

Risk Retention Groups: Market Influences

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Physician directed insurers, and specifically risk retention groups (RRG's) have come to play a large role in the medical malpractice market over the last thirty years. It is estimated that physician directed insurers accounted for 60% of the medical malpractice premiums as of 2003ⁱ. That figure may be on the rise, as the overall premium volume of health care risk retention groups grew 24% from 2003 to 2004.ⁱⁱ With a significant market share of medical malpractice insurance being purchased through RRG's, there is the need for a greater understanding of how these groups operate. A review of public statements by current risk retention groups revealed that many strictly limit membership to those with favorable loss histories. This trend raised the question of whether medical malpractice liability risk has become segregated in the market, with better underwriting risks purchasing coverage through risk retention groups and worse underwriting risks purchasing coverage through traditional carriers.

For the purposes of this article, information was gathered through a review of information on available RRG websites. Of particular interest was the insurer's discussion of its history, purpose and mission. Generally RRGs indicate, as we would expect, that they were created in response to the failings of the commercial marketplace, and that their primary objective since inception has been to maintain consistent coverage and pricing for their members.

This review of the histories and mission statements of the RRG's raised the question of how they determine proper underwriting criteria to meet their goals. In particular, the material would suggest that these RRGs seek only the "best risks" for coverage. For example, some RRGs advertise that the states in which they offer coverage are among the select few which have shown favorable loss histories. A number of groups also make the claim that they have very strict underwriting standards, and will not admit medical professionals who show a large potential for loss. If indeed RRGs take the better risks, we would anticipate that the traditional commercial insurers would provide coverage for much of the higher-risk market at a price. Such a situation, however, leads to a significant level of adverse selection, which in turn could disrupt the market, an outcome opposite of the stated goals of the RRGs we surveyed.

An example of how RRGs accept high risk while protecting their base is through their use of segregated cells. A segregated cell is often been used by an RRG when it wishes to include a member with a disproportionate amount of risk to the group, without assuming the risk which accompanies the member. All assets and losses relating to the member in question are assigned to a segregated cell

which maintains accounts isolated from the larger body of membership. In this way, the RRG is able to include the high-risk member without actually assuming any of the risk.ⁱⁱⁱ Through this structure, the group member gains access to reinsurance markets and tax benefits and the RRG gains another member to share in administrative costs, but neither party gains the benefit of risk sharing. At some point in time, if and when the member is seen to have improved its risk profile, the segregated cell may be dissolved and the risk is shared. Ultimately the group then increases its membership and the member gains the security of inclusion in the larger group.

The use of segregated cells among RRG's varies, as does the level of risk sharing among the cells. Some groups segregate a cell when they wish to include a member of an association for political reasons, and effectively share no risk until the point in time when the segregated cell is dissolved. Some groups use the segregated cell concept to isolate risk at low retention levels, but purchase reinsurance which attaches at each cell's retention limit, resulting in effective risk transfer.^{iv} Whether or not the use of segregated cells ultimately results in risk sharing among its members, it offers an RRG a means to limit its risk with a high-risk member.

For the sake of argument, let's accept the hypothesis that risk retention groups only accept the better risks in the industry, either by placing the high risk members into distinct cells or not accepting them at all. Considering the large market share of medical malpractice insurance purchased through RRG's, it follows that there would be a separation in the market between better risks, which are covered through RRG's, and worse risks, which would turn to traditional carriers. Jim Hurley, an actuary for Towers Perrin, indicates that if true, this hypothesis would be very difficult to prove. The information necessary to do so is not readily available. To do so, we would need risk adjusted premium rates among RRG's and compare the distribution to those from traditional insurers. Further, rate information may be distorted through the use of loss-free credits which reduce otherwise collected premiums back to a RRG's members based on their loss history. Because of the difficulty in collecting accurate and meaningful data, this is a hypothesis which may be untested for some time.

Mr. Hurley also states that the limitation of membership to good risks is not the advantage which risk retention groups have been acknowledged to have. He suggests that RRG's have thrived because they have a much greater ability to deal with legal and regulatory issues efficiently. They were set up by

professional associations or large health care organizations to maintain stable coverage and rates for the membership of the group. Eligible members of the RRG are generally determined by membership in the group which created the RRG. However, RRG's have largely managed to stay solvent in a volatile line despite their small size and lack of diversification. Judging by these results, it seems that the RRG's may have an advantage beyond regulatory efficiency. Perhaps risk segregation offers an explanation.

Another expert, who prefers to remain anonymous, points out that RRG membership eligibility is based on participation in a profession or industry of similar qualities. In terms of risk profile, he believes that these groups would tend to be more homogeneous than the clientele of a traditional liability insurer. Given that high-risk groups tend to purchase coverage from the residual market rather than RRGs (forming a group of high risks would not help the members much), this expert thinks that it is quite plausible that RRG's have a disproportionate share of the industry's better risks. This line of reasoning gives some basis to the premise that RRG's do not engage in the same level of risk sharing across the industry that traditional insurers do.

RRGs have become a major player in the medical malpractice insurance market, and appear to offer their membership stability in rates and coverage which is not always available through traditional carriers. Still, RRG's are not well known nor understood. Their small size and focused business, as well as their federal chartering, make them quite unique relative to the traditional market. Such characteristics appear to offer both greater (small size) and lesser (more focus) riskiness, which we believe warrants further review and study. The more we know, the better able is the market to aid in successful functioning of this important provider of professional liability insurance.

ⁱ United States General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*. June 2003

ⁱⁱ John J. O'Brien, JD, CLU, CPCU. "Medical Malpractice Insurance Crisis: Alternative Risk Transfer Solutions," *Wilmington Trust Corporation*, 2006.
<http://captive.com/service/WilmingtonTrust/images%20and%20pdf/medmalwhitepaper.pdf>

ⁱⁱⁱ Gisele Norris, DrPH, "Putting Segregated Cell Captives to Work for Complex Health Care Organizations," *Aon Focus*, March 2006

^{iv} Dennis Pillsbury, "All Risks Are Not Created Equal," The Rough Notes Company.
<http://www.roughnotes.com/rnmagazine/2006/november06/11p094.htm>