Affordable Care Act Medical Professional Liability (C) Working Group

November 17, 2014
Washington, DC
2014 Fall National Meeting
Washington, District of Columbia

AFFORDABLE CARE ACT MEDICAL PROFESSIONAL LIABILITY (C) WORKING GROUP
Monday, November 17, 2014
3:00 – 4:30 p.m.
Washington Marriott Wardman Park—Maryland—Lobby Level

ROLL CALL

John G. Franchini, Chair  New Mexico  Kevin Dyke  Michigan
Karen Weldin Stewart  Delaware  Tammy Lohmann  Minnesota
William W. Deal  Idaho  Mike Chaney  Mississippi
Andrew Boron  Illinois  Scott J. Kipper  Nevada
Stephen W. Robertson/Tina Korty  Indiana  James Mills  Oklahoma
Martin Hazen  Kansas  Laura N. Cali  Oregon

AGENDA

1. Consider Adoption of its Aug. 17 Minutes—Superintendent John G. Franchini (NM)  Attachment A
2. Hear Presentation from Fortress Insurance Company—Florence Marafatos (Fortress Insurance Company)  Attachment B
3. Hear Presentation from Pinnacle Actuarial Resources, Inc.—Timothy C. Mosler (Pinnacle Actuarial Resources, Inc.)  Attachment C
4. Discuss Any Other Matters Brought Before the Working Group—Superintendent John G. Franchini (NM)
5. Adjournment
Attachment A:
Consider Adoption of its Aug. 17 Minutes
The Affordable Care Act Medical Professional Liability (C) Working Group met in Louisville, KY, Aug. 17, 2014. The following Working Group members participated: John G. Franchini, Chair (NM); Carol Jones (DE); Tom Donovan (ID); Marty Hazen (KS); Kevin Dyke (MI); Phil Vigliaturo (MN); Jay Eads and Mark Haire (MS); James Mills (OK); and Laura N. Cali (OR). Also participating were: Joel Laucher (CA); and Joan Dutil (MO).

1. **Heard a Presentation from Mesirow Financial Structured Settlements**

Neil Herald (Mesirow Financial Structured Settlements) said structured settlements are a financial product prepared by the defendants and presented tax-free to the plaintiffs. For the first time in tort litigation history, plaintiffs can now get insurance policies, previously unavailable due to preexisting conditions. He said when involved in a case, the sources of leverage Mesirow reviews include client liability and causation facts, what jurisdiction the case is pending in, and providing annuities and lifetime benefits to clients at a cheaper rate than what the market provides. On a serious personal injury case, Mesirow receives an economic report from the company’s economist, and they are complex, convoluted reports. However, these reports provide the components of the present value formula, which include annual damages, discount rate, growth rate/inflation and duration period. He said when dealing with its clients, Mesirow looks to obtain information on medical/life care plan, economist reports, rehabilitation specialists, life expectancy experts, regional authority on public programs and any private health care policies. Mesirow tries to provide its clients with collateral sources or other benefits the plaintiff is receiving, such as special needs trust(s)—public aid and Social Security income (SSI), Medicare/Liability Medicare Set-Aside Arrangement (LMSA), federal Affordable Care Act (ACA), Social Security disability and school district therapies—Individuals with Disabilities Education Act (IDEA), and private disability. The most popular method of preserving benefits is a special needs trust. Mr. Herald said Mesirow can set up a special needs trust and have annuity payments feed into the trust.

Lynn Petrouski (Mesirow Financial Structured Settlements) said some key concepts of the ACA include elimination of discrimination based on preexisting conditions and removal of the annual and lifetime dollar limits for health care policy limits. Starting Jan. 1, 2014, the following “Ten Essential Benefits” must be included under all insurance plans with no lifetime or annual dollar limits: 1) ambulatory patient services; 2) emergency services; 3) hospitalizations; 4) maternity and newborn care; 5) mental health and substance abuse treatment; 6) prescription drugs; 7) rehabilitative and habilitative services and devices; 8) laboratory services; 9) preventive care; and 10) pediatric services, including oral and vision care. She explained that medical information was sent to life insurance companies that offer medical underwriting on structured settlements to derive a rated age to determine the cost of future care. In the provided example, the life care plan for a man 46 years old, rated at age 54, was estimated at a cost of more than $9.7 million. Using the purchasing power of the rated age, Mesirow created a life care plan just more than $6 million. Annuities are purchased for every year of care and are provided for the plaintiff’s entire life. Mesirow provided a guarantee benefit of more than $6.3 million, meaning it guarantees enough years’ worth of payments so that even if the plaintiff passes away before receiving the full benefit of the settlement, his or her estate would still receive at least the cost of the annuity.

Ms. Petrouski said under the ACA, Mesirow provides the plaintiff upfront with a cash payment for attorney fees; liens; expenses; one-time purchases; and the first year of care needs, less non-covered items. Mesirow then pays 100% of non-covered items, which include home care, recreation, home modifications, and transportation not covered in structure settlement plans. It also purchases premiums for the plaintiff’s health insurance policy and an annual amount for maximum out-of-pocket expenses, inclusive of deductibles. She said, in the example, an amount of $14,350 was purchased for the plaintiff, payable for 15 years, with a 3% annual growth. Mesirow prices for the most expensive policy, regardless if that is the policy selected. Whatever money is not spent is usable by the plaintiff. Because of these changes, the new cost of the annuity is now closer to $3.2 million, instead of the $6.1 million cost generated pre-ACA. The new total offer settlement of $5.7 million, as opposed to an offer of around $15 million or $18 million according to the present value provided by company economists for the life care plan. If a plaintiff would wait until a verdict is received, Ms. Petrouski said the cost of
the benefits provided would be closer to $7.3 million, and the plaintiff would not be able to purchase his or her benefits tax-
free.

Mr. Herald said there are two sides to litigation, and most of Mesirow’s clients are P/C insurers. The three arguments
plaintiffs usually make are: 1) the effects of the ACA on the plaintiff’s recoverable future medical expenses are speculative;
2) the evidence of collateral sources are prejudicial to the personal injury of the plaintiff; and 3) tort fees should bear the risk
that the future medical expenses will not be covered by medical insurance. He said these points are usually presented during
litigation, and Mesirow deals mainly with mediation. In the practical world of negotiating settlements, the argument could be
made that a plaintiff would not want to buy direct health care from a provider when he or she could pay insurance premiums
and be covered by health insurance.

Ms. Petrouski said the point of using the ACA and incorporating it into life care plans is to provide context to the plaintiffs.
Mesirow tries to show the plans it set up will provide the care plaintiffs need the rest of their lives. It is important for
plaintiffs to understand how the structures work, the pricing purchasing power of the rated age, tax-free benefits, and that
credible offers are being made.

Mr. Dyke said the new structured settlement approach under ACA seems to exemplify cost shifting. Costs usually handled by
structured settlement companies are shifted to health insurance companies. Ms. Petrouski said one of the primary pieces of
the ACA was to bring in a large pool of people to offset the cost of individual risks. Instead of plaintiffs having to purchase
health care with catastrophic risk, they are in with the general population and should compensate for the catastrophic injury
category. She said home care costs are typically the larger portion of life care plans, and while those can be covered in certain
health care policies, they typically are not. So, those benefits that are typically covered for healthy individuals should be
covered for injured individuals as well.

Mr. Donovan asked how Mesirow predicts medical trends and how it speculates a cost for future medical costs. Ms. Petrouski
said the settlements are set up to purchase the most expensive policy, which is not always the best and the chosen plan, so
plaintiffs should expect the individual to begin with a surplus. A 3% annual growth percentage was chosen so that in order to
increase health insurance premium, carriers have to present a strong case for the increase. As a result, there is some
confidence regarding premium stability.

Mr. Donovan asked if Mesirow anticipates many of the plaintiffs will qualify for the premium tax credit. Ms. Petrouski said
tax-free acceptance depends on the case and how the plaintiff uses the funds received.

Superintendent Franchini said it is a positive thing for the ACA to be used in this way for structured settlements, and it used
to be, after a catastrophic loss, access to affordable care was always an issue. Mr. Herald said the ACA changes the landscape
on how medical professional liability (MPL) cases are settled.

Mr. Laucher said Congress repeatedly talks about repealing the ACA. He asked if there were any contingent plans, should the
ACA, or any piece of it, be repealed. Ms. Petrouski said Mesirow does not foresee a repeal, but part of settling means the
injured is unable to come back to negotiate. Mr. Herald said legislation may be different in the future, but Mesirow deals in
day-to-day scenarios.

2. Heard a Presentation from the University of Arkansas College of Business

Lars Powell (University of Arkansas College of Business) said he and coauthors J. Bradley Karl (East Carolina University)
and Chip Wade (Mississippi State University) are looking into how the Medicaid expansion piece of the ACA affects MPL
insurance. More medical care provided means medical personnel and infrastructure could be stretched and more opportunities
for bad outcomes and MPL losses, but also for more defensive medical procedures. The change in health insurance coverage
among the population also means fewer unpaid medical bills. Bills that are difficult to pay become a catalysts for lawsuits,
and there is an expectation of a decrease in the frequency and severity of lawsuits. He said if patients have not had coverage
or resources to have long-standing medical procedures, they may have unrealistic expectations of how much their medical
care will help.
Mr. Powell said the Medicaid expansion will bring more low-income population into the health care system. As the average income of patients decreases, lost wages negotiated in settlements would be lower, but there is an opportunity cost associated with filing a lawsuit. He said individuals with lower incomes have a lower opportunity cost of time lost and tend to file more claims. Because of all the potential positives and negatives of the expansion, it makes it difficult to estimate problems and outcomes. He said there are two issues making this issue difficult to solve empirically. First, the answer to the impact to the $7 per person, though those results are not consistent with the academic literature. He said Washington, DC, is an outlier in the model suggests that if the number of lawyers were to increase by one percentage point, it would reduce MPL losses by $6.57 billion, so a $500 million increase would be a 7.6% annual increase in real MPL losses. Using 2012 data, total MPL losses incurred totaled around $500 million increase in MPL losses would be expected. Using 2012 data, total MPL losses incurred totaled around $6.57 billion, so a $500 million increase would be a 7.6% annual increase in real MPL losses.

Mr. Powell said changes are likely to persist over time. The NAIC might consider accommodating possible rate increases and an increasingly competitive market. He said to be mindful of other ACA-, attendant- and insurance-related changes that could affect MPL exposures, such as medical payment reforms, medical home concepts and physician payment schedules. He suggested legislators consider some actions as well, such as reforms that make the liability system more efficient, reforms that make the medical system more efficient, and creating guidelines for medical negligence to reduce uncertainty.

Mr. Donovan said the number of individuals in poverty was mentioned, so pre-ACA it would 100% of the poverty limit, but eligibility for Medicaid, post-ACA, was raised to 133% of the poverty limit. He asked how poverty was calculated in the model. Mr. Powell said the model’s definition of poverty may need to be adjusted to the Medicaid eligibility level.

Mr. Donovan said the presentation mentioned more defensive medical procedures, but he asked if that was likely given the higher demand of medical attention. Mr. Powell said he hopes to capture that data within the doctors per capita to gauge the potential strain on the medical system. He said it is likely that primary care physicians, as opposed to specialists, will feel most of the strain, and due to the increased number of patients, they may be more likely to order more tests. Mr. Laucher asked if Mr. Powell had done any research regarding different specialties of medicine and where the impact of a physician shortage may be felt most. Mr. Powell said he has not researched that information for his current project, but he agreed it would be worth looking into.

Timothy S. Jost (Washington and Lee University School of Law) said he thought Medicaid recipients were less likely to file claims than other malpractice victims. He said he had found some studies to support those findings, which he said makes sense due to little or no lost wages, any recoveries they receive would be subject to Medicaid’s secondary payer program, and they don’t have the same access to lawyers. Mr. Powell said there are conflicting studies, depending on data used, but agreed
with Mr. Jost’s point. He said the paper on which he is working is currently in draft form, and he will provide it to the Working Group upon its completion.

Mr. Dyke asked about the details used in the analysis, such as if particular years were used, if groups of years were used, if there was a holdout set used, or was the data just lumped together. Mr. Powell said in their sample, 800 or 900 observations by state by year were used, and they started running out degrees of freedom with the fixed affect model. He said the results are robust, and while the model has not be held out for predictability, he agreed it would be worth considering.

Andrea Routh (Missouri Health Advocacy Alliance) said she appreciated the thinking that went into the modeling and asked if the fact that approximately 80% of Medicaid spending in the states is spent on the 20% of people who are disabled and elderly was taken into consideration. She said the policyholder expansion under the ACA is likely not those individuals and suggested looking into whether that affects the model. Ms. Routh said lawyers who are not plaintiff attorneys and do not work on MPL cases should be taken into consideration in the model, as well. Mr. Powell said he was not aware of data purely on plaintiff attorneys. He said he meant for the data to represent public accessibility to lawyers, rather than advocating for a reduction in lawyers.

Mr. Powell said their model can produce state-specific results and offered to circulate the information to the Working Group.

Having no further business, the Affordable Care Act Medical Professional Liability (C) Working Group adjourned.
Attachment B:  
Hear Presentation from  
Fortress Insurance Company
Impact of ACA on Dental Professional Liability Claims

Presentation to:

OMSNIC

The Affordable Care Act Medical Professional Liability Working Group
November 17, 2014
Washington, D.C.

OMSNIC

DEFENDING THE SPECIALTY

OMSNIC

National Insurance Company, Risk
Retention Group (OMSNIC) is a stock insurance company, organized under the laws of the State of Illinois. OMSNIC operates under the Federal Liability Risk Retention Act of 1986 and provides primary professional liability coverage to Oral and Maxillofacial Surgeons nationwide.

Fortress

OMSNIC

Protecting & Defending

Fortress Insurance Company (Fortress) is a wholly owned insurance company by OMSNIC. Fortress is also domiciled in Illinois. The company has licenses in 50 states and the District of Columbia. Fortress is a stock insurance company and provides professional liability coverage to the general dental and dental specialty fields.
Florence Marafatsos, HIA, MHP, PAHM, ALHC
OMSNIC and Fortress Regulatory Manager

24 Years of Insurance Industry experience:
9 years in Claims
5 years in Actuarial
10 years in Compliance

Active in AICP
(Association of Insurance Compliance Professionals)

Affordable Care Act Background

The 2010 signing of the Affordable Care Act (ACA) by President Obama caused much speculation in the Property & Casualty Industry. Analyst and Actuaries developed opinions on the effect of ACA on medical professional liability giving rise to possible outcomes from the implementation of the Act.
Enrollees

There is not enough data to assess the overall impact but ACA is underway. Open enrollment in the Health Insurance Marketplace began October 1, 2013. Estimates are the number of uninsured dropped by 3.8 million* since 2013 sign up for coverage under the Affordable Care Act.

*Forbes.com September 18, 2014 Article “We Still Don’t Know How Many People Obamacare Enrolled”

Review of Severity & Frequency Drivers

The Committee has heard from several speakers who predict an increase in claims due to:

Severity

- Tort reforms
- Overturning of Damage Caps
- “I’m Sorry” legislation

Frequency

- Coverage/Network Changes
- Increased patient out of pocket expenses
- Easier to file a MPL claim vs. health claim
Impact on Companies

The Rand Report* estimated an increase in claim volume roughly between 1.5% and 10% with a 5% midpoint selection by combining results of their empirical study with the National Practitioner Data Bank data for the years 2008 to 2010.

While uncertainties remain, Rand states the effect of the ACA on medical malpractice claims volume will be fairly large.

* Rand Corporation © 2014 “How Will the Patient Protection and Affordable Care Act Affect Liability Insurance Costs?”

Dental Professional Liability

Dental Professional Liability (DPL) is a subset of Medical Professional Liability (MPL).

While much has been discussed on the potential impact of ACA on MPL claims, little has been discussed on DPL which has much lower frequency and severity than MPL claims.
Dental Professional Liability

The ACA provides pediatric dental benefits.

There has been confusion since regulators initially said consumers did not have to purchase the pediatric dental benefit if the purchase was made inside the exchange, while outside the exchange everyone was required to purchase the additional pediatric dental benefit.

Regardless, the ACA has more of an indirect than a direct impact on dentistry.

However, the dental profession often follows the trends in medicine. Therefore, we expect the ACA will have some consequences on DPL claims.

Predictions on DPL Claims:

To the extent the expanded pediatric dental benefits are purchased, there will be more patients and, assuming no changes in DPL frequency, more claims.
Predictions on DPL Claims:

ACA is changing the way medicine is being delivered, with consolidation of individual practices under hospitals or Affordable Care Organizations.

Dentistry has been undergoing a similar trend to more corporate dental practices. These practices are typically multi-office, multi-state and/or multi-specialty practices versus the traditional dentistry model. It is estimated that approximately 15% to 20% of dentists work in such corporate settings, with the percentage expected to continue to increase.

This has led to more “common loss” DPL claims, where multiple patients make claims with similar allegations based on the procedures and processes followed by a corporate practice, which extend across multiple dentists. This has resulted in a significant increase in frequency.

Impact on Oral and Maxillofacial Surgeons (OMS)

Corporate settings also affect specialists like OMS. It is not unusual in these practices for an OMS to travel between multiple offices/employers to provide service.

The AAOMS has issued specific guidelines for “itinerant” OMS to address new risks these practices can have, such as OMS not being available in a location for follow-up on complications, the use of different support teams at different locations and the possibility of inadequate equipment at each location.
DPL Impact - Medicaid

Some corporate dentistry models have specialized in treating pediatric dental patients under Medicaid. There have been widespread accusations of Medicaid fraud/improper billing against some of these entities.

While Medicaid fraud is excluded from coverage, many of these Medicaid claims are expanded to include allegations of overtreatment. This increases frequency (usually under the “common loss” types of claims), but severity is usually low due to the non-permanent nature of any proven damages.

Access to care has been an issue in dentistry which leads to an increase in pediatric and in some cases adult dentistry through state Medicaid programs. To address this, states have been expanding the scope of practice for hygienists with additional training (“dental therapists”).

There is a concern the training these individuals receive is not as extensive or thorough as a dentist’s training and that more claims will result due to misdiagnosis or inappropriate/poor treatment being rendered. We anticipate a higher frequency and slightly higher severity on these individuals, especially where higher risk dental procedures like extractions are permitted.

What Can the Insurance Profession Do?

The impact of corporate medicine and dentistry is yet to be felt on coverages offered and theories of litigation against physicians, dentists and allied health professionals and will require monitoring.

As corporations specialize in Medicaid, insurance departments and insurance companies could be a resource to the Medicaid programs in the design of reimbursement programs to ensure quality patient care is maintained with overtreatment defined upfront to reduce abuse of the Medicaid program.
What can the NAIC Affordable Care Act Medical Professional Liability Working Group Do?

In order to study the impact of ACA on MPL we must collect relevant data.

Will current state claim reporting allow the Committee to measure these potential impacts?

NO.

How to capture data?

- NAIC Model Act #77-1.

The stated purpose of the Model Law was to “ensure the availability of closed claim data necessary for thorough analysis and understanding of issues associated with medical professional liability claims, in order to support the establishment and maintenance of sound public policy.”

But this is simply not the case. Differences in state reporting requirements for medical professional liability claims result in anomalies, requiring extensive additional manual efforts on the part of the reporting entities.

The nature and amount of information reported varies significantly by state. Our internal tracking system identifies approximately 200 different pieces of data which may be required by any one state.
Comparison of State Reporting Parameters

Claim Reporting forms

Minimal data

Moderate
Formats and amount of information vary from state to state

OMSNIC and Fortress recommends the Working Group address the standardization of reporting as soon as possible to develop the information it will need to evaluate the ACA’s impact on MPL.

We believe that substantial standardization of reporting and sharing of data across agencies can be accomplished. This would assist companies in automating the reporting process and lead to more consistency and accuracy in the data reported.
Thank you.

Florence Marafatsos  
Regulatory Manager  
florence.marafatsos@fortressins.com

Opinions expressed are solely those of the speaker and subject to change without notice. Information is presented for educational purposes only. All data is from reliable sources. OMSNIC and Fortress disclaim liability from viewers reliance on any information contained in this presentation.
Attachment C:  
Hear Presentation from 
Pinnacle Actuarial Resources, Inc.
Impact of Health Care Trends on Medical Professional Liability

Agenda

• Disclaimer
• Greater access to health insurance
• Hospital employment of physicians
• Transition to EHRs
• Possibility of significant shifts in MPL costs
  • Upward shifts
  • Downward shifts
Disclaimer

Throughout this presentation, I will discuss the potential impacts of changes in health care. I can only speculate as to the impacts and, as we are in the initial implementation phases of the Affordable Care Act (ACA), it is too early to discuss the impacts with certainty. Ultimate long term impacts will depend on many factors including the actions of claimants, lawyers, insurers, regulators and health care providers.

Greater access to health insurance

- According to the 2011 US Census 15.7% of Americans do not have health insurance
- Potentially falls to near 0% under ACA
- What does the expanded access to health insurance mean for MPL?
Potential positive effects for MPL costs

- Patients will have access to affordable health care
  - Conditions will receive treatment earlier
  - Advantage for MPL as high severity claims frequently arise from advanced medical problems
- More frequent interactions with the health care provider
  - Promotes better lifestyle choices
  - Reduces future health issues

Potential negative effects for MPL costs

- Access to health insurance won’t change individuals’ behavior regarding their health
- A larger number of insureds could actually increase the delay in getting a doctor’s appointment
- Higher deductibles on health insurance policies could delay visiting the doctor until the condition is more severe
As a result of increased access to health insurance, MPL costs are

A Very likely to increase
B Somewhat likely to increase
C Equally likely to decrease or increase
D Somewhat likely to decrease
E Very likely to decrease

This is how the Pinnacle APEX audience voted (81 responders)

A Very likely to increase – 16.0%
B Somewhat likely to increase – 51.9%
C Equally likely to decrease or increase – 22.2%
D Somewhat likely to decrease – 9.9%
E Very likely to decrease – 0.0%
Increased hospital employment of physicians

- Recognition of scale advantages
  - Control of quality
  - Revenue advantages
  - Smaller administrative load
- Corresponding decrease in solo practitioners
- Increasing number of accountable care organizations (ACO)

Decreased number of solo practitioners

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Source: Accenture
Number of ACOs has tripled since Q2 2012

Source: Health Affairs Blog (www.healthaffairs.org/blog)

Effects of doctors becoming part of a system

- Favorable
  - Consistent risk management approach
  - Focus on patients, not on managing the practice
  - Motivation to succeed: ACOs that succeed in both quality care and lower costs can share in savings that may result

- Unfavorable
  - Physicians may take less responsibility as hospital employees than as independent practitioners
  - Poor performers could take longer to be detected in large health care systems
Effects of physician employment on claim resolution

- Improvement in claims handling with multiple defendants sharing a common employer
- Different claim handling practices between hospital programs and physician insurers
  - What happens when the hospital wants to settle and the doctor wants to defend
  - Higher limits
  - Closed claim reporting to regulators

Other liability issues

- Employment practices liability
- Tail liability

Assumes the doctor’s practice began 1/1/2009 and shut down on 1/1/2014 when the doctor went to work for a hospital
As a result of increased hospital and ACO employment of physicians, MPL costs are

A  Very likely to increase
B  Somewhat likely to increase
C  Equally likely to decrease or increase
D  Somewhat likely to decrease
E  Very likely to decrease

This is how the Pinnacle APEX audience voted (79 responders)

A  Very likely to increase – 6.3%
B  Somewhat likely to increase – 20.3%
C  Equally likely to decrease or increase – 32.9%
D  Somewhat likely to decrease – 38.0%
E  Very likely to decrease – 2.5%
Incentives for “meaningful use” of EHRs

An individual’s EHR is a digital record of their health information and can include
- Medical history
- Allergies
- Prescriptions
- Test results
- Radiology results
- Vital signs

Can potentially be shared by all of the individual’s health care providers

Viewed as a key component in achieving quality outcomes

EHRs are expected to reduce the number of bad outcomes

- Better access to information
- Include a complete history which will allow for detection of conditions that are growing worse
- Can be shared across health providers
But, how will the EHR affect costs once there is a bad outcome?

- MPL claim payment requires four steps
  - Bad medical outcome
  - Filing of a claim
  - Settlement or finding of negligence
  - Damages awarded
  - Use of EHRs moves the latter three out of four toward higher costs
- Also
  - Potentially higher standard of care given that more information is available to the doctor
  - Privacy concerns

As a result of the transition to EHRs, MPL costs are

- A Very likely to increase
- B Somewhat likely to increase
- C Equally likely to decrease or increase
- D Somewhat likely to decrease
- E Very likely to decrease
This is how the Pinnacle APEX audience voted (73 responders)

A  Very likely to increase – 5.5%
B  Somewhat likely to increase – 15.1%
C  Equally likely to decrease or increase – 28.8%
D  Somewhat likely to decrease – 42.5%
E  Very likely to decrease – 8.2%

Possibility of Significant Changes

• The impacts discussed previously could lead to moderate changes
• Is there the potential for real game-changing shifts like a doubling or halving of costs over the next 5 years
  • Seems more likely for MPL than other lines because of its proximity to the health care system

For MPL, healthcare system impacts the first two steps
Are there trends that could lead to significant upward shifts in MPL costs?

- Diminished relationship between patients and their doctors could affect jury attitudes during MPL trials
  - Affects amount of settlements
  - Affects frequency of claims

- Coordinated standards of care within health systems could lead to large multi-claimant actions

Are there trends that could lead to significant upward shifts in MPL costs?

A  Probably yes

B  Maybe

C  Probably no
This is how the Pinnacle APEX audience voted (80 responders)

A  Probably yes – 48.8%
B  Maybe – 36.3%
C  Probably no – 15.0%

Are there trends that could lead to significant downward shifts in MPL costs?

• Greater access to health care and the focus on quality could lead to a significant reduction in bad outcomes for patients
• Technology advances in health care could facilitate prevention and patient safety
  • Health monitoring devices
  • Sensor data
    – Smart bandages
    – Smart prescriptions
Are there trends that could lead to significant downward shifts in MPL costs?

A. Probably yes
B. Maybe
C. Probably no

This is how the Pinnacle APEX audience voted (80 responders)

A. Probably yes – 38.8%
B. Maybe – 36.3%
C. Probably no – 25.0%
Thank you for your time and attention

Tim Mosler
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678-894-7254
Discuss Any Other Matters Brought Before the Working Group