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Trends in Health Plans Serving Medicaid— 2000 Data Update

Prepared by
Suzanne Felt-Lisk
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Megan McHugh
Mathematica Policy Research, Inc

November 2001

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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Executive Summary

From 1997 through 1999, Medicaid managed care enrollment continued to rise, even in the face of growing concern about the willingness of health plans to participate in state Medicaid programs.[1] Overall, Medicaid enrollment in full-risk managed care organizations rose during the period by 21.3 percent. In 1999, 316 full-risk managed care plans served 11.4 million Medicaid enrollees in fully capitated programs in 45 states.

The characteristics of health plans serving Medicaid beneficiaries in full-risk programs vary considerably. At one end of the spectrum are large, commercial plans affiliated with national managed care companies. At the other are very small local plans—often owned by hospitals or health centers—that serve Medicaid beneficiaries almost exclusively. As an increasing number of commercial plans began to exit from the Medicaid market in 1997, concerns surfaced about where this new trend would lead:

- Would the departures continue and grow, or were they a temporary adjustment in the market?
- Would declining participation by commercial plans lead to the contraction or collapse of full-risk Medicaid managed care? Or would Medicaid-dominated plans fill the gap left by commercial plans exiting, and if so, what would this mean for beneficiaries?

This paper addresses these issues, building on previous work that describes the trends in commercial health plan participation in Medicaid managed care and the characteristics and roles of Medicaid-dominated plans through June 1997 (Felt-Lisk 1999; Felt-Lisk 2000). In addition to updating previously published information, this paper includes new analyses on the performance of Medicaid-dominated and commercial plans on selected HEDIS®[2] measures for Medicaid on the effectiveness of care and access to care, and on the extent to which health plans are restricting their Medicaid service areas at the county level within states as well as exiting from Medicaid in all counties in a state.

In brief, we find that during 1997–99, about the same number of commercial plans exited from state Medicaid markets in each year but at a much higher rate than in the years prior, with 15 to 17 percent of participating plans exiting annually. In 1997, commercial plan exits were concentrated in certain states and driven by the decisions of a few national managed care organizations (MCOs). In 1998 and 1999, the departures occurred more broadly nationwide. In addition, commercial plans rarely entered the Medicaid market in 1998–99, a major shift from previous years (see Figure ES-1 on the next page). By June 1999, only 37 percent of plans that are large and affiliated with a national MCO firm participated in Medicaid, compared with 56 percent in 1996. Similarly, only 41 percent of BlueCross BlueShield plans participated compared with 59 percent in 1996. Our analysis of 21 states that account for almost 90 percent of full-risk Medicaid managed care enrollment suggests that the exits continued at a high pace, though with some abatement, through June 2000.

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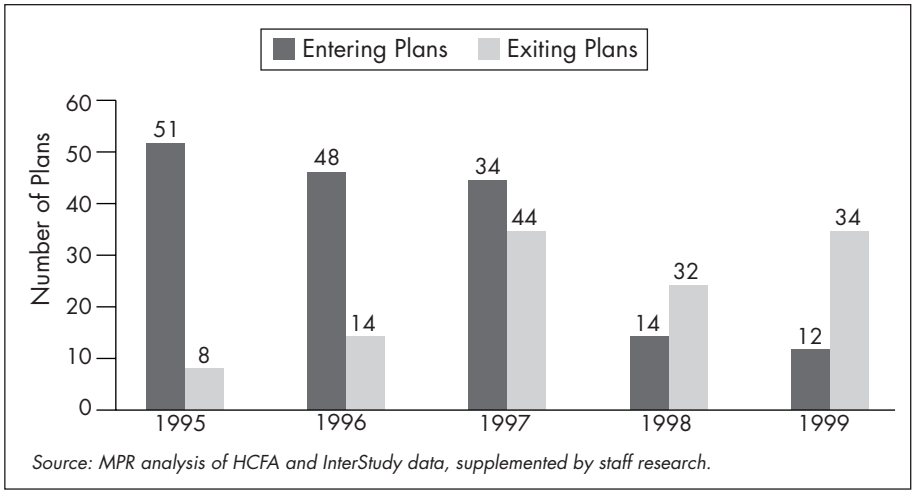
[1] See "Medicaid and Managed Care Fact Sheet," The Kaiser Commission on Medicaid and the Uninsured, February 2001.

[2] HEDIS is a registered trademark of the National Committee for Quality Assurance.

Figure ES-1: Number of Commercial Plans Entering and Exiting State Medicaid Markets, 1995–1999



Source: MPR analysis of HCFA and InterStudy data, supplemented by staff research.

A total of 1.2 million Medicaid enrollees in commercial plans that exited during 1997–99 experienced, at best, the burden of selecting a new health plan and at worst, discontinuity of care if they were required to change providers. About an additional 600,000 enrollees were in plans that were consolidated with another plan that served Medicaid; we cannot assess whether the transitions during the consolidation period were seamless or not from the enrollees' point of view. The total number of enrollees in commercial health plans that exited or consolidated increased by 140 percent from 1997 to 1998 (from 360,000 to 874,000), then dropped some, but remained at a relatively high level for 1999 (606,000).

Despite the large number of exits, the structure of Medicaid managed care remains relatively intact:

- Full-risk Medicaid managed care enrollment continued to grow nationally, from 9.4 million in 1997 to 11.4 million in 1999. The number of states with any full-risk enrollment rose from 43 to 45 during this period.
- Commercial plans throughout the nation still serve a majority of full-risk Medicaid managed care enrollees (58 percent in 1999). Our analysis of 21 high-volume Medicaid managed care states suggests that this figure dropped somewhat by mid-2000, but that it was still over 50 percent.
- The number of Medicaid-dominated plans and the size of their enrollment has grown since 1997, offering additional options for enrollees in commercial plans that have exited. As a group, these Medicaid-dominated plans also appear to have been financially stronger in 1999 than they were in 1997.
- Few counties that were part of a full-risk Medicaid managed care program in mid-1998 dropped out completely by mid-2000.

Policymakers have historically been somewhat reluctant to encourage the development of Medicaid-dominated plans because of quality of care concerns associated with the absence of a large commercial population that might enhance the pressure to perform well. However, an initial analysis of selected HEDIS performance measures for the Medicaid population does not

show a difference between Medicaid-dominated and commercial plans on a majority, though not on all, of the indicators reviewed. However, additional analysis of quality of care is needed to confirm this finding, since data for the initial analysis were limited in several ways; for example, data did not cover a broad spectrum of care (most of the indicators available pertained to women and children's health, and focused on preventive services). (See Moreno et al., 2001 for another analysis of this topic using survey data.)

The study's findings suggest that the exodus of commercial plans from full-risk Medicaid managed care first identified in 1997 has expanded into a national phenomenon, continuing at least through mid-2000. For the hundreds of thousands of Medicaid beneficiaries enrolled in these plans, the exodus represents a disruption in care. However, possibly because of the efforts by states and many other organizations to respond to the effects of the exits, they do not appear to have crippled full-risk Medicaid managed care programs. Our analysis of 12 high-volume Medicaid managed care states suggests that most beneficiaries still have at least one commercial plan option in their county. Further, Medicaid-dominated plans—which are inherently vulnerable because they depend almost entirely on revenue from the Medicaid program—appear to be surviving and growing in general, and were at least breaking even financially during the study period.

I. Introduction

From 1997 through 1999, Medicaid managed care enrollment continued to rise, even as concerns grew about health plans' willingness to participate in state Medicaid programs.[3] Overall, Medicaid enrollment in full-risk managed care organizations rose by 21.3 percent from 1997 through 1999.

Medicaid beneficiaries in full-risk programs enroll in health plans that vary from large, commercial health plans affiliated with national managed care companies to very small local health plans—often owned by hospitals or health centers—that focus almost exclusively on serving Medicaid beneficiaries. As more commercial plans began to exit from the Medicaid market by 1997, concerns surfaced about where this new trend would lead:

- Would the trend continue or was it a temporary adjustment in the market?
- Would declining participation by commercial plans lead to the contraction or collapse of full-risk Medicaid managed care?
- Or would Medicaid-dominated plans fill the needs as commercial plans exited, and, if so, what would the implications be for beneficiaries?

To inform these issues, this issue paper updates and builds on previous work that described trends in commercial health plan participation and the characteristics and roles of Medicaid-dominated plans through June 1997 and data from certain states through mid-1998 (Felt-Lisk 1999; Felt-Lisk 2000). This updated paper provides national data through June 1999 and data from 21 high-volume Medicaid managed care states through mid-2000. In addition to updating this previously published information, we include the following new analyses:

- The performance of Medicaid-dominated and commercial plans on selected HEDIS effectiveness-of-care and access measures for Medicaid
- County-level analysis that sheds light on the extent to which health plans are restricting their Medicaid service areas within states as well as exiting outright from state Medicaid markets

Table 1 on the following page lists all of the specific issues addressed in this brief, in the order in which they follow.

[3] See "Medicaid and Managed Care Fact Sheet," The Kaiser Commission on Medicaid and the Uninsured, February 2001.

TABLE 1
ISSUES COVERED IN THIS REPORT

Trends in Health Plans Serving Medicaid: National Data Through June 1999.

A. Entries To and Exits From State Medicaid Markets.
- Extent to which the trend in commercial plan withdrawals has continued
- Patterns of commercial plan participation across states and among different types of commercial plans

B. Roles of Commercial and Medicaid-Dominated Plans.
- Shifts in the roles of commercial and Medicaid-dominated plans since 1997

C. Characteristics of Medicaid-Dominated Plans.
- Changes in Medicaid-dominated plans since 1997
- Status of Medicaid-dominated plans that operated in 1997

D. Health Plan Performance on Selected HEDIS® Quality and Access Measures.
- Patterns of better and worse performance for different groups of Medicaid-serving plans
- Variations in plan performance by type of ownership
- Performance of plans that exited the Medicaid market during 1999/2000 compared with that of plans that remained in the Medicaid market during this period

Trends in Health Plans Serving Medicaid: Data for High-Volume Medicaid Managed Care States Through June 2000.

A. Entries and Exits: Have the Trends and Patterns Continued?
- Extent to which commercial plans continued to exit the Medicaid market at a similar pace
- Extent to which the roles of commercial and Medicaid-dominated plans have continued to shift

B. A Closer Look: Effects of Exit Trends at the County Level.
- Extent to which health plans are retreating from certain counties rather than exiting an entire state's Medicaid program
- Health plan choices remaining for beneficiaries in 2000
- Characteristics of counties most affected by health plan retreats and exits compared with other counties

C. Financial Status of Medicaid-Only Plans.
- Financial status of Medicaid-only plans in 1999
- Trend in financial status of Medicaid-only plans 1997–1999
- Financial status of Medicaid-only plans relative to commercial plans in the same state

II. Background on Types of Full-Risk Plans Serving Medicaid

In 1999, 316 full-risk managed care plans served 11.4 million Medicaid enrollees in fully capitated programs in 45 states. Table 2 below provides an overview of the types of plans serving Medicaid and the distribution of enrollees among plans that vary in the extent of their commercial enrollment. Commercial plans serve 6.5 million enrollees, or 58 percent of all full-risk Medicaid enrollees. We have defined commercial plans as all plans in which Medicaid enrollees make up less than 75 percent of the total plan enrollment. Commercial plans make up 57 percent of the plans serving Medicaid and include plans that are large and small, for-profit and non-profit, affiliated with national managed care firms or BlueCross BlueShield, and independent. In a majority of commercial plans, Medicaid enrollees make up less than 25 percent of the plan's total enrollment. A few commercial firms offer stand-alone Medicaid managed care products for Medicaid beneficiaries. We categorized these plans as "commercial" rather than "Medicaid-dominated" because they are part of a larger company with insurance product lines that are predominantly commercial in nature.[4] No research has examined the extent to which such plans are similar to commercial vs. Medicaid-dominated plans in their provider network structure, policies, and operations.

Table 2

Distribution of Participating Full-Risk Plans and Medicaid Enrollees, 1999

	Participating Mgd Care Plans		Medicaid Mgd Care Enrollees	
Plan Characteristics	Number	Percent	Number (000's)	Percent
Total	**316**	**100%**	**11,393**	**100%**
Medicaid Proportion of Total				
Commercial plans[a]	*181*	*57%*	*6,549*	*58%*
<10 percent	58	18%	799	7%
10–24 percent	57	18%	2,668	23%
25–49 percent	46	15%	2,228	20%
50–74 percent	20	6%	854	8%
Medicaid Dominated Plans	*135*	*43%*	*4,844*	*43%*
75–89 percent	12	4%	536	5%
90 percent or more	123	39%	4,308	38%

Source: MPR analysis of data from InterStudy and HCFA, supplemented by staff research.

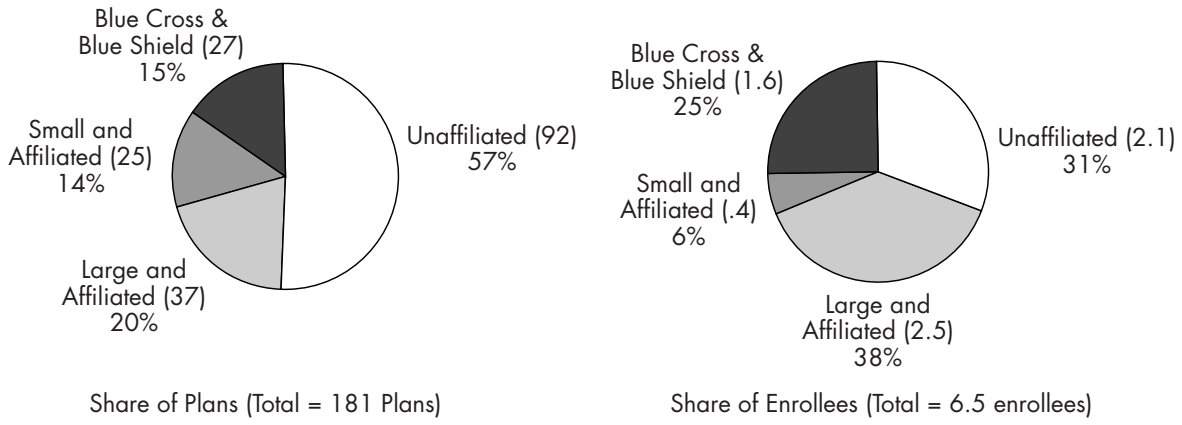
[a] *Stand-alone Medicaid products of commercial plans are included in the 10 to 24 percent Medicaid category; there were only a few of these products.*

[4] Because the number of such plans was small, we included them in Table 2 with commercial plans having 10 percent to 24 percent Medicaid proportion of total enrollment.

Medicaid-dominated plans now serve 4.8 million Medicaid enrollees, 43 percent of all full-risk Medicaid enrollees. They also make up 43 percent of plans serving Medicaid. Most of these plans are basically Medicaid-only plans, with very few non-Medicaid enrollees.[5] Before the Balanced Budget Act of 1997, the "75/25 rule" prohibited these plans from operating for more than three years without a waiver of requirements that at least 25 percent of each Medicaid-serving plan's total enrollment be non-Medicaid.[6] The rule was viewed as a quality-of-care protection, under the theory that if a plan is able to attract at least 25 percent of its enrollees in a competitive, commercial market, then the pressure from these commercial enrollees would help assure good quality care. The Balanced Budget Act of 1997 added new and more direct quality protections and eliminated the 75/25 rule, giving states more flexibility in plan contracting.[7] Since then, Medicaid-dominated plans may proliferate and grow without federal restriction. Medicaid-dominated plans are thus important to better understand, particularly given the earlier concerns and their growing presence in the market as some commercial plans stop participation in Medicaid managed care.

About half of participating commercial plans (51 percent) are not affiliated with a national managed care firm or BlueCross BlueShield (Figure 1). More than half (55 percent) of Medicaid-dominated plans are owned at least in part by providers (See section III.C below).

Figure 1: Medicaid Commercial Plans' Affiliation with National MCOs, 1999



Source: MPR analysis of HCFA and InterStudy data, supplemented by staff research.

[5] As enrollment in the S-CHIP program has increased since 1999, more of these plans may be serving S-CHIP enrollees as well as Medicaid. In this paper, Medicaid enrollment includes S-CHIP enrollment where the S-CHIP program is integrated with Medicaid, but does not include S-CHIP enrollment in stand-alone S-CHIP programs. More information on such plans' service to S-CHIP enrollees is being gathered through a survey project by MPR for KFF and should be available in late 2001.

[6] Medicaid-dominated plans could also form without federal restriction in states that had received waivers allowing this to occur.

[7] See Andy Schneider, "Overview of Medicaid Managed Care Provisions in the Balanced Budget Act of 1997," The Kaiser Commission on Medicaid and the Uninsured, 1997.

III. Trends in Health Plans Serving Medicaid: National Data Through June 1999

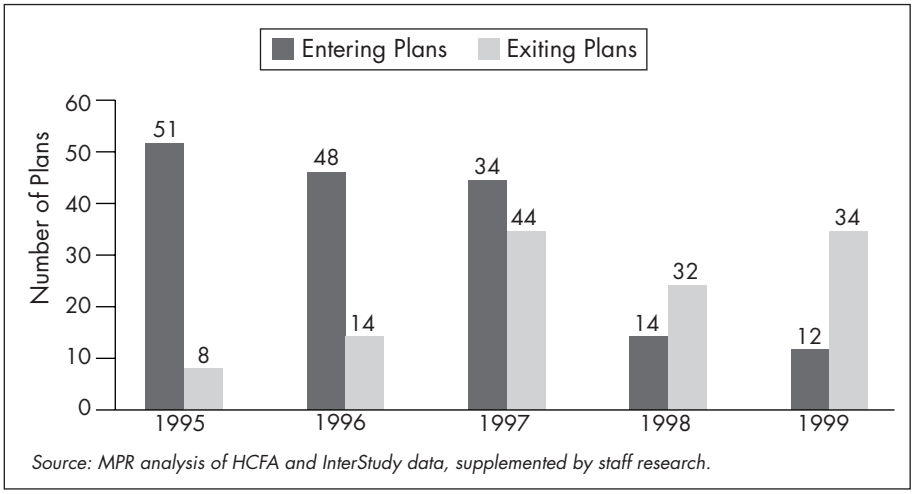
To provide an updated national analysis of the trends in health plans serving the Medicaid market, we added to our 1993–1997 health plan database by merging HCFA data on full-risk Medicaid enrollment by plan for June 30, 1998 and 1999 with InterStudy data on total enrollment and plan characteristics for July 1, 1998 and 1999. For simplicity, this paper will refer to the mid-1998 data as 1998 and the mid-1999 data as 1999. The data were supplemented by staff research to accurately match health plan names and data, clean and check data for reasonableness, and fill data gaps.[8]

A. Entries To and Exits From State Medicaid Markets

To what extent has the trend in commercial plan withdrawals continued?

Commercial plans exited Medicaid in much higher numbers in 1997 than in previous years (Felt-Lisk 1999). They continued to exit in similar numbers during both 1998 and 1999 (Figure 2). We count a total of more than 100 commercial plan withdrawals from state Medicaid markets from 1997 through 1999, more than three times the number of exits from 1994 through 1996. Thus, 15 percent to 17 percent of participating commercial plans withdrew from a state Medicaid market each year from 1997 through 1999. Commercial plans rarely entered state Medicaid markets during 1998 and 1999, a major shift from the 1995–1997 period (Figure 2).

Figure 2: Number of Commercial Plans Entering and Exiting State Medicaid Markets, 1995–1999



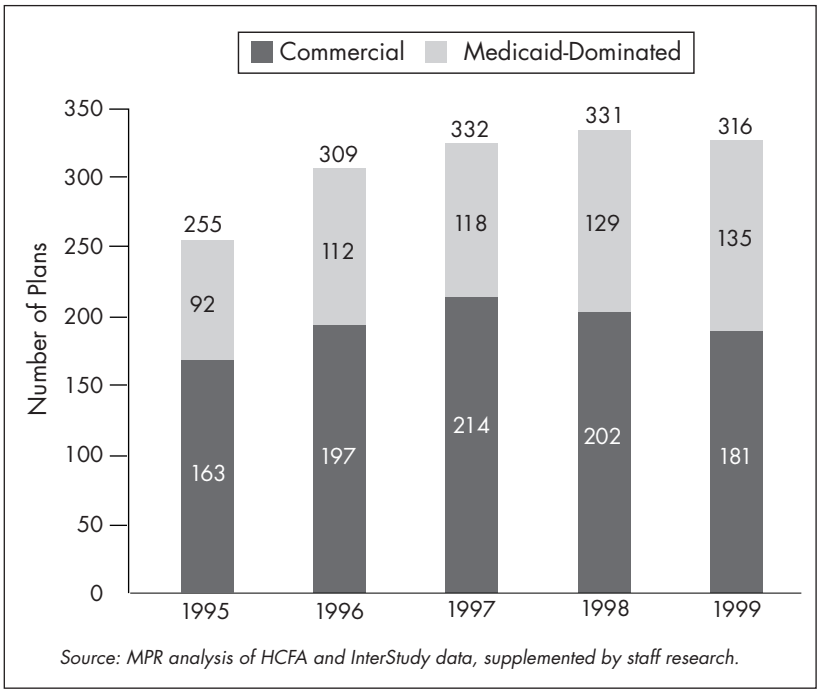
Source: MPR analysis of HCFA and InterStudy data, supplemented by staff research.

[8] See Appendix A for a more detailed description of the data informing this paper.

In 1999, just over half the plans that exited a state Medicaid market remained in that state's commercial HMO market (56 percent). That is a sharp drop from 1997, when 88 percent of the commercial plans that exited retained their commercial business in the state. The difference is primarily due to an increased number of mergers and acquisitions of commercial plans serving Medicaid during 1998–1999. Of the 66 commercial plans that exited from the Medicaid market during 1998–1999, 13 merged with or were acquired by another plan, most often a plan that serves Medicaid beneficiaries (11 of the 13).

As a result of the continuing exits and few entries in 1998 and 1999, the percentage of commercial plans participating in Medicaid dropped slightly, to near its 1995 level: 34 percent of commercial plans participated in Medicaid in 1999 compared with peak participation of 37 percent to 38 percent in 1996 and 1997. Consistent with this, the number of commercial plans participating in Medicaid also dropped in 1998 and 1999 (Figure 3).

Figure 3: Commercial and Medicaid-Dominated Plans Participating in Medicaid, 1995–1999



Source: MPR analysis of HCFA and InterStudy data, supplemented by staff research.

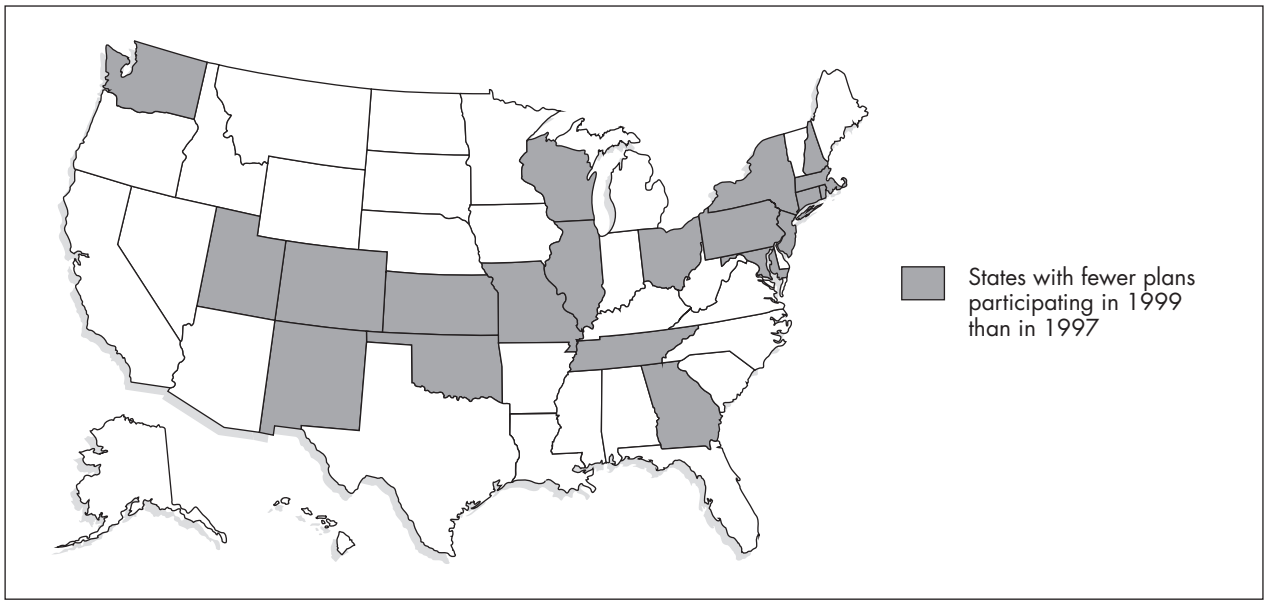
Only a few Medicaid-dominated plans (8 to 12 plans) exited the Medicaid market each year from 1997 through 1999.[9] Note that the Medicaid-dominated plans that exit the Medicaid market generally go out of business. Thus, it is not surprising some would continue in the Medicaid market longer than commercial plans, even if they faced the same pressures or financial considerations as commercial plans.

[9] The rate of exit for Medicaid-dominated plans is also low relative to the commercial plans' rate of exit for these years: 7 percent to 11 percent vs. 14 percent to 16 percent.

What are the patterns of commercial plan participation across states and among different types of commercial plans?

Since 1997, commercial plan exits have been widespread across the states, leaving 19 states with fewer commercial plans participating in 1999 than in 1997 (Figure 4). In total, these states experienced a net loss of 46 commercial plans. New York experienced a net loss of 6 and Pennsylvania, 5 commercial plans. A majority of these states lost 2 or 3 plans.

Figure 4: States with Fewer Commercial Plans in 1999 than in 1997



This pattern is very different from the pattern of entries and exits in 1997 (Felt-Lisk 1999). At that time, exits were concentrated in states that had developed relatively large capitated programs earlier than other states, and commercial plans were continuing to enter some states in significant numbers even as they exited others.

Our update shows only six states had more commercial plans participating in 1999 than in 1997. Their net gain in commercial plans was only one plan per state, except for Texas, which showed a net gain of three commercial plans. Appendix C, Table 1 shows commercial plan entries and exits by state in 1998 and 1999.[10]

Commercial plans that exited in 1998 and 1999 were more often younger plans and more often had larger Medicaid enrollments than those that exited in 1997 (Table 3). Otherwise, characteristics of the commercial plans that exited remained roughly similar for the two time

[10] Appendix C, Table 1 suggests that four more states would have had a net loss of commercial plans during this period except for Medicaid-dominated plans increasing their commercial enrollment so that they became classified as commercial plans (California, Delaware, Mississippi, and North Carolina). (Medicaid-dominated plans that ceased to meet the 75 percent Medicaid enrollment threshold were included as commercial plans participating in Figure 4 but are not included as entries or exits.)

Table 3

Characteristics of Commercial Plans Exiting the Medicaid Market, July 1997–June 1999

	Plans Exiting July 1996–June 1997		Plans Exiting July 1997–June 1999	
	Number	Percent	Number	Percent
Total Enrollment, 1997				
1–49,999	11	35%	24	41%
50–99,999	6	19	6	10
100–249,999	9	29	17	29
250,000 or more	5	16	12	20
Tax Status				
For profit	22	71	46	78
Not for profit	9	29	12	20
Unknown	0	0	1	2
Age of Plan				
<5 years	4	13	25	42
>=5 years	27	87	34	58
Medicaid Enrollment				
<20,000	26	84	40	68
20,000 or more	5	16	19	32
Affiliations				
Affiliated w/a National MCO Firm	17	55	28	47
BCBS	5	16	12	20
Other or no Affiliation	9	29	19	32

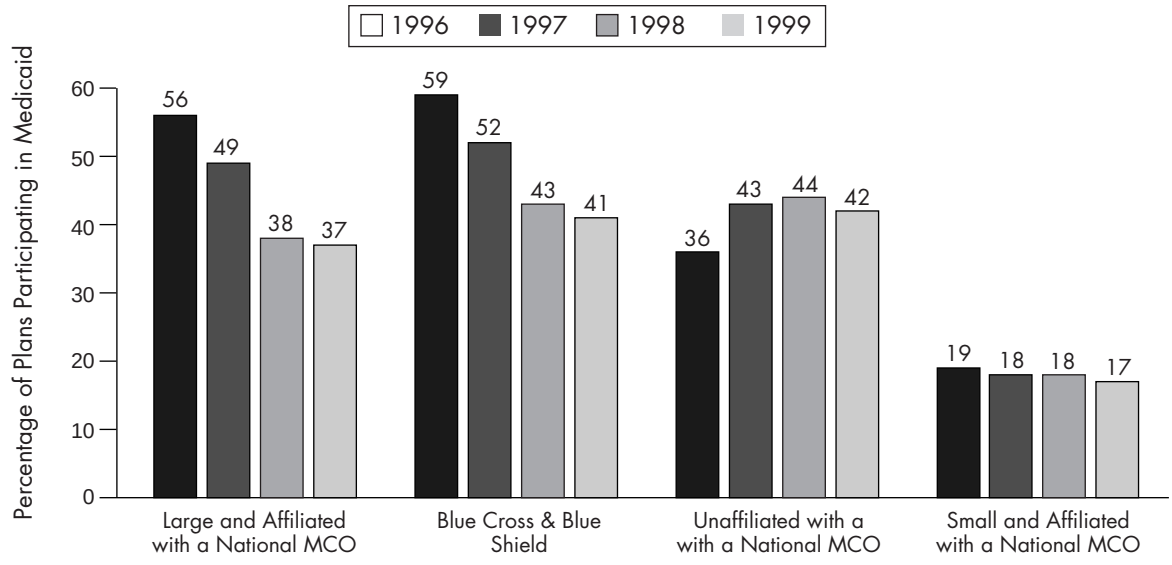
Note: Totals may not equal 100% due to rounding.

periods. About half the exiting plans were small plans (with fewer than 100,000 total enrollees), about half were affiliated with a national MCO firm, and more than 70 percent were for-profit plans (reflecting that commercial plans in general tend to be for-profit).

One result of all of the exits since 1996 is that the extent of participation by various types of plans has changed substantially. Only 37 percent of plans that are large and affiliated with a national MCO firm participated in Medicaid by June 1999, compared with 56 percent in 1996 (Figure 5). Similarly, only 41 percent of BlueCross BlueShield plans participated compared with 59 percent in 1996. Participation rates for other subgroups of commercial plans increased or remained roughly stable.

In 1997 about half the commercial plan exits were associated with a few national MCO firms, but the pattern of exits since then has been dispersed among various firms. MCO firms that withdrew from Medicaid in two or more states accounted for only about one-fourth of the exits (26 percent) in 1998 and 1999.

Figure 5: Percentage of Commerical Plans Participating in Medicaid, by Size and Affiliation, 1996–1999.



Source: MPR analysis of HFCA and InterStudy data, supplemented by staff research.

B. Roles of Commercial and Medicaid-Dominated Plans

How have the roles of commercial and Medicaid-dominated plans shifted since 1997?

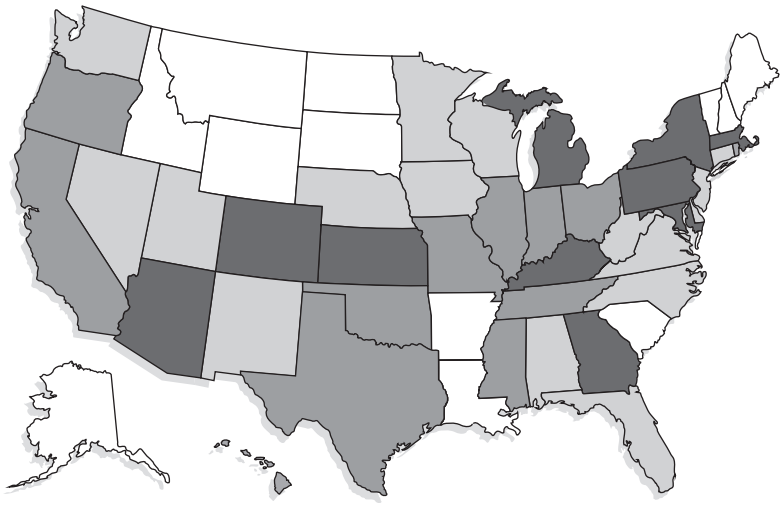
Nationally, commercial plans served 58 percent of Medicaid enrollees in 1999, down from 64 percent in 1997. Conversely, Medicaid-dominated plans' role in serving Medicaid beneficiaries increased during the same period. But the changes are perhaps less at the national level than one might expect, given the pronounced trend of exits from the Medicaid market. This can be explained in part by the fact that more of the commercial plans that remained in the Medicaid market are serving a large number of enrollees. Forty-three percent of participating commercial plans served 20,000 or more Medicaid enrollees compared with 38 percent in 1997.

Figure 6 shows that in 11 states, a majority of Medicaid managed care enrollees are now served by Medicaid-dominated plans, compared with 8 states in 1997. Also, Medicaid-dominated plans play an important role in 12 other states, serving 30 percent to 49 percent of enrollees. In 1997, this was true for only 7 states.

Nine states experienced a larger increase in the role of Medicaid-dominated plans than other states since 1997: Georgia, Hawaii, Illinois, Kansas, Massachusetts, Maryland, Minnesota, New Mexico, and Pennsylvania. In these states, the proportion of Medicaid beneficiaries served by Medicaid-dominated plans increased by 15 percent or more.[11] Appendix C, Table 2 shows the role of commercial plans in state Medicaid managed care programs, for each state, in 1999.

[11] The reverse was true for five states: Delaware, Mississippi, North Carolina, Nevada, and Washington. These states saw a substantial decrease in the proportion of Medicaid beneficiaries served by Medicaid-dominated plans. Note that the programs in Mississippi, North Carolina, and Nevada are small (fewer than 37,000 enrollees in total), and that the shift in Washington was because Medicaid-dominated plans began serving more commercial enrollees and thus were no longer classified as a Medicaid-dominated plan in 1999.

Figure 6: Percentage of Full-Risk Enrollees Served by Medicaid-Dominated Plans, by State, 1999



50% or more
Arizona, Colorado, D.C., Georgia, Kansas, Kentucky, Massachusetts, Maryland, Michigan, New York, Pennsylvania

30–49%
California, Hawaii, Illinois, Indiana, Missouri, Mississippi, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Texas

30%[a] or less
Connecticut, Florida, Minnesota, New Jersey, New Mexico, Utah, Virginia, Wisconsin, Nevada, Iowa, Vermont, Washington, West Virginia, Alabama, Delaware, North Carolina, Nebraska

Other[b]

[a]9 state programs with at least 10,000 enrollees had no enrollment in medicaid-dominated plans: AL, DE, IA, NC, NE, NV, VT, WA, WV.

[b]"Other": states with very limited or no fully capitated erollment (<10,000 enrollees).

Source: MPR analysis of HFCA and InterStudy data, supplemented by staff research.

C. Characteristics of Medicaid-Dominated Plans

How have Medicaid-dominated plans changed since 1997?

Medicaid-dominated plans were still smaller than other plans in 1999, but they had grown since 1997. Total enrollment in all full-risk plans also grew during this period; however, total enrollment in Medicaid-dominated plans grew more. In 1997, 15 percent of Medicaid-dominated plans and 70 percent of other plans serving Medicaid had more than 50,000 total enrollees. In 1999, the figures grew to 26 percent and 73 percent, respectively (Table 4).

Since 1997, Medicaid-dominated plans also have matured. More than half (58 percent) of Medicaid-dominated plans were less than 3 years old in 1997, but in 1999, only about a third (38 percent) were so young.

Hospitals increased their ownership of Medicaid-dominated plans from 1997 through 1999 (Table 5). The number of plans owned by hospitals has increased by 14, to 45 plans in 1999. Five of the new hospital plans are owned at least in part by academic medical centers. The number of Medicaid-dominated plans owned at least in part by physician organizations rose slightly as did the number of government-owned plans, while the number of plans owned at least in part by a federally qualified health center (FQHC) remained similar.[12]

[12] Four of the FQHC-owned plans in 1997 were no longer operating as Medicaid-dominated plans in 1999. Two of the plans went out of business, and two others were serving more commercial enrollees and no longer qualified as Medicaid-dominated plans. Three new Medicaid-dominated plans owned by FQHCs entered in 1998 or 1999.

Table 4

Characteristics of Medicaid-Dominated Plans and Other Plans, 1997 and 1999

	Medicaid-Dominated Plans		Other Plans Serving Medicaid		All Full-Risk Plans	
	1997	1999	1997	1999	1997	1999
Number of Plans	118	135	221	181	709	668
			Percent Distribution			
Total Enrollment						
<24,999	59%	52%	19%	14%	37%	34%
25–49,000	26	22	11	13	19	16
50,000 or more	15	26	70	73	44	50
Total Medicaid Enrollment						
<20,000	50	46	60	54	79	77
20,000 or more	50	54	40	46	21	23
Profit Status						
For Profit	37	35	63	63	69	68
Not for Profit	63	65	37	37	31	32
Age in 1999						
<3 years	58	38	12	13	26	24
>= 3 years	42	62	88	87	74	76

Source: MPR analysis from InterStudy and HCFA data, supplemented by staff research.

Similar to 1997, Medicaid-dominated plans in 1999 tended to enroll higher numbers of beneficiaries per plan than did commercial plans serving Medicaid; a majority (54 percent) had more than 20,000 Medicaid enrollees in 1999, compared with 46 percent of other plans serving Medicaid.

What is the status of Medicaid-dominated plans that operated in 1997?

More than three-fourths of Medicaid-dominated plans (79 percent) continued to operate as Medicaid-dominated plans in 1999 (Table 6). Of the 25 plans that no longer operated as Medicaid-dominated plans in 1999, 11 continued to operate with more commercial enrollment (Medicaid enrollees no longer make up 75 percent of their total enrollment), and 14 plans were no longer in business. While the majority of plans that continued as Medicaid-dominated plans increased their total enrollment, 17 plans experienced a reduction of more than 5 percent.

D. Health Plan Performance on Selected HEDIS®[13] Quality and Access Measures

Knowing more about the quality of care and access for Medicaid beneficiaries in various types of health plans would help to interpret the shifts in types of plans serving Medicaid, and the patterns

[13] HEDIS is a registered trademark of the National Committee for Quality Assurance.

Table 5

Ownership of Medicaid-Dominated Plans, 1997 and 1999

	Number in 1997	Number in 1999	Percent of all Medicaid-Dominated in 1997	Percent in 1999
Total Medicaid-Dominated Plans	118	135	100%	100%
PROVIDER-BASED PLANS	60	74	51%	55%
Hospitals	31	45		
Academic Medical Centers	11	16		
Federally Qualified Health Centers	24	23		
Physician Organizations	16	19		
OTHER MANAGED CARE FIRMS	33	34	28%	25%
Independent	22	24		
Affiliated with a Multi-State Managed Care Firm	11	10		
Amerigroup	3	4		
Americhoice/Managed Health Care Systems	2	2		
Genesis	2	2		
Medical Care Management Co.	2	1		
Managed Health Services Industry Corp.	2	1		
GOVERNMENT PLANS	19	22	16%	16%
County Organized Health System (CA)	5			
County Government – Other (CA)	8			
County Government – States other than CA	5	8		
State Government	1			
OTHER/NOT CLASSIFIED	14	11	12%	8%

Note: Percentages do not add up to 100% because a few plans include multiple types of owners. Similarly, because many plans were not owned by partnerships or coalitions of different types of providers, the number of each type of provider-based plan do not add to the total number of provider-based plans.

Source: MPR staff research

of entry and exit described above. But national data on quality and access for the Medicaid population by health plan have been scarce to non-existent in the past (Felt-Lisk 2000).

While still being refined over time, the National Medicaid HEDIS Database offers the first opportunity to compare the performance of different types of Medicaid-serving plans on selected quality of care and access indicators.

Our approach to this analysis and data limitations are described more fully in Appendix B. The quality and access indicators we use are 9 of the 11 measures reported as benchmarks by the American Public Human Services Association (APHSA) for 1997 data, and the two measures added for benchmarking in 1998.[14] Table 7 lists our short titles for the indicators (used in the

[14] We chose not to include two benchmark indicators that would otherwise have been available, because we viewed them as less easily interpreted: Inpatient utilization—general hospital/acute care, and ambulatory care-emergency room visits.

Table 6

Status of 1997 Medicaid-Dominated Plans, in 1999

	Number of Plans	Percent
Total number of Plans in 1997	118	100%
Continued to Operate as Medicaid-Dominated in 1999		
Yes	93	79
No	25	21
In business, but not as a Medicaid-dominated plan	11	9
Out of business	14	12
Change In Enrollment For Those That Continued To Operate		
Decrease <5%	17	14
Little Change (-5% to +5%)	11	9
Increase >5%	65	55

Source: MPR analysis of HCFA and InterStudy data, supplemented by staff research.

tables that follow) with a description of what is being measured. The benchmark indicators were selected by a project steering committee organized by APHSA; they were the HEDIS indicators with sufficient submissions from health plans to permit analysis for the Medicaid population.

Table 7

Description of Measures Used in Analysis

Measure	Description
Childhood immunization status	Percentage of children who reached age 2 in the reporting year who received all of the following immunizations: 4 DTP or DTaP; 3 OPV or IPV; 1 MMR; 2 Hib; 2 Hep B
Adolescent immunization status	Percentage of children who turned 13 in the reporting year who received the recommended second MMR immunization
Cervical cancer screening	Percentage of women age 21 through 64 years who received one or more Papanicolaou tests during the past 3 years
Checkup after delivery	Percentage of women who had a postpartum visit 3 to 8 weeks after delivery
Eye exams for people with diabetes	Percentage of members age 31 years or older with diabetes who receive a retinal eye exam in the reporting year
Children's access to primary care providers Ages 12 to 24 months Ages 25 months to 6 years Ages 7 to 11 years	Percentage of children who saw a primary care provider during the year
Well child visits	Percentage of children aged 3-6 years who received one or more well child visits with a primary care provider during the year
Prenatal care in first trimester	Percentage of women who delivered a live birth during the reporting years and had a prenatal care visit 26-44 weeks prior to delivery
Adolescent well care visits	Percentage of members aged 12–21 years who had at least one well care visit with a primary care provider during the year

The benchmark indicators focus largely on preventive services and on women and children. In the future, it will be important to add indicators of chronic care as these data become more available. Of note, we describe one group as different from another if the indicators for the two plans show that at least 5 percent more or 5 percent fewer Medicaid beneficiaries received the service appropriately (as defined by the indicator), across several indicators.

Are there consistent patterns of better and worse performance for different groups of Medicaid-serving plans?

Medicaid-dominated plans and commercial plans did not differ on a majority of the 11 indicators (Table 8). However, commercial plans outperformed Medicaid-dominated plans on four indicators-two of which measured children's access to primary care providers and two of which measured obstetrical access or service. Also:

- Nonprofit plans serving Medicaid performed better than for-profit plans (9 of the 11 indicators reviewed)
- Plans that were operational for at least three years performed better than plans that were newer (6 of the 11 indicators).
- Plans with at least three years of Medicaid service performed better than plans new to Medicaid service, even when both had been operational for at least three years (6 of the 11 indicators).

We found no difference on a majority of indicators between larger vs. smaller plans, nor between plans with larger or smaller Medicaid enrollments.[15]

Does plan performance vary by type of ownership?

Medicaid-dominated plans owned at least in part by an FQHC performed better than other types of Medicaid-dominated plans and also better than commercial plans on 5 of the 9 indicators for which we had enough data for comparisons (Table 9). The FQHC plans' performance were particularly high relative to other plans on immunization rates, cervical cancer screening, well-child visits in the third through sixth years, and adolescent visits.

The other plan groups we reviewed did not show much difference from one another, or the pattern was inconsistent. For example:

- Provider-owned plans[16] performed substantially better than "other" Medicaid-dominated plans[17] on immunization rates and well-child visits in the third through sixth years, but performed worse than the "other" group on two measures of children's access to a primary care provider.

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[15] We also reviewed the performance data that were available for plans in 21 states that exited the Medicaid market during 1999–2000 compared with those that remained. Although the number of exiting plans with data was very limited (between 2 and 15 plans depending on the indicator), the exiting plans averaged similar or lower performance compared with those that remained in the market.

[16] Plans owned at least in part by a provider other than an FQHC.

[17] Medicaid-dominated plans at least partly owned by individuals or organizations other than FQHCs, other providers, and local governments. Most of these plans are companies formed to focus on Medicaid managed care.

Table 8

Selected HEDIS Quality and Access Indicators for Medicaid: Types of Medicaid-Serving Plans Scoring Better or Worse Based on Mean Values

	Immunizations		Children's Well-Child Visits and Access					Other Measures			
					Children's Access to a PCP						
	Childhood Immunization Rate (Combo 1)	Adolescent Immunization Rate (MMR)	Visits in 3rd thru 6th yrs	Adolescent Visits	12-24 mos	25 mos 6 yrs	7-11 yrs	Cervical Cancer Screening	Eye exams for Diabetes	Prenatal Care in 1st Trimester	Check-ups After Delivery
Medicaid-Dominated plans	O	O	O	O	–	O	–	O	O	–	–
Other Medicaid-serving plans	O	O	O	O	+	0	+	O	O	+	+
Non-profit	+	+	+	+	+	+	+	+	O	O	+
For profit	–	–	–	–	–	–	–	–	O	O	–
New plans since 1995	–	O	–	–	O	O	–	–	O	O	–
Not new since 1995	+	O	+	+	O	O	+	+	O	O	+
Larger plans (>100K total members)	+	+	O	O	O	O	O	O	O	O	O
Smaller plans (< l00K total members)	–	–	O	O	O	O	O	O	O	O	O
Plans new to Medicaid (that are 3 or more years of age)	–	–	–	–	O	O	O	–	–	O	O
Plans not new to Medicaid (that are 3 or more years of age)	+	+	+	+	O	O	O	+	+	O	O
Plans with >20,000 Medicaid enrollees	O	O	O	O	O	O	O	O	O	O	O
Plans with <20,000 Medicaid enrollees	O	O	O	O	O	O	O	O	O	O	O

Note: Mean values were roughly similar to median values; comparing medians rather than means would not change the patterns shown here.

+ = Rate that is at least 5 percentage points above comparison group rate
o = Between 5 percentage points above and 5 below comparison group rate
– = Rate at least 5 percentage points below comparison group's rate

Table 9

Selected HEDIS Quality and Access Indicators for Medicaid: Plan Performance by Ownership Type

See Table 7 for an explanation of each measure.

		Medicaid-Dominated Plans				Other Medicaid-Serving Plans	
	All	FQHC-Owned	Other Provider-Owned	Local Gov't Plans	Other Medicaid-Dominated	All	Large and affiliated with a national MCO firm or BCBS
Immunizations							
Childhood immunization rate (Combo 1)	56%	61%	58%	56%	51%	56%	57%
Adolescent immunization rate (MMR)	46	54	47	NR	31	49	52
Children's Well-Child Visits and Access							
Visits in 3rd thru 6th years	54	67	55	56	50	52	50
Adolescent visits	29	40	31	25	29	27	25
Children's Access							
12–24 months	79	83	77	NR	80	86	80
25 months – 6 years	71	75	68	NR	73	76	72
7–11 years	71	70	68	NR	77	78	75
Other Measures							
Cervical Cancer Screening	63	71	61	NR	66	61	65
Eye Exams for Diabetes	41	NR	37	44	40	38	39
Prenatal Care in First Trimester	56	NR	49	59	58	62	65
Check-ups after Delivery	42	44	42	49	40	51	52

Note: Numbers are not reported for cells with 5 or fewer plans (marked NR).

- Commercial plans that were large and affiliated with a national managed care firm or BlueCross BlueShield did not perform differently from other commercial plans serving Medicaid (10 of 11 indicators).

There were too few local government-owned plans with data to compare with other groups on many of the indicators (5 of the 11). However, they performed about the same as the average for all Medicaid-dominated plans on most of the indicators for which there were enough data, and performed better than any other group of Medicaid-dominated plans on check-ups after delivery (and about the same as the commercial plans).

IV. Trends in Health Plans Serving Medicaid: Data for High-Volume Medicaid Managed Care States Through June 2000

A. Entries and Exits: Have the Trends and Patterns Continued?

In order to provide more timely and relevant information, we obtained data from state Medicaid agencies to assess commercial plan participation trends through June 2000 in 21 states with high Medicaid managed care enrollment.[18] Data were collected from Arizona, California, Connecticut, Florida, Hawaii, Illinois, Kentucky, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Washington, and Wisconsin. In 1999, these states accounted for 89 percent of full-risk Medicaid enrollment nationally.

Have commercial plans continued to exit the Medicaid market at a similar pace?

The exits by commercial plans slowed somewhat in both 1999 and 2000 in the 21 high-volume Medicaid managed care states, relative to the peak period during 1997–1998. Twelve percent and 10 percent of participating commercial plans exited in 1999 and 2000, respectively, compared with 16 percent to 17 percent during 1997 and 1998 (Table 10).

However, entries by commercial plans dropped to near zero in these states in 2000 (only two commercial plans entered the Medicaid market in these states in 2000). The downward trend in entries since 1996 and the trend in exits have resulted in a continuing downward trend in the number of commercial plans participating in Medicaid since 1997 in these states: 22 percent fewer commercial plans participated in 2000 compared with 1997.

Have the roles of commercial and Medicaid-dominated plans continued to shift?

Commercial plans continued to play a critical role in Medicaid managed care in these states in 2000, serving more than half the enrollees. However, the share of enrollment in commercial plans has continued to decline slightly in these states.

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[18] The 20 highest-volume Medicaid managed care states were selected as those with the highest enrollment in full-risk Medicaid managed care based on our first runs of the HCFA Medicaid managed care enrollment data for 1999. We added the 21st state so this set would include all of the 15 states for which similar data were collected for June 1998 under a previous project.

Table 10

Trends in Commercial Plan Participation in 21 High-Volume Medicaid Managed Care States, 1996–2000

	1996	1997	1998	1999	2000
Participating Plans					
Number of commercial plans participating	161	163	149	137	127
Percentage of participating plans that exited since prior year	7	17	16	12	10
Percentage change in number of participating plans (including exits and entries)	+21	+1	-9	-8	-7
Enrollees					
Number of Medicaid enrollees served by commercial plans ('000s)	4,345	5,383	5,546	5,803	5,748
Percentage of Medicaid enrollees served by commercial plans	63	63	57	56	54

B. A Closer Look: Effects of Exit Trends at the County Level

Using county-level data, we can examine several issues that offer additional insight on the previous analysis at the state level. Issues include (1) health plan "retreats"—the extent to which health plans are retreating from certain counties rather than exiting an entire state Medicaid market (which is what we measured in the state-level analysis); (2) types and numbers of health plans that remain as options for beneficiaries at the county level; and (3) characteristics of counties most affected by health plan exits.

This analysis was designed to use the 1998 county-level enrollment data by health plan that we had previously collected from 15 state Medicaid agencies, as well as the year 2000 data for those states that was collected under the current project. A few states were ultimately excluded due to data issues or unique program features, leaving the following 12 states whose counties' data are analyzed below: Arizona, Connecticut, Florida, Michigan, New Jersey, New York, Ohio, Oregon, Pennsylvania, Tennessee, Washington, and Wisconsin.[19] These 12 states included just over half of Medicaid enrollees in full-risk Medicaid managed care in 1999.

To what extent are health plans retreating from certain counties rather than exiting an entire state's Medicaid program?

Many more health plans retreated from Medicaid service in one or more counties than the number that withdrew from an entire state's Medicaid program. Just over one-fourth of health plans in the 12 states retreated from Medicaid in one or more counties, while another 15 percent

[19] California was excluded due to its unique program structure, which varies by county; Missouri because its enrollment data were available only by region, not by county; and Illinois because its Medicaid managed care program operates in only one county. New York City data were not included in the New York State analysis because they were not available by county (borrough).

exited the Medicaid market for the state entirely (Table 11). In 5 of the 12 states, at least half the plans that served Medicaid beneficiaries in 1998 either exited or retreated from the Medicaid market by mid-2000 (Ohio, Oregon, Tennessee, Washington, and Wisconsin).

Table 11

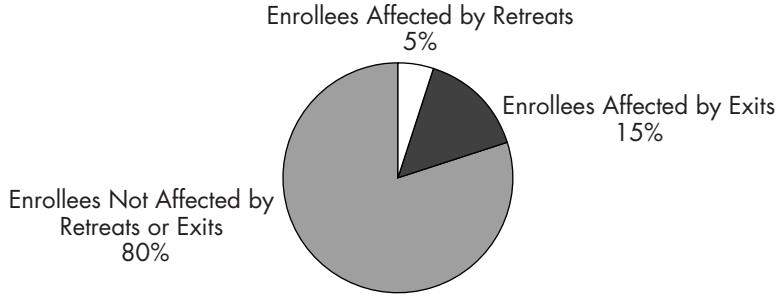
Plan Retreats and Exits from the Medicaid Market 1998-2000 (12 High-Volume Medicaid Managed Care States)

State	Total Number of Plans Participating in 1998	Percentage of Plans that Exited from State Medicaid Market	Percentage of Plans that Retreated from Medicaid in One or More Counties	Percentage of Participating Plans That Exited or Retreated
Total	174	15%	26%	41%
AZ	11	18	0	18
CT	7	43	0	43
FL	15	13	27	40
MI	20	5	30	35
NJ	10	40	0	40
NY	37	11	5	16
OH	13	23	46	69
OR	13	0	54	54
PA	9	0	22	22
TN	9	11	56	67
WA	12	33	33	66
WI	18	11	50	61

Source: MPR analysis of county-level enrollment data by plan, obtained from state Medicaid agencies.

Plans retreating selectively from counties affected fewer Medicaid enrollees relative to the full-scale exits from state programs. Only about 5 percent of these states' enrollees were affected by the retreats, whereas about 15 percent were affected by full-scale exits (Figure 7). In all, about

Figure 7: Enrollees Affected by Plan Retreats and Exit 1998–2000 (12 High Volume Medicaid Managed Care States)



Source: MPR analysis of Medicaid enrollment data by plan, by county obtained from state Medicaid agencies.
Note: For this analysis, a plan "retreats" when it exits the Medicaid market in one or more counties but remains in the Medicaid market elsewhere. It exits the Medicaid market of the entire state.

932,000 (or 20 percent) of the 4.6 million beneficiaries in Medicaid managed care in these states in 1998 may have been affected by plan exits or retreats.[20]

Health plans that chose to retreat rather than fully exit from Medicaid were more often nonprofit and not affiliated with a national managed care firm (Table 12). Both retreating and exiting plans were predominantly commercial plans.

Table 12

Characteristics of Plans that Retreated from the Medicaid Market During 1998–2000 (12 High-Volume Medicaid Managed Care States)

	Plans Exiting from State Medicaid Market		Plans Retreating from Medicaid in One or More Counties		Plans that did not Retreat or Exit	
	Number	Percent	Number	Percent	Number	Percent
Role of Medicaid						
Commercial-Based	19	73%	32	71%	44	54%
Medicaid-Dominated	7	27	13	29	37	46
Size and Affiliation[a]						
Large & Affiliated	8	31	5	11	11	14
Small & Affiliated	6	23	4	9	6	7
BCBS	1	4	4	9	6	7
Unaffiliated	11	42	32	71	58	72
Profit Status						
For Profit	18	69	24	53	34	42
Not-for-Profit	8	31	21	47	46	57
Missing					1	1
Total	26	100	45	100	81	100

Note: Numbers may not add up to 100 due to rounding.

Source: MPR analysis of data from HCFA and InterStudy, supplemented by staff research. Plans retreating from one or more counties were identified using county-level enrollment data by plan, obtained from state Medicaid agencies.

[a] *Affiliation indicates affiliation with a national managed care firm.*

What health plan choices remained for beneficiaries in 2000?

The retreats and exits did not appear to have eliminated many counties from state Medicaid managed care programs altogether. Only 3 percent of counties with full-risk Medicaid managed care enrollment in 1998 lost all full-risk activity by mid-2000 (11 counties in four states). Medicaid managed care enrollment in these counties had been low to begin with: less than 2 percent of each of these four states' 1998 enrollment were affected by the retreats and exits of all plans from these 11 counties.

[20] This figure counts twice enrollees who may have been affected by exits or retreats twice during this time period. That is, if an enrollee's plan exited and they joined a second plan that exited the following year, our aggregate enrollment data would count two individuals affected by the plan exits.

In fact, most beneficiaries still had a choice of health plans in 2000. However, 18 percent of counties had only one plan serving Medicaid (Table 13). The full-risk Medicaid managed care programs in these single-plan counties were by and large voluntary, so that Medicaid beneficiaries could opt to participate in a primary care case management program or select a physician under fee-for-service Medicaid if they did not choose to enroll in the one participating health plan.[21]

Table 13

Beneficiary Choice of Plans in 2000 (12 High-Volume Medicaid Managed Care States)

State	Total Number of Counties in Program in 2000	Percentage of Counties with Only One Plan in 2000	Percentage of Counties with Two or More Choices in 2000		
			Medicaid-Dominated Only	Commercial Only	Both
Total	496	18%	11%	19%	52%
AZ	15	0	13	0	87
CT	8	0	0	0	100
FL	45	42	0	47	11
MI	81	5	39	0	56
NJ	21	0	0	0	100
NY	41	39	0	10	51
OH	13	54	15	15	15
OR	32	41	28	3	28
PA	38	18	26	0	55
TN	95	0	0	0	100
WA	39	15	0	85	0
WI	68	24	0	49	27

Source: MPR analysis of Medicaid enrollment data by county and plan, obtained from state Medicaid agencies. Medicaid-Dominated or commercial plan status was based on MPR's analysis of HCFA and InterStudy data, supplemented by staff research.

About two-thirds of those counties offering beneficiaries a choice of two or more plans also offered a choice between at least one Medicaid-dominated and at least one commercial plan. About one-third did not: 19 percent of these counties offered only commercial plans, and 11 percent offered only Medicaid-dominated plans.

Were the characteristics of counties most affected by health plan retreats and exits different from other counties?[22]

We did not find any difference between those counties affected by health plan retreats and exits, and other counties. Counties that lost plan participation were no more likely than other counties to be health professional shortage areas (federal HPSA designation), rural, relatively poor and/or

[21] Oregon appeared to be an exception; our data show enrollment to be mandatory in 11 of its counties with only one participating plan.

[22] This analysis uses the 1997 Area Resource File along with our other data to analyze the following county characteristics: health professional shortage area designation, rural (non-MSA), the percentage of the county population that was nonwhite, and the percentage below the federal poverty level.

to have more non-white residents. This was true even in those states where a large proportion of the counties experienced losses of plans in 1998–2000 rather than a stable or growing number of plans.

Similarly, counties that had stable plan participation or gained plans between mid-1998 and mid-2000 had similar characteristics to other counties.

C. Financial Status of Medicaid-Only Plans

This analysis examines the financial status of Medicaid-only plans[23] over three years, 1997 through 1999, and compares it with the financial status of commercial plans. In addition, the financial status of Medicaid-only plans is analyzed based on plan characteristics.

We requested 1998 and 1999 audited financial statements from 12 of the 13 state Medicaid agencies and insurance departments that had provided 1997 data for the study that preceded this one. We received at least some data from 11 states, for 77 of the 86 plans in these states that were Medicaid-only from 1997 through 1999.[24] Thus, this analysis contains data for 63 plans in 1997, 59 plans in 1998, and 62 plans in 1999. We obtained three years of data for 43 of the plans. We also obtained comparative financial indicators for commercial plans from InterStudy.

There are two main financial indicators used in this analysis. Total margin (net income/total revenue) is a measure of the overall profitability of the MCO. Higher values are favorable. The administrative expense ratio (administrative expense/operating revenue) indicates the proportion of plans' operating revenue spent on administration. It is an indicator of efficiency in executing the plans' medical management strategies. Lower values are generally desirable from a financial perspective. However, lower values may not always be desirable from a long-term financial perspective if the administrative costs are incurred for quality improvement activities or to invest in infrastructure to improve management. See Robinson 1997 for a discussion of the limitations of using the medical loss ratio, and, by extension, the administrative expense ratio used here. We used medians rather than averages to express financial indicators across groupings because they are less sensitive to extreme values.

What is the financial status of Medicaid-only plans in 1999?

From the limited measures available, the Medicaid-only plans in the 11 states studied seem to be surviving well in 1999:

- Medicaid-only plans generally had modest positive total margins in 1999. The median total margin was 2.4 percent (Table 14). However, 15 of the 62 plans (24 percent) lost money in 1999.

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[23] Medicaid-only plans are defined as full risk plans in which Medicaid enrollment makes up at least 90 percent of total enrollment. We narrowed our focus to Medicaid-only plans for this analysis because the Medicaid program is clearly a strong driver of these plans' financial well-being, and we did not trust the accuracy of accounting practices that break out Medicaid profitability from other lines of business.

[24] Connecticut was not able to provide financial statements, but this had a minimal effect on our analysis because only 2 Connecticut plans qualified as a Medicaid-only plans in 1998 or 1999.

- Only 1 of the 62 plans in 1999 was classified at high financial risk; only 1 plan was classified at medium financial risk. (Table 15)
- The median administrative expense ratio for plans in 1999 was roughly similar to other plans at 12.6 percent. (Table 14)

Table 14

Median Values of Selected Financial Indicators for Medicaid-Only Plans Compared with Others, by State, 1999

	Number of Plans		Total Margin		Administrative Expense as a Percentage of Revenue	
	Medicaid-Only Plans	All Other Plans	Medicaid-Only Plans	All Other Plans	Medicaid-Only Plans	All Other Plans
All 11 States	**62**	**193**	**2.4%**	**-.02%**	**12.6%**	**14.0%**
Arizona	9	8	1.6%	-0.5%	10.2%	15.4%
California	8	19	11.3%	0.6%	11.3%	13.9%
Florida	2	22	0.6%	-1.7%	33.3%	14.3%
Illinois	2	29	6.1%	0.4%	29.7%	14.3%
Missouri	3	6	0.0%	-4.1%	14.9%	14.9%
New Jersey	2	10	4.4%	0.5%	19.4%	17.2%
New York	14	33	6.0%	0.2%	19.7%	14.2%
Ohio	4	18	-4.6%	-2.3%	17.3%	12.8%
Oregon	9	4	1.0%	0.3%	9.1%	11.4%
Pennsylvania	6	17	1.1%	0.3%	12.1%	12.8%
Tennessee	3	11	0.7%	-1.9%	11.1%	13.5%

Source: MPR analysis of financial statements of Medicaid-only plans collected from state Medicaid agencies and insurance departments in 11 states. Data on commercial plans is from InterStudy.

Note: Nationally, the 1998 median values for the indicators shown are: total margin –1.7% and administrative expense as a percentage of revenue 15.0% (HCIA 1999 and InterStudy 1999). The operating margins (net income/operating revenues) were also calculated and analyzed by state. Results were very similar to total margin. Differences between total margin and operating margin are only significant in the case of "all other plans," probably because those plans may have more non-operating (mostly investment) income or loss than Medicaid-only plans.

Table 15

Number of Medicaid-Only[1] Plans by Risk Category

	1997	1998	1999
High Risk Plans[2]	6	2	1
Medium Risk Plans[3]	4	1	1
Low/No Risk Plans	53	56	60

[1] *Medicaid-only are full-risk managed care plans in which Medicaid enrollment makes up 90% or more of total enrollment.*

[2] *High Risk is defined as having (1) negative net worth or a net loss greater than net worth, (2) negative net income, and (3) current ratio less than 1.*

[3] *Medium risk are all other plans having a negative net worth.*

Source: MPR analysis of financial statements of Medicaid-only plans collected from state Medicaid agencies and insurance departments.

Table 16 shows the financial indicators for Medicaid-only plans by type of ownership. Although the numbers of plans in some categories are small, it appears that for-profit plans were more profitable than not-for-profit plans, although they have higher administrative expense ratios. Also, not surprisingly given start-up cost issues, plans at least 3 years old were more profitable than newer plans.

Table 16

Median Values of Selected Financial Indicators of Medicaid-Only Plans by Plan Characteristics, 1999

	# of Plans	Administrative Total Margin	Expense Ratio
Profit Status:			
For Profit	18	2.6%	17.1%
Not-for-Profit	44	1.5	11.6
Total Enrollment:			
<24,999	33	1.2	14.9
25,000–49,999	12	4.0	11.3
50,000–99,999	12	2.5	12.2
100,000 or more	5	1.8	11.1
AGE:			
Under 3 years	13	0.9	14.9
3 years or older	49	2.6	12.6
Ownership:			
Provider	34	2.4	12.9
Hospital	19	2.5	10.7
AMC	6	-1.3	10.8
FQHC	15	3.2	19.7
Physician Org.	10	1.1	12.6
Other Managed Care Firm	15	2.7	15.4
Government Plan	12	4.3	11.2

Source: MPR analysis of financial statements of Medicaid-only plans, collected from state Medicaid agencies and insurance departments. Characteristics of plans from InterStudy, HCFA, and supplemented by staff research.

How does the 1999 financial status of Medicaid-only plans compare to previous years?

Medicaid-only plans were financially stronger in 1999 than in 1997 or 1998.

- Fewer plans were at medium or high risk in 1999 than in previous years. In 1999, only 3 percent of plans were at medium or high risk compared with 16 percent of plans in 1997 and 5 percent in 1998 (Table 15).
- Median total margins improved over the three years. The median total margins in 1997–1999 were -0.2 percent, 1.0 percent, and 2.4 percent respectively.
- A smaller percentage of plans lost money in 1999 than in 1997 or 1998. 24 percent of plans lost money in 1999 compared with 48 percent in 1997 and 34 percent in 1998.

- The administrative expense ratios of Medicaid-only plans improved from 16.1 percent in 1997 to 12.6 percent in 1999.

The 43 Medicaid-only plans for which we had data for all three years improved their median total margins and median administrative expense ratios during the three-year timeframe (Table 17).

Table 17

Median Financial Indicators for the 43 Medicaid-Only Plans With Data for Three Years

	Total Margin			Administrative Expense Ratio		
Year	25th Percentile	50th Percentile	75th Percentile	25th Percentile	50th Percentile	75th Percentile
1997	-5.3%	0.1%	2.1%	11.3%	15.9%	22.6%
1998	-0.3%	1.7%	7.5%	10.0%	12.1%	20.7%
1999	0.7%	2.6%	6.3%	9.6%	12.6%	19.4%

Source: MPR analysis of financial statements of Medicaid-only plans collected from state Medicaid agencies and insurance departments.

Also, the 1997 plans that survived improved financially over time (Table 18). Six plans were classified at high financial risk in 1997. In 1999, four of these six plans were operating at low/no financial risk. The four plans previously classified at medium risk were all classified at low/no risk in 1999. Three Medicaid-only plans operating in 1997 were no longer in business in 1999. These plans were not classified as high risk in earlier years.

Table 18

Analysis of the 1997 Medicaid-Only Cohort Number of Plans by Financial Status in 1999

1997 Classification (Number of Medicaid-Only Plans)	Medicaid-Only Plan in 1999			No Longer a Medicaid-only Plan in 1999			Missing Enrollment or Financial Data for 1999
	High Risk	Medium Risk	Low/No Risk	Still in Operation	Operating Under New Ownership	No Longer in Business	
High Risk (6)	0	1	4	0	1	0	0
Medium Risk (4)	0	0	4	0	0	0	0
Low/No Risk (53)	0	0	39	5	1	3	5

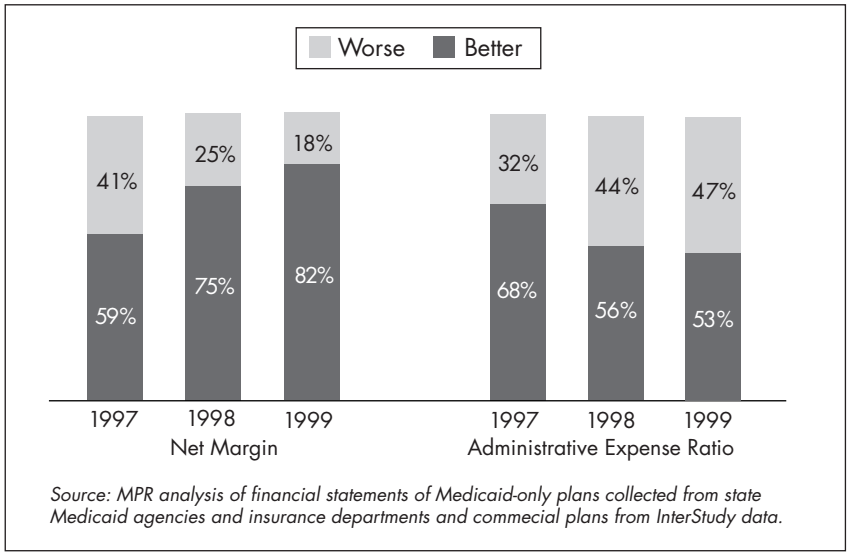
Source: MPR analysis of financial statements of Medicaid-only plans collected from state Medicaid agencies and insurance departments.

How do the Medicaid-only plans compare with commercial plans in the same state?

Medicaid-only plans had higher median total margins and lower median administrative expense ratios than their commercial counterparts in all three years. More specifically, in 10 of the 11 states analyzed in 1999, Medicaid-only plans had higher median total margins than the medians for commercial plans (Table 14).

Over the three-year time frame, Medicaid-only plans were increasingly earning higher total margins than the median total margin of commercial plans in the same state. In 1997, 59 percent of Medicaid-only plans were earning higher total margins than commercial plans. In 1999, the figure grew to 82 percent (Figure 8).

Figure 8: Percent of Medicaid-Only Plans Faring Better or Worse Than the median for Commercial Plans in the Same State



Source: MPR analysis of financial statements of Medicaid-only plans collected from state Medicaid agencies and insurance departments and commecial plans from InterStudy data.

While Medicaid-only plans had lower administrative expense ratios than commercial plans in the same state during the three years, the gap was closing on this measure each year. In 1997, 68 percent of plans had lower administrative expense ratios than commercial plans; this figure dropped to 56 and 53 percent in 1998 and 1999, respectively (Figure 8).

V. Key Findings and Discussion

Commercial plan exits from the Medicaid market that began in substantial numbers in 1997 continued through 1999 at a similar pace. They may have slowed slightly by mid-2000.

From 1997 through 1999, the pattern of exits by commercial plans from the Medicaid managed care market changed from one that was concentrated in a few states and a few national MCOs to a national phenomenon that was widespread across firms and that bypassed only a few states. After a period of expansion into new state Medicaid markets, many health plans may have reconsidered the wisdom of their expansions after poor financial performance in 1997. In contrast to 1997, many of the firms that withdrew from Medicaid in 1998 and 1999 ceased commercial business in the state as well, either because the firms merged or were acquired (most common), or because they went out of business altogether. This points to the close link between Medicaid service and overall health plan strategy.

The slowing of commercial plan exits in 1999 and 2000 in the 21 high-volume Medicaid managed care states is potentially encouraging. Perhaps states' Medicaid agencies have responded to the turmoil that the exit trends have caused by increasing payment rates. Such increases, combined with the more conservative overall approach to expansion that health plans have adopted, and more accumulated experience serving the Medicaid population may mean that commercial plan participation in Medicaid can soon stabilize, at least in many areas.[25] The higher volume of enrollees per plan served by the remaining plans may also make continued participation more attractive from a business perspective.

On the other hand, the slowed exits in 2000 might indicate a pause in a trend that will continue rather than a change in that trend. Many of the remaining commercial plans may be tenuous participants, simply holding a decision to exit to see whether payment increases that states have made signal future behavior or are a one-time act.

About 1.2 million beneficiaries faced short-term disruptions from the commercial plan exits from 1997 through 1999, but commercial plans remain a core part of Medicaid managed care.

About 1.2 million enrollees of commercial health plans that exited from 1997 through 1999, at a minimum, faced the burden of selecting a new health plan option and may have had to change providers and/or interrupt treatment plans. Roughly 600,000 additional beneficiaries were enrolled in commercial plans that consolidated with a different plan that served Medicaid; we cannot assess whether the transitions in such cases were seamless or not.

While recognizing the burdens of short-term disruption, we also found that commercial plans continue to serve a majority of full-risk Medicaid managed care enrollees. They also remain an option for beneficiaries in most counties in the states for which we had county-level data. Commercial plans serving Medicaid in 1999 more often had larger Medicaid enrollments than those in the market in 1997. Despite the exits, very few counties had been left with no health plans to serve Medicaid, and counties most affected by exits did not appear to differ from other counties. For example, they did not tend to be more rural, have higher levels of poverty, or have a higher percentage of the population with minority ethnic or racial backgrounds.

Medicaid-dominated plans are gradually playing a greater role in the Medicaid managed care marketplace.

Medicaid-dominated plans have gradually grown in number and have begun serving a larger proportion of Medicaid managed care enrollees. However, their role still varies widely by state; they serve a majority of enrollees in 11 states, but fewer than 30 percent of enrollees in 17 other states. Two concerns about Medicaid-dominated plans have been their financial stability and whether they provide high-quality care. Although the results here cannot lay these issues to rest, they do not sound any alarms on either issue.

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[25] However, even under this scenario, major changes to state programs, such as adding disabled beneficiaries to a mandatory program or moving to a regional bidding approach that dictates plan service areas for Medicaid, could lead to exit trends again increasing.

Medicaid-dominated plans will always be inherently vulnerable, because of their small size and predominant reliance on a single payer. Twelve percent of the plans that were Medicaid-dominated in 1997 had gone out of business by 1999. However, this does not seem an unusually high rate given that nearly 60 percent of the Medicaid-dominated plans in 1997 had operated for less than three years. New businesses tend to have a high failure rate across all economic sectors. Further, the Medicaid-dominated plans that survived generally had grown in both enrollment and financial strength from 1997 through 1999. They typically had achieved a financial margin at least at the level of other plans in their states.

In a first comparison of Medicaid-dominated and commercial plans' performance on selected HEDIS measures for the Medicaid population, Medicaid-dominated plans did not differ from commercial plans on most of the indicators reviewed. The indicators available for study focused on preventive services and on women and children. It will be important to repeat such analysis with more and better data in the future and for such analysis to cover care across a broader population and spectrum of care (including chronic illness and disability), particularly as more elderly and disabled medicaid enrollees are moved into managed care.

References

Felt-Lisk, Suzanne. *The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation*. May 1999. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

Felt-Lisk, Suzanne. *The Characteristics and Roles of Medicaid-Dominated Managed Care Plans. February 2000.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

Felt-Lisk, Suzanne. "Monitoring Quality in Medicaid Managed Care: Accomplishments and Challenges at the Year 2000." *Journal of Urban Health,* Vol. 77, No. 4, December 2000, pp. 536–559.

HCIA-Sachs. *Profiles of US Hospitals 2001.* 2000. Baltimore, MD: HCIA-Sachs, L.L.C.

Hurley, R. and M. McCue. *Medicaid and Commercial HMOs: An At-Risk Relationship.* 1998. Princeton, NJ: Center for Health Care Strategies, Inc.

Moreno, Lorenzo, Sheila D. Hoag, Leslie Foster, and Carol Razafindrakoto. *HMO Characteristics and the Experiences of Medicaid Beneficiaries: An Analysis from Four States*. 2001. Princeton, NJ: Mathematica Policy Research.

Robinson, James. "Use and Abuse of the Medical Loss Ratio to Measure Plan Performance." *Health Affairs,* Vol. 16, No. 4, July/August 1997.

Sloan, F., J. Mitchell, and J. Cromwell. "Physician Participation in State Medicaid Programs." *The Journal of Human Resources* 13 (Supplement): 211–245, 1978.

APPENDIX A

Appendix A: About the Data

The dataset used in this analysis was developed by Mathematica Policy Research, Inc. The Henry J. Kaiser Family Foundation (KFF) funded the addition of 1998 and 1999 national data and year 2000 data for 21 states that was used here. This update built on the dataset created under two earlier projects. The database was first created under a project sponsored by the Center for Studying Health System Change, that used 1993–1996 data. It was then enhanced with funding from KFF to include 1997 national data and 1998 data from 15 states.

Overview of the Creation of the Database. To develop and update the database, we have merged HCFA data on full-risk Medicaid enrollment by plan for June 30 of each year from 1993 to 1999 with HMO industry data on total enrollment and plan characteristics. HMO industry data from 1993–1995 were from the Group Health Association of America's (now the American Association of Health Plans) annual HMO directory, and the data for 1996–1999 were from InterStudy HMO directories 6.2, 8.1, 9.1, and 10.1, respectively. The merge process required matching plans that are listed by different names in the HCFA and industry sources, as well as matching new data to older data. We drew on information from other researchers, called some state Medicaid offices, asked some state HMO associations, and sometimes called individual plans to clarify ambiguities and supplement available information. Partially capitated plans, and plans that do not provide comprehensive medical services (e.g., behavioral health and dental managed care plans) were excluded from the database.

Of note, we used the following rule for combining plans' data over time. If a plan was acquired by or merged with another plan that was already in the state's market, we do nothing, since the old plan's data are contained in the acquiring plan's data after the acquisition. The number of plans in the state's market will thus drop by one. If, however, a plan is acquired by another plan that was not previously in the state's market, we label the old plan's data under the name of the acquiring plan, and change the old plan's characteristics to those of the acquiring plan. Therefore, we show no change in the number of plans in the market for those situations. Also, we combine multiple plans in the same state that have the same executive leadership, even if they are listed separately in InterStudy. We are uncertain whether such plans are organizationally distinct, and did not want findings of change to be driven by health plan decisions to report on a decentralized or centralized basis. Thus, our dataset is well-suited to study trends in health plans serving Medicaid, but is not particularly well-suited to studying the extent of organizational change in the broader health plan market.

Some of the numbers published in this brief differ slightly from similar numbers published in earlier briefs, although the differences are not large enough to affect the themes presented in the earlier reports. There are three primary reasons for the differences. First, although we have performed many checks in the course of each project that has developed and used this database, some errors remained that were addressed in subsequent rounds of analysis. Some errors still undoubtedly remain. Second, in a few cases, a plan's consolidated reporting of enrollment data for one year (e.g., across multiple states) required us to combine the data for two plans for other years to avoid false identification of change. Third, we were more consistent this year about consolidating (for each year in the database) multiple plan listings in a single state that had the same ownership and leadership.

Enrollment Data Collected from States. The year 2000 data for 21 high-volume Medicaid managed care states were provided by the state Medicaid agencies of those states. The month for which the data were provided differed slightly but were most often June 2000 (the month requested). In the county-level analysis, we also used similar data collected for 15 states under the previous study for KFF for mid-1998 (the 15 states for which we have data for 1998 are a subset of the 21 states for which we collected the year 2000 data). In the analysis, we used plan characteristics from 1999 because year 2000 data were not yet available.

Other Data Sources Used. Other data sources used in this report are:

- *Financial data from states and InterStudy.* For Medicaid-only plans, we extracted key data from annual, audited financial statements obtained from state insurance departments or Medicaid agencies. Our analysis combined data collected similarly for calendar year 1997 with data collected under this study for 1998 and 1999. Comparison data were calculated by using an extract from InterStudy's Med/Ops database for each year; the original source is annual insurance filings by health plans.
- *County characteristics.* County characteristics were identified using the 1997 Area Resource File.
- *Quality and access data.* Data on HEDIS measures of effectiveness of care and access to care were provided by NCQA at the aggregate level based on our specifications.

APPENDIX B

Appendix B: Additional Notes on Methodology for Analysis of Health Plan Performance

This appendix provides more detail about the methods used in the report to analyze health plans' performance on selected HEDIS effectiveness-of-care and access to care measures for the Medicaid population. Our objective for this analysis was to identify patterns in health plans' performance for the Medicaid population that could help to interpret the potential effects of other study findings about shifts in health plans' participation in Medicaid and the roles of various types of plans.

A. Data Sources and Approach

The national Medicaid HEDIS database, measurement year 1998, is the data source for analysis of health plans' performance on selected indicators of effectiveness of care and access to care. The database is maintained by the National Committee for Quality Assurance (NCQA) under the direction of the American Public Human Services Association (APHSA), with funding from The Commonwealth Fund.

The national Medicaid HEDIS database contains HEDIS indicators that were measured for the plans' Medicaid enrollees. Some plans self-reported these data on a voluntary basis, while others' data were obtained from state Medicaid agencies, some of which require this reporting. Also, in 1998, the measurement year that we used, some plans had had their data audited by an independent entity while others had not. The implications of these characteristics are discussed in the data limitations section below.

To conduct the analysis of quality and access indicators by plan characteristics, we needed to merge plan characteristics from the national health plan database (described in Appendix A and used throughout the report) with the plan-level HEDIS quality and access data. However, MPR did not have direct access to the national Medicaid HEDIS database, due to confidentiality constraints on release of health plan-level data. Therefore, with the permission of APHSA, we worked with NCQA to obtain aggregated data for specific groups of health plans of interest to our study issues.

First, NCQA provided us with a list of plans that reported to the Medicaid HEDIS database with data for 1998, and we matched them to plans in our database. In the process, we excluded several plans that reported to the HEDIS database but were partially capitated plans (and therefore excluded from our study). We also combined plans in several instances where multiple plans by the same plan owner reported data within the same state, but where the national health plan database includes them as a single plan in that state. Note that as a result of this matching process, the set of plans for which we analyzed these data likely differs some from the set for which other researchers including NCQA may choose to report.

Next, we provided NCQA with a request for selected statistics for the groupings of health plans of interest to the study, and a spreadsheet that identified the characteristics of interest to our analysis for each reporting plan. NCQA then provided tables of means, medians, and other percentile points (for the 10th, 25th, 75th, and 90th percentiles) for each quality and access

measure we requested, as well as the number of reporting plans for each group and measure. Data from these tables were used to prepare the report tables and to compare plan groups as described in the report text.

B. Limitation of Quality and Access Data

This analysis is intended as a first review of newly available quality and access data by type of health plan. Major data limitations, and how we accounted for them in our analysis, are described below.

1. Potential Bias from the Voluntary Nature of the Database

Since health plans serving Medicaid are not mandated to participate in the national Medicaid HEDIS database, it might be that only those plans with relatively high performance would report their data. This could lead to biased results. However, according to our data, 75 percent or more of the Medicaid-serving plans in the following states reported at least some data to the database: AZ, MD, ME, MI, NC, NE, NM, NY, OK, RI, VT, WA. We considered whether our analysis should be limited to plans in that group of states, however, a comparison of mean values on the selected indicators suggested no pattern of differences between plans in those states versus other states, so we decided to include all reporting plans.

2. Potential Bias and Imprecision from Incomplete Reporting

About half of the full-risk Medicaid-serving plans in 1998 (48 percent) reported at least some of the requested HEDIS data in 1998 and are thus able to be included in our analysis, including 56 percent of Medicaid-dominated plans and 43 percent of other Medicaid-serving plans. In addition to the plans that did not report at all, many plans that reported some data did not report complete data, so that the number of plans reporting for each indicator varied substantially. This incompleteness, along with the other data issues noted here, suggests our results are not precise figures for the groups of health plans we compare. Consequently, we do not report figures where fewer than 5 health plans reported any data, we only report as differences instances where at least 5 percent more beneficiaries benefited in one group over another, and we focus on identifying patterns consistent across several indicators. It remains possible that the patterns of plans reporting and not reporting data affected our results. Also because of this incompleteness, we were not able to analyze data by state or census region; what holds true nationally may not hold true for a particular state.

3. Audited vs. Unaudited Data

Relatively few plans' data were audited for the 1998 measurement year, so this analysis would not have been feasible using only audited data. NCQA conducted a comparison of means for the selected measures for audited and unaudited plans that showed no pattern of differences. As the number of plans with audited data increased in 1999 and is very likely to have increased again in 2000, this analysis could be repeated when those data are available to ensure that patterns remain similar with audited data.

4. Variation in the Type, Quality, and Completeness of Data Plans Use to Produce HEDIS Measures

As explained in the "National Medicaid HEDIS Database Users Guide" (NCQA August 2000), HEDIS allows plans to collect information either using administrative data, or administrative data plus paper or electronic medical records (the "hybrid method.") Administrative data used alone may underestimate rates in certain types of cases. For example, prenatal care visit timing may not be captured well if prenatal care visits are paid through a global fee for prenatal care and delivery. Plans that rely more heavily on administrative data versus other data may appear different from others due to the data collection method. We do not know whether or not some of the groups we compare in this analysis tend to use one data collection method more than another.

APPENDIX C

Appendix C: Supplementary Tables

Table 1
Commercial Plans Entering and Exiting the Medicaid Market, by State, Between July 1997 and June 1999

	Number of Commercial Plans		Number of Enrollees Affected by Exits
	Entering	Exiting	
Alabama	0	0	0
Arizona	1	1	46,300
California	1	3	268,600
Colorado	1	2	2,000
Connecticut	0	3	66,400
Delaware	0	1	13,000
District of Columbia	0	0	0
Florida	4	4	161,200
Georgia	0	1	29,400
Hawaii	1	0	0
Iowa	1	0	0
Illinois	0	2	3,300
Indiana	0	0	0
Kansas	0	3	7,900
Massachusetts	0	3	61,500
Maryland	0	2	108,000
Maine	0	0	0
Michigan	2	0	0
Minnesota	1	0	0
Missouri	0	4	33,400
Mississippi	1	2	2,000
Montana	0	0	0
Nebraska	0	0	0
New Hampshire	0	1	2,400
New Jersey	1	4	197,000
New Mexico	0	0	0
New York	1	7	53,600
Nevada	1	1	1,900
North Carolina	2	3	15,800
North Dakota	1	0	0
Ohio	0	1	15,500
Oklahoma	0	1	21,200
Oregon	1	1	11,700
Pennsylvania	0	5	117,000
Rhode Island	0	0	0
South Carolina	1	1	200
Tennessee	0	1	86,100
Texas	3	1	3,000
Utah	0	1	200
Virginia	1	1	4,500
Vermont	0	0	0
Washington	1	5	137,200
Wisconsin	0	1	10,300
West Virginia	0	0	0
Total/National	**26**	**66**	**1,480,600**

Note: States were excluded from the table if they had no commercial plans participating (KY) or no capitated program (AK, AR, ID, LA, SD, WY)

Table 2
Role of Commercial Plans in State Medicaid Managed Care Programs, by State, 1999

State[a]	Number of Full-Risk Enrollees (June 1999) (000's)	Number of Commercial Plans Participating	Percentage of Full-Risk Enrollees Served by Commercial Plans
Alabama	40	1–4	70% or more
Arizona	350	1–4	49% or less
California	2,511	10 or more	50–69%
Colorado	81	1–4	49% or less
Connecticut	230	1–4	70% or more
District of Columbia	74	1–4	49% or less
Delaware	69	1–4	70% or more
Florida	446	10 or more	70% or more
Georgia	10	0	49% or less
Hawaii	122	1–4	50–69%
Iowa	47	5–9	70% or more
Illinois	145	5–9	50–69%
Indiana	112	1–4	50–69%
Kansas	22	0	49% or less
Kentucky	159	0	49% or less
Massachusetts	142	1–4	49% or less
Maryland	348	1–4	49% or less
Michigan	669	10 or more	49% or less
Minnesota	268	5–9	70% or more
Missouri	277	5–9	50–69%
Mississippi	10	1–4	50–69%
Nebraska	28	1–4	70% or more
New Jersey	357	1–4	70% or more
New Mexico	209	1–4	70% or more
New York	630	10 or more	49% or less
Nevada	37	1–4	70% or more
North Carolina	34	1–4	70% or more
Ohio	245	5–9	50–69%
Oklahoma	98	1–4	50–69%
Oregon	287	5–9	50–69%
Pennsylvania	843	1–4	49% or less
Rhode Island	86	1–4	50–69%
Tennessee	1,313	1–4	50–69%
Texas	216	5–9	50–69%
Utah	74	1–4	70% or more
Virginia	150	5–9	70% or more
Vermont	66	1–4	70% or more
Washington	335	10 or more	70% or more
Wisconsin	186	10 or more	70% or more
West Virginia	47	1–4	70% or more
Total/National	**11,393**	**181**	**58%**

[a] *States with at least 10,000 Medicaid enrollees in full-risk plans were included in the table. AK, AR, ID, LA, ME, MT, NH, ND, SC, SD and WY were excluded.*

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