

Why Physician Groups Are Self-Insuring

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Given the medical malpractice crisis in a number of states, many physicians are looking at alternatives to conventional insurance coverage. These options typically involve some form of risk sharing where the medical group assumes additional risks based on experience. This article identifies several options—retrospective payment plans, risk retention groups, captives, and rent-a-captives—and their associated risks and opportunities.

Key words: Self-insurance, medical malpractice, captive insurance, rent-a-captive, risk retention group.

For the last several years, physician groups have been struggling to find medical malpractice insurance coverage that is reasonably priced and truly reflects the experience of their group. With conventional insurance companies, groups with good experience usually subsidize groups with poor experience. The companies claim that they discount or surcharge physician groups based on their experience, but many practice administrators remain skeptical that the premium truly reflects their group's experience.

The medical malpractice insurance crisis in more than 20 states over the last four years, with unpredictable premium increases averaging more than 20 percent per year, has caused many physician groups to look for alternatives to current professional liability insurance products. To control their malpractice insurance costs and to take advantage of their good experience, many larger medical groups are considering some form of self-insurance. Self-insurance requires that the medical group assume and fund for a portion or all of the risk that would otherwise be covered by an insurance company. These strategies can take several forms: risk sharing with an insurer, creation of a risk retention group (RRG), creation of a captive insurance company, or use of a "rent-a-captive."

WHY ASSUME THE RISK OF MEDICAL MALPRACTICE LIABILITY INSTEAD OF PAYING FOR INSURANCE? WHAT ARE THE RISKS OF SELF-INSURANCE?

Most practice administrators believe that by self-insuring, their physician group will ultimately pay less

because their group's experience is better than average and that they are rarely rewarded for better claims experience. The cost of self-insurance should be less if a group's experience is better than the average. However, few practice administrators focus on the key issues that contribute to self-insurance success in addition to good claims experience.

First, the medical group as a whole must agree to make a long-term commitment to self-insurance. Self-insurance strategies typically fail because the long-term commitment is not there. When the group's experience is worse than average or more costly than is budgeted during the year, additional contributions by the practice will be required, and many members of the group could differ as to whether or not to continue the self-insurance program.

Second, the physicians must be aware of the true risk that they are assuming. They must know that their experience has been better than average over the long term—not for the most recent years. To be confident about the group's experience relative to the average, an actuarial study will be required. With a 10-year underwriting cycle where at least three years will be worse than average, the group must appreciate the risk it is assuming. Few insurance companies are in the business for the short term. Doctors should also be in the self-insurance business for the long term.

Third, where more than one medical group is involved in a risk-sharing self-insurance program, the claims experience of each group should be relatively similar to assure that the risk pool can perform above average over the long term. One "bad apple" can truly ruin the entire risk pool.

Fourth, the underwriting, pricing, and funding of the risks should be left to professionals in the field. Too

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many physicians think they know the insurance business better than the professionals. This is a high-risk strategy.

Finally, long-term success depends on a commitment to risk management and state-of-the-art patient care. In the end, the business of self-insurance must start with managing patient care risks and providing the highest level of quality care possible in order for the self-insured medical group to realize its ultimate goal of predictable, low-cost professional liability insurance.

WHAT CHOICES DO PHYSICIANS HAVE TO SELF-INSURE?

There are at least four options for medical groups to consider and a number of other variations on the self-insurance theme.

Partner with an Insurer: Deductibles, Retro Plans

First, physicians can negotiate some form of self-insurance with their current or another carrier. These forms of self-insurance include deductible programs and retrospective payment plans (“retro plans”). The deductible program enables the group to assume a first dollar limit on each claim. For example, if the policy covers \$1 million per occurrence, the medical group could assume the first \$100,000 of each claim. This risk sharing will reduce the overall premium, but the group should seek the assistance of an actuary to determine how much of a discount the group should seek from the insurer for assuming the first dollar risk.

In a retro plan, the group receives a deep discount on the annual premium (the discounted premium is called the “deposit premium”) and agrees to be surcharged for poor experience up to an additional 25 percent of the nondiscounted annual premium (“swing premium”). The retro plan is usually based on a three-year “look back period.” That is, the first year’s experience is not determined for three years. During that time, the medical group gets a significant cash flow benefit. However, the company will require that the medical group collateralize the difference between the annual premium and the deposit premium. For example, if the filed annual premium for one surgeon is \$50,000, the deposit premium may be \$35,000 for good experience. After looking back over three years, the surgeon could be charged a premium up to \$62,500 for poor experience.

Risk Retention Groups

Some medical groups have chosen not to work with an insurer, but to create their own entity with other groups and share risk. One such structure is a RRG, which has become popular because of its low level of required capital. RRGs are regulated under federal law and

may operate in multiple states. Each group of physicians must invest in the RRG and provide any additional capital, if required. RRGs present a number of risks and misconceptions that physicians should be concerned about.

First, many insurance consultants will claim that the policy that is issued by the RRG is nonassessable. If the RRG fails, the physicians cannot be charged for additional capital. That is true to some extent. However, if the RRG fails and intends to issue a policy in the next year, the members of the RRG will be asked to make an additional capital contribution or the RRG will be forced to issue an assessable policy. An assessable policy will require that RRG members make an additional capital contribution if the level of capital is insufficient according to state law. Before joining an RRG, physicians should ask to see the legal opinion on assessability and have it reviewed by an insurance attorney.

Second, failure in an RRG is different from the failure of a state-regulated insurance company. State-domiciled and -licensed insurance companies participate in state guaranty funds. These funds are responsible for providing coverage and paying claims for insureds in the event of an insolvency. In an RRG failure, the doctors will not have coverage because RRGs are not part of the state guaranty fund. The doctors will have to handle any existing claims and pay all legal fees and other expenses. Third, RRGs are probably more risky than any physician group should undertake. What typically happens when an RRG requires more capital from its physicians is that the better groups leave, and the RRG is left with a much weaker pool of risks, usually requiring additional capital contributions. This creates a downward spiral toward insolvency. To make matters worse, tail coverage for the departing physicians may not be available, leaving many of the RRG’s physicians uncovered for claims during a prior period.

Captive Insurance

The third strategy that is gaining traction among large physician groups is the creation of a captive insurance company. A captive is a company that truly services only the specific needs of a single medical group. To be a cost-effective strategy, the group must be of significant size to handle the capitalization, start-up costs, and actuarial risk. Small groups of fewer than 50 physicians probably should not consider this option. Captives require serious insurance knowledge and an insurance consultant; an actuary as well as attorney should be involved.

First, the group must determine where the captive will be established—offshore or onshore. The most common offshore domiciles include Bermuda and the Cayman Islands. The most common onshore domiciles include Vermont and South Carolina. Each domicile has different capitalization and regulatory requirements.

Second, the group must determine the coverage and the appropriate level of funding based on the actuarially determined experience of the group.

Third, there must be a determination as to whether the group will purchase some form of excess reinsurance. Reinsurance is a form of insurance usually based on specific exposure. For example, after all claims paid in a given year exceed a mutually agreed upon level on each claim, the reinsurer will cover the remainder. The group should be sure that it is able to obtain reinsurance before creating its captive as this is the most uncertain aspect of setting up a captive.

Rent-a-Captive

In cases where starting a captive is problematic and the likelihood of obtaining reinsurance is “slim to none,” a group can avail itself of a rent-a-captive. In this program, the rent-a-captive charges an annual fee to access a captive cell and its reinsurance. It is important that the rent-a-captive is created as a segregated cell captive so that the risk of each participant in a cell of the captive is not commingled with the risks of all other cells in the captive. The main advantages of the rent-a-captive are the lower start-up costs,

professional captive management, knowledge of the legal and regulatory issues, and access to reinsurance. A medical group can gain access to a rent-a-captive when its own captive is financially and actuarially unattainable. In addition, hospitals that insure their employed physicians in their hospital captive are looking to spread their risk by putting their employed physicians in a rent-a-captive.

CONCLUSION

The above strategies are too complex to discuss all the key issues in this article. Any consideration of self-insurance should involve insurance professionals that have worked with self-funded programs and know the risks and the opportunities involved. Be wary of any professional selling just one option such as RRGs or captives before consulting with insurance companies. It may result in missing a less risky self-insurance opportunity. Finally, a realistic self-assessment of how any practice stacks up against its peers is essential before attempting any self-insurance program. After all, this is a strategy for only those practices that have better than average claims experience and can prove it over the long term. ■