



# 180°

A guide to what's hot in the world of Captives and ART



Issue 9, Q2 2006

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## The Captive Market and Medical Mal Practice

There continues to be medical malpractice insurance issues in the United States. The American Medical Association has reported on their website that there are "21 states in a full-blown medical liability crisis -- up from 12 in 2002. In crisis states, patients continue to lose access to care. In some states, obstetricians and rural family physicians no longer deliver babies. Meanwhile, high-risk specialists no longer provide trauma care or perform complicated surgical procedures."

In order to provide an alternative risk financing mechanism to commercial medical malpractice insurance many health care systems, physician groups and other health care providers have established their own captive insurance companies. The Cayman Islands is well known as the captive insurance domicile of choice for the health care industry. Per the Cayman Islands Monetary Authority statistics, as at December 31, 2005, of the 733 licensed Class B insurance captives in the Cayman Islands, 276 (or 38%) recorded their primary class of business as healthcare.

In this newsletter we have provided a brief overview regarding an issue that concerns many health care systems – should we add physicians to our sponsored captive who are not our employees but provide health care services at our institution? In addition, brief comments regarding physician groups or other health care providers who are considering establishing their own risk financing vehicle for their medical malpractice exposure are included.

### Adding Physicians to a Captive who are Not Employees

A common issue that arises in health care captives, where the sponsor of the captive is a health care system, is whether to add a medical malpractice program for physicians who provide services at their health care facilities but who are not employees (a.k.a. Voluntary Attending Physicians or "VAPs"). Adding a VAP program can create an opportunity to align the health care system and the VAPs interests in patient safety, quality improvement and risk management through a joint risk financing vehicle such as a captive insurance company; however there are many considerations in implementing such a program.

Those health care systems that utilize a captive insurance company for their medical malpractice insur-



ance program are at an advantage, especially if they are located in a medical liability crisis state. They can utilize the captive to provide coverage to physicians who provide health care services at their facilities when there is limited or no commercial market insurance coverage availability, or when premium rates have escalated to unreasonably high levels. The captive therefore allows that health care system to ensure patients have access to reasonably affordable

health care services from physicians of various specialties. There are however many issues to consider when evaluating the addition of a VAP program, which will be briefly outlined.

For physician groups or health care providers who are not affiliated with any health care system, but would like to utilize a risk financing vehicle without incorporating their own insurance captive, a segregated portfolio company owned by a third party may be a reasonable strategy. If information is needed regarding the availability of such a facility, please contact us at Strategic Risk Solutions and we would be pleased to assist you.

When reviewing the feasibility of a VAP program it is important to understand the structure of the existing captive insurance company. There are two main types of captive for the health care industry – the retrospectively rated model (a.k.a. the "Harvard" model) or the traditional captive model. The retrospectively rated model is normally used by a not-for-profit health care systems, and is named such because it issues insurance policies with a retrospective premium rating feature such that additional premium can be charged for adverse loss experience, or a premium credit for favorable loss experience, on the respective policy period. This model results in a net profit or loss that is zero to minimal, based upon the retrospective rating formula.

The traditional captive model does not contain a retro-  
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spectively rated feature in the insurance policy. It uses a policy form similar to a commercial insurance policy. It is important to know the captive model of the company considering adding the VAP program, since there are certain considerations particular to each type of structure.

In both captive model structures, the feasibility study of the VAP program should include internal and external experts. Internal experts can include the general counsel, chief financial officer, risk manager and department chairpersons. The internal experts will understand the

internal legal, financing and perception issues with such a program; and can best aid the development of a plan to disseminate information to the potential insured physicians. The external experts can include the insurance broker, captive legal counsel, actuary, captive insurance manager and auditor. The external experts will be able to advice on particular regulatory, tax, financing and accounting issues

*"21 states (are) in a full-blown medical liability crisis -- up from 12 in 2002. In crisis states, patients continue to lose access to care."*

— American Medical Association Website

based on the particular circumstances surrounding the captive.

In an effort to keep this article to a reasonable size, only a brief outline of some of the items to consider in the implementation of a VAP program are listed as follows, the need to:

- Create underwriting criteria that is approved by the captive directors
- Consider the amount of work performed by the physician at facilities outside the risk management and loss prevention control of the program in the underwriting criteria
- Appoint a representative to review the underwriting application of each physician
- Consider long term impact of physicians jumping in and out the VAP program as they desire
- Incorporate a risk management and loss prevention program in the program
- Consider if there are any special state regulatory issues, such as physician licensure laws affecting their insurance coverage
- Consider United States federal and state laws and regulations affecting hospital and physician relationships (i.e. in particular the issue of the perception of subsidizing physician premium needs to be addressed)
- Consider the development of actuarially determined

premium rates, whereby consideration for premium credits for risk management participation and joint defense may be considered

- Consider policy form, limits and what to do about tail coverage
- Consider if a state admitted insurance carrier is required to determine if program needs to be fronted, or can be issued direct by the captive
- Consider the use of excess of loss or aggregate reinsurance
- Consider capitalization requirements; and consider United States Federal tax implications such as federal excise tax, unrelated business income tax and federal income tax

One of the most important items in the implementation plan is to create a realistic timeline, with target dates and the responsible person for each item.

### The view from Insiders

There are many captive specialists that have been involved with the implementation of VAP programs. One of the more prevalent consultants is the law firm of Honigman, Miller, Schwartz and Cohn. We asked Julie Robertson, a partner at that law firm who concentrates her practice in the area of alternative risk financing for health care providers, to comment on her overall experience with the implementation of VAP programs.

Physician programs pose a unique set of issues for captive owners, both in terms of the legal and tax issues encountered and the time commitment required. We find that the programs that are the most successful are those that have the following characteristics:

- Articulated goals for the program (whether that be growth, providing an alternative to the commercial markets or fostering implementation of patient safety and quality measures).
- Physician champions within the organization to support the program, provide critical input on physician issues and reactions, and serve as a resource for other physicians in understanding the program.
- A thorough understanding of the program and the issues surrounding it before program implementation.
- A long term view and commitment to the program, which results in flexibility to adapt to changes in the commercial marketplace and legal and tax developments.

Mike D'Erano, the CEO of MaternOhio, a physician service organization which offers management services to obstetrics and gynecologic physician practices, concurred with the observations made above. Mr. D'Erano noted that the importance of a strong physician governance structure via multiple committees can not be emphasized enough, to ensure a successful program.

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*Acknowledgement – We would like to acknowledge the contributions to this article from Mike D'Eramo, CEO of MaternOhio which has a physician owned segregated portfolio company licenced in the Cayman Islands, and Julie Robertson, Partner of Honigman Miller Schwartz and Cohn, LLP, which is a Detroit, Michigan based law firm.*

## **Events**—Upcoming SRS events include:

- Brady Young is speaking on International Employee Benefit Captives at the Bermuda Captive conference on September 19, 2006.
- Ron Sulisz is speaking at the upcoming Cayman Captive Forum, November 28-30
- SRS is co-sponsoring the upcoming VCIA event in Atlanta on November 8, 2006. Check out the event tab on VCIA's website [www.vcia.com](http://www.vcia.com) for more information.

## **Client News**—Recent SRS new clients

- RCCS is a captive that was formed in Vermont by a group of 22 of the largest commercial roofing contractors in the United States that share a similar philosophy and commitment to safety.
- AHP is a segregated account captive that was formed in Bermuda by a mid-Atlantic based medical exchange to enable physician groups and hospitals to share in the underwriting results of their programs.
- Atlantic Fidelity Insurance Company is a single owner captive formed in the Cayman Islands to provide wind storm deductible coverage to various coastal real estate properties.
- UMass—provide captive management and consulting services for its captive that is domiciled in the Cayman Islands. SRS will provide accounting, regulatory compliance and insurance management services for the captive.

## **SRS Staff News**—SRS Vermont has a number of personnel announcements:

- We are pleased that Mary Thompson has joined SRS as an Assistant Account Manager. Mary worked most recently as an Account Payable Specialist at the Vermont Housing Finance Agency (VHFA). Mary will assist the Account Managers by providing accounting and regulatory services backup to them on their portfolio of captive insurance clients.
- We congratulate Sylvia King on her promotion to Account Administrative Assistant.
- We welcome Martha Bishop, Administrative Assistant (replacing Sylvia on the front desk).

## **Alaska – “The Hot New Domicile”**

By J. Brady Young

With the recent announcements that Alabama, Ohio, Delaware and New Jersey have recently passed captive legislation, we have been inundated with questions clients and others wanting to know whether one of these new states offers captive owners any unique advantages.

I don't want to minimize the efforts that the great states mentioned above are making to get in the captive domicile “sweepstakes”, but in my opinion, the last thing we need is another captive domicile. There are now over 20 U.S. states that have passed captive legislation plus numerous offshore domiciles that are trying to duplicate the success that Bermuda and Cayman have enjoyed. Frankly, there is not enough GOOD captive business to go around and the existing captive domiciles can more than satisfy the needs of existing and new captive owners.

While it is understandable that these new domiciles want to generate the economic development that comes along with being a successful domicile, it is unlikely they are going to be able to duplicate the kind of success that Vermont, South Carolina, Nevada, Hawaii and one or two other on-shore domiciles have created.

Why? The newcomers are too late-- the seasoned incumbents have gained a lot of momentum, are committed to keeping the business they have earned, and are looking for ways to expand. In addition, because of the types of captives they are interested in forming, many of the clients who flock to new domiciles would actually be better suited to the regulatory environment of an offshore captive jurisdiction. Finally, when you take a hard look at most of these new domiciles it is clear they do not have any material competitive advantages over the mature domiciles and in fact many have distinct disadvantages.

For example, Vermont has 25 staff in its captive division solely focused on regulating captives. Most of the newer domiciles do not have any dedicated staff focused on captives. Arizona assesses a flat fee of \$5500 instead of charging a percentage of written premiums. This combined with its other advantages (knowledgeable regulator, accessibility, solid service providers, etc) make it a viable option for newer captives or large captive owners considering re-domiciling from offshore, especially if the parent is based in the west or Midwest U.S.

In conclusion, it takes a lot more to be successful as a captive domicile than simply passing a captive law. To be and remain successful as a captive domicile, a state or jurisdiction must have: competitive costs, reasonable accessibility, knowledgeable captive regulators, strong service providers and good infrastructure.

For more information on SRS, visit us at [www.strategicrisks.com](http://www.strategicrisks.com)

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