Participants' communication skills are assessed via recordings of live patient consultations, both initially and at the end of the program.

The CCP was developed and piloted in Australia by CI. The CCP consists of three phases, whose central element is a three-day residential workshop with pre- and post-workshop activities; each phase complements the others.

**Phase one.** The initial phase focuses on preparation, which includes an assessment of communication skills, reflection on a simulated consultation, reading of reference material relating to physician-patient communication, and participating in a discussion with an allocated facilitator to set personal goals.

**Phase two.** This phase comprises a residential workshop including presentation of the research that confirms the fundamental importance of effective communication and its association with complaints and claims, development of specific communication skills and techniques, as well as individual goal setting, coaching, and feedback, and opportunities for personal reflection.

**Phase three.** This is the implementation and coaching phase. It includes ongoing mentoring, a reflective survey, and final discussion with the facilitator after a formal assessment of video-recorded consultations.

**The results**

The study aggregated the numbers for a variety of actions initiated by patients, including claims, pre-claims, and disciplinary and regulator referrals into a combined “event rate,” both pre- and post- CCP. The study period pre-CCP had a median of 16.6 years and post-CCP a median of 3.6 years. The event rate for the participants as a group post-CCP was cut by nearly one-half. The event rate pre-CCP was 0.42 or one event every 2.3 member years; the event rate post-CCP was 0.26 or one event every 3.8 years (P<0.0001).

The data for claims alone showed a reduction from 215 claims or one every 4.7 member years pre-CCP to 22 claims or one every ten member years post-CCP (P<0.0001). But the effect for individuals was not evenly distributed. Four doctors accounted for 75% of claims post-CCP, which would imply that a small number of doctors did not benefit from the intervention, while the impact on the remaining 54 was dramatic. An important subgroup of members (34) held full membership and clinical practice throughout and were not subject to any restriction or suspension from practice. In this group the event rate decreased by one-half; from 0.46 events per member year to 0.23 post-CCP (P<0.0001). Sixteen of the 34 doctors had no events post-CCP.

**Conclusion**

The study conducted by MPS showed a significant reduction in the number of actions initiated by patients against physicians after they had undergone an intensive clinical communication-skills training program. We believe these findings establish the CCP as an intervention that is highly effective in reducing future claims and litigation risk of physicians who are identified as posing a significantly higher risk than their peers. We also believe this study has important implications for predicting the future risk of members who do not show a significant reduction in such actions post-intervention.

Many indemnifiers face difficult choices in working with and for-
mulating management plans for doctors who are the cause of frequent complaints or claims because of interpersonal and communication performance issues. The MPS study shows a clear demarcation between responders and non-responders and suggests that is an opportunity to utilize the program to help those clinicians who are linked with a disproportionate number of claims and complaints and predict their future path, in the event that their rate of complaints and claims does not respond rapidly to the intervention.

References
How the New National Practitioner Data Bank Guidebook Affects Reporting

BY DONALD ILlich

The new National Practitioner Data Bank (NPDB) Guidebook is now available online, and PIAA members should understand how its guidance affects them. The Guidebook serves as the NPDB’s primary policy document; it clarifies and consolidates all of its current policies in one place.

Incorporating legislative and regulatory changes, such as the merger of the NPDB with the Healthcare Integrity and Protection Data Bank, the Guidebook offers users more—and clearer—examples of when and how to report and query. It includes more useful tables explaining policies, as well as live links to statutes, regulations, and the NPDB website.

The Guidebook includes a chapter on reports, which also contains a section on reporting medical professional liability (MPL) payments. This updated reporting information should be reviewed by PIAA members that have reporting obligations. The following article explains some of the highlights of the new Guidebook.

Reporting MPL payments
Each entity that makes a payment for the benefit of a healthcare practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or judgment for MPL against that practitioner must report the payment information to the NPDB. Conversely, a payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) that does not identify an individual practitioner should not be reported.

MPL payments are limited to exchanges of money and must have resulted from a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner’s provision of or failure to provide healthcare services. The Guidebook also states that a written complaint or claim can include, but is not limited to, the filing of a cause of action based on the law of tort in any state or federal court or other adjudicative body, such as a claims arbitration board. Eligible entities must report when a lump sum payment is made or when the first of multiple payments is made.

According to regulations, MPL insurers must report MPL payment information to the NPDB, but they are not eligible to receive information from the NPDB. In addition to MPL insurers, hospitals might be required to report MPL payments if they insure their practitioners and make payments on their behalf.

New Guidebook
The NPDB Guidebook includes clarifying language and better examples to help explain the correct procedures for reporting MPL payments, from the listing of the names of practitioners cited in claims to the definition of a written claim. Some of this additional language resulted from PIAA comments on a draft NPDB Guidebook.

Identifying practitioners. Here is one example illustrating how we have incorporated public comments. In response to a PIAA comment on identifying practitioners, some new language was added on page E-18 in the new Guidebook. Now, the Guidebook more explicitly states that “in order for an MMPR to be submitted to the NPDB on a particular healthcare practitioner, the practitioner must be named, identified, or otherwise described in both the written complaint or claim demanding monetary payment for damages and the settlement release or final adjudication, if any. Practitioners named, identified, or otherwise described in both the written complaint or claim demanding monetary payment for damages and the settlement release or final adjudication, if any, Practitioners named, identified, or otherwise described in the release but not in the written demand or as defendants in a lawsuit should not be reported to the NPDB.”

In addition, we describe in greater detail the possible reporting for practitioners not named as defendants. If a practitioner is named, identified, or described in the body of the written complaint or claim, but is not named as a defendant in the suit, the payment would still be reportable if (1) the practitioner is also named, identified, or described in the settlement or final judgment and (2) a payment was made on behalf of the named, identified, or described practitioner.
PIAA also suggested that the practitioner had to be named, not just identified, in either the complaint/demand or release/final adjudication. This suggestion was not adopted (page E-18). Instead, the Guidebook states that the practitioner need only be identified by title, such as "chief of surgery" or "the anesthetist who participated in the patient's surgery."

**Dismissal of a defendant.** Another PIAA comment on the draft Guidebook focused on the Guidebook text, "Dismissal of a Defendant from a Lawsuit" (page E-19). PIAA expressed the concern that the Guidebook leaves too much room for interpretation of the reporting requirements for dismissals from suits. In response, we clarified the requirements by adding new wording: "If a defendant health care practitioner is dismissed from a lawsuit prior to settlement or judgment, for reasons independent of the settlement or release, a payment made to settle a medical malpractice claim or action should not be reported to the NPDB for that defendant health care practitioner."

**Written claims.** The Guidebook also contains information on written payments, under the heading, "Written Complaint or Claim" (page E-18) of the Guidebook. MPL payments that should be reported to the NPDB must have resulted from a written complaint or a written claim demanding monetary payment for changes. The NPDB interprets this requirement to include any form of writing, including pre-litigation written communications. The NPDB, not any other entity, determines whether a written claim has occurred for purposes of filing a report.

**Payments made by individuals.** As noted on page E-17, the amount of the payment is irrelevant if a professional corporation or other entity composed of a sole practitioner makes a payment for the benefit of a named practitioner; it is reportable to the NPDB. In addition, payments made in connection with litigation (e.g., those made as a result of from professional peer review proceedings) may need to be reported. Peer review committees and others investigating patient complaints against practitioners should consider notifying practitioners about the reporting requirements before a payment is made.

**Other topics for MPL payers**

The following is information from the new NPDB Guidebook concerning three topics that are frequently discussed in regard to reporting MPL payments to the NPDB.

**Loss adjustment expenses.** Loss adjustment expenses (LAEs) refer to expenses other than those related to the compensation of injuries, such as attorney fees, billable hours, copying costs, expert witness fees, and deposition and transcript costs.

LAEs should be reported to the NPDB only if they are included in an MPL payment. The total amount of an MPL payment, a description of and amount of the judgment or settlement, and any conditions (including terms of payment) should be reported to the NPDB. LAEs should be itemized in the narrative description section of the reporting format. If LAEs are not included in the MPL payment amount, they should not be reported to the NPDB.

**High-low agreements.** A high-low agreement is a contractual agreement between a plaintiff and a defendant's insurer that defines

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the parameters of a payment that the plaintiff may receive after a trial or arbitration proceeding. The benefit to insurers is a limit on the amount they may be required to pay if the plaintiff wins the case. The benefit to plaintiffs is a guaranteed payment even if they lose the case or win only a small award. The defendant’s insurer agrees to pay the “low end” amount to the plaintiff if the verdict or decision is for the defendant. The defendant’s insurer is obligated to pay no more than the “high end” amount to the plaintiff if the verdict or decision is for the plaintiff.

A payment made at the low end of a high-low agreement must be reported to the NPDB unless the fact-finder (such as a judge, jury, or arbitrator) rules in favor of the defendant and assigns no liability to the defendant practitioner. If the fact-finder rules in favor of the defendant and assigns no liability to the defendant practitioner, the payment is not being made for the benefit of the practitioner in settlement of an MPL claim. Rather, it is being made pursuant to an independent contract between the defendant’s insurer and the plaintiff.

When a defendant practitioner has been found liable by a fact-finder, any payment made for the practitioner’s benefit must be reported, irrespective of any high-low agreement. If a high-low agreement is in place, and the plaintiff and defendant settle the case prior to trial, the existence of the high-low agreement does not alter the requirement that the settlement payment must be reported to the NPDB.

**Subrogation-type payments.** Subrogation-type payments made by one insurer to another are not required to be reported, provided the insurer receiving the payment has previously reported the total judgment or settlement to the NPDB. Subrogation often occurs when there is a dispute between insurance companies over which professional liability policy ought to apply in response to a lawsuit.

**Resources for MPL payment reporting**

There are some additional resources on the HSRA website, beyond the Guidebook, that can help with MPL payment reporting. They include:
- A webcast that gives step-by-step instructions for reporting
- A sample MPL payment report for use as a reference
- A flowchart that describes the path of an NPDB Medical Malpractice Payment Report.

**Contacting the NPDB**

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**Reference**

1. The NPDB regulations and Guidebook refer to medical malpractice payments which are defined broadly to include payments defined as medical professional liability payments.

The views and opinions of authors expressed in this publication do not necessarily state or reflect those of the U.S. Government.

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**PIAA Board Governance Roundtable**

March 10–12, 2016 • The Westin Kierland Resort • Scottsdale, Arizona

The PIAA Board Governance Roundtable is the preeminent educational and networking event for the Board members of PIAA regular and industry associate member companies.

This year’s roundtable will feature a medical professional liability (MPL) product management simulation to help leaders understand the interplay of the diverse factors that have an impact on the MPL insurance market. Some changes are planned for this popular exercise, including giving attendees new variables to contend with in their decision-making, to reflect current real world dilemmas MPL companies are facing today. Also, don’t miss special sessions on the role that board members play in moving an organization from average to great and tactics that can lead to richer discussions and greater productivity in the boardroom.

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WHY MPL INSURERS NEED MORE ACTIVE RISK MANAGEMENT

BY MARTHA WINSLOW, MAUREEN STAZINSKI, AND GENA RHEE

The medical professional liability (MPL) industry continues to evolve, reflecting changes experienced by healthcare professionals and insurance companies. These new market complexities faced by MPL insurance providers call for broader reflection on active risk management.

In essence, it is paramount to understand and measure the number of risks that MPL carriers undertake in pursuit of targeted returns. Therefore, it is a best practice for MPL insurers, regardless of size or complexity, to have an effective enterprise risk management (ERM) framework.

We believe these three questions are guideposts for the development of an effective ERM framework.

Question 1: What are the organization’s key risks, and are they clearly defined and documented?

A basic ERM building block is the identification of the insurer’s key mission-failure risks. It is useful to identify and organize those key risks into four “risk quadrants”:

- **Targeted performance**—Avoid sustained underperformance and excessive volatility that undermines stakeholders’ confidence
- **Capital adequacy**—Preserve capital to assure business continuity and avoid insolvency, impairment, and adverse actions by regulators or rating agencies
- **Liquidity**—Maintain liquidity to meet extraordinary policyholder obligations or unusual illiquidity in asset markets
- **Franchise value**—Avoid reputational risks or loss of employee engagement.

These key mission-failure risks are chronicled in a risk register. For each key risk, the definition should be clear and the key risk owner identified. The list of key risks should be updated annually or at the time of a major organizational change, such as an acquisition or a dramatic change in the legal or regulatory climate, such as the implementation of the Affordable Care Act.

Question 2: Is there a clearly defined risk appetite statement/framework tied to the organization’s mission?

A risk appetite statement, as illustrated in the chart below, is a proactive expression of the type and amount of risk an organization will take in the pursuit of its planned performance objectives as stated in its mission statement. Therefore, there are quantitative and qualitative elements to the concept of risk appetite.

Risk Appetite Framework

Risk is integral to an insurer’s business strategy, particularly for insurers that have high concentrations of long-tailed exposures such as MPL. The overarching element of a risk appetite framework is an insurer’s risk strategy. The risk strategy broadly expresses the risks an insurer will take.
to achieve its mission. Risks and missions can vary by type of insurer (stock versus mutual companies) and even across companies of the same risk profile that write similar amounts and lines of business. Therefore, even carriers that specialize in insuring MPL exposures can have distinctive risk strategies. In other words, the risk strategy is a qualitative expression of a specific insurer’s overall philosophy towards risk-taking. Risk tolerances are a quantitative extension of the risk strategy. Therefore, risk tolerances must be measurable so they can be continually monitored. They express quantitatively the amount of aggregate risk that the insurer is willing to accept, expressed in probabilistic terms, time horizons, and unacceptable mission impairment impacts. An extension of risk tolerances is risk limits, which are more granular tolerance levels expressed for specific risk sources and are used to implement the risk tolerances. Both risk tolerances and risk limits are defensive expressions of risk as they define a limit beyond which an organization will not go in pursuit of its mission. Given the long-term, cyclical and fluctuating financial history of MPL carriers, it can be a riveting challenge to select the customized list of risk tolerances and risk limits.

Parallel to risk tolerances, risk preferences frame risks as opportunities. They articulate the key risks that the organization believes are necessary to achieve its mission and are expected to contribute value-creating returns. An extension of risk preferences is risk attractiveness, a more tactical reflection of current conditions, both external and internal, that affect the appeal of different risks. As an example, with the rise of physician employment by hospitals, MPL carriers are experiencing a decline in their traditional exposure profiles. Therefore, in a desire to keep a similar amount of overall “topline” business, they must innovate and consider non-traditional risks (e.g., workers compensation in the healthcare space) in the context of risk preferences and attractiveness.

Once the risk appetite and tolerances are defined, it is important for the organization to control its key risks by holding adaptive buffers. There are resources, both financial and non-financial, that allow an organization to manage through any “bumps in the road” that may occur by helping to prevent an immediate breach of an agreed risk tolerance. The buffers provide management with time to develop and implement adaptive actions to respond to the risk at hand. Currently, the capital levels of MPL carriers have grown over the past several years, and have allowed these carriers to establish strong adaptive buffers. However, the development and maintenance of buffers carries a cost, so it is a useful exercise to prioritize the risks and buffers within each “risk quadrant.”

**Question 3: What metrics are used to monitor the exposure to key risks as guided by the risk appetite statement/framework? How often are these metrics reviewed?**

The metrics used to monitor an organization’s exposure to key risks will vary by organization and may vary over time. Metrics should be organized by the four “risk quadrants” as noted earlier and should address each key mission-failure risk and the adaptive buffer. While some of the metrics based on financial information may be reviewed annually, there are many metrics that can be reviewed more frequently. These metrics may currently be reviewed for purposes other than risk management. We suggest that MPL carriers reframe the discussion around such metrics and view them in a risk management/appetite framework. For example, target loss ratios, policyholder retention rates, information technology (IT) systems downtime and employee turnover are all metrics that are reviewed with some frequency. In addition to measuring these metrics against a stated goal, it would be helpful to tie them back to the risk appetite statement by framing the question around an organization’s risk tolerance level for that particular risk. This intertwined process is especially valuable and useful to MPL carriers as they face intense competition, partly driven by the decline in the commercially insured population that physician employment has created.

**Create, monitor, and amend**

MPL insurers are operating in a complicated environment with complex risks. Insurers should be proactive about their ERM processes, specifically defining and placing boundaries on the multitude of key risks they face by implementing a risk appetite statement/framework. The need to regularly monitor the results of a risk appetite statement/framework and to make adjustments as the MPL environment or insurer evolves is as important as its creation. The benefit of engaging in this ERM exercise is the identification of the business elements that are mission-critical, enabling the development of relevant programs to manage risk that will strengthen the organization against adversity, notably into the uncertain MPL insurance future.

For related information, see towerswatson.com/riskappetite.
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As a result of the ongoing trend of increasing captive-insurance formation during the past few years, many captive owners are managing captives that have substantial assets in their loss reserves.

Having operated legitimate captive insurance companies for the past few years, these owners understand the significant impact that paid claims can have on the future earning potential of the captive's assets. Although the losses are not typically large enough to jeopardize the solvency of the captive, when uncontrolled, they have a negative impact on the loss reserves. They can also compel the owner to postpone any plans to offer additional coverages, and put a serious dent in the long-term value of the captive, should the owner ever decide to liquidate or sell.

With these facts and long-term vision in mind, the most successful captive insurance companies have begun to implement loss-control services. As most captive owners are also owners of successful businesses, they are accustomed to having interactions with the loss control specialists provided by their traditional commercial insurance carriers. Just as in the guaranteed-cost marketplace, the captive's loss control services provider's main responsibility is to provide recommendations to the captive's insureds that are specifically designed to decrease the frequency and severity of potential losses.

But this situation is different from the relationship between a business owner and traditional insurance carrier; here, the reward for successful integration of an effective loss control program into a captive's risk management strategy belongs solely to the captive's owner. The reduction or elimination of loss costs (deductibles, administrative costs, accelerated depreciation, etc.) directly benefits the owner's insured business (or businesses), because these dollars are allowed to remain within the operating entities. As the captive's insureds now represent a better risk, the captive experiences lower claims costs and a larger loss reserve.

The symbiotic relationship that is created provides the captive with significant advantages and opportunities that would otherwise not exist:

- The positive performance of the insureds creates a more stable loss reserve, so the cap-
A stronger captive balance sheet makes it possible for the owner to write new/expanded coverages, transitioning more dollars away from the commercial marketplace and back to the captive owner’s interests.

The integration and successful performance of loss control services into the captive as well as its insured interests is conducive to a favorable score from the insurance rating agencies (A.M. Best, Moody’s, etc.). These ratings let the captive write coverages that require “rated paper” (i.e., workers’ compensation), reduce or eliminate fronting costs, and pave the way for a better negotiating position in the reinsurance marketplace.

Loss control programs are essential

Because the execution of these performance-enhancing programs is not a core competency of a traditional captive manager/attorney, the inclusion of an effective loss control program into a captive arrangement is often overlooked. Then, what may have been an unintentional exclusion can lead to significant gaps in an enterprise risk management strategy and (unnecessarily) puts the reserves (and future earnings) of the captive at greater risk.

When a captive owner selects a captive manager, attorney, or actuary, he utilizes the appropriate measure of due diligence. Due diligence should also apply to the selection of loss control providers for the captive insurance company. Best practices show us that an effective captive loss control program addresses not only the risks of each written coverage line; it also supports the overall mission of the captive and parent company, by lowering the total cost of risk for both entities. Loss histories and claim trends should be analyzed by the captive loss control provider and reported to the captive insurance company shareholders, annually, at minimum. With this extent of program-performance monitoring, the captive’s managers can tailor their loss control programs to reflect any emerging risks and thereby protect the captive’s assets more effectively.

Each captive insurance company and its written coverages are unique; correspondingly, a loss control provider should design and provide programs unique to the specific coverages of each individual captive. Because the exposures addressed by each type of captive coverage are inherently different from the associated hazard, the loss control programs should be designed to address the particular perils in the insured’s organization, as they relate to the specific coverage. For instance, if a captive is writing a coverage to reimburse the insured for revenue lost due to a regulatory actions (stemming from the ACA, HIPAA, etc.) incident, a captive loss control provider might make recommendations that would involve mock regulatory audits. Because this implementation of a recommendation and a particular program would, most likely, not reduce the likelihood of loss linked with another coverage type (say, a coverage providing defense cost reimbursement, or workers’ compensation coverage) the captive’s loss control provider should offer guidance to reduce the likelihood of unrelated risks, through separate loss control programs for the captive.

Financial game changer

Integrating effective captive loss control services into the operations of a captive insurance company can be a financial game changer for business owners. When the owners of a captive insurance company make risk management and risk mitigation a higher priority, this shift in strategy can protect against unnecessary loss, and make possible a significantly greater opportunity for asset growth, through the investment of more of the captive’s assets.

Furthermore, as the captive insurance company increases its reserves, it can decrease its reliance on third-party commercial cover for core risks. This is especially important for captives owned by small medical groups or a single practitioner: a well-structured enterprise risk management and loss control strategy in a captive insurance company can save up to $600,000 per year in taxes, without the need to alter the risks involved or the specifics of the operations of the owner’s interests.

The successful integration of loss control services into a captive arrangement helps provide some assurance that the impact of developments that now, or in the near future, will negatively impact the bottom line of the captive as well as its insureds is reduced, or even eliminated. As captives are becoming increasingly sophisticated in their insurance programming and their approach to investments, it is equally important that they be aligned with service providers that understand the liability and the asset side of the balance sheet. Because the potential loss of investment income and, more dramatically, captive solvency are so important, a captive owner should do everything possible to reduce claims costs and boost investment growth, before a loss occurs.

Another Perspective on Value-Based Care

“...[E]ven if the efficacy of a volume-to-value shift were established, the claim that Medicare’s new payment system decisively effects such a shift is premature. In the post-SCR era, physicians’ incomes will still largely depend on the number and mix of services they deliver. Even for salaried physicians, bonuses are often tied to targets based on volume and service intensity. At this juncture, ‘volume to value’ is as much (or more) a marketing slogan as it is actual policy.”

—Justin Oleander, PhD, and Miriam J. Laugesen, PhD, New England Journal of Medicine, September 24, 2015
By Eric R. Anderson

Media coverage of the Choosing Wisely campaign seems to have subsided of late. But it’s still an area of keen interest, and some debate, in the healthcare and medical professional liability communities. Choosing Wisely was launched in 2012 by the American Board of Internal Medicine (ABIM) Foundation, in response to an article in the New England Journal of Medicine that asked organized medicine to name five tests and treatments that were overused in their specialty but didn’t really provide any meaningful benefit for patients.

Right from the start, when Choosing Wisely released “Top Five” lists from nine specialty societies, it was major news. There was extensive coverage in both consumer publications and medical journals and, according to ABIM, hits on the Choosing Wisely website following the release numbered in the hundreds of thousands. Today, ABIM reports that more than 70 societies comprising more than one million clinicians are partners of the Choosing Wisely campaign.

Any initiative to reduce wasteful care, and encourage physicians and patients to talk about what tests and treatments they really need, is admirable—and it’s a bonus if some amount of cost savings is achieved.

But there are two sides to every coin. Unrecognized liability exposures could well arise from providing healthcare that is streamlined in the absence of comprehensive testing and assessment.

For example, according to researchers from Washington University School of Medicine in St. Louis, new guidelines proposed by programs like Choosing Wisely do not correspond with what neurosurgeons have seen with patients who have brain tumors. Currently, the Choosing Wisely guidelines suggest that imaging not be performed for uncomplicated headaches, and recommend that neuroimaging be ordered only if an otherwise stable headache patient begins to exhibit localizing neurological symptoms or signs.

The musings of one of the study’s co-authors are thought-provoking: “Although the intentions are laudable”, said neurosurgeon Ammar H. Hawasi, MD, PhD, “these guidelines are inconsistent with the neurosurgeon’s experience with patients with brain tumor.” The author’s note that if they had been adhering to the proposed Choosing Wisely guidelines, the patients with complaints of migraine or other headache might not have had imaging studies—with important implications for patient outcomes. With early identification and diagnosis of a brain tumor, treatment can begin rapidly.

Examples like this may be isolated or extreme. But they do exist. More than likely, we could find some for every medical specialty. The personal injury bar needs but a small window of opportunity for zeroing in on new theories of liability. So this type of guideline, without extensive research as a foundation, could well spell more litigation for all.

Of course, we should support the circumspect and sensible use of clinical guidelines that help healthcare professionals exercise sound judgment in reducing waste in the medical system. But we should ensure this is done without adding new risks in what is already a volatile and unpredictable legal environment.
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