Employed Physicians

What Are the New Risks?

Claims Leakage—How to Stop It

A N D

Physician Insurer 2Q 2013 Covers
A PIAA PUBLICATION FOR THE MEDICAL PROFESSIONAL LIABILITY INSURANCE INDUSTRY • 2013 SECOND QUARTER
At National Document Services, the pursuit of flawless execution is a way of life. That’s why we respond to every customer with energy and intelligence. And why we’ve invested in a proprietary, web-based document retrieval system.

Unlike others, we craft document management solutions tailored exclusively for medical professional liability insurance carriers and law firms. Whether it’s record retrieval, indexing and organizing, or secure online hosting, we have a solution that will meet your requirements.

NDS ensures peace of mind while saving you time and money.

For more information, visit our website at www.national-docs.com.

See what our tools, technology, and service can do for you!
Brand the PIAA for a Whole New World

These are exciting times at the PIAA. We are moving into our 36th year now, serving as the steadfast advocate for those with a stake in the world of medical professional liability (MPL), and the healthcare providers they protect. Much has changed since we were first established in 1977. The issues we once dealt with are quite different from what confronts us today. In order to address these and future challenges, the PIAA Board of Directors has been looking ahead: assessing the industry’s needs and opportunities, and positioning the Association for ongoing success on your behalf.

Toward this end, on page 4 of this issue of *Physician Insurer*, PIAA Board Chair Dr. Ted Clarke, who also is Chairman and CEO of member company COPIC, addresses the redevelopment and launch of the new PIAA brand—which will assist the Association in building on its record of relevance in the fast-changing MPL and healthcare arenas. We are very excited about the changes that you will see in the days ahead; we look forward to your feedback on our new brand identity and the corresponding messages for it.

Speaking of change, this issue’s cover story examines a trend discussed in healthcare and MPL circles: the expanding ranks of employed physicians. The authors of the article analyze some of the salient trends and emerging issues for physicians employed by hospitals, and then discuss the ways that this phenomenon may impact the overall MPL industry.

And just when you think you have a trend like this nailed down, new information emerges—like the data offered in our “Snapshot” article on page 45, which features results from a regional survey of physicians and their intentions about how they prefer to practice, as least in the near future. Surprisingly, a high percentage of the survey respondents said that they had not considered employment.

This issue of *Physician Insurer* also explores the incisive role that predictive modeling can play in MPL insurance. New applications in claims analysis can help claims administrators and actuaries home in on the potential for favorable or adverse development in the cost of a claim considerably earlier in its development. This timing can be critically important in sustaining the financial health of an MPL enterprise.

One other change that I would be remiss in not mentioning is the retirement of two visionaries from the ranks of our international members. Dr. John Gray, Executive Director and CEO of the Canadian Medical Protective Association and Dr. Pierre-Yves Gallard, President of Le Sou Medical will be stepping down from their respective positions in June. We are tremendously grateful for their time and dedication on behalf of the PIAA over the years. I encourage you to visit page 52, where you will find a joint interview with them that provides a brief glimpse into the thinking of these two industry leaders. We wish them all the best in their retirement and future endeavors.

I close by highlighting again our recent efforts in reinvigorating the PIAA brand. One of the most famous stories in the annals of rebranding is that of IBM. Today, some people may not remember that these letters once stood for “International Business Machines.” What they do remember, however, is that IBM is a company that has changed with the times. It began in the early twentieth century as a revered maker of punch card processors, adding machines, and typewriters. Later, it developed mainframe computers. Then, when computers went personal, IBM did too. When that business proved less profitable, the company made dramatic changes, sold off its hardware division, and emerged as a powerful consulting firm.

Like IBM, the PIAA will continue to evolve to ensure we’ll always be relevant and at the vanguard to meet your most vital needs.
The largest group, or 39%, of employed physician self-insurers do not allocate self-insurance costs to the level of individual provider or practice area.

—Cover story
ADD A LITTLE MUSCLE

Healthcare professionals are in a constant race to keep up with regulatory changes and technological innovation. So make sure your professional liability insurance programs have the strength and stamina to not only keep up, but stay a step ahead.

From MEDEFENSE™ Plus for regulatory risks, to e-MD™ cyber liability, to custom-tailored EPLI programs, we provide the supplemental coverages that keep you and your insureds fit, confident, and running strong.

For more information about our innovative reinsurance programs, call us at 818.808.4465 or visit us online at www.nasinsurance.com
How would you define the PIAA brand, and what does it mean to you? Last fall, an initiative to clarify the PIAA brand, prompted by the Association’s new strategic plan, got underway. At that time, the PIAA Board of Directors deliberated this very question. We also surveyed the leaders of the PIAA member companies, some key stakeholders, and other thought leaders from within the medical professional liability (MPL) and healthcare communities regarding this question.

As Chair of the PIAA Board of Directors, Chairman and CEO of COPIC Companies, and a practicing orthopedic surgeon, I am pleased to report to you on what we heard, and how we have acted on what we heard.

The answers that we got from all of these groups were strikingly similar: the PIAA is seen as the premiere trade association for everyone with a stake in MPL.

As I reflect on what we had heard, I can’t help but think back to the time when my company—COPIC—was founded. The COPIC of today is very different from what it looked like in 1981. Like many of today’s successful PIAA companies, it has morphed, as needed, over the years to keep pace with the changing world around it. Like its fellow PIAA companies, the milestones it has achieved along the way are many.

Today, the PIAA confronts a question that is quite a bit like the one that many of our respective companies had to deal with in years past: How can we adjust our business model to stay in sync with the evolving marketplace? After a good deal of research, discussion, and analysis, the PIAA Board, working closely with staff and our consulting experts in the field of brand strategy and development, determined that the Association must find ways to broaden its scope. The consensus is that it must be considered not just an entity that represents only the insurers of physicians. It must be looked upon as an indispensable Association for every group with a stake in MPL: hospitals, healthcare systems, allied healthcare professionals, and others.

For this reason, I am pleased to announce some exciting changes to the brand identity of your Association. Commencing on May 16, 2013, we will begin doing business as simply the “PIAA.” Rest assured that this decision was not taken lightly. Based on our research and feedback from surveys and interviews, omitting the full spelled-out form of the name, “Physician Insurers Association of America,” meant that we eliminated a
NO ONE IS BETTER PREPARED TO HELP YOU REACH THE TOP OF YOUR GAME.

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

Are you ready?

THE OPTIMAL SERVICE GROUP of Wells Fargo Advisors

428 McLaws Circle, Suite 100
Williamsburg, Virginia 23185
757-220-1782 • 888-465-8422
www.osg.wfadv.com

Joe Montgomery, Judy Halstead, Christine Stiles, TC Wilson, Bryce Lee, Robin Wilcox, Cathleen Duke, Kathryn Jenkins, Brian Moore, Loughan Campbell, Karen Hawkridge, Evan Francks, Vicki Smith and Brad Stewart

Securities and Insurance Products - NOT INSURED BY FDIC OR ANY FEDERAL GOVERNMENT AGENCY. MAY LOSE VALUE. NOT A DEPOSIT OR DEPOSIT GUARANTEED BY A BANK OR ANY BANK AFFILIATE.

Wells Fargo Advisors, LLC, Member SIPC, is a registered broker-dealer and a separate non-bank affiliate of Wells Fargo & Company. ©2013 Wells Fargo Advisors, LLC 0211-1214A 03/13
name that is seen by many as too limiting. This approach also speaks to our global reach. Our international members do business in more than 40 countries around the world.

I believe that it is critical that we retain the physician component so important to us all (represented by the “P” in “PIAA”)—which is a fundamental element in our DNA—and the corresponding tradition and history of the Association, while we consider what might happen in the future of healthcare.

In addition, a key point identified in our research is the substantial brand equity that the PIAA acronym has established over the years. By retaining use of the letters “PIAA,” we are able to capitalize on this all-important name recognition.

We also have developed a new tagline: “Our expertise is medical liability. Our passion is quality healthcare.” This description captures the essence of what PIAA members do—we understand MPL like nobody else, and we approach our work with a special kind of moral commitment to serve both MPL and the patients who come to healthcare trusting that care will be safe.

Our new logo is the symbol that represents our reinvigorated brand. The letters in the logo are prominent, to reflect the new, abbreviated name: PIAA. And, we selected a font that is bold and robust, and thereby conveys both strength and longevity.

The logo is a fusion of two icons that represent the full spectrum of healthcare providers: the caduceus and the staff of Asclepius (see box below). This signifies and honors the tradition and history of the PIAA. Our new adaptation of these symbols projects the anticipated growth and forward movement of our brand, in recognition of the evolution in healthcare and the PIAAs expanded role in the MPL insurance industry. It also symbolizes our mission to protect and connect the diverse types of MPL insurers that constitute our membership. Finally, this unique interpretation is intended to have a personal, humanistic feel, to communicate the passion that our members bring to their profession and those they serve.

As I look ahead, I am truly excited about where the future, and our new brand, will take us. In the past, we have been identified as a trade association of physicians insuring physicians. This perception clearly set us apart. But in recent years we have become much more than that. Our membership has grown in ways the PIAA founders may never have imagined. Our ranks have expanded to include hospitals, health systems, and those who insure not just physicians and institutions but also nurse practitioners, CRNAs, nurse midwives, and others. We will let everyone know that we are much more, under the auspices of the new brand. We will be inclusive of all who have the patient’s interests at heart.

Our focus will remain scalpel-sharp as we work to ensure the delivery of quality care, while also identifying the key factors in minimizing liability. We will always be unique, and we will always serve as a key resource for you, our members. I am confident that it is going to be a great journey.
MANAGING RISK ENSURES PROFITABLE GROWTH

GUY CARPENTER LOOKS AHEAD

Let’s make it happen
ny is testing its hand-cleaning compliance system. A Purell dispenser is mounted on a stand. The dispenser holds an electronic sensor. The sensor can read chips embedded in the identification badges of people who come within its range.

The happy result (in theory, at this point): hospitals will be able to specifically identify the doctors and nurses who fail to sanitize their hands.

And in case you’ve been wondering, the Centers for Disease Control and Prevention, in 2002, concluded, after reviewing the accumulated scientific evidence, that alcohol-based products like Purell were “more effective for standard hand-washing or hand antisepsis . . . than soap or antimicrobial soap.” In addition, CDC found that alcohol-based products were better at killing at drug-resistant pathogens than even soaps and detergents containing powerful antimicrobial agents.

Source: New Yorker, March 4, 2013

Recent years have seen the proliferation of Purell hand sanitizer to just about everywhere, including doctors’ offices and hospitals. New programs for “hand hygiene” emerge on a regular basis.

But now the folks who make Purell think they may have beaten the problem of unwashed hands. In a mockup of a hospital room, the company is testing its hand-cleaning compliance system. A Purell dispenser is mounted on a stand. The dispenser holds an electronic sensor. The sensor can read chips embedded in the identification badges of people who come within its range.

The happy result (in theory, at this point): hospitals will be able to specifically identify the doctors and nurses who fail to sanitize their hands.

And in case you’ve been wondering, the Centers for Disease Control and Prevention, in 2002, concluded, after reviewing the accumulated scientific evidence, that alcohol-based products like Purell were “more effective for standard hand-washing or hand antisepsis . . . than soap or antimicrobial soap.” In addition, CDC found that alcohol-based products were better at killing at drug-resistant pathogens than even soaps and detergents containing powerful antimicrobial agents.

Source: New Yorker, March 4, 2013

The National Association of Insurance Commissioners (NAIC) and the Federal Office of Insurance (FIO) have been doing a bit of boundary marking of late. On March 8, 2013, the NAIC went on the offensive, cautioning about “mission creep” from the federal government, including FIO. NAIC president and former U.S. senator Ben Nelson, speaking before the National Council of Insurance Legislators (NCOIL), stressed that the FIO and the NAIC each needs to stay in its own lane of traffic—FIO should do its own job, and “not our job.”

Having achieved a tidy division of labor, the two players will be empowered to collaborate and cooperate, as needed. Or at least, such is the theory at the moment.

Nelson noted that the dialogue between NAIC and FIO is ongoing, based on periodic conference calls, which, he pointed out, could become “formalized” to include updates on what FIO is doing internationally.

Right now, Nelson said, the plan is that the NIAC and its state regulators, as well as the FIO, will serve as the voice for the U.S. internationally. Some international supervisors are less than pleased, finding this arrangement cacophonous and confusing.

Nelson points out that FIO’s role in regard to matters international pertains to trade, and it should pursue that to create more jobs—at home and in South America. It will have to work that out with the U.S. Trade Representative (USTR). The FIO, Nelson suggests (sticking with the automotive metaphor), probably shares “a dual lane with the USTR on trade issues.”

Further defining the NAIC territory, Nelson said that it is important to inform everyone that FIO is not “step one” in federal insurance regulation. He paid a sort of compliment to FIO, noting that it is “beginning to understand that it is not a regulator.”

There appeared to be some oddly convoluted thinking in the last of Nelson’s remarks. Speaking in regard to potential intrusion from the FIO, and the dreaded encroachment of complex standards from the Federal Reserve Board now aimed at U.S. banks, Nelson said, “We are not just trying to protect the turf of state insurance regulators, although that is what we are trying to do.”

Source: captive.com, March 9, 2013

Federal Office of Insurance, NAIC: Uneasy Bedfellows

Source: captive.com, March 9, 2013
MPL Cases in Europe See Rapid Increase

Considering data from any compendium of MPL claims in the U.S., it may come as something of a surprise to read the latest news from Europe on MPL. In fact, the last ten years have witnessed what one European observer has termed “an epidemic of denunciations and/or litigation, judicial and extra-judicial, for cases of presumed malpractice or bad healthcare.”

The data appeared in a recent editorial by S. Davide Ferrara, who is affiliated with the International Academy of Legal Medicine, Institute of Legal Medicine, Department of Molecular Medicine, University of Padova, Italy; his editorial appeared in the International Journal of Legal Medicine.

At the low end in posting increases are Great Britain, the Baltic, and Eastern States. At the high end (more than 200% to 500% increase) are Germany, Italy, the Iberian countries, and the area around the Mediterranean.

The percentage of awards for claims between 2005 and 2010 reached its peak in Sweden and Denmark (40%), but was lower in Central and Southern Europe (average settlement, roughly €30,000 or $39,000 per case in all of the EU countries).

Accompanying the exponential growth in claims has been a proportional increase in the cost of MPL coverage. It has become increasingly difficult for some high-risk surgical specialties to find coverage—especially, gynecology and orthopedics.

The European Union hasn’t done much about this troubling situation. Ferrara comments, “Faced with this dramatic evolution, the European Union has thus far remained virtually inert.”

He notes that regulatory frameworks in the several European countries are not only divergent; they have radically different origins: “There are also no EU regulations, guidelines, and recommendations to prevent, or at least reduce, the multiplicity of regulatory frameworks and national operative systems. Today, one sees the coexistence of systems anchored in the common law juridical models or, more directly, traceable to Roman law.”

That’s not very helpful for MPL, but powerfully intriguing for a fan of history. Source: International Journal of Legal Medicine, March 2013

The Top Ten (Largest) Captive Domiciles

Not much more than a Web link in this story. Banking on the idea that knowing what the locals know about a jurisdiction can convey an all-important “home field advantage,” USLAW NETWORK, Inc. has compiled a field guide to the legal climate in every county in the U.S. The method used in creating the assessments might not meet a strict test for scientific rigor: “The document is supported by the common consensus of many lawyers whose understanding of each jurisdiction is based on personal experience and opinion.” Still, the guide is decidedly better than nothing at all. And it makes for interesting reading. You’ll notice in particular how counties deemed “conservative,” for instance, are cheek by jowl next to others considered “liberal.”

In short, the map might be a godsend to defense attorneys—but also to candidates looking to improve their “ground game” in the next elections.

And now, the URL: www.uslaw.org/juryprofiles.

Source: Business Insurance, March 10, 2013

MPL Cases in Europe See Rapid Increase

Considering data from any compendium of MPL claims in the U.S., it may come as something of a surprise to read the latest news from Europe on MPL. In fact, the last ten years have witnessed what one European observer has termed “an epidemic of denunciations and/or litigation, judicial and extra-judicial, for cases of presumed malpractice or bad healthcare.”

The data appeared in a recent editorial by S. Davide Ferrara, who is affiliated with the International Academy of Legal Medicine, Institute of Legal Medicine, Department of Molecular Medicine, University of Padova, Italy; his editorial appeared in the International Journal of Legal Medicine.

At the low end in posting increases are Great Britain, the Baltic, and Eastern States. At the high end (more than 200% to 500% increase) are Germany, Italy, the Iberian countries, and the area around the Mediterranean.

The percentage of awards for claims between 2005 and 2010 reached its peak in Sweden and Denmark (40%), but was lower in Central and Southern Europe (average settlement, roughly €30,000 or $39,000 per case in all of the EU countries).

Accompanying the exponential growth in claims has been a proportional increase in the cost of MPL coverage. It has become increasingly difficult for some high-risk surgical specialties to find coverage—especially, gynecology and orthopedics.

The European Union hasn’t done much about this troubling situation. Ferrara comments, “Faced with this dramatic evolution, the European Union has thus far remained virtually inert.”

He notes that regulatory frameworks in the several European countries are not only divergent; they have radically different origins: “There are also no EU regulations, guidelines, and recommendations to prevent, or at least reduce, the multiplicity of regulatory frameworks and national operative systems. Today, one sees the coexistence of systems anchored in the common law juridical models or, more directly, traceable to Roman law.”

That’s not very helpful for MPL, but powerfully intriguing for a fan of history. Source: International Journal of Legal Medicine, March 2013

The Top Ten (Largest) Captive Domiciles

Not much more than a Web link in this story. Banking on the idea that knowing what the locals know about a jurisdiction can convey an all-important “home field advantage,” USLAW NETWORK, Inc. has compiled a field guide to the legal climate in every county in the U.S. The method used in creating the assessments might not meet a strict test for scientific rigor: “The document is supported by the common consensus of many lawyers whose understanding of each jurisdiction is based on personal experience and opinion.” Still, the guide is decidedly better than nothing at all. And it makes for interesting reading. You’ll notice in particular how counties deemed “conservative,” for instance, are cheek by jowl next to others considered “liberal.”

In short, the map might be a godsend to defense attorneys—but also to candidates looking to improve their “ground game” in the next elections.

And now, the URL: www.uslaw.org/juryprofiles.

Source: Business Insurance, March 10, 2013
Think Excellence, Not Difference

The Three-Screen Approach

Embrace new ways to connect with the people who matter most

Think about the way you consume news and information today, as compared with ten years ago. Do you use a smartphone or tablet now? Record the news so you can watch it at a more convenient time? Monitor social media? Chances are, many of your go-to resources now didn’t exist ten years ago. From emerging digital platforms to advancements in mobile technology, businesses need to keep up with communication trends to stay relevant and engaged with consumers.

While some may find these technological changes overwhelming, I believe they actually present us with an unlimited opportunity. So embrace these tools, to your advantage. By practicing the “three-screen approach,” you will expand your customer reach, form meaningful connections, and help grow your business.

After I first heard about the three-screen approach, I had an “aha!” moment. This integrates communication across three screens—television, computers, and handheld devices—and is the result of the emerging confluence of three macro-trends.

- **Rapidly evolving technology.** Technology continues to advance and change the way businesses function. From increasing bandwidths and video capabilities to highly functional mobile devices and tablets, technology provides both customers and businesses with new tools and venues for communicating with one another.

- **A dynamic shift in how consumers connect with businesses.** Technology has drastically changed the way consumers get their news, make purchasing decisions, engage with brands, etc. Take news, for example: watching the evening news broadcast in real time and reading the morning paper are no longer the only options available. According to a study by Pew Research, people now get their news through five different channels. Approximately 55% of people watch the news on television, 39% of people get their news online or on their mobile device, and 29% read the newspaper.

Consumers expect they’ll be able to connect with businesses through any screen they choose. This means that, in order to stay competitive, businesses need to be active across multiple channels.

---

**Eric M. Morgenstern, APR, Fellow PRSA,** is President and CEO of Morningstar Communications, Overland Park, Kansas. Eric is a regular contributor to Physician Insurer magazine and presenter at PIAA workshops.
Looking for an investment strategy designed exclusively to satisfy the unique needs of insurance companies?

We Hear You!

Stop by Booths #301 and #303 to learn more about our customized portfolio management solutions.

Prime Advisors, Inc.
New ways in which organizations are packaging and disseminating information. Just as advancements in technology have changed the way consumers consume information, they have also spurred an evolution in how businesses are packaging and disseminating content to consumers. Businesses strive to find new ways to communicate with customers in a meaningful way across multiple, integrated channels. (For more on this topic, refer to my article on the four-channel media model in Physician Insurer, Second Quarter, 2010.)

Embrace the screens! Here’s how you can embrace the three-screen approach and drive your business forward:

■ Take your social and shared media to a new level. Social media can help you achieve your goals—whether you want to build customer loyalty or tap into a new generational market. Consumers are interested in hearing what other consumers have to say about a company, and social media allows them to share and distribute that information easily. Identify the social media platform or platforms to best reach your target customer base, and then develop a strategy for ongoing engagement and monitoring with that base.

■ Become a resource for your customers. The three-screen approach helps businesses serve as a knowledgeable resource for their customers. Position yourself as a thought leader, by providing customers with valuable information and engaging in two-way dialogue. For example, consider sharing information via a blog on your website, a YouTube video, or with posts on social media. When consumers come to recognize your business as a knowledgeable and trustworthy resource, they will choose to do business with you.

■ Introduce your business to the new world of omni-channel marketing. Multi-channel marketing is no longer sufficient in reaching consumers. Omni-channel marketing, which literally means “every channel,” allows businesses to reach their consumers in the way they want to be reached—talk about catering to the consumers’ needs! While it might be easy to feel threatened or overwhelmed by the increasing number of channels that consumers have access to, omni-channel marketing, integrated with the three-screen approach, will position your business for sustainable growth.

Heraclitus once noted that, “The only constant is change.” It’s never been more true: businesses need to evolve and embrace technology, or risk becoming obsolete. The three-screen approach works because it leverages technology to deliver content to consumers how and when they want it. Embracing new media and communications tools is a powerful way to build brand loyalty, reach new customers, and strengthen and grow your business.
MEDICAL PROFESSIONAL LIABILITY REINSURANCE

PROTECTING YOU,
PROTECTING HEALTHCARE

Leading the industry by keeping our clients in front

To find out more please contact:
Email: healthcarepractice@willisre.com, Tel: 952-841-6614
www.willisre.com
dealers. Legislatures and law enforcement agencies are becoming more proactive in their efforts to identify not only the patients who are looking for drugs, but also the physicians and pharmacies who are supplying them. Although these efforts are, purportedly, aimed at ferreting out those few providers who are unethically writing unjustified prescriptions, they may have serious consequences for physicians.

Legislation affecting physicians’ liability

In an effort to combat prescription drug abuse, some states maintain databases of prescriptions filled for controlled substances. California’s system, known as “CURES” (Controlled Substance Utilization Review and Evaluation System), is decades-old. It was originally conceived to identify patients who were “doctor shopping,” i.e., receiving multiple or excessive prescriptions. However, CURES is now seen as a potential source of data to identify and investigate those physicians who might be too-liberally prescribing drugs that are likely to be abused. Other states are adopting similar measures. Tennessee and New York have recently enacted laws that mandate database screening and reporting requirements for physicians prior to dispensing controlled drugs to their patients. The trend of focusing on the providers, as opposed to the patients, in the realm of drug addiction and overdose, is clear.

CURES: California’s approach and how it affects physicians’ potential liability

In an effort to combat prescription drug abuse, some states maintain databases of prescriptions filled for controlled substances. California’s system, known as “CURES” (Controlled Substance Utilization Review and Evaluation System), is decades-old. It was originally conceived to identify patients who were “doctor shopping,” i.e., receiving multiple or excessive prescriptions. However, CURES is now seen as a potential source of data to identify and investigate those physicians who might be too-liberally prescribing drugs that are likely to be abused. Other states are adopting similar measures. Tennessee and New York have recently enacted laws that mandate database screening and reporting requirements for physicians prior to dispensing controlled drugs to their patients. The trend of focusing on the providers, as opposed to the patients, in the realm of drug addiction and overdose, is clear.

Prescription Painkiller Addiction and Overdose: Factors Affecting Physicians’ Liability

It’s an all-too-familiar scene in medical offices across the nation: a long-time patient enters the office, clutching his back and wincing in pain. After taking a history and performing a physical exam, the physician concludes that the etiology is musculoskeletal and gives the patient a prescription for painkillers. But the question presents itself: under what circumstances will the healthcare provider be held liable, if that patient becomes addicted to the prescribed medication—or worse, overdoses and dies?

Abuse of prescription drugs is not new, but it is a growing problem—with more than 20,000 deaths a year in the United States from prescription drug overdose. Perhaps some of the increase in prescription drug abuse can be attributed to people’s perception that prescription drugs are safer than other drugs. In fact, 20% of Americans admit to having used a drug prescribed to them for non-medical reasons.

However, more recently, the spotlight has focused on the healthcare professionals who provide access to the drugs. The media have publicized physicians and pharmacies, depicting them as, substantively, no different from common drug dealers. Legislatures and law enforcement agencies are becoming more proactive in their efforts to identify not only the patients who are looking for drugs, but also the physicians and pharmacies who are supplying them. Although these efforts are, purportedly, aimed at ferreting out those few providers who are unethically writing unjustified prescriptions, they may have serious consequences for physicians.

Legislation affecting physicians’ liability

In an effort to combat prescription drug abuse, some states maintain databases of prescriptions filled for controlled substances. California’s system, known as “CURES” (Controlled Substance Utilization Review and Evaluation System), is decades-old. It was originally conceived to identify patients who were “doctor shopping,” i.e., receiving multiple or excessive prescriptions. However, CURES is now seen as a potential source of data to identify and investigate those physicians who might be too-liberally prescribing drugs that are likely to be abused. Other states are adopting similar measures. Tennessee and New York have recently enacted laws that mandate database screening and reporting requirements for physicians prior to dispensing controlled drugs to their patients. The trend of focusing on the providers, as opposed to the patients, in the realm of drug addiction and overdose, is clear.

Abuse of prescription drugs is not new, but it is a growing problem—with more than 20,000 deaths a year in the United States from prescription drug overdose. Perhaps some of the increase in prescription drug abuse can be attributed to people’s perception that prescription drugs are safer than other drugs. In fact, 20% of Americans admit to having used a drug prescribed to them for non-medical reasons.

However, more recently, the spotlight has focused on the healthcare professionals who provide access to the drugs. The media have publicized physicians and pharmacies, depicting them as, substantively, no different from common drug dealers. Legislatures and law enforcement agencies are becoming more proactive in their efforts to identify not only the patients who are looking for drugs, but also the physicians and pharmacies who are supplying them. Although these efforts are, purportedly, aimed at ferreting out those few providers who are unethically writing unjustified prescriptions, they may have serious consequences for physicians.

Legislation affecting physicians’ liability

In an effort to combat prescription drug abuse, some states maintain databases of prescriptions filled for controlled substances. California’s system, known as “CURES” (Controlled Substance Utilization Review and Evaluation System), is decades-old. It was originally conceived to identify patients who were “doctor shopping,” i.e., receiving multiple or excessive prescriptions. However, CURES is now seen as a potential source of data to identify and investigate those physicians who might be too-liberally prescribing drugs that are likely to be abused. Other states are adopting similar measures. Tennessee and New York have recently enacted laws that mandate database screening and reporting requirements for physicians prior to dispensing controlled drugs to their patients. The trend of focusing on the providers, as opposed to the patients, in the realm of drug addiction and overdose, is clear.

Prescription Painkiller Addiction and Overdose: Factors Affecting Physicians’ Liability

It’s an all-too-familiar scene in medical offices across the nation: a long-time patient enters the office, clutching his back and wincing in pain. After taking a history and performing a physical exam, the physician concludes that the etiology is musculoskeletal and gives the patient a prescription for painkillers. But the question presents itself: Under what circumstances will the healthcare provider be held liable, if that patient becomes addicted to the prescribed medication—or worse, overdoses and dies?

Abuse of prescription drugs is not new, but it is a growing problem—with more than 20,000 deaths a year in the United States from prescription drug overdose. Perhaps some of the increase in prescription drug abuse can be attributed to people’s perception that prescription drugs are safer than other drugs. In fact, 20% of Americans admit to having used a drug prescribed to them for non-medical reasons.

However, more recently, the spotlight has focused on the healthcare professionals who provide access to the drugs. The media have publicized physicians and pharmacies, depicting them as, substantively, no different from common drug dealers. Legislatures and law enforcement agencies are becoming more proactive in their efforts to identify not only the patients who are looking for drugs, but also the physicians and pharmacies who are supplying them. Although these efforts are, purportedly, aimed at ferreting out those few providers who are unethically writing unjustified prescriptions, they may have serious consequences for physicians.

Legislation affecting physicians’ liability

In an effort to combat prescription drug abuse, some states maintain databases of prescriptions filled for controlled substances. California’s system, known as “CURES” (Controlled Substance Utilization Review and Evaluation System), is decades-old. It was originally conceived to identify patients who were “doctor shopping,” i.e., receiving multiple or excessive prescriptions. However, CURES is now seen as a potential source of data to identify and investigate those physicians who might be too-liberally prescribing drugs that are likely to be abused. Other states are adopting similar measures. Tennessee and New York have recently enacted laws that mandate database screening and reporting requirements for physicians prior to dispensing controlled drugs to their patients. The trend of focusing on the providers, as opposed to the patients, in the realm of drug addiction and overdose, is clear.

CURES: California’s approach and how it affects physicians’ potential liability

CURES has been around in various forms since 1939, and it was once a model for other states. Its stated purpose is to assist law enforcement and reg-
Legislatures and law enforcement agencies are becoming more proactive in their efforts to identify not only the patients looking for drugs, but also the physicians and pharmacies who are supplying them.

Tennessee and New York take a more aggressive approach

In contrast to California’s permissive use of its CURES database by prescribers, Tennessee recently passed legislation that will require all physicians to access its Controlled Substance Monitoring Database before prescribing an opioid or benzodiazepine when given as a new course of treatment lasting more than seven days. Physicians who fail to comply with these requirements may be disciplined by the State’s licensing board.

The Tennessee law also requires facilities where controlled substances are prescribed and/or dispensed to provide electronic access to the database at all times. Failure to provide access to physicians could subject the site to $100/per day fine—although this penalty is only imposed when there is a persistent pattern or practice of not providing access to the website.

Factual considerations affecting physicians’ liability

Generally, a physician’s liability for an addiction or overdose case can be triggered by conduct at the initial prescribing phase, as well as the refilling and monitoring phases. However, the mere fact that a patient becomes addicted to a prescription drug furnished by a physician, or overdoses, is not considered negligence per se. Physicians can be held liable when they not only furnish excessive amounts of a drug to a patient, but also when they continue to refill the prescription without adequate monitoring or follow-up.

For example, in *Ballenger v. Crowell*, 38 N.C. App., 50, 60 (1978), the patient blamed his physician for his addiction. The court reversed summary judgment in favor of a physician, who had prescribed the patient narcotics for 12 consecutive years. The patient suffered from Marie-Charcot-Tooth disease, a chronic debilitating neurological disorder. Id. at 51. The physician first treated the patient with Pantapon and then, after two years, switched the patient to morphine sulfate, along with other medications. The patient’s subsequent primary care physician testified that the amount of morphine prescribed to the patient exceeded the “normal” amount prescribed to a patient suffering from Marie-Charcot-Tooth disease. Id. at 52. The subsequent provider added that such a large dose would only have been appropriate for a terminally ill patient. *Ibid*. In reversing summary judgment, the court also considered evidence that the standard of care for treatment of Marie-Charcot-Tooth disease no longer consisted solely of prescribing pain medication and, instead, required additional treatments. *Id.* at 54.

Physicians’ liability not established

In many circumstances, physicians are absolved of liability for their patients’ subsequent addiction or overdose. In *Posner v. Walker*, the court reversed and remanded a jury verdict against a physician, holding that the physician was not liable for the patient’s death when the
The evidence showed that the physician treated the patient for many years for injuries that caused great pain and, as a result, wrote prescriptions for several opioid medications. *Id.* at 659-663.

Nevertheless, when his patient ran out of Percocet and complained of unbearable pain, the physician sought a second opinion from a colleague, instead of simply writing another prescription. *Id.* at 661. After the consult and more analysis, the physician concluded that the patient did indeed require the medication to control her pain. *Id.* at 662. However, in addition to refilling her prescription, the physician also advised the patient to seek alternative treatment at a pain clinic—which the patient promptly refused. *Id.*

Subsequently, the physician learned that the patient had obtained opioid medications from two other physicians, in addition to himself. *Id.* at 662. He advised the other physicians to refrain from prescribing the patient further medication and explained to the patient that she must stop seeking medication from other physicians. *Id.* at 663. Several years later, the patient died as a result of a combined overdose from morphine sulfate, diazepam, and phenobarbital that had been prescribed to her by another provider. *Id.* at 664. However, because he had been proactive as soon as he had learned about his patient’s “doctor shopping,” this physician was absolved of liability for her death.

**Conclusion**

Prescription drug abuse is not new. However, it is a growing problem that is attracting more attention from lawmakers and law enforcement, nationwide. While prior efforts focused on detecting and pursuing the patients involved, increasingly, law enforcement is attempting to identify providers who are either negligently or intentionally over-prescribing. Now, this has prompted greater interest in the use of prescription databases. Some states, like California, permit, but do not require, physicians to refer to their databases.
base before writing a prescription.

However, other states, like Tennessee and New York, take a more aggressive approach and mandate use of the database. Irrespective of their particular jurisdiction, though, practitioners should expect to be judged on how they use these databases whenever they become available, and adjust their practices accordingly.

Footnotes
10. It should also not be ignored that some health insurers maintain similar databases based upon claims they pay to pharmacies for their members’ prescriptions. When these insurers detect a member who has received multiple prescriptions for drugs with high abuse potential, a letter is sent to the treating physician enclosing details of the prescriptions. It is not uncommon for these letters to find their way into patient charts. This kind of proactive effort on the part of health insurers, while aimed at preventing abuse through “doctor shopping,” can also provide fodder for civil claims of failure to properly monitor patients, or failure to take action once such a letter is received.
12. Id.

Isn’t it time for a fresh perspective?

Madison Scottsdale, LLC was formed specifically to meet the unique investment needs of insurance companies. A complete understanding of the operational, regulatory and tax environment each insurance company uniquely operates within is critical to the development of an optimal investment program. Our seasoned professionals possess both the industry and investment expertise and are dedicated to client service.

Over the past five years the markets have changed considerably. Is your investment program keeping up? Let us show you what we can bring to the table.

For information please visit our website at www.madisonscottsdale.com or contact Jeffrey Sise, Senior Managing Director at (800) 757-8120 or Jeffrey@madisonscottsdale.com

8777 N. Gainey Center Drive
Suite 220 Scottsdale, AZ 85258
Legislative Update

Substantial Progress on Congressional Agenda

While the 113th Congress is less than six months old, the Physician Insurers Association of America has already achieved substantial progress with its legislative agenda, bringing hope for more success before the 2014 elections. Through a comprehensive lobbying effort, the PIAA has made significant strides early in this Congress, reaping initial success as well as ample opportunity to advance the Association’s other initiatives.

Antitrust Reform
The PIAA’s first victory came with the introduction of H.R. 911, the Competitive Health Insurance Reform Act of 2013. This legislation would repeal the limited antitrust exemption for health insurers provided by the McCarran-Ferguson Act. At first glance, it may not be obvious that this bill represents a “victory” for the PIAA, since the Association has long opposed repeal of the McCarran-Ferguson Act for insurers. But in light of the history of this legislation, and of similar bills introduced in the past, H.R. 911 emerges as a significant advance for medical professional liability (MPL) insurers.

In past years, many bills have been introduced in Congress to repeal McCarran-Ferguson for some segments of the insurance industry. Shortly after Katrina hit the Gulf Coast, Congress contemplated repealing the limited antitrust exemption for all insurers (with a special eye on homeowners insurance). Also, during the many debates over health insurance reform that spanned several recent decades, debate over the antitrust exemption targeted health insurers. In some cases, MPL insurers were singled out.

What differentiates H.R. 911 from past initiatives is that, for the first time in memory, a McCarran-Ferguson repeal bill was introduced that specifically excluded MPL insurers, and indeed, all property/casualty insurers, from its auspices. This is the fruit of months of outreach efforts and negotiations initiated by the PIAA between insurance industry trade associations, advocates for McCarran repeal, and the office of Congressman Paul Gosar (R-AZ), the bill’s sponsor. During these discussions, the PIAA helped the supporters of McCarran repeal understand that previous bills went well beyond their stated intent of addressing concerns about the health insurance industry; without a specific exemption for property/casualty insurers, McCarran repeal legislation would have extended and lasting unintended consequences for many insurance consumers. At the same time, the PIAA worked with other insurance industry representatives to develop proposals that would protect property/casualty insurers from legislation whose intent was to target the health insurance industry.

The result was a bill that obviates the concerns of those who believe that McCarran provides an unfair advantage to health insurers (whether or not that claim is accurate is an issue for the health insurers), but does not inadvertently target MPL insurers as well. This is a tremendous victory for the PIAA and its member companies, because it excludes us from the antitrust debate before the debate even begins, thereby saving vast

Michael C. Stinson is Director of Government Relations at the PIAA.
Federal standards of care
The introduction of the Standard of Care Protection Act (H.R. 1473) marks another significant achievement, on several fronts, for the PIAA in the 113th Congress. This bill, which would prevent federal healthcare rules and regulations from being used to establish the standard of care in an MPL lawsuit, has long been a legislative priority for the Association.

Working with a coalition of some of our member companies, the PIAA worked closely with Congressman Phil Gingrey, MD (R-GA) to redraft a bill we supported in previous years. The original bill, the Provider Shield Act, was written to address concerns that the Affordable Care Act might unintentionally create new avenues for MPL lawsuits to be filed. The PIAA had advised that the principle applied here be taken one step further, so that no federal rules or regulations (such as Medicare’s payment rules regarding “hospital acquired conditions”) could be deemed to establish a standard of care. The new bill does exactly this, stating, “The development, recognition, or implementation of any guideline or other standard under any health care provision [of federal law] shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice case.”

The PIAA is also pleased to note that the bill is attracting new, bipartisan attention, something it had not fully achieved in its previous incarnation. With a common-sense approach to ensuring that elements of our health laws are not misused in order to game the legal system, and with the support of both Democrats and Republicans in the House, the Standard of Care Protection Act provides an excellent opportunity to move forward with one of the PIAA’s top legislative priorities.

Good Samaritan protections
Last year, the PIAA worked with a coalition of medical groups to draft, and advocate on behalf of, the Good Samaritan Health Professionals Act. That bill, based in part on a concept that the PIAA developed following Hurricane Katrina, would have granted temporary immunity from MPL lawsuits to healthcare providers who provided volunteer services to victims of a federally declared disaster. It gained significant momentum when it was offered as an amendment to another bill in 2012, and passed by a bipartisan vote of 251–157.

In this Congress, the same coalition is pursuing similar protections in the U.S. Senate, hoping to transfer last year’s House success to the other side of Capitol Hill. Early efforts have sparked bipartisan interest in this proposal, even from senators who have long opposed traditional tort reforms. The PIAA is confident that this initial show of interest can expand into full support for our Good Samaritan proposal. While it is too early to reveal the names of the senators we are targeting, stay tuned for future communications from the PIAA as this effort moves forward.

Federal MPL reforms
Several years have passed since the U.S. Senate seriously considered MPL reform legislation, and that appears unlikely to change, given the current makeup of that chamber. The first few months of the new Congress have been kind to the PIAA, but it is important to be realistic. Many legislative proposals begin to work their way through the enactment process; however, the vast majority never actually succeed. With that said, it would seem that the early success achieved by the PIAA represents outstanding progress, and paves the way for additional gains in the near future. If you would like to help the PIAA in our grassroots efforts to promote any of the proposals mentioned in this article, or any other matters monitored by the PIAA, please feel free to contact the Government Relations Department and express your interest.
However, the industry’s profitability continues to be squeezed from both sides, albeit slowly. Frequency increased again during 2012, for some companies. Like the continuing decrease in rate levels, this modest increase in frequency had only a minor impact on the industry’s underwriting results. More widespread increases in frequency, going forward, would further cut into the industry’s bottom-line results.

The increased capitalization and favorable operating ratios in the MPL industry of late have had one primary cause—the release of prior-year reserves. In 2012 in particular, reserve releases contributed 27 points to the industry’s operating ratio. Even without these reserve releases, though, the industry would have been profitable. However, these reserve releases represent a 6-point decline, relative to 2011. A continued decline over the next several years—perhaps combined with an increase in frequency—could change that picture significantly.

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 continue to be characteristic of a hard market. We believe that, taken together, these results suggest 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 could impact the adequacy of both rates and reserves. In addition, an increase in inflation could significantly devalue bonds, by far the largest asset class for MPL writers.

MPL insurers also continue to face uncertainties stemming from healthcare reform. Although the Supreme Court has...
MEDICAL INTERACTIVE COMMUNITY (MI)
We complement your Risk Management program.

Online Risk Management Education (CME/CE)
MiCapture™, A Risk Management Software
Preparing for Litigation Film Series
Telehealth Resources
Practice Management Education
Hospital and Facility Tools

Visit us at booth #300/302 at the 2013 PIAA Medical Liability Conference in Palm Desert, CA May 15 - 17.

Join the community.
Visit www.medicalinteractive.com or call 855.464.7475 for more information.
upheld almost all aspects of this legislation, most provisions of healthcare reform have yet to take effect, making the potential impact almost as uncertain today as it was a year ago. Healthcare reform will likely result in a decline in the availability of healthcare providers due to an increase in the insured population. Presumably, such an outcome could only impact MPL writers negatively, as patients begin to experience greater frustration with their providers.

In certain states, MPL insurers are facing challenges to the tort system itself. Within the past year, bills have been introduced in the Florida and Georgia legislatures that would remove MPL claims from the tort system and also expand the number of claims eligible for compensation, fundamentally altering the landscape for MPL insurers. The actual magnitude of the resulting increase in loss costs is unclear at this point, in particular, because of uncertainty as to the number of additional filed claims. Also unclear is how much leeway insurers will have to file for any resulting indicated rate increase. As of this writing, the Florida bill remains active, while the Georgia bill has been tabled.

To get a more detailed picture of the state of the MPL industry today, we have analyzed the financial results of a composite of 43 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 previous decade. Using statutory data 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 43 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 43 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 reflect 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, 2012, marked the sixth straight year of decreases in direct written MPL premium for our composite (Figure 1). Cumulatively, premium has decreased by almost $1.0 billion since 2006.
We are the
NATION’S LARGEST
INSURANCE-FOCUSED
CPA FIRM

Johnson Lambert is the nation’s largest insurance-focused CPA and Consulting firm. Having such specialized practice and vast expertise in your industry translates to a more efficient service to you. With our industry-specific knowledge, we offer customized solutions to address your business needs.

Financial Statement Audits
Internal Control Reviews
Tax Compliance & Consultation
Regulatory Services
Business Advisory Services
SOC 1, 2, and 3 Reports
Enterprise Risk Management

WWW.JOHNSONLAMBERT.COM

We are proud to be Silver Sponsors of PIAA’s Medical Liability Conference
Stop by our booth # 201

Marcia Jerding, CPA
Partner

Tim Nowak, CPA
Partner

Brandy Vannoy, CPA
Partner

Erik Braun, CPA
Senior Manager
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 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 the deficiencies documented in rate filings themselves. The reduction in frequency for MPL writers means that their rates are in a much better position now than they were a decade ago, although the 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 53%, which has risen to 67% since that time (Figure 2). The increase has largely been driven by the decline in reserve releases during 2012, but also by a modest increase in underwriting expenses and a small decline in investment returns. The 2012 combined ratio for the industry was 90%, up from 80% in 2010 and 82% in 2011 (Figure 3).

The investment gain ratio of 23% in 2012 declined from a 10-year high of close to 28% in 2010. This result was perhaps to be expected, given the declining impact of the write-downs taken on invested assets during 2008. In 2010, the realized capital gains ratio hit a 10-year high of 6% of net earned premium, as companies sold these previously devalued assets. Subsequently, there have been fewer devalued assets remaining from the 2008 time period, and the realized capital gains ratio has declined, settling at 4% in 2012. The decline in the investment income ratio has been similar, from near-ly 22% in 2010 and 21% in 2011 to slightly more than 19% in 2012.

The calendar-year loss and loss adjustment expense (LAE) ratio for 2012, 61%, was noticeably higher than the comparable figure for 2011, 54%. The increase was driven largely by the decline in reserve releases noted earlier, and discussed further below. The increase in the initial loss and LAE ratio carried for the 2012 coverage year was small. The loss and LAE ratio carried for the 2012 coverage year is about 88%, 1 percentage point higher than the 87% loss and LAE ratio carried for the 2011 coverage year as of year-end 2011. In light of the small increases in frequency in certain jurisdictions, along with continued rate decreases in virtually every locale, an increase in the initial loss and LAE ratio seems reasonable.

**Reserve releases**

As noted above, the industry was able to continue releasing reserves in 2012. However, the amount released declined noticeably for the composite, to just over $1.0 billion, from the high of more than
For nearly a century, Thuillez, Ford, Gold, Butler & Monroe, LLP has been the law firm doctors, hospitals and nursing homes have called to their defense.

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

You'll find us listed in Best's Directories of Recommended Insurance Attorneys and Adjusters and the Bar List Publishing Insurance Bar, Claim Service Guide, Physician Insurers Association of America Affiliate Defense Firm (PIAA) and on the web at www.thuillezford.com

Thuillez, Ford, Gold, Butler & Monroe, LLP.
Keeping the healthcare industry alive and well for 100 years.
$1.2 billion released each year in 2008 through 2011 (Figure 4). Despite the decline, the reserve releases remain material. Yet, they should be put in the context of the reserves carried by the composite, which for net loss and LAE totaled more than $10.1 billion as of year-end 2011. The release of reserves was driven by the ongoing impact of a lower frequency, combined for many companies with a relatively benign indemnity 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 been able to sustain favorable reserve releases, as this impact has proved favorable. This may also explain the decline in reserve releases during 2012, as the effect of the payment lag begins to run its course. 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 when reserves were subsequently 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 2014 or 2015. 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.

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). 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. Thus, for every claim reported, fewer dollars have been available each year to defend or settle the claims.

Note that, in Figure 5, we have adjusted the 2012 frequency to include a provision for “pipeline” claims (i.e., incidents that evolve into claims), in order to provide an indication comparable to the earlier report years. Prior development suggests that with the inclusion of these pipeline claims, the frequency for the 2012 report year would likely be between 8.2 and 8.4 claims per $1 million of gross earned premium. This suggests a frequency somewhat greater than in 2011. Thus, cumulatively, frequency (measured relative to premium) has increased by 20% to 25% 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 2012 fueled a significant increase in surplus during the year of about 9%, from $10.3 billion to $11.2 billion (Figure 6). This is a noticeable gain, but still less than each of the gains experienced 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). It is somewhat higher than the gain in surplus of about 6% in 2011. In addition, the biggest contributor to the gain in surplus was the favorable reserve development discussed earlier, which cannot be expected to continue at the same level 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 slightly more than 1,100% in 2012, 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 more than 6,700%.

**Policyholder dividends**

At the same time, the increase in surplus has been slowed by the significant amount of policyholder dividends that MPL writers have continued to pay. In 2012, the composite writers paid $260 million in policyholder dividends, or 7% of net earned premium (Figure 3). This was a moderate decline from the two all-time highs of more than $270 million paid by the composite in 2010 and 2011. Cumulatively, the composite has paid $1.6 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.

**When will the hard market come?**

In its most recent “Review & Preview” report, A.M. Best estimated a net reserve redundancy of $2.7 billion for the MPL line of business as a whole. This is approximately 9% of the carried net reserves, which implies a redundancy for our composite of $900 million. Thus, continued reserve releases can be expected to mask deteriorating underwriting results on current business, both prolonging the soft market and increasing the risk that rates may become inadequate in the future. Insurers face other risks to the bottom line as well: possible increases in frequency and severity, the potential for a decline in asset values, uncertain impacts of health-care reform, and a likely decline in market size, as hospitals continue to acquire physician practices, among others factors.

Looking ahead, we envision a continuation of the protracted soft market that we find ourselves in now. The amount of reserve releases will decline, but will nonetheless buoy the combined ratio of the industry, for perhaps several years to come.

We envision a continuation of the protracted soft market that we find ourselves in now. The amount of reserve releases will decline, but will nonetheless buoy the combined ratio of the industry, for perhaps several years to come. The composite writers paid $260 million in policyholder dividends, or 7% of net earned premium (Figure 3). This was a moderate decline from the two all-time highs of more than $270 million paid by the composite in 2010 and 2011. Cumulatively, the composite has paid $1.6 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.

Absent a significant shock to the capacity of the MPL industry, it will likely be several years before rates begin to increase again.
By increasing the number of physicians covered by a self-insurance program, hospitals are taking on significant administrative burdens, which include rating, underwriting, communications, and claim coordination.
The healthcare industry is undergoing a consolidation trend, on several levels. Most significantly, there has been an increase in employment of physicians by hospitals. Hospital systems have long been in the business of self-insuring professional liabilities. By including more physicians in their self-insurance programs, many are making a transition from self-insurer to insurance company, in the way that these programs are administered. This transition gives systems new opportunities for cost savings and increased efficiencies—but also exposes them to an expanded, less-diversified portfolio of retained risk.

Professional liability coverage for a growing employed physician exposure

Approximately 25% of the U.S. hospital industry participated in the 2012 edition of the “Aon/ASHRM Hospital and Physician Professional Liability Study” which focused on the changing relationship between hospitals and employed physicians’ professional liability coverage. Historical exposure data was collected from all of the 125 systems, and served as the basis for insights into the growth in employed physicians that are specifically covered under the system’s professional liability program.

From 2008 to 2011, growth in Class 1 Physicians, or “Internal Medicine Equivalents,” exceeded the growth (or decline) seen in other major categories of hospital activities (Figure 1). Participants in the study have seen, on average, 5% to 7% growth in physician full-time equivalents since 2006.

Participants in this year’s benchmarking project were asked a series of survey questions aimed at defining the common practices used by hospital systems to manage the employed physician professional liability exposures. Nearly 55 organizations responded to the survey; 80% of them are using self-insurance to provide professional liability coverage for their employed physicians (Figure 2). Only 13% of systems rely on commercial insurance entirely or in part (7%) to provide insurance for the employed physicians. These statistics reinforce the supposition that commercial insurance is still a part of the liability coverage solution.

Another survey question asked risk managers to rank the perceived advantages of hospital self-insurance
for employed physicians. Responding organizations identified three advantages, with nearly equal weight (Table 1).

So, there are several important goals that risk managers believe can be achieved through self-insurance of the physician exposure. All three reasons point to the improved efficiencies that hospital systems expect to gain by bringing the employed physicians into a self-insurance program.

The first two advantages cited show how often, and why, hospitals are consolidating employed-physician and hospital risks within their self-insurance programs. However, for systems that choose to integrate professional liability risks, the challenge is in the details. In implementing self-insurance for employed physicians, hospitals must address the significant administrative issues that relate to coverage and cost. The following survey questions and results show how organizations are handling these issues.

**Administration of the consolidated hospital and employed-physician risks**

**Limits of liability.** More than 30% of organizations provide limits of greater than $2 million to employed physicians (Figure 3). In many cases, this limit may be the same as the hospital’s excess insurance attachment point. Some systems impose a lower coverage limit on employed physicians. Of those systems providing the lowest coverage limits, most are subject to various state-sponsored coverages attaching below $1 million.

The application of the coverage limit can be shared or provided on an individual basis (Figure 4). An individual limit provides the physician with the full value of the coverage, regardless of the liability attributed to other parties. A shared limit is eroded by other parties, or internal to the hospital system, and therefore limits the systemwide exposure for one event.

**Prior acts and tail coverage.** Physician professional liability is often covered on a claims-made basis. Claims-made insurance responds to matters that are reported, but did not necessarily occur, during the policy period. This type of insurance coverage therefore gives rise to issues related to prior-acts and tail coverage for the physicians who are working within claims-made programs. Prior acts coverage refers to claims-related events occurring prior to the physician’s employment with the organization. Most hospital self-insurance programs, or 67%, do not respond to prior acts (Figure 5). A minority of the survey respondents, or 31%, cover prior acts for selected physicians.

A physician’s tail coverage refers to those claims that occurred while the physician was employed, but were not reported until after the physician had left the organization. The claims-made insurance protection technically responds only to claims reported during the coverage period, and it would not apply to such tail claims. The survey indicates that 86% of healthcare organizations are providing tail coverage to employed physicians upon their termination or retirement.

Some systems provide this coverage by using an occurrence coverage basis rather than claims-made. Other systems utilize the claims-made coverage form but explicitly provide the tail coverage benefit to employees. Hospitals appear to be converging on an industry standard of providing tail coverage but excluding prior acts for physicians who become covered by a self-insurance program.

**Cost allocation.** Healthcare organizations vary widely in how they allocate the ultimate cost for physician self-insurance. For nearly 33% of systems, the cost of employed physician professional liability is allocated to the individual, specific provider. This level of detail is similar to what is done in commercial insurance. Such an allocation might include consideration of specialty, part-time or full-time status, claims-made retroactive

---

**Table 1 Advantage of Self-Insuring Employed Physicians**

<table>
<thead>
<tr>
<th>Advantage of Self-Insuring Employed Physicians</th>
<th>Top Ranked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unified, joint defense of professional liability claims</td>
<td>36.7%</td>
</tr>
<tr>
<td>Cost savings relative to commercial insurance rates</td>
<td>32.7%</td>
</tr>
<tr>
<td>Improved control and uniformity of systemwide risk management</td>
<td>30.6%</td>
</tr>
</tbody>
</table>

---

**Figure 1 Cumulative Growth in Hospital Exposures 2008–2011**

- Psych Beds: -2.2%
- OP Visits: 8.6%
- IP Surgeries: 0.8%
- OP Surgeries: 13.4%
- Class 1 Physicians: 11.0%
- ED Visits: 4.2%
- Births: 1.0%

**Figure 2 Use of Hospital Self-Insurance for Employed Physicians**

- Percentage of systems with a majority of its employed physicians included in the system’s self-insurance program: 13%
- Percentage of systems with a majority of its employed physicians commercially insured: 13%
- Significant combination of self-insurance and commercial coverage: 80%
date, claim history, and other variables as identified by the organization. An individual allocation allows the system to tailor the cost to the specific characteristics of each insured, and then allows the insured to compare the expense to commercial alternatives. A system employing this level of detail in the allocation process must keep up to date on the cost of insurance that is offered in the commercial market.

More than 28% of systems allocate the costs of physician self-insurance to the level of each practice or specialty (Figure 6). This is a “middle-ground” approach: It differentiates insurance costs for high- and low-risk specialties, but does not identify the specific cost for an individual risk.

The largest group, or 39%, of employed physician self-insurers do not allocate self-insurance costs to the level of individual provider or practice area. These systems tend to think of the hospital and physician programs as a whole. Such systems may not track claims separately for physician and hospital liability. While this is clearly the simplest approach, these systems may not be collecting or monitoring information regarding liability trends specific to physicians, and they cannot compare their physician self-insurance costs with those in the commercial alternatives. These systems may also be unable to track physician liability trends as a contributor to their overall professional liability results.

**Employed physician liability cost trends**

Aon’s study examines cost trends for physicians employed by hospitals, specifically analyzing data from those systems that are able to track physician claims separately on their loss runs. This subgroup of the database represents approximately 15,000 Class 1 Physician Equivalents.

The following figures present overall loss rates and claim frequency per Class 1 Physician and claim severity (limited to $2 million per occurrence). The trend in employed-physician professional liability loss rates has been flat in recent years (Figure 7).

The claim frequency statistics indicate the probability of a non-zero claim occurring for a Class 1 Physician during a year of full-time employment (Figure 8). As a percentage of total claims, physicians tend to have more expense-only claims than hospitals. Approximately 30% of employed-physician claims result in an indemnity payment, compared with 38% for hospital-only claims.

Claim frequency for employed physicians declined since the years preceding 2005, and has remained relatively stable since 2008 (Figure 9).

Employed-physician claims tend to be approximately 25% to 30% larger than hospital professional liability claims. Employed-physician claim severity appears to have been driven by a stable inflationary trend in recent years.

The Aon/ASHRM study provides similar statistics for hospital professional liability. Generally speaking, employed-physician loss trends have mirrored the trends seen in hospital pro-
fessional liability over the past several years. This is an expected result, since both physicians and hospitals are influenced by the same societal, judicial, and economic factors that drive professional liability claims.

Looking ahead

By increasing the number of physicians covered by a self-insurance program, hospitals are taking on significant administrative burdens, which include rating, underwriting, communications, and claim coordination. These additional tasks are transforming many hospital self-insurance programs into something that resembles a traditional insurance company, particularly if they choose to allocate costs to individual physicians. In addition to administrative burdens, hospitals are increasing their overall exposure to professional liability through the self-insurance of employed physicians.

Fortunately, the loss environment over the past decade has not been punitive to the hospitals that have assumed these additional risks, as frequency is stable and severity has been increasingly only modestly, in line with inflation. However, long-range planning for these integrated programs should include careful consideration of what might happen to the combined portfolio of risks if there are deteriorating trends in claim frequency or severity.

For related information, see www.aon.com.

About the Aon/ASHRM Hospital and Physician Professional Liability Benchmark Study

The 13th annual edition of the Aon/ASHRM Hospital and Physician Professional Liability Benchmark Study was released in October 2012. The study examines trends in hospital and physician professional liability claim frequency, severity, and overall loss rates. Loss and exposure data were collected from 125 hospital systems, representing 25% of the U.S. hospital industry.
MPL Insurer Investments: Low Risk, Low Reward

The medical professional liability (MPL) insurance industry in recent years has experienced good results, driven largely by tort reform, aggressive defense of lawsuits, and reserve releases. Insurers have sufficient capital, giving them capacity to withstand large losses. However, the outlook is uncertain, as competition is bringing down rates and healthcare reform may increase claims frequency.

Lower investment yields are hurting MPL insurers in particular, due to the long-tailed nature of this line. With interest rates expected to remain low through 2015, companies with conservative investment strategies will be earning very little from their investments in the near future. Given their current capital positions, why don’t insurers adopt a more risky investment strategy?

For this analysis, we used data from A.M. Best.
as of December 2011 and Conning’s Peer Analysis tool. We created a peer index of 53 PIAA member companies with a combined $27 billion of total assets, and divided them into the following categories:

- Large insurers: companies with more than $400 million of assets
- Medium insurers: companies with $100 to $400 million of assets
- Small insurers: companies with less than $100 million of assets.

We also used A.M. Best’s composite of workers’ compensation insurers as a benchmark for investments in a long-tailed line of insurance.

**Industry outlook**

The MPL insurance industry has had high ROEs for the past several years, due in large part to reserve releases. In 2011, for example, reserve releases totaled nearly $2 billion and improved calendar-year loss ratios by more than 26 points. However, this level of profitability is being challenged by several trends. There is no guarantee that reserve releases will persist, with indications of a leveling off in improvements in loss frequency and in success in defense settlements. In addition, softening market conditions are expected to continue driving down premium growth. Finally, decreasing investment income is expected to reduce profitability even further.

Conning forecasts that investment income for the industry in 2013 will be almost $300 million lower than in 2011, with further deterioration in 2014 (Figure 1). The combination of lower premiums, fewer reserve releases, and declining investment income is expected to drive ROEs down to single digits in the next few years.

**A further look at investment performance**

The insurance industry has seen a decline in its investment yield in the past few years, driven primarily by a drop in interest rates. From 2002 to 2007, the five-year Treasury note yield aver-
By the end of 2012, this yield had dropped to 0.8%. As investment portfolios matured and rolled into a lower-yielding environment, the resulting decline in book yields had an adverse impact on insurers’ profitability.

Figure 2 shows the impact of low interest rates on investment yields for insurers. A tax-equivalent yield is used to provide better comparisons for MPL insurers that invest more in lower-yielding tax-free municipal bonds. These lines rely more heavily on investment income than others, because many losses take several years to settle, and assets are held over a longer period. Yields for medium and large MPL insurers have been fairly close to yields for workers’ compensation insurers in recent years. In contrast, small insurers have had much lower yields in recent years, due to higher concentrations of low-risk investments.

Interest rates are expected to stay depressed over the near term, as the Federal Reserve appears ready to stay involved in capital markets through its securities-buying program. According to “Action Economics,” the five-year Treasury note is forecast to increase to 1.28% for 2013 and 2.1% for 2014. Despite these low yields, insurers continue to operate within a conservative framework. If insurers wish to increase returns, available options include lowering credit quality, extending maturities, and seeking alternative investments.

Slight deterioration in credit quality

Figure 3 shows the distribution of bonds for each of three groups of PIAA MPL companies, as of year-end 2011. NAIC 1 designations are equivalent to Standard & Poor’s ratings of A- and higher, while NAIC 2 designations are equivalent to S&P’s BBB ratings. Bonds with designations of NAIC 1 or NAIC 2 are investment grade, while all other bonds are high-yield.

There was a slight shift in bond quality in 2011, as both workers’ compensation and MPL insurers saw their percentage of NAIC 1 bonds in their portfolios shrink. It is not clear how much of this shift was due to a conscious decision on the part of insurers to take on more risk or the result of downgrades to existing bonds.

Small companies are playing it safe when it comes to investments, putting 92% of their bond portfolios into NAIC 1 bonds. They could increase their bond yield by investing more of their assets in lower-credit-quality bonds. For example, a certain five-year corporate bond with an A rating had a yield of 1.1% in February 2013. A similar bond with a BBB rating had a yield of 1.84%—a pick-up of more than 70 basis points. Large and medium insurers also have leeway in choosing riskier bonds.

Bond maturities are structured to match liability payment patterns

Investments with longer maturities have higher yields than comparable investments with shorter maturities. For example, the yield on the ten-year Treasury note was more than 100 basis points higher than the yield on the five-year note. Average bond maturities for MPL insurers are close to six years, while average maturities for workers’ compensation insurers are about seven years.
The S&P 500 would earn a 2% dividend yield. This yield is slightly higher than the yield on the ten-year Treasury note. A portfolio of stocks in the S&P 500 Dividend Aristocrats Index would earn a 3% dividend yield, if payout ratios for these stocks remain constant.

In 2012, the S&P 500 had a total return of 13.4%, compared with 4.2% for the Barclays Capital U.S. Aggregate Bond Index. Investors in equity must also be aware of the downside potential of capital losses and generally higher volatility. In addition, equity investments carry higher capital charges for insurers versus investment-grade bonds. Insurers must assess their risk tolerance and capacity to take on additional risk before increasing their equity holdings.

What should insurers consider going forward?

Medical professional liability insurers could face millions of dollars in reduced investment income, as their older investments mature and are reinvested at lower rates. However, insurers can reduce the impact of falling rates by taking on additional investment risk. These companies could replace just a small percentage of A-rated bonds with BBB-rated bonds; that would increase their yields, but they would still hold a portfolio of investment-grade bonds. In addition, owning more equity securities can result in much higher payoffs than bonds. Eventual increases in interest rates will have a negative effect on the market values of bond portfolios, since bond prices fall when rates rise.

The question that insurers must ask themselves, however, is how they can most efficiently utilize their available risk capital without going beyond their traditional risk tolerance limits. While additional investment risk would result in higher expected income and improved return on capital, insurers who accept this risk must be confident that they have the financial strength and risk tolerance to absorb the potential downside.

According to key capital adequacy measurements, insurers appear to have the necessary capacity to take on additional investment risk (Figure 7). The PIAA insurers in our sample have a robust risk-based capital ratio—more than enough to avoid regulatory action. Similarly, the Best Capital Adequacy Ratio (BCAR) for this group is ample. Had the insurers’ stock portfolios lost even 50% of their value in 2010, they still would have an RBC ratio above the threshold level.

Insurers, however, cannot rely solely on capital measurements when deciding to take on additional investment risk. They must do a thorough analysis of both the risks and the benefits of changing their investment portfolios and consider the potential outcomes of adverse scenarios.
By applying predictive modeling in new and powerful ways, some medical professional liability (MPL) insurers are gaining an important edge. They can zero in on the potential for adverse, or favorable, development in the cost of a claim sooner along in the process. Knowing what is happening earlier means that mitigation strategies can be applied when they do the most good. With these techniques, one quarter to one half of the adverse development, which would otherwise have occurred, can be recouped for the company.

“Claims leakage” may be an unfamiliar term. According to industry literature, it has been defined as: . . . the difference between the actual claim payment made and the amount that would have been paid if more effective claim payment controls had been in place.

Speaking a bit more technically: Leakage is also calculated against the probability that a company utilizing leading practices with the same fact pattern would have identified and avoided the result.

How is leakage assessed, using the traditional approach? By examining a sample from the company’s closed-claim file considered to be representative of all of the claims. Then, for each claim in the sample, a questionnaire is completed, detailing some salient specifics about the claim. The results for the whole batch are then compiled, to investigate the overall issues pertaining to leakage, as well as some particular issues that may have exacerbated the leakage problem. The collection is used to generate refinements in the claims-handling process—which are then sent on to the claims department staff—in the hope that awareness of leakage issues will serve as a guide for stemming the leakage problem, in whole or in part.

But clearly, this is a limited sort of process. The approach to investigating claims may prove short-sighted—too narrow to reveal fundamental problems. In some companies, this basic approach has been enhanced with data mining and predictive modeling.

Ronald T. Kuehn, FCAS, MAAA, CERA, CPCU, ARM, FCA, Kim Piersol, FCAS, MAAA, and Todd Dashoff, ACAS, MAAA, ARM, are with Huggins Actuarial Services, Inc.
Enter: predictive modeling
With predictive modeling, companies aren't restricted to their closed-claim files to investigate the problem of leakage. Modeling can be used at any stage in the development of a claim: when the claim first happens, when it is reported, during the adjustment (development) period, or at settlement. The models can also provide guidance in:
- Claim assignment
- Coverage reviews (both primary and excess coverage)
- Claim investigation
- Negotiations
- Use of litigation
- Recoveries.

By offering critical insights into the specific drivers of claims costs, modeling can be used to inform the underwriting process. The information it provides can be applied in screening new applicants for coverage—or in devising more accurate pricing for a current book of business.

The first step in running a predictive model is gathering the data. For this, companies can use the same sort of questionnaire about claims that is applied in the traditional approach. Software vendors offer specialized online products that a company can use to develop a predictive model. Once the data on individual claims has been collected, the next step is to create the full database that is used in devising the model. The more data, the better, of course, for increasing the statistical—predictive—power of the model.

Here, though, you can add data that is external to the actual claims, to flesh out the picture of what may happen with a claim. Based on where the claim originated, supplementary data might include information on medical costs, how the local court system is used, and the income levels of potential claimants. But data like this is seldom free of cost; at minimum, it requires the staff time needed to locate it. So it’s wise to assess the potential benefit of supplementary data before making a decision on whether to start searching for it.

Now, with this model in place, companies can measure development at various intervals, for example, at initial reporting through 12 to 24 months. By observing the factors that subsequently lead to excessive increases, they can become more nimble in pinpointing the claims that may end up with big increases. Then, they can keep a close eye on the claims-handling of such claims, and thereby reduce the size of the increase—or possibly obviate it completely.

In most instances, the large claims aren’t treated with predictive modeling, since claims staff frequently know a good deal about what may happen with such claims at the time when they are reported.

Because claims adjusters can be more precise in predicting the future development of all claims, they are in a better position to prioritize their case loads, aware of the specific claims that have the red-flag characteristics identified via the modeling process. Procedures for loss mitigation can then be put in place, to minimize adverse development.

The relative accuracy of the model process can be assessed by reviewing what has happened with the claims that were highlighted by applying it as sources of possible leakage. Were the characteristics identified by the model valid indicators of what needs to be done to achieve savings? And if so, how great were the savings achieved? It may be that the model will need to be revised: different characteristics may have more predictive power than the ones initially selected, or perhaps more factors need to be added.

Work with the model is an ongoing, iterative process. Each time the model is applied, there is an analysis of its relative accuracy, followed by refinement in the selection of identifying characteristics. Communication thus assumes a critical role. It is crucial that the results of each iteration of the process be forwarded to the claims department, and any other party that may be affected by the change. At the same time, everyone involved needs to watch for any new causes of leakage.

And now, here is a case study that may help explain the workings, and value, of predicting modeling.

Case study: a regional P/C company
This property/casualty insurer, “Regional Medical Professional Liability Insurance Company” (RMPLIC) writes MPL coverage in several Midwestern states. Their principal customers are physicians, but they also provide insurance for some hospitals and offer general liability coverage, too. With claims offices in all of the states where they provide coverage, the company handles its own claims.

Here’s the problem. When RMPLIC’s actuary estimated reserves for years 2008 and earlier, based on available data as of June 6, 2009, he found that the reserves requirement for the company needed to increase by $25 million; total reserves prior to this calculation were $500 million.

Then, when the company actuary examined the reserve needs using data compiled as of September 30, 2009, the picture got worse. His estimates for required reserves indicated that another $25 million would be needed.

Quite understandably, RMPLIC managers were not happy,
and so they called in an outside actuary (let’s call this Actuarial Consulting Firm A) to take a second look at the data. But after its review was completed, the consultant said that he concurred with the company actuary estimates. So management brought in a second consultant (Actuarial Firm B), but again, their calculations yielded the same numbers as those of the in-house actuary.

Then, the company bought in Actuarial Consulting firm C, which proved able to offer a solution to the company’s problem—to the apparent need for a hike in reserves. Note in particular here how many elements are included in this analysis, which were necessary to understand the full picture of what had gone awry in the reserves analysis.

First off, Actuarial Firm C asked to see a detailed electronic list of every claim that had been active in the three years up through September 30, 2009. Then, they applied both modeling and data-mining techniques, which revealed that the company’s claims examiners were setting mature reserve requirements at a figure that was in fact 40% higher than the actual amount for which these claims had settled. However, their analysis for the interval between April 1, 2009, and June 30, 2009, indicated that the historical redundancy of 40% had started to drop. (This is why the in-house actuary had been right in saying that $25 million in new reserves was needed.)

For the subsequent interval, July 1, 2009 to September 20, 2009, the consulting firm found that the redundancy on closed claims continued to fall—once again, validating the work of the in-house actuary.

The next step for Actuarial Firm C was a new analysis, wider in scope, comprising all of the claims from June 1, 2009, and September 30 of that same year. When they segmented the claims according to percentage of closing redundancy, an interesting finding emerged: there were two distinct groups. The compilation labeled Group 1 were all around 40% (according to a scatter-
Another Problem: The New Claims Manager—Case Study of a Single-State MPL Insurer

In this case study, the culprit was the claims-handling policy adopted by a new claims manager.

The company's actuary had noted, in his quarterly review of claims, that new development patterns had emerged, which diverged from the company's historical data. When he told company managers about it, he discovered that a new claims manager—with a very different take on how to deal with claims—had been hired.

The new manager believed that the best way to minimize the cost of claims was to settle as many of them as possible, as quickly as possible. He assumed that this approach would generate substantial savings on loss costs, convinced that the longer a claim was open, the more the related costs, on both the indemnity and the expense side, would pile up. He considered the funds expended on a lengthy investigation of a case to be pretty much a waste of money.

But claims had in fact been settled too quickly. Example: a $1 million claim was settled in just six months from the time it was reported. In the usual circumstances, it would take at least four years for this company to settle a claim of this magnitude. Taking more time had brought the insurer a distinct advantage: plaintiffs became weary of the whole process, very much wanting to avoid a jury trial, and knowing that despite their convictions about the evidence, the whole thing might be lost anyway. They were willing to settle the $1 million claim at a 10% discount. And so $100,000 could easily be lost in a rush to get a claim finished and filed away.

In addition, the company lost the investment income that would have accrued from holding the reserves for the case for the full four years that had been required for settlement: nearly $125,510, assuming a 3% investment return on $1 million held for four years. In contrast, all that was saved in loss adjustment expense by adhering to the early-settlement program was a meager $5,000 per year.

So the total cost—leakage—of the claims manager’s approach to handling claims was $205,510, or 20.1%. It should come as no surprise that the claims manager subsequently lost his job.

plot analysis). In contrast, the redundancy for Group 2 was around 25% (again, by scatter plot). This was a new development; before April 1, 2009, all of the claims were essentially Group 1 in terms of relative redundancy.

So the firm zeroed in on the Group 2 claims. What was different? The company's claims auditors discovered that the claims handlers were settling for amounts that were excessive. In addition, the claims were being settled more quickly. This is what “claims leakage” meant, in dollar terms, for this company: $10 million in lost revenue.

The consulting actuary realized he needed to know more. He interviewed the claims adjuster who had handled both Group 1 and Group 2 claims, as well as the senior vice president in the claims department.

Here is what was discovered: The senior vice president had closed one of the company’s claims offices, in the early months of 2009, and had thereby gained $1 million in savings. He then distributed the open claims files from this office to the other RMPLIC offices. As it turned out, the claims staff who’d been unexpectedly burdened with bigger case loads countered by closing these claims rapidly, just to get them off their desk. The net result was that the $1 million in savings, achieved by closing one claims office, cost the company $10 million in claims leakage.

Once the company had identified what had happened, they were able to put in place the internal control and review policies necessary to ensure that the Group 2 claims were handled in adherence to the company’s usual standards. The happy result was that the claims for the period that ended on March 31, 2010, once again showed the historic level of redundancy: 40%.

Meanwhile, the in-house actuary’s estimates began to decrease, first for the claims for 2008 and earlier. Then, in the next two quarterly analyses done on data for this period, the estimate had dropped by $40 million. This was the same as his original estimate, made before the claims office had closed and subsequent developments significantly altered the company’s reserve position.

Conclusion
Companies of substantial size can lose thousands or even millions of dollars from claims leakage. If it takes a relatively long time for a company to detect a leakage, it may be a good while before prosperity can be restored. Leakage is usually the consequence of not having, and following, a clearly delineated policy for handling and settling claims. The policy, once it is widely communicated throughout the company to all claims staff, should be closely monitored for any deviation from what has been set down.

Bear in mind that identifying leakage requires data mining, along with the review of individual files. Only at this sort of granular level does it become possible to determine with confidence whether settlement values have been in alignment with the facts of a claim—and not inflated for one reason or another. For related information, see www.hugginsactuarial.com.
Many of us would be surprised at how medical professional liability (MPL) claims are resolved. That few plaintiffs recover money is well known. What may be startling is that most claims aren’t won, lost, or settled; they simply disappear. Nearly 60% of the MPL claims asserted against doctors and other medical professionals are eventually abandoned.

This is a failure for patients, who recover nothing, and for the medical system and defendants, who bear the resulting costs. It is also a missed opportunity for insurers. This article looks at the statistics on dropped claims, probes why plaintiffs abandon them, and suggests how insurers could lower their cost.

Dwight Golann is Professor of Law at Suffolk University Law School in Boston. He has written and lectured extensively about legal dispute resolution and is a member of the board of directors of Coverys, a PIAA member. The opinions expressed in this article are his own and do not express the policy of the company. He may be contacted at dgolann@suffolk.edu.
My suggestions are based on a study of 3,600 claims against physicians, hospitals, and other medical providers in Massachusetts closed over a five-year period. The study found that 58.6% of claims brought against individual defendants were abandoned, or “dropped.” Dropped claims were more than twice as frequent as settlements (26.6%) and almost four times as common as adjudications (14.8%) (Table 1).

These results are consistent with other studies. The PIAA, for example, recently reported in the 2012 Claim Trend Analysis that 64% (170,716 of 267,713) of the claims closed by its participating members over a 27-year period had been “dropped, withdrawn, or dismissed.”

There is another way to look at the data, from the perspective of a patient who brings a case. The typical MPL plaintiff asserts claims against more than one defendant—there were an average of 1.7 claims per patient case in my study—and different claims within a case often have different outcomes. The study counted a patient case as “abandoned” only if every claim in it was dropped. Under these assumptions, the rate of abandonment for patient cases was 46.4%.

Dropped claims impose costs on patients, their attorneys, providers, and on the medical system as a whole. The average cost of defending an abandoned claim, measured in terms of allocated loss adjustment expense, was $25,735; the average for a dropped case was $44,200. When a claim is dropped is important; for instance, the average cost of defending a claim dropped prior to suit was $1,188, while the cost for claims abandoned after five years or more was $45,712.

We don’t know how much dropped claims cost plaintiffs, because most lawyers charge on a contingency basis, and many do not keep track of their time. The plaintiff lawyers I interviewed drew a sharp distinction, however, between the cost of bringing an MPL case at all, which is high, and the cost of adding additional defendants to an existing case, which they viewed as relatively low.

MPL litigation imposes other costs, such as overhead expenses for insurers and plaintiff lawyers. Other costs, while important, are almost impossible to quantify; these include those related to a plaintiff’s anxiety or a doctor’s need to utilize defensive medicine.

**Why patients drop claims**

*Why do plaintiffs bring claims and later drop them?* The contingency fee system gives plaintiff’s attorneys a strong incentive not to begin work on cases that are later abandoned. It is therefore puzzling that claims are dropped so frequently. I interviewed some plaintiff’s MPL specialists to explore the causes.

I found that some plaintiffs abandon their cases out of frustration with a process that provides them no quick resolution (the average dropped claim had been pending for 2.75 years), and during that period forces them to relive traumatic events over and over. On their part, some lawyers probably drop claims out of frustration or because their practice priorities change. However, almost none of the plaintiff lawyers I interviewed cited these as leading reasons why they abandoned claims.

The reason cited by all plaintiff lawyers I interviewed—and named as the primary cause of abandonment by most of them—is that new information, acquired during the course of litigation, leads them to conclude that a claim is weaker than they had thought. A medical record may suggest that a required step in treatment was not taken, for instance, but a nurse later testifies persuasively in deposition that it was carried out and simply not recorded. Or a lawyer may file suit relying on an expert’s opinion, only to find that, as the expert sees more data, she becomes less willing to testify that malpractice in fact occurred.

The next most frequently cited reason for dropping cases was unforeseeable events that occur while a case is pending. If, for example, a patient alleging failure to diagnose cancer remains in remission...
for years, her life definitely improves, but her
legal claim gradually loses its value. The finding
of a significant co-morbidity may also weaken,
or completely sever, the causal connection
between a claimed error and the injury.

MPL claims can also become weaker for
reasons that might have been foreseen at the
outset, had the patient been more candid or the
lawyer done a better investigation. An attorney
may claim loss of companionship for a spouse,
for example, only to learn that the couple had
separated before the patient entered treatment.

MPL specialists say that lawyers who file MPL
cases only occasionally may let the vision of a
large award blind them to problems with a
claim, such as lack of a causal connection
between the claimed error and the subsequent injury. Some attor-
neys file cases that appear to have substance but are really too small
to justify the cost of a trial, with the intent to abandon them if they
cannot be settled.

Finally, plaintiffs sometimes add marginal defendants to cases
for tactical reasons. Lawyers expressed concern, for instance, that if
they do not sue a doctor who was marginally involved in a course of
treatment, the provider they do sue will attempt to shift blame to
his absent colleague—the so-called “empty chair” defense. Or a
plaintiff may add a hospital to a case primarily
to facilitate getting information in discovery,
and then drop it as a party. Until recently, non-
profit hospitals in Massachusetts had their lia-
bility capped at $20,000, which made it dan-
gerous to keep a hospital in a case that would
be tried.

Lower costs
Can the cost of dropped claims be lowered?
The fact that most claims are abandoned
prompts the question, Is it possible to reduce
the cost of handling them? One approach
might be to change the culture of the resolu-
tion process itself. Such an initiative would
have the following characteristics:

- Plaintiff lawyers would contact an insurer or provider about a
  potential claim rather than simply filing suit. For a limited period of
time, perhaps six months, the plaintiff and the insurer would work
cooperatively to develop information about the cause of the event
and its effect on the patient.
- After its investigation was complete, the insurer would explain
  its findings to the plaintiff and, if appropriate, make a good-faith
settlement offer. The plaintiff could discuss the findings with the
insurer and accept or negotiate over the offer.
If no settlement was reached, the offer would expire, and the plaintiff would be free to sue. The insurer, however, would not make another offer unless it received new information or a court decision.

No insurer appears to have focused specifically on reducing the cost of dropped claims, and as a result there is no hard data on whether such an effort would be effective. In 2001, however, the University of Michigan hospital system instituted a policy of aggressive investigation and settlement of adverse incidents. Within a few years, the average cost of resolving a case in the system decreased by 44%, from $405,921 to $228,308. Children’s Health Care of Atlanta adopted a similar policy and also reported sharp declines in the cost and duration of its MPL cases.

Admittedly, hospitals have special advantages in resolving claims, including immediate access to patients and the ability to settle in the name of the institution, avoiding the need to report physicians to the National Practitioner Data Bank. However, Toro, Inc., a maker of power tools that, like insurers, may not learn of injuries until long after they occur, instituted an aggressive program to resolve personal injury claims and reported after five years that its cost of dealing with such claims had declined dramatically.

Insurers have expressed concern that if they provide information efficiently, plaintiffs will bring more claims—building a better highway, in other words, will stimulate more traffic. The University of Michigan found, however, that its program reduced both the frequency of new cases and the percentage in which settlement payments were made. Toro also found that claims against it did not increase because they were resolved more quickly.

Insurers concerned about the risk of exploitation could proceed on a pilot basis. The first step would be to identify plaintiff lawyers unlikely to abuse the program. The phrase “trustworthy plaintiff lawyer” may seem an oxymoron, but when I asked plaintiff and defense lawyers and adjusters in Boston to identify opponents whose ethics they respect, each side was able to quickly suggest names.

Insurers should reach out to plaintiff lawyers to encourage early resolution. Doing so will reduce the frequency and cost of abandoned claims, sparing both physicians and their patients from litigation, which ultimately benefits no one.
Like me and my colleagues, I’m sure you’ve read many reports relating how physicians are changing their practices to respond to the changing healthcare environment. For example, just recently I read that more than 70% of physicians will be employed by 2014. Based on these projections, how does one plan for this extent of attrition? Or, should we bear in mind the comments of Mark Twain and Disraeli?

In reading many of these same reports over the past several years, we were perplexed as to why physician-hospital employment, recent healthcare reform, and other trends were not exactly playing out at the same pace within our own clientele. So, to try and get a better understanding of what might be occurring within our markets, we responded as any other self-respecting organization would: we did a survey!

In retrospect, we’ve seen some notable changes in our clients’ practices in regard to more allied personnel hires, mergers, new services being added, the entry of private capital, and the formation of joint ventures. Each of these provides us with new information that we can relay to our underwriters and, better yet, helps us find ways to use this information to plan for new types of coverage and risk management/patient safety needs in the future.

Though our data reflected some trends that corroborate what is occurring nationally, we also saw results that run counter to some of the popular trends others have noted—in particular, in regard to hospital employment. This survey helped confirm our own experience, and, in light of other information we gathered from regular client interactions, it has helped us work proactively to anticipate evolving coverage needs and, internally, helped us identify some new business opportunities.

Survey background
The intent of our survey was to ask our clientele about how they’re planning to adjust to the changes in healthcare. Our typical survey

“Figures often beguile me, particularly when I have the arranging of them myself; in which case the remark attributed to Disraeli would often apply with justice and force: ‘There are three kinds of lies: lies, damned lies and statistics.’”

—Mark Twain’s Own Autobiography: The Chapters from the North American Review

Steve Fargis is with Professional Risk Associates, a physician services firm specializing in medical professional liability, sfargis@profRISK.com.
respondent was 46 years old, a specialist in a small group, practicing in the mid-Atlantic. The majority of respondents were specialists (62%), fairly evenly spread among solo practice, small groups, and groups of ten and more, and similarly, by age groups of less than 45, 45–55, and 56–65 years of age. Fourteen percent of the respondents were more than 65.

The changing physician practice model
We asked if physicians were considering changing their practice, by reducing their practice to part-time, retiring, merging with another practice, or becoming employed. Approximately 50% indicated they are planning changes in their practice:
- 18% will reduce their practice to part-time
- 13% are planning to retire
- 5% are planning a merger
- 12% are considering hospital employment.

We found the retirement and part-time numbers to be in line with previously reported trends, but the low number considering hospital employment was a bit surprising.

- Hiring more allied health practitioners. Sixty-eight percent of respondents work with mid-level providers, and 30% of those are planning to add more of these in 2013. Twenty-six percent said they were planning to expand the scope of duties for their current mid-level providers. The majority of these were specialists, followed by 26% in primary care; only 17% were in solo practices. Interestingly, those who do not currently use any mid-levels are not planning to add any in the next year.

Those who are looking for joint ventures with other practices were predominately specialists and in smaller groups. Notably, these are also younger physicians, ages 31–45, who said that they would also seek private investment for expansion of their practice; this was more common than in any other age group.

This information has helped us identify potential coverage needs for those planning to make a change. Although 50% indicate that they will maintain the same practice profile, this information provides us with coverage insights, should they plan for future practice changes.

Selling to a hospital
Selling one’s practice to a hospital has been a national trend, and different from what we experienced in the 1990s; this time, the hospitals are unbiased as to specialty, location, and size of group. While we certainly see our share of physicians being hired, our trend does not comport with national statistics, e.g., more than 50% of physicians are employed.

In an effort to identify if our demographics were “behind the curve,” we inquired about physicians’ current thinking on hospital employment. The results appear to run counter to what we’ve read in terms of national data: only 12% of all survey respondents are even considering employment and only 9% of solos are considering employment.

Of those respondents looking for an exit strategy and are considering hospital employment, the majority have been in practice for more than 20 years in a small group, older than 55, and represent, with an even distribution, primary care, specialists, and surgical practices. Seventy-five percent of these practices indicated they are planning to sell within six months to one year.

Why the low number for those now considering employment? Have we peaked in terms of hospital practice acquisitions? While hospitals do appear to be in a cooling-off period, we wanted to identify why a practice may not have sold to a hospital. We found that among physicians who may have considered employment, there were some key issues that kept them from joining a hospital (Figure 1).

Of the 88% of responding doctors who said that they had not considered employment, the strongest two factors were (1) they did not want to lose autonomy, and (2) they felt they would not be able to make decisions about running their practice.

This information has helped us ascertain how soon we need to start talking to the practices we work with when they are considering employment, and what issues we should help them focus on in regard to their MPL coverage. Our success on this matter with clients has coincided with the timing of our involvement on their behalf—the earlier, the better.

What physicians think: related issues
- My practice and the impact of healthcare reform. Seventy-six percent said that healthcare reform will have no impact in the next year on their income, patient relationships, or practice group, and only 12% are planning to participate in an accountable care organization (ACO). Further, when asked if reform would help them improve their relationships with hospitals, health plans, or other practices, 78% felt that healthcare reform would not improve these relationships.
When asked whether healthcare reform would have a positive impact on their liability risk, 69% said no (Figure 2).

Those respondents who felt that there would be a positive impact from healthcare reform in the areas of income, patient relationships, payer relationships or liability risk were predominately specialists, older than 65, in a solo practice, or in a small group.

■ “My liability coverage is important to me because…”
The portion of the survey on liability reflected some strong convictions in response to the statement on the “importance of having control and input over settling a claim.” Eighty-eight percent acknowledged that having consent was very important to them.

Curiously, an overwhelming majority of those who are considering employment felt that having consent was very important to them as well, and they may fail to recognize that they will lose this coverage feature, along with personalized defense service and several other support features currently provided by their carrier. Further, insureds also need to consider, in their employment discussions with a hospital, the potential impact on their reputation that may arise from an inability to give or withhold consent and input on defense support, credentialing, and future insurability.

When asked about coverage for cyber-liability and regulatory coverage for Recovery Audit Contractor audits, more than 50% of physicians indicated that these coverage additions are very important. The expressed need for RAC coverage was most pronounced among younger physicians (31–45), and those older than 65—and there was no distinguishing difference in professional liability insurance, coverage remains a top concern.

■ “What is important to me in my practice…”
Those respondents who are in their first five years of practice ranked delivering a “high quality level of healthcare” as the most important factor for career satisfaction. Whereas those who had then been in practice longer, for 5–10 years, ranked this aspect lower and felt that “work-life balance” was most important.

However, those who were considering being employed by a hospital, within the next year, said that providing a high-quality level of healthcare was most important to career satisfaction; no one stated that having autonomy was important (though they still felt consent to settle was highly important!).

■ “Who can help me be more profitable?”
Respondents believe that six agents are in the best position to help make their practice more profitable (Figure 3).

Inflow of private investment
Overall, as the figure shows, payers appear to take the lead in providing the best opportunity for improved profitability.

Large groups and specialists view other practices, payers, and private investment as most helpful, in that order. The more interesting dynamic is that private investment was seen as an avenue for augmenting profitability, roughly the same extent as technology, and more than what government or hospitals could provide. Those more than 65 years old, however, noted that private investment could be as helpful as hospitals. While we have seen some instances wherein private equity groups acquired practices and supported specialty groups, it is likely this type of new “buyer” of MPL will become more prevalent as time goes on, requiring an understanding of their buyer behaviors, along with a new array of needs in regard to corporate coverage.

For related information, see www.profRISK.com.

Footnote
1. The survey population was limited to the mid-Atlantic geographical area but included all specialties, age ranges, group sizes, and length of time in practice, with a high statistically significant response rate from 3,500 clients of Professional Risk Associates.
Focused on Delivering
Customized
Investment Strategies to
Meet the Unique Needs of
Insurance Companies

Prime is proud to be the Platinum Sponsor for the PIAA 2013 Medical Liability Conference. Stop by Booths #301 and #303 to speak with our dedicated Investment Professionals.

Asset Management Services
To learn more about the services we provide, contact Patrick Tuohy, SVP:
860.331.3050
Patrick.Tuohy@primeadvisors.com

www.PrimeAdvisors.com
In September 2012, The Doctors Company published a study of medical professional liability (MPL) claims closed between 2007 and 2011 that involved neonatal injuries with the allegation of "delay in treatment of fetal distress." While the term "fetal distress" is no longer recommended to be used by clinicians, it is still commonly used by a legal system that has not kept pace with the changes in terminology used by the medical community. Clinicians more commonly use the term "fetal heart rate (FHR) tracings (usually ACOG Category II or III) predictive of metabolic acidemia."

We expected to find that the primary reason why care was delayed was nurses' inability to interpret patterns predictive of metabolic acidemia. We also anticipated that physicians had failed to respond to calls from nurses to come to the hospital to assess patients. Our assumptions were incorrect. Nurses had failed to recognize FHR tracings predictive of metabolic acidemia in only 11% of the cases. Physicians failed to go to the hospital after a request from a nurse in only 14% of the cases.

A detailed study of the claims revealed eight different causes for delayed responses. The most common reason for delayed care was that physicians did not make a timely decision to initiate a cesarean section after they had learned about Category II or III FHR tracings (43%). "Timely" was defined by the physician experts who reviewed these cases, based on the clinical information available to the defendant physician.

A review of the cases revealed multiple reasons why physicians did not initiate a cesarean section when there were Category II or III tracings predictive of metabolic acidemia. The most common reason was failure to diagnose the underlying cause of the abnormal pattern. An emergency response had been delayed by failure to recognize placental abruption, ruptured uterus, or tachysystole until the patient was clearly in crisis.

The second most common reason for a delay in performing a cesarean section was that the physician chose to attempt an operative vaginal delivery (using forceps or vacuum extraction) when confronted with Category II or III FHR patterns. The amount of time consumed by the attempt further delayed the decision to perform a cesarean.

**Recommendations**

We recommend that physicians should be reluctant to attempt instrumental deliveries in the face of tracings that do not exhibit moderate variability and accelerations. We also advise that physicians should develop an exit strategy that is communicated to the whole care team before an instrumental delivery is attempted. In other words, the surgical team should be notified about a likely emergency cesarean section so they will be ready if the operative vaginal delivery is unsuccessful.

Communication failures were a common theme in many of these cases. As an example, a family practice physician partnered with an obstetrician, but it was not clear who monitored the patient and who made the decision to undertake a cesarean section. The family practice physician did not have privileges to perform a cesarean section, so the procedure was delayed until the obstetrician’s arrival. In other cases, a house officer or senior resident was called to intervene, but he or she did not act absent the attending physician’s presence or permission.

Another issue was commu-
nunication breakdown occurring between nurses and physicians. The nurse, in each case, had communicated concerns about FHR tracings, but, in some situations, the physician failed to grasp the true status of the patient, disagreed with the nurse’s conclusions, or chose to wait and see whether other interventions would be effective before he or she came to the hospital to personally evaluate the patient.

Less frequently, physicians faced with early labor hesitated to deliver a neonate that was weeks or months premature. Other infrequent events were lack of anesthesia availability, equipment problems impeding the ability to adequately monitor the status of the neonate, or a belief that a birth was imminent, so an emergency cesarean section was not initiated.

Physicians who hold obstetrical privileges have challenging responsibilities. Many of the cases in which physicians hesitated to initiate an emergency surgical delivery were characterized by unusual situations. These physicians also worked under limitations of communication that sometimes resulted in outright miscommunication. Other issues included unclear lines of authority such that the physician hesitated to take action, in deference to the attending physician, or a failure to recognize complications that placed the life and health of the neonate at risk.

Asking the question “Could this happen here?” or “What could go wrong here?” encourages an analysis of the wide range of scenarios that can occur in any obstetrics department. Nurses, midwives, and physicians should learn to clarify messages designed to prompt immediate actions by physicians. Physicians who share in the management of pregnant patients should clarify the roles of each practitioner. Physicians who find themselves in an emergency obstetrical situation should be given clear authority to act immediately in the best interest of the mother and neonate.

We suggest that some form of structured communication tool be used between healthcare professionals. One such tool in common use is SBAR. Another is P.U.R.E Conversations in Obstetrics.3 This approach to communication helps in determining a purpose for the conversation, delivering the message in an unambiguous manner, ensuring that the interchange is respectful, and measuring in real time whether the conversation is effective in determining the plan of action.

Finally we believe that, “addressing these themes proactively and in real time should become a strategic activity for the physicians, midwives, and nurses who staff every perinatal unit. Increased readiness for complications—and enhanced recognition and management of them—improved communications, and mastery of the required technical skills should all work in concert to reduce the likelihood of these difficult and tragic outcomes.”4

Footnotes
2. Ibid.
What’s slowing you down?

Technology alone isn’t the answer. Delphi Technology is the only solution provider that gives you all the tools you need to win the race... an innovative technology solution AND more than 20 years of industry knowledge and business expertise.

* Policy Management  * Claims Management
* Financial Management  * Risk Management
* Reinsurance  * Document Management
* Advanced Workflow  * Policy Holder Services
* Physician eLearning  * Online Applications
* Incident Management  * Data Warehouse & Reporting
* Advanced Business Analytics  * Predictive Analytics

Stop by Booth #200 at the PIAA 2013 Medical Liability Conference and learn how the leading medical professional liability carriers and hospital systems are gaining a competitive edge with OASIS.

470 Atlantic Avenue, Suite 702
Boston, MA  02210

617-259-1200
www.Delphi-Tech.com
Two venerable figures from the PIAA’s International Section, for many years a source of keen insights for other PIAA members, are retiring this year. We were pleased for the opportunity to talk with them one last time before their respective departures, and asked them to ruminate on their years as leaders in the PIAA, in the global MPL arena, and as physicians. But first, here is a bit of background on these two eminent gentlemen.

Dr. John E. Gray joined the staff of the Canadian Medical Protective Association in 2000 and is the Executive Director and Chief Executive Officer. A graduate of Queen’s University, he practiced family medicine in Peterborough from 1974 to 2000. His interest in the medical profession is reflected in his more than 20 years on the executive committees of his county medical society and 10 years with the Ontario Medical Association, including one year as President. He had served five years on the board of directors of the Canadian Medical Association and two years on the council of the CMPA prior to his appointment to staff. He was a diplomate of the American Board of Family Practice until 2004, and is a fellow of both the American Academy of Family Physicians and the College of Family Physicians of Canada. In addition to his CMPA responsibilities, Dr. Gray is a member of the board of directors of the PIAA and chairs the International Section.

Dr. Pierre-Yves Gallard is a urological surgeon, and a former chief resident. He has been working in the Paris region for 30 years. In 1972, having completed his thesis on the medical and legal aspects of the accidents, incidents, and complications of abdominal surgery, he joined the medical council of Le Sou Medical and a few years later its board of directors. Since 2002, he has been the President of Le Sou Medical, and served as Chairman of MACSF Group from 2010 to 2012. Dr. Gallard is a member of the French Medical Association. He has also been an integral and active member of the PIAA International Section since its inception.

PI: How has the PIAA changed in the years you’ve been working with the Association?

Gallard: I have participated in the PIAA’s annual meetings over the last 10 years, including its workshops. I have always really appreciated the organization, the quality of speakers, and the innovative themes explored at these events. These meetings allow participants to keep abreast of changes specific to the health industry and of potential consequences for insurance companies. The PIAA’s International Section, and the dynamic approach undertaken by Dr. John Gray as its chairperson, have helped us to stay up-to-date on medical professional liability (MPL) and risk management issues in other countries. One concrete example of this is the joint effort undertaken to create a shared database. Though difficult, this effort is both important and exciting.

Gray: The PIAA has evolved into an authoritative source for MPL-related information. Through member-focused and effective effort, the PIAA has earned its reputation as a strong voice for the MPL industry, both in the U.S. and internationally. The PIAA boasts an impressive list of members, and strives to educate and connect MPL insurers and liability protection providers. The PIAA’s advocacy efforts have also emerged to help shape important U.S. legislation and regulations.

PI: What has been your most satisfying assignment with the PIAA?

Gallard: Without a doubt, some of my best memories will be the organization of the PIAA’s International Section Conference in Paris in 2008. With all PIAA
members in attendance, this event allowed for extremely meaningful information sharing. I was actively involved in choosing themes and coordinating with speakers, and I am proud to have had the opportunity of working with the PIAA’s very accomplished teams.

Gray: The CMPA has been a member of the International Section of the PIAA for a number of years. I have had the honor to serve as both Chair of the PIAA International Section as well as a member of the PIAA Board of Directors. I’m fortunate to have been the first, and so far the only, non-U.S.-based member to serve on the Board. As a Board member, I have had the privilege of driving forward the PIAA’s vision and working with a strong and varied group of experienced decision-makers, supported by a dedicated, collegial, and highly effective staff. One of my greatest regrets about my upcoming retirement is that I will lose regular contact and interaction with the many friends and colleagues I have met through the PIAA over the years.

PI: What reasons would you give for joining the PIAA to a non-U.S. MPL company?

Gallard: Although there are cultural and regulatory differences from one country to the next, it is important for us to share information about our practices, and our difficulties, as well as the issues we all face. The PIAA offers us a worldwide perspective on MPL liability. For members, it is a great melting pot for mutual enrichment and exchange, and that’s a real plus for anticipating what the future holds.

In regard to MPL and medico-legal risk management, it is extremely valuable for all members to learn from one another about matters related to regulations and procedures.

Gray: The CMPA joined the PIAA because of its leadership in the MPL industry, and to leverage the opportunity to interact with, benchmark, and learn from similar organizations from across the globe. Within this focused networking and learning environment, the CMPA has been involved in initiatives such as sharing medico-legal trend data and analysis, as well as risk management practices and products. Through our membership in the PIAA, we have increased our international profile and credibility in the MPL domain, while further benefiting from the greater span of information available to us.

The PIAA’s meetings and educational opportunities are also very valuable, and focus on members’ needs and current areas of interest. These sessions continue to inform the CMPA of emerging risk management education themes, and confirm common issues with fellow PIAA members.

We have also been pleased to moderate sessions and present information at a significant number of PIAA events.

PI: What are the greatest challenges to MPL companies in your country—e.g., excessive regulatory burdens, unfavorable investment environment?

Gallard: The greatest challenges currently are large-scale adverse events (Epinal Hospital radiotherapy accident, Mediator drug scandal, Poly Implant Prostheses [PIP] scandal, etc.) involving a number of practitioners and victims, and representing considerable costs for us as insurers. These cases sometimes bring us into confrontation with medical manufacturers. It is also worrisome to note that in spite of vigorous and solid defense, healthcare professionals are increasingly found guilty by the courts.

Moreover, the Solvency II
directive adopted by the Council of the European Union puts our activity at risk, given that we insure risks over the long-term that are not taken into account by the new accounting standards.

As a mutual insurance company, our first challenge is to protect healthcare professionals, to allow them to practice their profession in the best conditions possible. We must, in particular, remain watchful, since constraints imposed by public administrations can make medical practice more difficult for physicians, putting patient safety at risk.

Our system, based on mutuality, gives us the incredible opportunity to concentrate on critical needs, and remain at the service of the healthcare system within an increasingly demanding society.

Gray: Canada is facing an increasingly complex medical liability environment. This environment is impacted by substantial economic constraints on healthcare budgets, changing healthcare delivery models, expanded scopes of practice for non-physicians, changing relationships between physicians and healthcare institutions, emerging information and communication technologies, significant privacy issues, increased attention to patient safety, and ongoing issues with access to justice. These and other emerging issues are impacting the MPL environment in Canada, and affect not only the CMPA but also the myriad of hospital insurers across the country. The CMPA, which is not an insurance company, has managed to avoid much of the excessive regulation, including constraints on investment vehicles, which we are aware of in other jurisdictions.

PI: What kinds of insights can the MPL companies in the various countries gain from each other?

Gallard: The main issue today is how to determine what constitutes a medical error. Are we dealing with a medical fault or error, an adverse event, or a complication? Was the damage preventable? The experience of our Swedish colleagues on this issue is very informative.

We must also improve the way we estimate damages, and seek to be fair to victims, while remaining within the framework of reasonable limits. I find the practice of capping non-economic awards in certain American states most interesting. Estimates of damages must also take into account the patient’s previous health condition and what other experts practicing in similar circumstances would have done.

We have to remember that physicians must do everything in their power to treat and relieve the discomfort of their patients, but that they cannot be held to a standard that obliges them to heal ailments.

Finally, there is a way to improve the practice of future physicians—by making risk management an integral part of medical training. This is an ethical duty.

Gray: With access to global information through PIAA member companies, international members are well positioned to take note of early indicators of future trends and to examine what these may mean for their jurisdiction. The PIAA’s annual medical liability conference and function-specific conferences, such as the Claims and Risk Management Workshop, provide our staff with valuable exposure to individuals in similar roles at other PIAA organizations. In our view, the focused networking and learning facilitated by membership in the PIAA is invaluable.
Accelerate your success

Partner with Towers Watson

Need to accelerate your value creation strategies?

When you partner with Towers Watson, you benefit from our broad, deep and truly integrated capabilities in reinsurance intermediary services, capital markets, consulting and software solutions for property & casualty insurers and reinsurers. So you can achieve success faster.


Towers Watson. A global company with a singular focus on our clients.
PIAA Data Sharing Project

For 28 years, the PIAA has maintained the Data Sharing Project (DSP), which is now the world's largest independent medical professional liability research database. Storing detailed data on more than 267,000 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.
Strength in numbers.
Your participation in the DSP permits greater statistical power—and better information for patient safety. To learn more about participating in the DSP, please contact P. Divya Parikh, dparikh@piaa.us.
The PIAA thanks all sponsors of the 2013 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.
**Exhibitors**

- AAM – Insurance
  Investment Management
  www.aamcompany.com

- Advanced Practice Strategies, Inc.
  www.aps-web.com

- AQS Asset Management, LLC
  www.aqslc.com

- Bottomline Technologies
  www.bottomline.com

- CapVisor Associates, LLC
  www.capvisorassociates.com

- Clear Review, Inc.
  www.clear-review.com

- Delphi Technology, Inc.
  www.Delphi-tech.com

- Doctors Management
  www.drsmgmt.com

- ECR Institute
  www.ecri.org

- First Legal Network
  www.firstlegalnetwork.com

- Garretson Resolution Group
  www.garretsongroup.com

- GR-NEAM
  www.grneam.com

- Imperial PFS
  www.ipfs.com

- Johnson Lambert LLP
  www.johnsonlambert.com

- Law & Medicine
  www.lawandmed.com

- Madison Scottsdale L.C.
  www.madisonscottsdale.com

- Medical Interactive Community
  www.medicalinteractive.com

- Northern Trust Company
  www.ntrs.com

- Prime Advisors, Inc.
  www.PrimeAdvisors.com

- Ravello Solutions
  www.ravellosolutions.com

- Swiss Re
  www.swissre.com
A Salute to Doctors

BY ERIC R. ANDERSON

Whenever I attend a PIAA meeting, I’m amazed by the number of doctors and other healthcare providers who play an essential role in the successful operation of our member companies. These men and women dedicate countless hours of their time to learning the mechanics of medical professional liability (MPL) insurance and then working to find ways to improve the MPL climate—and thereby enhance patient safety. And, I might add, they do this while, very often, balancing multiple demanding tasks: the rigors of seeing patients, conducting hospital rounds, and attending to the day-to-day responsibilities of running a practice.

If you think about the insurance industry in a big-picture sense, the phenomenon of policyholder involvement stands out as unique to MPL—and, in particular, the PIAA companies. After all, I’ve had an auto insurance policy and a homeowners’ insurance policy for many years, but I can honestly say it’s never occurred to me to call up my carrier and ask if I can volunteer for them.

The founders of PIAA—the dedicated doctors and insurance professionals who started the Association more than three decades ago—would be proud to know that the tradition of policyholder involvement is still abundantly with us, woven deeply into the fabric of the PIAA companies. These pioneering individuals shared a belief that this sort of involvement was critical in differentiating the PIAA companies from other MPL carriers.

In fact, to celebrate one person who demonstrates this very special level of involvement, the Association established an annual award in the name of Peter Sweetland. Sweetland was a founding father, chief architect, and unrelentingly ardent supporter of the PIAA.

Over the years, the Sweetland Award winner has many times been a doctor. In 2013, this tradition continues, as we honor James Carland, III, MD, of the Mutual Insurance Company of Arizona (MICA). Dr. Carland is a former practicing pediatrician, longtime chief executive of MICA, past PIAA Board chair, and dedicated member of countless PIAA committees and sections. He exemplifies the drive, spirit, and commitment of all of the doctors who, like him, have worked so hard to ensure the availability of a stable source of affordable MPL insurance and a better MPL environment.

Now, the PIAA is on the brink of a new era. We have opened our doors, in recent years, to broaden our membership base beyond just companies that insure hospitals and healthcare facilities and physicians. We also include those who provide coverage to the ever-expanding ranks of allied healthcare providers, such as physician assistants, nurse practitioners, and all of the other specialists who have recently come to play a key role in our evolving healthcare system.

Like the doctors in the companies that launched the PIAA, the people who direct this newer cohort of PIAA companies are also, in many cases, policyholders. And we must all encourage them to participate in the PIAA even the possible way—at meetings, in information-sharing, in leadership roles, and as valued colleagues.

Eric R. Anderson is Director of Public Relations and Marketing at the Physician Insurers Association of America; eanderson@piaa.us.
Expert guidance in a changing market.

Healthcare reform, tort laws, and new technologies are causing constant flux in the medical professional liability market, even as insurers cope with day-to-day issues like loss reserve volatility, coverage requirements, and industry competition.

Milliman consultants can help you navigate the shifting landscape and gain a better understanding of your operations. Our independent, unbiased analysis draws on more than 60 years of professional experience to help you make wiser strategic decisions.

Get new insights on your business at milliman.com
PIAA INTERNATIONAL CONFERENCE
8-11 OCTOBER 2014
Amsterdam, the Netherlands

Save the date!
For registration and information check our website: www.piaa2014.com