



## 3 WAYS TO SAFEGUARD CAPTIVES AND CONSORTIUMS

Written By John W. Sbrocco

**S**top-loss captives and consortiums have been growing for years, with more of these arrangements coming to the self-insurance market than ever before. But there are caveats to consider before adopting either approach. The main decision that needs to be made will be made by the program manager.

Under the captive model, an employer invests in an insurance company by posting collateral in hopes that if the risk pool runs well, there will be a surplus, and if not, then there will be a loss on that investment, which no doubt causes friction.

In a consortium, like-minded employers leverage their purchasing power by sharing in the cost of their stop-loss policy to pool resources and spread risk across the entire group. Much like a captive, the risk pool is underwritten based on how well or poorly the arrangement is running. This helps smooth out the financial impact of high-dollar claims, reduces volatility and stabilizes renewals.

Many of these programs, however, deploy the same misguided strategies as fully insured health plans and, therefore, are likely to fail amid the backdrop of volatile claims and skyrocketing renewals in a hardening market.

The current model is unsustainable. Self-insured employers need to start moving their business because they see what's on the horizon with some of these programs, and I predict The Great Reset is coming. They can easily move business in good years, but not so much in bad years – and so they're going to have to do it slowly over time.

The good news is that there are proven strategies to avoid unnecessary risks and safeguard these programs. Here are three ways to accomplish this goal:

1. **Choosing private pools with cost-containment requirements.**

There's strength in numbers, as the saying goes, but it's equally important that the number of participants in a group captive or stop-loss consortium is strong to begin with. That means establishing risk pools that are private vs. public, require proven cost-containment measures and exclude misaligned third-party administrators (TPAs) and pharmacy benefit managers (PBMs). Confining membership to aligned, forward-thinking employers will minimize abuse and stabilize the pool.

It's ultimately up to the captive or consortium program manager to establish strict criteria for containing costs in order to enter the risk pool. It's akin to applying for a private country club membership or admission to another exclusive club. Without such standards, there's no way to rein in bad industry practices.

Examples of cost-containment measures include anything from addressing J codes used by providers for drugs or medical devices when billing for claims to pharmacy benefit carve-outs, as well as handling auto adjudication rates for high-dollar claimants. With self-funding and captives having become commoditized, it's important to embrace proven and tested practices that actually generate results in terms of the group's loss ratio.

Allowing just anyone into the group to share in the stop-loss and risk will dilute the pool and drive up the cost of healthcare, with good candidates subsidizing the risk of poor candidates. That amounts to a public-dumping group risk pool, which will only serve to spark massive stop-loss increases.

What happens is they end up cost-shifting to the regular-price group. But this old method for growing a pool of employers is not sustainable anymore because the claims are so big. They can't get the increase they need to subsidize it. The block needs the increase because business is being written at a loss, which is what happens in the fully insured world. It's easy to write bad business and still grow, but the aim is to write good business and grow at the same time, which, of course, is much harder to do.



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Requiring cost-containment strategies is one way for employers to avoid posting collateral and still preserve the key benefits of group purchasing, having a long-term strategy in place and no new laser rate caps. If an employer's partners managing the high-dollar claims profit from those that hit stop-loss, how can they ever control the risk pool?

## 2. Partnering with programs that are built for long-term stability.

The profit-driven vertical integration in recent years of health insurance carriers with their own PBMs and TPAs that control provider networks and hospitals is clearly aligned with the interest of shareholders, not plan sponsors or members whose claims data has largely been kept under wraps. BUCA-owned TPAs will auto-adjudicate nearly every claim, including those higher than \$100,000, without asking a single question about claimants on medical review and whether lasers are appropriate, or they're underwriting the renewals with block AI underwriting, which is asinine.

While independent TPAs that are paid a modest per-employee-per-month flat rate can significantly reduce those auto-adjudication rates with the help of sophisticated technology, there are hundreds of them in the marketplace, and not all of them are created equal. Some are consolidated and can actually manage claims well but may not be good at marketing and selling.

This last point is critical because the search for a certified TPA partner hinges on who is performing best from a loss-ratio standpoint, vs. simply adjudicating claims. It's vital to us because we participate in the risk, and our skin is in that game as a partner with the employer. The same thinking applies to so-called transparent PBMs whose pricing might be full of loopholes, pitches rebates, and whose practices fall short of a full specialty pharmacy carve-out strategy.

Sometimes TPAs will look past lasers on high-cost claims because there's a floating layer of \$500,000 risk that the employer captive, not the carrier, takes on. So, the TPA will put it in a public captive that waives lasers and is willing to take on bad risk. That may involve cutting down the attachment point to



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get close to fully insured, as well as driving up the premium to where it's becoming a level-funded model against the carrier level-funded programs, where it's all about maximum cost to sell business.

When you see that the attachment points are off 10 to 25 points, then you begin to wonder what the renewal is going to resemble. If a self-funded employer with \$500,000 in claims adds a 25% corridor plus trend, it should be over \$600,000 for the proper attachment point setting. Yet what we see in the market is some coming in at \$500,000, they're waving the flag that they're going to lose money, and you could see it.

### 3. Assessing risk-distribution policies.

In most markets, groups under 50 lives that have a bad claims year and face an above-average rate increase have a built-in safeguard to revert back to the age-banded pool. This adds instability with underpriced groups moving back to a fully insured arrangement.

But the key is when a group has been given a no new laser rate cap provision, what happens come renewal time is if they're only paying \$100,000 gross premium, you take out expenses, and there's \$70,000 to pay claims left over. You can only raise it 40% to 50% and cancer claims are \$200,000 on average. How can you ever catch up on that group? You can't. So, you put yourself in a position where you are always behind. That means you have to cross-subsidize it with every other member, and now they're not paying a proportionate share for that policy feature.

Think of it as a small group paying a portion for their insurance risk for that year, but are they paying enough for that policy feature in year two that they're going to hit the pool with? They're not capturing enough, so they can cheat next year and not pay enough because of these contract revisions. They're capping the aggregate, not only the spec side, and they're allowing the aggregate to apply toward premium claims, which is now financing aggregate claims with a 30% expense load.

It's insane. But this is a level-funded world where they're squeezing down these attachment points and then getting themselves into trouble with aggregate breaches of 50% to 60% of what the corridor is set at.

Ultimately, it's up to the captive or consortium program manager to verify that risk-sharing policies are equitable and that features like rate caps and no new lasers are reserved for larger groups. Assessing whether a program is being managed properly starts with a close examination of its growth model, including how new business is being underwritten, renewals are treated and with whom they're willing to work.

The name of the game is identifying high claimants on medical

review and ensuring that proper underwriting practices are in place to avoid being upside down on the group.

Bigger programs have embraced more of a block AI underwriting approach that seeks to achieve a certain premium level without regard to the group's overall makeup, which is never going to sustain the pressure of enormous claims that are being filed.

Look no further than several recent industry reports showing a troubling rise in multimillion-dollar claims. What happens is that they just slowly spread out the claims every year instead of recognizing that it doesn't make sense to underwrite certain groups they they're going to lose money on for years. They treat the floating layer like another spec.

The overarching aim is to avoid underwriting risk at the expense of the captive or consortium members with good claims experience that end up subsidizing those with poor claims experience.

We're now at a point where captives and consortiums are the new norm for midsize employers to self-insure their risk. The questions they should be asking about their program partners are these: who has proven and tested results, do they implement prudent business practice, and have they held the line on their vision? Knowing those answers will help unlock their success. ■

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