A Matter of MATURITY

AS CAPTIVES CONTINUE TO DEEPEN THEIR FOOTPRINT, INNOVATION IS SHAPING HOW SOLUTIONS ARE STRUCTURED FOR EACH RISK PROFILE

Written By Bruce Shutan

As the number of captive insurance programs swell and buyers become more sophisticated, the alternative risk transfer market continues to evolve. Self-insured employers that seek this added layer of protection in both the medical stop loss and P&C spaces are learning what different types of captive structures mean to various risk profiles and how they operate.

There are numerous captive classifications that include pure, group, association, industrial, branch, rental, protected cell and 831(b) electing captives, as well as risk-retention groups. While captive insurance companies date back more than a century, there has been significant growth in captives during the past 30 years with more than 7,000 such vehicles globally compared to about 1,000 in 1980.

Don McCully

When Medical Captive Underwriters President Don McCully wrote his first plan in 2010, there was about $150 million of stop-loss captive premium nationwide as part of a $12 billion stop-loss market. "Our stop loss is now $20 billion and stop-loss captive premium somewhere between $1.5 billion and $2 billion," he says.

And the market is expected to swell much further in the coming years. The captives insurance space will grow more than 25%, says Kari L. Niblack, Esq., president of Blackwell Captive Solutions (BCS), based on her own analytics and a Millman projection. She also sees significant maturation of medical stop-loss captives that serve as shock absorbers for increasingly sophisticated buyers to pool claims.

There are plenty of reasons why this is happening. Ward Humphreys, SVP for Risk Strategies, sees captives as a solution to the growing limits and exclusions traditional insurers are imposing on the group medical side. A classic example is gene therapy which is seeing $2.5 million to $3 million in claims with another $1 million in increases tacked on involving hemophilia or other genetic conditions.

"Thus far, we haven't seen the frequency of claims, but they are coming," he cautions, noting how that proverbial elephant in the room will make an appearance on a fourth renewal cycle. "We're going to see the response from reinsurers and stop-loss underwriters where there might be limitations or exclusions that apply. A captive is the perfect place to start building up reserves to anticipate those claims."

Ward Humphreys

SLAYING HEALTH CARE'S BIGGEST TAPEWORM

With captive solutions pouring into the middle market, McCully is bullish about its future. One major reason is to better manage specialty pharmacy, which he says is even more of a concern than what hospitals are charging.

"There's no greater tapeworm on health insurance today," he observes. "As we gain more control, you'll start to see programs exert themselves and say, 'hey, let's actually abide by the Consolidated Appropriation Act and transparency-in-coverage rule, and actually get some of these things in where when ERISA was passed in the '70s, it said the employer owns their data."

There's no secret sauce to what a captive does, explains Phillip Holowka, chief operating officer with Complete Captive Management Services. "The magic is the expense load that the captive can bring to an end user," he says, noting that startup captives have traditionally incurred higher loads from fixed and sunk costs within a newly formed group captive that erode profits.

Innovation is expected to mushroom as the captive space grows deeper roots and continues to mature. Helping employers become motivated to be more effective risk mitigators is the goal of a single-parent captive risk pool that Holowka describes as a "first-in-first-out" solution. When self-insured employers pay premiums into their captive, they are obviously the first payer of reimbursements out of that arrangement. "Only when your captive can't reimburse you any further is the risk shifting and sharing sent out to the other captive members," he explains.

Mindful that the group captive is effectively shifting all of its insurance company operations to the carrier, Holowka says the

question then becomes, what is the duty of a group captive when it is offloading its responsibilities to the fronting carrier?

At a recent industry event, he gave a presentation on another noteworthy trend: the direct-writer captive structure, which he says "absorbs the insurance company operations because it is issuing a policy whose language and is controlled by the captive, albeit approved by the cabinet domicile.

"The policy language is written to benefit the insured," he continues. "A reinsurance group captive's policy language is written to benefit the carrier's distinctive districts, so the direct-writer captive issues the policy, collects the premium, administers the claims, issues the reimbursements, assembles the financial statements. These are all the things that the group captive offloads to an insurance company fronted carrier."

Phillip Holowka

There's more required of the captive manager in a direct writer, Holowka says, and therefore, the level of service presumably will be deeper.

FLOATING RISK FOR MORE FLEXIBILITY

With a maturing market will also come more customized captive solutions. BCS, for example, offers a middle-risk layer to better serve clients, insuring the $250,000 floating layer above their medical plan's specific deductible. "Anytime you spread that risk, there's more predictability and stability, and it lowers premium costs for employers who may not otherwise be able to self-fund," Niblack explains.

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Kari L. Niblack, Esq.

Captives do not have to be complicated, or require a multi-year commitment, she notes. "I believe we should have the ability to work with any consultant as part of a three-pronged approach that is best for that client vs. awarding exclusive territories and broker dividends to try and shut out competition," she adds. "That to me is the secret sauce."

McCully's company is among a handful that is also offering a floating vs. fixed risk layer – the latter, he believes, being bad for employers because raising the specific limit compresses the percentage of premium that makes it into the captive.

"We take a floating risk above that," he reports. "Everybody pools their risk below $1 million and then they buy reinsurance, so it doesn't matter where the employer buys their specific limit. So each of those programs is a different nuance. We're not even getting into the expenses for running the program, or who owns the captive. We're just talking about how you transfer and assume risk."

UPPER AND LOWER-CASE CAPTIVES

The captive insurance market is essentially bifurcated into two buckets, observes Dale Sagen, VP and business development leader for QBE North America. There are branded products he calls "uppercase-C" group captive programs that can dive much deeper into cost-containment and are akin to 401(k)s or IRAs being actively managed on a daily basis.

"You could have a certain condition that is a pain point for the majority of employers," Sagen says of these targeted point solutions, which could involve anything from negotiating more favorable terms in pharmacy benefit manager contracts and treating musculoskeletal disorders to dealing with a shortage of primary care physicians and building a telehealth offering.

However, these formalized arrangements are just the tip of a growing iceberg. There are more than 7,000 "lowercase-c" captives in the market today, he says, adding that most aren't marketed and are for single-parent captive use to reduce costs alongside gaining more control and transparency in a regulated manner.

A turning point in the adoption of these programs came about 20 years ago when cell captives became popular, reducing the price point and barrier of entry for many organizations, according to Sagen. "You don't necessarily need as much capital or infusion of assets" with cells whose risk is walled off, he says.

Most medical stop-loss captives are single-parent vehicles that are either heterogeneous with employers from across different industries or homogeneous within a certain industry, Niblack observes. Her firm is working on quoting hospital systems for 2024 with the ultimate goal of creating a hospital cell. "They have different needs than other types of employers," she explains, noting a more complicated revenue structure, as well as E&O and professional liability concerns.

Niblack predicts tremendous growth in medical stop-loss coverage in single-parent captives wherein the employer pulls risk but still has all the necessary reinsurance protection. It also removes any barriers to entry for that solution in the middle market.

"If I were an employer with 200 lives on the fence about whether I could afford to be self-funded, and if I'm pulling risk with 10 other employers around that same size, that becomes an automatic yes and eliminates the uncertainty," she says. A tertiary benefit, she adds, is

the meaningful dialogue that occurs when like-minded captive participants share solutions.

ASSESSING BEST PRACTICES

As medical stop-loss captives continue to mature, Niblack predicts that more best practices will be identified. Noting there are key legal and tax benefits to joining a captive that are universal, she says there's an opportunity to synthesize stop-loss policy quotes into a one-page pro forma that highlights the enrollment and gross premium, as well as netting out vendor expenses to the penny on an annual basis.

"All of that should be very fluid," she suggests, "yet also easy to understand and have all the appropriate safeguards in place no different than we would ensure with the data itself."

Lower-hanging fruit that can be effectively benchmarked will invariably involve medical management, says Humphreys, noting that drug costs and hospitalization rates lend themselves very well to benchmarking in terms of a captive. How it is structured becomes harder. "If you're looking at an employer with 1,000 employees vs. a 20,000 employer group, and you don't know about the population, risk tolerance and capital availability," he explains, "those factors become a little bit harder to benchmark consistently."

The prospect of devising best practices for captive insurance programs is complicated by the fact that, as Sagen says, "if you've seen one captive, you've seen one captive." The uniqueness of each arrangement enables self-insured employers to customize the layer as they see fit.

"You can build out a quota share in which your risk partner is taking a portion of that captive layer," he explains, "and ultimately, it could be a baby step into a solution for a larger group of employers." Other


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Dale Sagen

ways it can be structured include employers owning the captive, bringing on a fronting partner or finding a risk partner to cap exposures for direct writing policies.

Whatever the arrangement that's in place, Sagen is a fan of strength in numbers. "There's something to be said for a group of employers in the same industry that decide, 'I don't necessarily think I can do this on my own,'" he says, noting how solutions may be built around tackling the high costs of therapeutic drugs, hospital PPO negotiations or other areas.

He has seen captive programs start with a close-knit group of just three homogeneous employers that expands over time and, on occasion, becomes a heterogeneous group after years of success.

However, benchmarking in an increasingly mature captives market is tricky, McCully cautions. For example, some customers have assessments while others do not, and the definition of assessment will differ from one program to the next. Also, no one is publishing their loss ratio inside the captive.

"It's not possible to determine the total medical spend in a captive with a $1 billion worth of total premium frankly without some sort of way to kind of validate it from a third-party perspective," he explains. "A.M. Best isn't looking at this stuff because we're all using fronting carriers, and if the captive programs losing money for the employers, even the fronting carrier doesn't want that to get out for fear they'll leave their program."

The outcomes of any captive solution ultimately will depend on both the source of coverage and claims history. "There is an arbitrage play, if you will, by stop loss from a reinsurer vs. a

stop-loss carrier, which is much more pool-oriented," Humphreys says. "So if you have a 10,000-life employer that's had good experience, they're going to get a lot more credit from a reinsure than they are from the stop-loss underwriter." The opposite is true for a group with poor experience that will receive better terms from the employer stop-loss arena than reinsurance, he adds.

Looking ahead, Niblack anticipates the continuation of narrow subspecialty captives that are highly innovative. Reference-based pricing clients, for instance, are taking on the risk of balance bills. "We are seeing captive solutions with small niche industries that previously have struggled to obtain any type of health insurance," she reports, noting how a group of skydivers formed their own captive.

Other examples include parlaying the six- or seven-figure cost of biopharmaceuticals, other specialty drugs or kidney dialysis treatment into either a second or third active risk solution. With subspecialties in the overall solution, "I think that's limitless as far as design and the healthcare industry problem that we're trying to solve for everybody," she says.

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.