HEALTHREFORMGUY

EMPLOYER EDUCATION SERIES

MEDICAL CAPTIVES

An Employer Guide to Smarter Self-Funding

How group medical captives work, what risk an employer keeps, how risk is shared, and what to evaluate before making the move.

A practical decision guide for CFOs, HR leaders, owners, and plan fiduciaries

START HERE

How to Use This Guide

What this guide helps you do

- Understand the captive structure in plain English.
- Compare captives with fully insured and standalone self-funded models.
- Evaluate cash flow, collateral, stop-loss, governance, and vendor requirements.
- Identify whether your organization is operationally and financially ready.
- Prepare better questions for captive managers, advisors, and underwriting partners.

The core premise

A captive is not simply a cheaper insurance quote.

It is a long-term risk-financing strategy. The employer accepts more responsibility for claims, data, contracts, and plan management in exchange for greater control and a better opportunity to retain favorable results.

Guide roadmap

- Pages 3-10: Structure, risk layers, funding, advantages, and tradeoffs.
- Pages 11-15: Employer fit, readiness, underwriting, stop-loss, and governance.
- Pages 16-20: Vendor strategy, cost management, implementation, due diligence, and decision planning.

Important educational disclaimer

This guide is for general education and planning. Captive terms, legal structure, collateral, taxation, stop-loss contracts, and member obligations vary significantly. Employers should review any proposed arrangement with qualified benefits, legal, tax, actuarial, accounting, and insurance professionals before making a decision.

CAPTIVE FUNDAMENTALS

A Medical Captive in Plain English

Simple definition

A group medical captive is a self-funded health plan arrangement in which multiple employers each retain a predictable layer of their own claims, share a second layer of risk with other participating employers, and purchase stop-loss insurance above the shared layer.

What the employer owns

- Its benefit plan and plan document.
- Its claim experience and data.
- Its share of favorable or unfavorable results.
- Its vendor and cost-management decisions, subject to captive rules.

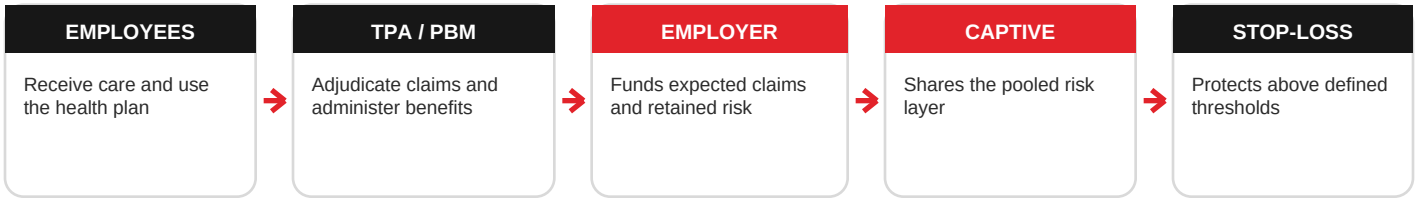
What the captive adds

- A shared risk layer across members.
- Collective purchasing power and governance.
- A financial buffer between the employer and stop-loss carrier.
- A community of employers with aligned incentives.

NOTES & PLANNING

CAPTIVE FUNDAMENTALS

How the Captive Structure Works



During the plan year

- Claims are paid as they occur through the TPA.
- The employer funds its claim account and fixed expenses.
- Claims above the employer layer may be reimbursed by the captive.
- Claims above the captive layer may be reimbursed by stop-loss.

After the plan year

- Claims continue through the contract runout period.
- The captive reconciles pooled experience, reserves, and expenses.
- Surplus may be retained, distributed, or used to strengthen reserves.
- Deficits may reduce member equity or trigger additional obligations, depending on the structure.

NOTES & PLANNING

COMPARE THE MODELS

Fully Insured vs. Self-Funded vs. Captive

DECISION FACTOR	FULLY INSURED	STANDALONE SELF-FUNDED	GROUP MEDICAL CAPTIVE
Who holds claim risk?	Insurance carrier	Employer + stop-loss	Employer + captive pool + stop-loss
Unused claim funding	Retained by carrier	Retained by employer	May benefit employer and/or captive, subject to terms
Claim data access	Often limited	Typically strong	Typically strong, with captive reporting
Monthly predictability	Highest	Variable	More variable than fully insured; often smoother than standalone
Upfront collateral	Generally none	Usually none beyond claim funding	Often required
Plan customization	Carrier-controlled options	High	High, within captive requirements
Renewal mechanics	Carrier rate action	Employer claims + stop-loss renewal	Employer claims + captive results + stop-loss renewal
Governance burden	Low	Moderate	Moderate to high
Best fit	Employers prioritizing simplicity	Employers with scale and risk capacity	Employers seeking control with shared protection

Key decision lens

The right model depends on more than the first-year premium. Compare total risk, contract terms, data access, collateral, vendor flexibility, governance, and long-term economics under realistic best-case and worst-case scenarios.

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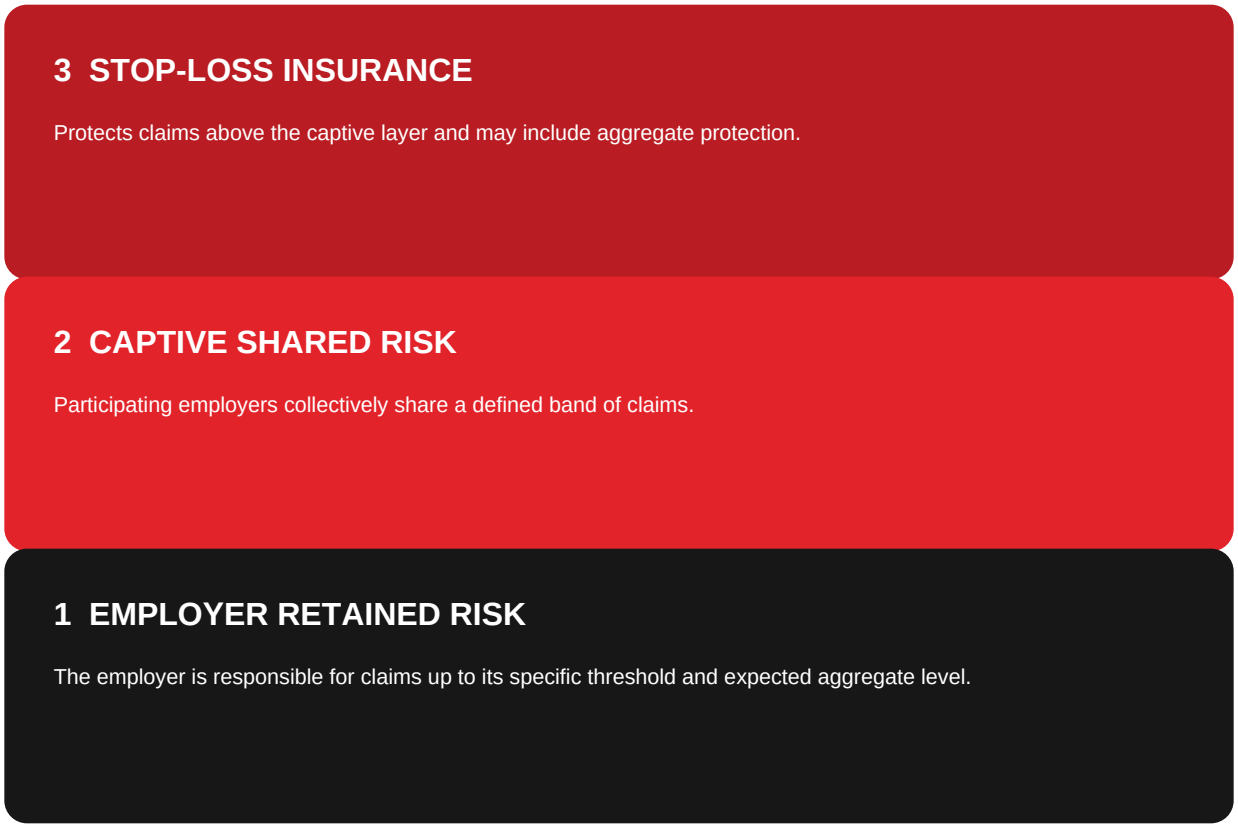
RISK ARCHITECTURE

The Three Layers of Protection



Illustrative only. Actual attachment points and risk layers vary by captive and employer.

Illustrative claimant example

$0-$75,000: employer layer | $75,000-$500,000: captive layer | Above $500,000: stop-loss layer.

A second protection - aggregate stop-loss - may limit total plan-year claim exposure, depending on the contract.

FINANCIAL MECHANICS

What the Employer Funds Each Month

1. Fixed expenses

- TPA and network fees.
- PBM and clinical program fees.
- Captive management and professional fees.
- Stop-loss premium.
- Compliance, analytics, and advisory costs.

2. Variable claim funding

- Medical and pharmacy claims paid through the plan.
- Claim funding may be level, budgeted, or paid as incurred.
- Cash requirements can vary materially from month to month.
- Strong banking and treasury processes are essential.

3. Captive capital or collateral

- Often funded at inception or over time.
- May be based on premium, exposure, or underwriting results.
- May take multiple years to fully release after exit.

4. Year-end reconciliation

- Outstanding claim reserves are established.
- Captive surplus or deficit is calculated.
- Member equity or distributions depend on governing documents.

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FINANCIAL MECHANICS

Collateral, Reserves & Exit Obligations

Why collateral exists

Captive claims may develop after the policy year ends. Collateral helps protect the captive and other members against unpaid obligations, adverse claim development, insolvency, or a member leaving before all liabilities are known.

Common forms

- Cash contribution or capital account.
- Letter of credit.
- Trust account or restricted deposit.
- Combination of premium and capital.

Questions to answer

- How is collateral calculated?
- When can it increase?
- When and how is it released?
- What happens after termination?
- Can losses from other members affect it?

Exit is not always immediate

An employer may stop participating at renewal but still remain financially responsible for prior-year runout, reserves, assessments, or capital until the captive closes those policy years. Review the exit provisions before joining - not when leaving.

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BUSINESS CASE

Potential Advantages of a Captive

Greater financial ownership

- Favorable claim performance may benefit the employer rather than the carrier.
- Pricing can reflect the employer's own risk profile over time.
- The captive creates a multi-year financial view instead of a one-year rate transaction.

More control and transparency

- Access to detailed claims and pharmacy data.
- More flexibility in plan design and vendor selection.
- Ability to target specific cost drivers and measure results.

Shared protection

- Risk is pooled with other employers in the captive layer.
- Collective size can strengthen purchasing power.
- The pool may smooth isolated large claims.

Strategic alignment

- Members are generally rewarded for better plan management.
- Governance encourages accountability and active decision-making.
- Long-term partnerships can replace annual carrier shopping.

Important expectation

Captives do not guarantee savings. They create a structure in which better-than-expected performance can be retained and poor performance is more visible. Results depend on underwriting, contracts, claims, management, and execution.

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BUSINESS CASE

Tradeoffs, Risks & Common Misconceptions

Real tradeoffs

- Monthly cash flow can be less predictable.
- Collateral can tie up capital.
- Large claims may affect future pricing or create lasers.
- Poorly designed contracts can shift more risk than expected.
- Success requires active management and executive attention.

Common misconceptions

- “The captive pays all large claims.” Only claims within defined contract terms are reimbursable.
- “Surplus is guaranteed.” Results depend on actual experience and reserves.
- “All captives are the same.” Structure, governance, fees, contracts, and alignment vary widely.

Watch for misaligned incentives

A captive can be surrounded by bundled vendors, opaque compensation, restrictive contracts, or point solutions that are difficult to replace. Employers should understand who is paid, how each party is paid, who owns the data, and whether vendors can be changed without leaving the captive.

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EMPLOYER FIT

What a Strong Captive Candidate Looks Like

Strong candidate characteristics

- Stable workforce and credible enrollment.
- Leadership willing to think beyond one renewal cycle.
- Financial capacity for claim variability and collateral.
- Commitment to data-driven plan management.
- Willingness to implement cost-containment strategies.
- Comfort with governance and shared accountability.

Caution signs

- Immediate need for a guaranteed short-term savings number.
- Very unstable enrollment or business outlook.
- No appetite for collateral or variable cash flow.
- Resistance to changing vendors or care pathways.
- Limited executive sponsorship.
- A desire to delegate every decision to the captive.

Employer size is only one factor

Group captives are frequently used by small and mid-sized employers, but there is no universal employee-count threshold. Eligibility depends on the captive, industry, location, participation, plan design, claims, financial strength, and underwriting standards. Quality of fit matters more than a headline size range.

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EMPLOYER FIT

Captive Readiness Scorecard

READINESS STATEMENT	0	1	2	NOTES
Leadership supports a 3-year strategy, not only a first-year quote.	Not ready	Partial	Ready	
We can tolerate claim variability and maintain adequate liquidity.	Not ready	Partial	Ready	
We are prepared to post and maintain collateral if required.	Not ready	Partial	Ready	
We have stable enrollment and reliable eligibility processes.	Not ready	Partial	Ready	
We will review detailed claims and pharmacy data regularly.	Not ready	Partial	Ready	
We are willing to evaluate and replace underperforming vendors.	Not ready	Partial	Ready	
We can communicate plan changes clearly to employees.	Not ready	Partial	Ready	
We have fiduciary, legal, and compliance governance in place.	Not ready	Partial	Ready	
We will implement measurable cost-management strategies.	Not ready	Partial	Ready	
We understand the captive exit and runout obligations.	Not ready	Partial	Ready	

How to interpret the score

16-20: strong starting point for captive evaluation. 11-15: potentially viable, but address gaps. 0-10: focus on readiness before moving forward.

This scorecard is a planning tool, not underwriting approval.

DUE DILIGENCE

Underwriting & Financial Evaluation

Data typically requested

- Employee and dependent census.
- Two to five years of medical and pharmacy claims.
- Large claimant detail and ongoing conditions.
- Current plan designs and contributions.
- Enrollment, participation, and eligibility rules.
- Current stop-loss terms, lasers, and disclosures.

Financial analysis should show

- Expected claims and reasonable trend assumptions.
- Fixed expenses, captive premium, and collateral.
- Specific and aggregate maximum exposure.
- Best-case, expected, and adverse scenarios.
- Three-year projected economics.
- Comparison to credible fully insured and self-funded alternatives.

Do not evaluate only the “premium equivalent”

Some proposals combine expected claims, fixed expenses, stop-loss, captive charges, and collateral into a single number. Ask which amounts are true expense, which are claim funding, which are capital, and which may be recoverable. Then model actual cash flow and maximum liability.

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DUE DILIGENCE

Stop-Loss Contract Considerations

Core contract terms

- Specific deductible: employer threshold per covered person.
- Aggregate attachment: total plan-level claim threshold.
- Contract basis: paid, incurred, run-in, and runout provisions.
- Lasers: higher deductibles or exclusions for known risks.
- Aggregating specific: extra amount before reimbursement begins.

Operational protections

- Advance funding: timing of reimbursements and cash-flow support.
- Covered benefits: confirm medical, pharmacy, and specialty claims.
- Exclusions and limitations: align with the plan document.
- Renewal protections: rate caps, laser limitations, or guarantees.
- Carrier strength: financial stability and claims-paying record.

Plan document alignment matters

The stop-loss policy reimburses the employer only when the claim is covered under both the employer plan and the stop-loss contract. Inconsistent definitions, exclusions, eligibility rules, experimental-treatment language, or late enrollment can create reimbursement gaps.

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CAPTIVE OPERATIONS

Governance & Member Accountability

Strong governance includes

- Clear ownership and voting rights.
- Transparent surplus and deficit allocation.
- Independent financial reporting and audit.
- Defined member standards and participation requirements.
- Regular board and member meetings.
- Documented conflicts-of-interest policies.

Employer responsibilities include

- Reviewing claims, pharmacy, and utilization reports.
- Approving a multi-year plan strategy.
- Monitoring vendors and performance guarantees.
- Maintaining eligibility and compliance controls.
- Participating in captive decisions.
- Taking corrective action when results deteriorate.

The best captives are communities, not just financing vehicles

Members should share a commitment to disciplined underwriting, transparent data, responsible plan management, and measurable improvement. Weak member standards can create cross-subsidization and erode trust in the pool.

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CAPTIVE OPERATIONS

The Vendor Ecosystem Around the Captive

Key vendor questions

Who owns the data? Which contracts can be changed independently? Are commissions and overrides disclosed? Can the employer replace an underperforming TPA, PBM, network, or point solution without leaving the captive? Are all performance guarantees measurable and enforceable?

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PLAN PERFORMANCE

Cost-Containment Strategies That Matter

PRIMARY CARE & ACCESS

Direct or advanced primary care, virtual care, and fast access can reduce avoidable downstream utilization.

PHARMACY STRATEGY

Transparent PBM contracting, specialty-drug management, rebates, formulary, and site-of-care controls.

HIGH-COST CARE

Centers of excellence, second opinions, oncology guidance, musculoskeletal care, and complex-case navigation.

SITE OF CARE

Steer imaging, infusion, surgery, and other services to high-quality, lower-cost settings.

NETWORK & CONTRACTING

Evaluate network discounts, direct contracts, reference-based pricing, and provider payment accuracy.

MEMBER ENGAGEMENT

Make programs easy to use, communicate clearly, and measure participation, savings, and outcomes.

NOTES & PLANNING

IMPLEMENTATION

A Practical 180-Day Captive Roadmap

1	**180-150 DAYS** **Define goals**	Leadership alignment, risk appetite, data collection, advisor roles.
2	**150-120 DAYS** **Model options**	Compare fully insured, standalone self-funded, and captive scenarios.
3	**120-90 DAYS** **Underwrite & diligence**	Review captive structure, stop-loss, collateral, fees, governance, and exits.
4	**90-60 DAYS** **Select partners**	Finalize TPA, PBM, network, stop-loss, captive manager, and contracts.
5	**60-30 DAYS** **Build & test**	Plan documents, eligibility feeds, banking, claim funding, communications, testing.
6	**30-0 DAYS** **Launch**	Employee education, enrollment, ID cards, support channels, escalation procedures.
7	**FIRST 90 DAYS** **Stabilize & measure**	Review claims, cash flow, member issues, vendor service, and early opportunities.

NOTES & PLANNING

DUE DILIGENCE

Questions to Ask Before Joining

ECONOMICS & COLLATERAL

- What is true expense versus claim funding or recoverable capital?
- How is collateral calculated, adjusted, and released?
- What is our expected and maximum three-year cash requirement?

GOVERNANCE & ALIGNMENT

- Who owns and controls the captive?
- How are surplus, deficits, voting rights, and conflicts handled?
- What standards must members meet to remain in good standing?

CONTRACTS & RISK

- What stop-loss contract basis, lasers, exclusions, and renewal protections apply?
- What happens if the plan document and stop-loss contract conflict?
- What liabilities survive termination?

DATA & OPERATIONS

- Will we receive complete, timely medical and pharmacy data?
- Can we independently audit claims and vendor performance?
- What reimbursement timing and cash-flow support are available?

VENDORS & EXIT

- Which vendors are mandatory and which can be replaced?
- Are all compensation, overrides, and referral arrangements disclosed?
- Can we leave the captive without losing access to our data or plan assets?

NOTES & PLANNING

DECISION PLANNING

Employer Decision Worksheet

Top 3 objectives

1. _____
2. _____
3. _____

Non-negotiables / deal breakers

1. _____
2. _____
3. _____

DECISION FACTOR	OPTION A	OPTION B	OPTION C
3-year economics			
Maximum exposure			
Collateral / exit			
Stop-loss terms			
Governance / control			
Vendor flexibility			
Data / reporting			

Next five actions

1. _____ Owner: _____
2. _____ Owner: _____
3. _____ Owner: _____
4. _____ Owner: _____
5. _____ Owner: _____

Key terms: TPA = third-party administrator | PBM = pharmacy benefit manager | Specific stop-loss = per-person protection | Aggregate stop-loss = plan-level protection