
Credit Assessment of ACAP-Member Safety Net Health Plans

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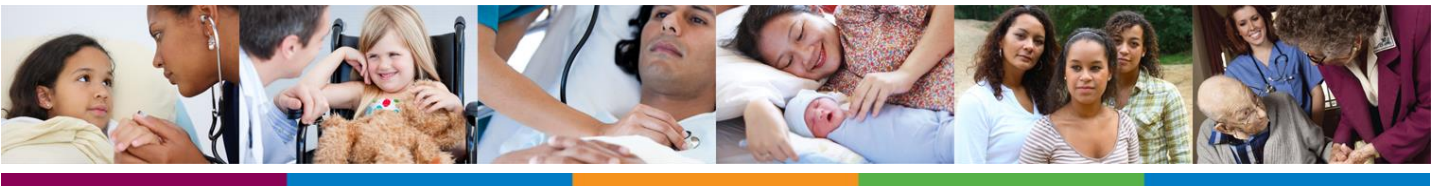


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Executive Summary

In 2014, the Affordable Care Act (ACA) will expand the availability of affordable health insurance coverage to additional individuals through both the Medicaid program and affordable coverage available through state and federal marketplaces. In addition, the availability of more coordinated care for those dually eligible for Medicaid and Medicare will also expand in 2014. Many of these new enrollees are expected to be covered by plans which are members of the Association for Community Affiliated Plans (ACAP).

ACAP is an association of community-based, not-for-profit Safety Net Health Plans. Its members provide health care coverage to approximately one-third of all Medicaid managed care enrollees, as well as enrollees in the Children's Health Insurance Program, Medicare and in several state-supported health insurance programs. Beginning in 2014, several ACAP plans will also provide coverage under the newly-established health insurance marketplaces.

The rise in Medicaid membership (especially with the onset of costly dual eligibles), as well as the increases in coverage available through the marketplaces, may result in a short-term reduction in the cash flow position of these ACAP plans and erode their capital position to a threshold that could limit the ability of plans to meet expansion demands. This anticipated increase in membership may create financial stress on those plans due to the high cost of some of their new enrollees and the speed with which plans will be required to expand their programs. For those plans that are able to expand, this situation could be exacerbated by the fact that many pay out more than 90 percent of their premium dollars on medical expenses. As a result, fewer premium dollars are available to build or contribute to their capital position, which could create financial instability.

Recognizing the import of this limitation, ACAP determined that it would be appropriate to assess the ability of and impediments to plans' ability to borrow moneys to meet the financial requirements of these expansions. To assess ACAP plans' ability to borrow, this study used data primarily from the National Association of Insurance Commissioners (NAIC)¹ which included 41 ACAP plans that enrolled Medicaid members and compared their financial solvency to 166 non-ACAP Medicaid plans, including both not-for-profit and for-profit plans. In addition, the study conducted interviews with Chief Financial Officers (CFOs) of two ACAP health plans, which focused on the access to funds to finance their Medicaid expansion.

The study conducted three major types of financial assessments. The first analysis evaluated key solvency ratios of ACAP plans compared to a benchmark of non-ACAP Medicaid managed care plans. The second financial analysis analyzed the ACAP and non-ACAP balance sheets in terms

¹ As discussed later, not all plans in NY, AZ, and CA report data to NAIC. Data on these plans were collected separately.

of the sources and uses of capital, while the final analysis estimated ACAP plans' debt capacity based on their cash flow.

ACAP plans' ability to borrow as well as maintain their solvency is supported by the following financial points:

- 1) Based on 2011 data, the total capital position of ACAP plans, reflected by their risk-based capital (RBC) ratio, is almost four and half times that of their authorized capital level and only slightly below (24 basis points) non-ACAP plans' RBC ratio. More importantly, the median RBC ratio for ACAP plans exceeds the NAIC's RBC minimum standard of two times authorized total capital. From a solvency perspective, in 2011 the average¹ ACAP plan's capital reserves far exceed the authorized capital level, which accounts for the various risks associated with each health plan's operation.
- 2) The recession of 2008 eroded the financial position of companies nationally. In 2009, ACAP plans generated a cash flow return of just over three percent from their total revenues. In contrast, in 2011 ACAP plans generated an almost five percent cash flow return on their revenues, which highlights ACAP plans' strengthening cash flow position. Moreover, their 2011 cash flow returns were two percentage points higher than the returns of non-ACAP plans, which generated a cash flow return of less than three percent. Although the study did not measure the key drivers behind cash flow, ACAP plans' improved cash flow might have stemmed from reduced operating expenses, enhanced revenues from expanding enrollment, and/or higher payments received. More importantly, ACAP plans generated a sufficient positive net cash flow return on their revenues to support future debt service payments as well as to enhance their overall capital position. Generating an upward trend in positive net cash flow over time allows ACAP plans to retain funds needed to increase their capital position through short and long term investments. More importantly, higher capital reserves by ACAP plans raises their risk-based capital levels and enhances their financial stability.
- 3) During the study period, balance sheet comparisons find both ACAP and non-ACAP plans with minimal outstanding borrowing, which underscores ACAP plans' excess capacity for debt borrowings. Of this limited borrowing, only 25 percent of ACAP plans reported an obligation due their parent, subsidiaries, or affiliates. In contrast, over 69 percent of non-ACAP plans had an obligation due to their parent, subsidiaries and affiliates. Thus, compared to non-ACAP plans, ACAP plans depend less on internal loans and payables to meet cash flow shortfalls. This outcome may infer that ACAP plans depend more on generating cash flow internally to build their reserves. Conversely, this suggests that non-ACAP plans can withstand potential operational cash flow shortfalls because they rely on the cash cushion of inter-affiliates to increase capital reserves. ACAP plans may have

greater fiscal solvency than non-ACAP plans because they depend less on credit obligations from external lenders and affiliated lenders.

- 4) In 2011, almost 80 percent of the total assets of ACAP plans were cash and investments. Moreover, their retained cash and investments are sufficient to pay their daily operating expenses for almost two months. Both of these outcomes mirror non-ACAP Medicaid plan benchmarks. Simply stated, the fiscal solvency of ACAP health plans is strengthened when their cash and investments reserves can cover any potential cash flow shortfalls resulting from the slower receipt of payments or rise in medical claims. This is less likely to be the case, however, during the expected transitional period as plans initially enroll, provide services to, and provide care management to new populations.
- 5) The debt-borrowing capacity for ACAP plans was projected based on median plan cash flow from 2009 to 2011 and an assumed interest rate of six percent on a five year loan. A conservative estimate of the debt borrowing capacity ranged from \$12 million for smaller ACAP plans (with less than 100,000 members) to \$38 million for larger ACAP plans (with more than 250,000 members). Although plan borrowing terms will differ in response to each plans' Medicaid expansion needs, these projections provide insights relative to plan size, historical average operating cash flow values, and assumed credit terms. The sizeable positive cash flow generated by ACAP plans also reflects greater solvency, a result of their ability to control and manage the costs of their Medicaid enrollees as well as their ability to collect on their payments in a timely manner.

ACAP plans face several barriers in their ability to borrow, supported by the following points:

- 1) Even with the higher cash flow margins among ACAP plans, interviews with two ACAP health plan CFOs (see Appendix 1) indicate that Medicaid health plans may have difficulty borrowing funds from outside lenders. Banks may be reluctant to lend for two reasons. First, banks implemented higher credit standards as a result of the 2008 credit crisis. Second, Medicaid health plans have limited or no prior experience borrowing from banks and have not developed any credit history to reflect their ability to pay outstanding obligations with lenders.
- 2) Other potential lenders, such as life insurance companies and private equity firms, are also hesitant to lend to health plans because the capital is being sought to support a new business line, specifically dual eligibles. These potential lenders view the financing of this line of business as start-up capital for a new venture for the health plan, one marked with great uncertainty regarding cost and payment. Finally, lenders are concerned that investing in a Medicaid health plan is high-risk because this business line depends on one payment source from highly regulated payer, the state Medicaid agency. Overall these concerns reflect risk factors that are basically unique to the Medicaid managed care industry.

- 3) Both ACAP and non-ACAP plans have limited experience borrowing from bankers and other potential lenders, such as insurance companies and private equity funds. Financial statement analysis found that only seven percent of ACAP and non-ACAP plans' current borrowing is from lending institutions. Relative to other major players in the health care industry, health plans borrow relatively less because they are not capital-intensive: plans do not require investment in plant and equipment. In contrast, the hospital industry is very capital-intensive and needs access to large amounts of debt capital to finance the purchase of medical equipment and facilities. Recent hospital industry standards show that hospitals finance more than 55 percent of their fixed assets with long-term debt.²
- 4) The majority of ACAP plans do not depend upon the capital cushion and support from a parent (e.g. health care system) or corporate affiliate entity (e.g. publicly-traded company). The results find that only 25 percent of ACAP plans had an obligation due to a parent, subsidiaries and affiliates, compared to more than 69 percent of non-ACAP plans. In short, ACAP plans depend less on internal inter-affiliate loans and payables to meet cash flow shortfalls, which reflects ACAP plans' dependence on generating cash flow internally to build their reserves. Conversely, this finding indicates that non-ACAP plans rely on the cash cushion of their parent, subsidiaries and affiliates to increase capital reserves and can withstand potential cash flow shortfalls from operations due to lower reimbursement and higher medical claims.

The aforementioned credit strengths of the ACAP plans far exceed their credit weaknesses, and it is noteworthy that the weaknesses stem mainly from industry-wide credit risk factors beyond the plans' control. These findings indicate that, on average, ACAP plans are both financially sound and creditworthy. More importantly, a loan guarantee program from the federal government would mitigate these Medicaid managed care industry-wide barriers by attracting lenders with the essential capital ACAP plans need to preserve their financial stability and expand their Medicaid programs into high cost programs. The ideal financial instrument to build up ACAP plan's capital is a surplus note, since this type of financial note is listed as capital on the balance sheet rather than a long-term liability account. As a result, this note increases the capital levels of ACAP plans and enables them to maintain their risk-based capital ratio above the insolvency thresholds that would force regulatory action by state insurance commissioners.

Background

With the onset of the Medicaid expansion provisions of the Affordable Care Act (ACA) in 2014, Medicaid enrollment growth is projected to increase by up to 17 million members by 2016, depending on how many states take up the Medicaid expansion option.³ Under the ACA, states are allowed to expand enrollment to childless adults below 138 percent of the federal poverty level. Many of these new enrollees will receive services through managed care plans. In addition, many states are also working to move their beneficiaries who are dually eligible for Medicaid and Medicare into the managed care arena to better coordinate the care delivered under the two programs. Finally, the individual insurance market expansion in the Exchanges will also have an impact on the expansion plans of managed care plans.

Safety Net Health Plans (SNHPs)—many of which belong to the Association for Community Affiliated Plans (ACAP)⁴—currently provide health care coverage to approximately one third of all current Medicaid managed care enrollees and are expected to enroll a significant proportion of these new Medicaid members as well as those who are dually eligible. SNHPs are not-for-profit, community-based health plans which primarily serve individuals enrolled in the Medicaid, Children’s Health Insurance (CHIP) and Medicare programs. As community-based programs, a large proportion of them are affiliated with other safety net health providers such as community health centers, public hospitals and children’s hospitals.

Providing managed care services to almost one third of all individuals enrolled in capitated Medicaid managed care, SNHPs provide high-quality, cost-effective care to their members. For example, five of the top ten managed care plans in the nation, as certified by the National Committee on Quality Assurance (NCQA), are Safety Net Health Plans. Moreover, ACAP plans have medical loss ratios higher than other managed care plans, demonstrating that they devote a greater proportion of their premium dollars to medical care than do other plans.⁵

Safety Net Health Plans have been a constant in the Medicaid program. While some commercial plans have left the Medicaid program during financially difficult times, SNHPs have remained and even expanded during those same times.⁶ As plans dedicated to serving Medicaid members, SNHPs are driven by their mission to provide services tailored to beneficiaries who often have special needs, which makes the delivery of appropriate health care more complex.

This anticipated increase in membership in these Safety Net Health Plans may create financial stress on those plans: due to the high cost of some of their new enrollees as well as from the speed with which plans will be required to expand their programs, plans may find themselves undercapitalized or unable to meet the expansion demands placed on them. For those plans that are able to expand, this situation could be further exacerbated by the fact that many of these health plans pay out over 90% of their premium dollars on medical expenses. As a result, fewer premium dollars are available to build or contribute to their capital position, which could create

financial instability. Furthermore, they may lack the cash reserve dollars to support the increased enrollment, particularly of the high-cost, dually-eligible population.

Study Aims and Approach

To mitigate these financial limitations, ACAP is soliciting the Federal government to consider a loan guarantee program to assist its member health plans to gain access to capital from lenders. To support such a program, ACAP contracted for an assessment of the current financial solvency condition of its members to evaluate the ability of this health plan sector to borrow and repay loans under such a program.

The aims of this evaluation include:

- To measure and evaluate the Safety Net Health Plans' RBC across various plan traits and membership size categories.
- To evaluate additional financial drivers by SNHP vs. non-SNHP plans, which may affect their ability to borrow. These financial drivers include liquidity or level of capital⁷ to pay off medical and administrative expenses; cash flow capability, or the flow of cash from premiums earned and other revenues to meet future debt service payments; and amount of capital on hand to pay off any outstanding debt or liability obligations.
- To project the debt capacity of SNHPs plans based on various ranges of their available cash flow.

For purposes of this study, SNHPs are defined as those which are a) a governmental entity or b) an organization incorporated as a nonprofit corporation under state law, no part of whose net earnings inure to the benefit of a private shareholder or individual, and which has more than 80 percent of its gross revenues from Medicaid, Medicare or the Children's Health Insurance Program.⁸ Since a list of such plans is not readily available, this analysis will use ACAP membership as a proxy for meeting the SNHP definition.

Solvency Measures

Almost half of all ACAP members are state-licensed health insurers that comply with statutory accounting principles (SAP). Under a SAP basis, state insurance regulators are focused on the adequacy of individual health plans' capital and surplus to pay claims as well as the overall solvency of the entity. The risk-based capital (RBC) ratio is the primary measure analyzed by state insurance regulators to assess the health insurers' level of surplus and capital relative to state regulated levels of minimum capital requirements. Health insurers are focused on complying with state regulation in maintaining their plans' solvency.

To broaden the analysis beyond that used by regulators, this study used four key ratios to measure the solvency of health plans, including the Risk-Based Capital (RBC) ratio, days in

capital, cash flow margin, and total capital to debt.^{9,10} These ratios were measured from 2009 to 2011, the most recent three-year period available when this study was initiated.¹¹

- **RBC ratio** measures the overall solvency of the health insurer and assesses the total capital of the health insurer relative to the state regulated level of minimum capital, which is based on the risk profile of the insurer.
- To measure the number of days of medical and administrative expenses that can be paid by the amount of capital held by the health insurer, the study will compute its **days in capital** which reflects the number of days a health insurer could pay its medical and administrative expenses from its capital sources. The ratio is defined as health insurer's total capital divided by its medical and administrative expenses per day.
- To measure a health insurer's ability to generate cash flow from its operations, the study will evaluate its **cash flow margin ratio**, which is defined as net cash flow from operations divided by total revenues.¹²
- To measure the amount of capital cushion to pay off outstanding claims and other liability obligations incurred by the insurer the study will measure the **total capital to debt ratio**.

Finally, to compare and contrast the percentage of capital from debt borrowings as well as percentage of capital from cash and investments to pay off debt obligations,¹³ the study will compare the sources and uses of capital between ACAP members and non-ACAP members. Sources of capital, such as total liabilities, total capital, debt borrowings, and amount due to parent or affiliates will be measured as a percentage of total assets. The uses of capital will examine percentages of total assets allocated to short-term investments accounts of cash, marketable securities and long-term investments such as stocks and bonds by ACAP members and non-ACAP members.

Sample and Study Methodology

The study identified ACAP member plans using information provided by the Association. The comparison group included non-ACAP health plans, identified as any full-service comprehensive health plans that are contracted with by their respective state to insure Medicaid members.¹⁴ The selection criteria for the study sample followed a two-stage process.

For the first stage, the study reviewed the CMS listing of Managed Care Plans insuring Medicaid members within its 2011 *Medicaid Managed Care Enrollment Report*.¹⁵ In reviewing the report, there were 231 full-service, risk-based capitation Medicaid plans as of 2011. To achieve a more representative sample size for comparison purposes, thereby limiting the potential for outlier values, this study applied a membership cutoff of 1,000 members. This criterion is comparable to the Affordable Care Act's (ACA) criterion for regulation of the medical loss ratio (MLR) for commercial health plans, whereby plans with at least 1,000 insured members must comply with this law. Plans with fewer members were also excluded since they were more likely to incur greater variability in financial accounts as well as lower levels of capital.

For the second stage, health plan financial data were identified from the National Association of Insurance Commissioners (NAIC) database from those plans that reported Medicaid membership. However, within the states of Arizona, California and New York, the majority of Medicaid plans that comply with state regulations do not report their financial data to NAIC. For plans in Arizona, California, and New York, financial data were accessed from their state’s Department of Insurance.

Based on this sampling process, a **final sample of 207 plans, including 41 ACAP plans and 166 non-ACAP plans**, was established.¹⁶ The final sample represents 89 percent of all full-service, risk-based capitation plans.

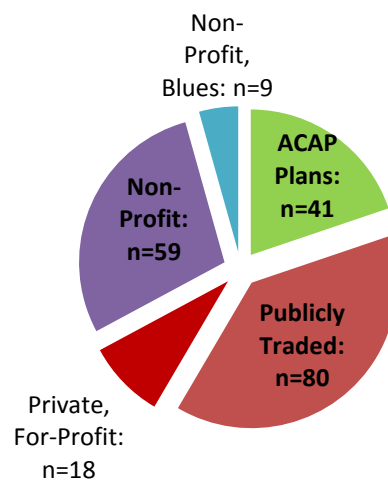
Several limitations with this analysis relate to the accounting guidelines in their financial filings. Health plans reporting NAIC data comply with Statutory Accounting Principles (SAP). SAP focuses on assessing the solvency of health insurers and excludes the reporting of non-liquid assets such as furniture and supplies. Health plans reporting their financial filings with the states of Arizona, California and New York comply with Generally Accepted Accounting Principles, which focus on the transparency of reporting revenues and expenses.

Therefore, one potential limitation of the analysis is the under-reporting of selected solvency ratios for health insurers from the three states since they do not comply with NAIC regulations.

A second limitation is the variance in the reporting of authorized capital, which is the critical account in computing the Risk-Based Capital (RBC) ratio. The NAIC data require health plans to report their authorized capital; however, for health insurers in the previously-mentioned states that did not report to their data to NAIC, a proxy measure was employed to measure authorized capital. For the state of California, the proxy measure for authorized capital was their reported required tangible net equity, which is based on at least 8% of health care expenditures. For the state of New York, the proxy measure for authorized capital was their reported cash escrow account fund, which is 5% of subsequent year’s projected medical expenses. For the state of Arizona, the proxy measure for authorized capital was based on the New York approach and measured by calculating 5% of medical expenses.¹⁷

Universe of Plans Studied

by Type and Ownership Status



In addition to comparing ACAP to non-ACAP plans, analyses were conducted comparing the various ratios among plans across a variety of characteristics:

- **Medicaid Focus:** Some plans provide the majority of services to individuals enrolled in the Medicaid program, while others do not. Since the focus of a plan's membership may have an impact on its financial status, it was determined that comparisons should be made on this characteristic. Based on ACAP's recommendation, the study defined Medicaid-focused plans as those with at least 51% of their total members enrolled in Medicaid.
- **Ownership:** Corporate mission and ownership may influence the outcome of these ratios. For example, health plans owned, affiliated or a subsidiary of parent corporations, such as publicly-traded companies or privately-owned for-profit companies, may limit the amount of capital retained by the health plan because capital is reallocated back to the parent company. Capital returned to the parent is typically paid out to stockholders or utilized for strategic or operational purposes such as acquiring health plans and improving infrastructure. Similarly, health plans owned by health care systems may limit the amount of capital on hand because their parent system has a higher priority in allocating capital toward their more capital intensive providers of care such as hospitals.¹⁸ Plan traits related to ownership categories of publicly traded, non-profit, private for-profit, and Blue Cross non-profit, were identified from NAIC and state filing data.
- **Plan Size:** Overall plan size may have an impact on the financial status of a plan. To address this issue, membership size categories were developed in conjunction with ACAP staff. The following total membership groupings provided for a relatively-proportional distribution of ACAP and non-ACAP plans within the groupings:

size category 1 = plans with total members below 50,000;
size category 2 = plans with total members between 50,000 and 100,000;
size category 3 = plans with total members between 100,000 and 250,000; and
size category 4 = plans with members above 250,000.

In terms of the methodology, the study measured each ratio value across the plan traits by its median value. The reason for measuring a median value for each ratio value was due to the smaller sample size within specific plan trait categories, especially in the case of the sampled ACAP plans. Using median values rather than mean values alleviated any impact of outlier values on the median value of the ratio.

The results of the analysis are presented in the following pages and are organized as follows:

- The first analysis assessed differences in median values for each solvency ratio by ACAP membership (ACAP plans vs. non-ACAP plans).
- The second analysis evaluated median differences for each solvency ratio across ownership status.

- The third analysis measured median differences in each solvency ratio by Medicaid focus status on financial solvency.
- The fourth analysis tests for effects of ownership status by controlling for Medicaid focused status. This analysis also categorized non-ACAP Medicaid focused plans into the ownership status of publicly traded, private non-profit and for-profit plans.
- The fifth analysis examined the median differences in each solvency ratio by membership size categories.
- The sixth analysis evaluated the sources and uses of capital as percentage of total assets using 2011 balance sheet accounts for ACAP members and non-ACAP members. Sources of capital, such as total liabilities and total capital, were measured as a percentage of total assets. The uses of capital examined percentages of total assets allocated to short-term investments accounts of cash, marketable securities and long-term investments such as stocks and bonds by ACAP members and non-ACAP members
- The final analysis estimated the debt capacity of ACAP plans. The study stratified ACAP health insurers by membership size categories within each membership size category and measured its cash flow available for debt service payments across membership size categories of the ACAP health insurers. The study assumed a range of debt service coverage ratios, ranging from a cash flow value of two times debt service payments to three and half times debt service payments to solve for a projected debt service payment. These projected debt service payments were applied to measure potential debt borrowing based on a five year bank loan and a given interest rate of six percent.

Results

Section 1: RBC Ratio Results

The Risk-Based Capital, or RBC, ratio measures the amount of capital on hand that the health plan possesses relative to state authorized control level of capital or minimum level of capital. For the overall comparison of ACAP compared to non-ACAP plans, the median RBC ratio for all three years indicates the ACAP plans had more than three times the level of authorized capital compared to more than four times the level of authorized capital for non-ACAP plans (see Table 1.1). While ACAP plans did have lower RBCs than non-ACAP plans, it is important to note that ACAP plans increased the value of their RBC ratio between 2009 and 2011 by more than 100 basis points. In 2009, their RBC ratio was only 3.23; however by 2011, the ACAP plans increased their RBC ratio to 4.49. More importantly, in 2011, the ratio value was less than 25 basis points lower than the non-ACAP plans and was almost four and half times its authorized capital. A separate analysis of the cash flow margin ratio (see below) found that it increased by two percentage points for ACAP plans. The rise in the cash flow margin contributed to higher capital reserves and RBC ratio.

Figure 1.1: Median RBC Ratio Analysis by ACAP/non-ACAP status, 2009-2011

Note: All charts in this report are presented as tables in Appendix 2.

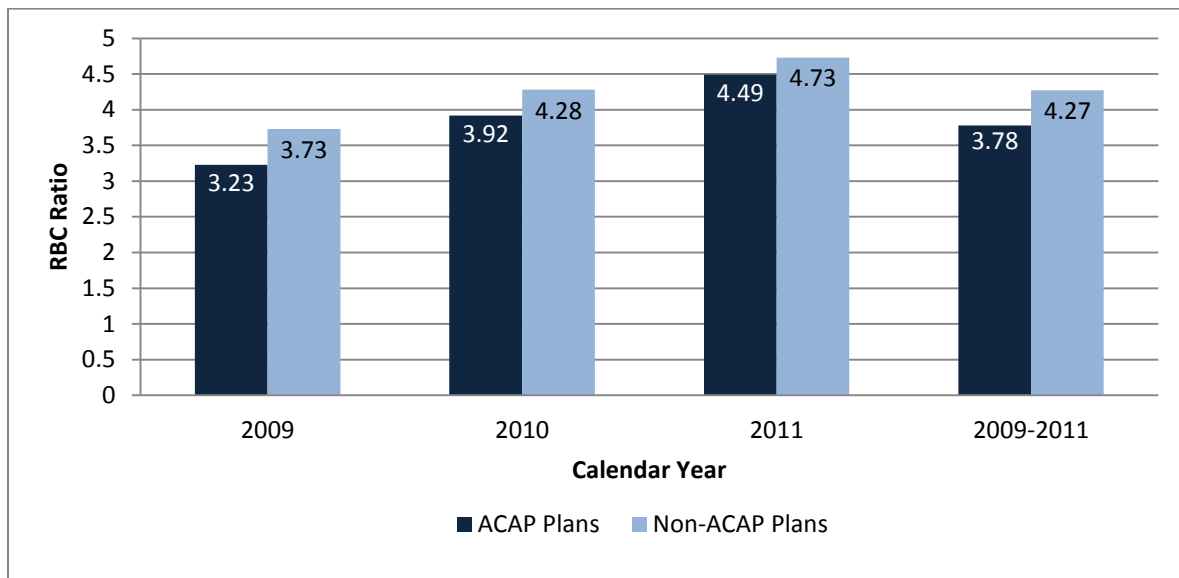


Figure 1.2 assesses ACAP plans relative to non-ACAP plans by ownership status of publicly-traded, private for-profit and non-profit plans, and Blue Cross non-profit plans. Except for 2009, ACAP plans' median RBC ratio for 2011 (4.49 vs. 3.73) and 2010 (3.92 vs. 3.69) were higher than non-ACAP private for-profit plans.

However, ACAP plans' RBC ratios from 2009 to 2011 were lower than non-ACAP publicly-traded and Blue Cross non-profit plans. Since ACAP plans are non-profit plans, the non-ACAP non-profit ownership plans were the ideal comparative benchmark group. The ACAP's RBC median over the three year study period was almost 100 basis points lower (3.78 vs. 4.73) than non-ACAP non-profit plans. Over time, all five ownership categories increased their RBC ratio from 2009 to 2011 with the non-ACAP Blues non-profit plans experiencing the largest increase of 173 basis points from 3.75 to 5.58, while ACAP plans had the second-largest increase of 126 basis points from 3.23 to 4.49.

Conversely, the non-ACAP private for-profit plans had minimal growth of only 23 basis points. (Note: Further investigation of the data found that two of the privately-held for-profit plans and declining financial ratios and eventually went bankrupt, which slowed the buildup of their RBC ratio.¹⁹⁾)

Categorizing plans by ownership status: Examples

- **ACAP plans:** Health Plan of San Joaquin, Kern Family Health Care, and Health Plan of San Mateo (all from California); Hudson Health Plan of New York; Neighborhood Health Plan of Rhode Island.
- **Medicaid-focused health plans owned by publicly traded companies:** Molina, Centene Corporation, Amerigroup.
- **For-profit plans owned by privately-held companies:** Care1st of California ; Ardent Health System of Tennessee.
- **Non-profit plans:** Kaiser Foundation, Group of California, and Group Health Cooperative of Washington State.
- **Medicaid plans owned by non-profit Blue Cross Plans:** BCBS of Tennessee, Michigan, and Minnesota.

Figure 1.2: Median RBC Ratio Analysis by ACAP and Ownership Status, 2009-2011

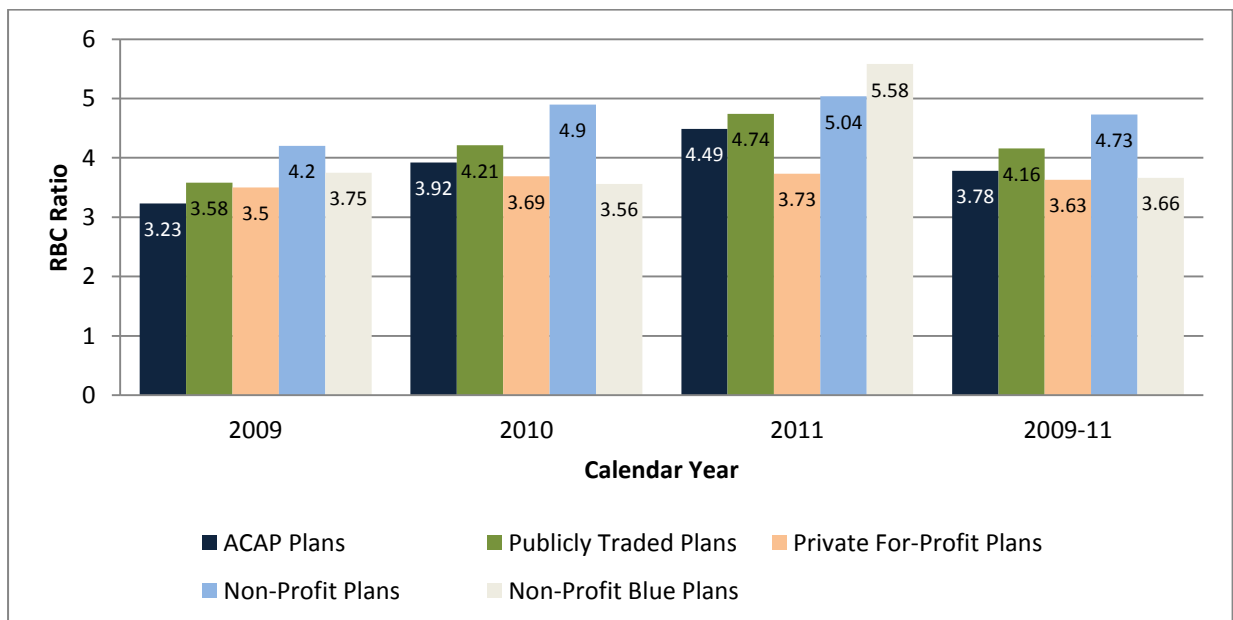


Table 1.3 compares ACAP plans to the subset of non-ACAP plans which are *not* Medicaid-focused, including those which are publicly-traded, non-profit and for-profit. ACAP plans, which are all Medicaid-focused, had a substantially lower median RBC over the three year period, (3.78) than publicly-traded plans (4.49) and non-profit plans (5.55). In 2011, ACAP plans' total capital was almost four and half times its authorized capital while publicly-traded plans were more than four and half and non-profit plans were five and half times their authorized capital.

However, ACAP plans' median RBC over the three year period (3.78) was more than 150 basis points higher than for-profit plans (2.19). Given the small sample size of five plans, caution must be taken in the analysis of for-profit plans, which in 2011 only had a RBC ratio of only one and half times its authorized capital (1.58).

Figure 1.3 Median RBC Ratio Analysis, Controlling for Non-Medicaid Focus, ACAP and Ownership Status

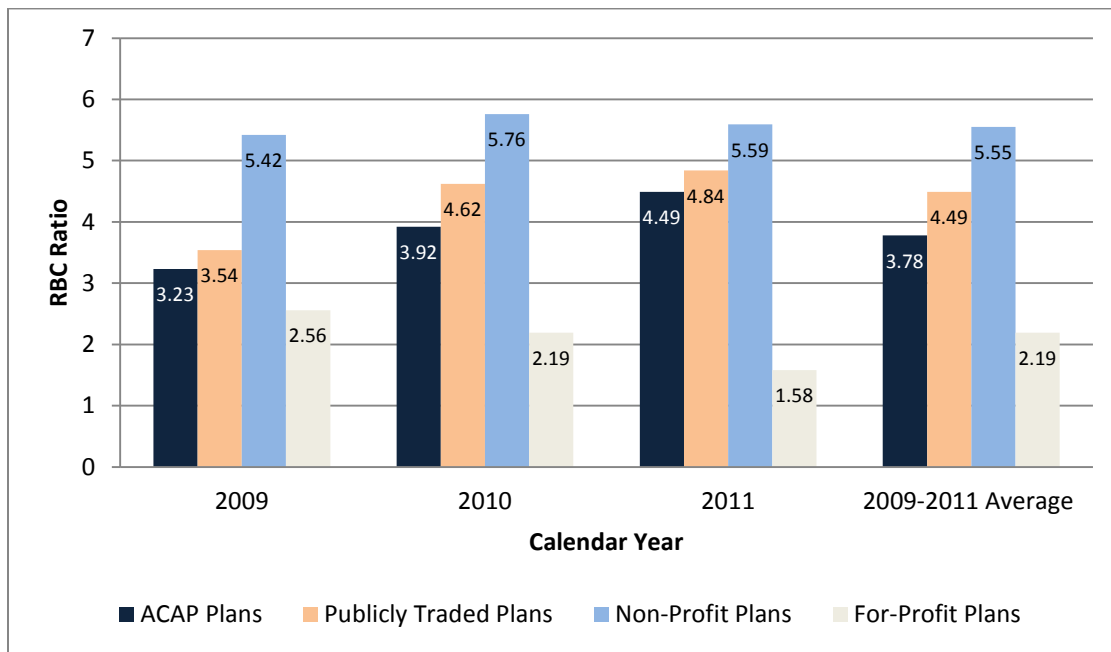


Table 1.4 compares ACAP plans to non-ACAP but Medicaid-focused publicly-traded, non-profit and for-profit plans. Over the three year study period, the median RBC ratio for ACAP plans (3.78) was below their publicly-traded (4.03) and for-profit counterparts (5.39). However, in 2011, the ACAP plans' RBC ratio (4.49) was almost four and half times amount of capital relative to authorized capital, which is almost in-line with non-ACAP plans (4.46) and only slightly below (seven basis points) publicly-traded plans (4.49 vs. 4.56).

Figure 1.4 Median RBC Ratio Analysis Controlling for Medicaid Focus, ACAP and Ownership Status

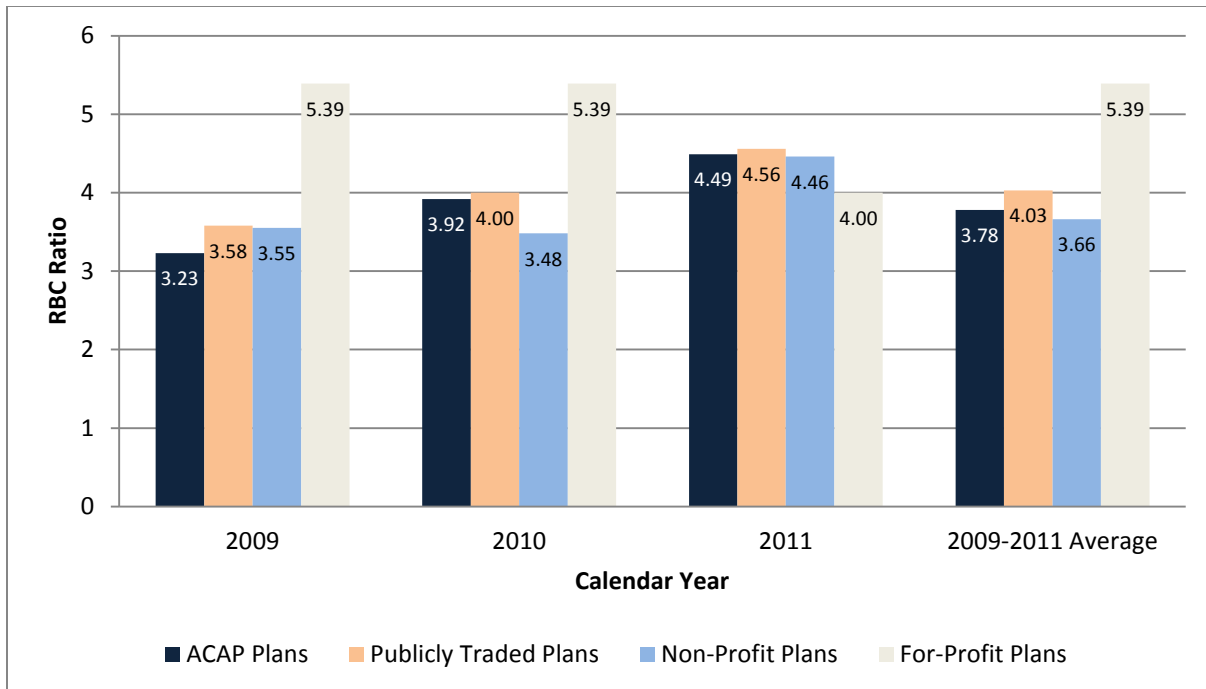


Table 1.5 presents the RBC ratio by ACAP and Membership Size Categories. Again, caution must be taken in the analysis given the small sample sizes across size categories for ACAP plans. ACAP plans with membership between 100,000 and 250,000 had the highest median RBC ratio over the three year period, 4.06, while ACAP plans with membership below 50,000 had the lowest median RBC ratio over the three year period, 2.39. **However, in 2009, the median RBC ratio for ACAP plans with less 50,000 members was 1.89. This RBC ratio indicates that total capital for ACAP plans was less than the state regulated threshold value of two times its authorized capital, at which point state insurance regulators requires health plans to file a plan to take correction action to increase their RBC ratio.** However, by 2011, these ACAP plans' median RBC rose to 4.64, which is slightly above the median RBC ratio for non-ACAP plans with similar membership size (4.46).

For ACAP plans with membership between 100,000 and 250,000, the RBC ratio increased from 3.23 in 2009 to 5.11 in 2011, while non-ACAP plans of similar size increased their RBC ratio from 3.82 in 2009 to 5.24 in 2011. **In 2011, ACAP plans in this membership category had the highest median RBC ratio of 5.11 across all ACAP membership size categories, which indicates their total capital is more than five times their authorized capital and was slightly below the RBC ratio of non-ACAP comparison group (5.24).**

The median RBC ratio over the three-year period for ACAP plans in the 50,000 to 100,000 membership category was 3.71; 50 basis points lower than the RBC ratio for the non-ACAP

comparison group (4.25). Finally the median RBC ratio over the three-year study period for the membership category greater than 250,000 members was almost equivalent for both ACAP and non-ACAP plans (3.78 vs. 3.79). However in 2011, ACAP plans within this membership had higher median RBC ratio (4.49 vs. 4.09)

Table 1.5: Median RBC Ratio Analysis by ACAP and Membership Size Categories

Year	<50,000 Members		50,000-100,000 Members		100,001-250,000 Members		>250,000 Members	
	ACAP (n=5)	Non-ACAP (n=37)	ACAP (n=10)	Non-ACAP (n=42)	ACAP (n=17)	Non-ACAP (n=45)	ACAP (n=9)	Non-ACAP (n=42)
2009	1.89	3.34	3.12	3.94	3.23	3.82	3.47	3.75
2010	2.39	4.38	3.93	4.23	4.35	4.75	3.79	4.00
2011	4.64	4.46	3.73	4.75	5.11	5.24	4.49	4.09
2009-2011	2.39	4.20	3.71	4.25	4.06	4.74	3.78	3.79

Summary RBC ratio

During the economic recession of 2009, ACAP plans had a median RBC ratio of 3.23 compared to 3.73 for their non-ACAP counterparts. State insurance regulators typically require plans to take corrective action when RBC ratio falls below 2 or, more specifically, when total capital is less than twice the size of their authorized capital. However in the case of ACAP plans, the total capital was more than three times their authorized capital. By 2011, however; ACAP plans' capital was almost four and half times their state authorized capital requirement, which is almost comparable to non-ACAP plans. This substantial rise in the RBC ratio among ACAP plans reflects how these plans were able to build up their capital position during the intervening years by, for example, improving their operations or gaining access to capital externally.

Although, the smaller sample size for ACAP plans across membership categories might be affecting the reliability of the RBC ratio values, ACAP plans in the largest membership category (over 250,000 members) had a RBC median value over the three year period that was almost equivalent non-ACAP plans (3.78 vs. 3.79). However, in 2011 the RBC ratio median for ACAP plans was more than 40 basis points higher than for non-ACAP plans. At the opposite end of the membership size category, ACAP plans in the smallest membership category, below 50,000 members, had a **median RBC ratio of 1.89, which is less than the state insurance regulated value that requires corrective action by health plans. However, by 2011, these smaller size ACAP plans had a median RBC ratio value that rose to 4.64.**

Section 2: Cash Flow Margin Ratio Results

The findings for the cash flow margin ratio are presented in tables 2.1 through 2.4 by ACAP status and other plan traits. For ACAP plans, their cash flow returns rose dramatically from 2.96 percent in 2009 to 4.86 percent in 2011, compared to just a slight improvement in the cash flow margin ratio over time for non-ACAP plans (see table 2.1). Over the study period, ACAP plans had significantly higher median cash flow margin ratio than non-ACAP plans—4.39 percent compared with 3.00 percent.

Figure 2.1: Median Cash Flow Margin Ratio Analysis by ACAP status

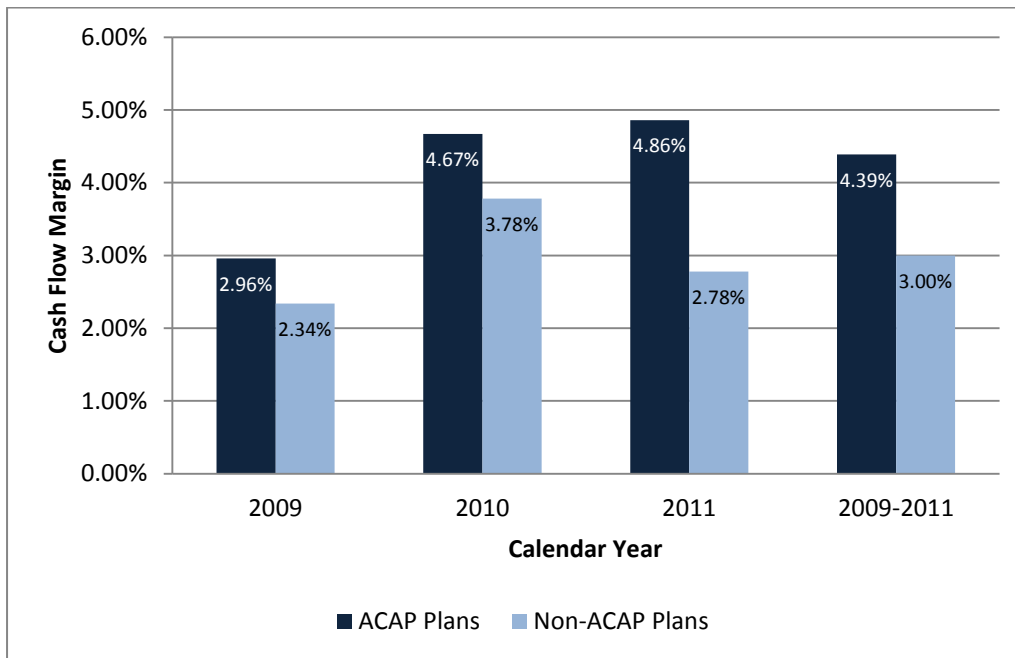


Table 2.2 assesses ACAP plans relative to non-ACAP plans by ownership status of publicly-traded, private for-profits, non-profit and Blue Cross plans. ACAP plans generated higher median cash flow margins (4.39 percent) over the three-year period than publicly-traded (2.60 percent), for-profit (3.66 percent), non-profit (3.52 percent), and Blue Cross plans (1.09 percent). In 2011, ACAP plans generated a median cash flow margin of 4.86 percent—nearly 200 basis points higher than the other four ownership categories. ACAP plans had the largest increase in their cash flow margin ratio, rising from 2.96 percent in 2009 to 4.86 percent in 2011. Conversely non-ACAP, non-profit plans experienced a decline from 4.09 percent in 2010 to 2.47 percent in 2011.

Figure 2.2: Median Cash Flow Margin Ratio Analysis by ACAP and Ownership Status

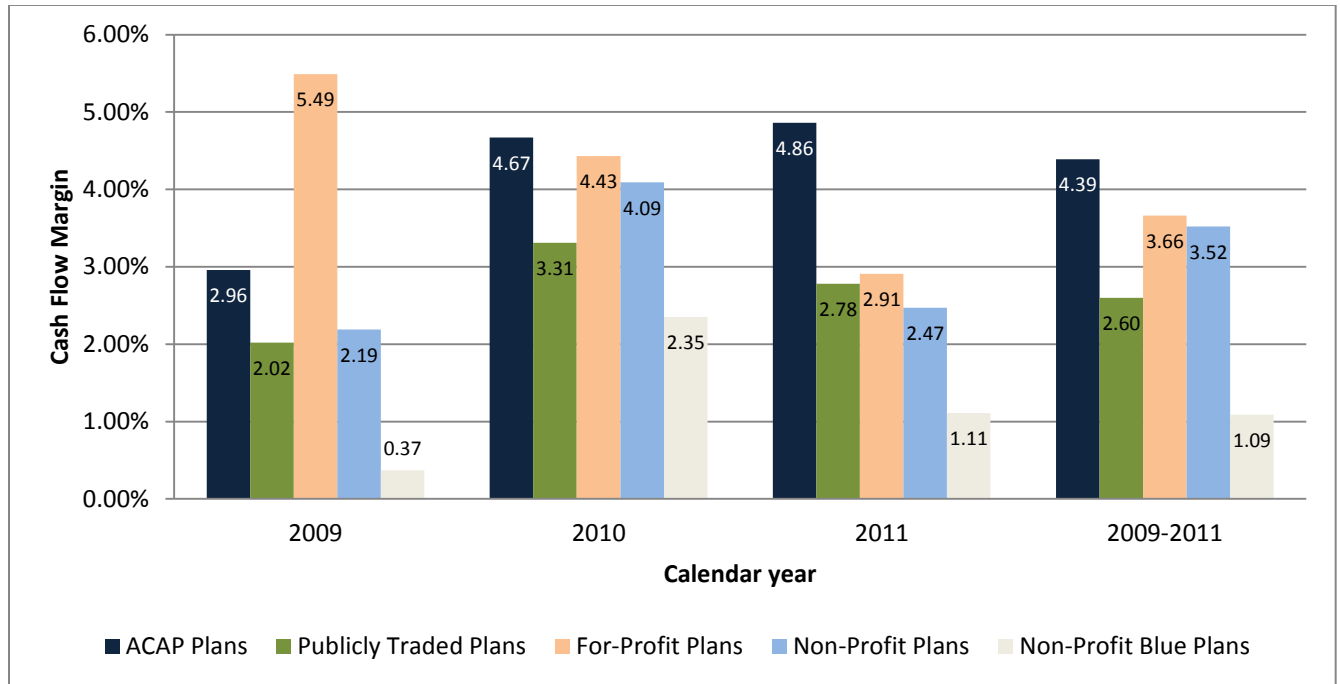


Table 2.3 compares the cash flow margin ratio of ACAP plans to non-ACAP, non-Medicaid-focused publicly-traded, non-profit and for-profit plans. ACAP plans generated higher median cash flow margins (4.39%) over the three year period than publicly-traded (3.08%), non-profit (2.89%), and for-profit (2.60%) plans. However, in 2011, ACAP had a cash flow margin ratio of 4.86 percent: substantially lower than the non-ACAP, non-Medicaid-focused publicly-traded plans' ratio of 5.69 percent, but significantly higher than that of non-profit (2.10%) and for-profit (2.21%) plans.

Figure 2.3: Median Cash Flow Margin Ratio Analysis, Controlling for Non-Medicaid Focus by ACAP and Ownership Status

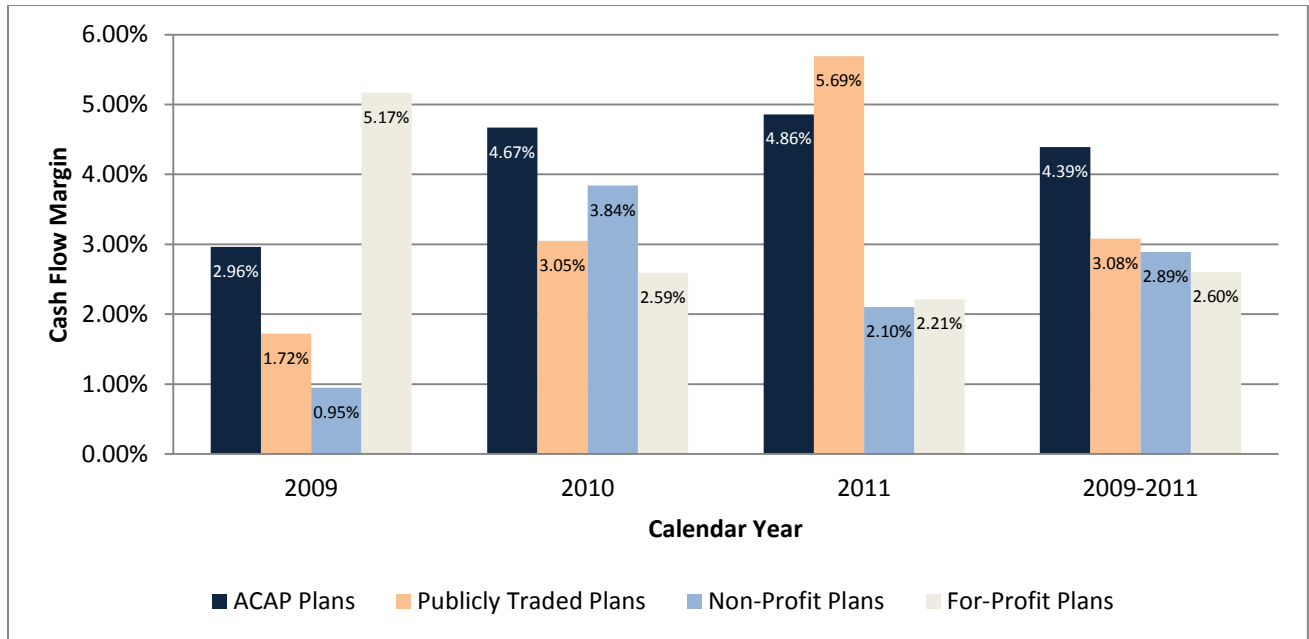


Table 2.4 compares ACAP plans to non-ACAP, Medicaid-focused publicly-traded, non-profit and for-profit plans. Over the three year study period, ACAP plans had higher cash flow margins (4.39 percent) than publicly traded (2.38 percent), non-profit (3.19 percent) and for-profit plans (3.68 percent). **In 2011, ACAP plans' cash flow margin ratio was more than 350 basis points higher than publicly-traded plans. ACAP plans' cash flow margin ratio was 4.86 percent, compared to 1.32 percent for publicly-traded plans.**

Figure 2.4: Median Cash Flow Margin Ratio Analysis Controlling for Medicaid Focus by ACAP and Ownership Status

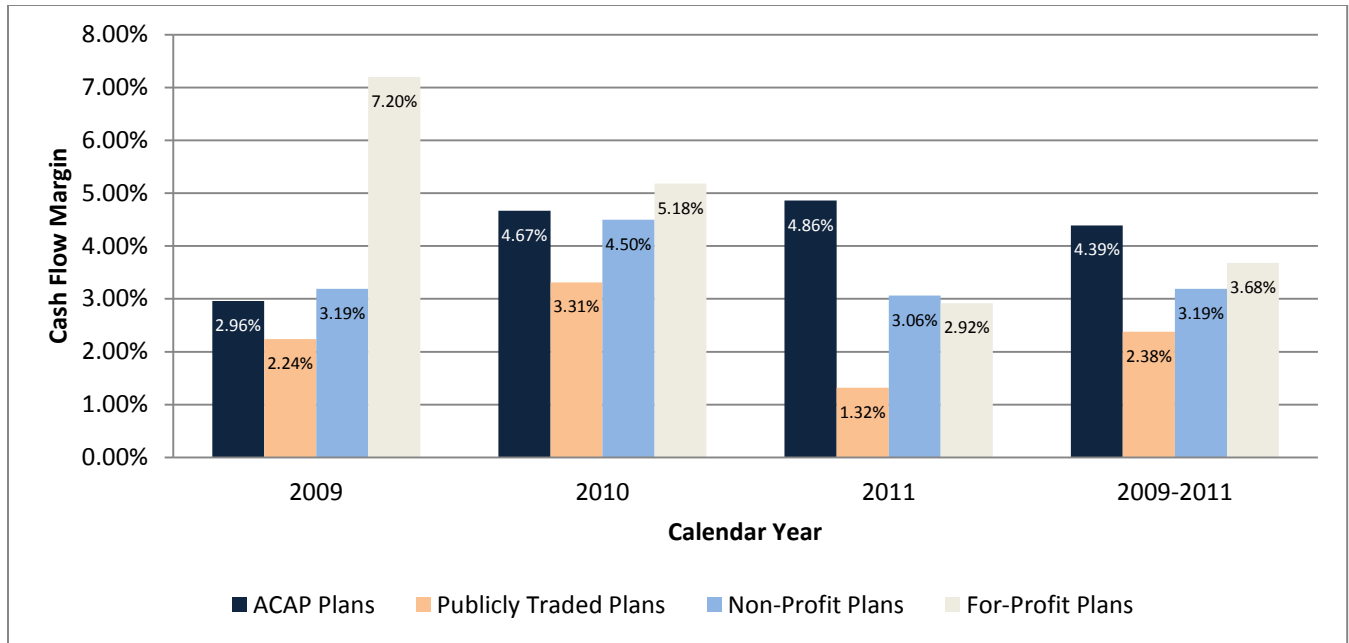


Table 2.5 presents the cash flow margin ratio by ACAP status and membership size categories. Over the three-year study period, the median cash flow margin ratio for ACAP plans was substantially higher across all membership size categories, except for ACAP plans with membership between 50,000 and 100,000. However, in 2011, across all membership categories ACAP plans generated higher cash flow margin than their non-ACAP counterparts, including the 50,000 to 100,000 membership category. In 2011, ACAP plans with less than 50,000 members had cash flow margins that were over 800 basis points higher than large non-ACAP (9.74% vs. 1.11%). Again, a caveat must be acknowledged for ACAP plans within this category, since this category has a sample size of only five plans. **For the remaining membership size categories, ACAP plans in 2011 generated from their total revenue a cash flow margin that was over four percent.** In contrast, non-ACAP plans in the remaining size categories for 2011 only generated a cash flow margin that was less than three percent for plans within 50,000 and to 100,000 membership and over 100,000 to 250,000 membership categories and 3.09 percent in 2011 for plans over 250,000 members.

ACAP plans within the membership categories of 50,000 to 100,000 and over 100,000 to 250,000 members experienced a dramatic increase in the cash flow margin ratio. **In 2009, for these two membership size categories, the ACAP plans were generating a negative cash flow position of -.86 percent and -1.98 percent, respectively. However, by 2010, the ACAP plans in these two membership categories were able to turn around this net loss position in cash flow and improve their cash flow returns to 4.61% and 5.22%, respectively.**

**Table 2.5: Median Cash Flow Margin Ratio Analysis by
ACAP and Membership Size Categories**

Year	<50,000 Members		50,000-100,000 Members		100,001-250,000 Members		>250,000 Members	
	ACAP (n=5)	Non-ACAP (n=37)	ACAP (n=10)	Non-ACAP (n=42)	ACAP (n=17)	Non-ACAP (n=45)	ACAP (n=9)	Non-ACAP (n=42)
2009	5.84%	2.51%	-0.86%	3.70%	-1.98%	2.27%	4.44%	1.63%
2010	9.95%	6.17%	4.61%	4.01%	5.22%	2.34%	2.58%	2.89%
2011	9.74%	1.11%	4.22%	2.93%	4.86%	2.01%	4.30%	3.09%
2009-2011	9.74%	2.82%	2.95%	3.66%	4.67%	2.26%	4.26%	2.76%

Summary Cash Flow Margin

ACAP plans’ cash flow margin returns trended upward during the study period from 2.96 percent in 2009 to 4.86 percent return in 2011. **In 2011, ACAP plans generated a cash flow return from total revenues that was almost five percent. In contrast, publicly-traded, private for-profit and non-profit plans were generating returns that were less three percent of their total revenues. However, in 2011, only publicly-traded, non-Medicaid focused plans generated a higher cash flow return (5.69 percent) than the ACAP plans.**

Across all membership size categories, ACAP plans generated higher cash flow margins than their non-ACAP counterparts in 2011. It appears that ACAP plans within the membership categories of 50,000 to 100,000 and over 100,000 to 250,000 members, might have implemented some operational changes—controlling and cutting medical and administrative expenses—thereby turning around a negative cash flow position in 2009 to a significant positive cash flow returns of over four and half percent by 2010. Generating sufficient cash flow to service the payments on their borrowings is a key underlying factor to attract capital from potential lenders. More importantly, a health plan can enhance its borrowing capacity when it generates a sufficient amount of positive cash flow. The section on Projected Debt Capacity Findings illustrates how a health plan’s ability to generate sizeable positive cash flow can increase a health plan’s borrowing capacity.

Section 3: Days in Capital Ratio Results

Figure 3.1 presents days in capital ratio between ACAP vs. non-ACAP plans, which measures amount of capital on hand to cover their daily operating expenses, both medical and administrative. The ACAP plans were able to improve their days in capital ratio by 11 days from 2009 to 2011. By 2011, this increase enabled the ACAP plans to be almost equivalent to the non-

ACAP plans days in capital of 54 days. Overall, these ACAP plans have sufficient capital to pay for 53 days of operational expenses, which is a vast improvement from 2009, when they only had 42 days of capital to pay for operating expenses.

Figure 3.1: Median Days in Capital Ratio Analysis by ACAP status

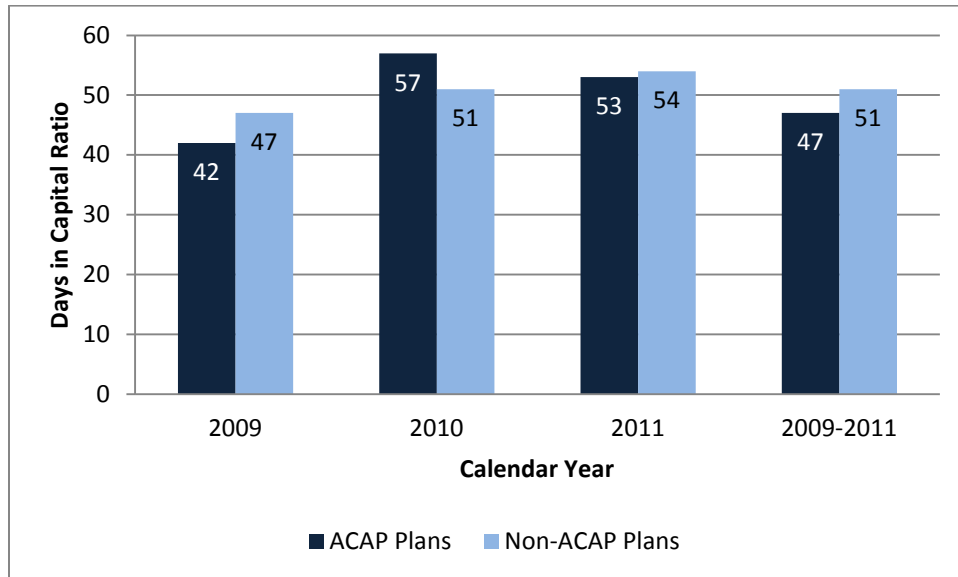


Figure 3.2 assesses the days in capital ratio between ACAP vs. non-ACAP plans by ownership status. For ACAP plans, 53 days in capital in 2011 was similar to the non-ACAP publicly traded plans in 2011. However, the days in capital ratio for ACAP plans was 14 days above non-ACAP private for-profit plans, seven days below non-ACAP private non-profit plans, and 23 days below non-profit Blue Cross plans. In 2011, Blue Cross had a days in capital median value of 76 days. Thus, these Blue Cross plans had over 76 days of capital to pay for their daily operating expenses.

Figure 3.2: Median Days in Capital Ratio Analysis by ACAP and Ownership Status

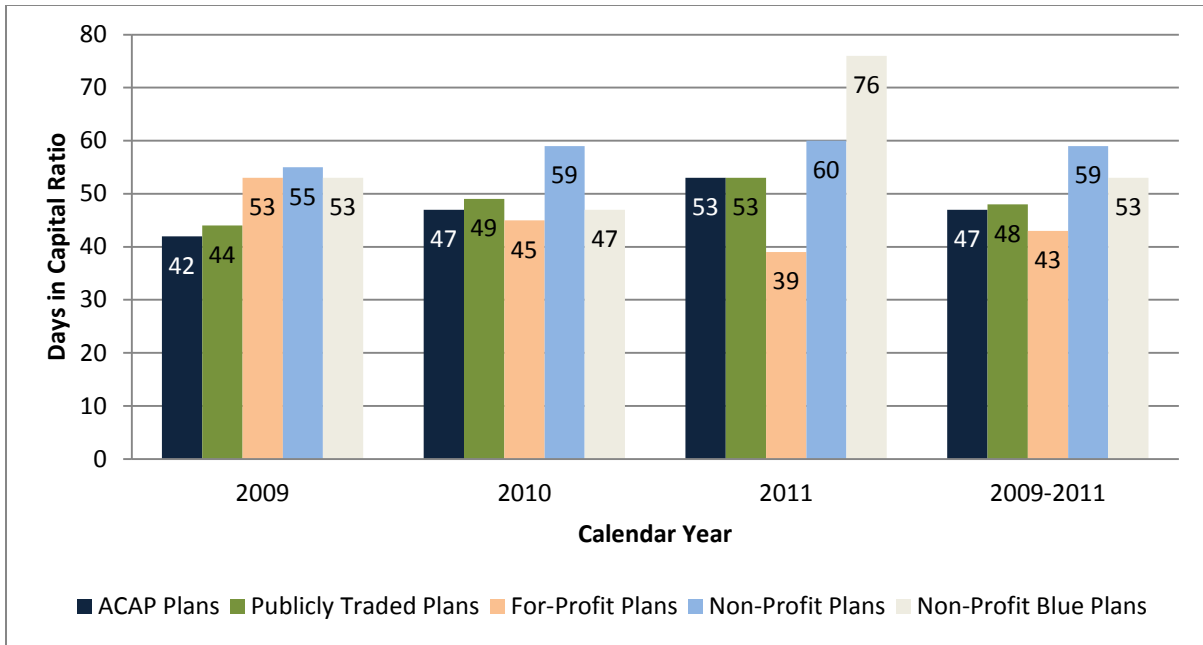


Figure 3.3 compares the days in capital ratio of ACAP plans to non-ACAP, Non-Medicaid focused publicly-traded, non-profit and for-profit plans. Over the three-year study period, ACAP-member plans had enough capital to cover 47 days of daily operational expenses, substantially more than non-Medicaid for-profit plans, which retained capital for only 28 days of daily operating expenses. Over the study period, ACAP plans had a slightly lower ratio than publicly-traded plans (47 days vs. 52 days) and a substantially lower ratio than non-profit plans (47 days vs. 75 days).

From 2009 to 2011, ACAP plans increased their days in capital ratio from 42 in 2009 to 53 days in 2011, while publicly-traded plans increased their days in capital ratio from 46 in 2009 to 52 days in 2011. In 2011, however, ACAP plans' median days in capital ratio was still significantly lower than non-Medicaid-focused non-profits (53 days vs. 76 days).

Figure 3.3: Median Days in Capital Ratio Analysis Controlling for Non-Medicaid Focus, by ACAP and Ownership Status

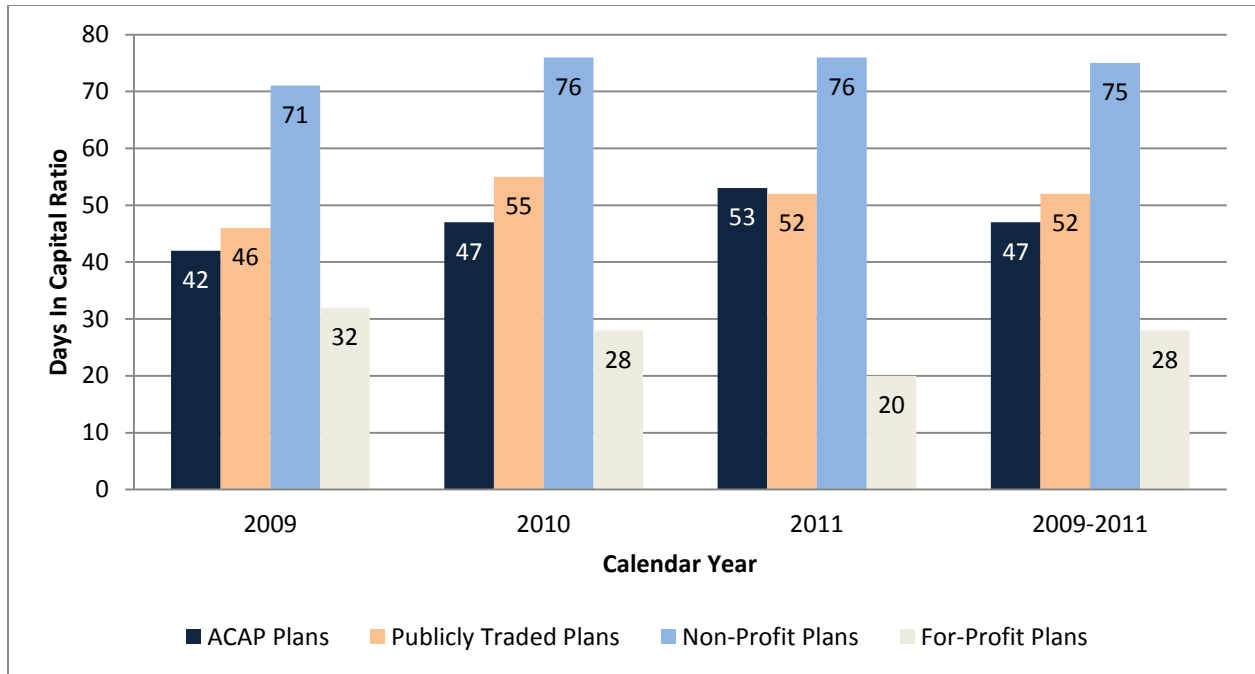


Figure 3.4 compares ACAP plans' days in capital ratio to non-ACAP, Medicaid-focused publicly-traded, non-profit and for-profit plans. In 2011, ACAP plans' days in capital ratio was the same as publicly-traded plans (53 days) and slightly higher, by only two days, than non-profit plans, which had almost 51 days of capital to cover their daily operating expenses. However, the for-profit plans are retaining substantially more days in capital to cover their daily operating expenses. In 2011, for-profit plans had 64 days compared to only 53 days for ACAP plans.

Figure 3.4: Median Days in Capital Ratio Analysis Controlling for Medicaid Focus, by ACAP and Ownership Status

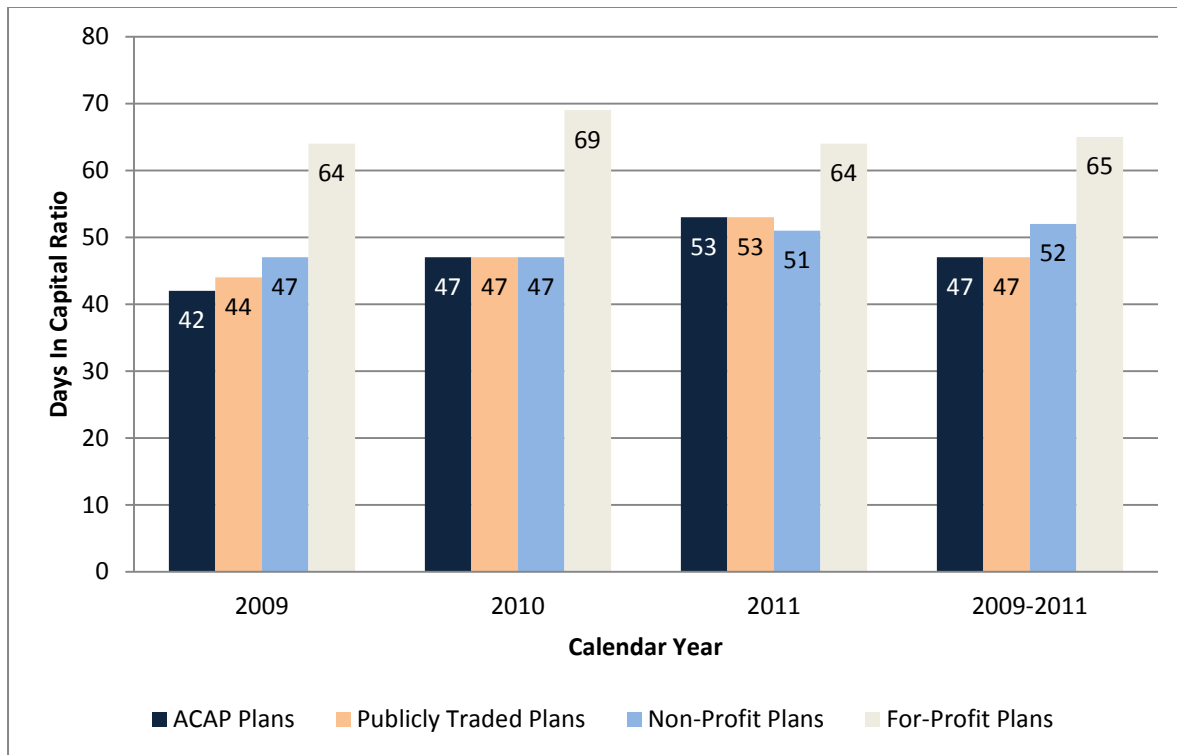


Figure 3.5 presents the days in capital ratio by ACAP status and membership size categories. ACAP plans with membership below 50,000 increased their days in capital ratio from 33 days in 2009 to 60 days in 2011, while their non-ACAP counterparts increased only from 45 days in 2009 to 53 days in 2011. In 2011, ACAP plans within the 50,000 to 100,000 membership had a days in capital ratio that was only two days below their non-ACAP counterparts—55 versus 57 days. In 2011, ACAP plans with membership between 100,000 and 250,000 had a days-in-capital ratio only nine days less than their non-ACAP counterparts, 54 days versus 63 days. However, in 2011, ACAP plans in the 250,000-plus membership category had a days in capital ratio which exceeded their non-ACAP counterparts by seven days: 53 days versus 46 days. Except for the smallest category, the ACAP plans maintained a median days in capital ratio over the study period of at least 47 days of capital to meet daily operating expenses.

Table 3.5: Median Days in Capital by ACAP and Membership Size Categories

Year	<50,000 Members		50,000-100,000 Members		100,001-250,000 Members		>250,000 Members	
	ACAP (n=5)	Non-ACAP (n=37)	ACAP (n=10)	Non-ACAP (n=42)	ACAP (n=17)	Non-ACAP (n=45)	ACAP (n=9)	Non-ACAP (n=42)
2009	33	45	48	56	42	47	45	45
2010	40	49	61	57	47	55	47	46
2011	60	53	55	57	54	63	53	46
2009-2011	40	49	55	57	47	56	47	45

Summary Days in Capital Ratio

Over the three-year study period, ACAP plans had 47 days of capital on hand to pay for daily operating expenses, which is only slightly less than 51 days of capital for non-ACAP plans. ACAP plans improved their days in capital ratio by 11 days from 2009 to 2011, which more than likely stems from a major increase in their cash flow margin ratio. For selected plan differences, ACAP plans over the study period retained fewer days of capital on hand than non-ACAP, non-Medicaid focused non-profit plans (47 days to 75 days) and non-ACAP, Medicaid-focused, non-profit plans (47 days to 52 days).

For ACAP plans, the greatest increase in days in capital ratio occurred with plans below 50,000 members. Their days in capital ratio rose from 33 days in 2009 to 60 days in 2011, while their non-ACAP counterparts rose from 45 days in 2009 to 53 in 2011. **More importantly, in 2011, across all of the membership categories, all of the ACAP plans were maintaining at least 53 days of capital to cover their daily operating expenses. In sum, ACAP plans may have improved their days in capital position because of expected higher Medicaid costs from expanding enrollment, including dual eligibles, and to enhance their overall financial stability.**

Improving days in capital among the ACAP plans may have stemmed from their rising cash flow margin ratio during the study period. Cash flow margin ratio trended upward during the study period from 2.96 percent in 2009 to 4.86 percent return in 2011. As a result, an upward trend in this cash flow ratio suggests that ACAP plans either retained these funds as cash holdings or used these funds to buy short and long-term securities. **This added capital provides the necessary cash cushion from which to draw in the event of any unexpected higher costs from the major Medicaid and other health insurance changes stemming from health reform.**

Section 4: Capital to Debt Ratio Results

Figure 4.1 presents capital to debt ratio among ACAP and non-ACAP plans. Capital to debt ratio measures the amount of capital on hand to pay off outstanding debt capital. To limit the financial risk of the health plan, management should attempt to maintain an equivalent amount of capital to debt—or a one-to-one ratio. This level of capital to debt indicates that the health plan has a sufficient amount of capital reserves to pay off all its outstanding debt obligations. Over the three year study period, ACAP plans had enough capital to pay only 86 percent of their total outstanding debt obligations. Conversely, non-ACAP plans had enough capital to pay off almost all, 97 percent, of their outstanding debt obligations. **However, ACAP plans did increase their capital position from 74 percent of the outstanding debt in 2009 to 98 percent of their**

outstanding debt in 2011. Thus, ACAP plans in 2011 had enough capital in reserve to pay down 98 percent of their debt obligations. In comparison, non-ACAP plans in 2011 had capital to debt ratio of 1.05, which indicated that they held enough capital to retire their outstanding debt while retaining five percent of their capital.

Figure 4.1: Median Capital to Debt Ratio Analysis by ACAP Status

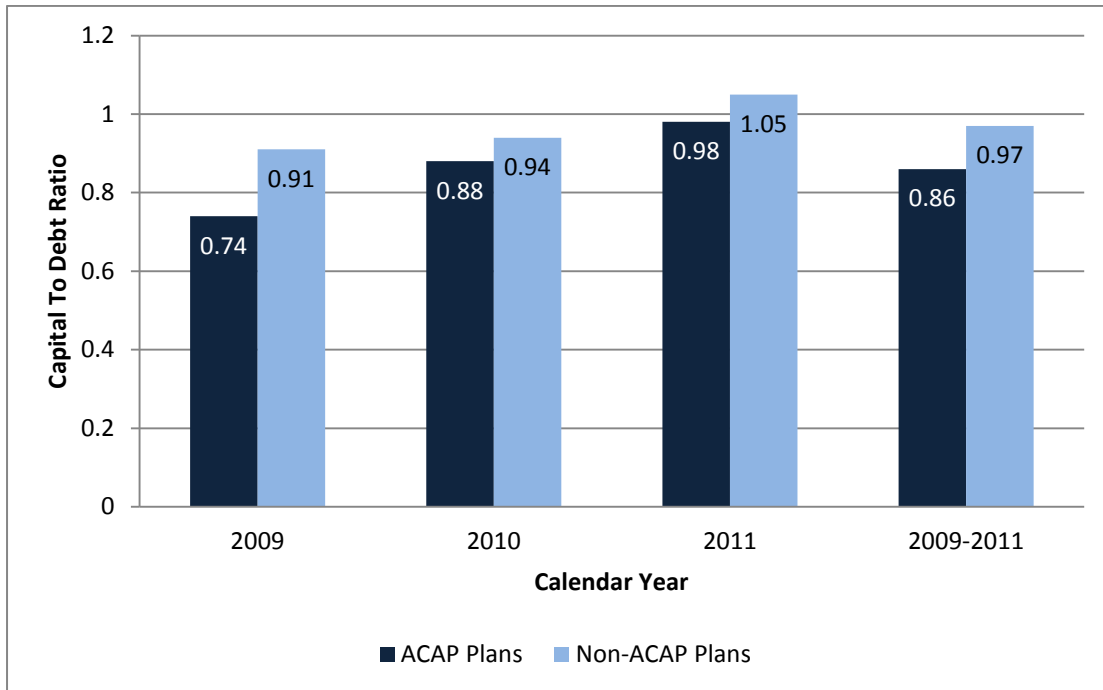


Figure 4.2 presents capital to debt ratio by ACAP and ownership status. For the three-year study period, ACAP plans' capital to debt ratio of .86 is higher than non-ACAP for-profit plans' ratio value of .74, but substantially lower than non-ACAP non-profit and Blue Cross plans, which had ratio values of 1.14 and 1.20 respectively. The capital to debt ratio for non-ACAP non-profit and Blue Cross plans suggests that these plans had enough capital to pay off all their outstanding debt and still have 14 percent and 20 percent, respectively, of their capital remaining. In contrast, ACAP plans had sufficient capital to pay off only 86 percent of their outstanding obligations and would not have any capital left over after paying their debt. However, ACAP plans raised their capital to debt ratio from .74 in 2009 to .98 in 2011. In contrast, their non-ACAP non-profit counterparts increased the capital to debt ratio from 1.08 in 2009 to 1.12 in 2011. As a result, by 2011, ACAP plans retained enough capital to pay off 98 percent of their debt and were only 2 percent short of the ability to pay all their outstanding debt. In contrast, the non-ACAP non-profits in 2011 had enough capital to cover all their outstanding debt and maintain 12 percent of their capital.

Figure 4.2: Median Capital to Debt Ratio Analysis by ACAP and Ownership Status

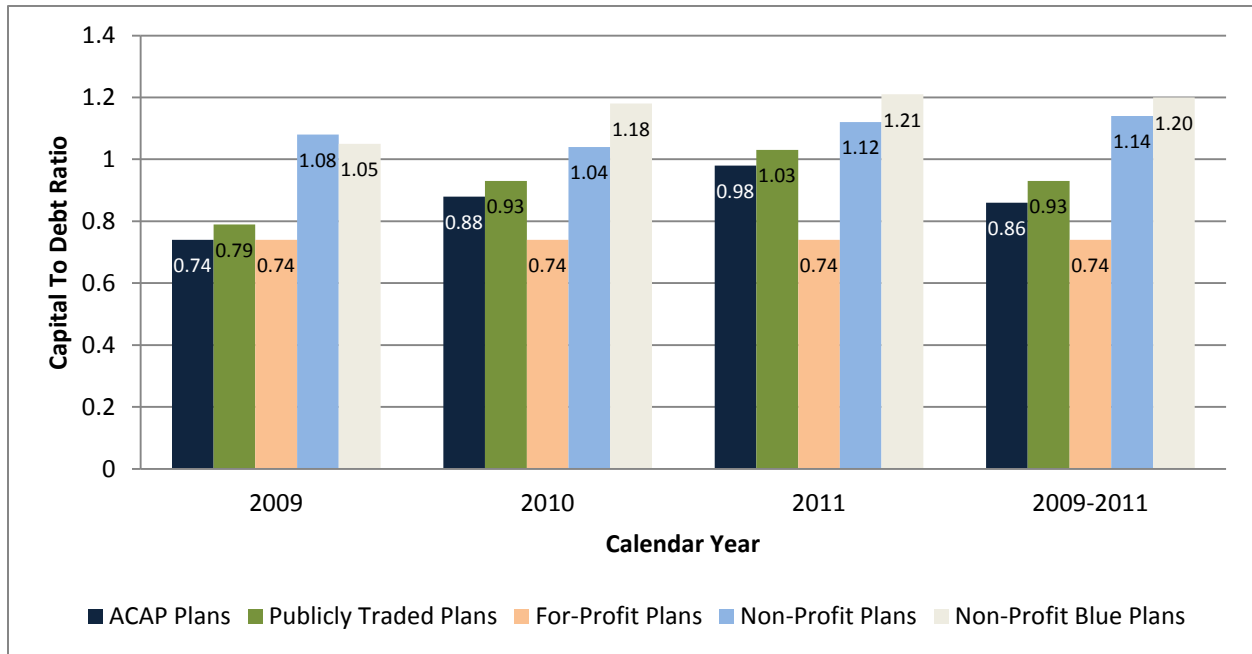


Figure 4.3 shows capital to debt ratios by ACAP and non-ACAP, non-Medicaid focused, publicly-traded, non-profit and for-profit plan. For the three-year study period, ACAP plans’ capital to debt ratio of .86 is higher than publicly-traded plans’ capital to debt ratio of .80 and substantially higher than the for-profit plans’ capital to debt ratio of .37. This lower ratio among private for-profit plans may stem from their parent company—privately held companies, hospital management companies, and so on—retaining a limited amount of capital within the plan in order to enhance the parent’s financial position. The NAIC’s 2009 /2010 health edition of its Financial Analysis Handbook notes this situation by stating that the financial condition and operation of the health plan “may be secondary to other missions of the corporate structure.” In addition, the extremely low capital to debt ratio among the privately held for-profit plans was impacted by the declining operation of two health plans which went bankrupt in 2012.²⁰ Again, the smaller sample size of just five plans might have contributed to the wide variation of the capital to debt ratio for these plans.

Conversely, non-Medicaid focused non-profit plans had a capital to debt ratio over the study period of 1.29, which was significantly higher than ACAP plans’ value of .86. Thus, these non-profit plans had capital to pay off all their outstanding debt obligations and still retain 29 percent of their total capital.

Figure 4.3: Median Capital to Debt Ratio Analysis Controlling for Non-Medicaid Focused by ACAP and Ownership Status

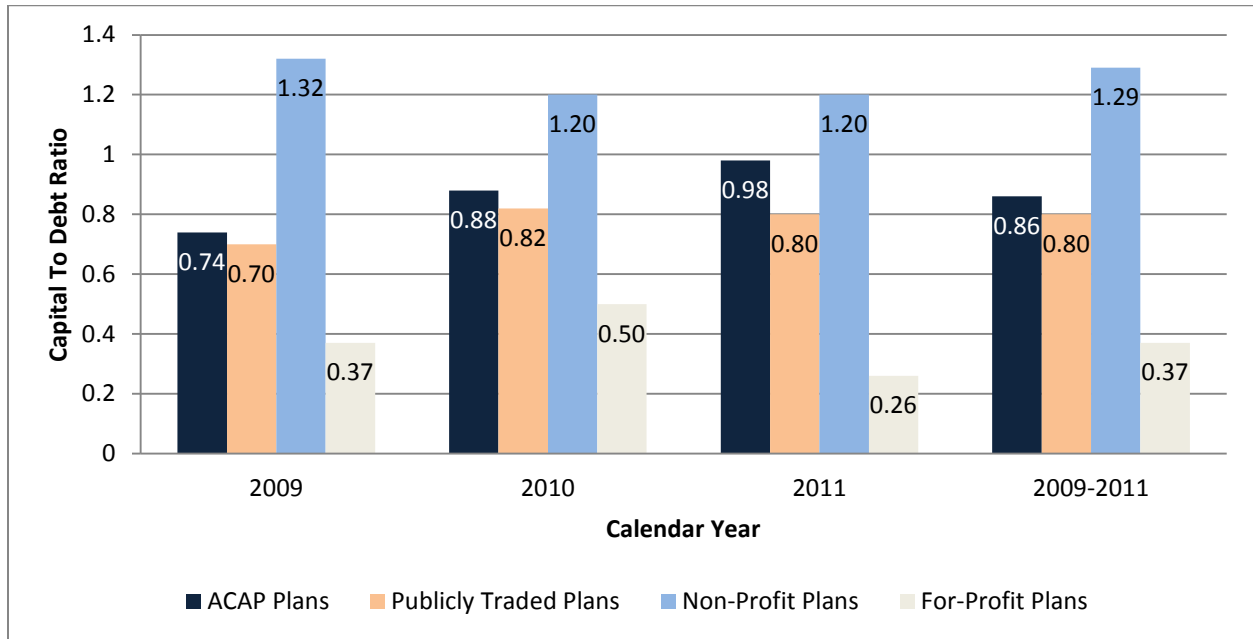


Figure 4.4 presents the capital to debt ratio analysis for ACAP and non-ACAP, Medicaid-focused publicly-traded, non-profit and for-profit plans. Over the three year study period, ACAP plans' capital to total debt (.86) was lower than that of the publicly-traded (.99) and non-profit (.95) Medicaid focused plans; however it was higher than that of for-profit plans (.79). Except for the for-profit plans, ACAP plans and both the publicly-traded and non-profit plans trended upward over the study period. In 2011, the publicly-traded and non-profit plans had capital to debt ratios of 1.10 and 1.05, respectively compared to .98 for the ACAP plans. Thus, the non-ACAP publicly-traded and non-profit Medicaid focused plans, in 2011, retained a sufficient amount of capital to pay off all their outstanding debt obligations and still retain at least 10 percent and 5 percent of their capital, respectively.

Figure 4.4 Median Capital to Debt Ratio Analysis Controlling for Medicaid Focus by ACAP and Ownership Status

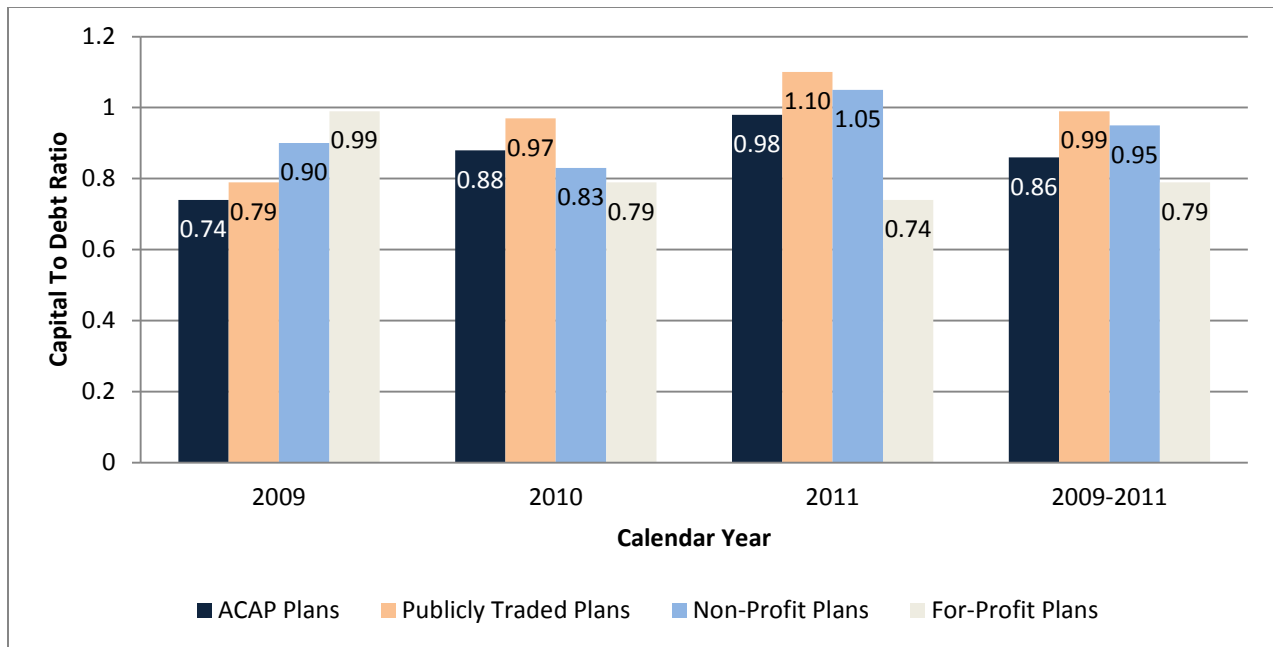


Table 4.5 presents capital to debt ratios by ACAP status and membership size categories. For the three year study period, ACAP plans with membership below 50,000 had enough capital to cover only 47 percent of their outstanding debt, while non-ACAP plans in the same membership size category had capital to pay off 91 percent of their outstanding debt. In 2011, ACAP plans with membership below 50,000 had the lowest capital to debt ratio with a value of .61, which indicates that these plans have enough capital to pay less than two-thirds of their debt obligations. In contrast, their non-ACAP counterparts in 2011 had a capital to debt ratio of 1.05, which indicates that they had sufficient capital to pay off all their debt as well as retain five percent of their capital. For ACAP plans with over 250,000 members, the capital to debt ratio improved from .76 in 2009 to .97 in 2011 compared to a marginal increase for non-ACAP plans, which rose from .73 in 2009 to .81 in 2011. **However, ACAP plans within this membership category had the highest median capital to debt ratio value of .93** over the three year study period, which was higher than the non-ACAP comparison plans, which had a ratio value of .78.

From 2009 to 2011, ACAP plans with membership between 100,000 and 250,000 experienced the greatest increase as well as the highest ratio value for the capital to debt ratio. ACAP plans ratio value increased to 1.32 in 2011 compared to .75 in 2009. In comparison, non-ACAP plans within the same membership category rose from .90 in 2009 to 1.17 in 2011. Therefore, ACAP plans within this membership category had enough capital to pay off all their outstanding debt and still retain 32 percent of their capital, while non-ACAP plans could pay off all its debt and retain only 17 percent of their capital.

Table 4.5: Median Capital to Debt Ratio by ACAP and Membership Size Categories

Year	<50,000 Members		50,000-100,000 Members		100,001-250,000 Members		>250,000 Members	
	ACAP (n=5)	Non-ACAP (n=37)	ACAP (n=10)	Non-ACAP (n=42)	ACAP (n=17)	Non-ACAP (n=45)	ACAP (n=9)	Non-ACAP (n=42)
2009	0.47	0.91	0.72	1.07	0.75	0.90	0.76	0.73
2010	0.48	0.75	0.75	1.06	0.88	1.03	0.98	0.80
2011	0.61	1.05	0.77	1.15	1.32	1.17	0.97	0.81
2009-2011	0.47	0.91	0.75	1.11	0.88	1.06	0.93	0.78

Capital to Debt Ratio: Summary

In general, **ACAP plans did increase their capital position from 74 percent of their outstanding debt in 2009 to 98 percent of their outstanding debt in 2011. Thus, ACAP plans in 2011 had enough capital in reserve to pay down 98% of their debt obligations.** By 2011, ACAP plans were two percent short from paying all of their outstanding debt while the non-ACAP plans of similar ownership status, specifically non-profit plans, had enough capital to cover all their outstanding debt as well as preserve 12 percent of their capital.

From 2009 to 2011, ACAP plans with membership between 100,000 and 250,000 experienced the greatest increase as well as the highest ratio value for the capital to debt ratio. ACAP plans’ ratio value increased to 1.32 in 2011 compared to .75 in 2009.

Conversely, the comparison group of non-ACAP plans within this membership size category had a capital to debt ratio of 1.17 in 2011. Thus both ACAP and non-ACAP plans within this membership category had sufficient capital on hand to pay off their debt while retaining at least 32 percent of their capital in the case of ACAP plans and 17 percent of their capital in the case of non-ACAP plans. In sum, ACAP plans appear to have strengthened their capital position over time to the point where they can cover all their debt obligations.

Section 5: Summary of Ratio Analysis

The summary points from the ratio analysis in terms of measuring the creditworthiness of ACAP-member plans compared to non-ACAP plans are as follows:

1. In 2011, half of the ACAP plans surveyed possess capital that was almost 450 percent of their state authorized level of capital and was well above the state-authorized capital level of 200 percent, which requires corrective action. More importantly, the ACAP plans raised their capital levels from just over 300 percent level of authorized capital in 2009, to almost

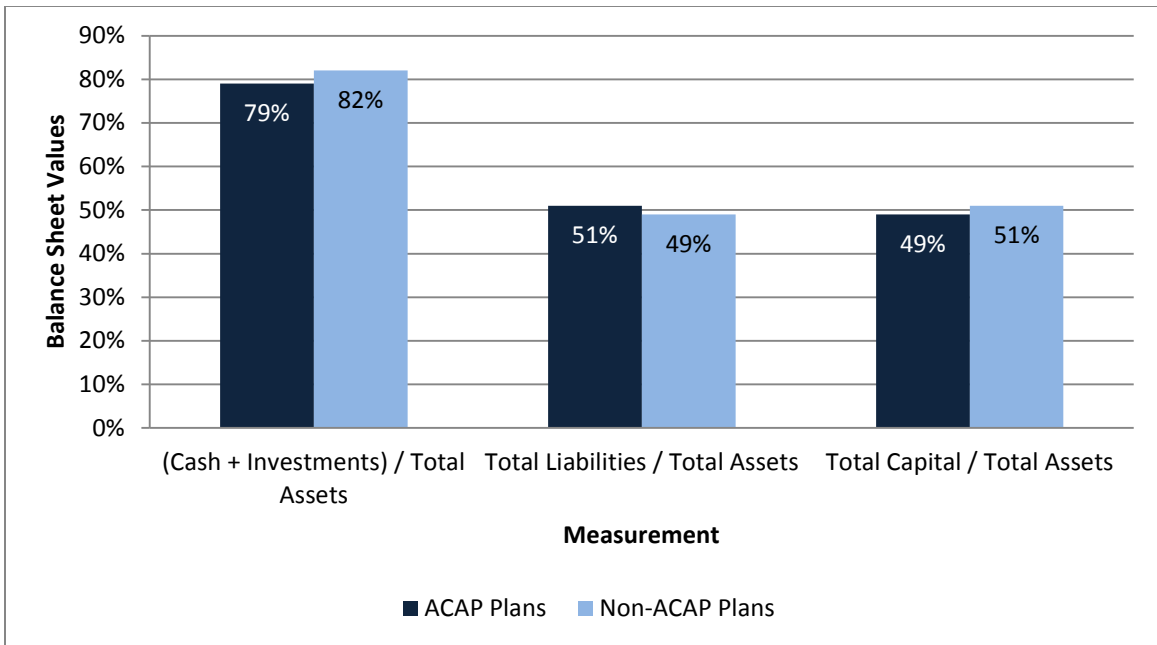
- 450 percent of authorized capital in 2011. This finding strengthens the credit position of ACAP-member plans.
2. Half of ACAP-member plans generated a cash flow return in excess of four and one-half percent on their revenues in 2011, compared to around a three percent cash flow return in 2009. Higher cash flow returns contributed to the increase in capital position and a higher RBC position. In comparison, half of non-ACAP plans earned less than a three percent cash flow return on their revenue in 2011. Assuming this trend continues, this outcome suggests that ACAP plans have the ability to generate the cash flow to pay their debt service requirements, and is viewed as a credit strength for ACAP plans.
 3. Half of ACAP plans retained enough capital reserves to pay for at least two months of daily operating expenses—a level comparable to non-ACAP plans. This equity cushion allows ACAP plans to pay for any unanticipated rise in medical costs, which may occur as Medicaid plans cover more-costly dual-eligible members. Overall, this outcome is viewed as a credit strength for ACAP plans.
 4. Half of ACAP plans possessed sufficient capital to pay off almost all of their outstanding debt. In 2011, ACAP plans had enough capital to pay off 98 percent of their outstanding debt. In contrast, non-ACAP plans had sufficient capital to pay all their outstanding liabilities as well as to retain an extra five percent capital cushion. This finding is viewed as a credit weakness, which may act as barrier for the ACAP plans to borrow or establish a line of credit with a lender.

Section 6: Common Size Balance Findings

The second major analysis assesses the sources and uses of capital as a percentage of total assets²¹ by reviewing the 2011 balance sheet accounts for ACAP members and non-ACAP members. The analysis also evaluates these total asset percentages by membership size categories. The main limitation of this analysis is the smaller sample sizes within the membership size categories for ACAP plans, which were only five plans for the smallest membership size and nine plans for largest membership size categories.

In terms of the uses of capital, the balance sheet asset accounts were reviewed and found that the largest dollar asset accounts were in the cash and investments, which were combined into one account, called “cash and investments.” For health plans, the vast proportion of their assets was expected to be in cash and investments since they need to possess a liquid asset base to pay off short-term obligations in the form of medical claims. The **uses of capital** were measured as a percentage of total assets allocated to cash and investments by ACAP members and non-ACAP members. The sources of capital were measured as percentage of total assets allocated to total debt and capital. In Figure 6.1, ACAP plans had 79 percent of their total assets in cash and investments while non-ACAP plans were slightly higher with 82 percent. ACAP plans had a higher percentage of total assets in their total liability account than non-ACAP plans—51 percent vs. 49 percent. In turn, ACAP plans had a lower percentage of their total assets in their total capital account (49 percent vs. 51 percent) than non-ACAP plans.

Figure 6.1: Common Size Balance Sheet Median Values by ACAP status



Across the membership size categories (Table 6.2), ACAP plans within the membership categories below 50,000 and between 100,000 and 250,000 had 75 percent of their total assets in cash and investments. In contrast, the same membership categories for non-ACAP plans had 83 percent of their total assets in cash and investments.

However, ACAP plans within two remaining membership categories—50,000 to 100,000 members and 250,000-plus members—had 85 percent of their total assets in cash and investments, while in comparison non-ACAP plans had 85 percent and 79 percent, respectively, of their total assets in cash and investments. Thus, ACAP plans with membership between 50,000 and 100,000 and above 250,000 had the highest amounts of their total assets in cash and investments.

In terms of the sources of capital, the study focused on total debt and capital accounts.²² All of these accounts were measured as a percentage of total assets.²³ For plans below 50,000 members, ACAP plans had a highest percentage of total assets in total liabilities and were 13 percentage points higher than non-ACAP plans—62 percent versus 49 percent. Conversely, these smaller ACAP plans had the lowest percentage of total assets in total capital compared with non-ACAP plans—38 percent versus 51 percent.

Across the membership categories, ACAP plans with membership between 100,000 and 250,000 had 43 percent of their total assets in total liabilities, which was the lowest percentage across all membership categories. The non-ACAP plans within the same membership category had a slightly higher percentage, with 46 percent. Conversely, these ACAP plans also had 57 percent

of total assets in total capital, which was the highest percentage across all the membership categories.

ACAP plans with total members between 50,000 to 100,000 had 56 percent of their total assets in liabilities while their comparison non-ACAP group had only 46 percent of their total assets in liabilities. ACAP plans with total members above 250,000 had 51 percent of their total assets in liabilities while their comparison non-ACAP plans had 55 percent of their total assets in liabilities.

Table 6.2: 2011 Median Common Size Balance Sheet Accounts by Membership Size Categories: ACAP vs. Non-ACAP Plans

Median Common Size Balance Sheet	<50,000 Members		50,000-100,000 Members		100,001-250,000 Members		>250,000 Members	
	ACAP (n=5)	Non-ACAP (n=37)	ACAP (n=10)	Non-ACAP (n=42)	ACAP (n=17)	Non-ACAP (n=45)	ACAP (n=9)	Non-ACAP (n=42)
(Cash + Investments) / Total Assets	75%	83%	85%	85%	75%	83%	85%	79%
Total Liabilities / Total Assets	62%	49%	56%	46%	43%	46%	51%	55%
Total Capital / Total Assets	38%	51%	43%	54%	57%	54%	49%	45%

The study also assessed ACAP and non-ACAP plans' liability accounts, measuring borrowing funds from lending institutions as well as from parent, subsidiaries or affiliated companies. The percentage values varied and were extremely small; therefore the study just counted the percentage of plans that reported this type of borrowing. The study found that 7 percent of ACAP plans and non-ACAP plans reported debt borrowings from loans.²⁴ The study also assessed health plans that incurred liability accounts to parent, subsidiaries and affiliate companies. The study found a greater disparity between ACAP and non-ACAP plans in terms of the percentage of plans with obligations due to their parent, subsidiary or affiliate companies. For ACAP plans, only 29 percent had an obligation due to a parent or affiliate company compared with 69 percent for non-ACAP plans.

Summary of Common Size Balance Sheet

The summary points from Common Size Balance sheet are as follows:

- 1) In 2011, both ACAP plans and non-ACAP plans had almost half of the total assets claimed as liabilities; the other half was claimed by owners of the plan.

- 2) In 2011, over half of the ACAP plans had more than 79 percent of total assets in cash and investment, which is almost comparable to non-ACAP plans, which had 82 percent.
- 3) ACAP plans within the smallest membership category (less than 50,000 members) and the medium membership category (100,000 to 250,000 members) had only 75 percent of their total assets in cash and investments, while ACAP plan in the larger membership categories of 50,000 to 100,000 and above 250,000 had at least 85 percent of their total assets in cash and investments.
- 4) ACAP plans with fewer than 50,000 members had 62 percent of their total assets in liabilities, which was the highest such figure. Conversely, they had only 38 percent of their total assets in capital, which was lowest percentage of total assets in capital.
- 5) ACAP plans in the mid-size membership category of 100,000 to 250,000 members had the strongest capital position with over 57 percent of their total assets in capital and only 43 percent of their total assets in liabilities.
- 6) Non-ACAP plans appear to have a greater percentage of obligations due to a parent, subsidiaries and affiliated companies: 69 percent, compared with only 29 percent for ACAP plans.
- 7) Only seven percent of ACAP and non-ACAP plans borrowed from lending institutions such as banks.

Section 7: Projected Debt Capacity Findings

The study computed for each ACAP plan its median cash flow over the three year study period. The median value cash flow was computed across three membership size categories for the ACAP plans. Given the smaller size for the smallest two membership categories, specifically plans with membership below 50,000 and between 50,000 and 100,000, the analysis combined these plans into this category and defined them as “small size” membership plans. The plans with membership between 100,000 and 250,000 were defined as medium size membership plans and the plans with membership above 250,000 were defined as large size membership plans.

The study assumed a given borrowing rate of six percent with the length of loan being five years and no outstanding debt on the balance sheet. As noted in interviews with CFOs, potential lenders (e.g., banks, private equity funds, insurance companies) assessed a great deal of credit risk with Medicaid health plans as they are dependent upon state funding from one primary source, the Medicaid program.. In addition, these health plans have fewer assets or collateral to reclaim in case of bankruptcy. Therefore, a conservative, high credit standard approach was assumed in projecting various debt service coverage ratio values.

The CFOs indicated that to gain access to capital they would issue a surplus note. The maturity or length of this note typically ranges from five to ten years. The advantage of the surplus note is that it is viewed by NAIC regulations as an equity capital account, not a liability obligation,

which in turn would raise its RBC ratio. Health plans make payments to the lender which accounts for the both principal and interest payments. However, state insurance regulators must approve any interest and principal payments to capital lenders. Regulators may deny capital payments to lenders to ensure the solvency of a health plan and require that the plan pays its medical claims first. Therefore, lenders of these notes are encumbered by state insurance regulators in receiving their payments. This regulatory requirement may result in potential lenders either not being willing to lend to health plans or requiring plans to avoid utilizing this type of financial instrument, which is essential in building capital equity reserves.

Three relatively conservative debt service coverage ratios were identified to enable an analysis of the potential borrowing capacity of various ACAP plans: cash flow of 2.5 times debt service payments; 3 times debt service payments and 3.5 times debt service payments. By dividing each median cash flow value by its ratio product of 2.5x, 3x, and 3.5x; the debt service payments were estimated across each size category. Finally the projected debt borrowings were estimated by using the present value annuity (PVA) function for five years at a rate of six percent.

In reference to Table 7a, the projected debt capacity given debt service coverage rate of cash flows that were two and half times debt service payments, resulted in projected debt borrowing capacity of \$17 million for small plans, \$21.5 million for medium plans, and \$54 million for large plans. In reference to Table 7b, the projected debt capacity given debt service coverage rate of cash flows that were three times debt service payments, resulted in projected debt borrowing of \$14 million for small plans, \$18 million for medium plans, and \$44.5 million for large plans. In reference to Table 7c, the projected debt capacity given debt service coverage rate of cash flows that were three and half times debt service payments, resulted in projected debt borrowing of \$12 million for small plans, \$15 million for medium plans, and \$38 million for large plans.

Table 7 Estimated Debt Borrowings by ACAP Plan Size Categories

*7a: Debt Service Coverage 2.5x; Interest rate 6%; Length of Loan 5 years;
Present Value of Annuity(PVA) 6% 5 yrs ACAP*

		Small ACAP Plans	Medium ACAP Plans	Large ACAP Plans
A	Median Cash Flows	\$10,089,208	\$12,800,000	\$31,720,038
B	Debt Service Coverage	2.5x	2.5x	2.5x
C = A/B	Debt Service Payments	\$4,035,683	\$5,120,000	\$12,688,015
PVA: 6%, 5 years	Debt Borrowings	\$16,999,766	\$21,567,303	\$54,446,536

7b: Debt Service Coverage 3x; Interest rate 6%; Length of Loan 5 years

		Small ACAP Plans	Medium ACAP Plans	Large ACAP Plans
A	Median Cash Flows	\$10,089,208	\$12,800,000	\$31,720,038
B	Debt Service Coverage	3x	3x	3x
C = A/B	Debt Service Payments	\$3,363,069	\$4,266,667	\$10,573,346
PVA: 6%, 5 years	Debt Borrowings	\$14,166,471	\$17,972,752	\$44,538,780

7c: Debt Service Coverage 3.5x; Interest rate 6%; Length of Loan 5 years

		Small ACAP Plans	Medium ACAP Plans	Large ACAP Plans
A	Median Cash Flows	\$10,089,208	\$12,800,000	\$31,720,038
B	Debt Service Coverage	3.5x	3.5x	3.5x
C = A/B	Debt Service Payments	\$2,882,631	\$3,657,143	\$9,062,868
PVA: 6%, 5 years	Debt Borrowings	\$12,142,690	\$15,405,216	\$38,176,097

In summary, the analysis shows the following:

- 1) For smaller and medium size ACAP health plans, the median cash flow supports between \$14 to \$18 million of debt borrowings under the mid-range restrictive debt coverage rate of cash flow that is three times debt service payments.
- 2) For larger ACAP health plans, their median cash flow allows for a substantially higher amount of debt capacity. In the less restrictive debt service coverage ratio of two and half times cash flow to debt service payments, these larger ACAP plans are estimated to have a borrowing capacity of \$54 million. Debt capacity declines to only \$38 million under a more constraining debt service coverage ratio of three and a half times cash flow to debt service payments.

Discussion

The primary aim of this study was to assess the creditworthiness of ACAP plans relative to non-ACAP plans that compete in the Medicaid line of business. The credit strength of the ACAP plans relates to several factors. First, ACAP plans improved their cash flow returns from revenues from 2009 to 2011. Their cash flow margin ratio rose to over four and half percent by 2011 from less than three percent in 2009. In contrast, non-ACAP plans, both non-profit and publicly traded, earned a cash flow return of less than three percent in 2011. Thus, these findings indicate that ACAP plans were generating higher cash flow than non-ACAP plans.

Second, ACAP plans enhanced their capital position from 2009 to 2011 as reflected by the three capital ratios measured within this study. In 2011, ACAP plans' capital position is almost four and half times their authorized capital compared to only just over three times authorized in 2009. In 2011, their capital to debt position reflects almost an equivalent amount of capital to debt compared to only 74 percent of capital to debt in 2009.

Finally, in 2011, ACAP plans had enough capital to cover almost two months of expenses compared to 2009 when they only had a month and half of capital to cover their expenses. More importantly, in 2011 these ACAP ratio values were just slightly below non-ACAP plans. In terms of cash and investments, 79 percent of ACAP plans' total assets are in cash and investments: comparable to non-ACAP plans, which have 82 percent. Thus, ACAP plans appear to have adequate capital cushion as well as cash reserves to meet a significant portion of their expansion needs. However, given the potential reserves needed to meet more expensive market expansions, such as those involving dual eligibles, plans may need to look to funding sources other than those generated internally.

Appendix 1: Interviews of Two Health Plans' Chief Financial Officers

Methods: Phone interviews were conducted to further explore perceptions of sources of capital needed to support expansion of Medicaid. The interviews were conducted by the author with the CFOs of two health plans which are ACAP members with the understanding of confidentiality. The interviews, conducted in February 2013, each lasted approximately 45 minutes. Both interviewees were asked these questions:

- How are reserve requirements impacting plan decisions related to expansions in the Medicaid, dual-eligible, and Exchange arenas?
- What sources of financing are being considered to expand reserves?
- What responses have been received from other entities when approached with respect to assisting your plan with reserve development?

The following summarizes the two interviewees' responses:

- Capital reserve requirements and Medicaid expansion: Capital reserve requirements and their influence on expanding Medicaid are of significant interest. Both CFOs indicated that expanding into the dual eligible population would negatively impact their plans' capital reserve position. Both indicated that during the initial two years of managing the dual population they anticipated an operating loss, which would erode their plans' reserve position. The operating loss would likely result from the high medical costs incurred from the dual beneficiaries coupled with the expected inadequacy of the rates. In addition, one CFO indicated that administrative costs may increase as well from the added expense of contracting out claim processing for dual beneficiaries.

The other CFO indicated that if his plan generated a profit from this line of business, its reserve requirements would still increase. This would occur because state regulators would raise the health plan's level of authorized capital position due to the risk and high cost associated with managing the dual-eligible population. However, he noted that the state regulators may not require corrective action if the RBC ratio falls to "one" because of the anticipated time necessary to manage plan costs and adjust rates to maintain adequacy.

The CFO of the second health plan suggested that his plan may decide not to expand if its capital reserve position declined.

- Surplus notes: Both CFOs indicated the surplus note as the financial mechanism used to access capital. Surplus notes are financial instruments unique to insurance companies and are viewed by NAIC regulations as equity capital, not a liability obligation. However, as one of the CFOs acknowledged, one aspect of this financial instrument is viewed as an obstacle by external capital lenders such as banks, insurance companies and private equity firms. State Insurance regulators must approve interest and principal payments to capital lenders. Regulators may deny payments to lenders to ensure the solvency of a health plan and require that the plan pays its medical claims first. Therefore, capital lenders are encumbered by state insurance regulators in receiving their payments.

- Sources of capital: One CFO acknowledged that the plan's parent owner acts as a potential source of capital and identified three associated financial benefits. First, the credit terms are easier and more flexible compared to bank loans: the health plan can borrow at prime rate, and delay interest or principal payments. Second, unlike a bank loan, the parent would not call in the loan. Third, the plan incurs no debt covenants. For example, the health plan would not be required to maintain a certain amount of cash on hand or a debt service coverage ratio, and would not have restrictions on future borrowings.

Conversely, one CFO discussed concerns surrounding this source of capital, particularly if the health plan consistently borrowed from the parent over time and failed to generate consistent earnings to become a self-sustaining entity. Under this scenario, the parent might decide to sell the health plan because it has become a capital drain.

In contrast, the other health plan did not have an affiliation with a provider possessing large amounts of capital to lend. Therefore, the CFO approached several external capital lenders: banks, insurance companies, private equity firm and vendors. These sources of capital do not account toward capital reserve and are viewed strictly as balance sheet liabilities.

This CFO listed three barriers associated with bank borrowing. First, banks remain reluctant to lend because of the 2008 credit crisis and often are unwilling to lend to borrowers with whom they have no prior experience, or to borrowers in business lines with which they are unfamiliar. Second, even if bank borrowing were to become available, plans would likely have to move their other banking services (checking and investing) to the lending bank as a condition of the loan. Third, other types of bank borrowings (i.e., lines of credit) would only cover short-term cash flow gaps during the year and would not improve the plan's capital reserve position.

As potential sources of capital, life insurance companies and private equity firms have several concerns about lending to Medicaid health plans. First, the amount of capital requested is almost equivalent to the amount of capital currently on hand. Second, life insurance companies and private equity firms are hesitant to lend because the health plan is requesting capital to support a new business line (duals), which these potential capital sources view as a start-up venture because it represents a new line of business for the health plan. Third, both are concerned that investing in a Medicaid health plan is high risk because this business line depends on one payment source from highly regulated payer, the state Medicaid agency. And state Medicaid agency budgets are at risk of being cut by state legislators.

Vendors had been approached as potential sources of capital by the CFO of the plan associated with the federally qualified health centers. This health plan outsources behavioral health services and pharmacy benefit management. Because these vendors have a vested interest in sustaining the health plan, they could provide needed capital during the plan's expansion to duals and become equity partners in the health plan. The

health plan could provide a return on capital to these vendors, who would receive a percent of the health plan's profits or higher management fees. However, a major concern is whether vendors could provide a sufficient amount of capital.

Appendix 2: Data tables

Table 1.1: Median RBC Ratio by ACAP/non-ACAP status

Year	ACAP Plans (n=41)	Non-ACAP Plans (n=166)
2009	3.23	3.73
2010	3.92	4.28
2011	4.49	4.73
2009-2011	3.78	4.27

Table 1.2: Median RBC Ratio Analysis by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP Plans			
		Publicly Traded (n=80)	Private For-Profit (n=18)	Non-Profit (n=59)	Non-Profit Blues (n=9)
2009	3.23	3.58	3.50	4.20	3.75
2010	3.92	4.21	3.69	4.90	3.56
2011	4.49	4.74	3.73	5.04	5.58
2009-2011	3.78	4.16	3.63	4.73	3.66

Table 1.3: Median RBC Ratio Analysis, Controlling for Non-Medicaid Focus, ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP, Non-Medicaid-Focused Plans		
		Publicly Traded (n=16)	Non-Profit (n=31)	For-Profit (n=5)
2009	3.23	3.54	5.42	2.56
2010	3.92	4.62	5.76	2.19
2011	4.49	4.84	5.59	1.58
2009-2011	3.78	4.49	5.55	2.19

Table 1.4: Median RBC Ratio Analysis Controlling for Medicaid Focus, ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP, Medicaid-Focused Plans		
		Publicly Traded (n=64)	Non-Profit (n=37)	For-Profit (n=13)
2009	3.23	3.58	3.55	5.39
2010	3.92	4.00	3.48	5.39
2011	4.49	4.56	4.46	4.00
2009-2011	3.78	4.03	3.66	5.39

Table 2.1: Median Cash Flow Margin Ratio Analysis by ACAP status

Year	ACAP Plans (n=41)	Non-ACAP Plans (n=166)
2009	2.96%	2.34%
2010	4.67%	3.78%
2011	4.86%	2.78%
2009-2011	4.39%	3.00%

Table 2.2: Median Cash Flow Margin Ratio Analysis by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP Plans			
		Publicly Traded (n=80)	Private For-Profit (n=18)	Non-Profit (n=59)	Non-Profit Blues (n=9)
2009	2.96%	2.02%	5.49%	2.19%	0.37%
2010	4.67%	3.31%	4.43%	4.09%	2.35%
2011	4.86%	2.78%	2.91%	2.47%	1.11%
2009-2011	4.39%	2.60%	3.66%	3.52%	1.09%

Table 2.3: Median Cash Flow Margin Ratio Analysis Controlling for Non-Medicaid Focus by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP, Non-Medicaid Focused Plans		
		Publicly Traded (n=16)	Non-Profit (n=31)	For-profit (n=5)
2009	2.96%	1.72%	0.95%	5.17%
2010	4.67%	3.05%	3.84%	2.59%
2011	4.86%	5.69%	2.10%	2.21%
2009-2011	4.39%	3.08%	2.89%	2.60%

Table 2.4: Median Cash Flow Margin Ratio Analysis Controlling for Medicaid Focus by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP Medicaid Focused Plans		
		Publicly Traded (n=64)	Non-Profit (n=37)	For-Profit (n=13)
2009	2.96%	2.24%	3.19%	7.20%
2010	4.67%	3.31%	4.50%	5.18%
2011	4.86%	1.32%	3.06%	2.92%
2009-2011	4.39%	2.38%	3.19%	3.68%

Table 3.1: Median Days in Capital Ratio Analysis by ACAP status

Year	ACAP Plans (n=41)	Non-ACAP Plans (n=166)
2009	42	47
2010	57	51
2011	53	54
2009-2011	47	51

Table 3.2: Median Days in Capital Ratio Analysis by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP Plans			
		Publicly Traded (n=80)	Private For-Profit (n=18)	Non-Profit (n=59)	Non-Profit Blues (n=9)
2009	42	44	53	55	53
2010	47	49	45	59	47
2011	53	53	39	60	76
2009-2011	47	48	43	59	53

Table 3.3: Median Days in Capital Ratio Analysis Controlling for Non-Medicaid Focused by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP, Non-Medicaid Focused Plans		
		Publicly Traded (n=16)	Non-Profit (n=31)	For-Profit (n=5)
2009	42	46	71	32
2010	47	55	76	28
2011	53	52	76	20
2009-2011	47	52	75	28

Table 3.4: Median Days in Capital Ratio Analysis Controlling for Medicaid Focused by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP, Medicaid Focused Plans		
		Publicly Traded (n=64)	Non-Profit (n=37)	For-Profit (n=13)
2009	42	44	47	64
2010	47	47	47	69
2011	53	53	51	64
2009-2011	47	47	52	65

Table 4.1: Median Capital to Debt Ratio Analysis by ACAP Status

Year	ACAP Plans (n=41)	Non-ACAP Plans (n=166)
2009	0.74	0.91
2010	0.88	0.94
2011	0.98	1.05
2009-11	0.86	0.97

Table 4.2: Median Capital to Debt Ratio Analysis by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP Plans			
		Publicly Traded (n=80)	Private For-Profit (n=18)	Non-Profit (n=59)	Non-Profit Blues (n=9)
2009	0.74	0.79	0.74	1.08	1.05
2010	0.88	0.93	0.74	1.04	1.18
2011	0.98	1.03	0.74	1.12	1.21
2009-2011	0.86	0.93	0.74	1.14	1.20

Table 4.3: Median Capital to Debt Ratio Analysis Controlling for Non-Medicaid Focused by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP, Non-Medicaid Focused Plans		
		Publicly Traded (n=16)	Non-Profit (n=31)	For-Profit (n=5)
2009	0.74	0.70	1.32	0.37
2010	0.88	0.82	1.20	0.50
2011	0.98	0.80	1.20	0.26
2009-2011	0.86	0.80	1.29	0.37

Table 4.4: Median Capital to Debt Ratio Analysis Controlling for Medicaid Focus by ACAP and Ownership Status

Year	ACAP Plans (n=41)	Non-ACAP, Medicaid Focused Plans		
		Publicly Traded (n=64)	Non-Profit (n=37)	For-Profit (n=13)
2009	0.74	0.79	0.90	0.99
2010	0.88	0.97	0.83	0.79
2011	0.98	1.10	1.05	0.74
2009-2011	0.86	0.99	0.95	0.79

Table 6.1: Common Size Balance Sheet Median Values by ACAP status

Common Size Percentages	ACAP Plans (n=41)	Non-ACAP Plans (n=166)
(Cash + Investments) / Total Assets	79%	82%
Total Liabilities / Total Assets	51%	49%
Total Capital / Total Assets	49%	51%

Notes

¹ The analysis is based on median values and not average values due to variation and smaller sample size of the corporate categories. However, the author uses median value in the same view as average value, although the two values certainly differ due to the distribution of the ratio values.

² Optum Insight Publication: *The 2013 Almanac of Hospital Financial and Operating Indicators*.

³ The June 2012 Supreme Court's decision did not allow federal government to require states to expand Medicaid eligibility by withholding funding, therefore; there exists the possibility that some states may opt out of expanding their Medicaid enrollment. See Sarah Kliff, 'The outlook for Medicaid expansion looks bleak', Washington Post April 25, 2013. <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/04/25/the-outlook-for-medicaid-expansion-looks-bleak/>

⁴ As of January 2013, ACAP, or the Association for Community Affiliated Plans, represents 58 not-for-profit, community-based plans in 24 states. ACAP plans currently serve more than 10 million Medicaid, CHIP and Medicare enrollees.

⁵ ACAP analysis of National Association of Insurance Commissioners (NAIC) data from calendar year 2007 – 2010.

⁶ ACAP. "Medicaid-Focused Health Plans Continue Outsized Growth as Medicaid Trends Toward Managed Care." February 2013. <http://ow.ly/omqOa>.

⁷ For this analysis, capital is defined as total capital and surplus, which is line 33 on the NAIC balance sheet. A financial analysis report of health plans within state of Massachusetts' Division of Health Care Finance and Policy defines excess of assets over liabilities as "surplus." NAIC also refers to this value as "adjusted capital"; see the five-year history form within NAIC health reporting forms.

⁸ This definition is a summary of the definition of governmental entity and Safety Net Health Plan, as incorporated in Section 9010(c)(2) (B) and (C) of the *Affordable Care Act*.

⁹ National Association of Insurance Commissioners (NAIC) 2010, Financial Analysis Handbook, Health Edition, 2009 Annual / 2010 Quarterly, NAIC. Kansas City, MO

¹⁰ Division of Health Care Finance and Policy, May 2010, "Study of the Reserves and Capital of Health Insurers in Massachusetts." <http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/10/insurer-reserve-report-05-2010.pdf>

¹¹ For state of Arizona, the study will be unable to measure the Medicaid plans' RBC because the state does not report its authorized capital and because these plans follow Generally Accepted Accounting Principles (GAAP)

¹² Cash flow from operations was measured from the Statement of Cash flow and includes adjusting excess revenues over expenses for non-cash expenses such as depreciation expense as well as working capital adjustments for current asset account such as counts receivable and current liability accounts such as claims payable and other payable accounts.

¹³ It is important to analyze the two primary sources of capital: both debt obligations and surplus/capital funds. Debt obligations are obligations that are required to be paid within a short time period, such as outstanding medical claims from providers and borrowings or loans from parent organizations or affiliates or banks. Loans are legal obligations that are required to be paid. Borrowings or loans can finance any capital shortfalls that a health plan may have, or purchase equipment needs for plans. Surplus funds reflect the earnings that have been retained by health plan to act as liquidity cushion when a health plan did not generate sufficient revenues to pay off its expenses funds. In addition, health plans may receive added capital infusion from issuing stock (for-profit only) or receiving capital funds from its parent or affiliate organizations.

¹⁴ ACAP included three plans from New York that were specialty plans.

¹⁵ The CMS 2011 *Medicaid Managed Care Enrollment Report Summary Statistics* of July 1, 2011 lists Medicaid managed care plans. It lists 175 Medicaid MCOs and 157 commercial MCOs, for a total of 330 plans. The report identifies a given plan multiple times in a given state because it covers different geographic markets within the state. Since a plan's financial statement measures statewide financial performance, the analysis collapsed these plans into one Medicaid Managed Care plan for the state. As a result of this adjustment, the final sample of plans was 231. For health plans in Arizona, total members were collected from the CMS Medicaid Managed Care Report enrollment. For health plans in California and New York, 2011 membership data were collected from their financial reports. For health plans collected from NAIC filings, 2011 total members were collected from NAIC filings.

¹⁶ Out of the 41 ACAP plans, 23 of these plans' data were collected from state databases of AZ, CA and NY

¹⁷ The study used proxy measures for RBC ratios for plans with states of AZ, CA and NY based on contingent reserve requirements of the state. In the state of New York, the study's author identified one plan that reported the NAIC RBC ratio and compared it to the RBC ratio based on contingent reserve requirement as the measured of authorized capital and found that the proxy measure was undervalued. Therefore the study's proxy RBC measure for the state of New York health plans may be undervalued relative to their NAIC value.

¹⁸ Burns, L and MV Pauly, "Integrated Delivery Networks: A Detour On The Road To Integrated Health Care?" *Health Affairs* July 2002 vol. 21 no. 4 128-143.

¹⁹ Universal Health Plan and DC Charter are in receivership. See the following articles:
<http://www.bizjournals.com/tampabay/news/2013/02/06/universal-health-care-files-for.html> and
<http://www.bizjournals.com/washington/news/2013/01/11/auditors-say-jeff-thompson-owes.html?page=all>

²¹ Total assets were measured as Net of Admitted Assets. Health plans complying with Statutory Accounting Principles (SAP) are focused on the solvency of plans and ensuring plans maintain a sufficient amount of liquid assets to pay claims and other expenses. As result, under these principles, plans must admitted certain types of assets accounts, specifically ones expected to have lower or no value in the extreme case of bankruptcy, such as prepaid expenses, furniture and equipment, data processing equipment and deferred income tax assets. In reviewing the asset data, the median non-admitted assets as percentage of total assets was less than 2.3% of total assets.

²² For health plans complying with NAIC statutory accounting principles, the capital account was called "capital and surplus." For health plans in Arizona, California and New York, there was variation in terms of the accounting principles followed. Some plans followed General Accepted Accounting Principles (GAAP) while others followed state statutory accounting principles. For GAAP and government accounting principles, the capital account was defined as either "reserve fund" or "net asset" accounts.

²³ For NAIC plans, the balance follows statutory accounting principles; therefore, total Liabilities and Capital /Surplus did equal Net Admitted Assets rather than Total Assets. Under these accounting principles, certain assets like furniture and equipment are excluded. Thus, for the common size balance sheet liabilities and capital are computed as percentage of net admitted assets for NAIC plans.

²⁴ Health plans may have established a line of credit with bank and not have accessed the line of credit; therefore, this information would be reported not on the balance sheet but in the notes to the financial statements.