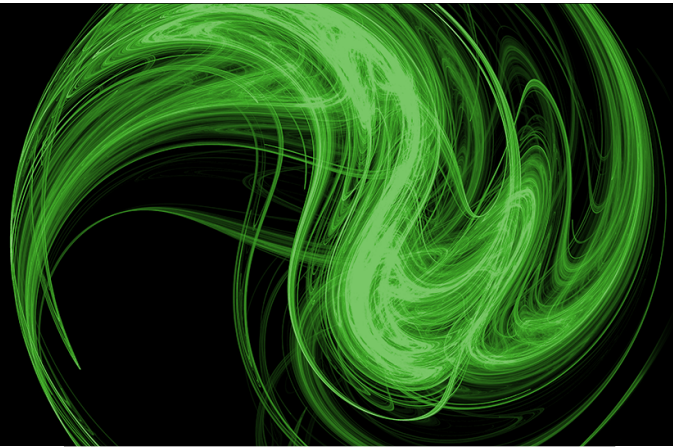


## Health plan financial performance: 2011-2016

### Chapter Two: Medicare Advantage and Medicaid managed care trends in the wake of policy and market turbulence



How have US health plans' government lines of business fared in the wake of health policy and market turbulence? While many health plans increasingly regard Medicare Advantage and Medicaid managed care as growth engines, our most recent analysis indicates that health plan financial performance in these segments between 2011 and 2016 varied widely, with significant differences related to scale, tenure, and geography. This paper presents six key findings:

- 1. Government programs accounted for a large and growing share of health plan revenue and underwriting gains.\*** The share of fully insured revenue attributable to Medicare Advantage and Medicaid managed care grew from 33 percent in 2011 to 46 percent in 2016. The share of total underwriting gains from Medicare Advantage and Medicaid managed care increased from 33 percent in 2011 to 57 percent in 2016.
- 2. The Medicare Advantage business experienced significant top-line growth and bottom-line volatility, including a notable decline in underwriting performance in 2014 and 2015.** Industry-wide underwriting gains declined from \$4.3 billion in 2012 to \$1.3 billion in 2015, before rebounding to \$4.8 billion in 2016.
- 3. In Medicaid managed care, aggregate plan revenue increased steadily between 2011 and 2016, and underwriting performance grew impressively before retrenching in 2016.** Medicaid managed care revenue increased from \$64 billion in 2011 to \$207 billion in 2016. Underwriting gains doubled in 2014 and 2015 before falling 50 percent in 2016.
- 4. The largest Medicare and Medicaid plans by national revenue captured a disproportionate and growing share of industry underwriting gains.** In Medicare Advantage, the top two plans generated 80 percent of aggregate underwriting gains and 46 percent of aggregate revenue in 2016. In Medicaid managed care, the top three plans captured 80 percent of 2016 underwriting gains and 37 percent of aggregate revenue.
- 5. Medicare Advantage performance variation widened beginning in 2014; smaller plans and newer entrants experienced substantial headwinds.** The median underwriting results of US health plans in the Medicare Advantage business were below breakeven levels between 2014 and 2016, and over 50 percent of plans reported losses during this period.
- 6. Medicaid managed care markets exhibited widening performance variation at the company and state levels beginning in 2014.** Medicaid plans in states that expanded Medicaid eligibility under the Affordable Care Act (ACA) had higher margins in all years except 2016.

\* Underwriting gains refer to the profit that an insurance company makes after paying all claims, and incurring general and administrative expenses. See methodology and appendix for further details.

**Key finding 1: Government programs business accounted for a large and growing share of health plan revenue and underwriting gains.**

At the industry level, the share of fully insured revenue attributable to Medicare Advantage and Medicaid managed care increased by 13 percentage points, from 33 percent in 2011 to 46 percent in 2016 (Figure 1 on page 4). The share of total underwriting gains from Medicare Advantage and Medicaid managed care increased from 33 percent in 2011 to 57 percent in 2016.

Underwriting gains in these two segments declined somewhat from 2011 to 2013, but increased every year between 2014 and 2016, even as underwriting gains from plans' overall fully insured business declined. As a result, the share of underwriting gains accounted for by government programs nearly doubled, from 33 percent in 2011 to 57 percent in 2016, demonstrating government programs' increased importance in the success of health plans' fully insured book of business.



**About this report**

This report is the second installment in the Deloitte Center for Health Solutions series on financial performance trends in the US fully insured health plans market. We segment the fully insured market into four primary lines of business: commercial group, commercial individual, Medicare Advantage, and Medicaid managed care. The [first installment in the series](#) provided summary observations on overarching developments in the market. This report focuses on trends in health plan government programs, specifically Medicare Advantage and Medicaid managed care.

As used in this series, "fully insured" refers to comprehensive medical coverage provided by state-licensed insurance companies that assume financial risk for covered health benefits in exchange for premiums paid by employers, governments, consumers, and other sponsors.

Our data sources do not include Medicare Advantage underwriting gain information in California for any year of the study or Medicaid managed care information for California in 2011. Since approximately 15 percent of national Medicare Advantage revenue in our data comes from California, this data limitation is important to keep in mind when considering our industry-level analyses in this segment.



### Methodology

This report presents results from our analysis of 2011 through 2016 annual statutory financial reports filed with state insurance departments by insurance companies operating within each state. For states other than California, we analyzed data obtained from National Association of Insurance Commissioners (NAIC) databases. Due to California's unique reporting requirements, we sourced data from the Department of Managed Health Care (DMHC) and California Department of Health Care (CDHC) for California-domiciled health plans. The California data sources do not include Medicare Advantage underwriting gain information by plan for any year in the study or Medicaid managed care information for 2011. This is important to keep in mind when considering underwriting gain performance at the industry level. The appendix includes a more detailed description of data sources and methodology.

The study's scope primarily focuses on US health plans' Medicare Advantage and Medicaid managed care lines of business. The study uses financial data reported by insurers to states according to statutory accounting principles, rather than the generally accepted accounting principles (GAAP) reflected in public companies' financial statements. There will, therefore, be differences in the results of this statutory data analysis compared to the financial reports of publicly traded health plans and other plans that provide public information based on GAAP.

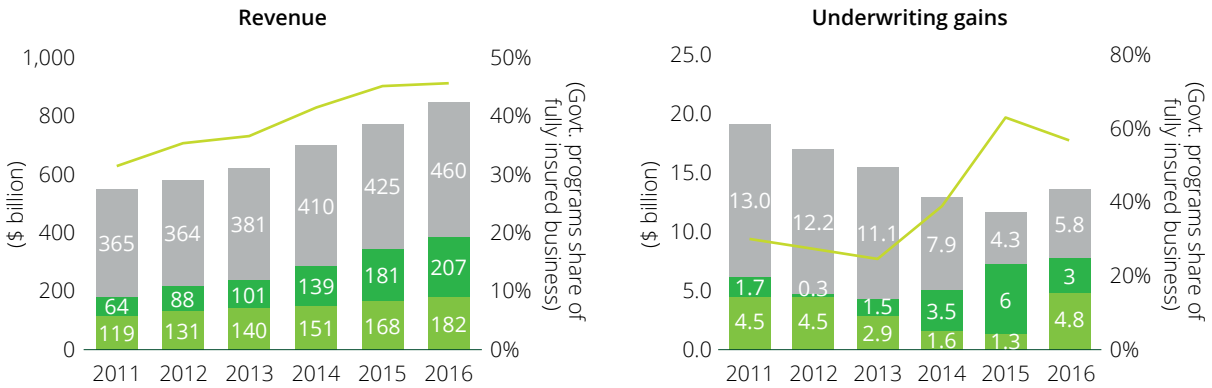
We analyzed health plans' revenue, underwriting gains, enrollment, and member months as reported in their NAIC, DMHC, and CDHC filings. We calculated underwriting margin as a ratio of a health plan's underwriting gains to revenue. For the state-level analysis, the unit of analysis is a health plan's reported data in the state(s) it is registered (state of domicile). It is possible that this reported data includes information from a health plan's operations from other states as well. However, since that level of detail is not available, our state-level analysis is based on health plans' state of domicile. This limitation is an important caveat to our analysis of state-level performance trends.

To minimize the influence of outliers, we excluded health plans that had fewer than 1,000 Medicare Advantage or Medicaid managed care enrollees in a particular state.

As used in this paper:

- **Revenue** is derived from the "total revenue" fields in NAIC/DMHC filings.
- **Underwriting gains** are derived from the "net underwriting gains" fields in NAIC/DMHC filings.
- **Underwriting margins** are calculated as underwriting gains as a percentage of revenue.

**Figure 1. Revenue and underwriting gains in the US fully insured health plan market by major lines of business, 2011-2016**



- Medicare Advantage
- Medicaid managed care
- Commercial individual, commercial group, and other lines of business
- Government programs share of fully insured business (RHS)

Notes:  
 1. Data on Medicare Advantage underwriting gains of California-domiciled health plans was not available and is, therefore, not included in the analyses.  
 2. Data on Medicaid managed care business for California-domiciled health plans for 2011 was not available and is, therefore, not included in the analyses.  
 3. Other lines of business include Medicare Supplement, Federal Employee Health Benefits Program, and other health lines of business.

Source: Deloitte analyses based on data from health plans' annual NAIC, DMHC, and CDHC filings

The share of fully insured revenue attributable to Medicare Advantage and Medicaid managed care increased by 13 percentage points, from 33 percent in 2011 to 46 percent in 2016.

**Key finding 2: The Medicare Advantage business experienced significant top-line growth and bottom-line volatility, including a notable decline in underwriting performance in 2014 and 2015.**

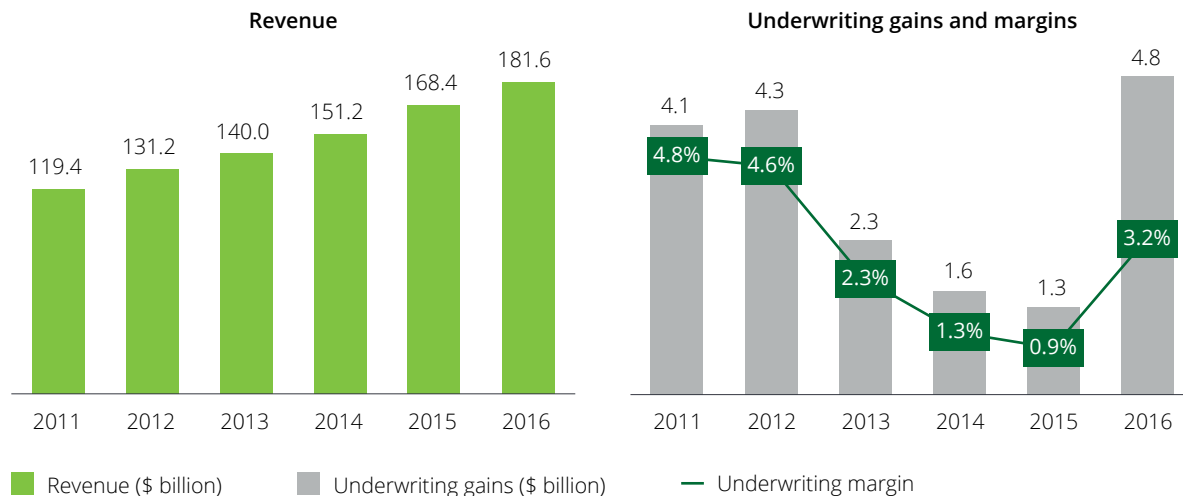
As seen in Figure 2, revenue in the Medicare Advantage business increased by over 68 percent between 2011 and 2016, from \$119 billion in 2011 to \$182 billion in 2016.

By contrast, underwriting gains and margins (for all states other than California, for which data is not available) declined between 2011 and 2015, with a

particularly pronounced decline in 2014 and 2015. However, performance appears to have improved in 2016. Industry-wide underwriting gains declined from a high of \$4.3 billion in 2012 to a low of \$1.3 billion in 2015, before rebounding to \$4.8 billion in 2016.

The 2014 and 2015 decline in Medicare Advantage profitability coincides with ACA-related payment policy changes, including reducing benchmarks to bring payments to health plans in line with traditional Medicare.<sup>1</sup> Concurrently, the ACA introduced a new quality rating program in which health plans receive bonus payments based on quality.<sup>2,3</sup> These policy changes could have been potential drivers of plans' performance in Medicare Advantage during this time period.

**Figure 2. Revenue, underwriting gains, and margin in the Medicare Advantage business, 2011-2016**



Note:  
 1. Since data on Medicare Advantage underwriting gains of California-domiciled health plans was not available, the underwriting margin calculation does not include California-domiciled health plans.

Source: Deloitte analyses based on data from health plans' annual NAIC, DMHC, and CDHC filings

**Key finding 3: In Medicaid managed care, aggregate plan revenue increased steadily between 2011 and 2016, and underwriting performance grew impressively before retrenching in 2016.**

Revenue in the Medicaid managed care business more than tripled between 2011 and 2016, from \$64 billion in 2011 to \$207 billion in 2016 (Figure 3). Underwriting performance grew steadily from 2012 to 2015—close to doubling each year in 2014 and 2015—before falling by 50 percent in 2016.

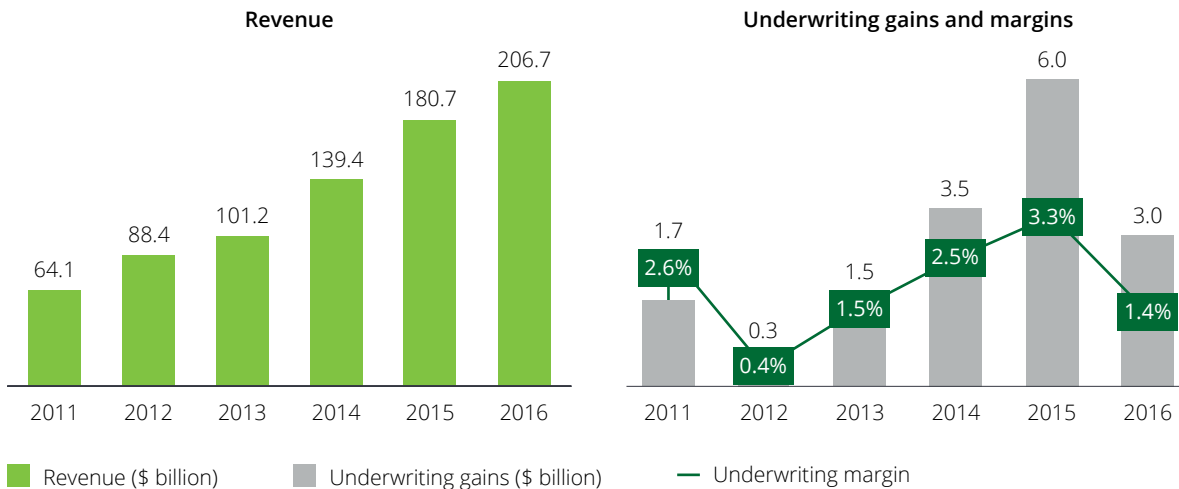
2014 and 2015 profitability improvement in the Medicaid managed care business correlates with the timing of the ACA policy changes. Most of the states that expanded Medicaid coverage under the ACA did so in 2014 and 2015, and most of these states (27 out of the 32 expansion states) chose to do so through managed care contracts. Indeed, in 25 of these states, at least 80 percent of the newly eligible population is enrolled in managed care arrangements.<sup>4</sup>

After the Medicaid expansions, profitability in Medicaid managed care declined. In 2016, underwriting gains declined by 50 percent, from \$6 billion in 2015 to \$3 billion. The underwriting margin declined from 3.3 percent in 2015 to 1.4 percent in 2016. The profitability decline in 2016 likely reflects both higher-than-expected costs associated with new Medicaid enrollees as well as the impact of state payment corrections in some Medicaid expansion states.<sup>5,6</sup>

**Key finding 4: The largest Medicare and Medicaid health plans by national revenue captured a disproportionate and growing share of industry underwriting gains.**

Our analysis covered the performance of the largest health plans compared to other market participants in both the Medicare Advantage and Medicaid managed care lines of business. In each segment, we found two health plan cohorts with performance strongly differentiated from that of other market participants.

**Figure 3. Revenue, underwriting gains, and margin in the Medicaid managed care business, 2011-2016**

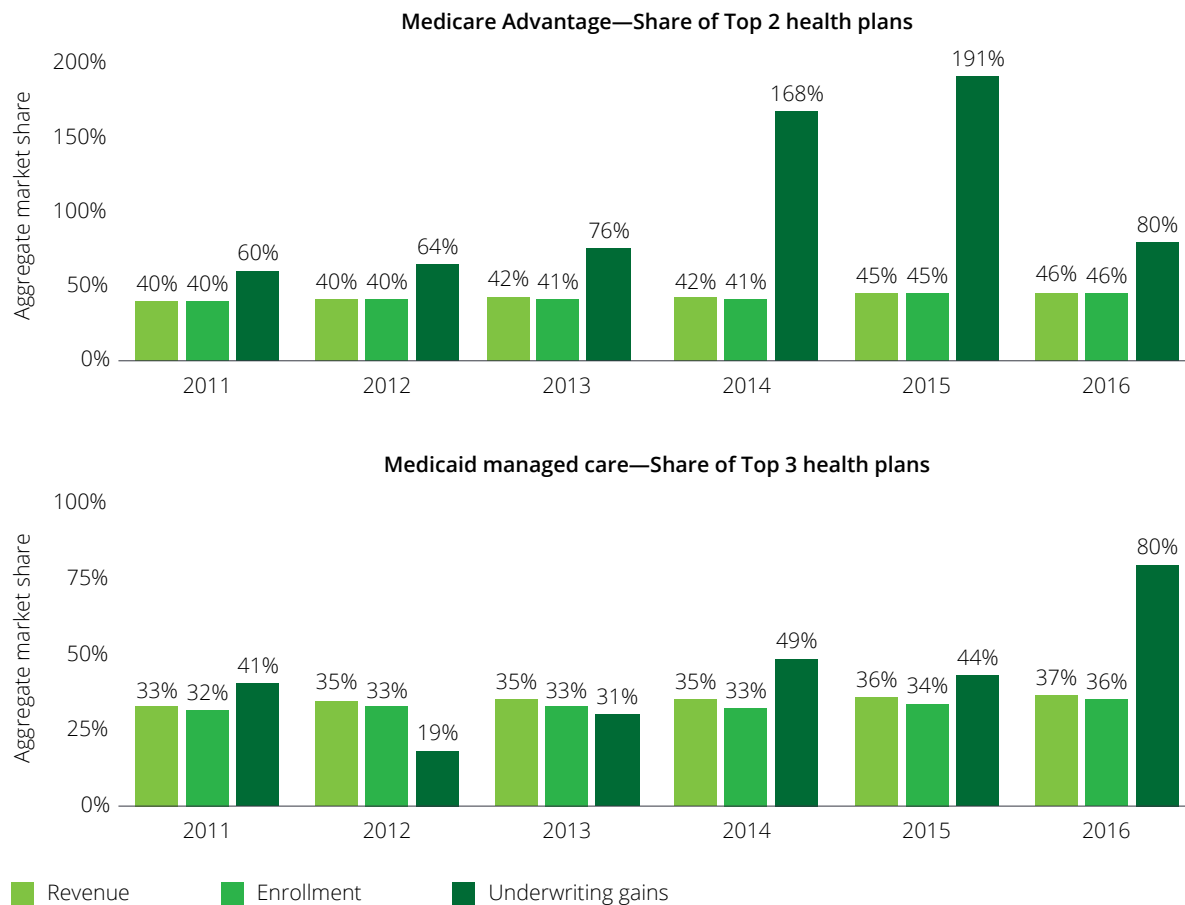


Note:  
 1. Data on Medicaid managed care business for California-domiciled health plans for 2011 was not available and is, therefore, not included in the analyses.

Source: Deloitte analyses based on data from health plans' annual NAIC, DMHC, and CDHC filings

According to our data, the two largest health plans by national Medicare Advantage revenue in every year from 2011 through 2016 (“Medicare Top 2”) were Humana and UnitedHealth. These two plans’ combined underwriting revenue increased steadily between 2011 and 2016, from \$2.7 billion in 2011 to \$3.9 billion in 2016. The companies’ share of underwriting gains grew even faster than their revenue. As Figure 4 illustrates, the “Medicare Top 2” share of industry-wide underwriting gains climbed significantly—from 60 percent in 2011 to 168 percent in 2014 and 191 percent in 2015—even as their share of enrollment and revenue grew more slowly. These top two plans were able to earn profitable margins while the remaining Medicare Advantage health plans were, on average, showing much lower underwriting gains in 2014 and 2015.

**Figure 4. Share of aggregate enrollment, revenue, and underwriting gains for top health plans by line of business, 2011-2016**



Notes:

1. Data on Medicare Advantage underwriting gains of California-domiciled health plans was not available and, therefore, health plans’ California business is not included in the analyses.
2. Data on Medicaid managed care business for California-domiciled health plans for 2011 was not available and is, therefore, not included in the analyses.
3. Top 2 health plans in Medicare Advantage are defined as the two health plans with largest national revenue in Medicare Advantage business in our data in each year between 2011 and 2016. These plans are UnitedHealth and Humana.
4. Top 3 health plans in Medicaid managed care are defined as the three health plans with the largest national revenue in Medicaid managed care business in our data in each year between 2011 and 2016. These plans are UnitedHealth, Anthem, and Centene.

Source: Deloitte analyses based on data from health plans’ annual NAIC, DMHC, and CDHC filings

In Medicaid, the three largest health plans by national revenue in every year from 2011 through 2016 according to our data (“Medicaid Top 3”) were Anthem, UnitedHealth, and Centene. As seen in Figure 4, the Medicaid Top 3’s share of all underwriting gains fluctuated somewhat between 2011 and 2015, but nearly doubled between 2015 and 2016—from 44 percent in 2015 to 80 percent in 2016. By contrast, the three largest plans’ share of revenue and enrollment increased more slowly during this time period.

The post-2014 increase in the largest plans’ share of aggregate underwriting gains in both Medicare Advantage and Medicaid managed care is attributable, in part, to the underwriting losses experienced by other health plans in each line of business. As discussed in greater detail in the sections below, we find that in Medicare Advantage, 62 health plans posted underwriting losses totaling -\$1.1 billion in 2016. In the

Medicaid business, 41 health plans posted underwriting losses totaling -\$2 billion in 2016. In aggregate analyses, these large losses weigh down overall plan performance in each line of business and magnify the largest plans’ shares of overall underwriting gains.

**Key finding 5: Medicare Advantage performance variation widened beginning in 2014; smaller-sized plans and newer entrants experienced substantial headwinds.**

Our analyses reveal significant, widening variance in plan performance beginning in 2014, with a notable increase in the number of plans with annual losses and a steep decline in average margins. The decline in performance was particularly pronounced among smaller plans and plans with fewer years of experience in the Medicare Advantage line of business.

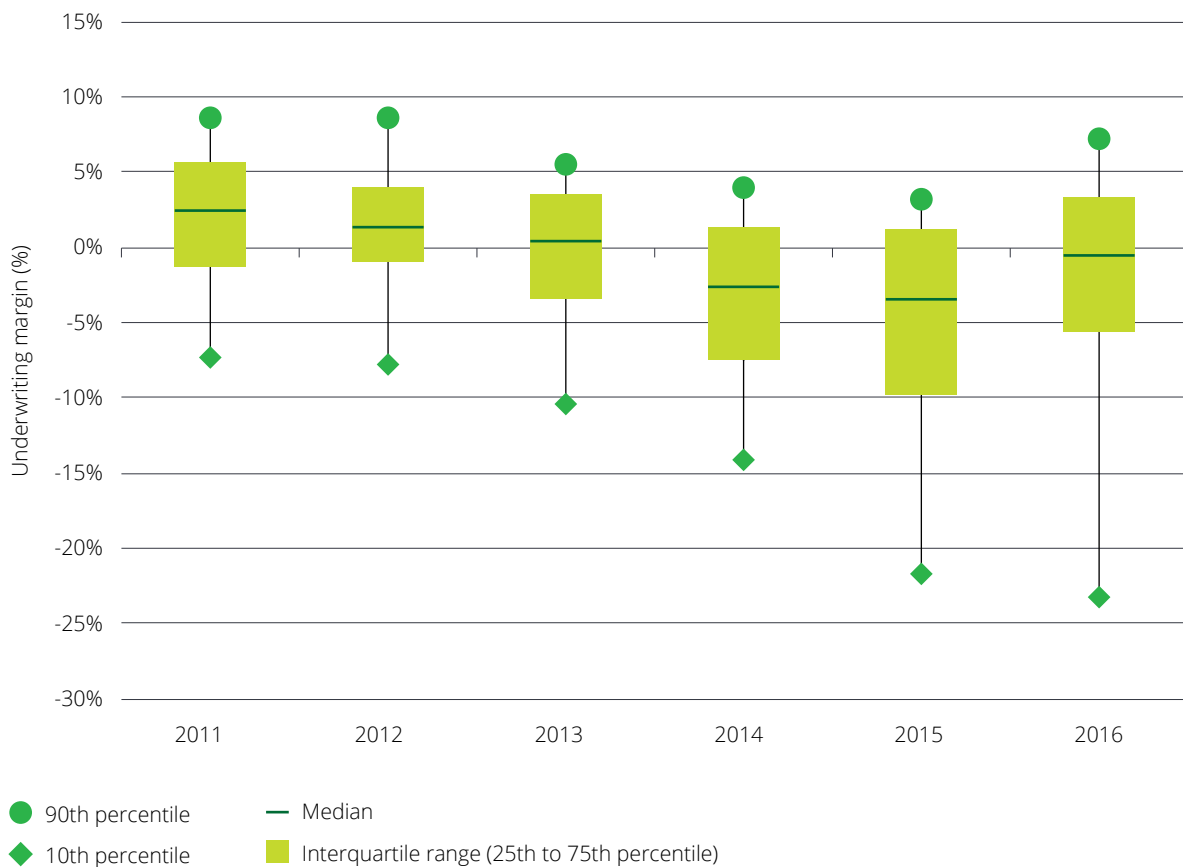
The Medicaid Top 3’s share of all underwriting gains fluctuated somewhat between 2011 and 2015, but nearly doubled between 2015 and 2016—from 44 percent in 2015 to 80 percent in 2016.



**Medicare Advantage plan performance variation widened between 2014 and 2016**

As shown in Figure 5, the variation in health plan performance in the Medicare Advantage business increased significantly beginning in 2014. Median underwriting results were below break-even levels between 2014 and 2016. The difference in margins widened between health plans in the 90<sup>th</sup> percentile of performance and those in the 10<sup>th</sup> percentile, as did the interquartile range (the range in performance for the middle 50 percent).

**Figure 5. Distribution of underwriting margins among Medicare Advantage plans, 2011-2016**



Note:  
 1. Data on Medicare Advantage underwriting gains of California-domiciled health plans was not available and is, therefore, not included in the analyses.

Source: Deloitte analyses based on data from health plans' annual NAIC, DMHC, and CDHC filings

### Proportion of Medicare Advantage plans with losses increased beginning in 2014

As shown in Figures 5 and 6, the increased variation in Medicare Advantage plan performance is largely driven by the higher number and proportion of plans reporting losses beginning in 2014. In that year and in 2015, over 60 percent of the 119 health plans that we analyzed reported Medicare Advantage underwriting losses. While this trend moderated somewhat in 2016, the number and proportion of plans with underwriting losses remained higher than pre-2014 levels. Although Medicare Advantage markets are generally regarded as stable, Figures 5 and 6 show the increased uncertainty for some plans in this line of business.

**Figure 6. Medicare Advantage plans with underwriting gains and losses, 2011-2016**

Medicare Advantage business	2011	2012	2013	2014	2015	2016
<b>All health plans</b>						
Number of plans	106	110	109	115	119	121
Underwriting gains (\$billion)	4.5	4.5	2.9	1.6	1.3	4.8
<b>Plans reporting underwriting gains</b>						
Number of plans	76	76	57	43	41	59
<i>% of plans reporting underwriting gains</i>	72%	69%	52%	37%	34%	49%
Underwriting gains—Top 2 (\$ billion)	2.7	2.9	2.2	2.6	2.5	3.9
Underwriting—Other plans (\$ billion)	2.2	1.9	1.3	1.0	1.0	2.0
<b>Plans reporting underwriting losses</b>						
Number of plans	30	34	52	72	78	62
<i>% of plans reporting underwriting losses</i>	28%	31%	48%	63%	66%	51%
Underwriting losses (\$ billion)	-0.3	-0.3	-0.6	-2.0	-2.2	-1.1

Notes:

1. Data on Medicare Advantage underwriting gains of California-domiciled health plans was not available and is, therefore, not included in the analyses.

2. Data on Medicaid managed care business for California-domiciled health plans for 2011 was not available and is, therefore, not included in the analyses.

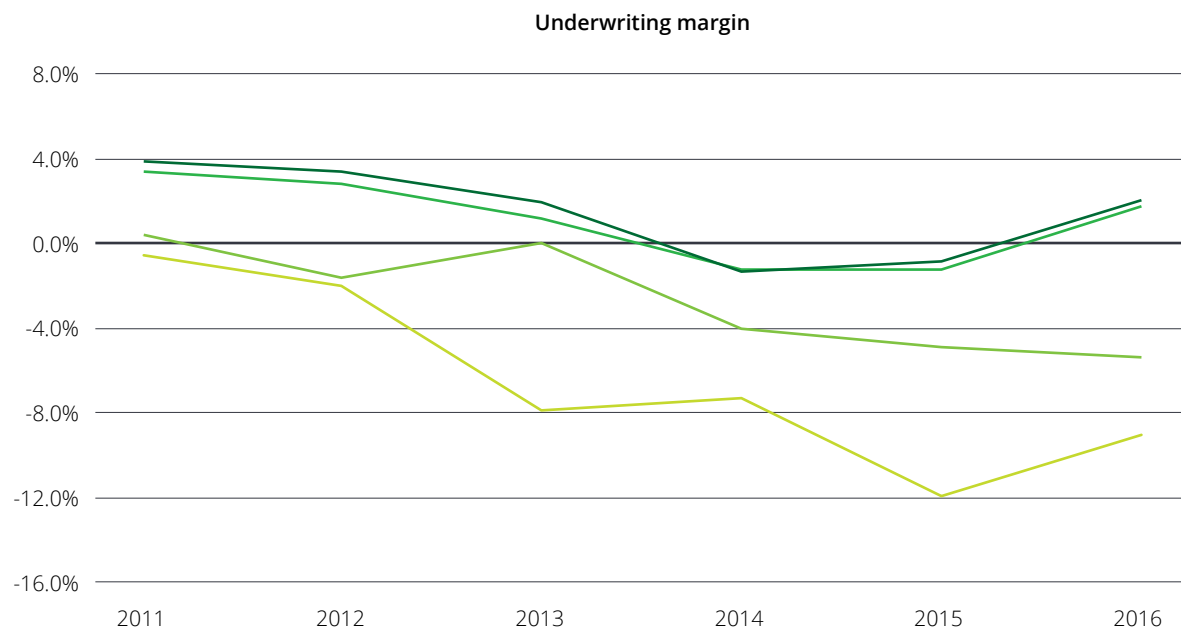
3. Top 2 health plans in Medicare Advantage are defined as the two health plans with highest national revenue in Medicare Advantage business in our data in each year between 2011 and 2016. These plans are UnitedHealth and Humana.

Source: Deloitte analyses based on data from health plans' annual NAIC, DMHC, and CDHC filings

### Larger plans had better performance

As Figure 7 illustrates, the less favorable performance results were concentrated primarily among the smaller health plans. For plans with 10,000 or more enrollees, the negative declines in underwriting margins in 2014 and 2015 are less pronounced. Even when we exclude the Medicare Top 2 plans from our analyses, we find that bigger plans had better performance during this period. In 2016, for instance, the 39 plans that had more than 50,000 members enrolled in their Medicare Advantage business (other than the Top 2) posted a total of \$1.2 billion in Medicare Advantage underwriting gains. By contrast, the 59 plans with fewer than 25,000 Medicare Advantage members had aggregate losses of -0.4 billion in 2016.

**Figure 7. Medicare Advantage underwriting margin by enrollment (plans other than Medicare Top 2 plans)**



**Health plans with**

- Greater than 50,000 enrollees
- 25,000-50,000 enrollees
- 10,000-25,000 enrollees
- Less than 10,000 enrollees

Note:  
 1. Data on Medicare Advantage underwriting gains of California-domiciled health plans was not available and is, therefore, not included in the analyses.

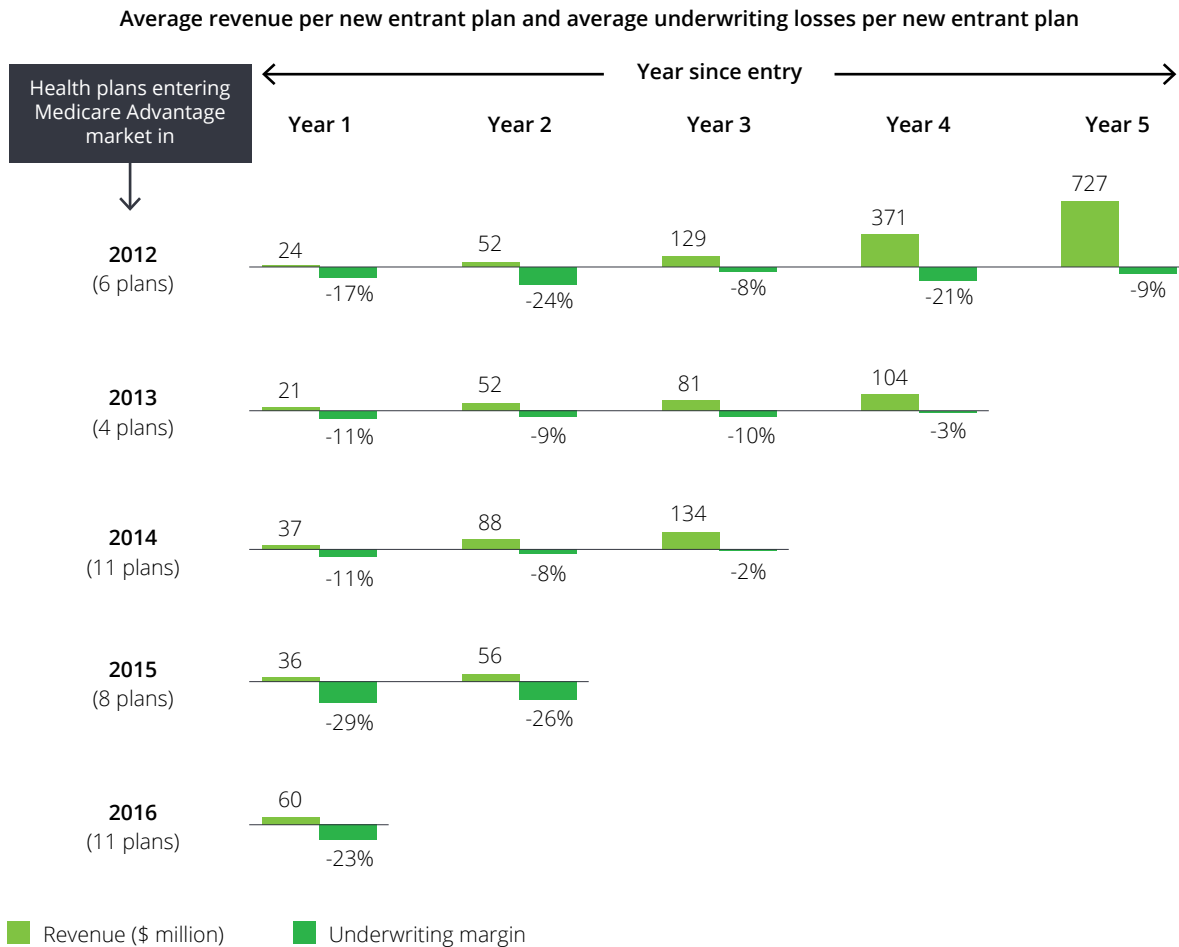
Source: Deloitte analyses based on data from health plans' annual NAIC filings

**Newer entrants in the Medicare Advantage business had less favorable results**

New entrants in the Medicare Advantage business were more likely to post underwriting losses during the time period we studied. As Figure 8 shows, health plans entering the Medicare Advantage business typically faced large losses during the first few years. Many of these new entrants almost doubled their revenue every year they were in business, which helped reduce their underwriting loss margins over time.

Still, post-entry negative margins appear to be quite persistent: Although aggregate revenue for the six health plans that entered the Medicare Advantage market in 2012 increased thirty-fold between 2012 and 2016, and total underwriting losses grew by fifteen-fold, the aggregate underwriting margin for these 2012 entrants was still negative five years after entry (-9 percent). This highlights the dual challenge of being new to Medicare Advantage during the tough plan years of 2014 and 2015.

**Figure 8. Revenue and underwriting margin of US health plans entering the Medicare Advantage business between 2011 and 2016**



Note:  
 1. Data on Medicare Advantage underwriting gains of California-domiciled health plans was not available and is, therefore, not included in the analyses.

Source: Deloitte analyses based on data from health plans' annual NAIC, DMHC, and CDHC filings

**Key finding 6: Medicaid managed care markets also exhibited widening performance variation at the company and state levels beginning in 2014.**

Health plans' performance in Medicaid managed care varied significantly by state. Some of these differences appear to be driven by policy changes under the ACA. As Figure 9 illustrates, between 2011 and 2013, underwriting margins in Medicaid expansion states were comparable to or even slightly lower than those

in non-expansion states. By contrast, in 2014 and 2015 during the ACA-related Medicaid expansions, aggregate underwriting margins in expansion states were, respectively, 2.6 and 1.4 percentage points higher compared to non-expansion states. In 2016, however, the aggregate margin in Medicaid expansion states was one percentage point lower compared to non-expansion states.

Medicaid managed care plans' financial performance varied, even among expansion and non-expansion states. Among Medicaid expansion states, for instance, plans in Michigan, Ohio, and New York had positive margins for at least five of the six years we studied, indicating some stability in state-level policy for Medicaid pricing.

**Figure 9. Underwriting margin in Medicaid managed care by state Medicaid expansion status, 2011-2016**



Note:  
 1. Data on Medicaid managed care business for California-domiciled health plans for 2011 was not available and is, therefore, not included in the analyses.

Source: Deloitte analyses based on data from health plans' annual NAIC, DMHC, and CDHC filings

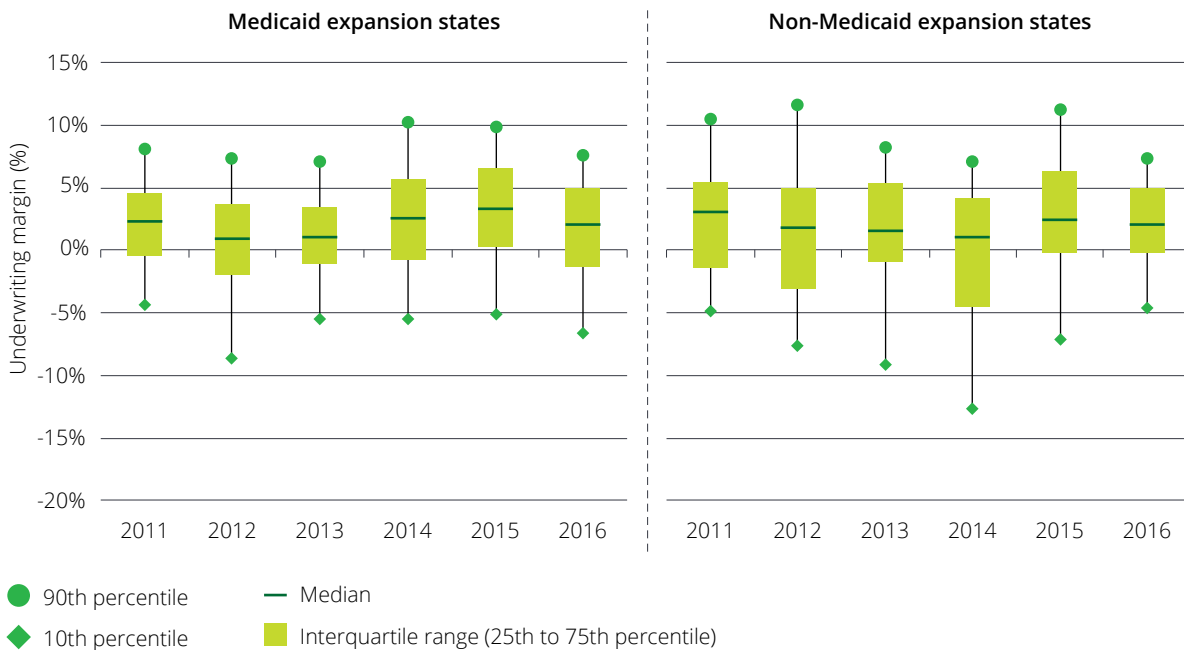
Furthermore, over 51 percent of health plans in these states saw positive underwriting gains for four years or more during this time period. Similarly, among non-expansion states, Virginia, Georgia, and Tennessee consistently had more favorable results compared to other non-expansion states, with positive underwriting margins for at least five of the six years covered in this analysis.

**Medicaid managed care plan performance variation widened between 2014 and 2016**

Our analysis found increased variation in Medicaid managed care plan performance, particularly beginning in 2014. Compared to Medicare Advantage

business, however, this performance variation was less pronounced. In 2016, 36 percent of 114 health plans reported underwriting losses in their Medicaid business. Furthermore, although the variation in health plan performance increased somewhat in 2014 and 2015 compared to previous years, median underwriting margins in Medicaid were positive in all years from 2011 to 2016 (Figure 10). The more favorable results in 2014 and 2015 appear to be driven by the performance of plans in Medicaid expansion states. As Figure 10 illustrates, the performance variation was lower in states that expanded their Medicaid programs compared to non-expansion states, particularly in 2014 and 2015.

**Figure 10. Distribution of underwriting margins in Medicaid managed care by state Medicaid expansion status, 2011-2016**



Notes:  
 1. Data on Medicaid managed care business for California-domiciled health plans for 2011 was not available and is, therefore, not included in the analyses.  
 2. Medicaid expansion states refers to states that expanded their Medicaid programs under the Affordable Care Act, irrespective of the year when the Medicaid program expansion happened.

Source: Deloitte analyses based on data from health plans' annual NAIC, DMHC, and CDHC filings

## Perspectives



**Wide reaching policy impact.** The Affordable Care Act brought many changes to Medicare Advantage and Medicaid managed care, affecting plan performance in both lines of business.

We attribute much of the decline in Medicare Advantage financial performance in 2014 and 2015 to ACA payment model changes. The ACA introduced a number of important revisions to existing payment methodology, including fundamental revisions to the Medicare Advantage benchmark model; bonus payments linked to quality ratings; and rebates to plans with below-benchmark bids. These ACA provisions were designed to reduce payments to Medicare Advantage plans, with the expressed intent of bringing Medicare Advantage payment levels per beneficiary closer to those in traditional Medicare fee-for-service (FFS) plans; and generating Medicare program savings to help finance other ACA spending priorities.

In Medicaid managed care, we find that plans in states that expanded their Medicaid programs under the ACA saw more favorable results in 2014 and 2015. However, some of these results could be transitory, as aggregate performance in the Medicaid managed care segment declined somewhat in 2016, in both expansion and non-expansion states.



**Scale, experience, and markets matter.** Health plans may be attracted to the relative stability and profitability of government program lines of business. However, our data shows that attaining profitability can be challenging even several years after entering the Medicare Advantage market, and that a number of smaller plans exit markets without ever becoming profitable. Additionally, performance trends vary greatly at the state level. Particularly in Medicaid managed care, state policies and payment rates are likely to drive differences in health plan financial performance.

## Looking ahead

Next up in our Health Plan Financial Trends series: a deeper dive into our analysis of 2011-2016 trends in the commercial group and commercial individual segments.

## Appendix

### Data and methodology

For this study, we used various sources for health plans' business in the two major government programs, Medicare Advantage and Medicaid managed care.

#### Medicare Advantage

We used health plans' state filings for 2011-2016 with the National Association of Insurance Commissioners (NAIC) for non-California-domiciled health plans, and with the California Department of Managed Health Care (DMHC) for health plans domiciled in California. The data was extracted from *SNL Insurance, an offering of S&P Global Market Intelligence*. For the state-level analyses, the unit of analysis is the health plan's state of domicile. For instance, UnitedHealth in Florida and UnitedHealth in California are two separate health plans for the purpose of our state-level analyses. For national and individual health plan-level analyses, the unit of analysis is a health plan's consolidated business from all the states. Consistent with other studies, to minimize the influence of outliers, we excluded health plans that had fewer than 1,000 Medicare Advantage enrollees in a particular state.

For health plans domiciled in states except California, we extracted the following data points for the analyses:

- **Revenue:** Defined as *Total revenues* of "Title XVIII Medicare" column in the "Analysis of operations by lines of business" table in the NAIC filing.
- **Underwriting gains:** Defined as *Net underwriting gain or loss* of "Title XVIII Medicare" column in the "Analysis of operations by lines of business" table in the NAIC filing.
- **Enrollment:** Defined as *Total members at the end of current year* of "Title XVIII Medicare" column in the "Exhibit of premiums, enrollment, and utilization" table in the NAIC filing.
- **Member months:** Defined as *Current year member months* of "Title XVIII Medicare" column in the "Exhibit of premiums, enrollment, and utilization" page in the NAIC filing.

For health plans domiciled in California, we extracted the following data points for the analyses:

- **Revenue:** Defined as "Title XVIII - Medicare" under Revenue in "2-income" tab of DMHC filings
- **Enrollment:** Defined as "Medicare risk" row of total enrollees at end of period column in "4-Enrollment" tab of DMHC filings.
- **Member months:** Defined as "Medicare risk" row of *Cumulative enrollee months for period* column in "4-Enrollment" tab of DMHC filings.

Information on underwriting gains for health plans domiciled in California was not available and was, therefore, excluded from the analyses.

One of the health plans in our data—Humana Insurance Company, domiciled in Wisconsin—operated with a "life insurance" license from 2011 through 2013, and with a "health insurance" license from 2014 through 2016. NAIC filings for life insurance entities contain information on health insurance premiums and medical losses in the Medicare Advantage line of business, but not on underwriting gains. Since the Medicare Advantage administrative loss ratio (ALR) for this entity was relatively constant between 2014 and 2016, we assumed the same rate of ALR for the previous years as well (2011 through 2013). We then calculated the underwriting gains for this entity between 2011 and 2013 by subtracting the medical losses (as reported) and administrative and other expenses (calculated using the imputed ALR).



### Medicaid managed care

We used health plans' state filings for 2011-2016 with the National Association of Insurance Commissioners (NAIC) for non-California-domiciled health plans. The data was extracted from *SNL Insurance, an offering of S&P Global Market Intelligence*. For health plans domiciled in California, we used California Department of Health Care data from Kaiser Health Foundation's (KHF) 2017 research study, "[Enriched By The Poor: California Health Insurers Make Billions Through Medicaid](#)." This data was available from 2012 through 2016. As 2011 data was not available, our analyses do not include results for California-domiciled health plans for 2011.

For the state-level analyses, the unit of analysis is the health plan's state of domicile. For instance, UnitedHealth in Florida and UnitedHealth in California are two separate health plans for the purpose of these analyses. For national and individual health plan-level analyses, the unit of analysis is a health plan's consolidated business from all the states. Consistent with other studies, to minimize the influence of outliers, we excluded health plans that had fewer than 1,000 Medicaid managed care enrollees in a particular state.

For health plans domiciled in states except California, we extracted the following data points for the analyses:

- **Revenue:** Defined as *Total revenues* of "Title XIX Medicaid" column in the "Analysis of operations by lines of business" table in the NAIC filing.
- **Underwriting gains:** Defined as *Net underwriting gain or loss* of "Title XIX Medicaid" column in the "Analysis of operations by lines of business" table in the NAIC filing.
- **Enrollment:** Defined as *Total members at the end of current year* of "Title XIX Medicaid" column in the "Exhibit of premiums, enrollment, and utilization" table in the NAIC filing.
- **Member months:** Defined as *Current year member months* of "Title XIX Medicaid" column in the "Exhibit of premiums, enrollment, and utilization" page in the NAIC filing.

For health plans domiciled in California, we extracted following data points for the analyses:

- **Revenue:** Defined as "Total revenue" in "Medi-Cal Managed-Care Financial Results" from California Department of Health Care.
- **Underwriting gains:** Defined as "Net profit (Loss)" in "Medi-Cal Managed-Care Financial Results" from California Department of Health Care.

Information on enrollment and member months for health plans domiciled in California was not available and was, therefore, not included in the analyses.

## Endnotes

- 1 Between 2011 and 2015, Medicare advantage payments declined relative to Medicare fee for service—from 110 percent of FFS costs in 2011, to 102 percent of FFS costs in 2015.
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Andreea Balan-Cohen managed the project and led the analyses and the writing. Amy Goodman contributed to the analyses, the writing, and helped manage the project. Priyanshi Durbha helped with the data collection.

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