Insolvency Risk In Health Carriers: Innovation, Competition, And Public Protection

A guide to the intricacies of insurance solvency regulation and its relevance to provider direct contracting, with lessons from the "banking crisis" of the 1980s.

by John L. Akula

PROLOGUE: Until recently, few have been concerned with the details of insurer insolvency except insurers, insurance commissioners, and their advisers. Now we face an expanding array of entities, many sponsored by health care providers, assuming the functions of insurers and also the financial risk. What happens when they experience financial difficulty? The sponsors of these new entities and the policymakers trying to determine an appropriate role for them need a better understanding of insolvency risk, and quickly. This paper addresses that need. The recent banking solvency crisis suggests that it may not be easy to strike a balance between protecting the public from insolvency risk and other policies—such as fostering competition—that can aggravate it.

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ABSTRACT: This paper reviews the framework of regulatory and managerial devices that have evolved in response to the special dangers to the public posed by insolvency of health carriers. These devices include "prudential" measures designed to decrease the likelihood of insolvency, and measures to "protect enrollees" in the event that insolvency occurs nevertheless. It also reviews the current debate over how this framework should be adapted to new forms of risk-bearing entities, especially provider-sponsored networks engaged in direct contracting with purchasers of coverage. Parallels to solvency concerns in the banking industry are explored.

THIS PAPER IS A PRIMER ON insolvency risk in health carriers. (By "carriers" I mean entities that take on insurance risk, such as indemnity insurers or health maintenance organizations [HMOs], but not self-insured employers.) Regulators and managers of carriers worry persistently about insolvency risk, which, when acute, pushes all other concerns aside. There is a strong public interest in avoiding carrier insolvency, but carriers are subject to the fiscal pressures common to all businesses, and insurance risk in addition. Carrier insolvency is not likely to recede as a policy concern. The problem becomes more complex with managed care and each new type of risk-bearing entity, and more pointed with pressures to reduce costs.

This paper reviews the framework of public oversight, corporate practices, professional standards, and practical wisdom that has evolved around this problem. It uses legal concepts because in regulated industries, law is an institutional "road map"; this is not a definitive legal analysis.[1] I begin with three key institutional elements: bankruptcy, public oversight in the federal framework, and corporate governance. I then turn to what I call "prudential" measures, that is, measures designed to reduce the likelihood of insolvency. I review specific prudential devices, including fiscal monitoring and net worth standards, and then the implications of provider risk sharing and "direct" contracting. Prudential tools do not always work, and I consider strategies for dealing with carrier fiscal distress. As insolvency looms, the focus shifts from keeping the carrier afloat to "protecting enrollees," that is, continuing coverage for which the carrier cannot pay, and I consider the protection provided by individual carriers and industry guarantee funds.

Bankruptcy, The Insurance Company Exception, And Banking

■ **Bankruptcy and survival.** Solvency is a governing principle in business: An organization that does not bring in enough money to meet its obligations is dissolved. This principle is codified in the federal law of corporate bankruptcy and state laws on corporate

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agents, which balance two interests: protecting creditors by distributing to them the assets of the debtor; and protecting the debtor by providing a chance to regain solvency if feasible and, if not, to liquidate, leaving its owners and employees with no liability. These two interests are embodied in popular characterizations: Some companies are "thrown into bankruptcy by creditors," while others "seek the protection of the bankruptcy court." The gentle treatment of debtors encourages risk taking; bankruptcy is destigmatized, and catastrophic losses shift to creditors.

Bankruptcy liquidations can be thought of in this way: Businesses dance on a sloped plateau, trying to reach higher—more profitable—ground. At the low edge is the abyss of insolvency. Each dancer is allowed to pull itself forward while pushing others back, so some totter near the edge. A corporation that goes over vanishes, but the people who invested and worked in it are caught by a kinder hand and encouraged to scramble back up to the dance.

■ **The insurance company exception.** The reach of bankruptcy law over businesses is subject to few exceptions. The most important is for insurance companies and banks. Defaults by insurers or banks cause great hardship. They are businesses and "in the dance," but prudential devices nudge them "back from the edge." Some do go over, and then priority should be given not to creditors generally, but to insured persons and depositors. This is at the core of "protection of enrollees."

■ **Competition and banking.** Traditional prudential regulation was based on the view that competition pushes health carriers to take too much risk. Unease about risk was reflected in other policies: an exemption from antitrust laws, and tolerance of underwriting exclusions. Nowadays health carriers are criticized for taking on too little risk and for competing in risk avoidance. Underwriting is constrained, and competition is encouraged.

Those concerned with insolvency risk think often about banks. Banks are subject to prudential regulation and were restricted from competing. After a shift to encouraging competition, banking prudential regulation failed spectacularly in the 1980s. The parallels are sobering, and we will keep banking in mind in this exposition.[2]

Public Oversight And Federalism

■ **State/federal roles.** The gap in federal bankruptcy law for in-

surance companies is filled by state statutes on carrier receivership and liquidation administered by state insurance commissioners, in keeping with states' primacy in the regulation of insurance generally. However, as the federal role in health care continues to grow and as more managed care carriers do business across state lines, state primacy may be reexamined, especially if there is dissatisfaction with states' performance. Thus far, there have been only a few federal inroads. For example, federally qualified HMOs are licensed and regulated by states but also are subject to federal regulation, which includes standards for fiscal soundness but no provisions for liquidation. Federal law can go further and "preempt" a regulatory domain, barring state regulation, conflicting or not. The Employee Retirement Income Security Act (ERISA) precludes states from any regulation of self-funded employers as insurance carriers.

■ **HMO insolvencies.** HMO insolvencies generally are state proceedings but, because of an ambiguity in the bankruptcy code, sometimes may be subject to federal bankruptcy court jurisdiction. There has been an interesting discussion of the relative merits of these forums. The legal technicalities do not concern us, but the policy implications do.[3] One is the impact of jurisdictional ambiguity on regulatory authority. For example, the influence of a commissioner seeking reforms in a troubled HMO is undermined if bankruptcy is an option. Proponents of federal jurisdiction point to the greater power of the federal forum. A federal bankruptcy court can reach across state lines, issue orders to state and federal agencies, and modify contractual obligations of the debtor. If a distressed HMO is a candidate for rehabilitation, these powers could be decisive. Insured persons as well as creditors may be better off, since an HMO is usually worth more as an ongoing concern.

Proponents of state jurisdiction note that in federal bankruptcy "one size fits all." State receivership provisions are crafted for carriers, are coordinated with other aspects of insurance regulation, and emphasize protection of insured persons rather than creditors. States have more experience with carrier insolvencies, and the National Association of Insurance Commissioners (NAIC) has been the most consistent source of thoughtful commentary. Even the power argument is not one-sided. States have cooperated successfully in liquidating multistate carriers. More importantly, the broad involvement of state regulators in the industry provides them with effective, if unpretentious, tools. For most insolvencies, the best outcome is a takeover by another carrier. Neither a court nor a commissioner can compel a rescuer to step forward, but commissioners—before whom many carriers have pending matters—have impressive powers of persuasion.

Again, the banking crisis is instructive. Banks can be state or federally chartered, and perhaps this has contributed to regulatory lapses. However, the long-term trend had been toward increasing federal regulation of all banks, especially in connection with federal deposit insurance—used by federal and state banks—and the insolvency risk assumed by federal agencies. The banking experience at least lays to rest the notion that, with Washington managing insolvency risk, we can rest easy.

Corporate Governance And Accountability

Most health carriers are private corporations, and corporate governance is the first line of defense against insolvency risk.

■ **Governance and insolvency risk in corporations generally.** Boards of directors (sometimes called "trustees" in charitable corporations) are central to corporate governance. They provide oversight and select the executives who provide daily management. Board members are not generally liable for wrongs committed by the corporation or for misjudgments by the board, so long as they act with care and commitment to the corporation's legitimate goals. For-profit corporations are accountable to shareholders, and not-for-profit corporations, to members or charitable purposes.[4] Corporations also may be charged by law with other duties. Sanctions for noncompliance typically are available only against the corporation but sometimes are permitted against persons who conduct the corporation's affairs, most often members of the board.

The law of corporate accountability mirrors the law of bankruptcy in its tolerance for entrepreneurial risk (or, in public charities, corporate missions that are not likely to generate revenues that cover costs). Going broke is unfortunate, but for corporations generally, there is no duty to avoid activity that risks insolvency or presumption of wrongdoing when insolvency occurs.

Nevertheless, a serious risk of insolvency pushes a variety of board duties to the fore. Board members may face penalties for failure to pay taxes or fund pensions; for transactions that deplete corporate assets; or for inadequate disclosure. Board decisions will disappoint many parties with little practical recourse against the corporation's depleted assets and who will try to reach board members, even if legal theories must be stretched. Sometimes no stretching is required. Since conventional sanctions against a corporation may have little impact if the corporation is failing anyway, many insolvency-related duties are imposed by law upon board members, who can be held accountable even as the corporation dissolves.

The threat of insolvency typically precipitates an expansion in the board's role. The board becomes involved in decisions left to

management in normal times, especially if management's abilities are in question. Management vacancies may be hard to fill, and board members may assume some executive positions on an interim basis. They may handle relationships with key outside parties such as lenders or regulators. These responsibilities are assumed under constraining circumstances. The company is hemorrhaging money and goodwill. Decisions that normally would take months are made in days. Recruiting new board members is impractical; it is too late to address board deficiencies.

However, when corporate governance works well, the needed commitment and skills are at hand. The outside directors normally contribute a small fraction of their time, but the ethic of board membership, reinforced by peer pressure and legal exposure, requires generous availability when the company is in need. A strong board can mobilize perhaps a half-dozen members who are experienced in dealing with fiscal hard times.

■ **Boards of carriers.** Carriers' boards and governance display some distinctive features, but the pattern has confusing implications for insolvency risk. One feature is mirrored by a New York statute that creates a rebuttable presumption that every director of an insolvent insurance company is guilty of a crime. This statute is extreme and perhaps unconstitutional if read literally. However, it reflects a broad policy of holding insurance company boards to an exceptionally high standard in avoiding insolvency, and suits by regulators against directors of insolvent insurance companies are commonplace. These boards must embody solid business skills, and few persons take on an insurance company directorship without this exposure in mind.[5]

Another feature is mirrored by the requirement in the federal HMO Act of 1973 that at least one-third of the board's members be drawn from the HMO's subscribers. Subscriber representatives typically lacked experience with corporate governance or fiscal management. It would have been unfair to apply to them an especially high standard of responsibility or, in many cases, to hold them to the standard applied to corporate boards generally. Business acumen also was diluted by the heavy reliance on physician board members in physician-initiated HMOs and by the reluctance of sophisticated businesspersons to serve on boards already weak in business skills because of the difficulties such boards have in managing problems such as fiscal distress. In 1988 Congress repealed the requirements for the board composition of federally qualified HMOs. No explanation was offered, but the HMO industry had experienced many distressed plans with well-intentioned but inexperienced boards, sometimes frozen by impending insolvency like the prover-

bial deer caught in the headlights of an onrushing car.

This broader tension remains. Managing insolvency risk requires business skills, but other responsibilities are important in health care, including professionalism and a commitment to patients and the community. Examples can be found of practices or laws asserting one or another of these interests, but none that balances them, which is what we need.

Prudential Tools: Fiscal Monitoring And Professional Accountants

The most fundamental prudential tool is reliable, timely monitoring of a carrier's fiscal condition.

■ **When is a carrier insolvent?** The most common solvency standard is "cash flow"—the availability of funds to meet obligations as they come due. Carriers are required to use a higher standard. Premiums are matched to estimated future obligations to which the premiums will give rise. A carrier is solvent if it has reserves and anticipated investment income large enough to meet those obligations. Reserves should reflect the average time lag between collection of premiums and payment of related liabilities. For medical malpractice carriers, the lag might be five years. For health carriers, it is short—perhaps three months—but even this requires substantial reserves. An HMO with that lag and $600 million a year in premiums should reserve roughly $150 million. With, say, $80 million, cash flow is fine, but the HMO is catastrophically insolvent.

■ **Some technical complexities of carrier accounting.** The short time horizon increases pressure for quick and accurate figures. A four-month delay in preparing audited financials is more serious when reserves should cover three months of claims than when they should cover five years. Another complication is risk sharing based on retrospective tests. Yet another is the expanding role of government as payer: Final settlement with private accounts takes weeks, but with government it often takes years.

The most important complication is the tempo of change in health care. Accounting is based on experience, which provides poor guidance if too much is changing. Consider "IBNR." An HMO's balance sheet matches premiums and health care costs accrued to a closing date, but some providers' bills will not be in yet. These expenses have been "incurred but not reported" (hence IBNR). Over time, the HMO tracks this "tail" and, based on experience, estimates IBNR. However, those estimates are usually wrong.

Consider a hypothetical HMO. Three years ago it began phasing in a point-of-service option. Out-of-network care generates slow paperwork. This past year the HMO's cost increases appear to have

slowed, so IBNR should fall. But if the trend reflects a shift to out-of-network care, IBNR will shoot up. Two years ago the HMO instituted estimated monthly payments to key hospitals. Final settlement is given low priority, so the data for estimating inpatient IBNR have deteriorated, and some hospitals may owe the HMO money. Primary care physicians are being shifted to soft capitation, and a new Medicaid contract has been signed; the impact of these on IBNR is guesswork. This example is realistic. IBNR is typically a big balance sheet item; for many HMOs different reasonable IBNR assumptions can double net worth or wipe it out.

Fast change pushes industry practices ahead of accounting principles, which change more slowly. Small changes can be implemented by professional consensus, but important ones require review by the American Institute of Certified Public Accountants (AICPA) and the Financial Accounting Standards Board (FASB), which takes years. Stability is valued because it inhibits manipulation and facilitates comparisons across time. Even when it is clear that business realities have outrun existing principles, it may not be clear what principles fit the new realities. Accounting changes often require upgrading fiscal systems and cannot push too far ahead of industry capabilities. Each industry change poses new problems: Accountants are now struggling with the treatment of provider-sponsored network assets.

In this time frame, managed care is young, and so are its accounting principles. Consider an HMO with an aging Medicare population. In many industries such exposure would be reflected in the financial statements, and an indemnity carrier might set aside a "loss reserve." However, HMOs routinely ignore such matters. Accounting principles may gain ground on industry practice, since the lag partly reflects the fact that health care accounting was not considered important until recently. The AICPA issued its first "Statement of Position" on prepaid managed care in 1989, drawing heavily on hospital accounting.[6] However, the AICPA is working toward the application of more sophisticated insurance and risk-sharing principles.[7] We also may see a rise in actuarial sophistication.

■ **The temptations of carrier accounting.** Financial difficulty is a competitive disadvantage for any business, but especially for carriers. Many businesses can keep their problems private, but carriers' fiscal condition is a matter of public record. Purchasers of health coverage fear the effects on continuity and quality of care. Providers also are vulnerable, because they often continue furnishing care even when payment is in doubt. A distressed health carrier faces rapid erosion of goodwill. Managers reporting to boards and carriers reporting to regulators are tempted to understate bad news.

There also is a rarer but more extreme threat to integrity: misappropriation. When one party is entrusted with funds that belong to others or are to be applied to their future benefit, a temptation arises and attracts those who view it as a business opportunity. Why not take the money, siphoning it into foreign bank accounts or living high on extravagant salaries and perks? Meanwhile, some money can be used to blunt public oversight; generous campaign contributions and salaries for ex-regulators can sometimes buy a few years of relaxed scrutiny. Nor must insured persons suffer in the short run; it is often best to treat current claimants generously, since pilfering can go on longer with an expanding subscriber base. There is money for a long run at a high time, so long as no one notices that the reserves are disappearing.

■ **Independent professional accountants.** Given these complexities and temptations, the monitoring system needs buttressing. This is provided primarily by accounting firms, whose professionalism is supposed to provide a blend of expertise, assistance to private parties, independence of judgment, and public accountability.[8] Carriers are required to retain an outside firm of certified public accountants. Regulators sometimes have the right to approve the choice, and carriers typically retain a large national firm. The firm periodically audits the carrier, reviewing the financial statements prepared by management and the carrier's fiscal systems. The firm presents the audited financial statements to the carrier's board with the firm's opinion on whether the statements conform to "generally accepted accounting principles" (GAAP). The opinion will be "qualified" as to serious deficiencies the firm has uncovered in the way the company reports its financial results. The firm also often submits a "management letter" to the board—in effect, a "report card" on financial management.

Several features of this arrangement buttress its integrity. The firm's partners undergo a long professional socialization. For the firm, the client is one of many, and the firm and its partners are liable for any negligence or misfeasance in the audit function to parties who rely on any client's financial reports. Large accounting firms are "deep pockets," and suits against them are routine. Reporting to the board provides insulation against pressures from carrier management. Over the years the firm learns a great deal about the client and ideally combines an outsider's independence and an insider's knowledge.

However, the system has weaknesses. First, outside accountants delve only so deep, and distortions may be hidden. Second, financial statements are technical and cryptic, and boards may not understand them. Third, pressures from clients to tilt financial statements

can be intense. Even with a board committed to accuracy, the accountants work daily with management, who may have a voice in selecting the audit firm and may retain the firm for consulting, which generates more revenue than the audit. Ideally, the board creates the expectation that the accountants be responsive to management in operational matters but committed to the board in evaluating fiscal condition and management. This balance is easier to state than to attain.

The risk of distortion rises if accounting principles are unclear and industry practice varies. Consider the treatment of "withholds" in the early years of HMOs. Many open-panel HMOs held back a portion—perhaps 15 percent—of the payments otherwise due member physicians and distributed it if the HMO's fiscal performance passed certain benchmarks, which rarely occurred in the early years of operation. If an HMO withheld, say, $20 million over five years, of which $17 million was spent on operations and $3 million was still on hand, what impact should this have on the balance sheet? A $3 million boost to net worth? A $14 million decrease? In the early days of HMOs, accounting treatment varied. If its accountants pressed for a conservative treatment, a carrier could complain that it would look worse than similarly situated competitors—a legitimate argument, and hard to resist when the carrier could shift accounting firms.

■ **The regulator's vantage point.** Another approach to the problem of integrity is to rely on public oversight. Statutes typically provide for intensive public monitoring of health carriers. They require periodic review of fiscal condition, grant regulators broad powers of audit and investigation, and allow carriers to be assessed all or part of the cost. However, apart from indemnity carriers, in which the tradition of regulation is most refined, many states have moved little toward publicly initiated oversight, relying primarily if not exclusively on the audited financial statements produced by the carriers' outside accounting firms. For indemnity carriers, outside accountants typically are required to submit additional financial statements prepared in accordance with "statutory accounting principles" (SAP), with information not required by GAAP. The SAP approach may be extended to other carriers.

Prudential Tools: Adequate Rates And Net Worth

■ **Adequate rates.** State statutes frequently allow regulators to disapprove rates (that is, premiums) unless they are "adequate, not excessive, and not unfairly discriminatory." *Adequate* means high enough for the carrier to remain sound. However, with increasing concern about cost and commitment to competition, the trend is to

let the market drive premiums, and once competition is entrenched, it is fruitless to insist that a carrier charge premiums higher than the market will bear. The "adequacy" standard is now typically applied only when other concerns emerge; for example, when a distressed carrier attempts to expand its market share with "low-ball" rates.

■ **Net worth standards.** Net worth standards remain a central element in prudential regulation. Valuing balance sheet items (like IBNR) is tricky, and conservative valuation rules in effect increase net worth requirements. Also, the net worth standard itself can be set at different levels. Standards for indemnity carriers are typically the strictest. For Blues plans and HMOs, standards are typically lower and sometimes nonspecific—the law might require assurances of fiscal soundness that are "satisfactory to the commissioner." It is my impression that enforcement efforts also are less strict.

There are several reasons for this more relaxed approach. First, the newer forms of carriers typically provide other assurances, such as a promise by affiliated providers to continue providing care even if the carrier runs out of funds. Second, net worth standards are a barrier to entry, and there has been a strong interest in encouraging the emergence of these new forms. Net worth requirements can be strengthened as segments of the industry mature, which is the path being taken in HMO regulation in some states. Third, Blues plans and many HMOs have been not-for-profit and encouraged to be so. Strict net worth standards favor for-profit businesses. Investment increases net worth dollar for dollar, but only for-profit companies can attract investors for initial capital or subsequent infusions. Donations to public charities have the same balance sheet effect, but most not-for-profit carriers are not public charities, and those that are typically have small endowments.

■ **Declining significance of net worth?** Many state regulators think that the time is right to rationalize and strengthen carriers' net worth standards. Some states have already acted, and the NAIC is developing proposed standards (through its Risk-Bearing Entities Working Group), which will apply to all carriers and include sophisticated adjustments for risk-sharing arrangements and other modern complexities. This approach, its proponents suggest, will adapt regulation to the proliferation of risk-bearing entities, create a fairer competitive environment, and render less likely a repetition of the HMO insolvencies of the 1980s. NAIC proposals typically prompt many states to action.

Improved net worth standards are useful. They provide a benchmark for regulators, managers, and purchasers. They nudge the industry toward prudence and away from risky strategies, and they can encourage or discourage particular contractual and risk-sharing

arrangements. However, net worth may be less central to prudential regulation than it has been in the past. In older-style insurance, management strategies tracked the net-worth calculation—estimating liabilities, investment income, and the uncertainties in both. The older regulatory tools—policing rates for adequacy and pushing companies to raise capital or drop problematic lines of business—had a direct impact on net worth. Fiscal viability in today's more dynamic market is tied more directly to managerial skill, network design, and market position. Even refined net worth standards fail to capture these dimensions.

More significantly, net worth standards are not an assurance that carriers are fiscally sound. Noncompliance is widespread. For example, some HMOs are chronically out of compliance, and many others drift in and out. Regulators permit this, but what else are they to do? Standards are not like a highway speed limit—even if carriers know they will be shut down, many will be unable to generate a surplus in a competitive market. And regulators are reluctant to shut them down for other reasons. The process is messy and costly, and the public interest in access, competition, continuity, and choice would be frustrated. Regulators do force carriers out of business but typically only when their fiscal condition is catastrophic and not because of noncompliance with official net worth standards.

Provider Risk Sharing: Downstream And Direct Contracting

■ **A brief history.** In the early Blues plans, participating providers often agreed not to bill subscribers if the plan could not pay, to assuage regulators' concerns about insolvency. The early open-panel HMOs typically shared risk with participating physicians through withholds. These arrangements worked well as a last defense against insolvency; high HMO withholds in many cases preserved solvency over long periods when costs were otherwise exceeding revenues. Modern risk sharing, such as capitation, may better distribute risk, control costs, and manage care, but the direct tie to insolvency has been broken; an HMO with capitated providers must make full payment, whatever its fiscal condition.

■ **The reach of regulation.** State statutes typically require licensure for several forms of health coverage: indemnity insurance, Blues plans, HMOs, and sometimes others. When a new form emerges, a question is raised: Is it operating improperly without a license, or is it beyond the reach of existing statutes? The first statutes authorized indemnity insurance, and early prepaid group plans and Blues plans were challenged as providing insurance without a license. Today the analogous issue is more complex: A new arrangement

might not be considered indemnity insurance but might fall within the definition of, say, an HMO. However, it still is common, in asking if any licensure requirements apply, to phrase the question as whether an arrangement is "the business of insurance."

Determinations are made by regulators, courts, and legislatures. Regulators often take a broad view of the business of insurance, arguing that it includes any arrangements in which risk is transferred and spread. However, clear prohibitions or sanctions against allegedly noncomplying entities are rare, and new arrangements sometimes go forward despite a regulator's chilling comments.

Courts have the final word on statutory interpretation and often take a less expansive view. They agree that risk transfer and spreading are central to insurance but note that these elements are present in many business relationships. If an innovative form of coverage is so different from those authorized by existing laws that to subject it to these laws would prohibit rather than regulate it, the question becomes: Did the legislature intend this prohibition? Evidence of legislative intent usually is lacking, and if the new arrangement is useful, many courts let it go forward. To regulators concerned with public protection, these courts respond that the legislature can decide if protection is needed and of what sort.[9]

There have been few court cases because legislatures typically resolve these issues by statute. For both Blues plans and HMOs, states adopted laws under which the new carriers were authorized and regulated by standards tailored to them.

■ **"Downstream" risk sharing.** The reach of regulation is being debated in "downstream" contracting, in which a carrier transfers risk to providers. With risk sharing expanding, even to "hollowing out" the carrier through global capitation arrangements with providers, some regulators are asking if licensure and prudential standards should be applied downstream. They raise several concerns. Providers are likely to be inexpert at managing this risk. Provider insolvency is a matter of public concern, especially for inpatient facilities. If a carrier and providers sharing risk drag one another down, this poses a double threat to continuity of care. Downstream risk shifting can be used to avoid regulation; for example, carriers can mask their losses by transferring them to a closely affiliated provider.

Counterarguments seem to have convinced most regulators for now. Downstream regulation would be burdensome and would discourage risk sharing. It would require public examination of proprietary contractual terms and would chill competitive deal making. Much can be accomplished by existing jurisdiction over the carrier—often more than is being accomplished now.

■ **Direct contracting.** A more pointed issue is posed by direct contracting, in which a provider or provider-sponsored network contracts with purchasers of coverage and assumes some or all of the insurance risk (through, say, a fixed premium or "risk corridor") with no licensed carrier involved.[10] Some employers are attracted by the savings and responsiveness that might result from "leaving out the middleman." Several bills in Congress would authorize Medicare to deal with provider-sponsored networks.

Direct contracting is a new development on which formal determinations are scarce. Some state regulators and the NAIC are arguing forcefully that providers entering direct contracts should be subject to carrierlike regulation, either by treating them as HMOs, or by developing new regulations. They note the danger to the public from insolvency risk, the competitive disadvantage to regulated carriers, and the ease with which an HMO license can be obtained in many states. For insurance regulators, any "unlicensed carriers" are a problem. First, their existence hampers efforts to regulate even those carriers over which jurisdiction is clear, since strict standards that can be "outflanked" only push more activity beyond a regulation's grasp. Second, the competitive disadvantage to regulated carriers undermines their fiscal soundness. Third, the market and political balance can shift rapidly; established carriers now oppose unregulated direct contracting but, if it is allowed, may quickly spin off provider-sponsored networks. There is strong support, especially among providers, for pushing ahead with light regulation at most, at least until we have more experience. One argument, that of encouraging entry, is familiar. However, there are others, and I attempt a summary, although this debate is just taking shape.

■ **Embedded risks.** Proponents of direct contracting confront head-on the argument that risk requires carrierlike regulation. Many contracts involve accepting and spreading risk. An obstetrics group that provides care during pregnancy for a predetermined fee, whether the pregnancy turns out to be simple or complex, is not an insurer. Neither is a hospital paid by diagnosis-related group (DRG). Is there a principled line between these and a physician/hospital organization (PHO) providing comprehensive care to families for a premium?

The risk assumed by a provider-sponsored network in a direct contract is different from the risk assumed by an insurance company because the provider-sponsored network's risk is embedded in a service relationship that would otherwise exist. Even the terms of payment are structured to serve other ends, including management of care and control of costs. The central insurance component—protecting against rare costly events—is arguably modest, since

health coverage also smooths payment for services used routinely if intermittently.

Advocates of direct contracting argue that providers and employers each bring to direct contracting commitments that protect consumers and that are weaker in other arrangements. Physicians and hospitals have a commitment to maintaining patient relationships and standing in the community that may be stronger than the immediate economic impact of a particular contract. They also bring legal and ethical commitments to their patients, including some obligation to continue care when payment arrangements unravel. For employers, health coverage is also embedded in a broader, more significant relationship. Even in dealings with licensed carriers, employers often take a role in protecting their employees if an arrangement unravels and may have some legal accountability in this regard.

Providers and employers engaging in direct contracting may be seeking a delicate balance. They may wish to provide assurances to patients and employees about the soundness of the new arrangements but also avoid full legal responsibility if an arrangement unravels. However, the left-out carrier "middleman" had clear obligations regarding the fiscal soundness of coverage, and there will be strong pressures to hold the remaining parties accountable. My guess is that the law will move toward expanded employer and provider accountability in these arrangements.

However, the law is unclear, and these arrangements will vary. Will employers be held primarily responsible because the initial undertaking to arrange coverage is theirs? Will payments to providers that look like premiums shoulder providers with carrierlike responsibilities, or can they argue that capitation is better viewed as a managed care payment device rather than assumption of the insurer role? We also will not know how well any legal obligations will protect employees and patients until we have experience.

■ **Providers, employers, carriers: Whom to trust?** The case for direct contracting is partly a critique of carriers. Consider a group of subscribers who have turned out to be a bad risk. Whoever bears the risk—provider, employer, or carrier—would rather not have it. However, critics of carriers suggest that since a carrier specializes in risk, its view will be the least complicated: It will want out. By contrast, the interests of providers and employers are embedded in ways that may sustain their commitment to continuing coverage. In this view, carrier regulation is not just protection against the dangers inherent in "insurance risk," regardless of who assumes it. It is protection against carriers, who trade primarily in risk and who thus are especially unreliable if risks are poor.

Confronting Severe Financial Deterioration

■ **Management options: "turnarounds" and the quality of care.** Consider a carrier in financial distress—not so severe that liquidation is the only recourse, but deteriorating so fast that it cannot survive without turning a corner. In most lines of insurance, the carrier must take its policy liabilities as fixed. "Turnarounds" focus on managing investments and shifting lines of business. By contrast, a health carrier can greatly influence how much care is provided, especially if the carrier provides it. Turnarounds can achieve dramatic savings if utilization controls were loose and tighter methods already used in the industry can be adopted.

This poses the hazard that, in pursuit of a turnaround, a carrier will underfund care, doing greater harm than if it closed its doors. In business generally, turnaround management displays a single-minded determination to cut costs. There are countervailing pressures in health care, especially the standards of providers and malpractice liability. However, some irresponsible cost cutting does not require providers' complicity, and malpractice liability often takes years to ripen. Abuses become more likely as we move toward a system with less "fat."

This concern falls into a regulatory gap. Managed care systems often are supervised by state departments of insurance and health, but the latter's role is typically minimal. Many states provide aggressive oversight by health authorities for hospitals and nursing homes in financial distress, fearing lapses in care. Similar oversight in managed care has yet to evolve.

■ **Regulatory options: the problem of forbearance.** Consider the following realistic scenario. A health carrier goes under. Commentators find evidence of fiscal problems going back years. They allege that management was irresponsible and that regulators missed opportunities to intervene when problems were smaller. Regulators' inactivity is viewed as less culpable but a more serious weakness: Managers cannot always be trusted, which is why we have regulators, but if regulators cannot be trusted, the system does not work.

There often is some validity to this criticism. Regulatory resources, skills, and motivation do not always reach as far as statutory mandates do. However, forbearance reflects some deep dilemmas, not just a lack of vigilance. Liquidation of a carrier is often messy, and the inevitability of its demise is clear only in hindsight. Evaluating forbearance is difficult, because only its failures make the newspapers. But, the critics say, even if "pulling the plug" would have been precipitous, what about less drastic intervention? The

record is often bare of such measures. If an HMO has a withhold, the regulators will often insist that it be raised, but most carriers do not have withholds, and no other device is broadly used. One reason is that other devices often do more harm than good. Regulators can place a carrier under closer surveillance or require a "plan of correction," but these measures and the reports they produce are typically public records and will be used by competitors to undermine further the distressed carrier. Regulators can restrict new accounts, but if a carrier is small or saddled with poor accounts, this restriction will aggravate its problems.

■ **Of forbearance "lock" and zombies.** In banking, some commentators were especially critical of forbearance with respect to the "zombie thrifts"—banks apparently beyond rehabilitation, which were not closed in part to avoid payout obligations for federal deposit insurance agencies beyond these agencies' resources. Forbearance was "locked in" once the industry's distress had become too massive for the resources allocated to address it. However, the zombie thrifts had no equity to lose and could hope to survive only through high-gain/high-risk investments using funds attracted with high interest rates on deposits. They gambled themselves further into the red, while forcing more prudent banks to take increasing risks to match their interest rates.

Protecting Enrollees: The Individual Carrier

As a carrier deteriorates financially, it will run out of funds to pay for care. The focus shifts from keeping the carrier afloat to protecting enrollees, who face two problems: unavailability of care, and being billed for care that the carrier should have paid for.

■ **Transfers to another insurer.** When a carrier cannot be rehabilitated, the solution of choice is a transfer of subscribers to a sound carrier, typically brokered by a commissioner or a court. The new carrier agrees to provide coverage under one of its policies to the failing carrier's subscribers in exchange for receiving premiums, all from a fixed date forward. The regulators will seek a waiver of preexisting condition clauses or waiting periods. Sometimes the rescuing carrier will absorb the failing carrier's provider network.

However, the shift to the new carrier may not be in place before the failing carrier has run up bills it cannot pay. The new carrier will refuse liability for care rendered prior to the period for which it receives premiums. Thus, protecting enrollees is often approached by delimiting a time period during which protection should be available, before the end of which a transfer should be effected. One commonly used period is sixty days, including thirty days immediately preceding and thirty days immediately following a declaration

of insolvency.

■ **Arrangements to "cover obligations."** When a carrier cannot pay providers in the normal course, but an arrangement has been made for providing care without insured persons' incurring financial liability, the carrier's obligations are said to be "covered." There are different devices for covering obligations, and a carrier may use several. Ideally, the effect is full coverage for a specified time period, but often that is not attained. The most important devices are discussed below.

"Hold-harmless" provider contracts. If a provider renders care expecting payment from a carrier and payment is not forthcoming, the provider usually has the right to bill the patient. However, a carrier can obtain an agreement from the provider that payment will not be sought from the patient; the patient is "held harmless." Hold-harmless agreements are possible only when the carrier and provider enter a contract. HMOs and Blues plans usually have such contracts, but indemnity plans usually do not. Providers with contracts will not necessarily agree to a hold-harmless clause. Providers who sponsor a carrier, such as the physicians in an open-panel HMO, usually sign hold-harmless agreements, but other providers may refuse. Even managed care plans will not have contracts with out-of-network providers used in emergencies or point-of-service options. "Statutory hold harmless," which by law bars providers from recovering against insured persons, has been for the most part successfully opposed by providers, who argue that they should not be the safety net for carrier failures over which they have little control.

Segregated reserves. Regulators can require a carrier to put aside segregated reserves to cover obligations, and these can be put beyond the reach of creditors. However, if required at the onset of operations, they are a barrier to entry. If a mature plan cannot generate required reserves, there is little a regulator can do.

Insolvency insurance. A carrier can purchase insolvency insurance. If the purchaser is declared insolvent, the issuer must pay certain of the purchaser's obligations incurred during a defined period, typically the sixty days mentioned earlier. However, shaky plans usually cannot buy coverage. Also, a policy runs for a year and will be canceled before insolvency is declared unless the purchasing carrier's decline is rapid.

■ **"Pulling the plug" and good timing.** If a declaration of insolvency is delayed while a carrier is losing money, at some point arrangements to protect enrollees will become inadequate. Unpaid obligations will exceed segregated reserves. Insolvency insurance, even if not canceled, reaches back from the declaration for a speci-

fied interval, and a carrier falling far enough behind in paying bills will have obligations the insurance does not cover. A failing carrier will lose attractive accounts, making a takeover less likely. State regulators must initiate a state receivership or liquidation, although the carrier may influence the decision. The carrier's board usually will initiate a bankruptcy proceeding, although sometimes creditors do so. Winding down is often at first a psychological "unthinkable," especially to inexperienced boards and regulators. When a carrier is deteriorating quickly, a delay of even a few months can greatly compromise protection of enrollees.

Protecting Enrollees: Guaranty Funds

The devices discussed thus far look to a carrier's own resources or to other parties willing to share by contract in the carrier's insolvency risk. A distressed carrier may be short of both. Hence the interest in "guaranty funds" (or "guaranty associations"), by which groups of carriers are required to protect each other's enrollees. Most indemnity carriers belong to a fund; it is less common for other health carriers to do so.[11]

Typically, a fund is established by state statute for a type of carrier doing business in that state. Participation is mandatory. The fund is run by a board that represents participating carriers and raises money by assessing these carriers. It typically is tapped only when a carrier is in liquidation and primarily for the protection of enrollees, and not to keep a failing plan afloat. Fund members may loan managers to a liquidating plan, since a well-managed winding down leaves behind fewer obligations. The scope of a fund's powers of assessment may be broad, but a fund typically has realistic access to limited assets and can be strained to the limit by the insolvency of a single substantial carrier. If several carriers are in trouble, the industry is probably in a downturn, which further limits, as a practical matter, the resources the fund can tap.

Carriers are ambivalent about funds; many HMOs oppose the creation of funds for them. Established carriers may resent what they view as the irresponsible competition engaged in by marginal carriers that are likely to end up in liquidation. When the established carriers must then make good a liquidation shortfall, they complain about paying twice for another's irresponsibility.

■ **Moral hazard.** A more subtle concern is moral hazard: the danger that funds may encourage fiscal imprudence. This must be considered from several vantage points. The main effect would not be on carrier management, since fund assets are used *in extremis*, when management is or soon will be gone. The effect on customers—typically employers—could be greater. Most commentators on

the banking crisis agree that federal deposit insurance increased insolvency risk by eliminating depositors' concerns about the high-risk bank investments that went hand-in-hand with higher interest rates. Similarly, employers may be less willing to pay more to deal with a clearly solvent carrier when a fund is in place.

Regulators also are vulnerable. Prudential regulation is costly to an agency, in political capital, staff time, and other resources. Funds tap private assets. Lax regulation and forbearance may reflect stingy use of agency resources even when the likely result is a more costly problem left to a fund.

Perhaps the most important hazard concerns political priorities. Funds appear to protect the public against carrier insolvency. This view cannot withstand a close look at fund resources but may provide politically sufficient assurances. In banking, deposit insurance appears to have anesthetized political concern about bank fiscal soundness; wasn't the public protected in any event?

■ **Company risk and industry risk.** The moral hazard argument is more pointed when we distinguish between "company risk"—the danger that an occasional carrier may be distressed for reasons peculiar to it—and "industry risk"—the danger that many carriers may become distressed for more systemic reasons. Funds offer some protection against the former, but their resources are too limited to protect against the latter. They resemble the federal bank deposit insurance agencies, whose resources were adequate for the occasional bank failure but not even a small fraction of what was needed for systemic solvency problems. For the public, company risk is the smaller danger, since the subscribers left adrift can be absorbed by a healthy carrier industry, although this process may not be entirely smooth. The potential harm to the public from industry risk is enormous, and no protective devices in place adequately address it. Guaranty funds protect against company risk, but moral hazard may increase industry risk.

However, moral hazard may have less significance in health carriers than in banking. Depositors rightly assumed that deposit insurance would be backed by the federal government; there is no such confidence in guaranty funds. Depositors have simple expectations—interest, and their money back—which deposit insurance protects. Health coverage is complicated. Even if a failed carrier's obligations ultimately are covered, subscribers will suffer apprehension and perhaps discontinuities in care.

Some Concluding Thoughts

■ **Muddling through.** It is difficult to systematically judge the seriousness of insolvency risk. With prudential regulation, insol-

vencies are uncommon, aside from the fallout of small players after a rush of new entrants. Crises involving groups of carriers are rarer, and meanwhile context changes. Experience with health carriers is especially limited. Even if we could measure the risk, it would be difficult to decide how much is acceptable. The benefits of prudential regulation are speculative and undramatic. Policies that conflict with it bring lower costs, easier entry, and greater freedom of action. Advocates of prudential regulation often feel disadvantaged in the tug-of-war over priorities.

For better or worse, the system of public and private prudential devices now in place is very flexible. Without structural or explicit policy changes, it can and does swing widely between relaxation and invigoration, depending upon recent experience. Much future wrestling with this problem may involve such "muddling through," which is fine unless it becomes too costly. We are smarter about banks, but it was an expensive education.

■ **Government's complex agenda.** Until recently, government's main concern in regulating carriers was protection of the public from insolvency risk. Government's agenda has become more complex. Cost, access, and competition have emerged as more important issues. Government also has become a purchaser of health services and a sponsor of health entitlements. This experience has not been happy. The Clintons' image of purchasers pushed to the wall by out-of-control costs better describes Medicare and Medicaid than the private sector. Government programs may be weak in limiting short-term benefits in the interest of long-term fiscal soundness—the virtue at the heart of prudential regulation. The most precarious carrier initiatives of recent years have been part of crash efforts to shift Medicaid to managed care.

State departments of insurance have a strong commitment to prudential regulation, constantly refreshed by responsibility for insolvent carriers. However, they and the NAIC are facing more political competition in efforts to frame policy for health carriers. There is no comparable tradition of commitment to prudential regulation in Washington.

■ **Carriers and private corporate governance.** For some corporations charged with a special public trust, tailored principles of corporate governance have evolved to buttress that trust, as with hospital corporate governance in connection with quality of care. Such principles for carriers could address prudential concerns and be woven from many threads: industry accreditation standards, insurance law, the fiduciary duties associated with health care, and the duties of employers when they provide employee benefits. I believe that such a development could be significant, but little has

happened yet, and the modern tendency is to look to regulation.

The banking experience suggests that public consideration of such principles may be easily distracted. With each wave of failures, there came to light some dishonest bankers who often were politically well connected. They made for good copy and provided opportunities for political advantage. However, if Americans believe that the bank failures were rooted in crooked bankers and politicians, and not in more institutional factors, the lessons of the bank failures were perhaps not learned after all.

■ **Employers and market-driven solutions.** As employers become more active in managing health care coverage, they lean toward market-driven solutions. Many big businesses believe that they have made solid progress in controlling costs, and an argument can be made for a market approach to insolvency risk. Prudential regulation assumes that carriers will take on too much risk. It substitutes the judgment of regulators, but the costs and benefits of regulatory options are different for regulators than they are for the public. One powerful incentive for regulators is avoiding blame. There are ways to avoid blame that may work better than doing a good job—ignoring a problem that will not ripen until a successor is in office, or alleging private-sector misfeasance.

Can we expect employers to bring better judgment to bear? Employers can evaluate the risk that coverage arrangements will be undone by insolvency and decide how much they are willing to pay to reduce it, by contracting with more solid enterprises, purchasing backup coverage, or retaining risk. If employers typically share in both the costs and the benefits of this protection, they perhaps are subject to better-balanced incentives than are any of the other institutions involved.

This may be a romanticized image of the market. Some employers will not have balanced incentives. The costs of being astute may be too high. Reliable information may not be available. However, if some companies have the right incentives and sufficient resources, perhaps they can push the market toward the right balance, with less astute buyers following behind.

ERISA has been key to the market-driven approach. Under ERISA a self-funded employer can arrange coverage without the involvement of a licensed carrier. If these arrangements work, the case for prudential regulation is weakened, although some have suggested that ERISA funding standards should be reexamined.

■ **Providers and the road not (yet) taken.** There is no consensus on the role of providers in our health care system. Some view the expertise and ethics of providers, especially physicians and hospitals, as a sound foundation for a health care system. Others are

inclined to have more faith in government and regulation. Until recently, and for several decades preceding, providers have been on the defensive. The antitrust laws have restricted a collegial physician role in financing and delivery systems. Provider "fraud and abuse" was criminalized and blamed for health care costs.

We may be seeing a shift in direction. Doctors and hospitals want the opportunity to sponsor comprehensive care and financial coverage, and political leaders appear increasingly willing to accommodate them. The laws on antitrust, fraud and abuse, and managed care all may be modified to this end. Those who view this fundamental shift as sound may not be dissuaded by narrow arguments about insolvency risk.

■ **The single-payer option.** Many health reformers consider our reliance on private carriers to be a mistake. Carriers are criticized on many counts: administrative expenses; restrictions on choice and paperwork burdens imposed on subscribers and providers; a for-profit business mentality that undermines more altruistic and egalitarian values; and a questionable commitment to quality. The single-payer solution, supported by many reformers, is a system without carriers. Carriers thus face exceptional "political risk" in health care reform. However, opposition to the single-payer option is strong. Many do not share the distrust of carriers, and distrust of government is perhaps more widespread. Carriers, with other stakeholders in the current system, are formidable political players.

Perhaps a more likely political direction would be to impose on carriers, via regulation, more responsibility for cost control. For those comfortable with a single payer, this holds the prospect of success even if it fails. Carriers may succeed in diffusing cost-control pressures to which they are directly subject through the rest of the system. If instead carriers' efficiency and viability are undermined, a public faced with "bailing out" a creaky carrier system may find the single-payer option attractive.

The Clinton Health Security Act is instructive in this regard. Let me outline what I think would have been a likely scenario had the act been implemented. When competition did not sufficiently suppress growth in premiums, the National Health Board would have enforced increasingly tight "budget targets" upon average premium growth within each regional health alliance. Wherever growth was too high, some or all carriers dealing with an alliance would have premiums reduced by an "assessment." Moreover, carriers were required to continue coverage for insureds even if payment was not made.[12] Slow payment and nonpayment would be commonplace. On the other hand, providers were required to continue to furnish care even if a carrier could not pay them.[13] A carrier subject to an "assess-

ment" could assess its providers in turn.[14] Thus, the usual contractual contingency—no payment, no deal—would be very much relaxed for carriers as both vendors and purchasers. Such a carrier system could absorb large losses and limp along for years, although it would suffer increasing inefficiencies and disruptions. Early on, the resources allocated to address carrier insolvency would be outmatched by the industry's shortfalls, and forbearance would be "locked in." As the carrier system became more debilitated, the attractiveness of a single-payer system would grow apace.

My Clinton plan speculations aside, the mix of a shaky commitment to the carrier system and the possibility of cost-reduction regulation focused on carriers puts insolvency risk in a new light. In recent decades, no deliberate effort was made to "squeeze" the banking system, apart from encouraging competition, but we experienced widespread insolvencies nevertheless. At great expense, the banking system was "bailed out"—but everyone agreed that we needed banks.

NOTES

1. These notes are a guide for the nonlawyer interested in pursuing these matters further. For an overview of insurance regulation, see R. Keeton and A. Widiss, *Insurance Law* (St. Paul, Minn.: West, 1988), chap. 8. On carrier insolvency, see D. Spector, ed., *Law and Practice of Life Insurance Company Insolvency* (Chicago: American Bar Association, 1993), which also discusses health carriers; and Practicing Law Institute, *Insurance Company Solvency* (New York: PLI, 1991). For evaluating legislation, the best resource is the National Association of Insurance Commissioners' (NAIC's) Model Acts. On the current policy dialogue, see Bureau of National Affairs, *Health Care Policy Report* (Washington: BNA, published weekly).
2. On banking regulation, see K. Spong, *Banking Regulation: Its Purposes, Implementation, and Effects*, 4th ed. (Kansas City, Mo.: Federal Reserve Bank of Kansas City, 1994). On insolvency, see L. Hooks, *Bank Failures and Deregulation in the 1980s* (New York: Garland, 1994); and L. White, ed., *The Crisis in American Banking* (New York: New York University Press, 1993).
3. See P. Cantilo, "Health, HMO, and Related Entity Insolvency," in *Law and Practice of Life Insurance Company Insolvency*, sec. 18.
4. Some insurance companies are "mutual," owned by policyholders.
5. See V. Vitkowsky and J. Irish, "Liability of Directors and Officers, and Accountants of Insolvent Insurance Companies," in *Insurance Company Solvency*, chap. 6.
6. See American Institute of Certified Public Accountants, *Audits of Providers of Health Care Services* (New York: AICPA, 1994), appendix on prepaid health care services.
7. See AICPA, "Prospectus for Proposed SOP [Statement of Position] on Accounting for Certain Predetermined Health-Care Arrangements" (Draft, 13 March 1996).
8. See the articles in *Law and Practice of Life Insurance Company Insolvency*, Part Four.
9. See, for example, *Jordan v Group Health Association*, 107 F.2d. 239 (D.C. Cir., 1939), still a leading case, rejecting a regulator's complaint against an early prepaid health plan. On the scope of "the business of insurance," see Keeton and

Widiss, *Insurance Law*, sec. 8.3.

10. For the regulator's perspective on downstream and direct contracting, see NAIC, "The Regulation of Risk-Bearing Entities" (Draft no. 2, 24 September 1996). For a sympathetic analysis of the NAIC's proposals, see A. Overbay and M. Hall, "Insurance Regulation of Providers That Bear Risk," *American Journal of Law and Medicine* 22, no. 2 and no. 3 (1996): 361–387. For a provider perspective, see American Hospital Association, "Regulation of Health Plan Companies and Provider Sponsored Networks: Practical and Public Policy Considerations" (Draft document, 25 April 1995).
11. See generally W. Dunham and D. Kinney, "Life and Health Insurance Guaranty Associations," in *Insurance Company Solvency*, chap. 10; and J. Blaine, "Organization and Capabilities of Life and Health Guaranty Associations in the United States," in *Law and Practice of Life Insurance Company Insolvency*, sec. 6.
12. *The President's Health Security Plan* (New York: Times Books, 1993), 81.
13. Ibid., 57. The *Health Security Act* imposes the obligation to continue caring for patients "[i]f a Plan fails." The proposed statute provided that a health plan would be deemed to be failing if it could not pay its bills or faced an imminent inability to do so. See *Health Security Act*, sec. 1204(d)(4).
14. *The President's Health Security Plan*, 106, 108.