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## Resource Paper

# Profiting from Proficiency: The Growing Importance of Medicaid-Focused Health Plans

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## Acknowledgements

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## EXECUTIVE SUMMARY

This study is the third examination conducted for the Center for Health Care Strategies of Medicaid managed care from the perspective of health plans. The first study, *Medicaid and Commercial HMOs: An At Risk Relationship*, was completed in 1998; the second, *Partnership Pays: Making Medicaid Managed Care Work in a Turbulent Environment,* was completed in 2000. The current study provides an update of the status of Medicaid managed care through mid-2003, a period marked by considerable uncertainty given state budget crises. Its principal focus is on the growing reliance of states on Medicaid-focused plans, i.e., those that are exclusively or predominantly serving Medicaid members.

### Study Focus and Design

Three questions guided this research:

- How do Medicaid-focused plans compare to other plans relative to financial and non-financial performance?

- Are there significant differences in the financial and non-financial performance of different types of Medicaid-focused plans?

- What are the implications to the state agencies of increased reliance on Medicaid-focused plans?

Multiple data sources were used to address these questions. The quantitative analysis used plan performance data from the 2001 Interstudy survey, for financial performance, and NCQA Quality Compass from the National Committee for Quality Assurance (NCQA), for non-financial performance. Financial performance was measured by three performance ratios: operating margin ratio, administrative cost ratio, and medical benefits ratio. Non-financial performance measured health plan quality by a number of measures including overall rating of the plan, member satisfaction ("getting care quickly," "getting needed care, etc."), and several clinical and access indictors.

The primary plan comparisons were made by the range of product focus (Medicaid-focused, multi-product), level of Medicaid membership (low, mid-level, high), plan sponsorship (provider-sponsored, other) and ownership status (for-profit, non-profit). The qualitative analysis used data collected from focused interviews of representatives of state agencies and plans. A total of 183 plans are included in the financial performance analyses; 59 plans are included in the non-financial performance analyses; 56 interviews, which included representatives from 13 state Medicaid agencies and 26 plans, are in the qualitative analyses.

## Financial Performance Findings

In terms of financial performance, health plans in the Medicaid managed care market were profitable, although the margins were narrow. Examination of plans by product focus found Medicaid-focused and multi-product plans achieving similar profit margins (three percent). Similarly, reported differences between profit margins of both for-profit and non-profit plans were nominal, within one percent. However, the profit margins of provider sponsored Medicaid-focused plans were lower than those of multi-product provider sponsored plans, possibly due to the higher medical expenses reflecting a greater percentage of revenue returned to their hospital or health care system. Compared to heath plans without a Medicaid product, these Medicaid-focused plans generated similar profit margins. Relative to publicly traded plans in the Medicaid market, two Medicaid-focused plans (Amerigroup and Centene) generated higher profit margins than multi-product publicly traded companies (Humana and Coventry) that offered a Medicaid line of business.

The financial performance analyses also suggest that economies of scale in administrative functions (marketing, claims processing, information technology) are realized as Medicaid enrollment increases, as in the case of Medicaid-focused plans. Additionally, Medicaid-focused plans with multi-state operations appear to benefit from economies of scale resulting from specialization in the Medicaid product line.

## Non-Financial Performance Findings

In terms of non-financial performance, for-profit plans received higher overall ratings from their members than non-profit plans, but the ratings of different aspects of care were not consistently higher. Plans with high levels of Medicaid membership were more highly rated than plans with lower levels of Medicaid membership, again a possible reflection of the rewards of specialization in the Medicaid product line. Using clinical and access indicators, the picture also is mixed, suggesting that plans participating in Medicaid are performing at similar levels despite diversity in ownership, focus, and size. Further comparisons of non-financial performance were made using 32 representative health plans from eight states to demonstrate how state-level patterns are consistent with those noted in aggregate data.

## Interview Findings

The interview findings supplement the previously discussed findings and offer thoughts on how state agencies and plan executives anticipate the future contracting environment. On one hand, interviewees see administrative relationships maturing and becoming more collaborative and consultative in most states – a perception shared by both state officials and plan executives. On the other hand, rate-related issues are seen as uncertain and further complicated by the continuing budget crises of the states. Across the 13 states represented in the interviews, the anticipated rate changes for the upcoming year range from a five percent reduction to a five-to-six percent increase.

Although plans may be willing to "tough it out" for another year, even currently profitable plans may question remaining in the Medicaid product line, particularly if they are multi-product plans.

Although as singularly specialized firms, Medicaid-focused plans seem particularly vulnerable to the vagaries of public sector contracting, they currently appear to be consolidating and capitalizing on their strategic positioning and performance. However, since the Medicaid-focused plans have nowhere else to go, they have a powerful incentive to make Medicaid managed care a successful enterprise for themselves, the state agencies, and Medicaid beneficiaries. Our interviews found health plans more involved in lobbying efforts, with their efforts also directed at educating new legislators on the particulars of Medicaid managed care.

Another important finding of this study related to the profitability of for-profit plans in Medicaid managed care. Although the growing prominence of for-profit Medicaid-focused plans casts a positive light on the Medicaid market from the vantage point of capital markets, their successes are a double-edged sword. The requirement of publicly traded firms to report their financial performance quarterly raises a new set of concerns that the state agencies may find challenging. Touting profitability to shareholders every 90 days will inevitably invoke concerns from some state policymakers and ire from many Medicaid providers, irrespective of the ability of these firms to support their claims of delivering real value.

## Study Conclusions

The principal study conclusions were the following:

1. The shift to further reliance on Medicaid-focused plans appears inevitable.

2. The observed variation in plan participation across states will remain.

3. Concerns about financial and non-financial performance weakness among Medicaid-focused plans have not become the reality.

4. Plans remaining in the Medicaid market appear to be increasingly strong, sophisticated, and more compliant with state requirements.

5. Experience suggests that state agencies and surviving plans invariably become more interdependent.

6. The prominence of investor-owned Medicaid-focused firms bolsters the market while raising challenging issues for the state agencies.
7. Durability of the Medicaid managed care market remains uncertain.

In summary, our update on the status of Medicaid managed care found the continued growth and financial viability of plans in this product line, particularly Medicaid-focused plans whose specialization appears to contribute to their favorable financial and non-financial performance. As the Medicaid managed care market has matured, collaboration between state agencies and health plans – not adversarial relationships – has emerged. However, the current budget crises facing the states, and health plans' tolerance of small rate increases or even decreases, render the future of Medicaid managed care uncertain from the perspective of state agencies, plan managers, and Medicaid beneficiaries.

## Introduction

State Medicaid programs are increasingly reliant on health plans that focus primarily on serving Medicaid beneficiaries. This trend has evolved over several years, but efforts to understand how well these plans are performing on both financial and non-financial indicators have lagged. In addition, while the sponsorship of Medicaid-focused plans varies, little attention has highlighted possible differences in performance across types of ownership. This study seeks to build a better understanding of the performance of Medicaid-focused plans and the implications of increased reliance on these plans by the state agencies, and ultimately, their Medicaid beneficiaries.

This study builds on data from multiple primary and secondary sources, including interviews with more than 50 respondents in 13 states. The study includes three principal sets of findings:

- Financial performance of plans.
- Non-financial performance of plans.
- Qualitative findings on plan participation and performance.

### Contemporary Context and the Role of Medicaid-Focused Plans

Since the late 1990s, Medicaid and private health benefits purchasers embarked on diverging tracks relative to contracting for managed care products. Private sector purchasers responded to consumer backlash and provider pushback by offering products with broader provider networks, scaling back active care management, reducing the richness of benefit packages, and promoting more consumer cost sharing in their efforts to reduce premium increases. Whether these efforts by private sector purchasers soften resistance to managed care, or repudiate it altogether, is open to debate, but they clearly contributed to the migration of millions of lives from HMOs to PPO products, and to the major transformation in HMOs themselves. The efforts are associated with, if not the cause of, sharply rising private premiums.

Medicaid agencies pressed ahead with conventional fully-prepaid HMO products, while a few shifted their focus to primary care case management models and/or disease management programs as alternatives to prepaid health plans. The states' rationale is quite clear: state programs cannot afford the rate increases that are now common in the

private sector. Many Medicaid agencies remain wedded to a belief in aggressive care management. They also are limited in the degree to which they can modify the standard Medicaid benefit package. Likewise, substantial cost sharing is largely infeasible and undesirable for financially challenged Medicaid beneficiaries.

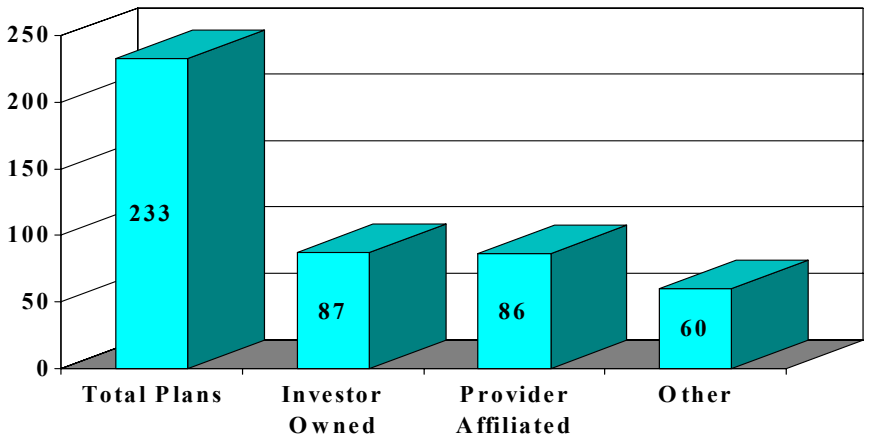
Less clear is how states find those health plans that are willing and able to continue providing traditional models of managed care, particularly when faced with a shrinking commercial market for the Medicaid product lines. Our prior studies of plan participation and enrollment patterns found that the surge in commercial plan participation in Medicaid waned since the late 1990s. The study findings raised concerns about the potential vulnerability of state agencies: Would States be able to sustain their programs, or would they grow excessively dependent on a small number of plans, many of whom would be enrolling primarily Medicaid beneficiaries? Would the states be faced with unacceptable pressure by plans for rate increases, or demands to accept lower levels of performance? Would plans threaten to sever their relationships with the states, perhaps leaving the states without plans interested in participating in their markets?

Although updating comprehensive trends on national plan participation is ongoing, the emerging picture finds states relying more extensively on Medicaid-focused plans. As the findings of the current study reveal, the *number* of participating plans is less meaningful than the *concentration* of beneficiaries in a few very large plans, for which Medicaid is the principal, if not sole, product line. In addition to these plans empirically classified as Medicaid-focused, those with 75 percent or more of their membership in Medicaid, there also is a set of commercially oriented plans with a strong specialization in Medicaid, either as a separate subsidiary (such as the Americhoice subsidiary of United Healthcare) or as a specialized operating unit formed to concentrate services on the Medicaid product line. *The interview findings of this study underscore that specialization, or concentration in serving Medicaid members, is viewed as an essential ingredient in success by nearly every respondent*—an important departure from our earlier study, where this unique specialization was viewed more skeptically.

Sponsorship of plans participating in Medicaid became more clearly defined in recent years, with two types of ownership dominating Medicaid managed care. Using 2002 Centers for Medicare and Medicaid Services data on plan participation, Figure 1 shows an approximate distribution of all full-service prepaid health plans, with more than 5,000 members participating in Medicaid managed care classified by type of ownership. Roughly 40 percent of these health plans are provider owned (or affiliated with health systems) and 40 percent are private investor owned with the remainder community-based, non-profit plans. Almost half of the investor owned plans are units of publicly traded firms, and include the plans owned by the three publicly held companies that currently focus solely on Medicaid: Amerigroup, Centene, and Molina. In the past two years these firms—called "pure plays" in the lexicon of the investor world—enjoyed considerable growth and success, indicating that private investors look favorably on firms specializing in Medicaid. As reported in our interviews, these firms, as well as others, are actively acquiring Medicaid-focused plans in a number of states. These acquisitions

indicate that states continue to have an adequate number of contractors, albeit ones of growing scale and with potentially disproportionate negotiating leverage.

**FIGURE 1: MEDICAID MANAGED CARE PLANS BY SPONSORSHIP IN 2002**




**Source: CMS Program Summary. Plans with > 5000 members**

How lucrative is Medicaid as a line of business, and is it financially attractive on a sustained basis? This question is brought into sharper relief as states struggle with unprecedented budget crises and are forced to consider a broad range of draconian measures to weather the financial storm. To date, Medicaid managed care programs and participating plans have fared reasonably well with few signs of immediate or serious difficulties arising. Likewise, states successfully navigated the adoption of new managed care regulations that emanated, after a protracted wait, from the Balanced Budget Act of 1997. The impact of the last of these regulations to go into effect, relating to the "actuarial soundness" of state rates, is still unclear at the time of this study. However, what is clear is that state Medicaid agencies and health plans find it increasingly important to demonstrate that Medicaid managed care is providing value, and that health plans are indeed earning profits from their participation.

### Purpose of the Study

This study addresses three questions:

- How effective are Medicaid-focused plans relative to financial and non-financial performance?
- Are there significant differences in the financial and non-financial performance of different types of Medicaid-focused plans?
- What are the implications to the state agencies of increased reliance on Medicaid-focused plans?

The first two questions draw on secondary data collected from Interstudy and NCQA and supplemented by publicly available data from individual states. The third study question uses data from protocol-driven interviews with Medicaid officials, health plan executives, trade association representatives, and advocacy group spokespersons from 13 selected states. After presentation of the findings, the final section of this report integrates the results and offers several conclusions based on interpretation of the findings.

## STUDY METHODS

The study uses quantitative and qualitative data to address the three study questions. Health plan financial data were analyzed on a national level for individual plans and on a company level for publicly traded managed care plans. Non-financial indicators of the health plan quality of care performance measure overall rating, member satisfaction, and a number of clinical indicators. These measures are valid measures of the concepts of interest, an assessment supported by the use of these measures as indicators of financial and non-financial performance in other research. These measures, derived from established databases, are reliable and provide consistent indications of financial and non-financial performance.

### Quantitative Analysis

The quantitative analysis used data from the 2001 Interstudy and NCQA Quality Compass. Interstudy data include financial, operational, and enrollment data for licensed HMOs, collected from the National Association of Insurance Commissioners. This data were supplemented with the financial statements of individual plans from Arizona. Data from HMOs with missing Medicaid enrollment were collected from CMS' Medicaid Managed Care Program Summary.[1]

[1] Available at http://www.cmms.gov/ medicaid/managedcare/er02net.pdf.

The Interstudy data provide detailed financial income accounts across Medicare, Medicaid, and all commercial business lines. Financial performance ratios were developed across these business lines and assessed by the range of product focus (Medicaid-focused, multi-product), range of market focus (single state HMO, multi-state HMO), level of Medicaid membership (low, mid-level, high), and ownership status (for-profit, non-profit). In addition to analyzing performance data nationally, a similar analysis was conducted on publicly traded managed care companies with Medicaid lines of businesses (and is included in Appendix A).

The NCQA Quality Compass database measures the quality of health care services and is derived from two sources: NCQA's Accreditation program and performance reports based on NCQA's Health Plan Employer Data and Information Set (HEDIS) specifications. Although this database covers several dimensions of quality of care, this study only measures a limited number of these indicators.

## Qualitative Analysis

To augment the quantitative analysis, telephone interviews were conducted with executives in 13 states who represented Medicaid agencies, Medicaid-focused plans, multi-product plans, and health plan trade associations (or hospital associations in selected states). The participating states were Connecticut, Florida, Minnesota, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, Rhode Island, Texas, Virginia, Washington, and Wisconsin. A total of 56 interviews were completed, representing approximately 80 percent of those targeted for interviews. Representatives from all 13 Medicaid agencies and from a total of 26 plans participated, although plans with predominantly commercial membership (multi-product plans) were underrepresented. The same 12-question interview protocol was employed with each respondent, with each interview averaging approximately 30 minutes. The 13 state plans that participated in the interviews represent more than 6.5 million beneficiaries in health plans, or 42 percent of all Medicaid lives in fully-capitated arrangements.

## Data Sources

The Interstudy HMO database presents the financial, operational, and enrollment information of individual licensed HMOs. In addition, financial filings (specifically 10-K reports) served as the basis for extensive analysis on the financial performance and operational performance of Medicaid-focused, publicly traded companies.

A total of 228 HMOs are represented in the Interstudy data, which include only data from licensed HMOs within each state. The Interstudy data exclude unlicensed health plans that offer Medicaid services as well as financial data from California, which were not available during the reporting period of interest. By obtaining data from Arizona through a special request, the number of plans included in our study sample increased to 237. However, in conducting the financial analysis of the health plan database, missing

data and extreme outlier values result in a total of 183 plans with complete and reliable financial data.

In light of the wide variation of financial indicators, median values were computed for all measures. Significance testing, specifically the non-parametric test of rank sum, was conducted to examine median differences between two independent variables, and the Kruskal-Wallis test was used to examine the median differences for three independent variables.

Non-financial performance reflecting health plan quality centered on three areas of interest: overall rating of the plan, member satisfaction with certain features of the plan, and clinical and access indicators, and were examined using summary measures drawn from the NCQA Quality Compass database.

The first measure, which reflects the health plan participants' overall rating of the health plan ("We want to know your rating of all your experience with your health plan"), is part of the HEDIS 2002 Consumer Assessment of Health Plans Survey 2.0H. Although the rating scale ranges from zero ("worst health plan possible") to 10 ("best health plan possible"), the NCQA database is limited to providing only the percentage of members who responded to this question with a higher rating (8, 9, or 10).

Three measures address satisfaction from the perspective of responsiveness, accessibility to needed care, and customer service. The first satisfaction measure reflects members' perceptions of responsiveness ("getting care quickly") and evaluates the ability of health plan members to access necessary care at the provider level. The score for this response is an overall composite index reflecting the percentage of members responding "always" or "usually" to a set of four questions (see Table 1). Higher scores reflect higher responsiveness and accessibility to plan services.

The second satisfaction measure ("getting needed care") assesses the perceived ease with which plan members can acquire needed care. The score for this response is an overall composite index reflecting the percentage of members who responded "not a problem" to a set of four questions (see Table 1). Higher scores reflect greater ease in obtaining plan services.

The third satisfaction measure relates to customer service. Customer service reflects how well the health plans disseminate information and respond to member questions. A higher rating suggests that members are using services appropriately and are having their claims covered.

Several clinical and access indicators that reflect the provision of preventive care also were compared across several types of plans, though the small sample size limited the generalizability of these analyses.

## TABLE 1: NCQA QUALITY COMPASS COMPOSITE INDICATORS

Responsiveness: "Getting Care Quickly"

1. When you called during regular office hours, how often did you get the help or advice you needed?
2. How often did you get an appointment for regular or routine health care as soon as you wanted?
3. When you needed care right away for an illness or injury, how often did you get care as soon as you wanted?
4. How often did you wait in the doctor's office or clinic more than 15 minutes past your appointment?"

Ease of Acquiring Necessary Care: "Getting Needed Care"

1. With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?
2. How much of a problem, if any, was it to get a referral to a specialist that you needed to see?
3. How much of a problem, if any, was it to get the care you or a doctor believed necessary?
4. How much of a problem, if any, were delays in health care while you waited for approval from your health plan?

Source: User Guide NCQA Quality Compass

### Analytical Approach of Interstudy Data

The financial, operational, and enrollment data of the Interstudy's licensed health plans were first evaluated on national and state levels and by Medicaid-focused versus multi-product plans. Medicaid-focused plans are single product plans with 75 percent or more of their total membership in Medicaid. Multi-product plans are health plans that offer both the Medicaid product as well as other commercial or Medicare products.

Other plan characteristics, specifically profit status and level of Medicaid membership, were examined. Profit status analysis compared for-profit with non-profit ownership plans. For-profit plans distribute their earnings to their owners and are not established for a charitable purpose. However, unique arrangements exist whereby for-profit plans are wholly owned subsidiaries of non-profit organizations. (This situation occurs in plans that were part of either some non-profit Blue Cross organizations that own a separate for-profit health plan, or a non-profit hospital or health system and operate under a for-profit ownership.). Table 2 provides the descriptive characteristics of these traits for the 183 plans.

## TABLE 2: MEDICAID-FOCUSED AND MULTI-PRODUCT PLANS: DESCRIPTIVE CHARACTERISTICS

| Plan Characteristics | | Medicaid-Focused | Multi-product |
|---|---|---|---|
| **Total Number of Plans** | | 75 | 108 |
| **Total Enrollment** (median) | | 49,361 | 121,245 |
| **Medicaid Enrollment % of Total Enrollment** (median) | | 100% | 20% |
| **Sponsorship Status** | | | |
| Provider-Sponsored | | | |
| | Number | 30 | 27 |
| | Percent | 53% | 47% |
| Non-Provider-Sponsored | | | |
| | Number | 45 | 81 |
| | Percent | 36% | 64% |
| **Profit Status** | | | |
| For-Profit | | | |
| | Number | 46 | 70 |
| | Percent | 40% | 60% |
| Non-Profit | | | |
| | Number | 29 | 38 |
| | Percent | 43% | 57% |
| **Medicaid Distribution** | | | |
| 25th Quartile | | | |
| | Number | 11 | 36 |
| | Percent | 23% | 77% |
| Median | | | |
| | Number | 34 | 57 |
| | Percent | 37% | 63% |
| 75th Quartile | | | |
| | Number | 30 | 15 |
| | Percent | 67% | 33% |

Within for-profit status, plans were either publicly or privately held. The stock of publicly held for-profit plans is traded on a stock exchange. In contrast, the stock of privately held for-profit plans is controlled internally by the owners of the corporation and is not publicly traded.

Level of Medicaid membership reflects a health plan's exposure to Medicaid by classifying health plans into three categories (low, mid-level, high) on the basis of Medicaid membership distribution for all plans (see Table 3). The low membership category, defined as plans in the bottom 25 percent for Medicaid membership, includes 47 plans with Medicaid membership of less than or equal to 13,671. The mid-level membership category includes plans who have Medicaid membership between the top and bottom 25 percent tiers; the mid-level category includes 91 plans with Medicaid membership between 13,671 and 62,067. The top membership category, plans in the top 25 percent for Medicaid membership, includes 45 plans with more than 62,067 Medicaid members.

**TABLE 3: LEVEL OF MEDICAID MEMBERSHIP CATEGORIES**

| Level of Medicaid Membership Category | Medicaid Membership By Category | Median Medicaid Membership By Category |
|---|---|---|
| High | > 62,067 | 108,114 |
| Mid-level | Between 13,671 and 62,067 | 30,589 |
| Low | < 13,671 | 7,146 |

**Financial Performance Ratios**

Unique to this study are the measures of performance by specific lines of business, including Medicaid. (Product line specific information was not available at the time of our two earlier studies.) These financial measures (see Table 4) evaluate the profitability of these plans for specific products and account for the driving cost factors, specifically medical and administrative costs. The three ratios reflect the financial health of the Medicaid product line: the operating margin ratio, the administrative cost/loss ratio, and the medical benefits/loss ratio. Since all plans studied offered a Medicaid product, the Medicaid premium revenue earned was measured from the Interstudy data. Table 4 displays the financial measures and their operational definitions.

- **Operating margin ratio**: Measures the amount of operating income earned from each specific insurance products' revenues. The operating margin gauges how well a plan controls its medical and administrative expenses for the specific product line, in this case Medicaid, relative to the profitability for this specific product line. The Medicaid operating income was computed by taking the difference between Medicaid premium revenue less Medicaid medical and administrative costs. The Medicaid profit margin ratio was computed by dividing Medicaid operating profits by Medicaid premium revenues.

- **Administrative cost (loss) ratio**: Measures the proportion of product revenue dollars paid for administrative expenses. The administrative cost ratio gauges how well a plan controls its administrative expenses relative to the revenue generated from the specific product line, in this case Medicaid. The Medicaid

administrative ratio was computed by dividing Medicaid administrative costs by Medicaid premium revenue.

- **Medical benefits (loss) ratio**: Measures the proportion of product revenue dollars paid for medical claims. The medical benefits ratio gauges how well a plan controls its medical expenses relative to the revenue generated from the specific product line, in this case Medicaid. The medical benefits ratio was computed by dividing Medicaid medical costs by Medicaid premium revenues.

**TABLE 4: FINANCIAL PERFORMANCE MEASURES**

| Financial ratio | Operational Definition |
|---|---|
| Operating margin ratio | Premium revenues – (Medical + Administrative expenses)/ Premium revenues |
| Administrative cost ratio | Administrative expenses / Premium revenues |
| Medical benefit (loss) ratio | (Medical expenses + Hospital expenses)/ Premium revenues |

## Analytical Approach with NCQA Quality of Care Compass Data

The NCQA measures of Medicaid plan quality focus on overall rating of the plan, member satisfaction, and selected clinical and access measures. Data were analyzed by comparing their median values across plan characteristics: product focus (Medicaid-focused, multi-product), range of market focus (single state HMO, multi-state HMO), level of Medicaid membership (low, mid-level, high), and ownership status (for-profit, non-profit). Both NCQA financial data and non-financial quality of care measures were available for 59 plans. Table 5 shows a profile of these plans.

## TABLE 5: NON-FINANCIAL DESCRIPTIVE OVERVIEW OF PLANS

| Plan Characteristics | Medicaid-Focused | Multi-product |
|---|---|---|
| **Total Number of Plans** | 18 | 41 |
| **Total Enrollment** | 75,728 | 225,455 |
| (Median) | | |
| **Medicaid Enrollment % of Total Enrollment** | 100 percent | 17 percent |
| (Median) | | |
| **Sponsorship Status** | | |
| Provider-Sponsored | | |
| Number | 6 | 9 |
| Percent | 40 percent | 60 percent |
| Non-Provider-Sponsored | | |
| Number | 12 | 32 |
| Percent | 27 percent | 73 percent |
| **Profit Status** | | |
| For-Profit | | |
| Number | 8 | 21 |
| Percent | 28 percent | 72 percent |
| Non-Profit | | |
| Number | 10 | 20 |
| Percent | 33 percent | 67 percent |
| **Medicaid Distribution** | | |
| 25th Quartile | | |
| Number | 2 | 13 |
| Percent | 13 percent | 87 percent |
| Median | | |
| Number | 6 | 23 |
| Percent | 21 percent | 79 percent |
| 75th Quartile | | |
| Number | 10 | 5 |
| Percent | 67 percent | 33 percent |

This study also analyzed health plans by these three financial measures across the distributions of the non-financial measures based on the NCQA Quality of Care Compass Data: overall plan rating, getting care quickly, getting needed care, and customer service. Out of the 183 health plans from the Interstudy data, we will able to merge the financial and operational data of 49 health plans with the NCQA Quality of Care Compass Data.

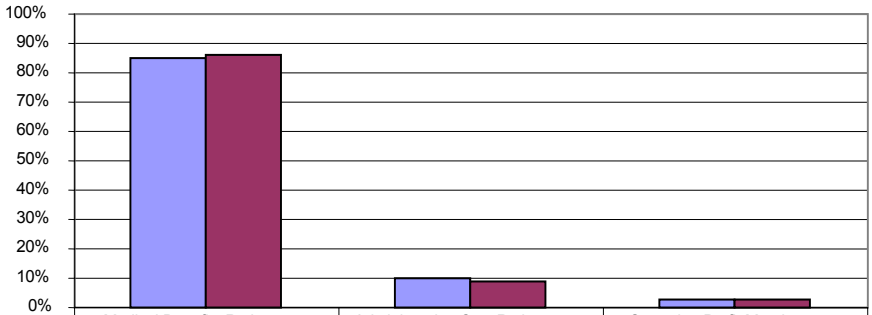
# ANALYTICAL FINDINGS

## FINANCIAL PERFORMANCE INDICATORS

### Performance of Medicaid-Focused vs. Multi-Product Plans

Figure 2 highlights differences in the financial performance of Medicaid focused plans and multi-product plans. The Medicaid medical benefits ratio for multi-product plans was only slightly higher (86 percent) than that of Medicaid-focused plans (85 percent). Conversely, Medicaid-focused plans reported a slightly higher administrative cost ratio (10 percent) compared to multi-product plans (nine percent). However, there was no difference in profit margin, with plans in both categories generating a profit margin of three percent.

**FIGURE 2: MEDICAID-FOCUSED VERSUS MULTI-PRODUCT PLANS**

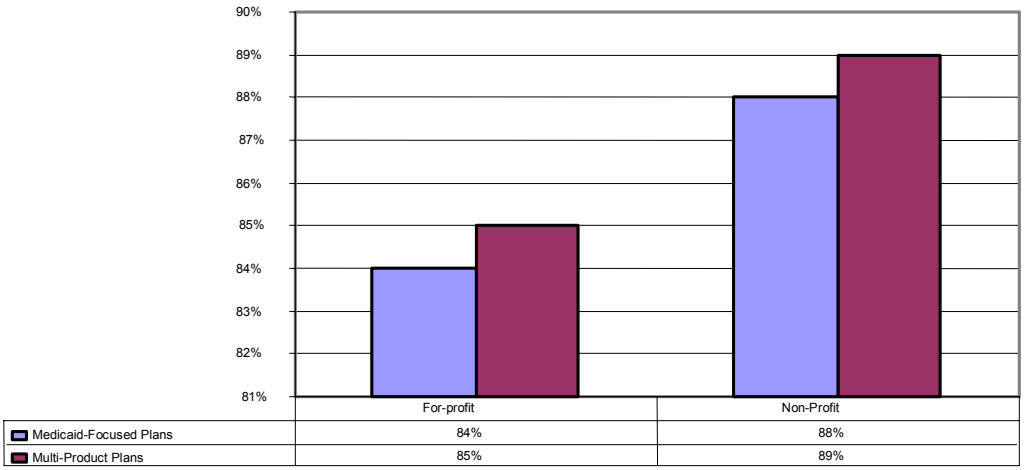



| | Medical Benefits Ratio | Administrative Cost Ratio | Operating Profit Margin |
|---|---|---|---|
| Medicaid Focused | 85% | 10% | 3% |
| Multi-Product | 86% | 9% | 3% |

### Performance of Medicaid-Focused Plans vs. Multi-Product by Ownership

Comparisons of the financial performance of Medicaid-focused plans to multi-product plans by ownership category appear in Figures 3-5**.** For-profit Medicaid-focused and multi-product plans reported lower medical benefits ratio (84 percent and 85 percent, respectively) than their non-profit counterparts (88 percent and 89 percent, respectively). For-profit Medicaid focused plans had the lowest Medicaid medical benefit ratio, which indicated fewer medical claims paid (see Figure 3). On the other hand, for-profit Medicaid focused plans reported higher administrative costs (see Figure 4), 11 percent compared to nine percent for non-profit plans and 10 percent for for-profit multi-product plans. Both for-profit plans, regardless of type of products offered, had the highest administrative costs, which suggest the incurrence of higher costs for salaries, marketing, and claims processing.

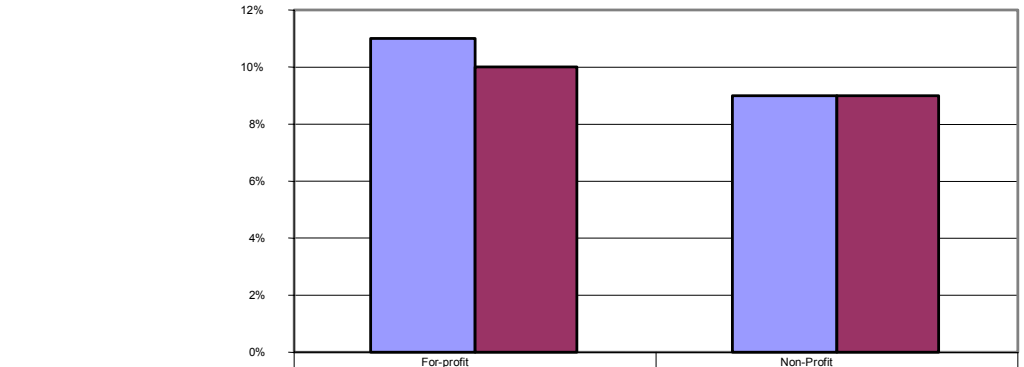
## FIGURE 3: MEDICAID-FOCUSED AND MULTI-PRODUCT PLAN MEDICAL BENEFITS RATIO BY OWNERSHIP CATEGORY




| | For-profit | Non-Profit |
|---|---|---|
| Medicaid-Focused Plans | 84% | 88% |
| Multi-Product Plans | 85% | 89% |

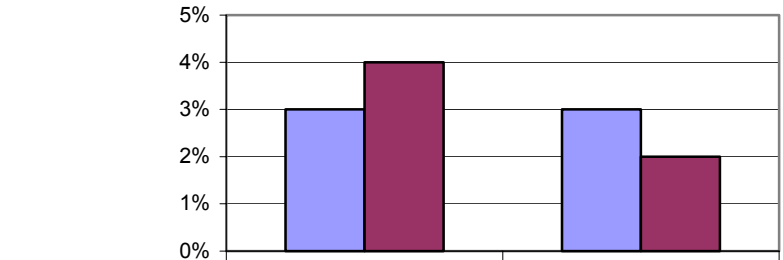
Higher administrative costs offset the lower payments in Medical benefits and resulted in the similar operating profit margin ratio, three percent, for both for-profit and non-profit Medicaid focused plans. Controlling medical and administrative expenses allowed for-profit multi-product plans to generate higher operating profit margins, four percent (see Figure 5), compared to two percent for their non-profit counterparts.

## FIGURE 4: MEDICAID-FOCUSED AND MULTI-PRODUCT PLAN ADMINISTRATIVE COST RATIO BY OWNERSHIP CATEGORY




| | For-profit | Non-Profit |
|---|---|---|
| Medicaid-Focused Plans | 11% | 9% |
| Multi-Product Plans | 10% | 9% |

## FIGURE 5: MEDICAID-FOCUSED AND MULTI-PRODUCT PLAN OPERATING PROFIT MARGIN BY OWNERSHIP CATEGORY

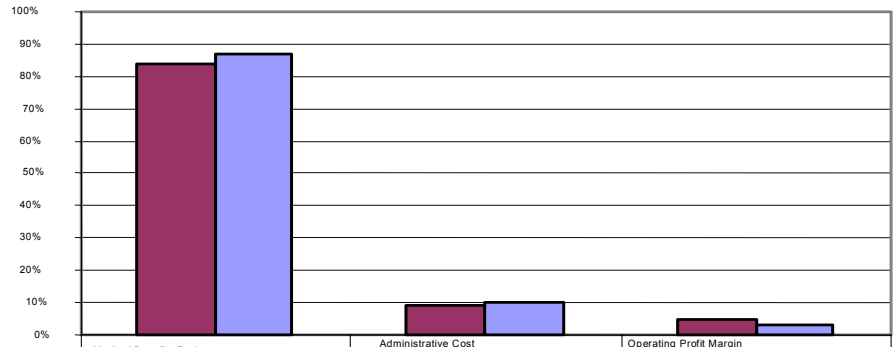



| | For-profit | Non-Profit |
|---|---|---|
| Medicaid Focused Plans | 3% | 3% |
| Multi-Product Plans | 4% | 2% |

### Performance of Medicaid-Focused Plans vs. Multi-Product Provider-Sponsored Plans Only

The financial performance ratios of health plans that are sponsored by a hospital or health system, defined as provider-sponsored organizations (PSOs ), also were examined. PSO Medicaid-focused plans had a higher medical benefit ratio, 87 percent (see Figure 6), compared to 84 percent for PSO multi-product plans. PSO Medicaid focused plans return a greater proportion of the premium revenue dollars, in the form of medical expenses, to the health system or hospital. PSO Medicaid focused plans also incurred a higher administrative cost ratio (10 percent) compared to that of PSO multi-product plans (nine percent). As a result, PSO Medicaid focused plans generated a lower operating profit margin ratio, three percent, compared to five percent for PSO multi-product plans.

## FIGURE 6: FINANCIAL RATIOS OF PSO MEDICAID-FOCUSED AND MULTI-PRODUCT PLANS

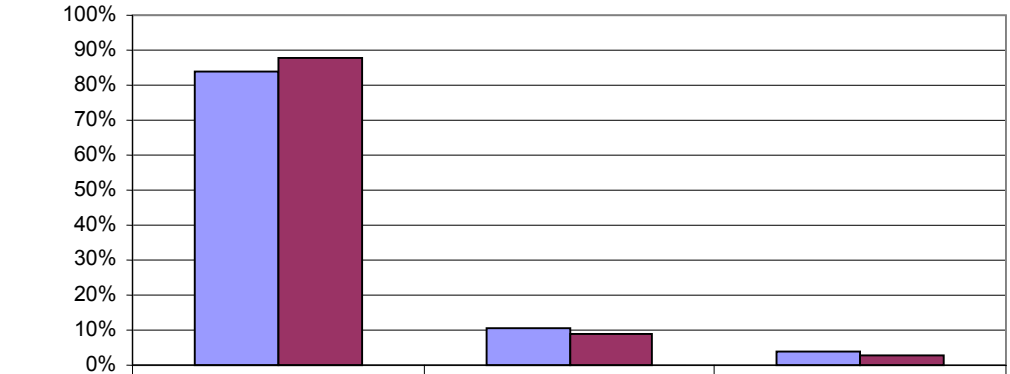



| | Medical Benefits Ratio | Administrative Cost Ratio | Operating Profit Margin Ratio |
|---|---|---|---|
| Multi-Product | 84% | 9% | 5% |
| Medicaid-Focused | 87% | 10% | 3% |

### Performance of For-Profit vs. Non-Profit Plans

Comparisons of the profit margin ratios of for-profit health plans with non-profit plans found for-profits generating a higher profit margin ratio (four percent) than non-profit health plans (three percent) (see Figure 7). Higher profits were earned by lowering medical expenses. For-profit plans' Medicaid medical benefits ratio was 84 percent, compared to 88 percent for non-profit health plans, making the difference statistically significant at the .01 level. In terms of Medicaid administrative expense ratio, non-profit plans reported a value of nine percent compared to 11 percent for for-profit health plans, which is statistically significant at the .01 level. (Appendix A presents a detailed analysis of the performance of Medicaid-focused investor-owned plans compared to selected multi-product firms).

## FIGURE 7: FINANCIAL PERFORMANCE OF PLANS BY OWNERSHIP



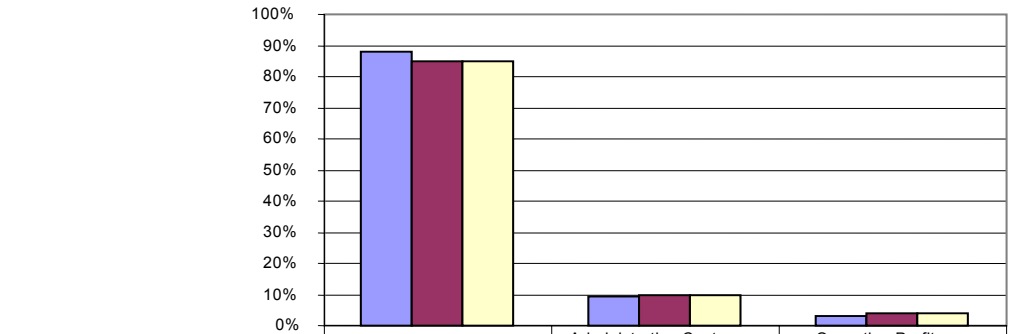

| | Medical Benefits Ratio | Administrative Cost Ratio | Operating Profit Margin |
|---|---|---|---|
| For-profit | 84% | 11% | 4% |
| Non-profit | 88% | 9% | 3% |

### Performance by Level of Medicaid Membership

Analyses of differences in the financial performance of plans by level of Medicaid membership were based on the membership level categories that appear in Table 3. The median number of Medicaid beneficiaries by Medicaid membership category ranged widely: 108,114 for the high membership category; 30,589 for the mid-level category; 7,146 for the low membership category. This clearly shows that plans in the high membership category may serve as many as three times the number of Medicaid participants compared to those health plans in the mid-level category, and as many as 12 times the number served by plans in the low membership category (Table 3).

Figure 8 shows the differences in financial performance by level of Medicaid membership. Plans in the high membership category reported the highest Medicaid benefits ratio, 88 percent. Plans in the low and mid-level membership categories had the same Medicaid medical benefits ratio, 85 percent. However, the administrative cost ratio was the same (10 percent) across all three categories of Medicaid membership. Thus, compared to plans with lower levels of Medicaid membership, plans with the highest number of Medicaid members failed to produce economies of scale in their administrative functions. The profit margins ratio, four percent, also was slightly higher for plans in both the low and mid-level Medicaid membership categories.

## FIGURE 8: FINANCIAL PERFORMANCE OF PLANS BY LEVEL OF MEMBERSHIP

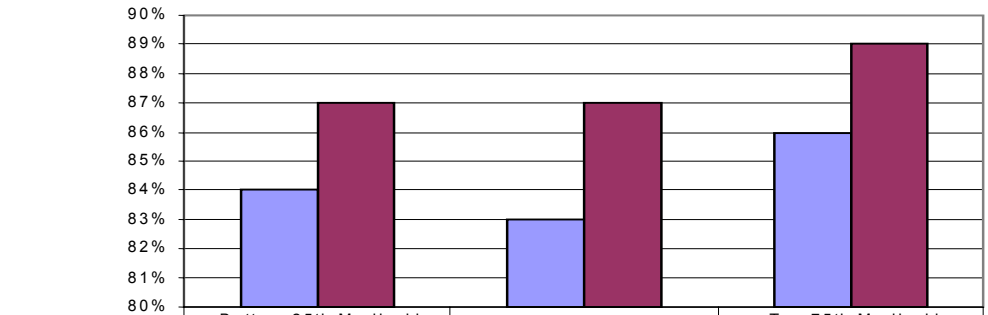



| | Medical Benefits Ratio | Administrative Cost Ratio | Operating Profit Margin |
|---|---|---|---|
| Top 75th Medicaid Enrollment | 88% | 10% | 3% |
| Median Medicaid Enrollment | 85% | 10% | 4% |
| Bottom 25th Medicaid Enrollment | 85% | 10% | 4% |

### Performance by Level of Medicaid Membership and Ownership Status

A comparison of the financial performance of plans in the three Medicaid membership categories (low, mid-level, high) by ownership status sheds a different light on financial performance differences (see Figure 9). Across all three Medicaid membership categories, for-profit plans yielded a lower Medicaid medical benefits ratio than non-profit plans in the same membership category. For-profit plans in the high membership category reported a significantly lower (at the .05 level) medical benefit ratio than high membership non-profit plans. However, both for-profit and non-profit plans with low and mid-level Medicaid membership reported lower medical benefit ratios than plans in the high membership category. For non-profit plans in the high Medicaid membership category, the medical benefit ratio was 89 percent compared to 87 percent for the plans in the low and mid-level categories. For for-profit plans in the high Medicaid membership category, the medical benefit ratio was 86 percent compared to 83 percent for the plans in the mid-level category (see Figure 9). Thus, plans with a large number of Medicaid members paid a greater proportion of their premium revenues in medical expenses, especially in the case of non-profit plans. In addition, regardless of level of Medicaid membership, non-profit plans paid more of their premium revenues in medical expenses than for-profit plans.

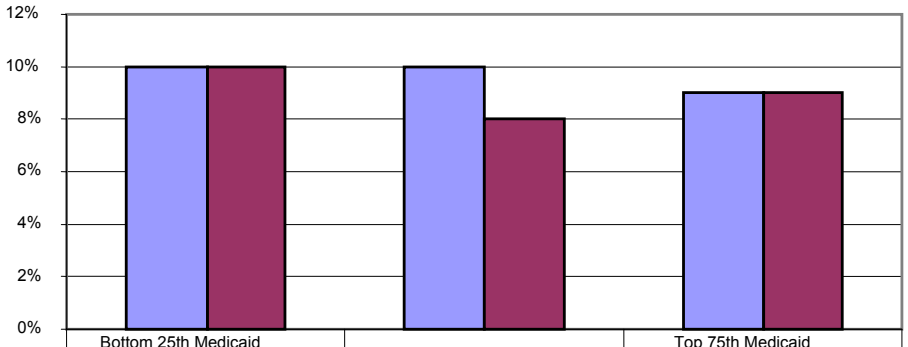
## FIGURE 9: MEDICAL BENEFITS RATIO BY LEVEL OF MEDICAID MEMBERSHIP




| | Bottom 25th Medicaid Enrollment | Median Medicaid Enrollment | Top 75th Medicaid Enrollment |
|---|---|---|---|
| For-profit plans | 84% | 83% | 86% |
| Non-profit plans | 87% | 87% | 89% |

Both for-profit and non-profit plans in the high Medicaid membership category had the same administrative cost ratio, nine percent (see Figure 10). However, for-profit plans in the high membership category incurred lower administrative costs (nine percent) than their for-profit counterparts (10 percent) in both of the lower membership categories. For non-profit plans, plans in the mid-level membership category had the lowest administrative cost ratio, eight percent, which is significantly lower (at the .01 level) than that reported by their for-profit counterparts.

## FIGURE 10: ADMINISTRATIVE COST RATIO BY LEVEL OF MEDICAID MEMBERSHIP



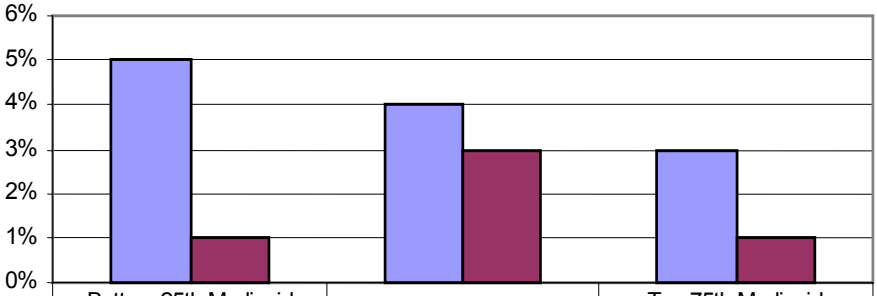

| | Bottom 25th Medicaid Enrollment | Median Medicaid Enrollment | Top 75th Medicaid Enrollment |
|---|---|---|---|
| For-profit plans | 10% | 10% | 9% |
| Non-profit plans | 10% | 8% | 9% |

Payment of fewer medical benefits may have contributed to the higher profit margin ratio of for-profit plans compared to their non-profit counterparts with the highest Medicaid memberships (three percent and one percent respectively) (see Figure 11). Controlling medical expenses and paying fewer claims resulted in the highest profit margins, five percent and four percent, respectively, for for-profit plans in the low and mid-level membership categories. The profit margins reported by for-profit plans in low and mid-level membership categories also exceeded those of all non-profit plans, regardless of their level of membership. Higher profits may be the underlying motive behind why these for-profit plans with fewer Medicaid members retain this business line.

**Performance by Level of Medicaid Membership and Product Focus**

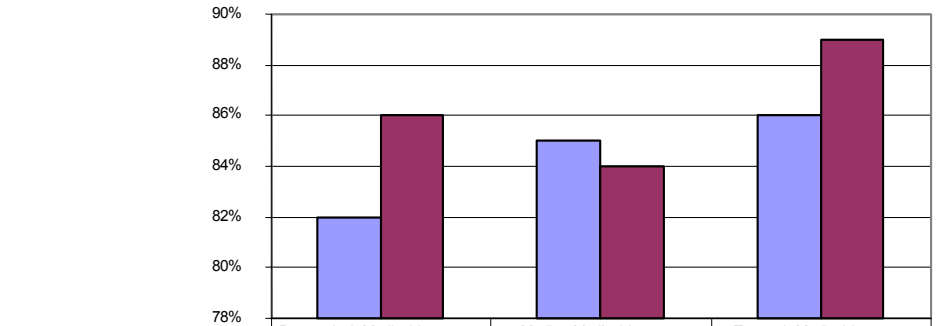
The final analysis of financial indicators examined performance by Medicaid enrollment and product focus (Medicaid-focused versus multi-product focused plans) (see Figure 12). For plans with the highest Medicaid membership, Medicaid-focused plans experienced a lower Medicaid benefit ratio (86 percent) compared to multi-product plans (89 percent). Similarly, for plans with the lowest Medicaid membership, Medicaid-focused plans also had a lower Medicaid benefit ratio (82 percent) compared to multi-product plans (86 percent) in the same level of membership category. Conversely, multi-product plans in the midlevel membership category had the lowest Medicaid benefit ratio (84 percent). These findings suggest that Medicaid-focused plans with fewer Medicaid members either control their medical expenses or pay out fewer dollars in medical claims.

**FIGURE 11: OPERATING PROFIT MARGIN BY LEVEL OF MEDICAID MEMBERSHIP**




| | Bottom 25th Medicaid Enrollment | Median Medicaid Enrollment | Top 75th Medicaid Enrollment |
|---|---|---|---|
| For-profit plans | 5% | 4% | 3% |
| Non-profit plans | 1% | 3% | 1% |

**FIGURE 12: MEDICAL BENEFITS RATIO BY PLAN FOCUS AND LEVEL OF MEDICAID MEMBERSHIP**

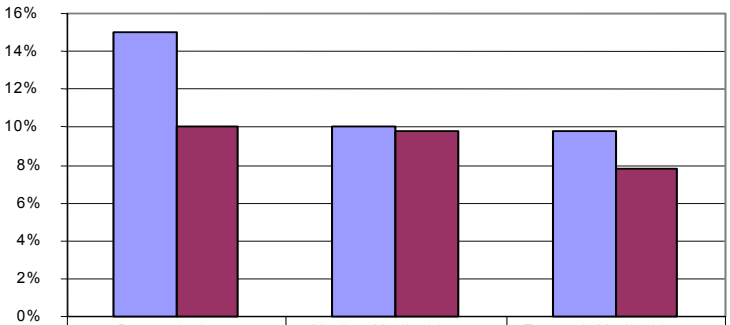



| | Bottom 25th Medicaid Enrollment | Median Medicaid Enrollment | Top 75th Medicaid Enrollment |
|---|---|---|---|
| Medicaid-Focused Plans | 82% | 85% | 86% |
| Multi-Product Plans | 86% | 84% | 89% |

Both Medicaid-focused and multi-product plans experienced a lower administrative costs ratio as Medicaid membership increased (see Figure 13). The administrative cost ratio for Medicaid focused plans was 15 percent for the low membership category, but only 10 percent for plans in the high membership category. For multi-product plans the administrative cost ratio was 10 percent for plans in the low membership category, compared with eight percent for those in the high membership category. For Medicaid-focused plans, the greatest decline (15 percent to 10 percent) in the administrative cost ratio occurred when median Medicaid membership rose from 9,460 (low Medicaid membership category) to 35,711 (mid-level membership category).

For multi-product plans, the greatest decline (10 percent to eight percent) in the administrative cost ratio occurred when median Medicaid membership rose from 25,610 (mid-level membership category) to 91,773 (high membership category). Thus, regardless of product focus, increasing Medicaid membership allows both Medicaid-focused and multi-product plans to experience economies of scale in their administrative functions (such as marketing, claims processing, information technology, administrative salaries, general overhead), and achieve lower per-unit fixed costs for their administrative services. For each Medicaid membership category, the differences were statistically significant between Medicaid-focused and multi-product plans. For the lowest level of Medicaid membership, the multi-product plans had a marginally significant (.10 level) lower administrative cost ratio than Medicaid-focused plans (see Figure 13). For plans in the high Medicaid membership category, the multi-product plans again had a significantly (.01 level) lower administrative cost ratio than Medicaid-focused plans.

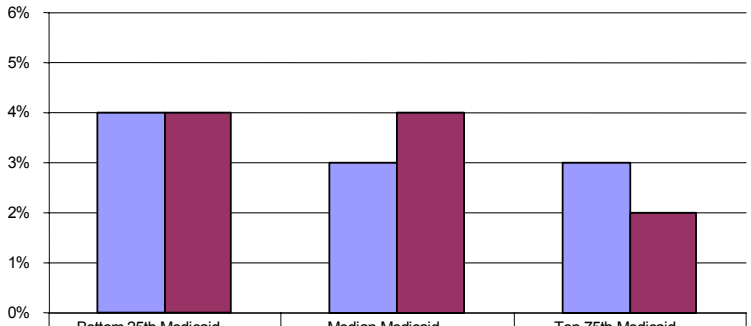
## FIGURE 13: ADMINISTRATIVE COST RATIO BY PLAN FOCUS AND LEVEL OF MEDICAID MEMBERSHIP




| | Bottom 25th Medicaid Enrollment | Median Medicaid Enrollment | Top 75th Medicaid Enrollment |
|---|---|---|---|
| Medicaid-Focused Plans | 15% | 10% | 10% |
| Multi-Product Plans | 10% | 10% | 8% |

For Medicaid-focused plans in the low membership category, the lower medical benefits ratio, reflecting fewer medical claims paid, was the impetus behind a higher profit margin ratio (four percent) compared to plans in the top membership category (three percent) (see Figure 14). A higher pay out of medical benefits also contributed to the lowest profit margin (two percent) for multi-product plans in the high Medicaid membership category.

## FIGURE 14: OPERATING PROFIT MARGIN BY PLAN FOCUS AND LEVEL OF MEDICAID MEMBERSHIP




| | Bottom 25th Medicaid Enrollment | Median Medicaid Enrollment | Top 75th Medicaid Enrollment |
|---|---|---|---|
| Medicaid-Focused Plans | 4% | 3% | 3% |
| Multi-Product Plans | 4% | 4% | 2% |

The Appendix to this study provides a *corporate level* financial analysis of the two publicly-traded Medicaid-focused plans—Amerigroup and Centene.

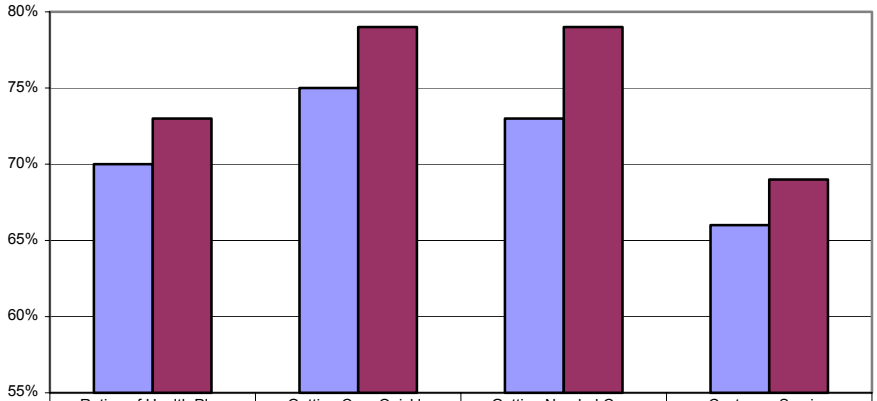
## NON-FINANCIAL PERFORMANCE INDICATORS

### Analysis of NCQA Member Satisfaction Scores by Plan Traits

Summary measures of plan quality derived from the NCQA database addressed the overall rating of the plan, member satisfaction, and physician turnover. Overall rating of the plan ranged from "best" to "worst" possible plans. Member satisfaction was examined in light of plan responsiveness ("getting care quickly"), accessibility to needed care ("getting needed care"), and customer service. Each of these four measures reflects the assessment of plan quality by its members. Each of these dimensions of plan quality was evaluated across plan characteristics: product focus (Medicaid-focused, multi-product), range of focus (single state HMO, multistate HMO), level of Medicaid membership (low, mid-level, high), and ownership status (for-profit, non-profit).

Comparisons of Medicaid-focused vs. multi-product plans found that multi-product plans received favorable scores from plan members across each of these four NCQA plan quality measures (see Figure 15) and were evaluated significantly higher on two of the measures – overall rating of the health plan and getting needed care (statistically significant at .05 and .01 level, respectively). State specific comparisons for multiple plans may be found in Appendix B.

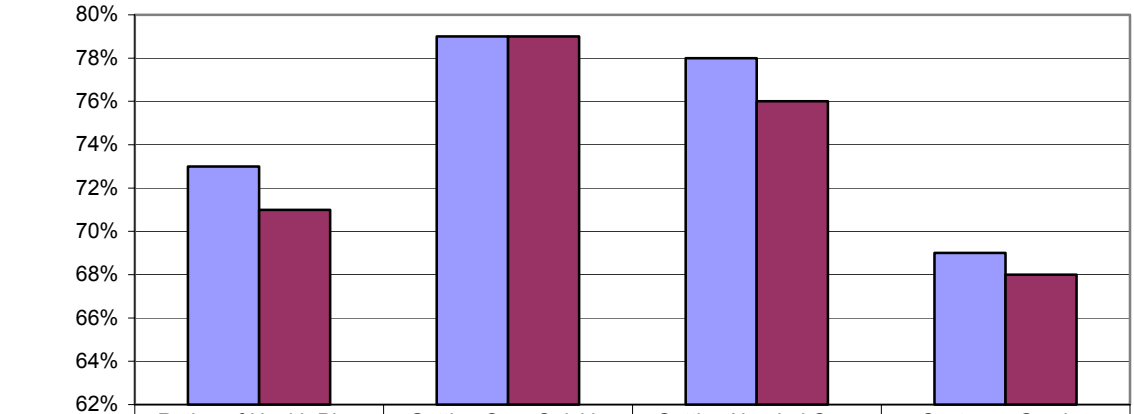
**FIGURE 15: NON-FINANCIAL PERFORMANCE OF MEDICAID-FOCUSED AND MULTI-PRODUCT PLANS**




| | Rating of Health Plan | Getting Care Quickly | Getting Needed Care | Customer Service |
|---|---|---|---|---|
| Medicaid Focused | 70% | 75% | 73% | 66% |
| Multi-Product | 73% | 79% | 79% | 69% |

Relative to ownership status (see Figure 16), for-profit plans received higher ratings for three out of the four of the plan quality measures, specifically overall rating of health plan, getting needed care, and customer service. Plan members made no distinction between for-profit and non-profit plans with respect to receiving their care quickly.

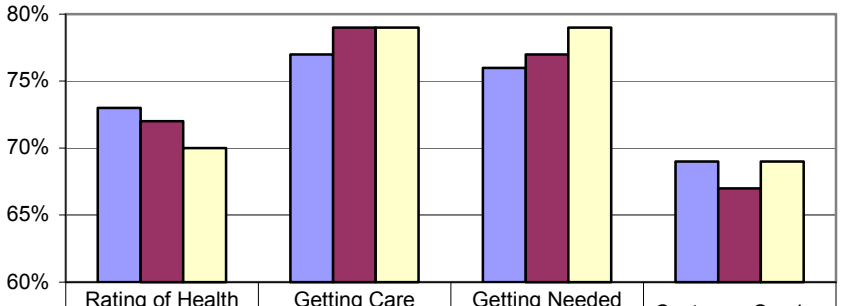
**FIGURE 16: NON-FINANCIAL PERFORMANCE OF FOR-PROFIT AND NON-PROFIT PLANS**




| | Rating of Health Plan | Getting Care Quickly | Getting Needed Care | Customer Service |
|---|---|---|---|---|
| For-profit | 73% | 79% | 78% | 69% |
| Non-profit | 71% | 79% | 76% | 68% |

Relative to level of Medicaid membership (see Figure 17), plans in the high Medicaid membership category received higher overall ratings (73 percent,) compared to plans with low membership levels (70 percent). In contrast, when compared with plans with high levels of Medicaid membership, plans with low membership levels received higher ratings (79 percent) for getting care quickly and getting needed care. However, in terms of customer service ratings, the ratings between low and high membership categories were equivalent.

## FIGURE 17: NON-FINANCIAL PERFORMANCE BY LEVEL OF MEDICAID MEMBERSHIP




| | Rating of Health Plan | Getting Care Quickly | Getting Needed Care | Customer Service |
|---|---|---|---|---|
| Highest Quartile Medicaid Enrollment | 73% | 77% | 76% | 69% |
| Median Medicaid Enrollment | 72% | 79% | 77% | 67% |
| Lowest Quartile Medicaid Enrollment | 70% | 79% | 79% | 69% |

### Analysis of HEDIS Clinical and Access Measures by Plan Characteristics

#### *Measure Definitions*

We also selected clinical and access HEDIS measures unique to child or adolescent health care. The clinical measures include four measures: 1) early initiation of the percentage of women who delivered a baby and received prenatal care during their first trimester of their pregnancy (prenatal care); 2) percentage of women who delivered a baby and who had a postnatal care visit between 21 and 56 days after delivery (postnatal care); 3) the percentage of children by age two who received the following immunizations (4 diphtheria-tetanus-pertussis, 3 polio, 1 measles-mumps-rubella, > 1 haemophilus influenzae type B, and 2 hepatitis B vaccinations before two years of age); and 4) the percentage of adolescents who received the following immunizations: measles-mumps-rubella by their 13th birthday.

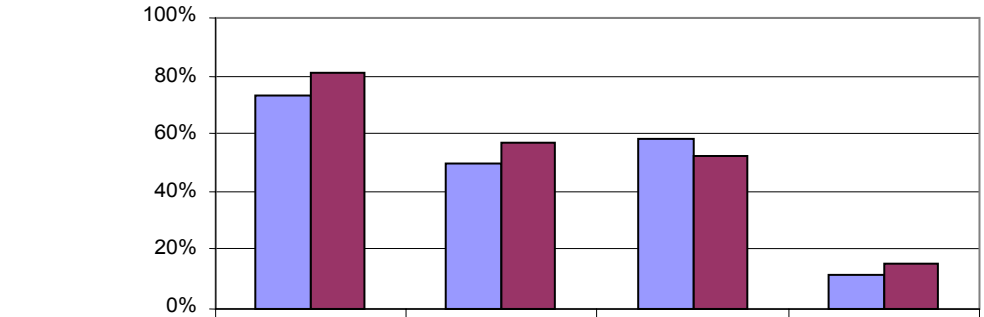
The access measures include three measures: 1) the percentage of adolescents who had at least one comprehensive well-care visit; 2) the percentage of children who had six or more well-child visits before they were 15 months of age; and 3) percentage of children who are three through six years of age and who received at least one well-child visit with the primary care doctor during the past year.

### Findings of HEDIS Clinical and Access Measures by Medicaid-Focus

In terms of clinical measures, Medicaid-focused plans had lower percentages for all clinical measures except for child immunization rates (see Figure 18). Postnatal care rates were statistically significantly lower at the .01 level for Medicaid-focused plans. For

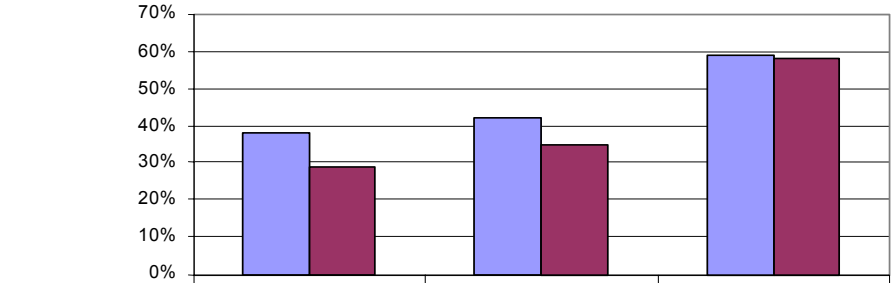
access measures (Figure 19), Medicaid-focused plans had higher percentages for all three measures then the multi-product plans.

**FIGURE 18: SELECTED HEDIS CLINICAL INDICATORS BY MEDICAID-FOCUSED AND MULTI-PRODUCT PLANS**




| | Prenatal Care | Postnatal Care | Child Immunizations | Adolescent Immunizations |
|---|---|---|---|---|
| Medicaid-Focused | 73% | 50% | 58% | 11% |
| Multi-Product | 81% | 57% | 52% | 15% |

**FIGURE 19: SELECTED HEDIS ACCESS INDICATORS BY MEDICAID-FOCUSED AND MULTI-PRODUCT PLANS**



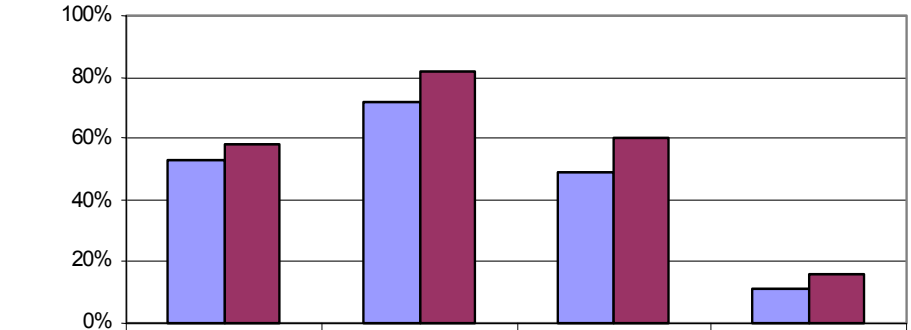

| | Adolescent Well Visits | Well-Child Visits, 15 months | Well-Child Visits, 3-6 yrs |
|---|---|---|---|
| Medicaid-Focused | 38% | 42% | 59% |
| Multi-Product | 29% | 35% | 58% |

### Findings of HEDIS Clinical and Access Measures by Ownership

In terms of clinical measures (Figure 20) non-profits had higher percentages for all clinical measures. Prenatal care and child immunizations were significantly higher at the .01 level for non-profits while postnatal care was significantly higher at the .05 level for

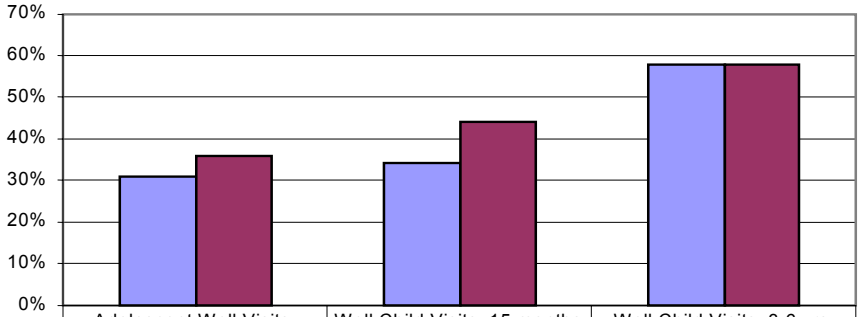
non-profits. For access measures (Figure 21), non-profit plans had higher percentages for two of the three measures – adolescent visits and well-child, first 15 months visits – but neither were significantly higher.

**FIGURE 20: SELECTED HEDIS CLINICAL INDICATORS BY FOR-PROFIT AND NON-PROFIT PLANS**




| | Prenatal Care | Postnatal Care | Child Immunizations | Adolescent Immunizations |
|---|---|---|---|---|
| For-Profit | 53% | 72% | 49% | 11% |
| Non-Profit | 58% | 82% | 60% | 16% |

**FIGURE 21: SELECTED HEDIS ACCESS INDICATORS BY FOR-PROFIT AND NON-PROFIT PLANS**



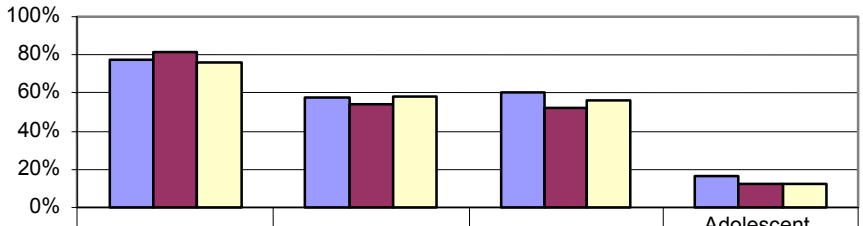

| | Adolescent Well Visits | Well Child Visits, 15 months | Well Child Visits, 3-6 yrs |
|---|---|---|---|
| For-Profit | 31% | 34% | 58% |
| Non-Profit | 36% | 44% | 58% |

### Findings of HEDIS Clinical and Access Measures by Medicaid Size

In terms of clinical measures (Figure 22), the largest Medicaid enrollment category had a lower percentage for the prenatal care than the median enrollment. However, immunizations for both children and adolescents were higher for the highest Medicaid

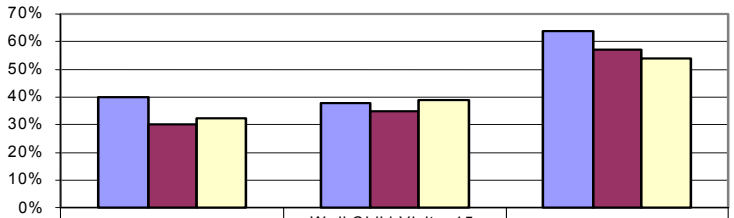
enrollment category. For access measures (Figure 23), the largest Medicaid enrollment category had higher percentages for adolescent visits and well-child for children ages three to six.

## FIGURE 22: SELECTED HEDIS CLINICAL INDICATORS BY ENROLLMENT




| | Prenatal Care | Postnatal Care | Child Immunizations | Adolescent Immunizations |
|---|---|---|---|---|
| Highest Quartile Medicaid Enrollment | 77% | 57% | 60% | 17% |
| Median Medicaid Enrollment | 81% | 54% | 52% | 13% |
| Lowest Quartile Medicaid Enrollment | 76% | 58% | 56% | 12% |

## FIGURE 23: SELECTED HEDIS ACCESS INDICATORS BY ENROLLMENT




| | Adolescent Well Visits | Well Child Visits, 15 months | Well Child Visits, 3-6 yrs |
|---|---|---|---|
| Highest Quartile Medicaid Enrollment | 40% | 38% | 64% |
| Median Medicaid Enrollment | 30% | 35% | 57% |
| Lowest Quartile Medicaid Enrollment | 32% | 39% | 54% |

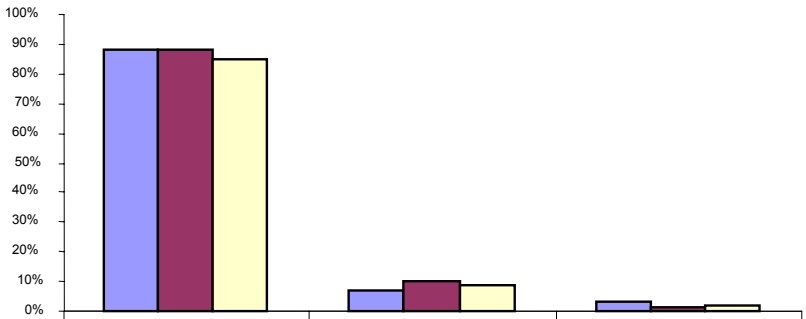
## COMPOSITE FINDINGS

### Comparisons of Financial Performance by Non-Financial Performance

Comparisons of the financial performance of plans by their non-financial ratings are available using data on 49 health plans. As the previous discussions noted, the overall

rating of health plans from the NCQA database reflects the percent of members who gave the plan a high overall rating (a score of 8, 9, or 10). The financial measurements included the same three summary indicators of medical benefits ratio, administrative cost ratio, and operating profit margin (see Figures 24-26).

## FIGURE 24: COMPARISON OF PLANS BY FINANCIAL AND NON-FINANCIAL PERFORMANCE DATA

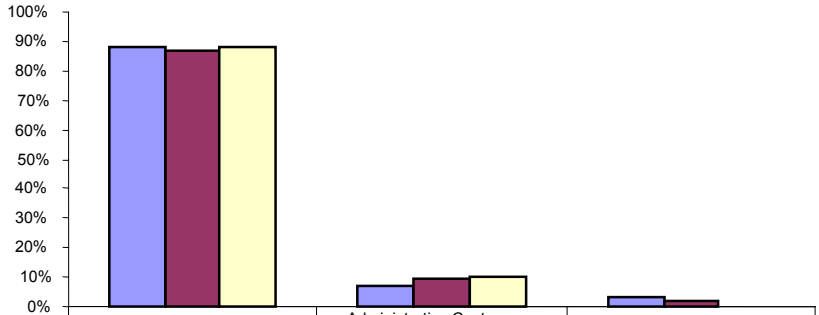



| | Medical Benefits Ratio | Administrative Cost Ratio | Operating Profit Margin |
|---|---|---|---|
| Top 75th Overall Plan Rating | 88% | 7% | 3% |
| Median Overall Plan Rating | 88% | 10% | 1% |
| Bottom 25th Over all Plan Rating | 85% | 9% | 2% |

The analyses suggest that plans rated more favorably (top quality) by their members reported a slightly higher medical benefits ratio (88 percent) than plans rated unfavorably (85 percent) (see Figure 24). Plans rated in the more favorably rated category also achieved a profit margin of three percent, by controlling their administrative cost ratio (seven percent). In contrast, plans rated less favorably earned a profit margin of two percent, which may stem from a lower medical benefits ratio (85 percent).

Relative to plan responsiveness ("getting care quickly"), health plans rated more favorably and less favorably reported the same medical benefits ratio for Medicaid (88 percent) (see Figure 25). However, the top-ranked plans had lower administrative cost ratio (seven percent) compared with the less favorably rated plans (nine percent). As a result of administrative efficiencies, top-rated plans earned a three percent higher profit margin than plans rated in the lowest category, and received favorable ratings for efforts in providing appointments for regular or routine health care, the frequency in receiving care promptly for an illness or injury, and the waiting time for an office visit to their doctor.

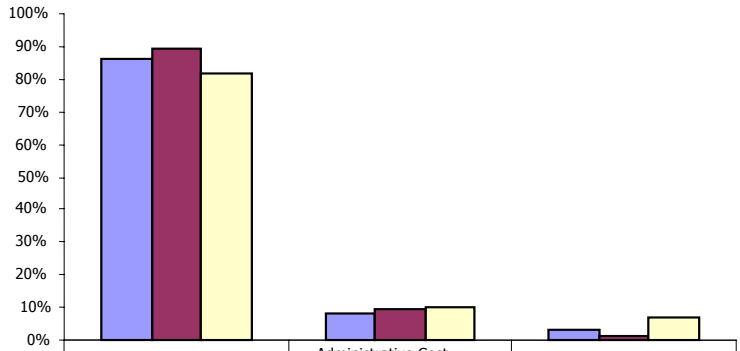
## FIGURE 25: COMPARISON OF PLANS: "GETTING CARE QUICKLY" AND FINANCIAL PERFORMANCE




| | Medical Benefits Ratio | Administrative Cost Ratio | Operating Profit Margin |
|---|---|---|---|
| Top 75th Getting Care Quickly | 88% | 7% | 3% |
| Median Getting Care Quickly | 87% | 9% | 2% |
| Bottom 25th Getti ng Care Quickly | 88% | 10% | 0% |

For the other satisfaction measure, which reflects the perceived ease of access to needed care ("getting needed care"), the health plans evaluated in the most favorable category had higher medical benefit ratios (86 percent) compared to 82 percent for plans in the least favorable category (see Figure 26). The administrative cost ratio was lower for plans in the top category. The lower medical benefits ratio contributed to higher profit margin ratio (seven percent) for plans rated least favorably. Thus, plans receiving a least favorable rating by members – in terms of ease of access to a doctor, nurse, or specialists, or health care services in general – earned higher profits.

## FIGURE 26: COMPARISON OF PLANS: "GETTING NEEDED CARE" AND FINANCIAL PERFORMANCE




| | Medical Benefits Ratio | Administrative Cost Ratio | Operating Profit Margin |
|---|---|---|---|
| Top 75th Getting Needed Care | 86% | 8% | 3% |
| Median Getting Needed Care | 89% | 9% | 1% |
| Bottom 25th Getting Needed Care | 82% | 10% | 7% |

**Source: Interstudy & NCQA 2001**

### Financial and Non-Financial Performance Analysis Summary

The financial and non-financial performance of plans serving the Medicaid market was examined with respect to specific plan characteristics: product focus, range of market focus, level of Medicaid membership, and ownership status. Our analysis revealed the following trends:

- Both Medicaid-focused and multi-product plans were profitable and achieved similar profit margins; however, assessment of the adequacy of these profit margins in fulfilling the short-and long-term objectives of these health plans is beyond the scope of the study.
- By incurring higher medical expenses, provider sponsored Medicaid-focused plans returned a greater proportion of their premium revenue dollars to their hospital or health care system. As a result, their profit margins were lower than those found for multi-product PSO plans.
- The difference in profit margin between for-profit and non-profit plans was minimal: only one percentage point. But it is notable that the two major investor-owned, Medicaid-focused plans had profit margins considerably higher than the average for-profit plan (Appendix A).
- For-profit plans with low levels of Medicaid membership earned higher profits than health plans with high levels of Medicaid membership.
- Economies of scale in administrative functions (marketing, claims processing, information technology) were realized by Medicaid-focused plans as their Medicaid enrollment increased.

- New, publicly traded Medicaid focused plans (Amerigroup and Centene) generated higher profit margins than multi-product publicly traded companies (Humana and Coventry) that offered a Medicaid line of business.
- Compared with multi-product plans, Medicaid-focused plans had slightly lower overall ratings from their members, though access and clinical indicators were similar.
- For-profit plans received higher overall ratings from their members than non-profit plans, though access and clinical indicators were slightly lower.
- Plans with the high levels of Medicaid membership received higher overall ratings from their members; however, members' ratings of some aspects of quality of care (responsiveness and accessibility to needed care) were slightly lower compared with those of plans at lower membership levels.

## INTERVIEW FINDINGS

Interviews supplemented the quantitative data analysis in this study. Fifty-six interviews were conducted using a uniform 12-question protocol (Table 6) and respondents included representatives from 13 state Medicaid agencies and a total of 26 plans, plus a number of trade association and advocacy group representatives. The interviews were conducted by telephone during May through July 2003 and averaged 30 minutes per respondent. Across the 13 states interviewed, there are 6.5 million Medicaid beneficiaries in prepaid health plans, about 40 percent of all Medicaid lives in such plans.

Rather than reporting respondents' comments question by question, the findings are summarized by seven broad categories that emerged during these interviews. Topics of interest include the contemporary contracting environment; plan participation; sponsorship of Medicaid-focused plans; operational differences between Medicaid-focused and multi-product plans; non-financial performance differences; financial performance differences; and current crisis-future developments.

### Contemporary Contracting Environment

Two key themes regarding Medicaid agency-health plan relationships emerged in the interviews: administrative issues and rate-related issues. One perspective sees administrative relationships maturing, and becoming more collaborative and consultative in most states—a perception typically shared by respondents from both state agencies and plan representatives. One veteran plan respondent put it succinctly: "[t]he Medicaid agency is responsive and interested in assisting and collaborating with plans." This viewpoint is now much more pervasive than when health plan and state level interviews were conducted during our previous studies for CHCS. Many states have standing committees that involve plans in several important program-related initiatives, including developing implementation schedules and performance indicators. Perceptions of rate issues, the other emerging theme, are definitely less upbeat: the words "tense,"

"strained," and "difficult" were commonly employed to characterize the current rate-setting environment and responses to budget problems. The partnership relationships that have evolved are being tested as both the health plans and Medicaid agencies are unable to fully anticipate the adjustments that budget distress requires. Overall, it is the uncertainty that appears most troubling to the plans, as many issues come into play at one time: eligibility, benefits, scope of benefits, and rates.

**Plan Participation**

While reliance by state agencies on Medicaid-focused plans has increased, surprisingly there remain a number of states in which such plans are still the minority in terms of participating plans. What is more striking, however, are the increasingly large memberships of the remaining plans and the degree to which states are more dependent on a limited number of players—both Medicaid-focused and multi-product plans. It is not uncommon to find 50 to 60 percent of beneficiaries in only two plans operating in a state. Notably, many state officials believe having fewer plans has enabled them to develop more constructive relationships with remaining plans. Some suggest that "we had way too many plans early on" and did not reap any noticeable benefits from greater competition. When these plans are Medicaid-focused, the mutual dependence between state agencies and health plans is very evident to both parties. Most observers believe reliance on fewer plans is a result of consolidation and attrition in the managed care market.

The growing dependence on Medicaid-focused plans is attributed to diminishing interest among commercial plans in Medicaid and the HMO product, and is not the result of a purposeful or conscious contracting strategy by the states. Several multi-product plan executives commented that they have to continually justify their rationale for remaining in the Medicaid market to their superiors. Even respondents from financially successful plans acknowledge that continued participation remains a year-to-year decision in some states. As the current data analysis shows, the improved financial position is, in part, because of administrative efficiencies associated with scale. The benefits of administrative efficiencies also seem to be occurring with multi-state investor-owned plans.

**TABLE 6: INTERVIEW QUESTIONS**

- How would you characterize the general contracting environment between participating managed care plans and the Medicaid agency in your state?
- Has plan participation in Medicaid changed in the past two years? If yes, how? If any plans have left the market in the past two years, why do you think they did so?
- How many plans in the state are Medicaid-focused and how has this changed over the life of the MMC program? (*By Medicaid-focused, we mean plans for which Medicaid and SCHIP enrollment represents the majority of the plan's enrollment and those commercial plans that have developed a separate subsidiary for Medicaid and SCHIP.*)
- To what extent is the state relying on plans that serve exclusively or predominantly Medicaid and SCHIP beneficiaries? In your opinion is this the result of a conscious strategy or simply market trends? Is the state actively trying to solicit and/or maintain MMC participation from commercial plans?
- Do you think there are any major operational differences between Medicaid-focused plans and multi-product plans (those with predominantly commercial membership)? Can you give us some examples?
- Have you observed any differences between Medicaid-focused plans that are provider-sponsored compared to those with non-provider sponsorship? If any, what are they?
- How would you characterize the relationship that Medicaid-focused plans have with their provider networks? How does this relationship differ across the types of Medicaid-focused plans, e.g., provider-sponsored compared to those owned by other investors?
- How would you characterize the relationship that Medicaid-focused plans have with their members? How does this relationship differ across the types of Medicaid-focused plans, e.g., provider-sponsored compared to other investors?
- Do you think there are any important differences in the quality of care rendered in Medicaid-focused plans compared to predominantly commercial plans? If any, what are they?
- Do you think there are any important differences in the financial stability of Medicaid-focused plans compared to predominantly commercial plans? If any, what are they?
- Do you expect that the Medicaid-focused plans currently participating in your state will remain in the Medicaid market in the future? How important are these plans in sustaining and growing MMC in the future?
- What changes have been made, or are anticipated to be made, in the MMC program in light of the budget situation in your state? How do you anticipate the budget situation will affect the MMC participation among health plans? Do you expect any plans to exit the market?

### Sponsorship of Medicaid-Focused Plans

In the 13 states represented in our interviews, 59 of the 97 participating plans are Medicaid-focused. Respondents from the state agencies report that as plans become available for acquisition, the publicly traded Medicaid-focused plans (Amerigroup, Centene, and Molina) as well as some investor-owned commercial firms with a Medicaid-focused subsidiary (e.g., United/Americhoice) are showing substantial interest. Most observers anticipate continued consolidation by the multi-state plans to aggregate their holdings as other plans exit the Medicaid market, or as provider-sponsored plans are sold. The provider-sponsored plans tend to be hospital affiliated or sponsored by a health center. Hospital participation remains tenuous as hospitals divest themselves of their managed care businesses and drop commercial products altogether. Health center-sponsored plans, which appear on stronger footing financially, are more compatible with the mission of the sponsoring organizations. In addition, most hospital-sponsored plans tend to remain small because their objective is to solidify market share for the sponsoring facility; thus, hospital-sponsored plans have little motivation to expand to other markets, even within the same state.

## Operational Differences between Medicaid-Focused and Multi-Product Plans

Compared to our earlier studies, *there is now a very clear consensus that plans that succeed in Medicaid are strongly focused and that commercial, multi-product plans are disadvantaged if they fail to develop a specialized emphasis*. Historically this has been especially true in terms of network development, while it is most striking today in medical management and active engagement/outreach with members. Representatives from plans in the Medicaid managed care market contrast their activities in Medicaid medical management with what activities are (or are not) occurring in commercial managed care, and stress that hands-on care management continues to be essential to success in Medicaid. As one plan executive observed, "we see the downstream effects of poverty, particularly in the inner city" and have to adapt our programs accordingly. This translates into a substantial investment of resources in communications, hiring of indigenous staff members, active community involvement, and extensive provision of transportation services. In addition, respondents emphasized that plans need to work proactively with Medicaid members to keep them (or their children, who represent 75 percent to 80 percent of Medicaid plan enrollment) participating and engaged. This means Medicaid plans must acquire and use special personnel, skills, and efforts not commonly found in other commercial plans.

State agency personnel see the Medicaid-focused plans as more nimble and responsive to their expectations, partially a function of relative staff stability and dedication. In contrast, multi-product plans are seen as treating Medicaid products as "off-brand" and relatively marginal, and multi-product plans appear less able to retain experienced staff in this product line. One multi-product plan's executive confessed: "to be honest, I wish we had a separate unit to concentrate on our Medicaid membership." Another commercial plan CEO noted that he thought it would be a mistake for Medicaid

agencies to try to mainstream care for persons with substantial care needs because he suspects most commercial plans are not well equipped to serve them. Commercial health plans that focus on Medicaid (United/Americhoice, Wellpoint/Unicare, and, in some markets, Humana, Wellpoint/Unicare, and Coventry) are viewed as having concluded that specialization is the path to success in the Medicaid market.

**Non-Financial Performance Differences**

Our earlier studies revealed concerns that state Medicaid agencies, faced with rapidly expanding managed care and increased dependency on newly formed Medicaid-focused plans, might find it necessary to relax performance expectations. Some observers worried that the provider "Medicaid mill" experience might re-appear at the health plan level. The majority of our respondents contend there are no substantial differences in quality of care between Medicaid-focused and other health plans. Two reasons are cited as contributing, in part, to these quality of care similarities: the stability and financial success of the surviving Medicaid-focused plans and the states' uniform application of contract terms, which yields more homogeneity coverage among all participating plans. Some state officials indicated that the states can demand even more of plans that are only participating in Medicaid, an observation supported by one plan administrator who noted that: "[i]f you don't do a good job, the state is all over us like white on rice."

Some respondents, including managers from some of the health plans, suggested that some Medicaid-focused plans do not compare favorably with other plans using HEDIS and CAHPS standards. This is consistent with the findings reported in the quantitative analysis. The observers contend these deficiencies may reflect infrastructure and reporting limitations, or emphasize Medicaid-focused plans' reliance on institutional providers like Federally Qualified Health Centers. Noteworthy was the claim by interviewees from several states that the plans, irrespective of sponsorship, are demonstrating continuous improvement on the performance indicators tracked by the states. Plan representatives also stressed that too often their critics fail to make "the really meaningful comparison:" how well are the plans performing relative to Medicaid fee-for-service. One Medicaid-focused plan CEO pointed to state performance reports and put it bluntly: "the state pays us only 88 percent of Medicaid fee-for-service, and but our members are getting better care than fee-for-service delivers."

**Financial Performance Differences**

Financial stability surfaced as a critical issue because most respondents recognize that pursuing a single line of business greatly increases exposure and vulnerability for the Medicaid-focused plans. While the operating margins of Medicaid-focused plans are comparable to those of multi-product plans, the Medicaid-focused plans offer less product diversification and are essentially dependent on a single purchaser of their services. One commercial plan administrator clearly questioned the wisdom of the state Medicaid agencies' excessive reliance on "one trick ponies." But, to date, observers from both states and plans do not interpret this mutual dependence as an impediment; rather,

this relationship is perceived as promoting collaboration. Some state officials noted that regulatory agencies in their states (particularly the departments of insurance) play an important role in ensuring that Medicaid-focused plans remain financially viable and that adequate rates are paid to sustain them.

Some respondents from investor-owned plans were less sanguine about the mutual dependency—which may explain their greater interest in political activism. However, these interviewees also touted the advantages of being a "pure play." Many plan executives expressed concern about growing problems with provider pushback, specially among hospitals (and most trenchantly, among children's hospitals) which are increasingly flexing their contracting muscles. Some observers also believe that Medicaid-focused plans vary in how they spend their money, an observation confirmed by this study's financial analyses: provider-sponsored plans pay higher fees to their providers ("our owners *are* our network"), while investor-owned plans pay lower fees to providers so they can reward their investors. However, the touting of profitability by some of the investor-owned plans heightens concern among policymakers and some providers who are besieged by budget woes and payment reductions.

**Current Crisis—Future Developments**

Although the states face critical allocation choices associated with budget difficulties, state agencies and plans remain committed to sustaining Medicaid managed care. Across the 13 states represented here, the anticipated rate changes for the upcoming year range from a five percent reduction in rates up to a five-to-six percent increase in rates. Many suggest a sense of "toughing it out" through this very unfavorable budget year and hoping next year will improve. In fact, whether the next budget year will be better is a key concern to most plan executives, although they believe their plans can sustain at least one year with rate increases falling short of medical care trends. As the financial analyses demonstrate, currently most plans are profitable, have some reserves, and until recently had received respectable rate increases. However, many plan executives are worried about the long-term prospects and are concerned that Medicaid may follow in the same direction taken by Medicare+Choice, where cost trends are consistently greater than rate increases. One plan executive soberly summarized the plight of these health plans: "clearly, the trend issue is life and death for us."

Still uncertain is whether and how the "actuarial soundness" regulation of the BBA of 1997 will affect the prerogatives of the states or the opportunities for plans. Overall, states and plans generally have accommodated the other BBA regulations with minimal hardship or consternation. However, respondents from some plans did acknowledge that budget problems had taken a toll on the number and talents of state personnel, which renders collaborative relationships more difficult. Another concern in several states is the impact of adult benefit waivers (permitted by expanded flexibility for states) on plan enrollment, if current Medicaid eligibles are shifted to slimmed-down benefit packages, and on plan relationships with providers, if plans receive sharply reduced premiums to enroll adults. We found a number of plans and states are discussing additional carve outs

or reductions in scope of capitated benefits to align risk with manageable costs. There were also a few comments about the potential for states to turn to administrative services only arrangements with plans, in which all medical cost risks would be retained by the Medicaid agencies, but we did not extensively explore this topic.

The extent to which plans are engaged in concerted political lobbying to obtain or improve rate increases is noteworthy. Interviews from our earlier studies revealed few plans open to discussing the importance attributed to directly approaching legislators. In contrast, the current study found that a broader spectrum of plans, and many of the health plan associations, have task forces and work groups of Medicaid-participating plans involved in lobbying. Representatives from several plans said they were even encouraged by Medicaid agencies to take their case directly to the state legislature. Several interviewees noted that because several states have term limits, many new legislators have little knowledge about Medicaid managed care, why and how the states are involved, and its success in delivering care to beneficiaries. Thus, lobbying efforts become educational activities. Some commercially-oriented plans participate in lobbying efforts, while others defer to the Medicaid-focused plans. One leader of a health plan task force aptly summarized the situation by stating: "We have to keep the pressure on the legislature to make them understand why they have to pay us a fair rate, and what we can deliver to Medicaid beneficiaries if they do so."

In sum, the findings here suggest that the current state budget crises will lead to even fewer commercial plans participating in Medicaid, and continued growth for the remaining plans, with a greater portion of those surviving Medicaid-focused plans. Compared to our earlier study findings, despite the current levels of interdependence, state officials now appear *less* concerned about possible exploitation/extortion by remaining plans using their dependence to their advantage. This suggests that a maturing relationship and, at the risk of sounding too sanguine, a sense of partnership has evolved in most of these states. It also may hint that both agencies and plans are treading water during this tough budget time, with both parties hopeful the bleak financial picture will improve in the not-too-distant future.

## STUDY STRENGTHS AND LIMITATIONS

This study increase our understanding of contemporary Medicaid managed care market dynamics and updates our two earlier studies for CHCS. The strength of this study is enhanced by its timeliness and by triangulation of data sources (quantitative and qualitative), the variety of performance measurements (financial and non-financial), and the overall scope of our investigation. Our financial analyses include complete data from 183 health plans; eight states and 32 different health plans serving their Medicaid beneficiaries were included in the state-specific analyses. Supplementing these examinations were interviews with respondents representing 13 state agencies and 26 plans, who cover more than 6.5 million Medicaid beneficiaries, or 42 percent of all Medicaid lives in health plans.

In spite of these research strengths, the limitations of this study warrant acknowledgement. Among these limitations are those arising from the financial and non-financial data available, the selection of the states of interest, and the timing of data collection. Both financial and non-financial performance measures are affected by the specific aspects of enrollment: states vary in the types of beneficiaries enrolled in Medicaid managed care, their geographic location within the state, and whether enrollment is mandatory or voluntary. Because the financial data are only for a single year, trends related to dynamic plan and marketplace changes are not detected. Rapid growth or decline in membership can distort financial indicators in significant ways.

While plans included in the financial database appear representative of the nationwide profile of participating plans, the database does not include those plans that focus solely on Medicaid that are not licensed as HMOs, and plans which do not report financial information in a format collected by Interstudy. Moreover, there were no data from plans in California in the Interstudy analysis; our prior studies found that some plan financial indicators in California may differ from those of other states because of the distinctive configuration of managed care arrangements found in Medi-Cal. Although comparisons of financial and non-financial data on plans at a state level were proposed, the reliability of plan-specific financial information from both Interstudy and state maintained databases made the value of comparisons questionable.

The non-financial data acquired from NCQA were available on the Medicaid product line from only 75 plans, and because of limitations in the availability of selected data elements, the number of usable plans fell to 59. The findings based on this analysis can only be viewed as suggestive at best. Data collection from individual states was very uneven, as anticipated, although a sizeable number of states now have publicly available non-financial information (standard HEDIS or state-specific forms). As with financial information, data from a single year limits identification of an overall pattern of performance.

The non-financial performance analysis was limited to a small set of measures. The selection of these particular indicators allowed for comparisons across plans on a parsimonious basis, similar to the analysis with the three financial ratios, and afforded a comprehensive look at performance by integrating financial and non-financial performance information. Future studies should address the creation of richer, cross-state comparisons and the development of performance benchmarks for plans.

The purposeful sample of 13 states was selected for interviews to provide diversity on a number of dimensions. For each state selected, participation in interviews was solicited from one multi-product and one Medicaid-focused plan as well as from state officials, trade associations, and consumer groups on a non-random basis. The level of willingness to participate was high overall, but compared to other groups represented, those from multi-product firms tended to see the study as not particularly pertinent to their interests. Although the total number of interviews provides a limited view of the Medicaid marketplace, the quantitative and qualitative findings were, in general, highly complementary. Because the interviews were conducted while a number of states were still debating their budgets, and the implications of the "actuarial soundness" regulations were still subject to much speculation, a number of the respondents cautioned that their perspectives could change in the coming months.

## CONCLUSIONS AND IMPLICATIONS

The current study advances our understanding of the evolving relationship of state Medicaid agencies and health plans, with this review updating our previous observations to mid-2003. Our findings are summarized by seven principal conclusions and the implications they suggest:

***1. The shift to further reliance on Medicaid-focused plans appears inevitable.***

Because commercially-oriented plans continue to exit the Medicaid market, Medicaid agencies have fewer contractors from which to purchase prepaid medical care. Those firms remaining in the Medicaid market appear to be shifting toward a more specialized focus that limits options to "mainstream" beneficiaries in private sector products and networks. To date, this gap is being adequately filled, in virtually all states, by Medicaid-focused plans with a growing percentage of Medicaid beneficiaries. A number of commercial or community-oriented multi-product plans have Medicaid products, but with the objective of intentionally limiting their exposure to the Medicaid product line. This, in turn, has limited the speed and magnitude of their growth, and indirectly expanded the relative importance of the specialized Medicaid-focused plans.

***2. The observed variation in plan participation across states will remain.***

Multi-product firms remain actively involved with Medicaid in a number of states, reflecting a relatively vibrant commercial HMO market and a contracting environment that encourages (Connecticut) or requires (Minnesota) broad-based participation among

health plans. In states where provider-sponsored plans are major participants in Medicaid (Wisconsin and Michigan), states continue to have several contractors involved because provider-based plans typically focused on a single market area (often to ensure maintenance of the provider's Medicaid market share). Although there is no explicit strategy to promote only Medicaid-focused plan participation in some states, state policy has influenced the mix of plans participating in the product line by encouraging plans to develop a very strong Medicaid focus to meet program goals and requirements (e.g. Pennsylvania). Finally, in some states (New Jersey and Texas) active acquisition strategies by investor-owned Medicaid focused plans yielded fewer, but larger, plans more firmly committed to the Medicaid product line.

***3. Concerns about financial and non-financial performance weakness among Medicaid-focused plans have not become the reality.***

Early concerns about state agencies' growing dependence on Medicaid-focused plans—a number were reported in our earlier report, *Medicaid and Commercial HMOs: An at Risk Relationship* —have not materialized. The current roster of Medicaid-focused plans is financially robust. States generally have not needed to relax contract requirements or arrange special financial accommodations (though there were some extraordinary interventions in a few instances). While member satisfaction levels for some Medicaid-focused plans appear to be slightly lower than other plans, beneficiaries have not shunned Medicaid-focused plans as inferior, or gravitated toward "mainstream" commercial plans when provided with the opportunity to do so. State officials in nearly every instance voice strong approval for Medicaid-focused plans and acknowledge no relaxation of performance standards. In general, meaningful performance differences on non-financial indicators appear to reflect plan size, maturity, and resource investments in infrastructure rather than Medicaid-focus or plan sponsorship.

***4. Plans remaining in the Medicaid market appear to be increasingly strong, sophisticated, and more compliant with state requirements.***

Health plans that have focused on Medicaid managed care are proficient and profitable. Plans remaining in the market have grown as other plans have exited, and they have used this growth to become more efficient and to accumulate resources needed to bolster their operating systems. Although the techniques used in care management are beyond the scope of this study, the interview findings suggest that plans that specialize in Medicaid develop more intensive outreach, are more frequently engaged in community-related initiatives, and employ more aggressive hands-on care management approaches for their members. They also report working very closely with their network providers to assure delivery of services commensurate with the needs and conditions of Medicaid beneficiaries. This increased sophistication is due to both the increasingly demanding contract requirements imposed by states (and indirectly from CMS) and recognition of the added efforts that health plans need to succeed in the Medicaid product line. Once again, this realization does not seem to vary directly by sponsorship, but rather by the degree of involvement in and commitment to serving higher need members.

***5. Experience suggests that state agencies and surviving plans invariably become more interdependent.***

The findings from this study validate one prediction in both of our earlier studies: that state agencies and health plans remaining in Medicaid managed care have moved to a higher level of interdependence or mutual reliance. In a number of states (Washington, Rhode Island and Ohio) more than half of all beneficiaries are enrolled in one or two plans that are Medicaid-focused, and this same pattern is repeated in most urban markets in other states. Medicaid payment rates are critical for the continued viability of these plans, and the plans, in turn, exert an enormous impact on the sustainability of the state's Medicaid managed care program. Both parties seem vividly aware of the extraordinary degree of their mutual dependence but, to date, this has motivated them to work as *partners, not adversaries*—as suggested in earlier studies. Without question the current financial crises in the states are severely testing the sustainability of relationships and increased brinkmanship appears inevitable. Next year will be a truer test of the lasting nature of these relationships as contract renewals become due, and as plans reconsider their tolerance for the rate increases proffered.

***6. The prominence of investor-owned Medicaid-focused firms bolsters the market while raising challenging issues for the state agencies.***

The growing prominence of firms like Amerigroup, Centene, Molina, and Americhoice (United Healthcare's subsidiary), collectively involved in more than 25 Medicaid-focused plans, casts a positive light on the Medicaid market from the vantage point of capital markets. These firms directly affect state Medicaid agencies by expanding or sustaining the number of contractors when they enter new markets, acquire available plans, or merge existing plans into larger plans. More importantly, their success on both financial and non-financial performance terms suggests they are earning their reported profits by meeting or exceeding contractual and clinical obligations. These firms also are openly and strongly committed to promoting political and financial support for Medicaid, perhaps more forcefully than previously done by other program advocates. Because these publicly traded firms must report financial performance on a quarterly basis, their growing involvement in Medicaid raises a new set of concerns that states may find increasingly challenging. Touting profitability to shareholders every 90 days will inevitably invoke concerns from some state policymakers and ire from many Medicaid providers, irrespective of the ability of these firms to support their claims of delivering real value.

***7. Durability of the Medicaid managed care market remains uncertain.***

Skeptics continue to raise concerns about the commitment of investor-owned Medicaid-focused plans, suggesting they could flee the market if profitability proves difficult to sustain, similar to what unfolded in the Medicare market and what has happened among commercially-focused plans in Medicaid. Although, as singularly specialized firms,

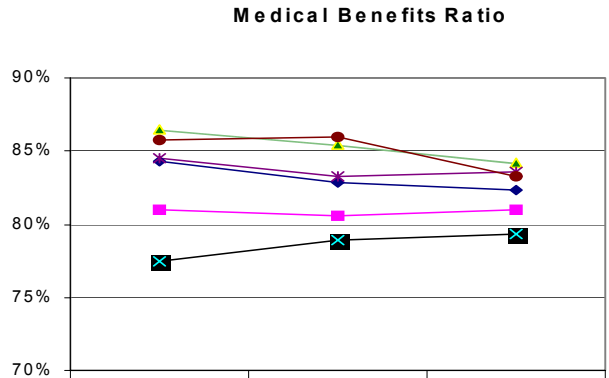
Medicaid-focused plans seem vulnerable to the vagaries of public sector contracting, they currently appear to be trading successfully on the upside growth potential of market aggregators or consolidators who can grow substantially and avail themselves of cross-market economies and synergies. To date, capital markets and investors have rewarded them for their strategic positioning and performance. Perhaps equally important, these Medicaid-focused plans have nowhere else to go, so they have a powerful incentive to make Medicaid managed care a successful enterprise for themselves, the states, and their beneficiaries. The provider-sponsored plans, as the other substantial segment of the Medicaid-focused plans, also have a strong interest in ensuring that Medicaid is adequately funded, at least in terms of provider payments. Although their long-term commitment to the Medicaid market is unclear, plan sponsorship allows providers to protect their market share and to avoid becoming overly dependent on the investor-owned Medicaid-focused plans that represent their principal competitors. The competitive tension between these segments of the Medicaid-focused market could prove valuable in enabling states committed to Medicaid managed care to maintain a viable set of contracting alternatives.

## APPENDIX: Financial Performance of Publicly Traded Medicaid-Focused Plans Compared to Multi-Product Health Plans

Given the impressive performance of the stock prices of the two publicly traded Medicaid-focused plans, a comparison of their recent performance with four other publicly traded managed care firms is warranted. Of the four publicly traded managed care firms, two have a significant Medicaid membership (Coventry and Humana) and two have no Medicaid membership (Oxford and Mid-Atlantic Medical). The for-profit Medicaid-focused health plans, Centene and Amerigroup, exhibited significant growth in their membership. In 2002, membership growth rates for Centene and Amerigroup were 75 percent and 25 percent respectively, while growth in premium revenue per member per month was either marginal (in the case of Amerigroup, 4.5 percent) or declining (in the case of Centene, –19 percent). As a result, for both plans, higher membership growth (in excess of 30 percent appears the key driver in generating premium revenue growth in 2002. From 2000 to 2002, Centene controlled its medical expenses, as reflected in the decline in its medical benefits ratio (see Figure A-1), from 84 percent to 82 percent. In contrast, during this same period Amerigroup's medical benefit ratio remained constant at 81percent.

In 2002, these two Medicaid-focused plans' medical benefit ratios were either slightly below or equivalent to the medical benefit ratios of the two multi-product plans (Humana and Oxford) and lower than Mid-Atlantic Medical's non-Medicaid plan. However, Oxford, a non-Medicaid plan, reported the lowest medical benefits ratio (79 percent) in 2002, although this was a slight increase from Oxford's ratio value (77 percent) in 2000. The two multi-product plans either incurred a constant medical benefit ratio (82 percent, as in the case of Humana, from 2001 to 2002) or lowered ratio value (in the case of Coventry, from 86 percent in 2000 to 83 percent in 2002).

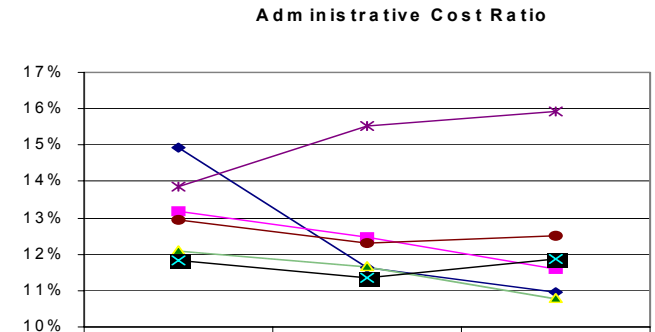
## FIGURE A-1: MEDICAL BENEFITS RATIO BY PLAN




| | 2000 | 2001 | 2002 |
|---|---|---|---|
| Centene | 84% | 83% | 82% |
| Amerigroup | 81% | 81% | 81% |
| Mid-Atlantic Medical | 86% | 85% | 84% |
| Oxford | 77% | 79% | 79% |
| Humana | 84% | 83% | 84% |
| Coventry | 86% | 86% | 83% |

Between 2000 to 2002, both Medicaid-focused plans lowered their administrative cost ratio; Centene's dropped from 15 percent to 11 percent while Amerigroup's declined from 13 percent to 12 percent (see Figure A-2). Membership growth enabled both companies to achieve economies of scale and to lower their per unit costs in processing the administrative claims for Medicaid enrollees, which in turn, resulted in a higher profit margin for both plans. In 2002, the administrative costs ratio for these two Medicaid-focused plans was equivalent to, or lower, than that of the two non-Medicaid focused and multi-product plans.

## FIGURE A-2: ADMINISTRATIVE COST RATIO BY PLAN

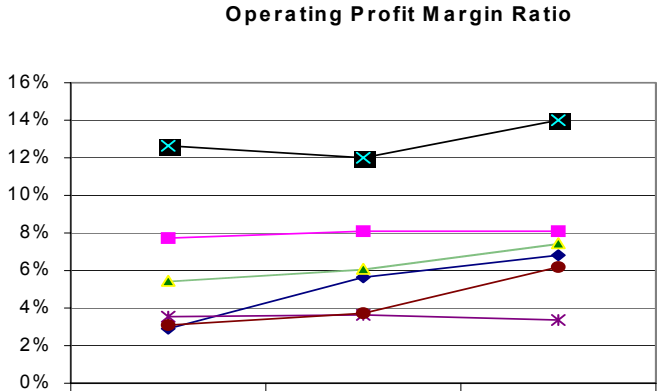



| | 2000 | 2001 | 2002 |
|---|---|---|---|
| Centene | 15% | 12% | 11% |
| Amerigroup | 13% | 12% | 12% |
| Mid-Atlantic Medical | 12% | 12% | 11% |
| Oxford | 12% | 11% | 12% |
| Humana | 14% | 16% | 16% |
| Coventry | 13% | 12% | 12% |

During the same time frame (2000 and 2002) the combination of declining medical and administrative costs generated an increase in Centene's operating margin ratio from three percent to seven percent. While controlling its medical expenses over this same period, Amerigroup maintained an eight percent profit margin. The profit margin of both of these Medicaid-focused plans is lower than Oxford's 2002 profit margin of 14 percent, but higher than Humana's profit margin of four percent and three percent in 2001 and 2002, respectively (see Figure A-3). However the two Medicaid-focused plans' profit margin ratio in 2002 were equivalent to Mid-Atlantic and higher than Coventry's six percent profit margin ratio in 2002.

The findings indicate that the financial performance of the two Medicaid-focused plans compares favorably with the others not wedded to this product line. Are these trends sustainable? Certainly, growth prospects for these firms are promising, but the current rate problems are a concern recognized but not yet addressed. Will these Medicaid-focused plans remain in the market if rate problems persist, or will they withdraw or exit, as occurred in the case of Medicare? The fact that these firms are almost exclusively invested in Medicaid distinguishes them sharply from the firms that participated in – and exited – the Medicare market. Because these Medicaid-focused plans do not have readily available alternative product lines to pursue, they are likely to remain in the market and become strong advocates for adequate financing of Medicaid services, financing necessary to provide them with sufficient revenues to justify remaining.

## FIGURE A-3: OPERATING PROFIT MARGIN BY PLAN




| | 2000 | 2001 | 2002 |
|---|---|---|---|
| Centene | 3% | 6% | 7% |
| Amerigroup | 8% | 8% | 8% |
| Mid-Atlantic Medical | 5% | 6% | 7% |
| Oxford | 13% | 12% | 14% |
| Humana | 4% | 4% | 3% |
| Coventry | 3% | 4% | 6% |