

**The Financial Performance of PSOs
During the First Year of the ACA Mandated Coverage**

**Michael J. McCue, DBA
Timothy R. Stack Professorship
Department of Health Administration
Virginia Commonwealth University**

ABSTRACT

Purpose: The passage of the ACA regulation in 2014 requiring mandated coverage for individual health insurance, has sparked a recent wave of health care providers sponsoring their own health insurance plans, which are called “provider-sponsored organizations” (PSOs). The aim of this study is to assess the financial performance of PSOs during the first year of mandated coverage under the ACA.

Methods: The study identified 35 PSOs and computed the median values of their financial performance ratios: medical loss, administrative cost and profit margin ratios. The study conducted a pair-wise Wilcoxon signed rank tests of differences in median values between 2013 and 2014, the first year of the mandated coverage. In addition, the study developed profit margin categories based on the bottom and top 25th quartiles of the profit margin ratio.

Results: Assessing the change in financial performance from 2013 to 2014 of 35 provider-sponsored organizations, reflects a significant decline in administrative costs of 2.3 percent, which contributed to a 5.2 percent increase in profit margin. Overall, PSOs offered primarily HMO plans and “on” exchange plans. However, PSOs in the top profit margin quartile increased their profit margin by 26.8 percentage points while PSOs in the bottom profit margin quartile decreased the profit margin by 19.7 percentage points.

Conclusion: For the overall sample of 35 PSOs, these findings imply that PSOs were able to reduce their operating losses by controlling their administrative costs. However, within the top profit margin quartile, PSOs were able to better manage and control their medical costs during the first year of the individual mandate, which contributed to a positive profit margin.

Introduction

In the 1980s and 1990s, both federal and state governments' initiatives to control health care costs of Medicare and Medicaid beneficiaries, coupled with corporate pressure to curtail rising healthcare costs among their employees, spurred the sponsorship of health plans by health care providers (Davis, 1997). In 1996, 737 hospitals and health care systems had arrangements with health plans by affiliation, joint venture, alliance or ownership (McCue, 2000). However, by late 1990s, provider-sponsored plans started to incur operating losses, which eroded the capital position of providers and led to the closure or sale of these health plans.

Several underlying factors in the health care marketplace have sparked a recent wave of health care providers sponsoring their own health insurance plans. First, the passage of the Affordable Care Act (ACA) expanded commercial individual plans to under- and uninsured populations. Second, a movement to bundled payment systems, which reimburse providers a fixed payment for specific services and achieving quality care benchmarks. Third, there has been vast improvement in information systems to utilize clinical data to design and manage patient care programs. Finally, there has been a shift by employers to contract directly with health care providers because of their lower cost and accessibility of a local network (Copeland, Schmidt, Shukla, & Kumar, 2015). Currently, there are 120 health plans sponsored by health care systems, which either offer an array of insurance products, Medicare, Medicaid and commercial insurance, or focus on a specific product line.

The first year of mandated coverage under the ACA for individual health insurance was 2014. A descriptive analysis found that health insurers selling health plans on the individual market loss \$2.5 billion in 2014 (Hall and McCue, 2014). Preliminary reports of financial losses on the individual exchange in 2015 and 2016 are causing the national, publicly traded health insurers to either consider exiting the market or not expanding coverage (Mathews, 2016a; Mathews, 2016b). Although, provider-sponsored plans account for only 4.3 percentage of the commercial market, an analysis indicates enrollment growth in the individual market increased to 670,000 members in 2014 from 270,000 members in 2010. The same analysis also found that 29 percent of health plans sponsored by provider-organizations on the individual market earned a profit (Khanna, Smith, & Sutaaria, 2016). The aim of this study is to conduct a more detailed financial assessment of how provider-sponsored insurers or organizations (PSOs) performed on the individual market during the first year of mandated coverage under the ACA. Specifically, this descriptive study will assess how much of the premium dollars generated by PSOs were paid out in medical claims and quality of care expenses as well as administrative expenses and how much was earned in profit, and to measure the changes in these measures from the prior year.

Data and Methods

Sample

The provider-sponsored health insurers or organizations (PSOs) were identified from the AIS (Atlantic Information Services) 2014 Directory. The study identified 52 PSOs covering individual members within the commercial health insurance market from the Directory. The financial data for the individual market were collected from CCHIO medical loss ratio (MLR) data basis for 2014 (CCHIO, 2014).ⁱ To identify PSOs that offered ACA-compliant health plans, the study merged the MLR data with the 2014 unified rate review template (URRT) rate filing

data.ⁱⁱ In addition, this rate filing data allowed the study to identify the number of ACA-compliant plans offered “on” versus “off” exchanges within the PSO sample.

Data for 2014 included medical claims from “run-out” expenses paid through March 2015. Run-out data was sampled because the database included the effects of the government’s premium stabilization program. This program was defined as: “the 3-Rs” (reinsurance, risk adjustment, and risk corridor payments).ⁱⁱⁱ The study adjusted the data for reductions in actual risk corridor payments and advance cost sharing reduction payments. Data prior to the onset of the mandated coverage included the run-out data for 2013; however, the 3-R adjustments did not take effect until 2014. Finally, to ensure reliable financial data, the study excluded PSOs with less than 1,000 members or non-credible insurers; and PSOs without MLR data in 2013, which resulted in a final sample of 35 PSOs.

Methodology

Given the small sample size of 35 PSOs, the study measured the median values of their financial performance measures and conducted pair-wise Wilcoxon signed rank tests of differences in median values between 2013 and 2014. In addition, the study developed profit margin categories based on the bottom and top 25th quartiles of the profit margin ratio. The study identified nine PSOs within the top 25th quartile earning a profit margin greater than 2.1 percent and nine PSOs within the bottom 25th quartile operating at a profit loss of 12.2 percent. The study measured the differences in financial performance ratios between 2013 and 2014 within each profit margin category.

To assess the key traits of these PSOs, which may impact financial performance, the study measured the growth in enrollment size between 2013 and 2014. As result of the mandated coverage within the individual market, median enrollment growth between 2013 and 2014 was 64 percent from 5,132 members in 2013 to 8,427 members in 2014. Across profit margin categories, median membership growth ranges from 23 percent in the bottom profit margin group to 36 percent for top profit margin category. This finding suggests both profit categories experienced substantial enrollment growth between 2013 and 2014.

The study also accounts for percentage of total plans offered by PSOs that were “on” versus “off” exchange plans as well as HMO versus PPO plans.^{iv} In terms of PSOs offering health plans “on” public market exchanges compared to “off” exchange, the study formed three categories: PSOs offering only “on” exchange plans; PSOs offering a combination of “on” and “off” exchange plans; and PSOs offering only “off” exchange plans. The study found that 54 percent of PSOs offered only “on” exchange plans, while 40 percent offered a combination of “on” and “off” exchange plans, and 6 percent offered only “off” exchange plans. Across two profit margin categories, 55 percent of the top profit margin group while 44 percent of the bottom profit margin group offered only “on” exchange plans. Within the top and bottom profit margin groups, 44 percent offered a combination of “on” and “off” exchange plans. Overall, there were no statistical differences between the frequency count of PSOs by profit margin categories and the frequency count of PSOs by exchange categories, which suggest the percentage of “on” versus “off” exchanges was similar across profit categories. Finally, the study found the type of plans offered by PSOs were primarily HMO plans, specifically 77 percent of all plans offered were HMOs.

Financial Performance Ratios

The study employed three ratios to assess financial performance: medical loss ratio, administrative cost ratio and profit margin (McCue, Hall, & Liu, 2013). Medical loss ratio (MLR) is defined as medical claims plus expenses for improving health care quality as a percentage of net adjusted premiums earned after reinsurance. The administrative cost ratio is defined by total administrative costs and claims adjustment expenses as a percentage of net adjusted premiums after reinsurance, and profit margin (or underwriting gain and loss) measures operating income earned from net adjusted premiums.

Results

All PSOs

In assessing the financial performance between 2013 and 2014, both administrative cost ratio and profit margin ratios were statistically significant (see Exhibit 1). Administrative cost ratio declined significantly by 2.3 percentage points while profit margin increased by 5.2 percentage points. In 2013, PSOs' health plans operating within the individual market incurred a median operating loss of 9.0 percent, while in 2014 this median loss was reduced to only -3.8 percent. Between the two time frames there was no significant change in medical loss ratio.

**Exhibit 1: Median Performance Ratios for all 35 PSOS
2013 to 2015**

	2013	2014	Change 2014-2013	<i>p</i>
Medical loss ratio	95.9%	91.8%	-4.0%	
Administrative cost ratio	13.7%	11.4%	-2.3%	*
Profit margin ratio	-9.0%	-3.8%	5.2%	*

* Significant at $p < .01$

PSOs in Top and Bottom Profit Margin Categories

Results by profit margin categories are in Exhibit 2. For PSOs in the top 25th profit margin category, significant results occurred for the changes in MLR and profit margin ratios between 2013 and 2014. The MLR decreased from 100.3 percent in 2013 to 82.4 percent in 2014, a decline of 17.9 percentage points. In 2013, the profit margin ratio was -15.8 percent and increased by 26.8 percentage points to 11.0 percent in 2014.

For PSOs in the bottom 25th profit margin category, significant results occurred for the changes in MLR and profit margin ratios between 2013 and 2014. In 2013, the MLR rose from 93.7 percent to 110.7 percent in 2014, an increase of 17.1 percentage points. In 2013, the profit margin ratio was -4.8 percent and decreased by 19.7 percent points to -24.5 percent in 2014.

Exhibit 2: Median Performance Ratios for 9 PSOs within Top and Bottom 25th Percentile Profit Margin Categories

	2013	2014	Change 2014- 2013	<i>p</i>
Top 25th Quartile Values				
Medical loss ratio	100.3%	82.4%	-17.9%	*
Administrative cost ratio	9.6%	8.7%	-0.9%	
Profit margin ratio	-15.8%	11.0%	26.8%	*
Bottom 25th Quartile Values				
Medical loss ratio	93.7%	110.7%	17.1%	*
Administrative cost ratio	13.7%	14.3%	0.6%	
Profit margin ratio	-4.8%	-24.5%	-19.7%	*

* significant at $p < .01$

Discussion

Overall PSOs reduced their operating losses by more than half after the first year of mandated individual coverage of the ACA in 2014. This improvement in profitability may have stemmed from growth in membership, which helped create economies of scale by lowering the fixed costs of administrative functions. A major administrative advantage of PSOs is their ability to capture both claims and clinical data, which in turn, limits the need for utilization review and creates efficiencies in claims processing (Khanna, Smith, & Sutaria, 2015). Although there was no significant change in MLR from 2013 to 2014, PSOs in the top quartile of MLR experienced a greater decline than PSOs in the bottom quartile. This outcome implies that PSOs incurring higher medical expenses in 2013 were able to better manage and control these costs during the first year of the individual mandate than those in the bottom quartile.

A more refined assessment of PSOs by profit margin categories and their changes from 2013 was also conducted. PSOs in the top profit quartile group reduced their MLR by 17 percentage points. An array of factors unique to PSOs ranging from enrolling healthy members, improving care coordination, and reducing the intensity of services, may have led these PSOs to control their medical costs and improve profitability. For the bottom profit quartile group, the opposite occurred with higher medical costs between 2013 and 2014 driving profit losses. This outcome suggests that these PSOs may have enrolled unhealthy, high acuity members that were greater utilizers of medical services. Conversely, this finding suggests that these PSOs may have lacked the medical infrastructure to manage and coordinate member care. For the remaining PSOs in the medium distribution, lowering administrative costs may have contributed to improved profitability. Again, the unique benefit of PSOs to integrate clinical and claims data, coupled with an increase in enrollment, may be underlying reasons for these lower costs.

A limitation of the study is the small sample size within the top and bottom 25th quartiles, which included only nine PSOs. Smaller sample size may have resulted in fewer statistical results. In addition, smaller sample size limited the analysis of higher cost PPO plans since more than 70 percent of the plans offered by PSOs were HMOs. Prior work (Coe, Finn, Miskufova, Oatman, & Weber, 2016) found that managed care plans, such as HMOs, incurred lower medical expenses and higher margins than PPO plans. Smaller sample size may have influenced the statistical association of “on” versus “off” exchange plans with financial performance, which was not statistically significant. Top profit margin PSOs offered a slightly higher percentage of “on” exchange plans, 55 percent, compared to 44 percent for plans in the bottom margin profit category, which suggests “on” exchange plans may have impacted the financial performance of PSOs. Members covered by “on” exchange plans were eligible to receive subsidies to pay a greater portion of the plan’s premium as well as cost-sharing costs. Another major limitation was the fact that 2014 was the first year of mandated individual coverage and health insurers did not have actuarial experience in projecting rates for high proportion of uninsured individuals with pent up demand for medical services. Recent studies (Blue Cross Blue Shield Association [BCBS], 2016; Blasé, Badger, Haislmaier, & Chandler, 2016) found substantial losses within the individual market during this first year. Future studies will be able to assess the financial performance of PSOs after the individual market has stabilized, which should help expand the sample size of PSOs and provide medical claims data beyond the first year of mandated coverage.

Information about the Author:

**Michael J. McCue, DBA
Timothy R. Stack Professorship
Department of Health Administration
Virginia Commonwealth University
Telephone: 804-828-1893
Email: mccue@vcu.edu**

References

- Blase B., Badger, D., Haislmaier, E.F., & Chandler, S.J. (2016, June 28). *Affordable Care Act turmoil: large losses in the individual market portend an uncertain future*. Working paper. Retrieved from <http://mercatus.org/publication/affordable-care-act-turmoil-large-losses-individual-market-portend-uncertain-future>
- Blue Cross Blue Shield Association (BCBS). (2016). *Newly enrolled members in the individual health insurance market after health care reform: the experience from 2014 and 2015*. Retrieved from http://www.bcbs.com/healthofamerica/newly_enrolled_individuals_after_aca.pdf
- Coe, E., Finn, P., Miskufova, M., Oatman, J. & Weber, K. (2016). Exchanges three years in: market variations and factors affecting performance. *Intelligence Brief (McKinsey Center for U.S. Health System Reform)*. Retrieved from <http://healthcare.mckinsey.com/exchanges-three-years-market-variations-and-factors-affecting-performance>
- Copeland, B., Schmidt, B., Shukla, M. & Kumar, N. (2015). Provider-sponsored health plans positioned to win the health insurance market shift. *Deloitte Center for Health Solutions*. Retrieved from <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-provider-sponsored-plans.pdf>
- Center for Consumer Information and Insurance Oversight (CCIIO). (2014). *Medical Loss Ratio Data and System Resources*. Retrieved from <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>
- Davis, G. S. (1997). Provider-sponsored organizations: the next generation of managed care? *Managed Care Journal*. Retrieved from <http://www.managedcaremag.com/archives/1997/9/provider-sponsored-organizations-next-generation-managed-care>
- Khanna, G, Smith E., & Sutaria, S. (2015). Provider-led health plans: the next frontier—or the 1990s all over again? *McKinsey & Company*. Retrieved from <http://healthcare.mckinsey.com/provider-led-health-plans-next-frontier%E2%80%94or-1990s-all-over-again>
- Khanna, G., Narula D., & Rao, N. (2016). The market evolution of provider-led health plans. *McKinsey & Company*. Retrieved from <http://healthcare.mckinsey.com/provider-led-health-plans-market-evolution>

Mathews, A.W. (July 27, 2016a). Anthem projecting losses on Affordable Care Act plans this year. *Wall Street Journal*. Retrieved from <http://www.wsj.com/articles/anthem-raises-outlook-reiterates-cigna-purchase-plans-1469617063>

Mathews, A.W. (August 2, 2016b). Aetna joins rivals in projecting loss on Affordable Care Act plans for 2016. *Wall Street Journal*. Retrieved from http://www.wsj.com/articles/aetna-tops-views-stops-aca-expansion-plans-1470134736?cx_navSource=cx_picks&cx_tag=contextual&cx_artPos=3#cxrecs_s

McCue, M.J. (2000). What determines hospital sponsorship of an HMO? *Inquiry*, 37 (3) 268-281.

McCue, M.J. & Hall, M. (2016). Promoting value for consumers: comparing individual health insurance markets inside and outside the ACA's exchanges. *Issue Brief (Commonwealth Fund)*. Retrieved from <http://www.commonwealthfund.org/publications/issue-briefs/2016/june/insurance-exchanges-promote-value>

McCue, M.J., Hall, M. & Liu, X. (2013, September). Impact of medical loss regulation on the financial performance of health insurers. *Health Affairs*, 32(9) 1546-1551.

ⁱ However, the MLR database does not provide detailed financial information about health insurers offering non-compliant plans on the individual market, specifically grandfathered plans.

ⁱⁱ Qualified health plan data allows one to measure financial performance of health insurers with plans offered on the public exchange. However, qualified health plan data were not available for 2013, therefore the study used medical loss ratio runout-data for 2014 and 2013.

ⁱⁱⁱ Blumenthal, D., "The Three R's of Health Insurance," Commonwealth Fund, March 5, 2014 <http://www.commonwealthfund.org/publications/blog/2014/mar/the-three-rs-of-health-insurance>

^{iv} The study included EPO plans, exclusive provider plans with the HMO plan category and Point of Service (POS) plans as part of PPO plan category.