Pareto Benefit Captives F.A.Q.s

We have found that we get a surprisingly common set of questions from prospective Members. We have created the following “Frequently Asked Questions” and accompanying answers in an attempt to provide more clarity. The answers tend to be long, but we are trying to be as descriptive as possible.

Can I keep my current benefit plan? Can I keep my plan year on a calendar year basis?

As a self-insured employer, you can have any plan design that meets the federal requirements that your TPA will administer. Most Members keep their existing plans when they enter the captive program, and slowly make adjustments over subsequent years.

About 40% of our clients run plan years (meaning the employee facing items like deductibles) on a different basis than their stop loss year (meaning the risk transfer for large claims). Most TPAs are able to handle the accounting for this.

What will my employees think? Will they be able to keep their doctors?

Each employer contracts with a Third Party Administrator (TPA) to adjust claims, provide ID cards, access to PPOs, and provide both employer and employee level customer service. TPAs typically have access to both local and national (e.g. Aetna, Cigna, United Healthcare) networks. Your consultant will work with you to determine the best partner for you, with an emphasis on breadth of network. In most cases, employees are not required to change doctors. In fact, the employees will have no idea that you’ve moved to a captive outside of some increased wellness incentives and a possible change of networks (e.g. from Blue Cross to Aetna).

Will this require more work?

Yes and no. It requires more thought but not more administration. The decision to join a captive program requires more due diligence than a typical insurance program. Members of the captive also spend more time developing a multi-year strategy in conjunction with their consultant – this is typically something new but it is also something that is typically seen as a positive. The program itself should not require additional administrative work. There are normally four more checks to write per month and the TPA is typically doing the same administrative tasks that an insurance carrier is doing today.

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What is Pareto's role? What is my consultant's role?

Pareto manages the captive, effectively acting as its management team or officers. Pareto does not act as a consultant to individual employers. Your consultant's role is essentially unchanged, as they will continue to advise you on benefits, regulations, and cost containment strategy. In some ways, the role of the consultant is actually broadening, as they (and you) now have many more levers to potentially pull to impact costs.

It appears I'll be sharing risk with other employers in the captive layer. Will I know who these employers are and will I know who is impacting the captive?

In any insurance program, you are sharing risk with other employers. In a fully insured program, you are sharing 100% of your premium with lots of employers that you'll never know. In a Pareto program, you'll be sharing about 20% of your total healthcare dollars, and it will be with like-minded employers that you will know. Furthermore, the captive is transparent, and Members will know the captive premium and claim amounts for all other Members.

What is the purpose of the capital? Do I put up capital each year? How much capital is required to join? Will I forfeit capital if I do not renew?

The captive is a licensed insurance company and needs capital to operate. Participating Members of the program become equity owners in the company – they receive equity in return for their capital. The capital is at risk and backstops the premium in the captive. If the claims exceed premium, capital is used to pay claims. The capital is used evenly across all Members on a pro rata basis and each program year is accounted for separately from others.

The amount of the capital is correlated to a Member's 'net captive premium', which is in turn commensurate with the Member's expected claims in the captive layer. The capital is typically 3-4% of the equivalent fully insured premium, meaning that it is similar to the taxes in a fully insured program (self-insured programs are not subject to the same taxes). The capital is typically around 11% of the stop loss premium.

A Member should expect to contribute capital at least twice. We will not know whether the first year's capital will be used or not when we get to the first renewal, and therefore require that the second year is also capitalized. When we get to the second renewal (third year), any unused capital from the first year can be "released" from the first year and applied towards the third year. In the same manner, year two excess can be applied to year four and so on.

If a Member leaves the captive, they are entitled to receive their capital back (while simultaneously returning their shares and signing a release with the captive), to the extent that it hasn't been used. The capital will be returned when the program year is closed out, and not at the time of the Member's decision to leave the program.

Is there more risk in a captive or self-insurance program?

This is one of our favorite questions. If you compare a self-insurance/captive program to a fully-insured program on a one year basis, the self-insured/captive program will almost always have "more risk". Most simpletons stop their analysis there and stick with that conclusion. We think that simplistic view is completely flawed and the conclusion wrong and misleading.

On a multi-year basis, we do not believe that self-insurance/captive program represents inherently more risk, as employers tend to pay their smaller claims and transfer the risk of large claims in any program. One of our Members said it best: "I think its much riskier to rely on an insurance company, my state government, and the federal government than to rely on myself, my consultant, like minded employers, and Pareto."

Do I have to attend Nashville meeting? Why Tennessee?

Attendance is not required but is highly recommended. The meetings have three goals: governance, education, and networking. Most Members that attend speak very highly of the meetings, and some Members believe that the meetings should be mandatory (on some level) in the future. The argument is that more engaged employers equates to better program experience.

We chose Tennessee as the domicile for all of our programs largely on the strength of their regulatory team. We enjoy a close relationship with Captive Department at the Tennessee Department of Insurance. In addition, Nashville itself has turned out to be a draw. It is centrally located with a good airport, fairly inexpensive, and a great place to have a beer and listen to live music following a day of insurance. This means we get greater participation and engagement from the Members.

Can I be kicked out?

It is possible to be kicked out of the program. It is what we jokingly call the "Survivor Clause" – getting kicked off the island. It is a privilege to be in the program and Members are required to adhere to certain cost containment guidelines. In order to be kicked out of the program, a majority of Members AND Pareto must vote the Member out. We do not expect a Member will ever be kicked out because of bad experience; we expect that a Member will be kicked out for failing to comply with the cost containment requirements.

What happens if a Member of the captive goes bankrupt?

Each employer sponsors a unique plan for the benefit of its employees and their dependents. Each Member has its own stop loss policy. Members do not share plans and Members do not share stop loss policies. If a Member's financial condition deteriorates (whether actually bankrupt or not), they may stop paying their stop loss premium or may stop reimbursing their plan for claims.

If a Member stops paying their stop loss premium, the stop loss carrier will cancel the policy and will stop reimbursing stop loss claims. Since the captive 'sits behind' the stop loss carrier (the captive does not issue any policies directly to employers) as a reinsurer, its exposure to the claims of that Member cease when the stop loss policy is cancelled.

If a Member stops paying their claims, they will be in default of various state and federal regulations, but these defaults do not transfer any responsibility to the stop loss carrier, the captive, or other Members.

Capital is collected at the beginning of each program year, greatly reducing any direct credit risk on the part of the captive. If a Member were to grow significantly, not pay the required additional capital AND go bankrupt, the captive would have some financial exposure. Both the likelihood and the amount in this complex scenario are fairly minimal.

How do you enforce the wellness/population health management requirements?

The population management requirements are part of the operating agreement, and failure to comply with the requirements could result in expulsion or forfeiture of distributions. Each Member is required to provide a letter at renewal "warranting" their current efforts and describing intended future efforts. Pareto also communicates with core population management vendors to verify who is participating in the programs.

Having said all of the above, a lot of the program is based on trust. We are comfortable playing the role of motivator and coach and rarely feel the need to play the role of enforcer or police. Members don't join the captive in order to freeload; they join in order to engage and to reduce claims. Self-selection is therefore the most powerful tool for wellness compliance.

How are large on-going claims treated? Can I have a "laser" on my stop loss policy?

Within the healthcare/health insurance space, there are often large, ongoing claims. An example is a dialysis claim, which might cost $20-30,000 per month and go on for 30 months. In the traditional stop loss market, these claims are typically excluded from coverage, as the stop loss policy is intended to provide coverage for unknown claims. These large ongoing claims are usually carved out of the stop loss policy with an amendment called a 'laser'. A laser essentially says that the stop loss policy will not cover a specific individual's claims.

Lasers are not a large problem for a large employer; picking up an extra $250,000 of claims in a given year is not terribly significant compared to the overall benefit budget. For a smaller employer, this extra $250,000 is a very big deal and the fear of a laser is one of the key reasons that smaller employers have not traditionally self-insured.

If an employer has known, ongoing claim when they seek admission to the captive, that claim can be lasered. It would be inappropriate and unfair to share those claims with the existing Members. At renewal, these lasers would be re-evaluated, with the laser either remaining, being adjusted, or, if appropriate, removed.

If a claim or condition arises AFTER an employer has been granted admission to the captive, then the claim would NOT be lasered and would be shared with all Members of the captive. The elimination of the exposure to these lasers is one of the key ways that the captive can mitigate year-to-year volatility normally associated with self-insurance.

Please keep in mind that the above Questions and Answers are meant to help explain the program, but do not serve to alter, amend, or change any of the documents associated with the program, and therefore should not be relied upon as definitive.

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