

**NATIONAL INSTITUTE FOR  
HEALTH CARE MANAGEMENT**

**"HEALTH PLAN SOLVENCY  
ISSUES UNDER HEALTH  
CARE REFORM"**

**WHITE PAPER ON REFORM ISSUES**

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**NATIONAL INSTITUTE FOR  
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**NIHCM**

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Table of Contents

Executive Summary.....i

Introduction.....1

Competitive Approaches to Health Care Reform.....3

Reform Elements That Threaten Solvency .....3

    Short-term pricing volatility .....3

    Premium caps and other pricing pressures.....5

    Untested entities managing care.....6

    Capital needed for new investment in systems infrastructure...7

    Mandated provider contracting requirements .....8

    Fee-for-service requirements .....9

    Continued Medicaid/Medicare underpayment and cost shift....10

Mechanisms To Limit/Prevent Financial/Insolvency Issues.....10

    Capitalization/reserve standards.....11

    Plan selection criteria.....11

    Risk adjusters .....12

    Linkage between premium limits and benefit costs.....13

    Reinsurance.....14

    Reasonable transition periods.....15

After The Fact Mechanisms To Deal With Insolvency.....15

Conclusion.....17

## EXECUTIVE SUMMARY

### Introduction

Health care reform based on vigorous competition among new and existing health plans will achieve many policymakers' objectives for reform. One risk that policymakers must consider as they design these competitive approaches is the potential for health plan insolvency: plans that fail to meet their financial obligations because they are unable to compete successfully. The risk of insolvency is especially great in the early years of implementation. Insolvency of health plans could strand consumers, leave providers without compensation, and further pressure limited health care budgets. In the long run, insolvency could be a financial and political threat to the viability of any reform scenario.

### Factors increasing the risk of insolvency

Trends in the marketplace and the complexity of the reform proposals themselves can contribute to the risk of health plan insolvency. Reform proposals typically include provisions to meet multiple and competing objectives. Some of those provisions, while meeting valid policy objectives in their own right, raise issues related to the ability of health plans to meet the financial demands of a competitive system. Such issues include:

- **Initial short-term pricing volatility** arising from expanded coverage of the uninsured with unknown health risk, the move from an employer choice to an individual choice model, and other factors that increase pricing uncertainty.
- **Artificial premium caps** that are not linked to benefit costs.
- **Untested new entities** such as provider-sponsored networks with little experience with managing comprehensive benefit packages within a constrained premium
- **The need for investment** in new infrastructures such as sophisticated computer systems to deliver high quality coordinated care.
- **Mandated provider contracting** provisions ("essential community" or "any willing" provider) that limit the ability of health plans to control the size, composition, and quality of their network of providers.
- **Support for fee-for-service** plans, mandated point of service products, and fee schedules, with limited ability to control costs.
- **Cost shifting** to other payors arising from underpayment by government programs.

## **Mechanisms to limit and prevent insolvency**

Insolvency is a traditional area for state insurance regulation, and options are available to proponents of reform to help assure the financial strength of health plans. These include:

- **Capitalization and reserve standards** and systems to monitor the financial health of plans.
- **Plan selection criteria** focusing on the ability to manage care and costs within a constrained premium to assure solvency without raising undue barriers to entry.
- **Risk adjusters**, though not yet developed, to address problems of risk selection.
- **Mechanisms linking premium limits to the real costs** of the benefits offered.
- **Reinsurance** for extremely high cost cases -- but avoiding incentives that reward plans for poor management practices.
- **Reasonable phasing periods** to allow for a transition to the new system.

## **Mechanisms to deal with insolvency when it occurs**

While preventing insolvency is the most important priority, a process for dealing with insolvency when it happens must exist. These include "hold harmless" clauses that protect policyholders, and guaranty funds, financed through contributions of plans, to cover losses once insolvency does occur.

## HEALTH PLAN SOLVENCY ISSUES UNDER HEALTH CARE REFORM

### INTRODUCTION

Proposals for health care reform have focused, at least in part, on establishing a stronger framework for competition among health plans providing or paying for benefits and services within a fixed premium amount.<sup>1</sup> The intended outcome is a market of lean but financially stable health benefit plans.

Nationwide implementation of such an approach on a rapid timetable is difficult. The structure of the health care marketplace varies throughout the United States, with markets much more developed in some areas than in others.

Further, the complexity and comprehensiveness of reform means that multiple and competing objectives of reform provisions may lead to conflicting results as they are implemented, making it more difficult for health plans to meet the demands of a competitive system. For example, provisions such as guaranteed access to fee-for-service plans, guaranteed contracting with certain providers, and/or regulatory limits on premiums reflect legitimate policy objectives to be considered in developing a health reform proposal. However, they could make it harder to implement a competitive framework successfully. To the extent that competitive pressures to lower prices are coupled with arbitrary premium caps and provisions that limit the ability of health plans to control costs, unsustainably financial consequences can result for health plans. The risks seem especially great in the initial years of reform.

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<sup>1</sup>President Clinton's plan, (S. 1757; H.R. 3600), Senator Chafee's plan (S. 1770) and Rep. Cooper's plan (H.R. 3222) all include variants of this type of framework. The single payer approach by Rep. McDermott and Sen. Wellstone (H.R. 1200; S. 491) does not envision such a competitive structure.

The financial viability or solvency of health plans<sup>2</sup> merits careful attention as policymakers consider the implications of implementing a reform plan. Under one implementation scenario, some health plans, especially smaller insurers, could opt to leave the health benefits market, or try to compete and later decide to leave the market. Such an outcome could be both programmatically and politically acceptable, and is seen by many as one of the objectives of reform.

However, under a different scenario, a number of plans could opt to compete in the market but fail to meet their financial obligations to pay claims. Insolvency of health plans --with subscribers scrambling to secure alternative coverage, unpaid providers, and cost shifting to others in the system -- could threaten the long-term political and financial viability of any reform plan.

Setting health plan financial standards to deal with the risk of insolvency is a traditional matter for state health insurance and health maintenance organization (HMO) regulation. State regulators establish reserve requirements, reinsurance rules, investment guidelines, rating requirements, and other rules to help assure the financial stability of health insurers and their ability to meet their claims obligations, and to deal with insolvency when required. Different requirements are usually applied to different products and forms of coverage (for example, insurance versus HMO coverage). Health reform scenarios generally envision a continuation of such a regulatory structure, with stronger federal standards in some areas.

This Issue Brief provides an overview of the solvency-related issues that should be reviewed and addressed as health plans, providers, self-insured employers (and so-called "corporate" alliances), and state and federal policymakers design and implement reform.

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<sup>2</sup>The term solvency in this report is used in a broad way to refer to the ability of a health plan to meet its financial obligations and pay for the benefits it has contracted to provide over the long term.

## **COMPETITIVE APPROACHES TO HEALTH CARE REFORM**

The competitive approach to health reform is designed to create a system in which consumers choose from among health plans that compete on the basis of price, quality, and service. Such proposals typically include a number of important elements such as a defined standard benefit package, standardization of insurance rating requirements, level employer contribution requirements and tax policy changes. Consumers choose among health plans offering the standard benefits, and face the out-of-pocket financial consequences of their choice: the individual who chooses a higher priced plan must pay more.

Reform proposals also typically include provisions such as insurance reforms and risk adjustment to minimize risk selection, and mechanisms to limit administrative costs. These mechanisms are designed to help health plans achieve greater predictability and limit costs within such a competitive model.

Although reform proposals typically include provisions that address problems of financial solvency, other elements of the reform plans could exacerbate concerns about the financial ability of health plans to meet their obligations in a reformed environment.

## **REFORM ELEMENTS THAT THREATEN SOLVENCY**

### **Short-term pricing volatility**

Short-term health plan pricing uncertainty is likely in the initial implementation of reform. Health plans that today set premiums based on their historical risk face the volatility of a shifting population and risk base, which can arise from a number of elements of reform.

First, competitive health reform proposals rely on different approaches to individual vs. employer choice and the use of purchasing cooperatives or alliances for the purchase of health benefits. The Clinton plan would require most of the market (all families of employees in firms of fewer than 5,000 employees) to join regional alliances which would allow individual choice of the full range of health plans offered by the alliance at a community rate. The Cooper plan mandates such alliances for firms up to size 100, and the Chafee plan would allow for potentially voluntary or competing alliances.

Quick movement from an employer choice to an individual choice model will likely pose increasing uncertainty and risk to health plans, especially in the first year. The issue for health plans is where to set the initial premium. What risk category of enrollees can they expect? How many? How does the health plan's current experience and enrollee base (under a model driven in part by employer choice of health plans) compare with their potential new enrollees?

A second factor that may affect pricing volatility is expanded coverage of the un- and under-insured -- one of the most important objectives of reform. How should health plans set premiums for these new populations, and for benefits more comprehensive than those now available to many? What can be expected in the form of increased use by the previously un- and under-insured, especially in their first year of coverage?

Finally, changes in the health plans and types of financing pose short-term uncertainty for health plan pricing decisions. New health plan entrants to the market, and exits from the market, result in potential restructuring of the risk pools -- with the constant risk of positive or negative selection. Financing changes such as a mandatory shift from self-insurance to premium-based coverage for many employers, such as that envisioned in the President's plan for all employers of fewer

than 5,000 employees, raise technical questions about how to estimate the cost of the "tail" of coverage under one product<sup>3</sup> while moving to another.

Competitive health reform proposals include the use of a "risk adjuster" to address much of the uncertainty over the type of population a health plan might attract. These risk adjusters are discussed later in this report. The theory is that a health plan would set its premium based on its estimate of the risk and cost of an "average" population. Payments to the plan would be prospectively "risk adjusted" based on the risk characteristics of its enrollees, compared with the average risk status of the entire population.

Such a mechanism is designed to protect plans and payers from the uncertainties of risk selection. However, it poses new uncertainties, not the least of which is that the risk adjustment methodology has not yet been specified, and risk adjustment mechanisms are currently considered primitive.<sup>4</sup>

### **Premium caps and other pricing pressures**

The potential difficulties faced by health plans under reform are highlighted by a central objective of reform: to lower the rate of increase in health spending -- which means a lower rate of increase in health plan revenues.

One source of that pressure arises from the pressure to constrain premiums in a restructured market -- one of the presumed outcomes of the competitive model. It is useful to ask what happens if the Chafee, Cooper, or President's plan work: what if they do result in more competition that lowers the rate of increase in premiums? Meeting that objective by definition lowers health plans' per capita

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<sup>3</sup>The "tail" of coverage is the cost of services used and claims incurred before the expiration of the contract, but not yet reported to the plan administrator. These obligations remain to be paid during a shift to a new product, and their cost must be estimated.

<sup>4</sup>Newhouse, Joseph P., "Patients at Risk: Health Reform and Risk Adjustment," Health Affairs, Spring, 1994.

revenue, which pose increased risk for the finances of health plans, especially in light of the short-term uncertainties and costs associated with reform. Further, there is a risk that some health plans submit "low ball" bids for business, requiring some administrative mechanism to deal with such bids.

This pressure is exacerbated by reform proposals that would impose a premium cap. In the Clinton plan, the pressures arising from a more competitive market are coupled with a regulatory limit on the average premium in each area. The rate of increase in premiums would be limited to levels far below the average historical increases.

Price caps are an artificial limit on premiums unrelated to market demand and the cost of serving enrollees - as such, they pose the greatest risk for health plan financial viability. Setting the premium limit will be difficult, especially in the first years. The mechanisms do not yet exist to accurately take into account factors such as changing demographics, geographic differences in health care costs, changing technology, service use and patient demand. Caps may be set unreasonably high in some areas and low in others; if set too low, health plans may not be able to control their costs within the artificially constrained premium level.

#### **Untested entities managing care**

One presumption under competitive health reform proposals is that new types of prepaid health plans might form. Most notably, provider-based plans would form networks and offer themselves as capitated health systems, much like today's health maintenance organizations (HMOs).

However, these new entities are typically not experienced at understanding risk and managing the cost of a comprehensive benefit package within a fixed premium. Organizations must have the capacity to understand insurance risk

and set accurate premium levels. Further, they must have the capacity to manage within the incentives of a prepaid premium: the capital, management, providers, data collection and reporting systems that allow them to control costs within the limits of the premium dollars while meeting the health care needs of their enrollees. Some of these new entities will undoubtedly succeed, but others will not have the human resources and management systems capacity to operate successfully within this new environment, and will be at great financial risk, especially in the early years.

#### **Capital needed for new investment in systems infrastructure**

Existing and developing health plans must make significant investments to adapt to changes in the health care environment. One estimate, for example, places the need for new capital at \$34 billion.<sup>5</sup> Investments will have to be made in the infrastructure of information systems to support the quality initiatives, integrated provider networks, and management, as well as in facilities and equipment in some cases. This new spending is required at the same time that price pressures in the reform plans, backed up by potential caps on premiums, may lower the rate of increase in health plan revenues -- again posing risks to the finances of health plans. And, the uncertainties of health plans' financial performance in the evolving marketplace may make it more difficult and expensive for health plans to raise the required capital in either the equity or debt markets.

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<sup>5</sup>Conning & Company. The Conning Commentary, January, 1994, p. 4.

### **Mandated provider contracting requirements**

Health reform proposals built on the competitive model do not typically dictate providers with whom a health plan must contract.

The President's plan, however, includes requirements that plans contract with and make special payments to certain "essential community" providers, such as community and migrant health centers and other providers designated by the Secretary of Health and Human Services, for an initial five year period. In addition, the proposal requires health plans to contract with academic health centers for certain specialty services. Requirements for contracting with "essential community" providers were also included in the reform plan approved by the House Ways and Means Committee's Subcommittee on Health, but with a greatly expanded list of "essential" providers, including many hospitals as well as all local health departments.

These provisions are one approach to dealing with valid policy concerns: to assure access to care for the newly insured, especially in underserved areas, and to provide some degree of financial stability for important community health organizations during the transition to a more competitive system. However, they could make health plan contracting and financial management more difficult and costly at a time when plans must manage their provider panels and payments in order to control costs and quality within a constrained premium.

From the perspective of health plans, the "essential community" provider provisions are one example of the even more troubling "any willing" provider provisions: provider groups seeking to be included as mandatory participants in benefit plans under "any willing" provider legislation (requirements that a health plan accept in their panel of providers any provider willing to meet its rules). Any willing provider provisions run counter to the core requirements of a system built

on competing managed care plans. Such provisions, if enacted, could further undermine the ability of health plans to manage their costs and quality within a constrained premium.

### **Fee-for-service requirements**

Health care reform proposals typically establish a standardized structure of benefit design. The Clinton plan, for example, prescribes certain health plan options that must be made available: 1) all consumers must be offered at least one fee-for-service plan, and 2) all other plans must offer a "point of service" (POS) option. POS plans provide services to enrollees through their own contracted provider system, but also offer enrollees the option to receive covered services from any other provider on a fee-for-service basis, with higher coinsurance by the enrollee.

The financial viability of the fee-for-service plan is potentially problematic if premium competition intensifies. These plans have limited mechanisms to control their costs, especially if they are precluded from increasing patient cost-sharing requirements.

The President's proposal attempts to address this problem, at least in part, by requiring the regional alliance to negotiate with the provider community to set a provider fee schedule for the fee-for-service plan. However, a regulatory fee schedule in the midst of a system designed to foster competition raises serious questions. One issue is whether any regulatory price controls will work over the long term. Second, if a fee schedule does limit spending in the fee-for-service plan in the short term, it could allow that plan's premium to be "artificially" competitive, and lessen the pressure for health system restructuring that is one of the underlying objectives of the competitive approach to health reform. Finally, a fee schedule arising from provider negotiations with the alliance (with the

providers negotiating with new anti-trust protection) could also set a payment standard that will make it more difficult for private health plans to organize and negotiate with providers.

### **Continued Medicaid/Medicare underpayment and cost shift**

Under health care reform, the federal and state governments continue to have a role in financing care for low income persons and Medicare beneficiaries.. The government as a payer will likely continue its current practice of paying less than adequate rates, imposing cost pressures on all other payers and on health plans.

Most reform proposals would finance some of the federal costs of reform through reductions in Medicare payments to providers, which shifts costs to other payers and health plans. Medicaid is also likely to continue to underpay. The Clinton plan, for example, pays for welfare cash assistance recipients at a level of 95 percent of the existing State Medicaid program payments -- payments that are already below current market levels in many states. These underpayments are financed through indirect subsidies from all other payers -- a cost shift that maintains financial pressure on the system.

### **MECHANISMS TO LIMIT/PREVENT FINANCIAL/INSOLVENCY ISSUES**

State insurance regulation and provisions in many of the health care reform proposals include mechanisms designed to regulate the system in a manner that limits the risk for health plan solvency. It is important to note, however, that states

vary in their capacity to implement further regulatory refinements, and a federal structure would likely have to be developed as well. Time must be taken to develop and implement any of the required administrative mechanisms at the federal and state levels.

### **Capitalization/reserve standards**

One approach to the problems of health plan insolvency involves setting initial capitalization, reserve, and solvency standards. The various health reform plans include elements of such provisions. For example, the Clinton plan requires that the National Health Board set minimum capital requirements that states must use in regulating health plans, including a minimum requirement of \$500,000 in capital for each regional alliance health plan. And it allows for additional requirements based on factors that could affect the financial stability of the health plan. The bill requires states to establish capital standards meeting at least these minimum requirements, as well as reporting and monitoring systems to monitor compliance. The issue is assuring that the standards are adequate to the need. Stringent capitalization and reserve standards are clearly a mechanism to limit the risk of solvency, and careful attention must be devoted to setting the appropriate levels.

### **Plan selection criteria**

Setting qualification criteria for health plans is another approach. Specifically, health reform proposals could set standards requiring plans to have the management capacity to successfully control costs within the constrained premiums. Federal Medicare law, for example, requires that participating Medicare plans meet standards under the federal HMO act, or comparable requirements.

The competitive health reform plans, however, do not typically include stringent requirements for health plans. The Clinton plan, for example, includes health plan requirements relating to benefits, rating, and provider arrangements. And it requires disclosure of utilization management protocols -- but it sets no standard for such management systems. The Cooper and Chafee bills provide no further specificity. The "single payer" approaches typically include more stringent standards for health plans operating on an a prepaid, at risk basis, incorporating standards similar to the existing Medicare standards for capitated health plans.

As with other areas of policy, conflicting objectives must be reconciled in dealing with approaches such as solvency standards and plan management criteria. On the one hand, it is important to set some standards to assure that plans have the financial and management capacity to succeed. On the other hand, it is important not to create substantial barriers to entry, or to restrain by regulation the appropriate management of health plans and evolution of the health care system.

### **Risk adjusters**

As noted earlier, the proposals for a more competitive health system include a "risk adjuster" in an effort to assure that payments to health plans reflect the risk characteristics of their enrollees. These risk adjusters can be viewed as a mechanism to address some of the problems of adverse selection which could lead to financial and solvency problems. However, while the risk adjuster is presumed to address the selection issue, the adjusters are not yet developed and the presence of the risk adjuster itself may lead to some uncertainty in the bidding process. Further, some fear that government will use "risk adjusters" as a mechanism to redistribute funds among health plans to achieve other purposes, such as implicitly financing government payment shortfalls. Finally, if adjusters are retrospective and not

prospective, they may also actually discourage better cost management by plans, since shortfalls can be made up after-the-fact.

### **Linkage between premium limits and benefit costs**

There is a possibility that premium caps will be included in a reform plan despite the underlying problems noted earlier. In that case, some mechanisms must deal with the risk that those caps will be set at levels that are insensitive to the real cost of providing services and meeting patient needs and expectations. Currently, in the Clinton plan, if the average regional alliance premium submitted by health plans exceeds the premium target, the key provision to remedy the problem is a federal assessment on the higher priced plans. This will bring the alliance average premium down to the premium target. The high priced plans subject to the assessment can respond to this constraint on their revenue by making comparable percentage reductions in their payments to providers.

It would be useful for policymakers to consider other mechanisms as well. For example, if there is a regulatory premium cap, the National Health Board or some independent body could be required to assess situations in which the market premiums exceed the target, and develop recommendations to address the problem. They could take a number of actions:

- confirm that the target accurately reflects the costs of the benefit package in that community;
- recommend lower provider payments or tighter utilization controls in the health plans;

- agree that the cap is too tight and either:
  - raise the target; or
  - reduce the required benefit package through increased cost sharing or reduced benefit levels.

### Reinsurance

Health plans, especially smaller or newer plans, can transfer some of the risk to which they are exposed through the purchase of reinsurance. They may purchase such reinsurance for certain high cost claims: the reinsurance protects them from the immediate financial consequences of an unusual number of the very high cost cases that can threaten financial viability and solvency, especially among smaller health plans.

Health reform plans either implicitly or explicitly assume that this reinsurance market will continue. The Cooper bill would require the Secretary of Health and Human Services to monitor the market and report to Congress on the availability of reinsurance and the impact of such reinsurance on the establishment of new plans and the solvency of existing plans.

The Clinton bill includes a mandatory reinsurance fund managed by the regional alliance, and financed by all payers. This reinsurance would be coupled with risk adjusters to protect plans from adverse risk selection. The bill also recognizes the difficulties of moving to immediate implementation of risk adjustment by noting that the reinsurance pool may be the dominant means to deal with the risk adjustment problem in the near term.

Reinsurance can mitigate against and spread the financial consequences of exceptionally high cost cases among all health plans. The problem, however, is that it is difficult to differentiate between high costs resulting from situations outside a

health plan's control, and high costs arising from the failure to provide good cost management and quality care. In the absence of such a distinction, mandatory reinsurance means that plans that fail to manage high cost cases, or fail to provide the quality care that avoids high cost follow-up, are subsidized to some extent for the consequences of their failure by the enrollees of plans that are doing a better job.

### **Reasonable transition periods**

One final approach to dealing with the risks of implementation is to provide for reasonable transition and phasing periods. Some of the short-term pricing volatility can be lessened by allowing transition and phasing periods between the current approaches and whatever reform scenario that policymakers choose.

### **AFTER THE FACT MECHANISMS TO DEAL WITH INSOLVENCY**

A final mechanism deals not with preventing insolvency, but with the consequences of insolvency. What happens when a plan fails to meet its financial obligations, and specifically, who pays? The Clinton bill requires states to establish a health plan guaranty fund as a mechanism to deal with this problem. The fund would provide the revenue to cover any outstanding claims against the failed plan; the fund is financed by assessments on all payers in the state. The bill also sets up new mechanisms to deal with the insolvency of the "corporate alliance" health plans, under which the Secretary of Labor would be appointed as trustee to administer the plan. Benefits would be guaranteed under these trusteeships, with financing from assessments on all corporate alliance health plans.

Such funds provide a definition of how to finance the insolvency situations that arise -- and, if adequately funded, protect the government from being the implicit payer of last resort. Again, however, it means that the health plans that fail

to manage themselves in a manner that allows them to meet their obligations are subsidized by other plans -- and by all premium payers.

Another approach often taken by state regulators requires the managed care plans include contract provisions with providers that put the risk of insolvency on the provider. If a plan becomes insolvent, the provider must "hold harmless" the policy holder -- that is, not seek reimbursement from a patient. This approach uses contract principles to assure recourse for stranded consumers.

## CONCLUSION

Existing and new health plans face insolvency when they are unable to compete successfully in a reformed health care marketplace. This poses risks for consumers and providers, and is a financial and political threat to the long-term viability of any reform scenario.

Successful implementation of reform requires attention to this risk, by achieving a balance among competing objectives of reform, and by including provisions that address the risks of insolvency.

First, policymakers should pay careful attention to provisions in reform plans that exacerbate the risk: these include the problems of short-term pricing volatility; premium caps; new, untested entities entering the health plan market; capital requirements; and mandated provider contracting requirements that increase health plan costs.

In addition, policymakers should consider mechanisms which directly address the problems of health plan insolvency. These include measures such as:

- strict capitalization and reserve standards;
- health plan standards focusing on the ability to manage care and costs within a constrained premium;
- adequate risk adjusters;
- mechanisms to link premium limits with the costs of the benefits offered;
- reinsurance;
- reasonable transition periods;

- "hold harmless" clauses; and
- guaranty funds to deal with insolvency when it does occur.

Policy makers must understand potential affects of reform bill provisions on the solvency of health plans and help prevent weak plans from leaving policy holders stranded. Competition among stable, well managed health plans is the best solution to health care costs increases and access to services for all.