

# Medical Loss Ratios in Medicaid Managed Care

Managed care is the primary Medicaid delivery system in nearly three-quarters of states, accounting for over half of federal and state Medicaid spending in fiscal year (FY) 2020 (MACPAC 2021). In a managed care delivery system, a state Medicaid program contracts with health plans to cover a defined package of benefits for an enrolled population through fixed periodic payments. These capitation payments are typically made on a per member per month basis. Capitation rates are typically developed prospectively and remain in effect for the duration of the contract (usually one year), regardless of changes in health care costs or use of services.<sup>1</sup>

Federal Medicaid statute requires that capitation payments made by states to plans be actuarially sound. That is, they should cover the anticipated health costs of the covered populations and services as well as appropriate amounts for health plan administrative expenses, reserves, and profit or reinvestment. The medical loss ratio (MLR) is a component of the rate setting approach meant to protect Medicaid from paying for excessive health plan administrative expenses or profits by ensuring that a sufficient percentage of the total capitation is spent on services or quality improvement.

In 2016, the Centers for Medicare & Medicaid Services (CMS) implemented detailed standards for demonstrating and enforcing actuarial soundness in Medicaid managed care, including a new MLR requirement. It required that health plans begin calculating and reporting an MLR in 2017 and that states develop managed care capitation rates such that each health plan can reasonably achieve an MLR of at least 85 percent starting in 2019. That is, the capitation rates should be sufficient to allow health plans to spend at least 85 percent of total capitation revenue on covered services, and no more than 15 percent on other activities such as plan administration and profit.

This issue brief begins with an overview of federal capitation rate setting standards and specific guidance regarding the MLR. It then describes the variation across states on several dimensions, including whether or not health plans must return any revenue if the minimum MLR target is not met and what is known about MLR results to date. The brief concludes with a discussion of a number of policy issues relevant to developing and implementing a Medicaid MLR.

## Overview

State Medicaid programs typically pay health plans for a defined package of benefits through fixed periodic or capitation payments. States contract on a capitated basis with comprehensive managed care organizations (MCOs) as well as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs), which are specialty health plans unique to Medicaid.<sup>2</sup>



Under a risk-based contract, a health plan is responsible for covering all of the costs for covered health care services for its enrolled members but has some flexibility in how it manages spending. If the total health costs for the covered population and plan administrative costs are greater than the total capitation payments from the state, the health plan will have a financial loss; if the total health and administrative costs are less than total revenue, then the health plan will have a surplus. Because capitation rates are established prospectively for each contract period, states have limited means to address excessive health plan gains or losses that may occur during the year.<sup>3</sup>

Capitation payments to risk-based Medicaid health plans must be made on an actuarially sound basis (§1903(m)(2)(A)(iii) of the Social Security Act). Federal rules require that state Medicaid managed care rates be developed in accordance with generally accepted actuarial principles and practices, be appropriate for the population and services, and be certified by qualified actuaries (42 CFR 438.4). Plans are required to calculate and report an MLR each year, and states must develop capitation rates in such a way that health plans can reasonably achieve an MLR of at least 85 percent for the rate year (42 CFR 438.8). As noted above, these rules are meant to ensure that a sufficient percentage of the total capitation or premiums are spent on health care or quality improvement. The MLR also provides a target for state actuaries when assessing the appropriateness of the proposed capitation rates. It is important to note that states have the flexibility to set an MLR higher than 85 percent.

Federal rules require Medicaid health plans to calculate and report the MLR using standards that are similar to those used in Medicare Advantage (MA) and the private market, while accounting for unique characteristics of the Medicaid program.<sup>4</sup> This is intended to allow comparisons of plan performance among the major health care programs and across states. Unlike MA and private plans, Medicaid plans are not required to issue rebates to enrollees or to the state if they do not meet their state's MLR standard. In Medicaid, the state can determine whether to recoup any excess revenue between the minimum threshold and what the plan actually spent on health care (in the form of a remittance back to the state) or whether to adjust capitation rates in future years.<sup>5</sup>

MLR requirements went into effect in 2019, and data on plan and state experience with them is expected to be available in 2022. These data will allow comparisons of plan performance across states and programs. It will also allow analysis of the relationship between the MLR requirements, other Medicaid rate-setting requirements (e.g., actuarial soundness), and Medicaid programmatic issues (e.g., use of partial capitation health plans, coverage and spending differences among populations).

An MLR is one of several tools that states can use to assess whether capitation rates are appropriately set and limit MCO profits. For example, states can require a profit cap or experience rebate, which requires the MCO to rebate a portion of its profit (over a certain amount) back to the state. This method is similar to an MLR but does not require clear delineation between medical and administrative costs and does not guarantee that a plan spends a certain amount of revenue on services. States can also use risk corridors, which plans may find preferable to MLRs and experience rebates as they allow plans to share in both upside (i.e., savings) and downside (i.e., loss) risk, versus keeping all of the downside risk that would occur under an MLR or experience rebate.



## Medical Loss Ratio Guidance

As noted above, federal standards for calculating the MLR apply to all Medicaid health plans, including MCOs, PIHPs, and PAHPs. States were first required to include contract provisions relating to MLR calculation and reporting to states for contracts starting on or after July 1, 2017 and then factor the MLR target into rate setting for contracts beginning on or after July 1, 2019. There are also specific regulatory requirements for how the MLR should be calculated and what should be included in each health plan report to the state (42 CFR 438.8).

The MLR is expressed as health care spending divided by revenue. For purposes of reporting by health plans, health care spending, the numerator of the MLR, is the sum of health plan spending on incurred claims and activities that improve health care quality as provided in the private market rules at 45 CFR 158.150.<sup>6</sup> Revenue, the denominator of the MLR, is adjusted premium revenue (premium revenue from the state minus federal, state, and local taxes and fees).

To be counted in the numerator, activities that improve health care quality must meet the following requirements:

- improve health care quality;
- increase the likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results and achievements;
- be directed toward individual enrollees or incurred toward the benefit of specific segments of enrollees;
- be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria by recognized groups; and,
- primarily fall into one of five categories: improve health outcomes, prevent hospital readmissions, improve patient safety, promote health and wellness, or enhance the use of health care data.

Administrative expenses (e.g., provider contracting, member services, utilization review, claims processing), and profit cannot be included in the numerator.

The denominator includes adjusted premium revenue, which is the health plan's premium revenue minus the plan's federal, state, and local taxes and licensing and regulatory fees. Incentive payments are not counted as premium revenue for purposes of the MLR; only capitation payments made for required services under the contract are included in the denominator. Pass-through payments are also excluded from MLR calculations (42 CFR 438.6(d)).

Each health plan must submit an annual MLR report that includes the calculated MLR, the underlying data components (e.g., premium or capitation revenues, total incurred claims, non-claims costs, expenditures on quality improvement activities) and methodologies for allocating expenditures, any remittance owed to the state (if applicable), a comparison of this information with the health plan's audited financial report, a description of the aggregation method used, and the number of member months for each MLR reporting year. The report from each health plan must be submitted to the state no later than 12 months after the



end of the contract year. States are required to take into account plan financial performance and comparisons of actual performance to estimated or target performance when setting rates for the future rate period.

States are required to submit a summary description of the MLR reports received from the health plans when they submit the rate certifications for a future rate setting period to CMS (CMS 2021a). States must provide a summary of financial performance by health plan (e.g., numerator, denominator, credibility adjustment, member months, and MLR percentage), and a comparison to the estimated or assumed measures used when developing the rates. CMS uses this information to review past results, including the accuracy of previous rate setting and the stability of program costs and rates.

If a state requires health plans to submit a remittance for not meeting the minimum MLR standard, the state must also return to CMS the federal government's share, along with a separate report describing the methodology used to determine the state and federal share of the remittance.

## Implementation of Medical Loss Ratios

States have always been allowed to impose a minimum MLR or similar medical spending target on contracted Medicaid managed care plans, as long as those targets met federal requirements for actuarial soundness. Some states required plans to meet a minimum MLR prior to the 2016 rule; a 2010 state survey found that 11 states had minimum MLR requirements, although the minimum MLR thresholds ranged from 80 percent to 93 percent and what was included as medical expenses differed by state (Gifford, Smith et al. 2011). However, not all states required remittances or enforced other financial penalties on health plans that did not achieve the minimum MLR. In 2013, 12 states had minimum MLR requirements, but only 6 attached financial penalties (CMS 2016).

### State MLR decisions

Federal rules require that states develop capitation rates such that health plans could reasonably achieve an MLR of at least 85 percent for the rate year and that health plans calculate and report an MLR each year. States have a number of choices in how they implement these requirements.

**Minimum MLR.** If a state requires a minimum MLR, it must be equal to or higher than the federal minimum of 85 percent (42 CFR 438.8(c)).<sup>7</sup> Between 2017 and 2019, 33 states adopted minimum MLR requirements for all of their plans and 25 set their minimum MLR at the federal minimum. Of the remaining eight states, one set it at 86 percent, one set it at 88 percent, one set it at 90 percent, and the other five states established different MLRs for different health plans depending on factors such as plan performance, enrolled population, type of service, and type of plan (OIG 2021). At least nine states had comprehensive managed care programs but did not require a minimum MLR.

**Remittances.** A state can also decide whether to require health plans to pay remittances if they fail to meet the state's minimum MLR or whether they can take other actions to demonstrate appropriate spending (e.g., make investments in population health activities). States can also use a different MLR



formula to calculate the MLR for remittance purposes (e.g., include investments in social determinants of health in the numerator). If a state requires a remittance, it can also determine the methodology for calculating or collecting remittances. For example, it can determine the amount owed based on a standard single MLR reporting year data or a three-year average (CMS 2020b). States can also require remittances from some types of plans but not others. As of September 2020, of the 37 states that had established minimum MLR requirements, 28 had remittance requirements for all of their plans and 4 had remittance requirements for some of their plans (OIG 2021).

**Population-specific or contract-wide application of MLR.** States can apply an MLR to only portions of a contract, calculate the MLR separately for different populations, or aggregate the MLR across multiple contracts (42 CFR § 438.8(i)). For example, a state may apply an MLR to populations that have previously been enrolled in managed care but exclude new populations or services that are being added to the contract until the health plans have gained experience managing their care. Several states require health plans to calculate and report on MLR for specific Medicaid populations (e.g., children in foster care) or geographic areas, but very few states apply minimum MLRs at the population level (OIG 2021).

**Use of other risk mitigation tools.** In addition to or instead of using a minimum MLR, states may use a variety of tools to adjust individual rate cells or overall health plan payments to account for variation in enrollee risk, uncertainty in the rate setting process, and health plan performance, as long as capitation rates continue to meet the actuarial soundness standard. These tools include risk adjustment, incentives and withholds, risk sharing and risk corridors, and mandatory stop-loss or reinsurance. Most state Medicaid managed care programs use a combination of approaches to manage program financial performance and stability.

## MLR experience

States are required to publicly report MLR results as part of the annual managed care program report available on each state website. Some states previously made Medicaid MLR results publicly available and other entities have compiled or estimated Medicaid MLR results at the plan and state level. However due to delays in developing standardized reporting templates, 2022 will be the first year that states are required to submit these reports to CMS and publish them (CMS 2021b).

In 2020, the U.S. Department of Health and Human Services Office of the Inspector General (HHS OIG) asked states to submit annual health plan MLR reports for reporting periods ending in 2017, 2018, and 2019 (OIG 2021). The OIG found that 34 states established minimum MLRs of 85 percent or greater during that three-year period. Of the 434 Medicaid health plans in those states, 91 percent (395) met the minimum MLR requirements. The average reported MLR of health plans that met the minimum MLR was 93 percent; the average reported MLR of health plans that did not meet the minimum MLR was 81 percent. Almost half of the 39 plans that failed to meet the minimum MLR were those that had to meet MLRs above 85 percent, although only about one-quarter of health plans overall were in states with higher MLRs. Twenty-two plans that failed to meet the minimum MLR were in states that required remittances and those plans paid back amounts ranging from \$1.8 million to \$40.2 million.



Milliman, Inc., a private actuarial firm, compiles and publishes Medicaid managed care financial results each year for a subset of Medicaid MCOs with revenue over \$10 million, based on public annual insurance filings (Palmer et al 2021).<sup>8</sup> A review of calendar year (CY) 2020 results for 181 MCOs found that in aggregate, the plans achieved an estimated MLR of 84.6 percent, which may have resulted from two effects of the COVID-19 pandemic (increased enrollment growth, which affects the MLR denominator, and reduced utilization, which affects the MLR numerator). About 75 percent of the MCOs included in the analysis were estimated to have an MLR at or above 85 percent. Over the past five calendar years, Milliman has estimated the aggregate Medicaid MLR to range from 86.9 percent in CY 2016 to 88.6 percent in CY 2019. Prior to CY 2020, 85 to 90 percent of the MCOs included in the analysis were estimated to have an MLR at or above 85 percent each year (Palmer et al 2019).

## Policy Issues

States, managed care plans, and other policymakers have raised a number of concerns regarding the design and implementation of a Medicaid MLR. Many of these concerns stem from the programmatic and actuarial differences between Medicaid and other major health programs, which can complicate efforts to apply a consistent measurement approach or standard across health care programs. Some of the Medicaid-specific issues are summarized below.

### Medicaid policies that can affect the target MLR

States also contract with many types of specialty health plans, including plans that only provide a subset of services and MCOs that serve specific populations including exclusively children, persons with chronic behavioral health issues, persons with HIV/AIDS, and persons who use long-term services and supports (LTSS). Depending on the administrative requirements of the contract, an 85 percent MLR benchmark may be too high for specialty plans that provide a subset of services and receive small capitation payments, or could be too low for specialty plans that exclusively enroll a high-cost population and are paid high capitation rates. In some cases, states that have established a minimum MLR for comprehensive MCOs do not require a specific MLR for specialty plans, due to these factors (OIG 2021). However, states must still develop capitation rates in such a way that health plans can reasonably achieve an MLR of at least 85 percent for the rate year, regardless of whether the plans have comprehensive or specialty contracts (42 CFR 438.8).

### Medicaid policies that can affect the numerator

Given that the numerator of a medical loss ratio is the amount of revenue spent on patient care and other allowable expenditures (e.g., activities that improve health care quality and fraud prevention activities), the larger the numerator, the higher the ratio and the more the health plan must spend on health care. MLR requirements are minimums and thus it benefits plans to have non-claims expenses included in the numerator. Non-claims expenditures that can be counted in the numerator include activities that improve health care quality and fraud prevention. Other health plan expenditures, such as general administrative expenses and profit are not included in the MLR calculation.





Medicaid health plans have affirmative contractual responsibilities regarding health care quality that do not apply to other types of health plans subject to the MLR requirements. For example, they must offer a network of providers that meets state-developed standards for access and availability, conduct initial screenings of all new enrollees, develop treatment plans for enrollees who require LTSS or have special health care needs, maintain a health information system, and participate in an external quality review (42 CFR Subparts D and E). Some of these activities clearly fall within the regulatory definition of activities that improve health care quality but others do not. For example, typical Medicaid health plan activities such as case management and activities supporting states' goals for community integration of individuals using LTSS fall within this definition. However, while network availability and accessibility is part of the quality section of the Medicaid managed care regulation, the cost of developing and executing provider contracts and provider credentialing activities is excluded from the list of quality activities that can be counted in the numerator of the MLR.

Activities that improve health care quality can include a number of things to improve health outcomes and reduce disparities, such as case management, identifying and implementing best practices, quality reporting, discharge planning, improving patient safety, wellness and health activities, and improving the use of health data and health information technology. CMS has not issued guidance to states on whether certain Medicaid-specific activities should be considered activities that improve health care quality or administrative expenditures. CMS has previously suggested that states should determine whether to include in the MLR numerator any activities not specifically described in the rule (CMS 2016). However, state-by-state decisions on how to attribute plan expenditures could lead to inconsistency in MLR calculations among states and between Medicaid and the federal, commercial, and Medicare MLR standards.

States and health plans have also asked CMS for direction on how to factor costs associated with addressing the social determinants of health (SDOH) into the MLR calculation, as many Medicaid programs now cover these in order to improve population health, reduce disparities, and lower overall health care costs (CMS 2020b). Recent guidance to states on approaches to address SDOH did not speak to whether expenditures on SDOH could count in the numerator as activities that improve health care quality or expand the interpretation of 45 CFR 158.150 (CMS 2021c).

## Use of subcontractors

Like other health plans, Medicaid health plans often subcontract with providers and third-party vendors to provide administrative and health services to enrollees. Generally, MLR accounting rules (for all payers) include the amounts a subcontractor actually pays a medical provider or supplier for providing covered services to enrollees in the numerator, and does not include profits or expenditures on administrative functions such as eligibility and coverage verification, claims processing, utilization review, or network development in the MLR calculation.

If the health plan pays the subcontractor a capitated amount through a risk-based arrangement, the subcontractor must classify and report revenues and expenditures associated with the administration of the Medicaid benefit consistent with the MLR reporting requirements. This allows the health plan to



comply with its reporting requirements to the state (42 CFR 438.230(c)(1)). The health plan may not count the entire capitated payment to the subcontractor as incurred health claims.

## Prescription drug rebates

As noted above, subcontractors must classify and report revenues and expenditures associated with the administration of the Medicaid benefit consistent with the MLR reporting requirements so that the health plan can comply with its reporting requirements to the state. Prescription drug rebates received and accrued by a pharmacy benefits manager (PBM) administering the covered outpatient drug benefit on behalf of the health plan must be deducted from incurred claims, regardless of whether the prescription drug rebate is received by the health plan (i.e., directly) or by the PBM (i.e., indirectly) (42 CFR 43.8(e)(2)(ii)(B)).

## Endnotes

<sup>1</sup> While this brief discusses the medical loss ratio requirements for Medicaid managed care, the same requirements apply to the State Children’s Health Insurance Program (CHIP) managed care entities for contracts and rating periods that begin on or after July 1, 2018 (42 CFR §457.1203).

<sup>2</sup> In Medicaid, managed care organization (MCO) refers to an entity with a comprehensive risk contract with the state. A prepaid inpatient health plan (PIHP) is an entity that has a capitation contract with the state that includes inpatient hospital or institutional services but does not include comprehensive health services. A prepaid ambulatory health plan (PAHP) is an entity that has a capitation contract with the state but does not provide inpatient hospital or institutional services or comprehensive health services. PAHPs that deliver only non-emergency medical transportation do not need to comply with the MLR requirements (42 CFR 438.9).

<sup>3</sup> In most states, managed care contracts and rates are in effect from July 1 and June 30, corresponding with the state fiscal year.

<sup>4</sup> The MLR requirement for private insurers, including issuers of employer group and individual coverage, was introduced in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) and went into effect in 2011. These provisions do not apply to self-funded plans (i.e., where the employer or plan sponsor hires a plan administrator but pays the cost of health benefits) because these plans are not considered insurers. In the individual and small group markets, the minimum MLR is 80 percent; for fully insured large group plans, the minimum MLR is 85 percent. In 2013, CMS published a final rule creating an 85 percent MLR requirement for Medicare Advantage and Medicare Part D plans, which went into effect in 2014 (CMS 2013).

<sup>5</sup> The federal government is entitled to the federal share of any state Medicaid recoveries, including MLR remittances. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P. L. 115-271) amended Section 1903(m) of the Social Security Act to temporarily allow states to keep a larger percentage of remittances from MCOs specific to the adult expansion group when they did not meet MLR requirements. Specifically, this allows states to retain an amount consistent with the federal matching rate applicable to the state’s traditional Medicaid population, which is generally between 50 percent and 83 percent, instead of the applicable matching rate for the adult expansion group (90 percent for most states) incurred by states after fiscal year 2020 and before fiscal year 2024.



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<sup>6</sup> The numerator would also include fraud prevention activities (438.8(e)(4)), if a similar rule is applied to private market plans. As of September 1, 2020, the MLR applicable to the private market has not been amended to include fraud prevention activities, so these expenses are also excluded from the numerator in the Medicaid MLR calculation.

<sup>7</sup> The MLR reporting year is defined as a 12-month period consistent with the period for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS, which is usually the same as the contract period (42 CFR 438.8(b)).

<sup>8</sup> This analysis is based on standard financial statements, which allows comparison of MCOs among states, but may not be consistent with other reports. For example, Milliman calculates an MLR using information from the annual (calendar year) MCO financial reports, but notes that the data available in these reports does not allow certain adjustments that are permitted by Medicaid rules. Milliman also makes estimates to adjust for quality improvement expenditures in the numerator and taxes and fees in the denominator. While Milliman's estimates allow comparisons among plans and states and over time using consistent methods and data, they should not be compared to the Medicaid MLRs calculated, reported, and used by MCOs and state Medicaid agencies for purposes of rate setting and program monitoring.

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