CLARITY White Paper

Healthcare Captives – An Important Risk Management Vehicle

Part 1: Foundations of Successful Claims Management

Introduction

The healthcare industry continues to evolve under the Affordable Care Act (ACA); more physician practices are being purchased and operated by hospitals. These new employment trends add new exposure for claims related to the negligent acts of employed physicians. In addition, hospitals are entering new operational agreements with other healthcare institutions, mergers and acquisitions abound. With these changes taking effect, now is the time for healthcare providers to look for more cost effective ways to insure their facility in managing these risks.

Regardless of these new trends, the cost of professional liability insurance remains one of the most significant costs that healthcare providers face. One way to control costs is by creating a captive insurance company, which offers healthcare systems an important vehicle for managing the financial risk. The successful management of a captive insurance company is a confluence of underwriting, risk-quality-safety management, and aggressive claims management. These three areas create a risk management triad that sustains a stable environment for the management of the professional liability risks of the healthcare organization.

Clarity Group, Inc. is pleased to present this series of White Papers on the successful management of a healthcare captive insurance company in the professional liability arena. This White Paper focuses on claims management and provides the elements that must be considered in an effective claim management system.

Foundations of Successful Claims Management

Over the past few decades, a focus on proactive risk management activities has been responsible for many improvements to the safe delivery of healthcare. Increased transparency, improved communication tools and numerous advancements in medical technology have all made an impact on the culture of safety in healthcare. However, no matter the strategy or track record, every healthcare

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provider faces the potential for unanticipated events that can lead to patient injury, and to a claim against the provider for medical negligence.

Management, from Incident to Claim

Early investigation and identification of the factors that lead to the incident is crucial. If the incident and a subsequent injury to a patient are caused by the action of a healthcare provider or anyone with a relationship to the institution, then every consideration should be taken to immediately apologize to the patient and his/her family and make a full disclosure regarding the medical error. In addition, an offer of fair compensation is key to achieving resolution for the patient and the institution, and can greatly reduce liability costs. The healthcare organization must have a "disclosure policy" in place. The staff needs to be aware of the policy and work closely with the organization's risk manager to insure that the disclosure is done correctly. Risk managers should develop a process for working with administration to offer compensation for the injury before the *patient* becomes the *plaintiff.*

Even when you have been proactive and all efforts have been made to reach a reasonable settlement, some patients will still seek the advice of legal counsel and may decide to file a lawsuit. When your organization receives a summons or formalized complaint, the focus needs to shift from event management to the effective management of the litigation process.

Best practices suggest that cases should be managed proactively rather than reactively. In the context of litigation management, a proactive risk manager has direct participation in the litigation process. With the reactive approach, the risk manager assigns counsel and waits for results. When the risk manager maintains control of the process, surprises are less likely and legal expenses can be better controlled. In addition, active participation is rewarding and promotes professional growth, increasing the risk manager's claims management expertise as well as gaining the confidence of senior management.

The cornerstone of effective claims management is the establishment of a consistent process. It is recommended that you create a manual that outlines the process you will follow. The following components are core to building the manual: a reserve philosophy and methodology, a settlement policy with authority levels for case settlement clearly defined, and guidelines to set reserves. The manual also needs to contain litigation guidelines to provide defense counsel with specific instructions and expectations in handling litigated cases.

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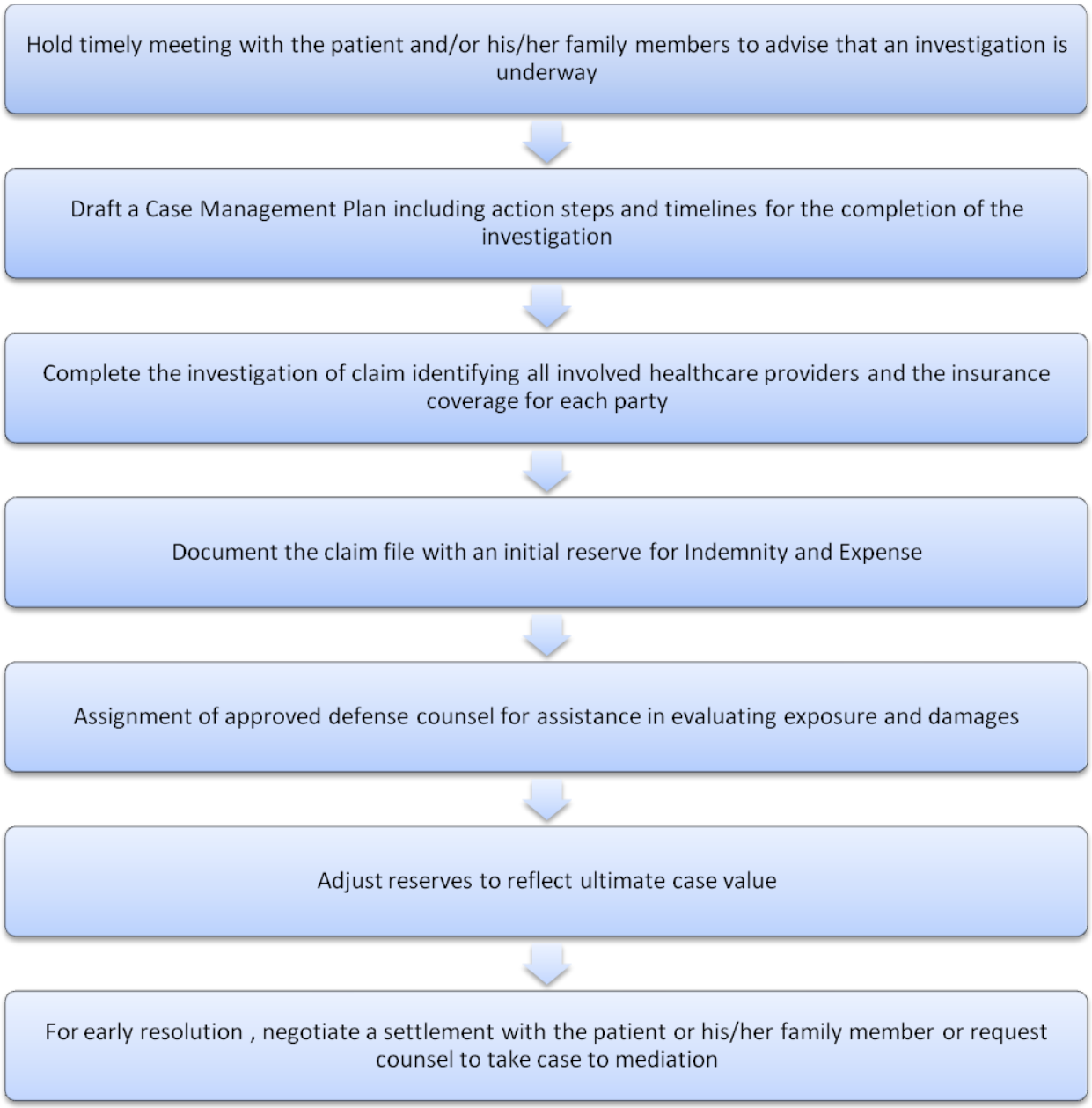
Claims Management - Best Practices

Below is a chart of a proactive claims management process, followed by a brief description of some key elements:



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Key Elements of the Claims Management Process

The following tools must be in place to achieve a successful and cost-effective outcome for all parties in litigated and non-litigated cases:

Reserve Philosophy & Methodology

- **Reserve Philosophy**: Reserves that are set for cases can have a significant impact on an organization's financial status. The philosophy of reserving is to establish realistic reserves within 12 months of receiving notice of an asserted claim, or a summons and complaint. This provides the optimum opportunity for financial management of the case.

- **Setting Reserves:** The case reserves should represent the best estimate of the cost or value of the case given the facts as known at any point in time. Case reserves can change as knowledge is acquired. Many factors should be considered in developing realistic reserves: an assessment of the insured's negligence and the involvement of any other co-defendants, an assessment of the plaintiff, including age, occupation and income, as well as the damages, both economic and non-economic. The opinion of defense counsel regarding local settlements and jury awards and their overall estimate of the value of the case is important to consider as well.

- **Reserve Methodology:** In setting initial reserves, the risk manager needs to follow the methodology outlined in the manual to ensure consistency. In the initial period, after an asserted claim is received and still little is understood about the merits of the case, indemnity and expense reserves should not be excessive.

Settlement Authority Guidelines

- **Settlement Policy:** Settlement authority levels should be established by the administration or the Board of Directors and documented to ensure consistency. In some cases, the risk manager will be given authority to settle cases below a certain dollar amount. For any offer being considered over that predetermined amount, the risk manager would need to prepare a case summary with a recommendation for settlement to be reviewed and approved by the appropriate administrator, committee or board.

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Attorney and Litigation Process Management

- **Approved List of Attorneys:** An approved list of attorneys who have trial experience in medical malpractice litigation needs to be created. It is important the organization selects the attorney for a specific case rather than the firm.

- **Litigation Management Guidelines:** Defense counsel should be provided with specific unambiguous guidelines regarding the handling of litigated cases. The document may include expectations as to when the initial case status report is due and how often the counsel is required to provide an updated report, as well as number of days for reports on discovery and depositions to be provided. It should also include any event during the litigation process where the risk manager would want immediate notification. Initial reports should include a case budget that is to be adjusted on a quarterly or semi-annual basis.

Claim Disposition

Final resolution of a claim can be achieved through:

- Pre-litigation negotiations with the patient or his/her family member
- Mediation or Settlement Conference
- Trial

Methods of a final resolution can be:

- An apology for the error/injury with a settlement offer
- Offer to establish a memorial or a foundation in memory of the deceased family member
- A structured settlement
- Cash settlement

Claims Management System

In today's era of communication technology, electronic systems are replacing paper files, dramatically decreasing work time while increasing efficiency in claims management. Having an intuitive and easy-to-use claims management tool is important in effectively managing claims from start to finish.

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The key components of an effective electronic system are:

- Ability to track indemnity and expense payments against reserves;
- Ability to diary important dates and follow-ups;
- Ability to detail the progression of the claim;
- Ability to track the legal aspects of the claim, attorney information and use of experts;
- Ability to generate reliable loss runs.

In addition, it is helpful to have a flexible claims system that has the ability to track serious events as precautionary files, to tie early investigation of events to the claims, and to enable consistent and reliable reporting under the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) to the Centers for Medicare and Medicaid Services (CMS).

A good claims system will offer all of this and more, thus enabling a healthcare organization to streamline the claims management process while empowering a proactive approach to claims management, ultimately increasing knowledge and decreasing the financial burden on the organization.

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For more information on Clarity Group, Inc. or the **Claim Management Module** of the **Healthcare *SafetyZone*® Portal** , please visit our website at www.claritygrp.com.

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