

Approach with caution

Jeanne Braun of Physicians' Reciprocal Insurers believes doctor groups and hospitals can benefit from a feasibility study before deciding to set up a captive

As the global insurance industry braces itself for the possibility of a hardening market, the popularity of captives as a risk-financing vehicle looks set to continue to grow. But as more companies become aware of the potential benefits of captive insurance, is there a danger that they will fail to fully consider the risks that entering into a captive arrangement entails?

According to Jeanne Braun, executive vice-president of hospitals and special programmes at Physicians' Reciprocal Insurers (PRI), while captives can represent a very positive opportunity for clients, there is not enough emphasis on what could potentially go wrong as there should be. This is something PRI seeks to address, as experience has shown the importance of hospitals and doctor groups exercising caution when considering whether or not to enter a captive arrangement.

Making the right decision

"Unfortunately, we have seen a number of doctor groups and hospitals rush to form a captive or RRG, a decision that they ultimately regretted – this is why we feel very strongly about ensuring that our clients know

about the possible downsides as well as the upsides before making a decision," she asserts. "Analysis we have completed for various clients have, in some cases, found that they are not well-positioned to enter into a captive arrangement for one reason or another."

A key factor in the decision-making process is the feasibility study, which enables a company to assess the relative risks and benefits of captive insurance – generally speaking, it should address issues such as capitalisation requirements, loss projections, risk margins and domicile choice.

"A healthcare captive feasibility study will look at a number of factors, such as the hospital's profile and the type and number of doctors who are employed there," adds Braun. "Another important factor is the historical analysis, which evaluates the types of claims and the severity of the outcomes both financially and clinically."

The main focus of the feasibility study, however, is the blend of exposures, both retrospectively and prospectively. It is also important to address, as part of the study, whether there will be any changes over time that will affect the level of risk, such as the hospital getting bigger or smaller, believes Braun. "This can

then provide a clearer picture of what the losses will look like and how they compare overall to a group of their size," she says.

According to Braun, the actuarial component of the feasibility is the most crucial. "It highlights what the actual claims experience of the doctor group or hospital has been in the past and can then project the level of claims that can be expected in the future," she explains.

Furthermore, because actuarial analysis plays such a major role in a hospital or doctor group's decision to opt for captive insurance or an alternative form of insurance, it is vital that they fully comprehend the implications of the data. "We always ensure that the client understands what the data is actually showing," confirms Braun, "because, on some occasions, it may in fact reveal that, from a risk-taking perspective, the process of entering into a captive arrangement may be more costly than they originally anticipated."

Actuarial analysis does, however, have limitations – namely, the fact that, in certain parts of the country, there are limits to how much data exists in relation to the healthcare sector. "This means that, on number of occasions, actuaries have to use data from other parts of the country for comparative



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purposes, which may or may not benefit the client,” explains Braun.

Missing or inadequate historical loss data can also cause substantial problems for actuaries. “Some of the issues we have seen in the past have resulted from hospitals or doctors managing their claims in-house or using inexperienced lawyers to manage their claims,” says Braun. “The lawyer or administrator will have coded the hospital’s payouts in the year in which the payout was made, but have failed to correlate it to the year in which the case actually took place. This means that the data will not be meaningful, a fact that the hospital may not have understood.”

However, despite potential limitations, failure to complete a feasibility study can have serious consequences for a hospital or doctor group considering captive insurance. “By not completing a comprehensive feasibility study, hospitals and doctors can limit the benefits of entering into a risk-sharing relationship with a captive,” observes Braun. “There may be a downside to adequately funding the loss, in addition to tax and legal implications, that they are not fully aware of.”

Although a feasibility study, and in particular, actuarial analysis, should play a key role in the decision-mak-

ing process, it is equally as important that a company is clear what they hope to achieve by entering into a captive arrangement and the potential risks of doing so. “In my experience, many clients forget to sit down and discuss amongst themselves what their goals are,” says Braun. “Everyone is very interested in setting up a captive, but they often fail to take the fact that it is a risk-taking venture into full consideration.”

While PRI is very aware of the many advantages that captive insurance can provide, if a client found that their losses were not necessarily supported by the premium they were currently paying, the company would recommend to them that they not participate in risk-sharing from a captive.

“This is because they would ultimately have to put more money in to cover their losses,” explains Braun.

“On the other hand, they may put a greater emphasis on risk management and change that around, which would be a very positive thing from our perspective,” she continues. “Nevertheless, there may be opportunities other than a captive for a hospital or doctor group to take a deductible and start participating in the risk by paying on indemnity when cases close.”



Jeanne H Braun is executive vice-president of hospitals and special programmes at Physicians’ Reciprocal Insurers (PRI). In this capacity, Braun administers programmes for hospitals and facilities and oversees the development of new products and services, including alternative risk-financing programmes.

Experience and knowledge

As the second-largest medical malpractice writer in New York State, PRI has the knowledge and the experience to provide their clients considering captive insurance with clear, comprehensive advice about the relative risks and benefits.

“Medical malpractice is our sole focus, and so we have the benefit of having substantial expertise in this area,” affirms Braun. “We have talented lawyers, underwriters, actuaries, claims staff and risk-management staff who are all focused on medical malpractice and consequently, we are in a good position to identify whether or not we feel that a doctor group or hospital is well-positioned to enter into a captive arrangement.”