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When I joined the PIAA more than 19 years ago, I was soon approached by the late John Andreotta of MLMIC who told me there was a real need for the PIAA to develop its own expert witness data. John was the very capable chair of our Claims Section, and he had been operating an informal information exchange about plaintiff experts with some of his counterparts in other PIAA member companies. The development of an expert witness database at a time before modern IT capabilities seemed like a major undertaking, and the critical mass of resolve needed to do this just did not materialize—until now. Previously, I had been one of a small group of people who developed and implemented the PIAA Data Sharing Project, and I know how difficult it was to get that effort up and running. The greatest hurdles were the acceptance of the principle that the PIAA could actually do this, and the cost to participate.

The PIAA Board has directed the development of our own dedicated expert witness database for exclusive use by our members. Almost two years ago, through a survey, we determined that such a facility was desired, and that we could expect sufficient member participation as to justify its development. We realized that this would not be an easy task, and like the Data Sharing Project, requires a significant capital expenditure to develop. It soon became evident that the PIAA did not possess the assets to get this accomplished in-house. The same was true of the Data Sharing Project, and we were fortunate that Peter Sweetland and the Medical Inter-Insurance Exchange of New Jersey stepped forward and undertook the development effort at minimal expense to the PIAA.

After what seemed like an endless search, the Association has entered into an agreement with a vendor—Second Chair—to operate our own, branded expert witness database. Second Chair has a solution that will enable us to get up and running in short order—in the fall of this year. Secondly, the critical factor was ownership of the data—which will consist of electronic and paper (converted to electronic form) transcripts, as well as other related trial documents. Our agreement assures that this information remains the property of the PIAA. A second survey of our members was recently conducted, and while they liked the conceptual framework of our database plan, they all feel it costs too much. Sound familiar?

The way the PIAA Expert Witness Database will be funded is through two charges. Participating companies will notify Second Chair of all new cases filed, and Second Chair will archive them and remind the companies to submit expert witness transcripts as they occur (and not years later when the case is closed as with other commercial products). Transcripts will be obtained, analyzed, keyed, and loaded into an Internet searchable database by Second Chair. The cost for reporting a transcript is $100. Participating companies will have unlimited access to their own reported information, and will pay $50 to download information reported by other PIAA members. This will be possible anywhere Internet access exists. The PIAA itself will have reviewing authority over this process, but will not incur any costs for development or operation.

Is $100 too much? On average, it costs about $5,000 to take a deposition. We tend to think of the costs as those incurred on the day it is taken. But, there are many other related expenses realized before and after the day of the deposition. For an extra $100 in ALAE, the PIAA Expert Witness Database will store this investment in a searchable, retrievable, electronic format for future use. Over time, our Expert Witness Database will become an invaluable tool for our members, potentially saving them millions of dollars in claim costs because of the timely and accurate information it can provide.

In the coming months, the Association will conduct an educational effort to introduce you to the PIAA Expert Witness Database and demonstrate its capabilities. Like the Data Sharing Project almost 30 years ago, this may be a tough sell. But, good things do not come easily, and I think you will find our solution for operating our own expert database to be reasonable and cost-effective in the long run. 

Over time, our Expert Witness Database will become an invaluable tool for our members, potentially saving them millions of dollars in claim costs because of the timely and accurate information it can provide.
Within the landscape of change, there is a developing path for profitable growth.

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Obese adults who undergo surgery, a new study reports, are less likely to develop respiratory insufficiency (RI) and adult respiratory distress syndrome (ARDS), and when they do, they are less likely to have fatal outcomes.

“Although the assumption has been that patients with obesity have worse peri-operative and long-term outcomes, this study clearly shows that in the setting of the respiratory syndromes, this is not the case, and obesity might actually be protective in this setting,” said Stavros G. Memtsoudis, MD, PhD, an anesthesiologist at Hospital for Special Surgery, who led the study.

The investigators suggest several theories about why this is so, and they hope that learning more about them can lead to protective interventions for non-obese patients.

Perhaps, obese people may just have more energy stores or better nutritional status, to help them weather an acute illness or surgery. Also, many factors associated with surgical procedures, including the release of inflammatory agents, can cause the lung inflammation that leads to RI/ARDS. ARDS is a life-threatening lung condition that prevents enough oxygen from getting to the blood. Fatty tissue may have some advantageous effect in the setting of the high-inflammatory state. It may act as a sink for the inflammatory proteins or cytokines, thereby neutralizing them.

“Some of the inflammatory proteins may adhere to fatty tissue and thus be removed from the circulatory system. This in turn may reduce the inflammatory process,” Dr. Memtsoudis said. “There is some laboratory evidence that suggests that.”

Or perhaps doctors are more vigilant with obese patients, because they worry that they will have more health problems. If this is the case, then “extending the vigilance and use of resources to monitor non-obese patients” while in the hospital could lower rates of RI/ARDS.

After Surgery, Obesity May Protect Against Respiratory Distress Syndromes

At last, an upside to overweight?

Many Inpatient Falls Just Can’t Be Prevented

What works in long-term care or home settings fails in hospitals

Inpatient falls that lead to severe injury or death are included in the Serious Reportable Events list from the National Quality Forum. The list, according to NQF President Jane Corrigan in a June 11, 2011 press release, “provides a critical opportunity to learn from mistakes and take swift action to improve patient safety.”

But this assumes that “swift
EHRs Improve Diabetes Care—Big Time

The difference cited in the study is almost incredible. But there it is. In an analysis of diabetes care done in Cleveland, 51% of diabetic patients treated at facilities that had electronic health records (EHRs) received all of the necessary care, versus 7% in facilities where records were stored on paper.

“A similar variation was also reported for diabetes patient outcomes—how well patients and their doctors were able to effectively manage their condition,” states a brief on the study from the Robert Wood Johnson Foundation, which funded the study. “For both care and outcomes, patients treated at practices with EHRs far outpaced those in paper practices across all insurance types—whether patients were on Medicare, Medicaid, a commercial plan, or uninsured.”

Source: Health Data Management, June 15, 2011

Duct Tape to the Rescue

The ‘Red Box’ helps prevent infections

A roll of red duct tape can provide a low-cost way to help reduce the spread of infections in U.S. hospitals. The infection prevention team at the Trinity Medical Center in the Quad Cities on the Iowa/Illinois border say they use the tape to delineate a “Red Box” safe zone, a three-foot square of red duct tape that extends from the threshold of the door of patients who have infections, inside the room. The box makes it possible for providers to communicate with patients in isolation or with “contact precautions.”

This is a simple but very effective mechanism to conserve resources and yet remain in touch with the patient,” Russell N. Olmsted, president of the Association for Professionals in Infection Control, comments. “It can serve as a model for healthcare providers who strive to deliver better care and reduce costs.”

Using the Red Box, in one study in a 504-bed Midwestern health system, produced savings of 700 hours and $110,000 a year. Healthcare professionals are required to wear personal protective equipment before they can enter an isolated patient’s room for any type of communication. But this procedure is time-consuming and expensive. The box also serves as a visual cue to remind providers that they are entering an isolation room.

Not explained is the question of how the researchers in fact determined the safe distance from a patient’s bed. With Petri dishes placed at one-foot intervals from the bed, and then incubated to check on bacterial growth (which sounds like a pretty nifty high-school science project)? Why three feet, and not four? You have to wonder if this is evidence-based, or just intuitive.

Source: UPI Health News, June 27, 2011
When walking on the edge of the ethical ocean, don’t let your knees get wet.” This was the answer I gave to a panel of accomplished practitioners when asked how I define my own take on ethics, as part of my “test” to get into the PRSA College of Fellows. It worked, and I was elected in 2001.

The shoreline analogy illustrates my contention that few ethical issues are black and white. Most of the ones we deal with during our professional careers ebb and flow against the shoreline. When dealing with the dilemmas that fall in the gray area, our actions must be determined by our own moral compass.

During the more than 30 years I’ve worked in integrated marketing communications, there have been several moments in my career where I had to navigate situations that didn’t have simple right-or-wrong solutions. I’d like to share with you five ethical lessons that have stuck with me.

Transparency is a model for better behavior
First, the recent macro transparency trend—being upfront and honest with your business practices—encourages ethical behavior. Consumers expect businesses to be upfront about their values, practices, products, and services—and even their mistakes. Ethical missteps are quickly publicized, and they can be irrevocably damaging for businesses. We have all read stories about businesses that have tried to hide unethical behavior. When they get caught, the story spreads like wildfire through the media, and the company forfeits the trust of the people who matter most: their customers. In the past, companies could conceal mistakes while highlighting something good they were doing on the side, as a distraction. Today, companies can’t simply do good; they must be good. The concept of being good should be completely ingrained among your company’s values.

Give people the benefit of the doubt . . . even if they don’t deserve it
I used to work with a woman who was always late; I’ll call her Tracy. One time, we had a client who needed a project by 9 a.m. the next morning. Tracy said that she would finish the project and make sure the client received it by 9 a.m. The next morning, Tracy was nowhere in sight. She didn’t show up at 9:15, 9:30, or even 10:00. As the minutes passed, I got increasingly angry. At 11:00, Tracy finally opened the door to the office. It was hard not to lose my cool immediately, and start yelling. Instead, I pulled myself together, calmly looked Tracy in the eye, and asked, “Help me understand why you are late.” Tracy burst into apologies as her eyes welled with tears. She said she hadn’t slept all night. Her cat was hit by a car. She was at the vet all night. The cat had just died, and after that, she had come straight to work. I consoled Tracy, and we immediately contacted the client. Luckily, the client understood, and we were given one more day to work on the project.

Our relationship would have suffered irreparable harm if I had immediately lost my temper when she walked in. Instead, by giving Tracy the benefit of the doubt, I was able to get to the heart of the situation and share the truth with the client. The ethical lesson I learned was to

"Give people the benefit of the doubt . . . even if they don’t deserve it."
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give people the benefit of the doubt at first, even if I don't think they deserve it.

**Trust your gut**
I once interviewed a woman for a job, which she definitely did not get. Let me tell you why. The day after the interview, the woman followed up not only with a thank you card (a plus!), but also, a dozen long-stem roses. I was incredibly confused. I asked around the office if this gesture could be interpreted as anything other than romantic. The answer from my coworkers was a resounding no. I thought back to the interview—I didn't give any impression that I was interested in this woman. My wedding ring and family pictures should have been a red flag. Either the job applicant was acting inappropriately, or she had very poor judgment. Either way, she didn't get the job. The ethical lesson I learned was to trust my gut: if something seems dishonorable, it is best to steer clear.

**Follow written—and unwritten—codes of conduct**
In my workplace, everyone adheres to a written, as well as an unwritten, code of conduct. We require that each new employee sign a copy of the formal PRSA code of ethics on day one, and everyone is expected to abide by it. There is also an unwritten code our office tends to follow. For example, if someone has to take a day off because of a personal issue, the team will support that person and try to lighten his load in any way they can.

If your company’s written or unwritten code of conduct doesn’t align with your personal ethical compass, you should do one of two things: try to change it, or leave. If you stand aside and allow ethical mishaps to happen, you are also guilty. As Edmund Burke put it, “All that is necessary for the triumph of evil is that good men do nothing.”

**Don’t forget to sharpen the saw**
Steven Covey’s *Seven Habits of Highly Effective People* contains one of my favorite ethical lessons: take time to sharpen your saw. Covey gives the example of a woodcutter with a pile of wood. If the woodcutter kept chopping the wood all day long without stopping, he would have only a small stack of wood to show for his efforts. But if he took occasional breaks to sharpen his saw, and then resumed chopping wood, he would end up with a much larger stack.

We need to take time to do the same. In our careers, this means we need to take time for ourselves, for professional development, attending seminars, reading books, learning from our colleagues, volunteering, and taking time off to regenerate. A sharpened saw cuts much more wood. And the broader perspective that results from investing time in yourself will help you find the wisest choices in ethical dilemmas.

**Keeping your knees dry**
It is up to you to develop and maintain your own personal ethical balance. Unlike simple clear-cut choices, most ethical business decisions are much more like a shoreline—with a small area that’s both wet and dry, depending on the exact circumstances. So when you have to work through those ethical situations, don’t wait until your mouth is barely above water. Once your toes, feet, and ankles get wet, it’s probably time to step back safely onto shore.
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West Virginia is now “squarely with the majority of jurisdictions in holding that caps on noneconomic damages in medical malpractice cases are constitutional...,” according to MacDonald v. City Hospital, Slip Op. No. 35543 (June 22, 2011). In MacDonald, the state Supreme Court soundly rejected a constitutional challenge to the noneconomic damage limitations, or “caps,” contained in the state's Medical Professional Liability Act. The court held that:

West Virginia Code § 55-7B-8 (2003) (Repl. Vol. 2008), which provides a $250,000 limit or “cap” on the amount recoverable for a noneconomic loss in a medical professional liability action and extends the limitation to $500,000 in cases where the damages are for: (1) wrongful death; (2) permanent and substantial physical deformity, loss of use of a limb or (3) permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities (both subject to statutorily-mandated inflationary increases), is constitutional. It does not violate the state constitutional right to a jury trial, separation of powers, equal protection, special legislation or the “certain remedy” provisions.

The Court’s opinion, which rejected several state constitutional challenges, is notable for its flat endorsement of the premise that legislative bodies do have the power to enact such limitations:

Upon review, we find that the Legislature could have reasonably conceived to be true the facts on which the amendments to the Act, including the cap on noneconomic damages in W. Va. Code § 55-7B-8, were based. The Legislature could have rationally believed that decreasing the cap on noneconomic damages would reduce rising medical malpractice premiums and, in turn, prevent physicians from leaving the state thereby increasing the quality of, and access to, healthcare for West Virginia residents. While one or more members of the majority may differ with the legislative reasoning, it is not our prerogative to substitute our judgment for that of the Legislature, so long as the classification is rational and bears a reasonable relationship to a proper governmental purpose. Further, even though the cap now contained in W. Va. Code § 55-7B-8 is significantly less than the original $1,000,000 amount, we cannot say that it is on its face arbitrary or capricious.

The statute

At issue in MacDonald was West Virginia Code § 55-7B-8, which limits damages for non-economic loss in medical professional liability (MPL) actions. “Noneconomic loss” is defined as “losses, including, but not limited to, pain, suffering, mental anguish and grief.” W. Va. Code § 55-7B-2(k). Passed in 2003 as part of a comprehensive set of reform measures driven by the unavailability of affordable insurance for healthcare providers, section 55-7B-8 amended the existing $1 million limit, lowering it to $250,000, regardless of the number of plaintiffs or the number of defendants.

Under section 55-7B-8(b), the limitation increases to $500,000 in three circumstances: wrongful death; “permanent and substantial physical deformity, loss of use of a limb or a bodily organ system”; or “permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life-sustaining activ-
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All of the limitations are subject to increases with inflation. To claim the protection of the limitations, a healthcare provider must have at least $1 million in insurance coverage.

The verdict
James MacDonald and his wife had sued his physician, Dr. Ahmed, and City Hospital, claiming that he had contracted rhabdomylosis, a debilitating neurologic condition, caused by the combination of medications that had been ordered by Dr. Ahmed. The plaintiffs alleged that Dr. Ahmed had been negligent in prescribing this combination, and in failing to monitor for its side effects, and that the hospital pharmacy had negligently failed to intervene, in not warning Dr. Ahmed about the potential risk for the disease inherent in this mixture of medications. After trial, a jury rendered a total verdict of $1,629,000, apportioning liability: 70% to the physician, and 30% to the hospital.

After the trial, the non-economic damages portion of the verdict was reduced by the circuit judge, to conform to the $500,000 limitation set forth in section 55-7B-8(b). Table 1 shows the original verdict amount, and the corresponding reduction, as ordered by the Circuit Judge.

The court
The Supreme Court of Appeals of West Virginia has five justices. Before the MacDonalds’ petition for appeal was granted, Justice Thomas McHugh voluntarily recused himself, because of his position on the board of trustees of a hospital. He was replaced by Ohio County Circuit Judge Ronald Wilson, appointed by the chief justice. After the briefing was complete, the plaintiffs moved to recuse Justice Menis Ketchum, claiming that during his campaign for election to the court, he had expressly stated that he

Table 1 Reduction in Non-economic Damages

<table>
<thead>
<tr>
<th>Damage Items</th>
<th>Jury Award</th>
<th>Reduced by Court</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past medical expenses</td>
<td>$92,000</td>
<td>$92,000</td>
</tr>
<tr>
<td>Past lost wages</td>
<td>$37,000</td>
<td>$37,000</td>
</tr>
<tr>
<td>Non-economic Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past pain and suffering</td>
<td>$250,000</td>
<td></td>
</tr>
<tr>
<td>Future pain and suffering</td>
<td>$750,000</td>
<td></td>
</tr>
<tr>
<td>Lost consortium to wife</td>
<td>$500,000</td>
<td>0</td>
</tr>
<tr>
<td>Total Non-economic</td>
<td>$1,500,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Total Verdict</td>
<td>$1,629,000</td>
<td>$629,000</td>
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<tr>
<td>Verdict as Apportioned</td>
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<td></td>
</tr>
<tr>
<td>City Hospital (30%)</td>
<td>$488,700</td>
<td>$188,700</td>
</tr>
<tr>
<td>Physician (70%)</td>
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<td>$440,300</td>
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</tbody>
</table>

The plaintiffs challenged West Virginia Code § 55-7B-8 before the Circuit Court, arguing that it violated several provisions of the West Virginia Constitution. The Circuit Judge denied the motion, and the plaintiffs then petitioned for appeal in the state Supreme Court.
would not overrule the damage limitations. Justice Ketchum denied the motion, but reconsidered, after his order had immediately appeared on an Internet blog site, stating he would not permit the court to be publicly maligned. Justice Ketchum was replaced by Jackson County Circuit Judge Thomas Evans. The case was therefore heard by three Supreme Court justices and two circuit judges.

The appeal
The plaintiffs challenged section 55-7B-8 on several grounds, arguing that it violated West Virginia constitutional provisions guaranteeing equal protection and prohibiting special legislation, guaranteeing trial by jury, establishing separation of powers, and guaranteeing open courts and certain remedy. The plaintiffs urged the Court to abandon precedent and apply strict scrutiny in examining the legislation, and argued at length that, since there had been no real “crisis” that the legislature had needed to solve in 2003 when it enacted section 55-7B-8, the legislation was invalid.

The opinion
In an opinion released on June 22, 2011, the Court followed two prior opinions, which had affirmed the original $1 million limitation: Robinson v. Charleston Area Medical Center, Inc., 186 W. Va. 720, 414 S.E.2d 877 (1991) and Verba v. Ghaphery, 210 W. Va. 30, 552 S.E.2d 406 (2001), finding that the reduced limits in § 55-7B-8 did not render the statute unconstitutional in any respect.

The Court began its analysis by restating the well-settled precedent of deference to the legislature:

In considering the constitutionality of a legislative enactment, courts must exercise due restraint, in recognition of the principle of the separation of powers in government among the judicial, legislative and executive branches. Every reasonable construction must be resorted to by the courts in order to sustain constitutionality, and any reasonable doubt must be resolved in favor of the constitutionality of the legislative enactment in question. Courts are not concerned with questions relating to legislative policy. The general powers of the legislature, within constitutional limits, are almost plenary. In considering the constitutionality of an act of the legislature, the negation of legislative power must appear beyond reasonable doubt.

The Court found it significant that the caps at issue differed from the prior $1 million cap, because they increased automatically, each year, to account for inflation. Moreover, to gain the protection of the cap, a healthcare provider had to have at least $1 million in insurance coverage.

The plaintiffs made two arguments, in contending that the statute violated the constitutional right to a jury trial. Relying on Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt, 691 S.E.2d 218 (Ga. 2010), the plaintiffs argued that the caps generally violated the right to trial by jury. They further argued that by setting limits, the statute violated the Constitution’s “reexamination” clause, which states: “[n]o fact tried by a jury shall be otherwise reexamined in any case than
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Case and Comment

according to the rule of court or law.” Both arguments were rejected. The Court found that Georgia’s constitutional provision—which states that the right to a jury trial is “inviolable”—was substantially different from West Virginia’s. Instead, “the right of jury trials in cases at law is not impacted. Juries always find facts on a matrix of laws given to them by the legislature and by precedent, and it can hardly be argued that limitations imposed by law are a usurpation of the jury function.” Considering the “reexamination” clause, the Court, as in prior cases, held that it did not apply to actions of the legislature.

The Court rejected the claim that the statute violated the constitutional separation of powers, stating that:

“If the legislature can, without violating separation of powers principles, establish statutes of limitation, establish statutes of repose, create presumptions, create new causes of action and abolish old ones, then it also can limit noneconomic damages without violating the separations of powers doctrine.”

Nor, the Court said, did Section 55-7B-8 violate the West Virginia Constitution’s equal protection and special legislation provisions. Here, the Court considered the plaintiff’s argument that there was no factual basis for the Legislature to conclude that lowering the cap from $1,000,000 to $250,000, or $500,000 in certain cases, would accomplish the legislative goals of attracting and keeping physicians in West Virginia and reducing medical malpractice premiums.” After carefully reviewing the factual findings contained in the legislation, which detailed the problems of unavailability and affordability of liability insurance for healthcare providers, the Court concluded, as stated above, that:

The Legislature could have rationally believed that decreasing the cap on noneconomic damages would reduce rising medical malpractice premiums and, in turn, prevent physicians from leaving the state thereby increasing the quality of, and access to, healthcare for West Virginia residents. While one or more members of the majority may differ with the legislative reasoning, it is not our prerogative to substitute our judgment for that of the Legislature, so long as the classification is rational and bears a reasonable relationship to a proper governmental purpose. Further, even though the cap now contained in W. Va. Code § 55-7B-8 is significantly less than original $1,000,000 amount, we cannot say that it is on its face arbitrary or capricious.

The Court cited several other jurisdictions reaching similar conclusions: Evans ex. rel Kutch v. State, 56 P.3d 1046, 1053, 1055 (Alaska 2002); Judd v. Drezga, 103 P.3d 135, 140 (Utah 2004); Estate of McCall v. United States, No. 09-16375,

Analysis

Both of the amendments to the West Virginia Medical Professional Liability Act, in 2001 and 2003, which included the lower limits for non-economic damages, were hard-fought legislative victories for healthcare providers and their insurers. The lower limits, according the West Virginia Insurance Commissioner, had served to stabilize the MPL insurance market in the state. The legislation also provided a mechanism for funding the startup of a mutual insurance company, which is now thriving and providing much-needed coverage for West Virginia physicians. The amendments also gave the state boards of medicine and osteopathy new tools for regulating physicians. For healthcare providers in West Virginia, the decision sends a concrete message that these much-needed reforms will stand, and that the limitations on noneconomic loss are indeed constitutional.

As plaintiffs continue to challenge tort reform nationwide, MacDonald provides a well-reasoned and rational opinion in arguing for the preservation of states’ reforms.

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Congressional Hearing Finds Medicare Secondary Payer Fixes Needed

The Medicare Secondary Payer (MSP) program, along with the corresponding mandatory reporting requirement recently implemented by the Centers for Medicare & Medicaid Services (CMS), was the subject of a recent Congressional hearing. Unlike the hearings held earlier this year on medical professional liability reform, there was no hostility in the room; both Republicans and Democrats seemed to be in agreement.

Conducted by the House Energy & Commerce Committee Subcommittee on Oversight & Investigations, the hearing was titled, “Protecting Medicare with Improvements to the Secondary Payer Regime.” Chairman Cliff Stearns (R-FL) set the tone for the hearing in his opening statement when he said, “CMS’s delays cause lawsuits to drag on, hinders timely payments to injured individuals, and causes uncertainty and increased costs for both large and small businesses.”

Ranking Member Dianna DeGette (D-CO) also acknowledged problems with the MSP program, stating that one goal of the hearing was to ask CMS “to work with lawyers and insurance companies to obtain justice in cases where [beneficiaries] have been injured or harmed.”

Cong. Tim Murphy (R-PA), sponsor of legislation to fix both the MSP rules and the mandatory reporting requirement (H.R. 1063—the Strengthening Medicare And Repaying Taxpayers [SMART] Act of 2011), also noted the need for change. “Only in Washington,” he said, “could someone who wants to send money back to the federal government be ignored.”

Cong. Murphy sharply criticized the current programs. “The current MSP system that we are investigating today discourages and even prevents companies from settling claims involving Medicare beneficiaries because CMS won’t tell the settling parties how much is owed,” said Murphy.

To help determine how these problems came about, and what might be done to resolve them, the subcommittee invited witnesses from both the federal government and the private sector to explain the inner workings of the Medicare system.

**Government testimony**

Deborah Taylor, the Director of Financial Management for CMS, and James Cosgrove, Health Care Director for the Government Accountability Office (GAO), were the first to testify. When their formal statements were over, the subcommittee members wasted no time in asking some pointed questions.

Much to the Members’ chagrin, Taylor was unable to provide responses to a multitude of questions about the dollar value of the MSP claims that CMS reviews, how many mandatory reports are rejected by Medicare, or the length of the response times for inquiries trying to establish the value of healthcare services owed to Medicare. She did tell the Subcommittee that the Medicare Secondary Payer Recovery Contractor (MSPRC) had more than 413,000 claims to process. Responding to very direct questions from Cong. Gene Green (D-TX) about the effectiveness and efficiency of the Medicare Secondary Payer Recovery Contractor (MSPRC) had more than 413,000 claims to process, hinting that this workload may be a significant problem for the contractor.

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MSPRC, Taylor acknowledged that there were indeed some problems. She told the subcommittee that CMS would go through a new competitive bidding process when the contract ends in mid-2012. She also stated that CMS was “looking into” the idea of establishing financial thresholds for determining whether a claim needed to be reported or if Medicare should even seek reimbursement.

Cong. Mike Burgess (R-TX) and Phil Gingrey (R-GA) both asked Cosgrove whether members of the public even knew about their obligation to repay Medicare. Cosgrove acknowledged that beneficiaries needed to be made aware of their responsibilities. Gingrey also asked if GAO had any recommendations about what needed to be fixed in the MSP process, and was told that GAO was currently studying that very question, and hoped to have a report filed by the end of the year.

Private sector input
The first two witnesses in the second panel represented, respectively, Publix Super Markets and Cincinnati Insurance Company. Both testified about the need for Medicare to provide more information about its demands in regard to settlements involving Medicare beneficiaries. The witness from Publix Super Markets struck a responsive chord in the members of the subcommittee, pointing out that their own efforts to settle claims against the company had been held up when Medicare demanded to be reimbursed for amounts as low as $1.59. The Cincinnati Insurance Company witness pointed out the incongruity of the mandatory reporting requirement, which obligates insurers to collect information such as Social Security numbers or Health Insurance Claim numbers (i.e., Medicare numbers), when CMS is warning beneficiaries to protect their privacy, by not revealing this information to any third parties.

Among the remaining witnesses were an advocate for beneficiaries and a trial lawyer. They concurred with the earlier witnesses, saying that Medicare was inefficient in resolving matters related to liability claims. The trial attorney stated that the current process slows liability claim payments to Medicare recipients and forces more claims out of the settlement process and into litigation than is necessary, and the consequence of this laggard behavior is that the Medicare Trust Fund loses out on potential
reimbursements. Citing the inefficiency of the MSPRC in particular, the advocate for Medicare beneficiaries stated that beneficiaries were frequently unable to get prompt answers from Medicare when trying to resolve a secondary payer issue, and, when given, answers were all too often in error.

Together, the four panelists stated what was needed was faster notification of Medicare reimbursement amounts, improved responsiveness of the MSPRC, and a statute of limitations on Medicare collections. Although they came from very different backgrounds, all the panelists agreed that an overhaul of the current system was needed, sparking Cong. DeGette to say, “We rarely ever see the grocery stores and trial lawyers sitting at the same table agreeing on an issue,” so the need for remedial action was clear.

PIAA concerns
The Association submitted a written statement for the official record, and provided it to every member of the subcommittee. The statement covered the issues troubling Medicare’s longstanding MSP regime, as well as its more recent mandatory reporting requirement. PIAA’s recommended changes for both programs include: eliminating the threat of insurers paying both the claimant and Medicare for health expenses; requiring that Medicare provide reimbursement information prior to settlement; requiring the attorneys for Medicare beneficiaries to report their clients’ information to CMS; creating safe harbors from penalties for companies making a good faith effort to report; making reporting thresholds realistic; and, exempting risk management payments or goodwill gestures from the reporting requirement. For more details on the PIAA’s views, please see the full testimony in the government relations area of the PIAA website.

Conclusion
While the Subcommittee on Oversight and Investigations didn’t focus its hearing on specific legislation, the proceedings did draw attention to H.R. 1063. The bipartisan support for MSP reform expressed at the hearing, and for the bill itself (currently, eight Republicans and 18 Democrats have joined Cong. Murphy in signing on to the bill), bodes well for efforts to fix what is clearly a broken system—even in what remains a highly partisan Congressional environment. *PIAA*
Clearly, we have entered a Brave New World in medical communication. And with that, a new era in what is, and is not, discoverable in the event of a medical professional liability lawsuit. In this two-part series, veteran defense attorney Pat Tazzara provides an overview of what to bear in mind for the prudent use of the new social media.

The medical community is a major participant in incorporating technological innovations in professional practice: electronic medical records (EMRs), electronic health records (EHRs), e-mail, social networking sites, and various electronic devices. Since plaintiff’s attorneys may request information shared in any of these forums, healthcare providers should be aware of the basic legal issues that may arise in this growing and rapidly changing arena.

During the discovery phase of a medical professional liability (MPL) lawsuit, healthcare providers had traditionally been required to “produce” (identify and turn over information and documents), for the opposing party’s inspection and review, various forms of “records” pertaining to their patient, including the hard copy medical record, radiographs (whether hard copy or on CD), pathology materials (tissue blocks, slides), medication records, appointment books, videotape of procedures, billing records, prescription records, etc.—essentially, “documents and things.”

As of December 1, 2006, amendments to the Federal Rules of Civil Procedure incorporated “electronic stored
information” as an additional area of required disclosure and production. The rules had been silent about the production of electronic data, and such information would have to be specifically requested. Now, the scope of discoverable information explicitly includes electronic data, unless it is specified that only traditional paper information is being requested.

“Electronic stored information,” under the new rules, is defined as information created, manipulated, communicated, stored, and best utilized in digital form, and requiring the use of computer hardware and software. Electronically stored information includes e-mail, web pages, word processing files, audio and video files, images, computer databases, and virtually anything that is stored on a computing device including, but not limited to, servers, desktops, laptops, cell phones, hard drives, flash drives, PDAs, and MP3 players. The expansive phrase is broad enough to cover all current types of computer-based information and flexible enough to encompass any future innovations.

As of April 2011, 22 states, including California, have adopted rules of civil procedure that closely track the federal rules. Eight states, including New York, have fashioned their own unique rules pertaining to e-discovery, and the remaining states have not yet incorporated specific rules. Although these latter states have not expressly enacted rule changes, many have incorporated concepts from the federal rules in their court rulings pertaining to computer storage. While it is inevitable that all of the states will address computer-stored medical information in some way, it is important to become familiar with a particular state’s rules before a litigation dispute occurs. Also, be aware that you may be asked to produce electronically stored information from such sources as EMRs, e-mail, and social networking site postings. All of these may be requested, and producing them is mandatory, once litigation arises.

Electronic medical records
More hospitals and doctors are using EMRs and EHRs in lieu of paper records. For example, Kaiser Permanente, through its KP Health Connect, enables all of its more than 15,000 physicians to electronically access the medical records of 8.7 million members nationwide, and it serves as a model for other systems.

The amended Federal Rule 26 is particularly important for the medical community as it transitions to an electronic format for its medical records. The new Rule 26(a) explicitly states that: “electronic stored information” is a separate class of discoverable information. The broad definition of “electronic stored information” encompasses not only the EMR itself, but potentially, as well, any existing data created using the computer, termed “metadata.” The existence of metadata, and its discoverability under the amended e-discovery rules, may be a milestone in medical liability lawsuits.

Metadata is information about a particular data set that describes how, when, and by whom it was collected, created,

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accessed, or modified and how it is formatted, including data demographics such as size, location, storage requirements, and media information. It is often referred to as “data about data.” Under Federal Rule 26(a), parties are required to produce the metadata that falls under the rubric of electronic stored information, if it is known to be relevant to the claims at issue. Therefore, production of metadata will reveal any changes made to records or documents, including deletions or additions made to EMRs by any medical personnel. In a case that involves allegations of altered medical records, for example, the metadata may be the source of the key evidence in the case.

With the addition of metadata, the number of “records” subject to production during litigation may be exponentially greater than the production involved with conventional paper records. Electronic stored data may also include several drafts of a single “final” document, such as an initial, working, and final draft. In addition, a single document may be stored in multiple places on the computer hard drive of the individuals who created and reviewed a document, on a company server, on laptops, on home computers, and on backup tapes. As a result, it is highly likely that duplicate and potentially conflicting versions of the same documents will be produced, as well as greater overall numbers of documents that will need to be produced in response to an opposing party’s discovery request.

In addition, an opposing party may send a “preservation letter” at the beginning of a lawsuit, or even before suit is filed, asking that the doctor or healthcare facility not only identify the type and source of all existing electronic information pertaining to a particular plaintiff, but also asking that the healthcare provider suspend the destruction of any possible relevant data, so that copies of all hard drive information may be obtained as part of the litigation. With this request, a defendant will be obligated to identify and preserve data that may otherwise have been destroyed or overwritten in his normal course of business or as part of their document retention policy. In addition, courts’ decisions have found that as soon as a party is aware of litigation or anticipates that litigation will be filed, that party has a duty to preserve or to stop destroying evidence relevant to that potential litigation. Under this obligation, all parties involved must cease the destruction of the relevant evidence—even data that would otherwise be destroyed in the normal course of business.
The Federal Rules also address certain limitations on what sorts of electronic data the parties in a lawsuit can be expected to produce. Some otherwise discoverable electronic data may not have to be accessed and produced if it is “not reasonably accessible” or where its identification and retrieval would pose an “undue burden.” The Amended Federal Rule of Civil Procedure 26(b)(2)(B) does not explicitly define, however, what constitutes data that is “not reasonably accessible” or that poses an “undue burden” that would release a party from producing certain electronically stored information.

The authoritative case that addressed electronic discovery issues prior to the amendment of the Federal Rules of Civil Procedure was Zubulake v. UBS Warburg LLC, 229 F.R.D. 422 ((S.D. N.Y., 2003). The court, in Zubulake, identified seven factors that should be used to assess the burden of discoverability, in order of importance as follows:

1. The extent to which the request is specifically tailored to discover relevant information.
2. The availability of such information from other sources.
3. The total cost of production, compared to the amount in controversy.
4. The total cost of production, compared to the resources available to each party.
5. The relative ability of each party to control costs and its incentive to do so.
6. The importance of the issues at stake in the litigation.
7. The relative benefits to the parties of obtaining the electronically stored information.

Zubulake’s seven-factor test has been heavily relied upon by courts around the country, as a guide for resolving e-discovery issues. Since the amendments to the Federal Rules of Civil Procedure did not set explicit limitations to the scope of e-discovery, however, there is still a hazy line in regard to the discovery scope and limits of electronic stored information. On October 2010, the Sedona Conference, comprising leading jurists, lawyers, experts, and academics, in addressing the issue of the proportionality requirement for discoverability of information stated, “The burden and costs of preservation of potential relevant information should be weighed against the potential value and uniqueness of the information when determining the appropriate scope of preservation.”

Because this area of law is still evolving, it is important for healthcare providers to be (1) aware of the type(s) of electronic information that they are creating and storing, and (2) prepared in case there is a request that data be preserved and turned over during litigation. Organizations should review and update their document-retention policies to include electronic data, and to establish definitions of what documents are and are not kept “in the ordinary course of business” and for how long. Archiving of e-mail and other data may also be considered, to make it easier to retrieve the information.

For related information, see www.taylorblessey.com.

End of Part One. Part Two, which addresses e-mail and social networks, among other matters, will appear in the Fourth Quarter 2011 issue of Physician Insurer.

New Study: Radio-Frequency Technology Effective in Preventing Retained Surgical Items

Patient population included high-BMI patients, at greater risk for retained objects

In a prospective study, done in an academic medical center and a U.S. Department of Veterans Affairs hospital, the sensitivity and specificity of radio-frequency (RF) technology was 100%, in 210 patients of various body size, including morbidly obese patients.

The sensitivity and specificity of RF technology was found to be 100%, in all subjects, in the bariatric procedures that were performed on them. RF was superior to the reported accuracy of intra-operative radiography, and has greater sensitivity than manual surgical counting.

A total of 840 readings were completed, with 404 of them taken from morbidly obese subjects. Of the 840 readings, none were incorrect.

“Surgical count discrepancies can occur as often as one out of eight surgical cases, and sponges are more difficult to find in morbidly obese patients,” said Victoria M. Steelman, PhD, RN, member of the board of directors of periOperative Registered Nurses (AORN) and lead author of the study. “As adjunctive technology to prevent retained surgical items is increasingly being used in the OR, it is important to ensure the sensitivity and specificity of the technology on all patients, including more challenging cases of those with higher BMI.”

Last year, a new recommendation from AORN advised that OR staff evaluate adjunct detection technologies to supplement surgical count procedures.
Medical Professional Liability Market:

Stormy Winds Begin to Blow
Medical professional liability (MPL) insurers have likely passed an inflection point in the market cycle. Its subtlety, however, may not be evident to the casual observer, especially when the industry is still reporting positive income results. Insurers’ continued strong financial position would typically allay all concerns. The problem is that a key measure of insurers’ profitability has started to show signs of deteriorating.

The index known as the calendar-year combined ratio—which measures insurers’ losses and expenses relative to their premium writings—jumped 4 percentage points, to 90%, in 2010. At this point in the cycle, most any increase would raise some eyebrows, but such a large jump has caught the attention of some analysts.

The 90% ratio is still far lower than levels reached at the height of the cycle, which led to the previous hard market when it topped 150%. Nonetheless, it seems to be rapidly approaching insurers’ underwriting break-even point of 100. Once the index moves above that level, insurers are losing money, from an underwriting perspective.

What may be even more of a concern is that MPL insurers’ current profitability largely stems from policies written years ago during the hard market of the early- to mid-2000s, when premiums adequately covered losses and then some. Over the four- to five-year period, industry premiums doubled to $10 billion, as insurers increased premiums to cover burgeoning losses.

On the heels of the premium increases that insurers were implementing, claims cost unexpectedly began to fall. From 2003 through 2007, insurers’ claims frequency fell approximately 40%. The combined effect has been that the ultimate value of the losses for the policies written during the early to mid-2000s is much less than insurers’ initial estimate. The loss reserves that insurers built up during the beginning of the decade are now buoying their sagging underwriting results for current policies.

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Reserve releases commence

Insurers first realized the redundancy of these prior-year loss reserves in 2005. Uncertain of the level of loss redundancy at that time, insurers moved cautiously, slowly releasing reserves, but momentum built in the ensuing years, and increased further in 2010. Based on data compiled by Milliman from a select group of physician MPL insurers, $5.7 billion in reserves were released over the six-year period, whereas the MPL industry as a whole released $10.2 billion in reserves over this period. While reserve figures are still evolving, the peak of reserve releases was likely reached in 2010, and insurers may have to start to put the brakes on the releases in the near future.

Reserve releases have kept insurers’ profitability on solid footing, at least on a calendar-year basis, but if we look at insurers’ results on what is known as a policy-year basis—results for just those premiums written during a given year, let’s say 2010, and any losses arising from those policies—we can see that the premiums that insurers are charging for their current writings are less than what actuaries expect the ultimate value of their future losses will be.

The effect of this underpricing can be seen in a 2010 policy-year combined ratio, which, when reserve releases are added back into losses, turns out to be 114%, an increase of 11 percentage points over the past 2 years. While losses for the most recent policy years are immature, this jump in the index should not be taken lightly, as it is more likely than not that we will see further increases in subsequent years due to current trends in claims and pricing.

Reserve releases have bolstered insurers’ results in recent years, but they also created conditions that promoted a soft or buyers’ market for MPL insurance. One way to think of the market impact of reserve releases is in terms of pricing. If reserve releases averaged between 20% and 25% of written premium, as they have for the past several years, insurers need to charge insurance buyers only 80 cents on the dollar to break even on an underwriting basis. This means that insurers can take on business at an underwriting loss in a given year, when they are releasing reserves, and still report a profit because of their accumulated excess reserves.

Loss of premium revenue

How much premium revenue have insurers waved off? Annual written premiums have declined by around $1 billion since 2006, due primarily to the combined impact of lower average costs and reserve releases.

Time, however, may be running out on the profitability resulting from excess reserves: the reserve releases may continue for only another three to four years, declining each year, if the current cycle unfolds similar to the previous one, which until now it has.

In 1989, when the hard market just previous to the last ended, the MPL industry reduced reserves by approximately $1.5 billion, and continued to generate excess reserves for some ten years afterward. The peak was reached in 1994, when reserve releases topped $2 billion or 46% of earned premium. Based on this timeframe and the pattern of reserve releases thus far, insurers are now approximately just past the midway point of the current reserve release cycle.

A challenging terrain

Unlike the previous cycle, however, insurers cannot rely on investment income to offset pricing discounts to the same extent they did during the 1990s and, for that matter, the past 30 years when generous investment income allowed insurers to periodically write business at an underwriting loss. But record low interest rates on bonds, which typically comprise approximately 80% of insurers’ investments, have not provided the pricing subsidy that insurers once had. Moreover, many MPL insurers also sustained investment losses in 2008, which may have accelerated reserve releases in that and the following year, and may have also shortened the time over which insurers can use reserves to support income.

At the same time, claims cost inflation remains stubbornly high. Even though insurers are seeing significantly less claims than they did ten years ago when claims frequency began to tumble, medical cost inflation has greatly increased the cost of each claim. Insurers also no longer benefit from a declining claims frequency, which appears now to be level.

The other dark horse for insurers is the potential impact of the Patient Protection and Affordable Care Act on the MPL mar-
ket. On the surface, the law is likely to have little direct impact for one simple reason: the law does not address MPL in any meaningful way.

The law, however, could increase the cost of care, as more people enter the healthcare system and began to utilize services. As medical costs increase, so would the cost of MPL claims, or what is known as claims severity. The increase in the raw number of people in the system—many of whom may not be as healthy as current healthcare users—would also increase exposure, which in turn could trigger a rise in number of claims or claims frequency. This situation—an increase in claims severity and frequency—is often toxic for MPL insurers.

In the long term, the increased numbers of people in the system cause medical costs to ease somewhat, as more people receive regular care, which promotes better overall health and lower costs. But over the next three or four years, the law’s potential drag on the MPL market lines up with a period when the cost outlook is already tenuous.

Whether this cost rationale becomes reality is a matter of considerable speculation, but it is plausible and contributes to the growing number of challenges facing MPL insurers.

Also counted among that number is the stall, if not reversal, in tort reform, which not too long ago had been instrumental in limiting punitive and non-economic damages in a number of states. In February 2010, the movement was dealt a considerable blow by a decision of the Illinois Supreme Court, which ruled a cap on MPL awards unconstitutional. And while the course of court rulings has rarely been clear, even to the most astute legal observer, state legislatures have rarely been motivated to take up actions to support MPL tort reform when insurers’ capital position is unthreatened.

And MPL insurers may face an ever-dwindling market, as more and more physicians leave private practice for employment in hospitals. Over the past several years, the movement that started some ten years ago seems to have gained traction and could accelerate when MPL insurers raise premiums. Rather than absorb double-digit premium increases, as many physicians did during the previous hard market, greater numbers may prefer to seek shelter under a hospital’s cover. This move would decrease MPL insurers’ market at a vulnerable time.

For now, the market is relatively calm. But it also seems that just as an array of positive factors converged during the beginning of the decade to propel MPL insurers toward profitability, negative forces are now gathering to disturb the market once again and send prices higher. How and when they take shape could greatly alter the trajectory of the cycle.

For related information, see www.milliman.com.
The Impact of Healthcare Reform on Medical Liability Insurers
The preliminary medical professional liability (MPL) insurance industry segment data for 2010 shows only a modest drop in premium and a greater decrease in paid losses. This data (see Figure 1) is based on calendar-year paid losses and earned premium for 95% of companies reporting. While favorable paid loss data portends good results in the near term, the operating environment is beginning to undergo a transition. The outlook for MPL will be affected by healthcare reform; the delivery of healthcare is changing, and with it, come changes in the customer base and the liability exposure of medical care providers. Changes from healthcare reform need to be addressed in the context of the current operating environment, which is stressed by growing physician shortages, lower reimbursements, and by the 76 million aging baby boomers who begin turning 65 this year. With this backdrop in mind, we have identified key health reform initiatives that will have an impact on MPL insurers. They include:

- The mandated use of interoperable electronic medical records (EMRs) for all patients
- The support for a more active role of nurse practitioners in the delivery of care
- A shift in reimbursements, from fee-for-service toward bundled payments that reduce the cost of care.

Increasing use of EMRs
The extent of use of electronic medical records (EMRs) for patients varies according to the source cited, but all indications are that meaningful use is in fact very low. In an August 2010 report from the American Hospital Association, a poll of 3,100 members showed that only 12% use EMRs, and only 2% have met government standards for meaningful use. Financial reimbursement penalties for not adopting EMRs begin in 2012.

Potential benefits of EMRs in reducing liability
There is evidence to support the premise that using EMRs decreases certain types of errors that can lead to MPL claims. The New England Journal of Medicine in 2008 surveyed more than 2,600 doctors who use some form of EMRs. Eighty-two percent said that EMRs improved the quality of clinical decisions, and 86% said that they helped avoid medical errors. Insurers can expect fewer systemic medical errors, and potentially lower liability, for organizations that successfully implement EMRs. But with EMRs come new opportunities for legal discovery, and research suggests this could increase claims frequency.

New opportunities for legal discovery
The U.S. Department of Veterans Affairs now offers a “blue button” technology on its website, through which patients can access complete, real-time medical records. Easier access to more complete medical records is the future of healthcare, and this will likely push MPL risk management in a new and important direction. EMRs will contain date and time stamps and show how long doctors spent reading (or not reading) medical care prompts. EMRs include metadata, so doctors can no longer write over medical notes or cross out sections without leaving a retraceable trail. The full medical record will be easier to recreate, and the possibility of data-mining by the plaintiff’s lawyers raises the likelihood that these requests for electronic information become active cases. The following are some possible target areas.

Practice standards—EMRs will come with best practices/decision support tools. If a doctor chooses to ignore a recommendation from an electronic prompt because it does not fit the health risk profile of the patient, this can serve as evidence of wrongdoing. This is particularly true if electronic protocols are considered part of the standard of care.

Redundant procedures—Electronic records are supposed to help in responding to government incentives to reduce costs (which will be passed down to the physician as higher reimbursements) by keeping an accurate record of prior procedures and testing. But physicians may open themselves up to greater liability if they fail to question the validity of prior results or fail to retest if an illness progressed.

Input errors—The Department of Veterans Affairs studied its computerized patient record system and found 7.8 document mistakes per patient. Such errors can obscure old symptoms and tests, leading to misdiagnosis.
**Coding**—EMRs will require proper coding to align medical protocols and treatment. Any subjective deviation from proper coding (which could occur if a particular procedure has a higher reimbursement, for example) may result in improper medical alerts that, if ignored, would again serve as evidence of wrongdoing.

**Healthcare entity-based negligence**—Hospitals and healthcare organizations are obligated to use safe and reasonable equipment. If doctor error arises from an improperly working EMR system that is implemented and supported by a hospital, lawyers can go for deeper pockets under legal theories of vicarious liability.

**Risk management will require audits of EMRs**

New risk management practices will need to be introduced, and an understanding of how lawyers will “data mine” EMRs is essential. Healthcare professionals need training in how to best utilize EMRs to improve patient safety and avoid liability exposure. Insurance companies can take an active role in this capacity: regular “best practices” audits to monitor progress will ultimately help reduce exposure. This includes other potentially admissible records such as e-mails and text messages. Auditing the complete EMR is a way for insurers to add customer value and improve loss results, allowing insurers to compete more on service and less on price.

**Expanding role of nurse practitioners**

Healthcare reform initiatives are set to expand the role of nurse practitioners in important ways. As more than 30 million new insureds are added to the system in 2014, there is federal support for expanding the role of nurse practitioners to provide more acute care, thus raising their liability exposure.

Federal dollars now support advanced training for nurses, as the national enrollment for nurse doctorates has jumped from 70 in 2002 to more than 5,000 in 2009. Nurses with doctorates are now using “doctor” as a preface to their last name, thereby blurring the line with physician (MD) providers. Twenty-eight states are seeking rules changes to allow nurse practitioners to work independently, as a remedy for physician shortages. In November 2010, CareFirst BlueCross of Maryland announced that it is allowing nurse practitioners to participate in its healthcare provider networks as independent primary-care providers, citing the influx of new insureds under healthcare reform as the reason for the change. We expect this trend to grow, particularly in underserved markets for healthcare.

**Increased exposure for mid-level care providers**

The challenge for insurers is to accurately price the increasing risk associated with nurse practitioners. But in a competitive environment where MPL insurers are posting considerable profits, raising rates may be problematic. Coverage for nurses and mid-level care providers is often written on occurrence-based policy forms. They can receive the same million-dollar limits of MPL coverage for a fraction of the cost for a physician. The growth in higher-acuity services delivered by mid-level care providers should be monitored; it has the potential to impact those providers who have disproportionate exposure.

Companies can take a few steps to try to stay ahead of trends. Moving from occurrence to claims-made policy forms can reduce exposure in certain cases. Shifting to pricing models that are based on the number and type of procedure performed (which are already electronically coded under reimbursement schedules) can help raise rates for the higher-risk practitioners. But transparency may remain an issue, because procedures are frequently coded as having been performed by a physician, when they were actually performed by a practitioner. Regular audits of nurses, clinicians, and other mid-level care providers are critical to containing loss exposure and assessing increasing risk (audits should include background checks, years of experience, and expanding roles in diagnostics and acute care).

Another way that insurers can add value is by ascertaining that practitioners are properly trained in how to improve the doctor/patient relationship. Mid-level care providers can be the first line of defense against MPL exposure, if they take the time to...
learn a patient’s medical history, understand and explain the reason for a doctor’s consultation, and follow up with an e-mail or phone call to make sure that patients are following treatment guidelines. Making patients feel more valued and cared for has been shown to correlate with lower claims frequencies.

**Growth opportunities under healthcare reform**

As healthcare reform initiatives drive a shift in liability exposure, they also drive a shift in the customer base. We estimate that the overall growth in volume of medical services will likely be as much as 20% over the next ten years, driven in part by healthcare reform. This is based on:
- A 12% increase from the 32 million individuals who will be added to the insured population in 2014 under healthcare reform, which will include many who were previously uninsured and marginally employed persons who had not been regular users of healthcare services. New initiatives that will encourage use include free preventive services (such as colonoscopies, mammograms, and child-wellness and developmental assessments through age 21) that are covered with no deductible.
- Another 5% to 7% increase from the addition of America’s 76 million surviving baby boomers who have begun to turn 65 in 2011. They require more care with age and will help drive growth of advanced medical and preventive services.
- An increase in preventive-care practices and advances in medical care (including emerging personalized drug therapies).

With this growth in demand for services, the shift wherein physicians join larger healthcare organizations is expected to continue. According to the Medical Group Management Association, 70% of physician group practices were physician-owned in 2005, but that had fallen below 50% by 2008, driven by lower reimbursements and revisions to the Stark Law. Now, costs of implementing EMRs, coupled with reform initiatives that reward efficiency of care, are driving more doctors to partner with hospitals and larger care organizations.

**Growth in clinical care facilities**

According to a 2009 report from the Bureau of Labor Statistics, growth in hospital care (while increasing) will be slower than growth in outpatient and clinical care facilities, due to the relative cost benefits of moving lower-acuity care out of hospital and emergency room settings. The assumption that the number of clinic care facilities is expanding rapidly is supported by several sources, including the Convenient Care Association, which counts approximately 1,200 retail clinics in 32 states and expects that this figure will triple by 2015.

Revenue growth for these clinics is expected to come, in part, from offering higher-acuity care services, thereby adding to their liability exposure and offering new opportunities for MPL insurers. According to an August 2010 article from Market-Watch, MinuteClinic (the CVS Caremark Corporation subsidiary and largest provider, with 300 clinics at present) reported a 36% increase in visits in the second quarter of 2010, compared with the prior-year quarter. The company attributes this growth in part to “expansion of services.” These are the first clinics to offer “comprehensive health monitoring for previously diagnosed conditions such as diabetes, asthma, high cholesterol and high blood pressure . . . services include lab tests and exams.”

There are other expanding markets that result from the more efficient delivery of healthcare. They include ambulatory surgery centers (expected to increase by 75% over the next decade, according to emedicinehealth.com), outpatient clinics and community health centers (which receive federal funding and are expected to double the number of people they serve by 2015), and other facilities such as medical hotels, home healthcare, onsite healthcare for large corporations, and remote patient monitoring.

**A path to outperformance**

The growth of larger healthcare and clinical organizations is coming at the expense of the shrinking market for smaller-group physician practices. The challenge for insurers is to leverage relationships and provide products and services that allow for expansion into these new markets, where provider liability is increasing. In addition, insurers must adjust risk management to focus on emerging exposures under healthcare reform. They must understand and monitor changes in the roles of nurse practitioners and EMRs to keep ahead of changes in claims trends. Within this landscape of change, there is a developing path for profitable growth. That path varies for each insurer, based on its understanding of the new healthcare environment in relation to its core competencies and the ability to reinvent itself.
Leveraging the Power of Analytics in Medical Professional Liability Underwriting

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The application of predictive modeling and advanced analytics has evolved impressively within the underwriting of both personal and commercial policies. Over the past decade, predictive modeling—in lines such as workers compensation, general liability, personal and commercial auto, and business owner policies—has progressed from a powerful tool used by only a few forward-thinking early adopters, to table stakes for most insurers. For companies that have effectively integrated end-to-end predictive modeling solutions, loss and expense savings now range from 4% to 6%.

Until recently, medical professional liability (MPL) insurers have generally been slow to take advantage of advanced analytics in underwriting. The reasons why fall into two categories.

How they think about it:

- Boards and senior executives question whether predictive models will work in a low-frequency/high-severity line of business like MPL.
- Underwriters and actuaries assume that they already know the “secret sauce” recipe for underwriting physicians: territory, specialty, and prior loss history.
- With positive financial results, declining frequency, and favorable development of reserves, many people think, “Who needs a predictive model, when we’re achieving profitability?”

How they manage operations:

- Companies may struggle with the quality of their data and the amount of information that isn’t captured electronically (e.g., information on the physician’s application).
- Companies wonder how they might deploy complex predictive models within their current information technology environment and fully integrate the models into the day-to-day workflow of their underwriters (in other words, nobody wants to end up with the world’s most expensive calculator sitting on the shelf).

Some misperceptions linger on, but recent trends—like the upturn in frequency, more aggressive competition, and the realization that reserve releases won’t last forever—have helped engender a new perspective. MPL companies are now looking to advanced analytics to gain a competitive advantage.

This article relates the actual results of a journey into pre-
predictive modeling. During the course of this journey, companies overcame operational barriers and achieved meaningful segmentation of their insureds—passing beyond tribal wisdom and the limits of internal data.

Vision to reality
The journey began with an idealistic vision: an MPL community-based approach to overcoming the barriers that impede widespread application of predictive analytics. Drawing on three powerful resources—the data of multiple MPL companies, a processing technology firm, and an actuarial and predictive modeling organization—this vision was realized, helping the group to:

- Access a large volume of internally generated, geographically dispersed MPL risk, financial, and claim data
- Leverage a common data structure to make it easier to compile data and maintain its quality
- Integrate external data sources, for greater insight than a typical insurer can obtain using internal data alone
- Use state-of-the-art modeling techniques, methodologies, and resources
- Promote operational integration, by deploying the model within the nation’s leading MPL claims-processing platform.

The analytics journey
It all began with the new collaboration within the MPL community. Data from five well-established MPL companies that all used the same insurance processing system was aggregated, to build predictive models that were confidentially customized for each company and deployed within a predictive-analytics module housed within the processing system. The approach comprised four specific areas:

1. Preparing the data
The company data gathered included ten years of data and more than 60,000 physicians. To account for changes in rating and the business cycle, actuarial analytics and adjustments were applied to the physician-level and policy-level premium, loss, and expense data. Internal predictive variables were supplemented with external third-party data, to provide a 360-degree view of physicians. The combined data was anonymized, using a coding system to maintain the relational integrity of the historical physician data.

Next, the data was separated into two tranches, setting aside 70% of the data for iterative training and testing of the candidate models, and the most recent 30% was used for validating the strength of the final model for segmenting risk. By separating the data in this way, the “lift” of the model could be independently evaluated with the validation data (Figure 1). “Lift,” as used here, is an illustration of the effectiveness of a model, comparing the results obtained with and without it. This graphical representation, or “lift curve,” is a key element in understanding the predictive model’s ability to segment physician loss ratios. The steeper the lift curve, the stronger the predictive ability of the model. The flatter the lift curve, the less predictive ability of the model.

In effect, the validation data were used to simulate how the predictive models would have performed if the new and renewal business models had been put in place during the time period when the data used in the validation were actually being experienced.

2. Selecting the variables
From our experience, the key to identifying the variables most likely to prove predictive requires a blending of art and science: the ability to leverage the vast knowledge of underwriters, while also keeping an open mind about the unexpected insights one can gain by leveraging traditional and non-traditional variables. At first, the “net” was cast very wide, and the data set included more than 500 potential internal and external variables. The key insights about the data early on came from a “univariate analysis”—understanding the predictive nature of each variable. This variable-by-variable focus offers an opportunity to examine signals in the data that are most predictive of a future outcome.

The iterative modeling process used a plethora of modeling techniques, starting with a quantitative and visual exploratory analysis of the data, and progressing to dimension reduction and data-mining techniques (e.g., correlation analysis, principal components analysis, variable clustering, decision trees, and so on).

The end result: the final model included more than 30 renewal business variables, carefully tested and vetted using the statistical tools of significance, confidence, and robustness, while at the same time checking to see that these were reasonably pertinent to current business operations, through a detailed understanding of underwriting and actuarial analysis specific to the MPL industry.
3. Refining the multivariate model

While building the predictive models, “pockets” of hidden predictive insights were discovered, using data-visualization techniques like heat maps and data-mining techniques like decision trees. These techniques go beyond traditional regression tools, revealing additional predictive insights by diving deep into the patterns underlying the data. By combining the reliability and quantitative rigor of statistics with advanced analytical techniques, the results, when viewed graphically, help to validate or invalidate long-held beliefs (i.e., “tribal wisdoms”) in underwriting departments.

Complementing the analytical tools, the community of companies offered their personal insights, based on years of underwriting and MPL industry experience.

4. Operational deployment

The results of the predictive models, based on the aggregate company data, are presented below. Each company, confidentially, tailors its own application of the predictive models, by selecting the specific subset of variables that company management and its board of directors believe best aligns with their strategic mission and commitment to their insureds. Then, each company confidentially develops its own “reason codes,” which help in converting raw scores into “English” that indicates significant drivers behind the raw score.

After this sort of calibration, the predictive models are deployed within the predictive-analytics module of the company’s processing system. In this way, analysis requests, return of results, and automated calls to action are promptly integrated into the day-to-day workflow of the underwriters and management team.

Model results

The lift curves shown in Figures 2-4 graphically illustrate the physician segmentation achieved by using multivariate equations for new and renewal segments of the market. Using a train/test/validate approach, the models were developed, trained, and enhanced using approximately 70% of the physician data. The validation results shown below were created from the remaining 30% of the physician data that was held in “cold storage.”

At the beginning of the cold storage period, each risk is scored using the predictive model, generating scores from 1 to 100, with lower scores corresponding to a lower predicted loss ratio, while higher scores correspond to a higher loss ratio. This score is represented on the x-axis of Figure 2, where each “decile” refers to a tranche of risks that comprises 10% of the aggregate premium. The loss ratio for each risk during the cold storage period is tracked and plotted along the y-axis in the appropriate decile.

For the new business model, the lift curve suggests that those risks making up the lowest 10% of scores have a loss ratio 46% lower than the average, while those in the highest 10% have a loss ratio that is 51% higher than average, during the year after the score was calculated.

The renewal business model can yield an even stronger lift (Figure 3). The lowest-scoring 10% of physician risks had loss ratios 41% better than average, and the highest-scoring 10% of physician risks had loss ratios that were 69% worse than average, in the year immediately following the calculation of the score.

Lift within specialty

It is common knowledge that physicians within a given specialty can show dramatically different performance, in terms of loss ratios. As shown in Figure 4, the model can also result in lift, within specialty, for classifications such as emergency room, family and general practice, general surgery, OB/Gyn, etc.

Conclusion

Although there are still some barriers to, and misperceptions about, the application of advanced analytics in a low-frequency/high-severity line of business like MPL, the lift curves shown here illustrate how advanced analytics can be of real value in predicting frequency and severity for future claims.

But the modeling journey is never really over. It evolves, as the breadth of company data grows, and as new data sources like patient satisfaction surveys, electronic medical records, and other information are incorporated into future recalibrations of the models.
Are We Approaching the Tipping Point?

Equilibrium in the MPL Reinsurance Market
There is little drama in the current medical professional liability (MPL) reinsurance marketplace. Both insurers and reinsurers in the MPL space continue to post positive results, and ample reinsurance capacity exists at favorable terms in the four MPL reinsurance markets: the United States, Bermuda, London, and Continental Europe.

Today’s MPL insurers experience a reinsurance environment that is best described as disciplined. In contrast to previous soft market cycles, MPL reinsurers have continued to abide by their stated guidelines on underwriting, pricing, and return on equity. In fact, we have witnessed several examples of MPL reinsurers terminating longstanding, profitable partnerships with clients if their rate-of-return criteria are not satisfied. We believe the resolve exhibited by reinsurers should be viewed favorably by MPL insurers, since the lack of naïve reinsurance capacity arguably prevents the primary MPL market from softening further. While the profitable results of MPL insurers generally afford them a strong hand in reinsurance renewal negotiations, cedants need be aware that the reinsurance market, in turn, will have an established “walk away” price.

Although the earnings reports of MPL reinsurers continue to appear robust, significant challenges exist. For example, reinsurance pricing margins have been eroded by the impact of cumulative primary rate decreases, increased use of credits, and reductions in the price of reinsurance. Investment returns also are nominal, due to historically low interest rates. Furthermore, the profitability of reinsurers has been fueled by the release of prior-year loss reserves. As redundancies decline over time, reinsurers will have to account for their underwriting decisions without the favorable backdrop of a loss reserve cushion.

Ceded premium for the MPL line continues to contract, with premium declines caused by increased ceding-company retentions, industry consolidation, and decreases in rates for both primary coverage and reinsurance. Other factors include the continued success of the captive and alternative market, coupled with the decline in underlying exposure count caused by lower occupancy rates, fewer elective surgeries, and provider consolidation.

While the MPL claims environment has remained relatively benign in recent years, we have witnessed several trends. First, claims frequency has risen slightly, in a small minority of states, after remaining at historic lows, while claims severity continues to increase within expected norms. Second, many of our clients have seen a higher frequency of multiple-insured or “clash” losses in recent years, caused by larger market shares and the tendency of the plaintiff’s bar to name all potential defendants in an MPL lawsuit.

In addition, the industry has witnessed an increase in losses in excess of policy limits. There is both direct and anecdotal evidence indicating that losses

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in excess of policy limits are on the rise, resulting from greater creativity on the part of trial lawyers (e.g., time-sensitive demands) and the low policy limits of the target defendant in several states. Furthermore, systemic MPL losses, or “batch” claims involving multiple plaintiffs, continue to be in vogue. Recent examples include allegations of unnecessary heart bypass surgery, hepatitis C infections caused by re-use of medical syringes, improper calibration of medical equipment, and contaminated surgical blades.

Rollback of tort reform remains another key challenge. We can safely expect changes to the MPL claims environments in Illinois and Georgia, after their tort reform packages were declared unconstitutional. Tort reform measures have also been narrowed recently in a handful of states, including Missouri and Michigan. With tort reform under attack by the plaintiff’s bar on a national level, insurers will need to be proactive in protecting and defending their claims environment from undue change.

Finally, there is the issue of emerging theories of MPL claims liability caused by the implementation of the Patient Protection and Affordability Care Act (PPACA) or replacement legislation. The confluence of these market challenges will afford MPL reinsurers little margin for error in subsequent reinsurance renewals.

**Today’s MPL environment**

Like MPL insurers, reinsurers in this space have witnessed improved profitability. At the height of the soft market in 1999, MPL reinsurers posted a loss ratio of approximately 185% percent and were heavily subsidizing the results of MPL insurers. Reinsurance of MPL business was a “loss leader” for reinsurers, and several prominent players withdrew from the line of business because of adverse experience. But then, as the primary and reinsurance markets hardened in the early 2000s, MPL reinsurers were able to raise premiums, and thereby reduce their loss ratios over time. Today, however, the net loss ratio (MPL insurers’ loss ratio after reinsurance recoveries) and ceded loss ratio (MPL reinsurers’ loss ratio on assumed business) have converged and are almost equal. Reinsurance pricing was flat on the overwhelming majority of MPL renewals at January 1, 2011 (Figure 1). While the MPL class has proved to be profitable for reinsurers, the market as a whole has been very disciplined. The following overarching issues have been closely monitored in each reinsurance transaction: adequacy of primary rates and unanticipated increases in claims frequency or severity.

**Primary rate adequacy.** Driven by a dramatic decline in claims frequency and a moderation in claims severity, many MPL insurers were able to reduce primary rates in recognition of positive claim trends. In fact, some MPL carriers have implemented cumulative, double-digit decreases in premiums. While MPL reinsurers have agreed to follow reasonable reductions in primary rates, they have not been shy in resisting if they believe primary rates are insufficient to produce a margin. Reinsurers contend that their excess-layer profit margins have been squeezed by cumulative decreases in primary rates (sometimes fueled by increased utilization of rating credits), coupled with a constant, upward march in claims severity.

**Unanticipated changes in claims frequency or severity.** While MPL reinsurers have benefited from the decline in claims frequency and the moderation of claims severity, they are concerned that these favorable trends will not continue in the future. While nationwide claims frequency is down by approximately 40% since the early 2000s, a minority of insurers have recognized a modest uptick in new claims reported in recent years. In regard to severity, reinsurers are concerned that the projected increases in medical cost inflation, the rollback of tort reform, and the desensitization of juries to blockbuster damage awards could result in the utilization of an inadequate severity trend, with pricing that is below actual claim costs.

**Emerging issues for MPL reinsurers**

In addition to the challenges presented by garden-variety MPL exposures, insurers and reinsurers may be subjected to additional exposures caused by the recent enactment of the PPACA. The PPACA mandates the use of electronic medical records (EMRs) for all patients by 2012. These EMRs have the potential to benefit the delivery of healthcare in the long run, by establishing a uniform standard of care and the sharing of best practices, making it easier to transfer patient records among physicians and hospitals rapidly, and reducing potential errors by monitor-
ing pre-agreed-upon medical protocols. While EMRs may produce long-term benefits to healthcare providers, the implementation of an effective EMR system may create additional exposure for both MPL insurers and reinsurers:

- **Systems errors.** If EMR systems are not designed effectively, output errors could occur, potentially resulting in improper drug-dosage recommendations or omission of required medical tests.
- **Programming.** EMRs will require correct data input in order to match healthcare standards with patients’ treatment and diagnosis. Any variance in inputting the correct code could result in false or omitted protocol warnings.
- **Broadened discovery.** EMRs could, arguably, increase the quantity of discoverable data available to the plaintiff’s bar. Lawyers may seek the greater depth of data available in EMRs and develop broader discovery requests. Examples would include typed copies of medical notes, log-in and log-out information, and all documented communications, including e-mails and phone records.

Claims frequency could rise as EMRs become fully operational. Standards of care will be included in the EMR system. Doctors who believe that they are acting in the best interest of the patient in extraordinary circumstances, yet vary slightly from the EMR best-practice protocol, may be subject to claims. It is difficult to imagine an EMR system that will be able to promulgate effective standards of care that will also be on point for all possible treatment solutions.

The shortage of physicians, especially primary care doctors, is a critical issue in many areas of our country. The PPACA will add 32 million insureds to a healthcare system already lacking a sufficient quantity of primary care physicians. While some of the new insureds will be healthy young adults, some percentage of the new patients may have pre-existing conditions or chronic illnesses, or reside in areas that are already underserved by physicians. These factors may make the new patients more challenging to treat. The shortage in primary care doctors may increase the patient loads of nurse practitioners, who are often overworked. Patient frustration and dissatisfaction are major drivers of MPL lawsuits. An overburdened healthcare system could lead to a higher incidence of patient angst and medical errors, in the years to come.

**Changes in reinsurance-buying practices**

Like primary MPL insurers, reinsurers are seeing declines in premiums, caused by rate reductions, persistent competition from alternative and captive markets, and a reduced exposure base resulting from provider consolidation. But perhaps the largest driver behind the lower volume of MPL reinsurance premiums is the trend toward higher net retentions on the part of MPL insurers. In this regard, many working-layer MPL reinsurance programs with a known frequency of predictable losses have been retained net, with only excess and casualty catastrophe reinsurance layers available to MPL reinsurers. This phenomenon not only reduces the quantum of available reinsurance premiums for MPL reinsurers, it also leaves markets with the added difficulty of having to assume risk on only the more volatile excess layers, without the benefit of supporting working layers to balance out the program.

MPL insurance executives are routinely asked about exposures or potential events that keep them up at night. Common causes of insomnia include: losses in excess of policy limits caused by outlier jury awards and allegations of bad faith, exposure to “systemic risk” events, rollback of tort reform measures by the plaintiff’s bar, and susceptibility to multiple insured, or “clash” losses. We have witnessed an increase in demand for reinsurance coverage for the casualty catastrophe exposures outlined above in the MPL insurance community. Just as reinsurance purchasing habits have evolved over time, proactive MPL reinsurers have expanded their risk appetite and underwriting parameters to develop creative and cost-effective reinsurance solutions to these growing casualty catastrophe MPL exposures.

**The look ahead**

Absent an industry-changing catastrophic loss event, the MPL reinsurance marketplace should be stable in the near term, in view of the historical and projected profitability of the underlying business. That said, MPL reinsurance profitability is being challenged by recent declines in both primary and reinsurance rates, increased use of rating credits by MPL insurers, coverage liberalization, and ever-increasing claims severity.

In fact, a handful of MPL reinsurers have been mandated by their capital providers to reduce their written premiums in the line of business, citing unfavorable market conditions. As working-layer reinsurance business becomes a scarcer commodity, reinsurers are being asked to assume risk on the more volatile excess and casualty catastrophe layers, which are also more difficult to price. Reinsurers in the MPL class, assuming risk from a variety of lines of business, are generally not blessed with the loss reserve redundancies currently held by most MPL insurers and are therefore left with a greatly reduced margin of pricing error. As we head into the January 1, 2012 renewal season, MPL insurers should take solace in the fact that the reinsurance marketplace is healthy—at least for now. While the party is not over, we may be approaching last call.
The spring 2011 edition of the Willis publication “Marketplace Realities” included a list of trends and issues for the healthcare professional insurance market. So we asked Mr. Plumeri which three were most important for MPL companies to watch closely, for setting rates, and why.

I think that the rate situation is a factor of a couple of things (besides the obvious supply and demand) that are converging at the same time. The risk management strategies that hospitals, doctors, and groups are now employing are simply better. So as a result, there are fewer incidents and fewer claims.

So that is one ingredient. There is another ingredient, a social sentiment that exists in this country that is different than before. There is a fear that if you drive doctors out of business, there won’t be anybody around to take care of you and your family. I hope that this social sentiment continues, and that it continues to thrive.

People have recognized that if you keep trying to sue doctors, just because this is a litigious place, it’s not going to work.

I think there is some tort reform—I don’t think it’s enough to talk about, but some. I think there needs to be a movement in that regard. I think that the PIAA and others need to be very mindful that this has to happen as well.

If you take all of these things together—risk management, social sentiment, and tort reform—you see that it is possible to have a world where a rate is a rate. Pricing in the insurance industry, and especially in the P/C world, is crazy. I’ve never been in a business where pricing is so roller coaster-like. This makes it impossible to predict your business.

How do you predict what your budget is going to be every year? How do you predict how much you can make and how the economics are going to work, if you don’t know what your rates are going to be?

So it’s better for all of us that this convergence takes place. If you can keep rates steady, then people will learn—on both sides of the equation, insurers and insureds—how to live in a world where the rate is X, and on that basis, make their businesses better and more efficient. The insureds can be better risk managers, and the insurers will have a more efficient business.

The unknown is obviously the government. And that’s what the challenge is, because nobody knows what’s going to happen. But I don’t worry about the unknown. When it comes, we’ll do something about it. If the rates are steady, you’re in a better position to deal with it.

I think that this part of the industry, medical professional liability, has a better shot at doing that—achieving steady rates—than the P/C business. It seems to be in everybody’s blood in P/C insurers—this business of “hard” and “soft” markets. I mean, there’s not a day goes by that I’m not asked about hard and soft markets. I’ve never been in a business where it’s hard or soft. My response is, it’s the market, period.

People worry more about that than they do making a better industry and a better business, for everybody.

I think that the medical professional liability part is much more visceral. But the P/C market in general should be much more visceral. I say to people, look out the window and tell me, what isn’t insured? Everything’s insured. So you’re in an industry where you ought to feel good that if you didn’t show up, none of this would happen. And this is even more true for the medical professional liability segment.
Expert guidance in a changing market.

Healthcare reform, tort laws, and the use of new technologies are causing constant flux in the medical professional liability market. At the same time, insurers must cope with day-to-day issues like loss reserve volatility, underwriting, coverage requirements, and competition within the industry.

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Charleston Place Hotel
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Sessions include:

■ Finance: MPLI Investment Results and Capital Market Opportunities — You’ll hear a 360-degree overview of the current investment market for insurance companies, against a background of trends in the general economy. The speaker will provide detailed information on the year-over-year performance in the MPL insurance industry, and suggest some smart options for portfolio strategies. He will highlight in particular the more attractive alternative investment vehicles currently on offer.

■ Human Resources: Compensation Update — PIAA human resource professionals need to keep up with compensation trends in the MPL industry. But is your compensation plan competitive? Does it need to be updated regularly? Are your compensation policies working for hiring and retaining a high-caliber staff? The session will explain recent compensation trends, and tell you about the policies that need to be in place for a competitive and compliant plan.

■ Information Technology: Technology Hot Topics — This session is a compact format, addressing several IT topics by a panel of presenters. The results of the Information Technology Survey Results (data from 2010), an overview of the PIAA Data Sharing project, and electronic vaulting (sending data off-site as part of a disaster recovery plan) will be covered in-depth.

■ Physician Re-entry to Practice: What Does This Mean for MPL Carriers? — Many physicians are going back into clinical practice, sometimes after a long period of inactivity. To meet requirements for re-licensure, the AMA has been encouraging re-entry programs. But what about the physician who hasn’t yet relinquished his license? How do MPL insurers evaluate an applicant’s current clinical competence, in underwriting? You will hear about one company’s experience with a task force on physician re-entry to practice.

■ Medi/Day Spas: What Is the Real Exposure? — Given the proliferation of medi/day spas, what is the real exposure for physicians working as medical directors there? Can the medical director be held liable for actions there? Can actions for which the medical director is liable be deemed outside the scope of his employment? Learn the answers to these questions and more in this informative session.

■ Minimally Invasive Surgery: Does Less Invasive Mean Less Risk? — You’ll get invaluable guidance on the risks associated with the most commonly performed surgical procedures. You will find out what kinds of additional training physicians need to perform these procedures. It will also cover the risks in each of the settings for the procedures: the physician’s office, the ambulatory surgical setting, and the hospital (inpatient).

■ Early Detection—Is It Too Expensive? — Two causes of action for MPL claims are delay in diagnosis and delay in treatment. But new healthcare guidelines tell physicians to order fewer screening examinations (or delay screening) for many potentially serious conditions, making early diagnosis virtually impossible. The speaker will discuss these issues and offer strategies for underwriting physicians while accounting for these new recommendations in the underwriting process.

■ Claims: Overview of Robotic Assisted Surgery — This session will review various types of surgical procedures where robotic assisted surgery is now in use. The speaker, a widely recognized expert in the field, will discuss the benefits, required training, and associated risks with robotic assisted surgery.

■ Risk Management: Simulation in Obstetrics—What Is It and How Do I Use It? — Simulation in medicine has become a hot topic once again. This session will tell you how to use simulation in the training of obstetricians and in maintaining their competency. The speakers will explain how simulation has been used in their organizations and talk about the benefits of this tool.

■ Claims: Anti-coagulation Therapy—the Essentials of Practical Risk Management — The presenters will discuss the range of clinical applications of anti-coagulation treatment, the drugs presently in use, and the new drugs coming on line in the near future. Correct procedures for monitoring blood levels of anti-coagulant will be covered as well.

■ Risk Management: Share with Me! What Works for You? — Participants will join in a discussion with their colleagues in risk management to offer each the essentials of practical risk management needed to improve patient safety. You’ll hear about risk-management guidelines, checklists, forms, sample policies and procedures, and the clinical management tools that have proved effective, reducing claims.

To view the complete agendas for any of these workshops, or to register online, go to www.piaa.us.
Economic and Capital-Market Perspective

BY LARRY WHITE

Take an informal poll. Ask this question: “Do you think interest rates will be higher in the next two years?”

Depending on your subjects and their willingness, you’ll probably hear more “yes” than “no” owing to such wide-ranging developments as government deficits, the end of quantitative easing 2 (QE-2), the Chinese economy, commodity inflation—the list goes on. Oddly, there are few compelling arguments explaining why interest rates might go lower. And yet, rates have gone down.

And today, in spite of a U.S. budget deficit that is almost triple that of 2008, rates remain low. Why?

We have a friend in (Helicopter) Ben

Since the first quarter of 2009, the Federal Reserve has been buying Treasury, agency, and mortgage debt in the open market, in addition to providing any number of “liquidity facilities” on an as-needed basis. Originally dubbed “quantitative easing,” the second round, begun near the end of 2010, is known as “quantitative easing 2” or QE-2. Both QE-1 and QE-2 are the policy and philosophical brainchild of the Federal Reserve chairman, Ben Bernanke, a.k.a. “Helicopter Ben,” who earned his moniker after a speech in 2002, when he quoted Milton Friedman about using a helicopter drop of money into the economy to fight deflation. Bernanke focused much of his academic career on the Great Depression and, as a Federal Reserve Board Governor, he delivered a speech, “Deflation—Making Sure It Doesn’t Happen Here,” that had been influenced, in part, by his observations on the more recent Japanese recession/depression of the 1990s. Clearly, it is Bernanke’s intention to avoid economic depression by way of easing credit. And, to date, this has worked: credit markets have stabilized, and economic metrics point to recovery, albeit slow and not so robust at this moment.

So the U.S. Treasury finds the principal buyer of its debt… right across town at the Federal Reserve? That’s a topic for another day. Regardless, QE-2, which expired at the end of June 2011 (and QE-3 if it happens) put a ceiling, or cap, on interest rates. Interest rate caps are not new. In fact, as recently as the years after World War II, rates remained low, until the late 1970s. In fact, between 1945 and 1980, real interest rates (the difference between the investment rate and the GDP) were negative roughly one-half the time, thereby reducing U.S. debt/GDP by 3% to 4% per year—almost 40% in a decade. The specifics and details of this “financial repression” are outlined in a paper published by the National Bureau of Economic Research, “The Liquidation of Government Debt,” and the items covered include:

- Caps or ceilings on interest rates
- Creation and maintenance of a captive domestic audience

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Larry White is Managing Director, AQS Asset Management, LLC.

Financial repression?

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- Caps or ceilings on interest rates
- Creation and maintenance of a captive domestic audience

And inflation works to the benefit of the borrower. So evidence suggests that our economy will inflate—but maybe not immediately.
Government ownership of financial institutions, restricted entry to the financial industry, and credit directed at specific industries.

Sound familiar? Consider: Is your portfolio being financially repressed? Could you, for example, purchase foreign-denominated bonds for your investment portfolio without running afoul of regulators or taking a serious risk-based capital haircut? As it turns out, this means that you are financially repressed.

The good news
As a domestic insurer, your portfolio is denominated in the U.S. dollar, so any foray into foreign currency will cost capital, regulatory hassle, and the potential for a serious currency hit. Your liabilities are denominated in U.S. dollars, too. So your only viable choice is to continue to invest in U.S. dollar-denominated debt; but what happens when profit margins are squeezed?

The cost increase is passed on to the consumer, in the form of higher rates. But isn’t that inflationary? Ultimately, yes. So when does the “ultimately” scenario occur? That’s the bad news. We just don’t know.

Here is what we do know, at this point:
- Our Federal Reserve, as financial regulator, is pursuing a policy of financial repression.
- Financial repression ultimately transfers inflation to consumers.
- Inflation reduces the debt/GDP ratio, which improves the United States’ ability to service its own debt.
- Fixed income produces negative real returns during periods of inflation.
- Financial repression can cause nominal investment rates to remain low for decades.

EXAMINING YOUR INVESTMENT STRATEGY?

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With over 25 years of experience managing a variety of medical malpractice insurance portfolios, Brown Brothers Harriman can help you develop an investment strategy customized to your unique risk and return objectives. Our Insurance professionals have extensive expertise in asset/liability and risk management as well as in tax, regulatory, and reporting requirements. We can offer assistance in investment strategy and policy design, customized benchmark selection and tactical optimization of investment portfolios.

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Markets will behave in a way that makes fools of the greatest number of people.

Old market adage, because it’s right.
And here’s what to consider in devising a strategy:

■ Timing interest rate moves, especially long-term moves, is costly and ineffective, because the horizons involved can span generations.
■ Portfolio hedging involves interest rate timing. (See “costly and ineffective,” previously discussed.)
■ The cheapest hedge available to most insurers is the liability side of their balance sheet.
■ Cost averaging works in all markets. Though it may seem counterintuitive to some extent, consistent reinvestment is key to consistent performance.
■ Cash flow forces cost averaging.
■ Consistent cash flow = consistent performance.

While many participants in today’s market saw the high rates of the early 1980s firsthand, that experience may be clouding their expectations for what will happen with rates in the future. Capital flows have much to do with the relative attractiveness of the issues of one country versus those of others, for attracting foreign investment. China holds more U.S. debt than any other sovereign nation, at rates that are not comparable to their internal rate of inflation. This is possibly because their trade relationship with the United States dictates their exposure to the U.S. dollar. The term “flight to quality” refers to money, domestic or foreign, that seeks the relative liquidity and stability of U.S. debt, and is short-term in nature. The financial reordering of the European Union is the source of such flows at this moment. These headlines comprise the news of the day, because they are easily understood.

Inflation is necessary for sovereign nations to liquidate their debt; however, high debt burdens typically counteract an economy’s ability to grow or inflate. To that end, financial repression in some form is brought to bear on captive investors, and it can last for decades.

Ultimately, the best hedge that insurers can use is rigorous asset-liability management, smart growth, and portfolio diversification.
Medical professional liability (MPL) insurers are looking at uncertain times ahead, coming off of one of the most successful years in their history. Insurers across the industry have been taking a closer look at expenses in recent years, and recently, MPL companies have been scrutinizing expenses more closely, too.

One area in particular, litigation expense, is closely analyzed, because many insurers have seen their internal legal spend, and the hourly rates of law firms they use increase, despite flat or even decreasing caseloads. In this environment, claims executives and litigation managers understand that their jobs rely on timely access to performance-oriented information.

The question becomes: how is the information fueling the availability of these metrics best derived and delivered, to provide optimum impact? For most insurers, the answer is not simple. Data is derived from multiple channels and captured in multiple databases, with various levels of integrity, availability, integration, and reporting flexibility. More often, the result is little to no real-time or retrospective transparency in regard to critical information, on either open or closed cases.

In response, most insurers now have some business intelligence (BI) tools to help them make better-informed business decisions. Much of the focus on BI programs has been at a level higher in organizations than is really appropriate for developing and executing an effective litigation-management strategy. Frequently, case-level information on budgets, case assessments, status updates, trial dates, closing reports, and scorecards may be completely unavailable, except on a one-off and non-reportable basis.

The advent of electronic billing systems does offer detailed spend, staffing, and phase data, but unless this information is linked with case segmentation and other case data, these one-off systems are usually relegated to little more than a “bill-cutting” role. In the absence of timely information, BI sent to the litigation management team typically relies on top-level historical claims, policy, and expense information from multiple systems, so it is nearly impossible to use it in making changes.

Truly useful BI requires three essential elements: case management data, detailed invoicing data, and robust reporting capabilities. Unfortunately, the technology involved is, in many instances, supported by disparate systems.

The new standard combines all three within a single, integrated and open platform that can incorporate new data from claims and payment systems, as needed. An integrated BI platform should be able to capture and draw upon budgets, offers, demands, trial dates, and outcomes across cases; these are normally derived from outside counsel, and are typically housed in siloed platforms.

Once aggregated and integrated claims information, as well as case management, e-billing, and reporting data, are available, the company gains greater control over litigated cases and is in a position to cut costs. Seamless system integration has certainly been a significant challenge in the past, but the greater challenge today is how to generate critical metrics and data. Both metrics

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and data must be meaningful, easily accessible, and configurable by professionals who range from claims managers to executives.

**Importance of integration**

The full capability of BI is unveiled when case information is combined with invoice information, because these areas are typically ripe for improvement, and precisely what needs to be done—where and with whom—is immediately accessible. Organizations with an e-billing system can expect to save 5% to 15% in legal fees, just by prescreening invoices for accuracy and compliance with performance guidelines. However, it is the fusion of that information with matter management-level information that makes BI so powerful for claims departments and litigation managers.

As they learn to capitalize on data-driven BI solutions, insurers can realize savings of up to 50%.

For example, if a typical BI analysis reveals an increase in both case numbers and cost, in a particular type of case, the BI tool can dissect that increase by case subtype, location, law firm, and so on. The invoice information is harvested to identify who is doing what, how often, with what level of resources, for what periods of time, and when. That information can be trended over time to see what, if any, change has occurred in regard to these elements.

Then, the information can be compared across law firms and personnel to determine the differences that result from the different approaches used in handling these cases. The invoice information provides complete transparency into the drivers of cost and also the identification of the individuals responsible, and that makes it possible to alter specific resources and activities.

**Examples:**

**Leveraging BI**

**Example number 1**

Using its integrated platform, one organization was able to analyze billing and outcomes related to specific cases in a particular jurisdiction, during a three-year period. Its goal was to determine which firms were providing the best overall results and why. It used BI tools, first, to identify the top performers by reviewing metrics including staffing profiles, billing practices, time allocations, and case durations.

The best results, they discovered, were achieved by firms that had a high degree of partner engagement early on and, for that reason, were able to resolve matters within the first six months. The company identified the top-performing law firms, and that provided guidance for future case strategy and planning.

**Example number 2**

After an integrated BI platform was in place, an insurer recognized that a law firm was charging reasonable rates, but nonetheless had the worst per-case cost in its jurisdiction. An analysis of billing data uncovered the causes—unit billing, redundancies, and excessive entries for individual line items—which suggested that the firm was perhaps more interested in generating fees...
than in matter resolution. Further comparison of similar cases, across different firms, revealed that the firm in question had also raked up the worst record in the outcome of cases.

Armed with this information, the department took action. Inaccurate billing is easy to spot, for individual or aggregate invoice review. Detailed billing information that suggests extraordinary costs can be identified, as can groups of cases or activities that can be handled more expeditiously by deploying alternate resources or processes.

Delivery at the point of operation
Having this information available allows a company to focus what it should do to improve performance. Also, the appropriate information can be sent to every level of management. Results, comparative performance, progress against objectives, and additional analyses can be electronically distributed. The level of information provided can be adjusted for each recipient, so that, for example, individual claims professionals receive only the information that is relevant to their priorities.

Dashboard information, tailored to each level of management, can be created to focus the organization on specific areas of performance and provide instant interpretation of the data presented.

Intelligence-on-demand
In the claims department, BI development is focused on how to make optimal use of the data. Claims professionals should be able to do this without having to interpret or be completely familiar with the underlying information. This work is described as “intelligence-on-demand,” and includes at least three areas, including workflow, informed decision support, and “what if” analyses. Most organizations are starting to consider cloud-based solutions. In the claims world, if the basic data streams can be supplied, cloud solutions can be adopted, to accelerate the use of BI, transforming it into a true intelligence-on-demand platform for users.

The technology incorporates focused, up-to-the-minute data, which makes the intelligence-on-demand uniquely timely and relevant. Implementing BI also means that intelligence-on-demand can be applied to any discrete segmentation that is selected, so the same rules and logic do not apply to overly broad groupings of cases. Because the intelligence-on-demand information is not only client specific, but also specific to particular groups of matters, scenarios, personnel, and actions, integration of these tools requires close interaction with claims management.

The institution of intelligence-on-demand is particularly significant for litigated claims, for which massive quantities of detailed information need to be processed and manipulated, at many levels, to make educated decisions on everything from the management of individual lawsuits to the direction of panels and vendors. In the lifecycle of litigation management, workflow triggers the management of claims in a timely fashion.
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Based on an understanding of all of the activities required to properly manage a particular type of claim, intelligence-on-demand platforms can draw upon prior cases that fall within the same category of case, to identify the optimum time intervals for undertaking specific activities.

Sophisticated intelligence-on-demand makes possible key business-operation calculations. This “what if” technology allows analyses on demand, to display any number of scenarios based on the determination of critical input values, followed by the projection of likely outcomes.

Informed decision support helps in making recommendations for selecting the best resources for managing particular types of cases and activities, and can even assist in recommending settlement values.

The output is based on objective data specific to the matter or activity type being analyzed, which eliminates the influences of human biases and generalities, to the greatest extent possible. The data is useful in any number of ways, from selecting counsel to evaluating ultimate exposure.

BI is widely available to all insurers; many are using it in a disciplined fashion to analyze claims costs on an ongoing basis, and zero in on opportunities for improving performance. Ongoing performance and results metrics are easy to develop within the BI tool, and these can be disseminated throughout the organization. Any format, from grid reports to dashboards, can be used. Once both BI and intelligence-on-demand are adopted by insurers, resources can be concentrated on defining the right guides and performance indicators for each area within claims and litigation management, thereby affording a new competitive advantage.

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For more than two-and-a-half decades, 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 270,000 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.

These charts represent cumulative data from the Data Sharing Project. All DSP reports can be purchased online at www.piaa.us.

Strength in numbers. Your participation in the Data Sharing Project permits greater statistical power—and better information for patient safety. To learn more about participating in the Data Sharing Project, please contact P. Divya Parikh, dparikh@piaa.us.
International

The SURPASS Checklist: Validation of Its Efficacy

Mistakes made in hospitals are an important issue that has been attracting more attention over the last few years, nationally as well as internationally. International medical file studies show that a significant percentage of the mistakes that injure patients are carried out by surgeons. The Dutch adverse event study published in April 2007 confirmed this view: of the 5.7% unwanted injuries that occur in Dutch hospitals, 40% are associated with surgical interventions. Thirty-four percent of these incidents are avoidable.

Development and Research
The Academic Medical Centre (AMC, Amsterdam) developed and validated the SURGical PaTient Safety System (SURPASS) checklist, which is a security instrument that traces the entire hospital pathway of the surgical patient, from intake to discharge. The checklist follows the course of the surgical patient, including all transfer points between the several locations in this process: polyclinic, pre-operative stage, holding, operation room, high care or intensive care, post-operative stage, and home.

SURPASS is multidisciplinary: the surgeon, anesthesiologist, surgical assistant, ward doctor, and nurse are all involved in filling it in.

The objective of the checklist is to enhance the safety of the patients. Avoidable complications, mistakes, pre-operative, and post-operative incidents, as well as incidents that occur during surgery, may thereby be reduced. In addition, the intent of the checklist is to improve communication and collaboration between professionals.

For the design of the checklist, examples from the aerospace industry were observed, and data and publications concerning mistakes, incidents, and complications in operations were compiled.

To validate the checklist, 170 procedures were observed, in a controlled multicenter setting. The complications and mortality among surgical patients were compared before and after the implementation of the checklist.

To gain more insight into the mechanism behind the effect and the relative contribution of each item in the checklist, incidents that were captured by using the checklist have been analyzed.

Also, surgical claims were examined to determine the percentage of the cases that could possibly have been avoided by using the checklist. For this effort, MediRisk placed its database at the disposal of the SURPASS researcher.

In a subsequent study, the effect of the checklist on the timing of antibiotic prophylaxis was examined retrospectively in two cohorts of surgical patients.

Results
The AMC completed a macro-scale study in 2010. Information on almost 4,000 patients on whom the SURPASS checklist was used was gathered in six hospitals. It was found that using the SURPASS checklist had a significant effect on mortality and complications.

In fact, using the SURPASS checklist cut mortality by 50%. Without it, about 1.5% of the patients operated on died; this fell to 0.7% after SURPASS was introduced. The number of complications also went down by more than a third, from 27.3% to 16.7%. The outcomes were compared to those of patients from five very highly recommended hospitals where no such checklist is used. In these control hospitals, there was no change in mortality in the study period.

In November 2010, the New England Journal of Medicine published the research results: mortality cut by 50% and a third less severe complications after clinical operations. After publication of the research results, SURPASS drew a lot of national and international attention. SURPASS also won the Patient Safety Award of the Dutch Health Care Inspectorate in June 2011.

MediRisk and SURPASS
As the largest mutual insurer of medical liability of hospitals in the Netherlands, MediRisk conducts an active prevention policy in cooperation with the research team that developed the SURPASS checklist. We would like to support and emphasize the importance of patient safety and risk reduction by collaborating with such research.

We are of the opinion that the SURPASS plays an important role in reducing avoidable injury to the surgical patient. Reducing hazardous moments, and thus reducing avoidable injury, eventually leads to a safer environment for patients and a more manageable premium. Besides this, the checklist contributes to the risk awareness of care professionals involved in the surgical care process.

The first results of the effect of the SURPASS checklist on the reduction of complications and mortality are very promising. Therefore, we keep encouraging the medical personnel to implement the SURPASS.
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Go to www.piaa2011.com for more information or to register.
This year marked a major advance in the evolution of the PIAA’s educational program. The PIAA’s Annual Meeting had been the medical professional liability (MPL) industry’s anchor event for more than 30 years. For 2011, this event was reengineered, with a new name that reflects the PIAA’s renewed sense of focus and commitment to providing a full range of information and expertise that is vital to working within the ever-changing world of MPL insurance.

In the stunning setting of the U.S. Southwest—Scottsdale, Arizona—experts on every aspect of MPL gathered on May 11-14 and offered the latest information, insights, and intelligence. They suggested new strategies for dealing with difficult emerging issues, like the potential ramifications of the Patient Protection and Affordable Care Act, for the MPL enterprise.

Equally important, the location and structure of the meeting fostered a rich diversity of interaction—between attendees and exhibitors, participants and expert speakers, and among the attendees themselves.

Everyone who attended the PIAA’s 2011 Medical Liability Conference left the meeting with a clearer perspective on the present and future of the MPL business.
Passion, sense of mission will guide future success of PIAA companies

Joe Plumeri gave a stirring speech to the assembled MLC attendees, asserting that they are more than an industry. They are also part of a movement—the individuals who make certain that healthcare is accessible. They are driven by a cause, and because of that, bring a good measure of passion to everything they do.

“You make sure that the people who care for people are able to care for people,” Plumeri said, adding that, “You have more in common with the environmental or tax protest movements. You protect the profession that is the most noble of all—healthcare providers.”

Plumeri compared the MPL insurers to his father, who, at age 80, decided to launch a campaign to bring a minor league baseball team to Trenton, New Jersey. His dream was realized when Trenton became home to the minor league Trenton Giants baseball team, as well as the New York Yankees AA Trenton Thunder.

That sort of passion will be crucial for the efficacy of the PIAA, he said, as it confronts new challenges, including those engendered by the Patient Protection and Affordable Care Act, and the increasing trend among physicians in joining hospital groups as employees, rather than operating as independent practitioners.

The PIAA companies, Plumeri said, confront a difficult choice: “You can accept a diminished role, or you could apply the tremendous courage, knowledge, and commitment that have characterized this very special movement, and figure out how you’re going to follow your traditional client base into this new arena.”

He noted that PIAA companies, born out of a crisis in MPL coverage in the 1970s, are no strangers to adversity. They have faced one mortal threat after another, and emerged from each stronger. Some companies, like the St. Paul Companies, had to exit the MPL business, because they couldn’t make money in it. But the PIAA companies transformed the business that had defeated St. Paul, because their sense of cause was a primary driver in their success.

The MPL segment, he pointed out, has outperformed the overall P/C business six years in a row. “Your combined ratio is the envy of the industry,” Plumeri said

The challenge for PIAA insurers now, he added, is to apply their courage and knowledge and figure out how to follow the new client base, to get profitability from that. He expressed his confidence that PIAA companies will endure: they know this customer base best, and they work harder on its behalf.

Plumeri predicted that PIAA companies will have gained a major entrée into the hospital MPL business in five more years—they will have more than half the market in this segment.

Joe Plumeri’s speech was the perfect kickoff for the MLC sessions that followed: inspiring attendees with a sense of deep pride, and exhorting them to find ways to continue to thrive, in an evolving healthcare environment.

Focus on a Session
“Multiple-Defendant Cases: Formulating an Effective Defense”

Among the presenters was Domenic A. Crolla, Esq., firm managing partner-internal, with Growling Lafleur Henderson, LLP. He spoke on the ethical obligations involved in representing multiple defendants, and how to devise appropriate vehicles for avoiding conflict of interest and promoting fruitful collaboration.

While conflict of interest (and even bad faith) may potentially be involved, Crolla said, in some cases, using one attorney or firm to represent all of the defendants may make it possible to devise, and retain, a more integrated and cost-effective defense.

Joint retainers are not prohibited, per se, Crolla pointed out. Courts have in fact recognized that the unique nature of some joint-retainer relationships will inevitably give rise to inherent “conflicts” that are expected and permissible. They are reluctant to intervene where a joint retainer creates only hypothetical conflict. The insurer-insured relationship is a prime example.
The approach to avoiding conflict should be deliberate and well thought out. There should be sufficient disclosure to the client to allow for an informed decision. Also, the client must consent, and robust conflict screens should be in place. Lawyers should also advise clients that no information received from one party in connection with the matter can be withheld from the other party, as being confidential. They need to let clients know, up front, that if a conflict does arise, they may be compelled to cease acting for one party, or to withdraw completely.

The potential benefits of joint defense agreements are significant, Crolla said. This arrangement fosters cooperation, good communication, and simple courtesy. And there is easy sharing of the vital elements of the case: basic resources, investigative responsibilities and costs, and the results of investigations, research, and confidential information.

While joint-defense agreements may vary in extent of formality, it may be wise to execute a formal agreement—especially prior to exchanging substantive or sensitive information. The agreement will identify the specific information, documents, records, knowledge that will be shared, and who will have access to shared information, versus the items that will remain privileged and confidential. It will also make note of any joint initiatives—such as joint interviews of prospective witnesses.

Even when codefendants request separate attorneys, protocols can be developed that coordinate the subsequent legal work. These may apply to more than just one isolated case. For example, there may be a protocol for efficiently and appropriately resolving claims when the defendants concur that an action is indefensible.

If codefendants can confer on the quantum of damages early on, and offer to settle with plaintiffs, Crolla said, they may be able to avoid the commencement of formal proceedings in these sorts of cases.

Two other presenters provided additional information on the possible pitfalls, and the potential benefits of using one firm in multiple-defendant cases.

David P. O’Neal, JD, vice president, claims and corporate counsel, Kansas Medical Mutual Insurance Company, suggested a strategy for formulating an effective defense. He pointed out that joint representation fosters a collaborative relationship with the insureds, and makes it easier to develop a common defense. There is stronger defensibility through unity, he said. Working as a team also avoids the possibility of fingerpointing. It also lowers the costs of defense.

Daniel Belsky, Esq., of Belsky & Associates, added a note of caution. Whenever an attorney is asked to represent multiple clients, he said, there is always a potential for conflicts of interest. The attorney should explore whether there are any significant or irreconcilable conflicts of interest. He should ask himself, to vigorously represent one client, do I need to take a position that is adverse to the other client? Each defendant needs to be advised that his task is only to defend the multiple defendants against the plaintiff’s claims—and not with respect to any rights or claims vis-à-vis one another. He also emphasized that all of the information communicated must be equally available to each of the defendants, with no secrets.

Focus on a session
“Identifying New MPL Exposures: Mid-Level Practitioners”

In light of the ever-increasing proportion of U.S. healthcare provided by mid-level practitioners like physician assistants and nurse practitioners, a thorough consideration of the liablility...
ty risks entailed is a crucial endeavor. In this session, three attorneys with deep expertise in this area provided a comprehensive analysis of what to think about—and what to do.

Savannah Sellman, Esq., partner, Clyde & Co., spoke on the requirements for prudent underwriting of mid-level providers. She noted that specialty-specific applications and underwriting guidelines are necessary for both advanced-practice registered nurses (APRNs) and physician assistants (PAs). The scope of practice for each type of professional should be carefully delineated, for each sort of practice setting they work in.

For example, a certified nurse specialist (CNS) usually focuses on a specific patient population, such as pediatrics, geriatrics, or women’s health. They may also specialize in certain types of diseases, such as cardiovascular health. They can practice in different environments—an operating room, emergency department, or critical care. As part of their daily routine, they may be engaged in:

- Clinical practice
- Teaching
- Research
- Consulting
- Management.

Supervision of these professionals is not legally required, and that should be accounted for in underwriting. Underwriters should consider the specific scope of practice where these mid-level practitioners are working; there are six population focus areas:

- Family or individual, across the full life span
- Adult, including gerontology
- Pediatrics
- Neonatal
- Women’s health (gender-related)
- Psychological/mental health.

In reviewing the practitioners’ applications, underwriters should check on education. Both the degree-granting entity and the post-graduate education programs should be accredited institutions. There are three types of graduate-level courses: advanced physiology, health assessment, and pharmacology. Extent of clinical training should be considered, too.

Certification should document competencies in the APRN core, role, and at least one population focus area. These professionals should have passed the national certification examination, and hold a license to practice in one of the four APRN roles.

It is important to limit the coverage to the specific certification. Prior coverage should have been a separate policy for the individual professional. The premium set should be commensurate with exposure—similar to physicians. It should also account for the specific relationship with physician colleagues, especially for nurse midwives and nurse anesthetists. Policies should be renewed annually. For risk management, companies should identify any deficits through query and assessment. Where there are deficits, companies should require training as appropriate, including continuing education, and require that insured report any changes in their scope or setting of practice.

Focus on a session
“Successful Investment Strategies for Today’s MPL Insurers”

In considering investments, speakers noted, there are several facts that all MPL companies have to face. First, there is no
“secret sauce” for investing—no magic recipe for high returns. Also, the current investment climate will most likely change only incrementally—not in great leaps forward. Finally, how a company considers its investment strategy will depend on how it looks upon the insurance market: anticipating a hard market, or hunkering down for more of the same conditions?

A snapshot of the current investment climate shows the close inter-relationship between what happens with investments and the rest of the MPL enterprise. Pricing discipline becomes even more critical in a low-interest-rate environment. Or, to look at the situation from the obverse perspective, the investment income “cushion” has declined dramatically.

What investments have MPL insurers opted to hold, given these conditions? Frank Conde, CFA, FCAS, MAAPA, Chief Investment Strategist at Prime Advisors, Inc., provided some details on PIAA companies’ current allocations. The average PIAA member’s portfolio, it turns out, is primarily in fixed-income instruments: 94.7% bonds (including 32.7%, corporate bonds, and 26.8%, municipal bonds). Only 5.3% is allocated to common stock and other equities. Average durations, for 22 of the PIAA companies, are in the range of 3.5 to 5.0 years; for eight and nine companies, respectively, durations average 3.3 to 4.0 and 5.0 to 5.5 years.

There is a real divergence in the extent to which MPL insurers allocate funds to municipal bonds. Fifteen companies have 30% to 40% of the funds in municipal bonds, six have 40% to 50%, and eight have more than 60% in these instruments. But seven companies have nothing—0%—in municipals, and 11 have 30% or less invested here.

The present environment is distinct from that of the early 2000s, when net earnings were buoyed by higher interest rates, which were then reinforced with strong, stable underwriting results—and these more than offset the cyclical decline in interest rates.

Surveying MPL companies’ traditional approach to investment, the presenters—which also included Jeff Schoenfeld, partner, Brown Brothers Harriman & Company, and Frank O’Neil, senior vice president for investor relations and corporate communications, ProAssurance Corporation—offered comments on how to improve it, to ensure better returns, and at the same time become more flexible in the event of adverse conditions like increasing inflation.

MPL industry asset allocations, it was noted, are exceptionally cautious, offer no protection if inflation rises, and fail to maximize either tax efficiency or total-return performance. Further, MPL insurers are under-allocated in municipals, Treasury inflation-protected securities (TIPS), and equities. Why are MPL insurers’ allocations in municipals so low? Are they, for example, worried about poor underwriting results and renewed losses?

In fact, while the municipal bond market may have appeared to perform poorly in late 2010-early 2011, as a result of fundamental, legislative, and technical developments, these bonds were in fact doing quite nicely. Although headlines might suggest that municipal credit trends are deteriorating, the credit cycle of municipal bonds (a fundamental aspect of this instrument) is becoming more favorable. And states are generating higher revenues now, with a growing economy, while they are reducing their expenditures.

Technical elements of these bonds are trending favorably as well. There were heavy redemptions of municipal bonds over 22 straight weeks—$40 billion—as retail investors reacted adversely to threatening headlines. But outflows are slowing now. Crossover buyers have increased demand to fill the void, and municipals have been the best-performing investment grade sector, YTD. Tighter corporate bonds spreads have rendered municipals more attractive, in most sectors, maturities, and ratings categories.

TIPS offer many advantages for MPL insurers. Since their principal value increases with inflation, they protect from periods of unanticipated inflation. A fixed coupon generates cash flows that rise with inflation. TIPS are less volatile than conventional Treasuries of equal duration, but since they are not highly correlated with conventional Treasuries, they bring a
good measure of diversification to an asset allocation.

And what about equities? The MPL group of insurers has moved in the opposite direction of the P/C segment overall, with lower allocations: 8.6% is the overall P/C industry average, vs. 5.3% for MPL companies. But perhaps MPL insurers should consider increasing their allocation to equities, since equity valuations currently are not high, and they offer investors a long-term hedge against inflation, especially those that generate meaningful free cash flows.

While the particular strategies that MPL companies adopt will differ according to their outlook on the future, any investment strategy should account for the basic elements of the near future in the market: low interest rates will continue, there is some risk of higher inflation, and the overall investing climate will improve only incrementally.

The Peter Sweetland Award
Robert P. Boren was this year's recipient of the Peter Sweetland Award of Excellence.

Mr. Boren was recognized for his significant contributions and dedication to the medical professional liability (MPL) insurance industry. Mr. Boren has served as the executive vice president and chief financial officer of State Volunteer Mutual Insurance Company for more than ten years and has been with the company for three decades, joining in 1981 as the vice president of finance. Active in the MPL insurance community, his list of committee appointments is extensive.

His service to the PIAA includes serving on the Association’s Regulatory Affairs Committee, CE Advisory Committee, and Technology, Human Resource, and Finance Section for more than ten years. Mr. Boren is currently an active member of the PIAA’s Audit Committee. He has also spoken at many PIAA meetings, most recently at the 2010 PIAA Leadership Camp.

Mr. Boren is currently an active member of the American Institute of CPAs and the Tennessee Society of CPAs.

“We are honored to present Bob with this award,” said Lawrence E. Smarr, president of the PIAA. “His hard work and dedication to the Association and the industry are inspiring, and we thank him for his many years of service.”

The Peter Sweetland Award of Excellence, established in 1993 by the Association’s Board of Directors, was created in honor of Peter Sweetland, one of the PIAA’s chief architects and ardent supporters. The Peter Sweetland Award of Excellence recognizes an individual who has provided great service to the industry and to the PIAA, and epitomizes the high ideals and ethics that Peter Sweetland stood for.
**Finding the Next Generation of MPL Professionals**

*BY ERIC R. ANDERSON*

I’ve spent some time recently thinking about what will happen when the existing crop of long-time, dedicated PIAA member-company professionals—the lifeblood of the medical professional liability (MPL) industry—decides that they’ve underwritten their last risk, evaluated their last claim, passed along patient-safety data to an insured for the last time, or signed off on their last set of financial statements. Who will replace them?

I may be thinking about this because I’m approaching my eighteenth year within the MPL industry; it is common, I think, to become more reflective with the passage of time. More likely, though, is the realization that attracting new talent will be vitally important to the continued success of PIAA companies and growth of the MPL insurance industry as a whole, as the current workforce begins to sail off into the sunset, to enjoy the fruits of their labor in retirement.

To see evidence that this issue has become real and may indeed be upon us, all you need do is peruse a recent study by Deloitte Consulting. Between 2004 and 2014, the study notes, the property/casualty industry as a whole, as the current workforce begins to sail off into the sunset, to enjoy the fruits of their labor in retirement.

To see evidence that this issue has become real and may indeed be upon us, all you need do is peruse a recent study by Deloitte Consulting. Between 2004 and 2014, the study notes, the property/casualty industry will need to fill approximately 85,000 claims openings and 25,000 underwriting jobs.

Who will be in a position to fill their places? But the key question is, are they working?

Example: if a job advertisement can’t be downloaded on a Smart Phone, it is highly probable that someone from Generation Y will never know about it. There are many important differences between the people who will be leaving the MPL industry in the next five years and the talent from Gen Y that we will need to enlist to fill their places. But the way that Gen Yers are accustomed to getting messaging must debunk the age-old stereotype—that insurance jobs are dull and inflexible.

But what may be equally important, though, is the realization that the time is now to understand the generation—Generation Y—that we must pursue and enlist as the next iteration of PIAA member-company employees. Several strategies have been advanced for addressing this issue. But the key question is, are they working?

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