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# WHERE THE ACTION IS: INNOVATIVE STATE HEALTH CARE INITIATIVES

By Nalini K. Pande\*

## I. Introduction

One of the major issues highlighted at the February 2007 Symposium on Innovative State Health Care Initiatives is recent state initiatives to increase access to health care and contain costs through managed care. Recently, Pennsylvania has capped the surplus of non-profit health plans to improve access to health care and contain costs; however, there are unintended consequences of such actions and alternative policy options exist. The Lewin Group, a health care policy research and management consulting firm, analyzed the capping of non-profit health plans' surplus by the Pennsylvania Insurance Department (PID). This article is a summary of that report.

Pennsylvania House Resolution 865 of 2004 directed the Legislative Budget and Finance Committee to examine the Commonwealth's options with respect to the regulation, oversight, and disposition of the reserves and surpluses of health insurers in Pennsylvania, specifically Blue Cross and Blue Shield plans. The resolution directed the Committee to analyze pertinent statutes, regulations, and other measures in effect that regulate such surpluses with particular attention paid to other states' laws and practices. It also requested the Committee to focus on potential alternatives with respect to the use of any excess capital surpluses to reduce premiums or to delay or moderate premium increases. The Committee then issued a competitive request for proposals for assistance in fulfilling the charge and awarded a contract to The Lewin Group.

## II. Background

Pennsylvania has four not-for-profit Blue Cross and Blue Shield health plans (Pennsylvania Blue plans): (1) Blue Cross of Northeastern Pennsylvania, based in Wilkes-Barre; (2) Capital Blue Cross, based in Harrisburg; (3) Highmark, headquartered in Pittsburgh; and (4) Independence Blue Cross, based in Philadelphia. Prior to the Lewin study, the public focus on the Pennsylvania Blue plans' financial activities had intensified. First, the Pennsylvania Blue plans, like health insurers nationwide, began to experience large increases in their earnings. Second, the softening of the economy at the same time that health care costs swelled increased the number of uninsured residents in Pennsylvania and made it more difficult for those with

insurance to afford it. Some stakeholders argued that the Pennsylvania Blue plans should contribute portions of their surpluses to help make health coverage more affordable. In February 2005, the PID took action to address these issues.

## II. Key Questions

The Lewin Group report<sup>1</sup> examined several key questions:

- Why do health plans need surplus?
- Is there a "right" amount of surplus for health plans?
- How are plan surpluses generally regulated and what has been the experience with the Pennsylvania Blue plans?
- What are the consequences of capping surplus and what are the alternatives to doing so?
- How have other states approached the issue?

First, why do health plans need a surplus? Most insurers contend, similar to the Pennsylvania Blue plans, that an insurer needs an adequate margin of safety to endure periods of adverse experience without triggering any form of regulatory intervention. Also, many health plans target surplus levels to cushion against a downturn in the underwriting cycle.<sup>2</sup>

Second, is there a "right" amount of plan surplus? Or, in other words, how much surplus is too much? An adequate margin of safety is especially important for Pennsylvania Blue plans because they are not eligible to participate in the state guaranty fund which protects consumers and health care providers if an insurer fails to meet its obligations. Lacking access to this safety net, Pennsylvania Blue plans must maintain larger surpluses to account for unforeseen risks.

Third, how are plan surpluses generally regulated and what has been the experience with the Pennsylvania Blue plans? In the past, the PID, like its counterparts in other states, focused on making sure that the Pennsylvania Blue plans held sufficient, *minimum* reserves and surpluses to ensure against insolvency. Pennsylvania joined most other states in enacting a variation of the National Association of Insurance Commissioners model health risk-based capital act, which addressed the minimums needed to ensure solvency.

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In addition to regulating surplus minimums, the PID also has statutory authority to govern Pennsylvania Blue plans' social missions, though at least one Pennsylvania Blue plan does not agree with the Department's view of the charitable obligations of the Pennsylvania Blue plans.<sup>3</sup> States have varied widely in their interpretations of "charitable and benevolent," a phrase within many not-for-profit Blue plans' enabling legislation. Whereas in Pennsylvania, the Pennsylvania Blues plans have traditionally served as insurers of last resort, in some states, the Pennsylvania Blues plans have operated like commercial insurers and generally have not been expected to provide significant levels of community benefit. In fact, the precise nature of the community benefit requirements stemming from this language has been a subject of much litigation.<sup>4</sup>

Prior to 2005, a combination of statutory expectations and company missions drove the Pennsylvania Blue plans' community benefit activities. For example, recent laws forced the Pennsylvania Blues plans to bid to participate in the Commonwealth's Children's Health Insurance Program (CHIP) and adultBasic programs,<sup>5</sup> in addition to offering coverage to individuals who meet specific criteria set out by the federal Health Insurance Portability and Accountability Act (HIPAA). Nationwide, only Pennsylvania and Michigan implemented HIPAA's requirements by designating their Blue Cross and Blue Shield plans as the sole carriers to offer coverage which must be offered regardless of health status or pre-existing conditions. In 2003, the Pennsylvania Blues plans also voluntarily committed to participate in the federal Health Coverage Tax Credit (HCTC) program created under the Trade Assistance Act.

Additionally, the Pennsylvania Blues plans' role as insurer of last resort has led the plans to offer subsidized coverage to any individual regardless of health status, even if the individual is not eligible under HIPAA (this is termed "guarantee issue coverage"). In contrast, insurers in most other states may decline to issue policies to individuals with serious health conditions, or may charge extremely high rates. Thus, Pennsylvania Blues plans—given Pennsylvania's statutory requirements in adultBasic, CHIP, HIPAA, as well as the Pennsylvania Blues plans' voluntary commitment to HCTC, subsidized guarantee issue coverage in the individual market, and direct charitable giving programs—are allocating percentage amounts of community benefit funding that are at least as generous as, if not more generous than, the amounts allocated by their counterparts elsewhere.

What has the PID done to regulate the Pennsylvania Blue plans' surpluses?

In 2004, the PID asked the Pennsylvania Blues plans to justify their surpluses and explain how the plans contribute to their communities. In February 2005, the PID released two key documents. The first document, a Determination and Order, outlined acceptable ranges for the Blue plans' level of surplus capital—efficient, sufficient, or inefficient. This document reported that none of the plans held excess capital and declared that any Blue plan having "sufficient" capital—three of the four plans stood in this category (at the time)—would not be allowed to include "risk and contingency factors" in its future rate requests.<sup>6</sup> Risk and contingency factors are margins that insurers build into rates to cover unforeseen events and fluctuations in medical claims. In the past, the PID has permitted up to a 5 percent risk and contingency factor in addition to projected medical claims and administrative costs for Blue plans and a factor of 5 percent or more for commercial insurers. The second issuance, "Agreement on Community Health Reinvestment,"<sup>7</sup> was executed by the Deputy Insurance Commissioner and the heads of the four Pennsylvania Blue plans and set forth a program in which the Blues plans, for the years 2005-2010, pledged more than one percent of their premium revenues to community benefits. The aggregate value of the pledges would total \$950 million, although not all of the funding was new. Notably, the agreement supplanted an order that had been in place since 1996 for Highmark, the largest of the plans and likely source for more than half of future community health reinvestment dollars.

When the consolidation of two predecessor entities formed Highmark in 1996, the Insurance Commissioner ordered Highmark, and Highmark alone, to allocate at least 1.25 percent of direct written premium to social mission programs. That order had no end date and as of 2004, Highmark spent about \$40-\$50 million annually on community benefits. Highmark projected 2004 outlays of \$94 million—about double its formal obligation under the 1996 order.

With the PID taking these two major steps to regulate Pennsylvania Blue plan surpluses, one should consider the consequences of regulating plan

In fact, the precise nature of the community benefit requirements stemming from this language has been a subject of much litigation.



surpluses. Rigid caps on surpluses could undermine competition if not managed prudently. The primary advantage of capping surplus levels is that it may slow the rate of premium growth if an insurer has surplus capital that is at or near its ceiling. However, an insurer may react by draining surplus in ways that do not involve rate relief, such as simply spending more on staff and infrastructure improvements. Also, the plan could create additional community benefit outlays, though this could conflict with an insurer's interest in building market share and improving performance.

In addition to uncertain benefits, negative consequences may also result from placing a numeric cap on insurers' surpluses, particularly if set at a low level. First, the intervention could create market instability if it resulted in artificially low premiums. Depending on the scale of the impact on premium rates, some competitors might be forced to exit the market, leaving consumers fewer choices. Second, the short-term savings could be followed later by pricing increases. Lastly, when insurers have less capital, insurers face lower credit ratings from independent rating agencies, forcing the plans to pay higher interest costs whenever they need to borrow.

Given these consequences, what are the alternatives to capping surplus? Traditionally, state insurance departments have attempted to influence premium levels in a number of ways: underwriting and rate-making rules, especially in the small-group and non-group segments; rate filing and approval processes; and setting minimum medical loss ratios. These regulations focus on insurers' abilities to generate earnings, rather than on how much surplus can be kept once earned. Because these approaches affect the rate-making process, they have a more direct and predictable impact on premium affordability compared to capping surplus levels. However, any type of rate regulation must consider carrier solvency and the importance of regulating carriers on a level playing field. Further, any type of regulation

that interferes excessively with traditional market forces and market pricing can have the unintended consequence of forcing carriers out of the market.

An important component of The Lewin Group report was to review other states' approaches in response to these issues. Very few states have chosen to regulate

the upper bounds of surplus capital accumulation. Until June 2006, Hawaii capped surplus at the level at which a non-profit carrier's net worth exceeded 50 percent of its annual health care expenditures and operating expenditures as reported on the plan's most recent financial statement filed with the Commissioner.<sup>8</sup> Alternatively, Michigan caps its risk based capital ratio (RBC) at 1,000 percent for Blue Cross Blue Shield of Michigan.<sup>9</sup> In comparison, Pennsylvania uses different RBC target ranges for its four Blue plans (550 percent to 750 percent for its larger plans, Highmark and Independence Blue Cross; and 750 percent to 950 percent for its smaller plans, Blue Cross of Northeastern Pennsylvania and Capital Blue Cross).

Some states have worked with large non-profit carriers to direct high surpluses toward community benefit health care initiatives. As discussed, in Pennsylvania, the state formalized the prospective "community activities" of its four Blues plans and the plans voluntarily agreed to commit \$150 million annually to a six-year community health reinvestment program. Until the creation of the Community Health Reinvestment Agreement in February 2005, only one other state, Maryland, had a formal requirement for community benefit outlays that applied exclusively to a Blue plan. Since then, Massachusetts has created formal community-benefit guidelines for non-profit HMOs in the state. This program included \$85 million to support basic health coverage for low-income and uninsured residents with the remaining \$65 million for other health care related community activities.<sup>10</sup>

Most recently, CareFirst announced a \$92 million initiative intended to address community benefits with \$60 million from a reduction in premiums against anticipated 2005 levels. This was in response to increased public scrutiny, especially by the Appleseed Foundation and hearings by the D.C. Insurance Commissioner on CareFirst BlueCross Blue Shield's D.C. affiliate, Group Hospitalization and Medical Services, Inc.'s (GHMSI) charitable obligation to the community.<sup>11</sup> It is important to note that the unintended consequence of imposing community benefit requirements on non-profit carriers is that such requirements serve as an indirect tax on carrier members who subsidize their community-benefit initiatives with their premiums. Some members prefer reduced premiums instead of using premium profits for these initiatives that serve the community as a whole.

## Conclusion

There are a myriad of ways to regulate surpluses in order to increase access to health care—each with its own intended and unintended consequences. Focusing on increased transparency can improve competition and efficiency, and stronger regulatory authority and oversight can provide a first step in addressing concerns of surplus accumulation. Targeting appropriate surplus levels is critical for managing financial risk. It is even more important for non-profit organizations which do not have access to equity markets and must fund investments in new products and infrastructure out of operating results' surplus or debt instruments. Surplus levels, which are held too low, may expose the organization to risk of failure during predictable periods of downturns in the underwriting cycle. They also limit the organization's ability to respond to changes in business conditions and demands for new products. But surplus levels that are too high may affect product affordability and could subject organizations to unwanted regulatory scrutiny. Since most states do not impose maximum surplus levels, it is incumbent on state insurance departments to review these issues in light of the circumstances and the critical considerations outlined above to increase access to health care and contain costs.

1 See THE LEWIN GROUP, CONSIDERATIONS FOR REGULATING SURPLUS ACCUMULATION AND COMMUNITY BENEFIT ACTIVITIES OF PENNSYLVANIA'S BLUE CROSS AND BLUE SHIELD PLANS (June 13, 2005), available at <http://www.lewin.com/NR/rdonlyres/E38A1263-0410-4E37-A300-4A1A4AC4EF3B/0/3192.pdf> (last visited Oct. 21, 2007). The Pennsylvania Legislative Budget and Finance Committee commissioned Lewin to conduct a study of the regulation and disposition of reserves and surpluses of the four Blue plans. Lewin found that the upper limits on surplus were reasonable.

2 See How Much Is Enough? Capital and Surplus Management for Health Entities, Society of Actuaries, <http://library.soa.org/library-pdf/rsa03v29n220pd.pdf>.

3 See Letter from Steven B. Davis, Chief Counsel, Office of Chief Counsel,

Penn. Insur. Dept. to Senator Gibson E. Armstrong, Chairman, Banking and Insurance Committee, Senate of Pennsylvania, regarding April 12, 2005 Hearing on the Pennsylvania Blue plans' Agreement on Community Health Reinvestment (April 27, 2005) (available as Appendix E in <http://www.lewin.com/NR/rdonlyres/E38A1263-0410-4E37-A300-4A1A4AC4EF3B/0/3192.pdf>) (stating that PID has traditionally interpreted the Pennsylvania Blue plans' enabling legislation to require that the Pennsylvania Blue plans act as insurers of last resort, and thus, the plans must offer open enrollment).

4 See Jane M. Von Bergen, *Pennsylvania Blue Plans Again Face Suit over Surplus*, THE PHILA. INQUIRER, Nov. 30, 2006 at A1. The Pennsylvania Supreme Court recently revived a lawsuit filed five years ago by the owner of a Bensalem, Pennsylvania appliance store, who wants Independence Blue Cross to return part of the surplus to insurance buyers. On Nov. 22, 2006 the Pennsylvania Supreme Court reversed a December 2002 Commonwealth Court decision dismissing the case. The class-action lawsuit will now go back to the lower courts along with three similar ones, each against one of the state's four Blue Cross and Blue Shield health plans. The cases have yet to address whether the surpluses are excessive and who has authority to determine whether the Pennsylvania Blue plans breached their obligations as nonprofits by holding too much surplus and not using such surplus to lower premiums or help the uninsured. Both the Pennsylvania Blue plans and the Insurance Department in Pennsylvania argue that the size of the surplus is a regulatory matter for the state Insurance Department.

5 See 35 PA. CONS. STAT. ANN. § 5701.1303(g) (2001); STAN DORN & JACK MEYER, PENNSYLVANIA: A CASE STUDY IN CHILDLESS ADULT COVERAGE STATE REPORT (Economic and Social Research Institute 2004).

6 See Insurance Department of the Commonwealth of Pennsylvania, Determination and Order, February 9, 2005.

7 Agreement on Community Health Reinvestment between Insurance Department of the Commonwealth of Pennsylvania and Capital Blue Cross, Highmark Inc, Independence Blue Cross, and Hospital Service Association of Northeastern Pennsylvania, Blue Cross of Northeastern Pennsylvania, Appendix D at 13 (Feb. 2, 2005), available at <http://www.lewin.com/NR/rdonlyres/E38A1263-0410-4E37-A300-4A1A4AC4EF3B/0/3192.pdf> (stating the Agreement specifically requires that the "Annual Community Health Reinvestment for each Plan shall be expended, distributed or utilized in the respective area of that Plan and solely for Permitted Community Health Reinvestment Endeavors. Sixty percent of the Annual Community Health Reinvestment for each calendar year . . . shall be dedicated to providing health insurance through state-approved programs for persons of low-income, including but not limited to adultBasic . . .").

8 See Haw. Rev. Stat. §§ 431:14F-101, 431:14F-106(a) (2006) (repealed 2006); See also Telephone interview with Lim Lloyd, Administrator of Health Insurance Branch, Insurance Division, Hawaii Department of Commerce and Consumer Affairs (Nov. 2, 2006).

9 See Mich. Comp. Laws Ann. ch. 550, §1204 (2003).

10 See Health Insurance Premiums, the Underwriting Cycle, and Carrier Surpluses, Spotlight on Md. (Md. Health Care Commission, Balt. Md.) (Mar. 2005).

11 See Press Release, CareFirst Blue Cross Blue Shield, CareFirst Affiliate, GHMSI, Pledges to Improve Affordability of Insurance, Expand Charitable and Community Investments (Mar. 24, 2005), available at [http://www.carefirst.com/media/NewsReleasesDetails/NewsReleasesDetails\\_20050324.html](http://www.carefirst.com/media/NewsReleasesDetails/NewsReleasesDetails_20050324.html) (last visited Oct. 21, 2007).