Healthcare Systems and Services Practice

The granularity of Medicaid MCO growth

Deborah Hsieh, David G. Knott, and Tim Ward

The granularity of Medicaid MCO growth

Despite present uncertainties, MCO leaders can still aspire to grow—and make decisions to support that aspiration. Our research shows that the key sources of growth for Medicaid MCOs are strategic, not operational.

Deborah Hsieh, David G. Knott, and Tim Ward

Medicaid enrollment in the United States has grown swiftly in recent years. More than 16 million people who were ineligible for the program in 2014, or had not yet enrolled in it, now have Medicaid coverage,[1] in large part because 31 states and the District of Columbia expanded Medicaid eligibility under the Affordable Care Act.[2] As a result, many public and private institutions have seen a large, rapid influx of Medicaid enrollees. In particular, managed care organizations (MCOs)—health insurers that sign contracts with state Medicaid agencies to deliver care to members for a set fee per month—have grown quickly. Between 2010 and 2016, MCO enrollment surged by a compound annual growth rate (CAGR) of 12%.[3]

As of late September 2017, without passage of "repeal and replace" legislation, the future pace of Medicaid enrollment growth will largely depend upon the actions of individual states, potentially in concert with ongoing efforts to change federal regulation (and perhaps renewed attempts at new legislation). Even with the longer-term prospects of Medicaid expansion or contraction unclear, in the near term managed Medicaid is expected to continue growing as states shift more lives, including special needs populations, to Medicaid MCOs.

In this environment, MCO leaders can still aspire to grow—and make strategic decisions to support that aspiration. To identify actions MCO leaders might consider to spur and sustain growth, we studied the factors that contributed to enrollment growth at 120 MCOs to analyze the strategies that yielded the best results. The granular perspective we developed revealed three key insights:

- The markets in which MCOs choose to compete are more important than taking market share from competitors
- Building scale is critical to growth
- Geographical detail matters

Admittedly, the Medicaid MCO market is a highly dynamic one, and so we plan to revisit our analysis of the sources of growth regularly.

Breaking down MCO growth

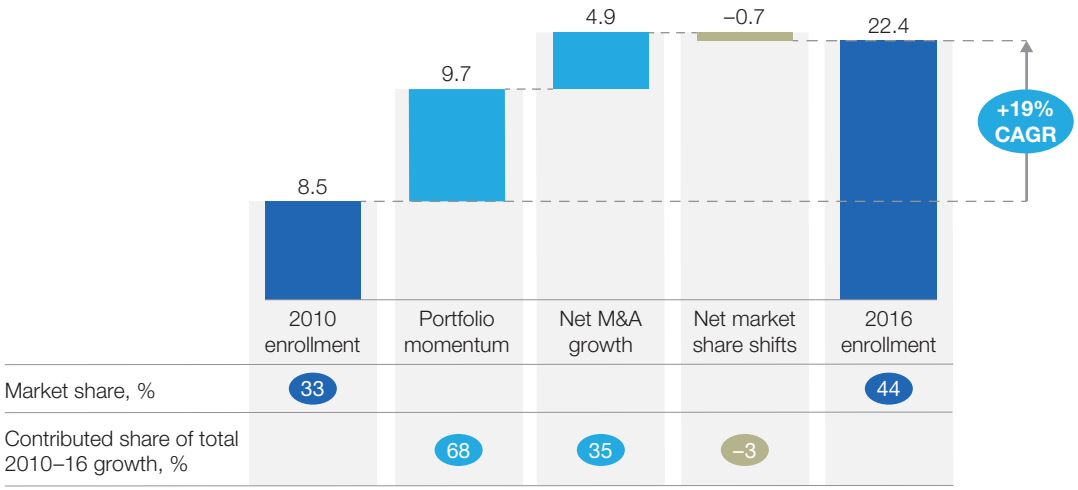
In 2008, the authors of *The Granularity of Growth*, a book that discusses McKinsey's research on corporate growth, described how leaders can push through the "tyranny of the average" by using a detailed approach to understand and capture pockets of opportunity.[4] This method enables leaders to isolate specific, actionable factors that can stimulate growth.

To understand the factors that spur growth for Medicaid MCOs, we took the same approach by disaggregating the three sources of growth. The first two—portfolio momentum and mergers/acquisitions (M&A)—largely reflect a company's strategy. (Portfolio momentum reflects how the company's existing markets are growing and what new markets it enters.) The third type—share gain in existing markets—relates primarily to operational execution. The sidebar, "Three sources of growth," provides fuller descriptions of these growth drivers.

EXHIBIT 1 Portfolio momentum and M&A enabled the five largest MCOs in 2016 to markedly increase enrollment[1]

Sources of Medicaid MCO enrollment growth for five largest MCOs, 2010–16

Number of enrollees, millions



CAGR, compound annual growth rate; M&A, mergers and acquisitions; MCO, managed care organization.
[1]Definition of "largest" is based on 2016 enrollment; excludes special-needs-only plans and US territories.

Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.

Using data from the Centers for Medicare and Medicaid Services, the National Association of Insurance Commissioners, and state agencies, we studied the performance of 120 MCOs in 34 states between 2010 and 2016. The sample included MCOs of all sizes and was broadly representative of the total US market.

Our research confirms the relatively unsurprising point that the most successful MCOs pursue multiple sources of growth and, as a direct result, perform better. Companies that achieved top-quartile performance in all three areas saw a CAGR in enrollment of 63% during the years we studied. The MCOs in the bottom quartile of overall performance (those that did not perform in the top quartile in any area) saw a CAGR of just 9%.

The less obvious finding is that it matters which sources of growth MCOs focus on. According to the authors of *The Granularity of Growth*, portfolio momentum and M&A together account for 95% of growth across industries. Our results confirm that this holds true for MCOs as well: in most cases, the two strategic components generated much more impact than the operational one did. However, only 31% of the MCOs we studied performed well in both strategic areas.[5] This finding suggests that MCOs should be focusing more actively on the strategic sources of growth, especially now that states may be revising their approaches to Medicaid. (It is worth noting, however, that if overall Medicaid MCO growth decreases, winning market share may become more important.)

"Where" and "what" beat "how"

For most MCOs, sustained enrollment growth comes more from "where to compete" choices (e.g., "which markets do I focus on?" and "what should I acquire?") than from "how to compete" actions to improve market share. Portfolio momentum was the key driver of growth for the Medicaid MCOs we studied, as it has been in other industries. At an aggregate level, M&A ranked second as a source of growth. However, some MCOs did achieve significant share gain. Our analysis showed that, with the exception of Centene, the MCOs that had the highest absolute growth from share gain were more likely to operate in a single, local market.

For the five MCOs that had the largest membership in 2016—Centene, Anthem, UnitedHealth, Molina, and Aetna—virtually all growth between 2010 and 2016 resulted from portfolio momentum and M&A, with the former accounting for almost 70% of the total growth (Exhibit 1).

Given the extent to which portfolio momentum drives growth at large MCOs, it should remain a top strategic priority. We believe that MCO leaders should pay particular attention to three factors that can spur MCO enrollment growth at the state level:

- Changes in eligibility
- The movement from fee-for-service reimbursement to managed care
- Underlying changes in the demographics of the population (e.g., population growth or broad changes in average income)

Bigger is usually better

Nationally, the overall Medicaid market grew at a 12% CAGR between 2010 and 2016, but large MCOs grew faster than smaller ones did (Exhibit 2). During those years, aggregate growth for the five largest MCOs in 2016 reached a CAGR of 19%, and the companies increased total market share. In contrast, aggregate growth for the smaller MCOs that year—those not in the top 15—was just 6% CAGR; these companies lost market share. Part of the explanation for the difference in performance is that scale increases an organization's ability to execute its strategies, particularly M&A, successfully. Our results show that it was mainly the larger MCOs that participated in and experienced growth as a result of M&A.[6]

Between 2010 and 2016, less than one-third of all MCOs performed well by gaining share in their existing markets (i.e., markets in which they participated in 2010 or, for brand-new players,

Three sources of growth

Disaggregating growth into three areas can help MCO leaders better understand and evaluate their company's performance.

Portfolio momentum. Growth an MCO achieves when its overall market enlarges (e.g., because the states it operates in decide to increase their use of managed Medicaid, or because the MCO expands into new states).

M&A. Growth from acquiring another MCO, minus any contraction from divesting assets.

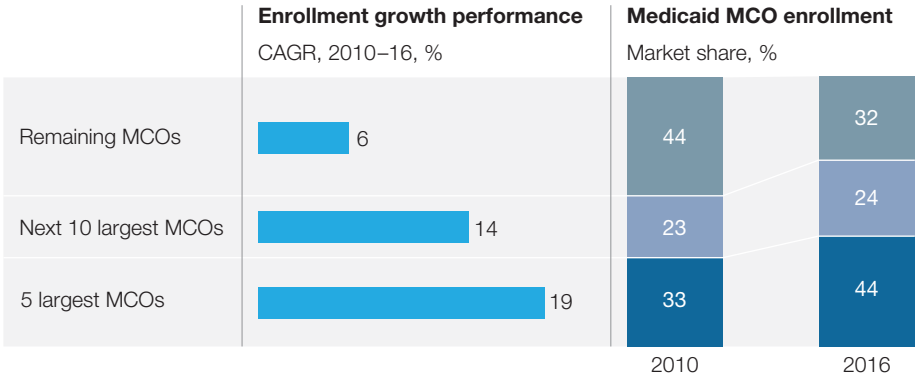
Share gain in existing markets. Growth from gaining market share from competitors in a state in which the MCO already participates.

the first market entered between 2010 and 2016). Players for whom gain of share was the most important growth driver were primarily smaller MCOs, given that M&A was less available to them.

Location, location, location

The details of geographical mix matter. Although some MCOs are constrained by mission or other considerations to a single

EXHIBIT 2 **Medicaid MCO enrollment growth varied widely across states**



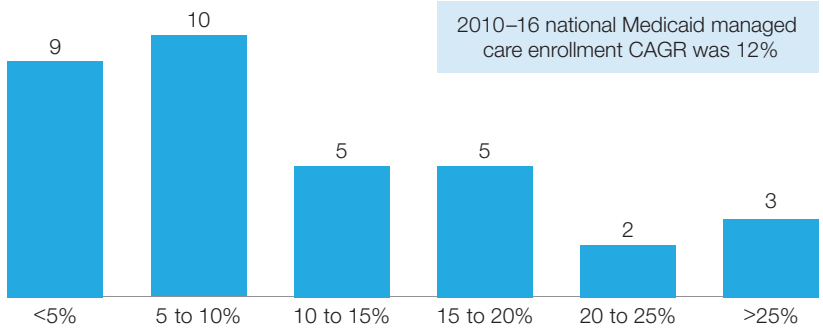
CAGR, compound annual growth rate; MCO, managed care organization.

Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.

EXHIBIT 3 **Medicaid MCO enrollment growth varied widely across states**

CAGRs for 2010–16 state Medicaid MCO enrollment growth[1]

Number of states



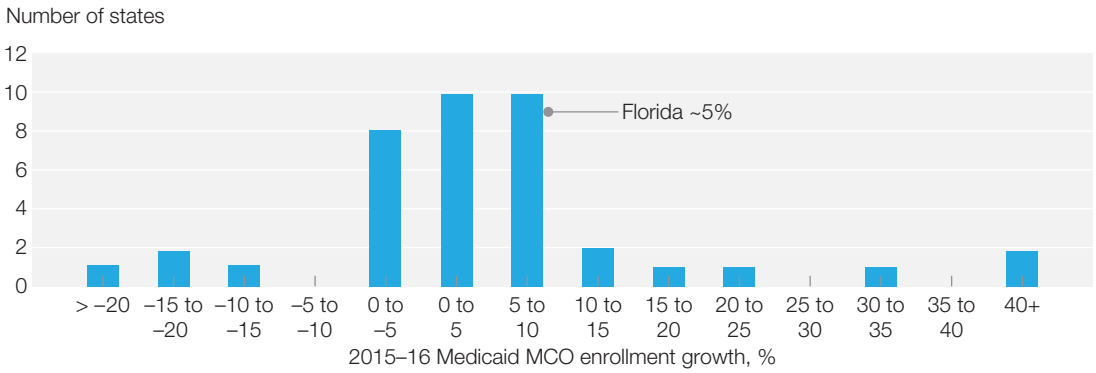
CAGR, compound annual growth rate; MCO, managed care organization.

[1] Excludes special-needs-only plans; for states with comprehensive managed care programs each year from 2010 to 2016 (N = 34).

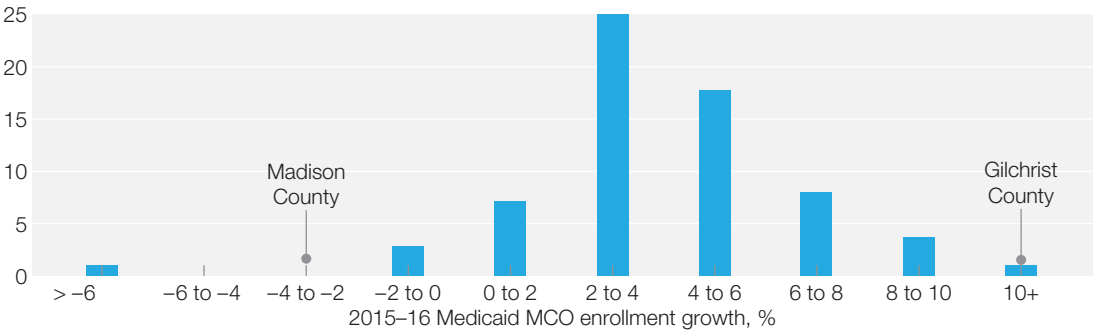
Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.

EXHIBIT 4 Breaking down growth into micromarkets can reveal new, actionable insights

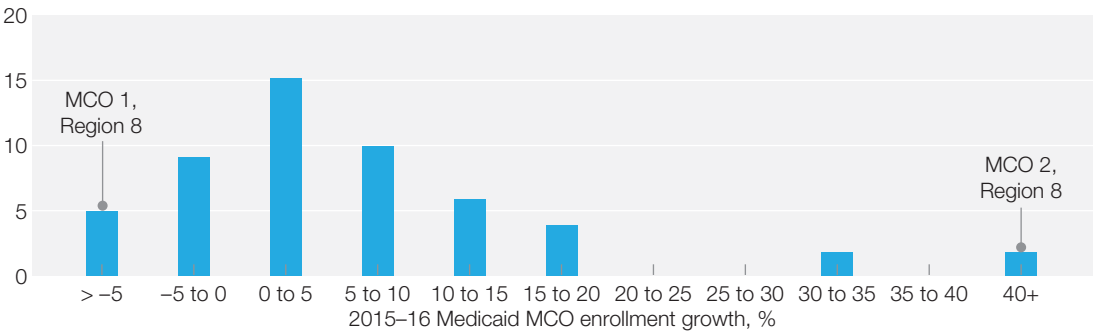
2015–16 Medicaid managed care enrollment growth by state



2015–16 Medicaid managed care enrollment growth by county



2015–16 Medicaid managed care enrollment growth by individual MCOs in Florida regions



MCO, managed care organization.

Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.

geographical market, others can—and do—choose where to compete.

Our results demonstrate that growth in managed Medicaid has not been evenly distributed. Taking 2015–16 as a sample, three areas (Louisiana, District of Columbia, and Iowa) experienced growth in the number of enrolled beneficiaries and grew at a CAGR of over 25% (Exhibit 3). However, in three other states, enrollment declined by more than 15% per year.

Growth varied significantly at the micromarket level as well. In Florida, for example, the number of Medicaid beneficiaries in managed care grew by 5% from 2015 to 2016. Not all Florida MCOs benefited from that membership growth, though. Some saw their membership rise by over 10%; others exited the market.

EXHIBIT 5 **Medicaid MCO companies by enrollment growth, 2010–16**

	2010–16 enrollment growth, members[1]	2010–16 enrollment growth, CAGR	Growth from each source, %		
			Portfolio momentum	M&A	Share gain
Centene	4,800,000	29	57	39	4
Anthem	4,600,000	33	50	56	–6
UnitedHealth Group	2,200,000	9	115	–2	–13
Molina	1,800,000	16	84	9	7
Aetna	1,200,000	13	74	44	–18
WellCare	1,200,000	13	205	16	–121
AmeriHealth Caritas	1,000,000	13	152	3	–55
LA Care[2]	900,000	48	20	0	80
Fidelis	700,000	16	30	0	70
Inland Empire Health Plan	600,000	18	112	0	–12
Kaiser	600,000	47	17	0	83
Meridian Health Plan	600,000	20	32	0	68
BlueShield of California	500,000	—	8	89	3
HealthFirst	500,000	15	34	37	29
HCSC	500,000	68	33	0	67

CAGR, compound annual growth rate; MCO, managed care organization.
[1]2010–16 membership enrollment growth is rounded to the nearest 100,000.
[2]Enrollment figures for California are based on California Department of Managed Health Care reports and estimates of subcontracting to other plans. California data also exclude prepaid health plan enrollment.

Source: Membership growth was estimated by accessing publicly available reports from the Centers for Medicare and Medicaid Services, state Medicaid websites, and company SEC filings and press releases, as well as data from the McKinsey Payor Financial Database (including information from NAIC filings and IRS Form 990) and SNL Financial. Data excludes special-needs-only and partial capitation plans and plans in US territories.

Geography helps explain these results. When we re-examined membership changes in Florida at a more granular level, it became clear that both overall growth rates and the performance of individual MCOs differed significantly among counties. Between 2015 and 2016, for example, managed Medicaid membership decreased in Madison County but rose substantially in Gilchrist County (Exhibit 4).

Granular geographical analysis at the county level or deeper can help MCOs identify specific pockets of likely future growth (often, a result of demographic or policy changes). The variations in potential growth that can be detected increase as granularity rises, and so choosing where to play must be done at a micromarket level.

Our research also indicates that geography is not the only dimension to consider on a granular basis when investigating growth opportunities. Within a single state or county, growth can also vary widely between program types and eligibility categories.

• • •

Our results indicate that for Medicaid MCOs, as for companies in other industries, the keys to growth at present are portfolio momentum (especially at a granular market level) and M&A (Exhibit 5). It is important for MCO leaders to give these factors sufficient weight in decisions about where to compete.

Deborah Hsieh *(Deborah_Hsieh@mckinsey.com) is a consultant in McKinsey's Silicon Valley office.* ***David G. Knott*** *(David_Knott@mckinsey.com) is a senior partner in the New York office.* ***Tim Ward*** *(Tim_Ward@mckinsey.com) is a senior partner in the Southern California office.*

The authors would like to thank Matt Carey, Nina Jacobi, and Cezanne Simon for their contributions to this article.

FOOTNOTES

[1]CMS. November 2016 Medicaid and CHIP application, eligibility determination, and enrollment report. November 2016.

[2]Kaiser Family Foundation. Status of state action on Medicaid expansion decision. Data as of January 1, 2017.

[3]McKinsey analysis of data from the Kaiser Family Foundation. Total managed Medicaid managed care enrollment. Data as of July 1, 2017.

[4]Viguerie P, Smit S, Baghai M. The Granularity of Growth: How to Identify the Sources of Growth and Drive Enduring Company Performance. John Wiley & Sons. 2008.

[5]We considered an MCO to be executing well in a given area if its growth performance was in the top quartile of all MCOs.

[6]Few MCOs outside the top 10, by either 2016 enrollment or 2010–16 enrollment growth, participated in and experienced growth from M&A.

Editor: Ellen Rosen (Ellen_Rosen@mckinsey.com)
For media inquiries, contact Julie Lane (Julie_Lane@mckinsey.com)
For non-media inquiries, contact Pam Keller (Pam_Keller@mckinsey.com)