

## Malpractice Carrier Financials Look Positive However More Physicians Move To Alternative Coverage

The annual number of malpractice claims (frequency) continues to fall. This change in claim frequency has helped commercial malpractice insurers recover substantially from the financial pounding the industry took between 2000 and 2004. The malpractice industry of 2010 is much stronger financially than it was eight years ago and there is capacity for more growth. According to A.M. Best, the medical malpractice market continues to remain soft, although experts seem poised for the next round of adverse claims news that always seems to follow improving financial conditions. According to the February 8, 2010 issue of *BestWeek*, "Soft market conditions persist in the medical malpractice liability space and provide a stark contrast from the early part of the last decade. A composite of the industry's 2003 combined ratios of 122.5 dropped steadily to reach 82 in 2008." As financial results become known for last year, many malpractice carriers are posting record-breaking low combined ratios (the lower the better) for 2009.

### The Growth of Alternative Markets

Premiums, however, are continuing to rise. As practice patterns change and physicians seek relief from ever higher costs, more physicians are covered for their malpractice through

"alternative" insurers such as Risk Retention Groups (RRGs) also known as "captives." This means the number of physicians insured by traditional "commercial" carriers is slowly declining. According to a report by Massachusetts Division of Insurance in 2008, RRGs typically used by large self-insured healthcare systems and major physician groups, expanded their market share from 2002 to 2008 by 13%. At the same time, licensed carriers lost market share by 10%. Licensed carriers' overall share of the market dropped from 64% in 2002 to 54% in 2008. The Division of Insurance reports that even though Massachusetts commercial malpractice carriers lost market share, they collectively increased total premium from \$153 million in 2002 to \$168 million in 2008 for a 10% increase. Collectively, RRGs increased their total premium from \$55 million in 2002 to \$113.7 million in 2008 for an increase of over 100%. Anecdotally, there are indications that premium increases among the RRGs are starting to catch up. For years captives offered doctors lower premiums but we are witnessing physicians returning to commercial carriers with more competitive premiums.

### Disappearing Occurrence Coverage

On a national level, the occurrence form of coverage has declined

dramatically during the last 20+ years. (See chart.) Massachusetts is one of the last bastions of occurrence form coverage as most doctors throughout the U.S. are using some form of claims-made coverage. There are many reasons why occurrence coverage is declining.

Medical Malpractice Premium, Occurrence vs. Claims-Made, as a % of Total

Year	Occurrence	Claims-Made
1985	61%	39%
1986	55%	45%
1987	44%	56%
1988	35%	65%
1989	32%	68%
1990	29%	71%
1991	29%	71%
1992	28%	72%
1993	27%	73%
1994	29%	71%
1995	31%	69%
1996	30%	70%
1997	28%	72%
1998	28%	72%
1999	30%	70%
2000	32%	68%
2001	29%	71%
2002	31%	69%
2003	29%	71%
2004	24%	76%
2005	23%	77%
2006	23%	77%
2007	21%	79%
2008	23%	77%

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Reinsurance carriers view claims-made as much more predictable and easier to underwrite. The long tails associated with occurrence coverage makes it less predictable for reinsurers (claims can come years after a policy ends) and therefore many reinsurers prefer not to cover it. When they do provide coverage it's usually much more expensive than claims-made. The rise in physicians moving into alternative types of malpractice coverage is also affecting the rate of occurrence coverage here in Massachusetts. The captives and Risk Retention Groups tend to use a form of so-called modified claims-made coverage. This is technically a form of claims-made with the "tail" built in so physicians can come and go without any tail concerns. In 2004 Connecticut Medical Insurance Company (CMIC) entered Massachusetts, and in 2008 they introduced their own form of modified claims-made coverage for medical groups having better than average claims experience. The CMIC program, called MQI, tends to be substantially less costly than occurrence coverage while providing the immediate built-in tail typical of modified claims-made. For more information on the MQI program call (800) 522-7426. ■

— Jack King

## The Board of Medicine's Proposed "Stealth Summary Suspension" Regulation

It is often repeated that The Massachusetts Board of Registration in Medicine is one of the more powerful state medical boards, both substantively and procedurally. Now the Board has proposed a regulation that will add to its power in a significant way.

### Summary Suspension Background

Probably nowhere has the Board come closer to the edge of due process requirements, than in the case of its summary suspension regulation, 243 CMR 1.03(11).

Reduced to its essence, the regulation allows the Board to suspend a license *without a prior hearing*, if the Board can support the action with a sworn statement or other documentary evidence that the physician is an "immediate and serious threat to the public health, safety or welfare." The physician has a right to a hearing on the necessity of the summary suspension within seven days. (Although there is no requirement that the Hearing Officer render a decision within seven days.)

It is hard to exaggerate the enormity of a summary suspension's consequences. With few exceptions, a summary suspension effectively ends the physician's career. It starts the physician on what is likely to be a

multi-year trek down a dark, expensive, procedural road with hearings, delays, a complete loss of income, reports to the National Practitioner Data Bank and other states which respond with reciprocal suspensions, all without the benefit of a final decision on the merits of the initial charges. To be sure, summary suspension has its place when the Board's investigation reveals it is dealing with a truly dangerous professional. But such cases are rare indeed.

### The Proposed "Stealth Summary Suspension" Regulation

With this background on summary suspension, it should come as an alarm to all physicians in Massachusetts that the Board of Medicine has put out for comment an amendment to its licensing regulation which has the potential to function as a "stealth summary suspension" provision. Currently, a "good moral character" requirement is in initial license applications only. The Board is proposing a new requirement that when renewing a medical license, the physician "has the burden to demonstrate that the applicant is of good moral character."

Presently, a physician accused of wrongdoing responds to a Statement of Allegations in an adjudicatory

hearing where the prosecutor has the "burden of proof." But under the Board's proposal, the same physician whose license is up for renewal suddenly has the burden of proving that he or she is of "good moral character." The prosecutor merely delivers the Statement of Allegations (or really any pending complaint) to the Licensing Committee and sits back. If the physician cannot prove he or she has "good moral character," the license is not renewed. The result has all the catastrophic effects of a summary suspension, without the name, and without troubling the prosecutor to prove his or her case as currently required — "by a preponderance of the evidence."

It would be cold comfort for the Board and its staff to reassure the profession that it will never use the proposed regulation this way. However, the Board has not been shy about using summary suspension. The issue is not whether the Board will ever use the "stealth summary suspension" weapon if it is in its arsenal, but whether the weapon should be in its arsenal in the first place.

William Ryder, Esq., the Society's Regulatory and Legislative Counsel, recently stated, "The MMS is actively involved in the process of reviewing and commenting on the full scope of the Board's regulations. Individuals with questions about the content of the regulations or the comment process may contact the MMS Department of Government Relations. ■

— Andrew L. Hyams, Esq.

*A partner at the Wellesley law firm, Kerstein, Coren & Lichtenstein, LLP, Mr. Hyams was General Counsel at the Board of Medicine from 1985-90. He currently represents physicians and other health professionals in regulatory and peer review proceedings. AHyams@kcl-law.com*

## PIAM Announces Affiliation With ThomasPartners, Inc.

PIAM has recently chosen ThomasPartners Inc. to offer financial planning and investment services with special fee arrangements to MMS members. Among its many distinctions, ThomasPartners was selected by the *Boston Business Journal* as the #1 ranked Independent Investment Advisory firm in the Boston area. They were also recently recognized by *Barron's* as one of the "Top 100 Independent Financial Advisory Firms" in the U.S.

ThomasPartners serves clients in all 50 states with over \$1 billion in assets under management and has extensive experience serving the medical community. ThomasPartners has assembled advantageously-priced services specifically designed to meet the needs of medical professionals. These services include comprehensive financial planning, college planning, retirement plans, risk/reward analyses, estate planning and tax-deferred benefit plan administration.

ThomasPartners also offers investment advisory and portfolio management services, again with reduced fees to MMS members. Depending on the client's specific needs, their services generally are delivered in separately managed accounts that are custodied at one of the larger firms like Schwab, Fidelity, and TD Ameritrade. As appropriate, these services embrace a dividend-driven philosophy, but may also allocate funds to fixed income securities, ETFs and other independent managers that deliver distinctive and successful strategies.

For more information you may visit their web site [www.thomaspartnersinc.com/mms](http://www.thomaspartnersinc.com/mms) or call Amos Robinson at (781) 431-1430. ■

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## Is Your Practice Prepared for the New Data Security Laws?

On February 22, 2010, the new Health Information Technology for Economic and Clinical Health (HITECH) Act breach notification requirements became enforceable. HITECH makes significant changes to HIPAA security requirements, requiring notice to individuals whose information is affected by a breach of privacy. There are four tiers of penalties, the most punitive ending at \$50,000 per violation with a cap of \$1.5 million.

Also, on March 1, 2010, the new MA data security laws went into effect. Massachusetts' breach notification law, 201

CMR 17.00, allows for civil penalties of up to \$5,000 for each violation and \$50,000 for each instance of improper disposal of "personal information" (PI). PI is a person's first name and last name (or first initial and last name) in combination with any one of the following: 1) Social Security number; 2) driver's license number or other state-issued identification card number; or 3) a financial account number, or credit or debit card number, with or without any required security code, access code, or PIN that would allow account access.

For a medical practice, there are two overlapping issues — the loss of both personal information and health information, as most patient data includes both. A simple loss of an employee's tote bag containing sensitive patient information, faxing a patient's test reports to the wrong number, or improperly disposing of old charts in an unsecured dumpster could result in costly ramifications for the practice. A recent article in *American Medical News* notes that the greatest risks to healthcare

providers in the area of maintaining patient privacy aren't offshore hackers or rogue employees, but rather simple accidents. For physicians, a lost Blackberry, flash drive or laptop can mean legal fees, an arduous process of notification, damage to the practice's reputation, and the risk of heavy penalties.

### Breach Notification

If a breach of information is discovered the data owner must provide notice to the MA Attorney General, the Director of the Office of Consumer Affairs and Business

*A simple loss of an employee's tote bag containing sensitive patient information could result in costly ramifications for the practice.*

Regulation, and written notice to each affected MA resident. If the breach af-

fects 500 or more individuals, major media outlets and the HHS must also be notified. Notification must be provided no later than 60 days following the discovery of a breach.

### Individual Notice

The data owner must provide affected individuals notice in writing by first-class mail (or by e-mail if the affected individuals have agreed to receive such notices electronically.) If there is insufficient or out-of-date contact information for 10 or more individuals, the data owner must post the notice on the home page of its web site or publish the notice in major print or broadcast media where the affected individuals likely reside.

Massachusetts' personal data breach notification law requires that notifications SHALL NOT include:

- 1) The nature of the breach
- 2) The number of residents affected by the breach
- 3) Any steps the Entity has taken or plans to take relating to the incident

- Notifications SHALL include:
- 1) Law enforcement entity notified, case number and contact information, if applicable
  - 2) Information that the consumer has the right to obtain a police report and the contact information needed to request a report, if applicable
  - 3) Information that the consumer has the right to obtain a credit report from any of the three credit bureaus
  - 4) Information that the consumer has the right to obtain a credit freeze, information regarding the costs of a credit freeze, information the consumer would need to provide and contact information of all three credit bureaus

### Media Notice

Data owners that experience a breach affecting more than 500 residents of a State or jurisdiction are also required to provide notice to the prominent media outlets of that area. This notification can be provided in the form of a press release to appropriate media outlets serving the affected area.

### Notice to HHS

Notice must be given to the Secretary for breaches involving more than 500 individuals. The Secretary will post on an HHS web site a list that identifies each covered entity involved in a breach in which the unsecured PHI of more than 500 individuals is acquired or disclosed.

PIAM is working on developing a new privacy coverage insurance that may help protect your practice in the event of a data loss. For more information call (800) 522-7426. ■

*PIAM Cases in Risk Management Online CME Coming Soon...*

— Barbara Lawrence

## Special EMR Loan Program for Members

Boston Private Bank & Trust Company is pleased to offer a special loan program for the physician members of the Massachusetts Medical Society to finance the purchase and implementation of Electronic Medical Records systems (EMR), and to finance practice technology improvements. This limited time program offers a combination of an attractive fixed rate, flexible repayment terms and minimal closing costs. Specific terms are:

**Loan Amount:** From \$150,000 to \$1,250,000

**Interest Rate:** Fixed for up to five years @ 6.5%

**Repayment:** Monthly, up to 60 months

**Documentation & Closing Costs:** Limited to the cost of a UCC search & filing fee

**Collateral:** The equipment being purchased and financed

**Prepayment penalty:** None

**Rate availability:** To guarantee receipt of the above listed rate, loan enquiries must be received by the Bank on or before 6/30/10.

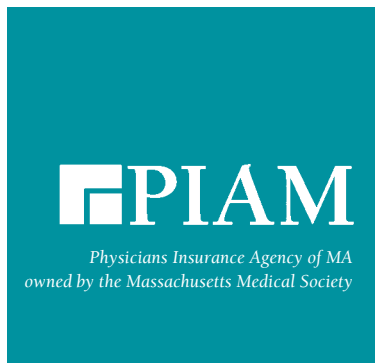
For additional information please contact David A. Bourret, Senior Vice President, at (617) 912-1915 or dbourret@bostonprivatebank.com. ■

*The commitment by Boston Private Bank to provide such loans is subject to the proposed Borrower meeting the underwriting standards of the Bank for commercial extensions of credit of this type. The Bank requires submission of financial statements by the practice group or physician borrower and by the practice owners, and bases its underwriting and loan decision primarily on that information and on information available to it from certain credit reporting agencies. Typically, the time between receipt of a complete loan application and funding of an approved loan is 30 days.*

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# PIAM Malpractice BULLETIN

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## Don't Miss the First Meaningful Use Requirement Deadline

Physicians and healthcare providers need to scramble to adhere to the government's plan to ensure electronic medical records (EMR) are implemented within a few short years. Adoption incentives will be activated in January 2011 and penalties for noncompliance begin in 2015. One of the major obstacles healthcare providers have encountered is what constitutes "meaningful use" of a certified EMR in order to be eligible for incentive bonuses. The Centers for Medicare & Medicaid Services (CMS) proposed Stage 1 criteria for meaningful use focus on electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information.

The Office of the National Coordinator for Health Information Technology (ONC) is working on finalizing the definition of "meaningful use" and the criteria will be completed sometime this spring. To accomplish this, ONC recommended specific objectives for physicians to meet as they begin using EMRs. Criteria for the 2011 deadline include:

- Developing capabilities to exchange health information where possible
- Providing patients with timely electronic access to their health information, including lab results, problem list, medication lists, allergies
- Generating and transmitting permissible prescriptions electronically

- Providing patients with electronic copies of discharge instructions and procedures
- Implementing clinical decision support rules relevant to specialty or clinical priority
- Submitting insurance claims electronically and verifying insurance eligibility electronically when possible

ONC also called for enabling patient access to personal health records by 2013 and will require that all providers participate in a national health data exchange by 2015. Many healthcare organizations have hesitated to make purchasing decisions about EMR systems until they understood more clearly what CMS would need from them. Since implementing an EMR system is a timely process including training and uploading existing data, final-

izing EMR plans should be a major goal for all medical providers in the next few months.

For more information go to the MMS web site [www.massmed.org](http://www.massmed.org).

You may also sign up for the *ARRA Advisor*, a free biweekly e-newsletter that provides the latest information from the MMS about the Federal Stimulus program, EMR adoption, Health Information Exchange quality measures and other related technology subjects. Go to [www.massmed.org/newsletters](http://www.massmed.org/newsletters). ■

– Barbara Lawrence

See *Boston Private Bank & Trust Special EMR Loan Program*, article on page 3.