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Medicaid Risk-Based Managed Care Financial Results: A Decade in Review

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Who cares about the financial results for Medicaid managed care plans? Well, as it turns out, almost everyone! At least this is true in today's world where Medicaid is in the national news on a daily basis. While the financial impact of Medicaid spending is a widely discussed topic in 2017, it was not always the case. When I first began this research almost a decade ago, it was an entirely different Medicaid universe. I would have never guessed that we were creating an annual report that would yield more than a dozen media inquiries a year, be quoted in the Medicaid managed care rule[1] and have us consorting with Ivy League researchers.

To put things in perspective, the first year of our report focused on financial results from calendar year 2008. George W. Bush was President, Barack Obama was still the youngster from Illinois looking to make his national debut, and Donald Trump was in his first year as host of "Celebrity Apprentice." Also, typing "ACA" into Google in 2008 would have yielded only such entities as the American Counseling Association, the American Camping Association or the American Canine Association. So to say things are different today would be a colossal understatement.

Medicaid has become a household term, with perhaps the largest spike in interest taking place right now with the debate in Washington related to repeal and replacement of the Affordable Care Act (ACA). Many casual observers may not have been able to tell that Medicaid was an integral part of the ACA from the time it was enacted in 2010. Most of the conversation focused on health care exchanges. It wasn't until the *National Federation of Independent Business (NFIB) v. Sebelius* lawsuit that many realized the far-reaching changes in store for Medicaid, that is, except for those who were in the trenches of Medicaid all along. The most significant change occurred in 2014 with the introduction of the new optional adult populations accessing Medicaid. Many of these individuals began receiving health care coverage for the first time.

With all of this change in the Medicaid market, we might be expecting large changes in the financial results for Medicaid managed care plans. Taking a look at the financial results published for 2008 and 2016 is sure to show this polarizing notion or two disjoint worlds, right? Well, interestingly enough, although

Figure 1
Financial Results for Medicaid Managed Care Plans

Financial Metric	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Number of companies	140	148	150	151	162	167	182	191	189
Medicaid revenue ($ Billions)	$39.5	$48.1	$54.6	$62.0	$73.8	$83.7	$110.6	$144.1	$163.7
Member months (Millions)	163	178	202	215	249	262	311	391	424
Medical Loss Ratio (MLR)	87.4%	87.9%	85.3%	85.5%	88.2%	87.4%	86.0%	85.4%	86.9%
Administrative Loss Ratio (ALR)	11.7%	11.5%	12.1%	12.1%	11.4%	11.4%	12.0%	12.0%	12.2%
Underwriting (UW) ratio	1.0%	0.6%	2.6%	2.4%	0.4%	1.1%	2.0%	2.6%	0.9%
Risk Based Capital (RBC) ratio	464%	447%	511%	515%	490%	467%	423%	407%	399%

Source: Adapted from Medicaid Risk-Based Managed Care: Analysis of Financial Results for 2016, Jeremy D. Palmer and Christopher T. Pettit, 2017, *http://www.milliman.com/insight/2017/Medicaid-risk-based-managed-care-Analysis-of-financial-results-for-2016/*.

the number of individuals covered and the capitation revenue illustrate this changing world, the average financial results are far from disparate. In fact, some of the metrics are so close as to be almost indistinguishable, as shown in Figure 1.

With such mundane conclusions like Medicaid has grown and the financial results are similar year to year, you may still be asking yourself why so many care about this research. With that in mind, the following is a top 10 list of conclusions I have ascertained over the better part of a decade in doing this research.

THE MAGNITUDE OF DOLLARS IS ASTOUNDING

Even actuaries may be impressed by the volume of dollars flowing through the Medicaid program. On the whole, Medicaid expenditures are more than $550 billion annually.[2] Our data sources include approximately $164 billion of capitation revenue for 2016. We have made several exclusions in our analysis that lower the number of Medicaid managed care plans included, most notably, the omission of managed care plan experience in the state of California because of the state's unique reporting structure. We remain optimistic that we will soon be able to include California as a huge addition to our research.

Over the entire nine-year period, we have observed $815 billion of capitation revenue, $706 billion of claim payments, $97 billion of administrative cost and $12 billion in underwriting gain.

ACTUARIES ARE AWESOME

This should not come as a surprise to you, but one of the key takeaways from doing this research over the better part of a decade is that the underwriting gains observed at a national level align very closely with the target underwriting gain used by the majority of actuaries throughout the country. The SOA recently commissioned a study related to calculating margin in Medicaid managed care.[3] My takeaway from that report was that the pricing assumptions for underwriting gain (or margin) among the states largely followed a bimodal distribution with modes at 1 percent and 2 percent. The actual nationwide underwriting gain observed over the recent past has likewise been in the 1–2 percent range. Who doesn't love the law of large numbers?

FILLING A VOID OF INFORMATION

Medicaid is the largest provider of health care insurance in the United States with almost 75 million enrollees.[4] However, expenditure and financial information is scarce or limited in most cases for Medicaid. Much of the reason for this void of information is the segmentation of the program by state and territory. The NAIC financial statements are timely and uniform across most states, allowing for comparison of high-level financial results. There is the promise of more timely and accurate data from CMS, and we, along with many of you, anxiously await its arrival.

MEDICAID EXPANSION HIT BIG

With the ACA came Medicaid expansion for states that chose to implement coverage for the new adult population under 138 percent of the federal poverty level. The enrollment surpassed most expectations and significantly increased the number of covered lives, and therefore the capitation revenue, for Medicaid managed care plans beginning in 2014, with the largest impact coming in 2015 and 2016. The Medicaid managed care plan profitability was also higher in 2014 and 2015 than previous years, adding to the windfall for the risk-taking plans.

One potential adverse impact of Medicaid expansion on Medicaid managed care plan financial results at a national level relates to the level of risk-based capital (RBC) that plans are required by state regulators to maintain on their balance sheets. The average RBC ratio decreased significantly in 2014 compared to previous years, and that level stayed lower through 2016. Notwithstanding the above decrease in RBC ratio, the overall national level of RBC remains approximately twice as large as required by most state regulators before regulatory action levels begin (200 percent).

UNDERWRITING CYCLES ARE NOT A MYTH

From a review of the underwriting ratios for 2008 to 2016, there appears to be evidence of an underwriting cycle within the Medicaid program. Following periods when underwriting gains have not been as high, the gains appear to have a correction of sorts that may be explained by the lag time in capitation rate-setting base data being two to three years behind the rating period. Thus, when claims are higher, the gains are lower, but eventually the higher experience gets into the calculation of Medicaid capitation rates, inflating later years. The same theory stated differently would be that after a couple of years of above-average underwriting gains, the capitation revenue catches up and reduces the gains back to target levels.

RESULTS VARY SIGNIFICANTLY BY STATE

This observation should not come as a surprise to health actuaries, but while the overall national financial results are stable over the years, the year-to-year fluctuation at the state and managed care plan level can be significant. Each state sets their own unique capitation rates that are individually certified as actuarially sound by a qualified actuary. The variance in results comes in numerous flavors, but some of the key trends would be data quality, Medicaid managed care plan efficiency and maturity of the program. Many of the larger national Medicaid managed care plans may have already figured this out and let the diversification of different states and markets assist in smoothing out the volatility.

MANAGED CARE IS HERE TO STAY

How did the term "managed care" survive all these years given that was a buzzword that died tragically in the mid-1990s in the commercial market from consumer backlash? Not only did the term "managed care" survive, the managed care programs have become the largest delivery system for beneficiaries across the country. Many states are embarking on strategies to implement Medicaid managed care to previously excluded populations such as Medicare-Medicaid dual eligibles, long-term care recipients and medically complex individuals through the development of CMS waivers. New states are rolling out managed care programs each year, and fewer and fewer states don't have some form of managed care program enacted.

The size and shape of managed care may change over time, but it is engrained in the Medicaid program such that it is not likely to be dismantled without a significant and sustained outside catalyst.

SPIN-OFFS CAN BE AS GOOD AS THE ORIGINAL

Counter to what you may think about what comes out of Hollywood, a spin-off can be as good as the original. One of the comments we have received over time is the trouble with digging deeper into the administrative costs reported by the Medicaid managed care plans. The problem with this, however, is that the NAIC source data used for our research don't allow us to get to Medicaid-specific administrative cost segmentation. The spin-off research became the solution to this reporting complexity. We truncated the studied Medicaid managed care plans to those that reported largely Medicaid experience in their NAIC report, allowing us to access the detailed administrative cost experience. The drawback, of course, is that we had to limit the number of plans we studied to fewer than 50 percent of the total plans. Even with this limitation, we included 77 managed care plans from 32 states and the District of Columbia in the report, making the administrative cost components worthy of high-level benchmarking, and this allowed for removal of state-imposed taxes that skew the results significantly by state.

THE DEFINITION OF MEDICAL LOSS RATIO

For purists out there, you may be struggling like I am with the idea that a medical loss ratio (MLR) could be anything other than claims divided by premiums. When MLR left the actuarial world and became a contractual metric for everything from commercial ACA plans to Medicare Advantage plans, so went the simplicity of the legacy MLR definition. To make matters worse for Medicaid, there is currently not a requirement for submission of the NAIC Supplemental Health Care Exhibit[5] that allows for direct calculation of the new MLR definitions. To avoid confusion in our reports, we needed to act to illustrate the potential difference in definitions as it changes the story significantly. In 2016, we estimated the difference between MLR definitions at approximately 4–5 percent, with the CMS definition being higher. After adjustment to proxy the CMS definition, we estimated that in 2016 only 15 percent of Medicaid managed care plans may be under the 85 percent MLR minimum.

THE INTENTION OF THE RESEARCH IS UNBIASED

How does one know that their work is unbiased? One method to test the bias is to look at those who are using the information. Are there pockets of individuals or entities that may have an agenda more heavily using the information, or is it consumed and cited by a large variety of stakeholders? I am pleased to state that this work has been cited and used by virtually all players in the Medicaid market, including Medicaid managed care plans, CMS, states, providers, beneficiary advocates and researchers. We take great pride in this result! ■

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ENDNOTES

1 Federal Register (May 6, 2016), Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, *http://federalregister.gov/a/2016-09581* (accessed May 6, 2016).

2 Total Medicaid Spending, *http://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel= %7B %22colId %22: %22 Location %22, %22sort %22: %22asc %22 %7D.*

3 Society of Actuaries, Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting (2017), *https://www.soa.org/Files/Research/medicaid-managed-report.pdf.*

4 Total Medicaid Enrollment, Table 1B: Medicaid and CHIP: March 2017 Monthly Applications and Eligibility Determinations, Updated May 2017, *https://www.medicaid.gov/medicaid/program-information/downloads/updated-march-2017-enrollment-data.pdf.*

5 NAIC Supplemental Health Care Exhibit Template, revised 10/13/2016, *http://www.naic.org/documents/cmte_e_app_blanks_16_blanks_revisions_a_frat_shce_p1.pdf.*