Reversal Of Fortune: Commercial HMOs In The Medicaid Market

A look at some plans that have gambled and lost in Medicaid managed care.

by Michael J. McCue, Robert E. Hurley, Debra A. Draper, and Michael Jurgensen

ABSTRACT: Between 1992 and 1996 the number of health maintenance organizations (HMOs) entering the Medicaid market grew at an average annual rate of approximately 22 percent. Participation among all ownership segments grew, resulting in a broad distribution of beneficiaries across the HMO industry. However, recent declines in financial performance within the industry appear to be more dramatic for plans with many Medicaid members. In addition, growing concerns about rate adequacy and volatility as well as expanding administrative demands raise questions about the long-term commitment of commercial HMOs to Medicaid participation. This paper analyzes operating characteristics and financial performance of licensed commercial HMOs from 1992 through 1996, drawing on in-depth interviews with health plan executives and managed care stock analysts.

The call to managed care to enter the Medicaid market was prompted by the notion that contracting with fully capitated plans would be an effective way to improve beneficiaries’ access to care, contain program costs, and achieve greater fiscal predictability in the Medicaid program. Because many of the plans entering the Medicaid market had been exclusively commercial, their newly enrolled Medicaid beneficiaries would have greater access to mainstream providers. In their desire to build membership and improve negotiating leverage with providers, managed care organizations (MCOs) would pursue opportunities to enroll substantial numbers of Medicaid beneficiaries through the accelerated solicitation and procurement processes often provided by the states. Running counter to this optimistic notion, however, has been the widely held view that, given Medicaid’s typically meager payment rates, providers would only serve Medicaid beneficiaries insofar as there were no other paying patients to replace them.

A recent analysis of health plans serving Medicaid beneficiaries examined various operational characteristics, including size, Medicaid enrollment, system affiliation, geographic location, and whether or not the plan was a new market entrant. Given the growth

Michael McCue and Robert Hurley are associate professors in the Department of Health Administration at the Medical College of Virginia (MCV) of the Virginia Commonwealth University in Richmond. McCue earned his doctorate in business administration and conducts research on the financial performance of health maintenance organizations and multihospital systems. Hurley is a nationally known authority on Medicaid managed care and has testified before state legislatures and the U.S. Senate. Debra Draper is a doctoral student in the Department of Health Administration at the MCV. Michael Jurgensen is director of health policy and medical economics at the Medical Society of Virginia in Richmond.
of Medicaid managed care and the volatility of this line of business, it also is important to assess the financial viability of MCOs that participate in Medicaid. Our study evaluates the financial structure of the HMO industry and how various industry segments, including predominantly commercial and Medicaid HMOs, are represented and performing in Medicaid managed care.

**Data And Methods**

This study encompasses the years 1992 through 1996, a period of rapid expansion of Medicaid managed care fueled in large part by the Medicaid waiver programs. We used Health Care Investment Analysts (HCIA) data to analyze plan characteristics and financial performance of HMOs that are licensed in their respective states of operation. The first analysis evaluates, over the five-year time frame, HMOs that are and are not participating in Medicaid based on the plans’ chain affiliation status; model type: closed (staff and group) versus open (independent practice association and network); federal qualification status; profit status; percent Medicaid membership; and ownership. “Percent Medicaid membership” is defined as the number of Medicaid enrollees as a percentage of the plan’s total membership. Based on this percentage, each plan was assigned to one of three categories: small (less than 26 percent Medicaid), medium (26–75 percent), or large (more than 75 percent). “HMO market segment” is defined in terms of ownership/sponsorship according to the following classifications: HMO Group affiliates; other not-for-profit; publicly traded; other for-profit; and Blue Cross plans.

The second analysis evaluates the financial performance of these plans, based on their medical and administrative loss ratios and operating margins. These ratios were defined in accordance with the Health Plan Employer Data and Information Set (HEDIS) 3.0 indicators of financial stability. The medical loss ratio is computed as the insurance revenue dollars paid in medical claims as a percentage of the plan’s total operating expenses. The administrative loss ratio is based on a similar computation, but it replaces medical claims dollars with the insurance revenue dollars paid in administrative expenses. The operating margin ratio is the proportion of operating income as compared with total insurance revenues. It provides the most valid measure of a plan’s overall financial performance. Specifically, it indicates how well a plan is controlling its medical and administrative expenses and generating a profit.

HCIA’s HMO database series provided the secondary financial and operating data for the individual health plans included in the study. The HCIA data contain descriptive, membership, utilization, and financial information extracted largely from HMOs’ periodic filings with their state insurance regulatory agencies. HCIA also uses information from the Health Care Financing Administration’s (HCFA’s) Office of Prepaid Health Care, the InterStudy Center for Managed Care Research, and various other supplemental sources when compiling its database.

Some limitations of the HCIA data warrant mentioning. A small number of companies, whose HMOs are licensed in multiple states, have filed consolidated data in their various states of operation. HCIA has eliminated all duplicate filings from the database, so information for any single HMO is represented only once. In these instances, however, the HCIA database assigns the plan’s total membership to the state of the plan’s national or regional headquarters. Therefore, we used additional information from the American Association of Health Plans (AAHP) to classify and refine plan data. Second, the database includes only those organizations identified and licensed by the individual states as HMOs. It underrepresents the entire population of fully capitated entities participating in Medicaid, particularly those in states with Section 1115 waivers. Our findings therefore are best understood as reflective of the participation and performance among licensed, commercial HMOs. Third, a few states are not reflected in the database, because either there were no HMOs operating in the state or the
state regulatory reporting methodology did not permit their inclusion.9

The HCIA database represents the following number of states (including the District of Columbia) and plans for each year noted: 1992 and 1993: forty-three states, 471 plans; 1994: forty-three states, 495 plans; 1995: forty-six states, 538 plans; and 1996: forty-seven states, 574 plans.10 Because of outliers and extreme variations of financial measures, median values were used in the analyses.

Our study also draws on information gleaned from in-depth interviews with stock analysts and Medicaid health plan executives, the details of which are reported elsewhere.11 The twenty-five executives interviewed represented sixty HMOs with more than 2.5 million Medicaid members, approximately one-third of the Medicaid HMO enrollment.

PLAN CHARACTERISTICS

The number of plans participating in the Medicaid market steadily escalated during the 1992–1996 period, reflecting a 121 percent increase (Exhibit 1). In 1992 there were 102 participating plans; by 1996 there were 225. Participating plans exhibited wide variation in their individual operating characteristics. In 1992, 43 percent of participating plans were chain-affiliated; by 1996 this figure had risen to 51 percent. The plans participating in the Medicaid market, like those in the industry as a whole, were overwhelmingly open models.12 In 1996, for example, 79 percent of the plans were open models, and only 21 percent were closed-model plans. In 1992, 51 percent of plans participating in Medicaid were federally qualified, but this dropped to 43 percent in 1996. The number of for-profit plans increased sharply, from 42 percent in 1992 to 58 percent in 1996.

Over the 1992–1996 period the majority of plans had small memberships (that is, less than 26 percent Medicaid membership), and the number of plans with midsize Medicaid memberships (26–75 percent) decreased. This trend indicates that a large number of new entrants into the market pursued a limited Medicaid enrollment, and a smaller group either entered the market as predominantly Medicaid plans or moved rapidly from a small to a large membership.

MARKET SEGMENTATION

Not-for-profit plans were the mainstays of the Medicaid market in 1992 (Exhibit 2). Among publicly traded plans, participation rates more than doubled over the five-year period, to 36 percent in 1996. The net (entrants less exits) number of publicly traded plans accelerated until 1996, when enthusiasm leveled off. Participation among other for-profit HMOs also soared, from 13 percent to 32 percent during the period. Among Blue Cross plans, Medicaid participation increased substantially, from 17 percent in 1992 to 40 percent in 1996 (not shown).13

Did the entry of additional plans into the Medicaid market lead to changes in the distribution of Medicaid membership across market segments? The Medicaid percentage of total enrollees in the HMO Group plans and in the other for-profit category grew substantially over the 1992–1996 period—from 7.7 percent to 13.1 percent and from 12.9 percent to 25.2 percent, respectively. It declined among publicly traded plans and other not-for-profits—from 34.9 percent to 23.9 percent and from 33.6 percent to 23.2 percent, respectively (not shown). However, by 1996 other not-for-profit, publicly traded, and other for-profit plans had each aggregated more than 20 percent of the Medicaid members in the study plans. By 1996 the distribution of membership among these plans was markedly more balanced than in 1992, signaling broad participation. However, as noted earlier, this finding

“Several stock analysts noted that rate adjustments cause capital markets to become skittish about HMOs in the Medicaid market.”
should be interpreted with caution, because unlicensed plans, particularly in states with Section 1115 waivers, may be underrepresented in the data.

**FINANCIAL PERFORMANCE**

**MEDICAL LOSS RATIOS.** Plans not participating in Medicaid experienced growth in their medical loss ratios (from 0.85 to 0.90) between 1994 and 1996 (Exhibit 3). During this same period, plans serving a large Medicaid membership reported medical loss ratios of 0.83 and under; in contrast, their counterparts serving a small Medicaid membership experienced an increase in their medical loss ratios, from 0.86 to 0.91.
ADMINISTRATIVE LOSS RATIOS. As one would expect, plans with large Medicaid memberships incurred higher administrative expenses than did those with fewer or no Medicaid enrollees (Exhibit 3). For predominantly Medicaid plans, the administrative loss ratio climbed from 0.17 in 1994 to 0.22 in 1996; for plans with small Medicaid memberships, this ratio remained between 0.13 and 0.14 during the period. The higher administrative costs among predominantly Medicaid plans are attributable in part to the fact that these plans are much smaller in overall membership than plans with limited Medicaid enrollment and apparently are not able to achieve the economies of scale of their larger counterparts. When contracting with these plans, Medicaid agencies will find that a smaller portion of their premium dollars is being applied to medical care for beneficiaries.

In our interviews with health plan executives, many attributed the high administrative costs to extraordinary turnover among Medicaid enrollees, insufficient volume to achieve economies of scale, and generally more extensive contract requirements than are found in commercial lines of business. The importance of higher administrative requirements was noted in particular by HMO executives with predominantly commercial members. These executives have limited their exposure to Medicaid because the financial uncertainty and volatility, and thus the expected returns, may not justify the added costs of serving these beneficiaries.

OPERATING MARGINS. Plans with a higher proportion of their membership in Medicaid earned the largest profits in 1992 and 1993, as reflected in their operating margins. After 1994, however, the operating margins for all plans, regardless of Medicaid participation level, dropped dramatically. For those plans not participating in Medicaid, the drop was greater than for the small and medium Medicaid participants. By 1996 plans not participating in Medicaid recorded an op-
Operating margin of –8 percent, as compared with an average of –3 percent for all participating plans.

Our interviews with health plan executives revealed that early success in Medicaid was achieved when enrollment was voluntary, marketing activities were largely unregulated, contract demands were limited, rate development was imprecise, and managed care enrollment was low but rising. In fact, representatives of some plans reported that the success of some early Medicaid market entrants (for example, Physician Corporation of America in Florida, which did a public offering in 1993) contributed to their belief that this was a lucrative business for plans in the right place at the right time.

Although nonparticipating plans experienced the greatest drop in margins, the picture changed dramatically for predominantly Medicaid plans as well, with operating margins dropping from 1 percent in 1994 to –8 percent in 1996. Lower financial returns resulted from factors that affected both revenues and expenses. Factors that may have curtailed revenues include rate reductions, more competition because of an increased number of qualified bidders, and inadequate risk adjustment for resource-intensive Supplemental Security Income (SSI) enrollees.

Several of the stock analysts we interviewed noted that rate adjustments, particularly unanticipated ones that result from states’ belief that their rates overcompensate health plans, cause capital markets to become skittish about HMOs in the Medicaid market. Although some states have a reputation as sound business partners, the unexpected actions of other states have had a greater influence on analysts’ evaluation of risk, resulting in the opinion that “Wall Street doesn’t trust Medicaid and state government.” Analysts interpreted the unexpected and substantial rate rollbacks by some states (for example, Florida, New York, Ohio, and Pennsylvania) as a cue to other states to initiate capricious, drastic rate cuts. One analyst we interviewed claimed that states are more eager to control costs than care. Another observed that “[p]oliticians are not willing to hurt Medicare because it relates to the middle class, but government does not mind hurting the poor.” This analyst viewed

### EXHIBIT 3

Health Plan Performance Measures By Percentage Of Membership In Medicaid, 1992–1996

<table>
<thead>
<tr>
<th>Percent of membership in Medicaid</th>
<th>Medical loss ratios</th>
<th>Administrative loss ratios</th>
<th>Operating margins</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0.87</td>
<td>0.85</td>
<td>0.85</td>
</tr>
<tr>
<td>Small (&lt;26%)</td>
<td>0.90</td>
<td>0.88</td>
<td>0.86</td>
</tr>
<tr>
<td>Medium (26–75%)</td>
<td>0.84</td>
<td>0.84</td>
<td>0.84</td>
</tr>
<tr>
<td>Large (&gt;75%)</td>
<td>0.85</td>
<td>0.82</td>
<td>0.83</td>
</tr>
</tbody>
</table>

**SOURCE:** Health Care Investment Analysts (HCIA), HMO database, 1992–1996.
Medicaid rate cuts as a safe cost-saving initiative because they affect a class of people that is not politically unified.16

For each year of the study period, the operating margins of publicly traded and other for-profit plans participating in Medicaid were greater than those of their counterparts that did not participate (Exhibit 4). Nonparticipating plans across all market segments experienced a dramatic decline in their operating margins between 1995 and 1996. The HMO Group, other not-for-profit, and other for-profit plans not participating in Medicaid incurred operating losses greater than (or equal to) 10 percent for 1996. Publicly traded and Blue Cross plans that did not participate in Medicaid incurred operating losses of 4 percent and 7 percent, respectively. In contrast, all of the participating plans across all market segments incurred operating losses of 3 percent or less.

PROBABLE CAUSES AND IMPLICATIONS


Favorable selection among enrollees and higher Medicaid rates may have contributed to the profitability of predominantly Medicaid plans prior to 1994. Higher administrative demands and increased requirements of participation and compliance may explain why predominantly Medicaid plans experienced greater financial losses after 1993 than did plans with a small proportion of Medicaid enrollment. Higher medical expenses do not appear to have driven these losses. This study measured only overall HMO operating margins not specific to any individual line of business. Declining operating results in other lines of business may influence the decision to participate in Medicaid.

Our interviews with both stock analysts and Medicaid HMO executives confirmed that the downturn in financial performance for predominantly Medicaid plans had three probable causes: rate inadequacy, substantial volatility, and excessive administrative burden resulting in higher costs. These factors, combined with the spiraling decline in profitability of other business lines and the pressure to meet the earnings estimates of stock analysts, explain why commercial HMOs are reconsidering their long term commitment to Medicaid business.17

**EXHIBIT 4**
Health Plan Operating Margins, By Medicaid Participation And Market Segment, 1992–1996

<table>
<thead>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>HMO Group</td>
<td>0.00</td>
<td>0.01</td>
<td>0.02</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>Other not-for-profit</td>
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<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Publicly traded</td>
<td>0.00</td>
<td>0.01</td>
<td>0.03</td>
<td>0.03</td>
<td>0.01</td>
</tr>
<tr>
<td>Other for-profit</td>
<td>0.01</td>
<td>0.02</td>
<td>0.01</td>
<td>0.02</td>
<td>0.00</td>
</tr>
<tr>
<td>Blue Cross</td>
<td>0.03</td>
<td>0.04</td>
<td>0.05</td>
<td>0.02</td>
<td>0.04</td>
</tr>
</tbody>
</table>

**SOURCE:** Health Care Investment Analysts (HCIA), HMO database, 1992–1996.
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NOTES
1. This phenomenon is known as the “two-market theory” of Medicaid. See F. Sloan et al., “Physician Participation in State Medicaid Programs,” Journal of Human Resources (Supplement 1978): 211–243.
4. The HMO Group is an alliance of more than thirty not-for-profit staff- and group-model HMO plans (www.hmogroup.org).
7. Ibid.
10. Ibid.
13. Blue Cross plans include both for-profit and not-for-profit plans but exclude those that have been converted to publicly traded entities. These plans are included in the publicly traded group.
14. Hurley and McCue, Medicaid and Commercial HMOs.
15. Ibid.
16. Ibid.