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Study of Capital Reserve Limits in Minnesota

Introduction

As directed by the Minnesota Legislature, MDH in consultation with the Minnesota Departments of Commerce and Human Services, and with assistance from a team of actuarial consultants, researched a set of questions concerning the implementation of upper thresholds for capital reserves for Minnesota HMOs. In conducting the study, MDH consulted with HMOs, other stakeholders, and consumers, as well as gathering perspectives from other states' regulators. The study presents considerations for the Legislature related to setting limits on reserves, discusses pros and cons of alternative approaches, and communicates a range of policy options.

Key points from the financial analysis include the following:

- In 2012, non-profit health plans, including HMOs and Blue Cross Blue Shield of Minnesota (BCBSMN), accounted for $9.825 billion or 75.6 percent of total health insurance premium revenue in Minnesota.
- HMOs held a combined volume of $1.785 billion in capital reserves in 2012, covering between 1.9 and 4.3 months of expenses. Insurance companies and Blue Cross Blue Shield of Minnesota held an additional $1.262 billion in capital reserves, and County-Based Purchasers an additional $64 million.
- Capital reserves in Minnesota have generally been growing over time.
- Roughly 25 percent of 2012 HMO capital reserves are estimated to have come from underwriting gains on Minnesota public insurance programs, and additional volume is attributable to investment gains associated with public program business.
- There are a range of policy considerations that appear to favor the establishment of an upper limit on capital reserves for Minnesota HMOs and/or insurers, but also a range of factors that do not support the establishment of a cap. Chief among these considerations are:
  - Accumulating a substantial volume of resources that were initially intended for health care access in health plan capital reserves may not represent an efficient use of tax-payer funded resources.
  - Minnesota's health plan market, like that of many other states, faces substantial uncertainties with state and federal health reform implementations. That, together with efforts underway to develop a set of expanded solvency criteria, may suggest it is prudent to wait for changes to "settle in."
- If it chooses to establish limits on capital reserves, the Legislature will need to carefully consider a range of questions in order to minimize the potential for unintended consequences, including the following:
  - Whether limits should apply only to HMOs or also to insurers;

- How capital reserve levels are calculated and what level is appropriate;
- Whether to look at capital reserves in a single year or across multiple years, and
- The potential impact of different approaches to capital reserve regulation on the ability of the insurance market to operate in an efficient, effective manner.

Capital Reserves

Capital reserves are generated by health plan companies through net income (profits) and investment gains over time. The primary purpose of requiring a minimal level of capital reserves is to ensure financial solvency. This means that health plans are financially positioned to meet obligations towards their members, even when unanticipated losses occur. Capital reserves are also used to make investments in infrastructure, fund growth in existing and new markets, support health care access programs and meet other business goals.

Approaches to assessing capital reserves

Insurance regulators use different methods to assess the solvency of companies selling health insurance. Under one method, regulators assess reserves in the context of how many months of expenses they could cover. Between 1993 and 2004, Minnesota HMOs were required to comply with a corridor of reserves covering between one month and three months of expenses.

In 2004, Minnesota adopted the Risk-Based Capital (RBC) framework. This approach, which was developed by the National Association of Insurance Commissioners and relies on a mathematical formula to assess five types of risks that are present to different degrees in various health plan companies, has been adopted by virtually all states.

Other approaches used by some states include expressing reserves in absolute dollars or as percent of revenue.

Minnesota's HMO and Insurance Market

- In 2012, Minnesota's combined fully-insured health insurance market generated $13.0 billion in health insurance premium revenue.
- Of this, non-profit health plans, including HMOs and Blue Cross Blue Shield of Minnesota (BCBSMN), accounted for $9.825 billion, or 75.6 percent.
- HMOs' share of the fully insured market has been declining steadily, reaching just 52.1 percent in 2012.
- County-Based Purchasers, organizations that exclusively serve public program enrollees within their political boundaries, earned $406 million in premium revenue in 2012, or 3.1 percent of the health insurance total market revenue.
- Public program business has increasingly become the primary product line for most HMOs, since commercial lines of business have transitioned to carriers' for profit insurance affiliates.
- In 2012, HMOs generated $3.9 billion in public program revenue across the Medicaid managed care programs (Prepaid Medical Assistance Program, or PMAP), MinnesotaCare, Minnesota Senior Health Option and Special Needs Medical Care), accounting for 53.1 percent of HMO total revenue.
- The net underwriting gain – earned premium revenue less expenses – from public programs for the period of 2003 to 2012 ranged from a low of 0.5 percent for Metropolitan Health Plan to a high of 3.1 percent for UCare.

Capital Reserves in Minnesota's Health Care Market (2012)

- HMOs held a combined volume of $1.785 billion in capital reserves. These reserves covered between 1.9 months to 4.3 months of HMO expenses.
- Minnesota insurance companies and the Minnesota nonprofit health service corporation, all of which are affiliates of HMOs, held an additional $1.262 billion in capital reserves.
- County-Based Purchasers' total capital reserves amounted to $64 million in 2012.
- With the exception of 2008, when investment losses affected capital reserves growth for Minnesota health plan companies, reserves have been steadily increasing. Since 2003, reserves for HMOs, insurance companies and Blue Cross Blue Shield rose 112 percent.
- It is difficult to estimate the portion of reserves that is due to earnings from Minnesota's public health care programs. Focusing just on net income, about $482 million or 24.9 percent of 2012 HMO reserves is estimated to have originated over the past 10 years from underwriting gains on Minnesota public insurance programs.

Conclusion

A significant consideration in favor of implementing an upper threshold for capital reserves is that HMO reserves of $1.785 billion in 2012, were substantially funded by underwriting earnings (24.9 percent) and investment gains (11.5 percent) from public health care programs. Accumulation of these resources, which were initially intended for health care access, in health plan capital reserves may not represent an effective use of tax-payer funded resources. For many HMOs, these resources only add marginally to stronger financial solvency.

Most prominent among the considerations against limiting reserves at this point are significant uncertainties over the next few years associated with implementation of state and federal health care reforms in Minnesota and the development of new and expanded solvency criteria by the NAIC. Depleting health plan company reserves might affect their ability to

- manage uncertainty related to Medicaid expansion; the transition of high-risk individuals into the non-group insurance market;
- the evolution of a Minnesota's health insurance exchange, MNsure;
- the implementation of risk adjustment mechanisms, re-insurance and risk corridors;
- the substantial investments in information technology necessitated by health reform provisions; and
- the payment reform efforts targeted at creating greater shared accountability between providers and payers, which all have the potential to result in significant financial uncertainties.

The report presents the Legislature with a set of considerations about how to implement a threshold, should it decide to move forward. These considerations include tradeoffs between how broadly limits are applied to the market, what methods would be used, whether there were a single standard for all firms or multiple ones, and what time periods, oversight and criteria to consider for spend-down of excessive reserves.

The report includes a discussion on appropriate levels of reserve thresholds, should they be implemented. Recognizing that there are no objective ways to determine appropriate levels, the discussion drew on stakeholder interviews and research in the literature and about other states.

- Guidelines in other states for maximum capital reserves range from 750 and 1,000 percent of RBC or higher.
- In general, consumer representatives thought an upper threshold should range between 200 and 400 percent of RBC.
- Insurers and HMOs generally thought that a limit was not necessary, but that if there was a limit, it should be at least three to four months expenses, or about 650 to 850 percent RBC.
- County Based Purchasers appeared generally comfortable with a limit in the range of 600 percent RBC.
- Considering the immediate uncertainties associated with health reform implementation, establishing an upper limit of less than 800 percent of RBC may not be prudent at this time.

The report concludes by presenting a list of policy tools that may assist the Legislature in accomplishing their goals in the absence of implementing capital reserve thresholds at this time.

These tools include:
(1) encouraging the Department of Human Services to consider continuing its practices of managing net income growth from Minnesota public health care programs, including through competitive bidding and the establishment of caps on profits;

(2) for regulators, considering the development of a process by which capital reserves are viewed as one factor in rate approvals;

(3) seeking greater transparency concerning consistency in allocation mechanisms of administrative expenses and investment income, the uniform allocation of Medicare and Medicaid revenue and expenses across reporting categories, the pricing of business service arrangements with affiliated companies, and changes in provider payment policies;

(4) conducting regular monitoring of capital reserves throughout the period of health reform implementation, including through Monte Carlo simulation and study of IBNR reserve assumption;

(5) studying evolving shifts in insurance risk in Minnesota's health care market between health plan companies and providers; and

(6) motivating discussions between rate payers, including health plan enrollees and the Department of Human Services, about appropriate uses of existing capital reserves outside of a regulatory framework, including through investments in population health, health and health insurance literacy and other measurable community benefit activities.