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REPORT ON CONCEPT OF A RESERVE CORRIDOR FOR INDEMNITY HEALTH INSURERS

Authorization for Study

Chapter 625, Article 3, Section 4 of the Laws of Minnesota for 1994 requires that the "commissioner of commerce, in conjunction with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements."

Background

First, it should be noted that in this context the term "reserves" is considered the practical equivalent of "surplus," "capital" or "net worth." Simply stated then, the statutory existence of a reserve corridor requires the regulated entity to maintain net worth in a defined range (e.g., some function of claims and expenses) - if net worth falls below the floor of the range, or if net worth exceeds the ceiling of the range, actions must be taken to resolve the situation.

While the purpose of a floor is clearly solvency-related, the presence of a ceiling is intended to keep an entity from accumulating too much net worth, to the detriment of those enrollees paying premiums for the coverage.

There is currently no legislative authority to impose a reserve corridor on (for profit) indemnity health insurers .

Current Use of Reserve Corridors in Minnesota Law

To date in Minnesota law, reserve corridors exist only in two non profit situations, which are discussed below:

HMO Law:

- 62D.042 Subd. 1 (b). After the first full calendar year of operation, organizations shall maintain net worth of at least 8-1/3 percent and at most 16-2/3 percent of the sum of all expenses incurred during the most recent calendar year, but in no case shall net worth fall below $1,000,000.

C. Competitive pressure (i.e., the desire for a high return on investment for owners) generally leads companies to maintain only as much capital as they believe they need. This same pressure can at times lead to a regulatory concern over the adequacy of pricing. On the other hand, some premium rates for indemnity health insurers are already subject to regulatory approval, and are required to meet prescribed loss ratio guidelines to ensure that rates are not excessive for the benefits provided. These factors all suggest that adequate capital, not excessive capital, should be the primary focus.

D. The annual statement instructions, which are applicable to all indemnity health insurers, require that regulatory levels of risk-based capital be reported in the company's annual financial statement. These levels are used by the regulator to monitor companies, specifically those with marginal levels of capital, as measured on a risk-adjusted basis. The overriding concern of the regulator, and the major regulatory issue, is for the company to maintain adequate capital to support its existing business and current level of writings. The focus of the risk-based capital structure, then, is on the maintenance of adequate surplus; no provision for an upper limit on surplus exists.

E. It is very common for indemnity health insurers to offer other forms of coverage (e.g., life insurance and annuities), and in many instances these other lines of insurance represent a significant portion of the company's total business. Further, company management may choose to vary the extent of its capital commitment to a particular line of business for specific business reasons. For example, perhaps health insurance is offered as a secondary line to augment the company's primary life insurance focus. In these various multiple line situations, it would be impractical to try to implement a reserve corridor concept for indemnity health insurance.

F. In addition to the annual statement reporting requirements, states have begun to introduce the risk-based capital for insurers model act in their legislatures for enactment. Several states have passed the law already. Once enacted, the law provides a state with the regulatory framework to enforce all the provisions of the risk-based capital structure, as they relate to companies which fail to maintain the proper level of surplus. Minnesota is introducing this legislation in the 1995 legislative session, and, pending enactment, very soon all licensed companies will fall under the provisions of the Minnesota act.

G. Would it be desirable (or even possible, given the legal problems which could present themselves to companies operating in other states which have enacted the risk-based capital model act) to impose a reserve corridor on indemnity health insurers? For example, the provisions and intent of a reserve corridor

may conflict with the risk-based capital standards which apply to Minnesota domiciled insurers doing business in other states which have enacted the law. As a result, would a reserve corridor serve to ensure that savings would be passed on to policy holders in the form of lower premiums or higher benefits, or would a reserve corridor simply be an impediment (or a critical obstacle) to the insurer's ability to run its business, remain adequately capitalized, and also comply with the risk-based capital requirements in other states?

H. Stock companies which are planning growth may be prohibited, by the corridor ceiling, from pre-funding that growth with capital contributions (which is desired from a regulatory standpoint). Likewise, a stock company with presumably excess net worth in its established health insurance line could remedy its corridor "problem" in the easiest way by declaring a shareholder dividend. This would circumvent the intended result of the corridor, namely, to return excess net worth to those paying for the coverage.

Conclusions and Recommendation

Conclusions:

After considering and researching the issues surrounding the concept of a reserve corridor for indemnity health insurers, the following conclusions have been reached:

1. Existing reserve corridor provisions in the HMO and non profit health service plan corporation statutes have proven useful in requiring the preparation of financial plans, but it is difficult to determine conclusively that these provisions have led to the primary intended result, to keep an entity from accumulating too much net worth. In addition, the establishment of a reserve corridor based on a simplistic function of claims and expenses ignores the risk profile of the entity.

2. A regulatory structure (e.g., loss ratio guidelines) already exists to govern the level of premium rates offered by indemnity health insurers. Some premium rate increases must by submitted for approval. In this way the policy holder is assured that the rates being charged under a policy are not excessive for the benefits provided. Protection from excessive rates is most effectively done under these provisions, rather than through a simplified reserve corridor.

3. The existence of the risk-based capital for insurers model act and efforts under way to have it adopted in all states, combined with its underlying focus on the adequacy of capital, run contrary to the concept of a reserve corridor. Such a corridor could, if the ceiling was in danger of being exceeded, require an insurer

to take some inappropriate action, possibly counter to the corridor intent, to reduce capital (e.g., a stock company declaring a dividend). And in fact, there may be serious ramifications to doing so in a state which has adopted the model act. For example, a reduction in capital could trigger regulatory action (in another state or even in Minnesota) under the terms of the risk-based capital act.

Recommendation:

In light of the above, the concept of a reserve corridor for indemnity health insurers would be counterproductive to effective solvency regulation, and would be an ineffective means to ensure the intended (but elusive) benefits sought. Therefore, no reserve corridor is recommended.