SOCIETY OF ACTUARIES

Article from:

Health Section News

December 2000 – No. 39

Industry Perspective

Consumer Protection - Continuation of Benefits in Event of HMO Insolvency

by Harry L. Sutton, Jr.

Author's Note: This article was written for the periodic magazine of NAMCR, the National Association of Managed Care Regulators, in late 1998. NAMCR was originally an operating subcommittee of the NAIC, but was eventually discontinued and maintained a separate existence. It was essentially ignored until recent rapprochement by the NAIC, particularly because of their emphasis on the rules of insolvency and how to deal with them at the state level — which because of an increasing number of insolvencies caught the attention of the NAIC.

Since the article was written, there has been an increasing reluctance in the HMO reinsurance market to provide any continuation of coverage in the agreement. Also, contract provisions regarding continuation of benefits have been tightened. A number of carriers will not consider writing it.

As indicated in the article, Medicare used to have its own requirement of two months of uncovered services. HCFA reduced that requirement to one month in 1999 and later removed the requirement of such an insurance provision subject to adequate hold harmless arrangements. A definition of these arrangements has not yet been published.

States continue to desire some type of continuation of benefits provisions in HMO reinsurance agreements. In occasional cases, the regulations require it, which will make some carriers refuse to offer reinsurance.

With the near insolvency of two major multi-billion dollar HMOs in Massachusetts, the Commonwealth passed new laws tightening up and expanding the liability of providers in the event of insolvency, thus minimizing the potential liability of a reinsurer offering continuation of benefits. At the present time, the NAIC HMO Model Act is being redrafted, including the insolvency provisions. As for Allianz, we have tremendously increased our emphasis on analysis of the financial status of the HMOs we reinsure. I can only assume that the other carriers in this business who continue to offer this extension of coverage in the event of cessation of HMO operations must be tightening up their scrutiny as well.

While a few states have recently added HMO guaranty funds to their statutes, there has been very little industry or carrier interest in expanding these provisions. The well managed HMOs feel that an aggressive competitor coming in with rates below cost will take market share away, and if it does not survive, will be bailed out by the guaranty funds.

A basic requirement in the Federal HMO Act of 1973 (and later by states) was a requirement of hold harmless agreements between the HMO and providers. There were a number of insolvencies in the 1970s, but the plans were small, and usually there were sufficient funds to cover most of the liabilities. Because of the hold harmless agreements, the providers were paid last and some business liabilities did not get paid. Nevertheless, protection was successful in that terminated subscribers were not dunned for claims by hospitals or doctors.

It was recognized, however, that a more formal protection of the subscribers was necessary for the post-insolvency period. There could be claims from non-con-tracted providers, including emergency claims out of the plan service area. It would be difficult for one state to enforce a hold harmless against a provider in a different state. In addition, if premiums had been paid in advance, or the date of cessation of operations of the HMO was in the middle of a month, there would be liabilities for some patients after the date of insolvency, unless the provider agreements made clear that coverage would continue up to the point for which premiums had been paid under terms of the original contract.

In the late 1970s, an arrangement was developed by a large carrier, a large non-profit HMO, and the Federal OHMO to come up with what they called “the insolvency provision” to be added to reinsurance agreements. Essentially, this continuation of benefits agreement included the following items:

1) A reinsurer would continue plan benefits for members confined in an acute care hospital on the date of insolvency until discharge from the hospital.

2) Coverage would be provided after the HMO ceased operating for continuation of plan benefits until the end of the period for which premiums had been paid (excluding benefits which were the contractual liability of a hospital or physician).

3) A conversion privilege was often provided for members who did not have an employer group to return to.

Of particular interest is the fact that benefits must be continued for any Medicare risk enrollee in the event of insolvency, as in (2). The problem with Medicare is more complex than for employer based organizations, since HCFA typically pays premiums on the 27th day of the prior month. In the event of insolvency at the end of a given month, the plan will have one full month of advance premiums for its Medicare members. There are estimates that the cost of the continuation provision could run between $50 and $100 per commercial member, and possibly $300 to $600 per Medicare member after plan closure.

Other permitted alternatives to reinsurance coverage included: Restricted Reserves, Letters of Credit, and Parental Guarantees all hold harmless agreements in provider contracts until the end of continuing liability. In the 1970s, enrollments of more than 10,000 to 15,000 were relatively rare, except for some of the older, larger, well-financed plans such as Kaiser, Group Health Cooperative, and HIP. The majority of HMOs were not-for-profit and were quite small. With the conversion to for-profit and the tightening of utilization controls on hospital use by HMOs, a low visible level of insolvencies resulted. Often HMOs would buy membership of terminating plans. As a result, reinsurers usually ignored the probability of insolvency.

Today, HMOs have total revenue in the range of $10 to $20 billion per year. In the event of a major insolvency, the liability for continuation of coverage could run into several hundred million dollars — even possibly as much as $1 billion!

HMO reinsurers have typically provided unlimited benefits for continuation of coverage in the event of insolvency, without really underwriting the financial condition of HMOs. This liability could bankrupt companies that sell HMO reinsurance. While state and federal regulators have demanded unlimited continuation of coverage provisions, it seems likely that significant changes in the continuation of benefits arrangements will occur during the next year:

- Already many carriers put aggregate limits of $3 to $5 million on the total liability for continuation of benefits.

- Reinsurers will tighten their definition of what would constitute eligible claims. For example, there are at least five insolvent HMOs in the jurisdiction of Florida. Reinsurers with loose provisions may find a substantial liability if enforced as written. Florida now also has the equivalent of a State Guaranty Association for HMOs. The continuing dissolution of HMOs may severely test the capacity of this Florida Guaranty Association to support the runoff claims through taxation of other HMOs.

- Historically, the HMO movement has fought strongly against the development of Guaranty Associations. The insolvency issue lacked urgency when HMOs were not-for-profit, small, and the provider hold harmless agreements were assumed to prevent large liability. With the size of current HMOs, the industry may need to rethink its antipathy to the solution of a state-by-state Guaranty Fund — including whether it should be added to the Health Insurance Guaranty Fund (excluding disability, long-term care and other non-medical benefits).

- On the other hand, HMOs that are at the 175% or 200% level of the Company Action Level under new Risk Based Capital rules are well enough capitalized to avoid specific excess reserves or reinsurance provisions, letters of credit, or other insolvency related requirements.

- HCFA is transferring effective control of the continuation of benefits for its Medicare contracts to state regulators. The HCFA "uncovered expenditures" calculation will no longer be used for a Medicare+Choice HMO or PSO. PSOs regulated directly by HCFA will still have the old requirement.

- It is now clear that some of the provisions permitted by the states, or HCFA, are not adequate insolvency protection: for example, adequate lines of credit (LOC) can be terminated at will, leaving the plan without access to capital; parental guarantees cannot be enforced if one state will not permit the capital to be transferred to a second state; use of unregulated intermediaries may interfere with hold harmless provisions.

- Major inadequacies of claim liability estimates have shocked NAIC and the actuarial profession into improving methods of estimation and enforcing certification requirements.

Harry L. Sutton, Jr. FSA, MAAA, FCA, is senior actuary of health care at Allianz Life Insurance Company of North America in Minneapolis, MN. He can be reached at harry_sutton@allianzlife.com.