Issue Brief
Findings from HSC

AT THE BRINK: HOW HARVARD PILGRIM GOT IN TROUBLE

by Linda R. Brewster and Paul B. Ginsburg

The Massachusetts insurance commissioner placed Harvard Pilgrim Health Care (HPHC) in receivership in January on the basis of large projected losses that put the nonprofit plan in a significant negative net worth position. Because Harvard Pilgrim was the largest health plan in the market, with substantial amounts payable to hospitals and physicians, its financial problems shook the Boston health care community. The story also attracted national attention because of the plan's prominence and its reputation for quality. The Center for Studying Health System Change (HSC) followed the Harvard Pilgrim story closely as part of its continuous tracking of Boston—one of the 12 Community Tracking Study sites visited every two years—and is able to put this event in broader context. Many of Harvard Pilgrim's problems are evident in plans elsewhere. This Issue Brief discusses the causes of the plan's financial problem and the state's response, which has preserved the organization.

State Shores Up Plan

In late 1999, when Harvard Pilgrim's losses ballooned, Massachusetts enacted emergency legislation to empower the insurance commissioner to take over the failing health plan. At the same time, Harvard Pilgrim's CEO was attempting to raise millions of dollars through bonds issued by a state public funding authority for the sale and leaseback of the plan's health centers.

During the due diligence process for the proposed financing, Harvard Pilgrim discovered a serious accounting error. Adjusting for the error made its losses much larger than previously believed, causing the bond issue to be canceled and forcing the state to take over the plan under the receivership law that had just been enacted on an emergency basis.

Three months later, buoyed up by rosier projections of Harvard Pilgrim's revenues and costs, the state announced that the plan could enter rehabilitation under limited state supervision. In lieu of selling the plan to a for-profit insurer, liquidating the plan or bailing it out, the state found a way to address Harvard Pilgrim's most significant problem—a lack of statutory capital.

By creating a plan to restructure Harvard Pilgrim's debt and allowing an accounting change that permits the plan to carry the value of its health centers at current market value, the state made it possible for the plan's balance sheet to show strongly positive net worth. Since then, the plan has taken solid steps toward recovery by raising premiums and lowering administrative costs.

Five key reasons for HPHC's problems emerged from HSC's interviews with leaders in Boston's health community and accounts of the story that were widely reported in the press. The causes of HPHC's decline can be found in factors that were unique both to the plan and the environment in which it operated:

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- difficulties related to the plan's transition away from the staff model;
- internal management problems, especially incomplete implementation of the earlier merger between Harvard and Pilgrim;
- attempts at rapid geographic expansion;
- health insurance underwriting cycle; and
- the state's political and regulatory climate.

Transition Away from the Staff Model

Since the early 1990s, Harvard Pilgrim had been grappling with its move from a staff model to a mixed model plan. This shift, which was facilitated by mergers, eventually resulted in a large physician network. During this period, not only were the plan's health center physicians agitating for greater control over their employment arrangements, but enrollment growth in the health centers also had stagnated and customer service ratings were slipping. It was not until 1998 that Harvard Pilgrim finally spun off its health centers, giving physicians 50 percent ownership of them and the right to contract with other plans.

In other communities across the country, staff model plans have fallen out of favor with consumers who want broader choice of physicians and more conveniently located offices. In addition, staff model plans have been at a competitive disadvantage relative to network models, which have been able to expand into new service areas rapidly and negotiate contracts with network physicians at deeply discounted rates, resulting in lower costs than those of plans with salaried physicians. Examples include the Group Health Cooperative of Puget Sound moving to a mixed model in 1993, and Kaiser Permanente contracting with independent physicians more recently.

Internal Management Problems

Compounding HPHC's difficulty in transitioning to a mixed model plan and contributing to the plan's financial woes was its inability to monitor its costs. Financial information system problems likely led the plan to unwittingly set its premium rates too low. It appeared that a priority was not placed on integrating the systems of the various merged plans. Harvard Community Health Plan and Pilgrim Health Care merged in 1994, and it was not until turnaround efforts began in July 1999 that Harvard Pilgrim entered into a 10-year contract with Perot Systems to build an up-to-date information system.

Integration issues affected other critical management areas, as well. Harvard Pilgrim had maintained predecessor organizations as substantially separate businesses, which made combining operational processes difficult, created barriers to merging the Harvard and Pilgrim cultures and resulted in a very complicated organizational structure. Eventually, the lack of integration led to duplication of efforts and caused problems with management accountability.

For example, the plan reportedly maintained a number of individual offices for managing provider contracts, and because there had been some overlap between the Harvard and Pilgrim provider networks before the merger, many physicians continued to have multiple provider numbers and contracting options after the two plans combined. At the time the plan was forced into state receivership, Harvard Pilgrim was in the process of reducing 20 different payment arrangements that had been customized for medical groups and hospitals into just three options.

Problems with financial information systems resulting from mergers or rapid internal growth of health plans are not limited to HPHC. Harvard Pilgrim's problems are particularly reminiscent of those of New York's Oxford Health Plans in which rapid growth overwhelmed its computer systems and led the plan to underestimate its costs and overestimate its revenues. In the Aetna/US Healthcare merger, a strategy to bring Aetna's business rapidly to US Healthcare's information systems platform led to widespread customer service problems, including lost membership cards and claims backlogs. With its more recent acquisitions, Aetna has adopted a phased-in approach to integrating operations in an attempt to avoid such disruptions and disarray in the future.

These examples point to problems that can develop when the strategy for integrating the operations and systems of merging plans occurs either too slowly or too rapidly. Yet, as Harvard Pilgrim's experience shows, a lack of information systems that can communicate among merging partners eventually leads to an inaccurate or incomplete financial picture of the new organization.

Rapid Geographic Expansion

At the same time HPHC was grappling with internal management issues and transitioning to a mixed model plan, it was pursuing geographic expansion aggressively into much of New England. Indeed, the strategy to pursue geographic expansion throughout the greater Boston market was an important factor behind the merger of Harvard and Pilgrim. Subsequently, through acquisition and internal growth, the plan expanded into western Massachusetts, New Hampshire, Vermont and Maine. Local observers say that these expansions have been financially draining for the plan and a major cause of its financial problems. HPHC also had not anticipated the strong competition from large national for-profit companies present in these markets.

Geographic expansion by local health plans is seen widely throughout the country, although the local circumstances differ. For example, New York City's Empire Blue Cross and Blue Shield and New Jersey's Horizon Blue Cross Blue Shield have expanded into each other's traditional territories. Some local plans have merged with plans that serve areas that are not adjacent. PHP in Syracuse, N.Y., merged with Health Care Plan of Buffalo, and Anthem Blue Cross Blue Shield in Indiana acquired Blue Cross Blue Shield plans in Connecticut, New Hampshire and Maine.

In some cases, such as Harvard Pilgrim moving into southern New Hampshire, the expansions are pursued to meet the needs of employers whose workforces are spread over increasingly broad areas. But in other cases, expansion is driven more by a perceived need to gain scale economies. Some plans have expanded into markets that are not contiguous with their existing markets, and many of these moves have not achieved their objectives.

Harvard Pilgrim's disappointments in geographic expansion are not unique, except perhaps for the degree to which they compromised the plan's ongoing viability. For example, a number of Kaiser's expansions in the east, such as Miami, North Carolina and Albany, N.Y., have not been successful, and Tufts Health Plan cited higher administrative costs than expected for withdrawing from some New England markets. Market observers have been skeptical about the prospects for other expansions throughout the nation, particularly those that are not contiguous.

Underwriting Cycle

Throughout the 1990s, the insurance industry experienced a boom and bust cycle that seems to have been more severe than similar cycles observed in the 1970s and 1980s. When the growth rate of costs underlying health insurance benefits dropped unexpectedly early in the decade, declines in the rate of premium increases necessarily lagged. As a result, health plans became highly profitable. This led plans to attempt to expand their volume by increasing market share in existing markets and entering new ones. Setting particularly low premium increases was a key part of this overall strategy.

However, when all plans in a market tried to build market share by keeping premium increases low, the result was lower profit margins, or even losses. As a result, health plans have experienced poor financial performance recently and generally have stopped entering new markets and withdrawn from selected markets.

Health plans in Boston experienced this underwriting cycle. The Tufts Health Plan expanded rapidly in the early 1990s. Boston also saw the geographic expansion of both HPHC and Tufts at that time. More recently, during the subsequent phase of the underwriting cycle, both plans withdrew from unprofitable markets, such as Rhode Island, New Hampshire and Maine.

The underwriting cycle was timed unfortunately for Harvard Pilgrim. The financially challenging part of the cycle came at the same time as the plan was spending heavily to reduce its reliance on its staff model delivery system and expanding into new markets. Its problems with monitoring its finances developed just when its competitors were setting premiums low in relation to cost, so that any inadvertent setting of premiums too low added to losses rather than diminished profits.

The fact that Boston is dominated by three locally based nonprofit plans—Harvard Pilgrim, Tufts and Blue Cross and Blue Shield of Massachusetts—likely made the underwriting cycle more extreme. This could have occurred because of the absence of plans based elsewhere or plans owned by provider systems that were more willing to withdraw from the market when health plan capacity was in greatest excess. Since providing health insurance is such a core activity for all three Boston plans, there might have been great reluctance for any or all of the plans to give up market share. In contrast, in Seattle, which also is dominated by local nonprofit plans, plans owned by a hospital system and a large physician group practice left the market during this phase of the underwriting cycle.

Political and Regulatory Climate

Political pressures and the regulatory environment in Massachusetts—though critical to the ultimate resolution of the Harvard Pilgrim crisis—also appear to have contributed to its problems. HSC's 1999 Community Report on Boston pointed out the extensive role that Massachusetts public officials play in the health system. This occurs formally, through legislation and regulation, and informally, by key officials attempting to influence decisions made by health care organizations.

Like other nonprofit health plans in the state, Harvard Pilgrim had been generally responsive to pressures from the political environment. As the plan's

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financial problems began to mount, it was forced to challenge the state despite the threat of regulatory action. For example, when Harvard Pilgrim sought to reduce the unlimited prescription drug benefit, required by state law, in its unprofitable Medicare+Choice product, the secretary of state criticized HPHC severely and threatened to revoke the plan's nonprofit status.

Fallout from the prescription drug coverage controversy set off a wave of negative publicity that led to calls for increased regulation of health plan services. While the debate continued, Harvard Pilgrim's financial condition deteriorated further, causing the state to place the plan under supervision. This move still did not enable the state to anticipate the severity of HPHC's financial problems, however, because neither the plan nor the state was aware of the full extent of the losses that the inadequacies of HPHC's information systems had concealed.

Historically, Massachusetts has maintained only limited monitoring and oversight of health plans, largely because the three dominant plans are local players, all of them nonprofit. When Harvard Pilgrim's financial difficulties first surfaced, the state did not have the regulatory authority to take over a financially troubled health plan. Also lacking were minimum net worth requirements for plans, which most states had already enacted, and disclosure of detailed financial records for all lines of business. Harvard Pilgrim operated in an environment where the state's role and authority in monitoring health plans was smaller than elsewhere and left the plan unchecked when its financial performance faltered.

Harvard Pilgrim also may have been affected by pressure from the Massachusetts Healthcare Purchasers Group's (MHPG) annual challenge to limit premium increases. The market clout of Boston purchasers traditionally has been limited because of a reluctance to risk antagonizing highly skilled employees with changes in health plans that contain costs. Boston plans' greater responsiveness to MHPG's pressure to hold down premium increases in recent years may be a reflection of the current policy environment and the strong antimanaged care sentiment expressed in state and national politics. To the degree that premiums were held below costs as a result of political pressure, this would have contributed to Harvard Pilgrim's financial problems.

Whatever contribution the regulatory environment may have played in causing the plan's financial distress or failing to make a timely diagnosis of its losses, the formal and informal processes undertaken by the public sector in crafting a solution to its insolvency showed creativity and leadership. As of this writing, state officials are convinced that Harvard Pilgrim's turnaround plan is working. Moreover, premium increases have started to kick in, bolstering the plan's cash position and enabling overdue provider claims to be paid.

By allowing the accounting adjustments that shifted millions of dollars to the plan's asset base and restored Harvard Pilgrim's statutory net worth, Massachusetts avoided a bailout that would have entailed an injection of state funds, loans from major creditors and other stakeholders, sale of the plan to a for-profit entity or liquidation. Each of these alternatives was fraught with implications for the health care system.

A Postscript

The Harvard Pilgrim story is far from over. More favorable forecasts of its revenues and costs have put on hold the difficult choices that have been debated by the community. For the most part, Harvard Pilgrim's financial difficulties are similar to health plan problems that have been seen around the country. While plans in other markets, and those who regulate them, may gain important insights from studying the Harvard Pilgrim experience, it is likely that similar turmoil will emerge elsewhere. Other states already may have implemented stronger health plan regulation, the kind that is being considered now in Massachusetts, but health plans in other states are unlikely to receive the same kind of proactive support that Massachusetts gave Harvard Pilgrim. ●

For more information about the Boston health care market, see "Market Stablilizes around Five Large Organizations," Community Report, Winter 1999.

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