Will InsurTech revolutionize MPL?
Change your approach to record retrieval and analysis with Ontellus.

Eight leading companies have merged to become Ontellus, a revolutionary, nationwide online record retrieval partner that empowers you to:

- Accelerate cycle times
- Improve outcomes
- Focus on strategy
- Achieve industry-leading, SOC2 level security

Competitive advantage becomes yours through better-informed decisions, faster turnaround and expedited case resolution.

Discover a whole new world of efficiency and data security at Ontellus.com.
These are challenging—but in some respects, exhilarating—times for medical liability insurers and indemnifiers. The changing healthcare delivery system and liability environment are creating uncertainty and the need for innovation like never before. Each organization must ensure it has optimal functionality today in its claims handling, underwriting, technology, and other key operations, knowing full well that external circumstances may compel a new approach tomorrow.

The products and services these companies offer may need to evolve as well. This requires regularly updated information regarding customers’ preferences and needs for their liability protections and risk management.

Fortunately, there are opportunities for like-minded organizations to explore these issues, such as the recently concluded PIAA International Conference in London that focused on the theme of “Change and Disruption.” Attendees from 24 countries around the world heard that change and disruption are not unique to one location; they are everywhere. The issues for insurers and indemnifiers across the globe have become similar. We have found that what is happening in one part of the world may well have already occurred somewhere else—or may happen very soon. Consequently, the sharing of information and experiences among participants is among the best ways for companies to learn and adapt in order to prosper.

This issue of Inside Medical Liability focuses on a number of topics that illustrate the power of change and disruption, and the imaginative and successful ways that PIAA members and others have been responding to challenges and embracing change.

The cover story of this issue, about the rapidly evolving dynamic of InsurTech products—innovations, business models, and apps being created to revolutionize traditional business—for the insurance sector, relates the evolving saga of this growing niche market. These developments have the potential to significantly change the manner in which insurers cover risk and do business.

Another feature in these pages discusses the complex issues at stake in dental imaging, and in particular those that involve the standard of care in a dental professional liability case. While this standard, like so much in healthcare, may be evolving, the author provides important guidance to help insurers and indemnifiers consider this critical component of any claim.

You will also learn in this issue how one PIAA member, KaMMCO, offers a prime example of how to take the initiative and embrace the changes in the healthcare delivery system and the growing need for more and better data. KaMMCO Health Solutions strategy is to innovate in the field of healthcare informatics and quality reporting—and their experiences are proving to be both fascinating and inspiring.

Finally, this issue features an analysis of recent MPL claims. The data used in this analysis is derived from the 2016 PIAA Closed Claim Comparative, which summarizes data submitted by participating members in conjunction with PIAA’s Data Sharing Project. In addition to other key findings, the article identifies two salient trends: both the proportion of large claims and the cost per large claim are increasing. The impact of these developments could well be increases in premiums, as needed to cover the rising costs.

As this year draws to a close, we can look back on 2017 as a year whose theme was “change and disruption” in the U.S. and around the world. The worlds of healthcare and medical professional liability are exciting and challenging. Rest assured, as we approach 2018, PIAA is working diligently to prepare for the future and to help ensure that our members are well positioned for the challenges ahead.
But behind the bright and shiny digital future, there are some lingering questions for the industry. When it comes to MPL cover, how far is too far in the individualization and real-time adaptation of policies?”

—Cover story
Delphi Medical Professional Liability provides insurance carriers with the most advanced software solutions available today giving them the power to:

- Significantly improve operational efficiencies
- Enhance levels of customer service
- Achieve end-to-end processing for the entire policy, claims, and financial lifecycle
- Achieve real-time automation, visibility, and control over operational processes
- Collaborate across the organization by providing timely and accurate information

What’s in it for you?

- The flexibility to more quickly respond to changing market conditions
- The ability to link your business more directly to your customers’ needs
- A system platform built on modern technology and open architecture providing the optimal environment for acquisition integration

Let Delphi Technology show you how we can transform your critical business challenges into measurable business results.

For more information, contact us at Delphi-Tech.com.
### COMING ATTRACTIONS

#### EVENTS & CALENDAR

**2018 Board Governance Roundtable**

*The Role of the Board in Mergers and Acquisitions*

When a company becomes involved in the mergers and acquisitions (M&A) market, its board of directors faces a unique set of challenges and considerations through every stage of a potential transaction—from inception and evaluation to execution and through integration. What can board members do to ensure their role in the deal process is optimized? And how can boards add value to minimize a deal’s risk? In this session, Victor Lopez-Balboa, Vice Chairman of the Global Financial Institutions Group and Global Co-Head of Insurance, Goldman Sachs, will discuss why and how deals take place, and the different cycles that impact M&A activity. He will provide an overview of what is important to know, as a board member, when it comes to M&A, and share a case study about a recent deal that took place in the insurance sector. In addition, he will provide key information on critical board responsibilities, how to evaluate M&A opportunities, and the crucial questions directors need to ask, as a board member, when it comes to M&A activity.

**2018 Dental Workshop**

*An Actuarial Look at Loss, Premium, Expense, and Other Data Trends in Dentistry/Oral Surgery*

In this session, Susan J. Forray, FCAS, MAAA, Principal and Consulting Actuary, Milliman, will provide an overview of the dental professional liability insurance marketplace, as seen through the eyes of an industry actuary. She will use data compiled from PIAA carriers as the basis for an analysis and discussion of claims trends, including both frequency and severity. Ms. Forray will also provide key comparisons of loss experience between dental and other medical professional liability coverages. In addition, other key data trends in dentistry/oral surgery will be discussed, including premiums and expenses.

---

**March 14-17, 2018**  
**CEO/COO Meeting**  
Hyatt Regency at Gainey Ranch  
Scottsdale, AZ

**March 15-17, 2018**  
**Board Governance Roundtable**  
Hyatt Regency at Gainey Ranch  
Scottsdale, AZ

**April 11-13, 2018**  
**Marketing Workshop**  
Loews Santa Monica Beach Hotel  
Santa Monica, CA

**April 11-13, 2018**  
**Dental Workshop**  
Loews Santa Monica Beach Hotel  
Santa Monica, CA

**May 16, 2018**  
**Leadership Camp**  
Waldorf Astoria/Hilton Bonnet Creek  
Orlando, FL

**May 16-18, 2018**  
**Medical Liability Conference**  
Waldorf Astoria/Hilton Bonnet Creek  
Orlando, FL

**July 25-27, 2018**  
**Underwriting Workshop**  
Westin Portland Harborview  
Portland, ME

**September 12-14, 2018**  
**Claims and Risk Management/Patient Safety Workshop**  
Swissotel Chicago, Chicago, IL

**September 26-28, 2018**  
**Technology, Human Resources, and Finance (THRF) Workshop**  
Grand Hyatt Washington  
Washington, D.C.

**October 11-12, 2018**  
**Corporate Counsel Workshop**  
Portland Regency Hotel  
Portland, ME

**Future PIAA Medical Liability Conferences**

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

**May 6-8, 2020**  
Omni Shoreham Hotel  
Washington, D.C.
I WON’T STEAL YOUR DATA.

BUT I WILL HOLD IT HOSTAGE.

Ransomware is rampant, affecting businesses in every industry. And cyber criminals are increasingly targeting small-to-midsize businesses as they know that many lack the privacy controls and IT support of larger organizations.

While state-of-the-art cyber insurance is an essential component of your clients’ data security strategy, a strong policy is only part of the solution. Cyber Liability coverage from NAS Insurance includes expert pre and post-breach services to help them prepare for, and defend against, the criminals seeking to hold their business hostage.

Visit the cyber experts at nasinsurance.com/cyber
When you seek new paths to success, you need a partner that has a firm grasp of your business. At Aon Benfield, we build the close relationships required to propel your firm forward and gain a foothold in profitable environments. Find out more at aonbenfield.com.
Achieve healthy and sustainable growth

Medical Professional Liability insurers operate in a challenging environment with rising litigation, managing capital, and growing their business. Aon Benfield’s Healthcare team has the experience and resources to help our clients achieve new and profitable growth in evolving areas.

To learn more, contact David Sullivan at david.sullivan@aonbenfield.com or visit aonbenfield.com.
‘It’s All in How You Define It,’ Pennsylvania-Style

Like so many states, Pennsylvania is between a rock and a hard place, budget-wise. But Democratic Pennsylvania Governor Tom Wolf has said he’s optimistic that the Republican-controlled legislature can produce a deal to patch a projected $2.2 billion budget gap.

Wolf said he’s cutting “over $2 billion to streamline government.” This includes hundreds of millions of dollars in “cost avoidance” that might have materialized anyway, such as hundreds of millions of dollars in transfers from a workers’ compensation fund and a nonprofit organization created by state law in 2002 to offer MPL insurance (this is the Medical Care Availability and Reduction of Error Fund, otherwise known as “MCARE”). MCARE, controversial from the get-go, has been providing a reliable stream of news for years now. But every two years, the Pennsylvania Department of Insurance is required to reassess the need for it, as Pennsylvania law mandates that the fund be closed at some point in the future, when market conditions permit. The news floodgate could close at any moment.

Especially toothsome in all this, though, is Governor Wolf’s euphemism for “tax increases” — the term “recurring revenue” is the preferred usage; this refers to “a new source of money that provides a reliable cash infusion every year” — in other words, tax increases.

Source: The (Harrisburg) Sentinel, September 19, 2017

For several years now, lawyers have been bombarded by legal-marketing companies assuring them that video is the next big thing. And yet, video hasn’t really yielded results for most lawyers. Even one of the pioneers of the lawyer video, New York MPL attorney Gerry Oginski, with his extensive video library, typically attracts hundreds, rather than thousands, of viewers.

But maybe lawyers can maximize viewership of videos, by posting items like explanation videos (more popular than commercials), or putting videos on the law firm’s practice page and creating separate versions for Facebook. But obviously, that doesn’t solve the dullness problem.

The best answer may be to crank up the volume, and the hysteria, somewhat like Crazy Eddie with his famous “blow-outs” commercials for audio stereos, in the heady days of the 1980s. For MPL, the current exemplar of this tactic is Bryan Wilson, the self-proclaimed “Texas Law Hawk.” Visit YouTube to get a taste of Wilson’s dynamic.

Source: Above the Law, September 2017
According to Horst Schultze, a staff writer at Medical Economics, “to build trust with patients, physicians need to take a page out of the hospitality industry’s playbook and do three things.”

First, Schultze says, doctors need to prioritize customer service and the patient experience. Like all customers, patients have some fundamental expectations: Customers expect the product to be free of defects. They expect timeliness. And they expect their interaction to be pleasant. Indeed, a satisfied customer, says Schultze, is one who walks away from an interaction that meets these expectations. But a loyal customer is one who walks away from an interaction that exceeds these expectations, because “their interaction was not just nice, it was caring.”

Schultze points out that (and this is not exactly news to most of us) “first impressions matter.” After that, the benchmark for comparisons is set vertiginously high: It’s the Ritz-Carlton that’s invoked. Something like a Marriott, for example, might have made a more reasonable target.

Here’s what healthcare professionals should be taking careful note of, Schultze says: “Ritz-Carlton employees never greet guests with ‘hi.’ Within nine feet of a guest approaching, they smile, look the guest in the eye, and say, ‘good afternoon, Mr. Smith.’ This is not only welcoming; it shows all guests they are individually respected and valued. This warmth permeates all interactions.”

Schultze asserts, “For doctors, that’s the key. The skills of diagnosing symptoms and offering treatments are not enough. Doctors should also make patients feel cared for, which would make diagnosis and treatment easier.”

And, flying in the face of the notoriously tight confines of what’s allowed by most health insurance policies, there’s this, “That’s why it’s unconscionable that the average time primary care doctors spend face-to-face with patients is 21 minutes annually. How can patients trust someone they only see for a few minutes?”

Good medicine requires more physician face-time with patients.”

But just like every other hypothesis, we say this one needs proof. And by the gold standard: a randomized, double-blind study. Incoming patients enrolled in this (proposed) in-depth research would be randomly assigned to a (group one) silver-tongued former employee of New York’s Waldorf-Astoria hotel (MD degree via an online med school) or (group two) a tiresomely nasty House, MD, clone.

Clearly, this rigorous-type project deserves funding. Perhaps Ritz-Carlton has a foundation? Source: Medical Economics, September 11, 2017

Who(m) Do You Trust?
A credit-rating enterprise, Experian, is offering patient identifiers

The idea of unique patient identifiers is not new. But credit-rating firm Experian says it’s ready to take it beyond just the idea phase. It’s offering to fix a years-long patient-safety problem by leveraging its expertise from the financial sector.

Dan Johnson, Vice President of Strategy for Experian Health, notes, “If the payer uses the same unique identifier to identify Dan Johnson, and a hospital is sending them a claim, it ensures the accurate linking of the correct patient across enterprises.”

Johnson said Experian’s wealth of credit bureau data makes it the perfect private-sector innovator for patient IDs. “The credit bureau is really good at matching identity,” he said. The company’s Universal Identity Manager, first released in 2016, relies on a combination of probabilistic and referential matching. Experian claims that combination makes the match more accurate than deterministic matching.

Experian has worked with Congress on the Ensuring Patient Access to Healthcare Records Act, which removes the business associate status from clearinghouses, thereby allowing them to use protected health information under HIPAA.

To which we, with all due respect, would like to respond with one rather troubling word about the putative safety of the Experian identifier system: Equifax.

Source: Modern Healthcare, September 8, 2017

They’ve Already Got Room Service
Should hospitals be more like hotels?

According to Horst Schultze, a staff writer at Medical Economics, “to build trust with patients, physicians need to take a page out of the hospitality industry’s playbook and do three things.”

First, Schultze says, doctors need to prioritize customer service and the patient experience. Like all customers, patients have some fundamental expectations: Customers expect the product to be free of defects. They expect timeliness. And they expect their interaction to be pleasant. Indeed, a satisfied customer, says Schultze, is one who walks away from an interaction that meets these expectations. But a loyal customer is one who walks away from an interaction that exceeds these expectations, because “their interaction was not just nice, it was caring.”

Schultze points out that (and this is not exactly news to most of us) “first impressions matter.” After that, the benchmark for comparisons is set vertiginously high: It’s the Ritz-Carlton that’s invoked. Something like a Marriott, for example, might have made a more
That flash of brilliance you see?  
It’s doctors and health care innovators uniting as a powerful source for good.

Here, the dream of healing the sick is as pure as it ever was. Here, the champions of the healers know they, too, have a champion. Constellation is a growing partnership of mutual liability insurers and health service companies.

Together we’re stronger. And together we’re embarking on a mission to change the future of health care.

To learn more about our vision, visit ConstellationMutual.com.
**PIAA Data Sharing Project**

**CARDIOVASCULAR DISEASE**

In the PIAA Data Sharing Project, cardiovascular disease continues to be cited frequently among patient outcomes leading to a claim or lawsuit. Approximately 7,000 claims and lawsuits closed between 2011 and 2015 were identified, of which 26% paid $416 million in total indemnity, with an average indemnity payment of $391,059.

- **Most Prevalent Presenting Medical Conditions**
  - Chest pain
  - AMI
  - Coronary atherosclerosis
  - Dyspnea and respiratory abnormalities
  - Heartburn

- **27% of closed claims involved diagnostic error**

- **Internal Medicine**: $362,804
- **Family Medicine**: $354,153
- **General Surgery**: $411,142
- **Radiology**: $393,505
- **Emergency Medicine**: $338,075

For more detailed information, see the PIAA MPL Specialty Specific Series reports or contact P. Divya Parikh at dparikh@piaa.us.

© 2017 PIAA. All rights reserved. This page may not be reproduced or distributed without express written consent from PIAA.
When an insurance company sets about the implementation of a new enterprise software application, the question of how to approach the transfer of data from the old to the new software arises. In fact, a “data conversion” has to be planned as a separate and parallel exercise to the implementation of the new software.

Data conversions are often the most complex and expensive components of a new system project, and almost without exception the most risky and unpredictable task. The data structure and complexity of the legacy system are likely quite different from the new application being implemented, the type of database may be different, the data integrity checks in the old system may be looser, and the entity relationship definitions in the new system may not be compatible with those in the older legacy application. But to the business users, the data stored in the legacy system remains critical to their business functions and decision-making.

The planning process will need to identify, among other things, the staffing requirements, the hardware and software that will be used, the test plan and test criteria, risk factors, and change control.

Steps in the process
It should be assumed that the process will be iterative, with each conversion revealing problems and issues that must be dealt with before another pass is made. For that reason—and because every conversion has unknowns in it—the conversion should begin as early as possible, and it will usually be on the critical path of procedures needed prior to going live with the new system.

The plan should be realistic about access to information on the source of the data: Is it well documented (it rarely is) and, if not, are IT staff available to help out with understanding the contents and functionality of the legacy system?

For initiation of the work, the target software must be in a fixed state. If the new system is being designed or customized, the conversion cannot be started fully, because the work being done makes the destination of the data a moving target. With the best of intentions, some changes to the new system will likely occur throughout the life of the project; the project plan should address how they will be coordinated with the conversion.

The method of balancing and validating the conversion should be documented. In effect, this is a test plan. A common issue occurs when reports from the legacy system are used to balance against the new system; but they have filtering or other calculations embedded in them, which means that they are not a 100% accurate representation of the database.

Is the data to be converted at a specified point in time, so that the new software can be the system of record from that point forward? This is the preferable way to do it—phasing the conversion is itself more complex, and requires that the company work with and
merge data from two systems until the process is completed—not an ideal situation.

The plan must consider the various dependencies within the insurance business. Claims are events that happen under a policy, so the policy conversion should be done before the data pertaining to claims. Name-and-address records will be needed for creating policies, so they should be completed before the policy conversion. If there is more than one source for the data, that adds complexity to the mapping and converting process, and it also has a bearing on dependencies. If there are plans to make other infrastructure changes (e.g., new hardware, new operating system, or a new database) during the time window of the conversion, the chain of dependencies can become even more complex, and also a risk factor.

The user should be consulted throughout the conversion project, for testing and for dealing with questions as they arise. As data is mapped from the legacy system to the new software, many decisions will be needed to address what should be done in the event of scenarios like these:

- Data is in the legacy system, but there is no place for it in the new system.
- Data is needed in the new system but is not available in the legacy database. Can the data be derived, or must it be entered?
- The “same” data is present in more than one place in the legacy system. Which should be used?
- The usage and code structure of a particular field is different in each system; for example, the legacy system may employ 80 codes for the various specialties, but the new system uses 120.

These and many more questions will arise that cannot be answered by IT. Then, once the question has been answered, the next decision will be about how to correct the data. There are generally two options: make corrections in the legacy system if that is possible (this is the preferred approach), or do it in an outside source. An “outside source” might be an Excel spreadsheet generated by IT wherein the anomalous records are listed with enough information that they can be identified and with sufficient space to enter the required data. These spreadsheets are then merged with the other incoming data when the conversion is run.

Perhaps the most critical decision concerns which of the data should be converted, and this is where the business users’ opinion becomes important. Just because the data exists doesn’t mean that it should be moved to the new system. There is a belief that if you can convert one year of data, you can convert 20—the only difference is machine time. This is a fallacy; the more data there are and the older it is, the greater the likelihood of anomalies and errors that can bog down the process. In thinking about what to convert, consider the following questions:

- Is the legacy data consistent, going back through the years? If, for example, a prior conversion was done 10 years ago, is the data prior to that point in the same format and quality as the data after it?
- What is the business- and regulatory-based need to retain the data? Paid receivables have very little value after the few months, when they may be required to support an inquiry. Perhaps the company had a line of business that was discontinued some years ago.

---

MPL Expert Witness Database

The MPL Industry’s First Choice for Their Defense
Attorneys Examination of Plaintiff Experts

Features include:
- Testimony on over 4,000 experts
- Over 7,000 transcripts
- Not just a transcript repository but focused analysis on the experts past testimony
- Analytics reports of the expert’s testimony “opinion” across all transcripts to compare past testimony to the case you are working on right now
- Online access for all authorized users
- Order as many transcripts as needed at no additional cost
- Flat monthly fee which covers all of your defense attorneys, paralegals, and claims professionals for access to the database

What participating members have said:
- Paralegal – “It was wonderful and so easy to use. Thanks for the help.”
- SVP Claims – “This is well on its way to becoming the premier medical malpractice defense expert witness database in the world.”
- Attorney – “Thank you so much. I really appreciate your help.”
- Paralegal – “Wow, thank you.”

For an online Internet demo which takes only 30 minutes, contact dcostello@secondchair.com or call 239 410 5797

Over 5,000 attorneys, paralegals, and claims professionals accessed the EWD in 2016
ago. Is that data needed?
- How far into the future do policy records need to be preserved to support late-reported claims and other transactions? And is there a way to add policy data for the rare late claim that may come in instances when there is no converted policy for it?
- Does the business require separate records for each and every claim payment and reserve transaction, or can they be aggregated by month, by quarter, or by year—depending on what reporting needs they have to support?
- Is there a data warehouse that can be used to preserve some of the legacy data for which the business cycle has been completed and is unlikely to be needed for a transaction or an inquiry? If the data needed for reporting only can be warehoused, that generally is a simpler process than converting it for doing a transaction.
- Is it more cost-effective to "convert" some data by manual entry? For example, for rate tables or name-and-address records for some entities, it may be cheaper to manually enter the data than to write software for what is a relatively small volume of records.

Migration occurs at a point in time when all of the testing has been completed and the conversion process is deemed ready for placing the data into production. If the volume of data makes it possible, the ideal would be to freeze input to the legacy system, say, on the Friday evening of a three-day weekend, run the conversions, and balance the data in time for the return to work. If this cannot be done, and the legacy system must still be used, the data entered into it since the point of the conversion will need to be recorded and then reentered in the new system—a risky process. Few companies can revert to the old system after the converted data has been in production for days or weeks; that underscores the need for a thorough job of data mapping and cleansing, and making a committed go/no-go decision when the conversion is done. It is also recommended that a test migration be done beforehand to check everything as if it were being done for go-live, and also to get an idea of the timing of the conversion process. And even with a well-done conversion, it should not be surprising if some data cleanups are needed during the first few months of using the new system.

For related information, see www.Delphi-Tech.com.
CONFIDENCE

Prime Advisors, Inc. is committed to providing the best performance-based asset management, tax optimization, asset liability modeling and accounting services to its clients across the insurance industry.

Prime tailors our investment strategies to each client’s needs, so you can be confident that your investment solution is uniquely right for you.

Contact: Dennis.Klimes@PrimeAdvisors.com (425)202-2075

Proudly serving PIAA members since 1997
MARKET LEADING EXPERTISE

At JLT Re, our trusted team combines market leading expertise and proprietary analytical tools with the freedom to challenge conventions. We create new insights and explore innovative capital solutions tailored to meet client needs.

UK & Europe  •  North America  •  Asia Pacific  •  Middle East  •  Africa

www.jltre.com
At times, it must seem to some PIAA members that the Association’s advocacy activities focus exclusively on Congress. After all, as I noted in a previous article about our Government Relations Survey (“Helping PIAA to Help You: The Biannual Government Relations Survey,” Inside Medical Liability, Second Quarter 2017, page 25), that’s the number-one thing our members say they expect from our public policy efforts—to interact with Congress. As a result, we are your eyes and ears on Capitol Hill, with a full-time focus on making sure that federal policies benefit your company, or at the very least, don’t harm it. “Full-time,” however, doesn’t mean exclusive, and so we work on many issues that are outside of the congressional purview.

State legislation
Recently, PIAA has substantially increased its state legislative activity, recognizing that state legislatures play a more significant role in insurance issues than Congress. One approach we take is to track and report on legislative initiatives that could have implications beyond the state in which they are being discussed. Through our newsletters and conference calls, we provide updates on hearings held on specific legislation, committee activities, and votes. We also compile annual lists of relevant state legislation that has been enacted, to help you keep up with what is happening in other states.

Once bills become law, however, we also track state judicial activities, to monitor the status of state tort reforms and other medical professional liability (MPL) related statutes. When invited by a member company, we also participate in amicus briefs. PIAA engagement ranges from providing data to support arguments made in the brief, to reviewing and revising the briefs to strengthen their legal arguments, to simply providing a national presence on a critical liability issue. Once decisions are handed down, we review and analyze the opinions, to help you determine how best to defend similar cases, should they arise in the state(s) where you do business.

Beyond analysis, we also provide more direct support, when requested, on behalf of individual states’ legislative advocacy efforts. In recent years, we’ve coordinated with PIAA members’ efforts to defeat no-fault-style legislation, provided data to help enact damage caps and other tort reforms, and created

Michael C. Stinson is Vice President of Government Relations and Public Policy at PIAA; mstinson@piaa.us.
model legislation (most recently, to promote "apology" protections and support prohibitions on "phantom damage" collections) to provide a starting point for those looking to enact new MPL laws in their state(s).

**NAIC/state regulation**

As any insurer knows, however, states' regulators can have a greater impact than their legislatures on MPL companies. PIAA regularly engages with the National Association of Insurance Commissioners (NAIC) to stay on top of all the latest developments in the insurance regulatory world. Some of this engagement involves having a presence at NAIC meetings; monitoring committees, working groups, and task forces; and interacting regularly with regulators and their staffs.

At other times, however, it's critical for PIAA to go deeper. One recent example of this is the NAIC's MPL Working Group.

As of late, the MPL Working Group has focused on state closed-claim reporting requirements. PIAA has utilized its expertise in claims reporting (thanks to the PIAA Data Sharing Project) to help advise the working group on key areas that need to be considered when addressing this issue. We've stressed with the working group to develop a survey of states with reporting requirements. We are hopeful that the results will help regulators gain a better understanding of whether or not these reporting requirements actually result in useful information for the states.

We also help address state-specific regulatory matters. Earlier this year, the Virginia State Corporation Commission issued proposed new rules regarding unfair claims-settlement practices. While the impetus for the change was allegedly to align the rules more closely with NAIC model acts, in reality, the new proposal deviated from the models in numerous ways. Working with some of our companies in the state, we developed a set of recommended changes to the proposed rules. In the end, the commission accepted several of our recommendations, thus changing requirements for occurrence policies, providing more time to respond to a claim, and loosening the requirements for explaining a claim denial.

**PIAA engagement ranges from providing data to support arguments made in the brief, to reviewing and revising the briefs to strengthen their legal arguments, to simply providing a national presence on a critical liability issue.**

that, before taking any action, the NAIC needs to have a thorough understanding of what states are already doing in this regard, and Superintendent Franchini of New Mexico (the working group chair) has agreed.

With that in mind, we've worked closely with the working group to develop a survey of states with reporting requirements. We are hopeful that the results will help regulators gain a better understanding of whether or not these reporting requirements actually result in useful information for the states.

We also help address state-specific regulatory matters. Earlier this year, the Virginia State Corporation Commission issued proposed new rules regarding unfair claims-settlement practices. While the impetus for the change was allegedly to align the rules more closely with NAIC model acts, in reality, the new proposal deviated from the models in numerous ways. Working with some of our companies in the state, we developed a set of recommended changes to the proposed rules. In the end, the commission accepted several of our recommendations, thus changing requirements for occurrence policies, providing more time to respond to a claim, and loosening the requirements for explaining a claim denial.

**Federal regulations**

While the federal government doesn't directly regulate the insurance industry, it can have a significant impact on those providing MPL coverage. Because of this, PIAA engages federal agencies in a variety of ways to ensure that your voice is heard, and that the interests of our industry are protected.

The National Practitioner Data Bank (NPDB) has long been a concern to many PIAA members, and thus PIAA has maintained close ties to the NPDB leadership. For many years, PIAA served on the NPDB's board (until the board was disbanded in favor of a less formal, open communication process for NPDB stakeholders). Since then, PIAA has stayed in regular contact with NPDB—submitting formal comments on proposed rule changes, inviting NPDB leaders to speak at workshops, and arranging meetings between PIAA members and the NPDB hierarchy.

Other agencies have, only more recently, begun work on issues relevant to PIAA members, and PIAA has responded by engaging them directly. The Agency for Healthcare Research and Quality (AHRQ) was in the process of developing a Communication and Optimal Resolution (CANDOR) program to address MPL claims when PIAA intervened to address a number of concerns. Among PIAA's recommendations were these: that insurers should always be consulted when such a program is developed and/or implemented, and that flexibility was a key requisite to accommodate local and regional differences in the delivery of healthcare. The final "tool kit" for such programs, as released by AHRQ, included those important concepts.

While the Federal Insurance Office does not have any regulatory authority, it has been charged with monitoring the insurance sector. As such, PIAA monitors the agency and cultivates ties to its staff to ensure that the inevitable mission creep will not encroach onto MPL issues.

**Conclusion**

Government relations extends well beyond Congress; it encompasses the entire gamut of governmental entities. For this reason, PIAA remains committed to interacting with governmental organizations in all varieties and at all levels of government. If there's an aspect of government that could affect your business, we are committed to addressing it, whether that means acting on your behalf directly, or supporting your own strategic public policy initiatives. PIAA's Government Relations objectives are designed to reflect your needs, and we look forward to doing that.
Not all Clouds are created equal.

Winning in today’s P&C market requires new, extraordinary levels of speed, efficiency and security. The Cloud can be a game-changing resource for all three. But, not all Cloud solutions are the same.

Duck Creek OnDemand is a complete, end-to-end SaaS solution. Sure, we take care of the physical infrastructure, hardware, VM management, and network security, but we also provide continuous software upgrades, industry content updates, and triaging for all incidents. One partner. No software license. 99.9% availability. All you need to focus on is your products. And we think that’s plenty.

Learn more at www.duckcreek.com.
Despite your policyholders’ best efforts to provide conscientious care, they may at some point find themselves the defendant in a lawsuit. Even if they have been involved in litigation before, they will likely have many questions for their attorney. One of the first they should ask, and one of the first elements of a case every lawyer will evaluate, is, “Has the statute of limitations expired?”

Statutes of limitations are passed by legislatures and are written laws that establish a time limit for a claimant to file a civil lawsuit. If a claimant does not file suit before the expiration of that time limit, he will be barred from bringing the claim. The time limit for filing suit depends upon: (1) the nature of the claim, and (2) the date when the claim accrued, or came into existence. The nature of a claim is important because there are different time limitations for different types of claims. The person bringing suit, however, is not allowed to frame a personal injury claim as a contract claim merely to avoid the time limitation.

In the context of medical professional liability (MPL), claims are frequently brought under theories of medical negligence or wrongful death. Statutes of limitations for medical negligence and wrongful death vary by jurisdiction. For example, in Kansas, a case “arising out of the rendering or failure to render professional services by a health care provider” must be brought within two years. (K.S.A. 60-514(c)) In Minnesota, however, a claim must be brought within four years. (M.S.A. § 541.076(b)) Some jurisdictions also have separate deadlines for filing wrongful death claims. In Maine, for example, a claim for wrongful death must be brought within two years, whereas claimants have three years to make a claim for MPL, or professional negligence. (Me. Rev. Stat. tit. 18-A, § 2-804 cf. Me. Rev. Stat. tit. 24, § 2902)

Determining the second element of the statute of limitations—the date when the claim accrued—is not always a straightforward exercise. A cause of action accrues as soon as the right to maintain a legal action arises, or, in other words, on the date a claimant sustains an injury, when the claimant learns of the injury, or when a claimant should have discovered the injury. (See, for example, K.S.A. 60-513(c) (statute of limitations commences when “the fact of injury becomes reasonably ascertainable to the injured party.”); Fla. Stat. Ann. § 95.11 (action must be commenced “within two years from the time the incident...should have been discovered with the exercise of due diligence.”)

Exceptions—longer time limits

There are circumstances, however, where the statute of limitations time period may be tolled, or held in abeyance, meaning that a
plaintiff may file suit outside of the initial deadline discussed above. There are three major instances where the statute of limitations may be tolled.

First, the time limit for minors to file suit is typically extended. If a claimant is a minor when the injury occurs, he is typically allowed to bring suit within some specified period of time after reaching the age of majority. Second, fraudulent actions taken to deceive the patient from discovering the physician's malpractice may also result in a tolling of the statute of limitations so the action does not accrue until the patient discovers the fraud. Finally, if the statute begins to run when the injury is reasonably ascertainable, it does not necessarily mean actual knowledge of injury, but, rather, can mean when the claimant has the obligation to reasonably investigate available sources to discover an injury. Unsurprisingly, there may well be conflicting evidence as to when the fact of injury became reasonably ascertainable. In some instances, if there is conflicting evidence about when the injury was ascertainable, the question is submitted to a jury to determine when the cause of action accrued.

Healthcare professionals may feel that with all of these exceptions, particularly with the knowledge aspect, there is potentially no end to when a claimant may bring suit. Some legislatures have addressed this uncertainty through laws known as “statutes of repose.” A statute of repose is not related to the accrual of (knowledge of) a cause of action. Instead, a statute of repose bars a litigant from discovering an injury. For example, although minors are allowed to bring a cause of action for medical malpractice be brought more than five years after the date on which the negligent or wrongful act or omission occurred.” Ga. Code Ann. § 9-3-71.

Similarly, although Georgia’s MPL statute of limitations is two years “after the date on which an injury or death arising from a negligent or wrongful act or omission occurred,” it is also true that, “in no event may an action for medical malpractice be brought more than five years after the date on which the negligent or wrongful act or omission occurred.” Ga. Code Ann. § 9-3-71.

For an MPL cause of action, the statute of repose begins to run from the time the adverse event occurs, regardless of the negligent doctor’s continued treatment of the patient. For example, although minors are allowed to bring a cause of action for MPL within a certain time after reaching the age of majority, the statute of repose bars an action for MPL by or on behalf of a minor that is commenced more than eight years after the time of the act giving rise to the cause of action.

Thus, in a case where an 18-year-old patient filed suit contending that a doctor failed to diagnose her scoliosis at age 3, her case was dismissed pursuant to the statute of repose. (Bonin v. Vannaman, 261 Kan. 199, 929 P2d 754 (1996)). Unfortunately, it is not always a straightforward exercise to figure out when the statute of limitations will expire in any particular situation. If healthcare professionals practice in a state that has a statute of repose, they may have some peace of mind to know that there is indeed a final end date after which a claim may not be brought. If they have questions about their state’s laws with regard to statutes of limitation, they should contact their MPL insurer’s risk manager or attorney to find out what the state's limitations are.

Even if they know their state’s limitations, physicians should always contact their risk manager or insurer as soon as possible if sued; they shouldn’t rely upon their own calculations. An attorney will undoubtedly evaluate whether the statute of limitations has expired, but will only have a short window of time for filing an answer to the petition and raising the issue on the healthcare professional’s behalf.

For related information, see www.gseplaw.com.

---

**Value of Patient-Reported Outcomes**

As comfort with patient-reported outcomes (PROs) has grown, feedback has increasingly underscored that clinicians find collecting PRos to be beneficial rather than burdensome. Evidence from experienced users suggests PRO collection is not only feasible and good for clinical care but also may enhance physician satisfaction and prevent burnout.”

— New England Journal of Medicine, October 5, 2017
As insurers, we are no strangers to a tightly competitive marketplace. But the upside to intense competition is that, in many instances, it motivates a culture of innovation, as players scramble to turn fresh thinking into ways they can improve their business models.

Nowadays, a great deal of business transformation is fueled by technology advancements, known in our sector as “InsurTech.” This is the term used to describe the blending of new and multi-faceted digital technology with the insurance industry.

As expected, there has been a considerable buzz about InsurTech among founders, investors, and incumbents. After a slower start, as compared with other industries, the InsurTech sector has seen some serious investment since 2014, both financial and strategic. 2015 was the year of peak investment volumes and jaw-dropping “Z” mega-deals (namely, ZhongAn and Zenefits), with deal numbers still rising well into 2016 and 2017.

Yet, there are distinct signs of the end of the honeymoon period, with cracks starting to show. This year, several InsurTech players have fallen short of their original plans, and others have found themselves struggling to gain traction. Is this the end of InsurTech hype—or is the industry merely experiencing a bump in the road? And if InsurTech players are going through a major shakeout, surely more successful new models are waiting in the wings? For medical professional liability (MPL) professionals, there are several clues that could help them stay ahead of the curve.

At first glance, there is a myriad of InsurTech players, clamoring for market share and boasting of an enormous array of products and services. This can be daunting for insurance professionals and their customers as well. To address this, in 2017 Oliver Wyman published a report, “InsurTech Caught on the Radar: Hype or the Next Frontier?” in partnership with InsurTech investor Policen-Direkt.

We took a structured and logical approach to assessing the global InsurTech landscape, identifying a number of emerging industry patterns. This was achieved by painstakingly gathering data from more than 1,000 InsurTechs and other relevant players, such as FinTechs, that are currently active within the insurance space. Some of our key findings could offer some valuable insights for MPL practitioners.

Understanding the InsurTech universe
Within the fast-moving world of InsurTech, there is no magic formula
that will guarantee survival or success. The first wave of InsurTechs generated a lot of activity, but little real disruption. This initial wave now appears to be coming to an end.

We now anticipate a second wave of InsurTechs, which are savvier, more creative, and no doubt more ambitious. They have the potential to truly change the way insurers cover risk. The question is: how will the insurance industry respond? In our report we mapped players’ activity, and organized them into 19 business model categories, within three segments: Proposition, Distribution, and Operations.

Segment One—“Proposition.” Today, as never before, organizations are developing innovative offerings of insurance-based products and services. Table 1 shows six business-model categories, and examples of players that use these models.

When we crunched the numbers in our database, we found that about a fifth of the total field of players are active within this segment. Comparing activity level with strategic assessment, two categories (Situational and Community Based) appear to be overcrowded. Here, we expect to see a shakeout of players, possibly including the demise of some well-known names. This represents the end of the first wave.

Conversely, in the other three categories, From Insured to Protected, Risk Partner, and Digital Risk, we see a lot of white space remaining. This offers ideal ground for the new and ambitious contenders from the second InsurTech wave to gain traction.

Segment Two—“Distribution.” Reinventing how insurance-based products and services are sold in the future will no doubt impact the bottom line. In this segment, we examined those business models that are taking advantage of new ways to sell products and services to consumers. Here we identified eight business model categories.

Players within the Distribution segment account for approximately 40% of all the InsurTechs listed on our global database. Here, two categories (Price Comparison Websites and Business to Consumer Online Brokers/Value Comparison Websites) appear to be overcrowded. Again, we anticipate that a number of players will drop off the radar, as part of a shakeout. In three categories (Affiliate Integration, Corporate Platform, and Financial Partner), we believe there is still ample white space; in other words, growth potential.

Segment 3—“Operations.” In this segment, we looked at how players have developed innovative offerings to operate insurance-based products and services, covering new ways to enable and run insurance businesses. Here we broke our findings down into five business model categories.

Covering approximately 40% of InsurTech players in our database, the activity level and strategic assessment of the companies in the Operations space are relatively well matched. Digital Sales Enablers appears to be the most overcrowded category in this segment. In contrast, the category “Underwriting” has more white space, and, therefore, far less competition.

Movements in the InsurTech universe

InsurTech has fueled widespread change across the entire insurance industry, but if you look at the results in context, some interesting patterns emerge. In the overcrowded areas, one common factor is that these resemble digital models that have worked in other industries. Examples include e-commerce (intercepting customer searches), launching digital versions of existing businesses, cutting large traditional businesses into digital pieces, or using digital communities.

These models clearly have their limitations for insurance, as insurance typically offers low-interest products. Hence, business models that require active engagement from customers—known as “pull”—will experience challenges. This is a core problem for many of the models copied from other industries, as they only work in the areas with active pull. Auto insurance is a good example of this.

Some similarities can also be seen in the areas with “white space,” i.e., room for growth. Here, they benefit from one of the most basic developments associated with the digital revolution, namely, the evolution of successful business models from offering a product, to providing a function, and one step further to solving a real need. Take life insurance, for example. While most of us are worried about risks in life, many people have a nagging doubt about whether these insurance products will really deliver what they need, in times of loss. Closing that gap in perception is a major preoccupation for the second wave of enterprising models, which are now emerging.

Their primary focus will be uncovering new ways to engage with their clients, thus evolving away from merely offering the classic insurance “product.” Up to now, such high-engagement models have tended to be very employee intensive and hence very costly. Consequently, they were only available at the high end of the market. Through digitalization, these could be opened up to the mass market. Figure 1 shows some examples.

Table 1. Business Models: Proposition

<table>
<thead>
<tr>
<th>Risk Model</th>
<th>Tagline</th>
<th>Example</th>
<th>Current Activity Level</th>
<th>Strategic Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>“We are the price leader for our target customers”</td>
<td>Micro insure, BIMA</td>
<td>🟢🟢🟢🟢🟢</td>
<td>🟢🟢🟢🟢🟢</td>
</tr>
<tr>
<td>Situational</td>
<td>“We provide instantaneous short-term cover for your current needs”</td>
<td>Cuava, inSuremyrentalcar.com</td>
<td>🟢🟢🟢🟢🟢</td>
<td>🟢🟢🟢🟢🟢</td>
</tr>
<tr>
<td>Community Based</td>
<td>“We use community mechanisms to lower the cost of sales or risk”</td>
<td>Teambrella, Banmahz, Baobaoji</td>
<td>🟢🟢🟢🟢🟢</td>
<td>🟢🟢🟢🟢🟢</td>
</tr>
<tr>
<td>From Insured to</td>
<td>“We not only insure you but also protect you”</td>
<td>Oscar, Biovation, eKincare</td>
<td>🟢🟢🟢🟢🟢</td>
<td>🟢🟢🟢🟢Ubergraph</td>
</tr>
<tr>
<td>Protected Risk</td>
<td>“We not only provide insurance products, but ensure you have exactly the right cover for your individual situation”</td>
<td>Getinsurance, TikR</td>
<td>🟢🟢🟢🟢🟢</td>
<td>🟢🟢🟢🟢SuccessListener</td>
</tr>
<tr>
<td>Digital Risk</td>
<td>“We cover risks that come with digital technology or digitally enabled models”</td>
<td>Assurely, Cloudinsurance</td>
<td>🟢🟢🟢🟢🟢</td>
<td>🟢🟢🟢🟢SuccessListener</td>
</tr>
</tbody>
</table>

What does this mean for MPL?

As a market sector, it is well understood that MPL is a type of insurance cover, with higher than average levels of customer engagement, as compared with
other categories of casualty insurance. We saw compelling evidence of this when doctors took the trouble to set up their own specialist insurance companies covering MPL, when this service was not offered through traditional carriers.

Deepening levels of customer engagement will certainly play a vital role in growth and competitive differentiation. Using increasingly sophisticated data sources will allow carriers to create bespoke solutions, which can be dynamically adapted as an individual's risk situation changes.

The advent of digital solutions, with their various doctor/patient interfaces, should provide a potential treasure trove of data, offering doctors and other healthcare professionals valuable insights into their patients' health. Digital offerings may even become part of the treatment or therapy itself. Examples include Arya, Player's Health, Human API, Livongo Health, and Noex.

In the future, additional data could be generated by digital models, which will extend beyond healthcare into lifestyle and wellness propositions. One such example is Vitality. Up to now, regulation has meant that it has been nearly impossible for insurers to directly access such data sources. The possibility of anonymizing and aggregating data might lead to a world in which insurers can gain a real-time view of doctors' patient portfolios, thus allowing them to further individualize their policies.

### The second-wave future

Connectivity and convergence: The pace of digitization within our industry is rapidly accelerating. This will lead to more digital offerings for patients in their "value chain of health risk," from the genesis of risk, to risk advice, risk management, risk coverage, risk services, and even to restitution. As a side effect, these developments will generate further data about a patient portfolio that—once anonymized and aggregated—opens up a world of possibilities beyond underwriting (Figure 1). Assessing and processing claims may look considerably different in the future.

But behind the bright and shiny digital future, there are some lingering questions for the industry. When it comes to MPL cover, how far is too far in the individualization and real-time adaptation of policies? A fine balance exists between good practice being rewarded with lower cost of coverage, and the very idea of insurance as a "risk collective." The latter relates to the concept of social inclusivity. Better technology means more data and more transparency, but could it lead to a situation where insurance cover is no longer available for everyone? Insurance companies already try to filter out "bad" risks from "good" risks, usually in form of a questionnaire to be filled out during the application process. "Big data" could take this sorting process to a whole new level. While this could lead to lower insurance premiums for some, for others it could mean exclusion. No doubt, many burning questions will arise, not just for the industry, but also for regulators and governments alike. One thing is certain, the race to catch the second InsurTech wave is on.
Johnson Lambert has been serving the insurance industry since 1986. Today we provide audit, tax, and advisory services to 500+ insurance entities nationwide; furthermore, we have focused experience with Medical Professional Liability insurance companies.

Services Include: Financial Statement Audits • Tax Preparation and Consultation Services • Service Organization Control Reports (SOC 1, 2 & 3) • Internal Audit Outsourcing and Co-sourcing • System (Pre/Post) Implementation Reviews • IT Audit Services • Cybersecurity Assessment • Various Other Customizable Solutions

e: info@johnsonlambert.com | w: www.johnsonlambert.com
Delay in Diagnosis of Breast Cancer:
Genetic Testing as a Risk-Mitigation Strategy

Learning Objectives:
1. Minimize the risk of incurring a “delay in diagnosis” lawsuit related to breast or ovarian cancer
2. Properly identify patients who meet criteria for genetic testing
3. Recognize and manage the risk associated with the absence of FDA regulation of genetic testing

FREE ONLINE CME COURSE

Delay in Diagnosis of Breast Cancer:
Genetic Testing as a Risk-Mitigation Strategy

For more information, please visit: www.myriad.com

START LEARNING:
Myriad: Your Trusted Educational Resource & Affiliate Partner of PIAA

Myriad has partnered with leading professional medical societies to help provide unbranded education on Hereditary Cancer Genetics and welcomes the opportunity to bring that education to your membership.

Here’s how Myriad can partner with your program:

- Educational grand round opportunities
- Unbranded workshops to help educate your membership on hereditary cancer
- Tools to help implement a Hereditary Cancer Risk Assessment program
- Expertise of regional Certified Genetic Counselors who can offer on-site proctorship, case reviews, and one-on-one “ask the expert” discussions

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

Are you ready?
Dental Imaging and the Standard of Care

BY CRAIG FONTAINE

The standard of care is a concept that is not likely to be in the forefront of a practitioner’s mind at the time of the delivery of care. Yet it becomes the central theme in the defense of virtually every dental professional liability (DPL) claim. Consequently, it would be worthwhile to give some thought to the issue in advance, especially when there is some potential for an adverse side effect from the treatment or an adverse outcome.

What is it?

The term “standard of care” is often misunderstood. To understand what it requires in practice, one must first understand this legal concept. The standard of care is a standard that is rooted in the legal concept of negligence. Generally speaking, one owes a duty of reasonable care not to harm others. This concept is familiar to all of us in the context of land ownership, the operation of an automobile, or the manufacture of a product. Negligence by a professional is often referred to as “malpractice,” and the duty that a doctor owes to a patient is often referred to as “the standard of care.”

Craig Fontaine is with Fontaine Alissi PC.
The standard of care is not what may be set forth in a single scientific paper or treatise; rather, it is defined by what is actually done in practice. That means that what constitutes adherence to, or deviation from, the standard of care is often context-driven. What may be actually done by providers in a small private-practice may not be the same as what is done by providers in a well-funded academic setting.

It is also important to know that the law does not require perfection. The concept involves reasonable prudence, in light of the attendant circumstances.

Who determines the standard?
When the subject matter to be considered by a jury is beyond the scope of the understanding for the average person, the law requires expert testimony to explain the subject to them, to help them in making an informed decision. Most states require that the standard of care be defined, and thus established, by expert testimony at the time of trial. Then it is the jury that actually decides what the standard of care was in a particular case. This decision is made by the jury after they have heard the experts on both sides offer their opinions as to what the standard of care is and what was specifically required of the defendant in the given circumstance. The jury then decides what the standard of care required of a practitioner in a given case and whether it was violated.

In virtually all DPL cases, both sides will have experts, and they will offer conflicting opinions to the jury. The jury will then decide what the reasonably prudent practitioner was required to do (or not do) in the circumstance of that case.

The conflict in expressed opinions is often due to the perspective from which each expert views the care in question. That is, the plaintiff’s expert will often view the treatment through the lens of hindsight and explain, for example, how a different radiographic assessment would have influenced the outcome. On the other hand, the defense expert will approach the analysis from the perspective of what was reasonably necessary for a proper radiographic assessment at the time treatment was rendered. Exposing the fact that the plaintiff expert is using hindsight in forming his opinions will help the defense, because most states do not permit the assessment to be made from that point of view.

Case in point
Let’s examine this issue more closely. A patient, in her 40s, comes in for mandibular third molar extractions, and subsequently experienced a pathologic fracture in the area of tooth #32. That patient presented to the oral surgeon on referral from her general dentist with a recent full-mouth series of radiographs taken by the general dentist. Though a panoramic radiograph was offered to her by the oral surgeon, the patient refused for two reasons: she did not want the additional radiation exposure, and she did not want to incur the added expense.

However, the oral surgeon felt that he had enough information to proceed with the extraction of teeth #17 and #32 anyway, based on his examination of the patient and the information gleaned from the full-mouth series. The patient was intravenously sedated, and tooth #17 was extracted in a routine fashion. Given the position of #32, the roots were sectioned first. Before the procedure was completed, the patient experienced a bleed and began to arouse from the anesthesia. A decision was made to discontinue the surgery, and the crown was left behind, to be removed at a later time. The patient was informed that the crown was retained.

About a week later, the patient heard what she described as a “pop,” felt pain, and returned to the oral surgeon for evaluation. A panoramic radiograph was taken, which revealed an inferior mandibular fracture below tooth #32. Figure 1 shows this x-ray, as well as the preoperative bitewings. There are several issues in the case, but the radiographic standard of care question presented was: should the oral surgeon have proceeded to do the surgery without a panoramic radiograph or cone beam CT?

Let’s examine the standard-of-care issue here. The plaintiff’s expert, who came from an academic setting, offered the opinion that the standard of care required more imaging. Specifically, the available presurgical full-mouth series did not clearly show the full apex of tooth #32. Consequently, more imaging was required (at minimum, a panoramic radiograph).

On the other hand, the defense experts offered the opinion that, given the position of the tooth, the full-mouth series was sufficient to satisfy the standard of
care. They affirmed that further radiographic analysis would not have altered the decision to perform the surgery, and added that the main reason for further radiographic workup would have been to better assess the potential for inferior alveolar nerve involvement, which was not at issue in the case.

The jury would have to decide what the applicable standard was and would likely base its determination on which expert presented himself as the witness who is more credible and made the most scientific sense.

Conclusion

There are multiple radiographic options available to most dental practitioners. The most common are:

- Periapical
- Bitewing
- Full-mouth series
- Panoramic
- Cone-beam CT.

To determine which are necessary in order to comply with the standard of care, you must consider not only what is necessary to make a clinical determination regarding treatment options, but also whether there are potential risks for the patient that may arise from the lack of information if a particular radiograph is not taken.

Specifically, the dentist should consider:

- Clinical need for information. If the radiographic information is necessary to make a determination regarding how to approach treatment, it is probably required by the standard of care.
- Patient consent. If the patient does not consent to recommended radiographic evaluation and the practitioner feels it is necessary to decide how to approach treatment, documentation of informed refusal and/or refusal to treat may be in order.
- Cost and availability. This may come into the decision-making process, given the availability in the local area and the associated costs of the technology.
- Radiation exposure. Does the benefit outweigh the risk? For example, in the case referred to above, the likely risk of not seeing the full root tip of tooth #32 is the potential to unwittingly involve the inferior alveolar nerve in the extraction process. It likely does not involve any increased or decreased risk of fracture.

The standard of care is always determined by what the standard was at the time of the events in question, not what the standard of care is at the time of trial. This is an important issue, especially as technology rapidly advances and the cost for that technology decreases. As the dental community adopts new techniques and technology, the standard of care evolves.

A final observation is that the old adage that a picture is worth a thousand words is certainly true in dental radiology. A single radiograph may end up being the piece of information that actually helps plaintiff’s counsel to establish that there was indeed a deviation from the standard of care in treatment provided. By way of example, see Figure 2, a misplaced post, and Figure 3, over-exuberance in the use of sealant in endodontic therapy.
We’re invested in the **people** behind the numbers.

When **you** win, we win.

When you work with Pinnacle, we start by getting to know your organization’s business goals, geographic and industry mixes, risks and corporate culture. You can trust that our consultants will provide you with the highest levels of professional expertise and service. We will communicate with you in your language, not ours. The result is a true partnership to help guide you through the available options and make better business decisions. **We believe in the importance of relationships, not transactions.**

**Commitment Beyond Numbers**

[Composite image with a logo and website link: pinnacleactuaries.com]
Recent headlines like these, in a variety of publications, have captured the attention of healthcare informatics professionals, and also of individuals in the medical professional liability (MPL) insurance business, who may be scratching their heads, wondering what exactly Kansas Medical Mutual Insurance Company (KaMMCO) is doing.

How has KaMMCO accomplished its transition, from a mutual MPL insurance company in Kansas, into a company that is breaking new ground in the field of healthcare informatics and quality reporting?

If you are a leader in a PIAA company, you have no doubt asked yourself how you can manage to evolve your organization to meet the challenges of a rapidly changing healthcare delivery market. In fact, every aspect of the traditional business model is being challenged, from more than 10 years of a relatively benign claims environment, which has resulted in significant reductions in premium base, to low investment yields and increasing competition from companies who at least seem to be “just like us.”

KaMMCO engaged in the same sort of soul searching a few years ago, when it became apparent that, in light of the conditions in the MPL insurance market, an adjustment in our course was required. KaMMCO, like most member companies in the PIAA, had been formed in response to a crisis. So, what does a PIAA company do when the crisis has faded, when the model of healthcare

Kurt Scott is CEO, KaMMCO and KaMMCO Health Solutions.
delivery is changing so profoundly that physicians and other healthcare professionals’ chief concern is the new quality reporting and pay-for-performance system being adopted in this country, and not MPL?

Policy decisions
So what did we do? It was a familiar drill: Research. Analyze. Evaluate assets. Assess risks. KaMMCO employed the principles that have served us well over the years in making policy decisions, only this time it was done in relationship to our own business model. We began the process of determining how best to achieve our transition with a fundamental question, “Why do we exist?” In the early days, the KaMMCO founding Chairman, Dr. Jimmie Gleason, was fond of reminding us, “KaMMCO is an advocacy organization which just happens to sell insurance.” His point here was that KaMMCO is more than just an insurance company. As it turns out, Dr. Gleason’s vision of KaMMCO’s identity was right on target, and it is one we have continued to strive for over the years; now, it once again became a guiding light as we contemplated our future.

KaMMCO possesses many of the same attributes as other PIAA members: a sound capital position, strong and trusted relationships with its insureds, a well-organized and efficiently operated organizational structure, and a committed and talented staff. KaMMCO is also fortunate to have built a strong relationship with the state medical society and hospital association, with whom we had partnered on various projects over the years, including a health information exchange and a quality collaborative.

KaMMCO is not, however, a regional or national insurance company, or large enough to grow into a national carrier through the acquisition of other insurance companies. Our path forward seemed to be framed by the attributes we already possess, the most important of which is our firm belief that we are an advocacy organization ready to advocate on behalf of physicians and other healthcare professionals in the areas that were of greatest concern to them.

Therefore, our company’s path follows that of the evolution in healthcare, in recent years, from volume to value.

New business model
KaMMCO’s plan has been fairly simple: take what we have learned as a successful physician-led organization, combined with our involvement in the health information exchange and quality collaborative in our state, apply a portion of our capital and infrastructure, and convert it into a business that physicians and hospitals need, in order to transition from a volume- to a value-based healthcare system.

As a result, two new subsidiaries were formed. KaMMCO Health
Solutions was created to provide the technology and “know-how” to build electronic-health-record interoperability, data warehousing, and useful analytics tools for physicians and hospitals both inside and outside Kansas.

KaMMCO Casualty Company was formed to offer insurance products to these new relationships built with physicians and hospitals, in instances where it made sense. While KaMMCO’s plan seemed clear and straightforward, executing the plan has been anything but simple. KaMMCO simultaneously became both an established MPL insurance company and a technology startup, with all of the attendant struggles that startup companies experience. The result of beginning to execute our plan has been the reformation of KaMMCO from a single-state, single-line MPL insurance company into a national healthcare company that assists healthcare professionals in managing the risk of delivering healthcare, by providing “best-in-class” tools designed and delivered by a provider-governed organization.

Dividends
KaMMCO’s introspection and hard work are beginning to pay dividends, in the way of partnerships with the medical societies of Georgia, South Carolina, Connecticut, New Jersey, Missouri, and Louisiana, in addition to our home state of Kansas. By involving actual practicing physicians and hospital professionals in the development of our analytics tools, KaMMCO’s analytics dashboards are being recognized for their ability to take clinical data and convert it into actionable intelligence, which is easily consumable by clinicians. Because the analytics utilize clinical records and are focused on the care received by the patients, regardless of where they received the care, we are able to put the patients at the center of the questions regarding quality.

As one nationally recognized quality expert put it, “You are answering questions concerning data and quality, which most people have not yet begun to ask.” Delivering quality care, in an efficient manner that provides a high level of satisfaction for both patient and provider, is also optimal risk management for any organization writing MPL, whether it is KaMMCO or any other PIAA company. KaMMCO’s efforts in this area are a natural extension of our physician advocacy roots; we just had to change our business model for it to happen.

KaMMCO is at the beginning of a long journey to reimagine itself. Because the company is provider-led and we put patient care at the center of everything we do, we have become more than just an insurance company. But then, it seems, we always have been.
Nearly 10 years ago, the Financial Accounting Standards Board (FASB) and the International Accounting Standards Board joined forces to explore the creation of a comprehensive accounting standard for insurance contracts.

The FASB eventually determined that making targeted improvements to the accounting principles that are generally accepted in the U.S. (GAAP) was the favored approach. The improvements were divided into two projects:

- Short-duration contracts: enhance disclosures
- Long-duration contracts: improve recognition, measurement, presentation, and disclosure (this project is ongoing).

Subsequently, the FASB issued Accounting Standards Update 2015-09, Disclosures about Short-Duration Contracts (ASU 2015-09), which requires additional disclosures to provide insight into an insurance company's initial claim estimates and subsequent adjustments, as well as the frequency, severity, and timing of future claim payments needed to settle the claim estimates. ASU 2015-09 is effective December 31, 2017, for calendar year, non-public companies.

New disclosures

Claims development tables
ASU 2015-09 requires that insurance companies disclose their undiscounted incurred and paid claims development, net of reinsurance, in tabular form. Allocated loss adjustment expenses (e.g., claims adjuster and attorney fees) are included, but unallocated loss adjustment expenses (e.g., claims adjustment expenses not attributable to a specific claim) are excluded from the claims development tables. The following provides details on how the FASB expects the data in these tables to be disclosed.

- Number of years
The FASB realizes that accumulating the data necessary to complete the disclosures may be challenging for some insurance companies. Therefore, the claims development tables do not need to include more than five years of data in the year of implementation, if it is impractical to gather the historical information beyond five years. In each subsequent year, the number of years disclosed increases until the 10-year maximum is reached. For short-tail categories, an insurer may elect to present less than 10 years of data. For long-tail categories, the insurer may disclose additional years, when the claim settlement period is expected to take longer than 10 years.

Magali Welch, CPA, CA, AIAF, is a Partner; Katie Glover, CPA, is a Manager; and Steve Merz, CPA, is a Senior Associate at Johnson Lambert LLP.
There are several ways to track and analyze claims count, for example,

- **Claims count**
- **Other disclosures**

The claims development tables must be disaggregated by accident year (AY). If an insurance company tracks its data by underwriting or policy year, that data must be converted to AY.

**Data—actuarial analysis**
The data required to create the loss development tables is primarily derived from the actuarial analysis. The actuary’s loss reserve expectation may not agree exactly with what the insurance company recorded. Insurers will need to determine how to resolve these discrepancies for this disclosure.

**Level of disaggregation (category)**
The data in the tables must be aggregated or disaggregated to provide useful information regarding the number of claims (frequency) and dollar amounts involved (severity). The FASB does not specify the level of disaggregation, but does provide suggestions that insurers may consider when making that decision:

- Information reviewed by the C-suite to assess financial performance
- Information provided in earnings releases, statutory filings, etc., whose intent is to help the users of financial statements to evaluate financial performance.

Insurers could also consider the level of disaggregation that the actuary uses when estimating claims liabilities. Appropriate categories may include:

- **Type of coverage**
- **Geography**
- **Market or type of customer**
- **Claim duration**.

A loss development table is not required for insignificant categories, which can be aggregated into one line item and need only be included in the reconciliation disclosure.

Insurance companies may want to maintain granular-level detail in case they decide to change the level of aggregation or disaggregation in future periods, as their loss development tables may need to be revised.

**Merger/acquisition/loss portfolio transfer**
Specific guidance is not provided for mergers, acquisitions, or loss portfolio transfers, except that they should be disclosed so that users can understand the amount, timing, and uncertainty of cash flows arising from the underlying claims, considering the relevant circumstances. Although several approaches to disclosing this information are appropriate, the SEC staff has indicated the retrospective approach best achieves the intention of ASU 2015-09.

**Historical average annual percentage claims payout**
Insurers must disclose the average annual percentage payout of incurred claims, net of reinsurance, by category for each year in the claims development tables. Explanation of large variations is encouraged.

**Changes in methods and assumptions**
Insurers must now disclose the methods used to calculate their best claims estimate, as well as the reasons for, and effects of, significant changes in methods and assumptions used to calculate the liability.

**Discounting**
The following disclosures are required when insurers discount their claims liabilities:

- **Amount of discount recorded for each balance sheet period presented**
- **Change in discounting recorded for each income statement period presented**
- **The income statement line items where discounting is recorded**
- **Range of interest rates used to calculate the discount**.

**Health insurance considerations**
Health insurance claims are defined as “claims related to the cost of medical treatments (other than claims related to liability insurance that covers claims against the insured for injury of or by others, such as, but not limited to, workers’ compensation, disability, and general liability insurance).” All disclosures are applicable to health insurance companies, except for the historical average annual percentage claims payout. In addition, health insurance claims are required to be disaggregated in the loss roll forward.

**Location of disclosures**
Due to concerns over auditor independence, incurred and paid claims development information for years prior to the current reporting period, as well as the average annual percentage payout disclosures, are presented as required supplementary information (RSI). RSI is not audited, but the auditor does perform certain limited procedures with this information. RSI can be presented within the financial statement notes, as long as there is a clear distinction between the RSI and other disclosed information, or in a supplementary schedule outside of the financial statement notes. All other disclosures are included in the notes to the financial statements and are audited.

**Illustrations**
The following illustrations are examples of disclosures.* For simplification, only one category is shown.
Supplementary schedules (unaudited)

The following is information about incurred and paid claims development as of and for year ended December 31, net of reinsurance and by category.

### Tables 1 and 2

Display information about incurred and paid claims development as of, and for, the year ended December 31, net of reinsurance and by category.

**Table 1. Homeowners’ Insurance (in thousands)**

<table>
<thead>
<tr>
<th>Accident Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$10,000</td>
<td>$9,900</td>
<td>$9,700</td>
<td>$9,800</td>
<td>$9,750</td>
<td>$9,600</td>
<td>$9,650</td>
<td>$9,575</td>
<td>$9,550</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>10,950</td>
<td>11,000</td>
<td>10,500</td>
<td>10,750</td>
<td>10,850</td>
<td>10,600</td>
<td>10,250</td>
<td>10,150</td>
<td>10,250</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>12,000</td>
<td>11,750</td>
<td>11,500</td>
<td>10,900</td>
<td>10,850</td>
<td>10,750</td>
<td>10,750</td>
<td>10,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>12,250</td>
<td>12,500</td>
<td>12,550</td>
<td>12,400</td>
<td>12,200</td>
<td>12,150</td>
<td>12,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>12,300</td>
<td>12,500</td>
<td>12,650</td>
<td>12,750</td>
<td>12,800</td>
<td>12,850</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>12,800</td>
<td>12,900</td>
<td>12,750</td>
<td>12,700</td>
<td>12,700</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>13,000</td>
<td>13,250</td>
<td>13,100</td>
<td>13,150</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>13,150</td>
<td>13,250</td>
<td>13,300</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>13,500</td>
<td>13,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>13,750</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$121,300</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 2. Homeowners’ Insurance (in thousands)**

<table>
<thead>
<tr>
<th>Accident Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$3,000</td>
<td>$5,000</td>
<td>$5,500</td>
<td>$6,000</td>
<td>$6,800</td>
<td>$7,500</td>
<td>$8,500</td>
<td>$9,000</td>
<td>$9,050</td>
<td>$9,075</td>
</tr>
<tr>
<td>2009</td>
<td>3,500</td>
<td>5,750</td>
<td>6,500</td>
<td>7,500</td>
<td>7,750</td>
<td>8,250</td>
<td>8,500</td>
<td>9,000</td>
<td>9,500</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>3,750</td>
<td>6,000</td>
<td>6,500</td>
<td>7,500</td>
<td>7,900</td>
<td>8,250</td>
<td>8,950</td>
<td>9,700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>3,750</td>
<td>6,250</td>
<td>7,250</td>
<td>7,750</td>
<td>8,000</td>
<td>8,950</td>
<td>9,700</td>
<td>9,950</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>4,250</td>
<td>5,500</td>
<td>6,750</td>
<td>8,000</td>
<td>8,950</td>
<td>9,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>4,125</td>
<td>5,250</td>
<td>7,000</td>
<td>8,000</td>
<td>9,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>4,000</td>
<td>5,750</td>
<td>7,250</td>
<td>7,750</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>4,600</td>
<td>6,000</td>
<td>6,950</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>4,750</td>
<td>6,125</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>4,850</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$82,150</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All outstanding liabilities before 2008, net of reinsurance: 1,400

Liabilities for claims and claims adjustment expenses, net of reinsurance: $40,550

### Table 3. Average Historical Claims Duration

<table>
<thead>
<tr>
<th>Years</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeowners’ Insurance</td>
<td>33.8%</td>
<td>14.9%</td>
<td>8.5%</td>
<td>7.2%</td>
<td>6.6%</td>
<td>4.9%</td>
<td>5.4%</td>
<td>5.7%</td>
<td>2.7%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>
Table 4. Average Historical Claims Duration

<table>
<thead>
<tr>
<th>Accident Year</th>
<th>Claims Paid in Year 1</th>
<th>Most Recently Re-Estimated Incurred Claims B</th>
<th>Percentage of Claims Paid in Year 1</th>
<th>Percentage of Claims Paid in Year 2</th>
<th>Total Claims Paid End of Year 2 D</th>
<th>Claims Paid in Year 2 E</th>
<th>Percentage of Claims Paid in Year 2 F</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$3,000</td>
<td>$9,550</td>
<td>31.4%</td>
<td>2008</td>
<td>$5,000</td>
<td>$2,000</td>
<td>20.9%</td>
</tr>
<tr>
<td>2009</td>
<td>3,500</td>
<td>10,250</td>
<td>34.1%</td>
<td>2009</td>
<td>5,750</td>
<td>2,250</td>
<td>22.0%</td>
</tr>
<tr>
<td>2010</td>
<td>3,750</td>
<td>10,500</td>
<td>35.7%</td>
<td>2010</td>
<td>8,000</td>
<td>2,250</td>
<td>21.4%</td>
</tr>
<tr>
<td>2011</td>
<td>3,750</td>
<td>12,000</td>
<td>31.3%</td>
<td>2011</td>
<td>6,250</td>
<td>2,500</td>
<td>20.8%</td>
</tr>
<tr>
<td>2012</td>
<td>4,250</td>
<td>12,850</td>
<td>33.1%</td>
<td>2012</td>
<td>5,500</td>
<td>1,250</td>
<td>9.7%</td>
</tr>
<tr>
<td>2013</td>
<td>4,125</td>
<td>12,700</td>
<td>32.5%</td>
<td>2013</td>
<td>5,250</td>
<td>1,125</td>
<td>8.9%</td>
</tr>
<tr>
<td>2014</td>
<td>4,500</td>
<td>13,150</td>
<td>34.2%</td>
<td>2014</td>
<td>5,750</td>
<td>1,250</td>
<td>9.5%</td>
</tr>
<tr>
<td>2015</td>
<td>4,600</td>
<td>13,300</td>
<td>34.6%</td>
<td>2015</td>
<td>6,000</td>
<td>1,400</td>
<td>10.5%</td>
</tr>
<tr>
<td>2016</td>
<td>4,750</td>
<td>13,250</td>
<td>35.8%</td>
<td>2016</td>
<td>6,125</td>
<td>1,375</td>
<td>10.4%</td>
</tr>
<tr>
<td>2017</td>
<td>4,850</td>
<td>13,750</td>
<td>35.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>4,725</td>
<td>13,375</td>
<td>35.6%</td>
<td></td>
<td></td>
<td></td>
<td>14.9%</td>
</tr>
</tbody>
</table>

*These calculations are for illustrative purposes only and would not be included in the disclosure.

Notes to the financial statements (audited)

Claims and allocated adjustment expenses incurred and paid by category, as of, and for the year ended December 31, 2017.

Table 5. Claims and Allocated Claim Adjustment Expenses Homeowners’ Insurance

<table>
<thead>
<tr>
<th>Accident Year</th>
<th>Incurred</th>
<th>Cumulative Paid</th>
<th>Total of Incurred-But-Not-Reported Liabilities Plus Expected Development on Reported Claims</th>
<th>Cumulative Number of Reported Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$9,150</td>
<td>$9,075</td>
<td>$5</td>
<td>39</td>
</tr>
<tr>
<td>2009</td>
<td>10,250</td>
<td>9,500</td>
<td>30</td>
<td>37</td>
</tr>
<tr>
<td>2010</td>
<td>10,500</td>
<td>9,700</td>
<td>90</td>
<td>38</td>
</tr>
<tr>
<td>2011</td>
<td>12,000</td>
<td>9,950</td>
<td>300</td>
<td>36</td>
</tr>
<tr>
<td>2012</td>
<td>12,850</td>
<td>9,250</td>
<td>900</td>
<td>35</td>
</tr>
<tr>
<td>2013</td>
<td>12,700</td>
<td>9,000</td>
<td>1,100</td>
<td>34</td>
</tr>
<tr>
<td>2014</td>
<td>13,150</td>
<td>7,750</td>
<td>1,500</td>
<td>31</td>
</tr>
<tr>
<td>2015</td>
<td>13,300</td>
<td>6,950</td>
<td>2,100</td>
<td>29</td>
</tr>
<tr>
<td>2016</td>
<td>13,250</td>
<td>6,125</td>
<td>3,100</td>
<td>26</td>
</tr>
<tr>
<td>2017</td>
<td>13,750</td>
<td>4,850</td>
<td>5,000</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>$121,300</td>
<td>$82,150</td>
<td>$14,125</td>
<td></td>
</tr>
</tbody>
</table>

Table 5 shows claims and allocated claim adjustment expenses incurred and paid by category, net of reinsurance, as of, and for, the year ended December 31, 2017.

Table 6. Reconciliation

<table>
<thead>
<tr>
<th>Description</th>
<th>December 31, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net outstanding liabilities</td>
<td>$40,550</td>
</tr>
<tr>
<td>Homeowners’ insurance</td>
<td>$42,526</td>
</tr>
<tr>
<td>Liabilities for unpaid claims and claims adjustment expenses, net of reinsurance</td>
<td></td>
</tr>
<tr>
<td>Reinsurance recoverable</td>
<td>$13,880</td>
</tr>
<tr>
<td>Homeowners’ insurance</td>
<td>283</td>
</tr>
<tr>
<td>Total reinsurance recoverable</td>
<td>$14,163</td>
</tr>
<tr>
<td>Insurance lines other than short-duration</td>
<td>3,315</td>
</tr>
<tr>
<td>Unallocated claims adjustment expenses</td>
<td>2,420</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
<tr>
<td>Total gross liability for unpaid claims and claims adjustment expenses</td>
<td>$62,434</td>
</tr>
<tr>
<td>Discounting</td>
<td></td>
</tr>
</tbody>
</table>

Table 6 displays the reconciliation of the net incurred and paid claims development tables to the liability for claims and claim adjustment expenses on the balance sheet.

*Some disclosures are from ASU 2015-09.
Will Severity Increases Finally Drive Premiums Higher?

By Timothy C. Mosler

For more than a decade, medical professional liability (MPL) insurers’ loss experience has been characterized by fewer claims and a relatively stable cost per claim. The magnitude of the frequency decrease has been extraordinary, resulting in highly favorable operating results for MPL insurers, as well as lower premiums for their policyholders.

Nearly as remarkable, during this period of plummeting frequency, the average cost per claim has increased only modestly. This article will examine the recent history of MPL claim severity trends, as well as recent changes in these trends and their potential impact going forward.

Overall claim severity trends

The data referenced throughout this article is extracted from PIAA’s 2016 Closed Claim Comparative, which summarizes data submitted by participating MPL insurers in conjunction with PIAA’s Data Sharing Project. The 2016 study includes data on claims closed from 2006 through 2015. Given the study’s level of detail, it is easily the largest nonproprietary data set available for studying MPL severity trends.

Figure 1 displays the average cost per claim, including indemnity and ALAE, by closure year, over the latest 10 years.

Expanding on the data in Figure 1, Figure 2 separates the claim severity amounts into their indemnity and ALAE components.

Key observations from Figures 1 and 2 include:

- After a period of stable per-claim costs between $320,000 and $340,000, through 2013, the size of the average indemnity payment increased during 2014 and 2015.
- ALAE increased in six of the nine years.
- While the increase in the average cost of ALAE as shown in Figure 2 can be significant, it is small enough relative to indemnity that the overall increase in the amounts shown in Figure 1 is small. The

Timothy C. Mosler, FCAS, MAAA, is a Director and Consulting Actuary with Pinnacle Actuarial Resources, Inc.
most significant increase depicted in Figure 1 occurs between 2013 and 2014, and it’s primarily driven by indemnity (indemnity increased by $35,000 and ALAE increased by $10,000).

While not shown in the figures, including ALAE dollars from claims that closed without indemnity would not significantly impact the pattern of increases in the overall cost per claim.

Because the indemnity component is driving the overall cost and has increased in the two most recent closure years, we also analyzed additional underlying indemnity trends.

**Analysis by claim size**

Figure 3 illustrates the percent of claims by closure year that fall within each indemnity-claim-size range. The smallest claims are shown to the left, and the largest claims are shown to the right. To help understand this figure, note that only claims closing with an indemnity payment are included, and all of those indemnity claims are included in one of the claim-size groups. So, the sum of a given closure year’s percentages across each of the five claim-size groups will always equal 100%.

On the right side of Figure 3, we notice an increase in the percentage of claims closing at more than $1 million in the 2014 and 2015 closure years. To quantify this increase, Table 1 shows the average of the 2014 and 2015 closure years for each size-group compared to the average for the 2006 through 2013 years. These percentages are very similar, with the exception of the increase in claims above $1 million and the corresponding decrease in claims in the $100,000–$250,000 range.

Note that for Figures 1, 2, and 3, the results could have been impacted by policy-limit changes. For instance, if a segment of policyholders previously purchased $1 million-limits policies and are now purchasing $2 million-limits policies, this would account for part of the increase in claims above $1 million. It’s possible that this contributes to the observed increases, but it is unlikely to explain the entirety of the severity increase or the shift to higher claim sizes. Other potential causes include changing jury views, erosion of tort reforms, and the verdict trends discussed later in this article.

A separate view of the data considers the average claim size per group, as shown in Figure 4. We can observe very consistent severities for the four lowest claim-size groups, but also a notable increase in claim severities for claims of more than $1 million. For this largest claim-size group, the three most recent closure years contain three of the four highest severities.

When considered together, Figures 3 and 4 demonstrate that the increase in overall severity is not driven by all claim sizes, but rather, by the largest claims. However, with these largest claims, two factors come into play: There are more large claims, and the large claims cost more.

### Table 1. Percentage of Claims by Size, 2006–2013 and 2014–2015

<table>
<thead>
<tr>
<th>Claim Size</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$100k</td>
<td>32.3</td>
</tr>
<tr>
<td>$100k–$250k</td>
<td>25.1</td>
</tr>
<tr>
<td>$250k–$500K</td>
<td>19.8</td>
</tr>
<tr>
<td>$500k–$1M</td>
<td>14.6</td>
</tr>
<tr>
<td>&gt;$1M</td>
<td>8.4</td>
</tr>
</tbody>
</table>
trends, it helps to consider changes in claim resolution. Figure 5 depicts trends by resolution type that appear favorable. There is an increase in the number of dropped, dismissed, or withdrawn (DDW) claims in which the defense wins without risking a verdict or making a settlement.

There is also a decrease in the number of settlements and a small decrease in the number of verdicts. These shifts indicate that MPL insurers are limiting the number of verdicts and their accompanying risk, but are also, in general, doing so without paying on claims they could have defended.

By drilling down into the outcomes of verdicts, we can see another material aspect of resolution changes. As shown in Figure 6, the number of plaintiff wins per verdict has sizably increased during the last two years.
years, rising from approximately 10% of 2013 verdicts to about 12.5% of 2015 verdicts. Expressed another way, plaintiffs used to win one out of every 10 verdicts. Now, they win one out of every eight verdicts. With a historical average of about $800,000 per plaintiff verdict and more than $1.1 million per plaintiff verdict for claims closing in 2015, any difference in the verdict rate can be material.

The trend shown in this graph could possibly be overstated by the increase in DDW claims. MPL insurers will always prefer a DDW claim to a verdict. But that leaves the tougher claims in the verdict category, and one could argue that it unfairly diminishes the MPL insurers’ verdict record. Not giving an insurer as much credit for a DDW claim as for a defense verdict is like not giving a boxer credit for a first-round knockout.

Figure 4. Average Severity by Indemnity Size Range, 2006–2015

Figure 5. Percent of Claims by Claim Resolution, 2006–2015
Figure 7 reproduces Figure 6, but with the plaintiff verdict wins expressed relative to both the number of verdicts and the number of DDW claims. As Figure 6 may have overstated the trend, Figure 7 represents a best-case scenario. There are likely to be a number of DDW claims that would have been decided in favor of the plaintiff had they gone to a verdict, but Figure 7 assumes that every claim would have been a defense verdict. Even in this best-case scenario, we still see an upward trend.

Looking Forward
In conclusion, both the proportion of large claims and the cost per large claim are increasing. These trends do not seem random, as they coincide with a higher percentage of plaintiff verdicts. Going forward, there seem to be two general paths that these trends could follow.

It could be that the current levels of severity, distribution by claim size, and plaintiff-verdict percentage are sustained at these levels or even reverse. In either of these cases, it's unlikely that they cause a material impact on premium or a continuing effect on the financial results of MPL insurers overall.

Alternatively, these metrics could continue to increase, in which case there will continue to be greater pressure on MPL insurers to settle more claims in order to avoid the risk of a large verdict. Further, as more claims are settled, that could provide an incentive for plaintiff attorneys to file more claims, given that there would be a greater chance of a payout, without the need to invest in the effort required to win a verdict. This sequence of events would almost certainly require premium increases.

If this is going to happen, it is probably still several years away, because the first step will be an increase in settlements.

Figure 5 shows that the movements have continued to be downward for settlements and, for 2015, they are near the lowest point in 10 years. Settlements as a percent of all claim resolutions will be a key number to monitor in measuring how any subsequent increases in severity are altering the insurers’ claims strategy and what the ultimate effect on premium will be.

The new 2017 PIAA Closed Claim Comparative will be released later this year, and we look forward to reexamining these trends with another year of data.
Transform The Way You Learn Online

Discover Three Dimensions of eLearning

Medical Interactive Community embraces a three-dimensional approach to the intelligent design of our self-assessments, courses and learning plans. Each layer of our strategic framework of learning is dependent upon how a learner responds. Learner responses are captured to show three dimensions of understanding of course subject matter: content accuracy, key risk management concepts and levels of risk severity.

To learn more about MI’s approach to risk management education, download our free whitepaper at info.medicalinteractive.com/3D 855.464.7475 | info@medicalinteractive.com
There has been no lack of media attention and alarm in recent years over the management of junior doctor rotas and the possible safety impact on patients and the trainees themselves. Yet, less regular coverage is devoted to the day-to-day concerns of hospital doctors who must deal with severe understaffing—and these concerns have become increasingly prevalent, if our advice line and a recent survey from Royal College of Physicians (RCP) are accurate indicators.

In the RCP survey, more than half of physicians stated the belief that patient safety has deteriorated, and 84% have experienced staffing shortages in their team. The report also found that only one in five doctors knew the identity of their NHS Freedom to Speak Up Guardian.

Concerns raised with MDDUS advisers are most often a consequence of ongoing multiple vacancies in posts, and the issues can include “too long” shifts, with on-call doctors becoming the primary contact for staffing a service, and staffing workarounds becoming not the exception but the norm.

Doctors may experience weeklong on-calls where work is steady across the 168 hours due to a poorly staffed department—or have to work 19 days in a row and 26 nightshifts across a month. Locum tenens doctors covering weekends in a hospital may finish shifts with no one available to whom they can safely hand over patients.

Eventual impact

There is general acknowledgement about how difficult it can be for trainees to speak up, but more often than not, doctors in more senior posts have already raised concerns with clinical leads over a period of time, with
no action being taken. They phone MDDUS requesting advice on what their next steps can/should be.

Prolonged workload or hours will have an impact on a physician’s health and may eventually lead to exhaustion, which can lead to error. Patient safety can be affected by a doctor’s presence as well as his absence.

In April 2016, the U.K. General Medical Council (GMC) issued specific advice on this subject, in response to the increasing number of concerns raised by doctors. The GMC states in its guidance that they recognize the pressures within the service and that “doctors may find themselves in difficult positions.”

They are clear that in instances where a doctor follows the GMC guidance—including the use of their flowchart to support decision-making—they “will be in a good position to justify their actions if challenged and should not face sanctions from the GMC.”

Doctors should know the established procedures for their workplace and the key individuals to contact for raising a concern (which should be done in writing). In addition, those doctors who are responsible for acting on concerns have a responsibility to act promptly and professionally.

This means “putting the matter right” (if that is possible), investigating and dealing with the concern locally (with clear timelines), or referring serious or repeated incidents or complaints to senior management or to the relevant regulatory authority.

**Actions**

Here’s what you should tell doctors to do in regard to working-hours issues:

- Make a specific record of concerns you have raised, and/or steps you have taken, where patient care or safety is being compromised. The GMC flowchart will help ensure that you have acted properly.
- Consider the risks to patients from any refusal to cover a shift.
- Consider your own health and well-being, including the possible impact on your clinical practice if you are becoming over-worked or exhausted. The GMC states that having done what you should, and made a record of your decisions and actions: “if you think you are too exhausted to cover a shift safely, you should not do so.”
- Where possible, work collaboratively with colleagues to find a solution.
- For contractual or employment concerns, consult with the British Medical Association or similar independent advisory services. However…
- If you are not sure how to act on a concern that relates to your ability to provide safe patient care, contact our medical advisers for advice.

For related information, see www.mddus.com.

---

**PIAA Board Governance Roundtable**

**March 15–17, 2018 • Hyatt Regency at Gainey Ranch • 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.

**Note:** PIAA Affiliate Partner personnel are not eligible to attend this meeting.

**At this year’s roundtable, you will put your merger and acquisition (M&A) acumen to the test in a team exercise that pits you against your PIAA colleagues! In this interactive session, you will be assigned to a team and compete against your fellow attendees in an exercise that explores the fast-paced and often complex world of M&A activity for board members. You will also learn from a seasoned expert on board governance in complex regulatory environments. He will help you gain an understanding of the fiduciary responsibilities of MPL insurer board members. Additionally, you will meet a cyber security expert from the Federal Bureau of Investigation who will provide the key information and practical guidance that board members need to become active partners in battling cybercrime.**

**WHY SHOULD YOU ATTEND THE BOARD GOVERNANCE ROUNDTABLE?**

- Created specifically for you: chairs, vice chairs, and directors
- Provides a forum where board members can gain invaluable industry insights, and share ideas and concerns with their colleagues in other companies
- Offers ample time for networking

**To register, or for more information, visit www.piaa.us**

**DON’T MISS THIS UNIQUE EDUCATIONAL OPPORTUNITY!**
To find the safer path, follow us.
We’ve been on it for nearly 50 years.

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

You and your insureds can turn to ECRI Institute to:

- Improve culture of safety
- Proactively assess risk
- Prevent adverse events
- Benefit from actionable safety recommendations
- Learn from and network with your peers
- Connect with ECRI’s 400+ experienced healthcare analysts and researchers.

When it comes to reducing risks, take our lead.
ecri.org/insurance
Inside Medical Liability: Despite its overall diversity, does the research conducted by the Wisconsin Institute for Healthcare Systems Engineering (WIHSE) align with some major overall themes?

Carayon: We’ve chosen four areas as the principal foci for our research: monitoring and anticipating safe care transition for vulnerable populations; smart automation and technologies for coordinating and communicating diagnosis and treatment; smart and connected patient-centered care; and patient safety—modeling, forecasting, and responding to healthcare-associated complications.

These also incorporate the Quadruple Aim described by Rishi Sikka et al. (BMJ Quality & Safety, October 2015). To the Triple Aim proposed by Don Berwick and his colleagues, the Quadruple Aim adds a fourth principle, which addresses the need to create “the experience of joy and meaning in the work of healthcare.”

IML: What have you done to support collaboration among disciplines?

Carayon: Over the years, we have created multiple opportunities for interaction and communication between engineers and healthcare people via efforts like co-teaching courses and the SEIPS short course.

“For SEIPS” stands for Systems Engineering Initiative for Patient Safety. This project is sponsored by the Center for Quality and Productivity Improvement (CQPI), an interdisciplinary research center housed within the University of Wisconsin-Madison’s College of Engineering.

The “SEIPS Human Factors and Patient Safety” short course is designed to provide an understanding of human factors engineering (HFE) and systems engineering and how this approach to patient safety can improve system performance and safety, prevent harm when error does occur, help systems recover
from error, and mitigate further harm. In addition to its didactic lectures, the course is organized with active participation, allowing for participants to apply HFE concepts and techniques when they learn them.

**IML:** What do engineers need to understand to become conversant with professionals in healthcare?

**Carayon:** For the tools used in engineering to work, we really need to understand what healthcare professionals do. Oftentimes, to be effective, we get really deep into the weeds to understand the processes associated with healthcare issues that we are addressing.

**IML:** Can you give an example where this approach was applied to a practical problem and actually worked?

**Carayon:** I can give you a simple example that you can probably relate to. When you go to a physician's office, you check in, and then you have to wait. Next, the medical assistant (MA) will take you to an exam room, then you might have the nurse or a MA take your vital signs, then the physician will see you, then eventually you might have to go elsewhere to have some tests—and then, you need to return to the reception desk to check out.

Oftentimes, you show up for your appointment 10 or 15 minutes early, but you end up waiting for a long time. Some people don't show up at all because, between the time they made the appointment and when they were scheduled to see the doctor, they felt better and didn't really want to sit around and wait for what they believe will be an unnecessary appointment.

So often, when you have lots of people waiting, someone will say, “We need to have more examination rooms, or we need to hire more staff.”

**IML:** So, how does your group approach this sort of situation?

**Carayon:** The way we look at the problem is this. First, we try and follow everyone around—follow a patient, follow staff, follow physicians around, just to make sure that we understand how things really work, from a system and process perspective.

Next, we will probably draw a couple of different what we call “flow maps,” or “process maps,” just to understand, again, what are the steps in the process, who is involved along the way, and how long each of these steps take.

After that, we might feed everything into a simulation model. Once we get data about different patient arrivals, we try to simulate the randomness. For example, in a doctor's office, you have some people who are scheduled to arrive, but don't all show up on time. And then
you have unscheduled arrivals, people who just walk in. And then you have people who leave because they get tired of waiting.

**IML:** What kind of answer does the model give you?

**Carayon:** With the data in the simulation model, and using some powerful statistical tools, we may be able to come back to the clinic and say, it’s not actually the doctors, because even as it is, physician utilization is maybe around 40%. And then, what about the need for an extra room?

In the end, we are able to demonstrate that even if you add an extra room and a doctor, what you actually needed is an extra nurse. Or, this particular piece of the process has three redundant steps, for example, people get their vitals checked three times by three different people. This points out there isn’t good coordination among staff members or between the various steps in the visit.

But if we put a process in place, such that the person has their vitals taken only once, and everybody is aware of that, patients flow through the system more seamlessly. So in the end we find that we don’t actually need to add either doctors or rooms—because we have enough capacity to meet demand.

Oftentimes, you see this in outpatient settings. But you also see this in EDs; the concept of ED crowding is quite significant.

**IML:** Do you have an example of how this works?

**Carayon:** Yes, we actually worked recently on a project like this. There is a presumption in EDs that since a lot of people use EDs instead of emergency care or urgent care, you end up having emergency physicians who are trained to take care of trauma and other complicated cases, seeing nosebleeds or stubbed toes.

So there is one line of thought that, for example, you could maybe have the less severe cases, the nosebleeds, the headaches, follow one flow with maybe a nurse practitioner on the staff, so that they don’t have to wait as long. And then maybe the more serious cases would go through a different flow.

That is the theory, and it makes sense: triage them at the beginning, and then send each person down the right path.

However, there is a point where it breaks down—and you can prove it mathematically—if you want to do this without adding any resources. Because all of a sudden, you are splitting the queue into two. Here is an analogy: If you stand in one line for a ticket, and from that queue they will send you to different agent, to check your ID or give you your bus ticket or whatever it is. That's...
because it’s more efficient to have a single queue. The moment you implement a “fast track,” but you don’t add more resources, you split the queue in two. So the processing time actually increases, such that at least one of those queues ends up grinding to a halt, eventually.

When “fast track” does work is when you split the flow into two, you also add a commensurate number of resources. But in that case, you start wondering, what had the most impact? Was it splitting the flow? Or was it adding the resources?

You have to control the variables so you get answers that are useful.

**IML:** Does your work enhance patient safety?

**Carayon:** Yes, both directly and indirectly. Most of the projects that we work on, I would say, impact patient safety, in the main, indirectly. When you have a very crowded ED, what happens is that you have a stressful, chaotic, work situation. If you don’t have a very efficient process to move patients through the ED, you might have patients who, basically, get tired of waiting and leave without being seen. This is obviously not good, because they’re not getting care.

Also, from the ED, patients either get discharged or get sent to the hospital to be admitted. If that process isn’t flowing, you have backlogs in the ED, so people are waiting in the hallways, or taking up the rooms, so people in the waiting room who need care can’t be seen. It sort of trickles down, and impacts it at every point.

If you think about what ideal care is, from a patient’s perspective, it is to be safe, to be seen by a person who can tell him what he has, and be able to direct him to the next step in care, as soon as possible.

So the more efficient the flow of patients through the ED, the more ill patients get care, which means that the fewest people will leave without being seen. It also means that fewer people are in the situation where they have been accepted to be admitted to the hospital, but are still physically in the ED. So now the ED doc gets frustrated: He needs that room for a new patient, but the inpatient doctor hasn’t taken the patient yet. So it creates chaos and a kind of limbo, neither of which is conducive to good care.

**IML:** So it’s the system that’s not working in this instance?

**Carayon:** Most people will do what’s best for the patient, and care for the individual patient, but the system is not really conducive to that. It’s the people that are picking up the slack, because the system isn’t really enabling them to focus on their patient as they would like to.

So, in an indirect way, if you have efficient care processes, then you have a less chaotic work environment, which is better for everyone involved. You have fewer patients that are waiting for a long time to get care, which means that the situation isn’t likely to degenerate as much. You have fewer people leaving without being seen. You have more people moving from the ED to the next destination of care—because people shouldn’t be delayed in the ED. This trip—to the next site of care—should be seamless. And the care provided is timely, and efficient—safer, throughout the continuum.

**IML:** Are there other ways that you work on patient safety?

**Carayon:** Yes, there are other ways we impact patient safety, methodologies that relate to human factors engineering. These include labeling clearly, and making sure that you have the right supplies when you need them, in the right order, so you don’t accidentally grab the wrong thing.

One of the times when patients may be in an unsafe environment is when there are handoffs. For instance, say, they were supposed to move from the ED to a medical or surgical hospital unit. But the patient and the family don’t really know where the medical/surgical unit is. And then in that process—the handoff has to really be done well—the arriving nurse needs to know exactly who the patient is and why they’re there. They’ve reviewed the chart and basically have the information.

So some of the work we do also involves working with processes that often occur during handoffs—from hospital to home care, for example, or in between departments or units in the hospital, as when someone gets transferred from the ED to an observation unit.

We make sure that the information flows seamlessly and that coordination occurs between different groups who care for the patient.

**IML:** Are you optimistic that all of the now-separate, sometimes Band-Aid-like efforts at patient safety improvements will one day be knit together into a comprehensive whole?

**Carayon:** Yes, and this is why we want healthcare systems engineering to be part of improving care. We (engineers) focus on improving work systems, care processes, and technologies that can support improvement of outcomes. We focus on the entire work system and all aspects of processes, not just the individual. Therefore, our approach is systemic and does not create silos.
BMS – An Exceptional Reinsurance Broker Delivering Strategic Solutions

As the medical liability landscape rapidly shifts, BMS’s commitment to delivering strategic solutions has made us PIAA’s leading risk advisor.

Our analytical, actuarial, and capital markets specialists focus on the needs and interests of your business to deliver exceptional risk and capital solutions.

Contact us at Specialty.Casualty@bmsgroup.com to learn how we can work together to meet your goals.
When you lose a loved one to an adverse outcome or there is a sentinel event, you just want an honest, transparent, and thoughtful conversation. You want to know what happened, in terms you can understand; you want accountability, to hear “I’m sorry,” and to know the problem is going to be fixed, so it doesn’t happen again to anyone else. And yet, all too often, these needs are not met.

I lost my 9-year-old daughter, Alyssa, to multiple systemic errors. There was no malice or intent to harm her; she just became a victim in the complex healthcare system where processes failed, fear of hierarchy prevailed, and they would not listen to me, her mom, the person who knew her best. It took the organization three years, seven months, and twenty-eight days to have the first honest and real conversation with me. We were first harmed emotionally, physically, psychologically, and financially with the loss of our daughter. However, we suffered a second tragedy when we were not told about what happened with her care—and this pain is completely avoidable and unacceptable.

Healthcare organizations have implemented policies and procedures to conduct disclosure conversations, but having this in print does not mean it actually transpires. It is important to have robust communication and resolution programs in place, so healing for the patients, families, and care providers is occurring, and learning is taking place within the organization to reduce harm to other patients.

Ironically, the very hospital where my daughter died is where I have given back so much of my time and energy. Even though it took years for us to collaborate and build trust again, it is possible if a shared goal of learning and keeping patients safe is at the core of the relationship. Patients and families have so much to provide to assist in the learning after adverse events. They are usually the only constant in the care, where all the other providers are individuals coming through a revolving door to spend but a few minutes. Each shares or takes their piece of the puzzle, but nobody has the vision of the whole picture like a parent, family member, or loved one who is there 24/7.

Many patients and families want to be involved in helping to fix the problem, and they can be a gift to the organization if allotted the opportunity. Unfortunately, if we don’t have these conversations with patients and families after harm, everyone loses. The organization loses because it does not have all the information to fix the problem if the patient and family voice is not heard. Healthcare providers suffer because they often want to tell patients about what happened, but live in a world of fear, and are stilled for a multitude of reasons. Patients and families suffer because they often blame themselves and carry the guilt because no one will talk to them. But perhaps, the most egregious is the harm other patients encounter because of a conversation that never transpired.

We are headed in the right direction with communication and resolution programs, but the trajectory will never be fast enough for me. I believe in this work and that is why I am intimately involved in it. I am a puzzle with many missing pieces because I still do not have all the answers of what happened to Alyssa, on a fateful day in March. It is her story, voice, and soul that are at the heart of transparency and communication after medical tragedies. If she saves only one life, she has given back an amazing gift, and her legacy lives on.
THE INSURANCE INDUSTRY IS CHANGING.

LET JACOBSON HELP YOU FIND FORWARD-THINKING LEADERS.

In today’s increasingly competitive labor market, human capital is critical to business success. An organization is only as strong as its employees. The Jacobson Group can help you stay up to date on the latest trends to attract top talent.

To learn more, visit jacobsononline.com/PIAA.

CONTACT US
+1 (800) 466-1578
jacobsononline.com/PIAA
Providing expertise and resources to support strategic decision making beyond the reinsurance transaction
HAS FORTUNE TURNED ITS BACK ON MPL INSURERS?

By Stephen J. Koca and Richard B. Lord

Much has been written about the future of traditionally physician-based medical professional liability (MPL) insurers: the impact of the industry’s consolidation, its ever-dwindling market, the relentless competition in the current soft market, and the uncertainty of healthcare reform.

And while predictions abound, clarity has been in short supply. So now may be a good time to step back and take stock of what has happened over the past year, before we try to move forward.

There is no better place to start than with the MPL industry’s profitability, which in 2016 was still strong, though income was derived from slightly improving investment income and still-favorable prior year loss development. Current policy year underwriting results (i.e., excluding the benefit of reserve releases on older policies) deteriorated by 3 points relative to 2015, likely owing to continued price competition. While the number of significant rate decreases has started to wane, there is as yet little evidence of increasing rates, with overall market pricing essentially flat. With flat pricing and increasing loss severity, particularly the steep upward trend in claims greater than $1 million, rates that were previously resulting in underwriting profits can quickly become inadequate.

Still, the 2016 operating ratio for MPL insurers stayed below the property/casualty (P/C) industry average, and A.M. Best analysis indicates that reserves were still more than adequate as of year-end 2016. However, the question abounds as to how much longer prior year reserve releases will be able to cushion MPL results, and critical to answering that is information about the adequacy of the initial reserves being posted on current policy years.

For more than 10 years, the industry’s results have been propped up by reserve releases from prior year policies, which were initially a huge boon to profitability. In the past two years, though, the benefit has moderated. Last year’s $0.9 billion reserve release, while still significant, falls far short from those posted between 2008 and 2013, when releases regularly topped $1 billion. Of note during 2016 is the number of companies with significant (defined here as greater than 20% relative to net earned premium) reserve releases, a sharp decline from 2015; and significant reserve development, a sharp increase from 2015.

Last year’s curtailment in releases created the first underwriting loss since 2004, as the loss and loss adjusted expense ratio jumped to 77%, and the combined ratio rose to 106%. Adding fuel to the burn-off in reserve releases, the first loss estimates for policies written in more current years have increased substantially year over year and also contributed to the deterioration in calendar-year underwriting results.

The financial picture that emerges vividly shows a fading, though still acceptable, performance. And, in reality, it is probably unreasonable to continue to expect MPL insurers to post operating ratios below 80%, as they did in the earlier part of this decade (Figures 1–3).

The long haul

As serious as the increases in losses are, relentless competition for a contracting market is probably MPL insurers’ main challenge. Rates continue to fall for MPL insurers, which are competing for a dwindling market of physicians—many of whom prefer the work-life balance of a hospital or a large group setting, and the often bundled insurance that comes with it, rather than the independence of private practice.

Since 2006’s high-water mark of $10 billion, premiums have declined 20%, ending 2016 at approximately $8 billion. Forced to compete with some companies with aggressive pricing, some MPL insurers have eased rates to levels that are now most likely inadequate. Better to retain a risk than to see it move to a competitor, according to the rationale for such decisions.

Stephen J. Koca, FCAS, MAAA, is a Principal and Consulting Actuary, and Richard B. Lord, FCAS, MAAA, is a Principal and Consulting Actuary, both with Milliman.
This traditional competition among insurers has been greatly exacerbated over the past 10 years by the migration of physicians to large-group practices or hospitals that are either self-insured or have formed captives. While difficult to track precisely, this trend is evident in the sharp drop in direct written premium for physicians when compared with the level or slightly declining premium for hospitals. Many believe that the uncertainty swirling around healthcare reform will only accelerate this trend.

Despite floundering premiums and the increasing sizes of loss, MPL insurers’ capital positions continued to grow in 2016. This increase is one of the best indicators that the soft market will likely continue for at least several years. For as long as MPL insurers continue to add to their capital, there is only a remote possibility that the market will harden. Income breeds, if not complacency, then the lack of resolve to alter one’s course. But as soon as MPL insurers see their income begin to evaporate and their surplus shrink, soft market conditions are likely to change, and change rapidly.

But for now, many MPL insurers, having accumulated substantial amounts of capital, have little incentive to change their ways. And in reality, no one insurer can move the market.

An age-old question
The specter of an ever-shrinking market and potentially dynamic changes in the healthcare market per se make for an uncertain future that goes beyond the challenges that MPL insurers have dealt with in their traditional cycle. In many ways, insurers are faced with an age-old question: Should they wait, hoping that more information will provide better direction? Or, by hesitating, will they miss an opportunity to gain a market advantage? The answer is by no means clear. Inaction seems as perilous as action.

One near fail-safe option for insurers is to look for ways to improve efficiency. A perpetual challenge, cost reduction has indeed stymied insurers throughout the P/C industry. In recent years, however, some data-savvy personal lines insurers have started to make headway on costs, by purchasing data on applicants that can speed the acquisition process. A convenience to applicants who no longer have to complete long questionnaires, this change also offers a verifiable source of accurate third-party information for insurers.

While MPL insurers admittedly face a much more complicated underwriting and claims process than personal lines insurers, the progress made by personal lines insurers points to the possible benefits that innovation can have on a long-standing process previously thought to be nearly intractable.

Taking a step further, big data analytics could help some MPL insurers differentiate risk or provide better targeted marketing opportunities. But for MPL...
insurers with high market concentrations in designated states, analytics may not be a necessary option, because they already have deep and extensive knowledge of their market. But for others, it can augment the underwriters’ ability to segment risk and facilitate laser-focused pricing strategies that would provide a distinct market advantage over other insurers, and even large medical groups or hospitals that lack pricing sophistication, as well as the flexibility to eliminate marginal physicians from their operations.

These examples are in no way intended to provide a roadmap for the future but, rather, some idea of the potential benefits possible from innovation in an uncertain market.

Competition is as much a part of the market as breathing is to life. But the flight of physicians to large groups or hospital systems could make the next downturn unlike any MPL insurers have experienced to date. Could the hard market hasten physicians’ migration? Will insurers be competing for an even smaller market? Will competition for fewer risks restrain the traditional hefty increases that insurers have charged in prior hard phases of the cycles? The future is indeed uncertain, but those insurers that choose innovation over habit are likely to be in a better competitive position.

For related information, see www.milliman.com.

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

Guy Carpenter is focused on this evolving and specialized market. As the recognized industry leader in casualty reinsurance products and other risk transfer solutions, we are uniquely positioned to offer clients seamless and innovative coverage solutions that respond to both known and emerging exposures.

We invite you to learn how our dedicated team of specialists leverages our industry experience, market intelligence and analytical expertise to customize proactive solutions to meet the specific strategic needs of the medical professional liability insurance market. Let us put our intellectual capital to work for you.

For more information, please contact: Steve Underdal at +1(952) 820-1030 or steve.underdal@guycarp.com
The Shifting Sands of Central Bank Monetary Policy

By Peter Cramer, CFA

As the economic recovery stretches into its eighth year, central banks across the globe are beginning to question the merits of maintaining excessively accommodative monetary policies. With equity markets in the U.S. flirting with all-time highs and the unemployment rate returning to pre-crisis levels, it is natural to wonder whether the economy still needs the extraordinary levels of stimulus that central banks have been providing.

Thus, several central banks have begun to alter their stance on monetary policy. This represents a dramatic shift for a global economy that has grown accustomed to the stimulatory effects of low rates.

The History of Easy Monetary Policy

To fully grasp the significance of this shift in policy, one must first appreciate the magnitude of the stimulus programs that were put in place to combat the global recession. The first attempt to stimulate the economy was by using conventional monetary policy. In the U.S., this meant cutting the Fed Funds Target Rate from 5.25% all the way down to 0.25% (effectively zero). In Europe, the European Central Bank (ECB) went even further, cutting the overnight Deposit Facility Rate to negative 0.40%. This marked the first time in modern history that a central bank was charging savers to invest money overnight, in an attempt to stimulate lending activity.

While near-zero rates (or negative, in the case of Europe and Japan) were helpful in ending the recession, more stimulus was needed, and hence central banks began to purchase the bonds of their respective governments. This process, which became known as Quantitative Easing (or QE), drove a massive increase in central bank balance sheets (Figure 1), as they bought huge quantities of government bonds in an effort to lower long-term interest rates. In the U.S., the Federal Reserve balance sheet increased from just under $1 trillion in 2007 to $4.5 trillion today, or from 6% of GDP to 23%. Europe and Japan had similar increases over the same period, going from 12.5% of GDP to 39% for the ECB, and from 21% to 94.5% for the Bank of Japan.

What has changed

The results of these programs were positive, as global growth has recovered and asset values have reached new highs. The extraordinary stimulus measures did come at a cost, however, which became evident over the past few years. The main risks of sustained periods of low rates are the impact on bank lending margins, the forgone income for net savers (such as retirees and pension plans), and the potential creation of housing and other asset price bubbles.

Banks experienced declining lending margins—or, the difference between what they pay customers for deposits and what they can earn on new loans—erosing the bank’s ability to generate the capital they needed to satisfy new regulations. This is because banks are reluctant to pass along negative deposit rates to retail consumers, who would rather take their cash and stuff it under their mattress than pay their bank to...
have seen in Canada, raise rates, and more after the Fed began to
tion we saw in the U.S.
This is exactly the reac-
tion we saw in the U.S.
so that central banks have begun to pull back
on their stimulus programs. The Federal Reserve has raised rates four times since the end of 2015, including two increases this year, and has outlined plans to begin reducing its portfolio of Treasury and mortgage securities. The Bank of Canada also began hiking rates, and the ECB and BOE have both hinted that they are not far behind. The following quote from Stephen Poloz, (Governor of the Bank of Canada), delivered on July 12, 2017, as he
hiked rates for the first time in seven years, captures the sentiment of most developed-
market central bankers:
“The most important thing here is the
economy clearly no longer needs as much
stimulus as we have been giving it.”

Impact of the shift from
dove to hawk
Since the implementation of such massive
stimulus measures had large stabilizing
effects, the unwinding of these same pro-
grams should have commensurately large and
destabilizing results.
The typical market reac-
tion to a shift from easy
to tighter monetary poli-
cy is higher interest rates
on government debt, and
a stronger currency.
This is exactly the reac-
tion we saw in the U.S.
after the Fed began to
raise rates, and more
recently, the reaction we
have seen in Canada,
Europe, and the U.K.
The fact that many countries are making
this shift at the same time, however, could
cause some problems. This is because cur-
rency movements do not occur in a vacuum,
and movements are made in relation to other
currencies. For a good example of how the
interconnected nature of global currency
markets can complicate the task of central
bankers, let us consider the recent pattern
that has emerged since the Federal Reserve
has embarked on its tightening campaign.
In response to strong growth, low unem-
ployment, and rising inflation, the Fed began
to raise rates in December 2015. This eventu-
ally pushed U.S. Treasury rates up, sending
the U.S. dollar higher versus most other major
currencies. The stronger dollar then works to
lower inflation by making imports less expen-
sive. Additionally, the appeal of safe-haven
assets improves as the yields of risk-free asset
(such as U.S. Treasuries) increase, causing a reversal
of the reach for yield. Risk
assets therefore begin to
suffer, and risk aversion
occurs, which is what we
saw in early 2016. The Fed
was then forced to question
their decision in the face of
increased global uncertain-
ty and falling inflation.
They walked back their
hawkish comments and
begin to skew dovish, which caused rates and
the dollar to fall, as we have seen over the past
six months. Eventually, the weaker dollar will
begin to prop up inflation, and risk assets will
regain their allure, allowing the cycle to start
all over again.
The question for market participants to
consider is whether or not this cycle will con-
tinue. The implications of the process continuing
are low rates for an extended period of
time, with repeated oscillations between risk
on and risk off. Conversely, a break from this
loop could come in two forms: a more sus-
tainable improvement in global growth that
allows for the simultaneous global implementa-
tion of more hawkish monetary policies, or
a new shock that causes the global economy
to fall back into recession. While there is
some evidence to support the more bullish
break to the upside in the near term, over the
medium and long term, one must begin to
question the viability of the economic recov-
ery as it rapidly approaches the longest period
of expansion in U.S. history.

For related information, see

Disclaimer
Nothing in this article should be construed as a rec-
ommendation to buy or sell any security. Prime
customizes portfolios for its clients. Therefore, the
portfolio that Prime would build for you would be
different from what is reflected in this article. Past
performance is no indication of future results.
Accredited CME for physicians
Online and Hardcopy
Educating physicians since 1991

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

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

- And many more!

For further information visit www.medrisk.com or contact:
Christine Nash Long 800 633 7475
chris@medrisk.com
Telemedicine: Is the Other Shoe About to Drop?

By Eric R. Anderson

The number of virtual patient visits has grown exponentially in recent years. In fact, more than 21% of Americans say they have used telemedicine in some way, according to a study by Accenture. And this number will likely to continue to increase.

The rise in telemedicine can generally be explained by a few of its most fundamental benefits: It expands access to care, bringing healthcare services to patients in rural or distant locations; it may lower the cost of healthcare and increase efficiency; and telemedicine technologies can reduce travel time and other related stresses for patients.

Despite its benefits, in the liability world there may be another telemedicine-related issue to wrestle with—claims. As the use of virtual patient visits expands, will medical professional liability (MPL) suits arising from these remote visits grow exponentially as well? This is literally the million-dollar question.

As I think about the traditional approach to delivering care, a key question comes to mind: Can healthcare professionals eliminate face-to-face interaction and still provide safe and quality medical care? Many of us who work in the world of MPL, as well as those contemplating entry into the practice of telemedicine, are concerned about the answer—and the liability ramifications that may emerge, over time.

At this point, though, the data shows a low incidence of claims linked with virtual patient visits.

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

While some form of telemedicine has been practiced in the U.S. for decades, there is very little solid data about the liability risks associated with it. According to emergency physician and attorney Joseph P. McMenamin, MD, JD, this is because the number of remote patient visits, as compared with the number of inpatient visits, is still very small. In addition, McMenamin says, a high proportion of suits involving telemedicine have been settled; settled cases don’t get reported as frequently as litigated cases, so it’s hard to learn about them.

This means that we are likely in that unenviable position where the best we can do is to use our professional savvy to monitor the outcomes of care delivery through this modality, analyzing the information we have compiled, and then (unfortunately), wait for the other shoe to drop. We just don’t know enough at this time to say definitively whether virtual patient visits will increase liability risk or lower it.

But what we do know, from past experience, is that the introduction of any new technology or a material change in the way healthcare is delivered, may give the plaintiff’s bar new opportunities for alleging malfeasance. They may well be salivating at the notion of making the electronic records that result from virtual visits admissible in court.

But this development also provides an opportunity for PIAA and its members: to help healthcare professionals learn about best practices in telemedicine and work with them in implementing the safest and most effective risk-mitigation protocols. In the end, we can all hope that the care delivered through virtual patient visits will result in positive outcomes. And, when outcomes are improved, that serves to lessen the probability of liability claims.
KEEPING DOCTORS IN MALPRACTICE.

For nearly a century, Thuillez, Ford, Gold, Butler & Monroe, LLP has been the law firm doctors, hospitals and nursing homes have called to their defense.

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


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

THUILLEZ, FORD, GOLD, BUTLER & MONROE, LLP
ATTORNEYS AT LAW

20 Corporate Woods Boulevard  °  Albany  °  NY 12211
P 518.455.9952  °  F 518.462.4031

Prior results do not guarantee a similar outcome.
Attorney Advertising.