

Analysis of ASHRM membership survey on healthcare captives

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This article explores the emergence of captives as a vehicle for managing healthcare risks. In 2006, the American Society for Healthcare Risk Management (ASHRM) surveyed a segment of its membership with experience and interest in alternative risk financing about the role of healthcare captives. This article summarizes the findings and generally assesses the responses for opportunities to educate risk managers more fully on the role captives can play in managing risks.

INTRODUCTION

As risk management continues to evolve to meet healthcare organizations' changing needs, many risk managers find themselves involved with the creation or operation of an alternative risk financing vehicle such as a captive insurance company. A captive insurance company is one that is established to provide coverage to a sponsoring entity as opposed to marketing and selling policies commercially to insureds. The sponsoring entity may be a parent corporation and its related subsidiaries, a professional association or other group.

The goal of a 2006 American Society for Healthcare Risk Management (ASHRM) membership risk financing survey was to identify opportunities for ASHRM to increase educational offerings on captive related topics, as well as to identify resources that members found valuable on the topic of captive management.

RESULTS

One hundred and sixteen members completed the survey, which was offered online during the fall of 2006. More than 78 percent of the respondents indicated that their organization currently utilized a captive insurance program for coverage in professional and general liability risks.

Results confirmed that the establishment of captives as an insurance mechanism to address healthcare risks has been a relatively new occurrence, as 74 percent of the captives were formed since 1997; 66 percent were formed since 2000 alone.

(See Figure 1.)

More than 70 percent of the captives began writing professional liability coverage after 1999, with almost 95 percent offering that coverage in claims-made form. More than 75 percent indicated that the captive provided coverage outside of professional and general liability, including workers' compensation, clinical trial exposure, property, directors and officers, managed care, errors and omissions and products liability.

The Cayman Islands remained the primary domicile of choice (more than 50 percent) with other domiciles including Bermuda, Vermont, Hawaii, Arizona, Texas, Nevada and South Carolina.

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FIGURE 1
Timeframe of captive creation

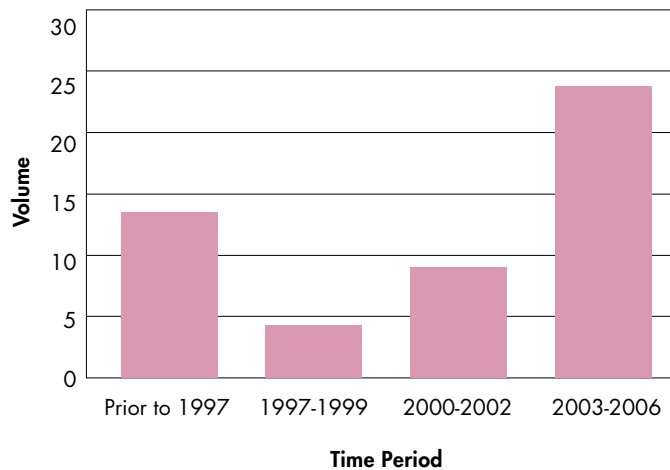
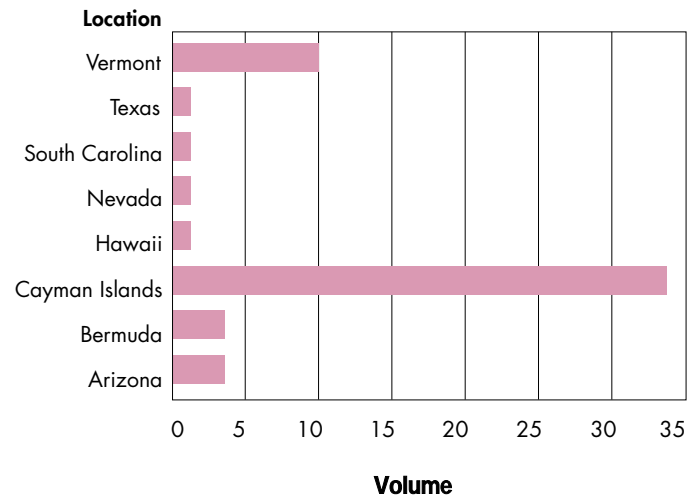


FIGURE 2
Domicile by volume



About half of the respondents have re-evaluated the initial domicile within the past five years, but more than 90 percent have remained in that domicile, even after the review. The primary attraction to a domicile was the financial/tax flexibility offered, followed by the amount of healthcare experience in the domicile. (See Figure 2.)

More than 60 percent of the respondents indicated that they felt that commercially insuring the professional liability/general liability (PL/GL) exposures for their facilities was becoming cost prohibitive and more than 75 percent felt motivated by this to consider the use of a form of alternative risk financing. All of the respondents indicated that their captive program carried excess limits through the commercial markets.

More than 76 percent of the respondents replied that the members of the C-suite, including risk management, drove the decision to create or implement the captive program. While only 28 percent of the risk managers indicated that they drove the decision, it was apparent in the survey results that the risk manager has played a key role in the ultimate decision to invest time, finances and staff to the creation and operation of a captive.

Almost 50 percent looked to their insurance brokers to guide them through the feasibility study and creation of the captive, with other consultants being utilized including a captive management company, outside counsel, actuaries and independent risk/captive consultants. (See Figure 3.)

More than 70 percent of the captive programs were organized as a single owner captive, insuring only the risks arising from the insured entities and/or providers. The captive programs principally covered those providers (various allied health/nursing staff, physicians, residents and medical students) noted to be employed by the hospital or clinic, with non-employed physicians included in about 20 percent of the programs.

At the time of creation, the majority of captive programs had between 200-750 acute beds, with total cost of risk between \$750,000 and \$42 million. These numbers changed dramatically when the respondents were asked to identify their current captive statistics. Most had more than 750 beds and the cost of risk increased to the top range of \$89 million.

Most programs (more than 72 percent) surveyed include self-insured retentions that exceeded the \$1 million level, indicating that the primary management of the program was handled by the organizational staff, rather than reliance upon commercial carriers for administrative support. Almost 100 percent indicated that the captive insurance policy language was reviewed on a periodic basis, and that the captive had an underwriting committee or process. More than 50 percent said they managed professional liability claims in-house, with another 25 percent utilizing a team that included both in-house and external staff.

Seventy-five percent of in-house staff handled the exposure monitoring of the captive, confirming that the decision to create a captive also included dedicating in-house staff to operations and management of captive related tasks. The exception was the issuance of certificate of insurance documents on behalf of the various insureds, which were more likely to be done by the on-site captive manager.

Only a third of respondents indicated that their captive had a grant program, where insureds could obtain grants from the captive for risk management projects, new technology and/or loss control related research (a third indicated that there were also other uses for these grants). The grants ranged from \$25,000 to \$75,000 per request, with some making up to \$350,000 available annually.

Board management is a key challenge for risk managers. More than 60 percent of the risk managers conduct a board orientation

FIGURE 3
Decision to create a captive



for new or existing board members, and more than 85 percent of the risk managers responding indicated that they attend the captive board meetings. Information presented by the risk manager includes various risk topics, including claims data, risk efforts and legal/financial issues or trends. (See Figure 4.)

More than 50 percent of the captive boards had medical staff leadership represented, comply with Sarbanes-Oxley Act practices, attended reinsurance/renewal meetings and met personally with domicile regulators on a regular basis. However, more than 60 percent of the boards did not have clearly defined board core competencies.

More than 50 percent of the captive boards reviewed quality indicators, quality benchmarks or other clinically based quality information. The sources for this information included information provided by brokers, industry publications, an in-house quality department, reports from the Centers for Medicare and Medicaid Services or American Institute of Certified Public Accountants' Statement on Auditing Standards (SAS 70). Sources might also include other internally developed benchmark reports. Unfortunately, more than 50 percent feel that they are not able to show a true reduction in claims frequency and/or severity since the implementation of the captive.

Respondents were asked to rank the various activities of the captive from 0-5, with 0 meaning "non-existent" to 5 meaning "best practice." Per Figure 5, most respondents felt that their captives were maturing and activities were "emerging" but only a few felt that the activities were consistent with best practices.

Respondents were then asked to identify the most significant challenges of owning and operating a captive to risk managers, when involved in the operations of a captive insurance company. Following is the list of challenges (order based on ranking by respondents):

- Resource requirements (obtaining necessary resources – staff/ time/funding)
- Board management (selection to orientation to management)
- Risk/loss control (measuring results as well as communicating results)
- Coordinating service providers (developing a cohesive and effective team)
- Claims management process (managing claims and measuring effectiveness)
- Financial strategies (measuring effectiveness as well as interpreting results)
- Effective/efficiency metrics (for all areas of operations)
- Insured education/management (communicating with insureds on coverage/premiums)
- Domicile justification (political issues as well as tax/ financial issues).

The survey respondents indicated that there were few formal mechanisms to learn about alternative risk financing and that communication between the healthcare entities frequently causes each captive decision to be made without strong industry information on metrics of success. Risk managers lean on external consultants, online resources, formal coursework and publications to get the information needed to address the specific captive issues at hand.

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FIGURE 4
Issues presented by risk manager

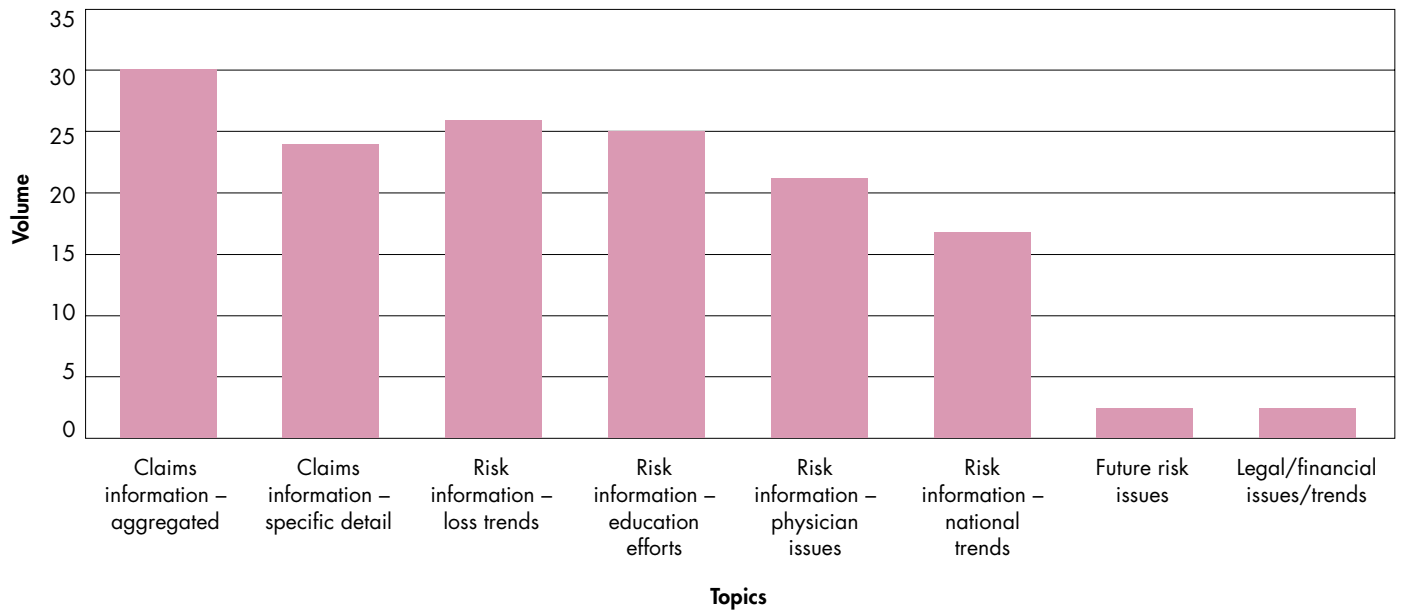
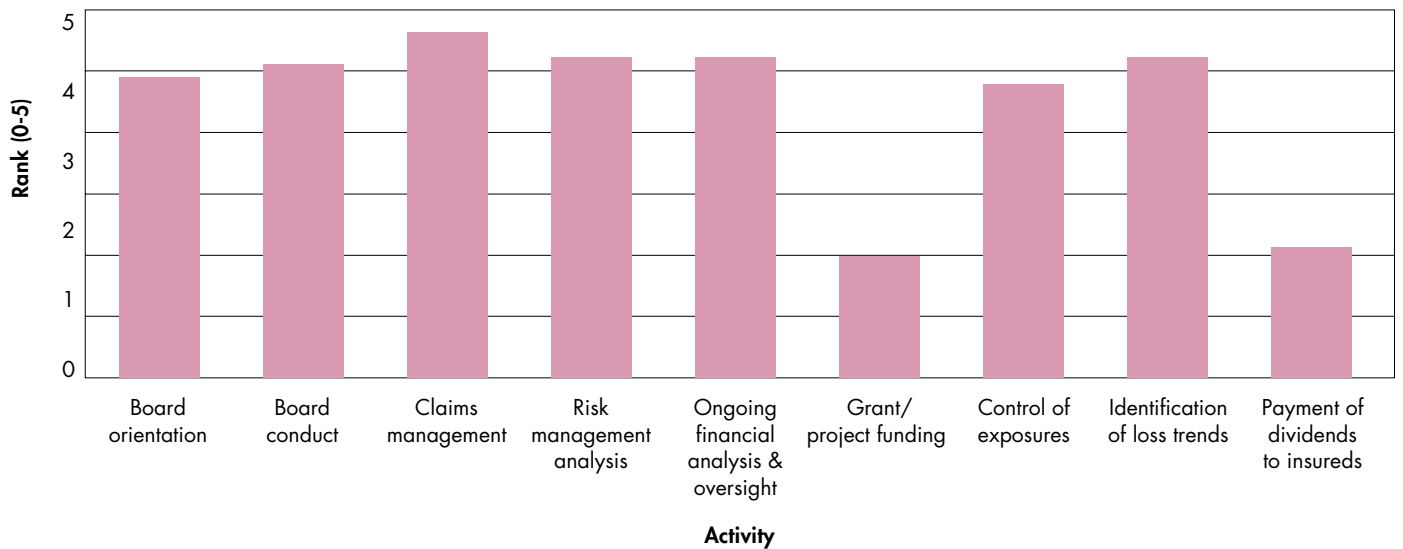


FIGURE 5
Ranking of captive operations



Following is the list of resources identified as having value for risk managers given captive management responsibilities:

- Utilization of consultants/service providers (captive manager, broker, third-party administrator, actuary)
- Attendance at various captive conferences (Bermuda, Cayman, Canadian, World Captive Forum, CBI programs on Alternative Risk Financing)
- Enrollment in the Associate in Captive Insurance certificate program through the International Center for Captive Insurance Education
- Membership in RIMS, as well as the Vermont Captive Insurance Association
- Subscriptions to IRMI resources (specifically the text *Captives and Management of Risk* by K. Westover), Business Insurance, Captive & ART Review, National Underwriter
- Online resources of www.captive.com, www.captivedailywire.com, various domicile comparison documents and resources, Tillinghast Captives 101
- Knowledge of domicile regulations and regulators
- Interaction with peer risk managers, reinsurers and legal counsel.

Respondents also identified key areas of knowledge that they had gained through experience, but would highlight as important for a new risk manager who was given captive management responsibilities.

Following is a list of captive management knowledge areas considered key to risk managers:

- Understanding of financials
- Building a strong infrastructure
- Justifying operating costs/return on investment
- Best practices for operations and metrics measurement
- Fundamentals of running an insurance company (funding/premiums)
- Establishing clarity around roles, of board and vendors
- Understanding of claims data.

CONCLUSION

Survey results confirmed that most healthcare risk managers are faced with some degree of involvement in their facility's risk financing efforts, including involvement in the creation or management of a captive insurance company.

ASHRM is dedicated to providing members with educational opportunities, and will identify key partnerships that will allow for increased future offerings of education in the realm of captive management.

Specifically, the ASHRM Risk Financing & Claims Interest Network provides the platform for the sharing of this advanced level of information, through linked resources, timely resource articles and a discussion forum.

For more information about the Interest Network, contact ASHRM at ashrm@aha.org or (312) 422-4580.

ABOUT THE AUTHOR

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