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# Issue Brief

## Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide

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**ABSTRACT:** In many states, Medicaid programs have contracted out the delivery of health care services to publicly traded health plans that are focused on managing the care of Medicaid members. Under the health reform law, states will be expanding the enrollment of their Medicaid programs and these publicly traded companies are expected to capitalize on this growing market. This study examined how publicly traded health plans differ from non–publicly traded ones in terms of administrative expenses, quality of care, and financial stability and found publicly traded plans that focused primarily on Medicaid enrollees paid out the lowest percentage of their Medicaid premium revenues in medical expenses and reported the highest percentage in administrative expenses across different types of health plans. The publicly traded plans also received lower scores for quality-of-care measures related to preventive care, treatment of chronic conditions, members' access to care, and customer service.

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### INTRODUCTION

State Medicaid programs increasingly rely on managed care plans to provide health services to Medicaid beneficiaries.<sup>1</sup> In 2000, the Centers for Medicare and Medicaid Services (CMS) reported that 18.8 million Medicaid enrollees, or 55 percent of the Medicaid population, were covered by various managed care arrangements. By 2009, CMS reported the number of enrollees receiving either comprehensive or limited benefits covered by managed care plans had nearly doubled to 36 million, or 72 percent of the Medicaid population.<sup>2</sup>

As states have expanded their managed care programs, they have increasingly entered into contracts with full-risk, comprehensive health plans that are owned by publicly traded companies. In 2009, there were 10 publicly traded companies in this market, four of which focused almost exclusively on managing the care of Medicaid enrollees.

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When states have solicited bids from health plans to provide care to the Medicaid population, publicly traded companies have consistently succeeded in winning these new contracts. Nonetheless, some policymakers and state Medicaid directors have voiced concern about the long-term commitment of publicly traded plans to Medicaid programs and their willingness to balance the expense of providing high-quality care with stockholder pressure to increase enrollment and earnings.<sup>3</sup> This issue brief provides a national and state-level overview of those Medicaid managed care plans that provide *comprehensive* benefits and have at least 5,000 members each (representing a total of 23.8 million beneficiaries). The analysis examines these plans by organizational traits and assesses both financial health and quality of patient care provided.

## MEDICAID PLAN TRAITS

According to a CMS listing of Medicaid managed care plans, there are a total of 225 full-service Medicaid health plans with more than 5,000 members. For the purposes of this analysis, the health plans that participate in Medicaid managed care programs have been segmented by ownership status into three categories:<sup>4</sup>

1. Pure-play, publicly traded health plans whose primary line of business is managing care for Medicaid enrollees. Four pure-play plans—Amerigroup, Centene Corp., Molina Healthcare, and Wellcare Health Plans—operated 37 state health plans.<sup>5</sup>
2. Multiproduct, publicly traded health plans that are owned by publicly traded companies that serve the Medicaid, commercial, and/or Medicare markets.<sup>6</sup> Companies in this category—Aetna, Coventry Health Care, Humana, Health Net, UnitedHealth Group, and Wellpoint—operated 45 state health plans.<sup>7</sup>
3. Provider-sponsored plans, which include plans that are owned, affiliated, or governed by health care systems, community health centers and clinics, or

physician practices. Fifty-six health plans were sponsored by a provider. Some of these plans are owned by large public hospitals or academic health centers that serve as safety-net providers or comprehensive private health care systems.

We also analyzed the plans by for-profit and nonprofit status. The pure-play and multiproduct plans are for-profit plans, while the provider-sponsored plans are either for-profit or nonprofit entities. In all, there were 135 plans operating as for-profit companies. Sixty-one percent of these were owned by publicly traded companies and 39 percent were owned by a health care provider.

The health plans were also analyzed by their focus. Medicaid-focused plans are defined as plans whose Medicaid enrollees account for 75 percent of their total enrollment.<sup>8</sup> Plans whose Medicaid population comprised less than 75 percent of total enrollment are classified as non-Medicaid-focused plans. There were 134 plans (60%) with a Medicaid focus. Of the pure-play, publicly traded companies, 89 percent were Medicaid-focused. In the remaining 11 percent, Medicaid enrollment fell slightly below this threshold because of the plans' participation in the Medicare market.

The study finds that overall, as plans invested in other products for other markets (especially Medicare), the percentage of Medicaid-focused plans declined from 66 percent in the 2004 analysis to 60 percent in 2009.

In a prior analysis of 2004 CMS Medicaid health plan data, provider-sponsored plans accounted for 32 percent of the health plans while publicly traded plans represented 26 percent.<sup>9</sup> In comparison, this study finds that provider-sponsored plans declined to 25 percent of the health plans, while the percentage owned by publicly traded companies—both pure-play and multiproduct—increased to 36 percent. The parallel contraction of the provider-sponsored plans may stem from the sale of these plans to publicly traded companies.

**MEDICAID ENROLLMENT BY OWNERSHIP STATUS AND STATE**

This study analyzed comprehensive health plans with at least 5,000 Medicaid enrollees, representing a total of 23.8 million Medicaid managed care enrollees. Exhibit 1 presents health plan membership by for-profit and nonprofit status, as well as by ownership status. Medicaid enrollment in for-profit plans exceeded enrollment in nonprofit plans (14 million vs. 9.8 million), while enrollment in multiproduct, publicly traded plans exceeded that of pure-play, publicly traded plans (5 million vs. 4.8 million). Provider-sponsored plans enrolled 4.8 million.

While the number of Medicaid members in publicly traded plans is still lower than the number in non-publicly traded plans, the total number in publicly traded plans has been increasing. From 2004 to 2009, the total Medicaid members enrolled in publicly traded plans rose from 5.6 million (32 percent of total Medicaid population) to 9.8 million members (41 percent of the total Medicaid members).

In terms of the state distribution of Medicaid enrollment, Florida, Georgia, Illinois, Texas, and Washington have more than 50 percent of their Medicaid enrollees managed by plans that are owned by pure-play, publicly traded companies. All the plans in Georgia are owned by pure-play companies. In general, publicly traded plans—both pure-play and multiproduct—have more than 50 percent of their Medicaid members enrolled in the following 14 states: Delaware, Florida, Georgia, Illinois, Indiana, Maryland, Missouri,

Nebraska, Nevada, Tennessee, Texas, Washington, West Virginia, and Wisconsin.

The multiproduct, publicly traded company UnitedHealth Group has the highest number of plans nationally with plans in 19 states, while Wellpoint has the second highest, with plans in seven states. In terms of pure-play, publicly traded plans, Amerigroup and Centene Corp. own plans in 11 and nine states, respectively.

**MEDICAID ENROLLMENT BY EXTENT OF MEDICAID FOCUS**

As noted in Exhibit 2, Medicaid-focused health plans had a total of 16.4 million members and accounted for 69 percent of total Medicaid enrollment, while non-Medicaid-focused plans enrolled 7.4 million members and accounted for 31 percent of total enrollment. Nearly three-quarters (73%) of those enrolled in nonprofit plans belonged to Medicaid-focused plans. A smaller percentage of the total enrollment in for-profit plans (66%) was served by Medicaid-focused plans.<sup>10</sup>

**PERFORMANCE OF MEDICAID PLANS**

We used financial filings for 170 health plans to compute standard financial performance measures for the health plans’ Medicaid business.<sup>11,12</sup> The box on page 4 describes the three most commonly used financial performance ratios for analyzing health plans engaged in the Medicaid market.<sup>13</sup> We also assessed the financial stability of health plans across plan traits by using cash flow statements and balance sheets to determine

**Exhibit 1. Medicaid Enrollment by Ownership and For-Profit Status**

Plan Enrollment by Type	Total Enrollment	For-Profit	Nonprofit
Total	23.8 million	14 million	9.8 million
By Ownership Status			
Pure-play, publicly traded	n/a	4.8 million	n/a
Multiproduct, publicly traded	n/a	5.0 million	n/a
Non-publicly traded	n/a	4.2 million	n/a
By Affiliation Status			
Provider-sponsored	4.8 million	1.6 million	3.2 million
Non-provider-sponsored	19.0 million	12.4 million	6.6 million

## Exhibit 2. Medicaid Enrollment by Plan Focus

Plan Enrollment by Type	Total Enrollment	For-Profit	Nonprofit
Total	23.8 million	14 million	9.8 million
Medicaid-focused	16.4 million	9.2 million	7.2 million
Non-Medicaid-focused	7.4 million	4.8 million	2.6 million

operating cash flow per member per month (operating cash flow PMPM) and the ratio of cash plus investments to unpaid claims.

A total of 116 Medicaid health plans reported data to the National Committee for Quality Assurance (NCQA) on two dimensions of health plan quality:

clinical quality and consumer experience. The box below describes these measures.<sup>14</sup> (For a description of the process used to collect the financial and quality-of-care data for these health plans, as well as the methodological approach employed to analyze the data, see [Data Collection and Methodology](#).)

### ABOUT THE MEASURES USED IN THIS STUDY

#### Medicaid Financial Performance Ratios

To measure the financial performance of the health plans' Medicaid business, we computed the following ratios from financial accounts: the medical loss ratio (MLR), which measures Medicaid medical expenses as a percentage of Medicaid premium revenues; the administrative cost ratio, which measures Medicaid administrative expenses and claims adjustment expenses as a percentage of Medicaid premium dollars; and the operating margin ratio, which measures the percentage of Medicaid pretax operating income earned from Medicaid premium revenues. Operating income measures the difference between Medicaid premium revenues, Medicaid-related medical and administrative costs, and claims adjustment expenses.

#### Quality of Care Performance Measures

**Health Plan Employer Data and Information Set (HEDIS).** The HEDIS clinical quality measures that were analyzed included:

The *Preventive Care* composite score, which was derived from five measures: 1) adolescent well-care visits; 2) childhood immunization status ("Combo 2"); 3) chlamydia screening in women (total); 4) well-child visits in the third, fourth, fifth, and sixth years of life; and 5) well-child visits in the first 15 months of life (six or more visits).

The *Treatment of Chronic Conditions* composite score was developed from eight measures related to cholesterol management for cardiovascular conditions, comprehensive diabetes care, and use of appropriate medications for people with asthma. These measures are as follows: 1) cholesterol management for patients with cardiovascular conditions—LDL-C screening; 2) diabetes care—blood pressure control (<130/80); 3) diabetes care—eye exams; 4) diabetes care—hemoglobin A1c test control (<8%), 5) diabetes care—LDL-C control, 6) diabetes care—medical attention for nephropathy; 7) use of appropriate medications for people with asthma (ages 12–50), and 8) use of appropriate medications for people with asthma (ages 5–11).

**Consumer Assessment of Healthcare Providers and Systems (CAHPS).** In order to assess performance in the area of consumer experience, the following three measures were analyzed:

*Overall Rating of Plan*

*Getting Care Through the Plan (composite measure)*

*Overall Customer Service (composite measure)*

**FINDINGS FOR PURE-PLAY, PUBLICLY TRADED PLANS**

Exhibit 3 presents the financial performance and quality-of-care findings for pure-play, publicly traded plans as compared with non-publicly traded plans.<sup>15</sup> Pure-play, publicly traded plans incurred a significantly lower medical loss ratio than non-publicly traded plans (84% vs. 90%). Conversely, pure-play, publicly traded plans incurred a significantly higher administrative cost ratio than non-publicly traded plans (14% vs. 10%). Higher administrative costs may have offset the lower medical loss ratio among pure-play plans and resulted in a less-than-1-percent operating profit margin. There were no significant differences with respect to the two financial stability measures.

Non-publicly traded plans performed significantly better than pure-play plans with respect to the HEDIS preventive care composite rate. Non-publicly traded plans also had a statistically significantly higher chronic illness care composite rate. This non-publicly

traded plan rate was 13 percentage points higher than that of pure-play plans (63% vs. 50%).

With respect to patient experience, non-publicly traded plans generated significantly higher rates than pure-play plans for overall rating of the plan, access to care (the “Getting Care” composite), and customer service.

**FINDINGS FOR MULTIPRODUCT, PUBLICLY TRADED PLANS**

Exhibit 4 compares the financial performance and quality-of-care findings of multiproduct, publicly traded plans with those of non-publicly traded plans. Multiproduct, publicly traded plans did not differ significantly for medical loss and operating margin ratios relative to non-publicly traded plans. However, multiproduct, publicly traded plans did report a significantly higher administrative cost ratio than non-publicly traded plans (12% vs. 10%). There were no significant differences with respect to the two financial stability measures.

**Exhibit 3. Assessment of Pure-Play, Publicly Traded Health Plans in Comparison with Non-Publicly Traded Plans, by Financial Performance and Quality-of-Care Measures**

Performance and Measures	Pure-Play, Publicly Traded	Non-Publicly Traded
Financial Performance Measures	n=35	n=95
Medical loss ratio	84%*	90%
Administrative cost ratio	14%**	10%
Operating margin	0.73%	0.96%
Operating Cash Flow PMPM (Cash + Investments)/Unpaid Claims	\$4.55 1.17	\$4.11 1.02
Clinical Quality Measures		
Preventive care composite	59%**	70%
n=	12	49
Chronic illness care composite	50%*	63%
n=	10	46
Consumer Experience CAHPS Measures		
Overall rating of plan	66%**	73%
n=	14	89
Getting care composite	75%*	79%
n=	13	64
Customer service composite	80%*	83%
n=	10	31

Notes: Ratio values are rounded. PMPM refers to per member per month.

\* Significant at .05 level.

\*\* Significant at .01 level.

Source: National Association of Insurance Commissioners data from 2009, Arizona and California state data from 2009, and National Committee for Quality Assurance data from 2010.

### Exhibit 4. Assessment of Multiproduct, Publicly Traded Plans in Comparison with Non–Publicly Traded Plans, by Financial Performance and Quality-of-Care Measures

Performance and Measures	Multiproduct, Publicly Traded	Non–Publicly Traded
Financial Performance Measures	n=40	n=95
Medical loss ratio	88%	90%
Administrative cost ratio	12%*	10%
Operating margin	0.94%	0.96%
Operating Cash Flow PMPM	\$5.40	\$4.11
(Cash + Investments)/Unpaid Claims	.65	1.02
Clinical Quality Measures		
Preventive care composite	62%**	70%
n=	18	49
Chronic illness care composite	52%**	63%
n=	12	46
Consumer Experience CAHPS Measures		
Overall rating of plan	72%	73%
n=	25	64
Getting care composite	76%	79%
n=	25	64
Customer service composite	81%	83%
n=	11	31

Notes: Ratio values are rounded. PMPM refers to per member per month.

\* Significant at .05 level.

\*\* Significant at .01 level.

Source: National Association of Insurance Commissioners data from 2009, Arizona and California state data from 2009, and National Committee for Quality Assurance data from 2010.

With respect to quality, non–publicly traded plans performed significantly better than multiproduct, publicly traded plans in the delivery of both preventive care (70% vs. 62%) and chronic illness care (63% vs. 52%). However, for all three consumer experience measures (Consumer Assessment of Healthcare Providers and Systems, or CAHPS), multiproduct, publicly traded plans did not differ significantly from non–publicly traded plans.

#### FINDINGS FOR PROVIDER-SPONSORED PLANS

Exhibit 5 compares the financial performance and quality-of-care findings for provider-sponsored plans with those of non–provider-sponsored plans. Provider-sponsored plans incurred almost the same medical loss ratio and profit margin (less than 1%) as non–provider-sponsored plans. However, provider-sponsored plans did report a significantly lower median administrative cost ratio than non–provider-sponsored plans (8% vs. 12%). Although statistically insignificant, operating

cash flow per member per month earned by provider-sponsored plans was more than two dollars less than that of non–provider-sponsored plans.

Provider-sponsored plans generated a significantly higher rate on measures of chronic illness care (64% vs. 56%) and preventive care (71% vs. 63%). For the three consumer experience measures, provider-sponsored plans had only a marginally higher rate for customer service (82% vs. 81%). The differences for the access to care and overall plan rating measures were not statistically significant.

#### FINDINGS FOR MEDICAID-FOCUSED PLANS

Exhibit 6 compares the financial performance and quality-of-care findings of Medicaid-focused plans with those of non–Medicaid-focused plans. Medicaid-focused plans reported a significantly lower median medical loss ratio than non–Medicaid-focused plans: it was lower by almost four percentage points (87% vs. 91%). On the other hand, Medicaid-focused plans incurred a significantly higher median administrative

**Exhibit 5. Assessment of Provider-Sponsored Status, by Financial Performance and Quality-of-Care Measures**

<b>Performance and Measures</b>	<b>Provider-Sponsored</b>	<b>Non-Provider-Sponsored</b>
Financial Performance Measures	n=42	n=128
Medical loss ratio	89%	88%
Administrative cost	8%*	12%
Operating margin	0.96%	0.86%
Operating Cash Flow PMPM (Cash + Investments)/Unpaid Claims	\$3.04 .96	\$5.26 1.02
Clinical Quality Measures		
Preventive care composite	71%*	63%
n=	24	55
Chronic illness care composite	64%*	56%
n=	20	48
Consumer Experience CAHPS Measures		
Overall rating of plan	77%	71%
n=	23	80
Getting care composite	79%	77%
n=	23	79
Customer service composite	82%*	81%
n=	10	42

Notes: Ratio values are rounded. PMPM refers to per member per month.

\* Significant at .05 level.

\*\* Significant at .01 level.

Source: National Association of Insurance Commissioners data from 2009, Arizona and California state data from 2009, and National Committee for Quality Assurance data from 2010.

cost ratio than non-Medicaid-focused plans (12% vs. 10%). The median operating margin ratio for Medicaid-focused plans was more than two-and-a-half percentage points higher than that of the non-Medicaid-focused plans (0.55% vs. -2.06%). Furthermore, non-Medicaid-focused plans operated at a financial loss of two percent. Medicaid-focused plans’ cash and short-term investments exceeded their unpaid claims by 20 percent while non-Medicaid-focused plans had cash and investments that would pay off only 79 percent of their unpaid claims. Descriptively, Medicaid-focused health plans generated the highest cash flow per member per month (\$5.46).

Medicaid-focused plans and non-Medicaid-focused plans did not differ with respect to HEDIS measures of preventive care and chronic illness care. Measurement of consumer experience revealed a significant difference only for overall plan rating, with non-Medicaid-focused plans performing better than Medicaid-focused plans (73% vs. 70%).

**FINDINGS FOR FOR-PROFIT AND NONPROFIT PLANS**

Exhibit 7 compares the financial performance and quality-of-care findings of for-profit plans with non-profit plans. For-profit plans significantly differed from nonprofit plans in financial performance only in the median administrative cost ratio. Nonprofit plans incurred a significantly lower administrative cost ratio than for-profit health plans did (10% vs. 12%). Both nonprofit and for-profit plans earned an operating profit margin of less than 1 percent (0.97% vs. 0.72%). Descriptively, for-profit plans’ operating cash flow per member per month was more than three dollars higher than that of nonprofit plans.

Nonprofit plans differed significantly from for-profit plans with respect to the preventive care composite measure. The nonprofit plans achieved a significantly higher preventive care composite score than the for-profit plans (71% vs. 63%). For the three consumer experience measures, for-profit and nonprofit ownership status did not differ significantly.

**Exhibit 6. Assessment of Medicaid-Focused Health Plans by  
Financial Performance and Quality-of-Care Measures**

<b>Performance and Measures</b>	<b>Medicaid-Focused</b>	<b>Non-Medicaid-Focused</b>
Financial Performance Measures	n=94	n=76
Medical loss ratio	87%**	91%
Administrative cost ratio	12%*	10%
Operating margin	0.55%*	-2.06%
Operating Cash Flow PMPM (Cash + Investments)/Unpaid Claims	\$5.46 1.20*	\$4.39 .79
Clinical Quality Measures		
Preventive care composite	64%	66%
n=	44	35
Chronic illness care composite	58%	59%
n=	43	25
Consumer Experience CAHPS Measures		
Overall rating of plan	70%*	73%
n=	62	41
Getting care composite	78%	78%
n=	61	41
Customer service composite	81%	84%
n=	36	16

Notes: Ratio values are rounded. PMPM refers to per member per month.

\* Significant at .05 level.

\*\* Significant at .01 level.

Source: National Association of Insurance Commissioners data from 2009, Arizona and California state data from 2009, and National Committee for Quality Assurance data from 2010.

**Exhibit 7. Assessment of For-Profit and Nonprofit Health Plans  
by Financial Performance and Quality-of-Care Measures**

<b>Performance and Measures</b>	<b>For-Profit</b>	<b>Nonprofit</b>
Financial Performance Measures	n=112	n=58
Medical loss ratio	87%	90%
Administrative cost	12%*	10%
Operating margin	0.72%	0.97%
Operating Cash Flow PMPM (Cash + Investments)/Unpaid Claims	\$5.28 1.06	\$2.07 .91
Clinical Quality Measures		
Preventive care composite	63%*	71%
n=	51	28
Chronic illness care composite	56%	60%
n=	43	25
Consumer Experience CAHPS Measures		
Overall rating of plan	71%	73%
n=	67	36
Getting care composite	77%	79%
n=	66	36
Customer service composite	81%	83%
n=	34	18

Notes: Ratio values are rounded. PMPM refers to per member per month.

\* Significant at .05 level.

\*\* Significant at .01 level.

Source: National Association of Insurance Commissioners data from 2009, Arizona and California state data from 2009, and National Committee for Quality Assurance data from 2010.

## DISCUSSION

### Enrollment Trends

Since 2004, the health plans of publicly traded companies have played an increasingly significant role in managing Medicaid enrollees while the role of plans sponsored by health care providers has diminished. This may be because publicly traded companies are acquiring provider-sponsored plans in need of capital to support their business. As an example, in 2006, a health plan owned by a major university health system was sold because it reportedly lacked the capital to invest in technology and wanted to reallocate its capital into patient care and research.<sup>16</sup> In 2007, a large Catholic health care system sold its health plan to Molina Healthcare, a pure-play, publicly traded company, for \$47.5 million in cash.<sup>17</sup>

More than half (60%) of the health plans serving the Medicaid population remain focused exclusively on it. This is only a slight decline from the 2004 analysis when 66 percent of all Medicaid plans were Medicaid-focused plans. Over this study period, the drop in Medicaid-focused plans may stem not from their withdrawal from the marketplace, but rather from their expansion into the Medicare and commercial markets.<sup>18</sup>

This analysis of 2009 CMS and National Association of Insurance Commissioners (NAIC) data on plans with at least 5,000 Medicaid enrollees revealed total Medicaid managed care enrollment of 23.8 million members. Health plans focused on delivering care to only Medicaid members represent 69 percent of this enrollment, while pure-play and multiproduct, publicly traded companies account for 27 percent and 15 percent, respectively, of the Medicaid-focused enrollment.

Under health care reform, the Medicaid market is expected to increase by 16 million members by 2019.<sup>19</sup> Medicaid enrollment growth of more than 650,000 members is expected to occur in markets such as California, Georgia, Florida, New York, and Texas, which have a large presence of publicly traded plans, both pure-play and multiproduct.<sup>20</sup> Given recent patterns in state contract awards to managed care plans,

it is reasonable to anticipate that plans operated by publicly traded companies will enroll the majority of the expanded Medicaid population. With the onset of health exchanges in 2014, states may also require Medicaid health plans to offer commercial insurance for individuals who require subsidies, which may allow them to retain current members who no longer qualify for Medicaid.<sup>21</sup>

### Medical vs. Administrative Costs

Financially, pure-play, publicly traded plans incurred lower medical costs in managing and delivering medical care to Medicaid beneficiaries compared with non-publicly traded plans. The reduced medical costs may be a function of more cost-effective care, the enrollment of healthier beneficiaries, restricted access to costly medical providers, and/or lower negotiated rates with contracted providers.<sup>22</sup> Medicaid-focused plans, which include pure-play, publicly traded plans, also appear to have achieved a lower medical cost ratio than plans with a non-Medicaid focus, perhaps for one or more of the same reasons.

Both pure-play and multiproduct, publicly traded plans and Medicaid-focused plans incurred higher administrative costs than plans that are neither publicly traded nor Medicaid-focused. One possible explanation is that the plans may have invested in administrative costs to control their medical expenses. Higher administrative costs may arise from spending more for skilled supervisors and employees who know how to address the distinct health care needs of the Medicaid population.

Investment in information technology may also account for the higher administrative costs among plans with larger memberships, especially those owned by publicly traded companies. Larger membership plans possess greater financial resources, which allow them to invest in technology to manage these programs.<sup>23</sup> Technology supports the case management programs and information systems that prevent unnecessary emergency department utilization and hospital readmissions and improve patient safety and outcomes. Because technology costs are expensed rather than

capitalized, one analyst claims that larger plans incur higher administrative costs.<sup>24</sup> Conversely, smaller plans with limited capital to place at risk are more likely to delay the purchase of technology until it is found to be cost-effective, thus reducing their administrative expenses.

Provider-sponsored health plans had the lowest administrative cost ratio overall. The plans may be incurring lower administrative costs because they can share marketing, medical management, and customer service costs with the affiliated health care provider.<sup>25</sup> Affiliation with a health care provider may also allow these plans to economize on administrative functions related to financial reporting and information systems. At the same time, provider-sponsored plans may not always be investing as aggressively in administrative infrastructure as non-provider-sponsored plans.

Finally, from the perspective of financial stability, the health plans appear to be financially stable with positive cash flow and adequate cash reserves.

### **Clinical Quality and Relation to Cost**

Publicly traded plans, both pure-play and multiproduct, performed significantly worse than non-publicly traded plans on clinical quality composite measures of preventive care and chronic illness care. In addition, pure-play, publicly traded plans performed worse than non-publicly traded plans on measures of consumer experience. The observed differences in quality were less marked in the other comparisons. Provider-sponsored plans had significantly higher rates than non-provider-sponsored plans for clinical quality measures, and appear to have the highest rates for clinical quality (but not for consumer experience) of any of the studied plan traits.

Both Medicaid-focused and non-Medicaid-focused plans and for-profit and nonprofit plans generally performed no differently than one another, with two exceptions: 1) Members of non-Medicaid-focused plans rated their plan more highly than did members of Medicaid-focused plans; and 2) nonprofit plans performed better than for-profit plans on the composite measure of preventive care.

It is worth noting that plans with higher administrative costs and lower medical costs appear to have lower performance on measures of clinical quality and patient experience.

The Affordable Care Act created greater standardization in the definition of medical and administrative loss ratios. Because it also expands Medicaid coverage and increases the stability of enrollment, administrative costs may decline as a result of less “churning” of enrollees. In addition, plans will be able to report quality-of-care measures for a higher percentage of their members since more members will meet the continuous enrollment parameters that apply to most quality measures.

Future research may help define the composition of the administrative costs as well as their allocation between the health plans and their parent companies. More research is also necessary to evaluate costs, quality-of-care measures, and plan traits as they relate to market factors (e.g., regional variation, size of Medicaid population, number of health plans) and state policy factors (e.g., mandatory enrollment, payment rate).

### **Study Limitations**

Overall, this analysis has several limitations. First, the number of observations within selected traits was small, especially for quality-of-care measures, which limits the statistical power of the study.

Second, publicly traded plans were underrepresented among the health plans reporting quality measures to NCQA relative to their prevalence. However, new federal reporting requirements may result in the increased availability of plan performance data beyond that which is currently reported to NCQA.

Third, the descriptive statistical approach of the median tests assesses the financial and quality-of-care measures in isolation of the plan trait and does not control for market and policy factors that may influence the variation of these measures.

Fourth, health plans in Arizona and California do not follow NAIC statutory financial reporting guidelines, but instead follow Statement of Financial Accounting Standards. Health plans following statutory

accounting principles prepare financial statements so investors can measure the plan's overall solvency and its ability to liquidate and pay claims at a given time. Conversely, under the generally accepted accounting principles, the entity is viewed as an ongoing concern with the financial statements prepared to measure the entity's earnings for the accounting period by matching revenues with expenses. The reporting of administrative costs may have been affected by these different accounting standards as well as the allocation of these costs by plans owned by parent companies.<sup>26</sup>

Finally, regional variation may also influence the outcome of the financial and quality-of-care measures. For example, the publicly traded plans that reported the quality measures assessed in this analysis had their largest geographic concentration in the South Atlantic states. Health care indicators in southern states tend to fall below those of the nation on average.<sup>27</sup> Regional variation in health care quality could therefore influence the findings on comparative quality.

## NOTES

- <sup>1</sup> For this report, the term “Medicaid” may include the Children’s Health Insurance Program (CHIP) since many states purchase managed care services for Medicaid and CHIP together.
- <sup>2</sup> Medicaid enrollment data were collected from the 2009 CMS Medicaid Managed Care Enrollment Report and the annual financial reports of publicly traded companies (Form 10-K), which are submitted to the U.S. Securities and Exchange Commission (SEC), <https://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/09June30f.pdf>.  
Financial reporting for Arizona and California health plans complies with generally accepted accounting principles for either the Governmental Accounting Standards Board for government plans or the Financial Accounting Standards Board for private health plans. Arizona financial data were collected from the Arizona Health Care Cost Containment System, and California financial data were collected from the California Department of Managed Health Care.
- <sup>3</sup> R. Hurley, M. J. McCue, M. B. Dyer et al., *Understanding the Influence of Publicly Traded Health Plans on Medicaid Managed Care* (Washington, D.C.: Center for Health Care Strategies Inc., Nov. 2006). The report found that these pure-play, publicly traded plans focused primarily on Medicaid. Since 2006, Molina Healthcare and Centene Corp. have expanded into Medicare Advantage Special Needs Programs while Amerigroup has expanded into Medicare Advantage.
- <sup>4</sup> For a detailed description of the data collection process, see [Data Collection and Methodology](#). The study selected plans with more than 5,000 enrollees because plans with lower enrollment may be smaller, start-up plans, which may have unstable financial performance measures. Moreover, this was the sample selection criterion applied by an earlier Medicaid managed care study by Hurley, McCue, Dyer et al., *Understanding the Influence*, 2006.
- <sup>5</sup> Barclays Capital, *2010 Managed Care Industry Guidebook* (New York: Barclays, Feb. 2010). The report notes Wellcare Health Plans is a government hybrid plan with both Medicaid and Medicare enrollees, with an enrollment of 42 percent Medicare. Because the health plan started as a Medicaid plan and has an enrollment that is 58 percent Medicaid, stock analysts still include Wellcare with other Medicaid managed care plans, including Amerigroup, Centene Corp., and Molina Healthcare.
- <sup>6</sup> Hurley, *Understanding the Influence*, 2006.
- <sup>7</sup> UnitedHealth Group and Wellpoint are multiproduct companies that have developed separate subsidiary companies that focus primarily on managing Medicaid members. In 2010, United HealthGroup renamed its Medicaid subsidiaries, Americhoice and Unison health plans, United Healthcare Community & State. Wellpoint operates three of its nine Medicaid managed care plans under the subsidiary “Unicare.” Because these subsidiaries are owned by multiproduct companies, they are categorized under that designation.
- <sup>8</sup> The definition of Medicaid-focused is drawn from two publications: Hurley et al., *Understanding the Influence*, 2006; and S. Felt-Lisk and S. Yang, “Changes in Health Plans Serving Medicaid,” *Health Affairs*, Sept./Oct. 1997 16(5):125–33.
- <sup>9</sup> Hurley, *Understanding the Influence*, 2006.
- <sup>10</sup> It is important to note when comparing table Exhibits 1 and 2 that plan ownership and Medicaid focus are not mutually exclusive. There were 22 individual health plans owned by multiproduct companies that had enrollment over the 75 percent threshold and as a result were described as Medicaid-focused plans. Conversely, there were four health plans that were owned by pure-play, publicly traded companies that had Medicaid enrollment of less than 75 percent and thus did not meet the definition of Medicaid-focused plans.

- <sup>11</sup> We collected financial data on 170 health plans from both National Association of Insurance Commissioners (NAIC) reports and financial data submitted to state health plan databases, including those of Arizona and California. Given our initial sample of 225 health plans, we were unable to collect financial data on 55 health plans for the following reasons: 1) we were unable to identify the data from either NAIC or state databases, or 2) for plans following unique state regulations (e.g., California's Knox-Keene), the financial data did not report the Medicaid line of business separately.
- <sup>12</sup> Comparing the 170 health plans with financial data to the 225 sampled plans, certain plan traits were underrepresented, including provider-sponsored ownership (25% vs. 27%) and Medicaid focus (55% vs. 60%). Conversely, the following plan traits were overrepresented: pure-play, publicly traded plans (21% vs. 16%), multiproduct, publicly traded plans (24% vs. 20%), and for-profit plans (66% vs. 60%).
- <sup>13</sup> National Association of Insurance Commissioners, *Financial Analysis Handbook* (Kansas City, Mo.: NAIC, Annual 2009/Quarterly 2010).
- <sup>14</sup> For both sets of measures, it is possible that variables not considered in the analysis could be influencing the results, including: 1) nonreporting to NCQA of quality measures by some Medicaid managed care plans; 2) geographic distribution of Medicaid managed care plans, as well as variation in enrolled populations by eligibility category; 3) variation in the treatment of the Children's Health Insurance Program (CHIP) by state, which would affect whether that population is included within Medicaid enrollment figures or tracked separately; 4) geographic distribution of reporting plans, which is a potentially relevant consideration because of regional variations in quality performance; and 5) small numbers of observations, particularly for pure-play plans.
- <sup>15</sup> Since this study focuses on publicly traded plans—both pure-play and multiproduct—the statistical analysis in Exhibit 1 compares non-publicly traded plans to both pure-play, publicly traded plans and multiproduct, publicly traded plans. We did not compare pure-play to multiproduct, publicly traded plans because of the small sample size in each group, especially for quality-of-care measures. For example, for the chronic condition composite measure, there were only 10 pure-play plans and 12 multiproduct plans.
- <sup>16</sup> M. Martinez, "Blues Finalizing Deal to Buy M-Care," *Crain's Detroit Business*, Sept. 12, 2006, <http://www.crainsdetroit.com/article/20060912/SUB/60912012/blues-finalizing-deal-to-buy-m-care>.
- <sup>17</sup> J. M. Johnson, "Mercy, Bush O'Donnell Sell Medicaid Plan for \$95 Million," *St. Louis Business Journal*, Sept. 17, 2007, <http://www.bizjournals.com/stlouis/stories/2007/09/17/story4.html>.
- <sup>18</sup> News and Strategies for Managed Medicare & Medicaid, "Medicaid MCOs Look to New Products for Growth Opportunities," Feb. 2004 10(2):1–2, <http://www.performrx.com/pdf/02-new-products.pdf>.
- <sup>19</sup> J. Holahan and I. Headen, *National and State by State Results for Adults at or Below 133% FPL* (Washington, D.C.: Kaiser Family Foundation, May 2010), <http://www.kff.org/healthreform/8076.cfm>.
- <sup>20</sup> J. Holahan and I. Headen, *National and State by State Results* (Washington, D.C.: Kaiser Family Foundation, May 2010). See <http://www.kff.org/healthreform/8076.cfm>.
- <sup>21</sup> E. Berry, "Mining for Medicaid Gold: Health Plans' Latest Profit Strategy," *American Medical News*, Dec. 6, 2010, <http://www.ama-assn.org/amed-news/2010/12/06/bisa1206.htm>.
- <sup>22</sup> Ibid.
- <sup>23</sup> Sherlock Company, "Why Isn't Health Plan Administration Scalable?" *Health Plan Navigator*, June 2008: 1–4, <http://www.sherlockco.com/docs/navigator/navigator-08-06.pdf>.
- <sup>24</sup> Ibid.

- <sup>25</sup> G. Herrle and T. Snook, “Healthcare Reform: Strategic Considerations for 2011,” Milliman Web site, Jan. 18, 2011. See: [http://insight.milliman.com/article.php?cntid=7490&utm\\_campaign=Insight%20Promos&utm\\_medium=web&utm\\_source=health&utm\\_content=7490](http://insight.milliman.com/article.php?cntid=7490&utm_campaign=Insight%20Promos&utm_medium=web&utm_source=health&utm_content=7490).
- <sup>26</sup> C. McDonald, J. Naklicki, and J. Dellicarri, *If You Don't Know Where You're Going, Any Road Will Get You There* (New York: CIBC World Markets, June 2007). The report studied the financials of Molina Healthcare’s plan and found minor differences in premiums and medical expenses depending on whether the financial filings were based on Statutory Accounting Principles and Generally Accepted Accounting Principles. However, differences were found in administrative costs, especially among health plans owned by parent companies, based on variation in the allocation of costs related to management fees, claims processing, and contract negotiating.
- <sup>27</sup> J. C. Cantor, D. Belloff, C. Schoen et al., [State Scorecard on Health System Performance: Chart Pack](#) (New York: The Commonwealth Fund, June 2007); Barclays Capital, *2010 Managed Care Industry Guidebook*, 2010.

## DATA COLLECTION AND METHODOLOGY

We identified 225 comprehensive, full-service, at-risk Medicaid health plans with more 5,000 enrollees using the Centers for Medicare and Medicaid Services (CMS) and National Association of Insurance Commissioners (NAIC) Medicaid enrollment data. We classified these plans across an array of organizational traits that were developed in a prior assessment of Medicaid managed care plans for the Center for Health Care Strategies as well as in a stock analyst report on Medicaid managed care. For the financial analysis, we collected data on 170 health plans: 161 from licensed NAIC financial data and nine plans from state health plan databases.

We collected quality-of-care data from the National Committee for Quality Assurance (NCQA) Quality Compass database for Medicaid health plans. The Healthcare Effectiveness Data and Information Set (HEDIS) clinical quality measures were selected using the following criteria: 1) the measures assess preventive care for children and young adults or treatment of common chronic conditions; 2) there is meaningful variation in plan performance nationally; and 3) the measures were reported by a large number of health plans. Using these criteria, we computed median preventive and chronic condition composite scores, which are described in the [text box on page 4](#). Out of 116 Medicaid health plans reporting data to NCQA, 79 plans reported data for all preventive care measures and 68 plans reported data for all eight chronic measures.

In order to assess performance in the area of consumer experience, a selection of HEDIS measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and reported by NCQA in 2010 for health plan performance during 2009 was assessed. The measures were selected using the following criteria: 1) the measures assess overall member experience with the health plan, and 2) the measures assess access to care in areas over which health plans typically have some degree of influence. Given this selection criteria, we chose three consumer experience measures: overall rating of health plan, getting care, and customer service.

Because of outlier values and their effect on mean values as well as the limited numbers of health plans within given plan traits, we computed the median values of the financial performance ratios and quality-of-care measures and conducted a nonparametric median test to assess median differences among plan characteristics. The median ratio value indicates that half the values fall either above or below the median value across individual plan traits.

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