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*Introduction by Nicole Williams Koviak**

Robert W. Mulcahey, a lawyer by training, has served as the Vice President and Chief Operating Officer of Stratum Med, Inc. (Stratum) since 1998.[1] Mr. Mulcahey also serves as the President for Stratum Insurance Company, a captive segregated portfolio insurance company domiciled in the Cayman Islands. The primary focus of Stratum Insurance Company, SPC, is to provide professional liability coverage for the physician groups associated with Stratum.

Speaking at Loyola University of Chicago School of Law's Annual Health Law and Policy Colloquium, Mr. Mulcahey provided an insurance industry perspective on the medical malpractice crisis, with a focus on the ability of physicians to maintain coverage viability during the medical malpractice crisis.[2] Skyrocketing medical malpractice insurance premiums and the lack of insurance coverage availability are forcing physicians to look for alternatives to traditional insurance. Similarly, insurance carriers have also been forced to respond to the medical malpractice crisis. For example, in December of 2001, the largest United States malpractice carrier in the United States, St. Paul Insurance Companies, stopped underwriting policies for physicians.[3] Similarly, effective January 1, 2003, the insurance

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1. In his role at Stratum, Mr. Mulcahey provides management to the corporation, which provides a variety of services to eighteen multi-specialty physician groups, including 2000 physicians in Illinois, Iowa, Wisconsin, Indiana, Michigan, and Ohio.

2. A recent study stated that "insurers blame rate hikes and policy considerations on what they describe as a rising tide of lawsuits and $1 million-plus jury awards." Joseph B. Treaster, *Malpractice Rates Are Rising Sharply: Health Costs Follow*, N.Y. TIMES, Sept. 10, 2001, at A1.

3. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS. (HHS), CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUT MEDICAL LIABILITY SYSTEM 14 (July 2002), *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.pdf; Symposium, *Medical Malpractice: Innovative Practice Applications Transcripts*, 6 DEPAUL J.HEALTH CARE L. 309, 313 (2003) [hereinafter Medical Malpractice Symposium]. St. Paul Insurance Companies covered nine percent of the country's physicians. *See* Nat'l Governors Ass'n (NGA), NGA Ctr. for Best Practices, *Addressing the Medical Malpractice Insurance Crisis* (Dec. 5, 2002), *available at* http://

branch of the Illinois State Medical Society stopped underwriting new malpractice policies.[4] Medical Inter-Insurance Exchange also pulled out of every state, PHICO Insurance Company went into liquidation,[5] and Frontier Insurance Group left the market last year.[6]

Mr. Mulcahey emphasized that in response to these drivers, insurers have looked to alternative risk financing.[7] Because of the tremendous growth in the area of alternative risk financing, three alternative risk-sharing options available to healthcare providers will be explored: captive insurance, risk retention groups, and purchasing groups.

I. ALTERNATIVE RISK FINANCING MECHANISMS

Escalating medical malpractice premiums have caused physicians and other healthcare providers to look beyond traditional insurance for more affordable options in order to continue practicing medicine.[8] If physicians do not partake in these alternatives, they may be forced to leave their practices altogether.[9] Contributing economic factors such as skyrocketing malpractice insurance rates, lower reimbursements, and high overhead may even start to cause a shortage in certain specialties, such as anesthesiology, cardiology, gastroenterology, neurosurgery, and radiology.[10] Nonetheless, healthcare providers contemplating leaving medicine or abandoning their current established practices now have several alternative risk mechanisms that may allow them to continue to practice. While a comprehensive look at these alternative risk mechanisms is beyond the scope of this paper, a brief look at each mechanism is instructive.

A. Captive Insurance

One common example of an alternative risk-sharing mechanism is

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www.nga.org/cda/files/1102MEDMALPRACTICE.pdf. The carrier's pull from the market left sixty percent of Nevada physicians without medical malpractice insurance. *Id.*

4. Medical Malpractice Symposium, *supra* note 3, at 313.

5. *See* Nat'l Governors Ass'n, *supra* note 3.

6. HHS, *supra* note 3, at 14; Medical Malpractice Symposium, *supra* note 3, at 313.

7. Alternative risk financing methods provides healthcare providers with possible alternative solutions to traditional insurance coverage.

8. Typically, physicians and healthcare providers seek medical malpractice insurance from traditional commercial multi-line property-casualty insurers like St. Paul Insurance Companies.

9. *How High Now? Premium Hikes of 25 percent or More Are Now Common, with More Double-Digit Increases Expected for 2004*, 81 MED. ECON. 1, 2 (2004) (noting that internists practicing in Miami, Florida, are faced with the highest rates for internists in the country, paying upwards of $65,000 in premiums, while general surgeons in Miami, Florida experience premiums over $200,000).

10. *Id.*

captive insurance. A captive insurance company is an insurance company which is owned by the entity it insures. There are several reasons companies establish captives, but historically captives have been popular with organizations that have difficulty obtaining affordable insurance coverage.

In light of the current expense of professional liability insurance, captive insurance is an attractive alternative for physician groups and hospitals. One of the main benefits of a captive insurance group is the reduction in cost it provides to its participating healthcare providers by underwriting their own insurance instead of paying third-party premiums.[11] A major lure of captives, noted by Mr. Mulcahey, is that they allow participating physician groups to pay more level premiums. Further, captive insurance provides customized coverage to meet the policyholders' specific needs and offers otherwise unavailable coverage with flexible funding and underwriting.[12] Control is an important aspect of captive insurance as captives not only offer physicians greater control over the underwriting process, rates, claim handling, and their investments but also provide incentives for loss control.

Although captives can effectively manage risk and eliminate some of the overhead costs associated with a traditional insurance company,[13] there are inherent challenges in becoming a captive insurer. For example, a captive insurance company has associated costs. Unlike self-insurance, a captive has associated license fees, directors' fees, management expenses, and audit fees.[14] Moreover, as Mr. Mulcahey pointed out, captives are having difficulty getting funding carriers because fewer multi-line funding companies are entering the funding business. In addition, exiting from a captive arrangement can be trickier and more complicated than exiting from other alternative risk mechanisms.

Despite the challenges, captive insurance is growing, not only in number but also in form. When exploring captive insurance as an alternative, there are three basic forms from which to choose: (1) a single parent captive, (2) a group captive, and (3) a rent-a-captive. Although an extensive discussion of each is beyond the scope of this paper, each arrangement will be introduced and defined.

In a single parent captive, the most common form, the captive insurer is a subsidiary that insures only the parent's risk or the risk of its brother/sister

11. Vt. Dep't of Banking, Ins., Sec., & Healthcare Admin., *The Advantages of Captive Insurance*, *at* http://www.bishca.state.vt.us/captives/Advantages.html.

12. *Id.*

13. *Id.*

14. Gregory K. Myers, *Commentary: Alternative Risk Fin. in the Traditional Ins. Marketplace*, ANDREWS INT'L REINSURANCE DISPUTE REP., May 19, 1997, at 3.

operations.[15] A group captive provides coverage to a group of entities that share similar risks.[16] Finally, a rent-a-captive is a captive insurance company organized and managed by a conventional insurer for the benefit of the insured.[17] A healthcare entity may choose a rent-a-captive when it is not large enough on its own or unable to capitalize a captive, but is willing to assume a portion of its own risk and share in the underwriting profits and potential investment income. Although a rent-a-captive requires less management, less administrative control, and does not require a capital investment, the insurer has more insolvency exposure.[18] Despite this potential drawback, it is easier for a physicians' group to leave a rent-a-captive than to dismantle a pure captive organization.

In light of all of the options for establishing a captive insurance company, creating a captive insurance company is a viable solution for physicians who are unable to obtain traditional insurance. Depending on the level of risk one wants to take, the various forms of captives provide physicians with additional flexibility and an opportunity to obtain affordable medical malpractice coverage.

B. Risk Retention Groups

Another type of alternative risk financing option available to the healthcare industry is the risk retention group. Risk retention groups grew tremendously in 2002 with twenty-one new formations.[19] Mr. Mulcahey called the growth in risk retention groups a "gigantic jump" and noted the all-time high in new registrations for risk retention groups. As Mr. Mulcahey observed, seven out of nine registered last year were in the healthcare industry.

One of the benefits of a risk retention group is the flexible licensure requirements. Unlike a traditional insurance company which must be licensed in each state it conducts business, a risk retention group is created and licensed under one state's law, but is authorized by federal law to sell

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15. Vt. Dep't of Econ. Dev., *Captive Insurance: Glossary of Terms*, *at* http://www.thinkvermont.com/captive/faq.cfm [hereinafter *Captive Insurance*]. *See also* Leon I. Jacobson, *Self-Insurance Using Captives and Risk Retention Groups, and Purchasing Groups*, *in* 439 PRACTISING LAW INST., COMMERCIAL LAW AND PRACTICE 389, 394 (1987).

16. *Captive Insurance*, *supra* note 15.

17. *See, e.g.*, American International Group (AIG), *Types of Captive Services*, *at* http://www.accessaig.com/accessaig/public/about/aims/captive_rent/0,4038,,00.html.

18. *Id.*

19. Cynthia Beisiegel, *Risk Retention Groups Owning Up to Success*, INS. J., Jan. 27, 2003, at 1 (quoting the Risk Retention Reporter statement that ninety risk retention groups existed nationwide at the end of 2002).

insurance in every other state without additional admission requirements.[20] Thus, physicians who form a risk retention group can obtain a license in one state, but sell insurance in all states. In addition to flexible licensure requirements, a risk retention group also provides its members with more control over the liability programs. Because members of a risk retention group own the insurance company, the greater control affords them lower rates, broader coverage, effective loss control, risk management programs, and stability of coverage.

Risk retention groups provide the typical advantages of traditional medical malpractice insurance, but are not without challenges and risks. Although risk retention groups offer their participating physicians lower rates, flexibility, and a higher means of sharing liability,[21] a participant is required to provide an initial capital outlay to create a risk management group.[22] In addition to the required capital outlay, members of a risk retention group are also burdened by the premium payments. While the financial challenges are one potential obstacle to a successful risk retention group, financial instability is an inherent risk and is predicated on the performance of the program's management.[23] As a result, participating hospitals and physicians face greater exposure to insolvency.[24] Thus, while alternative risk-sharing options could save money, participating hospitals and physicians often assume greater financial responsibility and risk for malpractice.

Not only are alternative groups risky from the participants perspective, these alternative groups may also pose problems for claimants. For instance, if one of these alternative groups fails, claimants seeking compensation for their injuries may face even more difficulty in receiving monetary reimbursement for their injuries than they do right now.[25]

Despite the challenges and risks of risk retention groups, this type of alternative insurance mechanism is gaining support from the states. The District of Columbia licensed its first risk retention group on June 5, 2003.

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20. Preferred Physicians Mut. Risk Retention Group v. Cuomo, 865 F.Supp. 1057 (S.D.N.Y. 1994), *vacated by* Preferred Physicians Mut. Risk Retention Group v. Pataki, 85 F.3d 913 (2d. Cir. 1996); 15 U.S.C. § 3901(a)(4) (2000).

21. Beisiegel, *supra* note 19, at 3.

22. *Id.*

23. *Id.*

24. *See* U.S. GEN. ACCOUNTING OFFICE (GAO), PUB. NO. GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTE TO INCREASED PREMIUM RATES (June 2003), *available at* http://www.gao.gov.

25. *Id.* at 40 (noting that claimants face more risk of not being reimbursed given that risk retention groups are free from state insurance department regulation). Seeking reimbursement from a physician personally is more difficult than enforcing a judgment against a solvent insurance company. *Id.*

As further proof of the growing acceptance of this mechanism, the Health Network Providers Mutual Insurance Co., which offers medical malpractice insurance for physicians in Houston, Texas, chose to structure the company as a mutual company to convey to the physicians that it was their company and that they had control over their insurance.[26]

Healthcare providers who want to participate in a risk retention group must consider funding requirements, commitments to risk management and expense control, the experience of the sought after risk retention group, and any limits on the participants' liabilities. Despite the challenges of risk retention groups, the benefits outweigh the risks and have allowed this alternative insurance mechanism to experience extensive growth in the healthcare industry.

C. Purchasing Groups

In addition to permitting the formation of risk retention groups, federal legislation enables healthcare providers to form purchasing groups. Like risk retention groups, purchasing groups have experienced dynamic growth in the marketplace. However, unlike a risk retention group, a purchasing group allows a number of members to purchase liability insurance coverage together from an insurance company.[27] Nevertheless, purchasing groups share many similarities with risk retention groups.

First, both alternative insurance mechanisms are permitted under federal law as long as they register with state insurance departments.[28] Furthermore, in order to participate in either form, federal legislation requires all members to be involved in a similar business so as to expose them to similar liability.[29] This common requirement provides for an easier transition if a purchasing group decides to reorganize as a risk retention group.

Despite the similarities, there are significant differences between purchasing groups and risk retention groups. Unlike a risk retention group, which federal law exempts from state law, a purchasing group is exempt only from certain types of state law.[30] Accordingly, purchasing groups must file in every state in which they intend to do business and a state may require an agent or broker of the purchasing group to acquire a license.

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26. Ins. Communications, *District of Columbia Licenses Its First Risk Retention Group*, RISK RETENTION REP., Aug. 2003, at 4.

27. 15 U.S.C. § 3901(a)(5) (2000); Ins. Communications, *RRG/PG Basics*, *at* http://www.rrr.com/education/index.cfm.

28. Nat'l Risk Retention Ass'n, *Frequently Asked Questions*, *at* http://www.nrra-usa.org/about_faq.html.

29. *Id.*

30. 44 C.J.S. *Ins.* § 35 (2003); 15 U.S.C. § 3901(a); 15 U.S.C. § 3903(a) (2000).

Additionally, the entities are regulated differently. The risk retention group is regulated by its domicile state while the purchasing group is regulated by both its domiciliary state and its insurer.[31] Also, unlike risk retention groups, purchasing groups are not insurance companies and therefore, maintain less risk.[32] Instead, it is the insurer from whom the purchasing group buys its policies who bears the risk.[33] Finally, while risk retention groups require their members to capitalize the company, members of purchasing groups are not required to do so.[34]

Purchasing groups are advantageous to all parties involved. First, these groups provide their members with tailor-made coverage, broader coverage terms, lower rates, and occasional dividends.[35] Second, purchasing groups offer their insurers the ability to achieve greater profitability. Third, members of purchasing groups achieve reduced premiums through the large number of insureds in the group. Finally, the agents of the purchasing groups are given the ability to add value to transactions and retain business.

While purchasing groups present another mechanism by which to obtain affordable coverage for risk, physicians and other healthcare providers must weigh all the nuances involved when deciding whether a purchasing group, or any of the other alternatives, is the best option.

II. THE INFLUENCE OF FEDERAL LEGISLATION ON STATE INSURANCE REGULATION

Over the last few decades, Congress has adopted federal legislation in response to escalating insurance medical malpractice premiums, providing physicians and hospitals with substitutes for traditional insurance coverage. The Product Liability Risk Retention Act of 1981 (PLRRA), although not enacted to help physicians or healthcare entities, served as a stepping stone for legislation enacted later to encourage the formation of alternative risk mechanisms to cover and insure medical malpractice risk.[36] The PLRRA was enacted in an attempt to make insurance rates more affordable for

31. 15 U.S.C. § 3901(a)(4); 15 U.S.C. § 3903(a).

32. Ins. Communications, *What is the Difference Between Risk Retention Groups and Purchasing Groups?*, *at* http://www.rrr.com/education/index.cfm.

33. *Id.*

34. Beisiegel, *supra* note 19, *at* 7.

35. Ins. Communications, *What Are the Advantages of Purchasing Groups?*, *at* http://www.rrr.com/education/index.cfm.

36. *See* Product Liability Risk Retention Act of 1981, Pub. L. No. 97-45, 95 Stat. 949 (1986) (codified as amended at 15 U.S.C. § 3901). The PLLRA was passed in response to the mid-1970s product liability insurance crisis. *See also* GAO, PUB. NO. GAO/HRD-86-120BR, INSURANCE: ACTIVITY UNDER THE PRODUCT LIABILITY RISK RETENTION ACT OF 1981 (Briefing Report to the Honorable Edward F. Feighan, U.S. House of Representatives) (July 22, 1986), *available at* http://www.gao.gov.

product manufacturers who had trouble obtaining certain types of traditional insurance coverage, thus increasing the availability of coverage.[37] According to the United States General Accounting Office (GAO), the PLRRA would enhance the affordability and availability of insurance to healthcare providers "by allowing groups of product sellers, manufacturers, and distributors to form risk retention groups or purchasing groups on an interstate basis."[38] The Act limited the States' control over insurance by exempting both risk retention groups and purchasing groups from "any state law, rule or regulation or order," with certain exceptions.[39] Thus, the legislation exempted risk retention groups from any discriminating state statute or regulation against the groups or their members, paving the way for medical malpractice insurance alternatives which would also have similar exceptions from discriminating state law.[40]

Subsequent federal legislation, the Liability Risk Retention Act of 1986 (LRRA), was adopted to expand the PLRRA and therefore allow risk retention groups and purchasing groups for all types of liability insurance, including medical malpractice, although still excluding personal liability and workers' compensation.[41] The new legislation also expanded the groups authorized to form risk retention groups beyond product manufacturers to include almost all businesses. Accordingly, the new legislation afforded healthcare providers the ability to organize a risk retention group as an insurance alternative.

Today, physicians that form these new groups must be aware of mandates states may impose. Although there are limitations on state control, there are certain items that a state may require including: registration with the state insurance commissioner compliance with orders for delinquency or dissolution proceedings; inclusion of a notice in all issued insurance policies that the risk retention group is not subject to all state insurance laws and regulations, thereby making state insurance solvency guaranty funds to be available; and compliance with hazardous financial condition injunctions.[42]

Despite the potential state mandates that are permissible under the

37. 43 AM. JUR. 2D *Ins.* §29 (2003); Preferred Physicians Mut. Risk Retention Group v. Cuomo, 865 F.Supp. 1057, 1062 (S.D.N.Y. 1994), *vacated by* Preferred Physicians Mut. Risk Retention Group v. Pataki, 85 F.3d 913 (2d Cir. 1996).

38. GAO Briefing Report, *supra* note 36, at 5.

39. 15 U.S.C. §§ 3901, 3902.

40. 43 AM. JUR. 2D *Ins.* § 29 (2003).

41. AM. HEALTH LAWYERS ASS'N, HEALTH LAW PRACTICE GUIDES § 9:73 (2003), *available at* http://www.westlaw.com.

42. 15 U.S.C. § 3901. Other allowable state mandates include requiring compliance with unfair claim settlement practices, payment of certain premiums or taxes, or compliance with state deceptive, false, or fraudulent trade practice laws.

LRRA, most courts have favored the alternative groups over state control. In cases where risk retention groups have claimed that state statutes discriminated against the group or its members, courts have looked to the history of the LRRA.[43] For example, New York's Excess Insurance Law provided one million dollars of free excess insurance coverage to doctors if their primary insurance coverage was written by an in-state licensed insurance company. A group of anesthesiologists who formed an insurance cooperative to share liability formed under Missouri law and offered insurance to New York practicing physicians argued that the New York law violated the LRRA.[44] Although the risk retention group eventually withdrew its lawsuit, the court concluded that the LRRA's legislative history indicated Congress' intention to exempt risk retention groups broadly from state law "requirements that make it difficult for risk retention groups to form or to operate on a multi-state basis."[45]

On the other hand, in *Ophthalmic Mutual Insurance Co. v. Musser* the court held that a Wisconsin statute, requiring healthcare providers to demonstrate proof of financial responsibility by carrying insurance obtained from an insurer licensed in Wisconsin, was neither discriminatory nor preempted by the LRRA.[46] The court followed the Eleventh Circuit's reasoning in *Mears Transportation Group v. State* that the discriminatory law must have a disparate impact on the risk retention group as compared to other non-domiciliary insurers, rather than as compared to licensed carriers in the state.[47] Accordingly, the court held that the Wisconsin statute fit within an LRRA exception allowing states to impose some regulation on these entities. The Seventh Circuit affirmed this decision.

A recent example of how the LRRA has helped alleviate the medical malpractice insurance crisis is evident in Pennsylvania, where several insurance companies no longer provide medical malpractice insurance to state physicians and hospitals. Consequently, as of January 2003, a total of ten risk retention groups were formed in the last two years and now provide liability coverage to Pennsylvania's physicians and hospitals.[48] The Pennsylvania Department of Insurance has claimed that risk retention

43. *See, e.g.*, Nat'l Warranty Ins. Co. RRG v. Greenfield, 214 F.3d 1073, 1082 (9th Cir. 2000) (holding that the LRRA preempted the Oregon Service Contract Act given that the purpose of the LRRA indicates intent to preempt state laws regulating risk retention groups).

44. Preferred Physicians Mut. Risk Retention Group v. Cuomo, 865 F.Supp. 1057, 1082 (S.D.N.Y. 1994).

45. Preferred Physicians Mut. Risk Retention Group v. Pataki, 85 F.3d 913, 916 (2d Cir. 1996) (quoting H.R. No. 99-865).

46. Ophthalmic Mut. Ins. Co. v. Musser, 143 F.3d 1062, 1070 (7th Cir. 1998).

47. Mears Transp. Group v. State, 34 F.3d 1013, 1016 (11th Cir. 1994).

48. *See* Ins. Communications, *Risk Retention Act Responds to Pennsylvania's Health Care Crisis*, RISK RETENTION REP., Jan. 2003.

groups are beneficial because they provide "additional insurance coverage options in a very tight medical malpractice insurance marketplace."[49]

As a result of federal legislation, physicians and hospitals have new avenues from which to obtain affordable medical malpractice insurance. Healthcare entities have typically moved to the alternative risk market when faced with affordability and availability issues. For this reason, many healthcare captives were started during the crisis years of the late 1970s, early 1980s, and the early 1990s, with the past two years reflecting record numbers of captive formations. The reason for these formations is primarily availability and the need to level out swings in the commercial marketplace. Most healthcare entities can financially manage yearly cost increases, but lack the ability to raise prices. Thus, thirty to one hundred percent premium increases such as those faced by many healthcare providers in a hard market is devastating. A captive or risk retention group allows the physicians or hospitals to spread those increases over a number of years. Likewise, the desire to control claims and defense costs are reasons to form these entities.

III. CONCLUSION

Physicians have several alternatives, including captive insurance companies, risk retention groups and purchasing groups, from which to choose in order to maintain viability during the ongoing medical malpractice insurance crisis. The lack of available and affordable insurance premiums has caused these alternative risk financing mechanisms to experience continuous and tremendous growth. Instead of quitting medicine altogether or giving up one's established practice, physicians now have alternative risk sharing options which allow them to continue practicing medicine. Each alternative insurance mechanism has unique advantages and disadvantages but each mechanism allows physicians to enjoy the increased purchasing power, cost-effectiveness, and flexible savings opportunities that these alternatives offer. For this reason, captive insurance companies, risk retention groups, and purchasing groups may offer an escape from the high premiums of traditional medical malpractice insurance.

49. *Id.*