# FINANCIAL IMPACT OF MEDICAID EXPANSION FOR HEALTH PLANS

BY ALLAN BAUMGARTEN

*Michigan accepted the opportunity to expand Medicaid eligibility under the Affordable Care Act, and the Healthy Michigan program began enrolling recipients in April 2014. Enrollment quickly grew to 600,000 persons with household incomes up to 138% of the Federal Poverty Level. The expansion population generally comprised single adults without children. In the past year the enrollment has held steady, dropping below 600,000 during each month as some people were dropped from the program for not re-establishing eligibility, then going back above 600,000 at the beginning of the next month, as new enrollees were added. Enrollment based on Temporary Assistance for Needy Families (TANF) eligibility has declined in the past year. At the end of 2015, there were a total of 1.632 million Medicaid enrollees in Michigan HMOs.*

*This paper reviews trends in Medicaid payments to HMOs in 2013, 2014, and 2015 based on data from the annual statements submitted by health insurers to the Michigan Department of Insurance and Financial Services. The statements follow the National Association of Insurance Commissioners format. Data are drawn from the exhibits of enrollment, revenues, and expenses by major line of business (commercial, Medicare and Medicaid). This paper presents data by health plan on their medical and administrative expenses and their underwriting income (before investment income or federal income taxes). Many of the measures are expressed as a "per member per month" (PMPM) number, which is a common metric for making these comparisons.*

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This research brief was supported by funding from the **National Institute for Health Care Reform** as part of a series studying the impact of a changing health care landscape on the people, providers, and economy in Detroit.

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**Exhibit 1** shows enrollment by HMO as of September 2016 in Healthy Michigan and in all Medicaid managed care in Macomb, Oakland and Wayne Counties. Enrollment in all Medicaid HMOs was approximately 737,000, of which Healthy Michigan accounted for about 219,000. Molina Healthcare has 208,000 Medicaid enrollees, or 28.2% of the total. UnitedHealthcare Community Plan and Meridian Health Plan are the second and third largest, respectively.

## RATE SETTING FOR EXPANSION POPULATION

Working with its consulting actuary, Milliman, Inc., the Michigan Department of Health and Human Services (at the time known as the Department of Community Health) developed monthly payment rates for the Healthy Michigan enrollees. (See Milliman, Inc., "Healthy Michigan—Medicaid Expansion Initial Rate Development," March 2014.)

For more than 10 years, Michigan has set payment rates for Medicaid HMOs. When the health plans present their bids during a competitive bid process, the rates are assumed, and the competition is about measures such as network access and quality of care, *not price*. In some states, including Minnesota, competitive bids for Medicaid health plan contracts still include a price component.

EXHIBIT 1

## Enrollment in Medicaid Managed Care, September 2016

| HMO | HEALTHY MICHIGAN ONLY | ALL MEDICAID | % OF ALL MEDICAID |
|---|---|---|---|
| Aetna Better Health | 7,483 | 34,941 | 4.7% |
| Blue Cross Complete | 40,316 | 90,082 | 12.2% |
| Harbor Health Plan | 3,704 | 8,094 | 1.1% |
| McLaren Health Plan | 10,778 | 27,194 | 3.7% |
| Meridian Health Plan | 50,431 | 144,080 | 19.6% |
| Molina Healthcare | 50,213 | 208,004 | 28.2% |
| Total Health Care | 15,307 | 55,014 | 7.5% |
| UnitedHealthcare Community | 40,573 | 169,506 | 23.0% |
| TOTAL | 218,805 | 736,915 | 100.0% |

In Michigan's 2015 competitive bid process, the HMOs were evaluated on how well their proposals aligned with four "pillars" or key goals that the state had set, such as improved administrative efficiency and better integration of mental health with physical health. (Minnesota also did a statewide competitive rebid in 2015 and two companies submitted very low bids and were rewarded with many new enrollees. Nine months into the new contract, one has announced that it is dropping out because of large losses.)

The payment rates for the Healthy Michigan population started from a base of data from previous years, including utilization rates for low-income adult Medicaid recipients and fee-for-service experience. The actuaries made adjustments upward from that base to reflect enhanced benefits available to Healthy Michigan recipients, including hearing aids and dental services paid at higher than fee-for-service rates, to improve dentist participation. The dental benefit added between $18.04 for a young adult to $27.52 for a recipient aged 55–64 years old.

The rates also include an additional amount for "pent-up demand," equal to about 10% of the updated base rates for each sex and age cell. Milliman offered this support for the additional "pent-up demand" payment: "The occurrence of pent-up demand typically appears in the first-year of enrollment as a spike in demand for previously uninsured individuals that will trend back to ultimate levels. This adjustment is for services that new beneficiaries may not have previously received due to inability to obtain their coverage. "

## TREND IN PAYMENTS TO HMOS

This analysis is based on annual financial reports that do not separate out the revenues, utilization, and expenses of the Healthy Michigan population from those of other low-income adult Medicaid enrollees. We have requested data from the Michigan Department of Health and Human Services that would permit a comparison of utilization by and spending on different eligibility groups.

The data include all 14 HMOs contracting with Medicaid in 2013 to 2015, not just those operating in the Detroit region. And while the vast majority of Medicaid enrollees served by HMOs are in low-income households, the state has launched voluntary programs for Medicaid recipients who are aged, blind, or disabled to move into HMO plans at a much higher payment rate. Their numbers are small so far, so this does not affect the averages by very much yet.

**Exhibit 2** shows that the average premium paid to Medicaid health plans increased by nearly $100 from 2013 to 2015, growing from $297.97 to $393.08 PMPM—an increase of roughly 32%. Average premium revenues increased in 2014 and again in 2015. Part of the increased payments can be attributed to the expanded benefits provided to the Healthy Michigan population, especially the enhanced payments for dental care. The 10% supplement for pent-up demand also was a major contributor to the year-to-year revenue increases.

EXHIBIT 2

## Comparison of Michigan Medicaid HMO Premiums, Per Member Per Month, 2013 to 2015

| HMO | PREMIUM PER MEMBER MONTH | | | CHANGE 2015/2013 | |
|---|---|---|---|---|---|
| | 2013 | 2014 | 2015 | % | $ |
| Aetna Better Health | $343.49 | $375.97 | $448.80 | 30.7% | $105.31 |
| Blue Cross Complete | 287.96 | 352.07 | 403.87 | 40.3% | 115.91 |
| Fidelis Secure Care | NA | NA | 261.64 | NA | NA |
| HAP/Midwest Health Plan | 302.93 | 357.01 | 405.70 | 33.9% | 102.77 |
| Harbor Health Plan | 308.23 | 373.17 | 425.59 | 38.1% | 117.36 |
| HealthPlus Partners | 287.22 | 317.16 | 360.97 | 25.7% | 73.75 |
| McLaren Health Plan | 295.94 | 341.04 | 393.30 | 32.9% | 97.36 |
| Meridian Health Plan of MI | 297.59 | 340.94 | 389.80 | 31.0% | 92.21 |
| Molina Healthcare | 297.93 | 343.10 | 400.08 | 34.3% | 102.15 |
| Priority Health Choice | 274.11 | 319.22 | 344.35 | 25.6% | 70.23 |
| Sparrow PHP (FamilyCare) | 260.73 | 311.14 | 348.16 | 33.5% | 87.42 |
| Total Health Care | 320.58 | 359.16 | 416.09 | 29.8% | 95.51 |
| UnitedHealthcare Community Plan | 300.45 | 338.53 | 392.67 | 30.7% | 92.22 |
| Upper Peninsula Health Plan | 285.78 | 332.52 | 436.81 | 52.8% | 151.03 |
| HMO TOTAL | 297.97 | 341.02 | 393.08 | 31.9% | 95.11 |

EXHIBIT 3

## Medicaid HMO Medical Expenses and Loss Ratios, 2013 to 2015

| HMO | MEDICAL EXPENSES PER MEMBER PER MONTH | | | CHANGE 2015/2013 | | MEDICAL LOSS RATIO | | |
|---|---|---|---|---|---|---|---|---|
| | 2013 | 2014 | 2015 | % | $ | 2013 | 2014 | 2015 |
| Aetna Better Health | $300.37 | $303.56 | $350.70 | 16.8% | 50.32 | 87.4% | 80.7% | 78.1% |
| Blue Cross Complete | 275.38 | 310.43 | 346.24 | 25.7% | 70.86 | 95.6% | 88.2% | 85.7% |
| Fidelis Secure Care | NA | NA | 255.69 | NA | NA | NA | NA | 97.7% |
| HAP/Midwest Health Plan | 266.48 | 289.42 | 323.64 | 21.5% | 57.16 | 88.0% | 81.1% | 79.8% |
| Harbor Health Plan | 261.25 | 307.94 | 272.19 | 4.2% | 10.93 | 84.8% | 82.5% | 64.0% |
| HealthPlus Partners | 262.35 | 287.36 | 322.06 | 22.8% | 59.71 | 91.3% | 90.6% | 89.2% |
| McLaren Health Plan | 276.64 | 297.20 | 343.35 | 24.1% | 66.71 | 93.5% | 87.1% | 87.3% |
| Meridian Health Plan of MI | 263.22 | 283.48 | 321.33 | 22.1% | 58.11 | 88.5% | 83.1% | 82.4% |
| Molina Healthcare | 253.96 | 274.41 | 311.48 | 22.6% | 57.51 | 85.2% | 80.0% | 77.9% |
| Priority Health Choice | 256.98 | 286.24 | 295.00 | 14.8% | 38.01 | 93.8% | 89.7% | 85.7% |
| Sparrow PHP (FamilyCare) | 238.73 | 270.29 | 297.39 | 24.6% | 58.66 | 91.6% | 86.9% | 85.4% |
| Total Health Care | 296.05 | 303.25 | 342.49 | 15.7% | 46.43 | 92.3% | 84.4% | 82.3% |
| UnitedHealthcare Community Plan | 277.09 | 275.81 | 305.79 | 10.4% | 28.69 | 92.2% | 81.5% | 77.9% |
| Upper Peninsula Health Plan | 262.02 | 282.26 | 357.37 | 36.4% | 95.35 | 91.7% | 84.9% | 81.8% |
| HMO TOTAL | 268.09 | 285.39 | 321.27 | 19.8% | 53.17 | 90.0% | 83.7% | 81.7% |

## TRENDS IN EXPENSES AND UNDERWRITING INCOME

Average medical expenses also increased in 2014 and again in 2015. As shown in **Exhibit 3**, the average medical expenses for Medicaid HMOs increased from $268.09 PMPM in 2013 to $321.27 PMPM in 2015—an increase of 19.8%. The average Medicaid premiums increased by 32% in that two-year period, much more than the increase of 19.8% in medical expenses during the same period.

While the state projected that the new enrollees would be above-average utilizers of medical care, in the first year that was not the case. The spread between premium revenues and medical expenses, usually a reliable predictor of health plan profitability, increased from $29.88 PMPM in 2013 to $71.81 PMPM in 2015.

As revenues grew, the average medical loss ratio—the percentage of premium dollars spent on medical services—declined in 2014 and 2015. The average medical loss ratio was 90% in 2013. It declined to 83.7% in 2014 and 81.7% in 2015. The new federal rules for Medicaid managed care programs will impose a minimum medical loss ratio of 85%. In 2015, eight of the Medicaid HMOs had a medical loss ratio of less than 85%, with five plans—Aetna Better Health, HAP/Midwest Health Plan, Harbor Health Plan, Molina Healthcare and UnitedHealthcare Community Plan—recording medical loss ratios of less than 80%. In 2013, when rates were lower, none of these HMOs had a medical loss ratio below 80%, and only Harbor Health Plan had a loss ratio below 85%.

In **Exhibit 4** we compare the Medicaid HMOs on their underwriting income and margins in 2013 to 2015. Underwriting income—profit before investment income and federal income taxes—grew from $41.3 million in 2013 to $298 million in 2015—an increase of 622%. While six HMOs lost money on their Medicaid operations in 2013, only four did in 2015. On average, these HMOs had an underwriting margin of less than 1% in 2013, which grew to 2.8% in 2014, and 3.9% in 2015.

To demonstrate the link between spread and profitability, we can look at HAP/Midwest Health Plan. Its spread increased from $36.45 in 2013 to $82.06 in 2015. It's medical loss ratio declined from 88% to 79.8%. And its operating margin increased from an already very strong 6.1% to 9.8%. In 2015, HAP/Midwest had a net income of $27.5 million, while Health Alliance Plan, its owner, reported a loss of $33.1 million on its commercial and Medicare plans. Unfortunately for that system, HAP/Midwest lost its profitable contract for Medicaid in the Detroit area as a result of the 2015 competitive bid process, and only received a small contract for Medicaid in the Thumb region.

## RISK CORRIDOR PROVISIONS

The rate setting method for Healthy Michigan enrollees, which was incorporated into the health plan contracts, created a risk corridor for the first year of the program. The state wanted to encourage participation by health plans and, recognizing that little was known about how much care the new enrollees would use, added a risk corridor arrangement. If utilization was higher than expected, the state would provide supplemental payments to mitigate losses for the health plans.

On the other hand, if utilization was lower than projected, the health plans would need to return a portion of their surpluses to Medicaid.

According to information provided by Medicaid and the Michigan Association of Health Plans, about $960 million in payments to health plans was subject to the risk corridor calculation. After the first 12 months of the program, from April 2014 to March 2015, the health plans were required to return $25.9 million to the state. They were able to keep about $82 million. The industry describes this as a shared savings arrangement, and not as the return of an overpayment. It can be seen as similar to Medicare ACOs, where unspent funds below the benchmark are divided between the government and the health plans. It is our understanding that the HMOs that projected having to return a portion of their profits to Medicaid would have established a reserve for those amounts. This would have reduced their premium revenues and created a liability on their balance sheets.

As of 2016, the state still sets separate rates for the Healthy Michigan population. However, the risk corridor provisions are no longer in effect and the health plans are at full risk for both the upside gain and the downside loss that they experience with their Healthy Michigan enrollees.

## SUMMARY

Michigan's decision to expand eligibility for Medicaid under the Affordable Care Act has enabled more than 600,000 residents to gain Medicaid coverage and has helped reduce the rate of uninsurance from 11% in 2013 to 8.4% in 2014 and to 6% in 2015. That is well below the national average of 9.4% in 2015. The expansion has also created a significant business opportunity for Medicaid HMOs, which reported very strong results in 2015.

While the third quarter financial reports for the HMOs in 2016 show some weakening of profits for the Medicaid health plans, it is clear that the Medicaid expansion has been very profitable for them. Whether the expansion will continue after 2017 remains to be seen, but we can expect the health plans to join with hospitals and others to advocate for maintaining that element of the Affordable Care Act.

EXHIBIT 4

## Underwriting Income and Margins for Michigan Medicaid HMOs, 2013 to 2015

| HMO | UNDERWRITING INCOME | | | CHANGE 2015/2013 | | UNDERWRITING MARGIN | | |
|---|---|---|---|---|---|---|---|---|
| | 2013 | 2014 | 2015 | % | $ | 2013 | 2014 | 2015 |
| Aetna Better Health | $5,577,238 | $ 8,038,018 | $ 9,765,217 | 75.1% | $ 4,187,979 | 3.4% | 4.3% | 4.2% |
| Blue Cross Complete | (9,026,336) | (13,893,604) | (1,606,286) | -82.2% | 7,420,050 | -7.3% | -5.4% | -0.4% |
| Fidelis Secure Care | NA | NA | (1,096,672) | NA | (1,096,672) | NA | NA | -21.4% |
| HAP/Midwest Health Plan | 17,249,765 | 29,955,878 | 43,549,048 | 152.5% | 26,299,283 | 6.1% | 8.2% | 9.8% |
| Harbor Health Plan | (41,064) | 650,948 | 8,507,596 | -20817.9% | 8,548,660 | -0.5% | 3.0% | 23.9% |
| HealthPlus Partners | (190,373) | (11,726,058) | (11,385,720) | 5880.7% | (11,195,347) | -0.1% | -4.0% | -4.4% |
| McLaren Health Plan | 11,043,203 | 25,060,302 | 29,432,948 | 166.5% | 18,389,745 | 2.5% | 4.2% | 3.7% |
| Meridian Health Plan of MI | 6,472,022 | 14,297,732 | 27,021,385 | 317.5% | 20,549,363 | 0.6% | 1.0% | 1.3% |
| Molina Healthcare | 25,367,482 | 54,009,070 | 81,916,430 | 222.9% | 56,548,948 | 3.5% | 6.0% | 6.7% |
| Priority Health Choice | (1,207,101) | (1,287,392) | 12,952,416 | -1173.0% | 14,159,517 | -0.5% | -0.4% | 2.9% |
| Sparrow PHP (FamilyCare) | 330,480 | (363,472) | (1,962,296) | -693.8% | (2,292,776) | 0.6% | -0.6% | -2.3% |
| Total Health Care | (6,357,354) | 5,633,563 | 6,660,626 | -204.8% | 13,017,980 | -2.9% | 2.1% | 2.1% |
| UnitedHealthcare Community Plan | (8,729,453) | 47,899,860 | 79,129,615 | -1006.5% | 87,859,068 | -1.0% | 4.8% | 6.5% |
| Upper Peninsula Health Plan | 774,346 | 4,837,261 | 15,153,510 | 1856.9% | 14,379,164 | 0.8% | 3.4% | 7.1% |
| HMO TOTAL | $41,262,855 | $163,112,106 | $298,037,817 | 622.3% | $256,774,962 | 0.9% | 2.8% | 3.9% |