New Member Impact on Medicaid Managed Care Costs

by Bela Patel Fernandez and Jeff Smith

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The recent economic downturn has caused shifts that cast doubt on some fundamental assumptions used in actuarial pricing. The national unemployment rate is now 9.8 percent[1], which is double the rate in January 2008. Increasing unemployment not only causes a lack of income, but also a lapse of medical coverage since the majority of working-age Americans participate in employer sponsored health care coverage.

For some, Medicaid is the safety net that provides access to affordable health care in trying times. Medicaid began in 1965 primarily as cash assistance for the indigent, but has now expanded into health and long term care services for low income, disabled, and elderly Americans. In this article, we will explore how the recession has impacted new member enrollment in the various state health care programs and the resulting impact on trend.

First, state health care programs cover three main categories of individuals:

- Temporary Aid to Needy Families (TANF): The majority of the members in the TANF program are pregnant women, mothers and their children. Recently, many states have expanded eligibility to include childless adults who also meet income requirements.
- Children's Health Insurance Program (CHIP): This program provides health care coverage for all children who meet eligibility requirements. The parents may not qualify for TANF coverage, however if their income falls within CHIP guidelines, the children of the family will be eligible for coverage under this program.
- Aged, Blind, Disabled (ABD): Individuals in this category are elderly and may have a disability. Some also qualify for Medicare coverage, and are also referred to as Dual Eligibles (Medicare/Medicaid).

New additions to the Medicaid rolls are, on average, more costly than their longer duration counterparts. There are two main reasons for this:

- **Time of Enrollment:** Medicaid enrollment often occurs when an individual is at the hospital or provider.
- **Pent -up Demand:** Care may have been deferred during a lapse in coverage. When eligibility is confirmed, members need to catch up on missing care.

To demonstrate this, Ingenix Consulting and AmeriChoice's Finance department undertook a study of new member health care costs to determine the overall financial impact. Ingenix reviewed claims cost data across several health plans that have experienced high rates of membership growth due to unemployment increases in their geographic region (see Table 1). The markets studied included Arizona, Maryland, Tennessee, New Jersey, New York, and Wisconsin. Both medical and pharmacy claims were examined.

TABLE 1

	Unemployment Rate		
State	2008	2009	Increase
Arizona	6.0%	9.1%	3.1%
Maryland	4.6%	7.2%	2.6%
New Jersey	5.8%	9.8%	4.0%
New York	5.8%	8.9%	3.1%
Tennessee	6.9%	10.5%	3.6%
Wisconsin	4.7%	8.3%	3.6%

Source: Bureau of Labor Statistics, Sept 2009, Seasonally Adjusted

A member's duration was based on their first month of eligibility. Interruptions in coverage during the study period were not included in total duration. For example, a member who enrolled in January 2009, lost coverage for March and April, and re entered the program in May 2009, would have May recorded as duration month three. Members were assigned to one of three duration classifications depending on the length of their membership (1–6 months, 7–12 months, and 13+ months). Claims cost was converted to a Per Member Per Month (PMPM) basis to enable direct comparison between the first two quarters of 2008 and 2009.

Findings

In addition to showing that new members have, on average, higher health care costs (see Table 2) the study showed that the proportion of short–duration members was increasing. However, not all markets are seeing the same rate of growth in new members or the same distribution of costs among the populations of differing duration.

Where this growth is significant, the increase in higher cost short-duration members brings with it increased overall health care cost.

As Table 3 shows, short–duration members grew as a proportion of total membership through the third quarter of 2009 and are projected to continue growing through 2010. Historically, the financial and encounter reports submitted to the states only reflect the costs associated with the durational mix of members during the reporting period (2007–2008). Just as the mix of young and old members can affect health care costs, the mix of short and long duration members can have the same effect. If states wait for this effect to show up in the encounter data used as the base to set capitation rates, the impact of more short-duration members will not be recognized until 2011 due to the lag inherent in claim and encounter submission. To reflect the additional cost associated with the recent greater influx of short-duration members in a more timely fashion, an explicit adjustment to the historical base rate or trend is needed.

The change in member mix has had a profound impact on average health care costs. Table 4 illustrates the cost impact of these new members. The relative cost due to the influx of more short duration members rapidly increased during the first part of 2009. This impact is expected to peak and then gradually ease as the proportion of longer–duration members begins to expand. The rate of this mitigation will depend on a number of factors including the state of the economy and its ability to begin reversing the unemployment trend as well as member persistency.

Conclusion

Based on this analysis, we can draw the following conclusions about Medicaid programs:

- New members cost more than existing members,
- new members comprise a greater proportion of membership than historically reported, given the high unemployment rates we are experiencing,
- historical data does not readily reflect this greater cost, and
- additional consideration must be given in pricing capitation rates to reflect this impact.

TABLE 2
TOTAL PMPM COSTS 0108-0209 BY DURATION

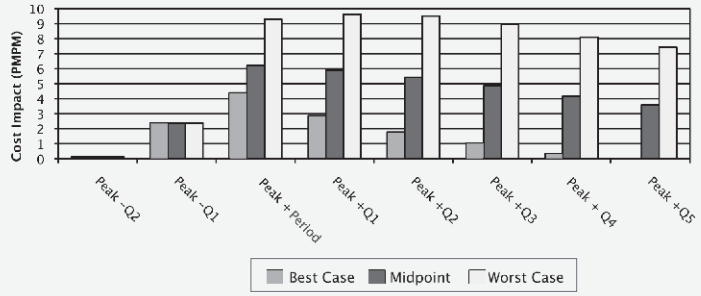


TABLE 3
AMERICHOICE AFDC/FHP MEMBERSHIP GROWTH & DURATIONAL MIX FOR HIGH-GROWTH PLANS (AZ,MD,NY,WI)

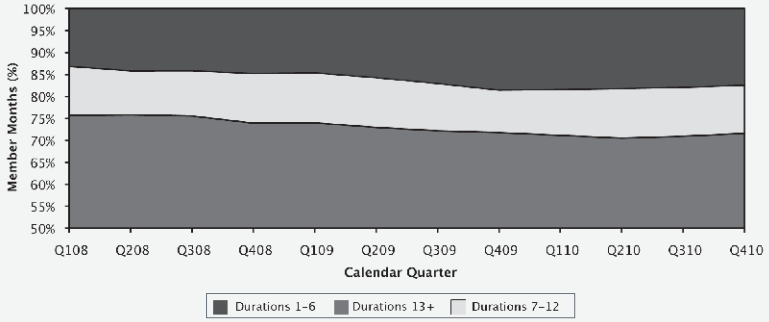
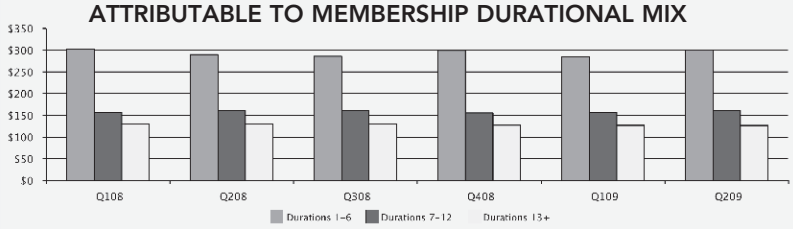


TABLE 4
AMERICHOICE MEDICAL COST INCREASE ATTRIBUTABLE TO MEMBERSHIP DURATIONAL MIX



Addressing the issue of health care cost in a Medicaid program is the joint responsibility of two parties—the health plan and the state. Health plans must be good stewards of public funds and work to keep inappropriate utilization down and operating costs in check. States must do their part as well by offering actuarially sound rates that encompass emerging cost trends through thorough data analysis and the inclusion of appropriate actuarial assumptions. ■