Shared Decision-Making: Enhancing Treatment, Reducing Liability

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PATIENT-CENTERED CARE

Creating a Path for More Patient-Centered Care

In 2015, the Institute of Medicine defined the phrase “patient-centered care” in this way: “Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.” As we approach 2019, we are still discovering both the benefits and challenges implicit in this concept.

In line with this evolution in how we think about care, there is now greater emphasis on the importance of communication, and the development and utilization of effective communication skills. As an organization comprised of medical professional liability (MPL) entities, we know first-hand, as well as from numerous studies, how poor communication can impact the healthcare experience and, in turn, MPL claims and litigation.

In order to continuously improve the patient experience, healthcare professionals are making use of traditional communication methods, and also adopting new and innovative approaches to engage with patients and their families. The move towards team-based care is also helping to equip practitioners for what will be needed for tomorrow’s medicine.

These and other changes to our healthcare system can be important factors when key decisions are being made regarding patient care. How this can best be accomplished is the subject of an article in this issue of Inside Medical Liability. The authors note that while the older concept of traditional informed consent and the newer theory of shared decision-making share many elements, the latter adds items like educational tools, which provide the patient a greater sense of control, in addition to a more complete understanding of their condition, treatment options, and the course of action selected. There is a growing belief among some practitioners that a meaningful shared decision-making process helps to establish a partnership between healthcare professionals and patients—an interesting approach to patient-centered care.

Another variation on this theme has been the rapid growth in deployment and utilization of telemedicine. Using telemedicine, patients can be diagnosed and treated by healthcare professionals in the comfort of their own home—very much an example of patient-centered care. However, circumstances are sometimes not as ideal or as complication-free as hoped. Nonetheless, the rapid expansion of telemedicine, and its almost uncheck growth can sometimes give the impression that there are few, if any, limits.

However, the regulation of telemedicine is still done on a state-by-state basis, while the use of telemedicine platforms is border agnostic. Both healthcare professionals and patients are often unaware of the other’s actual location and unaware of the significance of that fact. They want to know that the technology works; they are typically not aware or concerned with state borders. You will find in this edition of Inside Medical Liability an article with the essential details about the current limitations, across the United States, for both patients and providers, in accessing and making full use of telemedicine.

The authors point out that states may have implemented their restrictive policies for a variety of reasons, such as a fear of overutilization leading to growing costs, apprehensions about new technology, and increased liability risks.

It is critical to consider these challenges thoughtfully, while at the same time looking to successful models of telemedicine implementation for guidance. For example, some health systems have been reporting that telemedicine programs pay off in positive benefits such as increased clinic and in-patient capacity, reduced hospital readmissions, increased patient satisfaction, and quality of care, among others.

In the United States, the many and disparate state-based concerns and restrictions pose a great challenge to the continued proliferation of telemedicine. Advocates of telemedicine will need to find effective ways to achieve greater harmony among the states’ provisions and their inconsistent and sometimes conflicting approaches. If the state-based issues and inconsistencies can be successfully addressed, greater use of this technology can surely be a win/win for healthcare professionals and patients alike.

The MPL Association is continuing to closely monitor the discussions and public policy making regarding telehealth throughout the states, in Washington, D.C., and around the world. We continue to support the delivery of quality medical care and will assist to advance and defend the need for laws and regulations that provide clarity and recognize the needs of patients as well as those who insure or indemnify those healthcare professionals and institutions providing care. In this, as in covering the evolution of informed consent and shared decision-making, we can assist our members, with the goal of helping to improve patient outcomes while at the same time lowering the incidence of misunderstandings, claims, and litigation. 

"The rapid expansion of telemedicine, and its almost unchecked growth can sometimes give the impression that there are few, if any, limits."
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“With shared decision-making, the focus is on partnership in the treatment process. With that nuanced shift, the provider can share values and perspectives when asked.”
—Cover story
Your practice has evolved. Has you cyber insurance?
COMING ATTRACTIONS

EVENTS & CALENDAR

■ 2019 Board Governance Roundtable

Achieving Board Excellence

Boards today need to improve continuously and collaborate so that they function as a high-performing team, rather than merely fulfilling statutory requirements. But what is the best definition of Board excellence? More important, how can it be achieved? In this two-part session, Bruce Blessington, a former public company CEO with more than 25 years of experience in director and C-level management positions and a certified member of the National Association of Corporate Directors, will share his knowledge and experience to assist corporate directors in advancing their individual performance, as well as that of their board. Mr. Blessington will identify the characteristics of an effective board and discuss best practices in board dynamics, performance, and corporate governance.

■ 2019 Dental Workshop

Managing Emergencies in the Dental Office

Medical emergencies can and do occur in dental practice. Early and effective management of a medical emergency significantly improves outcomes and minimizes the potential adverse effects of such an event. Also, a practitioner’s ability to deal with medical emergencies is an important element in meeting his responsibility to his patients. Colin S. Bell, DDS, MSD, will teach attendees about the specific emergency procedures and protocols that should be in place to reduce liability and enhance the provision of safe care in the dental setting. Dr. Bell will incorporate several case studies in his presentation, so attendees will leave the session with a clearer understanding of the potential emergencies in the dental office, the standards of care for emergencies, and tips for mitigating the associated liability.

February 13, 2019
Webinar

March 13-16, 2019
CEO/COO Meeting
Hyatt Regency at Gainey Ranch
Scottsdale, AZ

March 14-16, 2019
Board Governance Roundtable
Hyatt Regency at Gainey Ranch
Scottsdale, AZ

April 3-5, 2019
Marketing Workshop
Kimpton EPIC Hotel
Miami, FL

April 5-21, 2019
Dental Workshop
Kimpton EPIC Hotel
Miami, FL

May 14, 2019
Chief Medical Officer Roundtable (by invitation)
Marriott Portland Waterfront
Portland, OR

May 15, 2019
Leadership Forum
Marriott Portland Waterfront
Portland, OR

May 15-17, 2019
MPL Association Conference
Marriott Portland Waterfront
Portland, OR

June 26, 2019
Webinar

August 28, 2019
Webinar

September 9-11, 2019
Underwriting Workshop
InterContinental Mark Hopkins
San Francisco, CA

September 11, 2019
Chief Medical Officer Roundtable (by invitation)
InterContinental Mark Hopkins
San Francisco, CA

September 11, 2019
International Risk Management Seminar
InterContinental Mark Hopkins
San Francisco, CA

September 11-13, 2019
Claims and Risk Management/Patient Safety Workshop
InterContinental Mark Hopkins
San Francisco, CA

September 25-27, 2019
Technology, Human Resources, and Finance (THRF) Workshop
Fairmont Chicago Millennium Park
Chicago, IL

October 24-25, 2019
Corporate Counsel Workshop
The Mission Inn Hotel
Riverside, CA

November 20, 2019
Webinar

Future Conferences
MPL Association Conference
May 6-8, 2020
Omni Shoreham Hotel
Washington, D.C.

MPL Association International Conference
October 7-9, 2020
Ottawa, Canada
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Crime of the Century (or Maybe Just the Decade?)

Insider Trading Scheme Linked to Medicare Reimbursement Rates

Four people criminally charged in 2017 have just been sentenced. The time to be spent behind bars stretches from one year and one day to three years. The crime? Working a scheme to secure confidential proprietary information related to Medicare reimbursement rates, and then trading on that for several years—“from at least 2012 through 2014,” according to the indictment.

The newly convicted parties include a health insurance agent, a senior staff manager in the Centers for Medicare & Medicaid Services, and two partners in the hedge fund Deerfield Capital Management.

After the misfeasors have emerged from prison, it might be wise to keep a close eye on the inventories of compression stockings and mobility scooters.

Source: Lexology, September 16, 2018

Be Wary of Siri

In a new study published in the Journal of Medical Internet Research (yes, there is a journal for that), a team of investigators found that the popular conversational assistants like Siri and Alexa were not terribly smart at figuring out what is happening in simulated health-related scenarios. Or they timed-out before providing any information. Or, even worse, delivered information and advice that would have resulted in varying degrees of patient harm had it been followed.

In fact, nearly 30% of the 168 answers provided by the personal assistants could have caused harm to the user, as assessed by a qualified internist and a pharmacist, including 16% that may have resulted in severe injury or death.

Despite the sophisticated natural language processing and artificial intelligence incorporated into these systems, the researchers cautioned against assuming that they can offer reliable healthcare advice.

While Apple, Amazon, and Google don’t explicitly state that their virtual assistant tools can or should be used to provide health advice, there are scores of add-on applications that will do something approximating that. At present, there are more than 1,500 “health and fitness” apps available.

For the study published in the Journal of Medical Internet Research, participants were told to ask Siri, Alexa, and Google Assistant structured questions about medications and several types of emergencies. There were also some “user-initiated queries,” in which participants could ask their own questions, in their own words.

Alexa won the top prize, of sorts. It failed for most tasks, but on the plus side, there were significantly fewer instances (2, or 1.4%) in which responses could lead to harm. Primum non nocere.

Source: Health IT Analytics, September 6, 2018
A Quiz on ‘Celebrity Malpractice’
From your good friends at ThePopTort.com

PopTort admits that its quizzes may not actually be a nifty way to spend time: “We do lots of quizzes on the important topic of medical malpractice and we can’t always say they’re much fun.” But the quiz posted on September 20, 2018, is special: “Today’s quiz is really gonna grab your attention. It’s all about celebrity victims of medical malpractice.”

And then the very first question left Observer (embarrassingly) stumped: “Who is the Oscar-winning actress whose singing voice was destroyed by medical malpractice?” There were only four choices, but they all seemed unlikely. The correct response, we discovered, was Julie Andrews.

There are a mere five multiple-choice entries in the PopTort quiz. Those hungering for more can go to the website of the Center for Justice & Democracy, where 22 celebrities who claimed adverse outcomes are listed. Anna Nicole Smith and Andy Warhol are numbers 21 and 22, respectively. We would venture to guess that this is the only list where both of these names are included.

Source: The PopTort, September 20, 2018
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$1.8 billion was spent for the defense of claims and lawsuits. The average cost was $52,012. 74% of the claims and lawsuits were resolved with no indemnity payment, but cost an average of $41,209 to defend. The remaining 26% resulted in an indemnity payment and cost $82,208 to defend.

Only 7% of lawsuits were resolved by a verdict and 89% were in favor of the defendant. The average cost to defend these lawsuits was $157,524.

Total indemnity incurred was $3.3 billion. For every dollar paid in indemnity, 55 cents was paid in expenses to defend or settle claims/lawsuits.

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ow that more companies are looking into cloud processing options, it’s a good time to define, for the non-IT business person, what the various offerings mean.

The use of cloud computing has been compared to the delivery of electricity to your home or office. We don’t give much thought about how power is generated or transmitted—we simply expect it to be available at the flick of a switch. Cloud computing is analogous to this—the cloud is computing power available on demand and delivered to any device that needs access to it. Just as the electrical grid needs wiring, light bulbs, and appliances that allow you to use electricity, cloud computing also needs the internet (the grid) and devices (PCs, tablets, phones, servers, etc.) connected to it.

The three cloud offerings

The three most common cloud offerings are described as software as a service (SaaS), platform as a service (PaaS), and infrastructure as a service (IaaS).

- SaaS is the most complete service: you receive the use of a working software application as long as you have a device that is internet-accessible. A software application is delivered in SaaS. Salesforce.com is the most famous pioneer in providing SaaS; Gmail is another example. There are two distinct approaches to providing applications using SaaS—multi-tenant and single tenant; these are described below. The key point here is that a functioning application is delivered to the business user ready for use, as opposed to infrastructure, which is used only by the IT folks. In fact, SaaS is particularly appealing to companies that do not have an IT staff, because all of the tech management of the environment is done by the SaaS provider.

- PaaS is simpler: it’s similar to SaaS but with the important difference that an application is not provided—it is pure infrastructure, offered along with the development tools that you need to build an application. Companies would use this arrangement for their IT group to gain access to the technologies they need as quickly and cheaply as possible to enable them to work on a project. Often, the appeal of PaaS is not just speed of access and cost, but also the ability to access the infrastructure provided for just a few weeks or months and then cancel the service when the project is done. That’s convenience, speed, and economy!

- IaaS: this is similar to PaaS, but without the development tools. The customer is provided with storage, hardware, operating system software, and networking, but he supplies the development tools needed for the task at hand himself.

So: If it’s a business end-user, he will be using SaaS (Gmail, Dropbox, or maybe an application from your enterprise system vendor, etc.). Only IT staff will use PaaS and IaaS, for software development.

Regardless of which of these three arrangements is used, cloud computing must:

- Be available everywhere—it relies on the internet, and in most cases, there are no installations or downloads needed on the device being used.
- Be available on demand—charges are
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

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There are two other terms to understand

Enterprise-wide SaaS application software comes in one of two “flavors”:

- **Multi-tenancy.** This means that a single instance of the software and all of the supporting infrastructure serves multiple customers. Each customer shares the software application and also shares a single database. The data is tagged in the database as belonging to one customer or another, and the software is smart enough to know who the data belongs to. Gmail and Salesforce are examples of multi-tenant systems. There are configuration options provided to each user that let him customize the behavior of the system to his own requirements. But these are limited, and they are the same for everyone.

- **Single tenancy.** In this scheme, a single instance of the software, and all of the supporting infrastructure, serves just one customer. With single tenancy, each customer has his own independent database. With this option, there’s essentially no sharing going on. Everyone has his own environment, separate from everyone else, and because of that, each cloud client can freely configure his system without regard for what the other users are doing.

Multi-tenant systems are not as flexible as the single-tenant ones. In the multi-tenant application, the designer has developed a product that, after its limited configuration options, is basically a one-size-fits-all. Insurance enterprise-wide systems are much too complex, and have too much variability in how they are used, to work within the confines of a multi-tenant system. Compare the system you use for policy administration, billing, claims, business intelligence, etc., to the (multi-tenant) Salesforce.com site. You’ll find that the unique features that are specific to your company are too varied to fit into Salesforce.com.

But there are some advantages to the multi-tenant scheme: One software program is used to service what can be millions of users. From that flow economies in both maintenance and support.

But there are also advantages to single tenant:

- **Enhanced security.** With single tenant, each customer’s data is completely separate from that of any other customer, so there’s little chance that one customer might access another customer’s data accidentally. Multi-tenant systems need their own security systems to achieve these same benefits, and the separation between the data of different customers is much “thinner.”

- **Greater reliability.** Single tenant is generally more reliable. The performance of one...
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customer’s system is not affected by the actions of the other customers. If one customer’s software instance goes down because of a bug, it will not affect the other customers’ sites.

- **Easier backup.** Backing up and restoring customer databases in a single-tenant system is extremely easy, since each client database has its own separate backup.

- **Easier migration from SaaS to in-house.** If a company wants to run the software on its own equipment later on, it—along with its data—can be imported quite simply.

- **Greater flexibility.** The single-tenant model offers customers a wide range of customization options, since both the database and software instances are unique to each customer. With single tenant, the underlying code can be modified and customized according to the customer’s preferences.

- **Control over upgrades.** In a multi-tenant system, all customers are upgraded at one time, in a single push of new code. In a single-tenant system, each customer has to be upgraded separately. This gives the customer full control over when and how an upgrade takes place. You may choose to delay or maybe even skip an upgrade cycle, if it comes at a busy time.

There is one more cloud-related term to understand: application solutions provider (ASP). This is similar to SaaS, except that the environment used is not shared among clients; it is an environment that is set up and managed exclusively for a single customer. So, it is similar to cloud offerings in how it works, but differs as a business arrangement; the sharing aspect of the cloud offerings is not a part of the deal.

At one point, the cloud was regarded as risky, suitable only for very large or very small companies, and that it brought with it data security and privacy issues. But Salesforce.com was first made available in 1999, so the concept is not new.

While not all cloud vendors are created equal, the big players like Microsoft and Amazon have by now had several years of experience under their belt. They wouldn’t have grown to the size they are today unless they were able to deal with these concerns. But all cloud vendors—some located anywhere in the world—are not created equal, so due diligence is needed. And frequently, there is a range of service-level options available, so care is needed in comparing one vendor to another.

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**TECH TALK**

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AFTER each two-year federal election cycle, the Medical Professional Liability Association conducts a government relations survey to find out what our members want and need from our advocacy efforts. In recent years, the subject of telemedicine has consistently been at or near the top of that list. Our 2017 survey found that three-quarters of respondents rated the expansion of telemedicine services as their most significant federal regulatory concern. At the same time, a majority of respondents said that creating national liability standards for emerging technologies was a high priority for them.

MPL Association members have good reason to be concerned. The federal government continues to expand access to technologies that provide alternatives to face-to-face interactions between health professionals and patients, and changes to our healthcare delivery system are bound to have meaningful repercussions for MPL insurers.

**Recent actions**

Many people consider Congress incapable of accomplishing anything (not without some just cause). In the last year alone, however, three bills advanced through the legislative process, resulting in expanded telemedicine services in the U.S. Each had bipartisan support, suggesting that even in the current highly partisan atmosphere in Washington, D.C., there are some issues where both sides can agree.

In February, Congress approved the Bipartisan Budget Act of 2018 (H.R. 1892). This comprehensive bill was primarily intended to keep the federal government funded and establish budget priorities for the ensuing months, but it also included a provision for expanding the use of telemedicine services to treat those in need of chronic care.

Specifically, the bill, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act (H.R. 4579), expanded the use of telemedicine services for both home dialysis and stroke-related care. Also, Medicare Advantage (MA) plans can now offer supplemental telehealth benefits to chronically ill beneficiaries, as well as additional benefits to all MA beneficiaries for utilizing telemedicine services.

A few months later, in June, the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (VA Mission) Act of 2018 (S. 2372), was signed into law by President Trump. As the name suggests, this bill targeted veterans’ healthcare needs. Rather than focus on specific treatments or conditions, as other bills have done, this legislation increases access to telemedicine services by allowing any licensed Veterans Administration (VA) healthcare professional to provide care via telemedicine to any VA patient, regardless of where either party is located. In effect, this preempts any state law that would require that the healthcare professional be licensed in the state where the care is provided (i.e., where the patient is located).

Most recently, Congress enacted legislation to address the opioid crisis, which included telemedicine provisions. Specifically, the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act or the SUPPORT Act (H.R. 6), amends the Medicare statute to expand the use of telehealth services for treating substance abuse, and instructs the Centers for Medicare & Medicaid Services (CMS) to provide guidance to states on how to provide substance abuse treatment via telehealth to Medicaid-enrolled individuals. As of this publication, the president has pledged to sign the bill, but the formal signing ceremony has not yet occurred.

Not all of the recent telehealth activity has arisen from the U.S. Congress, however. Earlier this year, the U.S. Department of...
Veterans Affairs issued a new rule overriding state medical licensing laws, thus allowing VA health professionals to provide care across state lines, without having to be licensed in multiple states. There were some questions about the VA’s authority to issue the rule, however, and that made it necessary to pass the VA Mission Act mentioned above, which codified this state law preemption.

Most recently, in its annual adjustments to the Physician Fee Schedule, CMS included changes in reimbursements for telemedicine. The proposal includes new payments for pre- and post-care telemedicine services to determine if an office visit is needed. If an in-person visit is appropriate, the healthcare professional will get a combined reimbursement for both the visit and the telemedicine interaction. If no visit is needed, reimbursement will still be provided for the telemedicine discussion. The proposal also calls for reimbursements for the evaluation of patient-transmitted data, inter-professional internet consults, and prolonged preventive services provided via telemedicine. Finally, the proposal calls for expanding the types of facilities that can serve as originating sites for telehealth services for renal dialysis and stroke patients, and seeks comments on reimbursements for substance abuse care provided by telemedicine.

What’s in store?
With so much government activity in 2018, is it reasonable to expect more in 2019 and beyond? Most certainly. Many other telemedicine bills were introduced in the 115th Congress (2017–2018), and some, if not many, of them will undoubtedly be introduced again in the 116th.

As I said before, the actions taken previously, even those that originated in the Trump Administration, enjoy broad, bipartisan support. Continuing efforts to expand the use of telemedicine services will proceed in the future, regardless of the outcome of the midterm elections (which, as of this writing, are still weeks away). But what, exactly, can we expect?

Looking at current legislation that was not enacted this year, it is clear that Medicare will be the likely vehicle for many of the future efforts to expand telemedicine services. What specific form those efforts will take, however, remains to be seen. Many stakeholders have rallied around a bill called the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act. This legislation would create waivers for health professionals participating in the Merit-Based Incentive Payment System (MIPS) that would exempt them from restrictions currently imposed on Medicare-based telehealth services. Those same waivers would be provided automatically to any health professional participating in an accountable care organization.

Other approaches may be somewhat more direct: for example, simply expanding the list of telehealth services reimbursed by Medicare or continuing to target specific services that could be provided, or specific populations that could be served, more efficiently through telemedicine. Congress also has the authority to address licensing issues that impede the interstate delivery of telemedicine services, as it did with care provided by the VA. Such an effort would be controversial, however, as it would certainly be viewed as diminishing the role of state licensing author-
ITIES (something many in organized medicine oppose) and infringing on state sovereignty (something that members of both political parties have opposed at times).

With or without legislation, regulatory agencies have some authority to make changes to federal telemedicine policies. For example, the Secretary of Health and Human Services is authorized to specify which services will receive Medicare reimbursements, by using an annual process to add or delete services from the Medicare telehealth list. In addition, future adjustments to the Physician Fee Schedule may provide further opportunities to expand access to telemedicine services.

What does this mean for MPL?
The possible implications of telemedicine expansion for MPL Association members are somewhat unclear, at this point. At the 30,000-foot level, any efforts that expand the number of patients a health professional sees open up the potential for new liability claims—simply as a matter of sheer numbers and the law of averages. Many additional questions, however, remain unanswered. For example, who bears the liability for a failure in the telemedicine communication system, the owner of the equipment or the equipment supplier? What about equipment on the patient’s end of the communication? Could the health professional be held responsible for missing something on a video transmission, even though the patient’s camera was set to a low-level resolution? Many of these questions will need to be answered before we can bring predictability into the issue of liability.

To the extent that telemedicine services are provided within a single state, many, if not all, of these questions may be answered by state governments. Interstate telemedicine raises additional challenges, however. For example, while the MPL Association has argued that the provider’s location should determine which state law will apply, some of our colleagues in organized medicine believe that the patient’s location is the only correct choice.

Thus far, none of the federal legislation we’ve seen has addressed these issues, and until such questions can be answered, liability related to telemedicine will continue to be a murky subject. This is why the MPL Association continues to raise liability concerns any time we discuss telemedicine with legislators and staffers on Capitol Hill. Even if we don’t provide them with solutions at this point, we recognize the importance of raising the issue—because no other groups in Washington, D.C., are doing so. By continuing to plant the seed with federal legislators, we intend to raise awareness of the issue, to ensure that any efforts to dramatically increase telemedicine delivery do not go forward until the liability issues have been addressed.

Conclusion
It is hard to predict how telemedicine legislation and regulation will look in the months and years ahead. By studying past proposals and maintaining relationships with key legislative and regulatory leaders, however, we have positioned the MPL Association to be a key participant in those discussions. In this way, we intend to help shape any liability-related issues that develop as federal telemedicine policy evolves.

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A llegations of mild traumatic brain injury (mTBI) in personal-injury litigation are increasing at an unprecedented level. This article highlights the unique challenges of mTBI claims and the best practices used by claims professionals and defense counsel to successfully defend them.

A mTBI—more commonly referred to as a concussion—is defined as a mechanically induced physiologic disruption of brain function, featuring the loss of consciousness for less than 30 minutes, loss of memory before or after the injury, post-traumatic amnesia, and/or feeling dazed, stunned, confused, or disoriented at the time of the injury. While a full-fledged TBI may lead to severe neuropsychiatric issues, approximately 90% of individuals who sustain mTBI make a full and fast recovery.

Despite this, over the past 20 years, the number of lawsuits alleging brain injuries has tripled. Perhaps this comes as no surprise given the publicity mTBIs have received in the media (think: the NFL players’ lawsuits), and the frequency with which accidents involving mTBIs result in large verdicts. For example, in Los Angeles, California, a 10-year-old plaintiff, who had a preexisting learning disability, was awarded almost $11 million for alleged mTBI arising from a rear-end collision. In Decatur, Georgia, a jury awarded plaintiff $11 million in damages for her alleged mTBI arising from a motor-vehicle collision with a pizza delivery driver. Similarly, in Pembroke, Georgia, plaintiff—a nursing student—claimed she sustained mTBI in a motor-vehicle accident and was awarded $15 million, despite the fact that she graduated from nursing school with honors following the accident.

Such verdicts undoubtedly impact the frequency of mTBI allegations. In fact, mTBI cases are the subject of more published articles than any other subject in personal-injury trial law. The trend of increasing mTBI claims is likely to continue, so it is important that defendants familiarize themselves with the issues and develop reliable litigation strategies to reduce the risk associated with such claims.

**Challenges in mTBI litigation**

Litigating mTBI cases poses at least three challenges for defendants. First, the potential loss exposure can be deceptively high—seemingly minor accidents can result in large claims. Plaintiffs’ lawyers sometimes wait until the end of discovery to allege mTBI, which disadvantages the defendant. Second, mTBI allegations typically involve subjective complaints made by plaintiff of “invisible” injuries (e.g., headaches, dizziness, forgetfulness), which are difficult to rebut with objective evidence. Typically, no “baseline” on plaintiff exists, i.e.,...
objective evidence demonstrating plaintiff’s pre-accident mental status. And, unfortunately, the use of conventional structural imaging (e.g., CTs/MRIs) rarely presents objective evidence of the existence of mTBI.¹

Third, mTBI cases are expensive to defend—they typically require the retention of neurologists, neuropsychiatrists, neuropsychologists, and/or radiologists, and may involve litigation events such as costly and time-consuming independent medical examinations. Defense experts are critical, as their analysis may be the only way to distinguish between mild and moderate/severe injuries and to identify cognitive, emotional, and behavioral conditions resulting (or not resulting) from these injuries.² Further, discovery related to mTBI is time-consuming and expensive, because it necessarily involves the collection of information about plaintiff’s “baseline” mental status from a variety of witnesses and sources.

**Strategies for defending mTBI cases**

Cases involving mTBI allegations can be successfully defended, but defendants must begin those efforts immediately. First and foremost, it is necessary to determine whether there is any risk of mTBI, even in the most minor accidents (e.g., slip and falls, low-speed rear-end collisions, etc.). In cases that may involve mTBI, defendants should hire skilled defense counsel that is experienced in litigating mTBI cases. Second, where an mTBI potentially exists, defendants need to aggressively develop baseline evidence of plaintiff’s mental status by evaluating all relevant records including pre- and post-accident medical records, employment records, educational records, military records, internet records and social media, independent medical exams, criminal records, financial records, etc.

Third, plaintiff’s deposition is critical to the defense of mTBI cases—defense counsel must make a thorough and sifting examination of plaintiff’s pre- and post-accident functioning. Plaintiff’s deposition should always be recorded, as the video can be later used at trial (for impeachment or comparison purposes) and by defense experts in their evaluation of plaintiff. Depositions of friends and family, as well as employers and co-workers, may also help disprove plaintiff’s allegations.

Fourth, the importance of the early retention of qualified experts cannot be overstated. In choosing an expert, it is important to consider the expert’s qualifications and track record. The expert must be well-versed in the medical literature and medical science surrounding mTBIs, which is constantly evolving. The expert will need to rebuff plaintiff’s experts and/or treating physicians, who often rely on methodologically unsound articles that link mTBI to permanent severe cognitive impairment.⁶ Defendants should consult with their retained expert regarding discovery-related matters, particularly in preparing for plaintiff’s deposition.

**Conclusion**

The “invisible” injuries associated with mTBI are difficult to defend. Minor accidents can result in major exposure, so it is critical to have an established strategy for the defense of such claims. It is essential for claims professionals to hire experienced counsel that will be proactive in the defense of any claim where mTBI could be alleged, as the early development of facts favorable to the defense reduces the risk associated with such claims. ¹⁰

**References**

2. Id. at 409.
5. See Wortzel & Granacher, supra, at 409.
6. Id. at 501.

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

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**Telemedicine: Just around the corner**

By next year, 95% of the nation’s top employers—companies with more than 500 employees—will provide telemedicine coverage as part of their benefits package, according to a new joint study by America’s Health Insurance Plans and the Coalition to Transform Advanced Care (advocacy groups for insurance companies and patients with chronic conditions). Meanwhile, other employers are set to provide telemedicine stations at the office so employees have easy access to a physician.

—Employee Benefit Advisor, October 11, 2018
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Choosing the right broker makes a difference
Informed Consent or Shared Decision-Making
A Meaningful Difference for Liability?

By Geri Amori, PhD

For better or worse, informed consent as a part of the healthcare delivery model arose from the legal system. Although philosophers may have opined about patient rights and autonomy, the law and the Centers for Medicare & Medicaid Services (CMS) established requirements that providers must follow to be in sync with regulations.
Entire businesses have arisen to guide providers in the process of documenting that they have addressed all of the elements in a full informed consent. Documenting these conversations is the gold standard for creating evidence of the communication process, and despite assurances that the “form is not the consent,” much emphasis, and legal language, is focused on ensuring that consent is documented in a way that the courts will recognize.

In essence, informed consent is intended to:

- Be a process—not a one-time event
- Ensure that anyone who is capable of having input in his care has the ethical right, or autonomy, to make the decision. Each person of mental capacity should be able to direct what and how things happen to his body.
- Go beyond a simple yes/no, to include:
  - an understanding of the treatment being proposed
  - why it is being proposed
  - material risks and benefits
  - alternatives, including taking no action
  - education about the alternatives
  - ability to provide informed refusal
  - the opportunity to have questions answered.

The ultimate goal of informed consent is for the patient to come to a fully informed agreement about treatment after engaging in productive communication with the provider. Regardless of the legal requirements for documented evidence of informed consent, providers must be willing to engage in discussions of care and treatment that take into account concerns such as patients’ medical literacy needs and cultural issues.

But instead of focusing on the documentation of informed consent, both the provider and the patient may be better served when the focus is on the process of the communication. The patient may be more likely to better understand the options, benefits, and risks of treatment, and less likely to misunderstand or become angry, which often triggers medical professional liability (MPL) litigation.

Enter: shared decision-making

Literature extolling the virtues of shared decision-making (SDM) appears as early as 1999, and the biannual International Shared Decision Making Conference has taken place since the early 2000s. Nevertheless, most of us have only begun to hear about SDM in the last seven or eight years, when the Agency for Healthcare Research and Quality developed its training module and when the state of Washington began to require providers to use the process for certain procedures.

According to G. Elwyn et al., SDM is “an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options to achieve informed preferences.” SDM is frequently touted as an ethical process and not a legal one. Except in those states where it is mandated, that is true, but that does not mean informed consent has no ethical basis for its existence.

In intention, informed consent and SDM are very similar. For both, the goal is informed, participative agreement between a patient and his provider about the course of treatment.

In addition, informed consent and SDM both:

- Arose from the conviction that patient autonomy should be respected
- Directly and indirectly require a communication process between the provider and the patient
- Delineate what is required in their process, including:
  - information about choices
  - information about risks and benefits
  - information about the option of taking no action
  - opportunities to answer questions.

A key difference between traditional informed consent and SDM is the use of approved educational tools. Tools designed for SDM conversations are, generally, professionally vetted, simply designed to enhance medical literacy, and attractive. They are intended to be used not only by individual patients but also as a basis for conversations between the provider and the patient. In the state of Washington, there has been strong advocacy for SDM, and it has been mandated for end-of-life care, joint replacement, and spine care, as well as maternity/labor and delivery.

In contrast, consent forms are often written by lawyers or those concerned with ensuring that the information meets the standard of the law. And although patient education may be provided as part of the informed consent process, it may not necessarily form the basis of the conversation with the patient.

Another key difference between informed consent and SDM is the role of the provider as participant. With informed consent, the sole responsibility for the decision lies in the hands of the patient/family, in support of patient autonomy. With SDM, the focus is on partnership in the treatment process. With that nuanced shift, the provider can share values and perspectives when asked. If the patient’s values and the provider’s values ultimately do not match, the patient can find a provider who is more in tune with his own values and the values of his family. The goal is to ensure that patients believe they have an advocate for their treatment goals who will perform a procedure or administer treatment according to their wishes. Moreover, because SDM includes sharing values and information, discussing potential treatments that are not allopathic is acceptable and a part of the process, although that is not always part of the discussion in traditional informed consent.
One size does not fit all patients or all situations

Although it may seem like the universal adoption of SDM in every aspect of care might be more advantageous than engaging in informed consent, there are good reasons we don’t “dump” informed consent and move toward universal SDM.

For example, in an emergency situation, the use of basic informed consent with family members may be considered sufficient. Furthermore, each patient/family member may want a different level of involvement regarding treatment decisions.

According to a 2004 study on the desire of patients to participate in decision-making, published in Annals of Internal Medicine, nearly all patients (96%) preferred to be offered choices and asked their opinions. This is significant because almost 3,000 respondents participated in this population-based survey of a representative sample of the U.S. population. However, 52% preferred to leave the final decision to their physician, and 44% wanted to rely on their physician for all information rather than seek out additional information themselves. Those preferring to exercise the most autonomy were typically women, healthier, and more highly educated.

Some older patients have been known to defer to their family’s wishes. The reasons vary: sometimes they don’t want to be a burden, sometimes they don’t fully understand the implications of the treatment options, or sometimes they are simply exhausted. Thus, not all patients want the same extent of involvement in their care.

Beyond the role of culture, personality also affects a patient’s level of involvement.

The following are true-life examples of two highly educated women, both of whom are attorneys. Both stories were directly related to me by the individuals involved. One reflected that, when she went through her bout with cancer, she was both too sick and too scared to make decisions. She needed someone to tell her what to do. She couldn’t process it all and felt it was a burden to be asked.

The other woman was involved in every detail of her cancer care. Her family researched with and for her and mapped out the medical options to discuss with the provider. According to her, “There is no shared decision-making. This is my body, and I make all the decisions.”

Two bright, educated women. Two totally different approaches to decision-making.

Which leads us to the wisdom that this process must be individualized. This wiser perspective, from both medical and medico-legal perspectives, is to encourage the building of strong relationships between patients and providers, so that medical choices are reflective of true communication and intelligent decision-making by the parties involved.

Ultimately, patients tend to feel that SDM is “real,” “caring,” and “about me, not about you.” It is possible that this perception is genuine and that it is more about how the discussion is conducted rather than about any of the information that is provided.

Implications for MPL

Although lack of informed consent can be a cause for legal action even when there is no injury, it is rarely invoked unless an injury has occurred. Furthermore, the literature supports that breakdown in communication is frequently a major factor in the decision to pursue litigation.

SDM processes require interactive and iterative communication to build the therapeutic relationship. By using patient-friendly decision tools to drive the decision-making conversation, as well as allocating time and energy to engage in effective communication about healthcare decisions, providers are likely to see a decrease in consent-related allegations. Furthermore, if we as a system can support financial rewards for providers who actively engage in this relationship-building decision process, we are likely to see collateral savings in fewer high-risk, low-yield procedures. Partnership is a two-way street. Professional liability thrives where the relationship is weakest.

What makes sense for the future?

Recognizing that we will always have to fulfill the requirements for informed consent as a baseline, perhaps it makes sense to augment the robust nature of that consent and advance the cause of patient-centered care, by including key elements of the SDM model. Informed consent and SDM do not need to be mutually exclusive.

References

3. King J, Moulton B. Group Health’s participation in a shared decision-making demonstration yielded lessons, such as role of culture change. Health Aff (Millwood). 2013;32(2):294-302.
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Looking Outside the Index for Structured Finance Investment Opportunities

BY THOMAS SWEENY AND LLOYD AYER

We believe this is especially the case for the structured finance world, thanks in part to its relatively small allocation in aggregate benchmarks, reflecting a less than 5% allocation in the more widely recognized fixed-income indices, such as the Bloomberg Barclays Aggregate Index.

This paltry allocation may make some investors think that structured finance is just a tiny piece of the fixed-income pie, but that isn’t the case. Instead, nearly $600 billion was issued in the structured finance market last year (Figure 1), and it remains a vital source of funding for a wide range of companies.¹

But while the issuance might be more than half a trillion dollars for the structured finance market, only approximately $120 billion made its way into reported indices, including the Bloomberg Barclays Aggregate Index. This leaves a sizable gap between the benchmark representation and what was actually available in the market.¹

This representation gap comes about because a variety of structured finance products are excluded from traditional indexes. The reasons for the exclusions vary by index, but they are usually focused on coupon type, private securitizations, and underlying securities asset. The combined impact is clear, though, as less than 10% of investable assets from the structured finance market found their way into aggregate benchmarks.

However, this lack of index representation and the fact that the market is overlooked could present investors with an investment that may complement their existing portfolios. With so many parties avoiding or glossing over the structured finance market, it may present an additional investment option for a diversified portfolio. That is, of

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course, if investors know where to look.

Where to look in structured finance
With only 10% of the total showing up in the broad benchmarks, there may be significant opportunities in the structured finance market that may be flying under the radar. One in particular that is worth highlighting at this time is collateralized loan obligations (CLOs), a segment that made up nearly 20% of structured finance issuance in 2017, but was virtually nonexistent in aggregate fixed-income benchmarks, as shown below.

There are several reasons why these actively managed pools of leveraged loans could be intriguing complements to traditional fixed-income portfolios. Not only does the sector have low correlations—based on analysis we conducted looking at correlations on total returns dating back to the start of the J.P. Morgan CLO index in 2012 versus major fixed-income asset classes—to other sectors of fixed income, their exclusion from traditional benchmarks may provide managers with strong research capabilities a chance to add value by selecting securities that may be poised to outperform traditional fixed-income sectors.

Diversification is also a key feature of CLOs, which may help in potentially reducing overall portfolio risk. In a typical structure, no single obligor makes up more than 2.5% of a given CLO either, so risks are well diversified from a company-specific perspective. Using Bloomberg information and based on our analysis of deals coming to market this year, on average, more than 80 issuers are represented in a typical CLO, with industry diversification principles taken into account as well, thereby spreading the portfolio’s risk profile.

Yield
In addition to the diversification of CLOs, investors should consider their yield. CLOs are generally tied to LIBOR and are typically less sensitive to interest-rate risks, because they are floating-rate structures, at least when compared to traditional long-duration fixed-income securities.

Consider a representative CLO capital stack (Figure 2). An average CLO (as of early second quarter 2018) may be heavily weighted to AAA-rated debt, which may target a yield of 100 basis points above LIBOR. However, it will also include lower-rated securities that, although in a less favorable credit position, help to boost yields. As Figure 2 shows, BBB-rated debt may offer up yields of 275 basis points above LIBOR, and although there is no guarantee these targets will be achieved, such returns can provide a nice income boost for investors, without materially changing the overall risk level in the portfolio.

By spreading out the holdings, while still being opportunistic when it comes to lower-rated securities, CLOs can offer the potential for higher yields without a proportionate increase in risk. This may potentially give CLOs an edge in terms of yield efficiency, at least when compared to other types of fixed-income instruments.

The bottom line
CLOs are attracting a renewed interest among the managers of insurance company portfolios, specifically among property/casualty insurers, not only as one element in their core/core+ strategies, but also as a satellite allocation through a separate account. Their RBC capital charge can make them capital efficient, while offering the potential for a higher-income opportunity, without taking on significant duration and default risk. This could be particularly important in an extreme rising-rate environment; having exposure to a floating-rate instrument may help preserve principal without sacrificing too much in terms of income.

CLOs, however, have grown in the past few years, which has led to some deterioration in investor protections. Along those lines, as some underlying loans are taking on more leverage, with fewer protections than in previous cycles, CLOs could experience higher losses in a future downturn. Furthermore, this asset class can be fairly illiquid, with higher trading costs relative to other similarly rated securities products.

With that said, CLOs have also proved to be a strong diversifying asset within a core investment-grade portfolio, given low correlations to other fixed-income sectors. The combination of favorable yields, high liquidity, and the ability to preserve surplus in rising-rate environments can make them a suitable option.

Footnote
1. Estimates are based on DWS comparison of 2017 issuance and Bloomberg Barclays Aggregate holdings, as of March 31, 2018.
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The Evolving Landscape of State Telemedicine Laws and Policies

Key Findings from a 50-State Telemedicine Survey

BY JACQUELINE MARKS AND RANDI SEIGEL

As the demand for telemedicine services continues to grow, states are implementing new policies related to the payment for, and provision of, care via telemedicine modalities for all patients. State Medicaid programs, other payers, and health systems across the country are increasingly relying on telemedicine technologies to address healthcare challenges, such as provider shortages, system capacity, and access to care. In response to this rapidly changing landscape,

Jacqueline Marks is a Manager, and Randi Seigel is a Partner, with Manatt Health Strategies.

Manatt Health conducted a comprehensive survey of state laws and Medicaid policies related to practice standards and licensure, Medicaid coverage and reimbursement, Medicaid-eligible patient settings, Medicaid-eligible provider settings, Medicaid-eligible technologies, Medicaid service limitations; and corporate practice of medicine across all 50 states and the District of Columbia.
Table 1 shows some terms and definitions thereof that are essential to understanding the present text.

The results of the survey revealed that nearly all state Medicaid fee-for-service (FFS) programs provide reimbursement for some telemedicine service, generally expanding access to telemedicine for their Medicaid FFS beneficiaries. While Medicaid managed care was not within the scope of the survey, because Medicaid managed care must generally adopt Medicaid FFS policies, in many cases the survey findings can be extrapolated as being the floor of the coverage available under Medicaid managed care.

The survey also highlighted that Medicaid FFS programs provide significantly more expansive coverage than what is available to Medicare beneficiaries. At this time, Medicare FFS provides coverage for telehealth for a very limited set of services that meet strict requirements related to the technology utilized, the originating site, and the provider type. Medicare only reimburses telehealth encounters for real-time audiovisual communications between providers and patients. Moreover, telemedicine services are covered only when the originating site is located in a rural area—either in a county outside of a metropolitan statistical area or in a health professional shortage area in a rural census tract—and when the originating site is a physician or practitioner office, a hospital, a critical access hospital (CAH), a rural health clinic, a Federally Qualified Health Center, a hospital-based or CAH-based renal dialysis center, a skilled nursing facility, or a community mental health center.

Only physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists or clinical social workers, and registered dietitians or nutrition professionals are eligible to receive reimbursement for the services provided. Accordingly, Medicare beneficiaries residing in urban areas do not have access to telehealth services.

Both overall and comparatively, state Medicaid FFS programs afford comprehensive coverage of telemedicine, allowing a broad range of services, providers, locations, and technologies that are eligible for reimbursement. Most states allow various types of providers to administer care via telemedicine, and few impose impactful restrictions on the types of services that can be provided through these modalities.

Key barriers and implications
Despite this notable progress, research revealed that in certain states, some major barriers to the provision of telemedicine services for Medicaid FFS beneficiaries remain.

- **Patient's home as a site of care.** Twenty six states’ Medicaid programs provide reimbursement for telemedicine services initiated from a patient’s home. The home is a critical access point for telemedicine services; it can help patients in rural or distant areas or who have mobility limitations connect with their providers without undue burden. This also enables health systems to increase clinic capacity by conducting routine follow-up or other visits that do not require a physical exam via live video conferencing (e.g., postsurgical follow-up or behavioral health therapy visits). Lack of Medicaid coverage for telemedicine originating from the home site likely deters providers and health systems from developing direct-to-consumer telemedicine programs, thus restricting patients’ access to care and limiting systems’ ability to transform care delivery through telemedicine.

- **Established patient relationship.** Nine states require a provider to have an established relationship with a patient before he/she can receive care via telemedicine, as a condition of reimbursement. In some states, such as Mississippi, an established relationship includes a prior physical exam. Established patient relationship requirements limit a patient’s ability to seek care via telemedicine for emergent issues. For example, if a patient suffers a non-acute injury but would like to seek immediate medical advice, he/she would not be able to receive care via telemedicine from any provider except the one who has previously treat-
ed them. This would preclude patients in states with such policies from seeking telemedicine care from a “white label” solution, such as the CVS MinuteClinic Video Visit platform. As a result, these patients may be required to receive in-person care from local urgent and emergency care settings, which, in many places, are already overcrowded. In addition, there are certain specialties, such dermatology and ophthalmology, where it would seem especially appropriate to allow telemedicine to be provided absent an established relationship.

- **Telepresenter.** As a condition for reimbursement, 10 states’ Medicaid programs require a medical assistant or provider to be physically present with a patient while he/she receives care from a distant-site provider via telemedicine; this assistant is often referred to as a telepresenter. This requirement imposes a major obstacle for patients, as their telemedicine visit is subject to a telepresenter’s availability and location. If the patient is not at an eligible site where a telepresenter is available to monitor the telemedicine visit, the patient’s care would not be reimbursed and providers may be unwilling to provide it. Because of the telepresenter requirement, patients are also precluded from initiating a telemedicine visit from their home or another nonclinical setting. This seriously undermines the availability of telemedicine for patients residing in rural communities or who have limited mobility or access to transportation—some of the patients who could benefit the most from telemedicine. Such policies also create staffing inefficiencies for providers and health systems. In order to meet the state telepresenter requirement, a medical assistant or provider must oversee a telemedicine visit rather than directly provide care to another patient at his site.

- **Beyond live video conferencing.** Nearly all state Medicaid programs provide coverage and reimbursement for live video conferencing, but fewer states reimburse for other telemedicine technologies, such as “store and forward,” remote patient monitoring, or e-mail/fax/phone. Twenty-nine states are reimbursing for at least one method in addition to live video, and 16 states are reimbursing for three of the four different telemedicine technologies (most states do not reimburse for care provided via e-mail/phone/fax). Expanding reimbursement to methods beyond live video enables both providers and patients the opportunity to engage in non-urgent telemedicine care, such as glucose monitoring for diabetic patients via remote patient tools.

- **Frequency limits.** Nine states place limits on the frequency with which Medicaid patients can receive care via telemedicine within a given timeframe. For example, Georgia limits hospital services to one telemedicine visit per patient every three days, and nursing facilities are restricted to one telemedicine visit per patient every 30 days. While many patients may need to access care via telemedicine only sporadically, such limits can place unnecessary barriers to care for patients with chronic conditions who may need to seek via telemedicine because they are located remotely from their providers or are frail.

- **Geographic limits.** Nine states’ Medicaid programs place geographic restrictions on telemedicine encounters. In these states, reimbursement within the Medicaid program is dependent upon the distance between the patient or originating site provider (spoke site) and the remote provider (hub site). For example, in Indiana, the state reimburses for telemedicine services only when the hub and spoke sites are greater than 20 miles apart. Under this policy, a provider at a major academic medical center would not receive reimbursement for a virtual consult conducted with a provider and Medicaid patient at a nearby community hospital, despite the fact that such a service could help the hospital retain the patient and avoid an unnecessary transfer. Additionally, geographic limits prevent patients located in rural areas from digitally connecting to care through telemedicine, although this is arguably one of the most valuable benefits of telemedicine.

**Looking ahead—telemedicine as a critical-care delivery tool**

States may implement the restrictive policies noted above for a variety of reasons—fear of overutilization leading to skyrocketing costs, new technology, and risk. There is little evidence to date that validates those concerns. Conversely, health systems have indicated that telemedicine programs and solutions are reaping the positive benefits of the technologies—increased clinic and in-patient capacity, reduced hospital readmissions, and increased patient satisfaction and quality of care, among others.

Telemedicine will be central to the role of healthcare delivery in the future. We predict that over time, as the evidence-base grows and patient demand for telemedicine increases, all payers (including state Medicaid programs) will continuously re-evaluate their telemedicine reimbursement policies and take proactive steps to reduce barriers to care and expand access to digitally enabled care.

**For related information, see www.manatt.com/Insights/Newsletters/Manatt-on-Health/State-Policy-Levers-for-Telehealth-50-State-Survey.**

**Notes**

1. Unless otherwise noted, the scope of this survey and the findings included in this article are limited to Medicaid fee-for-service. This is a known limitation given that many states are transitioning large portions of their Medicaid populations into managed care plans.

2. The Proposed Rule, Medicare Program; Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B, released on July 12, 2018, if adopted, substantially expands the reimbursement for certain technology—based services that fall outside of the statutory definition of telehealth.

3. Asynchronous “store and forward” services are reimbursed by the federal telemedicine demonstration programs only in Alaska and Hawaii.
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Actuaries must deal with uncertainty in calculating loss projections and estimating loss and loss adjustment expense (LAE) reserves. We can assess how actuaries view the riskiness of different lines of business by examining specific disclosures in the Statement of Actuarial Opinion (SAO) which provide loss and LAE reserve information. For insurers specializing in medical professional liability (MPL) insurance, actuaries appear to report more uncertainty in estimating unpaid losses, which is consistent with the higher volatility evident in historical loss development. There is also a maze of state-specific issues that actuaries have to work through when performing their loss reserve analyses.

**MPL losses are uncertain—the evidence**

A loss development comparison reveals that MPL is a risky line of business relative to other insurance lines. Schedule P, Part 2, of the statutory annual statement shows estimates of net incurred loss and defense and cost containment expense (DCC) over time for 10 accident years. Figure 1
shows the percentage change in the initial loss estimate for an accident year compared to the estimate 10 years later. These estimates consist of paid loss and DCC, case reserves, and held IBNR at year end.

Note that for accident years in the early 1990s and the late 2000s, loss estimates for MPL decreased considerably, which indicates that initial loss estimates were too high. However, for accident years 1998–2001, loss estimates increased substantially and in some years exceeded 20%. While homeowners/farm-owners (HO/FO) and private passenger auto liability (PPAL) experienced some volatility in loss estimates, the magnitude of the adjustments was minor when compared to MPL.

Since they work with greater uncertainty, insurers writing MPL have less premium leverage than others. Table 1 shows the average net written premium (NWP) to policyholder surplus (PHS) ratio (IRIS 2) for companies with more than 50% of premiums in a single line. Given that personal auto insurance is relatively more predictable than MPL, it is likely that less surplus is needed to protect policyholders, and personal auto writers can be more aggressive in taking on more underwriting risk per dollar of surplus.

**Actuarial disclosures in SAOs**

As part of the statutory annual statement, insurers’ appointed actuaries must file an SAO opining on the reasonableness of held loss and LAE reserves on the balance sheet. The opinion includes disclosures that provide insight on the level of uncertainty in the estimated unpaid losses. Many of these disclosures are tied to the Risk of Material Adverse Deviation (RMAD). The RMAD is a “yes or no question,” to which the opining the actuary must respond to the question of whether he believes that there are significant risks that could result in a “material” adverse deviation in reserves. The definition of what is a material adverse deviation is also determined by the appointed actuary. We can gain further insight into the differences between MPL writers and other insurers by comparing these disclosures.

Before responding to the RMAD question, the appointed actuary must first choose a materiality threshold that reflects the unique nature of the insurer. For example, the actuary may decide an insurer with impaired policyholder surplus would not be able to withstand much adverse loss development. In this case, the actuary could determine that if reserves increase by more than 5% of surplus, the adverse development would be “material.” Separately, if the insurer writes riskier lines (like MPL) where considerable adverse development is possible (Figure 1), a larger threshold

**Table 1. IRIS Ratio 2, by Line of Business**

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>IRIS 2 (NWP / PHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HO / FO</td>
<td>1.07</td>
</tr>
<tr>
<td>Personal Auto</td>
<td>1.59</td>
</tr>
<tr>
<td>Workers’ Comp</td>
<td>0.81</td>
</tr>
<tr>
<td>MPL</td>
<td>0.41</td>
</tr>
</tbody>
</table>

Source: S&P Global Market Intelligence
might be used to designate loss development as material.

Table 2 shows the choice of threshold by the appointed actuaries at insurers that had more than 50% of premiums in a single line of coverage. In fact, it appears that actuaries for MPL insurers do choose a higher materiality threshold, since small changes in loss estimates, in relation to PHS, are not as meaningful as they are for more predictable lines like HO/FO.

Once the appointed actuary selects the materiality threshold, he must then say whether or not there is an RMAD. Table 3 shows the RMAD disclosures by insurer type. Actuaries are more likely to acknowledge that MPL reserves can move significantly by stating that there is an RMAD, despite the fact that the materiality threshold is higher, on average, for MPL insurers. The results also show that workers’ compensation insurers disclose affirmative RMAD more frequently than MPL companies; however, Table 2 shows that the selected thresholds also tend to be lower.

What are the risk factors for MPL writers?

SAOs contain a significant amount of qualitative information that can be valuable in understanding uncertainty and in assessing the financial strength of an insurance company. The SAO contains a required section in which the appointed actuary must disclose risk factors—the combinations of risk factors or conditions relevant to the statutory entity. Understanding the risks faced by the MPL writer can help the company and its appointed actuary determine if there is an RMAD given its selected materiality threshold.

We reviewed several SAOs of the top MPL insurance writers, as well as several opinions from writers whose MPL book of business had adverse development in 2017. Among the largest MPL writers, there was substantial focus on its long-tailed reserves, the high coverage limits, and concentration risk by line and geographically. There were many additional risk factors mentioned across the opinions, but we’ll review these three key factors in more detail.

Long-tailed. MPL is considered a long-tailed line of insurance because claims can take a long time to be reported and, once reported, may take a long time to reach final settlement (Figure 2). There is also exposure to substantial amounts of LAE arising from the duty to defend a claim, even if the claim is ultimately settled for $0 of indemnity. For most MPL insurers, the latency in realizing the ultimate claims settlement value is a key consideration in determining whether their reserves have a significant RMAD.

The longer-term nature of MPL has a direct effect on ratemaking uncertainty. For short-tailed lines, losses are paid out quickly and the insurer can use the prompt feedback to adjust premiums. With long-tailed lines like MPL, it may take many years for an insurer to accurately estimate its ultimate claims once an exposure period expires. In the event that its reserves were deficient, the insurer’s financial results could suffer from underpricing for several years.

High limits. The high-severity nature itself of MPL claims can cause uncertainty in regard to a company’s held reserves. Consider a company that writes MPL coverage with $1 million per-claim limits. The company will have potential for late reported claims up to the claims limit and/or exposure on a direct basis to the extent its reinsurer fails. The MPL coverage that purchasers will most likely desire has high coverage limits, so offering lower ones isn’t a suitable remedy for this risk factor.
Concentration risk. Concentration risk can refer to the fact that a company has a large percentage of its writings in MPL or in a particular state or region (Table 4). In MPL, the fact that several companies write only MPL and only in a single state is a combination of risk factors often mentioned in SAOs. Writing within a particular state exposes the insured to risks such as adverse court decisions and other jurisdictional risks. Writing only MPL coverage can mean an absence of the diversification many large insurers have in the event their overall experience of the MPL book of business starts to deteriorate.

The presence of these risk factors does not imply a company is unhealthy; on the contrary, these are risk factors most of the country’s major MPL insurers face. Sometimes these risk factors can actually indicate a solid company due to the focus inherent in their operations. For example, barring an adverse court decision, a company specializing in writing MPL in a particular state may have a breadth of legal and insurance knowledge that makes it possible to offer its insureds the highest-quality coverage.

In our review of the companies with the highest dollar amounts of adverse deviation in 2017, we noticed that many of these insurers mentioned risk factors that were unique to their books of business. This makes some sense, as their reserves are deteriorating. Among risk factors cited by this group are change in mix of business, tort reform (or lack thereof), and specific factors such as opioid-related risks.

For companies whose reserve position is deteriorating, more specific risk factors will better communicate the risk of RMAD to their boards of directors and regulators. Specific legislative changes would affect writers in specific states and perhaps have substantially different impacts on insurers that write specific specialties. Multiple SAOs cited an example involving recent New York legislation. A bill known as “Lavern’s Law” lengthened the statute of limitations for certain cancer diagnosis-related claims. The ambiguity related to this law was listed as a specific risk factor that could lead to material adverse deviation.

**Conclusion**

MPL may be considered risky when compared to other lines of business; in particular, Figure 1 shows that MPL loss and LAE reserves are inherently uncertain. Additional information disclosed by appointed actuaries in SAOs underscores the relative risk of MPL. Actuaries appear to select higher materiality thresholds, more often disclose the RMAD, and mention unique risk factors that are specific to MPL. These disclosures provide an important communication tool for actuaries, insurance company management, and regulators.

**Footnotes**

1. Schedule P shows incurred loss patterns by accident year separately for MPL-occurrence and MPL-claims-made. The loss development patterns illustrated in Figures 1 and 2 are similar for the two coverage types.
2. The results shown here are from SAOs for insurers with more than $20 million of net earned premium for 2015, or 1,110 insurers.
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Medical Professional Liability Risks Associated with Medical Office Staffs

When Medscape published an article (July 10, 2018) on the various kinds of risks that healthcare practices may encounter in using non-physician staff members, Inside Medical Liability deemed that an especially important topic for all of our readers. We asked Hayes V. Whiteside, MD, Chief Medical Officer and Senior Vice President of Risk Resources at ProAssurance, who had contributed to the Medscape piece, to respond to several follow-on questions of potential importance for medical professional liability (MPL) entities. Below are those questions, with the corresponding answers.

**Inside Medical Liability: Are physicians responsible for what their medical assistants (MAs) do and do not do? And are some doctors not aware of this responsibility?**

**Whiteside:** There are legal and “non-legal” answer to this question. From a “non-legal” perspective, the actions of every employee in a practice setting reflect on the physician(s) in that practice. Thus, it’s vitally important that everyone in the practice understand and embrace a culture that seeks to maximize patient satisfaction and supports an optimal provider-patient relationship. From a legal standpoint, a physician may have direct liability for the conduct of his MAs if a lawsuit alleges negligent hiring (for example, not checking references or verifying education), negligent training (if the physician undertakes training), or negligent supervision (if, for example, there is no supervision of the assistant). The physician may also have indirect liability if he is the owner of the practice and the practice is liable for the conduct of the employees under the legal doctrine of respondeat superior, colloquially known as “captain of the ship.” However, if the physician is not an owner, it may be possible for the assistant to be found negligent for some act or omission and the physician to have no liability.

**IML: MAs perform such a wide range of duties. How can a physician monitor all of them?**

**Whiteside:** Physicians have to be able to rely on the assistants to perform their duties without constant personal oversight—otherwise, there would be no point in having an assistant. However, there should still be a certain level of oversight commensurate with the experience and competence of the MA. We recommend proctoring new assistants, conducting regular evaluations, and providing opportunities to maintain or enhance skills through continuing education. For certain clinical functions, like taking patient information, for example, physicians may review the same information taken by the assistant to ensure the information is complete. This may explain why patients may be asked the same question twice.

The practice environment should be such that MAs feel free to admit when a mistake is made. If the practice environment is not conducive to honest, open communication between the MA and the physicians, MAs will be more likely to keep quiet and hope no one notices. In that case, the first sign that a mistake was made could well be when a lawsuit is filed after a patient is injured.
**IML:** You have said, "Staff who have only basic clinical training may not be able to prevent a malpractice issue, but they sure can cause one." Can you provide some examples of especially egregious practices that might result in awards to plaintiffs?

**Whiteside:** One of the most common examples we see is the incorrect administration of medicine, such as when a patient has a known drug allergy. Wrong dosage, wrong medicine, and wrong vaccine can all lead to MPL issues. There are many common situations where this can occur. For example, a nurse might administer the maximum dosage of Dilaudid even though the patient was wearing a Fentanyl patch, which would ultimately lead to an error. In a surgical setting, a lack of training or communication can lead to a retained foreign object after surgery due to non-adherence to counting procedures. Lawsuits often emerge from situations in which patients, such as a woman in labor, are improperly monitored or the medical staff lacks the training needed to recognize a medical emergency and respond appropriately. With the proliferation of electronic medical records (EMRs), the improper or insufficient entry of information into an EMR can result in mistakes being made in subsequent treatment, thus exposing the practice to a greater risk of liability.

One example of a very poor outcome that resulted in settlement involved staff giving a pediatric patient Pediasure when the child had a known milk allergy. Subsequently, the child went into anaphylactic shock and died. Not only should the staff not have given the child the drink due to the allergy, but it was also against the office policy for staff to give any food or drink to a patient in the office.

Another situation that was difficult to defend involved an MA in a home health setting who entered the wrong home to draw blood on the wrong patient. This type of unnecessary mistake resulted in settlement, but the group could have avoided this mistake with proper training and procedures.

**IML:** What challenges are there in the office setting that make ensuring (for example) continuity of care more difficult?

**Whiteside:** Office-based practices must acknowledge and develop policies and procedures for the continuity of care among all providers and employees in the office. A physician may have a variety of experience and education levels in his practice, and knowing how to work together is vital to a successful practice. From the receptionist training the patients, to the MA taking vital signs and an accurate history and physical (H&P), to the nurse and physician who develop a treatment plan for the patients, the entire staff must be engaged and know their scope of practice. The practice must complete and document routine evaluation of employees’ skills and competencies. Proper training for tracking and follow-up, such as with referrals or appointments, may be a necessary component of training for all staff members.

**IML:** I have read that medicines and in particular injectable treatments pose a particular risk in using MAs. Why is this so?

**Whiteside:** Because MAs are not typically licensed employees, the key to ensuring they are acting within the prescribed scope of practice and at the highest level of competency, is specific on-the-job training and continuing education. With proper initial training and documentation of competency and proficiency, physicians can manage their liability in these circumstances.

One case in particular involved an MA and Rocephin injections where the patient had a known drug allergy to Cefadroxil, which is a drug much like Rocephin. Upon direction of the PA, the MA administered the Rocephin injection, and the patient had a severe allergic reaction. The defense of this case was difficult because the MA who administered the injections documented two different versions of the note. Proper training for not only administering injectable treatments but also education in how to appropriately document the medical record is vital to managing the risks associated with MAs.

**IML:** Transcribing information is also cited as a procedure prone to error. Do you agree?

**Whiteside:** Transcription is a helpful, time-saving tool that, if used properly, allows a physician to focus more on patient interactions than medical record-keeping. However, whenever a physician is relying on an employee or software for transcription of dictated medical information, there is a risk of error. Transposition of numbers, typographical errors, or the selection of the wrong medical term can have serious effects on patient safety. Often, when an error makes its way into a patient’s chart, it tends to be reproduced and repeated with each return office visit. That is why implementing a stringent proofreading protocol is of extreme importance.

For instance, a jury rendered a $140 million award against a hospital in Alabama, which used a foreign company to transcribe dictation made by its physicians. In that case, the service transcribed the physician’s discharge order, and the transcription included incorrect medication-dosage information for the patient. This critical error caused the patient to receive a dose of Levemir that was 10 times what the physician intended, which was fatal. This result would likely have been avoidable had the hospital implemented an effective proofreading protocol.

**IML:** What other measures do you think would ensure the safe use of MAs, given that they may have only minimal training?

**Whiteside:** Unlicensed employees must be educated about what falls within the scope of practice of licensed professionals (i.e., physicians and nurses) and unlicensed employees. Clearly defining an unlicensed employee’s responsibilities in a job description helps MAs understand the precise functions they are expected to perform. Unlicensed employees should be evaluated by a supervisor on a regular basis to assess their need for additional education and training. It is helpful to make a proficiency checklist covering the tasks required in the employee’s job description. These checklists document an unlicensed employee’s demonstrated proficiency in completing assigned tasks, and can serve as powerful evidence that the practice appropriately educated and trained the unlicensed employee.
Injection Errors: A U.K. Perspective on Causation and Prevention

Editor’s note: This article is based on an article published on the Medical Protection Society website.

A common cause of claims at Medical Protection is injection errors. While the monetary amounts involved have generally been low, they frequently cause anxiety to both patients and clinicians. But they are in fact easily avoided. This article looks at some typical cases, and explains how they might have been avoided.

By Dr. Dawn McGuire

Case study 1: wrong injection

Ms. F. attended an appointment for a three-monthly vitamin B12 injection. At the time when the appointment was made, the receptionist had entered the reason for it as “Depo injection.” Nurse C. proceeded to administer Depo-Provera, a contraceptive injection. She did not confirm with Ms. F. her reason for her appointment that day, nor did she check on the patient’s prescription history.

Only after the injection had been administered did Nurse C. realize that vitamin B12 had been recently prescribed for Ms. F., and her fears about the mix-up were confirmed when she clarified with Ms. F. the actual reason for her visit to the practice.

Subsequently, Ms. F. complained about Nurse C. and the practice apologized. Then, a significant-event analysis was conducted by the practice, so that everyone could learn from it.

However, Ms. F. instructed a solicitor to pursue a claim against Nurse C. In her complaint, Ms. F. alleged anxiety and mental distress from the injection of a birth control agent, because she was trying to conceive. Her solicitors obtained a condition-and-prognosis report from a consultant psychiatrist, whose diagnosis was that Ms. F. had an adjustment disorder that required a course of cognitive behavioral therapy.

Nurse C. did not have her own indemnity, but all three GP partners were Medical Protection members. This claim was therefore handled on a vicarious-liability basis.

The claim was settled for

Dr. Dawn McGuire is Medical Claims Adviser at the Medical Protection Society.
£5,500 ($7,204) in damages for Ms. F. Medical Protection was also liable for the solicitors’ cost, approximately £20,000 ($26,210).

**Medico-legal insight**

Over the last 12 months, Medical Protection has been notified of 10 similar claims, in England and Wales alone.

The most common mistake in these cases involved vitamin B12, used for vitamin B12 deficiency or pernicious anemia, and Depo-Provera; both of these are usually administered every three months. Other injections that were wrongly administered were the flu vaccination, depot antipsychotic medication, and Prostap, which is administered for prostate cancer, endometriosis, and uterine fibroids.

Injections can also be administered in the wrong site. The most common error is the administration of steroid injections (for example, Kenalog) in the deltoid muscle or thigh, instead of in the gluteal muscle.

Deep intramuscular injections must be given into the large muscles of the buttock. They should not be administered into the upper arm or the thigh, because this can result in unsightly lipid dystrophy.

For these sorts of claims, the minimum damages (monies paid to the patient) typically start from a low of £1,500 ($1,964) with a range that varies depending on the side effects experienced. The solicitors’ costs are usually higher.

**Learning points**

- Always check with the patient about the reason for their visit, and also check on their prescription history.
- Remind ancillary staff (nurses and healthcare assistants) who undertake these duties to be vigilant about these common errors.
- Bear in mind that GP partners may be liable for their nurses’ actions.

**Case study 2: flu vaccination administered with used needle**

Dr. A., a Foundation Year 2 doctor on general practice rotation, gave two patients their flu vaccinations at the time when they visited for the management of their chronic disease. Dr. A. then re-sheathed the syringes, and left them in the packs with the other unused syringes, as a memory aid to remind him to enter the flu vaccination code into the patients’ medical records later. He wrote the patients’ names on the label of the syringe, but then forgot to follow up as intended.

At the end of the clinic hours, the healthcare assistant collected the flu vaccination tray from Dr. A.’s consultation room and placed it back in the refrigerator, ready for the next day.

The next morning, Dr. O. saw Mr. P., for depression, and gave him his flu vaccination. After the needle had been inserted into Mr. P.’s arm, Dr. O. noticed that she was unable to depress the plunger of the syringe to administer the vaccine. It was then that she noticed that two of the syringes in the pack were empty but were labeled with patients’...
Dr. O. immediately informed Mr. P. of the error and apologized. She then proceeded to give Mr. P. the correct flu vaccination. Public health advice was sought, and a full serious-untoward-event investigation was undertaken within the practice. Mr. P., as well as the original two patients, underwent tests for HIV and hepatitis, all of which eventually came back negative. Mr. P. was advised to receive HIV-suppres- santt medication and hepatitis B vaccination while waiting for the final results.

Eight months after the incident, Dr. O. received a letter of claim from a solicitor’s firm, alleging clinical negligence and requesting £7,000 ($9,174) in damages. Medical Protection settled the claim, with a contribution from NHS Resolution, on behalf of Dr. A.

**Medico-legal insight**

In this situation, the pre-filled flu vaccination syringes came in packs of five, with needles attached. They are for single use only. Once administered, they must be disposed of in the needles waste container immediately.

During the last flu vaccination season (September to December 2017), Medical Protection was notified of three claims in which a used needle was readministered. In all three cases, the staff who administered the initial flu vaccination had re-sheathed the syringe and left it in the pack with the other unused syringes, which led to the subsequent inadvertent incidents.

In their claims, patients typically claimed severe distress and anxiety, because they had to undergo infectious disease screening and vaccinations (HIV and hepatitis B and C) for a period of six months. Fortunately, none of the claims we have received so far have resulted in transmission of these blood-borne diseases.

Damages typically range between £5,000 to £10,000 ($6,550 to $13,100), excluding solicitors’ costs.

**Learning points**

- Always dispose of used flu vaccinations immediately, and remind nursing staff and health-care assistants to do the same.
- If the nursing staff/health-care assistants do not have their own indemnity, the practice partners may become subject to clinical negligence claims based on the principle of vicarious liability.

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**For related information, see www.medicalprotection.org.**

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**Footnote**

1. The NHS foundation program is part of the continuum of medical education. It ensures that newly qualified doctors develop their clinical and professional skills in the workplace in readiness for core, specialty, or general practice training. Foundation Year 2 professionals begin to make management decisions as part of their progress towards independent practice.
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With the National Association of Insurance Commissioners (NAIC) finalizing its Insurance Data Security Model Law, many insurance entities are focusing on how and when their states’ regulatory agencies will apply the model law’s cybersecurity risk management and notification requirements. Ultimately, however, regulatory compliance should be viewed as but one aspect of a robust and multifaceted cybersecurity strategy.

The NAIC model law—why it matters
The final release of the NAIC’s Insurance Data Security Model Law is the culmination of two years of debate and development, as part of an effort to establish uniform industry standards and practices regarding the protection of consumers’ personally identifiable information. Regulatory requirements for protecting consumer data and responding to breaches vary from state to state, so one of the chief objectives of the NAIC has been to improve consistency across various jurisdictions.

This consistency in language is particularly important since several states—most notably, New York—have been developing their own cybersecurity risk management and notification requirements. To avoid further complicating things for insurance companies operating in more than one state, the final NAIC model law specifies that if a company is in compliance with New York’s Cybersecurity Requirements for Financial Services Companies, it should be considered in compliance with the NAIC model law requirements.

The model law was passed by the NAIC in October 2017. It has since been passed into law by at least one state and is on the docket for all other states to pass it into law soon.

The NAIC model law—a closer look
The development of the NAIC model law generated considerable discussion in the insurance industry as competing standards, principles, and ideas were suggested, debated, and ultimately resolved. The foundation for the model law is found in several earlier NAIC documents, including the NAIC Principles for Effective Cybersecurity Insurance Regulatory Guidance, adopted in April 2015. This document was not a law or suggested legislation, but rather a set of 12 guiding principles for state insurance regulators, insurers, and producers to follow as they set out to establish standards for protecting consumers and their data.

Another 2015 document, issued later in the year, was the NAIC Roadmap for Cybersecurity Consumer Protections. This road map contained a series of recommendations outlining a “bill of rights” for consumers regarding the protection of their personal and financial data.

The final NAIC Insurance Data Security Model Law incorporates the earlier principles and road map documents and expands upon them. Following are some of the most significant provisions:

- The model law requires all insurance licensees doing business in the state to develop, implement, and maintain a comprehensive written-information security program.
- Exceptions are made for licensees with fewer than 10 employees, and for employees, agents, representatives, or designees who are already covered by another licensee’s information security program.

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The model law requires that the written information security program must contain “administrative, technical, and physical safeguards” for the protection of nonpublic information. The program must also be commensurate with the size and complexity of the licensee, the nature and scope of its activities, and the sensitivity of the nonpublic information that is in its control, either directly or through third-party providers.

Licensees are required to perform annual risk assessments to evaluate the effectiveness of key controls, systems, and procedures, and must submit an annual certification to the state's insurance commissioner certifying that the company is in compliance with all of the security-program requirements.

Depending on the findings of the risk assessment, licensees must implement appropriate security measures such as access and authentication controls, physical access restrictions, encryption, testing and monitoring of systems to detect attacks and intrusions, and measures to protect against the destruction, loss, or damage of such information.

The licensee’s information security program must include a written incident response plan designed for a prompt response to, or recovery from, any cybersecurity event that compromises nonpublic information or the company's information system itself.

When a licensee discovers a data breach or cybersecurity event, it must notify its state insurance commissioner within 72 hours. If the breach affects the records of 250 or more residents of another jurisdiction, the licensee must notify that state's officials as well.

Rather than spelling out specific requirements for notifying affected consumers when a breach occurs, the model law defers to each state's existing data breach notification laws.

The model law establishes oversight responsibilities for a company's board of directors as well as specific details regarding third-party risk management requirements. It also includes an extensive list of standard definitions and general requirements, as well as details that must be included in each company's information security plan.

The model law does not spell out penalties for violations, but instead defers to each state's existing general penalty statutes.

As mentioned earlier, any licensee that is in compliance with New York's “Cybersecurity Requirements for Financial Services Companies” will be considered to be in compliance with this law as well. In addition, a licensee that maintains an information security program that meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA) will also be considered to be in compliance with the information security program requirements, but it must submit a written statement certifying its compliance.

The bigger picture—IT risk management

The adoption of the NAIC model law is part of a broader industry trend that has seen regulatory requirements related to cybersecurity become increasingly specific and far-reaching. The cybersecurity regulations issued by the New York State Department of Financial Services and recent updates to HIPAA guidance are examples of this heightened concern over cybersecurity. Knowing this, virtually all insurance-related businesses should already be making plans and studying what other regulated industries have done to adopt effective cybersecurity measures.

It is important to understand, however, that regulatory compliance is only one component of the overall risk management environment. The need for compliance is an important consideration, and often serves as the driving force for securing necessary resources. But a successful approach will look beyond compliance to take a broader, more holistic view.

The overall goal of a cybersecurity program—and of IT risk management in general—is to provide for the confidentiality, integrity, and availability of information assets. Typically, this involves numerous complex and highly interrelated components, as depicted in Figure 1.

The complex challenge of IT risk management can be made less overwhelming by organizing the effort into four broad steps or phases:

1. Conduct a risk and threat assessment. Inventory the relevant assets including applications, infrastructure, documentation, and third parties. Then evaluate the likelihood and potential impact of various types of incidents such as a breach or theft of data, as well as the effectiveness of existing controls designed to reduce the likelihood that an attack would be successful.

2. Define control objectives. Implement a unified control framework, whether based on the National Institute of Standards and Technology (NIST) framework or some other foundation. The framework should define the necessary controls to manage the identified risks.
3. **Implement risk management programs.** Implement programs to effectuate the control objectives and to manage the identified risks. One way to reduce the average cost of a breach is to have a dedicated incident response team in place, which decreases cost by improving the effectiveness and efficiency of the organization’s responsiveness and reducing the overall impact when an incident occurs. Nevertheless, a significant number of organizations have no breach response plan in place, and even more have plans that have not been updated recently.

In addition to the specific cybersecurity risk management programs illustrated in Figure 1, an effective overall third-party risk management effort is also important. Most organizations perform minimal oversight of their vendors’ control environments—a potentially costly weakness. A study by the Ponemon Institute found that third-party involvement in the cause of a data breach increased the average cost to the organization by almost 9% (from $158 per record when third parties were not involved to $172 per record when they were).²

4. **Conduct security assessments.** Use strong internal audit practices, penetration testing, and other security assessments that are already in place, and independently evaluate the effectiveness of its risk management programs.

In the longer term, these specific steps can help support companies’ efforts to pursue a more strategic approach to risk management. Such a strategic approach will also include analysis of residual risk as part of the process of defining each organization’s overall risk appetite and tolerance. Building on that understanding, companies can then determine the appropriate treatment strategy—avoid, transfer, mitigate, or accept—for each of the identified gaps or unacceptable risks.

**Security awareness—a shared responsibility**

Although the adoption of the NAIC model law has driven much of the recent discussion of cybersecurity issues in the insurance industry, it is important to recognize that cybersecurity is more than just a topic of passing concern. Rather, it is an ongoing, long-term challenge that requires strategic-level planning and commitment, along with consistent application of risk management practices.

As technological advances continue to accelerate, both the advantages and the risks will continue to increase. To deal with cybersecurity risk effectively—and to avoid becoming the next data breach headline—there must be an enterprise-wide recognition that cybersecurity is not just the concern of the risk management or IT functions. Instead, security awareness is everyone’s responsibility, and everyone has a stake in effectively managing the risk. KOL

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**References**


2 Ibid.
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It’s no secret that the medical professional liability (MPL) insurance market is in the midst of a difficult business climate. In addition to a shrinking market, today’s MPL carriers are facing a challenging reality about available talent.

Growing vacancies resulting from impending mass retirements and a widening talent gap are exacerbated by the scarcity of emerging professionals interested in joining the industry. There is simply not enough talent within the MPL pool to keep up with the demand.

In order to compete amid this challenging business and recruiting climate, MPL carriers must look beyond the confines of their specialization. The larger property/casualty (P/C) insurance market provides a valuable source of professionals who can offer diverse perspectives, drive innovation, and ensure future success.

Understanding the insurance labor market

Unfortunately, the competition is equally fierce in the greater insurance market. Retiring baby boomers and virtually nonexistent unemployment, combined with continued industry growth, are deepening the talent crisis. According to the 2018 Mid-Year U.S. Insurance Labor Outlook Study, recently conducted by The Jacobson Group and Ward Group, 62.6% of surveyed P/C insurers plan to increase staff during the next 12 months. Conversely, only 5.5% have plans to decrease their staff size.

Staff increases are mainly ascribed to higher volumes of business and expansion into new markets. The P/C insurance industry is growing; all insurers expect to maintain or increase their revenues in the next 12 months. More than half of those companies cited increased market share as the primary reason, followed by economic expansion and pricing increases, at 24.8% and 25.3%, respectively. P/C insurers are also growing their workforces at a faster rate than they previously anticipated. According to the survey, they have increased their employee base by 0.90% since July 2017, versus an anticipated rate of 0.79%.

Today’s insurers are tasked with closing the growing skills gap created by cuts to training programs made during the past decade that have intensified as tenured baby boomers vacate their long-held leadership roles. It is no surprise that executive positions topped the list of the P/C industry’s most difficult-to-recruit-for roles, at a rating of 6.9 out of 10.

This issue extends deeply to the MPL industry, as well. It has become increasingly difficult to find the right talent to fill its executive ranks. Industry-wide, there is undoubtedly a shortage at the mid-level as driven professionals left the industry when retirements were postponed and growth opportunities grew scarce during the recent recession. Unfortunately, the bench of talented leaders is sparse. Attracting and recruiting experienced and aspiring leaders capable of excelling in an evolving industry is even more challenging. The MPL industry must look outside its confines and possibly outside the insurance industry for its future leaders.

Filling technology positions is a priority for the P/C industry. Technology is streamlining time-consuming tasks and increasing the amount of information available to the MPL industry, redefining how they approach risk management and other functions enterprise-wide. The recent Insurance Labor Outlook Study reveals that the technology function is the area of highest demand for P/C insurers, with the claims function trailing only a tenth of a point behind. Claims remains of utmost importance for the greater P/C industry. The claims area is where the company’s promises are kept; and the function serves as a competitive differentiator, playing a critical role in delivering exceptional customer service and, ultimately, maintaining market share. P/C claims recruiting difficulty, which has historically hovered around a 5 rating, was reported at 5.4, an increase of 0.6 since January 2018.

Attracting talent to the MPL market

The MPL industry has a proud and inspiring story to tell. People are attracted to mission-driven organizations and look for social value and...
impact in their work. MPL carriers protect healthcare professionals during difficult times and help them practice medicine more safely. Leveraging authentic messages to illustrate these values to the insurance industry and the public is one step toward motivating others to join the cause.

The MPL industry must also ensure it is establishing an attractive culture to strengthen its employer brands and move its companies forward. Though only one element of a company culture, flexible and fluid work environments are no longer considered “nice-to-have,” but are becoming a requirement in this competitive talent marketplace. Integrated telecommunication devices and cloud sharing platforms allow employees to collaborate and communicate freely regardless of location; and many leading industries have already adopted flexible work arrangements to expand talent pools beyond geographical constraints. According to a Gallup survey, 43% of employed Americans spend at least some time working remotely. Breaking free of location boundaries will allow the MPL industry to consider candidates who do not wish to or cannot relocate, thereby expanding its candidate reach even further.

In addition, providing flexible work schedules can improve employee morale, engagement, and commitment. Flexible work hours allow employees to achieve a better balance between their personal and family needs and their careers. Employees appreciate having control over their work schedules, ultimately improving employee engagement, reducing turnover rates, and building a stronger employer brand to attract more qualified candidates to the table.

It is important to recognize, though, that not everyone wants the same benefits. Some employees may value the addition of paid volunteer days, while others may favor paid study days as they prepare for industry certifications. Some employees may be looking for financial planning resources, while others may welcome a subsidized gym membership. Some organizations are opting for benefits personalization, allowing individuals to select the perks they desire most from a menu of options. It is important to understand what benefits your employees value most and accurately reflect their wide range of preferences. Transparent and ongoing communication with staff is key. A unique and creative approach to benefits will certainly attract more candidates, while improving retention rates and employee-satisfaction levels.

A competitive compensation package is equally important in a candidate-driven market. High performers, who are content in their current roles, are not likely to make a move without significant financial incentives. Insurers may need to revisit their compensation structures to continue attracting—and retaining—quality talent.

The challenging talent climate is likely to persist, as the MPL industry’s current talent pool is no longer capable of supplying enough of the right professionals to propel organizations into the future. To thrive in this candidate-driven market, MPL organizations must look beyond their specialty line and into the larger insurance candidate pool. Bringing in diverse perspectives from the P/C industry will support innovation and business growth, allowing MPL insurers to continue advocating for healthcare professionals for years to come.
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I t is, therefore, a good time to look at the current composition of the investment grade corporate credit universe and perform an assessment of its risk profile.

How we got here
To help frame our analysis, it is important to look back at how we got here and understand why debt issuance increased as much as it did. To do that, we once again return to the actions of the U.S. Central Bank. As the Federal Reserve’s quantitative easing (QE) program took hold, and their purchases compressed interest rates, investors were pushed further out on the risk spectrum in search of yield. This search for yield ultimately compressed corporate borrowing costs and incentivized companies to take on record levels of debt.

But, this additional debt did not result in meaningfully higher debt service costs, since investors were all too willing to reach for yield and provide funds, as long as the corporations were able to maintain an investment grade credit rating (BBB or higher). The ability to deduct interest expense on this additional debt was the proverbial “cherry on the top.” These subsidies clearly tilted the scales, and corporations acted accordingly, placing an increased emphasis on debt issuance as opposed to equity financing.

The growth in BBBs is, therefore, the very logical result of corporate treasurers seeking to optimize their balance sheets. A BBB rating became a consequence of this financial strategy, with companies choosing to lever up in an abnormally low interest rate environment where investors demanded less compensation for a drop in rating, in an effort to acquire growth through M&A, due to their limited ability to generate organic growth. Some companies even chose to simply buy back their own shares with this cheap debt.

As a result, BBBs increased by 155% since March 2009 and now represent 50% of the entire investment grade market. BBB rated debt is now 12% of the U.S. nominal gross domestic product (GDP), a dramatic increase from 2008 when it represented just under 5%. Additionally, while the average leverage (debt/EBITDA) for high-yield companies has remained unchanged at 4.2x since 2007, the average leverage for BBB rated companies has increased to 3.2x, versus 2.1x in 2007. This represents an increase of more than 50% in leverage over the past 10 years.

Proponents of investment grade corporates argue that while the rise in BBBs portends future risk, the current macroeconomic backdrop remains supportive of the elevated leverage levels currently seen in the market. There is truth to that argument, as second quarter 2018 GDP came in at an annualized

BBBs: AN UNINTENDED CONSEQUENCE

BY BRIAN LINDE, CFA, AND PETER CRAMER, CFA

One of the most prominent themes of the corporate market for the past few years has been the impact of mergers and acquisitions (M&A). The recent increase in M&A transactions has led to a commensurate increase in the size of the investment grade bond index, while also contributing to record high leverage levels and a subsequent deterioration in ratings.

Many corporations have additional levers to pull if their ratings are at risk of a downgrade to high yield, such as dividend cuts and asset sales that could be used to redirect cash to debt reduction.

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The asset side from management to investment grade credit synergies, scope, scale, and a commitment to investment grade credit metrics, warrants a longer time horizon to return to pre-deal credit metrics. The agencies have been allowing companies 18–24 months to show progress in deleveraging, prior to downgrading to a rating more commensurate with their leverage levels. In essence, the ratings reflect future expectations rather than the current underlying credit fundamentals.

While expectations may work for the rating agencies, as investors we remain cautious given recent history showing that initial deleveraging targets have consistently been missed despite the strong economic backdrop. In fact, Morgan Stanley notes that across more than 100 investment grade M&A transactions of announced value of $5 billion or more, median leverage doubled from announcement to completion, from ~2.0x to ~4.0x. After five years, median leverage remained elevated at more than 2.5x. All it would take is a change in ratings methodology to see large-scale downgrades; thus, the prudent path is to proceed with caution.

Where are we headed?
While the current macroeconomic backdrop remains favorable, the elevated debt levels underscore just how different the current risk profile is versus historical averages. Leverage profiles of many post-M&A acquirers are more reflective of high-yield issuers (debt to EBITDA in excess of 4.0x) than they are of a more traditional BBB issuer. Consider that over the past 10 years, the average value of BBB leverage has been approximately 2.75x. Issuers with this metric in excess of 4.0x are, therefore, much closer to the current high-yield market average of 4.2x than they are to BBB ratings. To put these levels in starker contrast, 26% of investment grade nonfinancial debt is levered more than 4.0x as of second quarter 2018, versus 15% in 2014 Q4. Put differently, today approximately 25% of the investment grade market would be rated high yield if ratings were based solely upon leverage.

The next downgrade cycle is likely to be more challenging than previous cycles, given the elevated starting point for debt loads and the unprecedented nature of quantitative easing. The unintended consequences are evident as you look across investment grade corporate credit, where leverage is higher across all ratings buckets than it has been in previous periods, not just in BBBs. As the current recovery continues to grow long in the tooth and the Treasury curve flattens, the risk of a recession increases daily. Unless corporations reduce debt (which is always a difficult task in recessionary periods with falling equity values), then already-elevated leverage levels will be pushed even higher, negatively impacting corporations’ ability to service their debt, and ultimately leading to downgrades and defaults.

While the rating agencies remain sanguine, an end to the bull market and a turn in the credit cycle could leave many credits exposed for what their fundamentals say they are: high yield.

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IS HEALTHCARE READY FOR THE BLOCKCHAIN REVOLUTION?

BY ERIC R. ANDERSON

The next time you find yourself bored at a neighborhood party and decide you’d like to liven things up, bring up the topic of blockchain, and see what reaction you get. You’re likely to encounter one of three responses. Some people will see it as synonymous with cryptocurrencies, and then depart for the hors d’oeuvres table as fast as they can, convinced that your intention is to persuade them to invest their 401(k) in bitcoin. Others will declare that it’s an overhyped technology, with limited applicability to the real world. A third group, perhaps the most enlightened of the three, will give you a sheepish grin and admit that, while they don’t understand what blockchain is or does, they’d like to learn more about it.

Full disclosure: I’m in the third group. And, apparently, I’m in good company. A recent survey by SERMO, a global social network for physicians, asked 3,700 of its members: “Is blockchain technology ready to enter the healthcare world?” Instead of providing an answer, 49% of U.S. respondents and 47% of respondents worldwide admitted that they were “not aware of this technology.” So, clearly, blockchain has a formidable PR challenge in the healthcare space.

But healthcare, and MPL for that matter, may have an issue to resolve as well—how to determine and assess the potential benefits of this technology. Because, as the need for continuous improvement in healthcare delivery remains paramount importance to every stakeholder—healthcare professionals, patients, and MPL insurers alike—we need to bear in mind that there may be pivotal processes in healthcare and wellness that could be greatly improved by using blockchain technologies.

Case in point: According to the National Institute of Standards and Technology, blockchain may enhance health care record-keeping processes by centralizing patient data across the care continuum.

At their most rudimentary level, blockchains enable a group of users to record transactions in a ledger that is public to that community, such that no transaction can be changed once published. Notably, each block cannot be changed, deleted, or modified: it’s a permanent record that a given transaction occurred. That’s what has many observers excited about blockchain’s potential for healthcare data security. The fact that it’s open and decentralized means that it lends itself well to managing health care records and proving identity.

In addition, patient records—chronicling office visits, disease registries, lab results, and treatments—can potentially be stored through blockchain, including inpatient, ambulatory, and wearable-device data. This compilation of diverse information could help healthcare professionals find better approaches to delivering care.

Aided by blockchain technology, EHR interoperability could finally become a reality, and equally so, data storage a reliable and economical process. With a blockchain network shared among authorized providers, in a secure and standardized way, the cost and burden associated with data reconciliation would be eliminated.

So, after a bit of reflection, I think that blockchain may indeed have a useful place within the healthcare continuum. The question that remains, however, is this: will the promise of potential uses currently swirling around blockchain be translated into concrete implementation by the industry? Only time will tell.

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