Q&A with...
Christina Kindstedt, SVP, WillisTowersWatson

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Christina Kindstedt is Senior Vice President with WillisTowersWatson, and a widely recognized expert on captive insurance structures. Here, she provides some essential answers on what’s been happening recently in the alternative-risk-transfer market.

Inside Medical Liability: Do 831(b) captives play a role in medical professional liability (MPL)?

Kindstedt: 831(b) captives, also commonly referred to as “micro captives,” are exempt from taxation on underwriting income and are taxed only on investment income. They could only write less than $1.2 million in annual premium to qualify. Because of this cap, they haven’t played an active role in MPL. That could change now that the premium cap has been raised to $2.2 million, plus an inflation-linked increase annually thereafter. The other major change is ownership diversification which physician groups easily meet. As a result, 831(b) captives will be especially attractive for small to medium-sized physician groups.

IML: Has the appeal of captives decreased, in light of the dampening of P/C pricing cycles?

Kindstedt: Sort of, but not definitely. The types of companies that want to form captives know that they get into the captive insurance business for risk management and for the long haul. The types of companies that value pricing (read: a lower premium today) over all else tend to base their decision making mainly or solely on premiums. The former form captives, regardless of the market cycle, and they do reap the benefit of low pricing in the reinsurance market during the soft cycle. The latter will buy insurance from the traditional market as long as premiums remain low.

IML: How does a risk manager perform due diligence in determining if a captive makes sense for a healthcare entity?

Kindstedt: The risk manager should ask: Does the entity have a critical mass and enough diversification to spread the risks? What’s the entity’s risk tolerance for the retained layers? How much capital can the entity put up? What’s the long-term plan? These are just the beginner questions.

IML: How does a risk manager’s job change when the employer owns a captive?

Kindstedt: The Risk Manager’s (“RM”) perspective will change. The employer now has an insurance company that retains some of its own risks. The reason I use the word “some” here is that just about all captives reinsure to the commercial market.

The RM and his/her employer now need to manage the employer’s risks. For example, a certain medical procedure may bring the employer significant revenue. But if the procedure is still in its pioneering stage, it could expose the employer to potential risks and claims, against the employer’s own captive. Now the risk manager needs to weigh the risk and reward.

Another example happened to an MPL captive that we formed and now manage. When a patient brought a small claim against a physician because of the physician’s “poor attitude,” the physician’s employer who is the owner of the new captive was going to make the physician pay for the claim, although the claim clearly fell under the captive’s coverage. The captive owner’s argument was that if the claim showed up on the captive’s claims report, it would raise next year’s premium for the entire group. We explained to them that one small claim as this wouldn’t affect the group’s premium, but a system of such small claims would. By reporting it to the captive, the owner and we would become aware of a behavioral pattern if similar small claims were reported subsequently. The captive’s claims report serves as a dynamic data base from which we spot trends and customize risk management initiatives.

The captive world has many more such examples.

IML: What are the biggest advantages of captives for hospitals and healthcare entities?

Kindstedt: Like the example above, owning a captive elevates the hospitals’ and entities’ sense of risk detection and management.

IML: Similarly, what are the biggest disadvantages?

Kindstedt: There are more responsibilities for management. Now hospitals and physician groups wear two hats: providing healthcare as they have always done; AND managing risks.

IML: How does a hospital or healthcare system determine the best mix of self-insurance, self-insurance trust, and a single-parent captive?

Kindstedt: A feasibility study will weigh the pros and cons of each option. It very much depends on the system’s risk tolerance.