Medical captives on the rise

As more healthcare operations opt to self-insure, the strategic use of stop loss captives to augment traditional methods will also expand, as Phillip C. Giles, vice president—sales and marketing, accident and health, for QBE North America explains.

Self-funding has long proved to be the most efficient form of financing most lines of insurance coverage. Self-funding of healthcare insurance is no exception: in 2000, about 48 percent of all employers were self-funding their employee healthcare coverage. The percentage of self-insured employers grew steadily to the mid 50s by mid-decade. Now, fuelled by the Affordable Care Act (ACA), that percentage has eclipsed the 60 percent threshold and is expected to continue.

A few thought-provoking statistics from the close of 2013:

- 72 percent of employers with at least 500 employees self-fund healthcare.
- Employers with fewer than 100 employees make up 25 percent of the medical stop loss market if measured by number of employers. If measured by number of employees, that same segment represents only 2 percent of the medical stop loss market.
- 80 percent of employers purchase specific deductibles greater than $50,000. The median specific deductible across all plans was $85,000. The median for employers having less than 50 employees was $30,000 and $45,000 for employers having 50 to 100 employees.
- It was reported that 0.03 percent of self-funded employers had a specific deductible of less than $20,000.

More than 80 million individuals—60 percent of all workers under the age of 65—are covered by self-insured employer health plans. Given the rising cost of healthcare and the complexities associated with ACA compliance, more employers will explore self-funding as an option to assuage the cost of healthcare delivery to employees. With this sustained growth, the strategic use of stop loss captives to augment traditional self-funding will also expand.

Medical stop loss captives

Captives for medical stop loss generally follow the same structure as the more traditional casualty captives: both single-parent (pure) captives and group captive structures are becoming widely used.

Single parent captives

Most employers large enough to have an existing captive are already self-funding their employee healthcare benefits. Many employers of this size previously did not purchase stop loss, but since the enactment of ACA and its mandate of unlimited lifetime benefit maximums within a health plan, they now purchase high (unlimited) levels of coverage and assume lower layers into their captive.

Stop loss coverage by itself would not generate enough premium to justify forming a captive solely for that purpose, but it can be used to effectively expand the use and enhance the efficiency of an existing captive. It is also important to note that stop loss is not considered an employee benefit coverage and thus not generally considered to be "unrelated (third-party) business" by the IRS for tax purposes.

Group captives

There generally are two types of group captives: heterogeneous and homogeneous. The objective of both is to allow groupings of smaller (mid-sized) employers to replicate the risk profile of a larger single

employer to spread risk, promote stability, and achieve cost savings from different service providers.

Heterogeneous groups

These generally require a larger size in order to achieve an appropriate spread of risk among its diversity of participants. A larger size and risk spread are necessary to mitigate the increased risk variability and potential for increased underwriting volatility caused by the differing demographics among the participating employer populations.

For example, the risk profile of the employee population of a 250-life professional services firm is much different from the risk profile of a 250-life construction firm. Both could be members of the same heterogeneous group captive; size and risk spread needs to be in appropriate proportion to achieve sustainable stability.

Homogenous groups

Being industry-specific in their composition, these can be smaller as the underlying risk and underwriting profile is similar. The required size to achieve an appropriate spread of risk is not as great as in heterogeneous groups. Group captives are especially effective when formed by closely aligned groups (or associations) of like-minded employers within the same industry. Risk retention groups (RRGs) are a form of homogenous group captive.

RRGs are authorised by the Federal Liability Risk Retention Act (LRRA) to cover only liability risks but the potential exists for groups of employers participating in RRGs to form a parallel group captive for medical stop loss coverage. The average individual member size within homogeneous groups tends to be larger than in heterogeneous groups and, given the similarity of participants employee populations, an appropriate risk spread can be achieved within a smaller sized group.

There is a sub-category of group captives generally referred to as open-market captives. These captives are typically heterogeneous programmes sponsored by large brokers, captive managers or other programme administrators. They are 'open' to new members meeting the eligibility guidelines established for entry. The average member size within this category is typically smaller than in other group captives and is generally between 50 and 500 lives. Given the smaller average

member size and differing risk demographics, it is especially important for open-market heterogeneous captives to achieve significant size and appropriate risk spread to hedge volatility.

Within a group captive, each employer purchases specific and aggregate medical stop loss coverage according to its own risk appetite. The stop loss is purchased from the common insurer or reinsurer that will provide coverage to each member of the captive. The stop loss carrier will then cede a layer within the collective stop loss portfolio, attributable to all participating group members, to a captive owned jointly by all participating members. The actual captive participation level will be determined by the collective risk appetite of the insured members and can be structured on either an excess or a quota-share basis.

Group captives can increase leverage with carriers, provider networks and related service providers to generate volume-related discounting that typically would not be attainable by many individual self-insurers. Group captives are empowered with the control to select service providers, determine coverage participation levels, manage losses, share in the underwriting results (hopefully a profit) and direct the use of surplus. By retaining an additional participation layer through the captive, pricing volatility associated with the stop-loss coverage can be mitigated.

Whether they are heterogeneous or homogeneous, having the ability to leverage this combined strength helps mid-sized firms strategically balance risk retention and risk transfer to reduce the cost of risk and ultimately promote long-term stability for participants.

Risk management critical to success

Just as self-insured casualty programmes utilise loss control techniques to improve employee safety and mitigate claims, it is imperative for self-insured healthcare plans to employ effective cost containment measures. Programmes such as utilisation review, large case management and negotiated provider discounts, have proved over time their effectiveness for reducing the cost of claims after they occur.

Newer initiatives, such as employee wellness programmes and predictive modelling strive to preemptively reduce claim expenses by improving the overall health of the employee population. Increasing employee wellness will help significantly decrease the cost of providing employee healthcare coverage—not immediately, but over time as the effects of the wellness programme matriculate.

There will be some increased fixed costs associated with the implementation of risk management initiatives but the savings generated by the corollary reduction in claims costs—a much larger expense—will more than offset the initial expenses.

ERISA and state regulation

For stop loss captives it is also important to distinguish the concepts of self-funding and stop loss from employee healthcare insurance. The distinction is important as the captive itself must be kept separate from the actual benefit plan provided to employees. The US Department of Labor (DOL), by way of the Employee Retirement Security Act (ERISA), has regulatory jurisdiction over the plan itself but does not regulate insurance.

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In this regard, the DOL only regulates a plan sponsor's responsibilities as they relate to overall plan administration and the delivery of benefits to employees. Individual states regulate insurance: since the plan is self-insured, state insurance mandates are not applicable in relation to the plan.

Within a self-insured structure, the employer assumes the financial liability for all claim obligations of the plan. Medical stop-loss coverage purchased by the plan sponsor does not insure the plan; rather it indemnifies the sponsor for its claim obligations to the plan. Since neither the DOL nor ERISA has regulatory jurisdiction, a Prohibited Transaction Exemption (PTE) is not applicable to a medical stop loss captive and is not required from the DOL.

Continued growth expectations

Interest in self-funding and stop loss captives will continue to grow as medical costs continue to rise and the uncertainties related to ACA threaten the amount of control employers are able to maintain within more conventional insurance structures. Properly structured captives can stabilise or lower the cost of medical stop loss coverage and facilitate enhanced benefit delivery over more traditional self-insurance for many employers. ●

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