

CHAPTER 5

Financing Risk

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A risk exists if there is an event or action that can have a material effect on the financial or operational performance of the healthcare entity. The financial survival of a healthcare entity requires achieving the optimal balance between retaining risk and transferring risk. Sufficient funds or access to funds is required to ensure that adequate funds are available to finance the survival and recovery of the entity from a risk event, and to protect the ability of the healthcare entity to continue treating patients. Risk financing is, by common definition, the utilization of funds to cover the financial effect of unexpected losses or, simply put, to cover the costs related to unplanned adverse events. Sources of funds to pay for losses can be classified as internal (self-retention or a shared retention/captive program that uses collective funds from member organizations) or external (generally through the purchase of commercially available insurance).

EQUITABLE TRANSFER OR RISK _____

Insurance is defined as the equitable transfer of the risk of a loss from one entity to another, in exchange for payment. The amount charged to cover a specific dollar amount caused by the insured event is called the premium. The insurance transaction requires a payment to the insurer in

exchange for the insurer's promise to compensate (indemnify) the insured in the case of a financial loss. The insured receives a contract, called the insurance policy, which details the conditions and circumstances under which the insured will be financially compensated.

The International Organization for Standardization (ISO) has developed principles, a framework, and a process to guide the management of risk. The standards (which are voluntary guidelines) emphasize the fact that management of risk must be tailored to the specific needs and structure of the particular organization. Risk financing is presented as a risk treatment activity to modify the risk.¹ An evaluation of the cost-effectiveness of the risk financing selection is paramount to the decision of which risk should be financed. Does the risk financing choice eliminate or reduce the cost of the risk to the healthcare entity? It is important to recognize that some losses or elements of a loss may be uninsurable, such as uninsured costs and damage to employee morale and the reputation of the organization.

How does the governing body determine its desired level of risk? It is essential that the healthcare entity leaders determine tolerance for risk and the desired balance of financial offense and defense. The risk that is right for one entity may not be right for another. There is no universal

acceptance of risk level, although it is universally accepted from a business perspective that less risk may not always be better. The risk of an event—whether unexpected (such as a natural disaster or major regulatory change that is entirely beyond the healthcare entity’s control) or an adverse clinical event that while unexpected in the individual circumstance was expected from an understanding of the industry—must be measured, evaluated, and planned for. The point of risk management is not to always reduce risk but rather to add value through the management of risk. “A balanced approach means taking [on] risk that is appropriate to the hospital’s financial and competitive positions as well as financial goals and objectives, and that is consistent with the risk preferences of the board and management... [Application of this] strategy, which also informs all others, is clearly a joint responsibility of an organization’s board and senior executives who are accountable for managing the organization in a manner that ensures achievement of strategic financial goals.”²

FINANCIAL COSTS OF ADVERSE RISK

Included in the risk financing equation are the costs associated with identifying, minimizing, responding to, defending, and repairing the effects of an adverse event. Insurance, whether self-funded or commercially provided, is intended to cover associated costs. Loss of public or consumer confidence as a result of real or perceived safety concerns can lead to a significant loss of business and income.

Defense costs: Defense costs may exceed the settlement and may include lawyers’ fees, court costs, transcription fees, and various other legal costs.

Settlement or judgment: Three types of awards may be bestowed: *general*, noneconomic loss such as pain and suffering; *specific*, such as medical bills or lost income; and *punitive*, such as punishment for acts considered reckless or unusually harmful by the courts.

Loss reduction: These costs are required to change work practices to avoid future losses.

Morale: Continuous losses cause employees to question work safety, the professionalism of the healthcare facility, and the management. Thus the institution may need to spend money to boost morale.

Opportunity costs: When a facility takes too long to decide on new projects or abandons them altogether, the opportunity dissipates and the institution incurs costs.

Although criminal actions can have ramifications of tremendous proportion, they are typically uninsurable. In some cases, unintentional criminal acts can be insured. Risk managers can address only imputed liability to the entity. Internal controls and procedures can deal with this type of exposure.

A COMPONENT OF RISK MANAGEMENT

Risk managers must identify their many areas of risk exposure and determine how best to manage their financial consequences. Identification of these various exposures is an organized process that relies on in-house adverse incident reports, patient safety data, quality improvement metrics, insurance company loss data, employee loss information, complaints, patient satisfaction survey results, financial reports, accreditation and licensure surveys, and professional literature. An appropriate risk management plan includes

risk financing considerations. When formulating a plan, the risk manager must carefully evaluate the potential loss in terms of frequency of adverse events and the severity of their financial consequences. This analysis is central to the process of determining the most appropriate risk financing option.

Frequency refers to the number of times an event occurs and can be gauged in relation to any relevant period of time or area—per patient-day, per discharge, per year, per procedure in the emergency room area, per operating suite, or per intensive care unit. Risk areas of the entity should be studied both individually and comparatively over time, with some view of the facility's experience in relation to the experiences of other organizations. Typically, the most frequent adverse occurrences are of a minor nature, such as the loss of eyeglasses or false teeth. One of the difficulties in gathering accurate data is that such minor occurrences may go unreported. However, implementation of an occurrence screen procedure that requires employees to report specifically listed events may yield increased data about minor incidents. In essence, the “occurrence screen” is an integration of quality assessment and risk management.

Severity refers to the cost of the loss in dollars. Financial payouts can range from insignificant to catastrophic. A risk exposure that is infrequent and catastrophic can be one of the most difficult and time consuming to assess. Losses of that nature are difficult to plan for because their likelihood always seems remote and the size of the potential loss may distract attention from preventing other more prevalent, though less costly, potential losses.

Traditionally, a healthcare entity that experiences a combination of high-frequency and high-severity financial losses will find itself facing high costs and limited options. To counter these

possibilities, risk managers must consider various risk management techniques, including high retentions, self-insurance, internal loss controls, claim procedures, and protocols. After selecting appropriate frequency and severity distributions, the actuary can set up a model to analyze various retention levels and run the simulation.

AVAILABILITY OF FUNDS _____

The decision to finance losses internally versus through external alternatives speaks to the fiscal health of the healthcare entity, its current and future investment income, credit/debit ratios, capital requirements, future expansion, availability of cash, governmental regulations, and risk appetite of the governing board. The availability of acceptably priced, external risk financing alternatives is a key factor in the cost/risk calculation and is influenced by the healthcare entity's claim experience, its risk exposures, and the insurance market's cycle, competition, and availability of reinsurance investment performance. External availability of funds and pricing follows insurance market cycles, commonly referred to as “hard” and “soft” markets.

A major insurance broker in a report analyzing the 2012 insurance market indicates that the 2011 rates (the price paid for insurance by the insured) for medical professional liability insurance typically stayed flat or decreased. The broker notes that many signs point to an increase in premiums in 2012, although a fair amount of competition among insurance carriers is likely to occur. The availability of funds (i.e., capacity) remained stable and sufficient in 2011. The broker's forecast calls for less capacity at the excess layer and intense scrutiny and risk review, which will likely lengthen the renewal process. It expects combined loss ratios for the

medical professional liability market to begin to rise, although not dramatically (barring any significant industry events). Healthcare reform is changing the risk landscape, however, and the growth in the numbers of physicians employed by healthcare entities will confound the risk equation; moreover, data security continues to grow as an area of exposure.³

Another major insurance broker indicates that healthcare reform will influence property and casualty insurance. Medical professional liability may experience changes as a result, due in part to the employment of physicians who will require more rigorous underwriting, based not just on the traditional specialty rating and loss review, but also on infection rates, readmission rates, and other quality indicators. According to this broker, in 2011 most of the major lines of coverage for the healthcare sector experienced no market changes, except for a late-year increase in property premiums. By comparison, in 2012, it expects to see flat to increasing pricing for healthcare entities. For medical professional liability, this broker anticipates that the current market will remain stable with some price reductions, while retentions, deductibles, limits, and coverage terms and conditions remain fairly stable.⁴

A third major insurance broker questions whether the paradigm of regularly revolving hard and soft markets can continue to exist in these economic times. It recognizes that after years of falling pricing, the insurance market has become more efficient, with profits being earned despite lower premiums. “The industry appears to be resilient, prudent, elastic, nimble, and smart.” According to this broker, the changes in healthcare reimbursement will not threaten access to the capital that is available through the payment of premiums. Its report

indicates that reinsurance pricing for property increased marginally in 2011 but forecasts that 2012 reinsurance pricing will climb higher. This organization views umbrella and excess pricing as firming but not hardening, although the insurance carriers are reportedly seeking price increases in the range of 5% to 10%.⁵

In summary, according to an international asset management, strategic advisory, and insurance research firm that reviews the industry on a quarterly basis, new challenges from a weak and changing economic recovery as well as health reform and increased competition will result in a modest increase in both exposure and premium price growth for both 2012 and 2013. This translates into good news for healthcare entities, which will find broad availability of insurance markets and capacity, albeit at a slight increase in price.⁶

PREDICTIVE ANALYTICS

A risk financing program should be sensitive to the financial condition of the healthcare entity, insurance market cycles, and changing economics. With increased competition and healthcare entities searching for the best value for their insurance funds, predictive analytics has attracted exponential interest from all organizations interested in funding loss exposures. Like any other businesses in a difficult economic environment, healthcare entities are tightening their expense ratio so that they can survive and even prosper. Increased costs to deliver health care, availability of funds, need for capital to meet ever-increasing technological advances, governmental regulations and societal expectations, and uncertainty in the economy direct how and when to spend funds on the financing of risk.

Once the risk manager has identified possible financial treatment of adverse events, the next step is to measure the effects of each treatment. Quantitative analysis measures the event's risk variables—for example, the event likelihood, impact, timing, coefficient of variation, and probability distribution. The qualitative analysis measures the event's impact on the healthcare entity's strategic goals, culture, and stakeholders. Improvement is accomplished through predictive analytics, which includes applications in behavioral economics, data visualization techniques, and text mining.⁷

Four analytical elements are necessary to evaluate the cost-effectiveness of the risk financing equation:⁸

- Actuarial analytics
- Customer analytics and distribution insight
- Claims analytics
- Risk analytics and compliance

Not every healthcare entity will engage fully in the use of these analytics. Nevertheless, it is important to understand how the results of predictive analytics affect the risk financing decision. Insurance carriers perform these analytics, as do risk retention groups and captives. Self-insured healthcare entities also engage in use of these analytics with the assistance of consultants and actuaries.

Actuarial analytics relies on the basic fundamental premise that the less significant the risk, the less funding that needs to be allocated to that risk. In the past, actuaries have heavily relied on univariate or one-way analysis for pricing and monitoring price efficiency. As the actuarial profession moves forward, its practitioners are using multivariate statistical techniques such as generalized linear modeling for assigning costs so as to develop a more

accurate, reflection of risk. The critical question in assigning predictive costs pricing is this: "Which risk factors or variables are important for predicting the likelihood and severity of a loss?"⁸

For example, a significant, positive correlation exists between the precipitous delivery of a high-risk neonate, the likelihood of a claim, and the lack of sophistication, technology, and specialty-trained physicians in the Level 1 hospital. Actuaries might use this knowledge to specify obstetrical professional liability costs by level of the hospital emergency department and nursery. As a result, the Level 1 hospital might have a higher cost of risk assigned to the potential delivery of a severely challenged newborn, keeping in mind that there should be a lower frequency of patients experiencing complicated deliveries than in hospitals with specialty obstetrics departments.

The potential for variation related to the frequency of adverse events as correlated to severity of adverse events is a complicating factor. "Although many risk factors that affect price are obvious, subtle and non-intuitive relationships can exist among variables that are difficult if not impossible to identify without applying more sophisticated analyses."⁸ The risk financing decision algorithm weighs the probability of loss against the loss value. When the probability of loss is high, the decision may be to retain the loss, as the insurance markets may not insure the loss or will charge a high premium for doing so. If the healthcare entity does decide to retain the loss, its earnings and working capital must be capable of supporting the loss.

Claim payments and the management of claims are a significant expense in the risk financing equation. Effective management of the claims process is fundamental to the long-term

sustainability of the risk financing selection. Claims analytics is the process of analyzing data at all stages in the claims cycle, including first notice of loss, payout, and subrogation. Managing the cost of claims means making the best decision as each new point in the claim continuum is reached. As a claim becomes more complex with additional information, the cost and loss adjustment expenses accumulate. Accurately forecasting the loss reserve and ultimately predicting the outcome of a claim is a challenge. Using analytics to calculate an accurate loss reserve amount and benchmark each claim based on similar characteristics can improve the loss reserve accuracy. Claims analytics utilizes historical loss data to forecast future losses at various retention levels. The loss data must incorporate changes to exposure and inflation.

INSURANCE MODELS

Almost every type of risk exposure can be covered under a self-funded insurance program or through a commercially available insurance program. Each model has its own set of operational, financial and tax-related benefits.⁹ Commercially available insurance can be implemented quickly; its cost is fairly predictable, major exposures are usually covered, and the insurance company typically offers services that complement its insurance programs. Exposures not covered by the insurance carrier are not the carrier's responsibility or concern. If such events occur, the facility could still be exposed to substantial financial loss. In addition, part of the cost goes to insurance company expenses and profit.

Alternatives to the traditional insurance company programs include risk retention groups and captives. Self-funding may also be

an option, but requires a significant amount of capital and reserves. Before choosing any insurance program, the healthcare entity should undertake a historical analysis of claims and premiums for a period of five years, if possible. This analysis should consider the time value of money and loss costs, both prospectively and retroactively. An appropriately trained and experienced actuary should be engaged when assessing funding levels and acceptable amounts of risk.

Self-funding options include, but are not limited to, the following:

- Self-funded programs require the healthcare entity to fund the insurance program, including the cost of operating the program (e.g., administration fees, stop-loss premium, and variable costs [the claims expense]). The program also pays the claims costs incurred. Typically, the entity purchases stop-loss insurance so that additional monies will be available if the claims costs exceed the catastrophic claims levels in the self-funded policy. The total cost of a self-funded program consists of the fixed costs, plus the claims expense, less any stop-loss reimbursements.
- Captives are owned by those (healthcare entities) they insure for the main purpose of funding the owner's risks. The owners actively participate in decisions influencing the captive's underwriting, operations, and investments. Captive insurance companies primarily (1) insure the risks of their owners and sometimes related or affiliated firms and (2) return underwriting profit and investment income. Essentially, a captive is an insurance carrier whose purpose is to underwrite insurance policies on behalf of

its owner, in which the policyholders are the principal beneficiaries. Two basic types of captives are distinguished: single parent and group. A “single parent captive” is a subsidiary owned entirely by the parent. A single parent that provides risk financing only for the parent is called a “pure captive.” A “broad captive” is owned by a single parent but also sells indemnity contracts to participating firms. In contrast, a “group captive” is owned by multiple firms and, therefore, usually meets the Internal Revenue Service (IRS) rules for accounting for the contributions as tax deductions. Captives are typically formed because the members believe their knowledge of their industry—in this case, health care—is superior to what the commercial insurance market can bring to the table. Consequently, they believe the captive will be a profit center.

- Risk retention/purchasing groups (RRG) are liability insurance companies that are owned by their members. A purchasing group consists of individuals or firms of like characteristics that share similar insurance needs. Risk purchasing groups are formed under the provisions of the federal Liability Risk Retention Act (LRRRA) of 1986. The eligibility criteria for members of a purchasing group are set by the LRRRA. Under the LRRRA, the RRG must be domiciled in a state. Once licensed by its state of domicile, an RRG can insure members in all states. Because the LRRRA is a federal law, it preempts state regulations, making it much easier for RRGs to operate nationally. As the name implies, these groups do not buy commercial insurance policies, but rather retain the risk within the group. In effect, the

members insure one another against liability claims and lawsuits. Because a risk retention group is an insurer, however, it may purchase reinsurance. The rates and policy forms of risk retention groups are not regulated, and risk retention groups are not covered by a guaranty association.

Review of the financial consequences of these programs is based on the philosophy of the healthcare entity. If the entity is fiscally conservative, a gradual approach should be used. Additional considerations involve portability, flexibility, services, and protection.

- *Portability:* For multistate organizations or networks, the portability feature is extremely important. If the insurance coverage is statutory in nature, such as worker’s compensation or automobile liability, the ability to operate with a single insurance program in multiple states outside of conventional insurance is limited. States may require the insured to become licensed in each state for statutory coverage and to comply with all state laws. An alternative is to be “fronted” by a licensed insurance carrier, which would issue the policy and then reinsure with the self-insured program. Captives and their variations also can be used to address portability issues.
- *Flexibility:* Many financial programs, including some insured programs, require letters of credit or a bond to guarantee that the claims will be paid by the insured. Typically, the letters of credit must be collateralized. Often, programs require that each policy period have its own letter of credit or bond until all claims are liquidated. This mandate makes changing insurance carriers more difficult. Additionally,

there should be a consideration of whether there is flexibility when services are purchased individually.

- *Services:* Evaluation of the claim handling, investigation, claim payment, and loss control/risk management services is critical. Except for full insurance programs, the healthcare entity has an opportunity to choose the company, or third-party administrator, to service its claims or to perform loss control services.

Commercially available insurance is a contract between an insurance company and a business owner (healthcare entity). The purpose of the insurance is to minimize the owner's risks against losses through financial compensation, claims management, and risk control services. Insurance companies are rated based on their financial strength, assets and ability to settle claims. Rating companies include A.M. Best, Standard and Poor's, Weiss Research, Duff and Phelps, and Moody's Investor Service.

RISK RETENTION

Regardless of the financial method used to fund risk, deciding how much risk to retain has important financial implications. The costs associated with adverse events can be significant and, regardless of the predictive models used, can greatly exceed expectations. Fundamental to this equation is understanding of the importance of knowing "not to risk a lot for a little." If the cost of internally insuring a risk with substantial limits of protection at a cost competitive with the commercial premium is not possible, then transferring the risk (i.e., buying true insurance) may be the best alternative, regardless of past retention levels or expected short-term premium savings. If the cost of insuring a loss is equal to

the costs associated with the risk, then the entity should consider retaining these losses. Retaining these risks may be approached through a large deductible, self-insured retention or by not purchasing a policy to cover the risk.

Estimating the total cost of risk (TCOR) to better determine retention levels requires analysis of three components:

- Costs of risk transfer (i.e., insurance premiums paid)
- Costs of risk retention (i.e., costs of claims that are absorbed and paid directly by the insured through deductibles or other self-insurance mechanisms)
- Administrative costs related to managing or controlling exposures to risk, and to managing claims once they occur)

TCOR is then analyzed against one or more of the following to determine cost-effectiveness:

- Annual revenues
- Net cash flow
- Number of days of cash on hand
- Budgeted TCOR
- Working capital
- Net worth

The best or optimal level of risk retention is not necessarily the one that produces the lowest combined cost of retained losses and excess premiums. Rather, it is the one that provides an acceptable compromise between the financial constraints, as measured by key financial indicators, and the hospital system's appetite for risk. Determining the extent to which financial requirements are violated and envisioning worst-case scenarios will aid in the evaluation process.... The appropriate retention level is the one that provides a comfortable fit with the organization's own appetite for risk while at the same time satisfying predetermined

financial performance indicators. A disciplined methodology that properly quantifies financial exposure and downside risk implications will facilitate a more informed decision-making process.¹⁰

RISKS AND PERILS TO BE COVERED

A risk manager has the task of identifying exposures to loss and managing the potential effects of those exposures. This is a dynamic process that must be systematically approached on a recurring basis. The risk manager must understand each area of exposure. Obviously, this process is not a solo task; other professionals in administration and finance will be needed and should be available to assist in assessing the risks.

Automobile liability: Healthcare organizations may own their own vehicles for transporting supplies, equipment, patients, staff, or visitors. They may permit employees to use their own vehicles. Depending on the ownership of those vehicles, coverage may be available under the general liability policy, fleet policy, or hired and non-owned auto policy.

Aviation/aircraft liability: Injuries may be sustained while loading, transporting, or unloading aircraft. A general liability insurance policy excludes bodily injury arising from the loading or unloading of any aircraft.

Business interruption: Reimbursement of lost income may be necessary while the healthcare entity is being repaired or reconstructed from a covered peril so the entity can continue to pay bills related to utilities, staffing, and other overhead.

Business income and extra expense dependent on another: This coverage applies in the event that supply chain distributors and supply houses are unable to deliver supplies and/or

medications. Losses can include continuing operation costs, overtime, rented equipment, and patient communication, among others.

Crime/fidelity: Employee dishonesty and theft including forgery, robbery, safe burglary, computer fraud, and wire transfer fraud may harm the firm's standing. Such risks may include theft by an employee as well as robbery or theft loss on and off the premises. Coverage can include audit costs and investigation expense.

Cyber-liability: All healthcare entities rely on computer-based systems and information networks for such tasks as billing, medical records, patient registration, marketing, and others. Breaches to these systems can result in extortion, business interruption, loss or damage to a network, e-theft, invasion of privacy, identity theft, and infection of others' networks. Coverage can include the costs to comply with applicable laws requiring the organization to notify its customers or users of a security breach that could potentially compromise private information.

Directors' and officers' (D&O) liability: Members of governing bodies and the entity they govern are at risk for the effects of their decisions. Coverage is afforded for the personal management decisions, misuse of assets, and errors or omissions of the members of the board of directors, the officers, and the chief executive of the healthcare organization. D&O coverage can be expanded to include additional administrative personnel. A D&O policy covers only nonphysical injury, and aims to protect against management errors and omissions.

Emergency evacuation: This coverage is associated with the costs of emergency evacuation of patients, visitors, and employees during a natural or human-made disaster. It can involve transportation, staffing, housing, family notification, and even advertising.

Employment practices: Coverage may be provided for alleged improper employment practices. Common accusations include sexual harassment, discrimination, hostile workplace, and wrongful termination.

Employee benefit liability: This coverage deals with errors or omissions in the administration of the employee benefits programs, including the extent of the lost benefit.

Employee injury and illness/worker's compensation: This coverage is statutorily required in all states. Coverage for statutory benefits as allowed by state law includes medical payments, indemnity, and legislatively mandated benefits and covers injuries to family members arising from the employee's injuries. In a healthcare setting, this form of risk management is considered critical coverage, as a disease could be transmitted from an employee to his or her family members.

Fiduciary liability: Financial injury may occur to others arising from an employer's acting in a fiduciary capacity. Most such damages arise from employee benefit plans. This coverage addresses risk exposures as a result of the handling of money for employees. It includes employee payroll deductions for pension plans, savings plans, and various employee benefit options. Exposures arise from the loss of funds or benefits.

General liability: This coverage focuses on injuries to third parties arising from operations.

Licensing board disciplinary proceedings: Coverage is needed for the defense of a licensed professional who is alleged to have violated his or her professional code of conduct or practice act before the practitioner's licensing board. There are associated fees and costs, including fines and penalties, resulting from the investigation and defense of a professional board action.

Media expense: Adverse publicity may result in the need to respond through responsive advertising or hiring a public relations professional to best deal with the situation to manage the public response.

Medical equipment breakdown: Equipment failure can result in costs associated with mechanical or electrical failure and related losses and damages, communication disturbance, debris and pollutant cleanup, fire control, and data restoration.

Medical waste pollution: Medical waste generated by the healthcare entity, such as specimens, blood, and items that possess sharp points, can accidentally find its way into the mainstream waste, requiring the healthcare entity to clean up and remediate the waste and cover third-party damages caused by the accidental release of medical waste.

Patient confidentiality/privacy: Coverage for patient confidentiality or privacy breaches may include costs associated with an inquiry and investigation by state or federal authorities, including fines and penalties and defense of a Health Insurance Portability and Accountability Act (HIPAA) proceeding.

Peer review and medical staff credentialing: The facility may incur costs related to negligent peer review and credentialing allegations related to patient injury, Stark laws, competition, and racketeering.

Professional liability: This coverage deals with injuries to third parties arising from medical incidents. Liability typically arises from any and all services provided or not provided by an insured or someone for whom the insured can be held liable. A standard professional liability policy provides coverage when a patient is injured through the actions or lack of actions by healthcare entity staff as the

injury relates to the clinical condition of the patient. Examples of patient injuries include the following:

- Nosocomial infections
- Burns to the patient as a result of a surgical fire
- Operating on the wrong side of the patient
- Medication errors
- Anesthesia complications causing injury

Property: Structures, their contents, and goods in transit may become damaged. For many institutions, physical property is their largest asset. Before examining insurance programs or alternatives, property insurance underwriters usually require basic information about buildings, contents, electronic data processing equipment, valuable printed material and documents, unusual property, personal property of others, boiler and other machinery, and business income. In large organizations, the insurance valuation of various types of property can be a very difficult task. An initial review must identify the types of property to be protected and the various risk exposures to be insured against. The following sections address each type of property individually.

- *Buildings:* Valuation of the physical plant is primarily a function of the total square footage and the cost per square foot. Generally, the cost per square foot is based on the type of construction, local labor costs, and safety features such as automatic sprinklers.
- *Construction activities:* Along with the building, any off-site property, property in transit, contractor's equipment, and installed equipment must have proper coverage. Because either the contractor or the

building owner is responsible for these costs, the construction agreement should indicate acceptable coverage limits for automobile liability, worker's compensation, and general liability, naming the facility as an additional insured. If this is not done, the healthcare organization will be responsible for supplying the protection.

- *Contents:* Because the contents of buildings are so variable, this type of property is difficult to value, especially in a large facility. Physical contents of buildings include materials such as furniture, fixtures, and equipment. Disposable contents include inventories of medical supplies, spare parts, and housekeeping materials. Typically, the valuation of these contents is set at replacement cost.
- *Electronic data processing:* This property includes hardware and software, where valuation difficulty stems from the rapidly changing technology causing obsolescence in a short period of time.
- *Valuable papers, books, and documents:* These items includes the re-creation of critical documents such as medical records.
- *Personal property of others:* Such property consists primarily of leased equipment and the personal property of patients, guests, employees, and volunteers. Coverage includes the loss of patient property in the care, custody, and control of the facility or its employees.

INSURING AGREEMENTS _____

Insuring agreements state that the insurance company will pay those sums that the insured becomes legally obligated to pay. In other words, the law imposes an obligation on the insured. Further, the insurer responds to bodily

injury or property damage inflicted upon a third party. Even if the lawsuit alleges uninsured acts along with a covered act, the insurance company has a “right and duty to defend” the healthcare entity. Inclusion of an insured act obliges the insurance company to defend the entire lawsuit, although the insurance company reserves the right to decide whether to settle or to defend. Exclusions enumerate the coverages specifically taken out of the contract, such as work-related injuries, pollution, aircraft, and automobile liability.

Because of the dynamic and complicated legal structure of a healthcare organization, the “named insured” can include the entity, its owners or active directors, officers and stockholders, employees, and real estate managers. A conditions section of the policy outlines the “named insured’s” duties, rights, and responsibilities and the rights of the healthcare organization under the contract. Failure to properly review the conditions could mean restriction or denial of coverage when an event occurs.

A “consent” provision in an insurance contract identifies whether the insurance company needs the insured’s consent to settle a claim. This clause obligates the insurance company to pay up to the covered amount of any pretrial settlement or post-trial judgment. If the insured refuses to settle, this entity is personally responsible for any judgment amount in excess of the proposed settlement.

Liability insurance differentiates between “occurrence” and “claims made” coverage. “Occurrence” policies cover all injuries that occurred during the policy period, regardless of when they were reported. “Claims made” policies cover injuries reported during the policy period that occurred after the policy retroactive date. An advantage of an occurrence policy is

that it will cover all injuries during the policy period until the agreement is exhausted. A disadvantage is that medical malpractice claims may be made many years after the event. Any awards resulting from such claims are applied against dollar limits that seemed adequate at the time the insurance was purchased, which may prove inadequate at the time of award or settlement.^{11,12}

PROTECTION FOR A RAINY DAY _____

Healthcare entities cannot continue to operate without positive cash flow and a positive or even profit-and-loss accounting. Risk managers can assist in protecting the financial assets of their organizations against devastating losses. A knowledge of the options and key areas of risk transfer and insurance helps build a comprehensive risk management program. Within healthcare entities, there are experts who can help with everything from overviews of insurance coverage, to department-specific risks and exposures, to an entire restructuring of the risk finance program. External resources and professionals include insurance brokers, insurance agents, consultants, actuaries, and numerous others who have expertise in specific aspects of healthcare risk financing.

The finances of the healthcare entity can be crippled by an uninsured or underinsured loss. Conversely, benefits can accrue through cost-effective improvements in the overall program. Employee morale increases as losses decrease. Operational efficiencies are realized when the healthcare entity’s assets are properly protected. As complex as the risk management mission in financing and insurance is, the dynamic nature of the healthcare industry promises to lead to a higher level of sophistication with newer financial options to minimize losses.

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