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Health Plan Financial Report: Condition and Performance of Major Massachusetts Plans

For the Period 2015–2018 (2Q)

Prepared for the Massachusetts Medical Society
by Nancy Turnbull, November 2018

This report was prepared for the Massachusetts Medical Society in November 2018 by Nancy Turnbull, senior associate dean for Professional Education and a senior lecturer in health policy at the Harvard T.H. Chan School of Public Health.

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SUMMARY

This report provides an analysis of the financial status and condition of the major health plans operating in Massachusetts for the three-and-a-half-year period January 2015–June 2018. The analysis is based on a number of measures and financial ratios that are commonly used to assess the performance of health plans, focusing on size, profitability, efficiency, liquidity, and solvency. It is intended to provide information to Massachusetts Medical Society (MMS) members that will be useful in understanding the current financial status and competitive position of these health plans. One of the goals of the MMS in commissioning this report is to provide its members with ongoing financial information about the major Massachusetts health plans in order to understand the impact of federal and state health reform and other payment and system changes.

The assessment of health plan condition and performance represents the views of the author and not the MMS.

MAJOR FINDINGS

- The financial condition and performance of the major health plans in Massachusetts are generally strong.
- Enrollment trends have been mixed since 2015; half the plans have gained members while the other half have lost enrollment.
- The membership swings have been greatest at plans that contract with Medicaid, and most pronounced in the last six months as a result of the MassHealth ACO initiative. Some plans have large enrollment gains; other plans have major membership losses.
- Plans have generally been profitable over this time period, although margins for most plans have been quite modest. With the exception of HMO Blue, none of the plans were profitable throughout the time period; each plan had at least one unprofitable period.
- In the most recent six months the majority of plans were profitable, but profit margins were generally small, except at HPHC and Tufts Public Plans.
- Most plans have had a medical expense ratio (MER) (percent of revenue spent on medical expenses) within or above the benchmark range of 85–90%. In general, MERs have been fairly stable at most plans.
- Health plan administrative expense ratios (AERs) (percent of revenue spent on administrative expenses) are also within, or lower than, the benchmark range of 10–15%. AERs are generally lower at plans that have most of their enrollment in public programs.
- The health plans all have very strong liquidity, with high days of cash and current ratios and low days in premiums receivable (although, as of June 30, 2018, several of the plans that contract with MassHealth had a significant increase in premiums receivable, not uncommon at the end of the state fiscal year).
- All of the plans paid health care providers fairly promptly, with days of claims payable in the standard range of fewer than 45 days. The promptness of provider payment has been quite stable and consistent in recent years.

- Most of the health plans have strong solvency positions, with sound reserve positions, good equity ratios, and risk-based capital ratios well above minimum regulatory standards. The largest health plans — BCBSMA, HPHC, and Tufts — have stronger solvency positions than the smaller plans.
- With the exception of Fallon, the plans with weaker solvency positions have large, well-capitalized corporate parents that could make, or in many cases have made, significant capital contributions to bolster the financial condition of the health plans. Fallon's risk-based capital ratio is comparable to that of the other smaller plans.

METHODOLOGY

The data used in the analysis come from annual and quarterly state regulatory filings, filed by plans with the state Division of Insurance and available from the National Association of Insurance Commissioners. Health plan performance was assessed in five areas: membership size, profitability, efficiency, liquidity, and solvency. Eleven measures of performance are presented for each health plan. A more detailed description of each measure is contained in the Appendix.

Ten health plans are included:

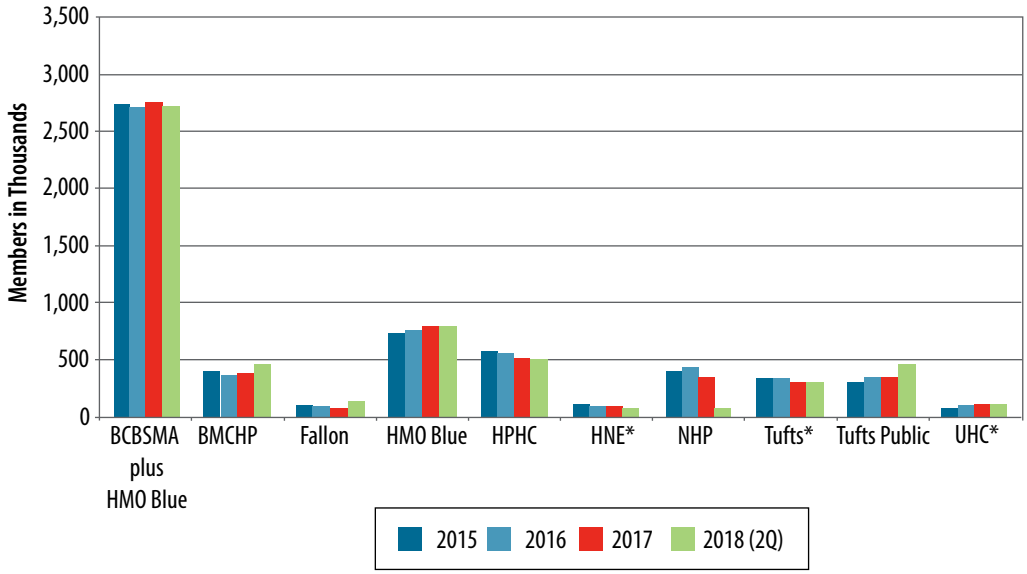
- Blue Cross Blue Shield of Massachusetts (BCBS), including HMO Blue
- HMO Blue separately
- Boston Medical Center Health Plan (BMCHP)
- Fallon Community Health Plan (Fallon)
- Harvard Pilgrim Health Care (HPHC)
- Health New England (HNE)
- Neighborhood Health Plan (NHP, but soon to be AllWays Health Partners)
- Tufts Associated Health Maintenance Organization (Tufts)
- Tufts Health Public Plans (Tufts Public, formerly Network Health)
- United Healthcare of New England (UHC)

Statutory Accounting: In their regulatory filings to the Division of Insurance, health plans are required to use statutory accounting principles (SAP) rather than the more commonly used generally accepted accounting principles (GAAP). The primary difference is that SAP is more conservative and does not permit health plans to recognize certain types of assets that are included under GAAP (e.g., receivables due more than 90 days; certain types of riskier investments). The chart on page 15 shows the year-end 2017 net worth for each of the plans in this report using statutory accounting, and the amount of health plan assets that were not admitted under SAP.

Insured vs. Self-Insured Membership: Some health plans report only insured membership on their regulatory filings, while others include insured and self-insured members.

1. Membership Size

ENROLLMENT: 2015–2018 (2Q)



	2015	2016	2017	2018 (2Q)
BCBSMA plus HMO Blue	2,781,229	2,773,693	2,857,912	2,777,530
BMCHP	307,801	289,987	313,235	406,830
Fallon	140,457	138,717	135,487	192,920
HMO Blue	749,919	761,219	793,299	791,179
HPHC	595,528	579,262	533,964	511,206
HNE*	178,595	163,986	155,369	132,644
NHP	421,777	438,286	350,427	140,151
Tufts*	306,230	307,234	298,451	295,635
Tufts Public	279,262	330,379	356,934	447,660
UHC*	114,216	127,755	144,096	153,504

* Insured members only

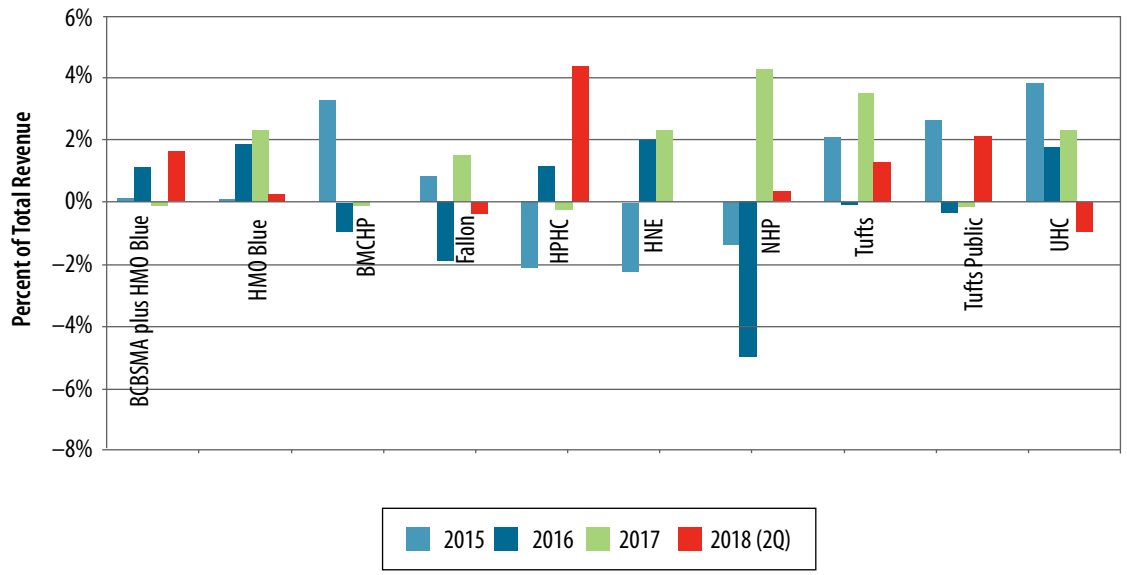
Observations

- Enrollment trends have been mixed since 2015; half the plans have gained members while the other half have lost enrollment.
- The swings have been greatest at plans that contract with Medicaid, and most pronounced in the last six months as a result of the MassHealth ACO initiative.
- Membership gains have been strongest at Tufts Public, BMCHP, Fallon, and UHC, all of which have grown significantly.

- Enrollment has declined dramatically at NHP, particularly in the first half of 2018. HNE and HPHC also had major membership losses.
- BCBSMA (including HMO Blue) had a very small membership decline over this period, although HMO Blue had membership gains.

2. Profitability

PROFIT MARGIN: 2015–2018 (2Q)



	2015	2016	2017	2018 (2Q)
BCBSMA plus HMO Blue	0.2%	1.1%	–0.1%	1.4%
HMO Blue	0.1%	1.6%	2.5%	0.4%
BMCHP	3.1%	–0.9%	–0.1%	0.0%
Fallon	0.8%	–1.8%	1.4%	–0.7%
HPHC	–2.1%	1.0%	–0.5%	4.5%
HNE	–2.3%	1.9%	2.3%	0.0%
NHP	–1.2%	–5.1%	4.3%	0.8%
Tufts	2.1%	–0.1%	3.3%	1.2%
Tufts Public	2.6%	–0.6%	–0.3%	2.2%
UHC	3.5%	1.5%	2.4%	–0.9%

Observations

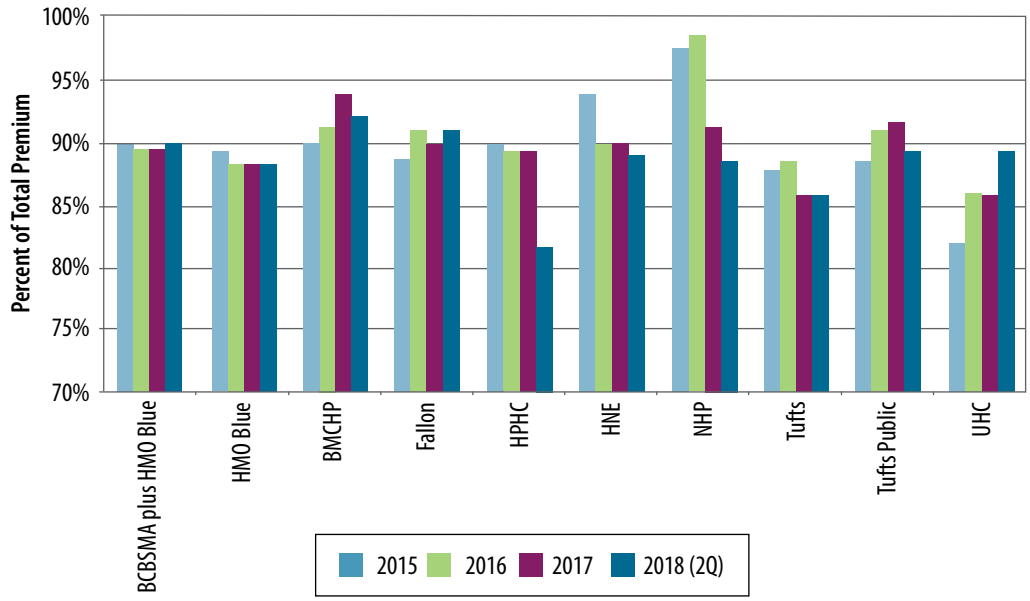
- Most plans have been profitable over this time period, although margins have generally been quite modest.

- With the exception of HMO Blue, none of the plans were profitable throughout the time period; each plan had at least one unprofitable period.
- In the most recent six months the majority of plans were profitable, but profit margins were generally small. The exceptions were HPHC and Tufts Public, which had strong financial performance in the first half of 2018, after losses in 2017.

3. Efficiency

a. Medical Expense Ratio (MER)

MEDICAL EXPENSE RATIO: 2015–2018 (2Q)



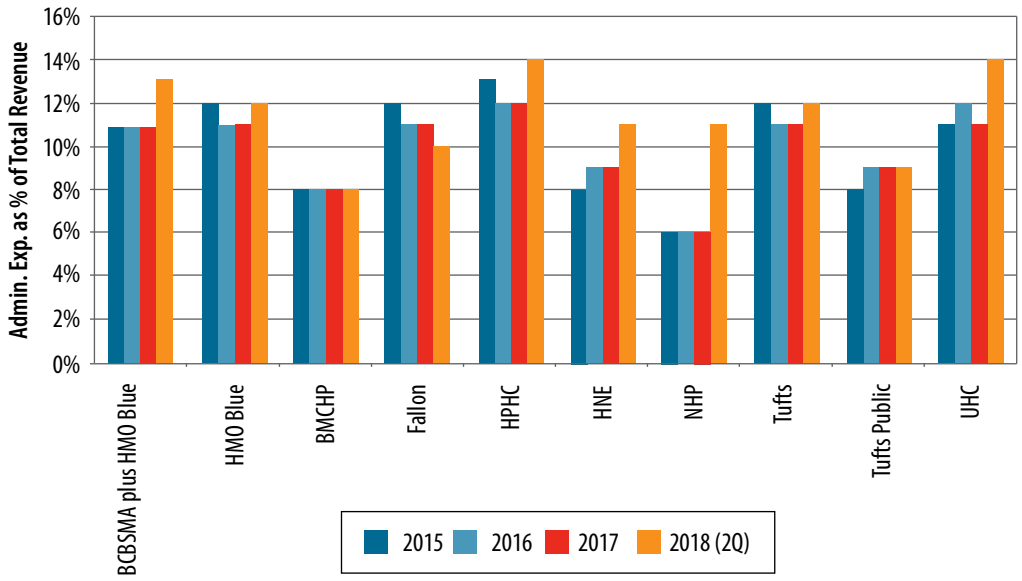
	2015	2016	2017	2018 (2Q)
BCBSMA plus HMO Blue	90%	89%	89%	90%
HMO Blue	89%	88%	88%	88%
BMCHP	90%	91%	94%	92%
Fallon	88%	91%	90%	91%
HPHC	90%	89%	89%	82%
HNE	94%	90%	90%	89%
NHP	97%	98%	92%	88%
Tufts	87%	88%	86%	86%
Tufts Public	88%	91%	92%	89%
UHC	82%	86%	86%	89%

Observations

- Most plans had MERs that are consistently in the benchmark range of 85–90%. In general, MERs have been fairly stable at most plans. Several plans, including NHP, had very high MERs in 2015 and 2016, and, as a result, poor financial performance.
- In the first half of 2018, HPHC had a significant reduction in its MER, which explains the plan's strong financial performance. NHP and Tufts Public also had reductions in their MERs, contributing to their positive financial results.

b. Administrative Expense Ratio (AER)

ADMINISTRATIVE EXPENSE RATIO: 2015–2018 (2Q)



	2015	2016	2017	2018 (2Q)
BCBSMA plus HMO Blue	11%	11%	10%	13%
HMO Blue	12%	11%	10%	12%
BMCHP	8%	8%	9%	8%
Fallon	12%	11%	9%	10%
HPHC	13%	12%	13%	14%
HNE	8%	9%	8%	11%
NHP	6%	6%	6%	11%
Tufts	12%	11%	11%	12%
Tufts Public	8%	9%	9%	9%
UHC	11%	12%	11%	14%

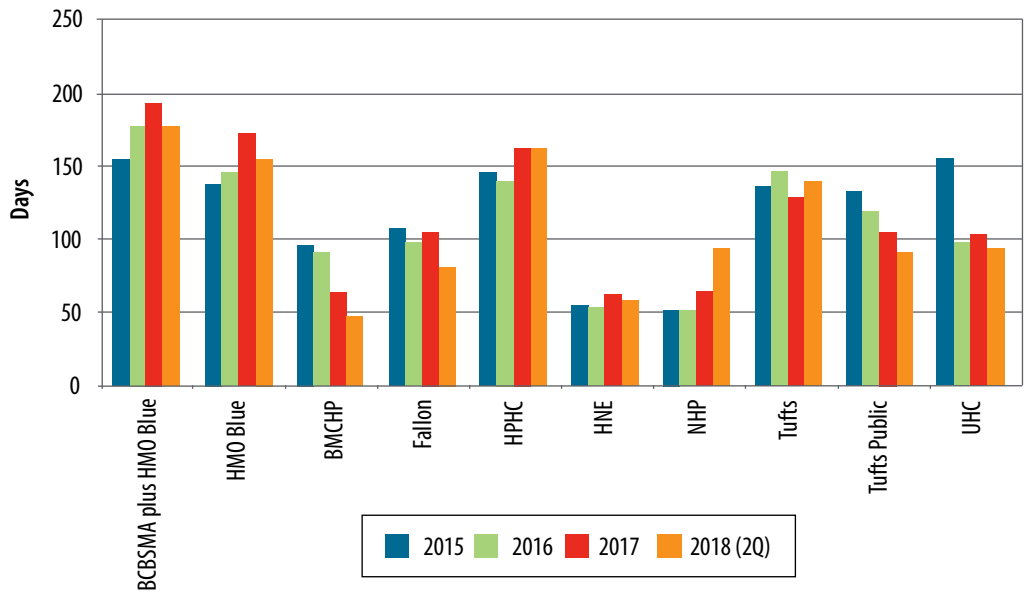
Observations

- Health plan AERs were within, or lower, than the benchmark range for this financial indicator (10–15%). Plans that contract only or mainly with public programs have lower AERs than commercial plans, consistent with the less complex product structure and other operational features of these public programs.
- AERs were stable at most plans. However, several plans had significant increases in their AERs, including BCBS, HNE, NHP, and United. These increases were generally the result of membership declines that were not matched sufficiently by administrative expense reductions to maintain a stable AER.

4. Liquidity

a. Days of Operating Cash on Hand

DAYS OPERATING CASH (WITH STOCKS AND BONDS): 2015–2018 (2Q)



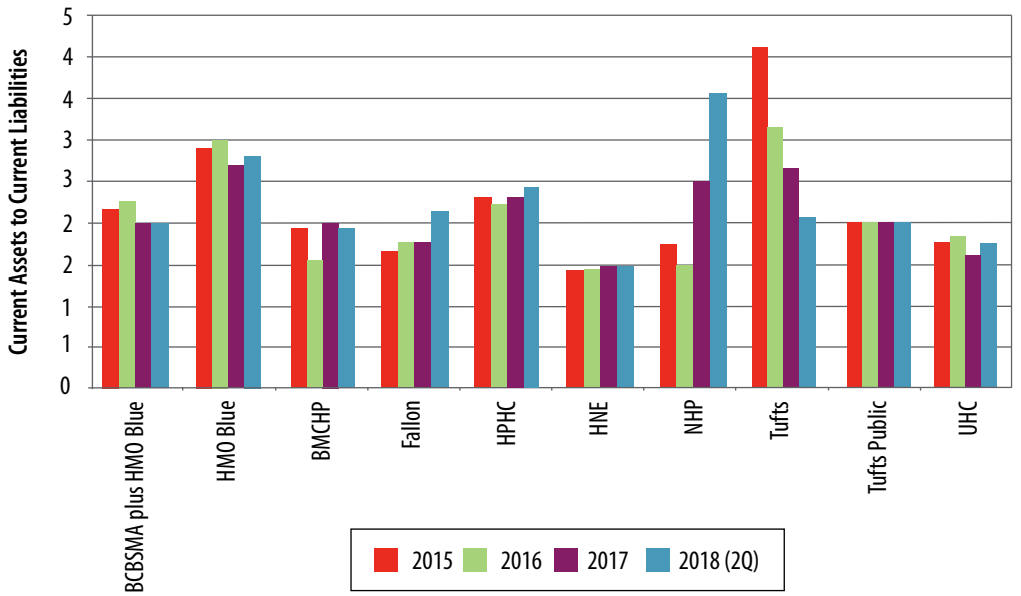
	2015	2016	2017	2018 (2Q)
BCBSMA plus HMO Blue	156	172	191	172
HMO Blue	130	145	168	158
BMCHP	92	86	64	47
Fallon	110	96	106	77
HPHC	144	136	167	167
HNE	59	55	73	70
NHP	52	53	65	87
Tufts	135	147	130	142
Tufts Public	133	118	103	85
UHC	158	96	103	88

Observations

- The cash position of almost every plan was far above the benchmark level of 30–45 days.
- However, with modest profitability at most plans in the first half of 2018, days of cash declined at a number of plans.
- BMCHP has a much lower level of operating cash than other plans and is just above the benchmark level for this financial ratio. This may be explained, in part, by the rapid membership growth of the plan in the first half of 2018.

b. Current Ratio

CURRENT RATIO (INCLUDING BONDS AND STOCKS): 2015–2018 (2Q)



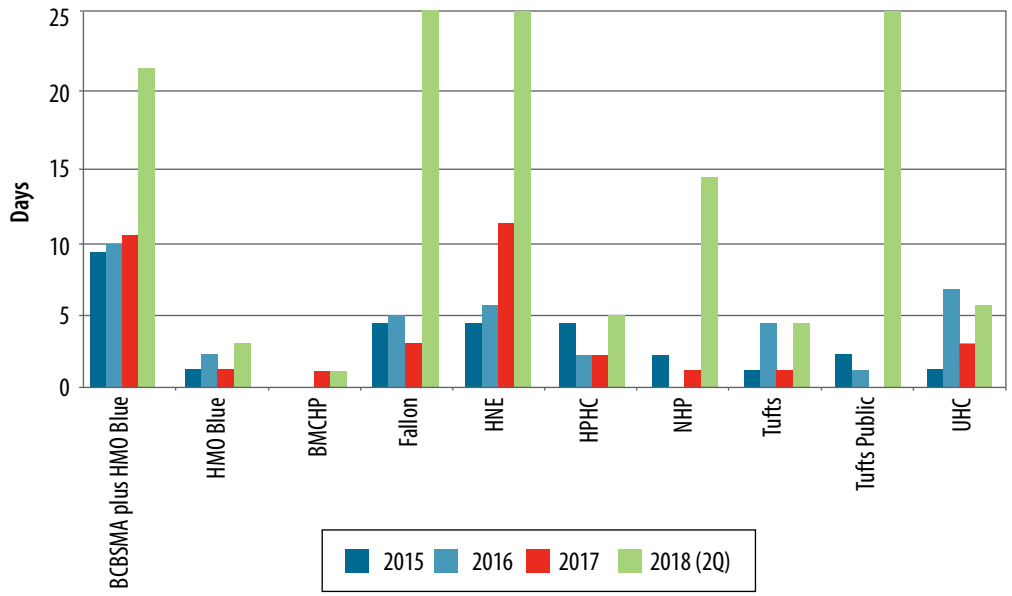
	2015	2016	2017	2018 (2Q)
BCBSMA plus HMO Blue	2.2	2.3	2.0	2.0
HMO Blue	2.9	3.0	2.7	2.8
BMCHP	1.9	1.6	2.0	1.9
Fallon	1.7	1.8	1.8	2.2
HPHC	2.3	2.2	2.3	2.4
HNE	1.4	1.4	1.5	1.5
NHP	1.8	1.5	2.5	3.6
Tufts	4.1	3.2	2.7	2.1
Tufts Public	2.0	2.0	2.0	2.0
UHC	1.7	1.8	1.6	1.7

Observation

- Every health plan has consistently had a current ratio well above the benchmark of 1.0. The ratio is stable at the plans.

c. Days in Premiums Receivable

DAYS IN PREMIUMS RECEIVABLE: 2015–2018 (2Q)

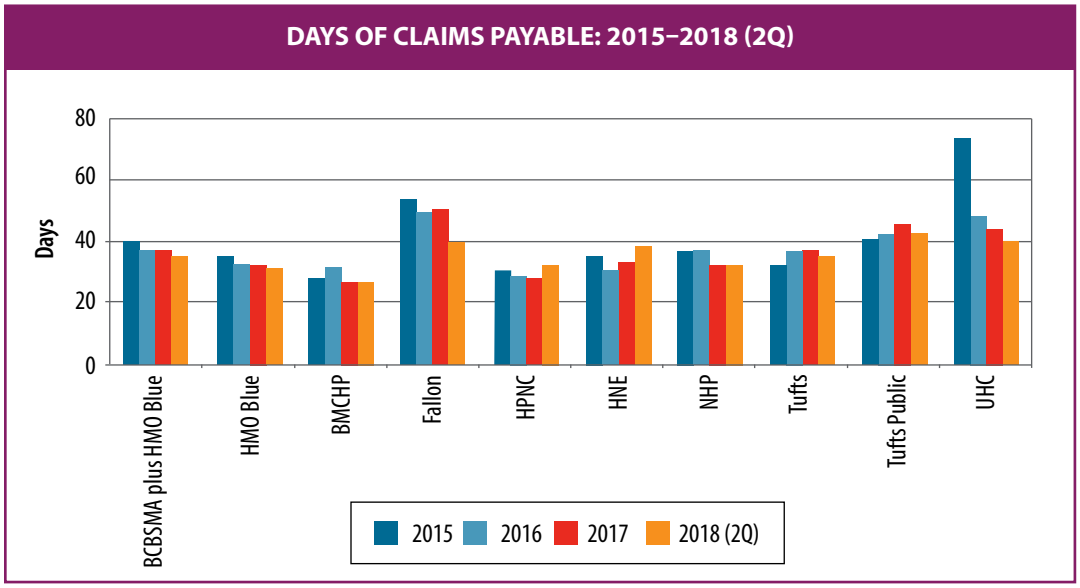


	2012	2013	2014	2015 (2Q)
BCBS plus HMO Blue	9	10	11	22
HMO Blue	1	2	1	3
BMCHP	0	0	1	1
Fallon	4	5	3	39
HNE	5	6	12	32
HPHC	4	2	2	5
NHP	2	0	1	14
Tufts	1	4	1	4
Tufts Public	2	1	<1	31
UHC	1	7	3	6

Observations

- Most plans were consistently within the benchmark standard for this ratio (<15 days), indicating that plans are collecting premiums promptly.
- As of June 30, 2018, the exceptions were BCBS, Fallon, HNE, and Tufts Public. Large receivables from MassHealth at the state's fiscal year-end explain the higher ratio at all of these plans except BCBS, which typically has a ratio above the other plans.

d. Days of Claims Payable



	2015	2016	2017	2018 (2Q)
BCBS plus HMO Blue	40	38	38	37
HMO Blue	36	34	34	33
BMCHP	29	30	27	27
Fallon	52	47	48	40
HPHC	29	28	27	31
HNE	35	30	34	39
NHP	36	36	32	32
Tufts	33	38	38	36
Tufts Public	41	42	46	43
UHC	74	47	43	40

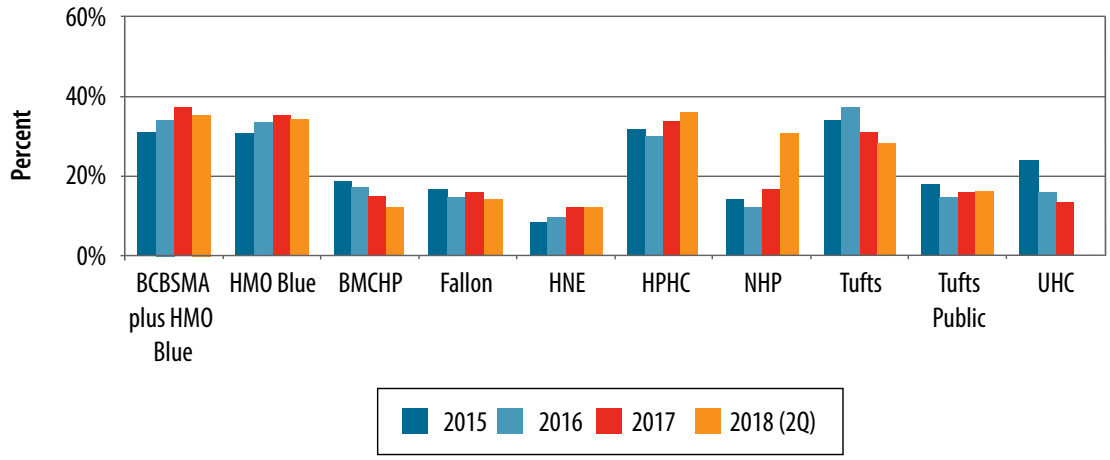
Observation

- All of the plans have consistently paid providers fairly promptly, with days of claims payable in the standard range of fewer than 45 days over this time period, and in the first half of 2018.

5. Solvency

a. Net Worth as a Percent of Medical Expense

NET WORTH AS A PERCENT OF MEDICAL EXPENSES: 2015–2018 (2Q)

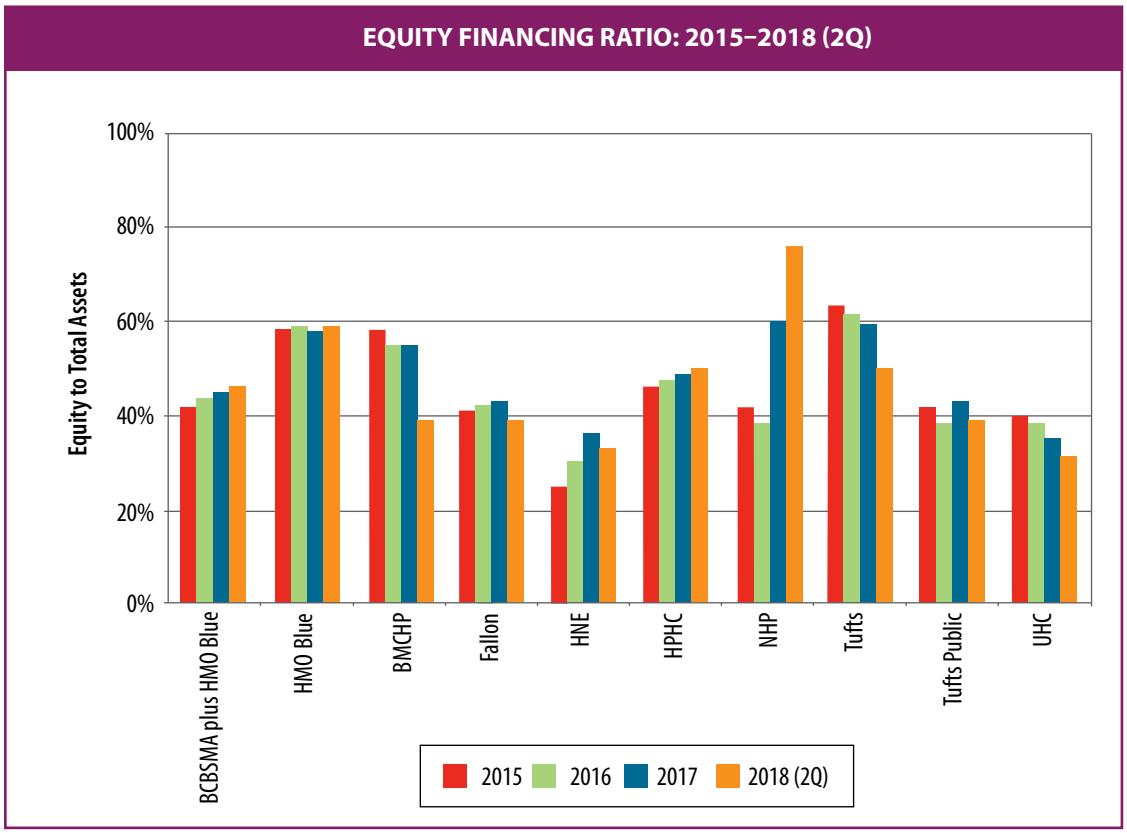


	2015	2016	2017	2018 (2Q)
BCBS plus HMO Blue	28%	31%	34%	32%
HMO Blue	28%	30%	32%	31%
BMCHP	18%	16%	15%	12%
Fallon	16%	14%	15%	12%
HNE	5%	6%	10%	10%
HPHC	30%	29%	33%	35%
NHP	9%	8%	15%	30%
Tufts	34%	35%	29%	27%
Tufts Public	17%	14%	15%	15%
UHC	23%	16%	14%	11%

Observations

- The largest health plans — BCBSMA, HPHC, and Tufts — had at least three months of medical expenses in reserve (a ratio of 25% or higher). NHP's solvency position improved as membership fell but the plan's net worth did not change.
- The other health plans — BMCHP, Fallon, HNE, Tufts Public, and United — have significantly less net worth relative to their size. With the exception of Tufts Public, the net worth position of each of these plans is not far above the benchmark level. (A ratio of 8.5% is equivalent to a plan having one month of medical expenses in reserve.)
- However, all of these plans except Fallon have well-capitalized parents. As shown below, Fallon's risk-based capital ratio is comparable to that of the other smaller plans.

b. Equity Financing Ratio



	2015	2016	2017	2018 (2Q)
BCBS plus HMO Blue	44%	45%	46%	47%
HMO Blue	57%	58%	57%	58%
BMCHP	55%	50%	50%	38%
Fallon	41%	42%	43%	38%
HNE	23%	30%	36%	34%
HPHC	49%	50%	52%	54%
NHP	42%	36%	60%	72%
Tufts	66%	63%	59%	50%
Tufts Public	41%	37%	43%	38%
UHC	40%	38%	35%	30%

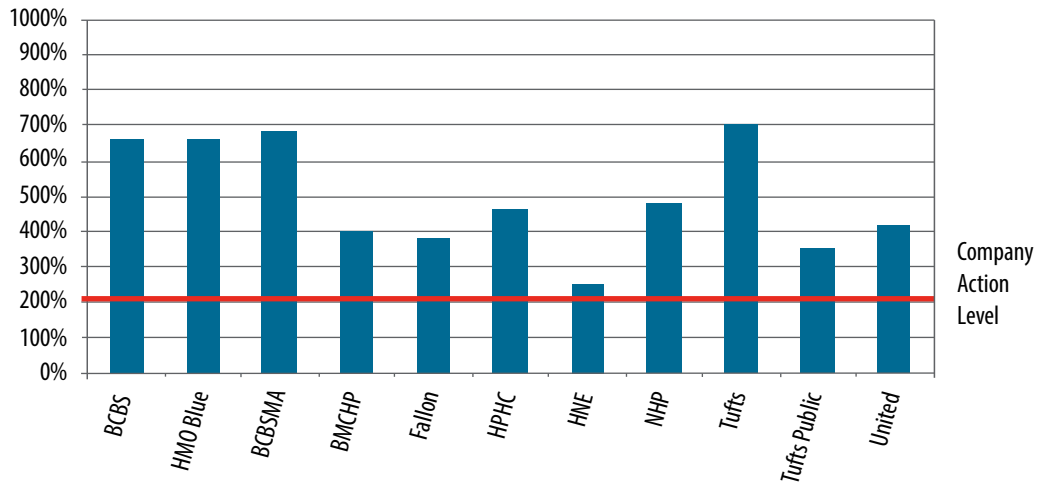
Observations

- Every plan is well above the benchmark level for this ratio (25%) as of June 2018. Over the entire time period, the ratio has been fairly stable at most plans.
- The solvency position of Tufts Associated HMO, the entity that is licensed as a health plan in Massachusetts, declined slightly because of a $25 million dividend payment to Tufts Health Plan, Inc., which assumed control of TAHMO in October 2017. In addition, Tufts Public received a $25 million surplus infusion from its parent, Tufts Health Plan.

- NHP's equity ratio improved significantly. Although the plan had very large membership losses, and a large decline in assets, its net worth remained stable, which improved the equity ratio. In contrast, BMCHP's equity position declined as net worth gains were much smaller than the asset increases that resulted from a significant gain in membership.

c. Risk-Based Capital (RBC) Ratio

RISK-BASED CAPITAL RATIO YEAR END 2017:
RATIO OF TOTAL ADJUSTED CAPITAL TO AUTHORIZED CONTROL LEVEL

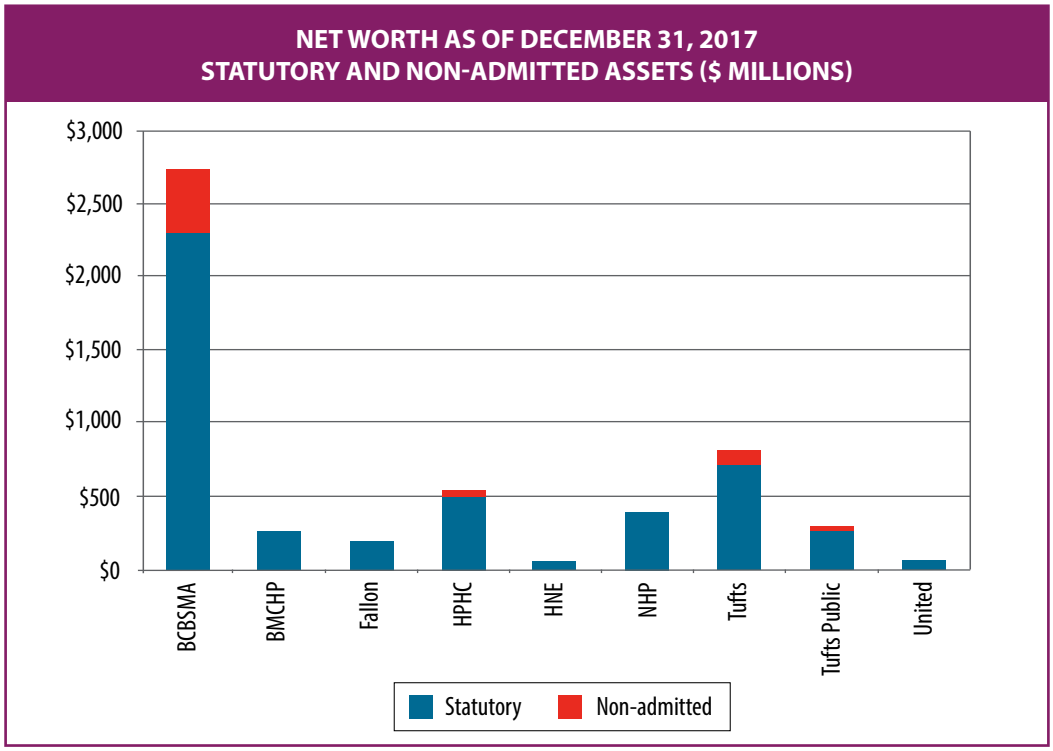


Under RBC, a health plan calculates its ACL — minimum required surplus — taking into consideration five different kinds of risk — the asset risk of affiliates, risk due to other assets (including other invested assets), underwriting risk, credit risk, and general business risk. The lower the RBC ratio, the worse the solvency condition of the plan. A health plan may be subject to specified actions by DOI whenever its RBC ratio is lower than 200%.

Observations

- This is a measure of solvency used by insurance regulators for regulatory monitoring. It is developed through a complex formula that takes into account the types of risk faced by a health plan (e.g., product mix, type of investments). The higher the RBC ratio, the stronger the solvency position of the plan. A ratio below 200% generally *requires* regulatory action and heightened oversight.
- All of the plans except Health New England are well above the Company Action Level.
- HNE has a large corporate parent, Bay State Health, so its relatively weak solvency position is of less concern than if the plan were independent.

Total Statutory Net Worth and Non-Admitted Assets



APPENDIX

Measures of Financial Performance Used in the Report

1. Membership Size

Total Membership of the Plan: Larger size is an advantage, giving a plan the potential for economies of scale in terms of administrative cost and negotiating better payment rates with providers.

2. Profitability

Profit Margin: The profit margin is calculated as net income (after taxes) divided by total revenue.

3. Efficiency

a. **Medical Expense Ratio:** The medical expense ratio is calculated by dividing total medical expenses by total revenues. The standard for this ratio is in the range of 85–90%. Health plans with ratios in excess of this range may not be managing medical costs effectively, or premiums may be set too low.

b. **Administrative Expense Ratio:** The administrative expense ratio is calculated by dividing the plan's total administrative expenses by total revenue. It measures efficiency in managing operations: a low administrative expense ratio indicates efficient plan administration. The standard for this ratio is between 10% and 15%.

4. Liquidity

a. **Days of Operating Cash on Hand:** Days of cash on hand, or days of operating cash, is calculated as cash and short-term investments divided by total expenses per day. It is a measure of operating liquidity and shows how many days of operating expenses the plan could pay with current cash balances. The standard for this ratio is 30–45 days.

b. **Current Ratio:** The current ratio is the current assets divided by current liabilities. The standard for this ratio is 1.0 or greater; lower values imply that the plan is using debt financing.

c. **Days in Premiums Receivable:** This ratio is calculated by dividing premiums receivable by premium revenue per day. The standard is 15 days or less. High levels of days in premiums receivable could indicate collection problems or difficulties with several large accounts.

d. **Days of Claims Payable:** This ratio is calculated as total claims payable divided by medical expenses per day (including incurred but not reported claims). It indicates how quickly, on average, the plan pays providers. The normal level for this indicator depends on a plan's contracts with providers, but the standard is in the range of 30–45 days.

5. Solvency

a. **Net Worth as a Percent of Medical Expenses in Reserve:** This ratio is calculated by dividing net worth by annual medical expenses. The ratio measures plan solvency and is an indicator of the ability of reserves to meet medical expenses. A ratio of 8.5% is equivalent to a plan having one month of medical expenses in reserve. A ratio of 6% is considered the *minimum* level by most regulatory standards..

b. **Equity Financing Ratio:** The equity financing ratio is calculated as net worth divided by total assets and measures the percentage of total assets that have been financed with equity. High values imply little debt financing for asset acquisition and low financial leverage. The standard for this ratio is 25% or higher.

c. **Risk-Based Capital Ratio:** This is a measure of solvency used by insurance regulators for regulatory monitoring. It is developed through a complex formula that takes into account the types of risk faced by a health plan (e.g., product mix, type of investments). The higher the RBC ratio, the stronger the solvency position of the plan. A ratio below 200% generally *requires* regulatory action and heightened oversight, and some states take action at higher ratios (e.g., below 300%) as well.

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