CHEAT SHEET

for Entire health care ecosystem

How Health Plans Make Money

An overview of the main ways plans make money in each line of business

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Key takeaways

- Health plans make money through premiums, quality bonuses, and investments. The specific mechanisms vary by line of business and sometimes by state.
- Premiums are the primary source of health plan revenues. Premium funds are collected into one large pool—this pool of money is used to cover medical expenses for all enrollees.
- Medical loss ratio (MLR) is the portion of premium dollars spent on medical claims and quality improvements versus the cost of administrative expenditures.

Terms to know

This brief will first cover these terms-to-know which will help explain the next section on how plans make money.

Source: Advisory Board interviews and analysis.

TERMS TO KNOW

Premiums

A premium is a fee paid to a health plan to provide medical and/or pharmacy benefits. Premiums can be paid directly from the consumer to the plan or given to the plan through a purchaser (such as an employer or federal and state funding on behalf of Medicare and Medicaid beneficiaries). Premium funds are collected into one large pool—this pool of money is used to cover medical expenses for all enrollees.

Health plan premiums vary across health insurance companies and differ according to the specific product a member (patient or individual receiving benefits) elects with their health insurer. For example, the average premium for an individual with health insurance through their employer was $7,739 per year ($645 per month) in 2021. Plans often use the per month, per member (PMPM) unit of measurement when discussing premiums, bonuses, costs, medical spend, and more.

Plan enrollment impacts plan premiums. Enrollment is the number of members that a plan insures so higher enrollment means more people paying premiums. As a plan increases enrollment, medical costs will increase so the premium pool of money needs to be large enough to cover expected medical claims for all members.

Consumers often consider the value of health plan benefits, plan performance in previous years, premium cost, and personal medical needs when deciding on a carrier and a specific product. Plans use previous year health and enrollment data to predict costs for the following year and factor this information into setting plan premiums.

Source: KFF, 2022, https://www.kff.org/report-section/ehbs-2021-section-1-cost-of-health-insurance/.

TERMS TO KNOW

Medical Loss Ratio

Medical loss ratio (MLR) is the portion of premium dollars spent on medical claims and quality improvements versus the cost of administrative expenditures.

$$\text{MLR} = \frac{\text{Claims costs (i.e. medical expenses) + quality improvement costs}}{\text{Premiums received – taxes and licensing/regulatory fees}}$$

MLR was first introduced with the Affordable Care Act (ACA). MLR was instituted to mitigate premium increases, help establish more transparency and accountability, and increase the value that consumers receive for their premium dollars.

MLR requirements mandate that health insurance companies use most of their premium dollars to provide health care and improve quality for plan enrollees. Individual and small group plans are mandated to spend at least 80% of premium dollars on medical expenses. Large group plans, Medicare Advantage plans, and Medicaid managed care plans must spend at least 85% on medical expenses and quality improvement initiatives.

Plans want to keep their MLR low but not lower than 80% or 85%. If a health plan's MLR is lower than the requirement, they must issue rebates to their members to make up for overestimating what the medical spend would be.

It is important to consider the MLR because plans must provide rationale for an increase in premiums. MLR requirements restrict payers from increasing their premiums solely to increase profits. Profit margins across plans are variable, with some health plans profiting as low as 2%.

Sources: "Medical loss ratio requirements under the Patient Protection and Affordable Care Act (ACA): Issues for Congress," January 2015 https://crsreports.congress.gov/product/pdf/R/R42735; "Medical Loss Ratio." *NAIC*, https://content.naic.org/cipr-topics/medical-loss-ratio#:~:text=The%20ACA%20requires%20health%20insurers,MLR%20requirement%20is%2085%20percent.

TERMS TO KNOW

Risk Adjustment

Risk adjustment is a methodology used to attach a person's health status to a number (risk score). This process is used to help predict healthcare costs, and plans rely on providers to code accurately and completely to capture the patient's entire health status.

Health plans receive funds based on their membership's risk scores which can vary at the county level (more funds are given for higher risk populations). For example, Albany county has a risk score of 2.14, while Boulder county has a 0.81 risk score in Medicare Advantage for 2020. **Risk adjustment is important because it is a way for health plans to appropriately budget and ensure they're being compensated appropriately for their pool of members.**

Risk adjustment is not the same as underwriting—a process insurance companies previously used to determine if a person was an acceptable risk, and if so, how much to charge in premiums based on their medical history. The ACA does not allow health plans to charge a member a different premium based on their medical history or preexisting conditions.

Additionally, risk adjustment protects members from adverse selection processes by spreading the financial risks across health plans in the market. Without risk adjustment stabilization, plans might opt for healthier members to lower risk and reduce projected medical spend.

Source: Norris L, Hinzey E. "When Is Medical Underwriting Still Used?", Verywell Health, 2022, https://www.verywellhealth.com/what-is-medical-underwriting-417811. Centers for Medicare and Medicaid Services, 2021, https://data.cms.gov/medicare-shared-savings-program/county-level-aggregate-expenditure-and-risk-score-data-on-assignable-beneficiaries.

Quality Bonuses

Health plans can receive financial incentives when they meet or exceed certain quality metrics or enrollment goals. These bonuses are paid directly to the health plan, and they become a part of the monetary pool used to provide benefits for consumers. Though these payments are in addition to funds collected from premiums, plans are usually required to use a portion to enhance member benefits and make quality improvements. In 2021, the average bonus per enrollee in Medicare Advantage plans was $446.

Health plans are typically evaluated annually, and these evaluations determine if the plan qualifies for additional funds. The Centers for Medicare and Medicaid Services (CMS) has a quality incentive program for Medicare Advantage plans. Additionally, some states have created financial incentive programs for plans that offer Medicaid products. State health care agencies create their own frameworks for how Medicaid plans can qualify for quality bonuses.

Investments

Health plans invest in stocks, bonds, and other ventures to increase their profits. Health plans often offer multiple products and have members across multiple lines of business (Medicare advantage, Medicaid, individual, or group plans).

Insurance companies can also acquire other companies to diversify their revenue streams. Recently, there has been a shift (especially from large, national carriers) to become diversified health solutions companies rather than focusing specifically on being a health insurance company.

Source: KFF, 2022, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-star-ratings-and-bonuses/.

How Health Plans Make Money

Plans make money through a mix of premiums, quality bonuses, and investments. This section will cover how health plans use these components to make money in each line of business:

Source: Advisory Board interviews and analysis.

Medicare Advantage

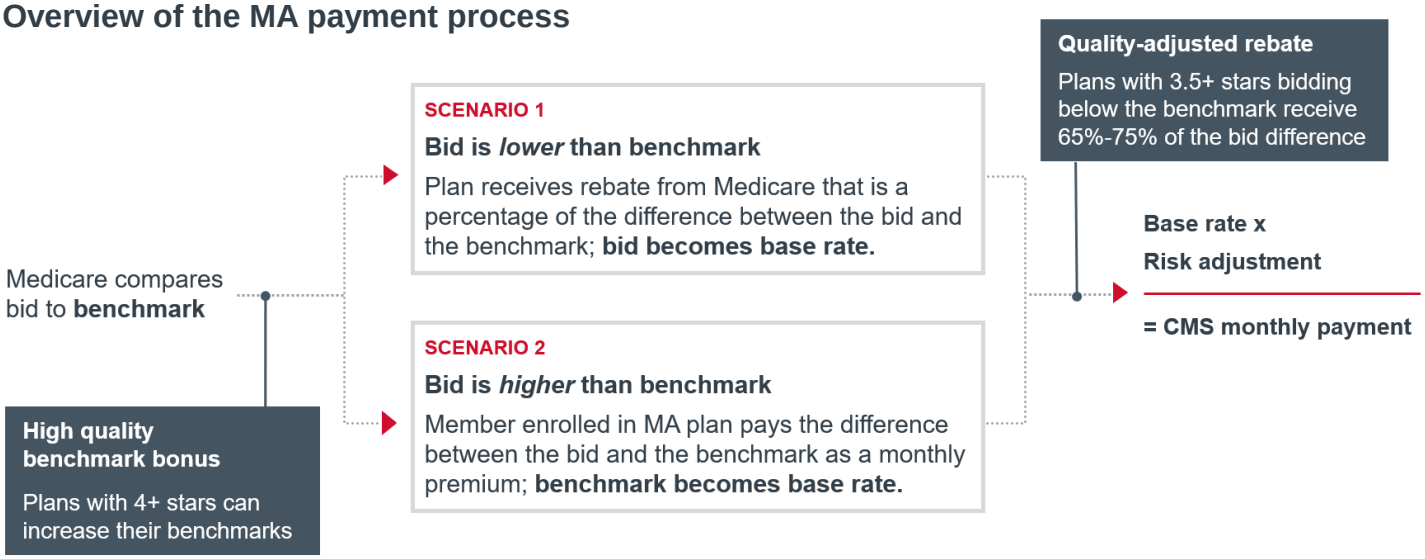
Medicare Advantage (MA) plans are private plan alternatives to traditional Medicare. Medicare Advantage insurers are contracted by the government to provide Medicare benefits and therefore assume the risks and costs associated with these members. Medicare Advantage is also known as Medicare Part C.

Premiums

The Centers for Medicare and Medicaid Services (CMS) provides a cost per enrollee (base rate) to private health plans through a bidding process. Payers can submit a bid based on estimated cost per enrollee. These bids are then evaluated against a benchmark. Benchmarks vary by county, as each county is comprised of people with different health care needs and health status.

If the plan has a bid higher than the benchmark, enrollees pay an additional premium directly to the health plan. The health plan and Medicare split the difference of the bid and benchmark if the plan has a bid lower than the benchmark. This difference is also considered a rebate that plans can use to create additional benefits.

Overview of the MA payment process



Source: "Bidding and payment", Bettermedicarealliance.org, 2022, https://bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_WhitePaper_MA_Bidding_and_Payment_2018_09_19-1.pdf; "How is Medicare Advantage Funded?" Medical News Today, May 21, 2020.

Following the bidding process, plan payments are adjusted based on the risk scores of their members. CMS calculates a member's risk score annually based on their chronic and severe acute conditions.

For a simplified example, let's say a fictitious plan submits a bid of $600 per beneficiary. Then this amount would be risk adjusted and for this example, let's say the risk score is 1.2 so the amount per beneficiary increased to $720 (because this county has higher risk beneficiaries than the average beneficiary). If the benchmark amount for this county is $1000 per beneficiary, then the plan would receive an additional rebate of a percentage of $280 (the difference between $1000 and $720).

Quality Bonuses

CMS introduced the quality bonus program in 2012. This program allows for two types of financial bonuses if the health plan earns a high star rating in quality performance measures.

CMS developed a five-star quality rating system comprised of five different categories related to member treatment: staying healthy, managing chronic conditions, member experience, member complaints and performance, and customer service. One star represents poor performance, and five stars represents excellent performance.

Plans that receive at least a 4-star rating receive a bonus that is 5 percent of the Medicare benchmark amount. If the plan is in an urban county with a high number of Medicare Advantage enrollees, they are eligible to receive a bonus that is 10 percent of the benchmark. Health plans can leverage bonus payments as profits, but they must still adhere to medical loss ratio requirements. MA rebates and quality bonuses allow plans to invest in wellness programs, risk stratification to better identify members with high needs, and other innovations.

Source: "What is Risk Adjustment – AAPC." Aapc.com, 2022, https://www.aapc.com/risk-adjustment/risk-adjustment.aspx.

Medicaid Managed Care

Health insurers that offer Medicaid managed care plans are typically referred to as Medicaid Managed Care Organizations (MCOs). Medicaid is funded jointly by the state and the federal government.

Premiums

The state contracts with MCOs to provide and manage Medicaid benefits for eligible members. Each plan receives a set per member, per month (PMPM) payment for Medicaid services. In 2018, the average PMPM rate of 12 states was $481.

Medicaid utilizes risk adjustment to determine the cost per enrollee paid to the private health plan. **Each state differs in their Medicaid risk adjustment protocol, reimbursement rates, and penalties.** Medicaid risk scores are primarily determined by patient encounters. Thus, it is important for the MCO to document patient data for appropriate reimbursement and profit.

In 2018, Medicaid plans made about 60 cents for every $100 in premiums—so a profit margin of 0.6%. Commercial health insurance is approximately 2.5 to 6 times more profitable than Medicaid health insurance.

Sources: "Medicaid Managed Care Rates and Flexibilities: State Options to Respond to COVID-19 Pandemic," KFF, 2022, https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/; Ko G. "Are Medicaid Health Plans Making Too Much Money? - The Source on HealthCare Price and Competition", 2019, https://sourceonhealthcare.org/are-medicaid-health-plans-making-too-much-money/; "Medicaid Plan PMPM Rates Rise 0.3 Percent in 2018 for TANF/CHIP In 19 States, 4 Percent for Expansion, HMAIS Analysis Shows", Health Management Associates, 2019, https://www.healthmanagement.com/blog/medicaid-plan-pmpm-rates-rise-0-3-percent-in-2018-for-tanf-chip-in-19-states-4-percent-for-expansion-hmais-analysis-shows/.

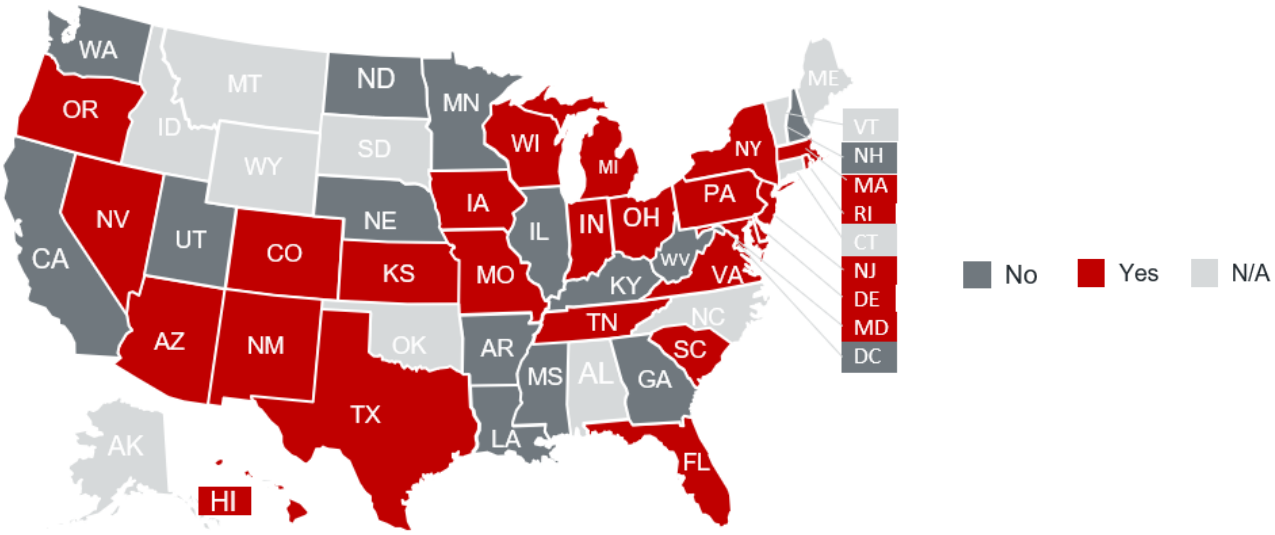
Quality Bonuses

Many states have programs that hold an MCO to a set of performance expectations that must be met to qualify for an incentive. Some states use minimum quality standards while others incentivize level of quality in varying increments.

These quality programs vary significantly by state. Some states may provide financial bonuses for quality performance, some may withhold dollars until quality metrics are met, some may use sanctions, corrective action plans, or make plan performance public information to encourage quality performance.

States with Pay for Performance or Performance Bonuses in Medicaid Managed Care, 2019

[1]



1. These states did not have MCOs in 2019.

Sources: KFF, 2022, https://www.kff.org/medicaid/state-indicator/medicaid-managed-care-quality-initiatives/?activeTab=map&currentTimeframe=0&selectedDistributions=pay-for-performance-performance-bonus&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Employer Sponsored Insurance (ESI)

Employer-sponsored plans are health plans offered through an employer. The Affordable Care Act requires businesses with over 50 employees to offer health insurance to their workers. Employer-sponsored insurance covers almost 155 million nonelderly people. These plans are also referred to as group plans.

Premiums

Premiums paid to a health plan to provide medical benefits for a group, is typically jointly funded by the employer and the employee. Prior to the employee electing the health plan, the employer contracts with a health insurance company to provide coverage. Employers compare prices and benefits across different insurers. Employees then choose a specific product that works for them and sometimes their families.

Some employers are self-funded which means that the employer covers the health care costs of their employees, and they work with a health plan or Third-Party Administrator (TPA) to help with the administrative aspects of delivering health care coverage. These plans are also called Administrative Services Only (ASO) plans.

TPAs or ASO plans are paid a per-member per-month (PMPM) administrative fee for managing health benefits. Employees still pay premiums that go towards paying for medical costs, but these medical costs are ultimately covered by the self-funded employer (and not the plan).

The Medical Loss Ratio mandate is only applicable to fully insured group plans and does not apply to Administrative Services Only (ASO) plans.

Source: "2021 Employer Health Benefits Survey - Summary of Findings", KFF, November 2021, https://www.kff.org/report-section/ehbs-2021-summary-of-findings.

Individual Market

The Individual Market is often referred to as the Marketplace. However, the individual market encompasses all health plans for individuals who do not have access to employer-sponsored or government-sponsored health coverage. The Marketplace was established, by the Affordable Care Act (ACA), to expand access to health care and help consumers find health coverage that best fits their needs. This section will focus on plans offered through the Marketplace.

Premiums

Marketplace plans are only allowed to set premiums based on age, location, tobacco use, individual vs. family enrollment, and plan tier. Additionally, each state has the power to limit how much each of these factors affect premiums.

Some members who elect a plan through the Marketplace qualify for one of two subsidies. One subsidy, known as the premium tax credit, reduces the premium amount for enrollees. This tax credit can be paid directly to the member's health plan and reduces the member's premium responsibility. The other subsidy available through the Marketplace assists members with medical costs from hospital stays or doctor visits and does not contribute to premium funds the health plan receives.

Plans in the individual market are also graded on a scale of five stars. These stars are based on scores in 3 different sectors: member experience, medical care, and plan administration. Because members have more autonomy in the individual market to choose a plan for themselves, these ratings are very important because members will want to choose plans with higher star ratings (and therefore these plans will receive more premium revenues).

Source: "How Health Insurance Marketplace® Plans Set Your Premiums", HealthCare.gov, 2022, https://www.healthcare.gov/how-plans-set-your-premiums/; "The Premium Tax Credit - The Basics | Internal Revenue Service", Irs.gov, 2022, https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics; "Premium Stabilization Programs", Cms.gov, 2022, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs; Barr S., "FAQ: Grandfathered Health Plans", Kaiser Health News, 2022, https://khn.org/news/grandfathered-plans-faq/.

Health plans offered through the Marketplace abide by medical loss ratio rules. The money plans receive from members and government subsidies must primarily be used on medical expenses for enrollees. Further, the Affordable Care Act mandates that plans offered through the marketplace must shift premium dollars to other health plans based on risk calculations for members across plans, this is also known as commercial risk adjustment. This methodology compares plans in each geographic area based on average risk of members. **Commercial risk adjustment is designed to stabilize risk by transferring funds from plan to plan.**

The risk adjustment program mandated by the ACA applies to non-grandfathered plans (grandfathered plans are plans that existed before March of 2010, or prior to the ACA) in the individual market, whether inside or outside of the exchange. Health insurance obtained through the Marketplace is inside the exchange, insurance bought directly from the insurance company is outside of the exchange. Plans that existed prior to the creation of the ACA are grandfathered under the law with fewer requirements.

Source: Advisory Board interviews and analysis.

Conversations you should be having

01 What can our organization learn about what health plans care about if their main revenue streams are premiums, quality bonuses, and investments?

02 How can our organization help plans increase their revenues to encourage them to partner with us? How should this vary by line of business?

03 On the flip side, how do plans *spend* money? How can our organization support payers in spending less money?

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