FRONTING CARRIER, YOUR POSITION HAS BEEN ELIMINATED

Randall Beckie and Phil Holowka investigate how medTRANS' story reveals opportunity for captives to transition from fronted to non-fronted medical stop loss risk coverage

MedTRANS, an association captive, reinsures medical stop loss risk for ambulance company employers. medTRANS replaced its fronting carrier with protected or incorporated cells that issue stop loss policies directly to their affiliated employers. The cells will cede the risk to medTRANS, which hosts the cells.

Axing the fronting carrier cuts administrative expenses in half and undercuts comparable commercial stop loss insurance premiums. Via economy of scale, medTRANS' expense ratio will halve again. Meanwhile, the participating employers gain transparency about health service decision-making and control risk management.

The conventional business model

Aside from Multiple Employer Welfare Associations (MEWAs), most existing medical stop loss risk pooling arrangements are designed as commercially fronted captive arrangements. For example, a conventional business model insures 20 employers each with 100 health plan beneficiaries, or 2,000 lives collectively. Each employer assumes the first $50,000 of annual claims from any individual beneficiary and transfers excess exposure over $50,000 to the stop loss captive via a commercial fronting carrier. The carrier retains 20% of the stop loss premiums and all exposure in excess of $300,000 per beneficiary per year, leaving the captive with a $250,000 working layer of risk that is funded with 80% of premiums. The captive arrangement depends entirely on the carrier's willingness to cover claims in excess of $300,000.

Randall Beckie

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Phil Holowka

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Cognisant of its indispensability, the carrier traditionally wants control of the entire stop loss programme from $50,000 up. Therefore the carrier issues the stop loss coverage to the employers or their health plans. The employers either collectively own the captive or they own cells which assume the underwriting profits from the captive.

Either way, employers traditionally hold captive insurance ownership interests similar to policyholders in a mutual commercial insurance company. In practice, a mutual insurance policyholder's participation in the profitability of the insurance company depends on the insurance company's declaration of a policyholder dividend. These policyholders have little say.

The carrier's agent may tout this as a way for employers to own a captive, noting that captive insurance is what smart money does. Unfortunately the only captive attribute of this traditional, fronted, mutual insurance company business model is some legal statute under which risk pooling entity is formed. The employers lack control, lack tax advantages and lack transparency.

Turning the status quo upside down

The new model turns the conventional model on its head: cells issue coverage directly to employers. ERISA, captive insurance statutes, and federal tax laws permit this, provided that the arrangement follows all the rules.

The cells cede the medical stop loss risk above an attachment point. The commercial insurer moves to the end of the cascade of risk transfer. Underwriting profits from retained premiums are retroceded to the cells, treated as a separate insurance company.

Actuarially speaking, at a critical mass of 1,000 lives, a pool's statistical credibility would increase from 72% with six months of seasoning to 100% with 12 months of seasoning. When reviewing new members for admission, claims experience is analysed more intensely than carriers do. A clinician

reviews current utilisation to forecast near term claims exposure. It turns out to be prudent underwriting protocol to personalise each employer's policy. A direct written captive arrangement performs that service where carriers typically do not.

Capital is conserved by laying off excess loss exposure to the A-rated commercial retrocessionnaire. Each cell's capital serves doubly by collateralising its retrocessionnaire obligation while also financing various property/casualty enterprise risk coverages that the cell may also insure.

Whereas cancer is the leading cause of loss for a commercial stop loss carrier, medTRANS' worst loss ever was neonatal triplets. The triplets (plus the mother) are separate health plan beneficiaries, so one maternity episode generated four large losses. Lessons learned: the fronting carrier overlooked the risk that burned the captive and not the carrier; also when bringing aboard new members, clinical scrutiny of prescription and medical claims is the definitive leading risk indicator.

Risk management strategy for medTRANS members differs from the way a carrier views risk. When an employee incurs severe illness, the employer pays three ways: (1) funding the medical claims cost, (2) losing workplace productivity from extended absence and (3) potential employee turnover. Sophisticated employers use their captive arrangement to insure the human capital costs that multiply the cost of mere medicine.

What makes direct insurance "new"

The novelty of medTRANS' structure lies in making captive insurance of employer medical stop loss risk rather pedestrian: medical risk becomes just another one among dozens of coverage types that a cell may insure.

By pooling risks homogeneously – medical risk separately from business interruption risk and so on – losses become more predictable. Regardless of whether a medical stop loss risk pool covers dozens of employers or thousands of employers, considerable know-how and experience is required to underwrite medical risk. But the same can be said about additional coverage types that captives insure.

Issuing insurance directly from cells broadens opportunities for tax planning. From a tax perspective, medical stop loss coverage could be characterised as either a life insurance or non-life insurance contract, depending on the details. Some employers prefer their cell captives to be eligible to make a section 831(b) election. Some prefer another strategy. An employer gains the luxury of choice about tax and investment strategy once its takes control of its cell captive away from a carrier and the carrier's agent.

Other captive managers have experimented with a monoline basis business model for medical malpractice insurance written by cell captives that belonged to physicians. To make the medTRANS business model feasible, the captive manager uses efficient and sophisticated accounting capabilities to handle financial reporting for transaction detail at the cell level.

> "Eliminating the fronting company empowers the employers to get serious about promoting wellness and helping their employees obtain more personalised healthcare"

Despite the fact that nearly one-fifth the US gross domestic product is spent on healthcare, promoters herald the newness of captive insurance solutions that include health insurance. Insuring medical risk is hardly a new idea. Yet small cell captives directly insuring medical risk may be perceived as a new idea, if only because traditionally styled medical stop loss carriers deplete the captive insurance advantages from such arrangements. A cell or a standalone captive could directly write employer medical stop loss risk for an employee group as small as two lives. In some states, a commercial carrier would be unable to do that. A captive operates under the laws and regulations of the state where it is domiciled, which could be elsewhere than the employer's home state.

Advantages of direct writing

Why is it not routine already for captives to directly write medical stop loss, considering that direct writing reduces state premium tax and eliminates the fronting fee and other profit-taking by the carrier? One answer: broker commissions of 10-15% of premiums motivate selling fronted solutions.

By putting the employer's cell captive in control of its underwriting agenda, the employer's insurance broker takes on a value-added role. The Affordable Care Act does not restrict an employer's choice to self-fund or fully insure its health plan, as the broker may recommend from year to year. When medTRANS was fronted, the participating employers conflated the captive management service team with commercial insurance agents. Removing the carrier creates transparency about who controls risk management and underwriting decisions.

Most importantly, eliminating the fronting company empowers the employers to get serious about promoting wellness and helping their employees obtain more personalised healthcare. When beholden to a health insurance carrier, medical case managers (whether employed by a TPA or the carrier) make decisions within the constraints of accepted health industry dogma.

That approach has contributed to following status quo:

- Medical errors are the third leading cause of death in the US, after heart disease and cancer.
- As John Ioannidis famously wrote: There is increasing concern that most current published research findings are false.
- Type 2 diabetes is epidemic due to American diets rich in carbohydrates and high fructose corn syrup in processed foods. What has traditionally been the medical response? Pharmaceuticals!
- Traditional fee-for-service reimbursement methods force prescribers to document procedures and medicines for treatment as opposed to encouraging prevention and maintenance care. Prescribers earn more money by testing and treating than by prescribing broccoli and exercise.
- Medical care in the US costs more than other wealthy countries without producing exceptional healthcare results.

Building medical stop loss captive insurance arrangements in a more transparent, efficient, flexible business model improves healthcare while saving money for employers and employees.