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## The Viability of Using Group Captives for Medical Benefits



BY PHILLIP C. GILES

The use of “captives” as a funding mechanism for employee benefits has become one of the more intriguing and complicated alternative risk topics in recent years. As interest continues, it is important to define the parameters for which a benefit captive is actually a viable option.

For all the attention that benefit captives receive, there are still currently less than two dozen captives authorized by the U.S. Department of Labor (DOL) to insure Employee Retirement Income Security Act benefits.

Although the gap between *interest* and actual *implementation* of benefit captives is still relatively wide, the chasm has narrowed during the past year. Much of the increased development has come from smaller to mid-

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sized employers exploring the practicality of using a captive to fund medical benefits for their employees.

Using a captive to insure employee benefits can provide several advantages; however, the actual scope of captives’ practical relevance needs to be put in perspective in order for this topic to be better understood.

### Group Captives Defined

In broad terms, a captive is an insurance company that has been established primarily to insure the risks of its owners or parents. The owners retain a portion of their own risk in a formalized structure rather than transfer it to a third-party insurer, hence the term “captive.”

As the owners of the insurance company, the insureds also become the primary beneficiaries of any underwriting and investment profits generated by the assets and surplus held in their captive.

Captives are effective in reducing the ultimate cost of risk because they allow the owners to retain predictable layers of risk while transferring the more volatile (unpredictable) layers to insurers or reinsurers. Captives

have been used extensively and effectively for several decades by large corporations as essential risk financing tools, primarily for casualty exposures such as automobile liability, general liability, and workers' compensation.

More recently, groups of smaller entities that would, on their own, be too small to form their own captive have banded together to create member-owned group captives. Group captives allow employers to collectively share risk, and purchase insurance (or reinsurance) and services based on the larger numbers and spread of risk associated with a larger entity.

Group captives have enjoyed significant popularity among mid-sized employers for handling property and casualty exposures, by making available most of the same benefits that large corporations gain through their own single-parent captives.

## Benefit Captives and ERISA

Because the DOL, by way of ERISA, strictly regulates the administration and delivery of employee benefits, employers do not have the same freedom to set up a captive to insure employee benefits as they do for casualty coverages. ERISA was created to achieve several objectives, among which are to protect employees' interests (rights) in a benefit plan as part of their compensation, and to streamline an employer's administrative burden in the delivery of benefits to employees.

In order to ensure that benefit plans are properly qualified, the DOL requires a plan to be free of any fiduciary conflicts of interest as determined by several broadly defined *prohibited transactions* outlined within ERISA.

A captive owned by an employer (i.e., the plan sponsor) and used to provide insurance to the benefit plan would, by its very nature, create an improper fiduciary (*party-in-interest*) relationship between the plan sponsor and the benefit plan. This potential conflict of interest would normally be considered a prohibited transaction under ERISA.

If, however, a benefit captive is able to meet certain requirements, showing that the interests of employees are appropriately protected, the DOL will provide an exemption allowing a captive owned by the plan sponsor to insure the benefit plan.

Among the several requirements for exemption are that the benefit plan use an "A" rated insurer, and also provide a material enhancement of benefits or a reduction in participation costs to its participants. These requirements help alleviate any fiduciary conflict issues by demonstrating that the plan's financial stability and employee welfare concerns are appropriately addressed as the plan's primary objectives.

## Practical Applicability

Just as ERISA can significantly restrict the use of a captive, this same legislation actually empowers a self-insured benefit plan with an amazing amount of regulatory flexibility—the ability to preempt state insurance regulations.

A fronted benefit captive does not have this ability and, for that reason, it is generally considered impractical and unnecessary for an employer to consider using a captive for what is probably its single-largest employee benefit expense—health insurance.

To date, the captives that have received DOL approval to insure ERISA-based benefits have only gone as far as to reinsure life, accidental death and dismemberment, and long-term disability coverages.

Premium rates associated with these lines of coverage are relatively small. Therefore, they require an employer that is large enough to generate enough premium volume to produce a return that is capable of offsetting the additional costs associated with both operating the captive and providing the enhanced benefits that the DOL requires for approval.

With appropriate premium volume, the profitability return and/or cost savings to a large employer can be significant. But even if profit/cost projections are marginal, a large employer may still pursue a benefit captive as a way to enhance the potential tax advantages of an existing casualty captive.

The Internal Revenue Service will consider employee benefits placed into a captive to be *third-party* business, which will increase the percentage of *unrelated business* required to help achieve tax deductibility of insurance premiums paid into the captive.

## ERISA Issues: Medical Stop-Loss Versus Health Insurance

This article intentionally discusses a *stop-loss* captive as opposed to a *health care* captive. This distinction is important, as the captive itself must be kept separate from the actual benefit plan provided to employees.

As mentioned above, the DOL and ERISA have regulatory jurisdiction over the plan itself, but the DOL does not regulate insurance coverage nor impose funding requirements or standards on employee welfare (health care) plans. In this regard, the DOL only regulates a plan sponsor's responsibility as it relates to the overall administration of the plan and its delivery of stated benefits to employees.

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 contractual obligations to the plan.<sup>1</sup> Since neither the DOL nor ERISA have regulatory jurisdiction, a prohibited transaction exemption (PTE) is not applicable to medical stop-loss captives.

It is worth noting that group purchasing arrangements for health care coverage are not new. Risk purchasing groups, multiple employer welfare arrangements (MEWAs), and multiple employer trusts (METs) have existed for many years.

The primary difference between these arrangements and stop-loss captives is that the first three directly involve insurance of the plan itself, rather than the plan sponsor, as is the case with stop loss. Such arrangements may be either of self-insured or fully-insured structures; however, within either structure the participating employers typically comingle plan funds and/or purchase insurance directly for the plan rather than the employer.

States already have regulatory jurisdiction over insurance, and the DOL, by way of ERISA, specifically empowers states to regulate MEWAs.

<sup>1</sup> The DOL affirms this distinction via Advisory Opinion 92-02A.

## Medical Stop Loss Captives

Using a captive to provide medical stop-loss coverage to self-funded plans can generate advantages for some employers, but a more significant opportunity arguably exists for group captives rather than large individual employers. Since self-insurance is generally considered the most efficient form of alternative risk transfer, individual employers that currently self-fund their health care plan are already likely to be experiencing the optimized cost savings and increased control associated with an alternative risk structure.

In most cases, the economic return of forming a captive exclusively for medical stop-loss would be hard to justify for an individual employer. But, it could make sense to expand an existing casualty captive to include medical stop-loss, as any additional fixed costs and capitalization charges would be minimal. The additional risk diversification and potential tax benefits associated with an increase in *unrelated premium* could help optimize the performance of the existing captive.

Employers that are not currently self-insuring health care would be the most likely candidates to attain the benefits of self-insuring while also participating in a captive for the stop-loss coverage. As mentioned earlier, self-insurance is the most efficient form of alternative risk in terms of optimizing control and reducing the ultimate cost of benefit delivery to employees.

The pricing of health care insurance varies greatly across different geographical areas. The availability of competitively underwritten and priced stop-loss coverage, especially for smaller and mid-sized companies, can also differ significantly across these regions.

By grouping together and forming a captive to collectively purchase and risk share stop-loss coverage, employers can take advantage of the increased underwriting credibility that larger numbers provide. The larger participation numbers will help spread risk and stabilize loss volatility within the retained risk layers of the captive.

The potential profit and investment return would help reduce the ultimate risk cost and potentially increase the availability of competitive stop-loss coverage, which might not otherwise be easily attainable by smaller employers within higher-cost health care markets. Increased numbers will also provide greater discounting leverage with provider networks and related service components.

In short, a group captive may be able to deliver stop loss coverage to individual employers at more competitive terms than what is attainable within the prevailing market, while simultaneously reducing long-term pricing volatility.

### Mechanics of a Stop-Loss Captive

The basic structure of a stop-loss captive is fairly simple:

- The group participants select a common stop-loss carrier to provide coverage to all members.
- Once a viable participation commitment (critical mass) has been achieved, each employer will establish and maintain an individual self-funded health care plan.

This will include choosing the desired plan design and all related service components, such as third-party administrators (TPAs), provider networks, and the like. Although each employer's plan is designed and maintained separately, the size advantages of the group can be leveraged if related components are collectively obtained from common providers.

- 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 then cedes a portion of the collective stop-loss portfolio, attributable to all participating group members, to a captive owned jointly by all participating members. The most common arrangement is to have a captive participation layer above the specific deductible and below the maximum reimbursement limit of the policy. For example, the captive would assume risk participation within the \$250,000, excess of \$250,000 layer of a policy having a \$1 million (or higher) limit. The actual captive participation level will be determined by the collective risk appetite of the insured members (with agreement from the ceding carrier), and could be structured either on an excess or quota-share basis.

- Individual member risk-sharing amounts within the captive are determined on a pro-rata basis according to the specific plan design and stop loss retention associated with each employer's participation.

As with any group arrangement, it is of paramount importance that the captive attain the appropriate level of critical mass necessary for initial funding, establishing reserves and sustaining losses. In the case of medical stop loss, participation of at least five separate employers totaling 1,000 employee lives should generally be considered the minimum needed to achieve the proper spread of risk necessary for sufficient underwriting stability and economic benefits.

### Still Evolving

Interest in self-funding and group captives will grow as medical costs continue to rise and the uncertainties related to health care reform threaten the amount of control employers can maintain within more conventional insurance structures.

Whether group captive participation will provide enhanced benefits over more traditional individual self-insurance is still open for debate. Since each member of a group captive must be large enough to self-insure individually, it is unclear whether a group captive will provide enough additional incentive for an employer to choose that route rather than simply maintain an individual self-insured plan.

Given the appropriate levels of participation and sufficient spread of risk, group captives can increase leverage with carriers, provider networks and related service providers to generate volume-related discounting that might not be attainable by smaller, self-insurers. By retaining an additional participation layer through the captive, pricing volatility associated with the stop-loss coverage can be mitigated.