Overview and recent developments in medical malpractice law in the United States

Thomas Heller

ABOUT ME

- I grew up in Detroit and graduated from the University of Michigan, with a B.A. from the Department of Literature, Science and Arts. I worked my way through law school at night at Wayne State University School of Law, while working days as a law clerk to the Honorable Hilda Gage, an Oakland County, Michigan Circuit Court Judge. While in Law School I was an editor for two years on the Wayne Law Review. Following graduation in 1979, I had a one year internship as law clerk to the Honorable Dorothy Comstock Riley of the Michigan Court of Appeals. During this year, I passed the Michigan Bar Exam.
- I entered the private practice of law in 1981, and for four years worked at the Southfield, Michigan law firm of Bushnell Gage Doctoroff and Reizen, doing general civil litigation. My wife and I moved to Seattle, Washington in 1985 and for about 12 years I worked at the firm of Keller Rohrback, doing insurance defense litigation. I operated my own firm, Heller Wiegenstein PLLC for 20 years. My practice focused on a wide array of insurance defense matters. Probably half of that work involved medical-legal issues of one sort or another. I worked in the asbestos defense arena for nearly 30 years and during that time was local counsel for John Crane. I tried and arbitrated many cases and also handled appeals in the state appellate courts. I served as an arbitrator on many occasions and served as a Settlement Guardian ad Litem.
- My family has always enjoyed traveling and we ultimately decided to relocate to Maribor, Slovenia for our retirement. We look forward to further travels in Europe and forging new relationships. I also hope to share legal knowledge with the local legal community.

WAYNE STATE UNIVERSITY
LAW SCHOOL

OVERVIEW OF MEDICAL MALPRACTICE LAW IN THE UNITED STATES – TORT LAW

- Claims for negligence against physicians, hospitals and other health care providers are part of the general body of law known as "tort law," which is designed to deal with injuries to both persons and property.
- Medical malpractice claims are one type of tort, known as the tort of negligence.
- The law of negligence provides that everyone has an obligation, known in the law as a "duty," to perform their actions with "ordinary" or "reasonable care." The degree of care required is commensurate with the risk involved with the particular act that is being carried out. As a rule, the greater the potential risk of harm is in the act being carried out, the greater the care that must be taken.
- The general idea is that if a risk of harm is reasonably foreseeable, and the actor's conduct falls below the standard of reasonable care and injury results, the actor will be held liable for all damages that proximately follow from the actor's negligence.

THE ELEMENTS OF A MALPRACTICE CLAIM

- Medical malpractice claims are generally, though not always, brought in state court and the law varies from state to state.
- However, as a general proposition, under principles of tort law, in order to win a lawsuit for malpractice, the plaintiff must establish the following:
  - (1) The person or entity being sued owed plaintiff a legal duty; and
  - (2) there was a breach of that duty; and
  - (3) that breach of duty proximately caused the plaintiff harm; and
  - (4) the plaintiff suffered damages.

ELEMENTS CONTINUED

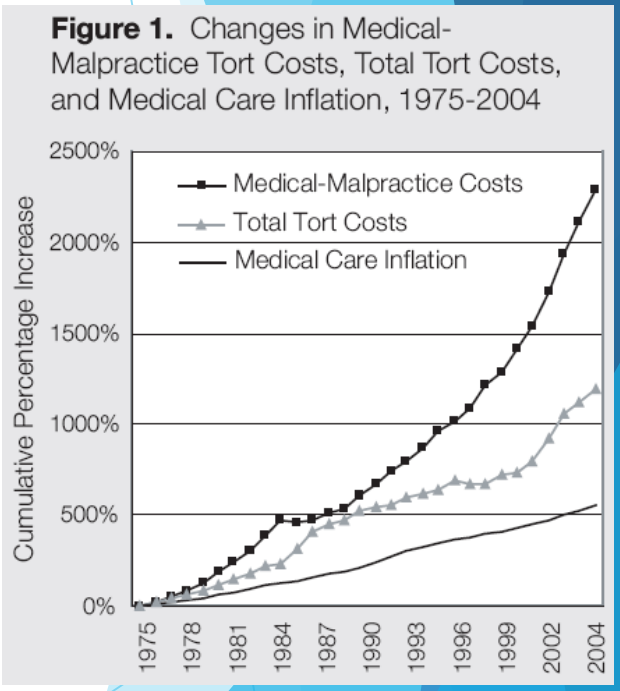
- Duty Element. Plaintiff must establish a “physician-patient” relationship. If there is, the physician (or health care facility) has a duty to exercise reasonable care in providing treatment. This element is usually easily met and is not contentious.
- Standard of care. The standard of care has expanded over time from a local standard to a national standard. Plaintiff must establish, usually through expert testimony, that the care provided fell below that standard.
- Proximate cause. Plaintiff must establish, again nearly always through expert testimony, that the “substandard care” actually caused the complained of injury. If the physician was negligent, but the negligent act did not “cause” the injury complained of, the physician will not be held liable to the plaintiff.
- Damages. Plaintiff must establish actual damages.

TYPES OF AWARDABLE DAMAGES

- Economic Damages. Includes past and future medical bills; past and future loss of income; past and future loss of services; damages stemming from future health care plan; past and future “other” out-of-pocket expenses, etc. Economic damages are subject to calculation, but are often hotly contested.
- General (non-economic) Damages. Includes damages for past and future pain and suffering; disfigurement; humiliation; anxiety; fear of future injury; loss of companionship, etc. General damages are highly subjective in nature, and not subject to calculation.
- Economic damages, in particular, are usually the subject of expert testimony from multiple disciplines such as medical doctors, economists and nurses.
- Punitive damages are allowed in some states for malicious conduct.

SO WHAT'S THE PROBLEM?

- The literature has showed that the number of medical malpractice lawsuits has occurred in waves over the lasts 50 years.
- Three periods of crisis in soaring medical malpractice costs occurred in the 1970s the mid-1980s and the late 1990s into the mid-2000s.
- Each "crisis" led to spikes in malpractice premiums and reductions in the availability of insurance coverage, especially for specialists that treat high-risk patients and especially for physicians in certain parts of the United States, such as New York and certain other eastern seaboard states. Claims experiences varies widely across the U.S.



SO WHO DO WE BLAME?

- Insurance carriers and health care providers point to a very flawed “tort system” and in particular argue the following points, among others:
  - (1) Too many “Trial Lawyers” and excessive litigation;
  - (2) Unreasonably high jury verdicts and settlements;
  - (3) Too many “so-called experts;”
  - (4) Flawed substantive rules that unduly favor plaintiffs;
  - (5) A flawed medical malpractice insurance market;
  - (6) Physicians forced to practice “defensive medicine.”

TRENDS IN CLAIMS AND PAYMENTS

- As one might expect in a country as broad, diverse and expansive as the United States, there has been tremendous variability in the number of claims asserted; the amounts of settlements paid and judgments awarded; and the costs of medical malpractice insurance from state to state and over time.
- According to the National Practitioner Data Bank [NPDB], total payments for physician medical malpractice claims in the U.S. more than doubled between 1991 and 2003, rising from $2.12 billion in 1991 to $4.45 billion in 2003.
- During that same period of time, the average payment rose from somewhere between approximately 88% to 131% or approximately $140,000 t0 $290,000.

TRENDS CONTINUED

- Data gathered by the NPDB and Physician Insurers Association of America (PIAA) show that the number of paid claims for medical malpractice increased at a fairly moderate rate of approximately 7% to 12% between the years 1991 – 2003 (claims estimates approximately 13,700 in 1991 to 15,000+ in 2003).
- The NPDB and PIAA estimate that the average defense costs per claim also roughly doubled from 1991 to 2001 (for paid claims roughly $21,000 to $44,000).
- But the number of claims asserted, and the amount of dollars paid per claim varies significantly across the various states.

PROBLEM REVISITED

- The periods of medical malpractice crises caused a number of undesirable consequences.
- Malpractice premiums for some physicians in some areas of the U.S. increased dramatically.
- Some insurance carriers pulled out of some markets or would not insure certain physicians that practiced in high-risk areas.
- Physicians decided not to practice in some states or to practice in lower risk areas in states where claims were prevalent.
- There has been a concern physicians began to overly practice “defensive medicine” which, in turn, has driven up health care costs.

TORT REFORM TO THE RESCUE!

- State legislatures have attempted to address the problems identified above in various ways, under the umbrella of what has been called “Tort Reform.”
- Tort reform has occurred more or less continually over the last 40 years. Some states have been more active than others, and a state by state discussion is not possible here. But some common attempts at tort reform appear in the literature and those will be discussed here.
- As might be expected, these reforms have largely been pushed by the health care and insurance industries and often opposed by various patient advocate groups and plaintiff trial lawyers.
- Some tort reform measures have been struck down as being in violation of state constitutions.

"Conventional medicine says take aspirin. In the absence of tort reform, defensive medicine says MRI and Cat Scan."

ATTEMPTS TO LIMIT DAMAGES AND ATTORNEYS FEES

- Health care providers believe that awards of non-economic/general damages (e.g. pain and suffering, humiliation) are too often arbitrary, excessive and punitive in nature, if not in name. Indeed, awards for non-economic damages can sometimes be very significant, amounting to many millions of dollars.
- Some states have attempted through legislation to limit, i.e., place “caps” on the amount of non-economic damages that a jury can award. Those limits vary, for instance: $250,000 to $1,000,000. This is the most frequently capped element of damages.
- Some (fewer) states have placed caps on the amount of so-called economic damages that a jury can award.
- Still other (fewer) states have placed caps on total damages.
- Some state courts have struck these caps down as violating equal protection laws of the states’ constitution, and on other grounds.

ATTEMPTS CONTINUED

- Under the American system, as a general rule in civil litigation, all sides pay for their own attorney fees (and for most but not all costs), win or lose. This is true in the absence of a statute, contract provision, or some recognized ground in equity. None of those exceptions typically apply in medical malpractice litigation.
- Plaintiffs' counsel in medical malpractice (and other personal injury matters) usually only receive a fee if their client either wins at trial or achieves a monetary settlement. This fee is therefore appropriately called a "contingent (on winning money) fee." The percentage of this contingent fee varies, but typically ranges from one-third to fifty-percent, and hence can be substantial. As noted earlier, health care providers have partially blamed the high costs of delivering health care on these excessive attorney fees.
- In response, as a further tort reform measure, some states have restricted the attorney's contingent fee to no more than a specific percentage of the total award, sometimes decreasing as the size of the award increases.

LIMITATIONS ON EXPERTS

- Most malpractice cases involve introduction of expert testimony to address issues of both liability (standard of care; breach of standard of care; and causation) and damages.
- Trial judges have an important "gatekeeping function" to insure that the proffered "expert" indeed has the requisite expertise to present testimony to the jury. Disputes over whether proffered experts can be allowed to testify are usually resolved in pretrial motion practice.
- However, some states have passed specific legislation regarding use of expert testimony in medical malpractice cases. For instance, some states require the experts be of the same specialty as the physician being sued, and/or that the experts actually be practicing (i.e., not retired) experts.
- Some states provide that the expert must practice or have training in diagnosing or treating the conditions similar to those of the plaintiff and must devote a certain percentage of his or her professional time to clinical practice of teaching in their field or specialty.

PRE-TRIAL SCREEING OF CASES

- Physicians and health care providers have complained that there are too many cases that proceed without any merit. One traditional protection against such meritless cases is that the defendant can make a motion before trial to dismiss a case in what is known as a motion for summary judgment.
- However, sometimes cases can drag on for many months, or even years, and at substantial expense, before such a motion can be brought, and even if the motion is successful, the defendant typically (with rare exceptions) cannot recover attorney fees expended in defending. Further, many trial judges are reluctant, except in the clearest of cases, to dismiss cases short of a full blown trial on the merits.
- In response, some states have passed legislation requiring the "pre-screening of cases," meaning that medical malpractice cases have to be screened by a medical review panel of experts, some other panel or official(s) or a mediator before the case can go to court.
- Some states require a plaintiff to show at the very outset of the case (i.e., when the case is instituted) that he/she has a qualified medical expert that will support the claim being presented.

ALTERNATIVE DISPUTE RESOLUTION

- There are various forms of Alternative Dispute Resolution, or ADR. These include arbitration and mediation. Both forms of ADR are frequently used in the United States in all forms of civil litigation.
- However, in some states, legislation has been passed in medical malpractice cases to permit physicians to require that disputes with patients be resolved by arbitration rather than through the courts.
- In some states, arbitration is voluntary but arbitration clauses are enforced and sometimes the results of arbitrations can be introduced in subsequent trials in court.
- Some states have initiated so-called Disclosure, Apology and Offering laws. Similar to early arbitration, these initiatives focus on early disclosure of mistakes, apologizing when appropriate, and offering up-front compensation in an effort to avoid costly and time consuming litigation.

MODIFICATIONS TO JOINT AND SEVERAL LIABILITY RULE

- The question here focuses on how damages are assessed when there are multiple defendants and who pays the damages awarded.
- Assume a case where there are four defendants: three physicians and a hospital. Following trial, the jury finds one physician 25% at fault; another physician 25% at fault; another physician 40% at fault; and, the hospital where care was provided only 10% at fault. Total fault here is 100%.
- The law on how liability is assessed, and who can be forced to pay what, varies from state to state. However, to simplify, the traditional rule in tort law has been that any defendant who is found to have been responsible to plaintiff for any percent (even 1%) can be forced to pay the entire judgment. The law calls this "joint and several liability."

MODIFICATIONS CONTINUED

- The joint and several liability rule comes into play where one or more of the defendants found to be at fault lacks sufficient insurance or assets to satisfy the entire judgment. Under the joint and several rule, the plaintiff can decide to satisfy all of the judgment from one defendant. So in the example above, the hospital would be, under the traditional rule, "jointly and severally liable" for the entire judgment, even though having been found to be only 10% at fault. (Note: the hospital in this example can attempt to force the other defendant(s) to reimburse it for the defendants' "share" it was forced by the plaintiff to pay.)
- The traditional reason underpinning the joint and several rule is that it is more fair to require a negligent party to pay more than its fair share of a judgment than to deny compensation to plaintiff.
- In the medical malpractice setting, and indeed in tort litigation more broadly, defendants have come to see this traditional rule as being unfair and requiring reform. In particular, well-funded defendants such as hospitals (or government defendants and large corporations in other civil litigation) argue the rule exposes them to liability well beyond their actual culpability, and therefore punishes them just because they have more insurance or more collectable assets.

MODIFICATIONS CONTINUED

- These concerns have led to modifications of the traditional joint and several liability rule. Some states limit the amount of damages from any defendant to the portion of the injury caused by that defendant. This rule in known as "several only liability."
- Legislation in other states provides that any defendant that is found responsible for 60% or more of an injury is jointly responsible for the entire amount, but defendants who are found liable for smaller "shares" of an injury are only responsible for their own share of the injury.
- Yet another state enacted a law that provides that a defendant that is found by the jury to have caused more than 50% of the injury can be found jointly and severally liable for the entire amount of any economic loss but is responsible only for its share of any non-economic loss.
- Other states have enacted other laws that have ameliorated the harshness of the traditional joint and several liability rule. It is worth noting that similar reforms have been made in tort liability not involving health care providers.

MODIFICATIONS TO THE COLLATERAL SOURCE RULE

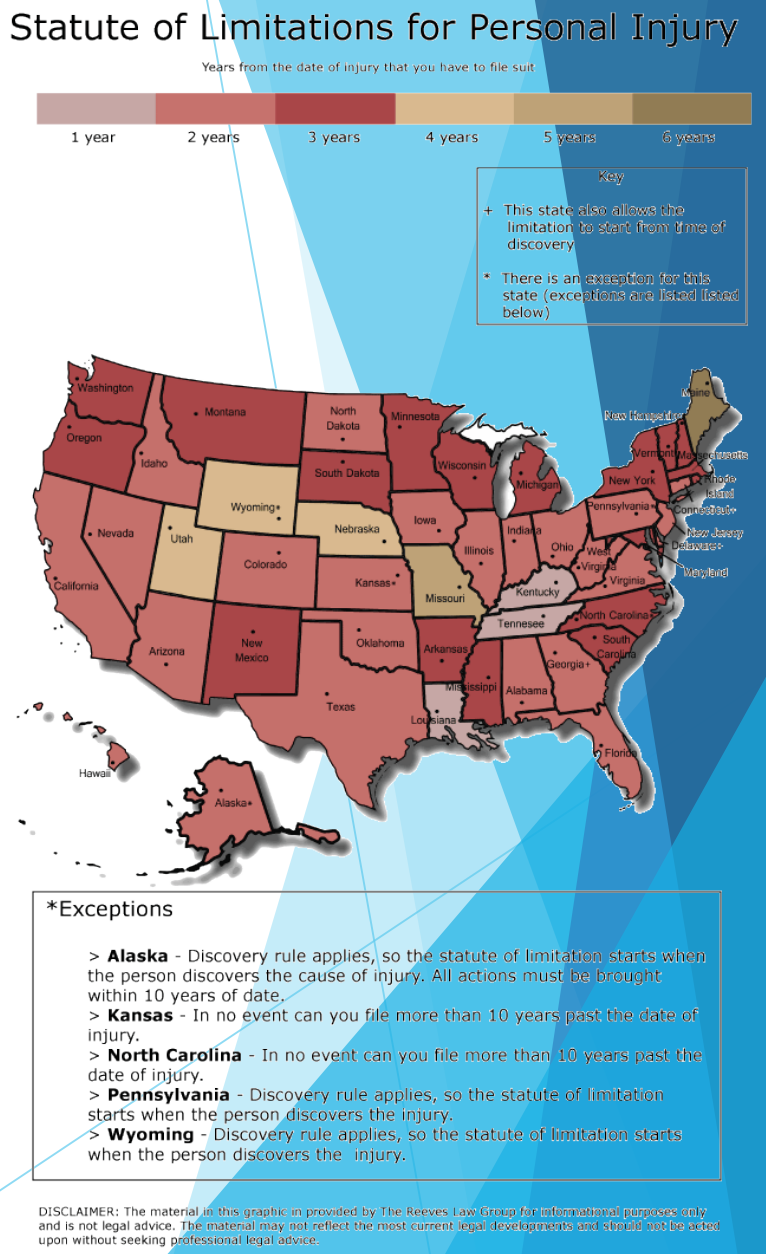
- Plaintiff proceeds to trial and wins on liability. The plaintiff presents evidence of past medical bills of $30,000. The jury awards plaintiff those damages, along with other forms of compensation, such as general damages for pain and suffering, that is, non-economic damages. The jury was not informed of this, but as it happened, the plaintiff had various forms of health insurance coverage that already paid for the $30,000 in past medical bills. The traditional rule, known as the "Collateral Source Rule," is that the successful plaintiff can collect the awarded $30,000 in medical bills even though those bills already were paid by some third party (e.g. typically a health insurance carrier.)
- The health care industry, including the insurers, argue the rule is unfair and has contributed to the rising cost of health care, and of malpractice premiums.
- In response to the complaints, some states have passed legislation in medical malpractice cases that has modified the Collateral Source Rule. Some states have passed laws requiring malpractice judgment awards to be reduced by collateral payments, and in other states the jury is informed of the collateral payments and can take them into account in deciding upon damages. Other states have modified the traditional rule in yet other ways, to again attempt to limit the harshness of the hard and fast rule.

STATUTES OF LIMITATION

- Statutes of Limitation govern the length of time an injured person has to commence a legal proceeding against a defendant. Health care providers have argued some of the statutes are too long.
- These statutes are designed to insure that claims are not allowed to be asserted so long after the triggering event that evidence can no longer be found to defend the claim, i.e., to guard against "stale" claims.
- There are competing interests in cases involving medical injury. On the plaintiffs' side, sometimes injuries sustained as a consequence of poor care (i.e., medical negligence) cannot be learned for many years after the care has been provided. Too short of a statute of limitations is unfair to the injured plaintiff. On the other side of the equation, a lack of clarity about when a claim might be asserted, and long statutory periods, leads to uncertainty and therefore can lead to increased medical malpractice premiums among other undesirable outcomes.

STATUTES OF LIMITATION CONTINUED

- In response, many attempts at tort reform have centered around the issue of the applicable statute of limitations in medical malpractice cases.
- Some states have shortened the statutory period.
- Some state laws start the “time clock running” from the time an injury occurred irrespective of whether it is apparent from that point in time or not, while others don’t impose a time limit until the injured person had a reasonable period to discover the injury.
- This later concept is known as a “discovery rule” and various states across the U.S. have written laws that limit the time a plaintiff has to initiate a claim after discovering the injury and/or the negligence that caused it.



PATIENT COMPENSATION FUNDS AND PRE-SUIT NOTICES OF CLAIM

- Some states have created Patient Compensation Funds. The idea is to place some upper limit or cap on the amount of damages that a physician has to pay, while at the same time insuring that the injured plaintiff can be made whole by receiving additional funds from a state sponsored patient compensation fund.
- Some states have passed legislation requiring a plaintiff, as a pre-condition of later filing a lawsuit, to first provide written notice to the potential defendant (i.e., physician or hospital) of the claim. The notice would have to include information such as the particular negligence asserted, the damages being claimed and like information. A typical time limit would be at least 30 or 60 days before filing suit. The idea here is give the parties a chance to settle without the need for a costly lawsuit. Some of these laws have been stuck down as in violation of state constitutional law.

HAVE THE TORT REFORM MEASURES WORKED?

- The answer to this question is not entirely clear, and has been the subject of many studies and articles. It has been stated that the relationships between tort reform, malpractice costs, and medical liability environment favorability are complex and nonlinear.
- From what I have read, it would appear that many studies have concluded that in states that have upheld damage caps, medical malpractice premiums have in fact gone down and it has been stated that the cap on damages has been the most significant and effective tort reform measure in helping to reduce malpractice insurance premiums.
- It would appear that there is more debate and uncertainty over whether tort reform measures of all types have actually decreased physicians' practice of engaging in "defensive medicine" to help avoid malpractice claims, and whether these measures have assisted in lowering the overall cost of health care in the United States.

HAVE THEY WORKED CONTINUED

- Reforms, especially caps on non-economic damages, seems to have worked in states including California, Colorado, Kansas, and Texas. Litigation in those states has decreased and malpractice premiums remain relatively low.
- While there has been less meaningful tort reform in these states, litigation is still very frequent and malpractice premiums are high in New York City, Washington DC, New Jersey and Delaware. Some physicians practicing in high-risk specialties such as OBGYN's and surgeons pay annual premiums of $100,000 or more.
- Pre-law suit screening requirements, where instituted, also seem to have limited litigation.
- The fact is, moreover, there are some areas of the U.S that simply are less litigious overall than other areas, such as Minnesota. Minnesota physicians pay some of the lowest malpractice premiums in the U.S. Therefore, state culture is also an important factor when looking at what is driving the amount of malpractice claims and the costs of malpractice premiums.

OTHER POSSIBLE REFORMS

- Some scholars have suggested that the state-by-state approach to resolving medical negligence claims in the traditional tort system is far too complicated, time consuming and expensive and therefore should be replaced entirely with a no-fault system that would offer certain compensation for injured patients.
- For instance, states all have industrial insurance laws for workers injured in the course and scope of their employment. Although the systems vary from state to state, the general idea is that when a worker is injured, he/she will recover defined benefits under the state worker's compensation laws, irrespective of whether anyone (i.e., the worker or the employer or a co-worker) was at fault in causing the injury.
- States have worker compensation funds that are established and paid for by the employers. When the worker is injured, he/she usually receives payment for medical bills, loss of earnings, and a lump sum payment for any permanent, partial disability.

OTHER POSSIBLE REFORMS CONTINUED

- The asbestos litigation is alive and well in the United States. As is true with health care providers, asbestos manufacturers and their insurers decried the handling of asbestos claims in the traditional tort system and for many years lobbied the U.S. Congress to establish an Asbestos Compensation Fund that would provide certain defined compensation to victims of asbestos-related diseases. The plaintiffs' trial lawyers fought this proposal tooth and nail and in the end the Congress narrowly voted the proposal down.
- It is difficult to see this proposal garnering the necessary support to ever become reality in the U.S.

SHIFT TO LARGE GROUP PRACTICES AND HOSPITALS EMPLOYING MORE PHYSICIANS

- Traditionally, many doctors practiced alone or in small groups. Each doctor or small group of doctors purchased their own medical malpractice insurance. For some of the reasons discussed earlier, from time to time; from place to place; and, from specialty practice to specialty practice, malpractice coverage either became very expensive or difficult to get at all. Both consequences were and are undesirable.
- Individual physicians traditionally were either employed directly by the hospital where they practiced (and hence covered by the hospitals' malpractice insurance) or merely had privileges to practice there, were not considered "employees" but rather, as "independent contractors" and hence would not have been covered by the hospitals' malpractice coverage, but rather by his/her own malpractice insurance.

Providence HEALTH SWEDISH Virginia Mason

REASONS BEHIND THE SHIFTS

- Traditionally, therefore, hospitals and staff physicians were separate legal entities, and different legal theories applied to each. Accordingly, hospitals were not liable for medical malpractice, since they were not the ones providing the treatment. Sometimes, however, special rules under the laws of Principal and Agency (such as “Apparent Agency”) were used by plaintiffs’ attorneys to get around this problem.
- Plaintiffs’ attorneys that represent injured plaintiffs have always had to concern themselves about suing the “correct” entities. If they sue only the hospital where care was provided, the hospital might turn around and as a defense to the claim assert that the physician that performed the allegedly poor medical services was not an “employee” but rather only an “independent contractor” and therefore assert the hospital is not legally responsible for that physicians’ conduct.

REASONS FOR SHIFTS CONTINUED

- Out of (legitimate) fear of attorney malpractice, the reasonably prudent plaintiff medical malpractice lawyer would typically join in the lawsuit both the hospital and all physicians that provided care to the injured plaintiff.
- The hospital defendant might argue the physician was not its employee and that it should not be held liable for the acts of that physician and sometimes the defendants would end up “pointing fingers” at each other, a tactic that often only plays into the hands of the plaintiffs’ counsel, as the jury often then comes to the conclusion that one or both of the defendants “must be” at fault if there is so much finger pointing.
- The traditional insurance model also was costly to the defendants, both the individual physicians and the health care facilities, both of which had to purchase insurance at increasing cost to both, especially during times of “crisis” as discussed previously.

REASONS FOR SHIFTS CONTINUED

- While the various tort reform legislation discussed earlier has met with some some success, the continued uncertainty regarding the availability of insurance and, when available, its cost, coupled with the desire to improve the quality of the delivery of health care and to control overall costs, among many other reasons, has led to certain systemic changes or trends in the health care system and the methods used to insure both individual physicians and medical clinics.
- I will discuss here some developments in Washington state, in particular, although I believe these comments hold true for many places in the United States as well.

CONSOLIDATION 0F PROVIDERS

- Over the past 15 to 20 years, the trend has been to larger and larger healthcare organizations and for hospitals to directly employ many more physicians. Along with the other reasons discussed in the previous slides, this has been driven by the need to consolidate to have a stronger bargaining position when negotiating reimbursement rates with first party health insurers.
- Further, more and more, hospitals are owned by, and physicians are employed by, these large healthcare organizations.
- In Washington, for example, there are very large institutions such as Virginia Mason, MultiCare, and the University of Washington, that employ very large numbers of physicians and other employees.

THE MOVE TOWARD SELF-INSURANCE

- Following the first national spike in medical malpractice claims in the 1970s, many of the traditional commercial insurance companies left the marketplace because of overwhelming losses. Healthcare providers either could not find insurance or, if they could, the premiums were very high. Physicians left certain states and shortages in physician care occurred in some high risk specialties.
- In response, and in addition to the trend of consolidation, both physicians and hospitals started to form their own risk pools or mutual insurance companies. In Washington state, for example, nearly 100 physician-owned insurance companies started up during this period to fill the void. In 1982, physicians in Washington state, along with the Washington State Medical Association, banded together to form what is now called Physicians Insurance (a mutual company), which insures about 80% of Washington physicians. Physician-owned companies insure more than half of U.S. physicians who buy their own insurance.

SELF-INSURANCE CONTINUED

- An overwhelming majority of hospitals now use the self-insurance model to provide liability coverage for their employed physicians. With many physicians now being directly employed by hospitals, this means that many physicians now are insured by the hospital where they work.
- This model allows hospitals to promote uniformity in physician practices.
- Hospitals often can self-insure a physician cheaper than is costs in the commercial market.
- However, both the physician going to work at a hospital, and the hospital, must look at the issues of who will insure the physician for "prior acts" or events that occurred prior to the physician's employment at the hospital and whether the hospital will offer "tail coverage," or coverage for malpractice claims brought forth after a physician is no longer employed by the hospital.

GROUP CAPTIVE ALTERNATIVE

- According to a recent study in the New England Journal of Medicine, only 1% of doctors account for almost one-third of paid medical malpractice claims. This study also found that just 6% of physicians had a paid malpractice claim during the study's time period of 2005 – 2014.
- Although these percentages are low, needless to say both physicians and other health care providers such as hospitals must insure themselves against the risk of a costly malpractice claim, and economic pressures have forced the healthcare industry to constantly search out new options to insure against those risks.
- One such option the healthcare industry has turned to is a group captive.
- In essence, a captive is an insurance company that is wholly owned and controlled by its insureds; its primary purpose is to insure the risks of its owners, who also benefit from the captive insurer's underwriting profits.

HOW THE CAPTIVE WORKS

- In a group captive, hospitals and other healthcare providers agree to share each other's risk of loss from professional liability and other exposures. This element of shared risk results in a requirement of greater accountability for each member.
- Group captive members can participate in collective and cooperative efforts, sharing best practices and identifying merging trends and issues, in order to have a learning organization.
- Members of the captive can rely on one another to offer insights to improve patient safety and prevent hospital errors from occurring.
- The further benefit of a captive is that through these cooperative efforts at minimizing risks through the promotion of best practices and patient safety, the captive ideally will generate profits from favorable operating results.

OTHER BENEFITS OF CAPTIVES

- Captives allow the owners to draft carefully custom-tailored insurance policies to fit their exact needs. This allows the owners to minimize, if not totally eliminate, exclusions found in the more typical insurance policies.
- Allows the owners of the captive to assign their own defense counsel when a claim is asserted, instead of having to use whatever counsel is assigned by the insurance company.
- The owner can administer claims on their own terms, instead of the terms dictated by the traditional insurance carrier.
- The primary purpose of the captive is to save money on insurance. By underwriting the insurance needs of the business, the captive can capture and retain the underwriting profits that would ordinarily be lost to the commercial carrier.

The End

- Thank you for listening!