Employee Benefits Captives and Healthcare Captives: Effect of the Supreme Court Ruling

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On June 28, 2012, the Supreme Court of the United States (SCOTUS) upheld the Patient Protection and Affordable Care Act (PPACA). The Court affirmed that Congress can tax or penalize any American who fails to purchase health insurance within the requirements of PPACA. The major change it made to the law was permitting states to opt out of the Medicaid expansion that allows people with household incomes up to 133% of the federal poverty level to participate in state Medicaid programs with broad eligibility criteria.

How does the Supreme Court ruling affect employee benefit captives and healthcare captives?

Let's start by looking at how captives are currently used for employee benefits or healthcare arrangements (i.e., the nature of risks being insured or reinsured by them and the issues facing those captives today), and then assess how the SCOTUS ruling affects each of these uses.

For purposes of this article, "healthcare captives" refers to those captives that are sponsored by hospitals or integrated healthcare delivery systems to cover professional liability and related risks. "Employee benefits captives" will be restricted to those captives that provide medical stop-loss coverage for a single employer or for groups of employers. Other uses of captives for employee benefits, such as the ERISA Prohibited Transaction Exemption arrangements or captives that write ancillary coverage (e.g., group term life, disability, dental) are outside the scope of this discussion.

Healthcare Captives

Though PPACA does little to directly affect the delivery of healthcare in the United States and the cost to provide that care, it does create some incentives for changes in the organization of healthcare providers that may improve the efficiency of care delivery. In particular accountable care organizations (ACOs) allow integrated healthcare delivery systems (i.e., hospitals and physicians working together) to take risks and enjoy rewards for providing high-quality and low-cost care to Medicare beneficiaries. This provision has been a catalyst for more provider integration. That is, we are seeing more and more hospitals acquiring physician practices and we're seeing smaller physician practices consolidating to create larger and more integrated practices. The addition of more physicians to hospital payrolls and hospital risks can affect the nature of the risk profile that a hospital has with respect to professional liability. If the hospital has a captive that is taking on some of that professional liability risk, it should evaluate how that risk is changing and plan accordingly. This risk profile change could have an impact on the future professional liability exposure of healthcare captives, which would then need to be considered when these captives establish their loss reserves and future funding levels.

The SCOTUS ruling does not directly affect these arrangements.

Employee Benefits Captives (Stop Loss)

With respect to medical stop-loss, many large employers have single-parent captives that cover some portion of the employer's risk for large-amount claimants under the employer's self-insured medical plan. In most cases, the employer is retaining at least the first $100,000 or more of claims per person in its self-insured medical plan and the captive provides coverage for at least some of the excess risk; the employer may purchase outside reinsurance for risks in excess of some threshold beyond which the employer does not wish to take risk (e.g., the employer retains the first $100,000 of claims in its self-insured health plan, the captive takes the next $250,000 of claims for that person, and an outside reinsurer covers the excess). As long as these arrangements are written in a way that the plan sponsor (the employer, not the employer's health plan) is purchasing the stop loss coverage to protect against financial variability arising from the health plan, and the stop-loss coverage is not paying medical claims but is reimbursing the employer for expenses that exceeded the expected, this coverage is not considered part of the employee benefit plan and is not subject to ERISA.

The issue facing the stop-loss market today is the threshold limits that determine if the coverage is first-dollar medical benefits or if it is stop-loss. If the coverage is considered first-dollar medical benefits, the coverage becomes subject to ERISA provisions and many aspects of state law (e.g., premium taxes, mandated benefits) as well as PPACA. Historically, stop-loss attachment points as low as $10,000 have been in place for some smaller employers who self-insure their benefits (generally employers with a couple hundred employees). Larger employers, with about two thousand or more employees, often have attachment points over $100,000, some as high as $500,000 or more. Large employers with single-parent captives that insure stop-loss with attachment points over $100,000 are not likely to be affected by PPACA unless the employer decides to discontinue offering medical benefits to their employees and let them fend for themselves on the state exchanges. The SCOTUS ruling does not affect this decision.

Smaller Employers

The real issue with stop-loss is with smaller employers that have or are considering captive arrangements to create a stop-loss pool. By "smaller," we mean groups of about 50 employees or more that are considering converting from a fully insured arrangement to a self-insured plan and purchasing stop-loss coverage with attachment points perhaps as low as $10,000, but typically around $25,000 - $50,000, with the captive covering a layer of claims (e.g., the next $250,000 per life) and then an outside reinsurer covering the excess. A catalyst for these employers to seek such arrangements is the effect that PPACA might have on the risk profile of the small group and the insured larger group marketplace.

The exchanges that take effect starting in 2014 allow individuals and small employers to purchase qualified health plans from insurers that are competing on the exchange. Persons whose household incomes are less than 400% of the federal poverty level (around $90,000 for a family of four) and who pay more than a certain percentage of income for their healthcare will get reduced rates for individual market plans purchased through an exchange funded by federal subsidies. The premium subsidy may reduce the number of uninsured, but often the unmet healthcare needs of this population will add to the cost of care for the rest of the insured risk pool. In addition, PPACA added assessments against insurance companies

that will be passed along to insureds as increases in rates, to the extent possible. These situations are causing some smaller employers with insured programs to seek self-insured arrangements that exempt them from some of these mandates.

The federal government is concerned that the remaining insured risk pool will be more costly if many of these employers become self-insured. As a result, the National Association of Insurance Commissioners (NAIC) and some states are reviewing their stop-loss laws and the NAIC Stop Loss Insurance Model Act to determine if stop-loss thresholds should be increased. If the minimum stop-loss threshold is increased, some smaller employers that are considering self-insurance with stop-loss protection may determine that the extra risk they take by self-insuring a portion of their coverage is too much for them to absorb, such that they do not participate in these captive arrangements. For example, California has proposed that the minimum specific stop-loss attachment point be set at $95,000; this threshold is more than many smaller employers (of up to a few hundred employees) might be comfortable retaining.

The SCOTUS ruling affirmed that Congress has the right to tax or penalize any American that does not have health insurance coverage in accordance with the terms of PPACA. This decision actually lowers the likelihood that the remaining insured pool will worsen compared with a decision that would have thrown out the coverage mandate. Had the mandate been overturned, it is likely that the new additions to the insured marketplace would mainly have been currently uninsured persons eligible for a rate subsidy by purchasing coverage. Though this influx would have included some healthy persons as well as unhealthy persons, it is likely that a greater proportion of unhealthy persons would have purchased insurance than healthy persons. With the mandate, the insured risk pool is more likely to add a broader cross-section of healthy and unhealthy lives.

Summary

In summary, the SCOTUS ruling by itself has little direct effect on the administration of healthcare captives and employee benefits captives. They should continue on the course they have been taking. The change towards the integration/consolidation of healthcare delivery systems that is due to PPACA could impact the future professional liability exposure of healthcare captives. The biggest force that may affect employee benefit captives is the potential for increases in the minimum stop-loss attachment point that is allowed; such a change will greatly reduce the growth in captive arrangements that pool the risks of multiple smaller employers that have self-insured stop-loss coverage.

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