Keeping Medical Liability Costs Down: How Captive Insurance and Damages Caps Could Help Control Rising Healthcare Costs

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I. INTRODUCTION

Insurance costs continue to rise annually generally because of increased administrative costs relating to processing and paying claims, litigation costs arising from claims, and certain types of risks becoming more expensive to insure.[1] Two issues contribute to large health care costs: (1) the use of defensive medicine, and (2) the increasing costs charged to consumers to help offset the high costs of medical malpractice insurance premiums.[2] Insurance for medical liability is among the most expensive types of insurance, costing physicians anywhere from $10,000 to $100,000 a year.[3] As of 2008,

1. Constance A. Anastopoulo, *Taking No Prisoners: Captive Insurance As An Alternative to Traditional or Commercial Insurance*, 8 ENTREPRENEURIAL BUS. L.J. 209, 212 (2013).

2. Press Release, Harvard School of Public Health, Medical Liability Costs in U.S. Pegged at 2.4 Percent of Annual Health Care Spending (Sept. 7, 2010), https://www.hsph.harvard.edu/news/press-releases/medical-liability-costs-us/.

3. Manoj Jain, *Even with Malpractice Insurance, Doctors Opt for Expensive Defensive Medicine*, WASH. POST (Aug. 31, 2010), http://www.washingtonpost.com/wp-

medical liability costs—including medical malpractice insurance, claims, and attorney and litigation costs—totaled 2.4% of the United States' annual health care spending, or roughly $55.6 billion each year.[4] Though these high costs might seem reasonable to insure against the possible risks often encountered in the medical field, even more costs are incurred as physicians often resort to an increased practice of defensive medicine—the practice of preforming more procedures and tests than medically necessary—in an attempt to avoid litigation.[5]

These rising costs often lead consumers, in this case physicians and medical institutions, to look outside of commercial insurance in order to affordably manage their risks. This leads consumers toward self-insurance and commercial insurance.[6] Captive insurance companies (captives) are subsidiaries created and wholly owned by non-insurance parent companies to provide insurance to the parent companies.[7] Over the last few decades, this form of self-insurance has gained a popularity that keeps growing in today's healthcare market.

This Note will discuss the history of captive insurance, the problems with the current state of medical malpractice liability, and ways in which health care costs related to health care malpractice can be decreased. This Note will also explore using captives as an alternative to commercial insurance companies and using damages caps as a way to keep down costs associated with medical liability.

II. BACKGROUND

Captives have existed for centuries, beginning with Frederic M. Reiss, who coined the term captive in the 1950s when he used it as a way to describe his creation of an insurance company that provided insurance only to its parent.[8] Reiss then incorporated American Risk Management in 1958. U.S. regulations at that time made it very expensive to form and operate captives within the U.S. This led him to look at offshore jurisdictions to domicile the captives.[9] He settled on Bermuda—which has since become the leading captive domicile.[10]

Though it took some time for the captive concept to gain popularity, there are thousands of captives worldwide, with over 3,000 currently domiciled in the U.S.[11] In general, captives largely remained domicile offshore due to the unfavorable U.S.

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dyn/content/article/2010/08/30/AR2010083003946.html (stating that the cost of medical malpractice insurance varies depending on specialty—a cardio-thoracic surgeon, for instance, would likely be paying closer to $100,000 in insurance per year).

4. *See* Press Release, Harvard School of Public Health, *supra* note 2 (showing that medical liability costs were 2.4% of healthcare spending annually).

5. *See* Jain, *supra* note 3 (discussing that doctors will often order a variety of not medically necessary tests so that they can diagnose patients and avoid liability). This practice is known as "defensive medicine." *Id.* Jain shares anecdotes of times when he did not think certain tests needed to be ordered, but contemplated ordering them anyway because of potential lawsuits. *Id.*

6. Anastopoulo, *supra* note 1, at 212.

7. Shanique Hall, *Recent Developments in the Captive Insurance Industry*, NAT'L ASS'N OF INS. COMM'RS (Jan. 2012), http://www.naic.org/cipr_newsletter_archive/vol2_captive.htm.

8. *Id.*

9. *Id.*

10. *Id.*

11. *Captives by State*, INS. INFO. INST., http://www.iii.org/publications/a-firm-foundation-how-insurance-supports-the-economy/a-50-state-commitment/captives-by-state (last visited Oct. 22, 2017).

regulations that made it costly to operate a captive domestically.[12] This was the case until the 1970s when the first law was passed in the U.S. to encourage captive formation—with Colorado, Tennessee, and Vermont being the first states to adopt the captive-favorable legislation.[13]

Though "insurance" is not defined in the Internal Revenue Code or the Treasury Regulations, it is clear through common law doctrine that "an arrangement will constitute insurance only if it incorporates requisite risk shifting and risk distribution."[14] Captive insurance is a form of insurance that has been under scrutiny by the Internal Revenue Service (IRS) for potentially failing to fall within the insurance definition.[15] In the 1970s and 1980s, the IRS believed that captives were not a legitimate form of insurance because of the lack of risk shifting, since risk was being shifted onto the captive—a subsidiary of the parent company—instead of an unconnected third party.[16] However, the role and treatment of captives has changed based on the interpretations of the courts[17] and the IRS,[18] who issued guidance in 2002 as to how to set up captives in compliance with the tax code.[19]

A. How Captives Work

Many companies and industries find forming captives for self-insurance purposes appealing because of the benefit of the parent company being able to profit from the captive. A parent company creates and owns a subsidiary company as the captive and pays premiums to the captives as it would to a commercial insurance company.[20] The captive then deals with any claims against the parent company.[21] The primary difference between insuring with a captive versus a commercial insurer is that if the claims paid by the captive are less than the premium, then the captive has made a profit, and thus the parent company—rather than a commercial insurer—benefits.[22] For example, if a parent company paid a premium of $100,000 to a commercial insurer and only had $50,000 in claims, the parent would lose out on the other $50,000 paid to the insurer as a premium. If the company paid the same $100,000 in premiums to a captive and there were only $50,000 in claims, the captive would retain the remaining $50,000 and the parent company would profit.

The worry about the captive process is that the amount in claims will exceed the premium amount paid, but there are ways for the captive to deal with this.[23] For instance, if the amount in claims were to exceed the premium amount paid, the captive would need

12. Hall, *supra* note 7 (describing how Reiss sought out other jurisdictions because U.S. regulations made it prohibitively expensive to operate captives in the U.S.).

13. *Id.*

14. Bobby L. Dexter, *Rethinking "Insurance," Especially After AIG*, 87 DENV. U. L. REV. 59, 59 (2009).

15. *Id.* at 60.

16. *Id.* at 60–61.

17. *See generally* Humana v. Comm'r of Internal Revenue, 881 F.2d 247 (6th Cir. 1989) (holding that premiums paid for insurance purposes from one subsidiary to another were deductible because the subsidiary did not own any of the captive's stocks).

18. Anastopoulo, *supra* note 1, at 215.

19. Paul Sullivan, *An Insurer of One's Own? It's Possible, With Caveats*, N.Y. TIMES (July 13, 2012), http://www.nytimes.com/2012/07/14/your-money/a-captive-insurance-company-offers-financial-benefits-if-not-abused-wealth-matters.html [hereinafter Sullivan, *An Insurer of One's Own?*].

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

a reinsurance policy to cover the claims or would have to pay them out of its reserves.[24] However, in paying premiums to a captive instead of a traditional commercial insurer, the captive remains an asset to the parent, while still insuring against possible risks.[25] For example, if the parent company decides to dissolve and discontinue their operations, the money in the captive will not dissolve with it. Rather, the funds "continue to belong to the parent," just "as any other asset would."[26]

1. Popular Types of Captives

Though there are various types of captives, three types of captives would be most favorable in the medical liability setting: (1) a single parent captive; (2) a group captive; and (3) Risk Retention Groups (RRGs). The single parent captive—the most common type of captive—is where the parent company creates the captive as a subsidiary that insures only the parent.[27] An example of a group captive would be if a single hospital were to create a captive to only insure risks and pay claims against the hospital, it would be a single parent captive. "A group captive provides coverage to a group of entities that share similar risks."[28] If several similarly situated medical practices, such as hospitals of similar size and capacity, were to create a captive together to insure against risks each practice is likely to face.[29] RRGs have been recognized as a form of captives since 1986, when Congress enacted the Liability Risk Retention Act of 1986. This Act specified that an RRG must be domiciled in the United States and in a state that regulated it as a captive insurance company.[30] The RRG may then operate nationally, as long as it registers in each state it intends to operate.[31] This makes RRGs more portable than other forms of captives. However, RRGs as captives are limited to writing liability coverage, meaning RRGs are limited in use and may only be used for liability purposes.[32]

2. Benefits of Captives

The true motivation that has historically driven the creation of the captive insurance company are: (1) the inability to purchase insurance to insure against a particular business risk from commercial insurance companies; (2) the high prohibitive cost of insurance; and (3) premiums paid[33] to the captive are tax-deductible business expenses.[34]

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24. Sullivan, *An Insurer of One's Own?*, *supra* note 19 (describing why a captive would need a reinsurance policy or pay out of its reserves).

25. Anastopoulo, *supra* note 1, at 217.

26. *Id.*

27. Nicole Williams Koviak, *An Insurance Perspective on the Medical Malpractice Crisis*, 13 ANNALS HEALTH L. 607, 609 (2004).

28. *Id.* at 610.

29. *Id.*

30. Eleanor D. Kinney, *The Potential Captive Medical Liability Insurance Carriers and Damages Caps for Real Malpractice Reform*, 46 NEW ENG. L. REV. 489, 498 (2012).

31. *See id.* (stating that the process to register a captive varies by state).

32. *Captives & Risk Retention Groups (RRG's)*, UTAH INS. DEP'T. (June 27, 2017), https://insurance.utah.gov/captive/research/captives-rrgs .

33. *See Why Form a Captive?*, OXFORD RISK MGMT. GROUP, https://www.oxfordrmg.com/why-form-a-captive/ (last visited Oct. 22 2017) (stating that premiums paid to captives are tax deductible providing that the premiums do not exceed $2.2 million a year beginning on December 31, 2016. This number will be increased to keep up with inflation. Premiums paid above $2.2 million a year will be subject to income taxes).

34. Kinney, *supra* note 30, at 497.

Captives provide for improved coverage availability and flexibility because they are specifically created and designed to meet the needs of the parent company and to address the risks of the parent.[35] Captive owners can write specific policies tailored to their business or industry and can go above what typical commercial insurance liability would cover.[36] This offers the parent company the opportunity to determine risks they are susceptible to based on its own experience. In doing so, parent companies are not bound by market-wide or industry-wide calculations, allowing for more flexibility.[37] It also reduces the parent's risk of being bound by the market standard or possible mismanagement by those in the industry, which leads to greater risk calculations.[38] Therefore, because the parent's own management determines the parent's risks, the parent has the possibility to enjoy lower costs associated with insuring against those risks.[39]

Captives also eliminate the often adversarial relationship between the insurer and insured.[40] Captives create a "symbiotic relationship" between the parent and the captive because the parent owns the captive and they both have the same incentive to pay claims within the contemplated risks from the captive's reserves.[41] In contrast, commercial insurance companies may have the incentive to delay paying claims, so they can retain the insured's premiums and maximize profits by paying the fewest amounts of claims.[42]

3. Risks of Captives

Though there are many benefits of captives, there are also risks associated with captives, primarily: (1) limitations on risk diversity; (2) costs and capitalization; (3) complying with state regulations; (4) access to reinsurance; and (5) the long-term strategy commitment of creating, operating, and maintaining a captive.[43] One of the benefits of traditional insurance that captives lack is the ability of risk pooling and risk diversification—which allows an insurer to reduce variance in its expected losses.[44] The lack of risk pooling—"[which allows] parties with unrelated risks to spread the risks across large numbers, thereby reducing the exposure of any one event"—impacts the costs and capitalization by this limited risk diversity.[45]

Certain types of captives can also pose external risks to the parent organization—small captives can be utilized by individuals, and often appear as tax scams.[46] In 2015, a lawyer put almost $1 million of earnings into a small captive, which allowed him to forgo paying income tax on that money.[47] One suspected danger of captives is a company's

35. Anastopoulo, *supra* note 1, at 216.

36. Sullivan, *An Insurer of One's Own?*, *supra* note 19 (describing why a business owner became interested in having a captive insurance company when his traditional insurance policy did not cover a claim).

37. Anastopoulo, *supra* note 1, at 216.

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. Anastopoulo, *supra* note 1, at 216.

43. *Id.* at 218.

44. *Id.*

45. *Id.*

46. Paul Sullivan, *I.R.S. Is Looking Into Captive Insurance Shelters*, N.Y. TIMES (Apr. 10, 2015), http://www.nytimes.com/2015/04/11/your-money/irs-is-looking-into-captive-insurance-shelters.html?_r=0 [hereinafter Sullivan, *I.R.S.*].

47. *Id.*

ability to use a captive as a tax shelter, which often raises skepticism for the widespread use of captives.[48]

Historically, large companies have utilized the benefits of captives, and now, small businesses are also seeing their benefit.[49] They can insure against risks with the likelihood of never actually having to pay out claims, thus retaining the funds in the captive with little or no tax.[50] This allows small businesses to insure against risks that they are unlikely to actually face, such as a dentist insuring against a terrorist attack[51] to reap the benefits of the captive. If a small business were to do that, they could face back taxes, penalties, and be denied the ability to deduct premiums as business expenses.[52] Though uncertain as to how much trouble these smallbusinesses would face with the IRS, given the high burden of proving that the business was abusing the law by insuring against something that was not actually a risk to them, it is possible that a small business may be able to get away with such a thing.[53]

B. Considerations When Forming a Captive

One of a parent company's most important decisions in creating a captive is choosing a domicile, especially when considering whether to choose an onshore or offshore domicile.[54] Taxes, regulation, infrastructure, and perception are among the most important factors to think about when considering where to domicile a captive.[55] Other considerations include costs for creating and operating the captive, capital requirements, and the parent company's industry.

Since captives are created in accordance to state laws, tax implications for registering as an insurance company vary by state.[56] The parent company's domiciled state regulates onshore captives. The number of captives in each state depends on whether the regulations are captive friendly.[57] There are also federal regulations relating to a captive's ability to use premium payments as a business expense for tax deduction purposes.[58] Organizations typically seek domiciles with more liberal regulations, such as Vermont and Delaware, and other states like Florida, are working to revise their regulations to allow for the successful establishment of captives.[59]

C. Captives and Medical Liability

Captives would be a way for physicians and medical institutions to insure against the risks of medical liability. However, there must also be reform within the sphere of medical liability to allow for maximum efficiency in the use of captives—adopting damages caps,

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48. *Id.*
49. *Id.*
50. *Id.*
51. Sullivan, *I.R.S.*, *supra* note 46 (describing how a tax lawyer worked with a dentist who set up a captive to insure against a terrorist attack in the dentist's office).
52. *Id.*
53. *Id.*
54. Hall, *supra* note 7 (describing the import of deciding where to domicile a captive).
55. Anastopoulo, *supra* note 1, at 216.
56. *Id.*
57. *See generally id.*
58. *Id.* at 214.
59. *Id.* at 219.

which are limits on the amount of money damages awarded to plaintiffs, in medical liability cases could be the answer.

1. Damages in Medical Malpractice Cases

In medical malpractice cases, there are three types of damages that could be awarded: (1) economic damages, (2) non-economic damages, and (3) punitive damages.[60] Economic damages typically include medical expenses, rehabilitation expenses, lost wages, and other financial costs including current and future costs.[61] Non-economic damages include pain and suffering, physical impairment, and inconvenience.[62] Courts award punitive damages to punish the defendant.[63]

A judge or a jury typically decides whether to award damages, and how much to award.[64] To help determine the cost of damages, parties will often introduce expert testimony, typically from a doctor and an economist. In medical liability cases, the experts must meet the *Daubert* test for their testimony to be admissible.[65] The *Daubert* test ensures that the expert testimony proffered was derived through sound methodology.[66]

As long as a doctor seeking to testify as an expert satisfies all prongs of the test, testimony should be elicited on the patient's medical condition, the medical standard of care, and whether such care was met. Similarly, an economist satisfying the test should be permitted to testify as to the economic impact the medical injury will have on the patient—or patient's family in a wrongful death action—in terms of costs of current and future medical bills and lost wages.

2. Damages Caps

In the context of limiting or capping damages, there have been proposals for damages caps on non-economic damages, as well as capping total damages. Congress attempted to pass the Health Act of 2004, which would have placed a $250,000 damages cap on non-economic damages. However, the Act failed to pass in the Senate.[67] Given that in 2008, non-economic damages were estimated nationally at $2.4 billion dollars, capping non-economic damages could significantly decrease the total costs of non-economic damages.[68]

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60. Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515, 516 (2005).

61. Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps,* 80 N.Y.U. L. REV. 391, 398 (2005).

62. *Id.*

63. Kelly & Mello, *supra* note 60, at 515–16.

64. *See generally Process of a Civil and Criminal Case*, LEADINGLAW., http://www.leadinglawyers.com/helpdesk/processofa%20civilandacriminalcase.htm (last visited Oct. 22, 2017).

65. Sharkey, *supra* note 61, at 440.

66. *See generally* Daubert v. Merrell Dow Pharm., Inc., 43 F.3d. 1311 (9th Cir. 1995) (holding that the proffered expert testimony was inadmissible because it was not based on scientific knowledge, and it was not relevant to an issue in the case, and thus, failed to satisfy the first two prongs of the *Daubert* standard). There are five factors under *Daubert*: (1) whether the theory or technique in question can be and has been tested; (2) whether it has been subjected to peer review and publication; (3) its known or potential error rate; (4) the existence and maintenance of standards controlling its operation; and (5) whether it has attracted widespread acceptance within a relevant scientific community. *Id.*

67. Sharkey, *supra* note 61, at 394 n.9.

68. Michelle M. Mello et al., *National Costs Of The Medical Liability System*, 29 HEALTH AFF. 1569, 1570 Ex. 1 (2010).

However, capping non-economic damages could lead creative plaintiff's attorneys to attempt to stretch economic damages, which in 2008 already totaled $3.15 billion,[69] by emphasizing future medical bills, future loss of earnings, and other economic costs to make up for what they could have been awarded above the non-economic damages cap.[70]

In addition to proposals for damages caps on non-economic damages, states could also impose comprehensive damages caps, which would put a cap on the total compensatory damages awarded.[71] Some states have even built flexibility into their damages caps models to account for the varying severity of injuries.[72] For example, Alaska caps damages at $400,000, or $8,000 times the numbers of life expectancy years, whichever is greater. In cases of severe permanent physical disability, the damages cap increases to $1 million, or $250,000 times the numbers of life expectancy years, whichever is greater.[73] Nevada also imposes damages caps.[74] However, judges have discretion to waive damages caps if warranted by aggravated circumstances.[75]

3. Damages Caps Nationwide

Damages caps on medical malpractice suits are not uncommon, as 33 states have adopted some type of damages caps by statute on medical malpractice claims.[76] For instance, in Mississippi, the noneconomic damages cap is $500,000, and in Montana noneconomic damages are capped at $250,000.[77] In addition, South Dakota capped noneconomic damages at $500,000 while Tennessee capped noneconomic damages $750,000, which can be increased to $1 million in cases of catastrophic injury.[78] Other states have imposed similar damages caps, typically with higher caps on economic damages and lower caps on non-economic and punitive damages. Approximately half of the 33 states that have enacted statutes for damages caps that allow the award to deviate from the imposed damages cap in extenuating circumstances, such as more than one practitioner being involved, wrongful death actions, or other especially catastrophic incidents.[79]

4. Challenges to Damages Caps

The constitutionality of damages caps, caps both on non-economic damages and total damages, has been called into question in many states. The most common constitutional challenges have been: (1) violation of the open-courts guarantee in many state constitutions; (2) the right to a trial by jury; (3) violations of equal protection; (4) due

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69. *Id.*
70. *See* Sharkey, *supra* note 61, at 395.
71. *Id.* at 414.
72. Kinney, *supra* note 30.
73. *Id.*
74. *Id.*
75. *Id.*
76. *See Medical Malpractice Damage Caps*, MED. MALPRACITCE CTR., http://www.malpracticecenter.com/legal/damage-caps (last visited Oct. 22, 2017) (listing all 33 states with damages caps and details about the cap).
77. *Id.*
78. *Id.*
79. *Id.*

process violations; and (5) separation of powers.[80] Generally, caps on non-economic damages have been upheld, and only in states that have applied stricter judicial standards have challenges succeeded.[81] Most challenges to partial damages caps have failed.[82]

D. Captives as the Platform for Medical Liability Reform

This Note argues that medical malpractice reform is necessary to contain and decrease health care costs and urges for medical liability reform through: (1) the total or partial use of captive insurance companies for medical malpractice insurance; and (2) placing damages caps on the amounts of damages that should be awarded to medical malpractice claims.

III. ANALYSIS

The rising costs of insurance and the already expensive cost for insuring against medical liability beg for reform that will reduce the costs faced by patients, physicians, and medical institutions without any increased risks. Health care costs associated with medical liability could drastically decrease through (1) the use of captive insurance companies as either an alternative, or partial alternative to traditional insurance companies for medical liability coverage; and (2) states adopting damages caps in medical malpractice cases.

A. Benefits of Captives for Insuring Against Medical Liability

Captives would significantly reduce a health care provider's cost because it would eliminate premium payments to a third party.[83] Captives provide more flexibility and options because the captive's parent is able to customize coverage to meet their needs and risks typically associated with their business that may otherwise be unavailable or less favorable with commercial insurance.[84]

Medical costs connected to defensive medicine might be reduced as well.[85] Defensive medicine increases the health care costs because not only are physicians already paying costly insurance premiums with traditional insurance but also the costs of the medically unnecessary tests and procedures.[86] The costs of these tests and procedures would be billed to the patient and either paid by the insurance company if they approve the charges or become the patient's responsibility if the insurance company declines the charges. Therefore, the use of defensive medicine is not only a problem for the physician, but it becomes a cost for the patient and health care system.[87] A study by Michelle Mello, a professor at the Harvard School of Public Health, found that in 2008, $45.6 billion was

80. *Medical Malpractice Damages Caps*, *supra* note 76.
81. *Id.*
82. *Id.*
83. Koviak, *supra* note 27, at 609.
84. *Id.*
85. *See* Jain, *supra* note 3 (describing the cost of medical insurance and how doctors practice defensive medicine and order unnecessary tests to avoid potential lawsuits). Based on the idea that doctors practice defensive medicine to avoid potential lawsuits, the inference can be drawn that heath care costs could decrease if unnecessary tests were no longer ordered to patients.
86. *Id.*
87. *See id.* (discussing the use of defensive medicine to avoid medical liability claims).

spent on defensive medicine.[88] Though it is difficult to collect empirical data and studies on what the overall savings could be from eliminating the practice of defensive medicine, a report from U.S. Department of Health and Human Services suggests that there could be a five to nine percent decrease in hospital costs nationally.[89]

It could be argued that damages awarded for non-economic and punitive damages serve as a deterrent to reduce the likelihood that physicians will commit malpractice. However, it is likely that these damage awards are an over-deterrence,[90] which results in the widespread practice of defensive medicine. When medical practitioners or institutions consider forming either a parent captive or group captive, this decision should not be made lightly since it can be more complicated to exit certain captive arrangements than it would be to leave a traditional insurance arrangement.[91] Medical practitioners considering a group captive must be diligent since the captive does not solely function for their insurance purposes, but also for the other entities for which the captive was created.

B. How Captives Can Be Used in the Context of Medical Liability

To use a captive for medical liability purposes, a physician or the physician's practice must pay an annual premium to the captive.[92] Because the premium paid to the captive is for insurance purposes related to the physician's business, the premiums paid to the captive would be deducted as a business expense for tax purposes.[93] Though captives have been recognized as a form of insurance, physicians must remember that the captive is still an insurance company and is subject to audits, annual actuarial reviews, and ongoing tax compliance and oversight, and regulatory oversight.[94]

1. Benefits of Damages Caps

Creating a captive for medical liability insurance purposes only scratches the surface of the costs that could be saved by physicians and the health care system as a whole—imposing damages caps on medical recovery could cut costs as well. Operating a medical institution and creating a captive in a state that has damages caps for medical malpractice claims would benefit the patient, physician, and, ultimately, the health care system for several reasons. First, it eases the adversarial relationship between the patient and physician. Second, the medical provider would have greater knowledge of their liability and the extent of liability—which could reduce or eliminate the use of defensive medicine. Finally, damages caps would avoid the overcompensation of claims and could also lessen the costs and frequency of litigation, as caps may incentivize patients and physicians to reach a settlement instead of litigating.[95]

Often times, medical providers fail to address and apologize for medical errors, which

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88. Press Release, Harvard School of Public Health, *supra* note 2.

89. Sharkey, *supra* note 61, at 411–12.

90. *Id.* at 404.

91. *See id.* (claiming it is more difficult to exit a group captive arrangement since there would be more than one entity with control over the captive).

92. Murtha Cullina, *Captive Insurance Companies: The Physician's "Hat Trick"*, MURTHA CULLINA LLP 2 (Mar. 2015), http://www.murthalaw.com/files/captive_insurance_companies_3_2015.pdf.

93. *Id.*

94. *Id.*

95. Kinney, *supra* note 30, at 493, 500.

can influence a patient's decision to file a medical malpractice claim.[96] Studies have shown that patients would have had a positive response to a physician's explanation or apology for a medical error, and the lack of such leads patients to seek accountability in the event of a poor outcome.[97] A study done by Charles Vincent and colleagues, surveying 227 patients and family members seeking to make medical malpractice claims, revealed the difference an apology or explanation would have made in their decision to file a claim.[98] Out of the 227 patients and relatives, 90% said they were taking legal action to prevent the medical error from happening to someone else or to receive an explanation from the doctor as to what happened and why the error occurred.[99] In addition, 40% of the 227 stated that they would not have brought a claim if they had received an explanation or apology.[100] Another study by Hickson and colleagues revealed that 20% of medical liability claimants felt that the courtroom was the only place they would be able to receive an explanation as to what happened.[101]

Physicians with traditional insurance may be less likely to admit error, explain, or apologize for an erred outcome because of the impact it may have with the insurance company and their liability. With traditional insurance companies, generally once a claim is filed against the physician, the insurance company takes over, and often the physician will not communicate with the patient regarding the alleged error because it is passed over to the hands of the insurance company. When insurance companies are not willing to admit liability and pay out claims, this leads to an adversarial relationship between the insurance company and the patient, which in turn, creates an adversarial relationship between the physician and the patient. This often results in a lawsuit and costly litigation.

A captive's structure is vastly different from traditional insurance because the insured is also the insurer. Therefore, the owners of the captive have complete control over claim decisions, and the captive's interests are aligned with the provider's interests, thereby giving the captive more flexibility when it comes to compensating the patient.[102] Damages caps would also keep medical providers more informed of their liability and what costs they could be looking at if a claim were brought against them.

In addition, though damages awards for non-economic and punitive damages could serve as a deterrent to a reckless physician, it is unlikely to deter physicians who did not intend or could not have foreseen the injury. It is also unlikely that punitive damages would deter physicians since studies have shown that punitive damages make up a very small percentage of damages awarded—with punitive damages totaling $1.7 billion in 2008.[103]

2. How Captives and Damages Caps Work Together

To put the benefits of captives into perspective,[104] consider a hospital that has created

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96. *Id.* at 492–93.

97. *Id.* at 492.

98. Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1611–12 (1994).

99. *Id.* at 1611.

100. *Id.* at 1612.

101. Jennifer K. Robbennolt, *Apologies and Medical Error,* 467 CLINICAL ORTHOPAEDICS & RELATED RES. 376, 377 (2009).

102. Kinney, *supra* note 30, at 500.

103. Mello et al., *supra* note 68.

104. For this Note, hospitals will be used as the prime example to explain the use and benefit of captives and

a captive for medical liability purposes. The amount that the hospital decided to put into the captive as premiums will determine how much the captive will be worth. If a hospital were to put a premium of $5 million into their captive semiannually, the captive would contain $10 million by the end of the year. Even a hospital with a lower net worth respective to others, such as Flowers Hospital in Alabama with a net patient revenue of $389 million dollars as of 2010,[105] it seems unlikely that taking $10 million a year and putting it into a captive will financially harm the institution. It seems even more unlikely that putting a comparatively small sum of $10 million into a captive would financially harm a hospital with a net patient revenue of more than $700 million.[106] It is possible that larger hospitals may need to account for more risk. Ultimately, however, the hospital would be the owner of the captive, and it could adjust how much should be paid into the captive based on its past liability exposure. Furthermore, the money placed into the captive remains a profit to the parent company. In a traditional insurance plan, the hospital would never see this money again.[107]

If we assume that a hospital has created a captive and decided to make a $10 million annual contribution via premiums into the captive for five years without a claim brought against them, the captive would then contain $50 million. This means that the captive, and thus the parent, has made a profit of $50 million since no claims were brought.

Suppose in year six, a lawsuit is brought against the hospital for medical malpractice. Hospital X has $50 million in a captive, and a patient brings a claim against the hospital that could result in either a $425,000 out-of-court settlement or nearly $1 million from a jury verdict.[108] First, because the patient would not be dealing with traditional insurance, there is a greater likelihood that an adversarial relationship would not exist when negotiating the claim. Traditional insurance companies typically try to avoid having to pay claims.[109] With a captive, the doctor's ability to work with the patient to provide information about the medical error may reduce the amount the patient is seeking in damages or decrease the likelihood that a claim will be filed at all.[110] Therefore, there is a greater likelihood that Hospital X would be able to settle the claim outside of court, which would be less costly than the average jury verdict.

If the same claims were to be brought against Hospital Y, who has traditional insurance rather than using a captive, the scenario might play out differently. First, we will assume that Hospital Y has paid $1 million in premiums for those same five years Hospital X paid $10 million dollars. Though it seems like Hospital X has paid more, considering the scenario of a medical liability claim in year six might change that. Assuming the same

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damages.

105. David Whelan, *America's Most Profitable Hospitals*, FORBES (Aug. 31, 2010), http://www.forbes.com/2010/08/30/profitable-hospitals-hca-healthcare-business-mayo-clinic_slide_2.html.

106. *See id.* (showing that some hospitals with the highest revenue in 2010 made over $700 million).

107. Sullivan, *An Insurer of One's Own?*, *supra* note 19 ("If a business paid a premium of $1 million to a regular insurer and had only $600,000 in claims, it would lose $400,000. If, however, it put the same amount of money into a captive, it would keep the extra $400,000 in the captive. This amount would then increase over the years.").

108. *See* Neil Chesanow, *Malpractice: When to Settle a Suit and When to Fight,* MEDSCAPE (Sept. 25, 2013), https://www.medscape.com/viewarticle/811323 (noting that though it is difficult to calculate an average medical malpractice settlement, studies have been able to produce amounts to try to provide an average).

109. Kinney, *supra* note 30, at 500.

110. *See generally* Robbennolt, *supra* note 101 (discussing the studies that showed there may be a decrease in medical liability suits if there was an increase in the flow of information from the doctor to the patient).

claim is brought against Hospital Y on behalf of an in-patient against the hospital that could result in either a $363,000 out-of-court settlement or nearly $800,000 from a jury verdict,[111] the Hospital could either settle or go to trial. In the settlement scenario, Hospital Y would be liable for $363,000, which would be paid by the traditional insurance company.

Hospital X would profit more than Hospital Y. Even if Hospital X had paid the same $1 million into the captive instead of $10 million, the captive would still retain $637,000; whereas, Hospital Y's benefit would only be that they do not have to pay the additional $363,000 settlement. In sum, Hospital X, through the use of the captive, would have saved $637,000 after paying out the claim, whereas Hospital Y loses $1 million dollars.

It is easy to see the financial benefit of captives when considering smaller claims. However, Hospital X could be financially burdened if, for instance, a claim brought against them exceeds the amount of money in the captive at that time. Though one way to avoid this is to pay higher premiums into the captive during the years directly following the captive's creation, another way is for states to impose damages caps on medical liability claims. If states were to impose comprehensive damages caps, limiting the amount that could be awarded for non-economic, economic, and punitive damages, or just damages caps on non-economic and punitive damages, health care institutions would be more knowledgeable as to what their potential liability could be for claims.

Consider the following examples: State A has a $10 million dollar limit on damages caps, inclusive of non-economic, economic, and punitive damages. State B has a $10 million dollar limit on economic damages, a $5 million dollar limit on non-economic damages, and a $300,000 limit on punitive damages. State C has no limits on the awards for any of the damages categories. A hospital in States A or B would have a greater idea as to how much they should pay in premiums into the captive, since a hospital in State A knows the most they would ever have to pay out in a claim would be $10 million and a hospital in State B would know that the most they would ever have to pay on a single claim is under $16 million. A hospital in State C would have no idea how much a single claim could cost them, and thus is less likely to know how much they should be paying into their captive and more likely to be unprepared for large damages claims.

Some states have already imposed some sort of damages caps structure into their tort system for medical liability. Alaska caps damages at $400,000 or $8,000 times the number of life expectancy years.[112] Alaska also provides for a different scheme for more serious medical errors that cause severe permanent physical disability, which increased the numbers to $1 million and $25,000 respectively.[113] Thus, it is more likely for hospitals in Alaska to anticipate what their prospective medical liability could be from a single claim, because there is a limit on the amounts that could be awarded, rather than hospitals in non-damages caps states.

These examples, though abstract, go to show that hospitals would be financially better off operating a captive to insure against medical liability than using traditional insurance. However, if the captive does not have a large enough sum to pay out claims, this could potentially hurt the parent company since the parent may have to take money from its reserves. That is why states should impose caps on damages—captive owners would be

111. *See* Chesanow, *supra* note 108 (discussing that though it is difficult to calculate an average medical malpractice settlement, studies have been able to produce amounts to try to provide an average).

112. ALASKA STAT. §§ 09.17.010-09.17.900 (2006); *see also* Kelly & Mello, *supra* note 60.

113. Kelly & Mello, *supra* note 60, at 517.

more aware of their potential financial liability and could also dissuade illegitimate medical malpractice claims from being brought. Just as awards for medical malpractice claims may serve as a deterrent for medical error and negligent practice by physicians,[114] caps on damages could also deter claims of medical malpractice that are frivolous, or not even a result of negligence.

IV. RECOMMENDATION

Hospitals creating captives to ensure against medical liability, and states adopting caps on damages in malpractice claims may benefit the medical providers, some patients, and the health care system.

Hospitals, with the opportunity to create a captive to insure against the risk of medical liability, should do so for their own benefit. The hospital would be less likely to face any scrutiny or claims of attempting to use the captive as a tax shelter, so long as the captive is actually being used to insure against medical liability claims.[115] Once the hospital decides to create the captive for the purpose of insuring against medical liability, they would have to choose where to domicile the captive. Since a majority of states have adopted captive friendly laws, it is very likely that a hospital could domicile the captive in its respective state.[116] Even if the hospital is not in a state that allows for captives,[117] they can still create a captive in a state that allows them and then operate nationally as a RRG.[118] Therefore, no hospital wanting to create a captive would be prevented from doing so just because the state in which they are located does not allow captives to be domiciled there.

A medical institution that chooses to create a captive in a state with damages caps would be in a better position to deal with medical liability claims than a medical institution with traditional insurance. Hospitals with captive insurance would benefit financially as they would be able to pay premiums into the captive instead of to a traditional insurance company, which would allow them retain funds in the captive that have not been paid out in claims—funds that would have instead gone to an insurance company.[119] In addition, since hospitals would be able to claim premiums paid to the captive as business expenses, which would be a tax deduction and another financial benefit.[120]

The use of captives to insure against medical liability and the imposition of damages caps would not only benefit the medical providers and patients, but the health care system as a whole. First, doctors would be less inclined to engage in defensive medicine, since they would be more aware of their liability risks because of the damages caps. Physicians would also be in a better position to explain any medical errors to the patients and settle

114. Press Release, Harvard School of Public Health, *supra* note 2 (describing how the medical liability system produces social benefits such as deterring future medical mistakes).

115. *See* Sullivan, *I.R.S.*, *supra* note 46 (providing the example of a lawyer who created a captive for purpose of insuring against terrorism and was able to avoid paying income tax by placing all of his income into the captive). This particular use of a captive would likely lead people to be skeptical about the notion that captives are not used as tax shelters. It seems like terrorism is generally an unlikely risk to be faced by lawyers.

116. *Captives by State*, *supra* note 11 (listing the number of captives by state).

117. Kinney*, supra* note 30 (discussing that RRGs may operate nationally as long as it registers in each state it intends to operate).

118. *Id.*

119. Sullivan, *An Insurer of One's Own?*, *supra* note 19.

120. *Id.*

rather than litigate.[121]

Patients would also benefit since with less sums of money having to be paid towards malpractice claims; hospitals and physicians would have more money that could be used to directly benefit patients such as declining costs in their health care. Having to allocate less money to paying out medical malpractice claims could lead to a decrease in cost for various tests and procedures, and could also decrease the overall costs associated with hospitals, such as the cost of a hospital stay.

Hospitals should create captives, and states should adopt damages caps for economic, non-economic, and punitive damages. Economic damages should have the highest caps since these damages would go towards paying costs associated with medical bills, lost wages, continuing medical assistance, and rehabilitation.[122] Non-economic and punitive damages should have lower caps since these damages are typically awarded for pain and suffering, physical impairment, inconvenience, and to punish the physician.[123] Adopting a model combining Alaska and Nevada's current scheme for damages caps would be ideal: capping damages at $400,000 or $8,000 times the numbers of life expectancy years, whichever is greater, and in cases of severe permanent physical disability, increasing the damages caps to $1 million, or $250,000 times the numbers of life expectancy years, whichever is greater.[124]

Though there may be the worry that patients who suffered medical error may not be able to recover sums necessary to help pay for economic damages they may face, this worry could be eased by following a model similar to Nevada that allows judges to exercise discretion in order to set aside or increase damages caps for the most egregious cases.[125]

Using captives and damages caps are one possible solution to the problem of rising health care costs. However, there may be other practical factors that should be considered before adopting the recommended approach. For instance, there should be a cost-benefit analysis done to determine what costs could be saved in the health care industry while also considering whether this approach would be overwhelming and severely injure patients with legitimate medical malpractice claims.

V. CONCLUSION

Medical liability and tort reform would financially benefit the health care industry. Through this Note's suggestion, there would be a decrease in the adversarial relationship medical malpractice claimants typically encounter with insurance companies, creating more transparency as to what the medical provider's potential liability and the claimants' potential recovery would be. There would also be a decrease in the amount medical institutions pay out in claims, which could decrease other costs incurred by patients and the medical institutions.

Even if the costs associated with malpractice insurance were minimally reduced through the use of captives and damages caps, it would still go a long way considering the health expenditure in the U.S. was at 3.2 trillion in 2015.[126] If captives and damages caps

121. Robbennolt, *supra* note 101, at 377.
122. *See* Kelly & Mello, *supra* note 60, at 516.
123. *Id.* at 516.
124. *Id.* at 518.
125. *Id.*
126. *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/research-statistics-

could reduce the $45.6 billion in defensive medicine costs, and $5.7 billion in malpractice claims payments,[127] medical providers and states should change their current schemes to allow for such changes.

Though controlling health care costs is an important concern, lawmakers should also consider the harm patients could face as a result of their decisions. For instance, if health care consumers would be so negatively impacted by the decision to implement damages caps for medical malpractice claims and to allow health care institutions to use captives as an alternative to commercial insurance, similar to the predicted detrimental impact that would result from the current administration's desire to repeal the Affordable Care Act, lawmakers should not act on such suggestions.[128]

data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html (last visited Oct. 22, 2017).

127. *Id.*

128. *See* Barack H. Obama, *Repealing the ACA without A Replacement — The Risks to American Health Care*, 376 NEW ENG. J. MED. 297 (2017) (discussing the risks of repealing the Affordable Care Act without replacement and the harms that would be faced by millions of Americans).