Regulatory capital strategies in an evolving health insurance landscape

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The relationship between health plans and healthcare providers continues to evolve as vertical and virtual integration permeate the industry. This dynamic landscape creates new financial opportunities for health plans managing regulatory capital.

We are in the midst of a transformation in the healthcare industry. Healthcare providers and health plans are vertically integrating through consolidation.[1] Many providers are forming Accountable Care Organizations (ACOs) to share financial risk with plans in virtually integrated partnerships.[2] Successful healthcare provider and health plan partnerships include strategies to optimize required capital and improve financial performance.

A health plan's required capital depends on how it contracts with providers. An effective contracting strategy can have a favorable financial effect by reducing the amount of required capital. Reduced capital can increase return-on-equity (ROE) or create available capital for other purposes.

Figure 1 illustrates a range of required capital as a percent of revenue for different provider contract types. The Company Action Level (CAL) is a key threshold in the Risk-Based Capital (RBC) framework. Health plans are generally required to hold capital that exceeds the CAL. Please refer to the appendix for additional detail.

FIGURE 1: REGULATORY CAPITAL BY PROVIDER CONTRACT TYPE

CONTRACT TYPE	REGULATORY CAPITAL CAL % OF REVENUE
NON-CONTINGENT EXPENSES	3.2%
CAPITATION	4.0%
BONUS/WITHHOLD ARRANGEMENT	6.3%
CONTRACTUAL FEE PAYMENTS	7.0%
OTHER OR NO ARRANGEMENT	8.1%

A health plan can reduce its capital requirement by more than half based solely on its relationship with healthcare providers. Given this range of outcomes, regulatory capital should be a key aspect of a productive provider partnership. Acknowledging this dynamic typically results in greater recognition of the value that providers can create in a partnership with health plans.

The theory

RBC is an important capital adequacy framework for U.S. health insurers. The National Association of Insurance Commissioners (NAIC) created the RBC framework, which is widely adopted by state insurance regulators. Based on four distinct risks, RBC formulaically sets thresholds that health plans must use to assess their financial position.

The largest driver of RBC for most health plans is underwriting risk—accounting for nearly 70% of industry-wide health plan RBC in 2016.[3] Underwriting risk represents the risk that medical expenses will fluctuate beyond the medical expense provision in health plan premiums. A key determinant of a health plan's underwriting risk is its managed care credit.

1 **Vertical integration:** A merger, acquisition, or joint venture between a healthcare provider and health plan that results in common ownership.

2 **Virtual integration:** A partnership in which financial risk is shared between healthcare providers and health plans in a value-based or accountable care arrangement.

3 Aggregated Health Risk-Based Capital Data. 2016 Data as of 6/28/2016. http://www.naic.org/documents/research_stats_rbc_results_health.pdf.

FIGURE 2: MANAGED CARE CREDIT PROVIDER REIMBURSEMENT CONTRACT CATEGORIES

CONTRACT TYPE	DESCRIPTION
NON-CONTINGENT EXPENSES	AGGREGATE COST ARRANGEMENTS AND FIXED SALARIES TO PROVIDERS
CAPITATION	PAYMENTS DIRECTLY TO PROVIDERS OR TO REGULATED INTERMEDIARIES
BONUS/WITHHOLD ARRANGEMENTS	FEE SCHEDULE PAYMENTS WITH BONUS OR WITHHOLD PROVISIONS
CONTRACTUAL FEE PAYMENTS	FEE SCHEDULES AND PROFESSIONAL CASE RATES
OTHER OR NO ARRANGEMENT	FEE-FOR-SERVICE (FFS) AND USUAL, CUSTOMARY, AND REASONABLE (UCR) PAYMENTS

The managed care credit reduces a health plan's required capital if its provider contracts reduce the uncertainty of future claim payments.[4] There are five provider contract types included in the managed care credit calculation, which are summarized in Figure 2.

The above contract types are in order of increasing claim fluctuation risk, resulting in additional required capital. Virtually integrated partnerships often evolve to share more risk over time, which reduces claim fluctuation risk. Vertically integrated partnerships should establish internal contracts to minimize claim fluctuation risk. Healthcare provider and health plan partnerships that consider managed care credit categories in contract development can optimize financial performance.

The practice

We researched 2016 health plan financial data to identify partnerships that achieved an effective required capital amount relative to revenue. Figure 3 summarizes the results of our outlier analysis. We found that some plans—which we call *two-sigma* plans—have achieved a favorable CAL as a percent of revenue by working closely with strong provider partners. *Two-sigma* health plans achieved a lower required capital amount than nearly 98% of the plans included in our study. *One-sigma* plans had lower required capital than more than 80% of competitors.

FIGURE 3: HEALTH PLAN REGULATORY CAPITAL OUTLIER ANALYSIS

HEALTH PLAN CATEGORY	REGULATORY CAPITAL CAL % OF REVENUE
TWO-SIGMA PLANS	3.5%
ONE-SIGMA PLANS	5.6%
OTHER PLANS	9.0%
INDUSTRY AVERAGE	**8.0%**

Two-sigma plans achieved an average required capital that is less than half the 8% industry average. Kaiser Foundation Health Plan is among the largest and most well-established integrated health plans in the U.S. As a result, multiple Kaiser subsidiaries have achieved two-sigma status.

Our research also indicates there are geographic concentrations of *one- and two-sigma* health plans. Wisconsin, the Mid-Atlantic, Georgia, and the West Coast all have a cluster of highly efficient partnerships between health plans and providers.

A health plan's required capital is complicated, often a function of multiple business segments and multiple healthcare provider relationships. However, health plans can achieve optimal financial performance and create strong partnerships by considering required capital when negotiating provider contracts.

When theory meets practice

Healthcare providers and health plans are integrating vertically through consolidation and virtually through sharing risk in ACO arrangements. In 2015, 13% of all U.S. health systems offered more than 100 health plans, which provided insurance coverage to 18 million individuals.[5] The number of contracts between ACOs and health plans is on the rise, reaching 715 in 2017.[6]

Opportunities to improve financial performance exist in vertically and virtually integrated partnerships. Vertically integrated organizations with healthcare providers and health plans under common ownership should evaluate internal contracts to optimize financial performance for all parties. Health plans negotiating with ACOs should consider how the provider contract type affects required capital.

4 Skwire, Daniel (2016). Group Insurance, 7th edition. ACTEX Professional Series. Chapter 39, p. 687.

5 Khanna, G., Smith, E., & Sutaria, S. (2015). Provider-led health plans: The next frontier—or the 1990s all over again? McKinsey & Company. Accessed August 22, 2017, at: http://healthcare.mckinsey.com/sites/default/files/Provider-led%20health%20plans.pdf.

6 Muhlestein, D., Saunders, R., & McClellan, M. (June 2017). Growth of ACOs and alternative payment models in 2017. Health Affairs Blog. Accessed August 22, 2017, at: http://healthaffairs.org/blog/2017/06/28/growth-of-acos-and-alternative-payment-models-in-2017/.

The world of regulatory capital can be complex, making it a difficult topic to productively negotiate. Healthcare provider and health plan partnerships can improve financial performance for both entities by considering required capital and including experts in negotiations. Achieving *two-sigma* status is possible for health plans that select committed partners and employ an effective regulatory capital strategy. Improved financial performance for providers and plans alike can lead to successful—and often lasting—partnerships.

Appendix

Figure 1 is an illustration to demonstrate the effect that provider contracting can have on health plan required capital. In practice, capital is a function of many variables including investment strategy, non-benefit expenses, and reinsurance arrangements. Underwriting risk specifically varies by business segment mix, provider contract type, and company size.

To develop the values in Figure 1, we relied on 2016 health RBC data published by the NAIC. We imputed a managed care credit for the industry based on published revenue and underwriting risk RBC component. We then varied the managed care credit to illustrate CAL under different provider contracting arrangements. Figure 4 summarizes the managed care credit assumed for each provider contract type.

FIGURE 4: HEALTH PLAN REGULATORY CAPITAL OUTLIER ANALYSIS

CONTRACT TYPE	MANAGED CARE CREDIT
NON-CONTINGENT EXPENSES	75%
CAPITATION	40%
BONUS/WITHHOLD ARRANGEMENT	25%
CONTRACTUAL FEE PAYMENTS	15%
OTHER OR NO ARRANGEMENT	0%

Bonus/withhold arrangements have a managed care credit that can range from 15% to 25%—we assumed 25% for the illustration in Figure 1. In our analysis, we assumed an 85% loss ratio and that all premiums and claims are from the comprehensive medical business segment. We did not vary other RBC components—asset risk, credit risk, and business risk—to isolate the effect of the managed care credit on RBC for health plans. In practice, other components of the RBC formula will change due to different provider contract terms.

We relied on 2016 statutory financial data to research health plan RBC summarized in Figure 3. Our sample was limited to plans that filed a NAIC health (orange blank) annual statement. Since underwriting risk varies by business segment, our study included health plans with more than 50% of total revenue from the comprehensive medical segment.

Two-sigma plans were identified as the top 2.3% of plans in our study with the lowest CAL as a percentage of revenue. *One-sigma* health plans were identified as the top 18.1% of plans in our study, excluding *two-sigma* plans. Plan group assignments are based on one-sided standard deviations in the observed sample assuming normality.

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