Options to Reduce State Medicaid Costs: Managed Care Medical Loss Ratio

Center on Budget and Policy Priorities

States, which jointly fund Medicaid along with the federal government, frequently seek ways to decrease their Medicaid costs in order to expand coverage, add new benefits, or fund the ongoing operations of their programs. For states that contract with managed care organizations to serve Medicaid enrollees, one source of savings is to require managed care plans that don't meet the state's required "medical loss ratio" (MLR) — the percentage of their premium revenue that insurers must spend on health care services rather than administrative costs and profits — to repay the difference to the state. Federal regulations require states to set plans' rates so that they meet an MLR of 85 percent for plan years starting in 2019. Yet most states don't require remittances from plans that fail to meet the MLR. A new federal law gives states that expanded Medicaid an additional incentive to implement an MLR with a mandatory remittance, as explained below.

What Is Medicaid Managed Care?

Nearly all states contract with managed care organizations to provide some or all covered benefits to their enrollees, with the state paying the plan a set monthly amount per enrollee (called a capitation payment) to cover the cost of those benefits plus the plan's administrative costs. Under this arrangement, managed care organizations profit when they keep their costs within their capitation payments and suffer a loss when they don't.

Nationally, over two-thirds of Medicaid beneficiaries received most or all covered benefits through managed care in 2016. More than 40 percent of Medicaid dollars go to managed care organizations.

What Federal Medicaid Funds Do States Receive?

The federal government contributes at least $1 in matching funds for every $1 a state spends on Medicaid. The fixed percentage the federal government pays a state, known as the federal medical assistance percentage (FMAP), takes into account the state's average per capita income relative to the national average. A state's FMAP cannot be less than 50 percent; Mississippi has the highest FMAP at 77 percent.

The federal government pays a higher matching rate for family planning services and services for individuals covered by the Affordable Care Act's Medicaid expansion. It will pay 93 percent of Medicaid costs for expansion-eligible enrollees in 2019, and 90 percent in 2020 and beyond. Family planning services are matched at a 90 percent rate in all states.

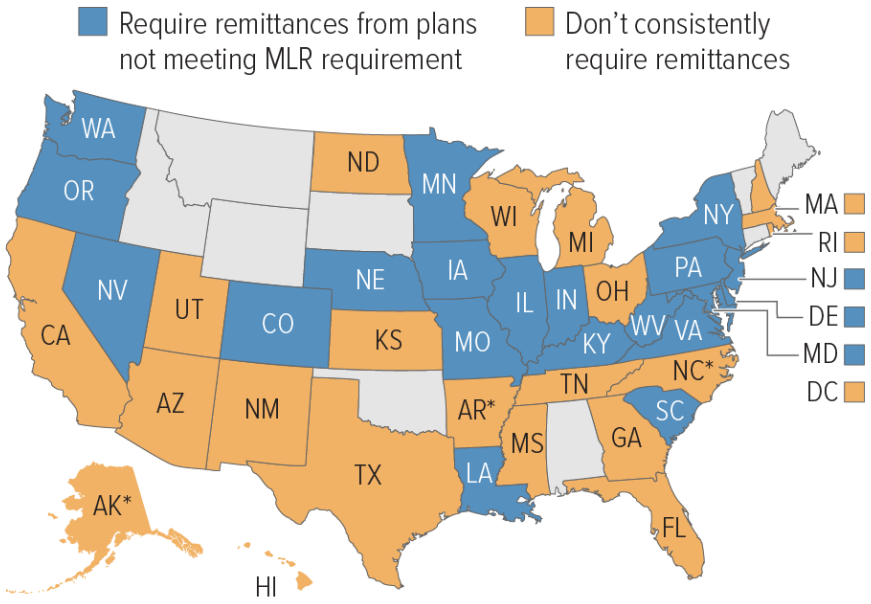
What Medical Loss Ratio Requirements Must Plans Meet?

Federal law requires large-group commercial health plans to maintain an MLR of 85 percent, meaning that they must spend at least 85 percent of the money they collect in premiums on health care services. If they fail to meet the 85 percent MLR, insurers must provide remittances to their customers to make up the difference. (Commercial health plans in the small-group and individual markets must meet an 80 percent MLR.)

Federal regulations finalized in 2016 require Medicaid managed care plans to calculate and report their MLR to the state annually for contracts that take effect on or after July 1, 2017. An MLR requirement encourages plans to keep their administrative costs low and gives states important information to help them set appropriate rates for the plans. Yet many states do not include MLR reporting requirements in their Medicaid contracts with managed care organizations; the federal government has not released information about states' compliance.

States are permitted but not required to include an MLR in their contracts with plans and recoup money from plans that fail to meet the minimum MLR. If a state sets an MLR, it must be at least 85 percent. For managed care plan years beginning July 1, 2019, federal regulations require states to set capitation rates in such a way that the plan is assumed to meet an 85 percent MLR. Only 20 states currently include a minimum MLR in their contracts and require the plans to provide remittances if they fail to meet the state's MLR (see map), though some states have adopted other cost-control strategies, such as profit caps for managed care plans.

Only 20 States Require Medicaid Managed Care Plans to Reimburse Them if They Don't Meet Medical Loss Ratio (MLR) Requirement



* AK, AR, and NC, unlike the other states in orange, had not contracted with Medicaid managed care plans as of July 1, 2018 but were scheduled to do so (AK and AR starting in fiscal year 2019, NC in 2020).

Notes: While all states had to begin collecting MLR data from plans in 2017, some don't include this requirement in their contracts, and some don't require plans to pay remittances if they don't meet an MLR standard. States in grey do not contract with Medicaid managed care plans. For contracts that take effect on or after July 1, 2019, federal regulations require states to set plans' rates such that they should meet a minimum MLR standard of 85 percent. States are permitted but not required to recoup money from plans that fail to meet the minimum MLR.

Source: CBPP analysis of Kaiser Family Foundation, "State Focus on Quality and Outcomes Amid Waiver Changes," October 2018.

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What Should States Do?

All states that contract with managed care plans to serve Medicaid beneficiaries should require that plans meet the minimum annual MLR of at least 85 percent in their contracts and require plans that miss that threshold to remit the difference to the state.

Last year Congress created an additional incentive for *expansion* states to take this step. Generally, states must share MLR remittances with the federal government at the rate that the state's Medicaid program is funded, so until recently, they had to share remittances for the expansion population at the enhanced FMAP that applies to the expansion group. However, the 2018 Support Act allows states to share MLR remittances for the expansion population at the state's *regular* FMAP, rather than the higher *expansion* FMAP. This should generate substantial savings in expansion states with mandatory remittances.

For example, New Hampshire's FMAP is 50 percent. Without the Support Act, if New Hampshire required remittances, it could keep 50 percent of the remittances for its traditional Medicaid population in 2019 but only 7 percent of remittances for the expansion population (since the federal match in 2019 for expansion enrollees is 93 percent). With the Support Act, it can keep 50 percent of *all* remittances.

Expansion states that do not require managed care plans to pay remittances should consider legislation requiring rebates for managed care organizations that fail to meet the minimum MLR. The state's share of remittances can be used to fund expansion, avoid Medicaid cuts, or make other enhancements to the state's Medicaid program.