MEDICAID AND THE FINANCIAL STATUS OF MICHIGAN MANAGED CARE ORGANIZATIONS

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TABLE OF CONTENTS

INTRODUCTION

Due to concerns about the status of Medicaid managed care in Michigan, including losses for providers on services, concerns about net worth, and timely payment issues, the State announced plans for a rebidding of Medicaid managed care contracts. These bids were opened during May 2000, but the details of the bids were yet to be released at the time of this writing.

The cost of any rate increases provided to Medicaid Qualified Health Plans (QHPs), based on bids accepted by the State, is one of the major issues in the Department of Community Health (DCH) budget bill (S.B. 964), which is currently in the House of Representatives, having passed the Senate in late March. It may also be the case that if the bids were to come in higher than one would expect given cost and revenue data, one could see significant changes in the Medicaid managed care program, up to and including its elimination.

In this paper the Senate Fiscal Agency (SFA) examines the overall financial status of QHPs based on their filings with the State Insurance Bureau in 1998 and 1999; looks at the Medicaid QHP profit and loss situation and how it has changed; examines QHPs which have had the largest losses on Medicaid; and estimates the rate increase required in Fiscal Year (FY) 2000-01 to end QHP losses on Medicaid.

THE FINANCIAL STATUS OF MICHIGAN MANAGED CARE ORGANIZATIONS

An examination of the financial statements of Michigan health maintenance organizations (HMOs), which include the bulk of the QHPs operating in this state, filed with the State Insurance Bureau each year, provides a fuller picture of the current financial status of the industry.

The global picture for the Michigan HMOs that reported data indicates that their net worth declined in 1999 from $428 million to $393 million, but that their net revenue picture improved significantly. These are not contradictory results; HMOs still lost money in 1999, they just lost less than they did in 1998, and a net loss on their income statement would imply a corresponding reduction in overall net worth, holding all other things constant.

The net revenue data are displayed in Table 1. It should be noted that the large year over year increase in premium revenue (as well as the increase in costs) is not the whole picture as the number of member months also increased significantly. Looking at these data in terms of costs and revenues per member month allows for clearer year to year comparisons to be made. Table 2 shows costs and revenues as costs and revenues per member month, excluding those HMOs that did not report member month data.

Table 1

THE OVERALL FINANCIAL PICTURE FOR MICHIGAN HMOS

	1998	1999	Change	Percent
Premiums*	**$4,243,247,000**	**$4,735,381,500**	**$492,134,500**	**11.6%**
Co-Pays and Recoveries	20,386,600	33,088,100	12,701,500	62.3
Medical Expenses	**(3,906,740,200)**	**(4,331,836,300)**	**(425,096,100)**	**10.9**
Premiums in Excess of Medical Expenses	356,893,400	436,633,300	79,739,900	22.3
Administrative Expenses	**(508,749,300)**	**(531,254,500)**	**(22,505,200)**	**4.4**
Net Income From Operations	(151,855,900)	(94,621,200)	57,234,700	(37.7)
Other Expenses	(2,056,500)	(5,212,600)	(3,156,100)	153.5
Other Income	68,168,500	53,495,700	(14,672,800)	(21.5)
Net Income	**$(85,743,900)**	**$(46,338,100)**	**$39,405,800**	**(46.0)%**

***Here and in subsequent tables, this includes premiums and other revenue for medical services**

Source: Annual Health Maintenance Organization Filings with the Michigan Insurance Bureau

Table 2

MICHIGAN HMO FINANCIAL PICTURE, COSTS AND REVENUES PER MEMBER MONTH

	1998	1999	Percent
Number of Member Months	29,206,321	31,604,259	8.2%
Premiums	**$141.82**	**$149.83**	**5.6**
Co-Pays and Recoveries	0.69	1.05	50.7
Medical Expenses	**(131.32)**	**(137.06)**	**4.4**
Premiums in Excess of Medical Expenses	11.20	13.82	23.4
Administrative Expenses	**(17.00)**	**(16.81)**	**(1.1)**
Net Income from Operations	(5.81)	(2.99)	(48.5)
Other Expenses	(0.09)	(0.16)	92.7
Other Income	2.33	1.69	(27.5)
Net Income	**$(3.56)**	**$(1.47)**	**(58.8)%**

Note: Numbers reflect only those HMOs that reported the number of member months. This means that simply dividing the numbers in Table 1 by the number of member months will not produce the numbers in Table 2, because the data from Table 1 for HMOs which did not report member month data had to be excluded from the calculations made to generate Table 2.

Source: Annual Health Maintenance Organization Filings with the Michigan Insurance Bureau

What one sees is that premium revenue increased faster than did medical costs, and that administrative costs actually decreased[1]. The net effect from 1998 to 1999 was a reduction in the loss per member month of 59%. Increases in premiums on the commercial side, combined with cost containment on the medical and administrative side, have led to an improvement in the financial status of Michigan HMOs.

The focus of this paper is on the Medicaid portion of Michigan HMO business, but one also needs to look at the non-Medicaid portion of the HMO business. This is especially true because the profit/loss situation for the Medicaid portion of the HMO business was strongly influenced by the fact that the HMOs signed multi-year contracts at a specific set of capitation rates and thus their Medicaid rates were the same in the first three quarters of 1999 as they were in 1998. Table 3 shows the year-to-year change, based on best available data, of the financial status of Michigan HMOs on their non-Medicaid business.

Table 3

MICHIGAN HMOS, NON-MEDICAID SERVICES

	1998	1999	Change	Percent
Premiums	**$3,424,053,600**	**$3,713,354,700**	**$289,301,100**	**8.4%**
Co-Pays and Recoveries	12,572,400	19,314,700	6,742,300	53.6
Medical Expenses	**(3,175,902,000)**	**(3,386,612,900)**	**(210,710,900)**	**6.6**
Premiums in Excess of Medical Expenses	260,724,000	346,056,500	85,332,500	32.7
Administrative Expenses	**(392,886,300)**	**(398,269,300)**	**(5,383,000)**	**1.4**
Net Income from Operations	(132,162,300)	(52,212,800)	79,949,500	(60.5)
Other Expenses	(2,056,500)	(5,212,600)	(3,156,100)	153.5
Other Income	58,192,200	42,993,400	(15,198,800)	(26.1)
Net Income	**$(76,026,600)**	**$(14,432,000)**	**$61,594,600**	**(81.0)**
Number of Member Months	23,760,011	24,163,918	403,907	1.7

Source: Annual Health Maintenance Organization Filings with the Michigan Insurance Bureau

When one examines the data, one sees a significant improvement in the bottom line. Overall losses on the non-Medicaid side declined from $76 million in 1998 to $14 million in 1999. The most significant factor in this improvement was an overall increase in premiums per member month of almost 7%. This increase is similar to the reported rate increases seen in the HMO market; there were clear indications that HMOs were losing money on the private market and that significant rate increases were inevitable. These rate increases have had the effect of improving the financial status of HMOs on the non-Medicaid side of the business. One would expect, assuming continued negotiated rate increases, that the financial picture on the non-Medicaid side would continue to improve in the year 2000.

MEDICAID AND THE QUALIFIED HEALTH PLANS

Officials from the Medicaid QHPs have repeatedly stated that they have been losing money on

Medicaid services and that the situation became significantly worse in 1999. The data reported to the Insurance Bureau appears to verify this claim (Table 4).

Table 4

MICHIGAN HMOS, MEDICAID SERVICES

	1998	1999	Change	Percent
Premiums	**$819,193,400**	**$1,022,026,800**	**$202,833,400**	**24.8%**
Co-Pays and Recoveries	7,814,200	13,773,400	5,959,200	76.3
Medical Expenses	**(730,838,200)**	**(945,223,400)**	**(214,385,200)**	**29.3**
Premiums in Excess of Medical Expenses	96,169,400	90,576,800	(5,592,600)	(5.8)
Administrative Expenses	**(115,863,000)**	**(132,985,200)**	**(17,122,200)**	**14.8**
Net Income from Operations	(19,693,600)	(42,408,400)	(22,714,800)	115.3
Net of Other Income and Other Expenses	9,976,300	10,502,300	526,000	5.3
Net Income	**$(9,717,300)**	**$(31,906,100)**	**$(22,188,800)**	**228.3%**

Note: These data were adjusted for consistency. One HMO did not report administrative costs in the Medicaid column of the report to the Insurance Bureau; others did not report "other income" in the Medicaid column. In each case the total amount was apportioned to the Medicaid column based on the percent of Medicaid member months for those HMOs.

Source: Annual Health Maintenance Organization Filings with the Michigan Insurance Bureau.

It should be noted that not all QHPs have to report to the Insurance Bureau. QHPs that are clinic plans (whose members' hospital costs are covered under fee for service) are not considered to be HMOs and do not have to file with the Insurance Bureau. This means that the database used to generate the tables does not cover all expenditures and revenues in the Medicaid managed care program. On the other hand, there is little indication, anecdotal or otherwise, that the financial experience of the plans that did not report is greatly out of line with the financial situation faced by the QHPs that did report.

Net losses on Medicaid services, for those QHPs reporting data and with adjustments to the data for consistency, grew from $10 million in 1998 to $32 million in 1999. This was at the same time that the managed care firms' net losses for non-Medicaid services declined significantly, from $76 million to $14 million.

One reason the losses increased so much was the lack of any increase between 1998 and 1999 in the Medicaid rates bid by the QHPs and accepted by the State. It is not the role of the SFA to assess or assign blame for this situation, but one should note that the QHPs bid knowing that they would receive the same capitation rates for each year throughout the contract (there was no agreement or understanding that rates would be increased during this period). It is true that unanticipated costs that entered into the picture had an impact on the QHPs' bottom line, but the QHPs did know their bid capitation rates would be in place for the entire contract.

An examination of the Medicaid data, when reflected as cost and revenue per member month

(adjusted to exclude those QHPs that did not report member month data and adjusting for inconsistency in data reporting), makes the picture even clearer (Table 5).

Table 5

MICHIGAN HMO FINANCIAL PICTURE, MEDICAID COSTS AND REVENUES PER MEMBER MONTH

	1998	1999	Change
Number of Member Months	5,446,310	7,440,341	36.6%
Premiums	**$135.82**	**$137.36**	**1.1**
Co-Pays and Recoveries	1.43	1.85	29.0
Medical Expenses	**(120.80)**	**(127.04)**	**5.2**
Premiums in Excess of Medical Expenses	16.46	12.17	(26.0)
Administrative Expenses	**(18.41)**	**(17.87)**	**(2.9)**
Net Income from Operations	(1.96)	(5.70)	191.5
Net of Other Income and Other Expenses	1.64	1.41	(13.8)
Net Income	**$(0.32)**	**$(4.29)**	**1250.8%**

Note: These data were adjusted for consistency. One HMO did not report administrative costs in the Medicaid column; others did not report "other income" in the Medicaid column. In each case the total amount was apportioned to the Medicaid column based on the percent of Medicaid member months for those HMOs.
Numbers reflect only those HMOs that reported the number of member months. This means that simply dividing the numbers in Table 4 by the number of member months will not produce the numbers in Table 5, because the data from Table 4 for HMOs which did not report member month data had to be excluded from the calculations made to generate Table 5.

Source: Annual Health Maintenance Organization Filings with the Michigan Insurance Bureau

Premiums per member month increased by 1.1%. This increase is not surprising, as the 4% increase in QHP rates for FY 1999-2000 took effect October 1, 1999. One would thus expect calendar year 1999 per member month premium revenue to increase by 1.0% over calendar year 1998 per member month premium revenue.

Medical costs grew by 5.2%, with slight changes in other costs and revenues. The net effect was a decline in net income of almost $4 per member month, which explains the significant worsening of the Medicaid QHPs' financial situation. In fact, the global decline in net income is completely explained by the increase in medical costs during a period when premiums were barely increasing.

A CLOSER LOOK

The above section was an examination of the global picture for the Qualified Health Plans and their Medicaid profits and losses. When one starts looking at individual QHPs, one sees a wide variation in how these plans fared in 1998 and 1999. In fact, one sees that the decline in QHP fortunes from 1998 to 1999 can be narrowed to the experience of two QHPs.

Great Lakes Health Plan went from a $1.1 million profit on Medicaid in 1998 to a $11.5 million loss in 1999. Wellness Plan went from a $2.5 million loss on Medicaid in 1998 (this number

includes the impact of Wellness Plan's "other income" on Medicaid, to make the Wellness data consistent with the data from other HMOs) to a $22.4 million loss. This total change for the two plans is a decrease in net income of $30.3 million from 1998 to 1999, which is greater than the decrease in net income of $22 million for Medicaid QHPs as a whole.

A closer examination reveals that both plans saw double-digit increases in their Medicaid health costs (relative to their change in premium revenue). This, combined with no increase in premiums, led to a significant deterioration in the two plans' financial status from 1998 to 1999.

In the case of Wellness Plan, the largest change was in expenditures on outside referrals, which climbed from $27.6 million (or 15.0% of costs) to $42.9 million (or 22.5% of costs). This $15 million increase explains the majority of the $20 million decline in Wellness Plan's net Medicaid income. The impact of any changes in pharmaceutical costs could not be individually examined, as Wellness did not report data on pharmaceutical expenditures, but it does not appear that increases in pharmaceutical costs or utilization were a major factor in Wellness's problems.

In the case of Great Lakes, the largest change was a prior year adjustment of $7.5 million. Great Lakes also faced a significant increase ($16 per member month) in inpatient hospital expenditures, from $14.4 million (or 23.0% of costs) to $29.9 million (or 31.8% of costs if one excludes the prior year adjustment). On the 1999 medical cost base, this equates to an increase in costs (all other factors held constant) of $8.9 million, which, combined with the prior year adjustment, more than explains the worsened financial position of Great Lakes in 1999.

Unlike Wellness, Great Lakes did report pharmaceutical expenditures. These costs increased from $15.7 million (or 25.1% of costs) to $23.7 million (or 25.2% of costs without the prior year adjustment). It is clear that pharmaceutical expenditures did increase, but that the increase was not out of line with the other increases faced by Great Lakes.

One of the issues raised in the discussion of QHP rates has been the level of growth in pharmaceutical costs. When one looks at pharmaceutical expenditures per member month for those QHPs reporting both pharmaceutical data and member month data in both 1998 and 1999, one sees a 12% increase in pharmaceutical expenditure per member month. If one considers, however, that a large portion of this cost increase came from the increased use and cost of psychotropic drugs, a cost that QHPs no longer have to cover, the increase, for all pharmaceutical costs other than psychotropic costs, is most likely in the range of 4% to 5%.

In conclusion, while most of the other QHPs saw their financial situation vis a vis Medicaid change only slightly in 1999 (and those other QHPs reported a small collective net profit on Medicaid in 1999), Wellness and Great Lakes saw major changes and the changes faced by these two QHPs explained most of the overall worsening Medicaid situation.

CHANGES SINCE 1999

There have been two major changes made since 1999 that should have a significant impact on the QHPs' Medicaid situation in 2000: First, the Legislature increased capitation rates0 by 4% for FY 1999-2000 (even though the QHPs had already signed contracts covering FY 1999-2000 at the capitation rates that were in effect the two previous fiscal years). Second, effective

February 1, 2000, the Executive removed the cost of psychotropic pharmaceuticals from the managed care program.

The first change, of course, is straightforward; one would expect that per member month revenues would increase. This should lead to the QHP financial situation improving more than it would have if no increase had been granted.

The second change is a little more complicated. The administration has estimated that roughly $18 million of the capitation rates slated to be paid in FY 1999-2000 reflected the costs of psychotropic medications in the rate base. Unfortunately for the QHPs, estimates are that the cost of psychotropic medications will total about $51 million in FY 1999-2000. This, in and of itself, would result in a worsening of QHP finances by over $30 million.

Psychotropic medications, as their name implies, are prescribed for mental health treatment. In the Michigan Medicaid program, these treatment decisions are made by doctors under contract with the Community Mental Health (CMH) system rather than by doctors under contract with QHPs. Thus, unlike the situation with other medications that are prescribed to Medicaid clients, QHPs have no oversight or ability to control utilization or costs for psychotropic medications.

There may be good reasons for this cost increase: new (and expensive) psychotropic medications have recently arrived on the market and these medications have proven to be very successful in the near term treatment of mental health problems. It is also true, however, that the increased cost and utilization of these medications were not included in the bid process; in other words, these costs were unanticipated.

The Executive branch responded to this unexpected increased cost to QHPs by removing payment responsibility for psychotropic medications from the QHPs effective February 1, 2000. Given that capitation rates are to be adjusted downward to reflect the $18 million, this change should just about reverse the $30-plus million net losses seen in 1999, and would effectively result in a $33 million increase in net funding to QHPs in FY 2000-01, the re-bid notwithstanding.

Leaving aside the issue of increased costs, one would expect that, given these changes, QHPs would see an improvement by FY 2000-01 of roughly $80 million in their financial situation compared with FY 1998-99. This would include $50 million due to the rate increase (when applied to all plans, whether or not they reported data to the Insurance Bureau) and $30 million due to the psychotropic policy change. Obviously, in the end, one must also take into account estimated cost increases in order to make an accurate projection of the future financial status of QHPs.

COST INCREASES

Qualified Health Plans face two types of costs: administrative costs and medical costs. Of course, given inflation, these costs will tend to increase over time, and any attempt to look at future years will require a reasonably accurate projection of these costs.

Administrative costs, typically, should increase at a rate similar to general inflation. It is

interesting, however, to examine the 1998 and 1999 data from the QHPs (Tables 2 and 5). If one looks at these data, one sees that administrative costs, per member month, actually decreased from 1998 to 1999, with a slight decrease overall (-1.1%) and a more significant decrease for Medicaid (-2.9%).

This result is not surprising, for several reasons: First, there are economies of scale and the Medicaid managed care program saw a significant increase in enrollment between 1998 and 1999. One would expect that administrative costs would not increase as rapidly as the membership, given that the cost increase would relate to the marginal administrative cost of a new member, which should be less than the average administrative cost. Second, one would expect, given that many of these managed care organizations are relatively young, that there would be a "learning curve" effect leading to greater efficiency over time. Finally, due to the financial difficulties faced by many QHPs, one would expect some explicit efforts to reduce administrative costs as these costs are the costs most easily controlled by a QHP. These cost containment efforts, especially on the Medicaid side, have probably played a major role in the actual reduction in per member month administrative costs from 1998 to 1999.

Given the downward trend, an estimate of a 2.5% annual increase in administrative costs for QHPs (which will be used below) is probably significantly overstated.

The rate of increase in medical costs is somewhat more difficult to estimate. The Medicaid data indicate that medical costs per member month increased by 5.2% from 1998 to 1999 (Table 5). Per member month premiums increased by 1.1% from 1998 to 1999. Given the FY 1999-2000 4% rate increase that took effect October 1, 1999, this 1.1% is just about what was expected for calendar year 1999. The 5.2% increase appears to be accurate relative to the premium base.

One could then assume that 5.2% is a reasonable estimate of the annual cost increase per member month, but one would be ignoring one other factor: the increased expenditures for psychotropic medications. A portion of this 5.2% increase is not due to actual underlying growth in medical costs that will continue to affect QHPs, but rather is due to a factor that, effective February 1, 2000, was removed from the cost base.

It is difficult to estimate precisely the rate at which psychotropic expenditures increased. It is known that the expected cost at some point in 1997 was $18 million per year and that the expected cost, by 1999, was $51 million per year. If one assumed that the costs increased at a straight line rate, one would assume that the increase was about $16 million per year, or about 1.3% of QHP expenditures. Removing this factor from the 5.2% increase above leads to an estimated increase in annual per member month medical expenditures of 3.8% (i.e., 1.052 divided by 1.013 gives 1.038).

It should be noted that this method of analysis does not differentiate among the factors that led to this 3.8% increase. The 3.8% estimate is a combination of increases in medical costs (medical inflation), changes in the acuity of cases, changes in the types of cases, increases in utilization of services, etc. All of these factors are reflected in this 3.8% figure. Furthermore, any costs related to the risk profile of the highest cost cases are already contained in the actual Medicaid QHP expenditure base. In other words, the 3.8% figure includes all factors that have been mentioned as influencing medical cost growth for managed care organizations.

While one may certainly argue that medical costs could increase at a greater or lesser rate subsequent to 1999, there is little evidence that the trends influencing the change from 1998 to 1999 will change in any significant way for the years 2000 and 2001. Thus, the 3.8% annual cost increase estimate appears to be a reasonable proxy for per member month cost increases in the near future.

There is one other factor that has not been considered in this analysis: the effects of potential future limitations on the number of QHPs providing Medicaid services in Michigan. Risk analysis makes it clear that if the number of QHPs is limited below the number operating now (as is expected to occur in the new bid process), average costs should decline for three reasons: 1) QHPs, with larger client bases, will be taking on less risk. 2) QHPs, with larger client bases, will be able to reduce average administrative expenses due to economies of scale. 3) QHPs, with larger client bases, will be in better position to negotiate volume discounts with providers. Each of these factors is difficult to quantify, but their presence means that the estimated FY 2000-01 cost base will likely be overstated.

ESTIMATION OF FINANCIAL "BREAK EVEN" POINT FOR FY 2000-01

Given the above data and assumptions on cost increases, it is a fairly straightforward process to estimate anticipated FY 2000-01 costs for Medicaid services bid for by QHPs, for those QHPs that reported data to the Insurance Bureau. One also can estimate the level of overall capitation rate increase for these QHPs that would be necessary to eliminate QHP losses, or reach a "break even" point, on Medicaid services.

In 1999, reported net Medicaid QHP losses (adjusted for consistency of data and including plans that reported data for both years, but not including clinic plans) were $32 million, for about 7.44 million Medicaid member months. Reported Medicaid medical costs were $931.5 million; Medicaid administrative costs were $133 million; premium and other medical revenue totaled $1,022 million; and other income totaled $10.5 million (Table 6).

Table 6

ESTIMATING THE INCREASE NEEDED TO ELIMINATE QHP LOSSES ON MEDICAID
(all numbers in millions)

	Medical Income	Other Income	Medical Costs	Admin. Costs	Net QHP Income
1999 Medicaid QHP Data	**$1,022.0**	**$10.5**	**$931.5**	**$133.0**	**$(32.0)**
Adjust for Psychotropic	(18.0)	0	(51.0)	0	33.0
Subtotal	1,004.0	10.5	880.5	133.0	1.0
FY 1999-2000 Premium Increase	40.0	0	0	0	40.0
Administrative Inflation (2.5%, 1 3/4 years)	0	0	0	6.0	(6.0)
Medical Inflation, etc. (3.8%, 1 3/4 years)	0	0	59.5	0	(59.5)
Subtotal	**1,044.0**	**10.5**	**940.0**	**139.0**	**(24.5)**
4% Inpatient Fee Screen Increase	0	0	9.0	0	(9.0)
11% Outpatient/MD Fee Screen Increase	0	0	35.5	0	(35.5)
Projected FY 2000-01 w/o Rate Increase	**1,044.0**	**10.5**	**984.5**	**139.0**	**(69.0)**
Increase Rates by 6.6%	69.0	0	0	0	69.0
Projected FY 2000-01 with 6.6% Increase	**1,113.0**	**10.5**	**984.5**	**139.0**	**0.0**

Note: Co-Pays and Recoveries are subtracted from Medical Expenses

The first adjustment to the data is to reduce premiums by $18 million and medical costs by $51 million to reflect the removal of psychotropic medication costs from the QHPs. This reduces the cost base to $880.5 million and premiums to $1,004 million. This change in net income of $33 million, coincidentally, pretty much eliminates the overall $32 million in losses seen by QHPs in 1999.

In FY 1999-2000 QHP rates were increased by 4%. This results in an increase in QHP premium revenue (for the QHPs that reported data to the Insurance Bureau) of $40 million, and one would project FY 2000-01 premium revenue (all other factors held constant) for these QHPs at $1,044 million.

Based on the analysis in the previous section, one would project a 2.5% increase in administrative costs both in 2000 and 2001 (since this analysis is looking at FY 2000-01, this equates to 1 3/4ths years of 2.5% inflation), or an increase of $6 million in administrative costs to $139 million.

Similarly, a 3.8% increase in medical costs from 1999 to FY 2000-01 (again, 1 3/4ths years of 3.8% inflation) would result in an increase of $59.5 million in medical costs on the base of $880.5 million, resulting in total medical costs of $940 million.

Finally, one would assume that "other income" remains at its 1999 level of $10.5 million.

Combining these factors, one sees revenue of $1,054.5 million ($1,044 million in premium and other medical revenue plus $10.5 million in other income) and expenses of $1,079.0 million ($940 million in medical costs and $139 million in administrative costs).

This, however, is not the end of the story. While there were no direct increases in physician or hospital fee screens in FY 1999-2000 (the 3.1% for hospitals was put into a pool distributed to hospitals based on outpatient services), there are fee screen increases included in the FY 2000-01 budget.

First, the Executive and the Senate have included a 4.0% increase in inpatient hospital payment rates for FY 2000-01. This increase would impose a clear cost on QHPs, as most of their inpatient payments are made (by contract) at the Medicaid DRG rates, which would lead to a maximum additional cost of $9,000,000 to QHPs in FY 2000-01. Second, the Senate has proposed an 11% increase in outpatient and physician fee screens for FY 2000-01 and QHPs also would have to consider those potential cost increases in their bids. The cost on the managed care side of the 11% increase in outpatient and physician fee screens, if QHPs paid for all such services at Medicaid rates, is about $35.5 million. Combining these two cost increases, which total $44.5 million, the final estimate of expenses is $1,123.5 million.

The gap between the revenue estimate and the expense estimate (i.e., the projected loss) for these QHPs, if there were no QHP rate increase in FY 2000-01, comes out at $69 million. For the record, this analysis projects that, in calendar year 2000, the QHPs will just about break even on Medicaid.

Given the rate base of $1,044 million, it is a simple calculation to project that, in order to get to a zero loss on Medicaid, these QHPs would, as a whole, have to increase their rates by 6.6%. Thus, a 6.6% rate increase (which is larger than the 4% rate increase originally built into the FY 2000-01 budget last year) would be necessary to eliminate completely QHP losses on Medicaid, assuming passage of the Senate's proposed 11% increase for outpatient and physician fee screens. If the Executive's 4% increase for outpatient and physician fee screens were adopted, the loss would decline by $22.5 million (from $69 million to $46.5 million), which would reduce the rate increase needed to get to zero loss to 4.5%.

Obviously, this projection does not take into account any rate of return. It is not the role of the SFA to estimate what an appropriate rate of return would be, but one should note that any such rate of return would have to be added on top of the 6.6%. If, for instance (just choosing a number), a 1.0% rate of return were deemed appropriate, then an overall QHP rate increase of 7.6% would increase rates sufficiently to eliminate all Medicaid losses and provide a 1.0% rate of return on expenditures. Obviously, if a greater rate of return is deemed appropriate then the increase would need to be adjusted accordingly.

If the overall increase goes well beyond the 6.6% plus a reasonable rate of return, then one would have to question whether QHPs were seeking Medicaid rates high enough to offset losses (or low rates of return) in their other areas of business.

It should be noted that individual QHPs would, if they wished to get to break-even and beyond, submit bids that would vary widely from the 6.6%-plus rate of return noted above. Some QHPs made profits on Medicaid in 1999 and, given the change in treatment of psychotropics and the 4% rate increase for FY 1999-2000, would not require nearly as large an increase as the average. Other QHPs, for instance Wellness and Great Lakes, would require double-digit rate increases in order to prevent losses on Medicaid services. But, overall, a 6.6% increase in rates should be sufficient to end any losses, and 6.6% plus a reasonable rate of return would ensure such a rate of return on Medicaid services for QHPs.

CAVEATS

In any analysis such as this one, a number of assumptions must be made (and several factors not included). Certainly the estimate of cost increases could be incorrect and could be either higher or lower. It should be noted that the administrative cost increases projected were, based on the 1998 to 1999 comparison, likely overstated. It also should be noted that the medical cost increases for 2000 and 2001 reflect a continuation of the cost increases from 1998 to 1999 for services that would continue to be paid by QHPs (i.e. services other than psychotropic medications). Finally, the medical cost increase was based on the actual cost increase per member month from 1998 to 1999 and thus reflected all acuity, utilization, and inflation concerns.

Three other factors were not included in the analysis, although they would have tended to reduce the projected rate increase: Any reduction in the number of QHPs operating in Michigan would tend to reduce average costs. Any reduction in the Senate's proposed 11% increase for outpatient hospital services and physician services would reduce costs. Third, the extent to which QHPs did not contract at Medicaid rates for outpatient and physician services would reduce cost increases.

Given the failure to adjust for the above factors, it would appear that, if anything, the estimated increase to ensure a zero QHP Medicaid loss for those QHPs that reported data to the Insurance Bureau in FY 2000-01 of 6.6% is actually overstated.

Finally, as noted above, this analysis does not include clinic plans because they did not report data to the Insurance Bureau. It is certainly possible that the experience of these plans is different from the experience of the plans that did report; in other words, they could have fared significantly better or significantly worse, and that could skew the data. The QHPs that reported data saw a 3% overall loss. If the experience of the clinic plans were 5% above or below a 3% loss (8% loss or a 2% profit), that would skew the 6.6% result by less than 1% up or down. Thus, while any data from the clinic plans could make a difference, that difference would not be huge. Along these lines, the actual dollar effect of a 6.6% increase across the total Medicaid managed care base would be in the area of $85 million.

CONCLUSIONS

Michigan Medicaid Qualified Health Plans, as a whole, lost money on Medicaid services in both 1998 and 1999, and the situation worsened between 1998 and 1999.

The worsened situation appears linked to two issues: First, the large growth in expenditures on

psychotropic medications and, second, the worsening financial situation of two particular QHPs, which both saw significant cost increases in 1999.

The 4% rate increase in FY 1999-2000 as well as the removal of the financial responsibility for psychotropic pharmaceuticals from the QHPs should lead to a significant improvement in the revenue situation of Medicaid QHPs in the year 2000.

By FY 2000-01, however, increased costs, including possible 11% increases in outpatient and physician rates, would lead to another large net loss for QHPs if capitation rates remained at the levels in effect in FY 1999-2000.

It is the SFA's estimate that, in order to have no net loss in FY 2000-01 on Medicaid, the net increase in QHP rates in the current bidding process would have to be 6.6%. Increases above that level would reflect, first, the goal of a reasonable rate of return on Medicaid services. If these increases were above 6.6% plus a reasonable rate of return then one have to consider the possibility that the QHPs would be using the Medicaid program to attempt to ensure profits and/or a higher rate of return on their overall business, including their non-Medicaid business.

END NOTE

1. One of the interesting aspects of these data is the fact that, in all cases for both years, premium revenue has exceeded net medical expenditures. The ratio of the latter to the former, expressed as a percentage, is often referred to as the "loss ratio". Because this ratio does not include administrative costs, there are some who believe that an acceptable ratio is somewhere between 85 to 88 percent. While there may be some question as to whether a 12 to 15 percent administrative cost is excessive, it should be noted this ratio for the non-Medicaid business of HMOs averaged 91.2% for the 1998 to 1999 period and 89.7% for their Medicaid business. The SFA's estimate, that a 6.6% increase in Medicaid capitation rates for FY 2000-01 would be required to eliminate losses, would lead to a loss ratio in the area of 88.4%.