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In our nation’s broken medical liability system, there is no greater victim than the patient. Year in and year out, millions of dollars, that could otherwise be used for the care and treatment of men and women, young and old, are wasted in a system that is unpredictable, inconvenient, and, too often, unfair—to patients and providers alike. The economic ramifications are staggering. Last year, the U.S. Congressional Budget Office estimated that savings to the federal government alone would total more than $54 billion over ten years if traditional medical liability reforms were adopted nationwide. That doesn’t begin to quantify the overall costs to our nation’s healthcare system.

The costs associated with maintaining our nation’s patchwork quilt of inconsistent and unpredictable medical liability laws and systems exacerbate state and federal budget crises, raise the costs of healthcare, health insurance, and medical liability insurance, and waste precious resources at a time when the country can ill afford it.

Yet, despite these facts, the fight for a fair and equitable medical liability system is still an uphill battle. Some states, like California, have gotten it right. Because of MICRA provisions enacted nearly 35 years ago, healthcare providers are plentiful, facilities remain open for business, and injured patients receive fair compensation. Other areas of the country have not fared as well.

In Illinois, for example, a study by the Northwestern University Feinberg School of Medicine reported that half of all graduating medical residents or fellows trained in Illinois leave the state to practice medicine elsewhere—and that Illinois faces a severe shortage of physicians if corrections are not made to its liability system.

Compounding localized problems are some eye-opening national statistics. The Bureau of Labor Statistics says the U.S. will need as many as 200,000 more doctors by 2020. Moreover, the Association of American Medical Colleges predicts a national shortage of 62,900 physicians in 2015, which is projected to double, by 2025, to 130,000 across all specialties.

When doctors decide where to practice, they consider many factors, including the threat of liability. They are less apt to practice in areas where litigation is likely—or in rural areas where fewer patients make it harder to pay high MPL premiums. There is a domino effect: soon, these areas begin to experience severe shortages in all-important specialists like Ob-Gyns and neurosurgeons. These barriers must be eliminated, so healthcare providers can continue practicing and patients can still get treatment.

The bottom line is that a broad diversity of interests—those of MPL insurers, healthcare professionals and facilities, consumers, community health centers, local government, public safety groups like those that speak for firefighters and police, and many others—are all aligned in the desire for a fair and equitable medical liability system and accessible healthcare.

So, what can be done? The PIAA, on your behalf, will continue to work diligently to preserve effective, time-tested state medical liability laws, while also advocating for the benefits of medical liability reform on a national level, through its support for bills like the federal Protecting Access to Healthcare Act (H.R. 5) passed recently by the U.S. House of Representatives. Unfortunately, there are no prospects for consideration of H.R. 5 by the U.S. Senate. However, you can make a difference. In this all-important election year, be sure to support those candidates who believe in repairing our broken medical liability system as a way to foster access to healthcare and reduce the high cost of our healthcare system. Your support is critical as we move forward in this essential work.
Claims are smaller but more frequent in the allied facilities space.

—Cover story

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In AHRQ data released in February 2012, nearly half of the 600,000 staffers from 1,100 hospitals surveyed said they believe their mistakes are held against them. Most think that their organizations are still more interested in punishing errors and enforcing hierarchy than in encouraging open communications and taking advantage of adverse-event reports to root out the fundamental causes of these events. Only 47% concurred with the statement, “Staff feel free to question the decisions or actions of those with more authority.” Fifty-four percent think that in an adverse-event report, it’s the person that is being reported, not the problem. Two-thirds are concerned that mistakes are permanently stored in their personnel file. And less than half agreed with the statement, “I feel free to question the decisions or actions of those with more authority.”

The numbers haven’t changed substantially since the first AHRQ report on patient-safety culture that was published in 2007. Granted, one-fifth of the hospitals are doing better in the performance category, “nonpunitive response to error,” but 16% have actually deteriorated. Most are simply about the same. Results are similar for the measures on open communication.


Easier Said than Done: Transition to a ‘Culture of Safety’

It seems to make excellent sense to suggest that healthcare systems switch from a culture of “shame and blame,” where individual providers are cited for medical errors, to one where adverse events are openly discussed. That’s been the general guidance from the Agency for Healthcare Research and Quality (AHRQ). An increasing body of evidence indicates that a higher safety-culture score correlates with better clinical outcomes and lower rates of hospital-acquired infection.

 Trouble is, it’s just not happening. In AHRQ data released in February 2012, nearly half of the 600,000 staffers from 1,100 hospitals surveyed said they believe their mistakes are held against them.

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Source: AHRQ, Hospital Survey on Patient Safety Culture: 2012 User Comparative Database Report, February 2012

Outrageous ICD-10 Codes

There’s been some talk of late about skipping ICD-10 entirely, and segueing right to ICD-11. The World Health Organization already has an “alpha draft” of the guide on its website; the final draft is due by 2015. But in the meantime, wrangling about the date for implementation of ICD-10 continues. Still, both sides agree on the occasionally hilarious specificity of some of the novel codes. Here’s a sample:

1. W5922XA, “Struck by a turtle.” Similarly, there are the mammalian-oriented codes W5612X, “Struck by a sea lion, initial encounter,” and W5609XA, “Other contact with dolphin, initial encounter.”

2. Incidents related to the increasingly anemic space program are included, too: code V9560XS, which speaks to an “unspecified balloon accident injuring occupant, sequela.”

3. The world of water sports gets due mention. The codes include V91.07XA, “burn due to water-skis on fire, initial encounter.” A bit closer to terra firma, there is V9600XS, which speaks to an “unspecified event, undetermined intent.”

4. And something akin to existential angst has its code as well: Y34, “Unspecified event, undetermined intent.”

5. Still, for good old-fashioned puzzlement, many observers like this one best, T7501XD, “shock due to being struck by lightning, subsequent encounter.” It would seem that lightning really can strike twice.

In Maryland, it’s an accepted, though little known, practice for hospitals to provide lawyer referrals to patients unhappy with their care. Several medical systems keep lists of vetted MPL lawyers. It may sound loopy, but in fact these attorneys have agreed to accept patient cases for lower fees, under the assumption that they will be settled quickly. Both the attorneys and the hospitals say that the system works for patients and their families, since this system obviates the long, draining litigation process.

Others see a clear conflict of interest at work. S. Allan Adelman, a past president of the American Health Lawyers Association, is skeptical: “The first question I would have is, would I even want to get a referral from a hospital? I think the whole relationship is tainted.”

But participants in the program say their endeavor is just one element in the whole tort reform dialogue in the United States. A spokesman for Maryland’s MedStar Health says that, “We have identified a small number of very seasoned, highly respected lawyers in the community who have impeccable reputations for being fair and honest.”

Source: Baltimore Sun, January 28, 2012

A new tool, intended to teach healthcare providers about deadly infections, is a Web-based game called Septris. It is (pretty obviously) modeled after the computer game Tetris. Developed by physicians, researchers, and education technology experts at Stanford University Medical Center, it can be played on a mobile phone, a tablet, or a computer.

Here’s what happens, once you log on. The game begins with the cartoon image of two patients on the left side of the screen. On the right are their vital signs—cues that can tip off the fatal presence of sepsis. Along the bottom of the screen are diagnostic tests and treatment options.

“As every second passes,” Stanford’s website explains, the patients’ images sink down on the screen, their vitals deteriorating. It takes less than two minutes for a Septris patient to die, which means that observations and decisions have to be made quickly. “The game’s objective is not just to keep the patient alive, but to cure them.”

Apparently, Septris is just one item in a hot new trend in healthcare—“Gamification.” A recent issue of Medical Marketing & Media comments, “Applying game dynamics to non-game environments created opportunities to engage people and exert behavioral changes with unprecedented success.”

And now, the Web address for Septris: http://cme.stanford.edu/septris/game/index.html.

Source: Fierce Health IT, February 21, 2012

A jury in Jacksonville, Florida, ordered Memorial Hospital to pay $10 million in punitive damages for what amounted to false advertising about its weight loss surgery “Center for Excellence” designation. And then, there was another $168 million in compensatory damages against bariatric surgeon John DePeri, MD, for brain damages that resulted in his patient, when leakage in the patient’s abdomen ensued after a weight loss procedure done in 2007.

Memorial Hospital had used the American Society of Bariatric Surgery’s Center of Excellence accreditation seal in the pamphlets it handed out to potential surgery patients. The seal was also prominent in the items that DePeri distributed when he spoke at informational forums at the hospital.

But in fact, DePeri hadn’t met the requirements spelled out in the bariatric society’s standards for becoming a Center of Excellence. Bariatric surgery can be tricky, so the society requires that all surgeons perform at least 50 procedures; DePeri had done only 21. There are also continuing education requirements, a minimum of 20 hours of coursework; DePeri had taken only one.

Surgical volume is important, of course. But some observers point out that what went so tragically wrong for the patient in this case was the doctor’s failure to follow up on the complications that ensued after the surgery. Nine days elapsed before the surgeon performed a follow-up surgery to repair his patient’s abdominal leak.

Source: JD Supra, February 13, 2012
your organization is today and the actionable steps needed to realize your future business goals. Whether you implement the plan with in-house talent, with the help of an agency, or a combination of the two, this proven method is fundamental to strengthening relationships and growing your business.

What you think
The first step in the Future Visioning process is to gather the perspectives and opinions of your organization’s leadership. The purpose of this session is to address big picture marketing questions, including the desired direction and vision for the company.

The perceptions and goals of the leaders in your organization will help in setting its strategic direction. After extracting this information, you can then synthesize and rearticulate these objectives later, in the Integrated Marketing Communications (IMC) program.

It is also important to identify the key stakeholders. By gaining a better under-
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standing of the people who matter most to your organization, you uncover insights into how to reach and engage with these important people most effectively.

**What they think**
The next step in Future Visioning is to determine what the people outside your organization think about your business, and the best way to do that is simply to ask. By conducting interviews with a handful of prospects and customers whose opinions accurately reflect those of your larger audience, you will establish a current snapshot of the public perception of your brand. It is important to include both fans and naysayers—long-time customers and those whose business you have lost. Knowing what your customers value most is essential to determining your organization's strengths and weaknesses.

**What you are currently saying**
Now that you’ve discovered what the leaders in your organization think and what the people who matter most to your organization think, it’s time to take a look at how you are currently communicating.

If you were to hire an accounting firm, one of the first tasks would be to review your financial records. The same general principle applies here. Conducting a comprehensive audit of all your communication “touchpoints” (every place your customer interacts with your brand or business) will help you understand what you are already saying and how you’re saying it. Look at advertisements, direct mail pieces, sales brochures, signage, how your logo is used in various media, and even e-mail signatures. Does every communication tool have the same message, and the same general look and feel? I once worked with a company that used both of the phrases “cost effective” and “cost efficient” in its promotional materials. While effective and efficient are basically interchangeable, the inconsistency in use of language deterred from the message.

Evaluate the messages from the recipient’s point of view. By looking at these individual pieces as a group, you’ll be able to identify the changes you need to make to express yourself more clearly and consistently.

**What you should be saying**
Now you need to determine what you want customers to know about your organization and develop your key messaging. The key message platform is the DNA of your brand—the essence of what your audience should think of whenever they think of you.

**How you should say it**
The final step of the Future Visioning process is to develop and implement your proactive IMC program. With a new position of excellence clearly articulated, it’s now time to tell your story across the spectrum of all of your marketing and communications activities. As I have discussed in previous articles, a successful marketing communications program is integrated across four channels. In its simplest form, The Four-Channel Media Model is broken down into paid, earned, shared, and controlled media. To create harmony among all your marketing touchpoints, your company must determine the right mix of content creation and distribution based on your goals and resources. The result is a well-orchestrated communications program that connects you with the people who matter most.

**Most organizations that compete in the same space aren’t truly unique when it comes down to the essence of products or services. Positioning your organization as your customer’s best choice is a much stronger strategy than positioning your company as different from your competition. By placing a focus on excellence, you create a long-term sustainable position that won’t change based on the whims of your competition.**

**The key message platform is the cornerstone of your IMC program. Take some time to develop both overarching and audience-specific messages, to provide a framework for talking about your organization in multiple situations. An overarching message is a summary using your points of excellence—the sentence or two you can share with someone at a party when they ask what your company does. Then, the audience-specific messages dive down into the specifics of how your company meets the varying needs of different audiences, and the messages should include objective proof points to enhance your credibility.**

Messages need to be clear, consistent, and effective across all your communications activities. Write it from the recipient’s point of view. Recipient-oriented messages provide audiences an answer to the question: “What’s in it for me?”

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Insurers Continue to Strengthen Position, Despite Prolonged Soft Market

The year 2011 was once again a year of financial growth for the medical professional liability (MPL) insurance industry. While the industry's combined ratio and operating ratio increased slightly from 2010, both remained near the low levels seen since 2006. Insurers were able to release reserves once again, and they returned a substantial portion of these releases as policyholder dividends. Despite the slight decline in financial results, the MPL industry once again set a record for the amount of dividends returned to policyholders during 2011. Surplus also grew moderately in 2011, providing the MPL industry with additional capital support.

At the same time, the profitability of the industry continues to be squeezed from both sides, albeit slowly. Frequency increased modestly during 2011 for some companies. Along with rate levels that have continued to decrease, this moderate increase in frequency had a small impact on the industry's underwriting results. Additional increases in frequency, going forward, could impact bottom-line results for MPL writers.

In addition, 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 2011 in particular, reserve releases contributed 32 points to the industry's operating ratio. Even without these reserve releases, the industry would have been profitable in 2011—but an increase in frequency going forward could change that picture.

Today's MPL market shows mixed characteristics. Increased competition has exacerbated declines in rate level and, for some insurers, has led to declines in the amount of business written as well—the result of underwriting discipline utilized in the face of this competition. These observations are characteristic of a soft market, yet the financial results demonstrated by the industry are very much characteristic of a hard market. Taken together, these results suggest to us that the industry is in a prolonged soft market, in which lower rate levels will continue to be the norm for several years to come.

Also facing MPL writers is a possible increase in inflation. Since 2007, increases in indemnity severities for MPL writers have been flat to small, although increases in defense costs per claim have been in the range of 6% to 8% per annum for most carriers. An increase in indemnity claim costs going forward, at a rate consistent with more typical levels of inflation, could impact the adequacy of both rates and reserves.

Possibly more concerning is the impact of inflation on asset values. Treasury yields reached historically low rates in 2011; even the 5-year Treasury bill had a yield of less than 1% per annum by the end of the year. An increase in yield rates going forward could significantly devalue bonds, by far the largest...
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asset class for MPL writers. Insurers could be forced to sell assets to meet ongoing obligations (whose costs have also been adversely impacted by inflation) for amounts that result in capital losses and, possibly, declines in surplus.

In last year’s “Industry Update,” we commented extensively on the possible impact of healthcare reform on the MPL industry. Since most provisions of healthcare reform have yet to take effect, and several are in fact still being deliberated by the U.S. Supreme Court, this potential impact remains almost as uncertain today as it was a year ago. If the reform is deemed constitutional, one likely outcome will be a decline in the availability of healthcare providers, as a result of an increase in the insured population. Presumably, such an outcome could only impact MPL writers negatively, as patients experience a greater level of frustration with their providers, and perhaps more adverse outcomes due to delays in obtaining medical care.

To get a more detailed picture of the state of the MPL industry today, we have analyzed the financial results of a composite of 46 specialty writers of MPL coverage ("the composite"), all of which can be considered well established. We have excluded the “startup” writers, because, nationwide, they remain a minority in terms of volume of written premium; 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 SNL Financial. 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 46 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 or otherwise left the market, as well as the multi-line commercial writers of MPL coverage. The companies in each of these three excluded categories are generally less well capitalized than the 46 companies included here. In addition, while the underwriting results of the startup companies have typically been comparable to those of the composite, 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 more favorable than a view of the industry as a whole.

**Written premium**

Last year, 2011, marked the sixth straight year of decreases in direct written MPL premium for our composite (Figure 1). Cumulatively, premium has decreased by almost $1.1 billion since 2005—more than 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...
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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 some characteristics that distinguish it 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 substantial 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 slightly reversed itself.

**Overall operating results**

As measured by the composite operating ratio, the industry appears to have reached its nadir during 2010. During that year, the composite posted an operating ratio of 52%, which rose to 59% in 2011 (Figure 2). The increase in 2011 was driven by a slight deterioration in underwriting results, as well as a small decline in investment returns. The combined ratio for the industry was 83%, up from the 79% combined ratio of 2010 (Figure 3).

The investment gain ratio of 24.5% in 2011 declined from a ten-year high of almost 28% in 2010. This was perhaps an expected result, given the declining impact of the write-downs taken on invested assets during 2008. In 2010, the realized capital gains ratio hit a ten-year high of 6% of net earned premium, as companies sold these previously devalued assets. In 2011, there were fewer devalued assets remaining from the 2008 time period, and the realized capital gains ratio declined for the MPL writers to 3.5% of net earned premium. The decline in the investment income ratio was somewhat less, going from close to 22% in 2010 to about 21% in 2011, comparable to other recent calendar years.

The calendar-year loss and loss adjustment expense (LAE) ratio for 2011 of 55% was slightly higher than the comparable figure for 2010, 52%. The increase was driven by smaller reserve releases in 2011 as well as an increase in the initial loss and LAE ratio carried for the 2011 coverage year, relative to what companies carried for 2010 a year ago. The loss and LAE ratio carried for the 2011 coverage year, as of year-end 2011, is about 87%, two percentage points higher than the 85% loss and LAE ratio carried for the 2010 coverage year as of year-end 2010. Given the small increases in frequency, along with continued rate decreases in many locales, this increase seems reasonable, and it may suggest a modest decrease in the level of reserve adequacy for the industry in 2012.

**Reserve releases**

Reserve releases for the composite in 2011 declined slightly, to just under $1.3 billion, from the all-time high of more than $1.3 billion in 2010 (Figure 4). While significant, these releases should be put in the context of the reserves carried...
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by the composite, which for net loss and LAE totaled $11.3 billion as of year-end 2010. The release of reserves was driven by the continued impact of a lower frequency, combined for many companies with a relatively benign severity trend during the past several calendar years.

While a lower frequency in MPL claims has been recognized 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 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 increases in reported frequency for some 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 are theoretically exactly adequate, 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 the older coverage years) in subsequent calendar years.

Finally, as we have mentioned several times now, the industry has seen a dramatic decrease in reported frequency over the past decade. However, for many companies, frequency (on a per-physician basis) has stabilized. For others, frequency 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 (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, in Figure 5, we have adjusted the 2011 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 2011 report year would likely be between 7.8 and 8.0 claims per $1 million of gross earned premium. This suggests a frequency slightly greater than in 2010. Thus, cumulatively, frequency (measured relative to premium) has increased by 15% to 20% since the 2007 year. This increase is largely the result of rate decreases (mostly in the form of greater premium credits, as opposed to manual rate changes) coupled with modest increases in “true” frequency—i.e., claim frequency per insured physician.

Capitalization
The industry’s strong operating results in 2011 resulted in a significant increase in surplus during the year of about 6%, from $10.3 billion to $10.9 billion (Figure 6). This is a noticeable gain, but still less than each of the gains experienced (on a percentage basis) in the years 2004 through 2010 (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 biggest 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 998% in 2011, 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 450% to a high of over 5,300%.

Policyholder dividends
At the same time, the increase in surplus has been slowed by the increasing amount of policyholder dividends paid by MPL writers. In 2011, the composite writers paid an all-time high of $277 million in policyholder dividends, or 7% of net earned premium. Cumulatively, the composite has paid almost $1.4 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 paid higher premiums. We expect that policyholder dividends will continue for several more years, given their historically cyclical behavior and the year-over-year increases seen to date.

In 2011, the composite writers paid an all-time high of $277 million in policyholder dividends, or 7% of net earned premium. Cumulatively, the composite has paid almost $1.4 billion in policyholder dividends since 2005.
Personal Take

Getting Better All the Time: The Decade-long Improvement in Patient Safety

PART TWO IN A FOUR-PART SERIES

In the past decade, tremendous innovation and passion have been brought to bear on the goal of improving patient safety. As an actuary, I’ve been excited to watch the sheer diversity of risk management programs and environmental, health, and safety initiatives. The big news is how well these programs have worked. Multiple factors have played a role in achieving an overall decline in claim frequency. In Part Two of this article, I describe the results coming from patient safety alerts and The Joint Commission.

Patient safety alerts: Getting the word out
We recognize the wisdom of warnings about potential hazards with products and services. The U.S. Consumer Product Safety Commission is responsible for protecting consumers from unreasonable risks of injuries from using products. As a parent, I’ve been grateful for the warnings on TV that helped me steer clear of unsafe toys. But many of us outside the healthcare profession might not know about the similar kinds of efforts, on behalf of patient safety, from organizations all across the country.

On March 20, 2002, Pennsylvania Act 13 was signed into law. As part of that law, the Act created the Pennsylvania Patient Safety Authority (PPSA). For its website, www.patientsafetyauthority.org, the PPSA collects and analyzes “serious events” and “incident” data from healthcare facilities and nursing homes across Pennsylvania to zero in on emerging trends and recommend changes in healthcare practices and procedures. The changes may help in reducing the frequency and severity of serious events and incidents.

The PPSA’s advisory library is a repository that dates back to 2004. The website lets users search using terms such as “discipline,” “audience,” “care setting,” “event,” “patient safety focus,” and “hospital-acquired infection.” The advisories issued by the PPSA cover a wide range of topics: medication errors, medications linked with a high number of alerts, adverse drug reactions, dangerous abbreviations, patient falls, foreign objects retained after surgery, surgical site infec-
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tions, and communication.

Here’s one example of a PPSA advisory alert. It illustrates how the PPSA identifies issues and then takes action to minimize future incidents.

In 2006, the PPSA received a report about a clinician who had nearly failed in resuscitating a patient incorrectly designated as Do Not Resuscitate (DNR), as indicated by the hospital’s yellow wrist band. Unfortunately, the nurse on duty at the time worked at two hospitals; the yellow wrist band had different meanings at each of them. After this incident, the PPSA surveyed all of the patient safety officers of Pennsylvania’s hospitals and ambulatory facilities. Figure 1 shows their findings, highlighting the inconsistencies of color-coding standards across the state.

The PPSA developed a list of risk-reduction strategies and then helped put together a national working group. Then, the Pennsylvania House of Representatives introduced a resolution to address the issue of color-coded wristbands.
wrist bands. And in 2008, the Agency for Healthcare Research and Quality (AHRQ) published one of its “innovation profiles,” describing a consortium of 11 Pennsylvania hospitals that adopted standard wristband colors, which decreased the number of falls and of allergic reactions as well. Figure 2, from the Hospital & Healthsystem Association of Pennsylvania and PPSA Implementation Toolkit, shows the final version of the color-coding for wristband alerts.

In this instance, the PPSA helped make safety happen, by tackling the color-coding issue locally, and, not stopping there, making a difference nationally, too.

**Work of The Joint Commission**

Another exemplar in providing effective patient safety alerts comes from The Joint Commission. From 1995 to June 30, 2011, the commission reviewed 7,922 sentinel events, from various settings, such as hospitals, psychiatric hospitals, ambulatory care centers, emergency departments, long-term care facilities, and home care. The sentinel events analyzed include delays in treatment, wrong site/wrong patient/wrong procedure or surgery, unintended retention of a foreign body, operative/post-operative complica-

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“Some people want it to happen, some wish it would happen, others make it happen.”

—Michael Jordan, Basketball Star

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**Figure 2 Final Version of Color Coding**

<table>
<thead>
<tr>
<th>Band Color</th>
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<tr>
<td>Red</td>
<td>Allergy</td>
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<tr>
<td>Yellow</td>
<td>Fall Risk</td>
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<tr>
<td>Green</td>
<td>Latex Allergy</td>
</tr>
<tr>
<td>Purple</td>
<td>DNR</td>
</tr>
<tr>
<td>Pink</td>
<td>Restricted Extremity</td>
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tions, patient falls, and medication errors.

Figure 3 displays, by year, the 573 medication errors reviewed by The Joint Commission.

Based on their research, The Joint Commission has published seven sentinel event alerts on medication errors:

1. Issue 11: High-alert medications and patient safety
2. Issue 16: Mix-up leads to a medication error
3. Issue 19: Look-alike/sound-alike drug names
4. Issue 23: Medication errors related to potentially dangerous abbreviations
5. Issue 35: Using medical reconciliation to prevent errors
6. Issue 39: Preventing pediatric medication errors
7. Issue 41: Preventing errors relating to commonly used anticoagulants.

In his book, It's Called Work for a Reason, Larry Winget observed, “Knowledge is not power; the implementation of knowledge is power.” The Joint Commission's sentinel event alerts, which offer background information, strategies for reducing risks, and recommendations for better practice, are helping organizations upgrade their patient safety programs by giving them lessons they can act on, right away.

Conclusion
So one key element in improving patient safety is a capacity for close observation of what has gone wrong, followed by a rigorous analysis of the actual data. But that can only take you so far. The next steps, whether that means a resolution in the state assembly, a national coalition, the development of risk management training, or a high-profile alert that contains information you might need to address a problem, may make the critical difference in whether a program takes hold—actually works—or not.

In Part Three of this article, we will explore how several medical specialties have added their own inventive programs to the national drive for greater patient safety.

Reference

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Definition: A “sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase ‘or the risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.”

Source: www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/
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be imposed on any primary payer source or registered reporting entity (RRE). Healthcare medical negligence claims are a lot like any other tort-based personal injury claim: the same claim assessment and payment reporting obligations are imposed, just as they are in the non-medical market.

This "Case and Comment" addresses some of the pitfalls in tort claim settlements, based on an analysis of published court opinions. First, the following are a few general comments on settlement agreements. A private settlement agreement between a responsible primary source and a beneficiary does not bind the United States. Attempted apportionment of economic and non-economic distributions sums that favors the Medicare beneficiary and leaves outstanding, non-reimbursed prior, paid medical expenses will result in recovery action. CMS cannot recover against non-beneficiaries who have legitimate derivative claims, provided that resolution is not deemed a mere diversion—a sham—for the benefit of the Medicare beneficiary. CMS will not disturb an apportionment made by final judgment and/or jury award. The MSP preempts state law. The United States' recovery rights are not mere rights of subrogation; they constitute an independent right of recovery:

"Compliance with the Medicare Secondary Payer Act (MSP) is an essential phrase in the vocabulary of claims management for any tort claim specialist. In brief, Medicare is the secondary payer to other available payment sources for the healthcare-related costs arising from a particular triggering (qualifying) event. Medicare is not obligated to pay when there is another responsible payment source.

From inception and until 2007, the federal government’s MSP recovery efforts were designed around trailing indicators. However, with the passage of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) and a computer-based reporting system up and running, the paradigm has changed. Reasonable protection of Medicare’s interests is no longer a passive component of claims management. As the Centers for Medicare and Medicaid Services (CMS) strive to perfect its MSP reporting and compliance processes, other government-sponsored health plans will follow in kind.

MSP and MMSEA compliance is not for the procrastinator. With each new update to the CMS compliance manual, a new data point or untested mandate may
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received payment for Medicare related items or services, including the beneficiary herself. See 42 U.S.C.A. § 1395y(b)(2)(B)(ii). This independent right of recovery . . . is not limited by the equitable principle of apportionment stemming from the subrogation right . . . . Nothing in the [language of the Act] limits Medicare’s right of full reimbursement.8

In settling claims, state laws that are designed to protect private interests or interfere with the MSP are preempted.9 For instance, a Texas law that sanctioned healthcare providers for not billing within 11 months of service and allowing for debt forgiveness to beneficiaries (payment forfeiture) was found to conflict with the MSP, with MSP compliance governing.10 An Indiana statute establishing a prioritized personal injury judgment lien to benefit a hospital was deemed unenforceable, because of conflict preemption.11

The statute of limitations for MSP recovery is six years, which commences when “facts material to the right of action are not known and reasonably could not be known by an official of the United States . . . .”12 Section 111 MMSEA reporting provisions benchmark this limitations period and include provisions for sanctions, fines, and interest assessment.

MSP and workers’ comp
To date, there are few published court opinions on MSP settlement issues, outside of the workers’ compensation (WC) arena. The WC arena has seen more activity because there have been so many ongoing recurring payment obligations and/or commutations, for which future medical expense set-aside funds were set up. Let’s consider next a few tort-claim opinions and, then, certain WC opinions and, finally, a practice pointer checklist provided for consideration in managing claims.

In Hackley, et al. v. Garofano, et al.13 a settlement was voided because there had been no real meeting of the minds before the settlement was consummated. The Connecticut Superior Court refused to enforce a settlement because, although the settlement amount had been agreed upon, the plaintiffs refused to disclose the Social Security numbers needed for MMSEA RRE reporting. The case arose from an injury to a minor plaintiff, who was still a minor at the time when his father attempted settlement. Since publication of
the Social Security numbers of both the injured party and the personal representative had not been included as a material term of settlement, the court refused to enforce it. The Court rejected plaintiffs’ arguments that the minor plaintiff was not Medicare-eligible, and also found that the father’s Social Security number could be demanded, since the MMSEA

affect[s] all parties involved in a payment of a settlement, judgment or award . . .

This is hardly the first settlement to be derailed because of unresolved questions relating to Medicare liens. Rarely, these have led to published decisions. See, e.g., Riccardi v. Strunk, Judicial District of New London, Docket No. CV 08 5008671 (January 22, 2010, Cosgrove, J.). More frequently, they have simply led to frustration and misunderstanding. Counsel would therefore be well advised to be aware of developments in this area of law and take them into account in fashioning unambiguous settlement agreements.14

Hence, the December 2011 CMS Manual Guide update includes a section outlining that RRE data field publication must include the Social Security number for the injured party, as well as the personal representative or, in a wrongful death scenario, an estate may obtain its own FEIN/Social Security number to fill in this field.15

The WC arena has seen more litigation traffic in the MSP arena, because of the process by which claims are resolved, and the types of injuries for which recovery occurs. A substantial portion of those claims involve commutations and the creation of set-aside funds. In Day v. Helmsman Mgmt. Serv. LLC16 the employer’s failure to fund a set-aside fund because of a post-settlement dispute, related to which party was specifically required to perform certain acts, prompted a suit for payment of actual medical expenses and punitive damages. Starrett v. Commerce & Indus. Ins. Co.17 involved an extra-contractual liability dispute, wherein the former WC claimant’s failure to pay MSP required future set-aside amounts, resulting in an extra-contractual liability claim. In Bindrum v. Am. Home Assur. Co.,18 similarly, the WC insurer assumed responsibility for obtaining CMS’s approval of a set-aside fund. The claimant was injured in 2003. In 2008, a settlement of a disputed WC claim was reached, for a cash lump sum of $225,000 and a set-aside trust to be funded by the defendants, up to a total settlement of $750,000. Under applicable state law, although the parties had each signed the settlement agreement, the agreement was not final until it had been approved by the governing state agency. The trust was not funded for several months after the settlement, and the trust beneficiary then sought to recover damages for the healthcare expenses incurred during the approval delay period.

Best practices
Here then are some pointers, for avoiding the pitfalls that may happen with settlements that involve Medicare beneficiaries and any beneficiary of a publicly sponsored health plan:

■ Early identification of beneficiary status and exchange of key personal identifiers as required by CMS
■ Ongoing comparative analysis of the CMS User Guide
■ Incorporation of key acts of specific performance and conditions before the payment of money and/or establishment of a set-aside fund; the specific actions needed are compliance with CMS-imposed beneficiary and representative disclosures of the material terms needed for RRE data field population and good faith settlement proof of reasonable protection of Medicare’s interests

■ Retention of a qualified Medicare set-aside analyst for claims involving commutations and settlement, particularly in non-Total Payment of Claim (TPOC) situations and in any claim involving ongoing recurring payments

■ Assessment of any state-law conflicts, such as assessment of interest, fees, and penalties for failed payment within a given date of settlement and incorporation of negotiated waivers in preliminary and final settlement agreements

■ Incorporation of documentation of CMS waiver and/or release of all claims as a material part of a final settlement agreement prior to Court approval and pre-suit, prior to payment of any negotiated sum

■ Express designation of all ICD codes applicable to the subject injury for which payment is made, as supported by medical evidence, eliminating those without evidence-based documentation in the medical records.
For the Defense
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Damages Considerations in Civil Liability Matters,
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Requirements, Tamela J. White and Allison Carroll,
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with Medicare Secondary Payer Act and the 2007
Defense
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SCHIP Extension Act of 2007, Tamela J. White,
Payer Act and Section 111 of the Medicare, Medicaid,
3. For general reference see, The Medicare Secondary
4.
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damages found for medical expenses where the
exercise its right of reimbursement only against
7.
6.
Pa. 1967). Id
5.
E.g., Zinman Denekas v. Shalala,
943 F. Supp. at 1079 (“Medicare will relent, however, and
exercise its right of reimbursement only against
damages found for medical expenses where the
medical and nonmedical damages items are deter-
dined by judgment or an arbitration.” (citing
1993), aff’d, 67 F.3d 841 (9th Cir. 1995)).
8. Zinman, 67 F.3d at 845 (citations omitted); see also,
and Dev. Comm’n, 461 U.S. 190, 204 (1983); Cox v. Shalala,
12 F.3d 151 (4th Cir. 1997) (federal law pre-empted
the North Carolina wrongful death act which placed a
$1,500.00 cap on third party recovery of medical
expenses; Medicare entitled to recover the $181,187.75
that it conditionally paid when the parties to the
wrongful death action settled the matter (citing Fla.
Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 142,
142-43 (1963)); State Farm v. State of California,
Supp., (C.D. Calif. 1997) (memorandum opinion) (Medicare entitled to recover the entire
settlement res where its conditional payments exceed-
ed the paying automobile insurer’s policy limits).
9. United States v. R.I. Insurer’s Insolvency Fund, 80
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Mandatory Reporting, Liability Insurance (Including
Self-Insurance), No Fault Insurance and Workers’
Compensation User Guide, Version 3.3, December 16,
2011.
16. 2011 U.S. Dist. LEXIS 17254 (W.D. Mo. Feb. 22,
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17. 2009 U.S. Dist. LEXIS 98435 (N.D. Okla. Oct. 22,
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On March 22, 2012, for the first time in nearly seven years, the U.S. House of Representatives passed comprehensive medical liability reform legislation. By a vote of 223-181 (with four Members voting “present”), the House approved H.R. 5, the Patient Access to Healthcare (PATH) Act. The good news is that the vote once again helps the public focus on the need to reform our medical professional liability (MPL) system. The bad news is that, due to various actions immediately before and during the debate on H.R. 5, there are now a substantial number of questions about what Congress actually holds in store for MPL insurers in the months, and years, ahead.

Immediate future
In the short run, there are several things we already know. First, the debate over MPL reform has ended for the year (in the halls of Congress, but probably not on the campaign trail). The House of Representatives has now spoken on this issue, so they won’t consume any more of their limited legislative time in reheashing the debate. In the Senate, reform supporters still face an extremely hostile environment, so there are no plans to offer such reforms, as either a standalone bill or an amendment to other legislation, this year.

While the House vote brings renewed momentum, which could lead to more visible support in the Senate, the votes simply aren’t there to win right now. Second, “states’ rights” advocates have altered the equation in Congress. Several former supporters of H.R. 5 voted against the bill, and others who expressed concerns about the bill based on the concept of federalism simply declined to vote at all. How they might sway votes in future Congresses remains to be seen. Third, numerous changes made to the bill could play into future debates. I’ll discuss those more below.

Tort reform
Taking a longer-term view, we see that the future of federal MPL reform remains somewhat murky. It is difficult to analyze the results of the final vote, because the bill contained a provision repealing the Independent Payment Advisory Board (IPAB), a controversial entity created by the 2010 passage of the Affordable Care Act. Some Republicans with states’ rights concerns (as mentioned above) may have supported the bill in the end because they want to repeal IPAB; they may not support a standalone MPL reform bill in the future. In addition, some Democrats, who might otherwise have been inclined to support reform, may have voted against the bill because they didn’t want to embarrass the President by voting against an element of his signature legislative victory.

Also, the bill that passed was not identical to previous versions of H.R. 5. While it contained most of the reforms the PIAA traditionally supports, reform of the collateral source rule and a ban on subrogation were dropped. These already-contentious issues will have to be addressed before the new Congress convenes next January, a process that will undoubtedly complicate matters for those who support reform. Furthermore, the provision related to limitations on punitive damages

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was altered somewhat, potentially opening the door for additional changes next year. While these changes would be unlikely to affect PIAA members, they could change the way some people think about the overall legislation—for both good and bad.

**Medical volunteers**
While not loudly heralded by some groups, a very important amendment was added to H.R. 5 before it passed in the House. Based on legislation previously endorsed by the PIAA (H.R. 3586, the Good Samaritan Health Professionals Act), the amendment grants immunity from liability lawsuits to healthcare providers who offer services, on an uncompensated basis, to victims of federally-declared disasters. In advocating for the amendment, Cong. Cliff Stearns (R-FL) noted the circumstances of a doctor who was evacuated to the New Orleans airport in the wake of Hurricane Katrina, yet was told he could not help injured people at the facility because of liability concerns.

Even more appalling, Congressman Stearns noted, was the story of a physician who was stopped by the Federal Emergency Management Agency in the middle of performing chest compressions on a woman, because of issues about possible medical liability. This common-sense approach to prevent situations like these from arising again garnered more support than any other proposal related to H.R. 5, passing by 251-157, a margin of 94 votes. The bipartisan vote on the amendment gives us good reason to hope that the proposal will be able to garner even more support, if it is uncoupled from more controversial measures, potentially paving the way for enactment in the next Congress.

**Emergency medicine**
Organizations affiliated with emergency medicine succeeded in adding another amendment to the bill—and this one is a bit more complicated than the amendment on medical volunteers. Specifically, this amendment (dubbed the Health Care Safety Net Enhancement Act) would cover any “hospital, emergency department, or a physician or on-call provider under contract with a hospital or emergency department” under the Federal Tort Claims Act for care provided under the requirements of the Emergency Medical Treatment and Active Labor Act (EMTA-LA). This would give providers the same protections afforded to community health centers and healthcare providers who provide Medicaid services at free clinics.

While the logic behind the amendment is sound—those required to provide care under a federal mandate should be covered by federal tort statutes—it fails to address the underlying problems with our MPL system. Thus, the amendment merely shifts costs from the providers involved, and their insurers, onto the taxpayer. Despite the fact that there was some opposition to the amendment on the House floor, those who opposed it never requested a recorded vote, and instead let the amendment be approved by voice vote.

**McCarran-Ferguson repeal**
It seems to happen every time when Congress begins debating MPL reforms: an amendment was once again offered to repeal the limited federal antitrust exemption provided to insurers under the McCarran-Ferguson Act. In a unique twist, this time the amendment was offered by a Republican, Congressman Paul Gosar, DDS (R-AZ). When first introduced, the amendment specifically referenced “health insurance issuers and medical malpractice insurance issuers” and applied to “the business of health insurance,” a broad term that could include any insurer who paid any medical-related claims.

However, after intense lobbying efforts by the PIAA and other insurance industry associations, Cong. Gosar was persuaded to remove the reference to “medical malpractice” from the amendment. Additional lobbying efforts eventually convinced him to clarify the amendment further, so that it clearly applies only to health insurance and not to any property-casualty line of business. The amendment then passed by a voice vote.

Regrettably, after the vote, reports surfaced that Congressman Gosar was considering fresh efforts to repeal the limited McCarran-Ferguson exemption—this time, with MPL insurers specifically included in the proposal. These reports have not been confirmed, but in any event, the PIAA is fortunate to have an ally who has already fired a powerful salvo back to the originator of this reckless idea. House Judiciary Committee Chairman Lamar Smith (R-TX) issued a formal statement during the debate expressing his concerns about repealing McCarran. He stated, “While the repeal of the McCarran-Ferguson exemption for health insurance does essentially nothing, repealing it for others types of insurance could be disastrous.” Chairman Smith’s leadership will be essential in our ongoing efforts to protect McCarran-Ferguson, and the PIAA will continue to work closely with him to defend your interests.

**Long-term prospects**
With House action completed, many questions remain about the future of federal MPL reforms. What will be the future legislative vehicle for federal reforms, the H.R. 5 that the PIAA and others have long endorsed, the H.R. 5 that passed this year, or a new, as yet to be determined version of H.R. 5? And what of the amendments mentioned above? Both Congressman Stearns and Congressman Gosar seem committed to finding new opportunities for getting their proposals enacted, which is obviously both good and bad news. Will the prospects be different if these proposals are tied to different bills, or treated as individual pieces of legislation? While we won’t be in a position to answer any of these questions immediately, the PIAA Government Relations Department is already working on finding the answers—and shaping them in a way that best protects the MPL insurance industry, as well as the doctors our members insure and the patients they serve.
MPL Coverage for Allied Healthcare Providers: The Story So Far
Pick up any magazine or tune in to any news program, and the U.S. healthcare environment seems to be in the midst of dramatic and all-encompassing change, where the overriding status quo going forward is one of uncertainty.

Despite this uncertain environment, one trend that analysts and commentators expect to continue is the integration of U.S. healthcare. This trend is evidenced by stand-alone hospitals combining to form healthcare systems, hospitals acquiring physician groups, and mid-level providers taking on more clinical responsibilities—thus clearly spanning the entire spectrum of healthcare.

The integration of healthcare increases the demand for mid-level providers, by blurring the traditional boundaries of medicine and driving more procedures and diagnostics to the nurse practitioners, physician assistants, and others, who are often referred to as “physician extenders.” These providers, along with the traditionally-defined allied healthcare professionals (i.e., registered nurses, dentists, and chiropractors), will have an increasingly important role in the delivery of healthcare.

For the PIAA member companies, this development potentially means a substantial increase in their customer base and demand for their product. To help prepare for this dynamic, the Willis Re Healthcare Practice Group has conducted an analysis of allied healthcare, and in this article we review market size, profitability, and relevant claims data.

Allied is smaller, but getting bigger

The allied healthcare segment has been growing, and will continue to expand. For each of the particular employment classes, the U.S. Bureau of Labor Statistics projects increases of 20%-25% between now and 2018. Absolute figures are perhaps more significant, with nurse employment projected to grow from 2.6 million in 2008 to 3.2 million in 2018, a gain of almost 600,000 new nurses. The Bureau of Labor Statistics projects that aggregate allied professionals employment is set to increase by 22%, to 3.4 million, by 2018. This increase in customer base will translate into greater demand for insurance-related products, and we have seen corresponding growth in statutorily-reported premium.

On the premium side, allied healthcare, encompassing both professionals and facilities, represented $1.5 billion of statutorily-reported direct written premium (DWP) in 2011, or 14.9% of total MPL DWP. This figure is up from 13.3% of total 2004 MPL DWP. Meanwhile, physician and hospital premium has decreased from $9.8 billion in 2004 to $8.6 billion in 2011, a change of 12.2%. The annual level of DWP in the allied healthcare segments is shown in Figure 1.

PIAA carriers’ growth within the allied space has been more dramatic, with market share expanding from 11.9% in 2004 to 43.1% in 2011. Market share within the hospital segment

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increased from 28.0% in 2004 to 28.4% in 2011, and decreased in the physician segment from 75.2% to 63.9% over that same time period. PIAA carriers’ annual market share by segment is shown in Figure 2.

**Allied has been more profitable**

Since 2004, the allied healthcare MPL segment has been the most profitable segment of the MPL industry. For PIAA carriers in particular, underwriting for allied professionals has been even more profitable than it’s been for the traditional physician segment. The eight-year average calendar-year incurred loss ratios by segment are shown in Table 1 for the U.S. MPL industry as a whole, as well as for the PIAA subset.

For PIAA carriers, incurred loss ratios have also improved since 2004, falling from 43.6% to 34.7% within the professionals segment and decreasing from 76.0% to 11.6% in the facilities segment. The PIAA carriers have reported relatively less premium in the facilities segment: $30 million in facilities versus just over $400 million in professionals, so these figures are therefore quite volatile and may be inconclusive. Calendar-year incurred loss ratios are shown for the two allied healthcare segments in Figures 3 and 4.

**Allied claims are small but growing**

The driver of higher total paid loss in the allied professional space is attributable to an increase in the size of average claim payments, as opposed to an increase in the number of claims. It is therefore an issue of severity rather than a frequency.

Of the 174,445 claim payments reported to the National Practitioner Data Bank (NPDB) between 2001 and the end of third quarter 2011, 20.3% have been made on behalf of allied professionals, as shown in Figure 5. Of those, roughly half have been made on behalf of dentists, and the balance on behalf of nurses, chiropractors, podiatrists, and other professionals.

The proportion of total paid loss attributable to allied pro-
fessionals has steadily increased since 2001, perhaps reflective of the increasing clinical responsibilities of these types of providers. In 2001, payments made on behalf of allied professionals comprised just 9.0% of the total paid loss reported to the NPDB for that year. Through the first three quarters of 2011, the proportion swelled to 13.4% of the total paid loss, a 50% increase. While physician claims still make up the bulk of U.S. MPL claim payments, losses related to allied professionals are increasing at a high rate. The historical paid loss for each group is shown in Figure 6.

Paid severity, or average paid per claim, has increased from just over $100,000 in 2001 to more than $150,000 in 2011, a 50% increase. Meanwhile, severity for paid claims against physicians has increased less rapidly, from around $265,000 in 2001 to $322,000 through the first three quarters of 2011, an increase of 21%. Therefore, increases in clinical responsibility by allied professionals are, conceivably, translating into higher average settlements and judgments. Paid severity for both physicians and allied professionals as a whole is shown in Figure 7. Segmenting the severity analysis further, paid severity levels are broken out for each of the four allied professional categories (dentists, chiropractors, nurses, podiatrists) and all others in Figure 8.

PIAA carrier experience similar to the rest of the MPL industry

To compare these broad industry claim statistics with those experienced by the PIAA member companies, we worked with PIAA data analysts to query the PIAA Data Sharing Project (DSP). The results show averages similar to what has been reported to the NPDB.

For the years 2001 to 2010, the DSP contains a total of 87,936 closed claims and 23,737 paid claims for all MPL lines. Paid claims resulted in indemnity payments totaling $7.7 billion, an average of $322,657. Total ALAE is $3.1 billion, for an average of $35,046 per closed claim. However, less than 1% of the total closed claims involved allied professionals. Of the allied professional claims that were reported, dental claims had average indemnity of $61,049 and average ALAE of $21,852, while all other allied professional claims had average indemnity of $251,849 and average ALAE of $22,279. These figures are broadly in line with what is reported to the NPDB.

Allied facilities claims trends

As the NPDB consists only of claims paid on behalf of individuals, claims paid on behalf of facilities are not reported. Consequently, our claims analysis for allied healthcare facilities is limited to what is available at a more macro level in the statutory annual statements filed with the NAIC. In short, compared with the hospital segment, claims are smaller but more frequent in the allied facilities space, with loss costs decreasing over the past few years.

Figure 9 depicts the number of paid claims per $1 million of direct earned premium (DEP) in this segment, on a calendar-year basis, since 2004. Frequency fell to a low of 4.48 paid claims per $1 million in 2007, only to spike to a high for the period of 7.50 paid claims per $1 million in 2011. The average number of paid claims per $1 million of DEP has been approximately
5.95. (In comparison, note that this same figure for the hospital segment is 3.95 paid claims per $1 million.)

Turning to severity, we examined the average paid loss per claim for the segment since 2004. While the frequency trend has remained relatively constant over the eight-year period, the average paid per claim has fallen. As shown in Figure 10, since peaking in 2004 at $73,519, paid severity fell to $37,173. The average paid severity has been $54,319 over the eight-year period, compared with $151,424 in the hospital segment. Thus, with the number of paid claims remaining relatively level and with average payment per claim falling, loss costs in the allied healthcare facilities segment have decreased since 2003. This factor, perhaps more than any other, has driven the high levels of profitability.

**Allied is currently dominated by a different type of carrier**

At present, the allied healthcare MPL lines are dominated by non-PIAA commercial carriers. As shown in Tables 2 and 3, with the exception of PIAA members ProAssurance, NCMIC, and The Dentists Company, the largest allied healthcare writers are primarily multi-line global carriers. Moreover, direct written premium is highly concentrated within the top ten largest writers, with around 75% of premium written by the top ten carriers in each segment.

There may be barriers to entry: some carriers have entrenched franchises, such as CNA’s Nurses Services Organization program. Others have capitalized on efficiencies from their extensive distribution networks. Some of this business is controlled by direct writers, others by agency networks, with a fair amount of the premium contained within MGA or affinity-style facilities. Some insurers (ProAssurance and the PICA acquisition, for example) have also bought their way into this segment. Accordingly, marketing, delegating authority, or developing a presence in this sector through acqui-
sition becomes seemingly possible. Some non-PIAA carriers have managed to do this quite quickly, as evidenced by high market-share growth at Ironshore and Allied World; the latter bought Darwin Professional Underwriters in 2008.

**Conclusion**

With the looming changes in U.S. healthcare, PIAA member companies will need to keep a close eye on the developing trends in their operating environment. With the continued integration of healthcare, the opportunities for carriers with underwriting expertise in the allied professionals marketplace are substantial. If traditional writers enter the allied healthcare segments at a faster pace, they can reasonably hope for greater profit.

In closing, I offer the following quote from Mark Twain: ”Twenty years from now you will be more disappointed by the things you didn’t do than by the ones you did...” The challenge, however, is predicting and managing a dynamic and ever-changing claims, legal, and regulatory environment.

Note: This article is based on publically-available NAIC data as of March 27, 2012.
For “Off-Label” Medicine, Knowledge Is Power

Identifying the pertinent “standard of care” is the common element in all medical professional liability (MPL) litigation. In most cases, it will be the care a physician “must” provide in a given set of circumstances. But at times, the focus will instead be on care the physician “may” provide, and the question will be whether a particular treatment regimen falls within a range of acceptable options. Such is the case with a physician’s “off-label” use of a drug or medical device.

An orthopedic surgeon treating a ruptured Achilles tendon without surgery, and concerned about possible immobility of the

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patient, recommends Motrin, not merely for pain, but also for its mildly prophylactic properties against the formation of blood clots in the patient’s lower extremities. A psychiatrist managing a patient’s treatment-resistant, refractory depression prescribes a controlled substance—oxycodone, an opiate used for treating pain—because of its benefits as a last resort for patients with such serious clinical depression. A vascular surgeon uses stents intended for other portions of the anatomy to treat peripheral artery disease in a patient’s legs. In each case, the physician is prescribing a course that has neither been approved nor rejected by the U.S. Food and Drug Administration for the medicine or device; it is an “off label” use.

Some “off-label” choices may be controversial, and if the care is not successful, or introduces adverse side effects, the likelihood is great that there will be an MPL claim. Accordingly, in all instances of “off-label” care, a physician, and his counsel, must be mindful of several considerations that may maximize the chance of successfully preventing or defending claims.

Guidelines
1. The “standard of care” is not defined by the treating physician’s solitary opinion, or even the personal opinion of individual experts. It must be a course of treatment corroborated by others, preferably acknowledged in the literature, discussed at professional meetings, or taught to healthcare providers as an acceptable option. The “off-label” use, therefore, must have received favorable attention in the medical community.

2. The law where the physician practices determines how broad the standard’s reach must be. Does the jurisdiction follow the “locality” rule, which requires conformity to what is acceptable within the state where the physician practices? Or does the jurisdiction require compliance with a “national” standard of care, which may be more forgiving of “off-label” treatment?

3. The “standard of care” should tolerate respectable minority views, or treatment options that, while not mandated, are accepted by the medical community in appropriate circumstances. If it were otherwise, there would be no evolution of standards to accommodate changes in thinking or advances of science. This principle underlies allowance of “off-label” treatment, as long as the putative benefits with a given patient outweigh the risks of the treatment.

4. The physician has a duty to be aware of pertinent information about the “off-label” application. If the maker of the medi-
OFF-LABEL MEDICINE

This area without directly interfering with the practice of medicine. ... \( \) is an \[O\]ff-label\ usage of medical devices (use of a device for some other purpose than that for which it has been approved by the FDA) is an \[o\]ff-label use and, if so, the physician may be held to constructive notice of them. The existence of such recommendations, warnings, or \[c\]ase studies, and the physician's treatment in the face of them, may be \[d\]evastating evidence against the physician if there is litigation \[r\]ising from the \[o\]ff-label use.

5. **Special attention must be given to eliciting—and documenting—the patient's informed consent.** In general, a patient must be aware of the nature and material risks of proposed treatment, with “material” being defined as (1) the most serious consequences (regardless of frequency of occurrence) and (2) the most frequently occurring consequences (regardless of seriousness). If the physician's chart lacks proof that, before consenting to the treatment, the patient was aware that the treatment was “off-label,” and if there are subsequent legal proceedings, the physician assuredly will be accused of failing to obtain the patient's informed consent to the treatment.

Zealous plaintiff’s counsel will argue that the doctor “experimented” on the unwitting patient, with alleged untoward results. Juries naturally may sympathize with the uninformed patient who has suffered, and who testifies that, had he known the treatment was not formally approved, he never would have agreed to it.

Patients should be told, in advance, that the proposed treatment is not formally approved but is recognized as appropriate and efficacious by medical authority, such as pertinent medical literature, for the patient's condition; and that sound medical judgment allows the use of the treatment in the given circumstances. If the physician cannot make that statement, he should not offer the proposed “off-label” treatment.

**Basis in law**

These commonsense notions derive from experience and are embraced in law and literature. No less an authority than the Supreme Court of the United States has noted that:

> “[O]ff-label usage of medical devices (use of a device for some other purpose than that for which it has been approved by the FDA) is an accepted and necessary corollary of the FDA’s mission to regulate in this area without directly interfering with the practice of medicine....

The FDA is charged with the difficult task of regulating the marketing and distribution of medical devices without intruding upon decisions statutorily committed to the discretion of health care professionals.


A Position Statement of the American Academy of Orthopaedic Surgeons provides:

> The American Academy of Orthopaedic Surgeons (AAOS) believes that surgeons may prescribe or administer any legally marketed product for an off-label use within the authorized practice of medicine in the exercise of appropriate medical judgment for the best interest of the patient. If surgeons use a product for an indication not in the approved or cleared labeling, they have the responsibility to be well informed about the product, to base its use on firm scientific rationale and on sound medical evidence, and to maintain awareness of the product's use and effects. Surgeons should appropriately counsel patients about the benefits and risks of the proposed treatment, and alternative treatments that might be available.

And the FDA itself counsels:

Good medical practice and the best interests of the patient require that physicians use legally available drugs ... and devices according to their best knowledge and judgement. If physicians use a product for an indication not in the approved labeling, they have the responsibility to be well informed about the product, to base its use on firm scientific rationale and on sound medical evidence, and to maintain records of the product's use and effects.

**“Third-party” claims**

Physicians need to be alert to these cautionary considerations not only to minimize their litigation exposure to their patients, but also to protect themselves against “third-party” claims by pharmaceutical companies or medical device manufacturers. A patient injured by a drug or device may elect to sue the manufacturer, and not his or her physician who prescribed the treatment at issue. (Indeed, because of legal doctrines providing “strict liability,” allowing recovery without proof of negligence, it may behoove the patient, and the patient’s lawyer, to do so.) In that circumstance, in order to pass some or all of the liability on to the physician, the manufacturer may add the physician to the lawsuit, and allege that the physician prescribed or used the drug or device as it was never intended, and ignored warnings or contraindications in the literature. The more informed the physician, the better the likelihood that liability will be avoided.

As Sir Francis Bacon said, “Knowledge is power.”

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To understand how reinsurance rates are likely to rise, we must first understand how reinsurance works. Simplified, reinsurance is a process whereby insurance companies "reinsure" their risk through other insurers, so they’re not exposed to the full amount of the loss, should a large claim occur. For example, if one company insures a skyscraper, which is then severely damaged during a storm, the company would have a huge amount of claims to pay out, which
could potentially put them out of business. By reinsuring their risk, the company will pay the first $X million of claims, and reinsure the rest through other insurance companies, which will then be liable for subsequent layers. This is illustrated in Figure 1.

What is modeling?
Like reinsurance, modeling allows insurance companies to reduce their overall exposure. For example, insuring all the houses on one street would prove risky if there was a flood on that street. Insurance companies therefore limit their exposure to specific threats (for example, flood or earthquake) and will place a cap on the amount they can insure in one geographic area. Modeling really demonstrated its worth in the wake of the September 11 terrorist attacks: insurance companies had a concentrated exposure, in that one location and for a number of risk types, including terrorism, property, business interruption, life, and medical.

Modeling often tends to be reactionary; when it’s proved incorrect, it’s adjusted. It is also difficult to be accurate in some instances—who could have predicted that the Japanese earthquake would have caused a tsunami and nuclear disaster?

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Solvency II
Solvency II is the European Directive intended to ensure that insurance companies retain enough capital to remain solvent. This requirement can result in an increased demand for reinsurance, from insurers, mutuals, and associations that have low levels of capital and are thus heavily reliant on reinsurance. In addition, insurance companies may in the future pull their capital from underperforming areas for which Solvency II states that they must retain a large amount of capital.

How does reinsurance affect the primary insurance market’s pricing?
Reinsurance is normally only called upon to respond following a

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large loss, as a result of which the reinsurance market will increase its pricing. This increase is passed on to the primary insurance companies, which then, ultimately, pass the cost on to the original insured. Thanks to modeling, rates tend to rise at a local level, but a major catastrophe in Europe can affect even the price of your car insurance in the United States.

**Increased reinsurance rates**

The insurance market tends to be cyclical, going from a "hard" to a "soft" market, rather than following the typical bell curve that is seen in many industries. Typically, the market turns hard after large losses or depletion of capital, or when reinsurance companies pull out of certain territories or classes.

Rates spiked in 2005 following hurricanes Wilma, Rita, and Katrina. However, the market became relatively flat after this initial hardening. There have been many losses since then, but none that have depleted capital.

The year 2011 was the worst on record for catastrophe losses. The Australian floods, New Zealand earthquake, and Thai floods were all unexpected losses, since they were not included in models and were therefore not factored into insurance pricing. In addition, the Japan flood had been modeled, but the subsequent tsunami was not adequately considered.

A.M. Best stated that the property and casualty losses in the first nine months of 2011 totaled $38.6 billion. One could be fooled into thinking that this meant an instant price hike. However, there was not one major event that had caused these losses; it was many small events.

In contradiction to these large losses resulting in a hardened market, there was not one single event that would have depleted reinsurers' capital funds. In addition, there is still a huge amount of capital available at the moment, with low return on typical investments. The reinsurance market appeals to corporations and hedge funds looking for a greater return. Thus, there is a constant flow of new reinsurance entrants into the market.

We are starting to see the market harden, but the trend is not as rapid as might be expected.

What does this mean for MPL insurers?

The start of 2012 has been quiet, compared with 2011, for catastrophe losses (by this time last year, we had already seen the Australian and Asian disasters), but we have potentially the largest single-unit marine loss in history, the Costa Concordia cruise ship, with estimated losses in excess of $1 billion (Reuters), which could push up global reinsurance rates.

For at least the last seven years, the U.S. medical professional liability (MPL) insurance market has been getting cheaper, although we have seen pockets of firming rates in isolated areas. In states where incumbent insurers exit, new entrants emerge, resulting in equal competition and soft rates.

Our general observation is that rates are the same as before, or marginally down. Chubb and CNA have been the exceptions to this rule: they are increasing pricing irrespective of individual-account characteristics. In fact, in certain circumstances, Chubb is non-renewing.

If an individual account has a severe loss record, rates are likely to start increasing, whereas, in the past, even those with significant loss records have seen reductions.

On the West Coast, employment practices' liability insurance has witnessed both price and scope of coverage getting tighter. Financial institutions' directors and officers insurance is also undergoing some re-rating.

As a result of the increased reinsurance pricing and Solvency II, there may be an increase in reinsurance prices for medical associations, risk mutuals, purchasing groups, and captives that have a low level of capital.

It is difficult to see how rates might increase in the near term. Although 2011 saw huge losses, the absence of one major loss, and the fact that there is still significant capital available in the professional liability market, may mean that the anticipated price hikes prove elusive. In addition, the anticipated flood of circumstances expected with the economic downturn hasn't materialized, although there is still substantial claims activity, in terms of both frequency and severity. Predicting the future of rate movement still remains an art, rather than a science.
In the early months of 2011, what had been two separate initiatives in New York State—one, to lower Medicaid costs and the other, to enhance the safety of obstetrical patients—were conflated by the plaintiff’s bar. What came about next, when that happened, raises some crucial questions about how best to educate legislators, and the general public, about the benefits of tort reform.

By April 1, there were clear winners. Medicaid costs, at least as budgeted, declined. On the other front, New York-Presbyterian Hospital/Weill Cornell Medical School reported that it had achieved a stunning 99.1% decrease in 2009 compensation payments, as compared with 2003–2006. Many of the programs it had put in place, like an eminently clear protocol for induction with oxytocin, could be adapted for other healthcare systems.

Dana Murphy is Editor, Physician Insurer.
The loser in all this was the notion of caps. Put on the table as an essential element in curbing Medicaid costs by Governor Andrew Cuomo’s Medicaid Redesign Task Force, the cap of $250,000 on non-economic damages was thrown under the negotiations bus, on the last night of the budget talks, March 31. By April 1, it was history.

The unexpected recommendation of a non-economic damages cap by a Democratic governor had provoked immediate condemnation from the patients’ rights advocacy groups and the New York Bar Association. Cuomo insisted that the cap was needed to improve the predictability of future awards and settlements, and would decrease the cost of MPL coverage for the state’s physicians and hospital systems. And that, it was presumed, would help them adjust to other cuts in the Medicaid budget.

Steady advances in obstetrical safety
The effect of medical errors and unsafe systems of care has had a profound effect on the practice of obstetrics and gynecology.

—M.D. Pearlman, Obstetrics & Gynecology, November 2006

For several years, obstetricians had been exhorting their colleagues to look for new quality control measures, innovative products, and novel pathways to creating a culture of safety.

By 2007, guidelines, as well as education and training, were called for to address potential safety issues like the interpretation of fetal heart rate patterns, use of magnesium sulfate, and the induction and stimulation of labor. Then, in late 2010, Douglas Kirkpatrick and Ronald Burkman declared that there was now ample evidence that “standardization of care improves patient outcomes.” They noted that, “this should also translate into a reduction in medical-legal expenses” (Obstetrics & Gynecology, November 2010).

The American College of Obstetrics and Gynecology (ACOG) has its own guidelines, and Kirkpatrick and Burkman assessed the relative success of several. For example, the goal of eliminating non-medically indicated inductions or elective repeat caesarian deliveries before 39 weeks’ gestation was first outlined in a 1978 ACOG Technical Bulletin. But data collected between 1999 and 2002 revealed, discouragingly, that 35.8% of repeat caesarians were still being done prior to 39 weeks.

At Maggee-Women’s Hospital in Pittsburgh, a quality assurance team and designated “champions” of process improvement attempted to decrease the percentage of pre-39-week inductions. But only when the induction process was changed, and now recommended that certain criteria be met, did the number of inductions decrease. A monthly review of inductions was added, with targeted education for doctors who did not follow the guidelines, and, in the event a physician failed to adhere a second time, a peer review letter would be sent to him, as well as the Vice President for Medical Affairs. Rates dropped—from 11.8% before the program and 10% after education alone—to 4.3% with targeted education and peer review.

Still, no one in the arena of plaintiff’s attorneys had noticed the articles that reported impressive increases in adherence to guidelines, like the Kirkpatrick and Burkman paper. The authors had appended the expected note of scientific caution about clinical guidelines: “There is some evidence to indicate a positive effect on malpractice litigation.”

Weill Cornell achieves 99% savings
But then, in February 2011, all that changed. An article from New York Weill Cornell Medical Center announced that, as a result of its obstetric patient safety program, MPL payments had been slashed by more than 99%. Amos Grunebaum and colleagues reported this stunning number in their article, “Effect of a Comprehensive Obstetric Patient Safety Program on Compensation and Sentinel Events,” in the American Journal of Obstetrics & Gynecology. And that is the sort of number that gets noticed.

There are many aspects of Weill Cornell that make it extraordinary. It is a tertiary academic referral center with a level 3 neonatal unit. It serves as a New York State regional perinatal center, performing 5,200 deliveries per year, 75% of which are managed by full-time faculty.

To get started on its safety program, the facility brought in a consultant, to assess the institution’s obstetric service in 2002, and from that point onward, the various elements of a comprehensive patient safety program were put in place. In 2003, labor and delivery team training was inaugurated, including special training in Crew Resource Management. A clear chain of communication was set up, which knit together the entire labor and delivery staff. Electronic medical record charting was introduced.

In 2004, the evidence that Misoprostol is not effective was deemed sufficient to prompt a guideline that this medication not be used, except in the event of a non-viable fetus. In 2005, a standardized protocol for induction or augmentation with oxytocin was put in place, as well as a standard oxytocin order template. EMR templates for shoulder dystocia and operative deliveries were established. Other elements in subsequent years included:

- Electronic antepartum medical records (2006)
- Routine thromboembolism prophylaxis for all caesarian deliveries (2006)
- Obstetric emergency drills (2006)
- Recruitment of a laborist (2007)
- Oxytocin initiation checklist (2009)
- Postpartum hemorrhage kit

“The 2009 compensation payment total represented a 99.1% drop from the average 2003–2006 payments (from $27,591,610 to $250,000),” the authors reported. They note in particular, in 2008 and 2009, there was not one MPL case involving a possibly brain-damaged infant. Also, “there has been no permanent Erb’s palsy since we began shoulder dystocia drills in 2008.”
The Medicaid spending story

Now, we have to back up a bit, to see what was happening in regard to Medicaid spending in New York State. Governor Andrew Cuomo had declared New York State “functionally bankrupt” in early February, and proposed a lean $132.9 billion budget for the state. It cut Medicaid funding by $2.85 billion for the fiscal year 2011 budget, and by $4.6 billion in the 2012–13 budget. New York, Cuomo said, has the most expensive Medicaid budget in the nation, that costs more than twice the national average.

To figure out how to make the cuts, Cuomo had appointed a Medicaid Redesign Task Force in January, comprised of lawmakers, as well as representatives of labor and healthcare. The group issued 79 recommendations, promoting the idea of a new Neurologically Impaired Infant Medical Indemnity Fund—and a $250,000 cap on non-economic damages.

At first, the response from the plaintiff’s bar was the same sort of half-argument, half-bluster that gets trotted out whenever the concept of a cap is introduced: “Caps are anathema with respect to equal protection/access to justice,” said the president of the New York State Bar Association, Stephen P. Younger. He added that caps are “bad policy,” representing the “clamor of special interests in the medical industry that long have pushed to restrict the ability of victims to be fairly compensated for medical malpractice.” The New York Bar’s Committee on the Tort System stated (February 23 memorandum), “We question the relationship between Medicaid reform and malpractice reform, whether malpractice reform is needed and/or advisable. . .”

Perhaps, there would have been little more than this expected sort of hyped-up non-logic, in the ensuing weeks, had it not been for the sudden spotlight on the Weill Cornell study.

The March 4 edition of Crain’s New York Business headlined its story, “Obstetricians take big steps to avoid malpractice,” and cited the 99% decrease in a following subhead. The article noted that “Consumer advocates are hailing the report as a breakthrough in patient safety and a better way to curb malpractice costs than tort reform.”

The New York-Presbyterian unit of Weill Cornell Medical Center responded with a proactive statement on the fledgling linkage between patient safety programs and the lack of necessity for tort reform. It pointed out the singular circumstances that had made possible the 99% decrease in payments. The results of their one study simply did not mean that any obstetrics unit in New York State could easily and immediately achieve similar reductions in MPL payments. They cautioned that, “Much more work needs to be done on adapting and developing new clinical methods, over a period of years.”

By March 12, the New York Times had entered the fray, with an editorial that conceded that “the malpractice system is undeniably flawed,” but then asserted, “But there are better and fairer ways to reform the system than a one-size-fits-all cap.” The dollar amount of the cap—$250,000—was deemed insufficient “for patients who face and greatly diminished quality of life.”

But then, the Times editorial shifted ground, noting that, “The best solution is to greatly reduce errors and bad outcomes that can lead to malpractice suits.” The author noted that Weill Cornell Medical Center had reported “a huge drop in compensation payments for patients alleging malpractice, after they instituted a rigorous safety program in 2003.”

New York-Presbyterian Weill Cornell fires back

In a letter responding to the editorial, the authors of the Weill Cornell article attempted to clarify an all-important distinction: “Enhanced patient safety alone cannot solve the liability crisis . . . the liability problem is too large and too diverse to be resolved solely by improved patient safety. We must have meaningful liability reform.”

But then, taking the whole issue one quantum leap further, Assemblyman Rory Lancman, a plaintiff’s attorney in MPL cases, introduced his bill, A. 6253, the “Medical Malpractice Savings Act,” that purportedly seek to “reduce medical malpractice costs by reducing incidents of medical malpractice.” In debating his bill, Lancman noted, “. . . we can just do as New York-Presbyterian did and eliminate incidents of medical malpractice in the first place.”

The supposed intent of A. 6253 was to replicate the results of Weill Cornell in every facility in New York State, by requiring that every Ob program licensed in the state “establish and implement a comprehensive obstetrics safety program to reduce medical errors and improve patient outcomes.” Facilities would be required to report their results, “including deaths, injuries, and malpractice payments,” to the insurance commissioner. Failure to report would be considered “grounds for the commissioner to investigate the standard of care at such a hospital,” and then, “take appropriate corrective action.”

Once again, New York-Presbyterian posted an urgent statement. The president and CEO of the hospital, Herbert Pardes, MD, argued, “Linking the findings of the [Weill Cornell] study to public policy would be a serious mistake.” They mentioned the standard caveats that need apply to any scientific study, “This work was conducted over a limited period at a single institution. Broad conclusions can never be reached on the basis of one study alone.”

The statement underscored the need for additional investiga-
tion: “Much more work must be done on adapting and developing new clinical methods over a period of years before firm conclusions can be drawn.” And Pardes once again tried to bring a measure of clarity to the relationship between results after patient safety initiatives, on one hand, and on tort reform, on the other: “The proposed policies in the Assembly bill would in no way be a substitute for enacting the serious program of malpractice reform proposed by the governor.”

Pardes concluded his plea for MPL reform with three concise sentences: “We badly need medical malpractice reform. Governor Cuomo is proposing it. New York-Presbyterian stands firmly behind the Governor, and we urge the Legislature to enact his program.”

The bill, A. 6253, was referred to the Assembly’s Judiciary Committee; after that, the trail for this bit of legislation grows cold.

The demise of the cap
Firing yet one more salvo, Stephan Younger asserted, as president of the New York Bar Association, “Medicaid doesn’t pay for malpractice awards. It has nothing to do with Medicaid. It is not a budget issue.”

The plaintiff’s bar pushed the argument further, depicting caps as a driver of costs, not part of a solution: “Medicaid costs would rise over time, not fall, if awards are capped, because eligible Medicaid recipients would end up seeking benefits from the Medicaid system when their awards were used up.”

Even the New York Senate’s Finance Committee chairman, John DeFrancisco, R-Syracuse, said that he doubted the $420 million in Medicaid savings predicted by Governor Cuomo.

So, on April 1, when the dust had settled on the intense month-long budget negotiations, the bill that emerged had dropped the cap completely. However, the plan to create an indemnity fund for neurologically impaired infants did survive.

What can we learn from the rise and fall of the cap that happened in New York State? First, MPL spokespersons need to be nimble in following, and effectively countering, the contentions of the plaintiff’s bar. But most important, it seems, is to realize what may be happening as risk management and patient safety programs come ever closer to achieving their goal of greatly limited medical errors. Those adverse outcomes that do occur may be depicted by the trial bar as events that could have been easily prevented—and are all the more despicable for that reason.

Learning how best to explain the need for both patient safety and tort reform—as Weill Cornell had to do, on the fly—may prove just as difficult as explaining the difference between risk-based and actual working capital. Our task is before us.

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To view the complete agendas for any of these workshops, or to register online, go to www.piaa.us.
Recent regulatory changes in Europe and the United States, some of which require that reinsurance contracts be executed before their start date, have been a central focus of concern in the reinsurance market. However, in spite of efforts to achieve a higher rate of completion of contracts at inception, it is still not always possible to achieve this goal. What is needed, then, is a new approach to drafting reinsurance contracts that could have significant potential benefits for ceding companies, reinsurers, and intermediaries, all striving to memorialize reinsurance transactions in a way that is accurate, cost efficient, and conducive to successful trading relationships.

This new approach comes in the form of a master trading agreement (MTA) concept, recently developed by the Brokers and Reinsurance Markets Association (BRMA). BRMA’s concept focuses on simplifying the contract process, through a relationship master agreement that obviates the repetition of negotiating and reviewing the same clauses multiple times in each individual treaty contract.

Following current industry practice, the reinsurance parties commemorate their deal via a customized written contract, which is generally renegotiated annually. By utilizing an MTA, it is possible that new ways will be found for reinsurance parties to streamline this rather cumbersome process, and ultimately achieve contract certainty.

The MTA defined
The MTA “is a negotiated contract that contains the relationship and common clauses generally found in reinsurance agreements which are not specific to any one reinsurance transaction.” In utilizing this concept, a separate MTA would be negotiated by the cedant with each of its reinsurers, because the MTA stands apart from, and is negotiated separately from, the deal-specific terms of each reinsurance program’s contract.

The terms of the MTA are incorporated by reference into the reinsurance contract and would typically supersede any terms that differ from the contract into which they are incorporated. The MTA focuses on clauses that are normally found in the reinsurance contract, but are not specific to the economics or other deal-specific terms of the particular program being memorialized in that contract. The categories of clauses that could work well in the MTA include:

- Relationship clauses, the clauses that define the broad interactions between the cedant and the reinsurer (e.g., arbitration, access to records)
- Common clauses, those that may affect the coverage of the reinsurance contract, but may be negotiated in advance (e.g., the definition of loss adjustment expense or extra-contractual obligations).

In sum, the MTA is a separate agreement between the cedant and its reinsurer, whereby they mutually agree on particular wordings that will be used across all of the reinsurance contracts between those two parties, in lieu of the particular wordings found in the reinsurance contracts themselves. Since the MTA is a continuous contract, its provisions would remain in effect until the parties agree to modify them.

Need for the MTA
Just 15 years ago, reinsurance deals were closed with only a “slip” or “cover note” (i.e., a listing of the key terms of the reinsurance) that was signed by the parties to the agreement, while complete contract wording was created and signed after the inception date. Recently, how-
ever, the industry has abandoned the slip altogether, and a full draft contract wording is negotiated prior to inception, with a final contract signed at inception, or within 30 days thereafter. Typically, the reinsurance contract terms are renegotiated annually; a majority of the contracts traditionally become effective on certain peak dates (e.g., January 1, July 1).

Further, the “broker” reinsurance market is a subscription market. A single reinsurance contract may have multiple reinsurers participating in it, and those reinsurers may have various preferences for different clauses in the contract. Because of these preferences, the hard dates, and the number of reinsurers involved, the parties must annually renegotiate a tailored version of the full contract wording, taking into account the wishes of the various reinsurers and the cedant. There may be multiple rounds of renegotiations in the months prior to, and sometimes after, the effective date of the contract.

One consequence of this process was that some reinsurance contracts were not signed by all of the parties at the effective date of the contract. Then, following the events of September 11, 2001, there were disputes about the definition of “occurrence” in the insurance binders covering the World Trade Center. Specifically, the disputes arose because the parties to these binders had failed to reach an agreement on contract wording before the loss occurred. While this particular dispute arose in the context of an insurance binder, the same problems can certainly emerge in regard to reinsurance placement slips.

This set of events exposed and highlighted a less than sophisticated business practice that occurs in both the insurance and reinsurance industries (i.e., incomplete definitions of terms at the point when a contract commences). In the wake of these events, some in the industry pushed for contracts that were signed at inception, with full disclosure of all contract terms and conditions. This movement within the industry was called “contract certainty.” As part of that movement, regulators in the United Kingdom and some in the United States now require full agreement by the parties on the terms of the deal at the effective date or very soon thereafter, preferably in the form of a full contract wording.

Now, reinsurance parties are more open to implementing new, cost-efficient methods of creating and signing reinsurance contracts. Ceding companies and reinsurers have made progress toward the goals of contract certainty, mainly by utilizing the speed made possible by computer technology and, at times, by adjusting staff as needed. The basic negotiation process, however, still remains much the same as it was decades ago. It has just been compressed into a shorter timeframe. On the other hand, the MTA represents a fundamental change in the reinsurance contract process: the parties agree on por-
tions of the contract in an efficient, proactive manner that fosters a healthy trading relationship between the parties. Because of the competitive and regulatory pressures that are linked to contract certainty, the MTA has arisen as a logical approach to creating a reinsurance contract and getting it signed.

Benefits of the MTA
The MTA makes it easier to achieve the goal of contract certainty: the reinsurance contract is completed and signed prior to its effective date. The MTA would accomplish this by ensuring that a substantial portion of the contract is already agreed on, by the time contract negotiations begin. The parties can then use their renewal negotiations to focus on the remaining deal-specific portions of the contract. Compliance with directives on contract certainty will obviate the need for further regulations.

The MTA would also reduce workloads during the peak periods, since much of the work would be done during a non-peak period. Use of the MTA should result in an overall reduction in the time spent on contract negotiations, the effects of which will endure for as long as the MTA remains unchanged.

By using non-peak time for negotiating the MTA, the parties will have more time to discuss any difficult contract issues and achieve greater clarity and understanding of those issues. This would also allow senior management of both parties to become involved in the discussions, especially if particular trading issues or company-wide directives are related to the contract terms. This enhanced understanding of the trading relationship should result in fewer contentious and costly disputes arising from the reinsurance program.

The MTA should give the cedant or reinsurer more confidence in their trading relationship, because each can be confident of concurrent wordings across all of their reinsurance contracts. Inconsistencies among various reinsurance contracts will simply not appear.

This should also increase the speed of trading between the parties, when speed is important, since they will be aware of each other’s preferences in how the key terms in reinsurance are used, and will have an upfront pre-agreement on most of their contract issues.

Conclusion
Like any new approach that changes fundamental industry assumptions about how things should be done, the MTA does require that the parties be willing to negotiate reinsurance contracts in a new way. Since the MTA is created via mutual agreement by the parties—and can be as narrow or as far-reaching as the parties desire—no concessions are required of them before they begin negotiations. The potential benefits to the reinsurance parties, and to the reinsurance industry as a whole, argue in favor of examining the possibilities of this new approach.


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Experience, Innovation...Results
In the Fourth Quarter 2011 Physician Insurer, we asked two actuaries from BMS Group, Michael D. Larson and David Spiegler, to give us some insights on the interplay between the financial markets, medical professional liability (MPL) insurance companies’ rates, and reserves. In our last issue, we heard Michael Larson’s take on the various asset classes in the portfolios of MPL insurers. Now, in this issue, David Spiegler talks about what showed up in BMS Group’s analysis of the 2011 data reported for the PIAA group of member companies.

**PI:** Were you surprised by the 2011 results for the PIAA member companies?  

**Spiegler:** I was. At the end of 2010, we estimated that they had approximately $1.8 billion redundancy remaining in their reserves. And then, they took down another $1.3 billion in 2011. We would have expected about $500 million of redundancy remaining. But it’s actually higher than that. BMS’s numbers are still preliminary, but it looks like a significant redundancy still existed at the end of 2011 despite another year of large reserve releases. In total, they’ve released $7.4 billion since 2005.

**PI:** What was that a result of sustained low levels of losses?  

**Spiegler:** What we are seeing in the numbers is that, compared with the amount of losses we would’ve expected to be reported for 2011, the actual amount was lower.

**PI:** Do your data sources impute any causal relationships for what happened? Or it is just numbers?  

**Spiegler:** At this point, it’s just numbers. We’re looking at aggregate figures for the PIAA companies, overall.

**PI:** So: there is still extra reserve strength left over, at this point?  

**Spiegler:** Yes, there are redundant reserves, though we are still working on quantifying the exact magnitude. The PIAA companies are well positioned. The booked reserve amounts still look like they are conservative. The combined ratios look like they are going up a little bit. But it is still very profitable. The expense ratio has kicked up a little bit, because the premium volume is down.

**PI:** What do you see happening with losses?  

**Spiegler:** Losses for PIAA member companies in 2011 are still coming in favorably. We hear a lot about “softening rates.” Do you have any specific numbers on that?

**Spiegler:** I don’t have hard numbers, but you can look at the premium volume for this group of companies. The peak of the hard market was in 2006. This group had $6.7 billion in aggregate premium then. It’s dropped every year since then, and it’s down to about $5.6 billion for 2011. While there may also be some exposure decreases underlying the drop in premiums, the rate levels have been declining for several years now.

But a lot of what we’re seeing is happening because loss experience is better than expected. In a typical soft market, every company is just trying to keep market share.

The market in general really hasn’t been anywhere close to the “point of pain,” where they might have had to take corrective rate action.
Premiums are dropping, regardless of the actual exposure. Here, they’re also dropping because the loss experience appears to indicate that they should be dropping.

**PI:** No signs of a hard market, then?

**Spiegler:** I don’t expect to see a hard market for at least two to three years. Of course, it depends on what happens in those two to three years, particularly with new trends in healthcare: with reforms, with larger companies swallowing up the smaller ones, and so on. It’s very hard to tell what the impact might be. An unexpected development in one of these could trigger a harder market.

But right now, that is just speculation.

**PI:** What’s happening with provider consolidation—hospitals buying physician practices that are currently insured by PIAA companies—and using self-insurance programs of captives instead?

**Spiegler:** We’ve asked all of our PIAA clients what concerns them at this point. They typically say that the prospect of their current insureds being absorbed by larger organizations does concern them. But at this point in time, the evidence is largely anecdotal.

However, you could certainly speculate that part of the drop in total premium for the PIAA companies is happening because these companies are losing clients to other organizations.

**PI:** Do you think that every doctor really wants to work in medicine as a salaried employee?

**Spiegler:** Probably not. But a big wild card will be in how the Supreme Court rules on the healthcare law. Because some doctors may be holding back, saying, yeah, I’d rather work in my own practice. If the healthcare law is not going to go forward, with accountable care organizations and other provisions, maybe I can just wait it out a while, and I won’t have to be acquired. Again, this is speculative.

**PI:** Advocating for tort reform is an important part of what we do here at the PIAA. But sometimes, as in Georgia and Illinois, gains in tort reform are lost. Do you see an impact in the data?

**Spiegler:** The impact of a rollback in tort reform in these states hasn’t shown up in the results yet. And it’s had only a minimal impact on reserves.

If you look at the data on MPL companies, you’ll see that this business has been doing well for a period of time now. So, while tort reform may be a future issue—and it certainly has been in the past—right now, things look good for this business.

**PI:** Even when there is a rollback in tort reform, you can’t help but wonder—if it’s in place long enough, it might work to change the litigious culture in a state.

**Spiegler:** Yes. It’s definitely true that any impact of a rollback happens slowly. It’s not as if they just flip a switch, and all of a sudden everything is changed overnight. It takes years to filter through the system.

**PI:** Have your clients seen any moderation in indemnity increases?

**Spiegler:** Yes. It’s definitely true that any impact of a rollback happens slowly. It’s not as if they just flip a switch, and all of a sudden everything is changed overnight. It takes years to filter through the system.

**PI:** Do your clients mention lowering trends in defense costs?

**Spiegler:** No, they say that the lower trends in indemnity don’t necessarily transfer over to defense costs. They don’t complain that they’re going through the roof, but it’s definitely something that they have to be concerned about, because it’s a big component of their loss costs.

**PI:** In conclusion, do you have any overall concerns about PIAA companies?

**Spiegler:** The market still looks good right now. But I would be cautious, because the longer it looks good, the more likely it is that companies may start to underprice their product—and reverse all of the good things that have happened over the last few years.
A mid the backdrop of a global economic crisis, high unemployment, emerging legal issues, and a divisive political environment, insurers have a full plate. Still, the financial strength of the industry remains very stable, despite the broader financial crisis affecting the rest of the economy.

The current state of the insurance industry’s labor market bears many similarities to the rest of the private sector—growth has been sluggish, but not jobless. The U.S. Bureau of Labor Statistics reported a November unemployment rate of 6.3% for the insurance industry. Fortunately, it appears there are signs of a swifter recovery ahead.

The latest “Semi-Annual Insurance Labor Outlook Study” has revealed continued optimism for the industry. Conducted by The Jacobson Group and Ward Group, this survey analyzes current labor trends and projects future staffing expectations. The study’s most recent iteration ran from June 30 to July 15, 2011. Participating companies shared their anticipated needs for staffing to paint a clearer picture of the industry’s labor market. The results show high expectations for this year.

As Figure 1 illustrates, the broader insurance industry is forecasting positive growth in revenues for the upcoming 12 months. Survey respondents were more bullish about revenue than at any other point in the history of the study. Although the PIAA companies are not projecting similar increases in revenue, this is important to note, because the labor pool is the same as that of the commercial insurers.

As expected, revenue projections correlate strongly with hiring projections. Forty-four percent of the labor study respondents plan to increase staff over the next 12 months, while 13% expect to decrease their staff. The reasons cited for adding to their staff also serve as signs of an improving market. Anticipated increase in premium volume was the primary motivator, according to 53% of respondents. Expansion into new markets or lines of business was the second greatest factor. Staff growth for topline-oriented reasons indicates a stabilizing environment.

Adding IT professionals

The demand for staff in various disciplines is cyclical and typically depends on the current economic or market situation. Currently, technology investments are getting attention. Growth in technology staff is geared toward massive investments into the technological infrastructure, as companies replace claims and billing systems with Web-based technology.

Other departments judged likely to see new hires were underwriting, sales and marketing, and claims. Companies that may have made too many cuts in staff during the recession are now looking to get their staff back up to optimal performance levels. Further, as many industry workers prepare for retirement, companies must increase their talent pipeline to account for an impending gap in skills.

The medical professional liability (MPL) sector needs to monitor rising employee costs. Since 1991, the costs of salaries and benefits for the MPL benchmark increased from 5.6% of net premiums written to 12.3% in 2010, as evidenced in Figure 2. This is a 220%
increase—an increase that is nearly twice as high as the rest of the insurance industry! This gives PIAA companies good reason to find ways to work more efficiently. Nearly all insurers are intensifying their efforts to evaluate their operating structure, integrate new technologies, and find ways to generate more premium growth.

A safe haven

We are pleased to report that the insurance industry continues to offer opportunity for growth and a relatively safe haven from the economic downturn. PIAA companies will need to be responsive to an ever-changing labor market, as well as to new developments in the economic and regulatory environments. The companies that can maintain a focus on operating performance and organizational efficiency will be positioned to achieve superior financial performance. It would seem that the industry has plenty to look forward to, as we push on through recovery, and forward-looking organizations should continue to assess their future needs for human capital.

Participation in the semiannual “Insurance Labor Outlook Study” is free and open to the entire insurance industry. The next study will be conducted in June 2012. For more information, or details on how to participate, contact Vince Albers of Ward Group at valbers@wardinc.com. For a full summary of the study’s findings, visit www.jacobsononline.com.

For related information, see www.jacobsononline.com and www.wardinc.com.
For 27 years, the PIAA has maintained the Data Sharing Project (DSP), which is now the world’s largest independent medical professional liability database. Storing detailed data on more than 260,000 closed medical and dental claims and suits, the database provides a rich resource for the investigation of the underlying causes and issues pertaining to medical professional liability claims. All DSP reports can be purchased online at www.piaa.us.

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To learn more about participating in the DSP, please contact P. Divya Parikh, dparikh@piaa.us.

The first and second charts graph the percent and average allocated loss adjustment expenses (ALAE) respectively in the last ten years.
This chart shows the percent of paid claims by indemnity payment threshold from 1985–2010.

**PERCENT OF PAID CLAIMS BY INDEMNITY PAYMENT THRESHOLD (1985–2010)**

2011 Claim Trend Analysis Exhibit 4a
The PIAA thanks all sponsors of the 2012 Medical Liability Conference. Many contributors are longtime supporters of the Association, and we gratefully acknowledge their participation. We are also pleased to welcome our new supporters. Thank you to one and all—your commitment is an integral part of our continued success. All sponsorships were provided by educational grants in accordance with the standards for commercial support as identified by the ACCME, ADA CERP, and NASBA.

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We often talk about the sorely compromised medical liability system and its global impact on our healthcare system. Macro-level issues—such as the lack of access to care and spiraling healthcare costs—can be resolved by repairing the system. Such changes will go a long way toward ensuring that healthcare and the medical liability system work better for everyone, so they are of course critical.

But it strikes me that equally important is the impact of the current medical liability system at the micro level. Specifically, I wonder how it is affecting generations of individual healthcare providers, compelled to practice in an environment where they’ve had to keep one eye out for a possible lawsuit.

Research has shown that surgeons who face litigation are at greater risk for emotional exhaustion, stress, and professional dissatisfaction. Results of a survey published in 2011, in the Journal of the American College of Surgeons, indicate that 24.6% of respondents had been subject to a malpractice lawsuit within 24 months prior to the survey. The researchers also found malpractice lawsuits were strongly and independently linked to depression and career burnout. The stress caused by malpractice litigation was rated as equal to that of financial worries, pressure to succeed in research, work/home conflicts, and coping with patients’ suffering and death. Surgeons who experienced a recent malpractice lawsuit also reported diminished career satisfaction and were decidedly less likely to recommend a surgical or medical career to their children or others.

A recent poll produced by The Doctors Company revealed similarly disturbing statistics. Of more than 5,000 physicians who responded to the independent survey, nine out of ten said that they would be unwilling to recommend healthcare as a profession. In addition, 43% of respondents said they were considering retirement within the next five years.

At one time in this country, medicine was looked upon as a noble profession. Children wanted to grow up to become doctors. The commitment to pre-med studies, the long hours of medical school, and the grueling standards for completing residency were considered acceptable sacrifices for the rewards, both personal and financial, that were to come. But somehow things went off track. And healthcare providers are now faced with what is revealed in the surveys—burnout, fatigue, and a yearning to exit from the practice of medicine.

How can we help our nation’s healthcare providers, your insureds, who have dedicated their lives to helping others? For one thing, we can double down on our efforts to fix our broken medical liability system. Our healthcare providers can really use a helping hand.

By Eric R. Anderson

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