The Challenges Of Medicaid Expansion Will Limit U.S. Health Insurers' Profitability In The Short Term

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The Challenges Of Medicaid Expansion Will Limit U.S. Health Insurers' Profitability In The Short Term

The expansion of Medicaid coverage under the Affordable Care Act (ACA) is likely, in Standard & Poor's Ratings Services' view, to result in significantly higher revenues for health insurers participating in this segment. But we don't expect profitability necessarily to increase for some of these insurers in the near term, or their credit profiles to improve. When the Supreme Court upheld the constitutionality of the ACA in 2012, it also made participation in an expanded Medicaid program optional for the states. So far, 26 states and the District of Columbia have agreed to expand Medicaid, and five more states are considering it. Altogether, 3 million new enrollees have signed up for Medicaid under the ACA expansion, according to recent government figures.

Although participating Medicaid Managed Care Organizations (MCOs) will see higher enrollment, the benefits for some of them are likely to be offset by lower profitability—at least in the initial year or two of the expansion. We expect newly eligible Medicaid enrollees typically to be more expensive to treat than the women and children that now constitute the vast majority of Medicaid beneficiaries, because they will likely be older and sicker—the expansion includes mandatory coverage for the childless, single, and working-age poor. Each insurer will also be affected by how much a state reimburses it to provide coverage. State reimbursement levels are set individually, not nationally, and can rise or fall according to budget and political pressures within each state. Reduced reimbursements can significantly diminish a Medicaid insurer's profitability. Moreover, each insurer's bottom line will be strongly affected by how well it deals with the ongoing shift of beneficiaries' into Medicaid MCOs. States are making this shift because MCOs can be significantly less costly to administer than traditional fee-for-service plans. However, when managed-care premiums don't cover medical costs—and there have already been instances in which they do not—insurers can lose money with this Medicaid coverage.

We believe that when all these factors are considered, the industry's overall operating margins will continue to narrow. Those margins now hover between 1% and 3%, having fallen since the recession. Insurers that are just beginning to offer Medicaid coverage, as well as some Blue Cross/Blue Shield plans, could see a loss in the first few years of the Medicaid expansion. Nevertheless, we don't expect earnings from the Medicaid segment to cause operating results at most health insurers to fall to levels inconsistent with our current ratings. Medicaid revenue and profits at most large insurers are only a small portion of their total revenues, although some insurance companies, such as Centene, WellCare, and Molina, focus almost exclusively on government market segments. The growth of Medicaid by itself will generally have a neutral impact on health insurance ratings in the near term.
Overview

- The expansion of Medicaid in 26 states and the District of Columbia has the potential to generate significant revenues for health insurers in this business segment.
- The new enrollees, however, are likely to be older and with greater incidence of disease.
- As the states look to control Medicaid costs, insurers will have to manage the ongoing shift to Medicaid MCOs and away from fee-for-service plans carefully.
- High medical costs and uncertainty about state reimbursement levels may result in losses or lower profits for some insurers.
- Despite these challenges, we expect our ratings on most health insurers in the Medicaid segment to persist in the near term.

Medicaid Expansion By The Numbers

Beginning in 2104, the government, under the ACA, extended health insurance for the poor to individuals between ages 19 and 65 who earned up to 138% of the federal poverty level. The former limit was 100%. The federal government also bears the full costs of all new Medicaid enrollees in the first three years of expansion. Subsequently, the states will pay 10% of the cost while the federal government covers 90%.

In April the Centers for Medicare & Medicaid Services (CMS) reported that 3 million people in the states opting for expansion had enrolled in Medicaid or the Children’s Health Insurance Plans (CHIP) since October 2013. (CHIP provides health coverage to children whose families’ incomes are too high to qualify for Medicaid and can’t afford private coverage. Like Medicaid, it is jointly funded by the states and the federal government.) Currently, according to CMS, there are 59.9 million people enrolled in CHIP and Medicaid, with 31 million of them (52.5% of the total) being children (see table 1). Non-disabled adults make up the next-largest group of the poor in the program at 11 million, or 18.6% of the rolls. There are 8.8 million Medicaid enrollees with disabilities (17%), and 8.3 million who are seniors (14%). The Congressional Budget Office estimates that the Medicaid expansion would add 6 million people to the program in 2014 (rising to 17 million by 2016) if it were implemented in all states. Many of the uninsured poor--by some estimates half of them--live in states that have yet to accept Medicaid expansion.

Table 1

<table>
<thead>
<tr>
<th>Medicaid Enrollment Snapshot</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Mil.)</td>
</tr>
<tr>
<td>Children</td>
</tr>
<tr>
<td>Non-disabled adults</td>
</tr>
<tr>
<td>Individuals with disabilities</td>
</tr>
<tr>
<td>Seniors and Medicare and Medicaid enrollees</td>
</tr>
<tr>
<td>Total as of February 2013</td>
</tr>
<tr>
<td>Total projected as of December 2013</td>
</tr>
<tr>
<td>Total projected as of December 2018</td>
</tr>
</tbody>
</table>

Source: CMS, CBO.
From 2011 through 2013 most insurers active in this segment saw their Medicaid revenues grow but remain a relatively constant percentage of total revenue. That is evident whether Medicaid is a small part of their business, as it is at Aetna (9% of all revenues from Medicaid in 2013) or all of it, as it is at Centene. WellPoint is the outlier. It saw a major increase in Medicaid-derived revenue, which tripled between 2011 and 2012 (see table 2), largely from the $4.9 billion acquisition of Amerigroup Corp., a specialist in Medicaid managed-care plans. Although there could be further consolidation in this market, we expect the Medicaid expansion to generate significant organic growth, which should prove beneficial given the slow growth in the commercial market segments.

Table 2

<table>
<thead>
<tr>
<th>Insurer</th>
<th>2011 Revenue (Mil. $)</th>
<th>Medicaid Revenue %</th>
<th>2012 Revenue (Mil. $)</th>
<th>Medicaid Revenue %</th>
<th>2013 Revenue (Mil. $)</th>
<th>Medicaid Revenue %</th>
</tr>
</thead>
<tbody>
<tr>
<td>United HealthCare</td>
<td>14,954</td>
<td>16</td>
<td>16,422</td>
<td>16</td>
<td>18,268</td>
<td>16</td>
</tr>
<tr>
<td>WellPoint Inc.</td>
<td>3,398</td>
<td>6</td>
<td>10,751</td>
<td>18</td>
<td>13,700</td>
<td>19</td>
</tr>
<tr>
<td>Aetna Inc.</td>
<td>1,440</td>
<td>5</td>
<td>1,677</td>
<td>5</td>
<td>3,845</td>
<td>9</td>
</tr>
<tr>
<td>Health Net Inc.</td>
<td>1,493</td>
<td>13</td>
<td>1,963</td>
<td>17</td>
<td>2,430</td>
<td>23</td>
</tr>
<tr>
<td>Centene Corp.</td>
<td>5,052</td>
<td>100</td>
<td>7,681</td>
<td>100</td>
<td>10,526</td>
<td>100</td>
</tr>
<tr>
<td>WellCare Health Plans Inc.</td>
<td>3,581</td>
<td>59</td>
<td>4,471</td>
<td>59</td>
<td>5,661</td>
<td>59</td>
</tr>
<tr>
<td>Molina</td>
<td>3,800</td>
<td>90</td>
<td>5,076</td>
<td>92</td>
<td>5,653</td>
<td>91</td>
</tr>
<tr>
<td>Horizon HealthCare</td>
<td>1,671</td>
<td>20</td>
<td>2,152</td>
<td>24</td>
<td>2,277</td>
<td>24</td>
</tr>
<tr>
<td>Services Inc.</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A.</td>
<td>4,727</td>
<td>56</td>
</tr>
<tr>
<td>Independence Blue Cross</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A.</td>
<td>4,727</td>
<td>56</td>
</tr>
<tr>
<td>Blue Cross Blue</td>
<td>1,696</td>
<td>33</td>
<td>1,691</td>
<td>34</td>
<td>1,673</td>
<td>31</td>
</tr>
<tr>
<td>Shield TN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

N.A.-Not available. Source: Company reports.

New Enrollees Mean New Challenges

New enrollees in states expanding Medicaid eligibility are likely to be noticeably different than the historical Medicaid population. With more serious health problems as a result of a lack of previous health care, these people—who now include single, childless adults—are likely to have a pent-up demand for health care that will result in greater-than-anticipated utilization rates. To deal with that possibility, insurance companies need to take care that the actuarial rates they set for medical costs reflect this reality. An inability to estimate them accurately could result in diminished profits or losses.

Expansion into higher-acuity segments of Medicaid, such as long-term care and managed care for the disabled poor, could mean significant revenue growth for insurers. But although government spending in these sectors is very high, it also comes with higher risks. Insurers who become overexposed to these segments without effective care coordination
and case-management models could easily see their overall financial position erode. Insurers who can utilize
more-established care coordination and case management with this population, however, are likely to see better
margins than their competitors.

The negative results from these new areas of coverage are likely to be most apparent in the initial year or two of
expansions. But our analyses lead us to believe that over time, health insurers will become more adept at assessing the
actuarial risks for these disabled new enrollees, and some will be able to operate profitably in this subsegment.

Expanding Medicaid to include these individuals may even result in insurers building in a "risk premium" in the initial
years of implementation due to the greater uncertainty surrounding the characteristics of the group.

The Transition To Managed Care Has Its Risks

State policymakers are generally pushing to shift more and more Medicaid coverage away from fee-for-service plans to
less-costly managed care plans. Some 38 states now deliver care through MCOs and many of those states are
expanding MCOs to cover individuals with more complex and costly health care needs, including persons with
disabilities and state long-term care. Insurers who want this business will bid to win the right to become the MCO
provider for a particular area.

But this comes with risks. Once again, the development of actuarially sound rates for moving Medicaid recipients into
managed care is critical. There are numerous risks associated with the initial implementation of a new program,
expansion into a new service area, or the provision of medical services to a population not previously in managed care.
Because there can be limited historical information on which to develop rates, the insurer needs to make assumptions
that may subsequently prove to be inaccurate. Rates of utilization can turn out to be significantly higher than
anticipated, or policymakers’ assumptions about the potential savings from utilization management could be flawed.

Moreover, because of the lack of actuarial experience for a particular program, region, or population, reserve levels
may be set inadequately. This can lead to elevated medical care costs and unexpected losses at the health plan,
impairing cash flows and other credit metrics.

These problems have already beset Medicaid managed-care plans around the country. Kentucky began the full
transition into managed care from fee-for-service—including its aged and people with disabilities—in 2011. Three
insurers—Wellcare, Centene, and Coventry—won contracts to provide those services. But all three have reported a ratio
of health care benefits to revenues (HBR) of more than 100%, representing a loss. Although the state granted Wellcare
and Coventry rate relief, Centene eventually left Kentucky and stopped providing Managed Medicaid in 2013.

Similarly, when Texas began expanding into new service areas to shift more of the disabled and elderly poor into
managed-care plans, by 2011 some of the insurers involved were reporting unexpectedly high HBR. To keep the plans
from closing down, the state increased its reimbursement to a group of these Medicaid insurers.

Profitability for Medicaid managed care depends on insurers accurately predicting and effectively managing medical
care costs. The ACA’s requirements for medical loss ratio (MLR; the share of revenues spent on medical care) do not
apply to Medicaid. However many states set their own minimum MLR thresholds ranging from 80% to 93%, meaning
that an insurer must spend between 80% and 93% of its revenues on medical treatment. Some states also have risk-adjusted provisions in their contracts with Medicaid providers that offer some relief if costs exceed expectations. Yet even with careful consideration of medical costs, careful actuarial models, and some safeguards from a state, an insurer's profitability is inevitably enmeshed with how well a state will fund its Medicaid program.

**State Funding Can Be A Volatile Ingredient**

Because Medicaid is only partially funded through the federal government, states pay a large share of the cost. Although the federal government will fully underwrite the cost of Medicaid expansion for three years, it shares the cost for existing Medicaid, and the portion paid by each state is typically its single largest budget item. During the recession several states cut the rates they paid to insurers between 1% and 5%. That squeezed profits at Medicaid insurers, and we see no letup in the immediate future, despite the higher revenues that are likely to accompany the ACA’s rollout.

Margins for these insurers will, in our view, generally remain between 1% and 3%. In addition, some Blue Cross/Blue Shield insurers that are new to Medicaid may be particularly vulnerable to losses during their initial entry into the Medicaid space before they ramp up their own capabilities or partner with insurers with more Medicaid expertise.

Just as an insurance company courts trouble when its estimates of medical costs are inaccurate, it can also be a challenge when state reimbursement levels are too low. In 2010 United Healthcare was the largest of four managed-care organizations to win a contract from the Department of Health Services to provide Medicaid services in six counties in southeastern Wisconsin. But after Wisconsin cut payment rates in 2011 and 2012, United Healthcare ended its contract, which covered 174,000 people insured through the Badger Care Plus program. United Healthcare's decision is a reminder that when a state struggles to balance its budget, as Wisconsin did in the aftermath of the recession, its decision to cut reimbursements can lead to a Medicaid insurer quitting the market.

A state's attitude toward paying for indigent care will likely have a big impact on the prospects of Medicaid insurers. According to surveys by policy journal Health Affairs, a majority of states that have chosen to expand Medicaid believe expansion will result in savings for their state's budget during the next decade. Many states that are not expanding believe expansion will be costly to the state, mainly due to the concern surrounding the future of the federal match rate.

**Medicaid Expansion Brings New Revenues And New Risks**

Unlike individuals seeking coverage on the insurance exchanges who had until March 31 to enroll, those seeking to enroll in Medicaid have no deadline, and states have no deadline as to when they can opt-in to ACA's Medicaid expansion. Therefore, it's difficult to quantify the ultimate impact of new outreach initiatives and streamlined enrollment processes. A majority of states have adopted a single, streamlined application through their Medicaid agency. A few others now offer online enrollment. Some states facilitate enrollment by transferring an individual's eligibility data from other support programs, like the Supplemental Nutrition Assistance Program, allowing enrollment based on the eligibility of minor children, or extending the annual enrollment period beyond the typical end of the first quarter. Although it's unclear how many of the eligible poor will enroll in Medicaid as a result of these and similar
Medicaid expansion will extend health coverage to millions of low-income individuals. Health insurers in the states that participate in this expansion appear ready for the influx and will likely see a jump in revenue. But how insurers contend with the additional pricing risk of this new and sicker population remains to be seen. Medicaid expansion is likely to be positive in the short term for insurers' business risk profiles because of higher enrollment, but the financial profiles for a few of them could be at risk.

Robert McNatt