(Managed care risk x administrative services) + captive = **success**

Developed primarily in property and casualty lines of business such as workers' compensation, captives are increasingly being used for healthcare employee benefits and medical excess of loss risks, says Mark Troutman of Summit Reinsurance Services.

The formula for success using a captive looks simple enough, but proper execution of all the variables can be complicated and time-consuming. Employer-sponsored healthcare benefits programmes are notoriously complex, especially for those who do not work with them on a 24/7 basis, but the opportunity for control over costs still makes them attractive.

For managed care health systems such as health maintenance organisations (HMOs) and their provider network hospitals, employer-sponsored programmes may be particularly sensible. Not only is the liability theirs to manage, but as the entities providing the healthcare services, they are also well positioned to control healthcare expenses on their own employee populations.

These managed care organisations can utilise the product offerings they provide to others, such as administrative services only (ASO) products, managed care contracts and medical management services, for their own benefit as an employer.

This article provides insights on why health plans become involved in the self-funded business segment, while highlighting the utilisation of a captive insurance company to manage a variety of risks it might assume. For a health plan or hospital, this may range from risk contracts from commercial and government payers, to HMO excess of loss coverage if they own and operate an HMO, to their own employee health plan liabilities.

The opportunity

Given health insurance reform and the medical loss ratio requirements imposed by the Affordable Care Act, payers are moving to value-based contracting to achieve the triple aim of improving the patient experience of care, improving the health of populations and reducing the per-capita cost of healthcare.

The formation of accountable care organisations (ACOs) by health systems, independent practice associations (IPAs) and multi-specialty clinics, including some supported by national payers, is significantly

expanding across commercial, Medicare and Medicaid lines of business. Some health systems and ACOs are acquiring or starting their own health plans, especially for Medicare Advantage business. With value-based contracting, the need arises for reinsurance to protect the ACOs, hospitals and medical groups from catastrophic medical claims.

Many hospitals participating in ACOs have affiliated professional liability (medical malpractice) captives. These captives typically have significant profits and capital available to allow them to assume other risks. ACOs can receive appropriate risk management guidance on the risks they are assuming from payers through their ACO contracts and can properly place various levels of this risk into a captive insurance company. This is exactly what has occurred for many years with medical malpractice risk and it has resulted in the profits being captured by the captives.

Additionally, ACOs can place their employee health benefits risk into a captive they own or rent. In the event that payers are providing stop loss coverage to ACOs through their ACO contracts, the health plan needs to evaluate the adequacy and pricing of the coverage offered. Most important, the health plan needs medical case management support for large claims in-network as well as those that leak outside the ACO network for any medical excess risks assumed by the captive.

Risk transfer

Employers and health plans face exposure to financial loss due to unforeseen events. Most mitigate this volatility risk with the purchase of insurance or reinsurance. The purchaser trades the certainty of a small known cost (the premium) for the promise that the insurance or reinsurance company will pay for unpredictable, catastrophic losses, thus protecting the entity's balance sheet. The premium becomes a predictable expense that can be budgeted.

Employers and health plans may utilise another risk transfer option: a captive insurance company, through which they can finance all or a portion of their risk. Although used primarily in property and casualty lines of business such as workers' compensation, professional and general liability, captives are increasingly being used for employee benefits and medical excess of loss risks.

There is no common standard for establishing the level of risk to be assumed. Risk tolerance per client varies across a wide range of factors. Plan size, coverage type, maturity of the plan, financial strength, access to capital and underwriting margins (targeted and actual) can all affect a client's risk tolerance.

Why self-funding?

Employers often choose to self-fund their healthcare benefits programme for at least one of the following reasons:

- Full plan design flexibility for Employee Retirement Income Security Act (ERISA) plans versus state-mandated benefit requirements for insurance policies and limited benefit options from insurance carriers. The employer can design the medical benefits plan to meet its specific needs;
- Control over reserves and cash flows. Claims are paid as they occur rather than prepaid monthly as premiums;
- Premium taxes are applicable only to a small percentage of the employer's overall healthcare expenditures, again due to ERISA; and/or
- Self-funded employers believe their own group claims experience and risk are better than average and will remain so. They want to receive the benefit of their own favourable claim experience, and they are prepared to take on additional risk accordingly.

Advantages of a captive

Advantages of placing employee benefits in a captive are similar to those for other types of coverage placed in a captive. These focus on cost and control issues, such as:

Coverage availability and flexibility

Captives can customise coverage when commercial insurance policies do not provide the desired coverage or charge higher premiums than anticipated.

Control of essential services

The captive's owners retain control of underwriting, pricing, investments and claim management. Loss control services and risk management can be focused on the unique needs of the parent organisation.

Information

Comprehensive data provides a firm basis for loss projections and can help with establishing appropriate insurance or reinsurance coverage for a captive. A captive owner is not subject to the limitations of the information management provided by the insurer or reinsurer.

Stability of insurance cost

The captive allows an organisation to realise insurance or re/insurance costs that are more closely related to its own loss experience and minimise fluctuations from year to year.

Appropriate reinsurance

A captive can determine what levels of risk are retained and where to seek quota share or excess of loss reinsurance for the more volatile portions of the programme. Furthermore, the captive vehicle provides the ability to aggregate several exposures. The aggregation of those risks facilitates the purchase of insurance protection over the entire pool of risks at an appropriate level. This provides the dual benefit of economies of scale and coordinated decision-making rather than having coverage and pricing decisions made in separate 'silos'.

Tax efficiency

A properly structured captive is allowed to take a tax deduction for loss reserves. This permits it to more closely match the timing of its revenues and expenses and allows for partial deferral of income taxes.

External resources

A captive often needs to employ a captive manager, auditor and actuary to comply with financial and licensing requirements. While

there is a cost associated with such service providers, there is also a level of expertise which can benefit the employer in the retention and/or transfer of risk.

Manage for success

Regardless of where the risk ultimately resides, population management is critical. This starts with disease management programmes targeted to all significant risk populations. To help further mitigate catastrophic claim frequency and severity, the managed care health plan will typically have a variety of internal and external medical management services designed to offer cost savings through appropriate care management that is focused on clinical outcomes. Examples of these types of programmes for managing catastrophic claims are shown in Table 1.

Summit Re has conducted a survey of key health plan reinsurance decision-makers, and their responses highlighted the most important issues currently facing their organisations:

1. Declining reimbursements, risk adjustment payment cuts, minimum loss ratio constraints, financial uncertainty regarding the 'three Rs': reinsurance, risk corridors and risk adjustment.
2. Provider risk-contracting strategies. Capitation is becoming more prevalent, primarily with Medicare risks, as large national regional chains demonstrate a desire to share risk with provider groups through capitation.
3. The high cost of specialty drugs.
4. Whether to expand into new markets such as employer stop loss, the exchange, dual eligibles and special needs populations.
5. Capital constraints and capital allocation.
6. Regulatory compliance.

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Conclusions

These are interesting and challenging times for all who purchase or provide healthcare plans. Captive solutions can, and should, play an important role in successfully managing risks assumed by health plan providers or faced by employers. A successful managed care plan should position itself to increase market share and drive volume to its affiliated provider organisations, while maintaining its financial viability through successful diversification. Health plans which include managed care, self-funding and a captive have a winning formula for success.

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Table 1: Programmes for managing catastrophic claims

Programme	Purpose
Consultative case management	Assistance with catastrophic cases, research on rare or unusual clinical situations, and suggestions for alternative care options
Transplant management programme	Access to credentialled centres of excellence and non-credentialled facilities for transplants
Congenital heart disease network	Access to centres of excellence for the treatment of congenital heart disease
Cancer services network	Access to centres of excellence for the treatment of complex cancers
Kidney management services	Access to dialysis centres and renal case managers for chronic kidney disease treatment
Neonatal management	Accelerating care when appropriate and offering evidence-based solutions on complex cases
National preferred provider organisation (PPO) network	Cost containment via PPO networks and claim re-pricing
Forensic review	Identifying inappropriate levels of care, non-covered services, experimental treatments, errors and unbundling. The course of care is also reconstructed to identify gaps between care provided and billed charges
Claim recovery	Post-payment claim recovery services related to coordination of benefits, Medicare responsibilities, judicial judgments and claim payment verification
Specialty pharmacy	Medication management and support services for patients with serious and chronic conditions
Pharmacy benefit management (PBM)	Maximising relationships with PBM vendors