MILLIMAN RESEARCH REPORT

Medicaid managed care financial results for 2017

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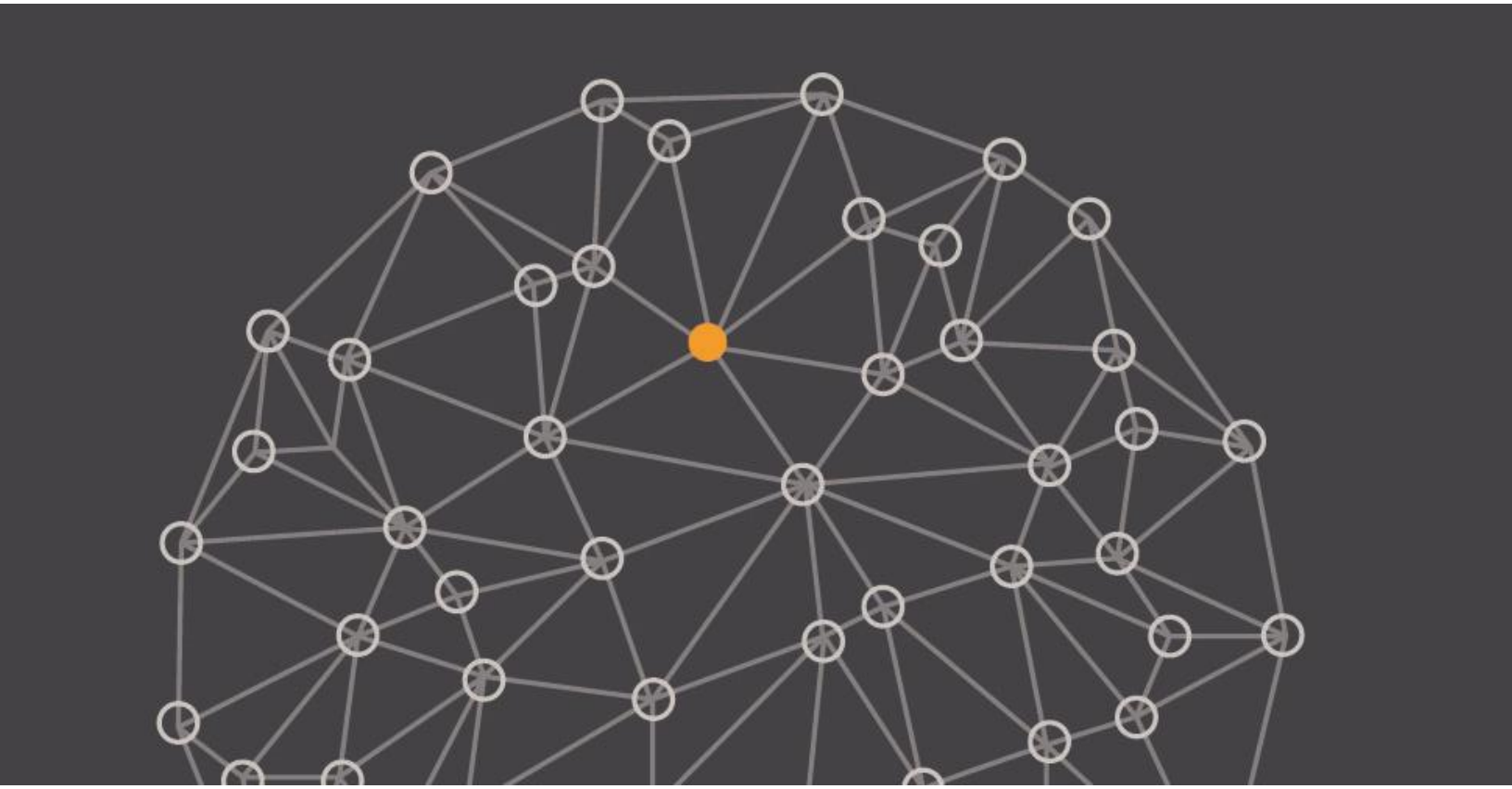

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Introduction

Ever since the Medicaid program was signed into law in 1965, managed care was utilized as a tool in Medicaid agencies' designs of their state-specific Medicaid programs.[1] Today, nearly every state utilizes some form of managed care to aid in the operation of its Medicaid program. Examples of different forms include comprehensive risk-based managed care, primary care case management, and limited-benefit plans. The form that accounts for the majority of Medicaid enrollment coverage is risk-based managed care, with approximately 65% of Medicaid-covered lives. Risk-based managed care is the platform from which Medicaid recipients receive healthcare benefits, at least in part, in 38 or more states in the United States, the District of Columbia, and Puerto Rico. Managed care organizations (MCOs) of all varieties contract with state Medicaid agencies to deliver and manage the healthcare benefits under the Medicaid program in exchange for predetermined capitation revenue.

Since the inception of the Patient Protection and Affordable Care Act (ACA) in 2010, and subsequent Medicaid expansion efforts in several states, the number of Medicaid beneficiaries as well as the number of MCOs operating in the Medicaid line of business has increased substantially. We have observed enrollment trends beginning to level out in comparison to recent years, but continue to identify year-over-year increases.

Most states require that a contracted MCO also be a licensed health maintenance organization (HMO), which includes the requirement to file a statutory annual statement with the state insurance regulator. The statutory HMO annual statement is a standard reporting structure developed and maintained by the National Association of Insurance Commissioners (NAIC), with prescribed definitions allowing comparisons among various reporting entities.

This report summarizes the calendar year (CY) 2017 experience for selected financial metrics of organizations reporting Medicaid experience under the Title XIX Medicaid line of business on the NAIC annual statement. The information was compiled from the reported annual statements.[2] Companies may be excluded from this report for the following reasons:

- Did not submit an annual statement
- Reported less than $10 million in annual Medicaid (Title XIX) revenue
- Specialized behavioral health plan or long-term services and supports plan
- Premium revenues indicate a limited set of covered services
- Reported values appear to be influenced by unusual circumstances
- Omitted from the NAIC database of annual statements utilized for this report.

This report includes information for eight MCOs operating in the Arizona Medicaid program that were outside of the NAIC annual statement information. We have noted limitations of this information where applicable in the report.

The primary purpose of this report is to provide reference and benchmarking information for certain key financial metrics used in the day-to-day analysis of Medicaid MCO financial performance. The financial results are summarized on a composite basis for all reporting MCOs. Additionally, this report provides differences among various types of MCOs using available segmentation attributes defined from the reported financial statements.

The target audiences of this report include state Medicaid agency and MCO personnel responsible for reviewing and monitoring the financial results of a risk-based managed care program.

This is the 10th annual iteration of the report, reflecting financial information for CY 2017. This report and the companion administrative cost report have been integrated into a single document to create a comprehensive resource of our analyses. Previous versions of these reports can be obtained from the Milliman website (milliman.com). The methodology used to generate this report is substantially consistent with the previous years' reports.

[1] National Counsel on Disability; Overview of Medicaid Managed Care; Retrieved May 9, 2018, from https://www.ncd.gov/policy/chapter-1-overview-medicaid-managed-care.

[2] National Association of Insurance Commissioners. Annual Statement Database, as delivered by SNL Financial, LC, all rights reserved.

Appendix 1 provides additional detail and stratifications of the financial metrics presented in this report.

Appendix 2 provides the methodology and assumptions utilized in developing the metrics presented in this report.

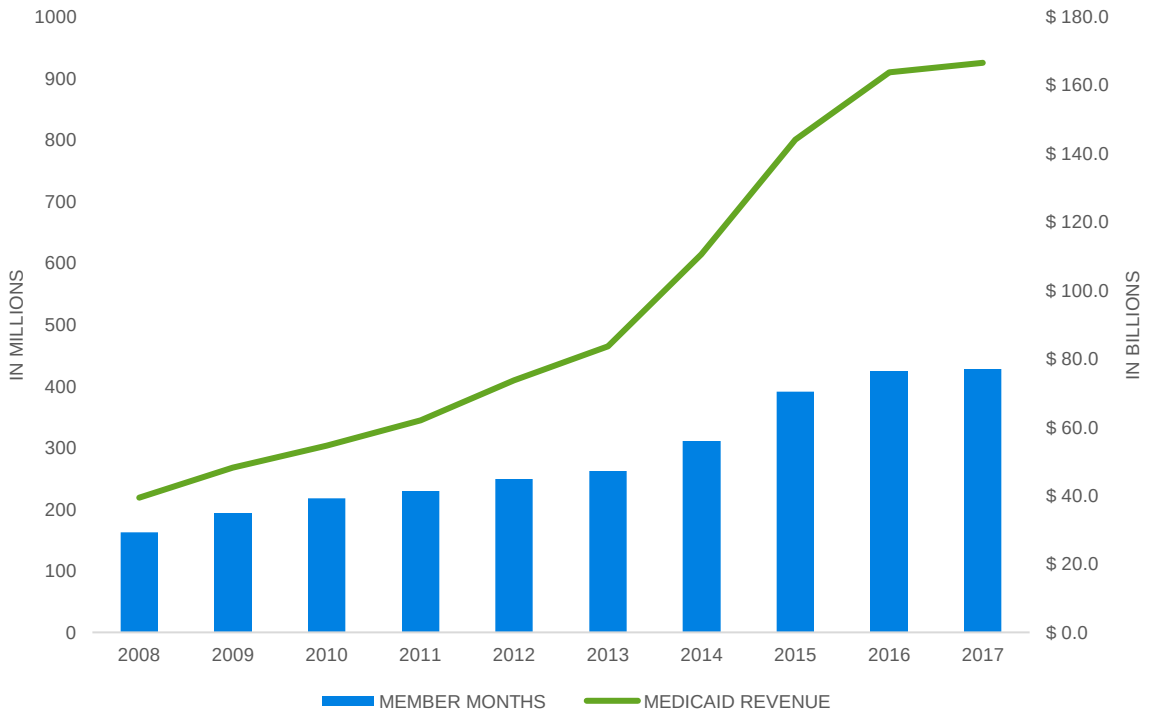
Appendix 3 illustrates the mapping of Centers for Medicare and Medicaid Services (CMS) regions.

Appendix 4 provides the listing of each MCO as well as the company attributes assumed for purposes of the MCO groupings included in this report.

Ten years of analysis

Analysis of the calendar year 2017 financial results for Medicaid MCOs marks the 10th edition of this report. Over the course of those 10 years, there has been significant growth and change in the Medicaid managed care market. Although companies have entered and left the Medicaid managed care market in those 10 years, the story has been relatively consistent: onward and upward. The continued growth of Medicaid managed care has resulted in increasing revenues to the participating MCOs along with progressively more assigned members, as illustrated in Figure 1.

FIGURE 1: HISTORICAL MANAGED CARE MEMBERSHIP AND REVENUE



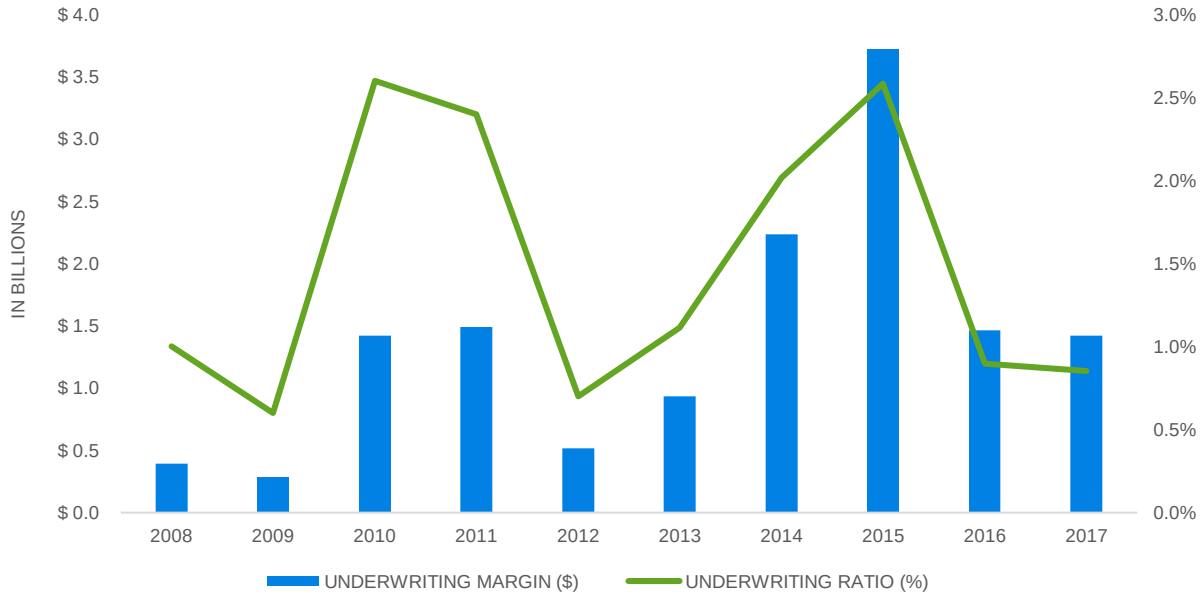
The observed growth cannot be attributed to just one item, however. From 2008 to 2017 there have been several factors contributing to the impressive increases in revenue and enrollment, most notably legislative changes and states' desires to transition away from historical fee-for-service (FFS) arrangements. The legislative changes include passage of the ACA in 2010, which paved the way for Medicaid expansion. With estimates of Medicaid expansion enrollment over 15 million nationwide, this alone has produced an almost 25% increase in total Medicaid enrollment. With several states opting to have the expansion members enroll in managed care, the membership base included in our study has grown exponentially. At the beginning of these expansion programs, actuaries contended with how to set capitation rates for a population that had not previously presented itself in a healthcare market. Capitation rates in these earlier rating periods were based on certain assumptions for pent-up demand and ultimate morbidity, but little to no historical experience for this population. During this period, the participating MCOs observed higher underwriting gains for 2014 and 2015. The gains observed for 2016 and 2017 have reverted to percentages observed in 2012 and 2013.

Furthermore, the increase in revenue has outpaced the increase in member months in recent years. Similar to the overall growth in Medicaid managed care, the resulting increase in average Medicaid MCO premium per member per month (PMPM) values has numerous contributing factors. These factors include general inflation trends, increases in provider fees and prescription drug costs, enrollment of Medicaid expansion lives at higher premiums, and the addition of high-cost services or populations to an already established managed care program. An example of the

additional services is the transition of long-term supports and services which are generally higher-cost than acute care services and would result in an increase to the average premium being paid to the MCOs managing the care of these newly covered services.

Another aspect of the narrative has been the relatively consistent performance of the MCOs identified in our analyses. We have observed variances from year to year and certainly across individual MCOs, but the underwriting performance has continued to reflect gains on a national basis. Figure 2 illustrates the variance in the underwriting ratio percentage on an annual basis, but highlights the growth in aggregate gains over these past 10 years. While the percentage underwriting gains have generally stayed between 0.5% and 2.5% over the past 10 years, a percentage point in underwriting gains represents a significantly larger amount of dollars in 2017 than 10 years ago.

FIGURE 2: HISTORICAL UNDERWRITING RATIO AND MARGIN



One offshoot of this expansion has been the reduction in risk-based capital (RBC) ratios across the Medicaid MCOs. The formula behind the RBC ratio is a comparison of the amount of capital held by a particular organization to the required amount of capital based on their at-risk business, known as authorized control level. The introduction of Medicaid expansion enrollees significantly increased the enrollment and size of the MCOs' business. Therefore, the authorized control level increased, but was not routinely met with an increase in actual capital consistent with historical RBC ratios. Although we have observed decreases in the average RBC ratio, the MCOs, in aggregate, continue to maintain capital levels about twice as high as the 200% company action level.

The observed changes over 10 year have been unprecedented, and we anticipate the next 10 years will continue to bring unexpected and new dynamics to the Medicaid managed care market. We have documented the year-by-year changes in this report and our prior research reports listed on the Milliman website,[3] and we will continue to monitor the Medicaid managed care market going forward. The focus in the remainder of this report are the results we analyzed specific to calendar year 2017.

[3] See http://www.milliman.com/insight/2017/Medicaid-risk-based-managed-care-Analysis-of-financial-results-for-2016/ for the analysis of CY 2016 financial results.

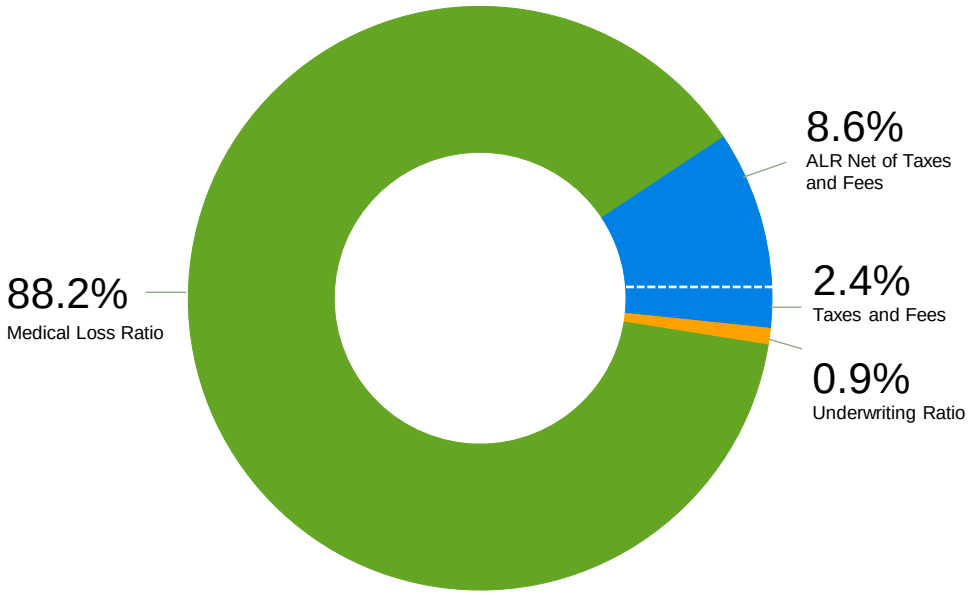
Summary of CY 2017 financial results

The CY 2017 financial information analyzed for this report comprises information for 186 reporting entities across 35 states, the District of Columbia, and Puerto Rico. The financial data for these MCOs were compiled to produce outcomes of key financial metrics for various company groupings. The distribution of results is summarized in this report to allow for user reference and benchmarking purposes.

The primary financial metrics that we have analyzed for this report include the medical loss ratio (MLR), administrative loss ratio (ALR), underwriting ratio (UW ratio), and RBC ratio. The selected metrics focus primarily on the income statement values of the financial statement, with the exception of the RBC ratio, which is a capital (or solvency) measure. The methodology and formulas behind these metrics is documented in Appendix 2.

Figure 3 summarizes the composite CY 2017 financial results for the 186 companies meeting the criteria selected for this study. The companies represent experience with over $166 billion in annual Medicaid revenue.

FIGURE 3: COMPOSITE CY 2017 FINANCIAL RESULTS

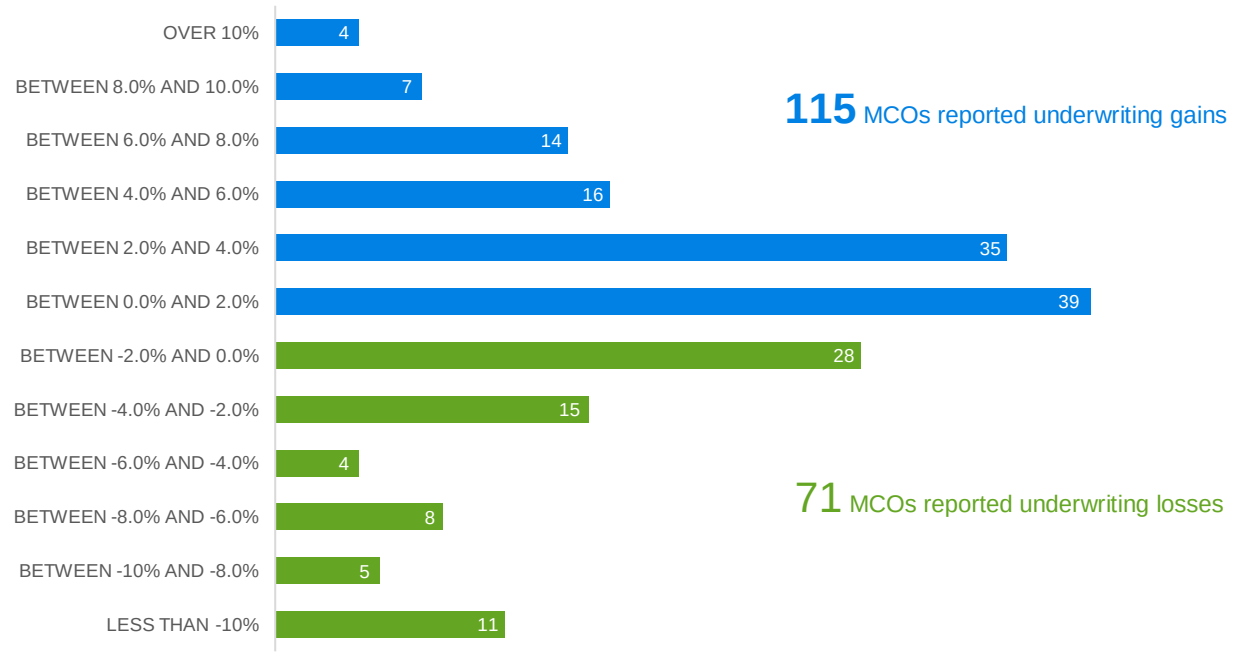


Notes

1. Values have been rounded.
2. Taxes and fees estimated based on a subset of the nationwide results.

While the composite underwriting margin is 0.9% across the identified MCOs, there were considerable variances in underwriting margin by MCO. Figure 4 provides a distribution of the number of MCOs within ranges of underwriting margin specific to CY 2017.

FIGURE 4: CY 2017 UNDERWRITING RATIO DISTRIBUTION

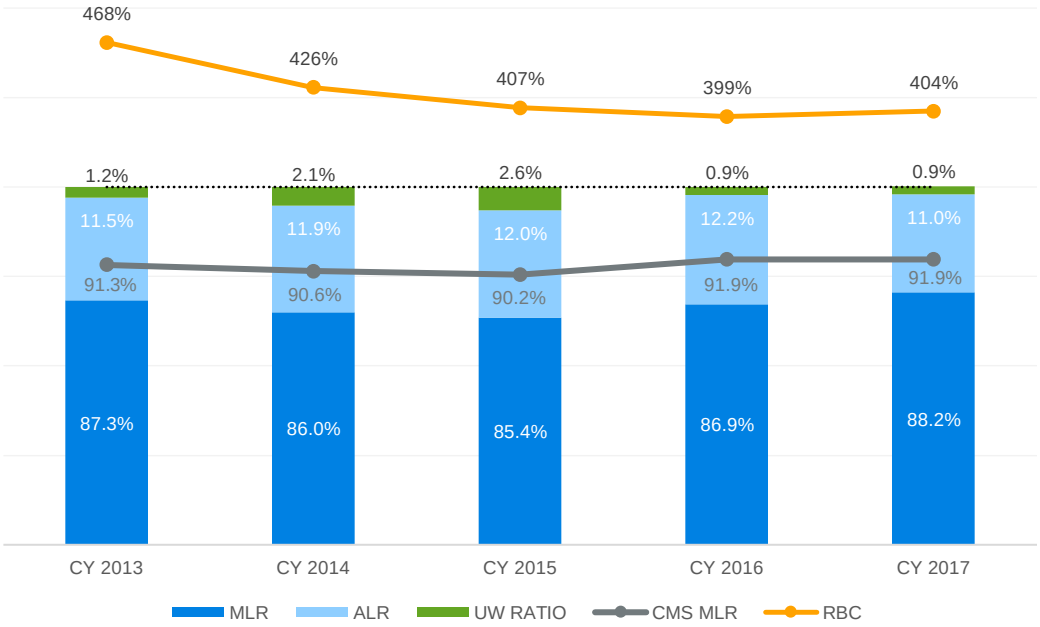


According to a recent study released by the Society of Actuaries, margin assumptions utilized in capitation rate setting generally vary from 0.5% to 2.5%.[4] Figure 4 illustrates that the actual reported underwriting results vary significantly from capitation rate setting assumptions at the entity level; however, in aggregate, the CY 2017 underwriting results of 0.9% are within the expected range. Of the 186 MCOs, over 60% of the entities reported positive underwriting gains in their Medicaid experience, with 115 reporting positive underwriting gains and 71 reporting losses.

[4] Society of Actuaries; Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting; Retrieved May 9, 2018, from https://www.soa.org/research-reports/2017/medicaid-margins/.

Over the past five years alone, the growth in Medicaid enrollment utilized in our analysis reflects over a 50% increase, with revenue nearly doubling, even after accounting for the Arizona MCOs for which additional information was first obtained for the 2015 update. Figure 5 summarizes the composite financial results for the most recent five-year period. The companies in each year are not the same; however, the criteria used to select the companies are consistent from year to year.

FIGURE 5: COMPOSITE FINANCIAL RESULTS



Notes

1. Values have been rounded.
2. Estimated CMS MLR developed to be consistent with prescribed CMS MLR calculation.

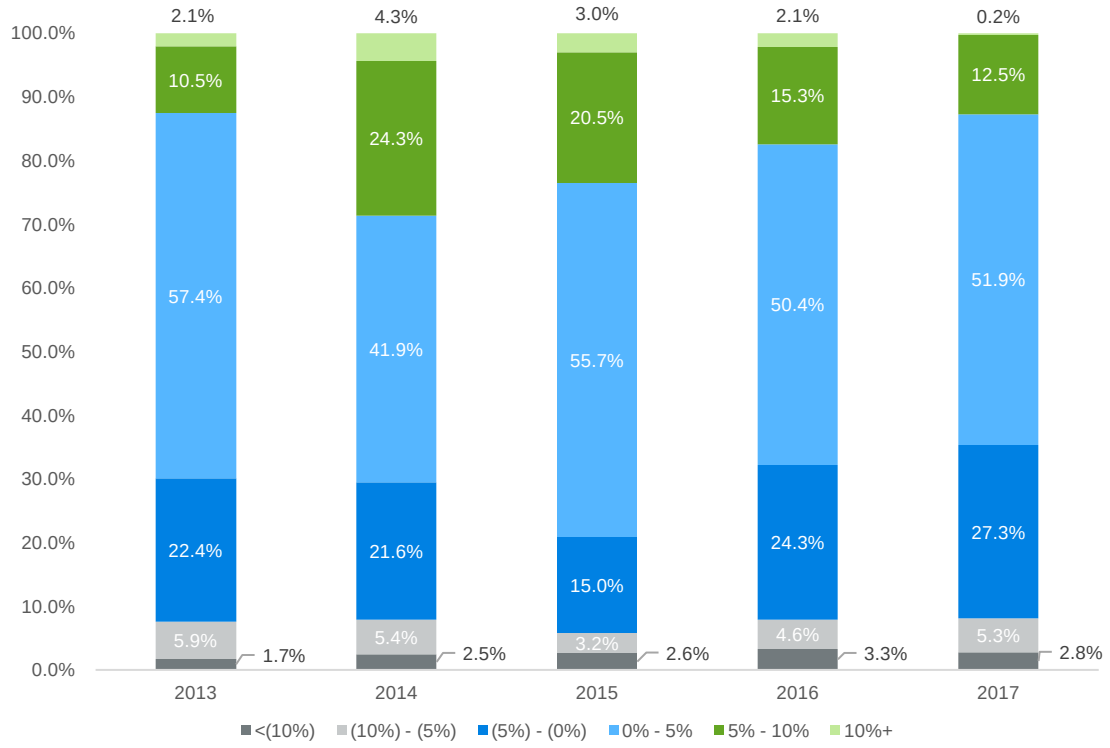
The results in Figure 5 illustrate a relatively consistent underwriting ratio between CY 2016 and CY 2017, with a 1.2% to 1.3% shift from the ALR to the MLR between the two years. The administrative cost analysis section of this report illustrates that the change in ALR and MLR appear to be primarily attributable to a decrease in the reported taxes and fees in CY 2017, which may be driven by the health insurance fee moratorium in CY 2017. Variances in the timing of how state Medicaid agencies reimburse MCOs for taxes and fees incurred and how the MCOs accrue this revenue and associated liability may impact this conclusion. The shift from ALR to MLR represents that, while the taxes have been historically paid to the MCOs as revenue and paid as an expense, the revenues paid to the MCOs for these taxes act as a pass-through and are not anticipated to change the at-risk portion of an MCO's business. Additionally, it would appear that the risk-based capital ratios are beginning to stabilize around the 400% level, down from the historical levels above 450% prior to Medicaid expansion efforts.

Because of the inconsistency between the MLR calculation based on information obtained from page 7 of the annual statement and that defined in the Medicaid and Children's Health Insurance Program (CHIP) managed care final rule (CMS-2390-F), we have estimated the CMS MLR, represented by the blue line in Figure 5. Consistent with the prior years' reports, we have estimated the CMS MLR under the definition prescribed in CMS-2390-F, by adjusting for quality improvement expenditures in the numerator and removal of applicable taxes and fees in the denominator. This change represents an increase to the composite MLR of approximately 4% to 5%. Based on the CMS MLR calculation, between 85% and 90% of the MCOs analyzed in this report would be at or above an 85% MLR. The 85% threshold is significant in that states may choose to implement a minimum MLR requirement of 85% or above in their MCO contracts, and the certified capitation rates must target an MLR of 85% or higher for rating periods starting

July 1, 2019, and after. Please note that the MLR calculated throughout the remainder of this report is not the estimated CMS MLR, but rather the one determined specifically as defined in Appendix 2.

While Figure 5 illustrates the overall changes in the underwriting results over the last five years, it is also important to understand how the underwriting results have varied across insurers. Figure 6 illustrates the distribution of underwriting results in the Medicaid managed care market for each calendar year from the MCOs included in our analysis.

FIGURE 6: DISTRIBUTION OF UNDERWRITING RESULTS BY YEAR



Note

1. The distribution is weighted by the revenue associated with each MCO's corresponding underwriting results.

It is interesting to note that, while the composite UW ratio has varied over the five-year historical period, the percentage of plans that have reported a loss over 5% has not varied as significantly. Conversely, the percentage of plans reporting an underwriting gain of over 5% has decreased significantly since the introduction of the expansion population in CY 2014.

The composite UW ratio reported by the MCOs in CY 2017 represents an aggregate underwriting gain of approximately $1.4 billion dollars in relation to the $166.6 billion of revenue received. CY 2017 marks the first year in which the summarized data reflects a relatively flat Medicaid managed care enrollment and revenue growth from the prior year's report. This stabilization of enrollment and revenue is attributable to relatively few states introducing new populations to managed care in CY 2017. However, with many states anticipated to either introduce coverage for the Medicaid expansion population or expand their current managed care programs, the Medicaid managed care enrollment and revenue trends may continue in future years.

The continued reporting and payment of funds related to the ACA-required health insurer assessment fee has had an impact on the MCO financials. It is important to note that the timing of receipt and reporting of the health insurer assessment fee amounts by the MCOs in this report, and potential corporate income tax gross-ups, vary across states and reporting entities. Therefore, we have not made any adjustments to the values in this report to account for these items. It is likely that this has caused a material variation in the reported revenues and the administrative expenses, especially due to the Health Insurer Fee (HIF) moratorium in the CY 2017 fee year.

Financial results by state

While the Medicaid managed care financial results are relatively stable at a nationwide level, the financial results may vary significantly from state to state. Figure 7 provides the average MLR, ALR, and UW ratio for each state or territory with at least one MCO included in this analysis. Please note that MCOs were assigned to their states of domicile, and results for MCOs that report operations from multiple states within one entity would therefore be included within a single state. For a limited number of MCOs, the state of domicile was manually adjusted to represent the state where the Medicaid business is currently operated. Additionally, the state of domicile, in certain cases, may contain only a limited number of MCOs operating in the state Medicaid managed care market to the extent certain MCOs operating in the state are excluded for reasons cited earlier in this report.

FIGURE 7: STATE OF DOMICILE

STATE OF DOMICILE	N	MLR	ALR	UW RATIO	RBC RATIO
ARIZONA	8	88.6%	10.2%	1.3%	N/A
COLORADO	1	85.7%	9.7%	4.6%	387%
DISTRICT OF COLUMBIA	3	79.1%	15.1%	5.8%	359%
FLORIDA	9	87.6%	10.2%	2.2%	336%
GEORGIA	4	83.5%	12.6%	3.8%	416%
HAWAII	4	88.8%	9.7%	1.6%	458%
IOWA	2	101.7%	7.0%	(8.7%)	244%
ILLINOIS	7	96.7%	8.8%	(5.5%)	322%
INDIANA	3	90.6%	9.1%	0.3%	429%
KANSAS	2	88.7%	11.0%	0.3%	438%
KENTUCKY	5	88.1%	8.9%	3.1%	474%
LOUISIANA	5	85.0%	13.3%	1.7%	351%
MARYLAND	4	86.1%	9.7%	4.2%	305%
MASSACHUSETTS	6	92.6%	7.5%	(0.1%)	389%
MICHIGAN	10	89.8%	8.6%	1.6%	333%
MINNESOTA	5	92.1%	7.8%	0.0%	570%
MISSISSIPPI	2	91.4%	12.8%	(4.2%)	328%
MISSOURI	3	92.5%	8.9%	(1.4%)	559%
NEBRASKA	3	92.7%	10.2%	(2.9%)	285%
NEVADA	3	84.9%	10.3%	4.7%	382%
NEW HAMPSHIRE	1	97.0%	12.5%	(9.4%)	319%
NEW JERSEY	4	86.3%	11.4%	2.3%	354%
NEW MEXICO	4	85.9%	16.0%	(1.9%)	398%
NEW YORK	7	91.3%	10.6%	(1.9%)	483%
OHIO	5	83.3%	14.2%	2.5%	355%
OREGON	2	92.1%	6.4%	1.5%	768%
PENNSYLVANIA	6	83.5%	12.9%	3.6%	413%
PUERTO RICO	3	91.0%	8.3%	0.7%	411%
RHODE ISLAND	2	90.7%	9.3%	(0.0%)	283%
SOUTH CAROLINA	5	88.0%	9.8%	2.2%	538%
TENNESSEE	3	84.9%	14.7%	0.5%	471%
TEXAS	21	89.3%	11.3%	(0.6%)	311%

FIGURE 7: STATE OF DOMICILE (CONTINUED)

STATE OF DOMICILE	N	MLR	ALR	UW RATIO	RBC RATIO
UTAH	3	86.5%	8.3%	5.2%	460%
VIRGINIA	5	87.1%	9.5%	3.4%	485%
WASHINGTON	5	86.4%	11.0%	2.6%	415%
WEST VIRGINIA	4	89.9%	8.4%	1.6%	420%
WISCONSIN	17	85.0%	13.1%	1.9%	453%

Administrative cost analysis

MEDICAID FOCUSED AND MEDICAID OTHER MCOS

The previous section of this report contains analysis of key financial metrics for 186 MCOs that reported operations in the Medicaid line of business, based on page 7 of the NAIC annual statement (*Analysis of Operations by Line of Business*). This section examines the administrative expenses reported by the MCOs on the *Underwriting and Investment Exhibit Part 3 – Analysis of Expenses* page. Because this information is only reported on an aggregate MCO level, detailed administrative expense information is not stratified by line of business (e.g., Medicaid). Therefore, the results presented in this section of the report are limited to the 94 MCOs that reported 90% or more of their total revenue from the Medicaid line of business[5] and are defined as "Medicaid focused." The administrative loss ratios reported by the Medicaid focused and the remaining 92 MCOs, which operate in multiple lines of business, were relatively consistent. The Medicaid focused MCOs account for approximately 52% of the Medicaid revenue summarized for purposes of this report, with an 11.0% ALR, 8.7% net of taxes and fees.

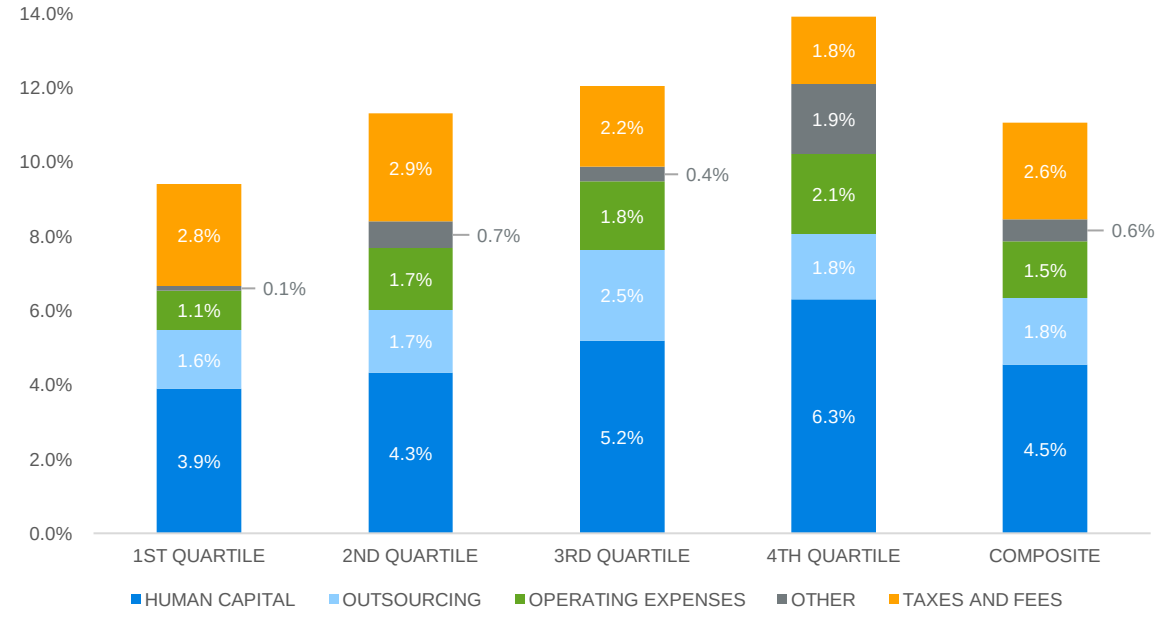
The remainder of this section summarizes the reported administrative costs for only the Medicaid focused MCOs. We additionally excluded eight Medicaid focused MCOs operating in the state of Arizona, resulting in a sample size of 86 MCOs. The information received for the Arizona MCOs was obtained outside of the NAIC annual statement information and did not contain the level of administrative cost detail necessary to develop the metrics illustrated in this report.

SUMMARY OF RESULTS

The primary expense categories that are used in the *Analysis of Operations by Line of Business* page include the claim adjustment expenses (CAE) and general administrative expenses (GAE). The CAE and GAE categories are further stratified by additional subcategories of expenses in the *Underwriting and Investment Exhibit Part 3 – Analysis of Expenses* page, which is the basis of the administrative expense categories illustrated in this administrative cost analysis.

Figure 8 summarizes the CY 2017 administrative expenses for the 86 companies meeting the criteria selected for this study by quartile of ALR performance. The administrative expenses are stratified by administrative cost categories summarized from the *Underwriting and Investment Exhibit Part 3 – Analysis of Expenses* page.[6]

FIGURE 8: ADMINISTRATIVE LOSS RATIO BY QUARTILE OF ALR PERFORMANCE



Note: Companies were ranked and grouped by the ALR net of taxes and fees.

[5] Revenue amounts not listed under the Title XIX Medicaid line of business are considered non-Medicaid for purposes of this report. To the extent that CHIP or other Medicaid revenue is reported in a line of business other than Medicaid, a plan may be excluded from the administrative cost section of this report.

[6] Further information on the administrative expense category classification is available in Appendix 2.

The results in Figure 8 illustrate the importance of analyzing the administrative costs net of taxes and fees, as the taxes and fees represent a significant but generally uncontrollable portion of the administrative costs incurred by an MCO. The taxes and fees levied on the MCOs vary greatly from state to state, making it difficult to analyze the reported administrative expenses without this adjustment.

In composite, MCOs grouped in the fourth quartile have higher administrative costs across all expense types than MCOs grouped in the first quartile. Human capital, costs related to salaries, wages, and other items specific to in-house staffing resources, accounts for the majority of the increase in administrative costs between MCOs in the first and second quartile versus the third and fourth quartiles. Differences between the first and second quartile are primarily attributable to operating and other expenses.

Figures 9 and 10 summarize the composite revenue and administrative expenses for the most recent five-year period for all companies matching the inclusion criteria indicated in this report. Unlike other figures in this report illustrating multiple years of financial results across all MCOs, the financial information included in Figures 9 and 10 has been limited to a consistent set of 54 MCOs that were in operation between CY 2013 and CY 2017. This limitation facilitates a more consistent review of the year-over-year administrative cost changes experienced by a closed group of MCOs.

FIGURE 9: ADMINISTRATIVE COST PMPM NET OF TAXES AND FEES BY YEAR

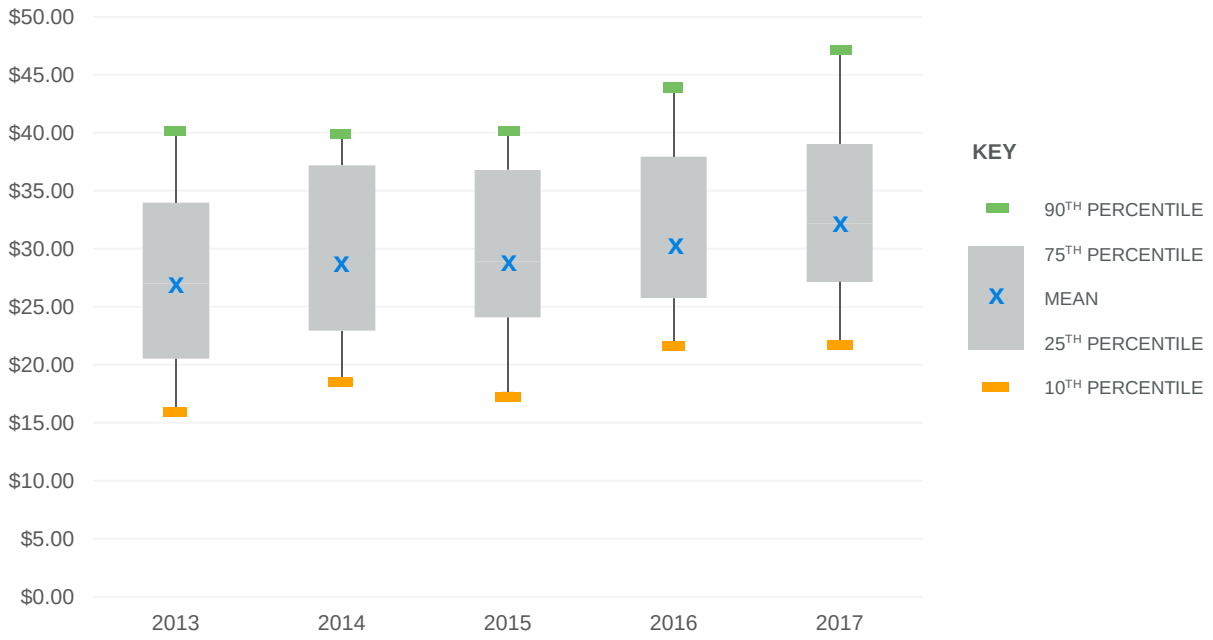
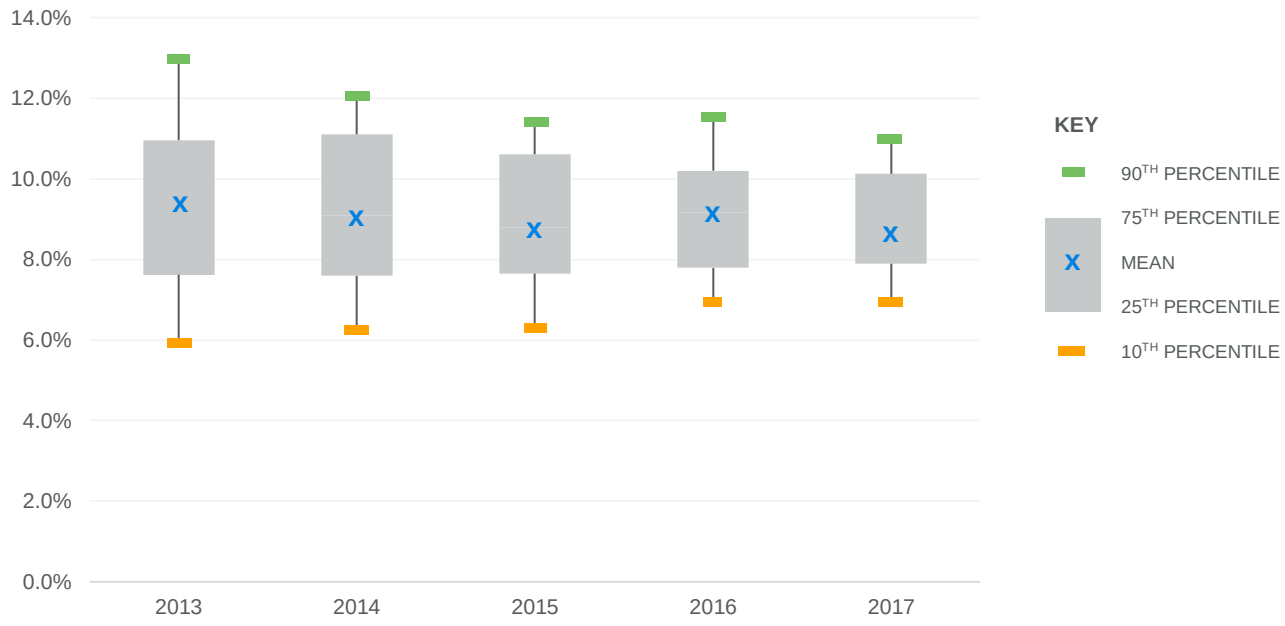


Figure 9 illustrates a consistent increase in the reported administrative cost PMPM from CY 2013 to CY 2017; however, the ALR net of taxes and fees observed in Figure 10 has been slightly decreasing over the same period. The PMPM increase from CY 2013 to CY 2017 is likely attributable to general inflationary trends as well as changes in the membership covered by the MCOs in this study, such as the introduction of Medicaid expansion members (which is likely a major contributor to the significant increase from CY 2013 to CY 2014), disabled members, and members requiring long-term services and supports, all of which have a higher claim and administrative cost. Transitioning more costly populations to managed care is anticipated to exert upward pressure on the administrative cost PMPM in the coming years, although the administrative costs may be partially offset by increased administrative efficiencies of the MCOs providing Medicaid coverage to a broader membership base.

While the administrative cost PMPM may be utilized to understand the administrative cost per member, the ALR represents the proportion of revenue that was used by the MCO to fund administrative expenses. Figure 10 illustrates the 10th, 25th, 75th, and 90th percentiles, as well as the mean, of the ALR net of taxes and fees over the last five years through a box plot format.

FIGURE 10: ALR NET OF TAXES AND FEES BY YEAR



Note: The ALR net of taxes and fees excludes taxes and fees from the numerator and denominator of the ALR calculation.

The ALR net of taxes and fees has generally decreased over the last five years. This result may be attributable to the introduction of more costly populations into managed care, as previously discussed. While more costly populations generally require greater administrative resources on a per member basis, the administrative expense is generally a lesser proportion of the total medical and administrative cost of providing services for these populations.

Additionally, the range of reported ALRs net of taxes and fees between CY 2013 and CY 2017 has notably decreased. In CY 2013, the difference between the 25th and 75th percentile of the ALR net of taxes and fees was 3.3%, and has since decreased to 2.2% in CY 2017. This variance again may be attributable to the disruptions in the Medicaid managed care market in CY 2013 and CY 2014 as the MCOs prepared to serve the new Medicaid expansion population.

Conclusion

Risk-based managed care represents a large portion of total Medicaid expenditures for CY 2017 and the amount of expenditures will continue to grow as Medicaid programs are anticipated to continue shifting membership to managed care organizations. Additional transition of members is also occurring for other populations that have traditionally been operated under fee-for-service arrangements. MCOs are an integral part of this delivery system and their financial results will help us understand the continued sustainability of risk-based managed care.

The results provide reference and benchmarking information for certain key financial metrics used in the day-to-day analysis of Medicaid MCO financial performance. It will be important to continue monitoring the results over time as the world of healthcare finance continues to evolve and pose new challenges.

Limitations and data reliance

The results contained in this report were compiled using data and information obtained from the statutory annual statements for Medicaid MCOs filed with the respective state insurance regulators. The annual statements were retrieved as of May 7, 2018, from an online database. In addition to the limiting criteria used to select companies in this report, certain MCOs may be omitted from this report because of the timing of annual statement submissions or their exclusions from the online database. For example, California is known to operate managed care programs, but they are not included in this report because there were no annual statements found in the online database for them.

The information was relied upon as reported and without audit. We performed a limited review of the data for reasonableness and consistency. To the extent that the data reported contained material errors or omissions, the values contained within this report would likewise contain similar reporting errors.

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Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Appendix 1: Financial metrics and MCO characteristics

In addition to the figures illustrated in the body of this report, we have analyzed the financial metrics stratified by certain MCO characteristics to understand the potential impact these characteristics have on the reported financial results. The figures in Appendix 1 illustrates the following financial metrics and MCO characteristics:

Financial metrics

- Medical loss ratio
- Underwriting ratio
- Risk-based capital ratio
- Administrative loss ratio
- Administrative loss ratio net of taxes and fees (Medicaid focused MCOs only)
- Administrative cost per member per month (PMPM) net of taxes and fees (Medicaid focused MCOs only)

MCO characteristics

- CMS region (see chart in Appendix 3)
- Annual Medicaid revenue
- Annual Medicaid revenue PMPM
- MCO type (Medicaid focused versus all other MCOs)
- MCOs operating in five or more states
- MCO financial structure
- State Medicaid expansion status
- Underwriting gain/loss

FIGURE 11: MEDICAL LOSS RATIO: CY 2017 RESULTS

MCO GROUPING	CATEGORY	N	REVENUE (IN $ BILLIONS)	PERCENTILE MEAN	10TH	25TH	50TH	75TH	90TH
COMPOSITE	COMPOSITE	186	166.6	88.2%	80.5%	84.1%	88.4%	91.6%	95.6%
CMS REGION	REGION 1	9	7.3	92.3%	88.2%	90.5%	91.1%	94.2%	97.0%
	REGION 2	14	13.3	89.6%	86.2%	86.9%	90.8%	91.9%	92.5%
	REGION 3	22	17.4	85.1%	79.0%	80.6%	86.4%	90.8%	92.2%
	REGION 4	28	36.4	87.0%	80.3%	84.0%	87.5%	90.3%	91.6%
	REGION 5	47	39.6	88.7%	78.7%	84.1%	87.8%	92.2%	95.8%
	REGION 6	30	29.3	87.9%	79.8%	83.5%	87.3%	92.2%	94.8%
	REGION 7	10	7.8	95.0%	87.1%	88.4%	90.7%	98.0%	101.3%
	REGION 8	4	0.8	86.3%	81.5%	82.4%	84.5%	88.0%	90.4%
	REGION 9	15	8.7	87.9%	83.9%	84.8%	88.3%	91.9%	111.3%
	REGION 10	7	6.0	86.9%	83.0%	84.1%	89.5%	91.4%	92.5%
ANNUAL REVENUE	$10 TO $250 MILLION	44	5.2	86.8%	75.7%	83.6%	87.0%	90.7%	95.0%
	$250 TO $600 MILLION	43	17.2	90.0%	80.3%	85.2%	90.0%	92.2%	98.0%
	$600 MILLION TO $1.2 BILLION	45	40.2	87.2%	80.7%	83.8%	87.1%	91.4%	92.9%
	MORE THAN $1.2 BILLION	54	103.9	88.4%	82.8%	85.9%	89.0%	91.6%	94.7%
REVENUE PMPM	LESS THAN $290	54	23.0	88.0%	78.8%	83.8%	87.6%	91.2%	96.0%
	$290 TO $425	69	62.0	87.8%	80.6%	84.4%	88.8%	91.6%	95.8%
	MORE THAN $425	63	81.6	88.6%	80.6%	85.7%	89.4%	91.9%	94.7%
MCO TYPE	MEDICAID FOCUSED	94	85.7	88.0%	80.6%	83.8%	88.0%	91.4%	95.8%
	MEDICAID OTHER	92	80.9	88.4%	80.2%	84.5%	88.6%	91.8%	94.7%
MULTISTATE OPERATIONS	FIVE OR MORE	94	101.2	87.7%	80.5%	83.8%	87.4%	91.2%	95.6%
	LESS THAN FIVE	92	65.4	89.0%	80.3%	85.6%	89.5%	92.2%	95.0%
MCO FINANCIAL STRUCTURE	FOR-PROFIT	130	119.8	87.8%	80.2%	83.8%	87.5%	91.2%	95.1%
	NONPROFIT	56	46.7	89.3%	83.8%	86.4%	90.6%	92.4%	98.6%
EXPANSION STATUS	EXPANSION STATE	106	105.1	88.3%	80.6%	84.7%	88.8%	92.2%	97.0%
	NON-EXPANSION STATE	80	61.5	88.0%	80.3%	84.1%	87.9%	90.7%	92.7%
GAIN/(LOSS) POSITION	REPORTED A GAIN	114	107.6	85.7%	79.0%	83.0%	85.6%	88.6%	90.5%
	REPORTED A LOSS	72	58.9	92.8%	87.7%	90.4%	92.1%	95.7%	100.1%

FIGURE 12: UNDERWRITING RATIO: CY 2017 RESULTS

MCO GROUPING	CATEGORY	N	REVENUE (IN $ BILLIONS)	PERCENTILE MEAN	10TH	25TH	50TH	75TH	90TH
COMPOSITE	COMPOSITE	186	166.6	0.9%	(6.8%)	(1.9%)	1.3%	3.7%	6.6%
CMS REGION	REGION 1	9	7.3	(0.4%)	(9.4%)	(0.4%)	(0.3%)	2.1%	3.2%
	REGION 2	14	13.3	(0.1%)	(3.0%)	(2.0%)	0.1%	2.5%	3.3%
	REGION 3	22	17.4	3.6%	(0.6%)	1.0%	2.3%	6.6%	8.3%
	REGION 4	28	36.4	1.8%	(4.9%)	(0.6%)	1.7%	5.0%	6.8%
	REGION 5	47	39.6	0.6%	(5.3%)	(1.1%)	1.3%	3.2%	7.3%
	REGION 6	30	29.3	(0.3%)	(8.7%)	(3.0%)	0.3%	3.9%	4.7%
	REGION 7	10	7.8	(4.0%)	(9.8%)	(7.0%)	(0.4%)	1.7%	3.0%
	REGION 8	4	0.8	5.1%	3.0%	3.8%	6.2%	7.9%	7.9%
	REGION 9	15	8.7	2.0%	(17.4%)	(6.9%)	1.6%	3.4%	6.2%
	REGION 10	7	6.0	2.5%	(4.0%)	0.8%	1.4%	4.9%	5.7%
ANNUAL REVENUE	$10 TO $250 MILLION	44	5.2	1.9%	(15.4%)	(1.7%)	2.0%	4.7%	8.5%
	$250 TO $600 MILLION	43	17.2	(0.7%)	(9.4%)	(2.9%)	0.0%	3.2%	5.7%
	$600 MILLION TO $1.2 BILLION	45	40.2	1.4%	(5.3%)	(1.1%)	1.8%	3.9%	7.8%
	MORE THAN $1.2 BILLION	54	103.9	0.8%	(4.3%)	(1.9%)	1.0%	3.4%	4.9%
REVENUE PMPM	LESS THAN $290	54	23.0	1.0%	(9.8%)	(1.1%)	1.6%	4.1%	7.8%
	$290 TO $425	69	62.0	1.2%	(6.9%)	(2.0%)	1.5%	3.8%	7.3%
	MORE THAN $425	63	81.6	0.5%	(5.3%)	(2.0%)	1.0%	3.3%	5.0%
MCO TYPE	MEDICAID FOCUSED	94	85.7	1.0%	(6.9%)	(1.4%)	1.6%	4.1%	6.6%
	MEDICAID OTHER	92	80.9	0.7%	(6.6%)	(1.9%)	1.0%	3.4%	6.4%
MULTISTATE OPERATIONS	FIVE OR MORE	94	101.2	1.1%	(6.1%)	(1.4%)	1.6%	4.6%	7.5%
	LESS THAN FIVE	92	65.4	0.4%	(6.9%)	(1.9%)	1.1%	2.9%	4.9%
MCO FINANCIAL STRUCTURE	FOR-PROFIT	130	119.8	1.0%	(6.7%)	(1.7%)	1.6%	4.6%	7.8%
	NONPROFIT	56	46.7	0.5%	(8.8%)	(1.9%)	1.0%	2.8%	3.9%
EXPANSION STATUS	EXPANSION STATE	106	105.1	0.9%	(9.4%)	(2.0%)	1.3%	3.6%	6.2%
	NON-EXPANSION STATE	80	61.5	0.8%	(5.5%)	(1.3%)	1.4%	4.0%	7.7%
GAIN/(LOSS) POSITION	REPORTED A GAIN	114	107.6	3.2%	0.9%	1.6%	3.2%	5.0%	7.9%
	REPORTED A LOSS	72	58.9	(3.5%)	(14.1%)	(6.8%)	(2.9%)	(0.9%)	(0.3%)

FIGURE 13: RISK-BASED CAPITAL RATIO: CY 2017 RESULTS

			REVENUE		PERCENTILE				
MCO GROUPING	CATEGORY	N	(IN $ BILLIONS)	MEAN	10TH	25TH	50TH	75TH	90TH
COMPOSITE	COMPOSITE	178	161.1	404%	255.5%	314%	381%	477%	631%
CMS REGION	REGION 1	9	7.3	366%	210%	319%	379%	410%	595%
	REGION 2	14	13.3	456%	294%	345%	413%	568%	743%
	REGION 3	22	17.4	411%	232%	315%	409%	499%	574%
	REGION 4	28	36.4	405%	255%	314%	379%	589%	702%
	REGION 5	47	39.6	417%	274%	315%	389%	470%	575%
	REGION 6	30	29.3	330%	217%	289%	344%	448%	608%
	REGION 7	10	7.8	343%	240%	300%	315%	477%	968%
	REGION 8	4	0.8	453%	387%	388%	429%	533%	598%
	REGION 9	7	3.3	430%	303%	312%	400%	539%	594%
	REGION 10	7	6.0	473%	340%	361%	428%	737%	971%
ANNUAL REVENUE	$10 TO $250 MILLION	42	5.0	509%	293%	348%	416%	575%	749%
	$250 TO $600 MILLION	40	16.0	454%	259%	308%	406%	565%	716%
	$600 MILLION TO $1.2 BILLION	44	39.4	433%	313%	329%	400%	475%	649%
	MORE THAN $1.2 BILLION	52	100.8	360%	233%	289%	335%	402%	473%
REVENUE PMPM	LESS THAN $290	49	19.4	433%	245%	323%	389%	530%	718%
	$290 TO $425	67	60.5	371%	263%	305%	372%	456%	595%
	MORE THAN $425	62	81.3	415%	255%	326%	399%	496%	649%
MCO TYPE	MEDICAID FOCUSED	86	80.2	386%	274%	315%	377%	496%	677%
	MEDICAID OTHER	92	80.9	413%	255%	313%	389%	473%	575%
MULTISTATE OPERATIONS	FIVE OR MORE	91	98.7	369%	289%	315%	362%	445%	595%
	LESS THAN FIVE	87	62.4	441%	231%	313%	433%	539%	631%
MCO FINANCIAL STRUCTURE	FOR-PROFIT	125	116.3	385%	274%	310%	368%	466%	620%
	NONPROFIT	53	44.9	441%	210%	318%	451%	539%	631%
EXPANSION STATUS	EXPANSION STATE	98	99.6	417%	255%	319%	380%	467%	631%
	NON-EXPANSION STATE	80	61.5	384%	261%	301%	384%	491%	657%
GAIN/(LOSS) POSITION	REPORTED A GAIN	111	104.6	418%	303%	333%	413%	537%	695%
	REPORTED A LOSS	67	56.5	386%	210%	271%	345%	419%	548%

Note: Arizona MCOs were excluded from this table, as RBC ratio information was not available.

FIGURE 14: ADMINISTRATIVE LOSS RATIO: CY 2017 RESULTS

			REVENUE	PERCENTILE					
MCO GROUPING	CATEGORY	N	(IN $ BILLIONS)	MEAN	10TH	25TH	50TH	75TH	90TH
COMPOSITE	COMPOSITE	186	166.6	11.0%	7.1%	9.0%	10.7%	13.0%	15.9%
CMS REGION	REGION 1	9	7.3	8.2%	6.0%	6.9%	9.2%	9.5%	12.5%
	REGION 2	14	13.3	10.5%	6.4%	8.7%	10.2%	11.8%	14.0%
	REGION 3	22	17.4	11.3%	7.4%	9.2%	10.1%	12.8%	16.2%
	REGION 4	28	36.4	11.2%	8.0%	9.3%	11.0%	13.5%	14.8%
	REGION 5	47	39.6	10.8%	6.7%	8.5%	10.5%	14.4%	16.6%
	REGION 6	30	29.3	12.4%	9.8%	11.4%	12.5%	15.0%	17.6%
	REGION 7	10	7.8	8.9%	7.0%	8.1%	9.7%	10.0%	11.5%
	REGION 8	4	0.8	8.7%	6.6%	7.7%	9.2%	10.2%	10.7%
	REGION 9	15	8.7	10.1%	7.8%	8.3%	10.3%	13.1%	14.8%
	REGION 10	7	6.0	10.6%	6.3%	6.6%	11.0%	12.1%	12.6%
ANNUAL REVENUE	$10 TO $250 MILLION	44	5.2	11.3%	6.9%	9.7%	11.9%	14.3%	20.1%
	$250 TO $600 MILLION	43	17.2	10.7%	6.6%	9.2%	10.4%	12.5%	14.3%
	$600 MILLION TO $1.2 BILLION	45	40.2	11.4%	7.6%	9.1%	11.6%	13.1%	15.7%
	MORE THAN $1.2 BILLION	54	103.9	10.8%	7.3%	8.8%	9.8%	12.1%	14.5%
REVENUE PMPM	LESS THAN $290	54	23.0	11.0%	8.2%	9.3%	11.2%	13.8%	17.0%
	$290 TO $425	69	62.0	11.0%	6.6%	8.8%	10.5%	12.7%	15.0%
	MORE THAN $425	63	81.6	10.9%	6.9%	8.6%	10.0%	12.8%	15.1%
MCO TYPE	MEDICAID FOCUSED	94	85.7	11.0%	8.0%	9.3%	10.5%	12.8%	14.8%
	MEDICAID OTHER	92	80.9	10.9%	6.7%	8.6%	10.7%	13.3%	16.6%
MULTISTATE OPERATIONS	FIVE OR MORE	94	101.2	11.2%	8.3%	9.5%	11.0%	13.0%	15.1%
	LESS THAN FIVE	92	65.4	10.6%	6.6%	8.3%	10.3%	13.0%	16.6%
MCO FINANCIAL STRUCTURE	FOR-PROFIT	130	119.8	11.2%	8.2%	9.3%	11.1%	13.5%	15.9%
	NONPROFIT	56	46.7	10.2%	6.3%	7.5%	9.4%	11.8%	15.7%
EXPANSION STATUS	EXPANSION STATE	106	105.1	10.8%	6.6%	8.3%	9.9%	12.8%	15.7%
	NON-EXPANSION STATE	80	61.5	11.2%	8.3%	9.7%	11.3%	13.2%	15.9%
GAIN/(LOSS) POSITION	REPORTED A GAIN	114	107.6	11.1%	6.9%	8.9%	10.5%	12.8%	15.1%
	REPORTED A LOSS	72	58.9	10.7%	7.2%	9.2%	10.9%	13.8%	16.4%

FIGURE 15: ADMINISTRATIVE LOSS RATIO NET OF TAXES (MEDICAID FOCUSED MCOS): CY 2017 RESULTS

			REVENUE	PERCENTILE					
MCO GROUPING	CATEGORY	N	(IN $ BILLIONS)	MEAN	10TH	25TH	50TH	75TH	90TH
COMPOSITE	COMPOSITE	86	80.2	8.7%	6.9%	7.9%	9.3%	10.6%	12.7%
CMS REGION	REGION 1	3	1.8	8.4%	7.7%	7.7%	9.6%	10.9%	10.9%
	REGION 2	5	4.6	9.2%	8.4%	9.2%	9.3%	9.8%	12.7%
	REGION 3	11	6.3	10.1%	9.0%	9.0%	10.9%	11.4%	12.4%
	REGION 4	17	19.3	9.5%	7.8%	8.8%	10.0%	11.2%	13.2%
	REGION 5	19	23.4	7.5%	5.0%	6.6%	8.5%	9.6%	12.7%
	REGION 6	14	13.7	9.0%	6.9%	7.9%	8.9%	10.0%	11.9%
	REGION 7	9	7.4	8.0%	6.9%	7.2%	8.9%	9.5%	11.1%
	REGION 8	1	0.1	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%
	REGION 9	3	1.0	9.4%	8.0%	8.0%	10.0%	11.9%	11.9%
	REGION 10	4	2.7	8.4%	6.3%	6.9%	8.3%	9.9%	10.6%
ANNUAL REVENUE	$10 TO $250 MILLION	12	1.7	10.7%	8.7%	9.4%	10.4%	12.2%	16.0%
	$250 TO $600 MILLION	23	9.4	9.7%	6.9%	9.0%	9.8%	11.1%	12.7%
	$600 MILLION TO $1.2 BILLION	28	24.7	9.2%	6.9%	7.8%	8.9%	10.3%	13.2%
	MORE THAN $1.2 BILLION	23	44.4	8.1%	6.6%	7.2%	8.4%	9.3%	10.4%
REVENUE PMPM	LESS THAN $290	19	9.7	9.7%	7.4%	8.9%	9.8%	10.6%	13.3%
	$290 TO $425	42	35.8	9.0%	7.6%	8.0%	9.3%	10.9%	11.9%
	MORE THAN $425	25	34.7	8.1%	6.6%	7.1%	8.5%	10.5%	12.7%
MULTISTATE OPERATIONS	FIVE OR MORE	56	51.8	9.0%	7.1%	7.9%	9.3%	10.9%	12.4%
	LESS THAN FIVE	30	28.5	8.1%	5.8%	7.6%	9.3%	10.3%	13.0%
MCO FINANCIAL STRUCTURE	FOR-PROFIT	66	58.8	9.0%	7.2%	8.1%	9.3%	10.9%	12.7%
	NONPROFIT	20	21.4	7.7%	5.0%	7.0%	9.1%	10.0%	10.9%
EXPANSION STATUS	EXPANSION STATE	49	53.1	8.1%	6.4%	7.6%	8.8%	10.0%	12.4%
	NON-EXPANSION STATE	37	27.2	9.8%	7.9%	8.9%	9.8%	10.9%	12.9%
GAIN/(LOSS) POSITION	REPORTED A GAIN	57	55.3	8.7%	6.9%	7.9%	9.3%	10.2%	11.9%
	REPORTED A LOSS	29	24.9	8.7%	6.9%	8.1%	9.3%	11.1%	12.7%

Note: This table is limited to Medicaid focused MCOs. Arizona MCOs were additionally excluded from this table, as detailed administrative cost information was not available.

FIGURE 16: ADMINISTRATIVE COSTS PMPM NET OF TAXES (MEDICAID FOCUSED MCOS): CY 2017 RESULTS

			REVENUE		PERCENTILE				
MCO GROUPING	CATEGORY	N	(IN $ BILLIONS)	MEAN	10TH	25TH	50TH	75TH	90TH
COMPOSITE	COMPOSITE	86	80.2	$ 32.69	$ 20.75	$ 27.68	$ 32.65	$ 40.53	$ 48.94
CMS REGION	REGION 1	3	1.8	$ 42.67	$ 34.60	$ 34.60	$ 40.86	$ 45.00	$ 45.00
	REGION 2	5	4.6	$ 29.85	$ 16.69	$ 17.39	$ 36.43	$ 43.65	$ 88.93
	REGION 3	11	6.3	$ 38.96	$ 27.69	$ 31.01	$ 39.85	$ 47.67	$ 56.45
	REGION 4	17	19.3	$ 33.75	$ 24.14	$ 29.84	$ 34.20	$ 38.03	$ 46.73
	REGION 5	19	23.4	$ 30.81	$ 15.76	$ 27.57	$ 30.18	$ 39.28	$ 47.62
	REGION 6	14	13.7	$ 31.44	$ 20.79	$ 25.98	$ 28.78	$ 33.10	$ 59.83
	REGION 7	9	7.4	$ 37.16	$ 17.97	$ 26.00	$ 38.81	$ 48.33	$ 64.92
	REGION 8	1	0.1	$ 21.22	$ 21.22	$ 21.22	$ 21.22	$ 21.22	$ 21.22
	REGION 9	3	1.0	$ 29.59	$ 27.68	$ 27.68	$ 33.52	$ 38.98	$ 38.98
	REGION 10	4	2.7	$ 25.85	$ 20.75	$ 23.55	$ 27.98	$ 30.01	$ 30.40
ANNUAL REVENUE	$10 TO $250 MILLION	12	1.7	$ 31.61	$ 20.79	$ 25.35	$ 33.04	$ 45.66	$ 63.65
	$250 TO $600 MILLION	23	9.4	$ 31.26	$ 17.46	$ 26.35	$ 33.10	$ 40.86	$ 45.73
	$600 MILLION TO $1.2 BILLION	28	24.7	$ 31.92	$ 17.89	$ 26.79	$ 30.01	$ 38.45	$ 64.92
	MORE THAN $1.2 BILLION	23	44.4	$ 33.66	$ 27.04	$ 28.31	$ 36.43	$ 40.53	$ 47.62
REVENUE PMPM	LESS THAN $290	19	9.7	$ 23.16	$ 16.69	$ 17.89	$ 23.98	$ 29.61	$ 31.48
	$290 TO $425	42	35.8	$ 30.76	$ 26.35	$ 28.31	$ 31.38	$ 38.98	$ 41.87
	MORE THAN $425	25	34.7	$ 41.49	$ 34.20	$ 37.45	$ 45.73	$ 56.45	$ 88.93
MULTISTATE OPERATIONS	FIVE OR MORE	56	51.8	$ 34.14	$ 24.47	$ 28.78	$ 34.93	$ 41.36	$ 48.33
	LESS THAN FIVE	30	28.5	$ 30.11	$ 16.85	$ 20.79	$ 30.35	$ 39.28	$ 60.05
MCO FINANCIAL STRUCTURE	FOR-PROFIT	66	58.8	$ 33.76	$ 24.14	$ 28.31	$ 34.36	$ 40.86	$ 48.94
	NONPROFIT	20	21.4	$ 29.64	$ 16.38	$ 19.32	$ 28.86	$ 38.93	$ 51.59
EXPANSION STATUS	EXPANSION STATE	49	53.1	$ 33.66	$ 26.35	$ 28.31	$ 35.61	$ 40.86	$ 48.94
	NON-EXPANSION STATE	37	27.2	$ 31.23	$ 17.89	$ 24.14	$ 31.01	$ 38.03	$ 56.45
GAIN/(LOSS) POSITION	REPORTED A GAIN	57	55.3	$ 32.85	$ 20.79	$ 27.68	$ 31.09	$ 39.28	$ 59.83
	REPORTED A LOSS	29	24.9	$ 32.33	$ 17.39	$ 28.31	$ 38.03	$ 42.34	$ 48.33

Note: This table is limited to Medicaid focused MCOs. Arizona MCOs were additionally excluded from this table, as detailed administrative cost information was not available.

Appendix 2: Definition of financial metrics

The financial metrics calculated for purposes of this report include the medical loss ratio (MLR), underwriting ratio (UW ratio), risk-based capital ratio (RBC ratio), administrative loss ratio (ALR), and administrative cost PMPM. These selected metrics focus primarily on the income statement values of the financial statement, with the exception of the RBC ratio, which is a capital (or solvency) measure.

The financial metrics selected encompass five of the primary ratios used by MCOs, state Medicaid agencies, and other stakeholders to evaluate the financial performance of an MCO. The metrics are defined in greater detail below.

MEDICAL LOSS RATIO (MLR)

MLR is a common financial metric used to report and benchmark the financial performance of an MCO. The MLR represents the proportion of revenue that was used by the MCO to fund claim expenses. The MLR is stated as a percentage, with claim expense in the numerator and revenue in the denominator.

In terms of the statutory annual statement, the MLR was defined as follows:

$$\text{MLR} = \frac{\text{TOTAL HOSPITAL AND MEDICAL EXPENSES + INCREASE IN RESERVES FOR A\&H CONTRACTS}}{\text{TOTAL REVENUE}}$$

WHERE: TOTAL HOSPITAL AND MEDICAL EXPENSES: TITLE XIX–MEDICAID (P.7, L.17, C.8)
INCREASE IN RESERVES FOR ACCIDENT AND HEALTH (A&H) CONTRACTS: TITLE XIX–MEDICAID (P.7, L.21, C.8)
TOTAL REVENUE: TITLE XIX–MEDICAID (P.7, L.7, C.8)

Certain states include pass-through type programs such as franchise fees or provider taxes. This would also include amounts related to the health insurer assessment fee and applicable income tax gross-ups. These items may or may not be included in the total revenue reported by the MCO because the reporting practices vary among plans. If reported in the total revenue, there should be a corresponding offset amount included in the administrative costs for this as well.

Actuaries and financial analysts use the MLR as a measure of premium adequacy and often compare the resulting MLR with a “target” level. The MLR alone is not sufficient to compare MCO financial results among various states and programs. The target loss ratios (the claim cost included in the premium or capitation rate) vary by state and populations enrolled. Additionally, there may be reporting differences among MCOs as to what is classified as medical expense versus administrative expense.

As previously noted, the definition of MLR for purposes of this report may not be consistent with other definitions, in particular the Medicaid and CHIP managed care final rule (CMS-2390-F). The Medicaid and CHIP managed care final rule allows for the reduction of taxes, licensing, and regulatory fees from the revenue, a credibility adjustment, as well as the addition of quality improvement expenditures to the hospital and medical expenses in the numerator. The estimated CMS MLR in Figure 5 above includes a 2% adjustment for quality improvement expenditures and removal of estimated Medicaid taxes, licensing, and regulatory fees from the revenue, which generally results in an additional 2% to 3% increase in the CMS MLR. However, other provisions, such as the exclusion of pass-through payments from the numerator and denominator of the MLR formula, could decrease the MLR percentage.

UNDERWRITING RATIO

The UW ratio is the sum of the MLR and the ALR (defined below) subtracted from 100%. A positive UW ratio indicates a financial gain, while a negative UW ratio indicates a loss. This financial metric is used to report and benchmark the financial performance of an MCO in consideration of both medical and administrative expenses. The UW ratio represents the proportion of revenue that was “left over” to fund the MCO’s contribution to surplus and profit after funding medical and administrative expenses. The UW ratio is stated as a percentage, with total underwriting gain or loss in the numerator and revenue in the denominator.

In terms of the statutory annual statement, the UW ratio was defined as follows:

$$\text{UW RATIO} = \frac{\text{NET UNDERWRITING GAIN OR (LOSS)}}{\text{TOTAL REVENUE}}$$

WHERE: NET UNDERWRITING GAIN OR (LOSS): TITLE XIX–MEDICAID (P.7, L.24, C.8)
TOTAL REVENUE: TITLE XIX–MEDICAID (P.7, L.7, C.8)

The UW ratio is focused on the income from operations and excludes consideration of investment income and income taxes. The UW ratio requires interpretation and considerations similar in nature to the MLR and ALR metrics outlined above.

RISK-BASED CAPITAL RATIO (RBC RATIO)

The RBC ratio is a financial metric used by many insurance regulators to monitor the solvency of the MCOs. The RBC ratio represents the proportion of the required minimum capital that is held by the MCO as of a specific date (the end of the financial reporting period). The RBC ratio is stated as a percentage or a ratio, with total adjusted capital (TAC) in the numerator and authorized control level (ACL) in the denominator.

The NAIC prescribes a specific formula to develop both the TAC and the ACL. Further, the MCO is subjected to various action levels based on the resulting RBC ratio, as follows:

- Company action level (TAC is between 150% and 200% of the ACL RBC)
- Regulatory action level (TAC is between 100% and 150% of the ACL RBC)
- Authorized control level (TAC is between 70% and 100% of the ACL RBC)
- Mandatory control level (TAC is less than 70% of the ACL RBC)

Further details and discussion of the RBC requirements may be found at the NAIC website (www.naic.org).

In terms of the statutory annual statement, the RBC ratio was defined as follows:

$$\text{RBC RATIO} = \frac{\text{TOTAL ADJUSTED CAPITAL}}{\text{AUTHORIZED CONTROL LEVEL}}$$

WHERE: TOTAL ADJUSTED CAPITAL: TOTAL ADJUSTED CAPITAL–CURRENT YEAR (P.28, L.14, C.1)
AUTHORIZED CONTROL LEVEL: AUTHORIZED CONTROL LEVEL–CURRENT YEAR (P.28, L.15, C.1)

Note:

The RBC ratio is not unique to the Medicaid Title XIX line of business as it is calculated at the company level. Therefore, companies reporting non-Medicaid business will reflect composite RBC ratios for all lines of business within the reported legal entity.

ADMINISTRATIVE LOSS RATIO (ALR)

ALR is also a common financial metric used to report and benchmark the financial performance of an MCO. The ALR represents the proportion of revenue that was used by the MCO to fund administrative expenses. The ALR is stated as a percentage, with administrative expense in the numerator and revenue in the denominator.

In terms of the statutory annual statement, the ALR was defined as follows:

$$\text{ALR} = \frac{\text{CLAIM ADJUSTMENT EXPENSES + GENERAL ADMINISTRATIVE EXPENSES}}{\text{TOTAL REVENUE}}$$

WHERE: CLAIM ADJUSTMENT EXPENSES: TITLE XIX–MEDICAID (P.7, L.19, C.8)
GENERAL ADMINISTRATIVE EXPENSES: TITLE XIX–MEDICAID (P.7, L.20, C.8)
TOTAL REVENUE: TITLE XIX–MEDICAID (P.7, L.7, C.8)

The ALR requires interpretation and considerations similar in nature to the MLR metric outlined above, most notably impacted by the state and federal taxes levied on MCOs across the different states. The ALR net of taxes and fees was estimated for Medicaid focused MCOs by distributing the total Medicaid CAE and GAE expenses by the expense allocation reported on the *Underwriting and Investment Exhibit Part 3 – Analysis of Expenses* page, and then subtracting out the estimated taxes. The ALR values net of taxes and fees illustrated in this report were calculated by excluding taxes and fees from both the numerator and denominator of the ALR formula.

ADMINISTRATIVE COST PMPM

The administrative cost PMPM is the second metric for analyzing administrative expenses because of the fixed cost nature of certain components of the administrative expense. The administrative cost PMPM was defined as follows:

ADMIN PMPM =	CLAIM ADJUSTMENT EXPENSES + GENERAL ADMINISTRATIVE EXPENSES	
	CURRENT YEAR MEMBER MONTHS	
WHERE:	CLAIM ADJUSTMENT EXPENSES: TITLE XIX-MEDICAID (P.7, L.19, C.8)	
	GENERAL ADMINISTRATIVE EXPENSES: TITLE XIXI-MEDICAID (P.7, L.20, C.8)	
	CURRENT YEAR MEMBER MONTHS: TITLE XIX-MEDICAID (P.30 GT, L.6, C.9)	

The administrative cost PMPM net of taxes and fees illustrated in this report estimated the taxes and fees consistently with the methodology utilized for the ALR net of taxes and fees.

ADMINISTRATIVE EXPENSE CATEGORIES

The administrative expenses reported on the *Underwriting and Investment Exhibit Part 3 – Analysis of Expenses* page are broken out into 25 specific line items. These line items were grouped into five administrative expense categories to better illustrate the components of administrative cost incurred by the MCOs. The subcategories were selected to be intuitive groupings as well as meaningful with respect to their relative magnitudes. The following descriptions outline each administrative expense category:

- Human capital: Administrative costs associated with the employment of MCO staff.
- Outsourcing: Administrative costs associated with functions outsourced to a third party.
- Operating expenses: Administrative costs associated with the day-to-day costs of running the MCO.
- Taxes and fees: Administrative costs associated with taxes and fees incurred by the MCO. Payroll taxes were assigned to the human capital category. Real estate taxes were assigned to the operating expenses category. Federal and state income taxes are not included on the *Underwriting and Investment Exhibit Part 3 – Analysis of Expenses* page, and are not included in this administrative expense category.
- Other expenses: Administrative costs for aggregate write-ins.

The *Underwriting and Investment Exhibit Part 3 – Analysis of Expenses* page illustrates administrative expenses across all lines of business. Throughout the figures illustrated in this report, the administrative costs in each administrative expense category were proportionally adjusted so the total Medicaid administrative expenses would match the amounts reported on the *Analysis of Operations by Line of Business* page.

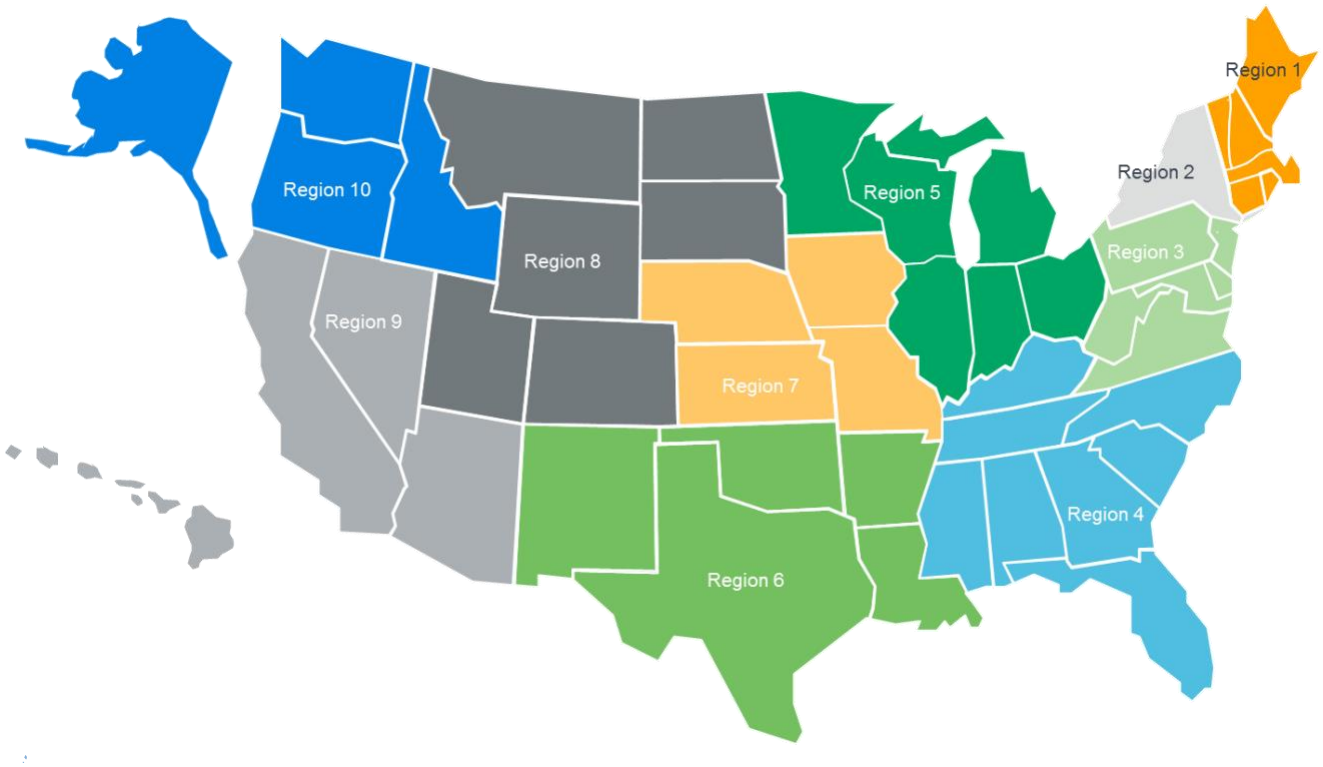
Additionally, Line 19 and Line 20 of the *Underwriting and Investment Exhibit Part 3 – Analysis of Expenses* page, "Reimbursements by uninsured plans" and "Reimbursements from fiscal intermediaries," were excluded from the administrative cost grouping, because these lines would likely be attributable to non-Medicaid business.

FIGURE 17: ADMINISTRATIVE CATEGORY DEFINITIONS

ADMINISTRATIVE EXPENSE BREAKDOWN		U&I EXHIBIT PART 3 EXPENSES (COLUMNS 3-4)
HUMAN CAPITAL	SALARIES, WAGES, AND OTHER BENEFITS	LINE 2
	BOARDS, BUREAUS, AND ASSOCIATION FEES	LINE 15
	INSURANCE, EXCEPT ON REAL ESTATE	LINE 16
	PAYROLL TAXES	LINE 23.4
OUTSOURCING	AUDITING, ACTUARIAL, AND OTHER CONSULTING SERVICES	LINE 6
	OUTSOURCED SERVICES INCLUDING EDP, CLAIMS, AND OTHER SERVICES	LINE 14
OPERATING EXPENSES	RENT	LINE 1
	COMMISSIONS	LINE 3
	LEGAL FEES AND EXPENSES	LINE 4
	CERTIFICATIONS AND ACCREDIDATION FEES	LINE 5
	TRAVELING EXPENSES	LINE 7
	MARKETING AND ADVERTISING	LINE 8
	POSTAGE, EXPRESS, AND TELEPHONE	LINE 9
	PRINTING AND OFFICE SUPPLIES	LINE 10
	OCCUPANCY, DEPRECIATION, AND AMORTIZATION	LINE 11
	EQUIPMENT	LINE 12
	COST OR DEPRECIATION OF EDP EQUIPMENT AND SOFTWARE	LINE 13
	COLLECTION AND BANK SERVICE CHARGES	LINE 17
	GROUP SERVICE AND ADMINISTRATION FEES	LINE 18
	REAL ESTATE EXPENSES	LINE 21
	REAL ESTATE TAXES	LINE 22
	INVESTMENT EXPENSES NOT INCLUDED ELSEWHERE	LINE 24
TAXES AND FEES	STATE AND LOCAL INSURANCE TAXES	LINE 23 .1
	STATE PREMIUM TAXES	LINE 23.2
	REGULATORY AUTHORITY LICENSES AND FEES	LINE 23.3
	OTHER (EXCLUDING FEDERAL INCOME AND REAL ESTATE TAXES)	LINE 23.5
OTHER EXCLUDED[7]	AGGREGATE WRITE-INS FOR EXPENSES	LINE 25
	REIMBURSEMENTS BY UNINSURED PLANS	LINE 19
	REIMBURSEMENTS FROM FISCAL INTERMEDIARIES	LINE 20

[7] These administrative expenses are excluded for purposes of allocating the expenses only; the actual Medicaid administrative expenses reported were not adjusted.

Appendix 3: CMS regions



Appendix 4: MCO groupings

STATE	MCO	CMS REGION	ANNUAL REVENUE	REVENUE PMPM	MCO TYPE	MULTISTATE OPERATIONS	FINANCIAL STRUCTURE	GAIN OR LOSS	EXPANSION STATUS
ARIZONA	CARE1ST	REGION 9	$250M TO $600M	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
ARIZONA	HEALTH CHOICE	REGION 9	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	GAIN	EXPANSION STATE
ARIZONA	HEALTH NET ACCESS	REGION 9	$10M TO $250M	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	LOSS	EXPANSION STATE
ARIZONA	MERCY CARE PLAN	REGION 9	$1.2 B+	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
ARIZONA	UNIVERSITY FAMILY CARE	REGION 9	$250M TO $600M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
ARIZONA	UNITED HEALTH CARE COMMUNITY	REGION 9	$1.2 B+	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
ARIZONA	UNITED-CRS	REGION 9	$250M TO $600M	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
ARIZONA	CMDP	REGION 9	$10M TO $250M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
COLORADO	ROCKY MTN HLTH MAINTENANCE ORG	REGION 8	$10M TO $250M	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
DISTRICT OF COLUMBIA	AMERIGROUP DISTRICT	REGION 3	$10M TO $250M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
DISTRICT OF COLUMBIA	AMERIHEALTH CARITAS DISTRICT	REGION 3	$250M TO $600M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
DISTRICT OF COLUMBIA	TRUSTED HEALTH PLAN	REGION 3	$10M TO $250M	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	GAIN	EXPANSION STATE
FLORIDA	COVENTRY HEALTH CARE OF FL INC	REGION 4	$250M TO $600M	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
FLORIDA	FLORIDA MHS INC.	REGION 4	$600M TO $1.2 B	$425+	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
FLORIDA	FLORIDA TRUE HEALTH INC.	REGION 4	$1.2 B+	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
FLORIDA	HUMANA MEDICAL PLAN INC.	REGION 4	$1.2 B+	$425+	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
FLORIDA	MOLINA HEALTHCARE OF FL INC.	REGION 4	$1.2 B+	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
FLORIDA	SIMPLY HEALTHCARE PLANS INC.	REGION 4	$1.2 B+	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
FLORIDA	SUNSHINE STATE HEALTH PLAN INC	REGION 4	$1.2 B+	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
FLORIDA	UNITEDHEALTHCARE OF FL INC.	REGION 4	$1.2 B+	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
FLORIDA	WELLCARE OF FLORIDA INC.	REGION 4	$1.2 B+	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
GEORGIA	AMGP GEORGIA MANAGED CARE CO.	REGION 4	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
GEORGIA	CARESOURCE GEORGIA CO.	REGION 4	$250M TO $600M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
GEORGIA	PEACH STATE HEALTH PLAN INC.	REGION 4	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
GEORGIA	WELLCARE OF GEORGIA INC.	REGION 4	$1.2 B+	$0 TO $290	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
HAWAII	ALOHACARE	REGION 9	$250M TO $600M	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
HAWAII	HAWAII MEDICAL SERVICE ASSN.	REGION 9	$600M TO $1.2 B	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE

STATE	MCO	CMS REGION	ANNUAL REVENUE	REVENUE PMPM	MCO TYPE	MULTISTATE OPERATIONS	FINANCIAL STRUCTURE	GAIN OR LOSS	EXPANSION STATUS
HAWAII	KAISER FNDTN HLTH PLAN INC. HI	REGION 9	$10M TO $250M	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
HAWAII	WELLCARE HEALTH INS OF AZ INC.	REGION 9	$250M TO $600M	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
ILLINOIS	AETNA BETTER HEALTH INC. (IL)	REGION 5	$1.2 B+	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
ILLINOIS	FAMILY HEALTH NETWORK INC.	REGION 5	$250M TO $600M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
ILLINOIS	HARMONY HEALTH PLAN INC.	REGION 5	$250M TO $600M	$0 TO $290	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
ILLINOIS	HEALTHSPRING OF TENNESSEE INC.	REGION 5	$10M TO $250M	$425+	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	EXPANSION STATE
ILLINOIS	ILLINICARE HEALTH PLAN INC.	REGION 5	$1.2 B+	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
ILLINOIS	MERIDIAN HEALTH PLAN OF IL INC	REGION 5	$1.2 B+	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	EXPANSION STATE
ILLINOIS	MOLINA HEALTHCARE OF IL INC	REGION 5	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
INDIANA	ANTHEM INSURANCE COMPANIES INC	REGION 5	$1.2 B+	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
INDIANA	CARESOURCE INDIANA INC.	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
INDIANA	COORDINATED CARE CORP.	REGION 5	$1.2 B+	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
IOWA	AMERIGROUP IOWA INC.	REGION 7	$1.2 B+	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
IOWA	AMERIHEALTH CARITAS IOWA INC.	REGION 7	$1.2 B+	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
KANSAS	AMERIGROUP KANSAS INC.	REGION 7	$600M TO $1.2 B	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
KANSAS	SUNFLOWER STATE HLTH PLAN INC.	REGION 7	$600M TO $1.2 B	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
KENTUCKY	AETNA BETTER HLTH OF KY INS CO	REGION 4	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
KENTUCKY	ANTHEM KY MNGD CARE PLAN INC.	REGION 4	$600M TO $1.2 B	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
KENTUCKY	HUMANA HEALTH PLAN INC.	REGION 4	$250M TO $600M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	EXPANSION STATE
KENTUCKY	UNIVERSITY HEALTH CARE INC.	REGION 4	$1.2 B+	$425+	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
KENTUCKY	WELLCARE HLTH INS CO. OF KY	REGION 4	$1.2 B+	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
LOUISIANA	AETNA BETTER HEALTH INC. (LA)	REGION 6	$250M TO $600M	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
LOUISIANA	AMERIHEALTH CARITAS LA INC.	REGION 6	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
LOUISIANA	CMNTY CARE HLTH PLAN OF LA INC	REGION 6	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
LOUISIANA	LA HEALTHCARE CONNECTIONS INC.	REGION 6	$1.2 B+	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
LOUISIANA	UNITEDHEALTHCARE OF LA INC.	REGION 6	$1.2 B+	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
MARYLAND	AMERIGROUP MARYLAND INC.	REGION 3	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
MARYLAND	KAISER FOUNDATION HEALTH PLAN	REGION 3	$250M TO $600M	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE

STATE	MCO	CMS REGION	ANNUAL REVENUE	REVENUE PMPM	MCO TYPE	MULTISTATE OPERATIONS	FINANCIAL STRUCTURE	GAIN OR LOSS	EXPANSION STATUS
MARYLAND	MEDSTAR FAMILY CHOICE INC.	REGION 3	$600M TO $1.2 B	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	EXPANSION STATE
MARYLAND	UNITEDHEALTHCARE	REGION 3	$600M TO $1.2 B	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
MASSACHUSETTS	BOSTON MED CENTER HEALTH PLAN	REGION 1	$1.2 B+	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
MASSACHUSETTS	CELTICARE HLTH PLAN OF MA INC.	REGION 1	$10M TO $250M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
MASSACHUSETTS	FALLON COMMUNITY HLTH PLAN INC	REGION 1	$10M TO $250M	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
MASSACHUSETTS	HEALTH NEW ENGLAND INC.	REGION 1	$250M TO $600M	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
MASSACHUSETTS	NEIGHBORHOOD HEALTH PLAN INC.	REGION 1	$1.2 B+	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
MASSACHUSETTS	TUFTS HEALTH PUBLIC PLANS INC.	REGION 1	$1.2 B+	$425+	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	EXPANSION STATE
MICHIGAN	AETNA BETTER HEALTH OF MI INC.	REGION 5	$10M TO $250M	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
MICHIGAN	BLUE CROSS COMPLETE OF MI LLC	REGION 5	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	GAIN	EXPANSION STATE
MICHIGAN	HARBOR HEALTH PLAN INC.	REGION 5	$10M TO $250M	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	EXPANSION STATE
MICHIGAN	MCLAREN HEALTH PLAN INC.	REGION 5	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
MICHIGAN	MERIDIAN HLTH PLAN OF MI INC.	REGION 5	$1.2 B+	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	LOSS	EXPANSION STATE
MICHIGAN	MOLINA HEALTHCARE OF MI INC.	REGION 5	$1.2 B+	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
MICHIGAN	PRIORITY HEALTH CHOICE INC.	REGION 5	$250M TO $600M	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
MICHIGAN	TOTAL HEALTH CARE INC.	REGION 5	$250M TO $600M	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
MICHIGAN	UNITEDHEALTHCARE CMNTY (MI)	REGION 5	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
MICHIGAN	UPPER PENINSULA HLTH PLAN LLC	REGION 5	$10M TO $250M	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	EXPANSION STATE
MINNESOTA	HEALTHPARTNERS INC.	REGION 5	$600M TO $1.2 B	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
MINNESOTA	HENNEPIN HEALTH	REGION 5	$10M TO $250M	$425+	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
MINNESOTA	HMO MINNESOTA	REGION 5	$1.2 B+	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
MINNESOTA	MEDICA HEALTH PLANS	REGION 5	$1.2 B+	$425+	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
MINNESOTA	UCARE MINNESOTA	REGION 5	$1.2 B+	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
MISSISSIPPI	MAGNOLIA HEALTH PLAN INC.	REGION 4	$1.2 B+	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
MISSISSIPPI	UNITEDHEALTHCARE OF MS INC.	REGION 4	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
MISSOURI	AETNA BETTER HEALTH OF MO LLC	REGION 7	$250M TO $600M	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
MISSOURI	HOME STATE HEALTH PLAN INC.	REGION 7	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
MISSOURI	MISSOURI CARE INC.	REGION 7	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE

STATE	MCO	CMS REGION	ANNUAL REVENUE	REVENUE PMPM	MCO TYPE	MULTISTATE OPERATIONS	FINANCIAL STRUCTURE	GAIN OR LOSS	EXPANSION STATUS
NEBRASKA	NEBRASKA TOTAL CARE INC.	REGION 7	$250M TO $600M	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
NEBRASKA	UNITEDHEALTHCARE (MIDLANDS)	REGION 7	$250M TO $600M	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
NEBRASKA	WELLCARE OF NEBRASKA INC.	REGION 7	$250M TO $600M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
NEVADA	AMERIGROUP NEVADA INC.	REGION 9	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
NEVADA	HEALTH PLAN OF NEVADA INC.	REGION 9	$600M TO $1.2 B	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
NEVADA	SILVERSUMMIT HEALTHPLAN INC.	REGION 9	$10M TO $250M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
NEW HAMPSHIRE	GRANITE STATE HEALTH PLAN INC.	REGION 1	$250M TO $600M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
NEW JERSEY	AETNA BETTER HEALTH INC. (NJ)	REGION 2	$10M TO $250M	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
NEW JERSEY	AMERICHOICE OF NEW JERSEY INC.	REGION 2	$1.2 B+	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
NEW JERSEY	AMERIGROUP NEW JERSEY INC.	REGION 2	$600M TO $1.2 B	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
NEW JERSEY	WELLCARE HLTH PLANS OF NJ INC.	REGION 2	$250M TO $600M	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
NEW MEXICO	HCSC INSURANCE SERVICES CO.	REGION 6	$600M TO $1.2 B	$425+	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	EXPANSION STATE
NEW MEXICO	MOLINA HEALTHCARE OF NM INC.	REGION 6	$1.2 B+	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
NEW MEXICO	PRESBYTERIAN HEALTH PLAN INC.	REGION 6	$600M TO $1.2 B	$425+	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	EXPANSION STATE
NEW MEXICO	UNITEDHEALTHCARE OF NEW MEXICO	REGION 6	$600M TO $1.2 B	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
NEW YORK	CAP DISTRICT PHYSICIANS' HLTH	REGION 2	$250M TO $600M	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
NEW YORK	EXCELLUS HEALTH PLAN INC.	REGION 2	$600M TO $1.2 B	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
NEW YORK	HEALTH INS PLAN OF GREATER NY	REGION 2	$600M TO $1.2 B	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
NEW YORK	HEALTHNOW NEW YORK INC.	REGION 2	$10M TO $250M	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
NEW YORK	INDEPENDENT HEALTH ASSN.	REGION 2	$250M TO $600M	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
NEW YORK	MVP HEALTH PLAN INC.	REGION 2	$600M TO $1.2 B	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
NEW YORK	UNITEDHEALTHCARE OF NY INC.	REGION 2	$1.2 B+	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
OHIO	BUCKEYE CMNTY HEALTH PLAN INC.	REGION 5	$1.2 B+	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
OHIO	CARESOURCE	REGION 5	$1.2 B+	$425+	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
OHIO	MOLINA HEALTHCARE OF OHIO INC.	REGION 5	$1.2 B+	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
OHIO	PARAMOUNT ADVANTAGE	REGION 5	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
OHIO	UNITEDHEALTHCARE CMNTY (OH)	REGION 5	$1.2 B+	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
OREGON	PROVIDENCE HEALTH ASSURANCE	REGION 10	$10M TO $250M	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE

STATE	MCO	CMS REGION	ANNUAL REVENUE	REVENUE PMPM	MCO TYPE	MULTISTATE OPERATIONS	FINANCIAL STRUCTURE	GAIN OR LOSS	EXPANSION STATUS
OREGON	TRILLIUM CMNTY HEALTH PLAN INC	REGION 10	$250M TO $600M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
PENNSYLVANIA	AETNA BETTER HEALTH INC. (PA)	REGION 3	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
PENNSYLVANIA	GATEWAY HEALTH PLAN INC.	REGION 3	$1.2 B+	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
PENNSYLVANIA	GEISINGER HEALTH PLAN	REGION 3	$600M TO $1.2 B	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
PENNSYLVANIA	HEALTH PARTNERS PLANS INC.	REGION 3	$1.2 B+	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
PENNSYLVANIA	UNITEDHEALTHCARE OF PA INC.	REGION 3	$600M TO $1.2 B	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
PENNSYLVANIA	UPMC FOR YOU INC.	REGION 3	$1.2 B+	$425+	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
PUERTO RICO	MMM MULTI HEALTH LLC	REGION 2	$250M TO $600M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
PUERTO RICO	MOLINA HEALTHCARE OF PR INC.	REGION 2	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
PUERTO RICO	TRIPLE-S SALUD INC.	REGION 2	$600M TO $1.2 B	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
RHODE ISLAND	NEIGHBORHOOD HEALTH PLAN OF RI	REGION 1	$1.2 B+	$425+	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE
RHODE ISLAND	UNITEDHEALTHCARE (NEW ENGLAND)	REGION 1	$250M TO $600M	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
SOUTH CAROLINA	ABSOLUTE TOTAL CARE INC.	REGION 4	$250M TO $600M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
SOUTH CAROLINA	BLUECHOICE HEALTHPLAN OF SC	REGION 4	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
SOUTH CAROLINA	MOLINA HEALTHCARE OF SC LLC	REGION 4	$250M TO $600M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
SOUTH CAROLINA	SELECT HEALTH OF SC INC.	REGION 4	$1.2 B+	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
SOUTH CAROLINA	WELLCARE OF SOUTH CAROLINA INC	REGION 4	$250M TO $600M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
TENNESSEE	AMERIGROUP TENNESSEE INC.	REGION 4	$1.2 B+	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
TENNESSEE	UNITEDHEALTHCARE PLAN	REGION 4	$1.2 B+	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
TENNESSEE	VOLUNTEER STATE HLTH PLAN INC.	REGION 4	$1.2 B+	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
TEXAS	AETNA BETTER HEALTH OF TX INC.	REGION 6	$250M TO $600M	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
TEXAS	AMERIGROUP INSURANCE CO.	REGION 6	$600M TO $1.2 B	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
TEXAS	AMERIGROUP TEXAS INC.	REGION 6	$1.2 B+	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
TEXAS	BANKERS RESERVE LIFE INS CO.	REGION 6	$1.2 B+	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
TEXAS	CHRISTUS HEALTH PLAN	REGION 6	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
TEXAS	COMMUNITY FIRST HLTH PLANS INC	REGION 6	$250M TO $600M	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	NON-EXPANSION STATE
TEXAS	COMMUNITY HEALTH CHOICE INC.	REGION 6	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	NON-EXPANSION STATE
TEXAS	COMMUNITY HEALTH CHOICE TX INC	REGION 6	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	NON-EXPANSION STATE

STATE	MCO	CMS REGION	ANNUAL REVENUE	REVENUE PMPM	MCO TYPE	MULTISTATE OPERATIONS	FINANCIAL STRUCTURE	GAIN OR LOSS	EXPANSION STATUS
TEXAS	COOK CHILDREN'S HEALTH PLAN	REGION 6	$250M TO $600M	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	NON-EXPANSION STATE
TEXAS	DRISCOLL CHILDREN'S HLTH PLAN	REGION 6	$600M TO $1.2 B	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
TEXAS	EL PASO HEALTH	REGION 6	$10M TO $250M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
TEXAS	HEALTHSPRING L&H INSURANCE CO.	REGION 6	$600M TO $1.2 B	$425+	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
TEXAS	MOLINA HLTHCR OF TEXAS INC.	REGION 6	$1.2 B+	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
TEXAS	SCOTT & WHITE HEALTH PLAN	REGION 6	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
TEXAS	SENDERO HEALTH PLANS INC.	REGION 6	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	NON-EXPANSION STATE
TEXAS	SETON HEALTH PLAN INC.	REGION 6	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
TEXAS	SHA L.L.C.	REGION 6	$250M TO $600M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
TEXAS	SUPERIOR HEALTHPLAN INC.	REGION 6	$1.2 B+	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
TEXAS	TEXAS CHILDREN'S HLTH PLAN INC	REGION 6	$1.2 B+	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	NON-EXPANSION STATE
TEXAS	UNITEDHEALTHCARE CMNTY (TX)	REGION 6	$1.2 B+	$425+	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
TEXAS	PARKLAND CMNTY HEALTH PLAN INC	REGION 6	$250M TO $600M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
UTAH	HEALTH CHOICE UTAH INC.	REGION 8	$10M TO $250M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
UTAH	MOLINA HEALTHCARE OF UTAH INC.	REGION 8	$10M TO $250M	$0 TO $290	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
UTAH	SELECTHEALTH INC.	REGION 8	$250M TO $600M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
VIRGINIA	COVENTRY HLTHCARE OF VA INC.	REGION 3	$250M TO $600M	$425+	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
VIRGINIA	HEALTHKEEPERS INC.	REGION 3	$1.2 B+	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
VIRGINIA	INOVA HEALTH PLAN LLC	REGION 3	$10M TO $250M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
VIRGINIA	OPTIMA HEALTH PLAN	REGION 3	$600M TO $1.2 B	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
VIRGINIA	VIRGINIA PREMIER HLTH PLAN INC	REGION 3	$1.2 B+	$425+	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
WASHINGTON	AMERIGROUP WASHINGTON INC.	REGION 10	$250M TO $600M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
WASHINGTON	COMMUNITY HEALTH PLAN OF WA	REGION 10	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	GAIN	EXPANSION STATE
WASHINGTON	COORDINATED CARE OF WA INC.	REGION 10	$600M TO $1.2 B	$0 TO $290	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	LOSS	EXPANSION STATE
WASHINGTON	MOLINA HEALTHCARE OF WA INC.	REGION 10	$1.2 B+	$0 TO $290	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
WASHINGTON	UNITEDHEALTHCARE OF WA INC.	REGION 10	$600M TO $1.2 B	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
WEST VIRGINIA	COVENTRY HEALTH CARE OF WV INC	REGION 3	$250M TO $600M	$290 TO $425	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
WEST VIRGINIA	HEALTH PLAN OF WV INC.	REGION 3	$250M TO $600M	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	EXPANSION STATE

STATE	MCO	CMS REGION	ANNUAL REVENUE	REVENUE PMPM	MCO TYPE	MULTISTATE OPERATIONS	FINANCIAL STRUCTURE	GAIN OR LOSS	EXPANSION STATUS
WEST VIRGINIA	UNICARE HEALTH PLAN OF WV INC.	REGION 3	$250M TO $600M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	EXPANSION STATE
WEST VIRGINIA	WV FAMILY HEALTH PLAN INC.	REGION 3	$250M TO $600M	$290 TO $425	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	GAIN	EXPANSION STATE
WISCONSIN	CHILDREN'S CMNTY HLTH PLAN INC	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	NONPROFIT	LOSS	NON-EXPANSION STATE
WISCONSIN	COMPCARE HEALTH SVCS INS CORP.	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
WISCONSIN	DEAN HEALTH PLAN INC.	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
WISCONSIN	GROUP HLTH COOP OF EAU CLAIRE	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
WISCONSIN	GRP HLTH COOP OF SOUTH CENTRAL	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	LOSS	NON-EXPANSION STATE
WISCONSIN	GUNDERSEN HEALTH PLAN INC.	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
WISCONSIN	HEALTH TRADITION HEALTH PLAN	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
WISCONSIN	INDEPENDENT CARE HEALTH PLAN	REGION 5	$10M TO $250M	$290 TO $425	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
WISCONSIN	MANAGED HEALTH SVCS INS CORP.	REGION 5	$10M TO $250M	$290 TO $425	MEDICAID ONLY	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
WISCONSIN	MERCYCARE HMO INC.	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
WISCONSIN	MOLINA HEALTHCARE OF WI INC.	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	GAIN	NON-EXPANSION STATE
WISCONSIN	NETWORK HEALTH PLAN	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
WISCONSIN	PHYSICIANS PLUS INSURANCE CORP	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
WISCONSIN	SECURITY HEALTH PLAN OF WI INC	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	NONPROFIT	GAIN	NON-EXPANSION STATE
WISCONSIN	TRILOGY HEALTH INSURANCE INC.	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID ONLY	LESS THAN FIVE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
WISCONSIN	UNITEDHEALTHCARE OF WI INC.	REGION 5	$250M TO $600M	$0 TO $290	MEDICAID OTHER	FIVE OR MORE	FOR-PROFIT	LOSS	NON-EXPANSION STATE
WISCONSIN	UNITY HEALTH PLANS INS CORP.	REGION 5	$10M TO $250M	$0 TO $290	MEDICAID OTHER	LESS THAN FIVE	FOR-PROFIT	GAIN	NON-EXPANSION STATE

About the authors

Jeremy Palmer is a principal and consulting actuary with the Indianapolis office of Milliman and is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Mr. Palmer joined Milliman in 2004 and currently has over 22 years of healthcare-related actuarial experience.

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The authors have developed an expertise in the financial forecasting, pricing, reporting, and reserving of all types of health insurance, including Medicaid and commercial populations. Much of their experience is focused on Medicaid managed care consulting for both state Medicaid programs and Medicaid managed care plans in more than 15 states and territories.

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