Private Market Insurer Participation in the Provision of Health Insurance in a Public Program: Minimum Medical Loss Ratios in Medicaid Managed Care Organizations

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INTRODUCTION

Medicaid managed care organizations (MCOs) are a large-scale public-private partnership. Over 70% of Medicaid beneficiaries are enrolled in a Medicaid MCO plan run by a private insurer. The goals and incentives of private insurers, state governments, and enrollees are not aligned. To maximize profits, private insurers may focus on reducing expenditures, which may be suboptimal for states and enrollees. State governments may have a vested interest in capping profits, as Medicaid is primarily funded through taxpayer dollars. Regulators strive to align incentives by designing and regulating the market structure of MCOs—to regulate the number of MCOs, the generosity of plans, and/or the monetary value to government to ensure Medicaid MCOs are willing to participate and enrollees receive necessary care.

The medical loss ratio (MLR) – the percentage of premium dollars spent on claims – is a common metric of health insurer profitability. Minimum MLR requirements in health insurance plans address the potential conflict between insurer profit and enrollee value by setting a minimum percentage of premium dollars spent on medical services. An MLR requirement protects consumers (enrollees or, in Medicaid, states) by ensuring most premium dollars are spent on claims that benefit enrollees. Some states require MCOs to reimburse the state through remittances when MCOs fall below the minimum MLR threshold. While the Centers for Medicare & Medicaid Services (CMS) mandates that Medicaid MCOs calculate and report an MLR annually, states can establish a required minimum MLR. State regulators determine enforcement, including whether MCOs must make remittances. Federal regulations mandated minimum MLR requirements for Medicaid MCOs starting in 2019. In this paper, we examine insurer response to a minimum medical loss ratio (MLR) requirement in the Medicaid managed care organization (MCO) market.

METHODS

Utilizing statutory financial data from the National Association of Insurance Commissioners (NAIC), sourced from the Exhibit of Premiums, Enrollment and Utilization (EPEU), we collect enrollment, premium dollars, and claims paid for all insurers that wrote health insurance business as a Medicaid managed care organization (MCO) from 2014-2023. In addition, we obtain data from the Kaiser Family Foundation on state-level minimum MLR requirements as well as data from the Center on Budget and Policy Priorities on state-level variation in Medicaid remittances.

We examine changes in the Medicaid managed care market as a result of MLR reporting and remittance requirements. Using a dynamic difference-in-difference estimator, we compare market structure and financial performance for states that do (do not) enforce minimum medical loss ratio requirements. We investigate differential changes in Market structure between enforcement and non-enforcement states. For the extensive margin, we consider changes in the number of insurers operating in enforcement states. For the intensive margin, we consider changes in the number of enrollees per MCO in enforcement states. Further, we analyze financial performance for insurers in enforcement and non-enforcement states, focusing on the medical loss ratio, premiums per enrollee, and claims per enrollee.

RESULTS

FIGURE 1

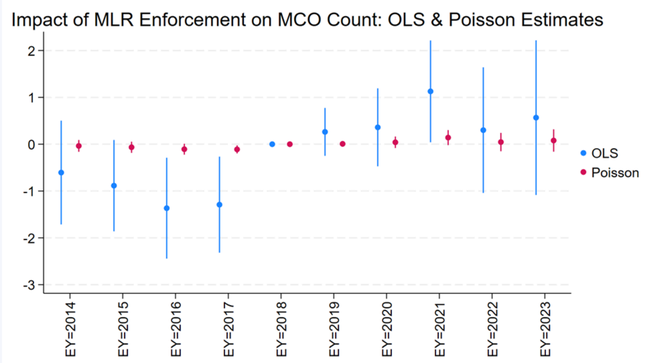


FIGURE 2

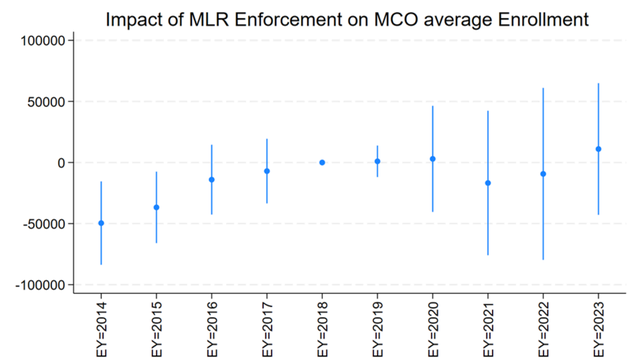


FIGURE 3

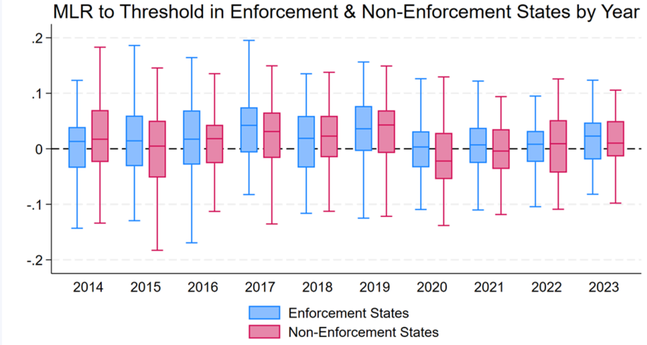
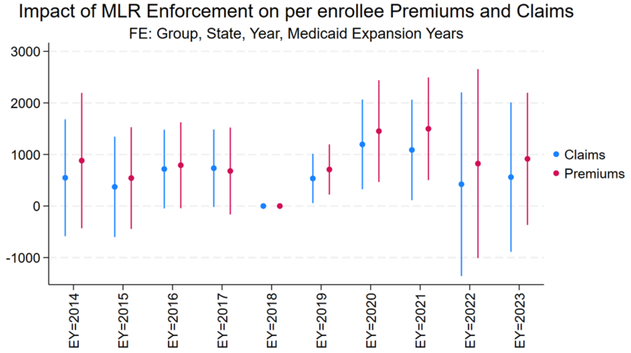


FIGURE 4



KEY FINDINGS

In examining whether MLR enforcement induced changes in market structure, the first two figures explore both the extensive margin—changes in the number of firms operating in a state—and the intensive margin—the number of enrollees per firm. The first figure presents annual difference-in-difference coefficients for the number of firms operating in enforcement and non-enforcement states by year. Both OLS and Poisson estimations show a slight decrease in the number of firms in enforcement states prior to enforcement and a slight increase afterward. This suggests that insurers viewed the state's decision to regulate MLR as a signal of potential profit opportunities. Next, we investigate differences in enrollment per Medicaid managed care organization between enforcement and non-enforcement states, finding no statistically significant difference.

The third figure examines changes in financial performance following MLR enforcement. The outcome variable is the difference between a firm's MLR in a given year and the regulatory threshold set by the state. A value of 0.03 indicates that an insurer's MLR was 3% above the minimum required by the state. The distribution of MLR-to-threshold values is shown separately for enforcement and non-enforcement states by year. Although not statistically significant, it is notable that the median MLR-to-threshold value was negative in non-enforcement states in the first two years after enforcement. In contrast, the median value in enforcement states remained positive throughout the sample period.

The fourth figure plots the coefficients from the difference-in-difference analysis, focusing on per-enrollee claims and premiums. In the three years following enforcement, both per-enrollee premiums and claims significantly increased in enforcement states compared to non-enforcement states.

SIGNIFICANCE

The Medicaid program is a needs-based public program that provides health insurance coverage to over 90 million people in America. Private insurers serve more than two-thirds of Medicaid enrollees through Medicaid managed care organizations (MCOs), with the five largest MCOs – Centene, Anthem, UnitedHealth Group, Molina, and CVS Health – accounting for fifty percent of Medicaid MCO enrollment nationally. Medicaid is the largest health insurance-related public-private partnership in the U.S. The medical loss ratio (MLR) – the percentage of premium dollars paid in claims – is a common metric of insurer profits. The Patient Protection and Affordable Care Act mandated that insurers in the individual and group markets meet a minimum MLR or pay rebates to enrollees. Since lower MLRs indicate higher insurer profits, the minimum MLR requirement serves as both consumer protection and a profit cap on insurers.

Following the success of ACA-mandated minimum MLR requirements in commercial markets, the Centers for Medicare & Medicaid Services (CMS) required all Medicaid MCOs to report MLR information. However, states decide whether and how to enforce minimum MLR requirements. In states with enforcement, when insurers fall below the minimum MLR threshold, they must remit payments to the state. We use Medicaid MCO statutory data from the National Association of Insurance Commissioners to evaluate how minimum MLR enforcement impacts the number of MCOs, premiums, claims, and expenses.

We find that minimum MLR enforcement does not significantly affect the number of or enrollment in Medicaid MCOs. Instead of deterring insurers, minimum MLR requirements and enforcement may promote entry and foster competition. Additionally, insurers in states with minimum MLR requirements have significantly higher premiums and claims, suggesting that regulatory enforcement caps profits and provides value to enrollees and governments funding Medicaid with taxpayer dollars.

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