MILLIMAN REPORT

Medicaid managed care financial results for Q3 2020

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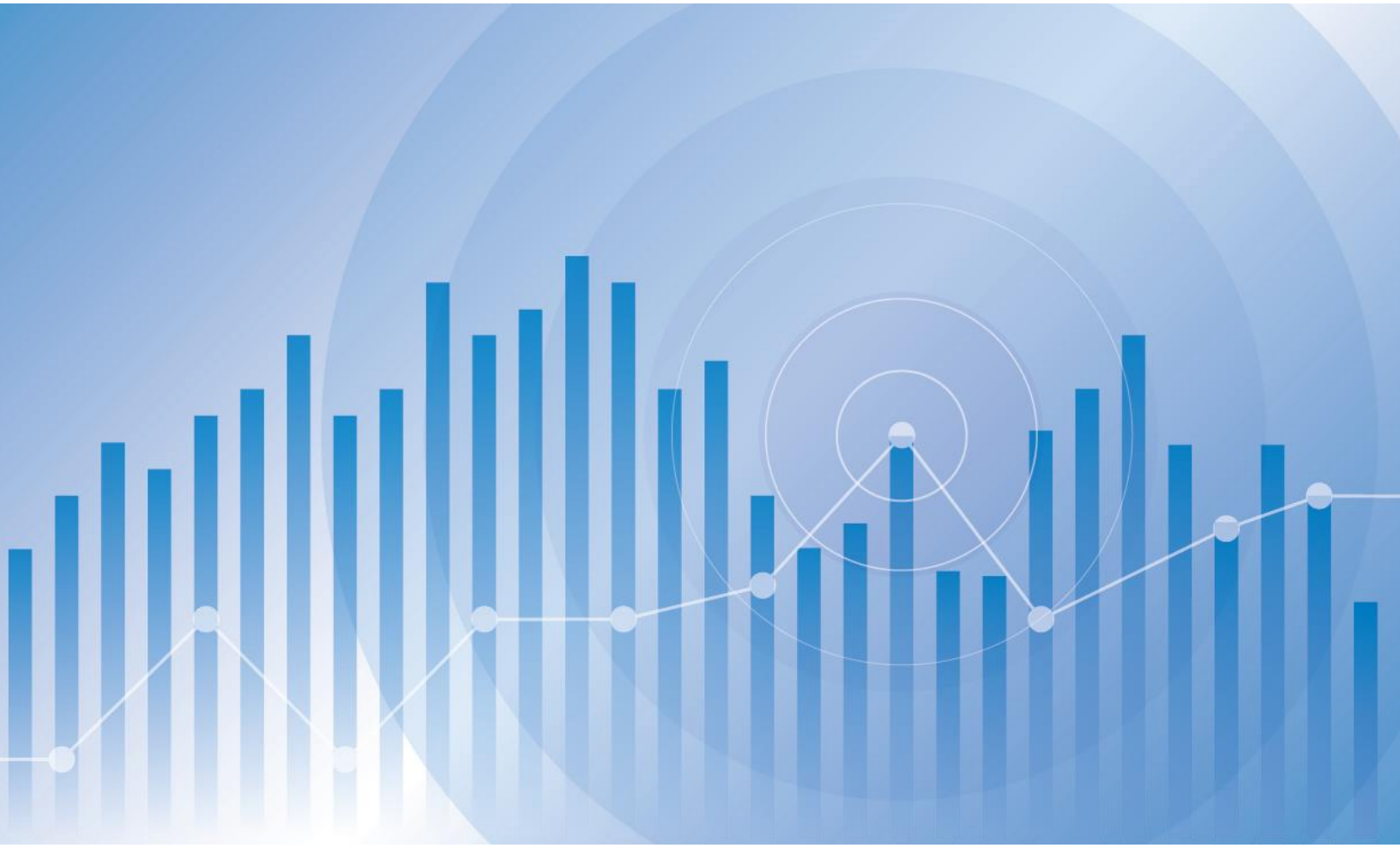

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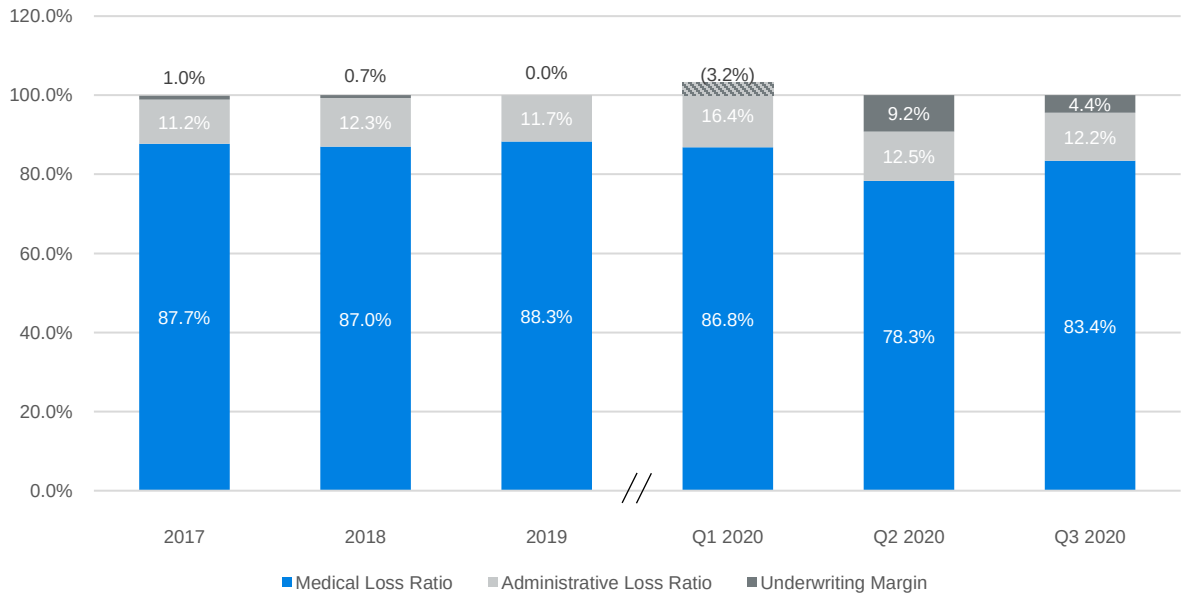
Executive summary

On March 13, 2020, the COVID-19 outbreak was declared a national emergency in the United States, retroactively to March 1, 2020. As a result, the Secretary of the U.S. Department of Health and Human Services (HHS) was given emergency authority to temporarily waive or modify certain requirements of the Medicaid program.[1] Additionally, state governments ordered various directives and protocols to help reduce the transmission of the virus. Although the levels of medical service utilization have impacted payers, providers, and healthcare markets differently since March 2020, dampened medical expenditures[2] has been a consistent theme. This report is intended to add additional insight into the financial effects of the pandemic on Medicaid managed care organizations (MCOs).

We previously analyzed financial information reported for the first six months of 2020 to help assess how the COVID-19 pandemic has impacted the financial performance of Medicaid MCOs.[3] This report provides an update utilizing third quarter (Q3) 2020 financial statements. Consistent with our Q2 report, we are focusing on the medical loss ratio (MLR) and underwriting margin financial metrics with additional review of the incurred but not yet paid (IBNP) reserves reported by MCOs through September 30, 2020. The Medicaid MCOs reviewed were limited to those with 90% or more of their revenue attributable to the Medicaid line of business and include organizations in 30 states, the District of Columbia, and Puerto Rico.

The graph in Figure 1 highlights the underwriting margins being reported on a national basis for the Medicaid-focused companies meeting the selection criteria for this study.

FIGURE 1: CALENDAR YEAR 2017 THROUGH Q3 2020 MEDICAID FINANCIAL RESULTS



Notes

1. Quarterly financial results are reported on a year-to-date basis, and therefore Q2 and Q3 2020 financial results were estimated based on the incremental change in the quarter.
2. Q1 2020 reported underwriting loss is 3.2%.

[1] The full text of the presidential proclamation is available at https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/.

[2] U.S. Bureau of Economic Analysis (September 30, 2020). News Release: Gross domestic product (third estimate), corporate profits (revised), and GDP by industry, second quarter 2020 (Table 2). Retrieved October 21, 2020, from https://www.bea.gov/sites/default/files/2020-09/gdp2q20_3rd_0.pdf.

[3] See https://us.milliman.com/en/insight/medicaid-managed-care-financial-results-for-q2-2020.

Figure 1 covers the period from calendar year 2017 through Q3 2020. Caution must be used when comparing the quarterly financial results in 2020 to the calendar years 2017 through 2019 metrics for the following reasons.

- Quarterly results inherently include seasonal variances and therefore must be interpreted with caution. The financial effects commented on in this report are beyond standard seasonal patterns and are presented without adjustment.
- With the unprecedented impact of COVID-19 on the healthcare landscape, many states are retrospectively making changes to their Medicaid managed care programs, including implementing risk corridors or making mid-year rate adjustments.[4] It is unclear to what extent these or other changes to the Medicaid programs are currently reflected in the MCO financial statements.
- Because of the cumulative nature of quarterly financial statement reporting, any restatements to the expenses and revenue reported in the prior quarterly financial statement would inherently be reflected in the quarter in which the restatement was reported.
- A greater degree of volatility will naturally be present in quarterly financial results relative to annual results.

KEY FINDINGS

- **Underwriting gain**. An estimated 9.2% underwriting gain was reported for Q2 2020 along with 4.4% for Q3 2020, compared to underwriting gains between 0.0% and 1.0% in calendar years 2017 through 2019.
  - This positive underwriting margins in 2020 may result in larger MCO gains in 2020 than previous years. However, it will be critical to observe what portion of the underwriting gains from the first nine months of 2020 will be reduced by realization of pent-up demand for healthcare services or affected by recent surges in COVID-19 cases across the country.
  - MCOs covering less costly populations, for example children or nondisabled adults, tended to report higher underwriting gains in Q2 and Q3 2020 than MCOs covering more costly populations with regular healthcare needs, such as disabled and long-term supports and services (LTSS) populations.
- **Medical loss ratio**. The 2020 MLR continues to run lower than the MLR observed in 2017 through 2019.
  - The emergency room (ER) benefit expense as a percentage of premium decreased by approximately 40% and 30% in Q2 and Q3 2020, respectively, relative to the average of 2017 through 2019.
  - Ambulatory medical visits in Q2 2020 appeared to decrease relative to prior periods, while Q3 2020 values reflect utilization more consistent with historical time periods. Changes in inpatient admissions in Q2 2020 and Q3 2020 were not discernibly different from utilization changes observed in historical periods.
  - Reserves (as a percentage of estimated incurred claims) held by MCOs in Q3 2020 are approximately 8.7% higher than in Q3 reserve levels reported in calendar years 2017 through 2019. This incremental reserve amount represents 1.2% of incurred claims through Q3 2020 and could be attributable to operational disruptions or uncertainty driven by the pandemic.
- **Administrative loss ratio**. The higher administrative loss ratio (ALR) and corresponding underwriting loss in Q1 2020 is attributable to the Health Insurer Fee tax being fully realized in this quarter for many MCOs. Therefore, the change in MLR may be a better metric to understand the potential impact of COVID-19 on health plan financial experience. The Q1 2020 MLR is slightly lower (approximately 1%) compared to previous reporting periods.

The remainder of this report provides additional analysis supporting our findings and discusses specific items contributing to the financial performance reported by the Medicaid MCOs through Q3 2020.

[4] Minnes, K. & Browning, L. (September 16, 2020). Delivering care and stewarding public resources in uncertain times. National Association of Medicaid Directors. Retrieved October 21, 2020, from https://medicaiddirectors.org/blog/2020/09/delivering-care-and-stewarding-public-resources-in-uncertain-times/.

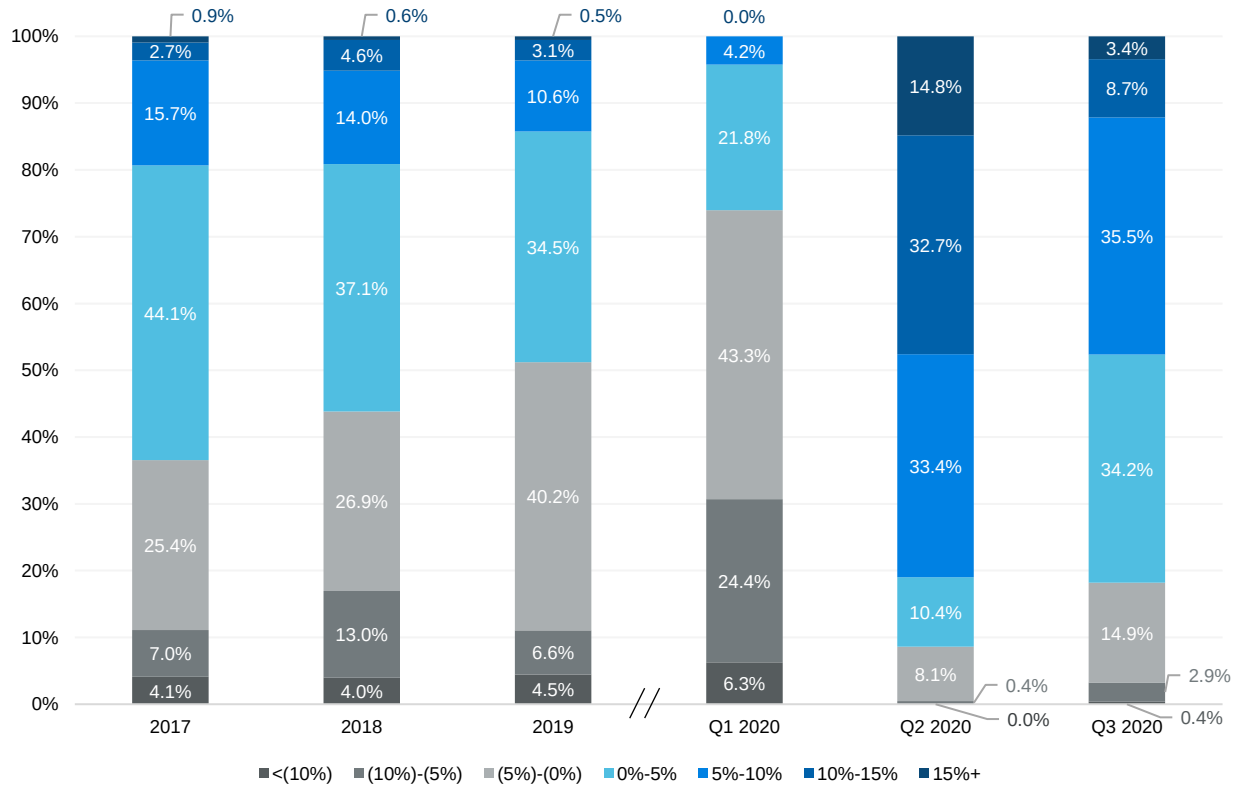
Underwriting margin

Figure 1 above highlights the average underwriting gains through the Q3 2020 reporting period for all MCOs included in this analysis. Although the reported financial performance reported by the MCOs in prior years has illustrated positive gains on average, the magnitude of the gains increased substantially during Q2 and Q3 2020.

UNDERWRITING MARGIN DISTRIBUTION

Figure 2 illustrates the distribution of underwriting margin for the MCOs included in our analysis for 2017 through 2019 and the first three quarters of 2020. Grey shaded sections in Figure 2 represent negative underwriting margin whereas blue sections correspond with positive underwriting gains.

FIGURE 2: DISTRIBUTION OF UNDERWRITING MARGIN



Notes

1. Quarterly financial results are reported on a year-to-date basis, and therefore Q2 and Q3 2020 financial results were estimated based on the incremental change in the quarter.
2. The distribution is weighted by the revenue associated with each MCO's corresponding underwriting results.

It should be emphasized that restatements of prior financial experience may be reflected in the Q2 and Q3 2020 reported values. With this caveat understood, Q3 2020 underwriting experience moderated relative to Q2 2020, yet financial results for MCOs were still materially better than historical norms.

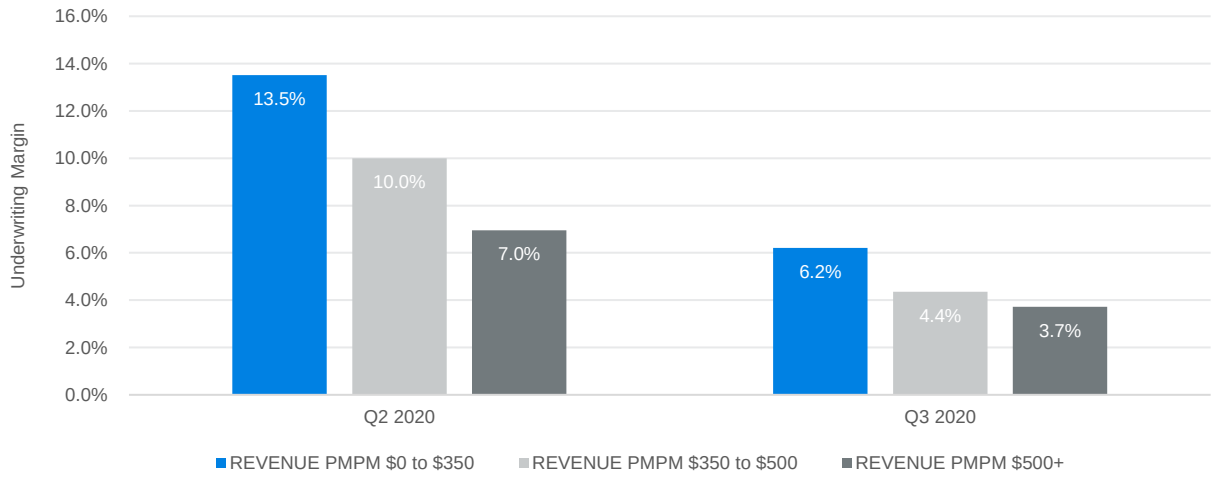
- Modest gains were observed each year from 2017 through 2019, but each year had at least 35% of managed care experience associated with a negative underwriting gain.
- While 91% of MCOs experience was associated with a positive underwriting gain in Q2 2020, this metric decreased by approximately ten percentage points in Q3 2020 to 82%. However, less than half of the MCO experience in 2019 was associated with an underwriting gain.

- Underwriting gains greater than 5% were observed for MCOs representing 81% of premium revenue in Q2 2020 and 48% of premium revenue in Q3 2020. In contrast, CY 2019 financial experience indicates 14% of premium revenue was associated with an underwriting margin exceeding 5%.
- Approximately 12% of MCOs observed underwriting gains of over 10% of revenue in Q3 2020, compared to 48% in Q2 2020. From CY 2017 to CY 2019, approximately 4% to 5% of premium revenue reflected underwriting gains in excess of 10%.

REVENUE PMPM

An MCO characteristic that may be contributing to the variance in underwriting gains reported during Q2 and Q3 2020 is the covered population. Figure 3 illustrates the underwriting gain by revenue per member per month (PMPM), a proxy for healthcare resource demand. As illustrated by Figure 3, plans with lower-revenue PMPMs reported higher underwriting gains in Q2 and Q3 2020. This relationship was not observed in 2017 through 2019 or in Q1 2020.

FIGURE 3: UNDERWRITING MARGIN BY REVENUE PMPM



Note: Quarterly financial results are reported on a year-to-date basis, and therefore Q2 and Q3 2020 financial results were estimated based on the incremental change in the quarter.

MCOs that provide coverage in states with higher proportions of lower-cost individuals, such as children, nondisabled adults, and expansion populations, may have experienced higher underwriting margins during Q2 and Q3 2020 compared to state programs that include higher-cost individuals such as disabled beneficiaries and LTSS populations in managed care programs. This could be a result of healthier beneficiaries having more discretion on whether to engage the healthcare system compared to an individual with chronic conditions who needs regular healthcare services.

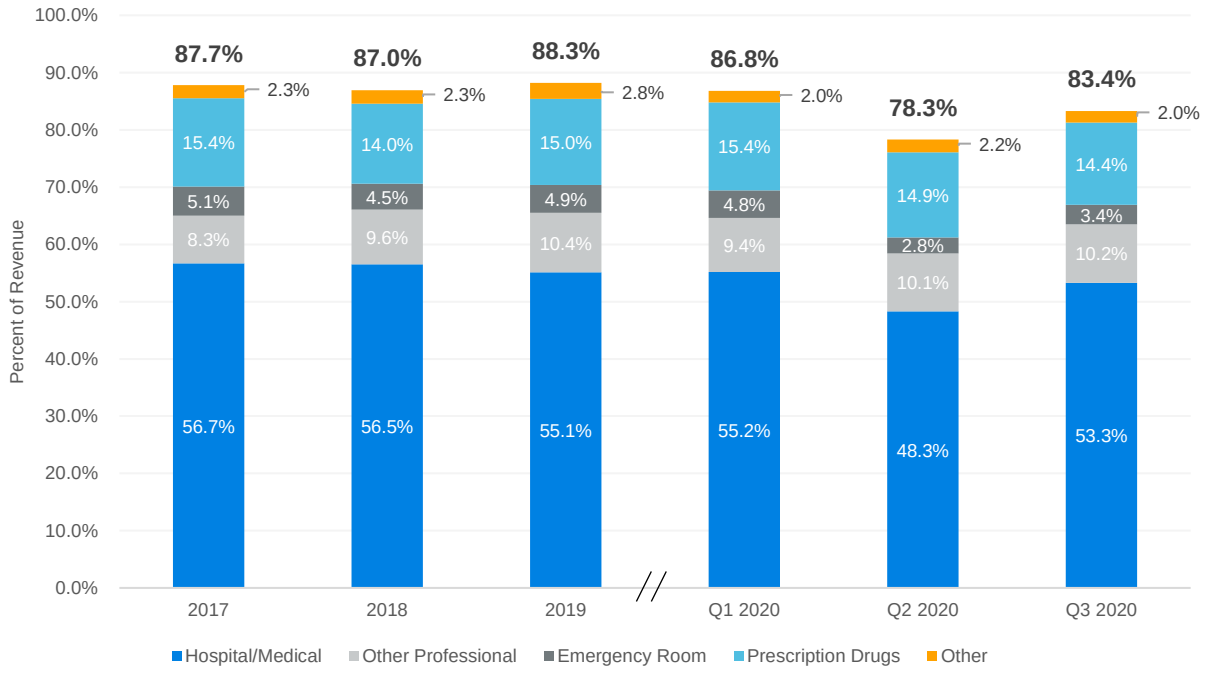
Benefit expense changes

To investigate the impact of COVID-19 on MCO benefit expenses, we reviewed additional detail on the splits reported in the National Association of Insurance Commissioners (NAIC) financial statements. This review focused on the financial data elements comprising the MLR and reported utilization metrics.

MLR STRATIFIED BY BENEFIT EXPENSE TYPES

To further understand the reported MLR, the benefit expense was separated into the service types as defined in the Statement of Revenue and Expenses page of the NAIC financial statements. This page of the financial statements stratifies the total hospital and medical costs into the following separate line items: Hospital/Medical Benefits, Other Professional, Emergency Room and Out-of-Area, and Prescription Drugs. Other minor line items were grouped into an “Other” category for purposes of this report. Figure 4 compares the MLR, stratified by benefit expense type, from 2017 through Q3 2020.

FIGURE 4: MLR BY BENEFIT EXPENSE TYPE



Notes

1. Values have been rounded.
2. Quarterly financial results are reported on a year-to-date basis, and therefore Q2 and Q3 2020 financial results were estimated based on the incremental change in the quarter.

The MLR fluctuates between approximately 87% and 88% from 2017 through Q1 2020 before decreasing to an estimated 78.3% in Q2 2020. We observed the MLR to be 83.4% in Q3 2020, roughly halfway between the reported Q2 2020 MLR and values observed in 2017 to 2019. The relatively stable distribution of the benefit expense types in the historical periods facilitates an understanding of the benefit expense types contributing to the decrease in Q2 and Q3 2020. The following observations may be made from review of Figure 4:

- The Q2 2020 emergency room benefit expense as a percentage of revenue decreased over 40% relative to the average of 2017 through Q1 2020. Q3 2020 emergency room benefit expense as a percentage of revenue subsequently increased by approximately 20% relative to the Q2 2020 values (2.8% vs 3.4%).
- The largest expense category of hospital/medical decreased by 10% to 15% relative to prior periods in Q2 2020. The hospital/medical benefit expense increased from 48.3% of revenue in Q2 2020 to 53.3% to Q3 2020, closer to the average of 2017 through 2019, 56.1%.
- While the decrease in prescription drug expenditures from Q1 to Q2 2020 is expected based on historical seasonal patterns, the continued decrease in Q3 2020 is not fully explained by seasonality. It will be interesting to monitor pharmacy expenditures through the end of the COVID-19 pandemic.

Additionally, it is important to note that Medicaid enrollment summarized for the MCOs included in this report grew approximately 10% from Q1 to Q3. This significant growth in Medicaid enrollment may also be contributing to the underwriting gains the MCOs are reporting during 2020. The observations above could be influenced by the covered lives coming on to Medicaid (or staying enrolled) reflecting a lower risk profile than covered lives in a pre-COVID time period.

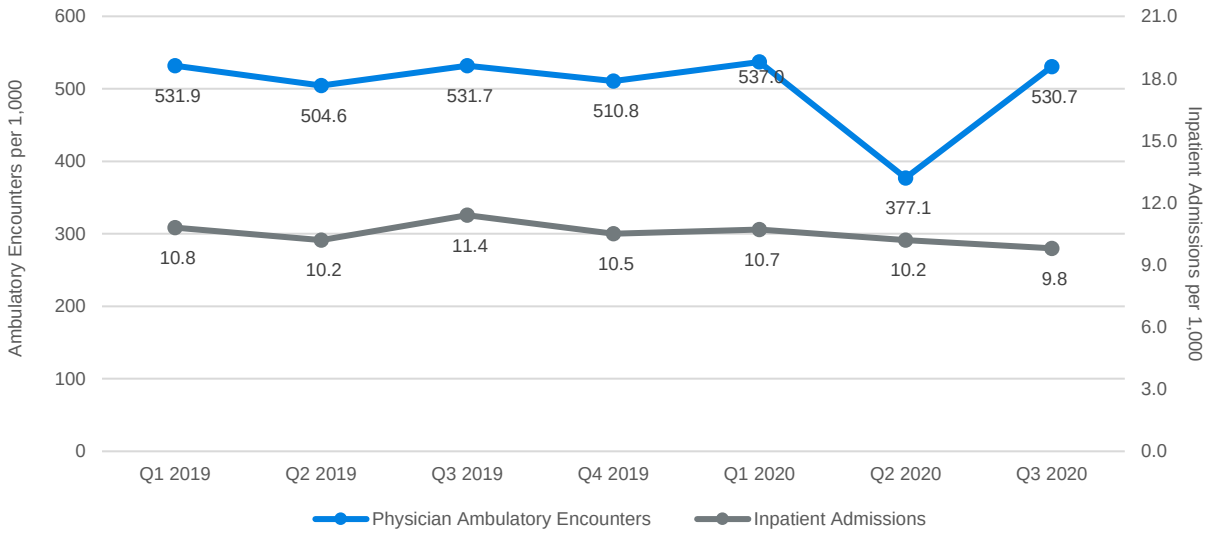
UTILIZATION

In addition to the benefit expense line items reviewed in the Statement of Revenue and Expenses, we analyzed the utilization information contained in the Exhibit of Premiums, Enrollment, and Utilization. Certain data adjustments were made to the quarterly values for certain MCOs for apparent errors that were reported in the noted exhibit (generally involved in the cumulative nature of the quarterly statements). This section explores the change in professional and inpatient facility utilization from 2017 through Q3 2020.

As illustrated in Figure 4, above, a significant portion of the benefit expense in the Statement of Revenue and Expenses is included in the hospital and medical line item, which includes expenses for both physician services and facility costs. We reviewed the utilization information contained in the Exhibit of Premiums, Enrollment, and Utilization to better understand the impact of COVID-19 separately for outpatient (ambulatory) and inpatient services. We did not include 2017 and 2018 experience in this analysis, as changes in the MCO mix materially influenced the utilization/1,000 metrics in these prior time periods.

Figure 5 illustrates the number of physician ambulatory encounters per 1,000 member months and the number of inpatient admissions per 1,000 member months.

FIGURE 5: UTILIZATION PER 1,000 MEMBER MONTHS



Notes

1. Quarterly financial results are reported on a year-to-date basis, and therefore quarterly financial results were estimated based on the incremental change in each quarter.
2. Data adjustments were made for apparent errors in the Exhibit of Premiums, Enrollment, and Utilization.

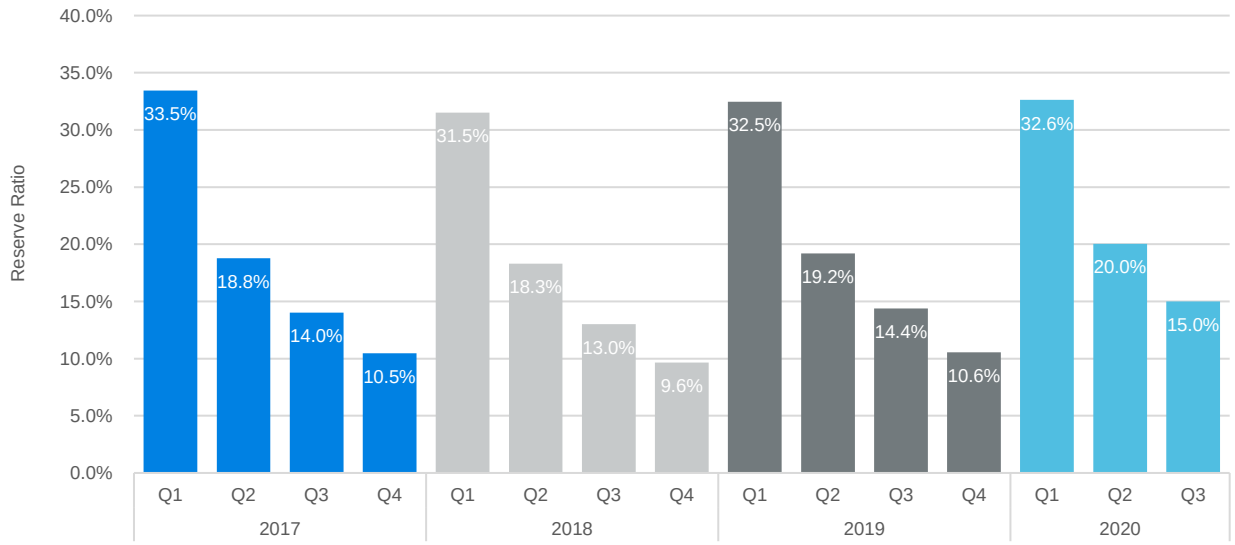
The utilization metrics illustrated in Figure 5 contain seasonal variances more significant than the metrics illustrated in previous figures. As such, it is most appropriate to compare quarterly 2020 utilization to the same quarter in 2019. Key observations from Figure 5 include:

- Ambulatory encounters were at the lowest level in Q2 during 2019. The physician ambulatory encounters reported in Q2 2020 represent a 24% decrease compared to Q2 2019 (377.1 in Q2 2020 relative to 504.6 in Q2 2019). Physician ambulatory encounters in Q3 2020 are consistent with the level reported in Q3 2019.
- Any COVID-19-related utilization impact on inpatient admissions in Q2 or Q3 2020 is not discernible relative to the normal seasonal volatility reported in the NAIC financial statements.

Reserves

One of the difficulties when reviewing quarterly financial information is the disparity in potential reporting practices for outstanding liabilities. The chart in Figure 6 summarizes the amount of claims the MCOs have estimated as unpaid as a ratio to the total estimated incurred claims (paid plus unpaid) in the year.

FIGURE 6: CLAIM LIABILITIES AS A PERCENTAGE OF REPORTED INCURRED CLAIMS BY QUARTER



Note: The values included in this figure reflect year-to-date metrics.

As one would expect, the reserves as a percentage of incurred claims for a given calendar year decrease over time throughout the year. This decrease is attributable to additional payments for claims incurred in prior quarters but paid in the current quarter. In each year from 2017 through 2019, the reported unpaid claims as a ratio of total estimated claims has dropped between 13.2% and 14.7% from the first to second quarter. The average Q2 liability ratio over that time is approximately 18.8%. However, we note that the estimated liability ratio for Q2 2020 is 20.0%, or 1.2% higher than recent years. Similarly, the average Q3 liability ratio from 2017 through 2019 is approximately 13.8%, whereas the estimated liability ratio for Q3 2020 is 15.0%. The increased level of reserve may be driven by disruptions to claim payment systems, delays in claim submissions from increased and retroactive enrollment, and greater uncertainty and corresponding conservatism during the pandemic.

Conclusion

The public health emergency was extended on October 2, 2020,[5] and it is expected that future experience will continue to be impacted by the COVID-19 pandemic. To assist with the fiscal stability of their Medicaid managed care programs during these uncertain times, many state Medicaid agencies implemented risk corridor programs in which they and the federal government will share in excess gains or losses with the MCOs. Based on the Q2 and Q3 2020 financial results, many Medicaid programs may be in a receivable position for time periods that encompass dates from April through September 2020. While the results for Q3 represent a directional trend back to historical experience, the reported gains continue to represent higher amounts than recent calendar years. However, there is significant uncertainty surrounding the virus's impact on deferral of care, pent-up demand, and the future cost of COVID-19-related hospitalizations and vaccines. It will be important for state Medicaid programs and their MCOs to continue to monitor the emerging experience to budget their programs going forward. Further investigation and analysis on the impact of the pandemic on 2020 experience will be presented in the report Medicaid Managed Care Financial Results for 2020.[6]

[5] See the renewal notice at https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx.

[6] See https://us.milliman.com/en/insight/medicaid-managed-care-financial-results-for-2019 for the 2019 iteration of this report.

Summary of methodology

Consistent with our annual Medicaid financial report, the purpose of this report is to provide a summary of reported financial information by the various managed care organizations (MCOs). We have focused our analysis on information reported through the third quarter (Q3) of calendar year 2020. This report summarizes the experience for selected financial metrics of organizations reporting Medicaid experience under the Title XIX Medicaid line of business on their NAIC statements.

The information was compiled from the reported quarterly and annual financial statements.[7] Individual reporting entities may be excluded from this report for the following reasons:

- Did not submit a health financial statement
- Reported less than $10 million in annual Medicaid (Title XIX) revenue
- Is a specialized behavioral health plan or long-term services and supports plan
- Premium revenues indicate a limited set of covered services
- Reported values appear to be influenced by unusual circumstances other than COVID-19
- Otherwise omitted from the NAIC database of health statements utilized for this report

For purposes of this report, we limited our analysis of 2020 financial results to the same MCOs that were utilized in our review of the 2019 experience and documented in the report Medicaid Managed Care Financial Results for 2019.[8] A limited number of plans from that list did not have financial experience available for Q3 2020 and thus are not included in this report. MCOs comprising the 2017 and 2018 financial experience were selected using criteria consistent with the 2019 MCOs, although the actual mix of health plans varied. The financial experience was limited to Medicaid-focused MCOs in order to draw Medicaid-specific conclusions.[9] Medicaid-focused MCOs are defined as those reporting 90% or more of their total revenue from the Medicaid line of business, resulting in 71 to 80 MCOs reviewed for any given time period. See Appendix 1 for further description of the calculations used to develop the metrics included in this report.

Limitations and data reliance

The results contained in this report were compiled using data and information obtained from the statutory annual and quarterly financial statements for Medicaid MCOs filed with the respective state insurance regulators. The financial statements were retrieved as of December 2, 2020, from an online database. MCOs for certain states, such as Arizona, California, and New York, have limited or no experience included in the NAIC financial statement database. To the extent that financial information is updated with future submissions, the results may change.

It is critical to note that we have not made any adjustments to the data reported in the financial statements, with the exception of minor corrections in the utilization metrics, nor have we accounted for any potential adjustments to financial experience that may be the result of risk mitigation mechanisms (e.g., risk corridors) that are in effect across various state Medicaid managed care programs.

Financial results specific to Q3 2020 were estimated by comparing the Q2 2020 financial results to the year-to-date Q3 2020 financial results. A consistent methodology was used to estimate the financial results specific to Q2 2020. Because of the cumulative nature of quarterly financial statement reporting, any restatements to the expenses and revenue accrued in Q1 2020 and Q2 2020 would inherently be included in the Q3 2020 financial metrics.

[7] National Association of Insurance Commissioners. Annual Statement Database, as delivered by S&P Global, Inc, all rights reserved.

[8] Palmer, J.D., Pettit, C.T., & McCulla, I.M. (June 2020). Medicaid Managed Care Financial Results for 2019. Milliman Research Report. Retrieved October 21, 2020, from https://us.milliman.com/en/insight/medicaid-managed-care-financial-results-for-2019.

[9] Revenue amounts not listed under the Title XIX Medicaid line of business are considered non-Medicaid for purposes of this report. To the extent that CHIP or other Medicaid revenue is reported in a line of business other than Medicaid, a plan may be excluded from the sections of the report relying on Medicaid-focused health plans.

This report is based on a limited subset of MCOs that reported 90% or more of their total revenue from the Medicaid line of business, as detailed information on benefit expenses and administrative costs is not split by line of business in the quarterly financial statements. It is possible that the observations made in this report may not generalize to all Medicaid health plans.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the financial performance of the Medicaid MCOs in 2020. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information in the NAIC financial statement database for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output, may not be appropriate for any other purpose.

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Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

About the authors

Christopher Pettit is a principal and consulting actuary with Milliman and is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Mr. Pettit joined Milliman in 2004 and currently has over 16 years of healthcare-related actuarial experience.

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The authors have developed an expertise in the financial forecasting, pricing, reporting, and reserving of all types of health insurance, including Medicaid and commercial populations. Much of their experience is focused on Medicaid managed care consulting for both state Medicaid programs and Medicaid managed care plans in more than 15 states and territories.

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Appendix 1: Definition of financial metrics

The financial metrics calculated for purposes of this report include the medical loss ratio (MLR), underwriting margin (UW margin), administrative loss ratio (ALR), revenue PMPM, utilization per 1,000, and reserve ratio. The components of the financial metrics were taken from the MCO quarterly and annual financial statements. Because many of the financial elements reviewed in this report are not available solely for the Title XIX Medicaid line of business in the quarterly financial statements, the financial statements were limited to Medicaid-focused MCOs.

The values reported in the quarterly financial statements are reported on a year-to-date basis. Financial values attributed to a specific quarter were estimated using the incremental change in the quarterly financial statements.

The financial metrics selected are used by MCOs, state Medicaid agencies, and other stakeholders to evaluate the financial performance of an MCO. The metrics are defined in greater detail below.

MEDICAL LOSS RATIO (MLR)

MLR is a common financial metric used to report and benchmark the financial performance of an MCO. The MLR represents the proportion of revenue that was used by the MCO to fund claim expenses. The MLR is stated as a percentage, with claim expense in the numerator and revenue in the denominator.

In terms of the statutory quarterly statement, the MLR was defined as follows:

$$\text{MLR} = \frac{\text{Total Hospital and Medical Expenses + Increase in Reserves for A\&H Contracts}}{\text{Total Revenue}}$$

Where:

- Total Hospital and Medical Expenses (P.4, L.18, C.2)
- Increase in Reserves for Accident and Health (A&H) Contracts (P.4, L.22, C.2)
- Total Revenue (P.4, L.8, C.2)

Note: Financial values attributed to a specific quarter were estimated using the incremental change in the quarterly financial statements.

Certain states include pass-through type programs such as franchise fees or provider taxes. This would also include amounts related to the Health Insurer Fee and applicable income tax gross-ups. These items may or may not be included in the total revenue reported by the MCO because the reporting practices vary among plans. If reported in the total revenue, there should be a corresponding offset amount included in the administrative costs for this as well.

Actuaries and financial analysts use the MLR as a measure of premium adequacy and often compare the resulting MLR with a “target” level. The MLR alone is not sufficient to compare MCO financial results among various states and programs. The target loss ratios (the claim costs included in the premium or capitation rates) vary by state and populations enrolled. Additionally, there may be reporting differences among MCOs as to what is classified as medical expense versus administrative expense.

The definition of MLR for purposes of this report may not be consistent with other definitions, in particular the Medicaid and Children's Health Insurance Program (CHIP) managed care final rule (CMS-2390-F). The Medicaid and CHIP managed care final rule allows for the reduction of taxes, licensing, and regulatory fees from the revenue and a credibility adjustment, as well as the addition of quality improvement expenditures to the hospital and medical expenses in the numerator. However, other provisions, such as the exclusion of pass-through payments from the numerator and denominator of the MLR formula, could decrease the MLR percentage.

UNDERWRITING MARGIN

The UW margin is the sum of the MLR and the ALR (defined below), subtracted from 100%. A positive UW margin indicates a financial gain, while a negative UW margin indicates a loss. This financial metric is used to report and benchmark the financial performance of an MCO in consideration of both medical and administrative expenses. The UW margin represents the proportion of revenue that was "left over" to fund the MCO's contribution to surplus and profit after funding medical and administrative expenses. The UW margin is stated as a percentage, with total underwriting gain or loss in the numerator and revenue in the denominator.

In terms of the statutory quarterly statement, the UW margin was defined as follows:

$$\text{UW Margin} = \frac{\text{Net Underwriting Gain or (Loss)}}{\text{Total Revenue}}$$

Where:
Net Underwriting Gain or (Loss) (P.4, L.24, C.2)
Total Revenue (P.4, L.8, C.2)

Note: Financial values attributed to a specific quarter were estimated using the incremental change in the quarterly financial statements.

The UW margin is focused on the income from operations and excludes consideration of investment income and income taxes. The UW ratio requires interpretation and considerations similar in nature to the MLR and ALR metrics.

ADMINISTRATIVE LOSS RATIO (ALR)

ALR is also a common financial metric used to report and benchmark the financial performance of an MCO. The ALR represents the proportion of revenue that was used by the MCO to fund administrative expenses. The ALR is stated as a percentage, with administrative expense in the numerator and revenue in the denominator.

In terms of the statutory quarterly statement, the ALR was defined as follows:

$$\text{ALR} = \frac{\text{Claim Adjustment Expenses + General Administrative Expenses}}{\text{Total Revenue}}$$

Where:
Claim Adjustment Expenses (P.4, L.20, C.2)
General Administrative Expenses (P.4, L.21, C.2)
Total Revenue (P.4, L.8, C.2)

Note: Financial values attributed to a specific quarter were estimated using the incremental change in the quarterly financial statements.

The ALR requires interpretation and considerations similar in nature to the MLR metric outlined above, most notably impacted by the state and federal taxes levied on MCOs across the different states.

REVENUE PMPM

Revenue PMPM illustrates the amount of premiums and other revenues collected by the MCOs per member per month (PMPM).

In terms of the statutory quarterly statement, the revenue PMPM was defined as follows:

$$\text{Revenue PMPM} = \frac{\text{Total Revenue}}{\text{Current Year Member Months}}$$

Where:
Total Revenue (P.4, L.8, C.2)
Current Year Member Months (P.4, L.1, C.2)

Note: Financial values attributed to a specific quarter were estimated using the incremental change in the quarterly financial statements.

UTILIZATION PER 1,000

The utilization per 1,000 metric is a framework used to estimate the volume of services provided per 1,000 member months. This report reviews the ambulatory encounters and inpatient admissions on a utilization per 1,000 basis. This information is available for the Title XIX Medicaid line of business in the Exhibit of Premiums, Enrollment, and Utilization and therefore the data was limited to Medicaid for purposes of this report.

In terms of the statutory quarterly statement, the utilization per 1,000 was defined as follows:

Utilization Per 1,000 =	Utilization Metric x 1,000
	Current Year Member Months
Where:	Physician Member Ambulatory Encounters (P.7, L.7, C.9)
	Non-Physician Member Ambulatory Encounters (P.7, L.8, C.9)
	Number of Inpatient Admissions (P.7, L.11, C.9)
	Current Year Member Months (P.4, L.1, C.2)

Note: Financial values attributed to a specific quarter were estimated using the incremental change in the quarterly financial statements. Additionally, page numbers reflect the page number on the quarterly financial statements. Values may be included on a different page in the annual financial statements.

RESERVE RATIO

The reserve ratio illustrates the claims incurred but not yet paid during the year as a percentage of the total claims incurred during the year. This information is available for the Title XIX Medicaid line of business in the Underwriting and Investment Exhibit and therefore the data was limited to Medicaid for purposes of this report.

In terms of the statutory quarterly statement, the reserve ratio was defined as follows:

Reserve Ratio =	Claims Unpaid and Incurred During the Year
	Claims Unpaid and Incurred During the Year + Claims Paid and Incurred During the Year
Where:	Claims Paid and Incurred During the Year (P.9, L.7, C.2)
	Claims Unpaid and Incurred During the Year (P.9, L.7, C.4)

Note: Unlike previous metrics, the reserve ratio is calculated on a year-to-date basis. Values may be included on a different page in the annual financial statements.