

mation, increasing from 31 to 55 members, with eight new members added this year. National Catholic provides a full range of liability coverages to three categories of Catholic members: archdioceses, dioceses, and risk pooling trusts. Bemis notes that the RRG has recently amended its articles of incorporation and filed a change of business plan with Vermont regulators in order to enlarge its scope of operations to include entities tied to the Church but not strictly attached to a particular diocese, such as the **Society of St. Vincent de Paul**, large Catholic affiliated nursing homes and hospitals, and similar Catholic-related facilities.

In addition, Bemis plans the formation of a management company as a wholly-owned subsidiary of National Catholic, bringing more full-time, experienced industry leaders into key positions at the company. As a part of its long-term planning, National Catholic will relocate its headquarters to Lisle, Illinois. Sandra M. Barutha, who served as underwriting manager for National Catholic while at AJG, will join Bemis at National Catholic.

National Catholic wrote gross annual premium of \$5.9 million in 1998, up from the previous year's \$5.6 million. Its policyholder surplus has grown steadily through the years, increasing from \$1.7 million in 1995 to \$31.2 million in 1998.

Bemis holds three professional designations including CPCU (Chartered Property and Casualty Underwriter), ARM (Associate in Risk Management), and Are (Associate in Reinsurance). He is a graduate of the University of Illinois, Champaign-Urbana. Bemis is the current chair-elect of the **National Risk Retention Association**.

Large Clinics Form PG Following Breakup of MedPartners, Inc.

When publicly traded **MedPartners, Inc.** abruptly exited its extensive physician practice management line of business late last year, many of the clinics under its management were left to fend for themselves, including finding replacement malpractice coverage or restructuring insurance arrangements set in place by MedPartners. Seven of the large multi-specialty clinics previously affiliated with MedPartners who had a successful malpractice program insured by Pennsylvania-domiciled specialty carrier, **Phico Insurance Co.**, rated A- by **A.M. Best**, wanted to continue their program and sought the assistance of insurance professionals to find a way to do so.

Tom Jones, partner in the Chicago, Illinois-based law firm of **McDermott, Will & Emery**, who assisted with legal issues, determined that formation of a purchasing group enabled by the Liability Risk Retention Act provided the ideal legal structure allowing the clinics to continue the benefits of the previous program, including tailor-made coverage and economies of scale. Jones explains that the **Medical Risk Purchasing**

Group, Inc. was created to provide professional and general liability for the current seven member multi-specialty clinics which operate in five states.

According to Marge Jacobs, senior vice president of Chicago, Illinois-based broker, **Aon Risk Services, Inc.**, that will serve as the program administrator for the Illinois-domiciled PG, registration of the PG is currently in process. She notes that while the PG currently operates in only five states where clinics are located — Texas, Illinois, Florida, Oklahoma, and New Jersey — the PG can expand into other states where suitable clinics exist.

The PG's president, J. Michael Condit, M.D., based in Houston, Texas at the **Kelsey Seybold Clinic**, explains that, "The favorable loss histories of our select group of clinics motivated us to restructure the MedPartners program in a manner designed to serve the specific liability insurance needs of our now independent clinics." Condit adds that the PG may be used for other group buying purposes as well, including purchase of disposable medical supplies. Looking ahead, Condit observes that, "Should today's favorable market conditions for physician malpractice insurance change, the PG could even become the seed for development of a captive or risk retention group."

New Off-Shore Captive Domicile: An American Indian Reservation?

Could an American Indian Reservation located within the continental United States function as an off-shore captive domicile? That's the intriguing question posed in an article appearing in the Fall 1999 edition of the CPCU Journal. The article, *Investigation of the Feasibility of a New Off-Shore Captive Domicile: An American Indian Reservation*, by Richard G. Rudolph, Ph.D., CPCU, and Eric L. Routman, J.D., CPCU, reviews the conditions that must be present for creation of an off-shore captive domicile as they relate to the unique status of American Indian Reservations or Nations as separate, sovereign powers that exist within the borders of the United States.

The authors cite several reasons that favor formation of an American Indian Reservation or Nation as an off-shore captive domicile. First, the opportunity for captive industry professionals to assist in the creation of a relevant, effective regulation. Second, the benefits to the Reservation from revenue flowing to it in the form of fees, taxes, and salaries of employees. Third, the benefit to the U.S. economy as funds flowing through the captive are kept in the United States.

Another major benefit of a "domestic off-shore" domicile, say the authors, comes from savings of administrative costs incurred by U.S. owners of foreign offshore captives who must conduct captive business outside the U.S. in order to be exempt from U.S. regulation. The authors point out that a Reservation's unique status as a "country within a country," provides by circumstance of law, that Reservations or Nations are

outside the full scope of state regulation authority and, to some extent, outside the scope of federal regulatory authority.

In addition, the authors cite various tax advantages for establishing the Reservation as a domestic off-shore captive domicile, contending that a captive domiciled in an American Indian Reservation is subject only to federal income tax, tribal income tax, tribal franchising or licensing fees and taxes, and tribal premium tax, should one exist. The authors point out the captive would pay federal income tax, but no state or local income tax.

Federal excise tax regulations apply to all off-shore captives, regardless of where they are domiciled. However, the authors suggest, "further research be conducted into the applicability of federal excise taxes on premiums paid by U.S. policyholders or U.S. insurers, as the transfer of the premium dollars to the 'foreign' corporation might not be considered an exportation of funds," since the money does not actually leave the federal banking system or the boundaries of the United States.

While the authors do not specifically mention risk retention groups in their article, RRGs could benefit from such a domestic domicile for reinsurance purposes, as many RRGs now have offshore captives which provide reinsurance to the RRG.

For more information or to receive a reprint of this article in its entirety, call the Members Services Department of the CPCU Society at (800) 932-2728.

Harvard Healthcare RRG Serves Growing Number of Institutions

Formation of a risk retention group offered an ideal way to address the growing needs of Harvard-affiliated healthcare institutions who, in the early to mid 1990s, were undergoing mergers, acquisitions and creation of multi-state networks. While an offshore captive formed in 1976 by the **Harvard Medical Institutions, Inc. — Controlled Risk Insurance Company (CRICO) Cayman** — had been able to provide liability coverages for almost two decades, the fast pace of change in the 1990's required that a captive have an onshore presence in order to carry out its functions. This need led to the formation of **Controlled Risk Insurance Company (CRICO) Vermont** in February 1995.

The RRG is operated by **The Risk Management Foundation of the Harvard Medical Institutions, Inc. (RMF)**, which provides claim management, loss prevention, quality improvement, underwriting, and related research for CRICO Vermont insureds. RMF president Jack McCarthy, who has been with the organization for the past ten years, recalls the reason for creating the RRG, explaining that, "We needed an onshore vehicle with admitted paper to be in line with

insurance regulations. Unlike the institutions which formed the Cayman Islands captive, the new hospital-physician relationships blurred the ownership status taking total ownership and control out of the hands of the captive." CRICO-Vermont now provides the primary professional and general liability insurance policies for the program's participating institutions, their employees, and eligible physicians. The RRG has more than \$475 million in assets and insures 19 hospitals with 4,200 beds, as well as 300 additional insured organizations in Massachusetts, Rhode Island, and New Hampshire and wrote gross annual premiums of \$39.8 million in 1998 up from \$36.2 million in 1995.

McCarthy observes that the RRG, which is owned by ten nonprofit associations affiliated with the Harvard Medical system, continues to grow as new managed care networks are developed and hospitals added through mergers and acquisitions. He notes that, unlike more traditional RRGs, CRICO-Vermont does not actively seek other markets. He says, "Our mission is to fund the malpractice and liability exposures of members and to prevent those claims in the first place."

According to Jack Hoffman, communications director for RMF, RMF spends a significant amount of its resources coding and researching cases to determine the cause of liability problems to educate medical personnel on their prevention. He observes that, in the last 10 years there has been a shift from liability claims resulting from practice or surgical procedures toward diagnosis. McCarthy adds, "We look at the frequency of claims across the Harvard system. We are evaluated on our ability to evaluate risks." Currently RMF is looking at how the use of e-mail impacts confidentiality and continuity-of-care issues so they can advise physicians of the risks involved. The RMF itself has a 25-person loss prevention department. Medical personnel can access 30 to 40 continuing medical education programs as well as numerous publications.

CRICO-Insured Institutions include Beth Israel Deaconess Medical Center, Brigham and Women's Hospital, Children's Hospital, Dana-Farber Cancer Institute, Deaconess Glover Hospital, Deaconess Nashoba Hospital, Deaconess Waltham Hospital, Harvard College, Harvard Medical School, Harvard Pilgrim Health Care, Harvard School of Dental Medicine, Harvard University Health Services, Joslin Diabetes Center, Judge Baker Children's Center, Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, McLean Hospital, M.I.T Health Services, Mount Auburn Hospital, New England Baptist Hospital, Partner's Community HealthCare and Spaulding Rehabilitation Hospital. McCarthy does not foresee anything dramatic on the horizon for CRICO-Vermont as "the real flurry of merger activity over the last three or four years has died down. Everyone seems to be trying to absorb that growth and change."