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Here’s an Investment That Always Pays Off

Not too long ago, I wrote here about the value that physicians provide as members of our committees and sections. And now, I want to extend that discussion to talk about volunteerism and the key role it has played in the development of the Association over the years, and how it continues to be one of our integral strengths.

When the PIAA was formed in 1977, it had no staff and no real budget—only the vision of the founders about what the Association might become. The first board of directors comprised insurance professionals selected from a group of about 20 individuals who collaborated to form the Association. These were the PIAA’s first volunteers, and in fact, they were all that we had to organize the business of the Association and get it moving. Most people leading the physician-owned and/or -controlled companies at the time recognized the need to collaborate and develop a unified strategy for survival, but it is the few, people like Peter Sweetland, Don Fager, Dr. Ivan Neubauer, and Dr. Jim Todd, who made it happen.

Now, volunteerism did not come without a price. The volunteers themselves gave their time, from their work and their leisure, to serve on the board and its first committees: Activities and Membership & Bylaws. Their employing companies also contributed, by covering travel expenses and using paid employee time to support their service. This is not unique to the PIAA, as other associations and public service organizations of various types also experience the same quandary.

What is remarkable, however, is that out of this part-time service emerged a purposeful and dynamic organization, whose collective membership, through its Association, would compel the leadership of an entire industry to become its recognized voice. Long before the PIAA had a full-time professional staff, our volunteers were testifying on Capitol Hill, appearing before the NAIC, and lobbying the Internal Revenue Service for changes in onerous new tax laws that would have deleterious effect on our members (in order, Moore-Gephart, Revenue Service for changes in onerous new tax laws that would have deleterious effect on our members; Moore-Gephart, Revenue Service for changes in onerous new tax laws that would have deleterious effect on our members). As a result of his service and his leadership, as constant and readily willing resource for staff regarding finance and accounting issues. As a result of his service and his leadership, as constant and readily willing resource for staff regarding finance and accounting issues. As a result of his service and his leadership, as constant and readily willing resource for staff regarding finance and accounting issues. As a result of his service and his leadership, as constant and readily willing resource for staff regarding finance and accounting issues. As a result of his service and his leadership, as constant and readily willing resource for staff regarding finance and accounting issues. As a result of his service and his leadership, as constant and readily willing resource for staff regarding finance and accounting issues.

I am now proud to lead a great staff of 18 other educated and experienced professionals who effect the policies and attain the goals of the Association. Still, the volunteer model is alive and well—sometimes still leading, and often leveraging the efforts of staff by providing experience and expertise in multifaceted areas requiring in-depth knowledge and years of experience. This is obviously evident when one looks at the quality and scope of the topics at our meetings and workshops. Nobody is more capable in deciding the key challenges and areas of interest to be presented or explored at these closed industry meetings. Volunteers are included on committees of the board to assure a representative eye of the membership not entrenched in any political or internecine activities that might be at hand.

Fortunately, having its employees or board members serve as volunteers for PIAA sections and committees pays a big dividend to the supporting PIAA member company. In my view, there is no greater educational experience in the industry. Committee and section members not only learn direct information through the conduct of the operation of their groups; also, their leading-edge knowledge rubs off on one another through their collaboration, and colleagues and friends are made for a lifetime.

An excellent example of this is the service of Bob Boren, CFO of State Volunteer Mutual Insurance Company (do you see the entendre here?), who has participated as a PIAA volunteer for, well, it must be many decades. I can remember working with Bob, John Wurzler from PICOM, and Wayne Kahle from MLMIC in representing the PIAA back in the late 1980s to challenge the NAIC regarding the misapplication of the newly developed Risk Based Capital solvency measure to claims-made insurance, which was a concept not really understood by the regulators. We were successful in convincing the NAIC to evaluate claims-made differently than occurrence coverage, based on the difference in the length and timing of the tail. All volunteers—no staff, no lawyers, no consulting accountants.

Continuing this example, Bob Boren has served in many volunteer roles for the PIAA, including as a member and long-time chair of the Finance, Operations and Technology Section (now THRIF Section), Audit Committee, faculty for the Introduction to MPL course, and CE Advisory Committee, among others. He has also spoken many times at PIAA conferences over the years, and has been a constant and readily willing resource for staff regarding finance and accounting issues. As a result of his service and his leadership, as well as Bob’s contributions to State Volunteer, the PIAA Board has selected him to be the recipient of the 2011 Peter Sweetland Award of Excellence, our highest honor.

Now, the point of all this is to not only recognize Bob Boren, but to convince some of you to become PIAA volunteers or encourage others on your staff to do so. For the sake of the Association and also for yours, I hope it is successful.
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Only in smaller towns and less densely populated areas will the solo-practitioner and small-practice model likely survive.
—Cover story

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A recent study by the American Association of Critical Care Nurses reveals that many nurses are afraid to speak up when they see doctors making mistakes in operating rooms. The study notes that safety protocols in the OR are just not sufficient to prevent harm to patients. The study was based on interviews with 6,500 nurses, and many of them cited the hierarchical structure of hospital staffing for their failure to speak up when doctors ignore standard precautions.

Eighty-five percent of the nurses surveyed said safety tools in the OR have warned them of a potential hazard to a patient—yet 58% said they did nothing about it.

Now new safety procedures, such as OR checklists, have become mandatory in hospitals. But four out of five of the nurses surveyed noted that they have concerns about the “dangerous shortcuts, incompetence, and disrespect” they observe.

More than half of those who reported safety violations say “near misses” or actual harm occurred as a result—but only 17% made comments about it.

But Kristin Peterson, president of the association that sponsored the study, points out that there has been progress: “Compared with what we learned in 2005, nurses now speak up at much better rates. They are now three times more likely to have spoken directly to the person and shared their full comments.”

 incident Reporting at M.D. Anderson Cancer Center Increases by 1,468%
New Coalition Promotes State-Based Regulation

A wiser option than the federal ‘Keystone Kops’?

You have to love the acronym: “SABIR.” Rather a dashing abbreviation for the more pedestrian “State Alliance for Balanced Insurance Regulation.” Comprising 15 middle-market property/casualty companies, plus several more from life and health, SABIR’s stated objective is to “bring some balance to the regulatory process.” These companies believe that regulation is best accomplished at the state level, where developments that its chairman, Ernst Csiszar (former president of the NAIC), terms the “agony of federal reforms in financial services,” can best be avoided.

SABIR’s immediate objective is to block any more federal regulation of the insurance industry. Its members were alarmed to discover that the American Insurance Association and the American Council of Life Insurers seem inclined to accede to centralized regulation. These companies organize themselves, and then compete, via the state-based system, and believe that it is simply unfair to develop a parallel federal system. Conflict between the two seems inevitable, they contend.

For example, if the federal-level system is equipped with a bailout mechanism for troubled companies, and customers know it, it will be difficult for a state-chartered entity like a bank to compete.

SABIR’s leaders believe that state regulation is clearly in the “if it isn’t broken, don’t fix it” category, describing that system, on its website, as “our nation’s long-standing and well-functioning system of state regulation of the business of insurance.”

Csiszar concedes that the state-based insurance regulatory system can sometimes be frustrating and costly, but says that federal regulators, in the wake of the recent financial crisis, “have looked like the Keystone Kops.”

Source: A.M. Best, February 28, 2011

Using Social Networking Sites for Tough Diagnoses

Surprisingly, liability risk is minimal

Doctors have always sought out the wisdom of their peers when stumped for a diagnosis, but in prior years, that search was usually confined to the hospital lounge or a physician-only website. More recently, open social networking sites have emerged as a venue for getting input from a whole crowd of doctors. In fact, this tactic, as a general approach to problem-solving, has been dubbed “crowdsourcing” by Wired magazine.

While some physicians might be concerned that using open sites might expose them to more liabilities, experts say that, as long as doctors are following the dictates of the Health Insurance Portability and Accountability Act, that won’t be a problem. What a physician says in a closed community shouldn’t differ much from what he would say in an open community. The patient identifiers included under HIPAA should not be disclosed in any forum, experts point out.

Robert Belfort, an attorney with New York law firm Mannet, Phelps & Phillips, notes that, in assessing which specifics to include in a social network query, doctors should use their best judgment, considering in particular their location (especially if they live in a small community) and the uniqueness of the facts being presented.

Howard Luks, MD, an associate professor of orthopedic surgery at New York Medical College in Valhalla, New York, is sanguine about the potential for social networking sites to provide answers when doctors are stumped for a diagnosis. He says, “The words ‘I don’t know’ are three very powerful words, and the more physicians are able to admit what they don’t know and seek the help of others, the better it will be for themselves and their patients.”

Source: American Medical News, February 28, 2011

So the hospital revamped its program, renaming it the Good Catch Program. Also, teams were formed, to encourage friendly competition to increase reporting of “good catches,” an end-of-shift safety report that allowed for identification and discussion of any concerns related to patient safety that occurred during the shift, executive leadership round and incentives, and a multi-disciplinary workgroup whose assignment was to promote the program.

The dramatic result, in just the six-month pilot phase of the program, was an astounding increase in reporting of potential errors, of 1,468%—a total of 2,774 reports.

A new taxonomy for the Good Catch events was put in place, to identify the potential level of harm associated with each. The change makes it possible to include the Good Catch reports in the facility’s incident reporting system. This allows the institution to meet the Joint Commission standards for reporting and makes possible a robust system for evaluating latent events that might contribute to errors.
By James L. Weidner

A Tribute to Larry Smarr

In 1992, an insurance executive from the Pennsylvania Medical Society Liability Insurance Company joined the PIAA as the Association’s president. With a background steeped in medical professional liability insurance and its various disciplines—including special expertise in the areas of rate making, statistical analysis, and interfacing with state insurance departments, to name but a few—it was clear that Larry Smarr was the right individual to guide the PIAA into the next century.

As we look back at Larry’s career on the eve of his departure from the Association some 20 years later, we are truly inspired by, and appreciative of, his leadership, guidance, and the many goals that he has attained on behalf of our organization.

From his early days at the PIAA, Larry exhibited a keen understanding of the needs of PIAA member companies. In 1993, he guided the PIAA’s move to Washington, D.C., in an effort to become a more visible presence at the federal level, to protect member companies from legislation that would restrict, or worse, endanger their operations. This move would benefit PIAA members for years to come.

James L. Weidner is Chief Executive Officer of the Cooperative of American Physicians, Inc., and Chair of the PIAA Board of Directors.

In the mid-90s, under Larry’s oversight, the PIAA refined its mission to consider how it could advance risk management, and thereby the safe practice of medicine. As a result, the Association took over the administration of the PIAA Data Sharing Project that had previously been housed at two member companies—and diversified the range of DSP products and outputs available to members and the public. Today, as a result of Larry’s commitment to this project, the PIAA Data Sharing Project has grown to become the largest independent database of medical liability actions in the world—and has solidified the Association’s reputation as a key and trusted source on MPL claims and insights on industry trends.

When you see Larry at the 2011 Medical Liability Conference in Scottsdale, be sure to stop him and offer some words of appreciation.

Thank you!

The Health Coalition on Liability and Access (HCLA) was formed under Larry’s auspices, and he served as chair of this national advocacy coalition for many years. Today, due to his contributions, the PIAA maintains a leadership role in HCLA as the coalition works to promote federal MPL reform to reduce healthcare costs and ensure patient access to quality medical care.

Over the years, the MPL industry has

Continued on page 8
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evolved. Under Larry's leadership, so too has the PIAA. An organization that once only accepted physician-owned and/or -operated MPL insurers as regular members, the scope of membership expanded during Larry's tenure to accommodate more risk-bearing entities in the health-care arena, including companies owned or operated by dentists, hospitals, podiatrists, and chiropractors. The Association also emerged as an international organization, welcoming MPL carriers from around the world. The PIAA now represents companies that provide coverage for more than 700,000 healthcare providers worldwide—which is no small feat, considering this is an organization that started with a mere handful of companies, all based in the United States.

Larry instituted the affiliate member category for firms that provide goods and services specifically tailored to the needs of PIAA companies, and this area of membership has grown, and now includes a category for defense law firms.

The PIAA educational offerings have expanded considerably as a result of Larry's expertise. Today's PIAA meetings and workshops are unmatched in terms of continuing education for MPL professionals—a standard that deserves our pride.

The founders of the Association met more than 30 years ago and described their vision for a new organization. Today, as a result of Larry Smarr's dedication to this organization, the PIAA has exceeded those expectations.

This year will mark Larry's 20th consecutive trip, as president, to the PIAA's May meeting. When you see Larry at the 2011 Medical Liability Conference in Scottsdale, be sure to stop him and offer some words of appreciation for his singular dedication, commitment, and long list of achievements on behalf of the PIAA.

---

A team of Manhattan obstetricians says it has dramatically reduced errors, and thereby cut its department's medical professional liability (MPL) claims by more than 99%.

“Any hospital could do it—it’s not about money, it’s about changing the culture to make it safer to deliver babies,” said Dr. Amos Grunebaum, who led his obstetrics team at New York Presbyterian Hospital/Weill Cornell in starting a comprehensive obstetrics safety program.

The new measures reduced errors and helped ward off unwarranted suits by clearly documenting everything doctors did right in cases where a bad outcome was not their fault, he said. And according to Dr. Grunebaum's report in the February issue of the American Journal of Obstetrics & Gynecology, these safety initiatives reduced “sentinel events”—such as avoidable deaths and serious injuries—to zero in 2008-2009, down from five in 2000.

— Source: Crain’s New York Business, March 4, 2011

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Attraction Marketing: The Art of Beckoning Clients

The act of selling can be a chore. It is full of closed doors, unanswered messages, and cancelled meetings. Instead of expending energy chasing would-be clients, the goal is to change your sales strategy, so instead of wasting your time, your role becomes picking up a ringing phone—to find a hot prospect at the other end.

Attraction marketing is a proactive philosophy that is designed to highlight your company through proactive marketing and communications, in order to beckon the right clients to your company, rather than cold-calling your way to poor results. Attraction marketing is not a short-term fix, but rather, a long-term approach your organization will need to make a commitment to, if you want to sustain long-term results.

Four stages of attraction marketing

The essence of attraction marketing is rooted in a simple blend of three elements: focusing on being great at what you do, telling your story clearly, and responding with enthusiasm and integrity. But, before your phone will ring, you have to lead your prospects through four stages.

Awareness. The prospect has to be aware that your organization even exists. Name recognition is important. How will your phone ring if your prospects aren’t aware of you?

Familiarity. The prospect must be familiar with what your organization offers in terms of products or services.

Consideration. Your organization must be in the prospect’s top of mind if they are to consider you when they are in need of medical professional liability insurance.

Trust. The final and most important step—the prospect needs to have a sense of trust that your organization is the right choice for them. Only then will they be motivated to pick up the phone and call you.

Maintain a cycle of success

Getting your prospects to the trust stage begins with creating a cycle of success. That cycle consists of knowing your company, telling your story, and then delivering on your promises.

Know your company

Understand what you do well, and what you don’t do well. Determine what your clients value most from your organization. Take a candid look at your organization by evaluating “What do we do well?”, “Where can we improve?”, and “What should we be doing that we aren’t currently?” The answers may be surprising. Use what your client values most to help determine your organization’s story.

Tell your story

Your organization’s story must be simple, easy to articulate, and recipient-oriented. Don’t tell them everything you want to tell; tell them the information that they need to hear. Your story should also follow the “What? So, what? Now, what?” model. The “what” of your story provides the information, the “So what?” of your story should provide an answer to why that information is important to them, and the “Now, what?” provides an action step.

Deliver on your promises

You know what your organization does well, and you have told your story, so now
execute flawlessly. Foster a spirit of continuous improvement so your company is always striving to be better. The goal is to gain validation from your current clients, because they are your first allies and will help tell your story.

Go with education, not promotion
Another important piece of attraction marketing is to create the right balance between educational and promotional strategies. Educational strategies leverage the expertise of your organization. The focus is on quality. Promotional strategies involve offering deals; their focus is on quantity. Promotional strategies work well for retail stores and fast food restaurants, but physician insurance groups need to focus the majority of their strategies on leveraging their expertise. Positioning your organization as thought leaders and industry experts through educational materials will draw prospects to your door.

Implementing your strategy
So now that you know the basis for how attraction marketing works, let’s look at how to implement an attraction marketing strategy.

Conduct a communications audit
Examine all of your marketing and communication materials. Do they look, sound, and feel the same? Are they benefit-focused and recipient-oriented? Do they support your attraction marketing strategy?

Create your key messages
Next you will need to determine your key messages that will be infused throughout all customer touch points—including marketing, sales, service, and operations. Start by perfecting your company’s elevator speech—the five-second explanation that encompasses your organization’s purpose. (See my article in the first quarter 2011 issue of Physician Insurer titled, “Message Orchestration: Creating a Harmonious Communications Program,” which explains this concept in detail.)

When you create your message, focus on what makes your organization excellent, not different. People don’t want to hear about how your organization is different from your competition; they want to hear why your organization is the best choice for them.

Proactively engage all four media channels
Once your key messages are crafted, this becomes the DNA of your brand as it is infused systematically throughout all channels. At Morningstar Communications, we use the Four-Channel Media Model, which comprises paid media (advertisements), earned media (public relations), shared media (social media), and controlled media (collateral). Make sure that your key messages are consistent throughout all these channels, and proactively engage in communication.

Attraction marketing gives you the tools to focus on the highlights of your brand by telling your story of excellence proactively to consistently reach the people who matter most for long-term, proven successes. This philosophy allows you to answer a ringing phone to new business.
including a bowel resection surgery to address certain complications arising from the original tubal ligation procedure.

She filed suit in West Virginia, and Dr. Bracken filed a summary judgment motion asking that the case be dismissed. Dr. Bracken argued that the complaint was barred under Ohio’s one-year statute of limitations based on Ohio Rev. Code Ann. § 2305.11.3(A) (2003) (Repl. Vol. 2010). Relying on West Virginia’s “borrowing” statute, Dr. Bracken argued that Ohio’s shorter one-year statute of limitations applied instead of West Virginia’s two-year statute of limitations. The circuit court found that the action “accrued” in West Virginia, but sent the “application of the borrowing statute” question to the Supreme Court of Appeals of West Virginia. The Court accepted the certification to answer the following question:

When a surgical procedure is negligently performed in a foreign jurisdiction, and as a direct result of that negligence the plaintiff/patient must undergo a subsequent surgical procedure in West Virginia, does the West Virginia borrowing statute, W. Va. Code § 55-2A-2 (1959) (Repl. Vol. 2008), apply?

The parties argued that the “accrual” of the cause of action dictated the applicable statute of limitations. Dr. Bracken argued the action accrued in Ohio, where the negligent act, the surgery, occurred; thus, the action was barred by Ohio’s one-year statute of limitations. Mrs. Willey argued the action accrued where the injury—the subsequent treatment—occurred, which was in West Virginia, with a two-year statute of limitations.

The court’s response

The Court rejected both arguments,

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Continued from page 12

finding that:

“[F]rom the allegations in the complaint, it is clear that at least part of the cause of action accrued in the State of Ohio. If the complaint in this matter rested solely upon damages resulting from the injury caused in Ohio, this Court would not hesitate to find that the borrowing statute applies. See W. Va. Code § 55-7B-4 (1986) (Repl. Vol. 2008) (“A cause of action for injury to a person alleging medical professional liability against a healthcare provider arises as of the date of injury.”). See also Syl. pt. 1, Jones v. Trustees of Bethany College, 177 W. Va. 168, 351 S.E.2d 183 (1986) (“The statute of limitations ordinarily begins to run when the right to bring an action for personal injuries accrues[,] which is when the injury is inflicted.”). However, as will be shown, the complaint in this case also seeks relief for harm caused in the state of West Virginia.

Ultimately, the unique facts of this case demand that, as a matter of public policy, the mere fact that an injury occurred in another jurisdiction will not automatically invoke the borrowing statute where additional injury occurs in West Virginia. (Emphasis added.)

The record in this case indicates that Mrs. Willey had to undergo corrective surgery in West Virginia as a direct result of the alleged negligence of Dr. Bracken. The Court relied heavily on the “Certain Remedy Clause” of the West Virginia Constitution, W. Va. Const. Art. III, § 17, as establishing public policy against denying West Virginia citizens the “right to redress in the courts of this State for injuries received in West Virginia.” The Court also relied on the West Virginia forum non conveniens statute, W. Va. Code § 56-1-1a, as additional support that public policy favors the concept that West Virginia citizens have remedy, in West Virginia, for their injuries. “The forum non conveniens statute allows an action to proceed in a West Virginia court when the action would be barred by the statute of limitations in a foreign court, unless the defendant agrees to waive the right to assert the statute of limitations defense in the alternative forum.” On the facts before it, then, the Court concluded:

The record in this case indicates that Mrs. Willey had to undergo corrective surgery in West Virginia as a direct result of the alleged negligence of Dr. Bracken. By virtue of the emergency surgeries to correct her ruptured sigmoid colon, Mrs. Willey was subjected to additional invasions of her body, which caused her to sustain pain, suffering, and economic loss in West Virginia that was directly caused by the
alleged negligence of Dr. Bracken in Ohio.

The Court, citing Webb v. Smith, 276 Va. 305, 661 S.E.2d 457 (2008), indicated that because Mrs. Willey exercised her right to seek damages for all of the injuries caused by Dr. Bracken, from the initial surgery as well as her subsequent remedial surgeries, “the public policy of this State demands that [she] be allowed to seek full redress, not partial redress, in a West Virginia court.” The Court issued a new syllabus point (which, in West Virginia, is the binding precedent of the opinion), which states:

> When a cause of action is filed in a West Virginia court seeking damages for a surgical procedure that was negligently performed in a foreign jurisdiction, along with damages for a subsequent surgical procedure performed in West Virginia as a direct result of the negligence in the foreign jurisdiction, public policy demands that the applicable West Virginia statute of limitations applies to the negligence committed in the foreign jurisdiction. Under these unique circumstances, the West Virginia borrowing statute, W. Va. Code § 55-2A-2 (1959) (Repl. Vol. 2008), has no application.

There is no doubt that Mrs. Willey’s suit was barred by the one-year statute of limitations in Ohio. Because she alleged as damages surgical procedures that occurred in West Virginia, the Court, using “public policy,” avoided the application of the borrowing statute. While this particular case is limited to its facts, it certainly suggests that a West Virginia resident claiming medical negligence in another state can avoid unfavorable foreign statutes by bringing suit in West Virginia. As long as the treatment for the injuries caused is provided in West Virginia, the plaintiff can invoke the longer statute of limitations (assuming jurisdiction over the defendant).

Perhaps the Court was influenced by the fact the doctor practiced in West Virginia and the surgery occurred just across the border in Ohio. Regardless, while Willey is limited to the unique facts before it, those facts, when examined, are not all that unique, in that it is certainly not uncommon that patients may seek medical treatment in different jurisdictions from time to time. Under the analysis of this case, one may have options when choosing their “litigation home.”
For Some in Congress, Myths Trump Facts

A
s many readers already know, a few months ago the U.S. House of Representatives Committee on the Judiciary held several meetings on medical professional liability (MPL) reform. In both the hearing (which included witnesses testifying both for and against MPL reform) and the markup (where the committee addressed specific MPL reform legislation), it was apparent that some Members of Congress simply don’t know much about our industry. In fact, several made demonstrably false statements about MPL insurers, a clear indication that inaccurate and misleading claims from the personal injury bar and their allies are still getting through.

As we move ahead with federal MPL reform efforts, and some of you work for state-level reforms, it is important to understand the misrepresentations made by personal injury lawyers, so you may counter them accurately and appropriately. Some of these are old and tired arguments with which you are already familiar. Others may be new, or variations on old arguments that require a fresh retort. In either case, careful preparation for these arguments is crucial, if we are to overcome those who believe the MPL system should be little more than a cash cow for personal injury lawyers.

While we can’t control the misrepresentations that our adversaries make, we can ensure that our own lobbying efforts counter-vail against their claims, by sticking solely to the truth, and facts, about our industry. In this way, we will maintain our credibility in Congress and the state legislatures, an important element in achieving legislative success.

Myth number one. MPL insurers routinely overcharge their insureds. Repeal of the McCarran-Ferguson Act’s limited antitrust exemption is the only way to get insurers to reduce MPL premiums. This argument came up twice when amendments repealing the McCarran-Ferguson Act were offered in the Judiciary Committee. In offering one of these, Cong. Maxine Waters (D-CA) said, “We need to hold medical malpractice insurers accountable for their anticompetitive practices that have contributed to skyrocketing healthcare costs.” This statement, however, ignores one important fact—there is no evidence of any anticompetitive behavior in the MPL insurance industry.

While anti-insurance industry witnesses at two Congressional hearings in 2009 railed against anti-competitive behavior by insurers, they could not provide any evidence that this activity actually happens in the MPL insurance industry. In addition, the Congressional Budget Office (CBO) reviewed McCarran repeal legislation in 2009 and found that, “state laws already bar the activities that would be prohibited under federal law,” and so there would be no benefit to consumers in enacting repeal legislation. The CBO added that premiums might actually increase if the McCarran exemption were repealed, because insurers would be subject to the expense of the new antitrust litigation.

In a 2010 report, the Congressional
Continued on page 18
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Continued from page 16
Research Service stated, “Further consolidation in the insurance industry as small insurers merge in order to gain the competitive advantage of additional information is a likely, albeit, ironic, possibility,” if McCarran were to be repealed. Clearly, the experts agree that myth number one has no credibility.

**Myth number two. Caps on non-economic damages make it impossible for children to collect in an MPL case because they have no economic worth.** Judiciary Committee members debated this issue extensively. An amendment from Cong. Debbie Wasserman Shultz (D-FL) aimed to remove the cap on non-economic damages for claims made on behalf of children. She cited the “need” for the amendment by stating, “…you don’t have economic damages when it comes to children,” and therefore the value of their lives can only be measured by non-economic damages. This statement is misleading on a number of levels. It is indeed possible to estimate lost wages for a child who will never have the opportunity to work. Also, children may have additional economic value to a family that can be reasonably estimated and compensated in a negligence claim.

Finally, it ignores the basic facts of how a case with an allegation of negligence involving a child is handled. Cong. Wasserman Shultz eventually went on to claim, “If an injured child cannot hold a negligent doctor or hospital accountable [via unlimited non-economic damages], that child’s mom or dad will rely on programs like SSI and Medicaid to pay for their care and support.” This is a new approach for the personal injury bar, to play up to public concerns about the federal budget deficit. This, however, ignores the fact that a cap on non-economic damages in no way infringes on the ability of a child to be fully compensated for all medical, rehabilitation, or other life care needs in the event of actual medical negligence, thus negating the need to seek federal assistance in those cases.

When presented with evidence of sizeable damage awards in California cases involving children, Cong. Hank Johnson (D-GA) finally admitted, “It sounds like perhaps California tort law is not as draconian as some would make it out to be.”

**Myth number three. Large non-economic awards are necessary to ensure that low-income earners are appropriately compensated in an MPL case.**
The argument in this case is simple, albeit false: It is unfair that a professional athlete and a construction worker could suffer the same career-ending injury as a result of medical negligence and not receive exactly the same level of compensation. This claim was put forth by Cong. Mel Watt (D-NC), in alleging that a cap on non-economic damages, "really is very discriminatory against poor people whose economic losses are always going to be less." To convey the fallacious nature of this argument clearly, you can recast it in terms of auto insurance—two individuals are in car accidents; neither is at fault and both of their cars are totaled. One was driving a Rolls Royce, and the other a Kia. According to Cong. Watt's argument, justice can only be achieved if both owners are given the exact same level of compensation for their losses (presumably by giving them both the value of the Rolls). It does not matter that one person lost something of vastly more value than the other—the argument states—they should both be compensated the same. You can point out that capping non-economic damages actually creates more equity because, in the former example, both the athlete and the construction worker would get the same award for the "pain and suffering" that comes with the loss of one's career. Apparently, though, personal injury lawyers think that it is not discriminatory to give vastly different awards to people in similar circumstances—as long as both awards mean a large sum in total damage for baying contingency fees.

**Myth number four. Federal MPL reform violates the Constitution and/or states' rights.**

The power of the Commerce Clause of the U.S. Constitution has come under question in deliberations on the Patient Protection and Affordable Care Act. Although this is not in itself an appropriate debate for this column, this issue is germane because it has been raised in regard to federal MPL reforms. Cong. Ted Poe (R-TX), in a Judiciary Committee meeting, stated, "I don't believe the Federal Government has any more authority to regulate healthcare under the Commerce Clause than it does to regulate liability caps in states under the Commerce Clause." In fact, Supreme Court precedent would disagree with Cong. Poe about MPL reform. While the Court struck down federal tort laws when no interstate commerce was involved (e.g., the federal ban on possessing firearms near a school zone), economic activity that includes interstate commerce clearly

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falls under Congressional purview. MPL insurance, while dominated by single state insurers, certainly has enough interstate activity to rationalize a federal role in some matters related to the industry.

With regard to states’ rights, the legislation in question goes out of its way to ensure that those are protected. In fact, H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act, specifically includes a provision to protect a state’s interest in developing its own tort laws. On the issue of capping damages, the bill allows any state to deviate from the federal cap simply by enacting its own limitation, which may be higher or lower. On other reforms, the bill merely establishes a baseline level of standards; states are free to enact stronger reforms at their own discretion. It is worth noting that while some legitimate states’ rights activists have focused on this particular issue, much of the recent debate has been spurred by the personal injury bar. Just like their false claims that tort reform would increase the use of federal welfare programs, personal injury attorneys are conveniently co-opting this issue, to use it to maintain their ability to line their own pockets at insurers’ expense.

Conclusion
While we cannot control the misrepresentations made by our adversaries, we can ensure that our own lobbying efforts counter their claims effectively, by sticking carefully to the truth and facts about our industry. In this way, we will maintain our credibility in Congress and the state legislatures, and in addition, sustain our progress toward effective MPL reforms throughout the nation.

What the ‘Experts’ Don’t Know
During the plaintiff’s expert’s deposition, it was quickly apparent that he was no expert. I assumed he was going to point to a random area of the upper abdomen and call it a “developing abscess.” As it turns out, he didn’t even understand the anatomy of a post-gastric bypass patient. He identified the excluded stomach, a normal finding, as an abscess. He said he had never heard of the term “excluded stomach.” As my first foray into medical litigation, I was amazed. Who goes to a deposition as an expert radiologist and doesn’t even know the anatomy of the patient? I think one of the problems we have with malpractice litigation is that as physicians, we’re trained to seek the truth. In a lawsuit, the truth is secondary to who can sell a story better.

—Source: Seminars in Interventional Radiology, February 2010
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Insurers Continue to Weather Soft Market, But Harder Times Loom Ahead

By most financial measures, the medical professional liability (MPL) insurance industry had one of its best years to date in 2010. The operating ratio was at an all-time low, and the combined ratio was nearly at its lowest point. Insurers were able once again to release reserves, and a large portion of the releases were returned as policyholder dividends. In fact, the MPL industry returned more dividends to its policyholders in 2010 than during any other year in its history. The industry’s surplus also increased relative to 2009, providing additional capital support for what may be challenging and uncertain times ahead.

At the same time, the profitability of the industry is being squeezed from both sides. Frequency has shown definite signs of increase, albeit relatively modest compared with the frequency decrease experienced several years ago. Along with rate levels that have continued to decrease, even a moderate increase in frequency could materially impact underwriting results. Making this observation more concerning is this: since it is not entirely clear what contributed to the sizeable reduction in frequency in the first place, it is difficult to identify and monitor the events or circumstances that might lead to its potential increase.

If the salient characteristic of a soft market is declining rates, or even just declining rate adequacy, then the MPL industry is clearly in the middle of a soft market now. However, if we narrow our definition and consider a soft market to be one where rates are believed to be insufficient to meet costs, then the MPL industry is somewhere in the middle of a transition from a hard to a soft market. And certainly, the increasing level of capitalization and decreasing operating ratio seen within the MPL industry are more characteristic of a hard market than a soft one—or at least, characteristic of an industry transitioning from the one to the other.

That said, the increased capitalization and favorable operating ratios experienced by the MPL industry of late have had one primary cause—the release of prior year reserves. In 2010 in particular, reserve releases contributed 34% to the industry’s operating ratio. Thus, even without these reserve releases, the industry would have been profitable in 2010—but an increase in frequency going forward could change that picture.

Of course, 2010 also saw the passage of healthcare reform, a significant source of uncertainty for the MPL industry at this time. If the universal mandate for health insurance coverage is upheld by the courts, physicians’ patient loads may be further strained. Patients may become frustrated with additional office wait times, their ability to make an appointment promptly, and with the amount of time a physician may be able to spend with them during an appointment itself. This additional frustration could contribute to a greater likelihood that an MPL claim will be filed, and thus contribute to greater frequency overall.
On the other hand, the universal mandate could also encourage previously uninsured individuals to seek medical care. Over the long term, adverse outcomes might be reduced if these individuals engage in preventive medicine. This development would presumably lower claim frequency, although which of the competing effects on frequency will have the greater impact is highly uncertain.

The impact of healthcare reform on claim severity is also uncertain. Possible changes in frequency could result in a very different mix of claims, with settlement costs greater for some and less for others. In addition, many MPL writers have benefited from a relatively modest trend in claim severity during the past several calendar years. If concerns regarding general inflation are realized, the trend in MPL claim severity can be expected to increase. However, it will be difficult to distinguish the impact of inflation on claim severity from other effects on MPL claim costs, such as the impact of healthcare reform.

To further discern the state of the MPL industry today, we have performed an analysis of the financial results of a composite of 48 specialty writers of MPL coverage, all of whom can be considered well established. We have excluded the “startup” writers, because, nationwide, they remain a minority in volume of written premium, so including them might have skewed our analysis of long-term trends because of the growth they experienced during the past decade. Data was obtained from National Underwriter Insurance Data Services from Highline Data. We have compiled various financial metrics for the industry, categorized by:

- Written premium
- Overall operating results
- Reserve releases
- Capitalization
- Policyholder dividends.

In viewing the financial results discussed below, it is important to consider that the 48 companies included here are all long-term MPL specialty writers. As mentioned above, they exclude the startup writers and any MPL specialty writer that has become insolvent, as well as the multi-line commercial writers of MPL coverage. The member companies of each of these three excluded categories are generally less well capitalized than the 48 companies included here. In addition, while underwriting results of the startup companies have typically been comparable to the composite considered here, the underwriting results of the multi-line commercial writers have generally been somewhat less profitable. This was of course also true for the writers that became insolvent. Thus, the results presented below are indicative of the experience of long-term specialty writers today, which is inherently better than a view of the industry as a whole.

**Written premium**

Last year, 2010, marked the fifth straight year of decreases in direct written MPL premium for our composite (Figure 1). Cumulatively, premium has decreased by almost $1.0 billion since 2005—close to 20% of the premium written in this year. To put that in perspective, consider that
in the close to 30-year history of the MPL industry, no period of decreasing premiums has lasted longer than two years, and the greatest consecutive year premium reduction was 7%. On the surface, this would suggest that the circumstances of the current market are much worse than those of the previous soft market of the late 1990s through 2001.

Yet the current market has distinct characteristics from the previous soft market. Both have shown decreasing rate levels, but only in the previous soft market was there clear evidence of rate inadequacy, such as higher target combined ratios and large differences between the indicated and selected manual rate changes in filings. The reduction in frequency experienced by MPL writers puts their rates in a much better position now than they were a decade ago, although that decreasing frequency trend appears to have reversed itself.

**Overall operating results**

The industry posted its strongest operating results to date during 2010, with a composite operating ratio of 52% (Figure 2). This was driven by underwriting results that were comparable to 2009 and a slight improvement in investment returns. The combined ratio for the industry was 79%, comparable to the levels posted in the past several calendar years (Figure 3).

The realized capital gains ratio for the MPL writers hit a ten-year high of nearly 6% of net earned premium, as companies sold assets for amounts greater than their carried values, due to previous write-downs. The investment income ratio was at 22%, comparable to other recent calendar years. The resulting investment gain ratio of 28% was the highest experienced by the composite since 2001.

The calendar-year loss and loss adjustment expense (LAE) ratio for 2010 of 52% was slightly lower than the 2009 ratio of 55%, which was driven almost entirely by greater reserve releases in 2010. The loss and LAE ratio carried for the 2010 report/accident year as of year-end 2010 is comparable to that carried for the 2009 report/accident year as of year-end 2009—both were about 85%.

However, given the increasing frequency, along with continued rate decreases in many locales, this is in itself indicative of a decreasing level of reserve adequacy for the industry in 2010.

**Reserve releases**

Reserve releases for the industry in 2010 were at an all-time high of close to $1.4 billion, or 34% of net earned premium (Figure 4). While significant, this should be put in the context of the reserves carried by the composite, which for net loss and LAE totaled $12.1 billion as of year-end 2009. The release of reserves was driven by the continued impact of a lower frequency, combined for many companies with a relatively modest severity trend during the past several calendar years.

While the lower frequency has been known for some time, provisions in the reserving process for many companies initially assumed that the decrease in loss payments would be less than the decrease in reported frequency. In other words,
companies assumed that the decrease in reported frequency would be driven by fewer “nuisance” or “closed no payment” claims. While this has been the case for some writers, most writers have seen that the decrease in frequency has affected claims of all types equally, while some have in fact seen a greater decrease in indemnity claims than in their reported claims overall. Due to the three- to five-year payment lag, only during the past several years have companies begun to see the impact of the lower reported frequency on claim payments themselves, and as a result, the industry has experienced favorable reserve releases as this impact proves favorable. However, this continues to be an area of significant uncertainty in the reserving process, particularly in light of the recent increase in reported frequency for many companies.

It is also important to recognize that a history of favorable calendar-year reserve development is not necessarily indicative of redundant reserves currently. In fact, a review of calendar-year development segregated by Schedule P year shows that favorable calendar-year reserve development has historically continued two to three years past the point at which reserves were later found to be adequate. Thus, if the industry is currently at a level where reserves will be theoretically exactly adequate at the end of 2011, history would suggest we will see favorable reserve development on a calendar-year basis through 2013 or 2014. This would then be followed by adverse development (at least for older Schedule P years) in subsequent calendar years.

Finally, as we mentioned several times before, the industry has seen a dramatic decrease in reported frequency over the past decade. However, for many companies, the trend in frequency (on a per-physician basis) has turned upward again, typically, beginning in 2009. Given the rate decreases of the past several years, frequency has of course increased more relative to premium than to the number of insured physicians (see Figure 5).

While actuaries typically measure frequency as claim counts relative to the number of insured physicians, at the end of the day, it is premium dollars that must pay these claims, and thus considering frequency as claim counts relative to premium is a relevant statistic for insurers. Measured on this basis, we see that frequency per $1 million of gross earned premium reached its lowest point for the industry in 2007. Reported frequency has increased each year since this time.

Note that, on Figure 5, we have adjusted the 2010 frequency to include a provision for “pipeline” claims (i.e., incidents that evolve into claims), in order to provide an indication comparable to the older report years. Prior development suggests that with the inclusion of these pipeline claims, the frequency for the 2010 report year would likely be between 7.6 and 7.8 claims per $1 million of gross
earned premium. This represents an increase of roughly 4% to 7% over 2009, which was itself approximately 6% higher than 2008. This increase is the result of rate decreases (largely in the form of greater premium credits, as opposed to manual rate changes) and modest increases in “true” frequency—i.e., claim frequency per insured physician.

Capitalization
The industry’s strong operating results in 2010 resulted in a significant increase in surplus during the year of about 11%, from $9.5 billion to $10.5 billion (Figure 6). This is a sizable gain, but still less than each of the gains experienced (on a percentage basis) in the 2004 through 2009 years (with the exception of 2008, when industry surplus increased only slightly, due to the effect of other-than-temporary impairment on assets). In addition, the largest contributor to the gain in surplus was the favorable reserve development discussed earlier, which cannot be expected to continue over the long term.

To put the industry’s capitalization level in a broader context, consider the Risk Based Capital (RBC) ratio for the industry. This metric provides a comparison of a company’s actual surplus to the minimum amount needed from a regulatory perspective (although, from a practical perspective, given market fluctuations, many would consider the actual amount of capital needed to be well in excess of this regulatory minimum). The RBC ratio of our MPL composite increased to 961% in 2010, and, over the last several years, has followed a pattern of increase similar to that of surplus. However, individual RBC ratios vary considerably within the composite, from a low of 400% to a high of about 3,900%.

Policyholder dividends
Slowing the increase in surplus has been the increasing amount of policyholder dividends paid by MPL writers. In 2010, the composite writers paid in excess of $270 million in policyholder dividends, or nearly 7% of net earned premium (see Figure 3). Cumulatively, the composite has paid more than $1.0 billion in policyholder dividends since 2005. The historical pattern of policyholder dividends is very similar to that of reserve development. Thus, a large portion of the after-tax income resulting from reserve releases has been returned to policyholders.

Typically, these dividends are paid to all renewing policyholders as a percentage of premium. Thus, on a dollar basis, the dividends have provided greater benefit to those physicians who have historically

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paid higher premiums. We expect that policyholder dividends will continue for several years, given their historically cyclical behavior and the year-over-year increases seen to date.

**Forecast**

In its most recent “Review & Preview” report, A.M. Best estimated a net reserve redundancy of $3.5 billion for the MPL line of business as a whole. This is approximately 12% of the carried net reserves, which implies a redundancy for our composite of $1.4 billion. Thus, continuing reserve releases can be expected to mask deteriorating underwriting results on current business, both prolonging the soft market and increasing the risk that rates may become inadequate.

In addition, healthcare reform is a potential risk to MPL writers, at both the bottom line and the top line. At the bottom line, MPL writers could be subject to increased frequency and severity. They could also be subject to greater uncertainty in measuring these changes, as a result of changing characteristics of claims and an inability to distinguish the impact of healthcare reform from other cost determinants, such as inflation. This inability creates additional uncertainty in setting reserves and rate levels going forward.

At the top line, insurers face competition, not just from other writers in the standard marketplace, but also from hospitals and accountable care organizations (ACOs). The competition from hospitals is not new; for several years now, hospitals have increased their employment of physicians, often by purchasing independent physician practices. ACOs are an emerging source of competition, and they have gained momentum with the passage of healthcare reform. It is possible that the structure of many ACOs will include liability coverage for member physicians (whether these physicians are employed by the ACO or, if they retain an independent practice, as part of a group purchasing arrangement). Under either arrangement, the market for the coverage offered by traditional physician insurers can be expected to shrink.

Looking ahead, we envision a protracted soft market, in which continued reserve releases will buoy the combined ratio of the industry. However, we expect that reserve releases for the industry have likely peaked, and will decrease during the next several calendar years. While we do not expect filed rate decreases to be the norm, additional usage of schedule credits, along with the impact of an increasing frequency, will continue to erode rate adequacy. Thus, it will likely be a matter of years before we enter a true soft market—under its restricted definition of inadequate rates—and several years after that before the market can be expected to harden.

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Hospital Physician Practice Acquisitions and the Disappearing Private-Practice Physician:

What Does the Future Hold for MPL Insurers?
Much has changed since the “bedpan mutuals” were first established in the 1970s. Data from the American Group Management Association indicates that the number of solo or two-physician practices has dropped precipitously: from 78% in 1975, to slightly more than 30% today. According to the Center for Studying Health System Change’s 2008 Health Tracking Physician Survey, solo and two-physician practices make up a mere 32% of U.S. physicians, by practice type (see Figure 1, following page).

Meanwhile, the number of “hospitalists” (defined here as doctors who treat patients throughout their entire hospital stay), has increased to more than 30,000 physicians, today.

And the list of changes goes on: expanded use of physician extenders, the ongoing evolution of patient safety programs, major technological advances, the aging of the physician workforce, implementation of electronic medical records, the rollout of the Never Events concept, patient-centered medical homes—and more.

These changes in the physicians’ business environment have transformed the delivery of healthcare, in general, and in medical professional liability (MPL) insurance, more specifically. MPL insurers now confront a market with a declining number...
of insurable physicians. The decline started several years ago, when alternative market mechanisms like captive insurance companies, risk retention groups, and self-insurance arose to fill a need exacerbated by availability and affordability issues in the “standard” marketplace.

With the passage of the Patient Protection and Affordable Care Act (PPACA), we see this trend escalating, as hospitals ramp up their acquisition of physician practices to forge closer links for referrals, generate higher revenue, and benefit from the opportunities for shared savings available under PPACA. Since most MPL carriers insure individual physicians and physician practices, the remainder of this article will focus on the impact of physician demographics, and hospital acquisitions, for MPL insurers, and how they do business, in the future.

1. Background: Forces That Shaped the Current Market

Hospital acquisitions—lessons learned from the 1990s

Just like today, the 1990s saw an incredible spike in the number of hospitals that opted to acquire physician practices. In 1999, the Office of Inspector General issued a report, Hospital Ownership of Physician Practices, which noted, “According to the Health Care Advisory Board, a group that serves chief executives and senior administrators of more than 1,400 hospitals and health systems, the number of physician practices owned or managed by a hospital rose from 4,126 practices in 1993 to 11,234 practices in 1995, an increase of 172 percent.”

However, the actual extent of success afforded by these acquisitions varied significantly, with many transactions underperforming the initial expectations of hospital management. So, these are some lessons learned from the 1990s:

■ Proper due diligence is essential for each practice.
■ Don’t get caught up in the acquisition euphoria and overpay for a physician practice.
■ Effective employment contracts are a must.
■ Physician practices are operated differently than hospitals.
■ Don’t underestimate the extent of changes in your operations that will be needed to effectively manage physicians and their practices.

A solo practitioner’s perspective

Dr. Lisa Eng, an Ob/Gyn based in Brooklyn, New York, believes that market forces are in fact driving private practitioners to extinction. Survival as a solo practitioner today has been threatened by a myriad of economic and social challenges, such as high MPL premiums, declining reimbursements, rising overhead costs (e.g., rent, electric, supplies, technology), and unpredictable income, all at work in engendering an overall sense of “learned helplessness.”

Unfortunately, patients have been slow to realize how the world has changed for solo practitioners. Patients are still demanding of a physician’s time; they often expect perfection, and typically don’t want to wait for it or pay for it. There has been no paradigm shift for the patient, in any meaningful way, toward a role of true “consumer.” Instead, patients in essence want five-star concierge-level customer service, at rock-bottom HMO reimbursements levels. To a great extent, this attitude is the result of a healthcare system that doesn’t require that patients function as informed consumers: they have employer-provided insurance, low co-pays, and only a limited responsibili-

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ty for the consequences of their healthcare purchasing decisions. Also, consumers don’t factor in the administrative costs of practice. It takes nearly three billing staff to handle the work generated by one physician: one to bill for services, one to follow up with the insurance company, and one to chase down payments from patients. And it is likely that the PPACA will exacerbate the situation, driving up costs or reducing the levels of service.

Hospitals struggle with capturing payments too, and some observers believe that hospitals could be in rougher shape in the wake of the PPACA. However, because hospitals operate at high volume levels, they are in a better position to absorb bad debt than solo practitioners and small groups. Hospitals also benefit from lower-cost health insurance for their employees, discounted group rates for their faculty practice employees, and lower supply costs. Hospitals can also hire personnel to generate additional income: writing grants to capture “meaningful use” payments, HEAL grants, etc. Although solo practitioners and small groups don’t face the same sorts of pressures from unions and rising pension plan liabilities, they nonetheless struggle to survive in challenging states like New York.

Believe it or not, the average “retirement” age from obstetrics is just 47 years old, as physicians choose to drop obstetrics from their Ob/Gyn practice, to save on their MPL premiums. For example, based on filed rates, an Ob/Gyn practicing in New York’s Nassau County or Suffolk County could pay close to $200,000 in annual premium for an MPL policy covering obstetrics/gynecology—major surgery. But if the same physician were to drop the practice of obstetrics, the premium could fall to under $100,000 a year, for a policy that covers only gynecology—major surgery. Although it is a difficult decision for many Ob/Gyns, who enjoy delivering babies, electing to stop obstetrics coverage, which provides a 50% reduction in expenses, just makes too much economic sense, especially when dropping obstetrics also reduces the stress of an MPL suit for a “bad baby” case.

Many of today’s graduating physicians are earning advanced degrees in business (MBA), public health (MPH), and law (JD), ultimately preparing themselves to be business professionals, administrators, MPL attorneys, or insurance company professionals. In fact, many younger physicians are focusing on everything but the clinical practice of medicine.

The future that we are training our residents for is a simple dichotomy: either group practice or hospital/faculty practice. With physicians demanding more time off, more reasonable work hours, and actual vacations, recent trends are positive, representing a healthier work-life balance. And in light of declining reimbursements, the decision not to devote one’s entire life to the care of patients has become much easier. As Dr. Eng recalls: “I remember staying awake for days while I was in training. Although challenging, this prepared me for private practice, because there was nobody else to hand off the work to.” Today, interns are not allowed to work shifts longer than 16 hours. She says, “Imagine what would happen if I could tell my patients, as an attending physician, ‘I’m sorry, it’s been 16 hours, and even though you haven’t delivered your baby yet, I need to head home for eight hours of rest now.’ What would happen if my shift was over, during surgery? Can you imagine what the newspaper headlines might look like?”

Unfortunately, there is plenty of evidence that the status of medicine today may not be as bright for solo practitioners as it used to be.

2. Hospitals’ Challenges with MPL Coverage

Clearly, the world of physician practice is changing rapidly. With the passage of PPACA, hospitals and health systems have come to realize that acquiring physician practices is a desirable way to own the patient relationship and, ultimately, the specialty referrals linked with it, like neurology, gastrology, and cardiology, that yield the most profitable patient interactions. With healthcare reform shifting the focus of primary care physicians, multi-specialty groups, and hospitals from paying for numbers of procedures to paying for healthier outcomes, hospitals are rapidly positioning themselves to benefit from accountable care organization (ACO) initiatives. If an ACO can improve quality and reduce spending across the entire continuum of care, as
compared with the current baseline spending levels, the ACO receives a share of the savings.

Under the various ACO models proposed to date, hospitals would seem to be in the strongest position to successfully coordinate care, and thereby benefit from the potential shared savings. For geographic areas with the right level of population and physician density, hospitals will surely drive the ACO efforts, going forward. Only in smaller towns and less densely populated areas will the solo-practitioner and small-practice model likely survive.

**Insurance options for hospitals**

Hospitals have several options for protecting their organization, and its healthcare providers, against MPL claims and suits. In the early days, hospitals primarily purchased guaranteed-cost policies; premiums were determined based on the hospital’s overall bed exposure (i.e., the number of acute care beds, nursery beds, rehabilitation beds, emergency room outpatient visits, surgical outpatient visits, etc., converted to an occupied-bed equivalent, using risk-adjusted relativities). The purchase of occurrence policies, and later, claims-made policies, allowed hospitals to shift the preponderance of their MPL exposure off of their balance sheets—and onto those of an insurance company.

As insurance premiums increased, over the ebb and flow of three hard market cycles, hospitals began to look for remedies to reduce the volatility of their insurance spend. Early solutions included high deductibles and self-insured retentions.

Eventually, because of high-profile MPL insurance company insolvencies, the exit of major commercial carriers from the MPL market, and the acceptance of alternative-risk-transfer solutions in domiciles like the Cayman Islands, Vermont, South Carolina, and Bermuda, hospitals began forming their own captive insurance companies and risk retention groups, to bring their MPL insurance exposure in house. In recent years, the universal drop in MPL frequency has helped make these decisions look very successful. However, it remains to be seen whether combining the risks of running a hospital with the risks of professional liability will be an attractive economic move, especially with signs of increasing frequency emerging.

**Hospitals insuring physicians**

Although some hospital captives and risk retention groups have insured employed physicians and voluntary attending physicians (VAPs) in the past, today’s acquisition trends will likely expose hospital risk managers to an expanding population of insured physician specialties. Since hospital risk managers typically don’t have experience in underwriting large physician books of business, the potential exposure to adverse selection, attritional loss accumulation, and large jury awards may increase. To the extent that newly insured physicians expose the hospital’s captive to higher-risk specialties, frequently the target of large-dollar MPL lawsuits, the captive or risk retention group may need to reconsider its capital levels, defense strategy, and amount of reinsurance protection.

**3. Opportunities for MPL Insurers**

So how do MPL insurers fit into this changing world? From today’s perspective, physician insurance companies do not typically write policies with the high limits that hospitals require. For smaller physician insurers, writing hospital policies of this magnitude would likely require additional surplus, reinsurer approval, and lengthy discussions with regulators. However, one thing is for certain: the insurable physician population has already declined rapidly since 1975, ultimately decreasing the market opportunities for physician insurers. Without adjusting for the realities of a post-PPACA environment, some carriers may struggle to survive over the next few decades, as top-line erosion converts to higher expense ratios and, eventually, the erosion of the bottom-line and surplus levels. This reality can be self-fulfilling, to the extent that lower surplus levels may inhibit the capacity to deploy new strategies, such as writing in new jurisdictions or insuring hospital exposures.

Physician insurers, with a keen eye on the future, should use their expertise and deep knowledge of physicians to take advantage of the new market reality. We believe there are several areas where physician insurers can provide valuable expertise to hospital risk managers.

**Underwriting**

MPL insurers excel at underwriting physicians in different states, territories, and specialties. Years of underwriting experi-
ence, combined with detailed actuarial analysis of each specialty's historical performance, allows MPL insurers to monitor, track, and develop rates for individual specialties.

Hospitals, which lack the data necessary to determine the cost of insuring individual physician specialties, could benefit from leveraging the MPL insurers' expertise in underwriting. Traditionally, hospital risk managers have estimated the cost of insuring employed physicians by leveraging industry benchmarks. One approach has been to utilize the rate-filing information from physician insurers in the state where the hospital is located. Another approach has been to convert physicians into their occupied-bed equivalent, using conversion factors provided by the hospital's actuary. However, both approaches are somewhat imprecise, and may miss the mark completely, especially as the hospital's insured-physician population grows.

■ Claims handling and litigation management
MPL insurers have spent years defending meritorious and non-meritorious claims. According to data from the PIAA, approximately 70% of claims result in no payment to the plaintiff. Also, some 5% to 6% of claims go to trial, and of those claims that go to trial, approximately 80% result in a defense verdict. So hospitals could obviously benefit from accessing this deep knowledge about claims and defending against them.

There are times when it is wise to settle MPL claims quickly, and there are other times when pursuing an MPL claim all the way to a jury verdict is the smartest move. Knowing which path to take, which defense expert to use, and when to push, in the claims process, is critical to ensuring the future success of hospitals that are aggressively acquiring physician practices.

■ Risk management and physician education
MPL insurers across the country have spent years mining their claims data, developing risk management classes that focus on improving patient safety and reducing medical malpractice risk. For example, CRICO/RMF, which serves 11,000 physicians, 20 hospitals, and 240 other healthcare organizations associated with the Harvard medical community, continuously analyzes its 25 years of claims data. Their analysis, which indicates that 62% of their claims come from four high-risk areas (see Figure 3, page 36), allows CRICO/RMF to develop guidelines, training programs, and office-practice enhancements that improve patient safety and save lives.

The physician-owned and/or -operated MPL industry has, collectively, through the PIAA Data Sharing Project (DSP), also created a significant resource for mining patient safety and risk management data. The PIAA DSP, which houses detailed data on more than 270,000 medical and dental claims and suits, is now the world's largest independent MPL research database and provides a rich resource for the investigation of the underlying causes and issues pertaining to MPL claims.

Classes developed by MPL insurers cover topics such as informed consent, documentation, effective patient communication, patient handoffs, electronic medical records, apologies, and specialty-specific training. With so much valuable educational information available, the hospital might not need to reinvent the wheel, in providing physician education.

As the practical realities of PPACA emerge, additional risk management opportunities may come to light. It will be critical to show value-added services, and physician insurers are in a unique position to bring their expertise to bear.

■ Third-party administrative (TPA) services
MPL insurers are in the business of underwriting, defending, and paying claims for individual physicians. Given their MPL expertise and historical claims database, it is a small step for most MPL insurers to also provide TPA services to hospitals.

Hospitals may be comfortable using benchmarks to determine the cost of insuring physicians today, but when their insured-physician count increases by 1,000% due to acquisitions, there is no doubt that the calculation of their actual MPL risk will need to be more precise. There will be opportunities for physician insurers to help educate hospital risk managers on the level and cost of risk being retained, and these engagements may open the door to greater partnerships among the parties in the future.
In 2004, James Merritt, Joseph Hawkins, and Phillip Miller published their book, *Will the Last Physician in America Please Turn Off the Lights?* The book discussed the causative factors behind America’s serious physician shortage. In a similar vein, we sit here today, wondering if another book might be published in the near future, *Will the Last MPL Insurer, Not Acting Largely as a Third Party Administrator, Please Turn Off the Lights?*

There is no doubt that densely populated urban areas will continue to see a diversity of practice models, ranging from concierge medicine (for those that can afford it), cash-only practices, and blended practices to “medical malls,” where physicians can share overhead costs such as rent, personnel, and supplies. There will always be a need for physicians who offer specialized services, in customized and unique ways. However, the number of physicians choosing these options in the future might not be large enough to stem the top-line erosion of MPL insurers’ financial results.

As we note here, the time is now for MPL insurers to seize every opportunity to control their destiny in this rapidly shifting world. Although the number of insurable physicians and physician practices may be declining, there is no doubt in our minds that the most agile and forward-thinking MPL insurers will invent new ways to capitalize on the evolving healthcare landscape, by bringing their significant underwriting, claims, and risk management skills to bear with hospitals, independent practice associations, “medical malls,” and ACOs, all across America.

**Resources**


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4. Conclusion

“The great majority of physicians (89%) believe the traditional model of independent private practice is either ‘on shaky ground’ or ‘is a dinosaur soon to go extinct.’”

Based on a total of 2,379 completed physician surveys.


How would the MPL industry answer a similarly worded question:

Which best describes your view of the MPL insurance company of today?
1. It is a dinosaur soon to go extinct.
2. It is on shaky ground.
3. It is relatively robust and viable.

Given the MPL industry’s financial performance in 2010, answer 3 still seems like a pretty safe bet, in the short run. That being said, what do you think the answer could be in five years, if prior-year reserve releases disappear, if frequency returns to historical levels, or if additional capital prolongs the soft market?

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**Resources**


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**Figure 3** High-Risk Areas

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>26%</td>
</tr>
<tr>
<td>Surgery</td>
<td>24%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>7%</td>
</tr>
<tr>
<td>Medication</td>
<td>5%</td>
</tr>
</tbody>
</table>

It’s probably the best-known axiom in the healing arts. But a little more than ten years ago, the medical establishment was shocked when a study reported that there was much cause for a more recent saying circulating among American healthcare consumers. “If you don’t want to get sick,” it goes, “stay out of the hospital.”

The report, To Err Is Human: Building a Safer Health System, asserted that, every year, 44,000 to 98,000 deaths are caused by medical mistakes.

In the decade since the Washington-based nonprofit Institute of Medicine issued those findings, Detroit’s Henry Ford Health System—like medical organizations across the United States—has worked to find a comprehensive means to an end: the elimination of any harm in all its hospitals and healthcare facilities.
And after a two-year period of significant progress toward that end, Henry Ford is extending its campaign to “do no harm” until the end of 2013, with the goal of cutting in half the number of injuries in its hospitals.

The No Harm Campaign was launched in early 2008, soon after the Henry Ford’s board of trustees set the elimination of harm—including harm to its employees—as the system’s top priority. It set a goal of cutting “harm events” by 50% by the end of 2010. As that initial two-year term comes to an end, Henry Ford has recorded significant progress—eliminating nearly a fourth of all such instances system-wide.

While that’s less than the original, ambitious goal, the launch period for the No Harm Campaign included assembling both the knowledge base and infrastructure necessary to eliminate harm from Henry Ford facilities.

For example, all of its hospitals have had to establish consistent methods of defining harm events, measuring them, and assembling related data so that all facilities can be “on the same page” before creating and standardizing preventive measures for lasting change toward the ultimate goal of becoming a “harmless organization.”

As the two-year start-up period for the No Harm Campaign went on, Henry Ford President and CEO Nancy Schlichting explains, improvements picked up speed even while Henry Ford opened a new hospital with its own new patient load. Despite this increase, she says, “We have decreased harm events by 90 events per month. This early critical work takes time to reach the point where all parts of the system reach simpatico—a tipping point—after which new process improvements and results gain momentum for faster spread and continued innovation. Henry Ford Health System is nearing that tipping point.”

What is harm?
To establish the scope of the campaign, Henry Ford adopted a broad definition of “harm.” It includes:

- Any physical injury that results from or is contributed to by medical care, including failure to provide treatment indicated by a patient’s condition
- Any such event that leads to additional “monitoring, treatment, or hospitalization.”
- Any such event that results in death.
- Any such event, whether or not it’s considered preventable, that results from medical error, or takes place in a hospital.

No comprehensive definitions, standards, or solutions to what constitutes harm have yet been created or adopted for U.S. hospitals. While various health agencies continue to work on it, Henry Ford has moved forward with its own global measure. These include seven categories of harm within its broader definition:

- **Infection-related**—includes all catheter-related bloodstream infections or urinary tract infections; surgical infections; pneumonia related to the use of a patient ventilator; and all common hospital-acquired infections—such as *Clostridium difficile*, an increasingly hard-to-treat bowel infection linked to the use of antibiotics; and the antibiotic-resistant staph infection commonly known as MRSA.
- **Procedure-related**—includes all complications directly related to surgery and other medical procedures.
- **Medication-related**—focuses on all harm related to the use of insulin, blood thinners, narcotics, and other drugs that contribute to half of all such events.
- **Falls**—includes any fall by a hospital patient or visitor that results in injury.
- **Pressure ulcers**—any “bedsores,” as well as wounds caused by medical equipment.
- **Kidney failure**—any instance related to radiology imaging that uses contrast material, to sepsis, dehydration, and drug-induced renal failure.
- **Employee injury**—includes falls, needle sticks, and back injuries and violent acts.

What’s being done about it?
Overall, Henry Ford has cut hospital-related infections by 22% since the beginning of the No Harm Campaign. During the past year, this decrease has been led by focusing on *Clostridium difficile* bowel infections.

The marked improvements are the result of a stepped-up focus on all hygienic practices. These range from the most basic—hand washing—to better isolation of infectious patients, enhanced tracking of antibiotic use through specialized system-wide pharmacy software, and the use of a chemical “antibiotic lock” in catheters used to treat kidney dialysis patients. This “lock” procedure alone has reduced dialysis-related bloodstream infections by two-thirds since the start of the No Harm Campaign, bringing Henry Ford into compliance with national benchmark standards.

The goal of reducing surgery-related harm has led Henry Ford to system-wide participation in the American College of Surgeons’ National Surgical Quality Improvement Project. Its

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purpose is to ensure higher-quality surgery—including postoperative outcomes and care—by collecting, analyzing, reviewing, and acting on specific data, then reporting the results to the ACS for a constantly updated set of “best practices.”

Practices to reduce medication-related harm in Henry Ford hospitals have focused on the drugs that pose the highest risk to patients: insulin to control blood sugar, narcotics for pain control, and blood thinners to prevent clots.

This focus led to a new protocol for tight control of diabetic blood sugar, started as a pilot project at the new Henry Ford West Bloomfield Hospital in 2009, and has since been adopted by other Henry Ford hospitals. The new controls have cut incidents of hypoglycemia by 45% at Henry Ford Hospital alone.

Another pilot program, dealing with anti-clotting medications and their use, has slashed the risk of related patient hemorrhages by more than 80% since it was launched by Henry Ford Hospital in 2008.

Called the Pharmacist-Directed Anticoagulation Service (PDAS), the program was designed to improve the selection, dosage, and monitoring of blood thinners, both in the hospital and during the transition to outpatient care. The PDAS has already been cited by the American Society of Health-System Pharmacists and the national Hospital Care Collaborative as a model for managing anticoagulants.

In addition, all Henry Ford hospitals have intensified their focus on the use of narcotics to improve patient satisfaction with pain relief while preventing or correcting over-sedation.

New procedures for nursing rounds have been designed to reduce falls by agitated or confused patients, more than half of which are related to using the toilet. At first, this included attending all such patients while they were using the toilet, but the patients themselves were so unhappy about this that the practice is now used only if the patient agrees.

The incidence of patient pressure ulcers peaked at the end of 2009, but it now is dropping in response to new rules to monitor specific areas of the skin under medical devices and equipment. For example, oxygen tubing was found to cause pressure ulcers where it was draped over the ears. New devices to protect the ears are now used in all Henry Ford hospitals.

Kidney failure related to the use of contrast dyes in radiation imaging was the focus of one preventive program begun at Henry Ford Hospital, and it is now in use throughout the system. One of the most aggressive such renal care programs in the country, the Henry Ford project is keyed to avoiding unnecessary imaging tests, increasing fluids for patients at risk in the use of contrast dyes, and heightened tracking of patients who are given such contrast material.

Efforts to reduce employee injuries, however, have had mixed results. Harm from sticks by contaminated needles dropped from 2009 to 2010, but job-related back injuries increased during the same period.

What’s next?

Henry Ford has a full agenda of programs started during the first term of the No Harm Campaign, which will continue to be enhanced during the coming three years, as well as new safety initiatives for launch in the same period.

The Speak Up Campaign, launched in fall 2009, does what it says—encourages all employees to speak up when they see or suspect harm or the potential for it in patient care. The vast majority of employees surveyed in 2008 said that they already felt encouraged to report such cases; in 2010, the total increased to 83%.

The Speak Up Campaign is now being augmented with a new employee training course—Speak Up, Speak Out: Creating Safe Environments.

New system employees and medical residents will continue to receive a Web-based self-training program called Patient Safety 101, launched in 2008 and already provided to nearly 14,000 employees. The program encourages employees to offer their own point of view and other feedback through an interactive feature.

Yet another program, Human Factors in Patient Safety, addresses the “fallacy of perfect human performance.” The need for this program became obvious when 80% of surveyed Henry Ford staff said they believed healthcare is “very safe” or “mostly safe.” The training educates employees about human limitations in healthcare, and the need to adopt personal safety practices.

Improved communications between healthcare providers and patients, as well as between the providers themselves; electronic prescriptions and delivery of test results; and procedures to eliminate mislabeled lab specimens are also among the now continuing campaign to make Henry Ford Health System facilities as safe as possible for those who are treated, and those who work there.

And the goal continues to be Do No Harm—first, last, and at all points in between.
Impact of Healthcare Changes on MPL Insurance Rating—Per-Patient-Visit Rating

Charles W. Mitchell, FCAS, MAAA, is a Consulting Actuary, and Eric J. Wunder is an Actuarial Assistant, Milliman, Brookfield, Wisconsin.
As more physicians move from independent practice to group or healthcare system employment, there is new interest in alternative procedures for medical professional liability (MPL) insurance rating. One method that is becoming more popular is a rating system based on the number of patient visits, procedures provided, or hours worked, as opposed to an annual per-physician rate. Given the likelihood of a continued shift from independent practice to employment, it is important to understand the benefits and complexities of this type of rating procedure. In this article, we will focus on per-patient-visit rating; however, a rating based on number of procedures performed or hours worked is similar in concept.

Benefits

Per-patient-visit rating is most often used in, and probably best suited for, rating physician groups or healthcare entities that consist of fairly homogeneous risk exposures. Emergency physician groups, urgent care centers, or other walk-in medical clinics are the ones most commonly rated on this basis. Per-patient-visit rating may be advantageous in these situations for several reasons.

First, there may be a relatively high rate of turnover among the employed physicians. The per-visit group rating eliminates the need to add or remove individual physicians from the policy as they come or go from the group.

Second, there may be significant uncertainty as to how many hours physicians will be working in these employment settings. For instance, some physicians may work only a few shifts a week, while others may work many shifts a week. A group purchasing liability insurance on behalf of its member physicians that is rated on an annual per-physician rate basis would presumably pay the same rate for each physician, assuming that they are all classified as full-time. In this case, the group is overpaying for the physician who works fewer hours and underpaying for the physician who works more.

The same is true for the group as a whole when they purchase liability coverage using annual per-physician rates. Under this rating method, premiums will be too low for a group with fewer physicians who work longer hours and provide more services, all else equal. The opposite will be true for a group that is more adequately staffed and working fewer hours per physician. It seems reasonable to assume that, generally speaking, the more adequately staffed group would be a better insurance risk. Ironically, however, this is the group that may be overcharged using an annual per-physician rate.
The number of patient visits is a better measure of the actual liability exposure. If utilized properly, per-patient-visit rating enhances the insurance company’s ability to measure and price liability risk more precisely.

Third, when rating is done on a per-visit basis, the patient-visit total is usually audited at the end of the coverage year, and the premium is adjusted to reflect the actual amount of services provided during that year. When using annual per-physician rates, the premium is set at the inception of the policy and not adjusted in the event that a physician increases or decreases his workload during the policy period.

Last, in the case where a policy covers multiple locations or clinics, there is an additional advantage: it is easy to track and allocate insurance costs by location accurately. If physicians practice at various locations or rotate among locations, with per-patient-visit rating, there is little need to track the movement of individual physicians for allocating insurance costs.

**Complexities**

The main concept in per-patient-visit rating is this: the insurance company is no longer insuring the individual doctor, but, rather, the patient visits of the whole organization. This leads to issues and complexities that need to be well thought out before this type of rating structure is adopted.

First, although this type of insurance coverage attaches to the *patient visit* of the organization, the *individual physician* subject to an MPL claim will need to address that claim. This may create some difficulty when a claim insured under the group policy is made against a physician who is no longer with the group. Physician cooperation is a vital component of effectively defending or settling an MPL claim. A physician who has separated from a group may be less inclined to cooperate fully, particularly when the separation between the group and the physician has not been amicable.

Second, because there is limited underwriting of the individual physician, the insurer will find it difficult to reject a physician whom the group has decided to hire. This may be a challenging transition for traditional MPL underwriters. They will need to focus on assessing the organization as a whole, with an emphasis on risk management and patient safety procedures, as well as the extent of management’s consideration of MPL risks in the hiring process.

Third, several complexities are related to properly pricing the claims-made coverage that is most often offered by MPL insurers. One example: when mature claims-made coverage is provided to an organization and a new physician replaces another within the group, the insurer must still collect a mature claims-made premium for the patient visits of the new physician, even if that particular physician would otherwise be categorized as a first-year claims-made exposure. This is required because, as the group’s claims-made policy is renewed, it insures all claims reported against the group that are related to patient visits serviced by the group. This includes claims associated with the patient visits of the prior doctor, and the insurance company needs to collect premium for this exposure. In the example above, the mature claims-made premium charged for the new doctor can be thought of as a combination of the first-year claims-made premium for the new physician and the tail exposure of the previous physician, picked up as part of the renewing group claims-made policy.

Similarly, an insurance company should be careful in developing the claims-made premium when the number of patient visits is changing over time. As stated previously, rating on a per-patient-visit basis lets the insurance company account for changing exposures. However, the rates and rating factors must be determined appropriately. Here is an example when physicians leave an insured entity and are not replaced. In this situation, if an insurer computes the premium by applying an unadjusted rate to the calendar-year patient visits for the prospective coverage year, as is commonly done, the insurer will not collect enough premium. As the organization’s claims-made policy is renewed, the group policy continues to pick up the expected reported claim exposure of the historical patient visits, even for the physicians who are no longer with the group. However, because the insurer will apply the unadjusted rate to the projected patient visits for the prospective coverage year, which are now fewer than what has been historically insured, it will collect too little premium.

There are various ways to account for changes in exposure over time when rating claims-made coverage on a per-patient-visit basis. One way is to include the historical growth rate in the development of the mature claims-made rate and claims-made step factors. However, this approach requires an assumption about the growth rate of exposures. Unless the step factors are updated annually, it also assumes that the growth rate will be the same over time. Without some adjustment process, this proce-
In the second quarter of 2011, there is no difference in the calendar-year or a significant number of physicians join or leave the group. Conversely, of calculating the appropriate premium when a growing over time, and the lag between the occurrence and reporting of claims creates a lag in reported claim exposure. The opposite is true if the number of exposures has been declining over time. Notice that this method eliminates the problem, previously discussed, of calculating the appropriate premium when a significant number of physicians join or leave the group.

Notice that the number of 2011 calendar-year visits is higher than the 2011 claims-made equivalent visits. If an insurance company applied an unadjusted per-visit rate directly to the 2011 calendar-year visits, it would in essence overcharge the insured group for claims-made coverage. This is because the exposure is growing over time, and the lag between the occurrence and reporting of claims creates a lag in reported claim exposure. The opposite is true if the number of exposures has been declining over time. Notice that this method eliminates the problem, previously discussed, of calculating the appropriate premium when a significant number of physicians join or leave the group.

Note that if patient visits are constant over the historical exposure period, there is no difference in the calendar-year or claims-made equivalent exposures. This assumption underlies per-physician rating. When we rate on a per-physician basis, we assume that all full-time doctors perform the same number of services each year. This unrealistic assumption is eliminated if ratings is done on a per-visit basis and the actual historical exposures are used, as demonstrated above.

The example above illustrates the exposure calculation for a mature claims-made policy. If you were rating a first-year claims-made policy for 2011, you would need only the last line of Table 1, and the per-visit rate would be applied to the 1,320 visits. If you were rating a second-year claims-made policy, you would need the last two lines of reported claim exposure (1,680 + 1,320 = 3,000). Notice that in this example, it requires five years of calendar-year-exposure information to properly rate one mature claims-made coverage year. This is due to the assumed claim-reporting pattern in this example, which reflects an expectation that all claims occurring in a period will be reported in five years.

When an insurance company introduces a per-patient-visit rating option, it may not have the historical patient visits, and related claims experience, needed to directly project per-patient-visit rates. The company may need to convert an existing per-physician rate to a per-visit rate. This requires that the per-physician rate be divided by an estimated average number of visits provided by a physician per year. This estimate is critical. If the estimate is too high, the rate will be too low, and vice-versa. This problem is eliminated if the company has the historical patient-visit information, and related claims experience, needed to derive the per-patient-visit rate directly.

Prior acts and tail coverage need to be considered, and understood, as they relate to this coverage. Prior acts coverage may not be available, or insured separately from the standard claims-made group policy for new physicians joining a group. Including any prior acts within the claims-made group policy would require adjusting the historical exposures of the group to account for the added exposure. One way to address this issue is by requiring physicians to purchase tail coverage from their previous insurance carrier rather than obtaining their prior acts coverage within the new group's insurance structure. However, this approach may act as a disincentive for a physician to join a group.

Tail coverage can be a tricky issue, too. As long as the group continues to renew its claims-made coverage, there is no tail claim exposure for individual physicians who leave the practice, because the late-reporting claims will be covered under a renewing group claims-made policy. However, if the group stops renewing the claims-made coverage, all physicians, including those who have left the group in previous years, may be facing an uninsured tail exposure. The physician employment agreement must explain, in clear language, how tail exposure will be handled in this situation. Perhaps the most straightforward way to handle this exposure would be to require that the group buy a tail policy endorsement, attached to the group policy if it is non-renewed for any reason.

**Conclusion**

As changes in the healthcare landscape continue to entice doctors to leave private practice and instead become employees with physician groups or healthcare systems, group rating, and possibly per-patient-visit rating, will continue to assume increasing importance. In implementing and utilizing this type of rating, it is important to understand its subtleties and complexities, to ensure proper measurement and pricing of the exposure.
Managing Investment Risks, Securing Higher Returns:
Proceeding with Caution in a Still-Troubled Market
Throughout the credit crisis of 2008, many insurers of all types suffered losses in their investment portfolios, including members of the PIAA. The subsequent recovery has also created significant challenges for companies depending on fixed income portfolios to provide investment gains, while at the same time providing adequate security for the principal needed to back policyholder liabilities. While the crisis itself has passed, MPL insurers will likely continue to face a difficult investment environment in the years ahead. This article describes the performance of the PIAA fixed income portfolios through the crisis and recovery, and offers insight on how to prudently manage the risks in the current markets while still achieving acceptable investment returns.

As shown in the Table 1, P/C company portfolios were valued at 2.7% below book value on average, as of December 31, 2008. PIAA companies fared relatively better, posting unrealized losses of only 1.6% of book value. PIAA portfolios tended to be of relatively high credit quality, and they had low allocations to non-agency mortgage-backed securities (including sub-prime securities); therefore, they had smaller price declines in 2008 than did portfolios made up of more risky securities (Table 1).

2009-2010 Recovery
The past two years have offered a sharp rebound in most asset prices, as both stocks and bonds produced strong returns in 2009 and 2010. Looking at 2009 bond returns by line of business, PIAA companies showed a relatively tighter distribution of returns than did P/C companies overall, as 90% of the PIAA companies had estimated bond returns of 5.85% or greater in that year. The top- and bottom-performing portfolios in the life, health, and P/C lines overall (Table 2) generally contained more volatile holdings that either recovered strongly in 2009, or continued to falter and did not bounce back from 2008’s losses. Again, PIAA portfolio managers tended to avoid these bonds, so their returns tended more toward the middle of the pack in 2009 (Table 2).

Current situation (January 2011)
At the current time, significant challenges remain for the fixed income investor. Yields on Treasury bonds remain well below historical averages, and below the levels where they stood leading up to the crisis. At the same time, credit spreads (the additional yield earned for investing in non-Treasury bonds) are approaching the very low levels seen prior to the crisis. The problem that this poses for insurers is the low level of absolute yield available in the traditional instruments found in most portfolios. Corporate bonds typically make up the largest share of the taxable bond portfolios of insurance companies. Using the Barclays U.S. Corporate Bond Index, we can track available yields on a broad group of publicly traded corporate bonds. As Treasury yields fell and credit spreads dropped, the yield on the corporate bond index hit an all-time low (using the Barclays dataset stretching back to 1971) of 3.29%. The 2010 headlines highlighted corporations such as Johnson & Johnson, IBM, and McDonalds issuing 10-year fixed maturity debt at the lowest rates on record. As indicated in Figure 1, the corporate index yield has dropped from more than 9% in late 2008 to 4% today. In the 20 years prior to 2008, this yield averaged 7.0%.

The ability to grow surplus with investment income has decreased.
**Difficulties faced by MPL insurance companies**

When implementing an investment strategy, most PIAA companies try to find a balance between maximizing investment income and preserving the safety of the principal. The ability to grow surplus with investment income has decreased, right at the time when underwriting results may begin to deteriorate. Investment yield is providing a low margin of error when pricing policies. With yields at or near all-time lows across the board in most fixed income sectors, there is no clear asset play that offers attractive expected returns for the risks taken. The segments of the bond market that offer higher current yields are mostly those that are historically volatile and do not match the industry’s need to ensure the safety of the principal invested. Companies with lower levels of capital are finding no easy path to increasing surplus through investment income. Companies with higher levels of capital are not satisfied with the return they are earning in putting their capital to work in the bond market.

Another challenge is the murky outlook for economic conditions going forward. While credit markets have recovered, and the most pessimistic scenarios have been avoided, signs of sustained rebounds in the job market and in housing prices have been frustratingly absent. The recent volatility in bond yields has been accompanied by uncertainty about the underlying strength of the economy, and there are concerns about the size of the federal budget deficits. With top-line growth difficult in this environment and lots of cash on corporate balance sheets, it is likely that merger and acquisition (M&A) activity will increase; this development could be positive for stockholders, but it is generally bad for bondholders. These conditions make selection of securities a crucial task; many corporations will prosper in the years ahead, but others are likely to falter, causing investment losses for holders of their bonds. Determining which holdings will outperform can make a significant difference in the fixed income returns of PIAA insurers.

**How to address the challenges**

Finding sufficient return in the low-yield environment requires extensive research and innovative thinking in asset selection. This requires a dedicated team of research analysts whose sole focus is on sorting through the wide array of publicly and privately traded securities to uncover advantageous risk/reward relationships. One potential opportunity for finding yield is investing in the debt of strong market leaders of the industries that are currently out of favor with investors. Carefully chosen issuers will have sufficient balance sheet strength and market presence to maintain their leading positions, while market sentiment currently allows them to trade at above-average yields, compared with the market as a whole.

Another potential source of higher yields is international exposure. Most investment policies will require all holdings to be in dollar-denominated securities. An insurer may be able to achieve some exposure to leading foreign companies by using Yankee bonds, 144a securities, and private placements (as described below). These investments will offer greater diversification from the potentially sluggish U.S. recovery, but will not add currency risk to the portfolio, because they will be denominated in dollars.

A bond buyer must be concerned about more than yield; he should consider as well the creditworthiness of borrowers and their ability to weather another downturn in the economy or an extended period of slow growth. Investors should favor lending to companies that will be able to maintain their capacity to pay debt service, even in the absence of robust growth. One method of doing this is by lending to companies that prefer to issue debt in the private rather than public markets.

Private placements are a primary asset class used by most

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**Table 1  2008 Year-end Unrealized Loss Positions**

<table>
<thead>
<tr>
<th>Company Type</th>
<th>Bond Portfolio Market Value</th>
<th>Unrealized Loss</th>
<th>Unrealized Loss (in%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>1,899</td>
<td>(198)</td>
<td>-9.4%</td>
</tr>
<tr>
<td>Property/Casualty</td>
<td>1,536</td>
<td>(43)</td>
<td>-2.7%</td>
</tr>
<tr>
<td>Combined</td>
<td>3,435</td>
<td>(240)</td>
<td>-6.5%</td>
</tr>
<tr>
<td>PIAA</td>
<td>15.8</td>
<td>(0.3)</td>
<td>-1.6%</td>
</tr>
</tbody>
</table>

Source: Highline Data

**Table 2  Estimated 2009 Fixed Income Pre-Tax Total Return by Line of Business**

<table>
<thead>
<tr>
<th>Percentile</th>
<th>Life</th>
<th>PC</th>
<th>Health</th>
<th>PIAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>1.65%</td>
<td>1.38%</td>
<td>-0.12%</td>
<td>5.05%</td>
</tr>
<tr>
<td>20%</td>
<td>4.80%</td>
<td>3.72%</td>
<td>0.96%</td>
<td>6.74%</td>
</tr>
<tr>
<td>30%</td>
<td>7.48%</td>
<td>5.30%</td>
<td>2.15%</td>
<td>7.08%</td>
</tr>
<tr>
<td>40%</td>
<td>9.44%</td>
<td>6.46%</td>
<td>3.48%</td>
<td>8.50%</td>
</tr>
<tr>
<td>50%</td>
<td>11.26%</td>
<td>7.59%</td>
<td>5.45%</td>
<td>8.90%</td>
</tr>
<tr>
<td>60%</td>
<td>13.09%</td>
<td>8.50%</td>
<td>7.05%</td>
<td>9.55%</td>
</tr>
<tr>
<td>70%</td>
<td>14.70%</td>
<td>9.40%</td>
<td>8.52%</td>
<td>10.20%</td>
</tr>
<tr>
<td>80%</td>
<td>16.11%</td>
<td>10.85%</td>
<td>10.14%</td>
<td>10.88%</td>
</tr>
<tr>
<td>90%</td>
<td>18.17%</td>
<td>13.53%</td>
<td>12.21%</td>
<td>11.96%</td>
</tr>
</tbody>
</table>

Source: Highline Data and Prime Advisors, Inc. analysis
large life insurance companies and some P/C and health insurers. Most private issues contain higher levels of protection for the lender than publicly issued debt; these come in the form of covenants addressing change-of-control, debt coverage ratios, asset tests, negative pledge tests, and other similar restrictions. The effect of these covenants is to prevent the borrower from taking certain actions that would reduce its ability to pay interest and principal on its debt.

These contractual provisions can be particularly important in a cycle that may see increasing M&A activity. Such M&A activity generally increases company debt and operating leverage, thereby resulting in lower bond prices and downgrades. The change-of-control provisions and other covenants in private placements give holders of these securities more protection from adverse future events.

A valuable opportunity in the private-placement debt market is the additional yield that can be earned by purchasing private placements, rather than similar credit-quality public debt. This additional yield is compensation for the lower liquidity of a private placement, as there are few buyers available to purchase the security if an insurance company holder wishes to sell. Currently, private placements may yield an additional 40 to 100 basis points (0.40% to 1.00%) over similar public bonds. For an insurer able to hold the security to maturity, this additional yield and stronger covenant protection are attractive compensation for giving up some degree of trading liquidity.

Figure 2 shows the average private placement allocations for life, P/C insurers, and PIAA insurers in several size classifications. As may be expected, larger insurers tend to invest in more privately placed bonds than smaller ones. The chart shows that life insurers tend to use significantly more private placements than P/C insurers, with the largest carriers holding nearly 30% private placements in their portfolios. By comparison, private placements are essentially unused in all but the largest of the PIAA companies, and large companies use them only sparingly. Because of certain purchase restrictions, private issues are best used in companies with more than $100 million in invested assets (Figure 2).

**Conclusion**

Although the credit crisis of 2008 has passed, significant perils remain in the fixed income investment markets. Prudence requires that the management and oversight of bond portfolios be conducted with these risks firmly in mind and addressed. The low-yield environment and economic uncertainties present risks that must be navigated with experience and care. PIAA companies should be aware of the options available for proceeding forward in this market, ensuring that they have included strategies that will provide the greatest opportunities to achieve satisfactory investment returns, without incurring unwarranted risk.
BMS is a leading insurance and reinsurance intermediary founded in 1980. BMS services clients from locations in London, Bermuda, and North America, focusing on reinsurance, program, and specialist insurance brokering. Theresa Schugel was appointed in November 2010 to lead the expansion of its global specialty casualty practice, which has strong expertise in medical professional liability, lawyers’, and accountants’ professional liability, workers compensation, D&O, and other general liability classes. Theresa spent the last four years leading Aon Benfield’s Global Healthcare and Lawyers Professional Liability Practice, in addition to her role as Global Team Leader on specific accounts. Formerly CEO of the Benfield subsidiary Paragon Strategic Solutions, Theresa also led a national healthcare origination team for Benfield. Prior to her time at Benfield, Theresa spent 14 years working for The St. Paul, primarily within their Medical Services Division and as the ceded reinsurance buyer for all lines.

**Q:** During 2010, which events surprised you in the medical professional liability market?

**A:** Initially, I would say that I was surprised not to see more M&A activity within the medical professional liability carriers. We certainly saw a consolidation of the customer base for this sector. However, we didn’t see the same degree of consolidation between the carriers themselves. The consolidation of the customer base is a result of the increasing trend for hospitals to employ physicians, and that is really driven by the decrease in Medicare reimbursement, as well as a reduction in the sources of revenue for physicians. The effect of that trend has been this push towards the consolidation of the customer base, but this did not correlate to an increase in M&A activity for the carriers. There were a handful of deals that took place, but not that many.

Second, I have been a bit surprised by the continued pace of development within the alternative market. The risk retention groups and the rent-a-captives, as an alternate market sector, have continued to grow. I am surprised because the current rate environment is pretty attractive, and generally the alternate markets are formed to obtain rate relief, but that does not appear to be the primary objective in the current environment.

**Q:** You recently joined independent specialist broker BMS Group. Have your first few months with the group been all that you expected?

**A:** It really has, and at the risk of sounding a bit clichéd, and even more! Organizations are often defined by their people, and BMS is a great example of an organization where the people have a passion for what they do and at the same time have the autonomy and flexibility to do what is best for the client. That is a very powerful equation in this challenging market.
Q: BMS has a U.K. and U.S. platform. Do you think it is possible to provide a niche offering while trying to expand and cover both markets?

A: What BMS has is really an integrated platform, U.K. and U.S. I view it as critical to our success that we operate truly as one team. There is no “we” and “they” in the way we approach the market. Taking the London expertise and reputation and exporting that platform to the United States has meant that we have capitalized on both. What I have learned in the short time I have been with BMS is that our customers have encouraged us to expand our footprint in the United States, to further leverage the approach that we bring to the market, with our one-team, one-platform concept. In doing so, it is critical that we maintain the strong servicing standards that are at the foundation of our approach.

Q: Healthcare reform is a hot topic at the moment. What are your views on the potential implications to the PIAA member companies?

A: We really do not know for certain what the impact will be, especially in light of recent developments. However, I would expand on that in a couple of areas. First, clearly there is the potential for increased demand. With the reform comes the introduction of the proposed wellness initiatives, which in turn could potentially increase the overall use of the medical services provided through the reform bill. We have also seen an increase in home healthcare, a trend that is expected to continue. So this and the wellness initiatives could both increase the demand for MPL coverages.

Furthermore, there is the pressure within Congress to repeal the antitrust exemption through the McCarran-Ferguson Act. The medical professional liability sector was able to bypass this, because the final enactment of the healthcare reform did not include a repeal of McCarran-Ferguson. As we know, there were threats that it would be included—but it did not happen. Also, national tort reform for medical professional liability was not included—a topic experiencing heightened attention in the last few months.

Therefore, if you take both components, the implications of McCarran-Ferguson and the potential consideration of national tort reform, both issues associated with strong political agendas, could resurface in the future and require further consideration by the PIAA member companies.

Q: How will BMS be reinventing itself in 2011 to better adapt to the changes in the specialty casualty market?

A: This question brings me back to our opening discussion around one trend we have seen in the market, for more and more physicians’ groups to be employed by hospitals and the implications to the PIAA sector. In other words, their client base is shrinking, and it is forcing the PIAA members to ask themselves: “What do I want to look like and how can I reinvent myself?” In parallel, BMS is reinventing itself. We are at a point in the current market cycle where companies are required to step back and evaluate where and how they can be most successful.

Competition is intense and top-line growth is extremely challenging. You couple that with the uncertainty we touched on with healthcare reform, and this further reinforces the need for companies to explore various options and alternatives. BMS is well-positioned to be a strategic alternative to these companies—as a function of our size, agility, our unique approach, and the service differentiation we bring to the market. All of these factors speak to the types of things that we are doing to further build our brand in the market to do what is best for our customers. Reinventing means developing relevant analytics for clients and prospects. As we reinvent, I also think of further accessibility and, as we discussed, our need to build out our platform in the United States. It also requires a unique synergy and market responsiveness, between the customer and the market; by “market” I mean both the reinsurer and the reinsurance intermediary. This dynamic that we bring to the market is something that I am certain will be very well-received and moreover, will be timely and relevant in satisfying this need for a viable alternative in the market.

Deaths from Medical Error?

Because the IOM numbers in “To Err Is Human” are still cited, almost by rote, in articles on patient safety, let’s see how one analyst responded.

“We reviewed the studies cited in the IOM committee’s report. They substantiate its statement that adverse events occur in 2.9% to 3.7% of hospital admissions. Supporting data for the assertion that about half of these adverse events are preventable are less clear. In fact, the original studies cited did not define preventable adverse events, and the reliability of subjective judgments about preventability was not formally assessed. The committee’s estimate of the number of preventable deaths due to medical errors is least substantiated. The methods used to estimate the upper bound of the estimate (98,000 preventable deaths) were highly subjective…”

Don’t Miss the PIAA Fall Workshops!

September 14–16, 2011
Technology, Human Resources, and Finance Workshop
Omni Shoreham Hotel
Washington, D.C.

Sessions include:
- Finance: MPLI Investment Results and Capital Market Opportunities — You’ll hear a 360-degree overview of the current investment market for insurance companies, against a background of trends in the general economy. The speaker will provide detailed information on the year-over-year performance in the MPL insurance industry, and suggest some smart options for portfolio strategies. He will highlight in particular the more attractive alternative investment vehicles currently on offer.
- Human Resources: Compensation Update — PIAA human resource professionals need to keep up with compensation trends in the MPL industry. But is your compensation plan competitive? Does it need to be updated regularly? Are your compensation policies working for hiring and retaining a high-caliber staff? The session will explain recent compensation trends, and tell you about the policies that need to be in place for a competitive and compliant plan.
- Information Technology: Technology
Hot Topics — This session is a compact format, addressing several IT topics by a panel of presenters. The results of the Information Technology Survey Results (data from 2010), an overview of the PIAA Data Sharing project, and electronic vaulting (sending data off-site) will be covered in-depth.

October 5–7, 2011
Underwriting Workshop
The Fairmont Olympic Hotel
Seattle, Washington

Sessions include:
- Physician Re-entry to Practice: What Does This Mean for MPL Carriers? — Many physicians are going back into clinical practice, sometimes after a long period of inactivity. To meet requirements for re-licensure, the AMA has been encouraging re-entry programs. But what about the physician who hasn’t yet relinquished his license? How do MPL insurers evaluate an applicant’s current clinical competence, in underwriting? You will hear about one company’s experience with a task force on physician re-entry to practice.
- Medi/Day Spas: What Is the Real Exposure? — Given the proliferation of medi/day spas, what is the real exposure for physicians working as medical directors there? Can the medical director be held liable for actions of employees, even if they aren’t under his supervision? Learn the answers to these questions and more in this informative session.
- Minimally Invasive Surgery: Does Less Invasive Mean Less Risk? — You’ll get invaluable guidance on the risks associated with the most common minimally invasive procedures. You will find out what kinds of additional training physicians need to perform these procedures. It will also cover the risks in each of the settings for the procedures: the physician’s office, the ambulatory surgical setting, and the hospital (inpatient).
- Early Detection—Is It Too Expensive? — Two causes of action for MPL claims are delay in diagnosis and delay in treatment. But new healthcare guidelines tell physicians to order fewer screening examinations (or delay screening) for many potentially serious conditions, making early diagnosis virtually impossible. The speaker will discuss these issues and offer strategies for underwriting physicians while accounting for these new recommendations in the underwriting process.

November 2–4, 2011
Claims/Risk Management Workshop
Charleston Place Hotel
Charleston, South Carolina

Sessions include:
- Claims: Overview of Robotic Assisted Surgery — This session will review various types of surgical procedures where robotic assisted surgery is now in use. The speaker, a widely recognized expert in the field, will discuss the benefits, required training, and associated risks with robotic assisted surgery.
- Risk Management: Simulation in Obstetrics—What Is It and How Do I Use It? — Simulation in medicine has become a hot topic once again. This session will tell you how to use simulation in the training of obstetricians and in maintaining their competency. The speakers will explain how simulation has been used in their organizations and talk about the benefits of this tool.
- Claims: Anti-coagulation Therapy—the Medicine, the Monitoring, and the Malpractice — The presenters will discuss the range of clinical applications of anti-coagulation treatment, the drugs presently in use, and the new drugs coming on line in the near future. Correct procedures for monitoring blood levels of anti-coagulant will be covered as well.
- Risk Management: Share with Me! What Works for You? — Participants will join in a discussion with their colleagues in risk management to offer each the essentials of practical risk management needed to improve patient safety. You’ll hear about risk-management guidelines, checklists, forms, sample policies and procedures, and the clinical management tools that have proved effective, reducing claims.

To view the complete agendas for any of these workshops, or to register online, go to www.piaa.us.
On the surface, the U.S. economy appears to be well on the road to recovery from the most devastating recession since the Great Depression. Gross domestic product has rebounded on the heels of renewed inventory accumulation, an early uptick in capital spending, a more confident consumer, and improved foreign demand. The banking system has been released from the ICU, and the farmer is singing the praises of higher prices for products, livestock, and land.

Corporate profits have rebounded impressively. As of early March, interest rates have settled down from their recent trading-range highs, and stock prices have weathered several bouts of selling, while extending their fall and winter rally. Why is it, then, that a certain uneasiness continues to permeate Main Street, and what might that portend for trends in the economy and capital markets over the near future?

Economic inflection points are difficult to detect in advance, particularly two months forward from a publication deadline. It’s a bit like “picking fights with thunderstorms and charging into trees.” Nonetheless, it appears that such a point may soon be upon us, for lurking in the background is the realization that this recovery is as different from recent recoveries as the credit-induced recession that preceded it differed from its recent forebears. The rate of growth in GDP, eight quarters into the recovery, is still far below the average of post-war recoveries. Retail sales remain lumpy, threatened by meager gains in real disposable income and the crossover effect created by much higher food and energy costs. The housing industry, in general, and home prices in particular, are struggling to carve out a bottom. Perhaps most important, the prospects of full-time employment remain elusive for the vast majority of the 8.5 million unfortunate souls who lost their jobs during the Great Recession. (Nearly as many additional workers have accepted part-time employment, in lieu of something more permanent.)

Fiscal policy is spewing red ink at record rates, the Fed has tripled the size of its balance sheet in the course of redefining the term “monetary intervention,” and commodity prices have gone parabolic on a worldwide basis. While classic signposts of inflation—such as unit labor costs and the personal consumption expenditure deflator—remain well behaved, the “average Joe citizen,” who continues to eat and drive to work every day, is facing increasingly difficult tradeoffs in making ends meet.

Apart from these worrisome crosscurrents, there are several headwinds that the economy may soon have to contend with. Barring a serious economic relapse, the unprecedented peacetime fiscal stimulus that has helped to “prime the pump” over the past two years is likely to evaporate very soon, as a spirited group of new House conservatives work to re-scale the federal budget and lower the upward trajectory of the national debt. Even such recovery-sensitive support programs as extended unemployment insurance and “infrastructure improvements” are squarely in their crosshairs.

A more conservative fiscal philosophy has also materialized at the state and local levels, where large budget deficits are likely to force cutbacks in services and employment that cannot help but have a further negative impact.

Barry Connell is Managing Principal of the Shamrock Advisory Group LLC, investment consultants to insurance entities; Barry@shamrockag.com.
on the national economy.

The Fed’s massive monetary intervention also appears to be in its late stages. Armed with potentially (much) higher near-term producer and consumer inflation numbers—on both a headline and core basis—the current voting members of the Federal Open Market Committee are unlikely to cotton (no pun intended) to a new round of quantitative easing that would risk even higher inflation in the future. After all, prices of many feedstock commodities—petroleum products, industrial metals, and grains—have nearly doubled over the past year or so.

Even the price of farmland, long resistant to short-term inflationary trends, has risen 20% in many parts of the Midwest over the past year. Are these the smoke signals of a more permanent trend? (Of course, absent more pronounced improvement in employment and consumer spending, Chairman Bernanke may take a more dovish position, arguing that the ongoing weakness in money turnover and velocity has at least temporarily reduced the risk of money-supply-induced inflation.)

The season of our discontent

As spring turns to summer, this recasting of fiscal and monetary policy should provide a moment of truth on the underlying or fundamental strength of the economy. A worrisome chain effect could develop, as consumer spending is diverted by higher food and energy costs (each 1 cent increase in the cost of gasoline reduces alternative spending by approximately $1.2 billion) and exports suffer from “growth-hiccups” in the European Union (arising from internal austerity measures) and the Asian economies (struggling to contain persistent inflationary pressures). The possibility of a prolonged and potentially more serious “oil shock” resulting from further unrest in the Middle East is particularly worrisome, as a persistent $100+ price tag on crude oil would likely reduce domestic GDP by at least a percentage point. Clearly, a convergence of these various forces would quickly undermine the recovery.

It is therefore quite possible that the current “macroeconomic trend” may soon subdivide. Near term, there may be some downward pressure on the growth rate of GDP as the factors cited above wash through the economy. Inflation may become a front-page item for a few months, as the price spikes in petroleum and industrial and agricultural products work their way through the system. Higher input costs and flat-to-somewhat-lower sales from abroad (the source of the majority of sales gains for American companies over the past year) could...
negatively impact corporate profit margins over the near term, particularly in industries that enjoy limited pricing power.

In the intermediate term, however, as federal and state budgets stabilize and foreign economies once again catch their stride, organic growth should replace the effect of the stimulus programs, driving unemployment down and permitting the Fed to normalize interest rates, particularly at the short end of the yield curve. This should result in a more consistent growth pattern that, barring exogenous shocks, could persist for some years. In such an environment, corporate earnings should flourish.

With respect to the capital markets, these divergent trends would, at first, likely depress intermediate and long-term interest rates, but thereafter, as growth re-accelerates, force a gradual increase through the upper bounds of their recent trading range. Over the near-term, sector spreads may widen somewhat, but then resume their decline as economic growth picks up. Stock prices might be expected to retrace some of their recent gains before moving toward their all-time highs.

**How sweet it was**

With perfect hindsight, the Great Recession provided exceptional investment opportunities. However, the ability of the average MPL company to capitalize on these opportunities was largely dependent on a combination of cash flow, then-current portfolio exposures, and capital gain and loss constraints. The realities were such that while some changes were possible and executed upon, ingrained asset-allocation practices and natural tendencies toward risk aversion, initially at least, mitigated against a drastic change in portfolio holdings. The further decline in interest rates through much of last year, while abetting a total-return objective, served notice to yield-based investors that the party lights were dimming. Stock investors willing to stay the course continued to prosper, as the rising tide of corporate earnings floated nearly all boats.

Preliminary results from the 2010 Peer Group Analysis study conducted by the Shamrock Advisory Group confirm widely diverse reactions by individual companies within the MPL industry to last year’s investment trends. On a year-over-year, industry-wide basis, yield on invested assets declined fairly significantly, particularly in the taxable-security arena. Average maturity exposure and average rated quality of fixed-income security holdings declined somewhat, while common stock exposure increased, all within the context of a somewhat higher level of portfolio turnover. Operating results were enhanced by significant improvements in both loss and combined ratios. This helped generate somewhat higher operating margins and a gratifying improvement in surplus.

As Act I of the current economic recovery draws to a close, the near- and intermediate-term uncertainties surrounding the economy remain significant. Those uncertainties could easily give rise to a renewed spate of market volatility and, at minimum, a brief reversal in the trends that most observers had hitherto assumed were well established.
Retained surgical items (RSI), such as sponges, towels, or gauze, are not typically given a second thought—that is, until one is inadvertently left inside a patient after surgery. According to the American Hospital Association, America’s hospitals perform nearly 30 million surgeries and deliver 4 million babies each year. Perhaps the most alarming statistic, according to recent surgical literature, is that an estimated 1,500 to 2,000 RSI cases occur each year in the United States. In fact, there is growing evidence that these estimates are conservative and that the actual number of incidents involving retained surgical items may be even greater. RSIs are classified among the growing list of “Never Events” for which the Centers for Medicare and Medicaid Services (CMS) and private insurers will no longer provide reimbursement.

Despite strict counting protocols, surgical sponges are unintentionally left inside patients after wound closure. These types of preventable events are a potential source of morbidity for patients and a liability for care providers and institutions.

The complications with surgical items left behind are significant—post-procedure infection, pain, bowel perforation, abscess, follow-up surgery, and in some instances death. Patients may also have expenses from additional follow-up visits or medication. In addition to patient safety and care issues, incidents of RSI can also result in re-operative expenses, legal issues, and compromised reputation for providers.

RSI incidents also negatively impact operating room (OR) efficiency, and staff may spend an inordinate amount of time rectifying miscounts if not all surgical items are accounted for. When this happens, nurses may need to be pulled in from other areas in the OR to assist.

Cases with retained surgical items can be often linked to high-risk emergency and trauma situations that lead to unexpected findings and strict time pressure on OR staff, resulting in “no-time-to-count procedures.” However, no type of surgery is “immune” to the risk of a retained surgical item, which can also occur in laparoscopic surgeries, elective cases, and even in procedures performed in ambulatory settings, among others.

One study published in 2008 by the Journal of the American College of Surgeons, noted that 62% of retained surgical items were detected after the surgical count was reported as correct. Other surgical literature suggests that up to 88% of cases with retained surgical items are associated with falsely reported correct counts.

In August 2010 the Association of periOperative Registered Nurses (AORN) made public the results of a comprehensive Healthcare Failure Mode and Effect Analysis (HFMEA) titled: “Limitations of the Surgical Count.” The HFMEA found that the top five causes for potential failures involving surgical counts are: distraction, multitasking, not following procedures, time pressure, and emergency cases. These causes account for 91% of all cases yielding to surgical count failures. The presenter, Victoria M. Steelman, PhD, RN, concludes: “Counting is not enough to prevent retained sponges 100% of
the time, and peri-operative nurses should evaluate technology for assistance. AORN’s recently revised Recommended Practices for Prevention of Retained Surgical Items also includes a new recommendation that peri-operative nurses evaluate technology to assist with the surgical count.

The rise of adjunctive technology
Bellevue, Washington-based RF Surgical Systems is looking to eradicate the problem of retained surgical items with a state-of-the-art detection system designed to alert operating room staff automatically if a foreign object is left behind. The company recently released the latest version of its technology platform—the RF Assure Detection System—which features an automatic detection mat that allows for “hands-free” patient scanning. The system safely and accurately reads through deep cavity tissue, fluids, and bone to detect if any radio frequency tagged surgical sponges, gauze, or towels remain in a patient following surgery. With the push of a button, the system can perform a complete scan in 15 seconds, mitigating the risk of a retained sponge, even during emergency situations. Additionally, the system has a dual-detection mode with a wand that is used to perform a quick scan to rectify sponge counts and is useful for extended coverage needs in cardiac, trauma, and bariatric cases.

Besides radio-frequency detection, there are other technologies available on the market to prevent RSI. Radio-frequency identification (RFID) systems utilize a large wand to both detect and count surgical materials, though users have reported that the wand can be cumbersome, and the system has “blind spots” or areas where accurate detection is difficult to guarantee. Additionally, these systems use high-frequency platforms known to be more susceptible to decreased performance in harsh environments such as fluids and metals and can be costly to implement.

Barcode counting uses uniquely tagged items, which are scanned manually, requiring perfect alignment with the reader. Though the barcode counting system features reporting/performance capabilities and is very portable, this technology is not a detection system and is not capable of locating missing surgical items to rectify a miscount or addressing the risk of a retained surgical item which may still occur when the count is accurate. Additionally, this method can be time-consuming to use, because OR staff must manually scan each item to account for it, often making it an inadequate option in trauma or “no-time-to-count” situations. Barcode scanning also requires the staff to handle soiled sponges, which increases risk for exposure to biohazards.

Sponge counting bags offer hospital staff an easy-to-use, low-cost way to visually account for surgical materials. However, this technology offers no way to locate any missing materials and is subject to human errors, again, due to the manual nature of this method.

Finally, x-rays may be used in cases where a retained item is suspected, though this method does not guarantee detection, and this also involves more time and additional expenses.
Clinical data

Interim results from the largest prospective multi-center study on the effectiveness of radio-frequency detection technology to improve surgical counts and staff wound closure confidence were presented at the American College of Surgeons Clinical Congress meeting in October 2010. Results indicated that the system allows for the early detection of missing items, reducing the number of unnecessary x-rays and associated anesthesia time, demonstrating that the technology is easy to operate and is a valuable check and balance to enhance patient safety in surgery.

Additionally, according to a published study in the American Journal of Surgery, the sensitivity and specificity of RF sponge technology are much higher than published reports of surgical counts or published findings of intra-operative radiographs for retained sponges. The sensitivity and specificity of detection of the RF sponges through the torsos of subjects of varying body habitus were 100%.

The incident of a retained surgical item is an error that is highly preventable. As attention to error and patient safety grows, both with patients/consumers, regulatory bodies and hospitals, healthcare providers will continue to invest in and innovate solutions that mitigate human error. Such technology can improve not only care and patient safety, but also efficiency and workflow in the OR, saving time and cost on a daily, ongoing basis.

TOOLKIT

BACKGROUND: Prompted by an increase in interventional pain treatments performed at the level of the cervical spine, we investigated the characteristics and patterns of injury in MPL claims collected from January 1, 2005 to December 31, 2008.

METHODS: We compared claims arising from cervical pain treatments with all other chronic pain claims collected from the American Society of Anesthesiologists’ closed claims database between 2005 and 2008. Claims for spinal cord injury underwent in-depth analysis for mechanisms of injury and use of sedation during the procedure.

RESULTS: Claims related to cervical interventions represented 22% (64/294) of chronic pain treatment claims. Patients who underwent cervical procedures were healthier (American Society of Anesthesiologists’ score, 1-2; P < 0.001) and were more often women (P = 0.011). Of the patients who underwent a cervical procedure, 59% experienced spinal cord damage compared with 11% of patients with other chronic pain (P < 0.001), with direct needle trauma as the predominant cause (31%). General anesthesia or sedation was used in 67% of cervical procedure claims associated with spinal cord injuries but in only 19% of cervical procedure claims not associated with spinal cord injuries (P < 0.001). Of the patients who underwent cervical procedures and had spinal cord injuries, 25% were non-responsive during the procedure compared with 5% of the patients who underwent cervical procedures and did not have spinal cord injuries (P < 0.05, κ = 0.52).

CONCLUSIONS: Injuries related to cervical interventional pain treatment were often severe and related to direct needle trauma to the spinal cord. Traumatic spinal cord injury was more common in patients who received sedation or general anesthesia and in those who were unresponsive during the procedure. Further studies are crucial to define the usefulness of cervical interventions and to improve their safety.

Source: Anesthesiology, March 7, 2011

Claims after Cervical Interventions

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You are probably familiar with the PIAA’s work on behalf of H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare Act. This legislation, based largely on California’s MICRA statute, is the primary vehicle for the renewed attempt at federal-level medical professional liability (MPL) reform during the 112th Congress.

While tort reform continues to be a critical—albeit elusive—goal of the Association, the PIAA has been active as well on a different, yet equally important, legislative track, to protect the interests of its members and their policyholders. In February, Congressman Phil Gingrey, MD (R-GA), and Henry Cuellar (D-TX) working with an informal coalition that included the PIAA and several of its members, introduced federal legislation aimed at protecting healthcare providers from new lawsuits that might possibly arise from language included within the pages of the gargantuan Patient Protection and Affordable Care Act (PPACA).

The bill, H.R. 816, the Provider Shield Act of 2011, states that practice guidelines or standards arising from the PPACA may not be used as evidence of a standard of care in an MPL claim. No less than 14 provisions in the PPACA have the potential to throw open the doors to a glut of new MPL litigation. So the introduction of this bill, which garnered broad support from Reps. Lamar Smith (R-TX), Paul Broun, MD (R-GA), Sam Graves (R-MO), Tim Murphy, PhD (R-PA), and Dan Benishek, MD (R-MI), is a welcome sight to the MPL industry.

We know from past experience that the personal injury bar, in a way that only its members know how, is exceedingly adept at ferreting out new and previously untapped avenues for the filing of MPL claims. The PPACA, absent the constraints of the Provider Shield Act of 2011, could further enrich trial lawyers—at the expense of MPL insurers, healthcare providers, and patients alike.

Dramatic increases in the volume of MPL litigation lead inevitably to greater losses and loss adjustment expenses for MPL insurers, higher premiums for healthcare providers, and an accompanying increase in the practice of defensive medicine. These factors put an additional financial burden on an already economically strained healthcare system—so it is truly in all of our best interests to see H.R. 816 through to fruition.

As your advocate, the PIAA will continue to seek out new potential causes of action that the personal injury bar may use, and halt or constrain them, before they emerge as a threat to PIAA member companies. This is one service that an association that is national in scope, like the PIAA, is uniquely positioned to provide.

Eric R. Anderson is Director of Public Relations and Marketing at the Physician Insurers Association of America; eanderson@piaa.us.
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