Research

Actuarial Soundness of Medicaid Managed Care

ROBERT BOOK | OCTOBER 19, 2012

Throughout much of its history, the Medicaid program has been plagued by three major problems: insufficient access to care for beneficiaries, lack of coordination and continuity of care, and rapid growth in total program costs. Beginning in 1982 and accelerating in the 1990s, states began to address these problems by contracting with private health insurance companies to provide care for at least some Medicaid beneficiaries through capitated managed care arrangements, using Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)--like provider networks. By 2010, these Medicaid Managed Care Organizations (MCOs) provided coverage for 53 percent of all Medicaid beneficiaries in 35 of the 50 states, plus DC and Puerto Rico. Some states make MCO enrollment mandatory for all but a few categories of beneficiaries; others provide MCOs as an option along with a state--run fee--for--service plan.

MCOs have the ability to provide some services that cannot generally be provided in the fee--for--service framework, such as disease management and care coordination. These additional services can significantly benefit patients. In addition, MCOs can improve access to care for beneficiaries. Some evidence suggests that compared to state--run fee--for--service, managed care can reduce overall Medicaid program costs, while providing better patient outcomes.

From a state's perspective, the key difference between Medicaid managed care and the “traditional” fee--for--service arrangement is that instead of paying providers directly according to a fee schedule, the state pays the MCO a fixed monthly fee for each enrollee, in exchange for which the MCO provides all covered services for that enrollee. Another benefit a state derives from an MCO program is more predictability in budgeting by reducing the variability of program cost. By paying a specific amount per member per month, the state transfers the financial risk of variation in each beneficiary’s health care needs from

taxpayers to private companies. One of the key challenges is to determine the appropriate monthly payments. Payments should be high enough to cover the MCO's cost of providing care and to induce the MCO to stay in the Medicaid managed care business, but not so high as to provide above--market profits at taxpayer expense.