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**Commercial Health Plan Participation in Medicaid
Managed Care: An Examination of Six Markets**

Nationwide, enrollment in Medicaid managed care has increased more than five-fold in the last decade—rising from 2.7 million enrollees in 1991 to 14.3 million in 1999. This enrollment surge brought about rapid growth in the number of health plans participating in the Medicaid market, especially among commercial health plans.¹ Recent reports, however, indicate that commercial plans are leaving or curtailing their participation in Medicaid managed care (Meyer 1997; Hurley and McCue 1998; Hurley and McCue 2000). Commercial plan withdrawals are of some concern as one of the policy goals of Medicaid managed care (MMC) was to provide Medicaid enrollees with access to mainstream health care providers in order to eliminate or avoid a two-tier system of care. Managed care may also help states achieve greater quality of care.

This paper presents findings from an in-depth look at six local health care markets—Denver, Detroit, Milwaukee, Miami, New York, and Seattle. With the exception of Detroit, all of the markets experienced changes in commercial plan participation in MMC between 1997 and 1999. Most notably, four commercial plans exited the New York City MMC market, leaving only two commercial plans participating in the city's Medicaid program.

This research suggests that no single factor explains why some plans choose to participate in MMC in a particular market and some do not. Generally, a combination of factors—often, but not always, economic—determine whether a plan enters, exits, or opts not to participate. The relative importance of these factors varies from market to market. Key determinants often include the adequacy of Medicaid capitation rates; anticipated enrollment volume; plans' ability to negotiate discounted fees and utilization controls with providers in a market; the administrative costs of participating in MMC; the relative financial attractiveness of other lines of business (Medicare and commercial) in the same markets; and social or philosophic factors.

¹ For this study, we defined a commercial health plan as one in which Medicaid accounts for 50 percent or less of overall plan enrollment in the state. Other definitions of commercial plan have been used (Felt-Lisk and Yang, 1997; Hurley and McCue 1998).

Commercial plans' decision to participate in the Medicaid market largely boils down to a business decision: Does it make financial sense to enter and remain in the market? While many of the costs that enter this cost-benefit equation are driven by the condition of the overall health care market, some are not. Thus, if states are interested in keeping commercial plans participating or attracting new plans to participate in their MMC program, they should explore strategies to help stabilize the MMC market.

States should recognize, however, that several of the market-based conditions plans use to determine their participation may be beyond their control. This research presents clear evidence, however, that state efforts to ensure adequate capitation rates and stable enrollment would improve the climate for commercial plan participation in the Medicaid market.

This issue paper is organized as follows. We first describe the background and approach used to conduct the study, including site selection. This is followed by an overview of the health care characteristics of the study markets. The next section presents study findings. We conclude with a discussion of our results and recommend strategies that could be used to encourage commercial plans to participate in the Medicaid managed care market.²

BACKGROUND AND STUDY APPROACH

Although enrollment in Medicaid managed care has grown more than five-fold over the last decade, recent reports indicate that commercial plans have begun to leave or curtail their role in Medicaid managed care (Meyer 1997; Hurley and McCue 1998; Hurley and McCue 2000). One national study, for example, found that after a steady rise in participation between 1993 and 1996, commercial plans started to exit the Medicaid market with more than twice as many withdrawing from the market during 1997 compared to 1996 (Felt-Lisk and Yang 1997). A follow-up study, which focused on 15 high-volume MMC states, revealed that plan pullouts continued in 1998 (Felt-Lisk 1999). In a few instances, plan exits have been particularly widespread and several states—such as Ohio and Vermont—have been forced to return to fee-for-service Medicaid in all or selected parts of the state. Further, health plans' refusals to participate in MMC have limited some states' MMC program plans (for example, Georgia, Ohio, Kentucky, and New York).

With nearly every state having now implemented some form of MMC, commercial plan withdrawals are cause for some concern as one of the policy goals of MMC was to provide Medicaid enrollees with access to mainstream health care providers in an effort to eliminate or avoid a two-tier system of care. It was also hoped that commercial plans would promote more competition in the Medicaid managed care market. A more competitive market, the thinking was, would help states achieve greater cost savings, another goal of MMC. It may also help improve quality of care.

In this study we conducted an in-depth look at six local health care markets—Denver, Detroit, Milwaukee, Miami, New York, and Seattle—to gain a better understanding of the factors associated with the decision by commercial plans' whether to participate in MMC. We focus on local health care markets in order to capture the role that purchasers, other insurers and providers play in a plan's participation decision. Given the wide variation in local health care markets,

²For a more detailed analysis of commercial plan participation in Medicaid managed care in each of the study sites, see the full background paper by Coughlin et al., November 2000, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, Publication # 2223.

earlier studies, with their emphasis on plan participation at the state level (Felt-Lisk and Yang 1997; Hurley and McCue 1998; and Felt-Lisk 1999), cannot capture the full complexity of the decision making process. Among other factors, we investigated the influence of capitation payment levels, enrollment potential, and local health care market conditions on commercial plans' decision to enter the Medicaid market. In addition, we assessed the role of state Medicaid managed care policies and other policies on plans' decision making process.

In selecting the study sites we sought a cross-section of Medicaid markets along several dimensions, including level and recent growth of MMC enrollment, level of MMC capitation payments, and the extent and stability of commercial plan participation in MMC. To carry out the study, we visited each of the six sites between July and October 1999. To obtain different perspectives on why commercial plans have chosen to participate, not participate or have withdrawn from the Medicaid managed care program, we interviewed a range of stakeholders, including plan representatives (both from health plans that are participating in MMC and those that are not participating), state Medicaid officials, and local market experts.

OVERVIEW OF STUDY STATES

The six local markets that we selected for this study represent a cross-section of the nation's 58 large urban areas with populations greater than 1,000,000 (Table 1). Within those markets, Seattle and Miami are of about average size (around 2.3 million residents), Denver and Milwaukee are smaller than average, and Detroit and especially New York are substantially larger than average.

Table 1—Enrollment Characteristics of HMO Market by Site, 1999

MSA	Population	HMO Penetration		Share of HMO Enrollment In:		
		1999	% Change 1996-1999	Commercial	Medicare	Medicaid
Denver	1,938,642	48%	41%	85%	10%	4%
Detroit	4,473,853	28%	120%	74%	3%	23%
Miami	2,152,437	65%	23%	82%	10%	8%
Milwaukee	1,459,805	42%	-3%	81%	4%	16%
New York City	8,692,782	33%	20%	80%	7%	13%
Seattle	2,312,978	19%	-9%	49%	21%	30%
Average for all large MSAs*	2,318,824	39%	23%	82%	8%	10%

*Areas with a population greater than 1,000,000.

Source: Interstudy, 1997, 1999.

Overall Managed Care in the Study Sites. Total HMO penetration (Medicaid, Medicare, and commercial) varied across the markets, ranging from a low of 19 percent in Seattle to a high of 65 percent in Miami in 1999. Compared to 1996 levels of penetration, HMO enrollment was growing in four sites (Denver, Detroit, Miami, and New York) and declining in two sites (Milwaukee and Seattle). The very high growth in Detroit (120 percent) reflects the rapid expansion of Michigan's MMC program in a market with limited growth in commercial managed care. Commercial managed care has been slow to expand in Detroit, largely due to the dominance of the automobile industry and the resistance to managed care of its unions. Seattle's comparatively low HMO penetration and commercial enrollment reflects the area's preference for

traditional coverage (such as preferred provider organizations), as well the limited opportunities for cost savings under managed care, primarily because local health costs and service use, especially hospital care, were already low (Fountain et al, 1999).³

As shown in Table 2, the types of HMOs operating in the six markets also varied widely. For example, the Denver and Milwaukee markets are dominated by HMOs with national affiliation, while such HMOs are less common in Detroit and New York City. Among the markets with a more local focus, New York has a large share of provider-sponsored plans (including hospital-owned and community-based), while such plans are less common in Detroit. The Miami and Seattle markets are fairly evenly split between plans with national affiliations and state-based plans, with the state-based plans including both provider-sponsored and other plans. Milwaukee was the only site with no provider-sponsored plans.

Table 2—Selected HMO Characteristics by Site, 1999

MSA	HMO Affiliation/Sponsorship ¹			Index of Competition (1999) ²	Number of HMOs	Average Percent HMO Operating Margins (1998) ³
	National	State Provider-Sponsored	Other			
Denver	61%	15%	23%	0.822	13	-2.0%
Detroit	31%	23%	46%	0.799	13	-1.7%
Miami	47%	24%	29%	0.849	17	0.4%
Milwaukee	57%	0%	43%	0.789	7	-0.4%
New York City	27%	48%	25%	0.804	29 ⁵	-2.5%
Seattle	44%	22%	33%	0.619	9	-1.1%
Average for all Large MSAs ⁴	N/A	N/A	N/A	0.787	N/A	-1.5%

Source: Interstudy, 1999.

¹ For plan affiliation, following Interstudy’s definition, national is defined as a firm that operates HMOs in two or more states with a combined enrollment of 10,000 or more members. Blue Cross and Blue Shield plans were considered state affiliated and put into the “other” category. Provider-sponsored plans can be sponsored by hospitals, clinics, or physician groups; other state plans include plans owned by investors.

² Using Interstudy’s definition, index of competition is calculated as one minus the sum of the squared HMO market shares. A value close to one indicates several nearly equal competitors whereas a value close to zero indicates a monopoly.

³ Percent HMO Operating Margins is defined as net profit or loss as a fraction of premium revenue.

⁴ Areas with population greater than 1,000,000.

⁵ New York City’s HMO count includes HMOs and Prepaid Health Services Plans.

³ It should be noted that Seattle’s comparatively low HMO market penetration is partly due to the health care services contractors which function much like an HMO but are not licensed as one and thus would not be included in Interstudy’s data.

All six of the HMO markets were fairly competitive.⁴ Miami, with 17 plans and an index of competition of .849, was the most competitive market. By contrast, Seattle, with 9 plans and an index of competition of .619, was the least competitive. In part this was due to the Seattle HMO market being heavily dominated by the Group Health Cooperative of Puget Sound, one of the oldest HMOs in the nation. Finally, the financial situation of the HMOs in our six sites varied. On average, HMOs in large urban areas had an operating margin of -1.5 percent in 1998. Consistent with that average, plans in five of the six study sites lost money as a share of premium revenue, with plans in New York City reporting the lowest operating margin, at -2.5 percent. Only plans in Miami had a positive operating margin, although only at 0.4 percent.

Provider Markets in the Study Sites. The competitive pressures of managed care have led to the rapid consolidation of hospitals in many of the six sites, with mergers, acquisitions, affiliations and joint ventures occurring with great frequency. For example, the Miami hospital market, which was dominated by independent hospitals in the early 1990s, is now dominated by three hospital systems (Lipson et al., 1997). Similarly, there are now essentially three independent hospital systems in Milwaukee and four in Denver. Less consolidation has occurred in the hospital markets in Detroit and New York City, which continue to have considerable excess capacity.

There has been less change in physician practice patterns, with physicians in most sites tending to be in small practices. An exception is the Milwaukee market, where there are now two large independent practice associations. There also appears to be some increase in physician organizations in response to pressures of managed care in Miami and Denver. For the most part, according to local market experts, physicians have had less negotiating power with plans in the six markets. However, this appears to be changing in some markets, especially Seattle where physicians were described as walking away from risk, with a “hardening of price” taking place.

Medicaid Managed Care in the Study Sites. As with the overall managed care market, the Medicaid managed care market across the sites also varied. In five of the six sites, enrollment in MMC was mandatory before 1999. The exception was New York City, which implemented mandatory MMC in selected parts of the city beginning in August 1999. Three of the sites limited mandatory MMC to welfare and poverty-related Medicaid enrollees (Milwaukee, New York and Seattle) whereas Detroit, Denver and Miami also required SSI enrollees to enroll in MMC (Table 3). In addition, two sites (Denver and Miami) included a primary care case management or PCCM program as an MMC option. Similarly the Detroit market included partially capitated “clinic” plans (which provide primary care services only) as an option under the mandatory program.⁵

Enrollment in full-risk MMC ranged from 79,000 persons in Denver to 653,000 in New York City (Table 3). Enrollment growth was most rapid in Detroit and Miami, reflecting the implementation of mandatory MMC in Detroit and the increased auto-assignment to HMOs (rather than the PCCM program) in Miami. The modest size of the program in Denver and the limited growth

⁴ Using Interstudy's definition, plan competition in each of the markets is based on market shares: A value close to one indicates a market with several nearly equal sized competitors, whereas a value close to zero indicates the presence of a monopoly plan.

⁵ Effective December 1999, Detroit's clinic based plans were phased out unless the plans secured an HMO license.

between 1997 and 1999 reflects the state’s comparatively small Medicaid program, beneficiaries’ option to enroll in a PCCM rather than an HMO, and the state’s implementation of its mandatory program before 1997. Enrollment in full-risk MMC fell in three sites (Milwaukee, New York City, and Seattle), a change that was partly attributed to declining Medicaid case-loads as a result of welfare reform, and the strong economy.

MMC enrollment in HMOs was split between Medicaid-dominated plans and commercial plans. Defining commercial plans as plans in which Medicaid enrollment accounts for 50 percent or less of the plan’s enrollment in the state, we found small shares of full-risk Medicaid enrollment in commercial plans in New York (11 percent) and Detroit (13 percent). In contrast, Medicaid enrollment in commercial plans was over 70 percent in Miami and Milwaukee, and nearly 90 percent in Seattle.

Table 3—Overview of Medicaid Managed Care Program By Site

Site	Mandatory Enrollment of SSI Population	Statewide Medicaid Full-Risk Plan Enrollment			Percent of Medicaid Full-Risk Enrollees in Commercial Plans by Site, 1999	State MMC Rate as Percent of Median State ¹	Index of State MMC Rate as Percent of Median State AAPCC ¹
		1999 (thousands) ²	% Change 1997-1999				
Denver	Y	79	11.1%	33.2%	0.92	0.92	
Detroit	Y	434	170.5	13.2	0.84	—	
Miami	Y	370	157.3	73.1	0.80	0.64	
Milwaukee	N	183	-10.8	77.1	0.83	0.95	
New York City	N	653	-1.7	11.0	0.97	0.90	
Seattle	N	420	-5.1	88.0	1.07	1.15	

Source: InterStudy, 1999; Holahan et al. 1999.

¹ These data come from Holahan et al., 1999. The median state represents the median among the 41 states that responded to the survey which was mailed to 45 states with capitated MMC programs at the time of survey fielding. Information for Michigan was not available from the Holahan et al. study. Instead, information from Lipson et al. (1997) was used for Michigan which estimated that Michigan’s Medicaid rates were about 84 percent of national average Medicaid fees in 1997.

² Ideally we would like to show the share of Medicaid enrollees enrolled in managed care by site. Unfortunately, these data are not available for all sites.

Using results from a recent survey, Table 3 also lists state MMC capitation rates for each site (Holahan et. al., 1999).⁶ Specifically, we show the state MMC capitation rate relative to the median of responding state’s MMC rates. As shown the capitation rates paid under MMC among the study sites ranged from well below the rate on the median state in Detroit, Miami, and Milwaukee to somewhat above in Seattle, which was 107 percent of the rate in the median state. The capitation rate in New York was about the same as the median state.

⁶ The survey did not obtain rate information from Michigan. To provide some proxy for Michigan rates we used information from another study which estimated that Michigan’s MMC rates in 1997 were about 84 percent of national average Medicaid fees (Lipson et al. 1997). It should be noted that the capitation data reflect the state average rate, not the market. Given that most of our study states adjust rates for geographic location (that is urban versus rural), data presented in the table likely underestimate the rate levels of payment in the sites included in this study.

To obtain a perspective on how Medicaid rates compare to Medicare rates, we also show (in the last column) the ratio of the state Medicaid capitation rates compared to the median of the responding states' Medicaid rates to the state Medicare adjusted average per capita cost (AAPCC) for Medicare compared to the median percentile of the responding states' AAPCCs.⁷ The ratio indicates whether a state's Medicaid rates are high relative to the fee-for-service (Medicare) alternative. If a state has a low Medicaid/Medicare ratio, Medicaid rates would likely appear low to plans. Alternatively, if a state has a high Medicaid/Medicare ratio, Medicaid rates would appear more adequate. To the extent that the variation in Medicare FFS is highly correlated with the variation in private sector FFS, the Medicaid/Medicare ratio would be an indicator of the opportunity costs facing plans in serving the Medicaid population in a particular market.

As shown, in all sites except Seattle, the Medicaid/Medicare ratio was less than one, indicating that participating in the MMC program did represent some opportunity costs for plans. Miami has the lowest ratio (0.64) which may be partly attributed to the very high Medicare rates in Miami. Denver, Milwaukee and New York City ratios were all higher—ranging from 0.90 to 0.92—suggesting that Medicaid rates were more in keeping with the FFS market, though still low. Finally, Seattle had a ratio of 1.15, suggesting that MMC rates in that site exceed FFS.

Recent Plan Entry and Exit. In Table 4 we show commercial plan entry and exit in the local market over the 1997-1999 period, distinguishing those plans that entered (or exited) through mergers or acquisitions. We separated merger and acquisition entry and exits as such plan movement represents more of change in plan name as compared to an entirely new plan entering or a plan completely leaving the Medicaid market. With the exception of Detroit, all of the markets experienced changes in commercial plan participation in MMC over the period. Most notably, four commercial plans exited the New York City MMC market, leaving only two commercial plans participating in the city's Medicaid program. In Seattle, there was substantial activity primarily as a result of plan mergers and acquisitions. However, two commercial plans did exit the Medicaid program over the 1997-99 period. Denver and Miami saw both entry and exits, with a key acquisition in the Miami market of the largest Medicaid-dominated plan by a large commercial plan. Finally, the Milwaukee market saw both the entry of a new plan into the market as well as the exit of two commercial plans through merger and acquisition.

The net result of the plan entries and exits was that between two (New York) and seven (Miami) commercial plans participated in MMC in each of the six markets in 1999. Further, for two-sites (Denver and Detroit) the number of commercial plans participating in Medicaid over the period was constant, one site (Miami) gained a plan, and three sites (Seattle, New York, and Milwaukee) lost plans. Finally, for-profit commercial plans accounted for the bulk of participating plans in Miami (five out of seven) and in Milwaukee (four out of five). By contrast, in Detroit one out of four participating commercial plans were for-profit, and in Seattle, two out of five commercial plans were for-profit.

⁷ The AAPCC, calculated county-by-county, reflects average Medicare fee-for-service expenditures adjusted for age, sex, Medicaid enrollment, institutionalization, and work status, and is an attempt to capture relative variations among states in Medicare FFS expenditures.

Table 4—Commercial Plan Entry and Exit by Site, 1997-1999

Site	Commercial Plans Entry and Exit in MMC by Site ¹ (1997-1999)				Number of Commercial Plans Participating in MMC by Site, 1999	Number of For-Profit Commercial Plans in MMC by Site, 1999
	New Entry	Entry by Merger/ Acquisition	Exit by Merger/ Acquisition	Other Exit		
Denver	1	0	0	1	3	1
Detroit	0	0	0	0	4	1
Miami	1	1	0	1	7	5
Milwaukee	1	0	2	0	5	4
New York City	0	0	0	4	2	1
Seattle	0	3	3	2	5	2

¹Commercial plan is defined as Medicaid enrollment accounts for 50 percent or less of overall plan enrollment.

In some instances, the table overstates the stability in the markets as it does not capture plan decisions to pull out of some geographic areas in a market or to cap its MMC enrollment in the market, both of which occurred in some of the six study sites. In Detroit and Denver, for example, some plans are capping Medicaid enrollment. In other sites, such as New York and Seattle, commercial plans are limiting their marketing efforts or development of provider networks as a way to restrict Medicaid enrollment.

Study Site Summaries. Before discussing the case study findings on what factors influence plan participation, we summarize key characteristics for each of the six sites.

- *Denver.* While Denver's overall managed care market is heavily dominated by commercial plans, only a few participate in MMC. As a result, the bulk of Denver Medicaid enrollees—66 percent—are enrolled in Medicaid-dominated plans. The limited role of commercial plan participation in the Medicaid market has been the case since the state started its mandatory MMC program in 1990s. An important reason for this is Denver's highly competitive and rapidly expanding commercial managed care market.
- *Detroit.* Detroit's health care market is characterized by excess provider capacity (especially among hospitals), high levels of employer sponsored coverage, and limited growth in the commercial managed care market. A strong union presence—reflecting the strength of the automobile industry in the state—has been a major factor in curtailing the growth of commercial managed care. While commercial managed care has been stagnant, MMC has increased rapidly in the late 1990s, due to the state's implementation of mandatory managed care. Although capitation rates are below the national average, the majority of HMOs operating in Detroit participate in MMC. Further, commercial health plan participation in the Medicaid market has been stable over the 1997 to 1999 period, with no plan exits or entries; however, several plans have placed limits on MMC enrollment levels as they assess

their continued participation in MMC. Although there is broad commercial plan participation in the Medicaid market, nearly 90 percent of beneficiaries are enrolled in Medicaid-dominated plans, many of which are provider-sponsored.

- *Miami.* Despite capitation rates 20 percent below the national average, a highly competitive managed care market, and rapid hospital consolidation, nearly three-quarters of Miami Medicaid beneficiaries are enrolled in commercial plans. Further, plan participation, at about half of the plans in the market, has been fairly stable, with only one commercial plan exiting the market over the 1997-1999 period. The steady participation of commercial plans is partly explained by the state's increased auto-assignment to HMOs rather than to PCCMs and plans viewing Medicaid as being an attractive market relative to the volatile commercial market.
- *Milwaukee.* The Milwaukee managed care market is highly competitive and recent data indicate several major plans are losing money. Until 2000, commercial plans have been active participants in MMC. There are no provider-sponsored plans in Milwaukee, due to both the protections given to safety net hospitals and clinics by the state, and Wisconsin's comparatively low uninsurance rate. Despite low Medicaid capitation rates, plans to date have been able to earn a profit on Medicaid, largely because of their ability to secure advantageous contracts from Milwaukee's hospitals, which were described as having excess capacity.
- *New York City.* Among the study sites, New York had the largest number of commercial plan exits from the Medicaid. Between 1997 and 1999, four commercial plans left the MMC market, and no new plans entered. The Medicaid market is dominated by the prepaid health service plans (PHSPs), which are primarily not-for-profit, consist of almost entirely Medicaid enrollees, and are generally controlled by hospitals or community health centers. In 1999, only 11 percent of the city's Medicaid beneficiaries were enrolled in a commercial plan. The exodus of commercial plans has occurred despite New York's capitation rates being about average for the nation. Commercial plan withdrawal from Medicaid is partly attributed to New York's particularly competitive commercial managed care market, which is reflected in plans' reported operating margins of -2.5 percent in 1999—a full percentage point below the national average for large MSAs.
- *Seattle.* While Seattle has experienced some commercial plan volatility, nearly 90 percent of Medicaid beneficiaries were enrolled in commercial plans in 1999. In part commercial plan's continued participation in Medicaid can be explained by the state's comparatively generous MMC rate, the highest among our study sites. It can also be explained by the limited enrollment growth in commercial managed care. Seattle's HMO penetration has fallen in recent years and was only 19 percent in 1999, 20 percentage points below the national average for large MSAs. Commercial managed care enrollment accounts for only about 50 percent of the city's overall HMO enrollment, again well below the national large MSA average of 82 percent.

FACTORS INFLUENCING PLAN PARTICIPATION IN THE MEDICAID MANAGED CARE MARKET

Our case study findings suggest that no single factor explained why some plans choose to participate in MMC in a particular market and some do not. Generally, it was a combination of factors—largely economic but not always—that determined whether a plan entered, exited, or opted not to participate in the local Medicaid market.

Adequacy of Medicaid Capitation Rates. Without doubt adequacy of capitation rates was the central factor influencing health plan participation. Indeed, rate sufficiency, given market conditions, was stressed in all sites as tantamount to a successful MMC program. However, participation in a particular market was not simply an issue of plans participating in markets with high rates and not participating in those with low rates. Indeed we found plans exiting markets that had comparatively high rates (for example, Seattle) but staying in or entering other markets with relatively low rates (for example, Miami and Milwaukee). Similar findings have been reported for health plan participation in the Medicare managed care program (US GAO 1997). Our results indicate that it is Medicaid capitation rates relative to other factors (discussed directly below) that matter rather than the level of the rates.

MMC Rates Relative to Provider Costs. A central factor in a plan's decision to participate in the Medicaid market is how well plans can negotiate rates and others factors (e.g. utilization controls) with providers that affect the costs of care. Perhaps most important are provider rates. In markets with more competition among providers (that is, excess provider capacity) or lower provider consolidation, plans are able to hold down costs by negotiating more advantageous provider contracts—both in terms of actual payments rates as well as risk arrangements. For example, among our sites, Detroit was viewed as a market with opportunity for plans to cut costs because of excess capacity among providers, especially hospitals. In Milwaukee, despite low capitation rates, until recently, commercial plans reported earning profits in the Medicaid market. Plans attributed this, in large part, to excess capacity among providers. By contrast, hospitals in Miami and Denver were described as being highly consolidated and as “pushing back” on risk and demanding higher payment rates from plans. Seattle plans also reported an increasing resistance among providers to assuming risk.

We found that in some markets in which key hospitals operate health plans, the ability to negotiate favorable hospital rates may be limited. An important example of this was the Denver market. In that market, the safety net providers—including three hospitals and several federally qualified health centers (FQHCs)—formed a health plan that serves almost exclusively the Medicaid population. To protect their patient base and promote their plan, the hospitals have either refused to contract with competing plans or are demanding reimbursement payments at or above market rates. This strategy increased the costs of participation in the market for other plans. (It also made network development difficult for some plans.) To a lesser extent, commercial plans in New York City, where many hospitals also operate plans, reported encountering comparable issues.

The costs of providing health care can also be influenced by the level of uncompensated care in the health care system. That is, in markets with lower levels of uncompensated care providers' costs would tend to be lower. Lower provider costs, in turn, may result in providers' contracting at lower rates thereby reducing plan costs. Indeed Milwaukee health plans asserted that the comparatively low levels of uninsured in the state has influenced plans' ability to secure low cost contracts with providers.

Additional Health Care Costs of the Medicaid Population. Plans across all six markets reported that the costs of serving the Medicaid population are higher than the costs of serving the commercial populations because Medicaid enrollees are distinct from those groups both in terms of their medical needs and use of health care services, especially emergency room use. Further, plans maintain that program rules under Medicaid (for example, an inability to impose copayments) can make it difficult for plans to change inappropriate use of services by Medicaid enrollees. Plans felt that the costs associated with the Medicaid populations are particularly high if disabled groups—such as SSI enrollees—are included in a state’s MMC program. While plans acknowledge appropriate risk adjustment to capitation rates would largely mitigate these issues, most states at present use only fairly crude adjusters which, plans believe, do not fully compensate for the higher costs Medicaid enrollees, particularly the disabled.

A related matter was that many plans asserted that in the wake of welfare reform—in which Medicaid enrollment nationally dropped by 11 percent between 1995 and 1997 (Ku and Bruen, 1999)—the Medicaid population is, on average, sicker than before the reform. As a result, the plans believe, the costs of serving the Medicaid population has increased. Indeed, New York state made an upward adjustment of capitation rates in 1999 to account for the shift in Medicaid casemix.

Other MMC Cost Issues. Beyond medical costs, plans identified other costs associated with participating in the Medicaid market as key factors in the participation decision. We have grouped these costs into two categories—administration and economies of scale.

Administrative Costs of MMC. Beyond medical costs, many commercial plans report high administrative costs associated with the Medicaid program. However, plans’ perceptions of the burden of such costs varied across the six sites. In Wisconsin, for example, plans cited the limited state reporting requirements and the state’s flexible attitude toward those requirements as an important way they have kept their costs down and been able to live with the low Medicaid capitation rates. By contrast, health plans in Miami and New York City almost universally complained of onerous and costly state reporting requirements.

Across all six sites, plans maintained that welfare reform has caused higher “churning” among Medicaid enrollees, adding further to their administrative costs. Another consistent concern of plans was that administrative costs would likely increase in the future as the MMC provisions, (such as new reporting requirements) included in the 1997 Balanced Budget Act are implemented.

Plans also examined administrative costs from a long-term perspective. A key issue for plans: Is the state a good business partner? Plans’ perceptions of this also varied widely by site. Health plans in Milwaukee describe the state as being a solid business partner and MMC as a stable line of business. Because the plans have a substantial degree of trust in the state not to act arbitrarily and to respond reasonably to changes in the broader health care market, Milwaukee plans have viewed Medicaid as a good long-term investment.

In contrast, plans in other sites generally viewed the state as a much less reliable partner. Indeed, in some cases, plans have either exited or chosen not to participate in the MMC market in part due to uncertainty surrounding the state’s administration of the program. In New York, for example, plans tended to view the Medicaid program as an unstable investment. Among other things, this stemmed from a major shift in the state’s rate setting policies in 1996—which led to substantial rate cuts as well as mounting reporting requirements.

More broadly, many plans felt that as a public program, Medicaid is subject to political volatility making it a risky market in which to do business. That is, unlike the commercial market, Medicaid rates and program requirements are determined in a political arena that is often unpredictable. In particular, several plans expressed concerns that the backlash against managed care has made it tempting for state legislators to cut funding for MMC. In some cases, the backlash has also made legislation to promote managed care initiatives less likely.

Anticipated Economies of Scale. Another consideration for plans as they assessed participation in MMC was the expected enrollment volume in the market. Plans reported increasing returns to scale in the MMC market and often in the overall managed care market. Thus, relatively low MMC rates were viewed much more favorably when they were associated with a larger expected volume of lives. According to plans, greater enrollment allows them to spread administrative and other fixed costs associated with MMC across more lives and pool risk more effectively (especially in MMC programs with limited risk adjustments in the capitation rates). Further, greater overall enrollment provides a stronger foundation for their negotiations with providers. However, some plans reported limits on the value of increasing the share of their business from Medicaid. That is, the plan ran the risk of being perceived as having “too much” Medicaid, which could potentially reduce their ability to bargain effectively with providers.

Lack of enrollment volume was an issue in several sites. In Denver, several plans—including participating and non-participating plans—cited insufficient enrollment as a major factor when considering the Medicaid market. Indeed some commercial plans have exited the Denver market and others have chosen not to enter because of low enrollment and the high risks associated with low enrollment. The lack of volume in the Denver Medicaid market stems from several factors, including the relatively small size of the Medicaid population, the state-run PCCM program that competes with plans for enrollees, and the dominance of the safety net plan—which enrolls more than 75 percent of Denver Medicaid enrollees.

Commercial plans in New York also indicated the lack of volume was a reason for exiting the Medicaid market. The lack of enrollment was due in large part to the long delay in implementing the mandatory managed care program. Indeed as of early 2000 only a few areas of New York City are under mandatory enrollment whereas the state had hoped to have much of the city mandatorily enrolled by that time. The delay and uncertainty has been costly to plans, causing some to scale back on their Medicaid programs.

Detroit plans also expressed concerns that low enrollment has been costly. Plans reported that they had entered the MMC market despite low rates based on an expectation that the MMC caseload would be spread over relatively few plans. They argue that the state, with its “any willing HMO” contracting rule, has allowed too many plans in the program given the enrollment volume. Further, state restrictions on marketing have made it difficult for plans to actively “grow” their MMC caseloads. The resulting low enrollment coupled with the state’s low capitation rates have made MMC an unprofitable market over the last couple years for nearly all plans. However, commercial plans are staying in the market—at least in the short term—largely because they need overall volume as the commercial market has not been growing.

Similar circumstances were present in Seattle. Commercial managed care has been stagnant in recent years in Seattle, and Medicaid offered plans new enrollees. The MMC market has been particularly important to the several national plans that have recently entered the Seattle market: The national plans have yet to achieve a significant market share in Seattle—which historically has been dominated by three homegrown plans—and the Medicaid program offered them an opportunity to gain enrollment.

Finally, a common theme expressed by plans was the impact of welfare reform on their plan's Medicaid enrollment. Plans in all sites asserted that the drop in Medicaid enrollment has made fewer lives available to health plans which has driven up their average costs and, in some cases, contributed to their inability to cover their costs under MMC.

Expected Returns to Investment In Other Markets. Plans considering investing in the Medicaid market assess the relative returns in other competing markets—both the commercial and Medicare markets. This assessment includes comparing rates, projected enrollment and costs. How Medicaid was assessed by commercial plans varied from site to site. In Denver, Medicaid was perceived as not being as attractive as in other markets—especially the commercial market. While Denver plans generally viewed Medicaid rates as being adequate, they maintained that the Medicaid line of business did not offer a competitive advantage (for example, added enrollment offered under Medicaid was not sufficient to be a stabilizing factor for plans' commercial business) in what has been described as a highly competitive HMO market (Baumgarten, 1998). That, coupled with low enrollment potential under Medicaid and costly administrative requirements, was seen as resulting in inadequate returns from Medicaid that did not compare to that of other markets. A similar situation occurred in New York where the commercial HMO market was increasingly competitive and plans pulled out of Medicaid in part because they needed to focus resources on maintaining markets which offered greater potential returns, especially given the lack of growth in MMC in New York City.

By contrast, despite the low capitation rate, Medicaid was viewed as an attractive market in Miami. According to plans, although MMC rates are “too low,” the returns on MMC are reported to be better than under commercial managed care. There has been aggressive competition for commercial lives—primarily so that plans could meet the commercial enrollment thresholds that were required to qualify as Medicare and Medicaid plans (prior to the 1997 Balanced Budget Act change)—which caused a price war among Miami plans. Further, the Miami commercial market, which has a strong small group component, was described as being highly volatile whereas the Medicaid market was viewed as more stable.

Other State Policies That Affect the MMC Market. Beyond MMC programmatic features, other state policies can profoundly affect plans' costs and thus participation in the Medicaid market. For example, until 2000, Washington had a policy that required plans that participated in MMC to also contract for the Basic Health Plan (BHP), the state-sponsored subsidized health insurance program. This contracting requirement has proven very costly for plans as BHP attracted a high-risk, high-cost population. The requirement dissuaded some plans from entering the market, and at least one plan exited the Medicaid market because of the contractual link. Perhaps more importantly, the Medicaid-BHP link has tainted plans' perception of the costs associated with participating in the MMC program.

A similar situation is developing in Wisconsin where the state has recently required plans participating in Medicaid to also contract for its new BadgerCare program, which, among other things, expands coverage to previously uninsured, low-income persons. Plans are to be paid Medicaid rates for BadgerCare enrollees but plans fear that the BadgerCare population will be a high-risk population with pent-up demand. As of early 2000, one major plan had announced its withdrawal from MMC because of the new contracting requirement.

At a broader level, welfare reform has significantly affected the Medicaid managed care program. Mentioned earlier, the reform has caused a significant drop in Medicaid enrollment, which, among other things, has affected plans' Medicaid caseloads and casemix.

Social and Philosophical Factors. Plans facing the same MMC rates and other costs can make very different decisions about participating in the Medicaid market. We found that sometimes other—noneconomic—factors influence plans. An important one was a sense of social mission or obligation; that is, in some cases plans felt a need to serve the Medicaid population as a way to give back to the community. This sentiment tended to be held by local or state-based, non-for-profit plans as opposed to national plans, and was particularly strong among Milwaukee and Detroit plans.

Brand image was another factor. Some plans either chose not to enter—or limited their participation—because of concern that the Medicaid program would affect the plan’s reputation. This was a particular concern among Florida plans, primarily in response to several widely reported scandals about Medicaid managed care plans in the early 1990s. Related to brand image was some plans’ reluctance to expand their MMC caseload beyond a marginal level for fear of being perceived by providers and employer groups as a “Medicaid plan.” Further, several plans reported not participating—or greatly limiting their participation—because they did not want to disturb existing contracting relationships with the providers in their network who were not interested in participating in MMC.

PLAN DECISION FACTORS BY SITE

The relative importance of the factors discussed above varied by market:

- *Denver.* While Denver plans acknowledged that MMC rates were adequate, only a limited number of commercial plans participate in the Medicaid market. The major reason plans cited for not participating was that Medicaid did not offer an advantage in the fiercely competitive commercial Denver HMO market. A related factor is the limited number of lives in the Denver MMC program, which has resulted in part from state policies, including the continued operation of a PCCM program, an option under Colorado’s mandatory program. Finally, the dominance of the safety net plan, which accounts for 75 percent of Denver’s MMC enrollment, made it difficult for other plans to expand.
- *Detroit.* In 1997, Michigan switched from voluntary to mandatory enrollment in MMC for almost all of its Medicaid population. This represented both a significant shift in MMC and a substantial growth in Detroit’s overall managed care market, providing plans an opportunity to gain market share quickly in a stagnant commercial market. At the same time, MMC rates were substantially reduced through a competitive bid process. Plans participated in Medicaid, despite the low rates, because of the need to maintain market share and with the expectation that the state would limit the number of plans in the MMC market. However, the state did not limit the number of plans, resulting in plans operating on a smaller scale than they had anticipated. To date, plans have stayed in the market despite losses on the Medicaid line of business in anticipation of market exits by others—both voluntary and involuntary—as a result of the low rates. A strong sense of mission among plans has also contributed to Detroit commercial plans staying in the Medicaid market.
- *Miami.* With the implementation of mandatory enrollment in MMC in 1997, commercial plan participation in the MMC market in Miami has remained stable. About half of the 17 HMO’s in the Miami market were participating in MMC in 1999, with the MMC market dominated by two large commercial plans. Although they have

remained in the market, smaller HMO's reported needing greater numbers of Medicaid lives to offset low rates, high fixed costs, and the risk associated with MMC (especially the risk associated with the SSI population). This issue has become more pressing over time as the Medicaid caseload in Florida has declined with welfare reform and a strong economy. While there seems to be some consensus that there are too many plans given the size of the MMC market in Miami, there does not appear to be consensus that plans will exit. In fact there is some suggestion that the market has stabilized, with small plans finding their market niche—either a population or geographic specialization within the culturally complex Miami market.

- *Milwaukee.* Until 2000, the Milwaukee MMC market was stable with a high level of participation of commercial plans. Such stability has been achieved despite Wisconsin's relatively low capitation rates, and is attributed to several factors, including the state being regarded as a reliable partner and the comparatively low administrative burdens imposed by state. Plans' sense of mission was another factor: that is, Milwaukee plans, which are largely non-profit with a strong regional focus, felt that participating in Medicaid was the appropriate thing to do for the community. Another important factor is that plans have been able to secure favorable contracts with providers which has helped keep plan costs down. However, the Milwaukee market may be changing. Providers have become more consolidated making rate negotiations more difficult, and the state is requiring plans that participate in Medicaid to also participate in the BadgerCare program, a new insurance program for the uninsured. Plans will be paid Medicaid rates for BadgerCare enrollees but plans fear that the population will be much sicker than the Medicaid population.
- *New York City.* Almost all the commercial plans have left the New York MMC market. This has occurred for several reasons—Medicaid rates perceived as being low by plans, high administrative burdens imposed by the state, and plan difficulty in developing provider networks given the market power of the city's hospitals. Another important factor contributing to commercial plan exits has been plans need to concentrate resources on the keenly competitive private market. New York MMC is now dominated by several provider-sponsored plans, many of which are sponsored by safety net hospitals and clinics. These plans are unlikely to leave the Medicaid program as they rely on the revenues that Medicaid patients bring.
- *Seattle.* The Seattle MMC market enjoys broad commercial plan participation, with nearly 90 percent of enrollees in commercial health plans in 1999. Several factors account for the active participation of Seattle's commercial plans, including adequate capitation rate, social mission, and plans' desire to gain market share. The latter factor has been especially important to national health plans which have recently entered Seattle, a market heavily dominated by local, homegrown plans. While Seattle has solid participation from plans, the market has experienced some exits. In part this was due to inability to get providers to contract at rates the plans could afford under the capitation rate. Another factor for plans has been the state policy of linking Medicaid and BHP contracting.

DISCUSSION

In this paper we examined factors that influence commercial plans' participation in six Medicaid managed care markets. Study findings suggest that no single factor explained why plans choose to participate in MMC in a particular market. Instead, a combination of factors—generally economic but not always—determined whether a plan participated in the Medicaid market. Although Medicaid payment levels were critical, participation in a particular market was not simply an issue of high or low rates. Indeed we found plans exiting markets that had comparatively high rates (for example, Seattle) but staying in or entering other markets with relatively low rates (for example, Miami and Milwaukee). Results suggest that it is MMC rates relative to other factors in each market that matter rather than the level of the rates.

We identified several factors that are important to a plan's decision making process, including:

- Level of MMC capitation rates.
- Anticipated economies of scale from MMC.
- Returns to investment in other managed care markets.
- MMC rates relative to provider costs.
- Administrative costs of MMC.
- Social and philosophical factors.

The relative importance of these and the other factors varied widely across the six study sites. Indeed, the set of factors that influence plans seem to be unique to each geographic market. In several of the study states, plans had pulled out of some markets in a given state but stayed in others. Moreover, several of the most important factors affecting plans' decisions—for example, the level of provider consolidation or level of competition in the commercial market—are external market forces, and largely outside the control of the Medicaid program and state policy-makers.

A key stated policy goal for many states' MMC initiatives is to provide Medicaid enrollees access to mainstream health care providers. The principle way states were going to achieve this goal was through the participation of commercial health plans. Although it is unclear whether commercial plans provide a higher quality of care or better patient outcomes compared to safety net plans—the other major MMC alternative—if a state is interested in having commercial plans participate in the Medicaid market, our study results suggest some policies that states could use to encourage commercial plan participation. For example, establishing actuarially sound and stable capitation rates is highly important as plans are more likely to participate in markets where MMC rates are expected to cover the costs of providing care in that market. Equally important are state policies that affect the non-medical costs of serving the Medicaid population. Results suggest that states should be judicious in determining what they need from plans to ensure a quality managed care program as administrative and reporting requirements represent real costs to plans.

For states wanting to promote commercial plan participation, officials could also help reduce the costs of serving the Medicaid population by making other changes in program rules, such as establishing “lock-ins” and guaranteeing eligibility for longer periods to reduce beneficiary turnover. This is particularly important given the impacts of welfare reform on Medicaid enrollment. Other strategies states could use to reduce plan costs include investing in beneficiary education about managed care.

Another way states can promote participation is to ensure sufficient enrollment volume to plans. This could be achieved by limiting the number of plans awarded contracts. It should be noted that this strategy could backfire if plans are too limited, as it would likely affect the balance of power in contract negotiations between the state and plans. For some states this may entail eliminating vestiges of fee-for-service Medicaid (like PCCM programs) or moving additional populations into MMC. Finally, states can limit ties between the MMC program and other state policies. Such links can sometimes lead to unintended outcomes—for example, the adverse selection under the Medicaid-BHP tie-in in Washington.

In sum, commercial plans’ decision to participate in the Medicaid market largely boils down to a business decision: Does it make financial sense to enter the market? While many of the costs that enter the cost-benefit equation are driven by the condition of the overall health care market, some are not. Thus if states are interested in keeping commercial plans participating—or attracting new plans to participate—in their MMC program, a number of strategies can be implemented. Adopting such strategies may help stabilize the MMC market. They may also help states provide access to mainstream providers, a key goal of many states’ MMC initiatives.

This issue paper was prepared by Teresa A. Coughlin, Sharon K. Long, John Holahan, Jessica Kasten, Susan Goldenson, and Stephanie Kendall of the Urban Institute. For a more detailed analysis of commercial plan participation in Medicaid managed care in each of the study sites, see the full background paper by Coughlin et al., November 2000, Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, Publication # 2223. Findings from this study will also be presented in the Spring 2001 issue of the journal *Inquiry*.

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