Opioid Epidemic
Repercussions for MPL?

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Embrace Change—or Watch Out for the Consequences

The urge to resist change and maintain the status quo—to do things the way we have always done them—can be potent. In business, as in our personal lives, it takes circumspection and nerve to recognize and accept the actual paradigm shifts that are happening in the environment, and then act on this insight to explore the new opportunities they present.

In thinking about change, I’m reminded of an urban legend about frogs. It seems that a frog is discerning enough to jump out of a pan of boiling water. But if you submerge him in cold water that’s heated very slowly, the frog won’t recognize his imminent peril and….well….let’s just say you can dine on frog’s legs that night.

Last year, after considering the daunting changes facing the medical professional liability (MPL) insurance industry, the PIAA Board of Directors developed a new strategic plan. I am pleased to inform you that implementation of the plan is well underway. I look forward to bringing you updates on our progress in the coming months, and telling you how these accomplishments will benefit both you and your policyholders to guide our industry into the future.

In the meantime, we will keep a close watch on the direction of the complex moving parts that make up the MPL industry and, when necessary, we will adjust our compass accordingly. In this quarter’s edition of Physician Insurer, we chronicle a number of areas that are worthy of attention. Our cover story discusses the epidemic of opioid misuse, and new state- and federal-level programs intended to curb it. The article also points to an emerging, and troubling, phenomenon: a recent increase in claims wherein a physician is held responsible, at least in part, for the drug-related death of an individual. Trial lawyers have zeroed in on this cause of action as potentially lucrative, since it involves a dramatically charged subject—drug misuse—and an easily blurred line regarding responsibility for a death from opioid toxicity.

In another article, authors survey the landscape for MPL companies—which looks fairly sanguine at the moment—and discuss the full panoply of factors now in play that could lead to a somewhat less favorable picture in 2013 and beyond. Another feature story highlights the common errors in financial reporting among self-insured entities, and explains how to avoid them and not run afoul of auditors and/or regulators. When it comes to any kind of insurance, keeping accurate financial accounts and records is one of the essential foundations upon which a company will be judged and its future is dependent.

So, back to the frog. You may have heard that the story is dubious. When modern biologists attempted to replicate this experiment with real frogs—it failed. But nineteenth-century biologists claimed to have seen this behavior in frogs; that’s when the story began.

Clearly, the PIAA is not facing anything as drastic as the frogs in the urban legend. But there is no doubt that the world of MPL and the delivery of healthcare are in for some seismic shifts. The PIAA, as your trade association, must be positioned to deal with these changes.

Hockey hall of famer Wayne Gretzky once said: “A good hockey player plays where the puck is. A great hockey player plays where the puck is going to be.” The PIAA aspires to greatness. We’ll work diligently to discern, at each point, just where the healthcare puck is headed next. And we’ll let you know about it before the water even gets warm.
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There is no test that is 100% accurate in identifying the motivation of those who request strong drugs like opioids in an office visit.
—Cover story

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MPL Gets Down and Dirty: Hulk Hogan Sues

Hulk, we’ve discovered, is suing the Tampa, Florida, area Laser Spine Institute for medical malpractice. Hulk always thinks big, of course, and is asking for $50 million in damages. He alleges that the procedures done on his back by the clinic were useless, as well as injurious, thereby circumscribing his future income.

From the “Tampa Bay Times,” we find that Terry Bollea’s (we’re assuming that this is “Hulk’s” real name) attorneys Wil Florin alleges “negligent conduct” on the part of Laser Spine Institute, which resulted in a “provable loss of past and future income of ($50 million) during the last chapter (emphasis, very much ours) of an internationally successful athletic and entertainment career,” for Bollea.

The complaint comments that, “numerous prominent spine surgeons” recommended traditional spinal surgery for Bollea, but that the Spine Institute told him that would effectively end his career. Now, the lawsuit asserts that Bollea was “the victim of multiple unnecessary endoscopic surgical procedures that further destabilized his already existing injured back.”

After a fruitful career in “faux wrestling,” we pause to wonder that Hulk/Terry has anything remotely resembling a spine left. We’ll be sure to provide updates, on this precedent-setting case.

Source: The Tampa Bay Times, January 15, 2013

“How You Can Help ProPublica Cover Patient Safety”
Or maybe not….

In response to newspapers’ staff cuts, a new Web-based forum for preserving investigative journalism, ProPublica, was born. It defines itself as an “independent, non-profit newsroom that produces investigative journalism in the public interest.” One topic that the news hounds took up recently is patient safety, noting its intent to “explore quality of care in the U.S.”

An important element of the exploration, apparently, is its “Patient Harm Facebook Community,” part of its effort to “use social media in the service of journalism.” ProPublica tells website visitors that this is how they can “help the group cover patient safety.” Specifically:

Our goal was to reach out and open a dialogue with patients who’ve been harmed while undergoing medical care. It’s a major problem affecting more than 1 million patients a year, and although the healthcare system has moved to address the issue, results have been slow in coming.

ProPublica promotes its equal-opportunity policy, noting that, “We’ve also invited participation from doctors, nurses and other medical providers, many of whom have contributed comments and shared expertise.” That may be so, but a fairly long interval spent scanning the website failed to reveal any healthcare providers who’d ventured there. Instead, there was this, under the heading, “Medical Errors Cover-up”: “After an elective surgery that left my brain unable to know where my body is from the neck down without looking at my limbs…”

It’s unnerving to think just how useful the trial bar may find social-networking sites like this.

Source: www.ProPublica.org
In November 2012, Canada’s National Post ran a story that managed to seem both obvious and ominous. A growing number of hospitals say that patients and their families are secretly recording doctors and nurses. Some of it sounds like low-end James Bond. The Canadian “National Post” reports the story of a video camera concealed inside a teddy bear, and another hidden within the workings of a clock radio, used to record doctors and nurses as they treated a patient.

And make no mistake. This stuff is being successfully used as evidence. The footage from the clock radio camera emerged as evidence in a suit alleging substandard care at Sunnybrook Health Sciences Centre in Toronto. One physician, Dr. Brian Goldman, who writes for the Canadian Broadcasting Company, draws a sharp line between overt and covert tapping of provider-patient interactions. During one night shift, when he was just about to stitch up a patient’s cut, his buddies asked if they could record the stitching. Dr. Goldman thought that was “kind of cute and innocent.” In contrast, on another occasion, a cell phone set on a pillow in a patient’s room suddenly began to “talk” during a consult on a likely diagnosis and treatment plan. One of the patient’s relatives, also a physician, piped up from the cell phone, with a variant on the diagnosis. Goldman had to quickly review everything he had said to that point, to reassure himself that he “hadn’t been rude or condescending.”

This problem may have a sane resolution: hospitals across Canada are developing policies that prohibit videotaping without the consent of healthcare providers and patients. We fervently hope they work out.

Source: CBC Radio, December 19, 2012

Big Brother Is Watching—and Listening, Too

Patients’ secret recordings of MDs and nurses

ECRI has once again published a list of the technologies most conducive to potential adverse outcomes, noting that, “Our annual list will help you make smart decisions about your safety initiatives in the coming year.” One head of an academic health science system, commenting on technology in healthcare, notes that, “Medicine used to be simple, ineffective, and relatively safe. Now it is complex, effective, and potentially dangerous.” This statement, notes ECRI, “captures the essence of why a list like this one is needed.”

And here it is:
1. Alarm hazards.
2. Medication administration errors using infusion pumps.
3. Unnecessary exposures and radiation burns from diagnostic radiology procedures.
4. Patient/data mismatches in EHRs and other health IT systems.
5. Interoperability failures with medical devices and health IT systems.
6. Air embolism hazards.
7. Inattention to the needs of pediatric patients when using “adult” technologies.
8. Inadequate reprocessing of endoscopic devices and surgical instruments.
9. Caregiver distractions from smartphones and other mobile devices.
10. Surgical fires.

Source: ECRI, January 2, 2013
At the start of each new year, it’s important to set goals. Some may be personal, like stepping up your workout routine or spending more time with your family. Others should be geared toward professional development—for example, learning a new skill or expanding your network.

I speak to business professionals quite often about the importance of intentional networking. As I’ve mentioned before in this column, I define networking as, “building or strengthening personal relationships, with no predetermined end in mind, which is a win-win for both people…someday.”

I have seen first-hand how intentional networking can grow a business. At Morningstar Communications, more than 90% of new business engagements come from referrals. Building meaningful connections through intentional networking will help build your personal and company brand, expand your company’s reach, and present new opportunities through collaboration.

Here are a few tips to help you become more strategic in your networking efforts in the new year:

■ **Share/get.** Before a networking event, ask yourself what it is you hope to get from it and what you would like to share. These may or may not be work-related. For example, maybe you want to tell someone about a great new smartphone app you downloaded, or maybe you’re looking for a talented graphic designer. With this predetermined end in mind, you will speak more deliberately in your conversations and leave the event feeling confident that you accomplished what you set out to do.

■ **Think quality versus quantity.** One of the most common misconceptions about networking is that the quantity, not quality, of the interactions is the most important measure of their success. Many people will go from one person to the next, collecting business cards, but not making any truly meaningful connections. Next time you’re at a networking event, try writing three things about each person you meet on the back of his business card. For example, “likes tennis, has two daughters in college, and serves on the board of XYZ.” This technique will ensure that you’re having better conversations, and it’s also a quick way to compile notes you can use to refresh your memory when you follow up with someone you’ve met.

■ **Stretch your networking.** Years ago, I made a list of the business professionals I was interested in meeting. I then challenged myself to connect with just one person on the list each month and invite him or her to coffee or lunch (on me). Some of them agreed, others did not, but the most important thing was having the courage to ask. The relationships and insights I’ve gained as a result have been instrumental in helping to build both my personal brand and our company.

■ **It’s not who you know—it’s who knows you.** Once, at a networking event, I introduced myself to someone I’d wanted to meet for a good while. I was excited that we finally connected, and called her to follow up. You can imagine my disappoint-
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ment when the person very politely said that she didn’t remember meeting me. No matter how many people you meet, it doesn’t count for anything unless they remember you. Needless to say, from then on, I made it a point to try and be more memorable—but always in a good way!

■ The power of a hand-written note. Your mother was right. Sending a hand-written note thanking someone for their time, saying it was nice to meet them, etc., is one of the best ways to cut through the clutter and show sincerity. It is worth a minute of your time, and 44 cents in postage, to make a positive, personal, and lasting impression.

And so I challenge you to hone your intentional networking skills. If you can be thoughtful and strategic in your approach, you’ll form lasting connections and create a strong foundation for growing your business.

The Best List of All: Judicial Hellholes

Once again, the American Tort Reform Association (ATRA) has issued its list of outstandingly dismal locations for civil litigation. These are jurisdictions that ATRA says are “among the most unfair and out of balance in the nation.” The big news is that Philadelphia, which ranked number one for two years in a row, has now been replaced by California.

And so, this year’s list:

■ California
■ West Virginia
■ Madison County, Illinois
■ New York City and Albany, New York
■ Baltimore.

It’s a bit disturbing here that there are only five, though, isn’t it? We’ve come to expect a full roster of ten. Maybe we can solve that by adding the jurisdictions on ATRA’s Watch List, locations that “also bear watching due to their histories of abusive litigation”:

■ Philadelphia
■ South Florida
■ Cook County, Illinois
■ New Jersey
■ Nevada
■ Louisiana.

That makes 11; not quite perfect. But note one of ATRA’s special “Dishonorable Mentions”: the Missouri Supreme Court, for striking down the state’s limit on subjective non-economic damages in MPL lawsuits. We can’t wait for next year’s list.

Source: Business Insurance, December 12, 2012

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Jury instructions

Many observers have stressed the risk of jurors using social media. There have been dozens of cases around the country involving jurors' use of social media during trials. As one author put it, social-networking sites have "wreaked havoc" on the jury system.1 The problem is pervasive; in 2010, the U.S. Judicial Conference Committee on Court Administration and Court Management issued model jury instructions on the use of social media and Internet research.2 In October 2011, a survey of active and senior federal court judges found that 60% had adopted the jury instructions from the Conference Committee.3

But it is hard to tell how effective these jury instructions really are. Many, if not most, jurors, presumably comply with their jury instructions.4 However, there is evidence that a small but measurable number will ignore them and make covert use of the Internet. "Any time you get involved in litigation, it is paramount that you control the results that appear when your name is entered into the search box. Public opinion is going to be formed by what people find out online about a company or an individual prior to a verdict. Also, jurors and researchers, and whoever else is involved in the case, may look people up online even though they were instructed otherwise. You never know what is going to happen behind closed doors. What people read could very possibly influence the verdict," said Reputation Changer General Manager Cliff Stein.

Also, the medical community has been generating evidence on the phenomenon of Internet addiction disorder (IAD) for several years now. Although not officially recognized by the American Psychiatric Association, many believe that IAD is real. If so, it makes the problem of persuading jurors to follow a judge's instructions all the more difficult to deal with.

Consult

Online Protection of a Medical Facility

A medical facility can employ anywhere from just a few to a couple of hundred physicians at any one time. Outside of their work, many of these physicians may have personal issues. While physicians may assume that they're checking their problems at the front door when they walk into work, their online reputation does not always follow suit.

Now, there are new companies (Reputation Changer and Digital Whiteout are two examples) that work with their clients/physicians to change what people can read about them online. A physician who is involved in a legal dispute in his personal life—for example, divorce—can easily be identified in a simple Google search. Even though a potential patient may concentrate his initial search on the physician's professional background, details of his personal life can pop up, too.

"A physician's personal life is frequently interwoven with his practice. We always try, especially in a legal situation, to separate the personal identities—their lives outside of medical practice—from their business," CEO of Digital Whiteout Chris Cicero said.

In the past, it was easier to keep private life out of the public eye. Now, the increase in Internet connectivity, and the exponential growth of social media, has conflated the doctor's personal with his public persona. The average American household spends as much time online as he does watching television. In fact, individuals younger than age 44 spend more time online than watching television. So one uncatalogued move in today's society can lead to a ruined reputation.

Internet, easy tool for sullying a reputation

Mentally unstable clients and ex-spouses seem to be the major players in defaming a physician's reputation. In some extreme cases, physicians were compelled to engage in litigation with an ex-client/spouse who had put up billboards or websites defaming their reputation.

While a physician may feel wholeheartedly that he has been wronged by some content posted on the Internet, a jury of peers may think otherwise, because they've assumed the veracity of that content. We should anticipate that jurors will make use of the Internet and social media during the litigation process. How or when this will happen is difficult to predict. But it is a safe bet that it will happen. To assume that a juror won't go online, at some point during litigation, is naive and potentially dangerous.

Michael J. Sacopulos is the CEO of Medical Risk Institute (MRI); msacopulos@medriskinstitute.com.
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Repairing a client’s online reputation

Some litigators are moving beyond mere recognition of the issue. They are proactively creating and polishing online reputations for potential advantage in litigation, in the event that jurors stray from the courtroom into cyberspace.

“A potential juror is the first person you are trying to influence. Everyone is there searching all sort of terms on their iPhones all the time. You can’t really differentiate a juror from any other person searching, so you just take a blanket approach, and everyone will be covered,” Chris Cicero said.

Industry experts argue that once someone anticipates being sued or is served papers, it is best to get a jump start on what potential jurors, lawyers, and investigators will find when they look online. They caution that the longer the negative information is visible online, the greater chance that it will spread virally by people who read it.

“What happens is this: every time an item (a physician’s name, for example) is clicked on, that increases the likelihood that the term will appear earlier in the list of results—this is search optimization at work. So, the provider becomes more visible and, again, there is a greater chance they will get picked up by other sources online and even more people are going to read it. And then these people will have an opportunity to become engaged in the lawsuit. Negative results can proliferate very quickly. It is something you want to take care of, as soon as possible,” Reputation Changer General Manager Cliff Stein said.

PR department armed and waiting

Firms like Reputation Changer and Digital Whiteout use a proactive approach in assuring that there is positive content on their clients in cyberspace. Some PR firms have new, favorable content waiting in the hopper for the occasions when litigation looms.

“Say there is a legal judgment against a client, and that is publicized via the press. You obviously don’t want that fact to be the more prevalent information about him online,” Cicero said.

In the shadows

At this point, it seems realistic to acknowledge that trials no longer take place solely in the courtroom. And this trend leads to some uncomfortable consequences. When and what goes through a juror’s search engine is impossible to know fully. Anticipating some level of juror misconduct via online activities seems both unsettling and justified. Like it or not, we have entered an age of shadow litigation.

References

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Q: And when was that?
A: I don’t recall when it was, but I did request them.

It is unlikely that this testimony, without additional evidence, would be enough to establish when this patient discovered her potential claim. As discussed here, the Nevada Supreme Court recently provided guidance that practitioners may be able to use, to clearly establish a start date for the time period during which a patient must file an MPL suit.

Winn v. Sunrise Hospital and Medical Center

In Nevada, it has been established previously that a plaintiff discovers his or her injury when he or she “knows or through the use of reasonable diligence, should have known of facts that would put a reasonable person on inquiry notice of his cause of action.” This is often referred to as “inquiry notice.” In Winn v. Sunrise Hospital, the Nevada Supreme Court recently used the following timeline to expand on what it means for a plaintiff to be on “inquiry notice” and when such notice will start the clock on a plaintiff’s claim.

December 14, 2006:
13-year-old Sedona Winn underwent what her father, Robert Winn, considered to be “minor repair heart surgery.”

December 15, 2006:
Sedona’s father was told that Sedona had suffered a brain injury during the procedure that left Sedona comatose.

The physicians were reportedly unable...
to explain how this drastic result had occurred from a relatively minor surgery.

■ **January 2007:**
  Mr. Winn had retained an attorney, who sent correspondence to the hospital requesting Sedona’s medical records.

■ **February 14, 2007:**
  Plaintiff’s counsel received only 182 pages (of what would ultimately be thousands of pages) of medical records, which included the postoperative report.

■ **December 2007:**
  Additional records were received.

■ **February 12, 2008:**
  Plaintiff received a complete copy of Sedona’s medical records.

■ **February 3, 2009:**
  Plaintiff filed suit in District Court naming Sunrise Hospital and Medical Center, operating physician Michael Ciccolo, MD, Clinical Technician Associates, LLC, Robert Twells, CCP, and Lee P. Steffen, CCP.

All defendants then sought to dismiss the plaintiff’s complaint, arguing that it had been filed after the expiration of the one-year statute of limitations, as specified in Nevada law. The State District Court held that the father, Robert Winn, had discovered his daughter’s injury on December 15, 2006, the day after her surgery. As such, the Winn’s complaint was deemed untimely, because it had been filed after the date established by the one-year statute of limitations rule. The Winns subsequently appealed.

On appeal, the Nevada Supreme Court held that the plaintiff’s claim as untimely will largely depend on your jurisdiction’s analysis of when an injury is discovered.

investigate further into whether Sedona’s injury may have been caused by someone’s negligence.” Accordingly, the Nevada Supreme Court disagreed that Robert Winn had discovered his daughter’s injury the day after surgery, reasoning that “it is unlikely that an ordinarily prudent person would begin investigating whether a cause of action might exist on the same day as being informed that his or her child’s surgery had gone drastically wrong.”

Instead, the court found that Winn had discovered Sedona’s injury by February 14, 2007, when he received 182 pages of incomplete medical records, including the post-operative report. By this point, the court explained, the plaintiff had hired an attorney and received the post-operative report, which noted that air was inappropriately present in Sedona’s heart during the procedure. The court held that it was this point “at the latest” when the plaintiff had access to facts that would prompt an ordinarily prudent person to investigate whether Sedona’s injury was caused by medical negligence.

Interestingly, the court declined to decide when the earliest date was that Winn discovered Sedona’s injury. The court rejected December 16, 2006, as the discovery date, but held that February 14, 2007 was the latest date when the injury was discovered. The court thereby left the period from December 17 through February 13 open for interpretation as to the earliest possible discovery date. Courts hearing similar arguments about when the statute of limitations begins have also left gaps, stretching from weeks to months, unaccounted for.

For example, in **Greene v. Legacy Emanuel Hosp. and Health Care Center**, the Supreme Court of Oregon evaluated the following timeline to determine whether the plaintiff’s claim was untimely:

■ **July 26, 1995:**
  Plaintiff underwent a minor outpatient abortion procedure. The procedure resulted in complications that required the plaintiff to remain in the hospital for 11 days after that.

■ **August 22, 1995:**
  Plaintiff had retained counsel, who requested plaintiff’s medical records.

■ **November 10, 1995:**
  Plaintiff’s counsel received the medical records.
November 14, 2007:
Plaintiff served her complaint.

The defendant sought to dismiss the case, arguing that the applicable statute of limitations barred the plaintiff’s claim. On appeal, the Supreme Court of Oregon rejected the plaintiff’s argument that she did not discover her injury until she had obtained an expert opinion who stated that the physician defendant had been negligent. Rather, the court held that the plaintiff discovered her injury sometime between the date she left the hospital, in August 1995, and the date when her attorney received a copy of her medical records, on November 10, 1995. The court explained that the complications that the plaintiff had suffered “were not momentary adverse side effects that commonly result from the abortion procedure to which plaintiff had consented.”

Similarly, in Runstrom v. Allen, the Supreme Court of Montana dismissed the plaintiff’s claim as untimely.7 In Runstrom, a minor-age patient was brought to the emergency room after sustaining a broken femur in an ATV accident. The next day, he died. His father immediately requested an autopsy. A few weeks after the patient’s death, the father received the autopsy report and medical records. He filed a claim almost four years later. He argued that he did not discover his son’s injury, despite the fact that he had received the medical records, because he was not a trained medical professional. However, the court rejected this argument and found that at some point between the minor’s death and plaintiff’s receipt of the pertinent medical records, he had discovered his son’s injury, for purposes of the statute of limitations.

Conclusion
These court decisions do not hinge on what the plaintiff actually knew about his or her care and treatment. Rather, the courts have held that the statute of limitations begins, at a minimum, when plaintiffs or their counsel receive a copy of the pertinent medical records. It was the receipt of these medical...
records that the courts found “at the latest” would prompt the plaintiff to investigate whether an injury was caused by a practitioner’s negligence. Plaintiffs are given some leeway, from the date of the injury until the date of receipt of medical records, to connect an unexpected injury to a provider’s alleged negligence. Medical providers and their staffs can take preventive steps to limit the extent of this leeway, with thorough documentation.

Proving the date when a patient discovered her injury will generally be in the hands of an attorney, once an MPL complaint has been initiated. However, medical providers can assist in establishing the earliest possible discovery date, by carefully documenting any and all requests for records, and indicating when the records were provided to the patient. Regardless of how the records are requested, it is imperative that the request date and the date the records were provided be specifically documented in the patient’s file. As the cases discussed here demonstrate, these dates will be crucial for establishing when a patient’s claim was “discovered.” More important, this date can be vital to an attorney looking to have a plaintiff’s claim dismissed because it was filed after the final date of the applicable time period.

Footnotes
1. Certain identifying information has been changed for privacy reasons.
5. Nevada Revised Statute Section 41A.097 provides that “an action for injury or death against a provider of health care may not be commenced…1 year after the plaintiff discovery or through the use of reasonable diligence should have discovered the injury.”

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At the end of 2012, Congress was consumed by a division and deadlock that seemed to permeate the entire Capitol. With both parties talking about the “fiscal cliff” and the apparently unbridgeable gap between them in attempting to deal with it, it seemed that our legislators couldn’t accomplish much of anything. Fortunately, that wasn’t completely true, and the result was some outstanding news for liability insurers.

The good news came in the form of H.R. 1845, originally introduced to establish a demonstration project that would “examine the benefits of providing coverage and payment for items and services necessary to administer IVIG [intravenous immune globulin] in the home.” If you don’t think that has much to do with medical professional liability (MPL) insurers, you’d be correct. The original bill, however, was amended before it was considered in the House of Representatives. Title II of the new bill, the Strengthening Medicare and Repaying Taxpayers Act, is in fact a huge victory for anyone who has, or may have, to reimburse Medicare for healthcare services provided to a Medicare beneficiary.

**History**

Originally introduced in 2010 by Congressmen Patrick Murphy (D-PA-8) and Tim Murphy, MD (R-PA-18), the bill (then called the Medicare Secondary Payer Enhancement Act of 2010, H.R. 4796) was a response to industry’s outcry over the Mandatory Medicare Reporting Requirement enacted in 2007. That law created a new mandate: liability insurers were required to report to Medicare any payment made to a Medicare beneficiary. When combined with the Medicare Secondary Payer (MSP) law—a statute, largely ignored, under which liability insurers could end up paying a Medicare beneficiary’s healthcare expenses twice, once to the beneficiary and once to Medicare—the reporting requirement posed numerous problems for many parties.

Congressman Murphy’s bill was designed to ease this burden by, among other things: establishing a threshold for claims that did not have to be reported, making reporting penalties discretionary, and giving reporting entities the ability to request information about any repayments. Despite its common-sense approach to many MSP issues, the bill languished in committee for the remainder of the year.

After Patrick Murphy’s defeat in the 2010 elections, Tim Murphy assumed a new role as lead sponsor of the bill, and he was joined by Democrat Ron Kind of Wisconsin. The bipartisan nature of the bill survived the change in congressional leadership that ensued in the wake of the 2010 elections. With a newly redrafted bill (which addressed several problematic elements in the original version), everything was in place for another effort to address insurers’ concerns.

**112th Congress**

The bill was introduced on March 14, 2011 in the new Congress, with a new number (H.R. 1063) and a new name (the Strengthening Medicare and Repaying Taxpayers [SMART] Act). Now, there was greater momentum for passage...
of the bill. By the time the Energy & Commerce Committee’s Subcommittee on Oversight and Investigations held a hearing on MSP issues, in June 2011, 22 members of Congress had become cosponsors of the bill.

The sole purpose of the hearing was to gather information; it wasn’t focused on any particular piece of legislation. But the need for H.R. 1063 quickly became evident. Then-Subcommittee Chairman Cliff Stearns (R-FL) castigated the Centers for Medicare & Medicaid Services (CMS), asserting that its bureaucracy harmed both injured parties and insurers. Members of the committee were quickly frustrated when the government witnesses were unable to answer questions about key issues such as the dollar value of the MSP claims that CMS reviews, and how long it took CMS to respond to any inquiries about the value of healthcare services that was owed to Medicare.

Private sector witnesses (representing a range of interests, from insurers to personal injury lawyers) provided many examples of the difficulties they face in dealing with CMS’s regulatory regime. There was one positive aspect in all this, however: the witnesses all agreed that it was possible to make fixes to the system, and that these changes could be made in a way that would satisfy all of the parties in a liability claim. The PIAA joined in the consensus, in a written statement submitted to the subcommittee.

At this point, the need for a legislative fix was eminently clear, and congressional support grew rapidly. In the ensuing months, support for the bill was evidenced in the swelling number of cosponsors: to 140.

**Action**

While behind-the-scenes efforts to move the bill forward picked up after the hearing, many months would pass before further congressional action would take place. Eventually, in September 2012, the House Energy and Commerce Subcommittee on Health held a markup early that month. After statements from both the chair and vice chair of the subcommittee praising the bill, it was unanimously approved. A little more than a week after that, the full committee approved the bill, with no dissent.

Before it arrived in the full House of Representatives, H.R. 1063 was combined with the aforementioned H.R. 1845 (now renamed as the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act), to expedite the process of approval for two widely endorsed Medicare proposals. After a brief debate, on December 19, the House passed the new bill, by a margin of 401-3, before sending it on to the Senate. That chamber didn’t need a roll call vote: it approved the bill two days later, by unanimous consent. It was then sent to the White House, where President Obama signed it into law on January 10, 2013.

**A new law**

In its final form, Title II of H.R. 1845 contains five major elements. First, it gives beneficiaries, their designees, or the insurer (if approved by the beneficiary) access to Medicare payment information within 120 days of the “reasonably expected date of a settlement, judgment, award, or other payment.” CMS is required to make all appropriate information available on the Internet, and the total dollar amount noted on the designated website, “within 3 business days before the date of the settlement, judgment, award or other payment shall constitute the final conditional amount subject to recovery” by CMS.

Second, under the new law, CMS must establish an appeals process for any insurer that wants to challenge Medicare’s effort to seek repayment for any medical item or service provided to a beneficiary involved in a liability lawsuit. Third, it establishes a repayment threshold that is equal to what it would cost Medicare to recoup funds it is owed. That amount then becomes (1) the minimum amount for which the government is able to seek reimbursement for healthcare goods and services and (2) the reporting threshold for entities that are required to report to CMS under the mandatory reporting requirement. Fourth, under the law, the $1,000-per-day penalty for failing to meet the reporting requirement, formerly mandatory, became discretionary, so that penalties would not be levied against those who had made a good faith effort to comply with the appropriate guidelines. Fifth, beginning in mid-2014, the reporting requirement will be modified: reporting entities will not be required to provide either the Social Security or the Medicare number of the beneficiary named as the subject of the report.

**Conclusion**

Some elements of the MSP and Mandatory Reporting Requirement programs still aren’t perfect, but the Strengthening Medicare and Repaying Taxpayers Act provides much needed improvements to both systems. It also provides reason to hope that Congress may be able to work together, in a bipartisan fashion, to achieve a mutually beneficial goal. As the role of government in our healthcare system continues to expand, this victory for liability insurers may well serve as a precedent for future victories.
The Opioid
During the past decade, the United States has witnessed an alarming increase in the use of opioids. Today, Americans, who represent just 4.6% of the world’s population, consume 80% of the global opioid supply, 99% of all the hydrocodone, and two-thirds of the world’s illegal drugs, overall.\(^1\) According to the U.S. Centers for Disease Control and Prevention, deaths from an overdose of opioid pain relievers now exceed the number of deaths linked to heroin and cocaine, combined.\(^2\) In 2009, drug-overdose deaths actually surpassed the number of deaths from motor vehicle accidents, for the first time since the government began tracking drug-related fatalities in 1979.

In his November 15, 2012, CNN special “Let’s End the Prescription Drug Death Epidemic,”\(^3\) Dr. Sanjay Gupta noted that one American dies every 19 minutes from an accidental overdose. And the most vulnerable members of our society have been particularly affected: the number of newborns with neonatal abstinence syndrome (NAS) has tripled in the last ten years, because more and more pregnant women are abusing opioids.\(^4\)

Here, we investigate why we’re seeing a surge in opioid use, and then offer some heartening news: physicians, law enforcement agencies, attorneys general, and organizations are all working to combat this alarming epidemic. However, doctors and the companies that insure them will need to keep a close eye on an emerging phenomenon: an increase in claims wherein a physician is held to be responsible, at least in part, for the drug-related death of an individual.

**States and federal agencies fight back**

In June 2011, Florida Governor Rick Scott signed the Anti-Pill Mill Bill (HB 7095) into law. Championed by Florida Attorney General Pam Bondi, the bill toughened criminal and administrative penalties for doctors and clinics that traffic in prescription drugs. The bill establishes standards of care for doctors who prescribe narcotics, requiring them to register with the Department of Health, while banning doctors from dispensing the most frequently abused narcotics.

For pharmacies and wholesale distributors, the bill toughened oversight and strengthened the effectiveness of the prescription drug database, by decreasing the amount of time allowed for entering required data on pain medications. Attorney General Bondi’s Pill Mill Initiative website describes Florida’s Prescription Drug Diversion and Abuse Roadmap (2012–2015) and discusses the drivers that led to the crisis. It explains the role of the Statewide Drug Task Force, Regional Strike Force Co-Chairs, drug courts, and the state’s program for substance abuse treatment.\(^5\)

On June 11, 2012, the State of New York passed the Internet System for Tracking Over-Prescribing Act (I-STOP), the first law in the United States to mandate that physicians consult a database of a patient’s prescription history before prescribing a controlled substance. Introduced by Attorney General Eric T. Schneiderman, the bipartisan legislation passed by an over-

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whelming majority in the Assembly (116–0) and in the Senate, by 58–0. By requiring doctors and pharmacists to report and track controlled narcotics in real time, I-STOP focuses on preventing doctor shopping and stolen or forged prescriptions. It eliminates automatic refills for hydrocodone, and includes provisions aimed at reducing the number of patients addicted to painkillers.

On June 26, 2012, West Virginia Attorney General Darrell McGraw filed a lawsuit against pharmaceutical drug distributors. In the complaint, West Virginia noted that medical providers, pharmacies, and distributors of controlled substances cost West Virginia hundreds of millions of dollars, every year. The complaint also noted that defendants acted negligently, recklessly, and at times illegally—all in contravention of West Virginia law. The lawsuit has definitely raised eyebrows among pharmaceutical distributors and their insurers.

In October 2012, Tennessee district attorneys kicked off a statewide campaign, Deceptive Danger, to combat the increasing use of prescription medication and synthetic drug abuse among the state’s youth. The campaign includes an educational outreach effort for public middle schools and high schools throughout the state.

Across the country, the U.S. Drug Enforcement Administration (DEA), along with state and local agencies, is aggressively prosecuting individuals who prescribe opioids illegally and those who operate “pill mills.” In some cases, doctors, physicians, nurse practitioners, and pharmacies have been compelled to surrender their federal licenses to dispense controlled substances; in more serious cases, they’ve had to forfeit their medical licenses to state medical/pharmacy boards. The DEA has also begun to revoke the registration of some pharmacies, banning them from selling controlled substances like OxyContin, Vicodin, Ritalin, and Xanax.

Physicians and medical boards taking action
Physicians and medical boards are also attacking the problem. The Federation of State Medical Boards provides guidance to physicians on the responsible prescribing of opioids. The website www.fsmb.org/pain-resources.html provides links to resources from federal and state governments, medical-specialty society sites, educational materials, pain assessment tools, treatment consensus statements, guides, and guidelines.

The mission of Physicians for Responsible Opioid Prescribing (PROP) is “to reduce morbidity and mortality resulting from prescribing of opioids and to promote cautious, safe and responsible opioid prescribing practices.” Their website, www.supportprop.org, provides an opioid-prescribing guide called Cautious, Evidenced Based Prescribing, which documents the myths vs. facts about chronic opioid therapy, and lists the dos and don’ts for acute pain management and chronic pain management. The site also provides educational videos, links to other websites, and news stories on opioid prescribing and the opioid-abuse crisis.

The number of physicians who’ve had their license suspended by state medical boards for unlawful distribution of controlled substances and prescription drug fraud is on the rise. Medical boards are actively addressing the inappropriate and illegal prescribing of drugs. With more stories making the news about doctors forging prescriptions, becoming illegally involved with pain clinics, creating fictitious patients, not taking preventive steps on behalf of patients dying from overdoses, not checking into patients’ history of prescription drug use, and more, it’s clear why medical boards have been compelled to take action.

Insurance companies
The State of West Virginia’s lawsuit against pharmaceutical drug distributors is already impacting insurance companies, as distributors look to their commercial general liability and commercial umbrella policies to pick up the costs of defending against the lawsuit. However, some insurers, like Cincinnati Insurance Company (CIC) are making sure that policyholders understand what their policies do and do not cover. In its October 2012 Complaint for Declaratory Judgment against their insured, CIC documents why the insurance policies they issue do not require that a company defend or indemnify the insured. The 23-page
document walks the reader through CIC’s policy language, specifically addressing items such as the insuring agreement, the definition of an occurrence, and the definitions of bodily injury and property damage; it also provides details on when the insurance protection does not apply.

With prescription drug costs accounting for approximately one-fifth of all workers’ compensation (WC) medical expenses, WC insurers are doing more to control the cost of these drugs. They’ve been setting up comprehensive prescription drug networks, supporting tort reform efforts, promoting evidence-based pain diagnoses, performing utilization reviews, weaning injured workers off of addictive prescriptions drugs, and helping workers return to work more rapidly. The Pennsylvania Commonwealth Court issued a recent decision which found that an injured worker’s overdose is compensable under workers’ compensation coverage, J.D. Landscaping v. WCAB (Heffernan), so WC insurers will need to stay focused on what happens with policyholders’ opioid medications.

For the medical professional liability (MPL) insurers of physicians and hospitals, medication errors from faulty prescribing, incorrect charting of allergies, improper dosing, and poor handwriting have been around for many years. An analysis of 2,646 claims closed by The Doctors Company in 2011 revealed that 5.8% contained medication-related errors. These claims, 17.5% of which were related to narcotic analgesics, involved all of the medical specialties. The errors identified in these claims include:

- Wrong medication (32%)
- Monitoring errors (21%) (most involved Coumadin, Lovenox, and Gentamicin)
- Wrong dosage (17.5%)
- Failure to follow guidelines or protocols (13.5%)
- Drug administration errors (10%)
- Ordering errors (6.5%).

With the expanding use of electronic medical records, computerized physician order entry, risk management training, and government efforts, there’s been some progress in reducing medication errors. However, the impact of opioid addiction, on both patients and their families, is just beginning to emerge as a cause of action in MPL claims. With the news media shining a bright light on hospitals and physicians, we may see more lawsuits for wrongful death, for physicians’ prescribing patterns that are allegedly conducive to drug addiction, and improper supervision of mid-level healthcare professionals in the very near future.

In December 2012, Newsday.com reported that Long Island State Supreme Court Justice William B. Rebolini is allowing the family of a victim in the deadly Haven Drugs pharmacy robbery to proceed with a wrongful-death lawsuit against the doctor who prescribed the shooter’s prescription medication. The judge stated that “a medical provider may owe a duty to protect the public from the actions of a drug addict, and he may be found to have breached that duty if he creates or maintains the addiction through his own egregious conduct.” Even though the victim is not the doctor’s patient, the doctor’s role in overprescribing pills to the pharmacy shooter may create a duty to protect the public from the actions of a drug addict.

It will be important for MPL insurers to monitor cases like the Haven Drugs pharmacy robbery. Could this ruling signal an emerging trend toward broadening the scope of what constitutes a physician’s duty in opioid prescribing? As courts across the country add further clarification about the physician’s role in protecting patients and the public from opioid addiction, insurers should take advantage of federal, state, and physician efforts like PROP for ongoing education of their insureds on new opioid-related laws and court cases, as well as strategies for minimizing risk, such as the Food and Drug Administration’s Risk Evaluation and Mitigation Strategy (REMS).

Physicians in a dilemma

The vast majority of physicians are first committed to caring for their patients according to the Hippocratic maxim, “First, do no harm.” Most physicians are well aware that some addicts will do
just about anything to get drugs, and they will make it as difficult as possible for these addicts to gain access to opioids. Otherwise, they do harm to these addicts by feeding their addiction.

It is not always apparent, however, which patients have a legitimate need for pain control vs. those who are merely feeding an addiction or want the drugs for later resale. There is no test that is 100% accurate in identifying the motivation of those who request strong drugs like opioids in an office visit. The physician must decide based on the personality and history of the patient in front of him, and use his best judgment to determine whether the patient has a legitimate need for pain control and, if so, if an opioid is appropriate. On one hand, denying a legitimate need for pain control harms those patients who really are in pain. On the other, feeding opioids to an illicit drug seeker harms him, by enabling his illicit and self-destructive activity.

Deciding where to draw the line can be very difficult; in many cases, the physician is caught in a “damned if you do, damned if you don’t” dilemma. Education may be helpful, but physicians have been wrestling with the question of just how to differentiate patients with valid requests for pain medication from those likely to abuse these drugs, ever since their medical school days. So mandating additional training may be considered unnecessary and burdensome: just look at some of the reactions posted on the American Academy of Family Physicians website to the notion of mandatory CME.

In contrast, the methods and databases that enhance a physician’s ability to filter out drug seekers from patients with legitimate needs are welcomed by physicians when they are convenient and add new knowledge. As the federal government, MPL insurers, and boards of medicine all look to find better ways to help physicians sort through this dilemma, they need to bear in mind that, in the vast majority of cases, the problem lies with the addiction per se, and the individuals who are trying to get access to opioids. Pain Physician, March 2008.

References

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Conclusion
So, while the United States has admittedly seen an epidemic in opioid abuse, substantiated by the sobering statistics presented in the article, the tide seems to be turning:

- **States** are passing new laws, imposing stiffer penalties, educating citizens, and coordinating with federal agencies, in order to prosecute wrongdoers more aggressively.
- **Medical associations and medical boards** are educating their members, encouraging the practice of well-informed pain management, and suspending the licenses of physicians and clinics who abuse the trust of patients.
- **Physicians** are recognizing the importance of pain management through educational campaigns, training, and the efforts of organizations like PROPs.
- **WC insurers** are taking good advantage of states’ efforts, evidenced-based guidelines, utilization reviews, and pain management specialists to help injured workers.

However, given the relentless coverage of the opioid abuse epidemic by the news media, the states, medical boards, judges, and jurors are increasingly likely to find individual physicians, pain clinics, distributors, and insurance companies culpable for this epidemic. The time is now: everyone involved in prescribing for and managing pain should take another hard look, to see how they can help in resolving this crisis. For related information, see www.deloitte.com.

For background information on the problems of drug diversion and neonatal abstinence syndrome, see www.piaa.us.
Navigating the Decisions of Self-Insurance Financial Reporting

A primer for MPL carriers looking to new markets and for self-insurers

With the growth of self-insured entities, and as medical professional liability (MPL) carriers look to expand with new products and services, such as consulting services, Physician Insurer will offer some timely guidance for working in these new markets. Here, we present some expert advice for avoiding the major pitfalls in accounting for self-insured entities.

The speed of change in healthcare has amplified to an unprecedented rate. With healthcare reform, increased merger and acquisition activity, expanding regulatory compliance requirements, and continued downward pressure on reimbursement and margins, healthcare management is faced with difficult challenges and decisions on a daily basis. In addition to these and other issues, hospital and physician group practice management may also be concerned about increases in MPL insurance costs with the next renewal cycle.

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Self-insurance, in the form of a large retention program or a captive, has historically been used to help control total insurance expense. However, when you’re focused on addressing day-to-day operating challenges, it may be difficult to stay up-to-date on the requirements for financial reporting of self-insurance, and the decisions about it you need to make. This article provides background, insight, and guidance into some of the core issues that come up frequently, in regard to financial reporting for MPL self-insurance programs.

**What are the common program decisions in financial reporting?**

Many self-insured programs in the United States comply with the guidance and standards for accounting and financial reporting for MPL established by certain sections of the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). Programs with captives should ensure compliance with the guidance and standards that are generally accepted in the domicile of the captive.

Non-governmental healthcare entities should follow the guidance contained in ASC Section 954-450, Contingencies, while governmental healthcare entities should also consider the requirements of Governmental Accounting Standards Board Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*, as amended. In accordance with ASC Section 954-450, healthcare entities should accrue for the best estimates of the ultimate costs of MPL claims, including the amounts needed to litigate or settle such claims, when the related incidents occur, as of the reporting date, if the related loss is probable and reasonably estimable.

ASC 450-20-50 requires disclosure of the carrying amount of discounted accrued MPL claims and the interest rate(s) used to discount the claims. There is some diversity in the approaches used to select discount rates. Common among these are: (a) the return on investments used to pay the claims expected to be realized over the period during which the claims are expected to mature; (b) a risk-free rate; and (c) the rate paid by highly rated corporate bonds with maturities matching the average length of an MPL award payment. The selected discount rate(s) may need to be adjusted for the impact of expected changes in future economic conditions.

**Percentile.** While many companies outside the healthcare industry do not record liabilities with a contingency margin, it is not uncommon for healthcare entities to evaluate MPL liabilities at a percentile, such as the 75th percentile. ASC 954-450-25 indicates that the liability recorded is independent of funding considerations, which may include the adjustments needed to bring a funding requirement to a selected confidence level.

The definition of “best estimate” is not specifically provided in ASC 954-450-30, but it indicates that the entity should use all relevant information, including the entity’s own historical experience, as well as the experience of the industry as a whole. The actuarial central estimate is often considered as the “best estimate,” and does not explicitly include a contingency margin.

**Gross vs. net presentation.** In August 2010, FASB issued Accounting Standards Update (ASU) 2010-24, *Healthcare Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries*. Effective for financial statements with fiscal years, and interim periods within those years, beginning after December 15, 2010, ASU 2010-24 requires that healthcare entities report MPL and similar liabilities on a gross basis, reporting separately any receivable related to anticipated insur-
ance recoveries.

While early adoption was permitted for this standard, many healthcare entities have only recently reflected the change in their financial statements. ASU 2010-24 reduces the diversity in practice related to healthcare entities’ reporting of MPL claim liabilities and related anticipated insurance recoveries, and does a better job in reflecting the exposure of the healthcare entity to credit risk from the insurer: the healthcare entity generally remains primarily liable for payment of claims until the insurer makes payments. For most entities that have adopted ASU 2010-24, there has been no net impact on financial statements.

In October 2012, the AICPA issued four Technical Practice Aids (TPAs) that provide clarifying guidance for ASU 2010-24. These TPAs:

- Clarify that the guidance in ASU 2010-24 would apply to other contingent liabilities that are similar to those of MPL, such as workers’ compensation and directors and officers claims
- Clarify that the adoption of ASU 2010-24 would not affect an entity’s accounting policy for legal costs for contingencies other than MPL
- Address the presentation of insurance recoveries in instances when the insurer pays the claims directly
- Address accounting for insurance recoveries under retrospectively rated policies.

**Accrual.** Its managers determine whether a company will provide for self-insured losses, and, if so, how much, but adequate reserves must be recorded as of a specific financial reporting date. The interpretation and application of an “accrual” varies in practice, according to the judgment of the healthcare entity’s managers. A common application is the contribution amount (or expense provision) for the next fiscal or policy year of exposures. The new occurrence-year contribution (expense provision) minus total payments for the program during the year provides a quick estimate of the change in liability during the fiscal year. You can also think of an accrual as the change in unpaid claim liability estimates during the fiscal year. Similarly, you can also add the payments made during the year to the change in unpaid claim liability as a total expense. While the interpretations may vary by application, the core elements remain similar.

**Other considerations.** You may want to get some guidance from an actuary or auditor for booking a liability within a range and then determining the acceptable range, the impact of large losses in unpaid claim liability estimates, reconciling data, the degree of credibility you have in your loss development, and emerging trends. The managers of captives can also help in working through some of the particular requirements of a specific domicile, and even with on-site meetings.

**How can you best ensure that the program is compliant?**
The following practices will help in keeping on the right course toward full compliance in financial reporting.

- Update the key parties whenever you make changes.
Frequent conversations are beneficial. At minimum, you should have annual conversations with the actuary and auditor. If changes occur, in either the program or your loss experience, it is important that all parties understand all of the program changes that have been enacted by management, as soon as possible. Table 1 shows some common questions.

- **Create a checklist of requirements.** The best way to stay “on top” of the requirements may be to use a single source that lists all of the requirements and indicates when each is due. In addition, it may make sense to determine who will complete each task and to have a strategy in place for efficiently completing the task.

- **Seek timely advice.** Guidelines are best interpreted by experienced professionals who have the skills needed to understand the current practices and communicate any change from the past. Auditors and actuaries make every effort to update management on a timely basis of any changes that would affect the financial reporting of the entity’s liability, but you can help out by proactively asking for advice for any changes you find out about.

- **Request more frequent evaluations.** When a program experiences adverse or favorable loss activity or undergoes multiple changes during a fiscal year, you can always ask for an interim actuarial study. You’ll need to determine your comfort level with the program’s current amount of activity, with the goal of reducing year-end “surprises.” Additional analysis may also be helpful during an audit.

- **Obtain an outside opinion.** If you don’t have sufficient confidence in the current direction of the program, you can request a second opinion, from an outside actuary. This additional guidance will provide an unbiased, independent estimate or interpretation, and may provide confirmation of the program—or at least stimulate a productive discussion for understanding the underlying reasons for the differences.

There should be a plan in place for handling any changes in financial reporting during the year, whether due to changes in loss experience or updated accounting guidance. The benefits of a strong working relationship between a company’s managers, actuary, and auditor should not be underestimated. All three must work together effectively, and understand each other clearly, to add value and insight, and best meet the financial-reporting needs of the healthcare entity.
Today, with medical professional liability posting loss ratios in the 50s, and in a political environment leaning more to the left, I don't really see much opportunity for traditional tort reform. By this I mean caps on non-economic damages. But that doesn't mean that states' legislators are not still interested in medical malpractice.

The goal of new reforms is containment of costs—but also fairness. Many of the ideas have really germinated from the patient safety movement, and they are centered on restructuring the patient-provider relationship. They include disclosure and apology, and also use root cause analysis to further learning from what has happened.

The cost savings come from reduced litigation, but really, it's the defensive medicine costs that legislators are focused on. This is what they're trying to unlock right now.

And fairness is an issue that is popping up in Texas right now: patients need access to compensation. Another prime issue is shortening the time that it takes to settle.

**Massachusetts**

So I would like to talk about a couple of states in particular. In August 2012, Massachusetts passed a healthcare law. One notable element in the law is what has been called "the disclosure, apology, and offer approach to medical malpractice." Massachusetts legislators believe that an apology by healthcare providers can prevent a lawsuit. They are requiring a 180-day period of communication between the provider and the patient. They call that the "cooling-off period." The cooling-off period is designed to give the provider time to disclose the event, offer an apology, convene a root cause analysis, and negotiate compensation.

Now, patients still have access to the courts to pursue a tort action, after the cooling-off period. But the apology then would be inadmissible in court.

**New Hampshire**

Also, this past summer, New Hampshire passed legislation, overriding the governor's veto in order to pass "The Early-Offer Alternative." This “alternative” is optional. And it's similar to the
Massachusetts law. However, here, access to the courts is not in any way restricted. The patient has the option to bypass the early offer and go straight to the courts.

But for the patients who do take the early-offer option, the new law provides detailed procedures, and it outlines the responsibilities of the patient and the provider: guidance on how to negotiate a payment. I think what’s really interesting here is the concept they have of “additional payment.” They have a table of additional (non-economic) damage payments, which are tied to the type of injury and the type of harm.

So when a patient in New Hampshire is considering the alternative, they can make a decision in terms of what they can expect. And that would be on top of the more typical things like lost wages and other economic losses.

**Oregon**

Turning to Oregon, in 2013, MPL reform is a priority. And they’re also talking about an early-discussion and resolution type approach. But they’re also introducing the concept of mediation, so that’s a little bit different from what Massachusetts and New Hampshire are doing. Again, though, what happened in mediation would be inadmissible in court.

So you can see, in Massachusetts, New Hampshire, and Oregon, legislators are trying to create an alternative path to resolution, but still preserving access to the courts.

**Florida**

Florida is going in a different direction. They’re debating a House bill that proposes a patient compensation system aimed at replacing the current MPL litigation system. The patient compensation system has goals of reducing defensive medicine and increasing patients’ access. It’s similar to workers’ comp.

When the patient interacts with the system, they apply and get assigned an advocate to help them navigate the system. There would also be an independent medical review panel that examines the claims for their merits, and a compensation department would be established to recommend compensation, based on schedules. An administrative law judge would be involved to ensure fairness, and a quality improvement council would be designed to develop the root cause analysis, and to establish best practices.

So one of the things that’s interesting about the patient compensation system is the definition of “medical injury.” In the tort system, “negligence” is the standard language. But in the patient compensation system, “medical injury” is used instead. Presumably, this is a little bit broader than the concept of “negligence,” but also more restrictive than no fault.

The “medical injury” standard is something that would have to be worked out. But it would be designed to provide compensation to patients who had a medical injury that could have been avoided, under the care of an experienced practitioner. So it’s sometimes referred to as “avoidable harm.”

So, to conclude: the first wave of these legislations are really centered on restructuring the provider-patient relationship, after the medical injury. Cost reduction is central to all of these laws, and they’re talking about the defensive medicine aspect of it as well.

It will be interesting to see if the structured provider-patient relationship approach is enough to alleviate the providers’ fear of litigation. It seems as if the patient compensation system might be the best to address this fear of litigation.

**Also: fallout from the ACA for MPL**

In the pre-ACA environment, it was reasonable to presume that a client would be unable to purchase health insurance after a medical malpractice event. The injuries from the medical event would typically be enough to trigger policy limitations, or even rejection, as a result of pre-existing conditions.

As a result, future medical expenses frequently made up a large portion of an MPL settlement. Future medical costs were problematic, because they are very hard to predict. And access to the medical system is often the claimant’s biggest concern.

So cost estimates presented in settlement negotiations were often the worst-case scenario.

Under the ACA, with no pre-existing conditions, no medical underwriting, no lifetime maximums, affordable premium, and a maximum on out-of-pocket expenses, one could argue that an injured party will always have access to health insurance at an affordable cost.

So the total for the health insurance and the out-of-pocket expenses are now likely to be significantly below the worst-case scenarios for future medical expenses that were calculated in the pre-ACA courtroom setting.

Further, the new individual mandate requires that everyone purchase insurance, or face a penalty, and a medical malpractice settlement really won’t change that legal obligation. It’s really not limited to medical malpractice. Auto injuries and workers’ comp would be the same.

So if it’s supported by courtroom decisions, the ACA could have the unintended consequence of dramatic savings for MPL insurers, through reduced costs of future medical expenses.

Several people have been thinking about this. I read one paper where the authors concluded that the ACA could end up being the most effective tort reform ever implemented. So this is a developing situation right now, and I think it will be very interesting to see how the courts interpret this line of argument.

But it’s certainly something that providers and defense lawyers should be considering in medical malpractice.
During the crisis years of the 1980s, states adopted a variety of tort reforms, all meant to preserve medical professional liability (MPL) coverage at reasonable prices. In different states, there were various combinations of legislative innovations, such as caps on non-economic damages, changes in joint-and-several liability, pre-litigation screening panels, and revisions to common law collateral source rules.

Among the most intriguing, and potentially promising, of these reform proposals was Maine’s Medical Liability Demonstration Project. The Project advanced the notion that clinical guidelines, fashioned by medical experts and adopted by state medical boards, could serve as an affirmative defense. As long as a provider could show evidence that he had followed the protocols expressed in the guideline, he would be out of the case.

At the same time, the State of Maine was working to find practicable reforms to stem the ever-escalating cost of health insurance. The proliferation of defensive medicine was clearly one culprit in
higher costs. And during the same period, new research had revealed disparities in patient outcomes, along with a notable divergence in physician practice from specialty to specialty and region to region that was quite possibly linked to these disparities.

So, while the guidelines were certainly intended to provide some measure of relief to physicians strapped by MPL costs, they also seemed to hold promise for stemming health insurance costs and promoting greater consistency in patient outcomes.

The other reforms in Maine

There were three prior rounds of tort reform before the Medical Liability Demonstration Project was enacted. Notably, a system of pre-litigation screening panels for MPL cases was introduced. The panel process, mandatory unless waived by all of the parties involved in an action, has proved effective in lowering defense costs and speeding up time to resolution for claims. In 2008, the American Medical Association reported that Maine's system showed a decided advantage, compared with that in Virginia (a voluntary screening law) and that in Florida (no screening law). Claims without payment made up 84.1% of the total in Maine, versus 75.9% in Virginia, and 31.6% in Florida.1 Average total claims costs were $82,287, $144,174, and $782,686, respectively.

During the same legislative session that gave rise to the Demonstration Project, there was considerable floor debate about the adoption of a cap on non-economic damages and the impact of changes in collateral-source rule reform. The cap never made it out of debate, but Maine does have law on its books under which MPL awards are offset by collateral payments “where the collateral sources have not exercised subrogation rights within 10 days after a verdict for the plaintiff.”2

While the Medical Liability Demonstration Project was never put to the test, because not one defendant ever invoked the guidelines-based defense during the years it was in effect, prelitigation screening panels and reform of collateral source rules have proven their value, by virtually every measure.

Daniel Kessler, a Senior Fellow at the Hoover Institution, groups caps and collateral source rule changes into a single category, “direct reforms.”3 These, he says, directly reduce expected MPL awards, and thereby dampen what Kessler terms “malpractice pressure,” which includes claim frequency, payments to claimants, and MPL premiums. These he contrasts with “indirect” reforms, notably limits on joint and several liability and the imposition of mandatory periodic payments. For these reforms, there is only inconsistent evidence of an impact on liability and therefore on malpractice pressure.

Nineteen guidelines

Convinced that physician practice guidelines could work to pro-
mote high quality healthcare and lower costs in Maine, a coalition was formed for the sole purpose of designing a plan to achieve this goal. The fruit of their efforts was a proposal known as the Medical Liability Demonstration Project. The Project advanced a legislative agenda that would insert physician practice guidelines into Maine’s MPL proceedings. It specified the drafting of “risk management protocols ... designed to avoid malpractice claims and increase the defensibility of the malpractice claims that are pursued.” An ancillary goal was to “help to reduce the costly battle with experts that often occurs in malpractice cases.”

The original proposal would have granted immunity to physicians who adhered to the guidelines, but that was revised to the concept of an affirmative defense, perhaps because the Judiciary Committee of the Maine legislature was simply not comfortable with the concept. Immunity is generally reserved, in Maine, for certain protected government officials.

Here is official statutory language on the affirmative defense: “In any claim for professional negligence against a physician ... in which a violation of a standard of care is alleged, only the physician or the physician’s employer may introduce into evidence, as an affirmative defense, the existence of the practice parameters and risk management protocols developed and adopted pursuant to section 2973 for that medical specialty area.”

Note that the guidelines could not be used against a physician—they would only come into play if a doctor invoked the affirmative defense. The trial bar, predictably, opposes all such legislation. The American Association for Justice website comments, “One-way use of guidelines raises fundamental issue of fairness and constitutionality.”

Four medical specialties were selected to take part in the project, based on the interest expressed by leaders in their state medical organizations. These specialties had widely accepted national guidelines in place prior to the beginning of the project. The first group was radiologists, eager to test the efficacy of new standards that had just been established by the American College of...
Radiology. The American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists had time-tested guidelines in place. Emergency room physicians were also included, based on the surprise that the ER was one site especially prone to defensive medicine.

The representatives of the specialties convened to decide which specialist guidelines in use at the time would be included in the Demonstration Project. This was an important decision: the guidelines accepted by the Maine State Board of Licensure would emerge as state regulations—thereby conveying on them the full force of law, if used in an affirmative defense against an MPL claim.6

In the end, a total of 19 guidelines were chosen. When the project got under way, in January 1992, there was modest reason to believe that an important new tool for streamlining the cumbersome and costly MPL process had been put into place.

Contents of guidelines: example
The guidelines for Ob/Gyn included ten detailed protocols that covered cesarean deliveries, hysterectomies, tocolysis, ectopic pregnancies, breech deliveries, perinatal herpes simplex virus infections, intrapartum fetal distress, and prolonged pregnancy.7

The guidelines included a caveat, however: an “extenuating circumstance” exception for cases where it was not medically necessary or appropriate to adhere to its provisions. The radiology guideline was more explicit: “The ultimate judgment regarding the propriety of any specific procedure or course of conduct must be made by the radiologist, in light of all circumstances presented by the individual situation.”8

And yet despite all of this effort and careful thought, not one case ever used the guidelines-based affirmative defense, right up until the year it was finally allowed to expire, 2000.

Why?
In an article published recently in the AMA’s Virtual Mentor, Gordon Smith, JD, executive vice president of the Maine Medical Association, analyzed the reasons why the project simply never gained traction.9

In the initial discussions for the project, defense lawyers had argued that it might not be possible to write protocols of sufficient scope to be acceptable to the medical profession, but also detailed enough to reflect the fact pattern in a particular MPL case. The fear that juries might think that the guidelines represented a “cookbook” approach to medicine was a problem, too. The innate conservatism of defense attorneys was an issue, and some were concerned that despite all of the work done to be explicitly clear about it in the statute—guidelines would somehow be used against physicians.

But perhaps the biggest issue, Smith contends, was that “all of the protocols put together did not touch a significant portion of medical practice.” He adds, “That being the case, it is not particularly surprising that no cases emerged.”

But something was gained
Still, the Maine Demonstration Project did serve some good ends. The guidelines were widely distributed, to all of the doctors in the covered specialties. Like any experiment, the project provided a controlled environment in which the power of a potentially valuable reform could be tested. In the years since the Maine project, the numbers of professional guidelines has grown exponentially. Most observers agree that physicians who adhere to protocols should be protected, at least to some extent, from assertions of medical malpractice.

And so Smith concludes, “The Maine Liability Demonstration Projects did not prove otherwise. It simply did not confirm that this treatment fits the diagnosis.”

References
Over the past 40 years, the medical professional liability (MPL) insurance market has fluctuated between two extremes—periods of calm, characterized by relatively tame cost trends and an ample supply of insurance capacity, and periods of crisis, exemplified by rising costs and a lack of available, affordable coverage from commercial insurance carriers. Over the last several years, the MPL market has been stable. However, several factors may converge in the near term to drive MPL costs up, pushing the market back into crisis.

An examination of historical trends in the MPL market, and the key drivers of MPL costs, provides a perspective on the challenging future landscape and overall health of the MPL market.

Current MPL environment

Since the peak of the most recent MPL crisis in the early 2000s, MPL claim frequency has stabilized and even declined in some periods. Claim severity has been benign, and increased profitability for MPL insurers has led to widely available insurance coverage at affordable rates.

Table 1 illustrates the “underwriting cycle” from an insurer-profitability perspective over the past 15 years. The combined ratio, calculated as a ratio of losses and expenses associated with writing insurance policies to the premium charged, provides a measure of the profitability of MPL insurance coverage. The “hard” market, running from the late 1990s to the early 2000s, follows the unprofitable years in which combined ratios rose significantly higher than 100%. At the height of unprofitability, combined ratios reached nearly 150%, indicating that insurers were paying nearly $1.50 in loss and expense for every dollar of premium collected.

Significant rate increases in the latter part of the hard market began improving profitability in 2003, and as loss experience improved over the subsequent years, the MPL line became profitable once again. As profitability improved, more companies began writing MPL coverage, leading to increased competition, which has further contributed to rates remaining affordable.

Between 2001 and 2005, two primary factors converged to improve MPL profitability to the level that has prevailed since that time. There was a shortage of MPL insurance: when St. Paul/Travelers left the MPL market in 2002, the remaining companies selling MPL were in a position to raise their rates. The other factor was state-level tort reform.

Although insurer combined ratios demonstrate that the market, as a whole, remained profitable through year-end 2011, and frequency and severity trends continue to be relatively stable, there are questions about how long the MPL market can sustain this level of profitability. MPL insurance coverage for the more recent policy periods actually may not be as profitable for insurers as the chart would seem to imply. The reason for the potentially misleading results is that, for policy years 2005 through 2008, insurers estimated reserves assuming that the adverse results of the preceding years would continue, because the impact of the various tort reforms was uncertain.

Results, as it turned out, were favorable, and insurers lowered their cost estimates accordingly. As a result, they “released reserves.” These reserve releases, on policy years 2005 through 2008 in particular, have more than offset cost increases relative to premiums in the recent policy years, as insurers began to decrease rates to retain or attract business. But as reserve releases run out, and insurers continue to decrease premium rates, the MPL combined ratio for commercial insurers will begin to rise.

The future of MPL costs

Two factors determine MPL costs: claim frequency (the number of claims filed and paid) and claim severity (the average dollar amount of each claim). Complex underlying phenomena lead to changes in claim frequency and severity; in Table 2, we provide examples of these potential drivers.

Because multiple economic, behavioral, and legislative factors
act together to affect claim frequency and severity, predicting these trends with any degree of certainty is exceedingly difficult. However, exploring several potential key factors, as discussed below, may provide insights into future MPL cost trends in the near and long term and allow insurers to respond proactively.

Challenges to state reform initiatives. Over the past several years, a number of challenges to the tort reform initiatives of the mid-2000s have emerged. In August 2012, for example, the Missouri Supreme Court overturned a 2005 tort reform provision that capped non-economic damages at $350,000, ruling the cap unconstitutional. Similar challenges currently before the supreme courts of Tennessee and Mississippi put non-economic damages caps in both states at risk of elimination and could represent an early sign of erosion of the broader tort reform initiatives implemented during the last decade.

In addition to a direct impact on claim severity, the erosion of non-economic damages caps may increase indirectly the number of lawsuits filed, due to greater incentive for the plaintiff’s bar to pursue MPL lawsuits due to the potential for larger awards.

Increased healthcare utilization. The U.S. Census Bureau projects that the percentage of the U.S. population 65 years and older will increase steadily in the near and long term (Table 3), with several implications for future MPL costs:

- An older population likely will lead to greater utilization and additional strain on the healthcare system, which could result in an increased risk of adverse healthcare outcomes and MPL claims.
- Like the U.S. population as a whole, the healthcare provider community is aging steadily. Without a significant growth in the influx of healthcare providers in training in the coming years, the number of healthcare professionals available to meet the increasing demand for services may not be able to keep pace with demand, further taxing the system and increasing the likelihood of adverse outcomes from.

**Table 2  Drivers of frequency and severity trends**

<table>
<thead>
<tr>
<th>Frequency Driver</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful tort reform (or rollback of</td>
<td>Increasing the burden of proof for plaintiffs—requiring them to prove the merits of their claim—may dissuade the filing of borderline injury cases.</td>
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<tr>
<td>previous tort reform)</td>
<td></td>
</tr>
<tr>
<td>Societal attitudes toward torts</td>
<td>The public may view large, notable jury awards as frivolous, which may lead future juries to react less favorably toward plaintiffs.</td>
</tr>
<tr>
<td>Shifts in physician behavior or practices</td>
<td>Increased utilization of the healthcare system may lead to increased reliance on physician extenders, such as physician assistants and nurse practitioners; to provide care and ultimately increase the incidence of injuries and claims. The introduction of an early ‘apology’ program could help to mitigate the likelihood of an injured party filing a lawsuit.</td>
</tr>
<tr>
<td>Changes in utilization of medical services</td>
<td>Increased utilization of medical services may lead to a strain on the medical system and healthcare providers and increase the likelihood of misdiagnosis, leading to MPL claims.</td>
</tr>
<tr>
<td>Changes in population demographics</td>
<td>An aging population increasingly will access the healthcare system with complicated medical issues, raising the potential for misdiagnosis, adverse outcomes, and more MPL claims.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity Driver</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>General inflationary pressure</td>
<td>The general cost of goods or services increases over time causing claim awards or settlements to rise.</td>
</tr>
<tr>
<td>Medical inflation</td>
<td>Over time, healthcare cost inflation impacts the cost to settle an MPL claim. For example, the cost to provide care to a patient permanently injured as a result of negligent medical care depends, in part, on future medical inflation.</td>
</tr>
<tr>
<td>Cost-shifting impact of Medicare liens</td>
<td>Historically, Medicare inadvertently paid some costs, associated with the future healthcare of a claimant over the age of 65, resulting from an injury sustained from medical negligence. In the last few years, Medicare has increased its diligence in seeking reimbursement for amounts paid for medical care that resulted from an insured injury. While the focus, thus far, has been on workers’ compensation claims, Medicare is likely to apply similar diligence to other coverages, such as MPL.</td>
</tr>
<tr>
<td>Societal attitudes toward jury awards</td>
<td>Societal attitudes can impact the size of jury awards significantly. For example, in an economic downturn, the amount that a jury views as a “large” award may be lower than the amount considered “large” during a thriving economy.</td>
</tr>
<tr>
<td>Successful tort reform</td>
<td>Placing caps on non-economic damages can reduce jury awards significantly.</td>
</tr>
</tbody>
</table>
medical services that may lead to MPL claims. Also, various aspects of the Affordable Care Act (ACA) will test the healthcare system over the next several years. The Congressional Budget Office projects a decrease of 14 million uninsured people under the age of 65 by 2014 and a 30-million-person drop in the number of uninsured people by 2022, as compared with the number of uninsured there would be if the ACA not been enacted. The introduction of the ACA may put additional strain on the healthcare system, creating the potential for adverse medical outcomes. A possible mitigating factor is the possible reduction in MPL costs resulting from better early diagnosis and prevention of potentially more serious (and complex) healthcare issues that could result from the expansion of primary care services.

Changes in physician and healthcare structure. The expected increase in healthcare system utilization, as well as certain provisions of the ACA, may lead to changes in the healthcare delivery model through expanded reliance on physician extenders, such as physician assistants and nurse practitioners. The Bureau of Labor Statistics projects that employment opportunities for physician assistants will grow by 30% from 2010 to 2020, compared with 14% projected overall job growth.

Filling critical shortages in primary care physicians over the next decade with physician extenders may reduce much of the strain on the healthcare system and therefore MPL claim costs. However, hospitals and supervising physicians will have to provide adequate oversight of physician extenders to avoid increasing MPL costs due to claims alleging negligent supervision.

MPL insurers are at a crossroads as the impacts of various stresses—including tort reform, healthcare reform, and an aging population—converge on the healthcare system. While industry combined ratios remain at a profitable level, insurers are likely to experience diminished profitability, as rates continue a gradual decline and the source of prior-year reserve releases becomes exhausted. How well the MPL insurance industry anticipates and proactively responds to these trends will go a long way toward determining the health of the industry over the next decade.

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- **Creating Social Media Prose: What Is Different and What Is Not?**—What is different about writing social media content? Traditional media is essentially a monologue, with the content pushed out. In contrast, social media is primarily created to build a community, to foster a dialogue, and to draw a targeted audience into your company’s orbit. This session offers a hands-on, practical approach to writing material for social media.

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- **Dental Trends Aren’t Very Interesting, Until They Get REALLY Interesting!**—The most important trends that now affect dentistry are revealed in this session. The speakers will explain “Baby Boomer” demographics and shifting patterns of care as well as the evolving trend towards group practice.

- **Generational Claims: Examining New Exposures**—This session will explore a typical claim from the vantage point of three generations of professionals: young practitioner, mid-level practitioner, and experienced practitioner. The claims used in the case studies presented will come from Dental Section member companies, and each will include an overview of the claim and a discussion of its key aspects.

- **Generational Claims: Risk Management Tips and Techniques**—In a follow-up to the previous session on generational claims, a risk manager will analyze the risk management elements involved in “generational” issues and offer tips, techniques, and insights for enhancing patient safety and mitigating loss.

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While the 113th Congress does have some new faces, many suspect that the new actions of the new Congress will not vary greatly from those of the 112th. However, for reform of the medical professional liability (MPL) system, that outcome might not be inevitable—not if a fresh approach and a new strategy are adopted.

In a recent webinar hosted by the PIAA, Steven A. Borg, Vice President, The Keelen Group, and James Wootten, Chairman, Partnership for America, discussed some possible components of a successful strategy, similar to what’s worked for other groups, that may achieve the long-elusive goal of comprehensive federal-level tort reform or at least elements thereof.

Borg: How to get “from politics to policy”
Stephen Borg underlined the critical problem for MPL reform in the U.S. Congress. Over the past decade, Congress did vote in favor of MPL reform measures, in bills that focused on provisions such as caps on non-economic damages. But both Democrats and Republicans had expressed interest in advancing MPL reform. Republicans had their “Pledge to America,” a roadmap for their upcoming work in the 112th Congress. Among other goals, the pledge asserted that, “We will enact common-sense medical liability reforms to lower costs, rein in junk lawsuits, and curb defensive medicine.”

And in his State of the Nation speech for 2011, President Obama had said that he was “willing to look at other ideas to bring down costs, including one that Republicans suggested last year—medical malpractice reform to rein in frivolous lawsuits.”

But as the months went by, the fortunes of tort reform fell on hard times. Efforts to win passage of HR 5 in particular failed in the 112th Congress, Borg says, because a “perfect storm” had gathered against it, in part because it was repeatedly included in discussions of repeal to the Affordable Care Act (ACA)—which thereby solidified it as a distinctly political issue. It has become a “wedge issue,” nearly as divisive as other hot-button issues like gun rights. Then, during the Supreme Court deliberations on the ACA and its subsequent upholding of nearly all of it,
Congress began to pull back from engaging on any aspect of U.S. healthcare.

Borg points out that although there aren’t many fresh faces in Congress, there are at least two new and vocally supportive advocates for tort reform in the House, both Democrats and both from California: Dr. Ami Bera and Dr. Paul Ruiz. And both sides of the aisle have expressed a willingness to tweak the ACA; tort reform might be on the agenda of possible “tweaks.”

Requirements for securing passage
There is no shortcut to gaining traction with a bill in Congress, no matter how soundly based and potentially beneficial it might be. Borg underscored that it takes many kinds of efforts, all in concert. For example, representatives from the PIAA and its member companies will need to sit down with Members and their staffs, to explain the MPL issue in detail, and discuss how it specifically affects their districts.

Borg provided webinar participants with detailed instructions in how to build the essential coalitions for advocating on behalf of a reform bill—for example, creating state-based coalitions made up of insurance companies, doctors, and patients. These coalitions can enhance the work done by the PIAA and its partners in creating awareness, and generating enthusiasm, for the bill.

Members of Congress need the right messages, and persuasive language, to see that tort reform is a win-win that will benefit both the public and healthcare providers as well as MPL insurers.

James Wootten: creating messages that work
Wootten pointed out one strong argument for pursuing federal tort reform is that state-level reform is somewhat in disarray, at this point. Many states have passed MPL reform in the last 20 years, but others have not been able to do so, because of the influence of personal injury lawyers. Some state supreme courts have nullified enacted reforms.

Meanwhile, conflict is becoming acute between evidence-based practice guidelines, reimbursement rules, and standards of care used in state court systems.

So, in looking to advance federal tort reform, what might be some essential elements in the requisite messages for Congress? Wootten sees some “common denominators” in prior successful reform campaigns. Among these, he says, are three: a widely appreciated consumer benefit, fairness, and sufficient backing by business interests.
HR 5, he says, does not achieve these. It is not seen as bestowing any discernible benefits to patients. Some provisions, such as the cap on damages for pain and suffering, have been depicted as unfair. He comments that, “The issue of caps on damages divides state and federal legal reformers, and also keeps potential Democratic allies in Congress on the sidelines.” One potentially powerful partner on behalf of HR 5, the trade association America’s Health Insurance Plans, has opposed HR 5, though, behind the scenes, because of its prohibition on subrogation.

A better plan

Instead of further expenditures on behalf of HR 5, Wootten advocates developing another sort of strategy, one that specifically includes a sophisticated, targeted approach to Democrats that will lead to sufficient bipartisan support to ensure passage of a reform bill. This requires a legislative product that will fit well with the strategy, and forethought on how to deal with any opposition that the strategy may generate.

During the webinar, Wootten told participants how to go about doing this. First, he notes, there are some excellent examples to emulate, reform efforts that successfully conveyed the first of the three common denominator objectives: benefit to consumers. For Bio-Materials, it was patients and their families that were the subject of messaging. For the Y2K program, it was small businesses.

In the instance of MPL, the reform messaging must stress the benefit to patients—not just doctors and other providers—namely, improved safety, greater access, lower cost, and heightened quality.

Benefits for patients and consumers

For illustrating one approach to gaining consumers’ appreciation of what’s at stake for safety in tort reform, Wootten cites the example of the U.S. Air Force in improving its safety record, faced with the loss of 1,214 of its airmen in 1952. Between then and 2002, the Air Force embarked on a program that entailed a constant learning loop, which comprised planning, briefing, executing, debriefing, and then incorporating the lessons learned into the next mission plan. He then raises the evocative question, “Imagine how that would work if at every step of the process the pilots were worried about getting sued, and that everything they said could be used against them in court, where the plaintiff’s experts on flying had a stake in the outcome?”

Wootten notes the stellar success of the feedback learning loops for the Air Force: by 2002, the number of airmen lost during the year dropped from the 1,214 of 1952, to only nine.
To help audiences understand what’s at stake in improving access, for the general public, Wootten says that advocates of tort reform can cite the impact of reform in Texas. There, the well-documented influx of doctors after the passage of reform is a highly visible benefit. There is also sound and substantial evidence that legal reform will lower the incidence of defensive medicine, thereby affording savings to both patients and the general public (via lower costs for healthcare and, potentially, health insurance premiums).

What is less well known, Wootten points out, is that California’s MICRA law was passed by emphasizing the essential role of reform for keeping open the state’s clinics for minorities, women, and immigrants.

For impressing the public about the savings that may accrue from tort reform, Wootten marshals the full roster of data elements that are often used only in isolation:

- The cost of medical errors ranges from $17 to $29 billion annually.
- The cost of unrealized savings from health IT is estimated at $77 billion annually.
- Defensive medicine costs some $100 billion to $200 billion, every year.
- The MPL system is estimated to have cost $29.4 billion in 2005.
- The Congressional Budget Office estimates that MPL reform (which includes damage caps) would save roughly $54 billion over ten years.

Wootten showed participants how to take a fresh look at the reform issue: how to discern what matters to the various stakeholders, how to craft messages that will resonate with each of these, and how to “work the legislature” in the most efficient way possible. The information is essential for PIAA companies, as they strive to gain passage of a bill that will bring real relief to the MPL enterprise.

Editor’s Note: This presentation was the first in the PIAA’s 2013 webinar series. Watch your e-mail and PIAA’s weekly electronic newsletter, Newsbriefs, or check the PIAA website for information on upcoming events.
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An explanation of the key terms in the financial statement known as the “Yellow Book”

This article is based on an actuarial review of the financial statement commonly referred to as the “Yellow Book” in the property/casualty insurance world. Here, I use illustrative results that are based on data that are fictitious, but nevertheless reflective of my analysis of numerous PIAA companies. The conclusions are typical of observations across many companies, and thus somewhat indicative of the state of our industry. The objective here is to explain some of the diagnostics created from the “Yellow Book,” along with observations on them, for an illustrative review.

Like a medical doctor, an actuary must identify a company’s concerns, diagnose the causes, and then recommend corrective actions. Similarly, our effectiveness often depends on our ability to communicate the results in a way that others can understand. Both medical and actuarial practitioners are frequently required to handle challenging and unpredictable situations—in many cases, with limited information to use in making key decisions.

Just as a patient benefits from a regular checkup, PIAA member companies would be well served to undergo regular preventive examinations by an actuary. While actuaries cannot claim to have saved lives, I view this exercise as a learning opportunity for a better understanding of the key intelligence on the financial health and well-being of a medical professional liability (MPL) insurance company.

In previous articles, I have provided some content for improving your operations, and your understanding of actuarial concepts as well. Since reserves and rates are critical to the financial results of any insurance company, a deeper understanding of your own reserve and rate adequacy can only be a good thing, and perhaps a necessary element in due diligence in management’s reporting to its board of directors.

I have broken down my analysis of “Yellow Book” concepts into the following categories:

■ Rate-level position
■ Current coverage year results
■ Reserving dynamics and trends.

Rate-level position
The best way to assess the rate-level position using a...
financial statement is to reference Schedule P of the “Yellow Book,” and I am grateful to the group responsible for getting Schedule P included in the Annual Statement, the NAIC. Without Schedule P, there would be very little in the way of comprehensive historical data, on a coverage-year basis, for performing this analysis. Viewing results on a coverage-year basis strips out the effect of prior years’ loss and ALAE reserve development, which, for PIAA members, has been significantly favorable, and it could be shielding us from recognizing mounting pressures on rate adequacy.

The first item to review is the year-over-year net earned premium, to look for patterns of decline or increase. A pattern of decreases would tend to raise the fixed expense ratio (the converse is also true), which directly impacts indicated rate levels. Therefore, simply reviewing the chart of net earned premium over time can yield insights into the rate-level position.

A second and more important metric to review is historical coverage-year ultimate loss and allocated loss adjustment expense (ALAE) ratios. In this case, a pattern of increases is again averse to maintaining adequate rate levels. Figure 1 provides the results, based on a hypothetical company, and this pattern is showing a marked trend of increases in the most recent coverage years, with a 25-point increase in the latest two years (from roughly 55% up to 80%). It is important to note that the data in Figure 1, and in a number of the subsequent charts, are likely impacted to a material degree by the rate-level reductions that most PIAA carriers have implemented over the past several years (in the form of manual rate reductions as well as increased premium credits).

Absent the actuarial reports, I am unable to explicitly quantify this impact, although in terms of overall direction, any rate-level reductions would tend to increase loss and ALAE ratios, as well as increase claims frequency (as measured in this article, because we do not have the full complement of data), all else being equal.

Nevertheless, rate reductions are in a sense equivalent to an increase in claims cost and/or frequency, in that all will move the ultimate loss and ALAE ratios upward and erode relative rate-level adequacy.

This type of trend in the underwriting results, as displayed in Figure 1, presents a threat to rate-level adequacy, with a 2011 loss and ALAE ratio likely at, or above, the pricing targets.

What caused this large increase, beyond rate reductions, becomes the next item to explore, and it will be presented in conjunction with the analysis of the current-year results. A final component to monitor is the indicated load for unallocated loss expenses (ULAE) that is included in the rates, and reviewing the pattern in the ratio of ultimate ULAE to earned premium will yield important information about the impact of this frequently overlooked component (Figure 2). For reference, the fixed nature of ULAE costs in relation to earned premium volume tends to result in an
increasing ratio in times of declining premium. The ULAE costs appear to be impacting rate adequacy, and overall, I conclude that a closer inspection of the actuarially indicated rate levels by management is warranted, to address concerns about rate-level adequacy.

**Current coverage-year results**

To gauge the current coverage-year ultimate loss and ALAE ratio, it is instructive to chart the historical initial loss and ALAE ratios, and then follow up with a breakdown of the trends in claims frequency and severity. Figure 3 presents these results for this sample company, and the most recent results stand out as deteriorating.

It is clear that either frequency or severity has taken a turn for the worse. First, Figure 4 displays the historical ratio of the number of reported claims (as of 12 months) to gross earned premium. While a better denominator for measuring claims frequency would be an exposure base, such as base-class-equivalent physicians, that information is not contained in the “Yellow Book.” In reviewing Figure 4, you see a generally stable pattern, with moderation in coverage-year 2011, so this factor would not be contributing to the deterioration in coverage-year results beginning with 2010.

Figure 5 provides insight into the trends in claims severity, and it is clear that severity is driving the poor results-to-date in the most recent coverage years. Fortunately, claims severity can moderate over the life of a coverage year, and there may be reasons to allay any concerns; however, without more
information, predicting future developments is purely guesswork. With the 2010 and 2011 average case reserve levels considerably higher than in the company’s prior history (as of 12 months of maturity), the first department to talk with would be claims. Perhaps, the recent batch of open claims happens to be more severe; if so, that fact would need to be directly considered in the actuarial estimates.

Alternatively, it is possible that case reserves are now being established in a different and more conservative way than in the past. If so, that factor would need to be considered as well, but the news for the company’s financial health would likely be better. The worst case scenario is that the claims department believes that the claims environment has deteriorated during the past two years, and now has concerns about the impact on open claims for older coverage years as well. This situation would then become an issue for both rates and reserves. It is also an enterprise risk and a real threat to the company. Once again, without any further investigation, we cannot get definitive answers to these challenging situations.

Reserving dynamics/trends

The final key area of financial results to explore is the dynamics and trends in the reserving process. The first step is to measure for any shifts in reserving philosophy with regard to posted loss and ALAE reserve developments. Towards that end, I have compiled Figure 6, which shows the percentage change in estimates, by coverage year, between 12 and 24 months after the initial estimates are made. All else being equal, one might expect a generally stable pattern in this ratio over time (although, in the MPL market, when is all else ever equal?). As Figure 6 shows, for this sample company, there are typically favorable (negative percentage) changes between 12 and 24 months.

However, coverage-year 2010 had more significant favorable development than the company has seen historically, and, for reference, we would see that the developments for coverage years 2009 and 2008 exhibit similar results. I do not believe that this is a result of the claims emergence, during the year, that was better than the historical average, and it would be worth inquiring about the sources/reasons for this reserve development.

Furthermore, one possible implication would be a shift in the relative reserve adequacy of prior years. Absent more information, it is difficult to speculate about the causes, although I believe it warrants discussion with an outside actuary. For the time being, it would be my responsibility to bring this to the attention of management.

While there are other meaningful diagnostics related to reserve position, you have to have the actuarial report to properly gauge the results and implications.

Conclusions

Don’t forget that actuarial reports provide for a fuller and more accurate review than you can get using only an Annual Statement. With this caveat, my overall conclusion is that rate adequacy is an area well worth further exploration, in light of increasing severity. Also, the unusually favorable reserve development during 2011 may have shifted the relative adequacy of the reserve position for this hypothetical company.
PI: Can you give us an update on the frequency and severity trends that you're seeing for MPL? One company recently reported that frequency is “better than expected,” and pegs the increase in severity at 3% to 4%.

Larson: To a great extent, we're seeing “more of the same” with respect to frequency and severity trends. Frequency, for both healthcare providers and institutions, has generally been flat over the last five to six years, after having dropped quite precipitously over the 2002–2005 timeframe. I think some carriers were expecting to eventually see an uptick in frequency, but we have not seen that; hence the reports of frequency being “better than expected.”

Severity trends have been fairly consistent for quite some time now, but at relatively moderate levels: 3% to 5% for healthcare providers and something a bit higher than that, 4% to 6%, for healthcare institutions. We've not seen or heard anything to date that would lead us to believe that there is any increased risk of significant pressure on those severity trends, at least in the very near term.

PI: Do you have any sense of what's helping to depress severity trends?

Larson: People who have looked back have had a difficult time explaining exactly why the frequency dropped off as much as it did in that 2002–2005 timeframe. Similarly, people don't necessarily have hard-and-fast answers for why the severity trends have moderated, other than that, in general, as you look at the last five to seven years, you notice that general inflation hasn't been that great. Also, interest rates have been decreasing and are now at all-time lows. So, to the extent that general inflation rates and interest rate levels are at all correlated with the awards typically given in MPL cases, that might help explain, to a certain extent, the moderated severity trends.

PI: Have there been any notable changes in large-loss trends or loss ratio trends? Some companies have noticed a trend toward “large losses.” Does that show up in your analysis?

Larson: With regard to a greater incidence of “large losses,” we've heard a bit of discussion from market participants about an increased awareness of the potential for “super” losses, but we've not actually seen any increase, per se, in the rate of incidence of these kinds of losses. We don't necessarily see any company with an explicit uptick in the frequency of those very large losses.

Looking at changes in loss ratios, the combination of moderate severity trends and continued rate decreases since the 2004–2006 timeframe means that loss ratios today are much higher than they were in the mid-2000s. As an example, a carrier that experienced a direct loss ratio of 55% in 2005 would today probably be expecting a direct loss ratio in the low 80% range, assuming that they've taken the same average price reductions over that time period as was taken by the industry. While the loss ratio deterioration from 55% to something in the low 80% range looks quite negative, a company with a direct expense ratio equal to the industry average, 21%, is probably still generating a small economic return from underwriting.

PI: Has recent competition in the MPL line been affecting pricing, from your vantage point?

Larson: Given the consolidation that has occurred over the past few years, you'd expect that there should be less competition in the market. And, typically, less competition translates into greater pricing power for the remaining market participants. So, based on this, you'd think that the market should be experiencing an...
It is hard to push price increases through when there are other carriers waiting in the wings who would gladly write the policy at the expiring premium levels.

upward trend in pricing. But, in general, we're not seeing this happen in any significant way. We've been seeing companies implement price changes that are typically in the -5% to +5% range, depending on the company and the jurisdiction.

PI: Are any differences by medical specialty showing up? Larson: No, not necessarily. We have a client base that covers both individual providers as well as healthcare facilities. We're not necessarily seeing any significant pressure points on one or another. It seems to be pretty consistent across the space.

PI: Has the trend toward increasing employment of physicians by facilities affected pricing in any way? Larson: It definitely changes the game a bit. Now you have more and more individual physicians being employed by healthcare facilities. As a result, you may see them being rolled into the overall insurance program of that facility. In the past, you might have had Insurance Company A that was focused specifically on providing insurance to healthcare facilities and Insurance Company B that was focused solely on providing insurance to healthcare providers.

Going forward, you'll now have a blended exposure and, as an insurance company, you'll need to be able to address the exposures that exist for facilities as well as providers. How insurance companies do that is where it gets interesting. You may end up seeing partnerships, in some cases, where companies that don't feel they have the expertise to adequately price and provide coverage for the large facilities end up partnering with companies that feel they have the ability to handle the exposure for large facilities, but don't have the expertise from an individual-provider perspective. But, I don't know that this will necessarily translate into significant price differences, or price pressures, that didn't exist previously.

PI: If less competition should, in theory, be putting upward pressure on pricing, what are some of the other factors that are keeping the price increases in check? Larson: There are two other factors that I think have been key in keeping price increases in check: one fairly obvious and the other not as obvious. First off, a lot of the companies that are actively writing MPL have seen the strength of their balance sheets improve dramatically over the last seven years. So they can be more accommodating on the price side of the equation, if they need to be, to acquire new business or retain existing business. It is hard to push price increases through when there are other carriers waiting in the wings who would gladly write the policy at the expiring premium levels.

Secondly, to the best of my knowledge, there is only one remaining publicly traded stock insurance company that is primarily an MPL insurer. As a result, a lot of the companies that are actively writing MPL today, and that have these much stronger balance sheets, are either mutual insurance companies, insurance exchanges, or a risk retention group (RRG). Unlike publicly traded stock companies, which are primarily focused on maximizing returns for the stockholders, these other types of insurance organizations are focused on providing the most benefit to the policyholder, which in turn makes them more willing to forego the pursuit of price increases, especially when they have very strong balance sheets that may contain excess capital.

PI: Do you think that the outcome of the recent elections will have any impact on how MPL companies do business? Larson: The outcome of the most recent elections will certainly have an impact from the standpoint that it is now guaranteed that the Patient Protection and Affordable Care Act (PPACA) will continue to be rolled out and implemented. The creation of accountable care organizations (ACOs) will undoubtedly give rise to changes in “exposure points,” and will require the development of new insurance products developed specifically for an ACO—and their potentially new and unique exposure points.

People can define an ACO, but until you have enough of them up and running, on a large-scale basis, most of the discussion is theoretical—hypothetical—trying to envision how these things are going to be rolled out, how they're going to work, what the exposure points may be, and whether the exposure will be greater or lesser. We just don't know for sure.

The way in which healthcare costs are to be reduced under the PPACA is something that MPL companies will also need to constantly monitor and evaluate. Cost-saving initiatives quite frequently have unintended consequences, such as providing plaintiffs with new opportunities for filing claims.

PI: Have there been any changes in how MPL insurers use reinsurance—for example, in the ratio of ceded vs. retained financial risk—in the last few months? Larson: Not necessarily in the last few months. As I mentioned earlier, balance sheets for companies writing MPL insurance have, on average, strengthened significantly over the past seven years. As a result, many of these companies are in a much better position to be able to retain more risk than they did in the past. As a result, we have seen some companies opt to retain more risk by increasing their per-claim/per-occurrence retentions or by modifying their reinsurance structure in some other way to effectively retain more risk. Having said that, let me note that these changes have definitely been company specific. I can't say that there's been any wholesale change that has been commonly implemented throughout the industry.

PI: How does investment income compare to 2009 levels? Do you see an increasing interest in equities, in a search for higher yields? Larson: In general, the trend in investment income over the past two to three years has been down a bit, but probably not as much as you might think. Risk-free investment returns have definitely been
under pressure, as yields on U.S. Treasuries have declined to record lows. But, companies have been able to avoid a “U.S. Treasury” type drop in overall investment income returns, by continuing to invest in equities and by strategically investing in other fixed-income securities such as municipal bonds, corporate bonds, and mortgage-backed securities. We’ve also noted an increased appetite from some companies, but not necessarily MPL companies, as respects their willingness to invest in alternative investments.

PI: How has the ongoing automation of claims processing affected the actuarial side of the enterprise?

Larson: Initiatives that focus on the increased automation of claims processing will definitely impact the data that actuaries so naturally rely upon. Changes in the speed with which claims can be processed and/or reserved, along with changes in the makeup of claim record variables, are changes that actuaries need to be aware of.

PI: And of course, I have the usual question about reserves. Any significant changes here?

Larson: While we continue to see companies recognizing reserve redundancies on prior accident/report years, we also continue to see what we perceive as reasonably conservative reserving practices being employed on the more recent accident/report years. So, while reserves are not nearly as redundant now as they were five years ago, we do still feel that there is a bit of redundancy remaining.

PI: What elements of the MPL business might keep an executive up at night?

Larson: Two “up at night” issues for MPL executives that were previously mentioned are the impact of the PPACA and the changing provider landscape, where more and more healthcare providers are opting to be employed by healthcare facilities instead of being part of a solo or group practice. This changing employment relationship between providers and facilities could lead to some interesting changes in the dynamics of the MPL insurance marketplace in that it may provide greater opportunities for companies who are willing to write MPL for both healthcare institutions and providers, and correspondingly less opportunity for those companies that had been focused solely on healthcare facilities or individual providers. In addition to these, MPL executives are undoubtedly concerned about the possibility of a protracted soft market, given the strength of many of the MPL companies’ balance sheets today. They may also be concerned about the longer term impact of continued consolidation within the MPL industry.
For 28 years, the PIAA has maintained the Data Sharing Project (DSP), which is now the world’s largest independent medical professional liability research database. Storing detailed data on more than 267,000 closed medical and dental claims and suits, the database provides a rich resource for the investigation of the underlying causes and issues pertaining to medical professional liability claims. All DSP reports can be purchased online at www.piaa.us.

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Mobile Apps for the MPL Masses

By Eric R. Anderson

As I read some recent statistics about mobile apps in the insurance industry, my first thought was that this just might be an area that is ripe for innovation by PIAA companies—an excellent vehicle for strengthening their relationships with policyholders.

A study by the research firm Strategy Meets Action found that only 22% of insurers have launched sales-related mobile apps that can offer product information or quotes. Even fewer, 18%, have deployed service-oriented apps.

It seems, then, that there is an opportunity for the insurance industry to launch new mobile apps. The question is, will healthcare providers be interested in this technology? I’m fairly certain that the answer is yes.

Clinicians are adopting mobile health technology at a brisk pace, according to a survey by the Healthcare Information and Management Systems Society. Among other findings, they’ve discovered that the number of clinicians who used mobile technology to collect data at the bedside rose to 45% in 2012, up from 30% in 2011. In addition, during the same period, the number of clinicians who used mobile technology to monitor medical-device data increased to 34%.

The time may be ripe for creating the mobile apps that can provide support for the essentials of their professional liability coverage.

For example, insurers could offer, across multiple access channels, a platform that includes user-friendly features such as a “renew policy” function, or that facilitates the filing of a claim. And new clients could get a quote via a mobile app, which would also provide some basic information about the key provisions in the policy.

The bottom line is that today’s healthcare providers, like most other business professionals, want information at their fingertips. If companies aren’t finding ways to provide these tools, they could see a drop-off in numbers of customers in the coming months and years.

Of course, as you might expect, distributing mobile apps may involve some challenges. Security remains paramount—so the development of formulas for complex passwords and the encryption of information, and maybe even an app that can wipe out all of the information stored on a lost or stolen tablet or smartphone, will be necessary.

However, providing an app like this offers a tremendous marketing opportunity for insurance companies. Securing a presence in customers’ smartphones can keep a company in the forefront of customers’ minds. The expansion of online business and of mobile applications has had a direct correlation with an increase in sales—so insurance companies that miss out on apps may lose out financially as well.

As the users of online media come to spend more time with apps on their smartphones and tablets, leaving their PC-based Internet connection behind, it could well be an opportune time for forward-thinking insurance carriers to develop and deploy their own professional liability-specific, customer-focused mobile apps.

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