Trends in Employee Health Benefits & Captive Utilization

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August 13, 2014
Session Objectives

Topics to cover:

• Rising costs of medical coverage
• How to best utilize a captive – group, single-parent, or cell facility – to finance these costs, particularly for small to medium sized entities
• Use of a fronting carrier compared to writing directly and then seeking reinsurance
• Domicile selection
• Changing roles of players
Rising Cost of Benefits

Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 1999-2013

Rising Cost of Benefits

Average Annual Premiums for Single and Family Coverage, 1999-2013

* Estimate is statistically different from estimate for the previous year shown (p<.05).

Percentage of All Firms Offering Health Benefits, 1999-2013

*Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits. The percentage of firms offering health benefits is largely driven by small firms. The large increase in 2010 was primarily driven by a 12 percentage point increase in offering among firms with 3 to 9 workers. In 2011, 48% of firms with 3 to 9 employees offer health benefits, a level more consistent with levels from recent years other than 2010. The overall 2011 offer rate is consistent with the long term trend, indicating that the high 2010 offer rate may be an aberration.

Trend Towards Self Insurance

Percentage of Covered Workers in Partially or Completely Self-Funded Plans, by Firm Size, 1999-2013

* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: Sixty-one percent of covered workers are in a partially or completely self-funded plan in 2013. Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006. Therefore, conventional plan funding status is not included in the averages in this exhibit for 2006. For definitions of Self-Funded and Fully Insured plans, see the introduction to Section 10.

Trend Towards Self Insurance

Figure 3

Source: Various tables that can be found at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp

Mid-sized firms are expected to convert
Captive Utilization

Use of a captive:
1. Pre-funds the risk
2. Allows risk-sharing across employers, business units, lines of coverage, and policy periods
3. Segregates financial statements
4. Achieves insurance company status for tax and accounting
5. Improves governance (capital allocation, actuary, auditor)
Trend Towards Captives

There is a growing number of captive solutions:

- **SINGLE-PARENT CAPTIVES**
- **GROUP CAPTIVES**
  - Heterogeneous groups sharing or segregating risk
  - Affinity groups based on region or industry, e.g.,
    - Central Coast Mutual ("Aspire") – founded by a hospital with goal of insuring local employers
    - Maine Wellness Association – same members as the successful Workers Compensation pool
    - EMBS in Montana – founded by an agency for local employers using common service providers
    - EdHealth – today’s case study
Single Parent Captives

• 9* to 100** (or more?) captives include employee medical
• Especially those that already pool international medical risks over multiple country plans
• Diversify risk portfolios by type of risk
• Buy down business unit deductibles
• Smooth budgets over policy periods

* Statistic reported at the 2014 World Captive Forum
** Heard from captive managers at the World Captive Forum
Risk Financing Options

Single Parent Example

A
- Insured Claims
  - $75,000
- Self Insured Claims
  - $24 million
- 2013 Policy

B
- Insured Claims VOLATILE
- Self Insured Claims
  - $30 million
- 2015 Higher Loss Limit

C
- Insured Claims VOLATILE
- Captive Layer Claims
  - $7.5 million
- Self Insured Claims
  - $22.5 million
- 2015 Captive Participation

$400,000

$750,000

$20,000
Educators Health Case Study
What Is EdHealth?

A health insurance collaboration founded, owned, and governed by its members

• Purpose: provide an integrated program which designs and coordinates the management of each participating institution’s self-funded health care plan

• Members may be colleges, universities and secondary schools that are members of Collaborative Educational Ventures of New England (CEVoNE)
What Is EdHealth?

EdHealth LLC is the “parent” company that oversees the overall program, consisting of:

• A group of self-insured plans with individually member-set self-insured retention attachment points

• A pooled stop-loss insurance program administered by a Vermont registered reciprocal captive
What Is EdHealth?
Why Was EdHealth Started?

Process began in 2006 by The Boston Consortium for Higher Education (TBC) in order to find ways to slow the rise of medical insurance costs.

Babson
Bentley
Berklee
Boston
Boston

Brandeis
Emerson
MIT
Northeastern
Olin

Suffolk
Tufts
Wellesley
Wheaton
A Two-Pronged Approach

1. In early 2007, work began on a Health Management Initiative – a program to help lower the levels of claims.

*Healthy You* was launched in 2010 and is now a part of the EdHealth program.
A Two-Pronged Approach

2. In mid-2009, work began to develop a program to more efficiently and cost effectively provide medical insurance to participating institutions. Components included:

- Create savings for participants through a more efficient financial structure and group purchasing power
- Multi-institution participation to take advantage of large numbers of employees to minimize risk volatility and costs, while allowing for renegotiation of administrative, network and other external charges
Launch

- March 2011 – Collaborative Educational Ventures of New England, LLC (CEVoNE) formed. Currently 24 members
- July 2012 – EdHealth LLC formed in Massachusetts
- April 18, 2013 – Educators Health Insurance Exchange of New England (EdHealth Captive) granted Vermont license #991
Launch cont.

• July 1, 2013 – EdHealth launched operations with six initial members

• January 1, 2014 – Three additional members joined. Approximately 7,000 employee lives covered

• Member recruitment for January 1, 2015 underway
How Does EdHealth Work?

• A common set of plan designs
  – Member designed
  – Evolving over time to meet member needs
  – Some options available
  – Member-specific stop-loss attachment points (set by member)

• Governance
  – EdHealth LLC: Board of Managers (5)
  – EdHealth Captive: Subscriber Advisory Committee (7)
How Does EdHealth Work?

- Program administrator: USI Insurance Services
- Captive manager: AIG
- Actuarial and underwriting consultant: Spring Consulting Group
- TPAs: Harvard Pilgrim Health Care and Tufts Health Plan
- Stop loss insurer: QBE
- Legal: Primmer, Piper, Eggleston & Cramer
- Banking: TD Bank
- Audit: Saslow, Lufkin & Buggy
## How Does EdHealth Work?

<table>
<thead>
<tr>
<th>EdHealth Captive</th>
<th>Stop Loss Insurer</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Excess of Stop Loss coverage)</em></td>
<td><em>(Excess of 125% of expected EdHealth Captive Claims)</em></td>
</tr>
<tr>
<td>Optional: EdHealth Captive</td>
<td></td>
</tr>
<tr>
<td><em>(Excess of 125% of Participant's expected SIR)</em></td>
<td></td>
</tr>
<tr>
<td>Participant’s Self Insured Retention (SIR)</td>
<td>EdHealth Captive (e.g. Next $400K per claim)</td>
</tr>
<tr>
<td><em>(e.g. $100K per claim, up to 125% of expected)</em></td>
<td>Stop Loss Insurer (e.g. Excess of $500K per claim)</td>
</tr>
</tbody>
</table>
Benefits to members

Lower cost than fully insured plans

• Negotiated lower fees with TPAs
• Larger group = better pricing, less volatility
• EdHealth is not trying to make “profits”
• Members may retain their broker/consultant relationships on a direct basis
Benefits to members

Estimated magnitude of savings

• Feasibility study: Avg. = 5.5%, range from 4% - 9%

• Early adopter #1: Projected 10% growing to 20% in 4 years

• Early adopter #2: Projected 5.7% in year 1

• Initial actual results have been very good
Challenges

“There is no more delicate matter to take in hand, nor more dangerous to conduct, nor more doubtful of success, than to step up as a leader in the introduction of change. For he who innovates will have for his enemies all those who are well off under the existing order of things, and only lukewarm support in those who might be better off under the new.”

- Niccolo Machiavelli, *The Prince*, circa 1513

Nowhere is this more true than in higher education!
Challenges

• Resistance to change in higher education
• Different approval process in each school
• Magnified by multi-school collaboration
• “Competitors”
• Initial small numbers
EdHealth Members as of 1.1.14

Worcester Polytechnic Institute

Regis College

Lasell College

Berklee College of Music

Wentworth Institute of Technology

Wellesley College

Olin College of Engineering
Looking Ahead

• Membership expansion – discussions with VT, NH, CT and MA schools underway

• Expansion of membership services, including *Healthy You* and other group-purchased services

• In keeping with the conference baseball theme, EdHealth is a solid hit: we have rounded first base and are on the way to second, and it looks like it could be an inside-the-park home run!
Middle Market Employee Benefit (EB) Captives
Middle Market EB Captives

• Overview
• Structural Differences
• Client Base
• Evolution
• State of Market
  • Health Insurance
  • Captives
• Regulatory Horizon
• Future Expectations
Middle Market EB Captives

• Growth in market
  • Interest in self funding

• Fronted programs
  • Primarily heterogeneous

• Reasons
  • Current is not simple
  • Maturing market
  • ACA confusion
  • Claims transparency
  • Increasing expense – business risk
  • Wellness and credibility
Structural Differences

• Direct writing
  • Employers share credit risk
  • Responsibility for claims
  • Reinsurance interaction

• Fronted
  • Credit risk
  • Defined collateral
  • State approval
  • Heterogeneous marketing
  • Plan domicile
  • Fees
Structural Differences

Risk Transfer

Group Captive

Individual Self Insured Retention (SIR) Layer
Preferred Client Base

• 100 – 400 covered employees

• Entrepreneurial spirit, financially stable

• Desire to take ownership of medical and prescription benefit premiums

• Desire to be part of a group
Evolution

• Increase in self funding
  • Lack of pricing transparency
  • Purchasing decisions elevated to senior management
  • Increase of affiliated study groups

• Captive evolution
  • Affinity groups to heterogeneous
    • Underwriting discipline
  • Captive structure changes
  • Financing less interesting over time – wellness and communication!
State of Market

- Employee benefits
  - ACA ensures everyone has insurance coverage
    - Cost and volume of claims
    - Pay or play
    - Complexity
  - Wellness and incentives
    - Are they effective tools?
    - Recognition by larger market
  - Frustration and confusion
State of Market

• Employee benefit captives
  • Few carriers involved compared to total stop loss providers
    • Fewer that do well
  • Cost sensitivity related to pricing
  • “Large” captives are still small part of market
  • Manual vs. captive underwriting
  • Reporting requirement and pricing
  • Competition is not other captive managers
Regulatory Horizon

• ACA
  • Reporting requirement
  • Minimum loss ratios
  • Guaranteed renewability
  • Self funding

• State pressure
  • Attachment point minimums in California, Rhode Island

• Captive Domiciles
  • Allowable by most, onshore and offshore
  • Not in Washington, D.C. and New York
Future Expectations

- Wellness and transparency
- Reference based pricing
- Supportive vs. exchange states
- Unbundled services
- Self funding and alternative options will continue to grow
- Captives will become risk management companies
- Continued growth
Questions?