Rising medical malpractice costs are inflicting real pain on patients, doctors, hospitals, nursing homes, and insurers. Insurers are paying out significantly more in claims than they collect in premiums, and many have scaled back their exposure to the medical malpractice market and, in some cases, exited the market completely. Insurers that remain have imposed significant rate increases in order to cover their costs.

According to the American Medical Association (AMA), the medical liability situation has reached a crisis point in at least 20 states and is looming in many others. Trauma Centers and specialist practices, such as obstetrics and gynecology, are increasingly under threat. Also under pressure are the nation’s hospitals, nursing homes, and other health care facilities. These facilities are being forced to close or to reduce the range of services they can offer to the communities they serve.
Medical malpractice insurance coverage problems are regional or state specific, so the severity of the situation differs from state to state. Various state legislative attempts at malpractice reform have been implemented, including peer review, state catastrophic funds, caps on damages (particularly non-economic damage caps), prohibitions on venue shopping, mandatory arbitration, and outright insurance premium rate control (i.e., California’s Proposition 103).

While these attempts have experienced some success, the medical malpractice crisis continues to grow. Accordingly, the medical community can continue to wait for further state and federal legislative mandates, or this community can seek a proactive approach to dealing with this problem—the alternative risk transfer solution.

The Alternative Solution

Today’s medical malpractice insurance market is a mix of traditional insurers, provider-owned groups (physicians and hospitals), and alternative risk transfer entities. The primary alternative market structures available to health care providers are risk retention groups, captive insurance companies, reciprocals, and purchasing groups. The majority of medical malpractice alternative vehicles are formed as risk retention groups or captives. While captives and risk retention groups are formed for the same purpose, there are important distinctions and benefits associated with each of these vehicles.

Control is the primary reason for implementing an alternative risk transfer (ART) solution: control over underwriting guidelines and procedures, control of rates, control of coverage, and control of claims. Certain physicians may find that coverage is not available in the commercial market because of the nature of their practice, claims history, or gaps in their coverage. ART solutions are better positioned and provide the flexibility needed to administer such individual differences. In addition, seekers of an alternative solution may be motivated to find a risk transfer vehicle that will not lump their exposure with poor underwriting risks. Statistics support the theory that a few physicians are responsible for a majority of the medical malpractice claims.

Accordingly, ART options, including the formation of onshore/offshore captives and risk retention groups, are becoming increasingly popular in the health care community.
The charts below indicate that health care captives will grow significantly in coming years. Of the 12 new Risk retention Groups (RRGs) added to the Risk Retention Reporter in the first quarter of 2006, ten are in health care.

### Growth of Health Care Captives

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Risk Retention Group Formations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>0</td>
</tr>
<tr>
<td>2002</td>
<td>11</td>
</tr>
<tr>
<td>2003</td>
<td>47</td>
</tr>
<tr>
<td>2004</td>
<td>36</td>
</tr>
<tr>
<td>2005</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
</tr>
</tbody>
</table>

Source: Risk Retention Reporter

### Types of Health Care RRGs

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Hospitals</th>
<th>Physicians</th>
<th>Nursing Homes</th>
<th>Other Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>23</td>
<td>13</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>2004</td>
<td>9</td>
<td>14</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>2005</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>34</td>
<td>27</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Risk Retention Reporter

### Health Care Premium ($M)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Risk Retention Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$403.6</td>
</tr>
<tr>
<td>2002</td>
<td>$579.8</td>
</tr>
<tr>
<td>2003</td>
<td>$890.8</td>
</tr>
<tr>
<td>2004</td>
<td>$1,102.2</td>
</tr>
<tr>
<td>Total</td>
<td>$2,976.4</td>
</tr>
</tbody>
</table>

Source: Risk Retention Reporter
Types of Alternative Risk Transfer Vehicles

Risk Retention Groups (RRGs)
Federal law actually created the concept of Risk Retention Groups. The initial purpose of these groups was to mitigate the impacts of a different crisis - the availability of product liability insurance. The original federal act was known as the Product Liability Risk Retention Act of 1981 (PLRRA). Subsequently in 1986, the Liability Risk Retention Act (LRRA) was adopted to allow risk retention groups and purchasing groups for all types of liability insurance, including medical malpractice.

Risk retention groups do not have to be licensed in every state like a traditional insurance company. A risk retention group is licensed and created under state law but, pursuant to federal law, is authorized to sell insurance in all states.

The members of the risk retention group own the insurance company and are insured by the insurance company. Owners must be insureds and insureds must be owners. This form of ownership is required by law, and it enables members to have control over rates, coverage, loss control, defense costs, risk management, and underwriting. Furthermore, the group has control over the selection of managers, auditors, actuaries, attorneys, and other service providers necessary in operating the RRG.

RRGs are primarily used by small to medium size hospitals or medical centers, small to medium size assisted living or nursing home organizations, as well as physicians’ groups.

RRGs have a distinct advantage over all other available alternative risk financing vehicles. They are the only entities authorized to actively market and sell insurance in all 50 states without being subject to the extremely cumbersome and costly state-by-state regulatory environment imposed on all other forms of insurance carriers, provided they have properly registered in the states where they operate, they are in good standing in their state of domicile, and they abide by the owner/insured requirements under the LRRA. In most cases the only other means by which groups of individuals and small organizations could operate a multi-state alternative risk program would be to partner with a fronting carrier. A front is a multi-state admitted commercial carrier that allows other entities to utilize its paper, and sometimes underwriting and claims services, for a fee. Unfortunately, the recent hard market and medical malpractice crises have resulted in many fronting carriers discontinuing their operations, and the ones that have remained have increased their fees and collateral requirements significantly. Without the ability to utilize the RRG structure, most groups of individuals and small organizations that have gathered to form alternative risk financing vehicles in recent years would not have been able to afford to do so.
Captive Insurance Companies (Captives)

A captive insurance company is an insurance company that insures the risks of its owners and is licensed in a domicile that permits licensing of such groups. This includes onshore domiciles like Nevada, Vermont, South Carolina, and Delaware, as well as offshore domiciles like the Caymans and Bermuda. Unlike risk retention groups, a captive is only authorized to write insurance in the domicile where it is licensed and, as such, is subject to regulation in each jurisdiction where it conducts business.

Traditionally, offshore domiciles have been selected by medical malpractice groups because of lower minimum capitalization requirements and less conservative premium-to-surplus ratio requirements. The Cayman Islands, in particular, have gained a reputation for understanding the health care profession’s insurance needs and providing a high level of expertise in the regulation of medical malpractice captives. Because of this receptivity towards medical malpractice captives, the Caymans seem to be the location of choice for those seeking to establish an offshore facility.

More recently, captive formation in onshore locations has gained significant momentum. This is in part due to the increase in the number of U.S. domiciles allowing the formation of captives, an improvement in the captive laws and regulations in U.S. domiciles, the renewed tax haven perception of offshore domiciles due to the recent Enron debacle,

With these vehicles, medical professionals have direct involvement in risk and loss control and do not have to subsidize the overhead and profits of a commercial carrier of malpractice insurance.
and changes to tax laws that have eliminated many of the tax benefits of offshore jurisdictions. Vermont has become the onshore health care leader and the number one worldwide domicile in terms of premium size for health care, with in excess of 85 captive programs and $1.2 billion in health care premiums.

Another distinct advantage to a captive, particularly for larger health care facilities, such as urban hospitals with a wide variety of risks, is that the captive can provide all lines of coverage, including commercial auto, worker’s compensation, and employer’s liability. These types of coverage are not available under risk retention or purchasing group programs.

The forms and types of captive structures available continue to evolve every year. However, most captives can be categorized under three main groupings: Single parent or pure captives; group captives; or rent-a-captives.

**Single Parent**

Single parent or pure captives represent the majority of active captives. They are typically stock corporations owned 100% by their insured parent. An example of a single parent captive would be a large hospital that insures its malpractice risk, including the liability of all staff physicians and all staff.

The hospital, through its own captive, now has the advantage of being able to offer customized coverage and level premiums without severe fluctuations. In addition, the hospital will not have to worry about lack of insurance availability from year-to-year within its primary layer. The hospital will have control over investment return, control over the underwriting proposal, and increased control over staff through risk management programs.

Single parent or pure captives are primarily used by medium or large hospitals, or medical centers, as well as medium or large assisted living or nursing home organizations.

**Group Captives**

Group Captives provide insurance to groups that share similar risks. Many group captives operate much in the same manner as single parent captives except, as the name implies, they are owned by and insure a group of entities or individuals. This captive form is typically chosen because the participants are not large enough to form their own single parent captive. While most single parent captives may require minimum capital ranging from $120,000 to $250,000, group captives may require up to $1.0 million in capital.

Associations may form a group captive that is owned by the association members or by the association itself. In addition, non-profit associations can sponsor or own captives, e.g., Medical Associations. The non-profit association captive is typically set up as an exempt organization and must only cover controlled affiliates. Distributions to members are generally prohibited.
Group Captives are primarily used by small and medium size hospitals or medical centers, small to medium assisted living or nursing home organizations, as well as physician's groups. Physician captives would often need a minimum of 60 to 100 physicians to be viable depending on the type of practice/specialty.

Rent-a-Captives
In certain respects, rent-a-captives are a relatively new type of captive and have grown significantly in popularity in recent years. This structure is designed for those insureds who want to take small steps in entering the alternative market or who cannot afford to fund the capital and operating cost requirements for a free-standing captive. Rent-a-captives combine characteristics of single parent and group captives.

As the name implies, rent-a-captives allow third parties to insure their own risk in the captive for a fee. The rent-a-captive owner fronts the capital and surplus required for the underwriting of risk and also typically provides many of the services required for the administration of the program. Therefore, rent-a-captive users relinquish a large part of the management control of their program to the rent-a-captive owner.

The biggest advantages of rent-a-captives are ease of access, as they are typically turn-key operations; lower start-up costs as no capital infusion is required; and possible lower ongoing costs of operation from pooling of services.

It is important to note, however, that while no start-up capital is required, the rent-a-captive owner may require significant levels of collateral or guarantees to protect the owner from insurance losses that may be greater than expected. Because the rental facility is typically a non-admitted carrier, a fronting company usually issues the paper and reinsures into the captive cell under a reinsurance agreement securitized by a letter of credit or other security.

In the late 1990s, a new form of rent-a-captive was introduced, known as the protected cell, the segregated cell, or the sponsored captive. These captives operate virtually the same way as pure rent-a-captives except that the risk of the participants or users is kept separate from each other. In other words, the assets of one participant cannot be used to pay the losses of another participant in the event of adverse results. However, it is important to note that, while most captive experts feel confident about its contractual validity, the segregated cell legislation has never been tested in the Courts.

Risk Purchasing Groups (RPGs)
Risk Purchasing Groups came into existence as a result of the federal Risk Retention Act of 1986. Unlike a risk retention group an RPG is not an insurance company, but an association of insurance buyers with a common identity (e.g., a medical
specialty society) who form an organization to purchase liability insurance on a group basis. Since an RPG purchases coverage from an insurance carrier, no capital contributions are required in order to join. The company from which the RPG purchases insurance need not be licensed in every state. The purchasing group’s insurer must indicate how much premium was generated by the purchasing group in each state on its National Association of Insurance Commissioners’ annual statement. Physicians considering purchasing insurance through an RPG should inquire about the strength of the insurance company that provides coverage to the purchasing group.

**Reciprocal Insurance Companies**

A reciprocal insurance company is an unincorporated association in which the insureds have subscriber accounts and there is joint and several liability among subscribers. Basically, a reciprocal insurance company is a group of individuals or entities that exchange promises – each subscriber agrees to pay its pro rata share of certain risks of the other participants.

Reciprocal arrangements are not corporate entities, but less formal arrangements overseen by a common attorney-in-fact appointed by the subscribers. The reciprocal form (also known as an “inter-insurance exchange”) has been around for over 100 years.

A reciprocal may have an advantage over a risk retention group because in certain states it qualifies as an insurance company and may contribute to the state insurance guarantee fund. Therefore, in the event of insolvency, claimants can make a claim against the insurance guarantee fund. A reciprocal may insure any subscriber, whether related to the organization or not. Accounting is done through the subscriber’s accounts and income is allocated annually to members.

**Hybrid structures**

It should also be noted that in some circumstances, or to achieve specific goals, there might be benefits in combining some of the above structures. For example, some tax exempt organizations involved in the health care industry have formed reciprocal risk retention groups. This structure has the benefit of providing both the ability of writing insurance in all 50 states (RRGs) and accessibility to some tax advantages offered by the reciprocal structure to tax exempt organizations. Detailed tax implications of hybrids is beyond the scope of this paper.
Decision-Making Process—

Should we use an Alternative Risk Transfer Vehicle?

As discussed previously, the use of alternative risk transfer vehicles as a means of addressing the national epidemic of skyrocketing medical malpractice insurance costs has grown considerably. With these vehicles, medical professionals have direct involvement in risk and loss control and do not have to subsidize the overhead and profits of a commercial carrier of malpractice insurance.

Alternative vehicles afford the physician the opportunity to take control of his or her response to situations where malpractice has occurred or has been alleged. Through trial and error, many well-run alternative vehicles have learned to place strong emphasis on early recognition, and even give acknowledgement to the patient when a medical error takes place. In fact, this is the method of operation for several successful physician-owned captives. This is sometimes a very difficult step for a physician to initially take, and it may not be the procedure historically taken. Physicians are concerned that actions taken post error will be subject to examination in subsequent court proceedings.

Regardless of their philosophy of handling claims, since alternative risk transfer vehicles do require a commitment of time and resources, they may not be the best solutions for all medical malpractice insurance needs. Accordingly, there are a few key variables that should be analyzed when evaluating the feasibility of such a vehicle.

—Premium Size. To overcome the start-up costs and ongoing operating expenses, ART programs will often require annual premiums of $1 million or more to have long-term viability.

—Good historical loss experience. An insured with a good historical loss record that is experiencing premium increases resulting from the commercial insurance market cycles is an ideal candidate for a captive program.

—Commercial market availability. As previously discussed, medical malpractice insurance costs are skyrocketing and the availability of commercial insurance for this market is declining. ART vehicles provide more control over insurance rates and ensure that insurance will be available at levels necessary to cover malpractice exposure.

—Risk retention appetite. While they are real insurance companies, captives (especially single parent) are really a formalized form of self insurance. An adverse result at the captive level will negatively impact the results of its parent(s) through financial consolidation or via premium increases. If your organization is risk adverse, a captive may not be right for you.

—Dedicated project leader. An ART is a complex entity subject to accounting, tax, and regulatory guidelines that may be unfamiliar to the organization(s) or individuals considering this form of insurance. The presence of a dedicated project leader, with senior management credibility or credibility with peers, in the case of physician group captive programs, will greatly enhance the successfulness of forming and operating the alternative risk transfer vehicle.
Should I form a Captive or a Risk Retention Group?

Both captives and risk retention groups are viable ART vehicles for dealing with today’s medical malpractice insurance problems. However, as evidenced by the table on page 11, each has specific characteristics that must be considered when making an informed decision.

It should be noted that with any well run medical malpractice alternative vehicle, whether it is a captive or a risk retention group, the insured or insureds should be involved as much as possible in all major decisions impacting the operation of the entity, as well as all issues surrounding the ART’s ongoing operation.

Of course, prior to implementing any ART, a feasibility study must be completed, which will include an actuarial study, as well as a financial and operations evaluation of the insurance situation. In addition, a feasibility study should, if it reaches the conclusion that an alternative risk transfer vehicle is the best solution, provide for consideration of one or a few proposed structures, including a comparison of domiciles and available ownership considerations.

Tax Treatment of Alternative Vehicles

A very important issue facing the designers of an alternative structure for both taxable and tax-exempt health care organizations and practitioners is the deductibility of premiums paid to the ART program and the tax treatment of the captive or risk retention group itself. This topic is well beyond the scope of this paper, but should be addressed with professionals prior to setting up any type of ART vehicle.

Captives and Wealth Protection and Wealth Preservation for Physicians

Many physicians are also very interested in the possible employment of captive vehicles for wealth protection and wealth preservation strategies. These considerations should be discussed with the physician’s advisors. Captives can be used in the areas of insured-owned life insurance, annuities, and disability policies, as well as employee benefits.

Conclusion

In conclusion, ART vehicles, when structured and run properly, can effectively manage risk and control insurance costs. In addition, ARTs bring the advantage of direct involvement in risk and loss control, along with the potential for reduced premiums for health care practitioners. ARTs can provide a viable alternative to waiting out the medical malpractice storm.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Captive (Single or Group)</th>
<th>Risk Retention Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td>More flexible—3rd party ownership may be possible</td>
<td>Owners must be insureds and insureds must be owners</td>
</tr>
<tr>
<td>Capitalization</td>
<td>Minimum ranges run from $120,000 to $500,000</td>
<td>Minimum ranges run from $500,000 to $1,000,000</td>
</tr>
<tr>
<td>Lines of business insured</td>
<td>All lines except personal</td>
<td>Liability risk only</td>
</tr>
<tr>
<td>3rd party business allowed</td>
<td>Yes, in some domiciles—typically restricted to controlled unrelated business</td>
<td>No—owners must be insureds and insureds must be owners</td>
</tr>
<tr>
<td>Formation legislation</td>
<td>State law of domicile chosen</td>
<td>Federal law—Liability Risk Retention Act of 1986</td>
</tr>
<tr>
<td>Regulation</td>
<td>Flexible—regulated under the captive laws and regulations of the domicile</td>
<td>National Association of Insurance Commissioners (NAIC)</td>
</tr>
<tr>
<td>Where it can be formed</td>
<td>In any onshore or offshore jurisdiction with some form of captive law on its books</td>
<td>Onshore only, in any of the 50 states—typically formed in states with some form of captive law</td>
</tr>
<tr>
<td>Where it can legally operate</td>
<td>Only authorized to sell insurance in the domicile where it received its license—writing insurance in other jurisdictions would require the use of a fronting insurer</td>
<td>Authorized to write insurance directly in all jurisdictions where it is licensed or registered—without being subject to regulation in any location other than its domicile.</td>
</tr>
<tr>
<td>Investment restrictions</td>
<td>Minimal—typically subject to the prudent man rule</td>
<td>Strict—typically follows a form that closely resembles the NAIC prescribed rules with limitation on types of securities</td>
</tr>
<tr>
<td>Cost of operation</td>
<td>Predictable—varies based on size and number of lines of business insured. Can be more expensive if a fronting insurer is required</td>
<td>Typically more expensive due to higher state premium tax rate and filing fees—varies based on size, number of lines of business insured, and number of states where it operates</td>
</tr>
</tbody>
</table>
John J. O’Brien, JD, CLU, CPCU

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Wilmington Trust SP Services (South Carolina), Inc.

John is responsible for overseeing the design, implementation, formation, and ongoing management services required by captive insurance company clients. His duties also include liaising with regulatory authorities.

Prior to joining Wilmington Trust SP Services (South Carolina), Inc. in 2005, John was the CEO of Charleston Captive Management Company. Generally acknowledged as one of the earliest proponents of the captive industry in South Carolina, John founded the first captive insurance management company in the state and helped form the South Carolina Captive Insurance Association, serving as president and as a member of the board of directors.

John has over three decades of experience as an attorney in private practice and in the insurance industry. He holds a JD from the University of Tennessee and earned his bachelor’s degree from LaSalle College. He has taught and written extensively on insurance matters and addressed insurance conferences in many locations. He has also testified as an insurance expert in state and federal courts.