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Insuring Physician Groups

Physician groups have been one of the most active sectors of the alternative market accounting for many of the recent formations of risk retention groups (RRGs). Why is this? Drawing on information presented in our recent webinar with John Mize from Towers Perrin and Jeff

Johnson from Primmer Piper Eggleston and Cramer, we take a look at the current trends for insuring physician groups.

The Insurance Market for Physicians

There have been several distinct phases in the insurance market for physicians over the past 35 years.

- Prior to the mid 1970s: most physicians were commercially insured.
- Mid-1970s to mid-1980s: insurance crises in both of these decades saw many commercial insurers exit the market and physicians faced with a lack of available insurance coverage. State medical societies supported the creation of mutual insurers to address this coverage shortfall. Many physician owned insurers were created during this period and the Physician Insurance Association of America was created to represent this group of alternative market insurers.
- Late 1980s – 2000: the original group of physician insurers matured and successfully filled the gap left by the exit of commercial insurers. Most were successful and built up capital. The physician insurers themselves began to resemble commercial insurers with the hiring of professional managers and expansion into multiple states as they look to more effectively use their retained surplus.
- Early 2000s onwards: another crisis in the medical malpractice market saw St Paul, a market leader, withdraw from the market. Physician rates increased significantly and we again saw a surge in the creation of physician owned captives and RRGs. A new alternative market was formed providing competition to commercial insurers and the original physician insurers.

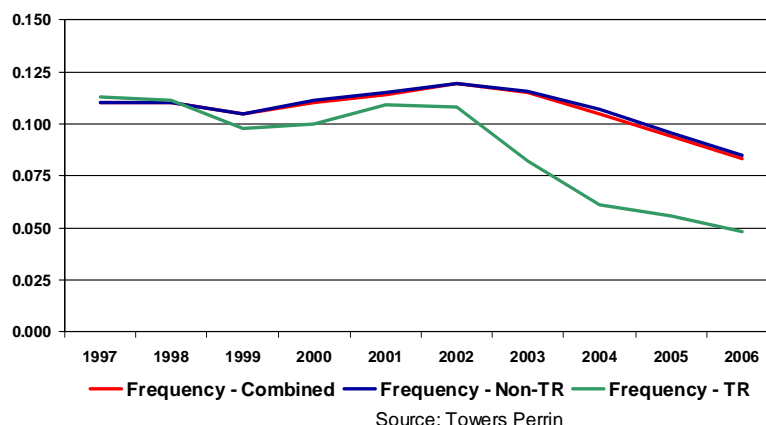
Stabilizing Claims Experience

The insurance crisis in the early 2000s also coincided with the start of a downward trend in claims frequency. As shown in Exhibit A, claims frequency trended downwards quite significantly from 2002—2006 and that trend has been consistent between states that have enacted tort reform and those that have not. The explanations most often given for the decrease are:

- Plaintiffs attorneys becoming more selective.
- An increased focus on patient safety.
- Public awareness that medical malpractice was creating stress on the healthcare system.
- The effect of tort reform.

The indications are that this downward trend in frequency has leveled off in most states in the last couple of years.

Exhibit A: Trends in Claims Frequency



Over the same period, claim severity has been increasing. For a \$1,000,000 limit, Towers Perrin estimates that severity has generally been increasing at 4-5% per year. This increase offsets the declining claims frequency leading to largely stable claims experience since the early 2000s. This has helped stabilize the insurance market as well, although if frequency has stopped its downwards trend claims experience should resume an upward movement.

The Current State of the Market

Results in 2008 were favorably for most commercial and physician insurers. Underwriting results were strong, in part due to the prior years' favorable claims development. This was offset by relatively poor investment results, although most physician insurers maintain conservative investment portfolios.

There is still an excess of surplus to premiums in the market. Generally the market is soft with no particular signs of firming. Pricing is aggressive, particularly among groups. However the market varies considerable by state and there continue to be state specific problems. For example New York has experienced difficulties with its assigned risk program (MMIP) which has adversely affected the insurance market in the state.

The market is also being affected by activities in the healthcare industry, where hospitals are increasingly buying physician practices. This is putting downward pressure on physician insurers' premiums. It is also creating challenges for hospital insurance programs, in how to cover these physicians.

The Use of Captives for Physician Groups

In the current phase of the alternative market, we have seen three distinct approaches to using captives to insure physician groups:

- Hospital sponsored: employed and affiliated physicians are included under the hospital program. Often the physicians program is kept separate to the hospital program by using a segregated cell within the hospital's captive.
- Insurer sponsored: insurers have responded to the push for captive programs by creating sponsored captives and offering physician groups a cell within the sponsored captive. To date, there has not been significant adoption of these programs.
- Standalone group captives: a group of physicians forms its own captive. These captives require the approval of the institutions where the physicians practice.

Regulatory Compliance

Many hospital captives formed offshore. Some physician captives have also followed this trend, while other physician groups have used cells within a hospital sponsored captive. Domiciling offshore usually means more flexible regulation and experience in working with healthcare captives, particularly in the Cayman Islands, which has specialized in this area.

Offshore physician captives can face regulatory constraints in marketing to third parties in the US. They may also not be recognized under physician financial responsibility laws which require US licensed insurers. These regulatory constraints have led many physician groups, either standalone or hospital sponsored, to form on-shore risk retention groups. This structure provides the physician group captive with a license to write in all US states. The RRG should also be able to satisfy the financial responsibility statutes in all states, except Wisconsin.

A RRG can insure the risks of its owners, affiliated entities and individuals. As it writes direct, it has control over the underwriting of the physicians rather than being reliant on a fronting company. This allows the RRG to set its own rates, develop its own policy form and control the handling of claims.

Non-profits can also organize the RRG as a reciprocal. The Federal tax code allows reciprocal insurers to allocate income to subscriber savings accounts which, when owned by a non-profit, are not taxed. For profit entities, such as physician practice groups may participate but are taxed on allocations made to the subscriber savings accounts. Non-profit owners benefit from the reciprocal structure without penalizing the for-profit owners.

Benefits of Captives

Captives are formed for a variety of reasons, including:

- Control: a captive reduces its members' dependence on the insurance industry. Typically the captive will have control over claims handling and risk management activities.
- Lack of available affordable coverage: the majority of captives are formed in response to problems in the insurance industry.
- Long-term stability of premiums. Captives can insulate physicians from the full effects of swings in the insurance market.

- Strategic or entrepreneurial reasons: the inclusion of physicians under a hospital program.
- Perceived ability to capture profits. There is often a perception that certain low risk groups do not get the appropriate credits from the insurance industry and are subsidizing poorer risks.

Long-Term Success

One of the major benefits realized by mature healthcare captives and RRGs has been in patient safety. The captive has provided the data and been the catalyst for risk management efforts, by:

- Improving trends in claims experience, particularly a decline in severity
- Identification of high risk practice areas
- Implementation of mitigation techniques.

Risk management is rarely the driver in the formation of a captive, but it can be a significant factor to maintaining a captive and adding value over the long-term.

Current Challenges

Healthcare captives formed in the initial wave have had 20-30 years to mature. Those that have survived have weathered changes in the market and have successfully funded the risks of their members. Captives formed in the last decade are still in the early stages of maturity and their long-term success has yet to be realized. The dramatic improvement in claims frequency since 2002 has led to more competition to new captives than was probably expected. This can affect growth plans and prevent the captive from reaching critical mass as expected. Critical mass is crucial to the long-term viability of a group captive. Greater volumes will provide more predictability in claims experience, reduce expense ratios and provide for better reinsurance terms. Unrealistic growth expectations can leave a start-up captive or RRG exposed to changes in market conditions. Founding members are required to absorb high cost structures for longer than expected at a time when affordable insurance becomes available again from commercial insurers.

Lessons Learned

Even with the current soft insurance market for physicians there are situations where the creation of a captive or RRG makes sense. What lessons can a prospective captive owner learn from prior captive experience?

1. Long-term commitment: the members must be committed to the captive for the long-haul. The captive will not survive if the members view it as just another insurance company.
2. Prudent business plan: the captive should be conservatively funded with realistic growth plans. There is no point in risking a lot to save a little.
3. A sense of urgency: captives are formed to solve an insurance problem. If the problem is not sufficiently important to the prospective members then there will be no urgency to form the captive.
4. Risk management approach: focus on the risk management benefits. This is the long-term benefit which can not be easily matched by commercial insurers (if at all).
5. A cohesive group: it is difficult to form a group for insurance purposes alone. An existing cohesive group led by a champion of the captive is needed to coral prospective members.

Interview with an Icon: Jack McCarthy

In this quarter's interview with an icon we talk to Jack McCarthy, President and CEO of CRICO, the medical malpractice insurer owned by the Risk Management Foundation of the Harvard Medical Institutions.(RMF). Mr McCarthy just started his 21st year at CRICO.

180: CRICO is viewed as the poster child for healthcare captives. Why has it been so successful?

JM: there are a number of reasons but one consistent theme is our focus on data. Since its inception, CRICO has managed claims in-house. As well as providing control over claims, it has allowed us to develop a strong database of claims information. With credible data and detailed analytics we have been able to have meaningful discussions with our member institutions and physicians about loss prevention.

180: You are now making your data available via your RMF Strategies division. Why?

JM: It allows us to gather data and knowledge. The benchmarking initiative was started after our Board asked how we compare to others. It started with market coding of claims data and selling the data for benchmarking purposes. We were then asked to interpret the data and from there RMF Strategies has expanded into a consulting operation around improving patient safety. In coding the data we look at the clinical issues behind the claim not just the insurance aspects.

We currently have 75,000 claims in our database, which makes it the largest and best coded database of medical malpractice claims in the industry. Our goal is to have every academic institution in the database. We are also now including non-claim data such as patient complaints and near misses.

180: What have been the biggest changes at CRICO under your watch?

JM: We have really moved to focus more on clinical risk management and patient safety , specifically:

- Focus on Board composition: we have made a conscious effort to bring more clinicians onto the Board, providing a balance between Trustees, CEOs and clinicians. We have also focused on succession planning and bringing in talent from outside.
- Treating the physician as our customer not the institution. We hired a Chief Medical Officer to be more focused on physicians and clinical risk management. This was a radical change but allowed us to move from a legalistic approach to risk management to a clinical and research based approach.
- Viewing medical malpractice claims as systems issues. We started viewing claims from the perspective of the patient and their experience. It is a much more holistic view reaching across departments. What we found was that nearly all claims came from a break-down somewhere in the system. It has allowed us to get more actively involved in patient safety.

180: How does CRICO improve patient safety?

JM: In addition to the data analytics identifying trends, we sponsor patient safety initiatives and provide incentives to implement risk management procedures. An example of one of these incentives is our OB simulator training. Obstetricians participating in the program receive a 10% premium discount. Claims have fallen 50% since the introduction of the program. Overall 8-9% of CRICO's premiums go to patient safety between direct grants and premium incentives.

180: Have you seen competition from the commercial market as claims experience has improved?

JM: No, we have not been affected by competition. The market in Massachusetts is made up of CRICO, ProMutual and other captives. There are very few commercial insurers. 10 years ago CRICO had about 1/3rd of all physicians in the state with ProMutual having the majority. CRICO now has 12,000 physicians which is about 50% of all physicians in the state. We work co-operatively with ProMutual and don't view them as competition.

We have a limited market. All insureds, physicians and institutions, must be affiliated with the Harvard Medical School. For affiliated physicians we are very competitive on both price and limits. This has allowed us to expand our share of affiliated physicians. We have also been able to grow as the network expands.

180: What are your future goals?

JM: There are five areas where we would like to make progress:

1. Patient Safety: there is an tremendous opportunity to re-define patient safety. We are moving from incentives to participate to requirements to participate, but it needs to be driven by the hospitals not RMF.
2. Leadership development within the hospitals
3. Programs to manage the risk in ambulatory care across physician networks.
4. Managing international risk exposures as our member institutions expand overseas.
5. The continued growth of RMF Strategies and the claims database.

180: What changes would you like to see in healthcare risk management?

JM: More transparency in the claims process. Historically the industry has been reluctant to give patients information about medical mistakes for fear of being sued. With better education about disclosure of information, patients are gaining access to their data earlier, often with a better understanding and resolution of mistakes.

180: What has surprised you about the captive industry over the past 15 years?

JM: The industry has grown more than I anticipated. I would not have predicted the emergence of risk retention groups or the increase in the number of onshore domiciles with captive laws. Service providers in the captive industry have provided high service. The ability of the recent captive and RRG start-ups to survive speaks to the quality of the services they have received from their providers.

Domicile News

Cayman Added to OECD White List

In August, the OECD added the Cayman Islands to its white list of jurisdictions that substantially implement international tax standards. The recognition came after the country implemented a Tax Information Exchange Agreement with New Zealand, its 12th, on August 13th. Leading offshore captive domiciles now on the OECD white list include the Cayman Islands, Bermuda, Barbados and the British Virgin Islands.

VCIA Appoints New President

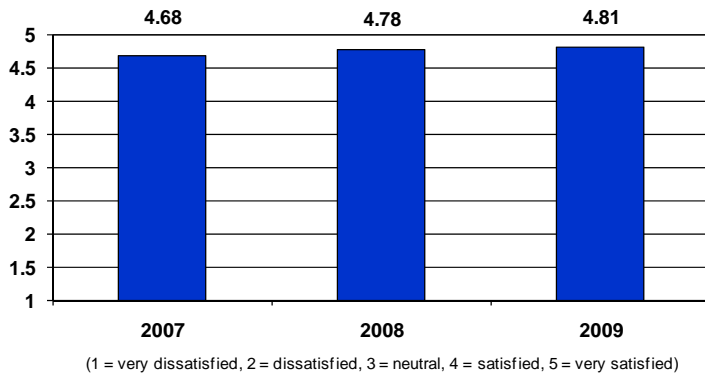
Early this month, VCIA announced the appointment of Richard Smith as the new President of the Association effective October 15, 2009. Mr. Smith is currently the Deputy Commissioner of the State of Vermont's Public Service Department. He will replace Molly Lambert at VCIA. Ms Lambert has been appointed as the USDA's State Director for rural development for New Hampshire and Vermont.

SRS News

SRS Receives High Marks in Customer Survey

In August SRS announced the results of its annual customer survey. For the third straight year, the company received satisfied to very satisfied ratings from its customers. Ratings were slightly higher than previous years.

Overall Level of Satisfaction with SRS



Full survey results can be viewed at www.strategicrisks.com.

SRS Vermont Recognized

SRS Vermont recently recognized for its involvement in the local and business community.

- A bronze award given by the United Way for the active participation shown by its employees.
- A certificate of Employer Appreciation from the Champlain Valley Association of Insurance Professionals for the active involvement of its employees.

Congratulations to everyone involved.

Staff News

Sandy Sparano has joined SRS (Arizona) as an account manager based in our Scottsdale, AZ office. Sandy was formerly Controller for Pinnacle Engineering in Scottsdale, AZ and prior to that, CFO at Marquette Venture Partners in Chicago, IL.

Industry Events

SRS will be participating in the following upcoming industry events. Please contact us at info@strategicrisks.com to arrange meetings with our team at any of these industry events.

October 20-23 HCIC Annual Forum: SRS is exhibiting at the conference to be held at the Grand Hyatt, Kauai, HI. Ann Wick will be attending.

October 21, VCIA Road-Show, Denver: SRS is co-sponsoring this event to be held at the Marriott Denver City Centre.

October 22-25, ASHRM: Wayne Cowan, Ron Sulisz and Seamus Tivnan will be attending the conference to be held at the Colorado Convention Center in Denver.

December 1-3, Cayman Captive Forum: Wayne Cowan, Ron Sulisz, Seamus Tivnan and Brady Young will be attending the conference to be held at the Ritz Carlton

SRS Webinar Series

SRS hosts monthly webinars on topical issues affecting the captive insurance industry. Upcoming webinars include:

- September 23: The pros and cons of group captives
- October 16: Captive Taxation 101

Strategic Risk Solutions (SRS) is an independently owned captive management and consulting firm. The company is an approved manager of captive insurance companies in most leading onshore and offshore domiciles. SRS is committed to being the premier provider of captive management and advisory services in the territories in which we operate.

For more information on SRS, visit us at www.strategicrisks.com.

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