Medicaid MCOs and cost savings – What the evidence says

May 7, 2024

Governor Lamont is reportedly considering a plan to have private insurance managed care plans (MCOs) run Connecticut's Medicaid program. From 1996 through 2011, Connecticut Medicaid was run by MCOs, and it was deeply troubled. The program ended under pressure from advocates, providers, and legislators. Since the MCOs left Connecticut Medicaid, access and quality of care have improved, and the state has saved billions of taxpayer dollars.

Findings from the literature:

The evidence does not support Medicaid managed care saving money for states. According to MACPAC, Medicaid's federal oversight commission, the National Conference of State Legislators, and KFF, despite many studies, independent evidence does not support MCOs' promises to save money for states. Syntheses of independent, peer-reviewed studies, cited below, also do not find evidence of savings.

MCO inefficiencies include advertising to attract healthy members, federal taxes that states like Connecticut do not pay, overlap of functions between MCO and agency staff, agency staff to manage MCO contracts, and costs to collect data, sort out the differences between MCOs, reporting, and accountability enforcement.

Without MCOs, Connecticut leads the nation in Medicaid cost control. According to DSS financial reports, Connecticut taxpayers have saved billions of dollars since MCOs left our program in 2012. DSS financial reports also find that Connecticut Medicaid spends just a third of what other states spend on administration, the lowest rate among states.

Last year Connecticut spent only 21.9% of our state budget on Medicaid, well below the US average of 29.6%. **Connecticut's lower Medicaid spending frees up $3.96 billion in our budget**, compared to the average state, for other policymaker priorities.

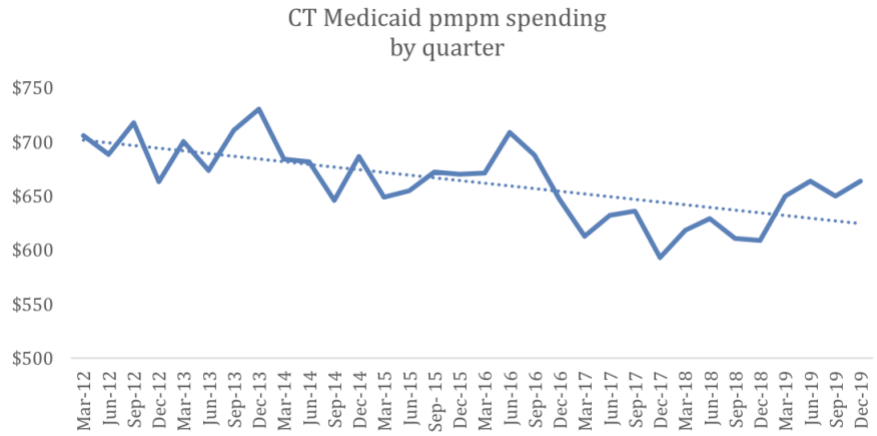
Sources:

Managed care's effect on outcomes, *MACPAC*, accessed 4/18/2024
According to MACPAC, Medicaid's federal oversight commission, there is no evidence that MCOs save money for states or improve access or quality of care. Some "argue that a capitated payment system that pays MCOs a set amount per enrollee and not on how much treatment is provided may create incentives to undertreat patients to minimize treatment costs."
https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/

E Hinton et al, 10 Things to Know About Medicaid Managed Care, *KFF* (2024)
"While the shift to MCOs has increased budget predictability for states, the evidence about the impact of managed care on access to care and costs is both limited and mixed." The Medicaid MCO market is very consolidated which raises prices. Medical loss ratios for MCOs are down in recent years, indicating that profits are up. States had to pass risk corridor legislation to recoup just a portion of MCO overpayments from underservice due to COVID, while Connecticut received 100% of those savings.
https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care

Medicaid Managed Care 101, *NCSL* (2023)
"Key Takeaways -- States and territories have increasingly relied on managed care organizations, or MCOs—commercial insurance companies contracted by the state—to manage state Medicaid systems. While there is mixed evidence on managed care's impact on quality and costs, it is the predominant Medicaid delivery system."
https://www.ncsl.org/health/medicaid-managed-care-101

Medicaid switch from MCOs saving taxpayers billions, *CTHPP* (2020)
Analysis of DSS financial reports finds that "if Medicaid per member per month costs had held steady at 2012 levels, taxpayers would have spent $2.25 billion more by last year. [2019]"



https://cthealthpolicy.org/medicaid-switch-from-mcos-saving-taxpayers-billions/

Financial Trends in the Connecticut HUSKY Health Program, DSS report to MAPOC, 2/10/2023
Despite significant enrollment growth, Connecticut's Medicaid spending trends are below national levels and per member costs are stable. Including MCO administrative spending, in 2021Connecticut Medicaid spent only 2.75% on administration, compared to 8.5% national average.
https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20230210/HUSKY%20Financial%20Trends%20February%202023.pdf

E Hinton et. al. State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid, KFF (2022)
Connecticut's current program, without MCOs, has adopted all the available tools MCOs use to control costs or improve quality and access to care. We don't have to share any savings with MCOs.
Connecticut has implemented every quality reform cited by other states. Connecticut Medicaid has also implemented four of five payment reforms and is in the process of implementing the last one.
https://www.kff.org/medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/

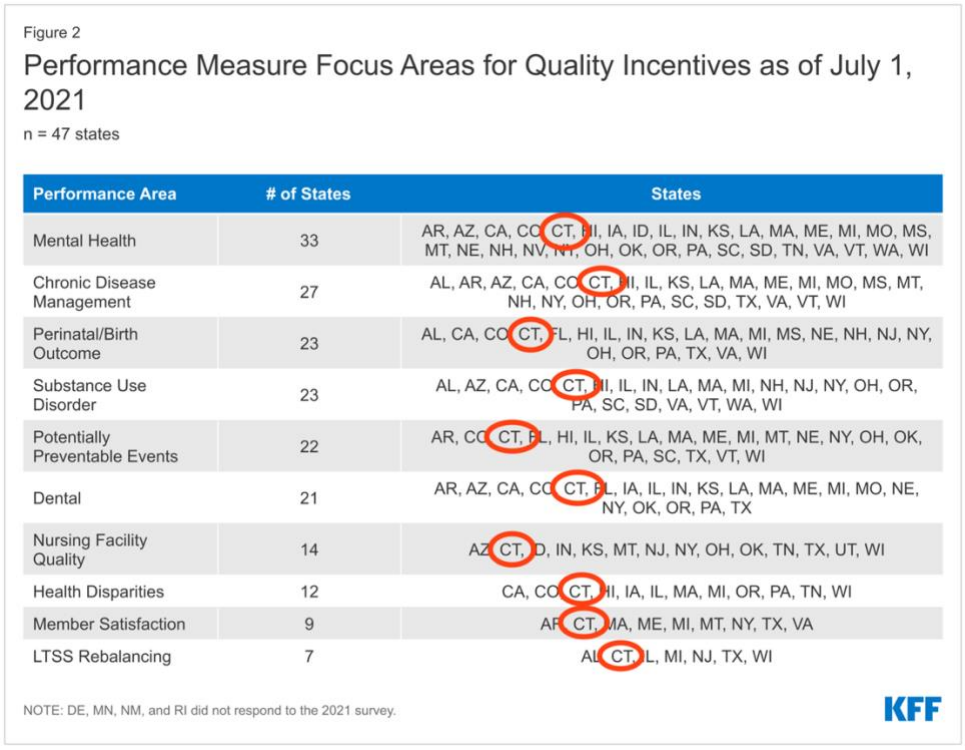


Figure 2

Performance Measure Focus Areas for Quality Incentives as of July 1, 2021

n = 47 states

Performance Area	# of States	States
Mental Health	33	AR, AZ, CA, CO, CT, HI, IA, ID, IL, IN, KS, LA, MA, ME, MI, MO, MS, MT, NE, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, VA, VT, WA, WI
Chronic Disease Management	27	AL, AR, AZ, CA, CO, CT, HI, IL, KS, LA, MA, ME, MI, MO, MS, MT, NH, NY, OH, OR, PA, SC, SD, TX, VA, VT, WI
Perinatal/Birth Outcome	23	AL, CA, CO, CT, FL, HI, IL, IN, KS, LA, MA, MI, MS, NE, NH, NJ, NY, OH, OR, PA, TX, VA, WI
Substance Use Disorder	23	AL, AZ, CA, CO, CT, HI, IL, IN, LA, MA, MI, NH, NJ, NY, OH, OR, PA, SC, SD, VA, VT, WA, WI
Potentially Preventable Events	22	AR, CO, CT, FL, HI, IL, KS, LA, MA, ME, MI, MT, NE, NY, OH, OK, OR, PA, SC, TX, VT, WI
Dental	21	AR, AZ, CA, CO, CT, FL, IA, IL, IN, KS, LA, MA, ME, MI, MO, NE, NY, OK, OR, PA, TX
Nursing Facility Quality	14	AZ, CT, ID, IN, KS, MT, NJ, NY, OH, OK, TN, TX, UT, WI
Health Disparities	12	CA, CO, CT, HI, IA, IL, MA, MI, OR, PA, TN, WI
Member Satisfaction	9	AR, CT, MA, ME, MI, MT, NY, TX, VA
LTSS Rebalancing	7	AL, CT, IL, MI, NJ, TX, WI

NOTE: DE, MN, NM, and RI did not respond to the 2021 survey.

KFF

State Expenditure Report, *National Association of State Budget Officers* (2023)
Last year Connecticut spent only 21.9% of our state budget on Medicaid, well below the US average of 29.6%. Our lower Medicaid spending frees up $3.96 billion in our budget for other priorities.
https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2023_State_Expenditure_Report-S.pdf

D. Lassman et al, Health Spending By State 1991–2014: Measuring Per Capita Spending By Payers And Programs, *Health Affairs* (2017) 36(7):1318-1327.
In a study published in Health Affairs, Connecticut Medicaid cost control was the best in nation. Between 2010 and 2014, the average annual change in

Connecticut's Medicaid per person costs fell by 5.7%, while the US average rose by 1.2%. Over the same years, Connecticut's Medicare and private health insurance costs were up 1.2% and 3.3%, respectively. respectively.https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0416

Montoya et al, Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update, *Annual Review of Public Health* (2020) 41:537-549
Review of 32 peer-reviewed studies found no evidence of savings, improved access to care or quality. "Early proponents of managed care argued that private insurers would be more effective at delivering higher-quality care and at reducing the cost of care. States also desired budget predictability. While there are incidences of success, research evaluating managed-care programs show that these initial hopes were largely unfounded."
https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-040119-094345

M Sparer, Medicaid managed care: Costs, access, and quality of care, KFF (2012)
This review of peer-reviewed literature finds little evidence of savings from Medicaid MCOs. "The peer-reviewed literature on the cost implications of Medicaid managed care is quite thin, especially given the anecdotal claims of cost savings by policymakers at both the state and federal levels." The author outlines seven reasons Medicaid MCOs are unlikely to save money including already low provider rates, states were already using the common cost control tools used by MCOs, Medicaid cannot impose significant cost sharing, the costs of administration, improving access will increase utilization and increase costs, MCOs have little ability to change delivery systems, and federal requirements for actuarily sound rates give MCOs a lever to increase state payments.
http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106

Goldsmith et al, Medicaid Managed Care: Lots Of Unanswered Questions, Health Affairs Forefront (2018)
The authors raise multiple concerns with Medicaid managed care including excessive profit taking, investors' roles, five-fold variation in administrative overhead, significant variation in reserves, and little or no administrative savings in state agencies. High risk Medicaid members including seniors and people with disabilities can be more profitable for MCOs than healthier members. The authors found no independent, peer-reviewed evidence that MCOs save states money. (The only evidence of any savings was in papers from consulting firms that work for state Medicaid agencies and a meta-analysis by Mathematica found no savings.) There is also no evidence of improved quality of care for members in MCOs.
https://www.healthaffairs.org/content/forefront/medicaid-managed-care-lots-unanswered-questions-part-2

Duggan et al, Has the shift to managed care reduced Medicaid expenditures? Evidence from state and local-level mandates, *National Bureau of Economic Research* (2011) Working Paper 17236
Authors from the Wharton School and the Congressional Budget Office found no evidence that the shift to managed care saved Medicaid money. In fact, there is evidence it increased spending and "did little to reduce the strain on the typical state's budget."
https://www.nber.org/system/files/working_papers/w17236/w17236.pdf

Has Medicaid Managed Care Delivered On Its Promise? *Tradeoffs* (2021)
"Despite the lack of evidence that managed care has achieved its goals, it continues to grow in its dominance of Medicaid, with more states making the switch and states adding more complex populations into these plans. Some states have responded, changing their programs in varying ways to try to achieve better value, but experts stress that more rigorous research is necessary to measure the impact of these changes." The article notes that Connecticut is one the states moving away from MCOs, and four years later, patient costs were down 7% while the number of physicians participating the program grew by 7%.
https://tradeoffs.org/2021/11/04/medicaid-managed-care/

J Ortaliza et. al. Health Insurer Financial Performance in 2021, *KFF* (2023)
Medicaid has become a significant source of profits for health insurance companies. In 2021, gross profits per member were higher in Medicaid Managed Care (and Medicare Advantage) than in private plans.
https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/

Experience of the Five Largest Publicly Traded Companies Operating Medicaid Managed Care Plans During Unwinding, *KFF* (2024)
From 2022 to 2023, Medicaid MCO revenue growth ranged from3% to 18%, despite a 10% drop in enrollment.
https://www.kff.org/medicaid/issue-brief/experience-of-the-five-largest-publicly-traded-companies-operating-medicaid-managed-care-plans-during-unwinding/

P Galewitz, States To Help Pay Obamacare Tax On Insurers, *KFF Health News* (2014)
Because Connecticut's Medicaid program does not use MCOs, we do not have to pay for federal MCO taxes under the Affordable Care Act, either directly or through higher MCO payments. In 2014, those taxes totaled $700 million in extra costs for other states' Medicaid programs. '"I do not feel I am getting anything in return for this," said Tennessee Medicaid Director Darin Gordon.'
https://kffhealthnews.org/news/states-to-help-pay-obamacare-tax-on-insurers/
CMS FAQ on federal Medicaid MCO taxes
https://www.medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf

Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures, *GAO* (2018)
Federal evaluators found both state and CMS evaluations of Medicaid 1115 waivers (usually based on MCOs) were not credible. They found only one with evidence of savings.
https://www.gao.gov/assets/d18220.pdf

J Marr et. al. Hospital Prices in Medicaid Managed Care, *JAMA Open Network* (2023) 6(11):e2344841
Medicaid MCOs pay widely varying prices for hospital services. Sometimes over Medicare's cost-based rates, especially for imaging.
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812254