Medicaid Profitability During the Public Health Emergency

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Introduction

The pandemic is widely viewed as a windfall for insurers because of the decrease in the utilization of healthcare. It is less well understood how profitability trended in Medicaid managed care. The COVID-19 pandemic had a significant impact on health care in all health care market segments: Commercial, Medicare, and Medicaid. However, the impact on Medicaid was more profound with enrollment growing from 74 million in March 2020 to 87 million in April 2023. This was primarily driven by the suspension of Medicaid eligibility recertification (redetermination). This led to a large increase in managed Medicaid revenues. Because of the pandemic, and the associated public health emergency (PHE), the US went through the cycle of a spike in infections, lockdowns, school closures, another spike in infections, vaccinations, gradual reopening, and return to a new normal. There was a high number of hospitalizations, deferred services, pent up demand, and potentially sicker patients because of deferral of necessary care. While there is still a lot to understand as far as the health acuity of the Medicaid population and the new normal, one thing we can look at is the financial performance of the managed Medicaid health plans for the last three years.

The purpose of this report is to see how managed Medicaid health plans (managed care organizations--MCOs) fared financially in 2020-2022 compared to prior years. To do this, we used the annual statutory financial filings to look at the health plans underwriting margin[1] for managed Medicaid.

Our findings show that while margin did increase, the Medicaid margin levels were explainable, and not abnormal relative to other lines of business experience.

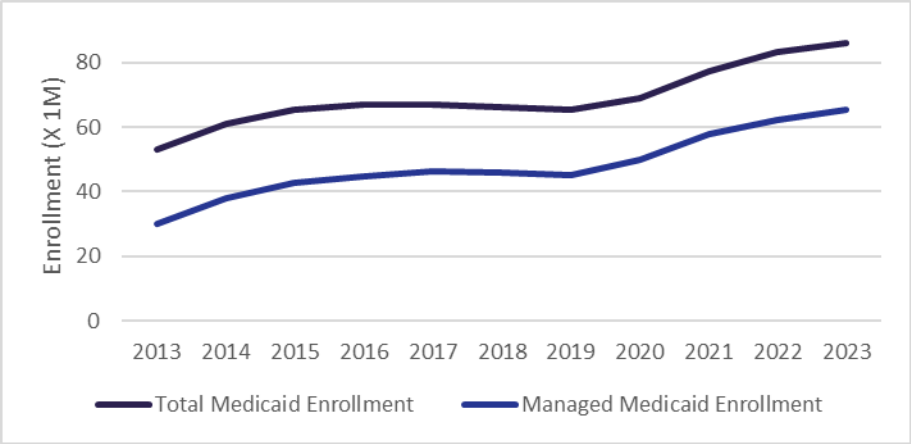
This paper discusses the general process that determines margin levels for MCOs and their historical experience before the pandemic, how the pandemic changed margin levels and underlying causes, and what the findings might mean for the future.

[1] In this report we look at underwriting margin (margin) which is revenue – claims – admin. This does not include investment income, depreciation, or taxes.

Background

MCOs and Rate Settings

In 2023 about 76% of all Medicaid beneficiaries are enrolled in an MCO.[2] The following chart shows total Medicaid and managed Medicaid enrollment from 2013 to 2023 covering the period from before Medicaid expansion to the end of the PHE.



Nearly every state has some enrollment in an MCO. While states set the parameters of their Medicaid programs and oversee them, MCO's are responsible for implementing the programs. MCOs, generally, pay the day-to-day claims of the beneficiaries to providers and in turn are compensated by the state for administering the program. A state typically contracts with multiple MCOs to give members choice and encourage competition between the MCOs. Pricing stability is important for the sustainability of managed Medicaid and its continued expansion.

Payments to health plans primarily take the form of a capitated rate (a monthly payment per enrolled member) that covers claims, administrative costs and provides for a risk margin and cost of capital. Unlike Commercial and Medicare Advantage rate setting where the plan sets the rates, in managed Medicaid, the states, through their rate setting actuaries and the data that helps informs their recommendations, set the rate. This is an annual process; however, it is common to have mid-year rate changes for a variety reasons, including Medicaid fee for service fee schedule changes or unforeseen circumstances. While the rates are normally set prospectively for a twelve-month period, the CMS rate setting guidelines[3] also provide for retroactive adjustments. While the states do have the power in setting the rates, they are constrained in multiple ways. First, they are constrained from setting the rates too high by state budgets as well as CMS rate setting rules and review. They are constrained from setting rates too low by the CMS rate setting rules and review and the need to maintain MCO participation and other critical provisions like network adequacy. As part of that need to maintain MCO participation and follow CMS rate setting rules the rate includes a margin.

[2] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/
[3] https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html

Margins for MCOs in any given year are influenced by three factors. The first, is the targeted margin set by the state. States typically include 1-2% margin in the rates. The second is how aggressive or conservative[4] the assumptions are that set the capitated arrangement. Different states and different budget situations result in capitated payment variance. A more aggressive approach can mean that small, unexpected increases in cost can result in lower profitability. Finally, the actual cost of members is important. Healthier than expected membership can increase profits while costlier members, relative to expectations, can decrease profitability.

Given the number of moving components, what has been the historical experience of MCO profitability?

Data

We used NAIC (National Association of Insurance Commissioners) statutory filings to look at managed Medicaid financial performance before and during the PHE. This study is based on data for 239 health plans covering 63% of all Medicaid members in 2022[5]. See the Appendix for details.

The Pandemic

The COVID impact started in March 2020. There was an increase in COVID related health care costs for hospitals and other treatment. There were also COVID related decreases in healthcare cost as people deferred care. Behavioral changes related to the PHE such as social distancing, home schooling, and work from home also impacted healthcare utilization. For example, influenza was very low during the 2020- 2021 flu season. COVID's impact was directly related to age with the older populations suffering much more from its affects.

The following table shows key statistics by line of business (LOB) for the health plans in this study[6].

[4] Aggressive and conservative refer to the likelihood the rates will be too low (too aggressive) or too high (too conservative).
[5] The Children's Health Insurance Program (CHIP) is not included in this analysis. CHIP Title XXI is not included in the Medicaid Title XIX reporting in the NAIC statements.
[6] See Methodology section of the appendix. The included members are for insured plans. A lot of Commercial members are covered by self-insured arrangement and are not reported in the AIC filings. Medicare Advantage only plans were not included in the study group.

	2014	2015	2016	2017	2018	2019	2020	2021	2022
Managed Medicaid									
Avg Enroll (x 1,000)	27,806	33,102	36,681	41,666	43,016	42,714	45,893	54,071	59,180
Revenue (x $M)	$107,719	$139,712	$161,516	$174,183	$187,711	$200,403	$233,227	$274,424	$313,795
Rev PMPM	$322.83	$351.72	$366.94	$348.37	$363.64	$390.98	$423.50	$422.94	$441.87
Claim PMPM	$277.17	$301.20	$318.98	$308.76	$318.11	$347.70	$360.73	$364.24	$381.59
Adm PMPM	$39.50	$42.69	$44.85	$37.43	$43.55	$43.16	$50.99	$44.48	$47.02
Medical Loss Ratio	85.9%	85.6%	86.9%	88.6%	87.5%	88.9%	85.2%	86.1%	86.4%
Admin Loss Ratio	12.2%	12.1%	12.2%	10.7%	12.0%	11.0%	12.0%	10.5%	10.6%
UWG Margin	1.9%	2.2%	0.8%	0.6%	0.5%	0.0%	2.8%	3.4%	3.0%
Commercial									
Avg Enroll (x 1,000)	20,780	21,683	20,380	19,093	18,004	17,598	17,477	17,510	17,136
Revenue (x $M)	$88,462	$93,753	$95,642	$97,201	$100,322	$98,994	$104,196	$102,347	$102,382
Rev PMPM	$354.75	$360.32	$391.07	$424.23	$464.36	$468.76	$496.82	$487.08	$497.87
Claim PMPM	$302.54	$310.85	$335.64	$352.24	$374.97	$395.21	$400.27	$429.36	$428.89
Adm PMPM	$52.18	$53.00	$55.09	$53.02	$64.19	$59.63	$70.02	$61.02	$65.63
Medical Loss Ratio	85.3%	86.3%	85.8%	83.0%	80.7%	84.3%	80.6%	88.2%	86.1%
Admin Loss Ratio	14.7%	14.7%	14.1%	12.5%	13.8%	12.7%	14.1%	12.5%	13.2%
UWG Margin	0.0%	-1.0%	0.1%	4.5%	5.4%	3.0%	5.3%	-0.7%	0.6%
Medicare Advantage									
Avg Enroll (x 1,000)	4,755	5,470	6,028	6,636	7,114	7,482	7,961	9,040	12,095
Revenue (x $M)	$55,508	$65,938	$75,492	$83,256	$93,199	$103,404	$114,655	$132,971	$186,071
Rev PMPM	$972.76	$1,004.46	$1,043.65	$1,045.48	$1,091.66	$1,151.72	$1,200.17	$1,225.81	$1,282.05
Claim PMPM	$846.21	$876.64	$876.50	$893.76	$925.97	$982.19	$986.76	$1,056.75	$1,090.93
Adm PMPM	$111.73	$116.76	$123.28	$113.34	$130.55	$122.63	$143.02	$126.73	$129.54
Medical Loss Ratio	87.0%	87.3%	84.0%	85.5%	84.8%	85.3%	82.2%	86.2%	85.1%
Admin Loss Ratio	11.5%	11.6%	11.8%	10.8%	12.0%	10.6%	11.9%	10.3%	10.1%
UWG Margin	1.5%	1.1%	4.2%	3.6%	3.2%	4.1%	5.9%	3.4%	4.8%

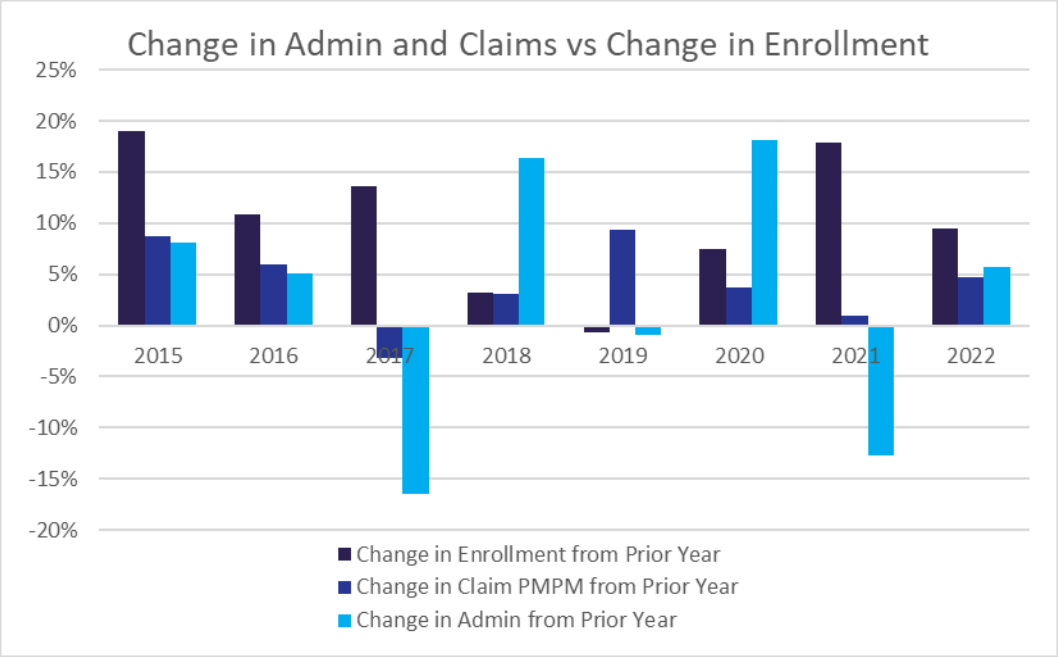
Observations

MCO profitability since the implementation of Medicaid expansion appears to conform to three time periods: 1) initial Medicaid expansion, 2) low margin/stability; 3) Covid pandemic/PHE.

1. **2014-2015: Initial years of Medicaid expansion**. This was the period of managed Medicaid pricing uncertainty because of the lack of historical claims experience for Medicaid expansion members, and the use of risk corridors to limit gains and losses. Because of the pricing uncertainty the rates were a little more conservative.
2. **2016-2019: Stability -** This was a period of low margins, significant growth in managed Medicaid as more states implemented managed care and managed Medicaid expansion continued.
3. **2020-2022: Covid PHE**. During the Covid PHE, Medicaid enrollment grew 44%. Alongside this large enrollment growth, margins increased from about 0.5% in the prior years to a little under 3%. The increase in margins was driven both by a decrease in medical loss ratios (claims divided by revenue) and a reduction in administrative loss ratios (admin divided by revenue). The most difficult part of rate setting is estimating future claims so the lower MLRs indicate some pricing conservatism. The decrease in administrative loss ratios (ALR's) resulted from administrative expenses being spread over a larger membership.

Why did MCO margins increase during this time? As of all complex processes, there are multiple explanations.

The table below shows the change in admin PMPM and claims PMPM compared to the change in enrollment. For the PHE years enrollment grew dramatically claims growth was low and after 2020 admin growth was also low. In this nine-year period there was a negative correlation between enrollment growth and claim PMPM growth (correlation coefficient of -0.38) and between enrollment growth and admin PMPM growth (correlation coefficient of -0.18). While these are not strong correlations over the entire period of the study, the graph shows the correlations were stronger during the PHE.



Below are three key sources of the increase in margins for MCOs during this time frame.

Uncertainty in Rate Setting/State Budget Flexibility

The primary reason for the increase in margins during the PHE was uncertainty in the rate setting process. For 2020, the annual rate setting process occurred before the pandemic was known so there was a limit to what states could do about pricing to the new reality of the pandemic. However, 2021 and 2022 occurred with at least some, albeit imperfect, knowledge about the pandemic. Fundamental to the rate setting process is base data (claims experience) that is representative of the experience of the population for which the rates are being developed. For the expansion population in 2014 there was no historical experience, so the rate setting actuaries had to use a proxy population, make a lot of assumptions, and typically used a risk corridor to limit gains and losses. This is similar to the calendar year 2021 and 2022 rate setting situation where there was no historical claims experience that included the impact of Covid. The willingness to be more conservative in rates also was likely influenced by states'

budget situations. The increased Medicaid Federal funding during the PHE reduced budgetary pressures[7] to reduce spending which would have decreased the natural downward pressure on the rates.

Claims Cost Increase Less Than Expected

The next reason is that claims cost increased far less than expected/historical experience. From 2014 through 2019 claims cost PMPM increased around 6.3% per year. From 2020 through 2023 claims cost increased only 1.8%. It's important to note that Medicaid MCOs were not the only line of business to experience an increase in margin for 2020 in all LOBs MLRs went down and admin went up. This would be indicative or deferred healthcare and the increased administrative cost in the health plans of trying to manage the impact of the pandemic. Medicaid's pressure on margins was likely higher than other lines of business since as the payer of last resort, was often insulated from high Covid costs related to older Americans.

Cyclical Patterns

Finally, there is reason to think that MCO margins would have increased even absent the PHE. During the period of 2016 to 2019 the national average margin was pulled down by 11 states that had negative profit margins. The following table shows the average margin for the eleven states that had an average negative margin for 2016-2019 compared to the other states for three times periods:

	2014-2015	2016-2019	2020-2022
States with negative margin 2016-19	-0.1%	-2.8%	2.3%
Other states	2.8%	1.9%	3.1%

Part of the increase in margin during the PHE could be a return to a normal level of margin after a period of suppressed margins from 2016-2019. Correlation is not causation and the rate setting process is very complex. An understanding of what caused the low margins would require detailed research. Nevertheless, the low margin in 2016-19 is confined to 11 states and the change from 2016-2019 to 2020-22 is much larger in those 11 states. In other words, there is a strong (negative correlation) between average profit margin during 2016 to 2019 and the increase in profit margin during the PHE.

Leading up to the PHE, Medicaid MCOs had historically low profit margins. There have been several studies on managed Medicaid margins[8]. According to their findings, most Medicaid rate certifications have explicit margins included and those margins ranged from 0.35% to 3.15%; based on a return on required capital this would indicate 1-2% margin. During this period the health plans would have been advocating for reasonable margins. Consequently, it is possible margins would have increased

[7] https://www.kff.org/medicaid/issue-brief/medicaid-spending-and-enrollment-updated-for-fy-2022-and-looking-ahead-to-fy-2023

[8] https://www.soa.org/resources/research-reports/2022/medicaid-underwriting-margin-model/
https://medicaidplans.org/wp-content/uploads/2020/07/MHPA-Underwriting-Gain-Development-Report_June-2019_FINAL.pdf
https://www.soa.org/resources/research-reports/2017/medicaid-margins/

regardless of if the PHE occurred. However, the PHE likely contributed to higher profit margins both via more conservative rate setting rates and lower claims cost.

Conclusion

Our findings show that while margin did increase, the Medicaid margin levels were explainable, and not abnormal relative to other lines of business experience.

During the PHE margin increased to an approximately 1% above the 1-2% target range used by the states in rate setting. The margin during the PHE is like that during the Medicaid expansion, which was also a period of increased uncertainty. The rate setting process worked well in aggregate as measured by margin. One thing that contributed to this is the distributed nature of the rate setting with over 40 states setting rates.

While the increase in membership occurred over a three-year period, this gave states at least three rate setting cycles to set and refine rates. The unwinding will generally occur over a one-year period. Rate setting will be more difficult because of this compressed time period. The issue is not just a change in membership but how the acuity of the covered population will change. Sicker members are more likely to continue coverage because they are less likely to be able to work and thus will still qualify for Medicaid. We expect the states to use more mid-year rate adjustments to deal with this additional uncertainty.

It will be interesting to see how well the rate setting process works during the implementation of redeterminations and the large decrease in Medicaid enrollment. The expectation is that the dis-enrollees will have lower acuity than those who keep coverage resulting in increase in the per capita claim cost.

Please contact Ed Mailander at 720.501.3310 | ed.mailander@wakely.com or Michael Cohen at 202.568.0633 | michael.cohen@wakely.com with any questions or to follow up on any of the concepts presented here.

Glossary

CHIP: The Children's Health Insurance Program is a program administered by the Department of Health and Human Services that provides matching funds to states for health insurance to lower income families with children.

Cost of Capital: MMCs are required by state regulators to how a minimum capital called risk-based capital (RBC). If a health plan's RBC drops below 200% the state regulator starts to take actions to assure company solvency. At 100% of RBC, the state regulator takes over control of the health plan.

Managed Medicaid: Providing health coverage to Medicaid enrollees through managed care plans instead of the state administered fee for service plan.

Public Health Emergency (PHE): The Department of Health and Human Services declared a Public Health Emergency for Covid-19 that began in March 2020 and ended in May 2023. The HHS made resources available to help mitigate the impact of the pandemic. With respect to Medicaid, states were provided additional funding to cover the cost of the states' Medicaid program on the condition that they suspended redetermination of eligibility.

Redetermination: the process state Medicaid agencies use to determine that a Medicaid enrollee continues to be eligible for Medicaid coverage. This is typically done on an annual cycle.

Risk corridor: a financial arrangement that limits the health plans gains or losses generally as measured relative to the MLR assumed in the pricing. A typical arrangement would limit gains or losses to 3%.

Underwriting Margin: Revenue after reinsurance minus claims expense after reinsurance minus claims administrative expense and other administrative expense. This does not include investment income, which is usually small as a percentage of revenue for health plans. This is reported in the statutory filings on an incurred basis.

Methodology

Data Sources

- NAIC annual filings sourced from SNL database (extracted in December 2023):
    - SNL Health Group
    - SNL Health Group Coe
    - Company name
    - SNL Company Code
    - State of domicile
    - Analysis of Operations Page 7
        - Line 7 Total Revenues
        - Line 17 Total hospital and medical
        - Line 19 Claims adjustment expenses
        - Line 20 General administrative expenses
        - Line 21 Increase in reserves for A&H contract
        - Line 24 Net underwriting gain
    - Exhibit of Premiums, Enrollment and Utilization Page 30
        - Line 6 Current Year Member Months
    - Exhibit of Five-Year Historical Data
        - Line 5 Total Revenue
        - Line 14 Total Adjusted Capital
        - Line 15 Authorized control level risk-based capital
- National Health Expenditures https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical
- Medicaid Margin studies for not-for-profit status and target margin estimate.
- Kaiser Family Foundation for checking enrollment and health plans by state and to identify any health plans missing from the data.

Calculation Methodology

- Started with 1,300 health plans, eliminated companies with no Medicaid revenue, low revenue PMPM to remove behavior health only, dental only, and other non-comprehensive care companies. This resulted in 239 companies in the study.
- Calculated the ratios (MLR, ALR, and Margin) and PMPMs used in the exhibits.
- California is not included in this study. California has about 10 million Medicaid members in 2020 however the health plans do not file NAIC annual statements. Is included in this study. New York had about 5 million Medicaid members in 2020, the largest health plans do not file NAIC statements because they are government owned entities or other entities not regulated by the state insurance department.

Appendix

Average Membership (x 1,000) by State for MCOs included in this study.

State	2014	2015	2016	2017	2018	2019	2020	2021	2022
AR	0	0	0	0	298.326	321.907	339.689	373.15	403.264
CO	28	35	37	39	38	37	133	153	161
DC	135	128	127	148	190	191	185	174	185
FL	893	1,687	1,952	2,435	2,311	1,971	2,138	3,818	4,245
GA	1,144	1,250	1,283	1,315	1,388	1,407	1,539	1,748	1,917
HI	234	243	258	263	259	249	269	321	347
IA	0	0	138	187	182	411	648	717	768
IL	1,049	1,752	2,284	2,305	2,730	2,652	2,696	3,089	3,259
IN	878	901	1,075	1,135	1,103	1,074	1,235	1,513	1,688
KS	236	236	247	233	230	213	230	257	282
KY	690	907	1,221	1,284	1,278	1,247	1,181	1,158	1,175
LA	407	928	1,224	1,457	1,473	1,475	1,554	1,704	1,777
MA	790	871	877	825	784	765	802	892	950
MD	563	553	566	599	607	658	732	877	955
MI	1,330	1,534	1,694	1,779	1,773	1,755	1,894	2,148	2,234
MN	685	809	815	844	875	839	927	1,066	1,119
MO	472	542	603	762	804	710	771	941	1,165
MS	155	393	517	503	464	451	450	462	377
NC	0	0	0	0	0	0	0	834	1,755
NE	140	146	149	240	246	244	262	333	374
NH	47	71	61	60	60	82	101	127	141
NJ	1,334	1,566	1,629	1,641	1,635	1,567	1,655	1,885	2,024
NM	465	519	544	549	521	435	458	497	515
NV	320	389	432	463	476	457	511	613	668
NY	1,024	1,115	1,257	1,212	1,225	1,181	1,187	1,330	1,399
OH	2,038	2,369	2,449	2,506	2,468	2,382	2,529	2,807	2,920
OR	119	134	273	265	299	349	1,226	1,381	1,479
PA	2,153	2,623	2,950	3,050	3,137	3,222	3,569	4,011	4,379
PR	1,409	1,031	1,307	1,256	1,259	1,162	1,137	1,073	1,278
RI	208	238	255	279	272	252	256	282	294
SC	726	733	745	770	771	799	847	963	1,043
TN	618	897	985	929	887	920	970	1,061	1,127
TX	2,702	2,942	3,031	3,138	3,110	3,039	3,311	3,965	4,457
UT	153	176	195	190	179	168	212	274	311
VA	439	469	476	510	605	831	981	1,131	1,242
WA	996	1,316	1,490	1,557	1,511	1,560	1,645	1,830	1,963
WI	1,100	1,175	1,177	1,178	1,196	1,183	1,310	1,588	1,744
WV	202	264	385	422	408	390	425	491	527
Grand Total	25,881	30,941	34,710	36,327	37,054	36,651	40,312	47,885	52,647

Year over year trends for average enrollment, revenue PMPM, Claims PMPM and Admin PMPM.

	2014	2015	2016	2017	2018	2019	2020	2021	2022
Managed Medicaid									
Avg Enroll (x 1,000)		19%	11%	14%	3%	-1%	7%	18%	9%
Rev PMPM		8.9%	4.3%	-5.1%	4.4%	7.5%	8.3%	-0.1%	4.5%
Claim PMPM		8.7%	5.9%	-3.2%	3.0%	9.3%	3.7%	1.0%	4.8%
Adm PMPM		8.1%	5.1%	-16.5%	16.3%	-0.9%	18.1%	-12.8%	5.7%
Commercial									
Avg Enroll (x 1,000)		4%	-6%	-6%	-6%	-2%	-1%	0%	-2%
Rev PMPM		1.6%	8.5%	8.5%	9.5%	0.9%	6.0%	-2.0%	2.2%
Claim PMPM		2.7%	8.0%	4.9%	6.5%	5.4%	1.3%	7.3%	-0.1%
Adm PMPM		1.6%	4.0%	-3.8%	21.1%	-7.1%	17.4%	-12.9%	7.6%
Medicare Advantage									
Avg Enroll (x 1,000)		15%	10%	10%	7%	5%	6%	14%	34%
Rev PMPM		3.3%	3.9%	0.2%	4.4%	5.5%	4.2%	2.1%	4.6%
Claim PMPM		3.6%	0.0%	2.0%	3.6%	6.1%	0.5%	7.1%	3.2%
Adm PMPM		4.5%	5.6%	-8.1%	15.2%	-6.1%	16.6%	-11.4%	2.2%

Average Margin by State

State	2014	2015	2016	2017	2018	2019	2020	2021	2022	2014-15	2016-19	2020-22
AR	0.0%	0.0%	0.0%	0.0%	0.5%	4.0%	8.5%	3.0%	6.7%	0.0%	1.1%	6.1%
CO	3.3%	0.6%	0.0%	4.3%	3.6%	-0.9%	1.0%	3.4%	5.1%	1.9%	1.8%	3.2%
DC	5.2%	5.2%	7.1%	5.8%	8.1%	-1.5%	0.7%	0.8%	-3.6%	5.2%	4.9%	-0.7%
FL	-10.5%	-3.2%	1.9%	1.0%	-0.9%	0.6%	4.1%	6.0%	3.9%	-6.8%	0.7%	4.7%
GA	2.5%	3.1%	3.0%	3.8%	2.8%	4.2%	3.6%	4.9%	5.8%	2.8%	3.4%	4.8%
HI	-1.5%	-2.5%	3.5%	2.2%	-4.6%	-13.5%	-0.6%	2.9%	0.1%	-2.0%	-3.1%	0.8%
IA	0.0%	0.0%	-26.4%	-6.1%	0.7%	3.3%	5.1%	4.3%	3.5%	0.0%	-7.1%	4.3%
IL	4.0%	-4.1%	-6.0%	-8.8%	-4.5%	-1.0%	1.1%	3.4%	1.2%	-0.1%	-5.1%	1.9%
IN	0.7%	2.7%	2.1%	0.4%	3.2%	4.4%	2.2%	0.7%	2.1%	1.7%	2.5%	1.7%
KS	-6.5%	6.3%	1.9%	0.3%	0.8%	-3.5%	0.7%	4.0%	2.9%	-0.1%	-0.1%	2.5%
KY	7.7%	6.9%	2.5%	3.1%	1.1%	0.7%	2.9%	2.8%	1.6%	7.3%	1.9%	2.5%
LA	-1.2%	1.0%	0.7%	1.7%	-0.5%	-0.1%	1.4%	0.1%	-0.3%	-0.1%	0.5%	0.4%
MA	-2.4%	0.9%	-2.1%	0.3%	-1.3%	-2.3%	-0.8%	0.8%	0.2%	-0.7%	-1.3%	0.1%
MD	4.7%	-4.1%	6.1%	4.2%	3.9%	3.8%	6.2%	3.8%	6.5%	0.3%	4.5%	5.5%
MI	3.2%	4.2%	2.0%	1.6%	2.4%	3.2%	2.7%	3.4%	2.6%	3.7%	2.3%	2.9%
MN	3.3%	3.7%	-6.8%	0.0%	1.6%	-1.9%	2.3%	2.4%	6.4%	3.5%	-1.8%	3.7%
MO	0.0%	1.0%	1.9%	-1.4%	2.0%	-3.7%	6.0%	9.0%	6.7%	0.5%	-0.3%	7.2%
MS	-0.2%	-3.7%	-2.3%	-4.2%	-1.3%	-4.4%	5.3%	1.2%	0.9%	-1.9%	-3.0%	2.5%
NC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-6.8%	0.5%	0.0%	0.0%	-2.1%
NE	4.7%	3.0%	2.1%	-2.7%	0.9%	2.3%	2.6%	4.2%	0.9%	3.9%	0.6%	2.6%
NH	-4.0%	-7.0%	-7.0%	-9.4%	-2.9%	-7.6%	-0.8%	0.2%	-1.4%	-5.5%	-6.7%	-0.7%
NJ	4.3%	4.2%	4.9%	2.3%	0.4%	-2.6%	3.1%	3.0%	3.7%	4.3%	1.3%	3.2%
NM	4.0%	2.8%	3.0%	0.5%	2.2%	2.8%	4.4%	5.3%	3.6%	3.4%	2.1%	4.4%
NV	9.1%	4.8%	3.4%	4.7%	3.9%	5.0%	1.8%	9.5%	9.6%	6.9%	4.3%	7.0%
NY	1.9%	2.4%	-3.0%	-0.9%	-0.2%	-2.4%	-1.6%	-0.2%	2.2%	2.2%	-1.6%	0.1%
OH	2.8%	5.6%	0.0%	2.5%	2.7%	0.7%	2.7%	2.9%	5.2%	4.2%	1.5%	3.6%
OR	9.3%	6.8%	3.1%	1.7%	-0.7%	1.0%	1.1%	1.8%	2.9%	8.0%	1.3%	1.9%
PA	0.5%	2.0%	3.0%	2.4%	1.4%	0.0%	1.5%	2.9%	3.5%	1.2%	1.7%	2.6%
PR	0.0%	0.6%	0.2%	0.5%	1.7%	-1.3%	0.4%	1.5%	-11.9%	0.3%	0.3%	-3.4%
RI	3.5%	3.1%	0.1%	0.0%	-1.3%	-1.3%	0.6%	1.5%	0.6%	3.3%	-0.6%	0.9%
SC	3.4%	5.0%	4.6%	2.2%	1.9%	-0.2%	2.8%	1.3%	3.8%	4.2%	2.1%	2.6%
TN	6.3%	4.5%	3.6%	2.4%	-1.0%	1.3%	0.9%	5.6%	4.5%	5.4%	1.6%	3.7%
TX	1.0%	1.0%	0.7%	0.0%	-0.1%	-0.4%	5.7%	4.3%	2.6%	1.0%	0.0%	4.2%
UT	2.8%	3.3%	4.4%	5.2%	4.9%	4.6%	4.7%	6.9%	9.3%	3.1%	4.8%	7.0%
VA	4.5%	4.6%	4.5%	3.7%	-2.7%	1.4%	5.1%	8.2%	4.4%	4.6%	1.7%	5.9%
WA	-2.5%	1.1%	1.0%	2.6%	1.1%	0.8%	3.7%	2.7%	2.6%	-0.7%	1.4%	3.0%
WI	2.2%	3.0%	0.8%	-2.5%	2.7%	1.8%	8.9%	5.9%	3.3%	2.6%	0.7%	6.0%
WV	13.9%	2.1%	3.3%	1.1%	2.8%	0.1%	5.6%	11.6%	8.6%	8.0%	1.8%	8.6%
Grand Total	1.9%	2.2%	0.7%	0.6%	0.5%	0.1%	2.8%	3.4%	3.0%	2.0%	0.5%	3.1%

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Learn more about Wakely Consulting Group at www.wakely.com