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The Characteristics and Roles of Medicaid-Dominated Managed Care Plans

Prepared by
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Mathematica Policy Research, Inc.
for
The Kaiser Commission on
Medicaid and the Uninsured

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ABOUT THE AUTHOR

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Felt-Lisk also led the development of a new database of health plan-level information for analyzing characteristics and trends in health plans' service to Medicaid. She publishes regularly and was the author of several chapters in *Contemporary Managed Care: Readings in Structure, Operations, and Public Policy*, edited by Marsha Gold.

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EXECUTIVE SUMMARY

Medicaid-dominated plans – defined as full-risk managed care plans in which Medicaid enrollment makes up 75 percent or more of total enrollment – are increasingly important to understand because both policy and market changes are encouraging their growth. The continuing geographic expansion of Medicaid managed care in many states and shifts to mandatory programs has resulted in the enrollment of 9.3 million Medicaid beneficiaries in full-risk managed care, 3.4 million of whom are in Medicaid-dominated plans, up from 1.6 million in 1994. There is also evidence of a shift toward greater enrollment in Medicaid-dominated plans in several states (Felt-Lisk 1999). The Balanced Budget Act of 1997 provides states with more flexibility to pursue Medicaid managed care in ways that may encourage the growth of Medicaid-dominated plans. State policies that support these plans and decreasing participation in Medicaid by commercial plans in some areas are other factors increasing the role of Medicaid-dominated plans in Medicaid managed care.

This paper provides a national profile of Medicaid-dominated plans and presents more in-depth descriptive information on the role these plans play in 15 high-volume Medicaid managed care states that together account for over three-fourths of full-risk Medicaid managed care enrollment. It builds upon previous work that examined recent changes in the Medicaid managed care market.[1] The national data presented here come from a database developed specifically for this analysis by combining HCFA and HMO industry data and supplementing it with staff research (see Appendix B: About the Data). More detailed data on Medicaid-dominated plans in 15 states were collected from state Medicaid agencies in Arizona, California, Connecticut, Florida, Illinois, Michigan, Missouri, New Jersey, New York, Ohio, Oregon, Pennsylvania, Tennessee, Washington, and Wisconsin.

In June 1997, 118 Medicaid-dominated plans served 3.4 million Medicaid enrollees, representing 36 percent of all Medicaid enrollees in full-risk plans. Medicaid-dominated plans are widely distributed throughout the states, though to date they have played a much more important role in some states than in others. Just over half (58 percent) of the Medicaid-dominated plans are located in 5 states: New York (20), California (19), Oregon (9), Arizona (8), and New Jersey (6).

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[1] See Suzanne Felt-Lisk, "The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation," the Kaiser Commission on Medicaid and the Uninsured, May 1999.

The key findings from this analysis are as follows:

- ***Size, Ownership, Accreditation, and Tax Status***
  - ***Medicaid-dominated plans are typically small plans.*** More than half of these plans have fewer than 25,000 members, and only 15 percent have more than 50,000 enrollees, compared with 44 percent of all full-risk managed care organizations.

  - ***Medicaid-dominated plans vary widely in ownership type.*** Provider-based plans account for roughly half of all Medicaid-dominated plans. Hospitals are the most common type of provider owner. Slightly over 20 percent are owned by Federally Qualified Health Centers (FQHCs). Provider-based, Medicaid-dominated plans are largely not-for-profit organizations. Other managed care firms that are independent or owned by multi-state managed care companies account for 29 percent of the Medicaid-dominated plans, and these are largely for-profit plans. Most of the remaining Medicaid-dominated plans are owned by government entities, and these plans are concentrated in California.

  - ***The vast majority of Medicaid-dominated plans had not received full accreditation by mid-1998.*** Only five (four percent) of Medicaid-dominated plans had received full-accreditation by the National Committee for Quality Assurance (NCQA), and an additional 2 were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In contrast, 34 percent of all full-risk Medicaid plans had full accreditation from NCQA in mid-1998.

  - ***Nearly two-thirds of Medicaid-dominated plans are not-for-profit, compared with only 31 percent of all full-risk Medicaid health plans.*** This large share of not-for-profit Medicaid-dominated plans reflects the fact that most provider-owned plans and all government-owned plans are not-for-profit. Overall, not-for-profit, Medicaid-dominated plans enroll one-fourth of all full-risk Medicaid enrollees.

- ***In the 15 states for which we have detailed data:***
  - ***Medicaid-dominated plans are disproportionately concentrated in areas with greater concentrations of ethnic minorities, higher levels of poverty, and fewer health care resources.*** The types of counties in which Medicaid-dominated plans focus their activities varies widely across states, from very densely populated urban areas to frontier. But within most states, the counties in which they focus their operations have a higher racial and ethnic minority population and a higher percentage of families in poverty, or are more frequently designated as Health Professional Shortage Areas.

- ***Medicaid-dominated plans currently do not dominate in most Medicaid markets; they also do not serve the disabled/elderly Medicaid population in managed care to a greater extent than other plans.*** In a majority of counties (58 percent) in the 15 states we analyzed, Medicaid-dominated plans serve less than a third of the Medicaid managed care enrollees, and in almost one-fifth of counties that are part of a mandatory program, there is no Medicaid-dominated plan serving the area.

- ***Nearly a third of the Medicaid-dominated plans in the 13 states for which we have data appear at financial risk. However, the financial status of Medicaid-dominated plans appears no worse than other plans in their states, and many are faring better.*** Nearly half of the Medicaid-dominated plans lost money in 1997. We estimate that 30 percent are "at medium or high financial risk," based on having financial liabilities that exceed their assets and other indicators. However, in what was a bad year for the HMO industry, these plans did not fare worse than other plans. Unfortunately, our analysis is limited by the potential inconsistencies in accounting across types of plans, and the absence of several important indicators (e.g., days in accounts receivable, measures of capital structure).

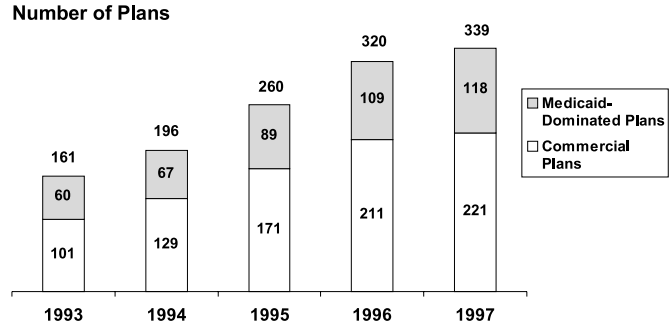
- ***Medicaid-dominated plans tend to serve a relatively low percentage of enrollees in mandatory program areas for both families and special needs populations, and serve a relatively higher percentage for both population groups in voluntary program areas.*** This pattern was somewhat more pronounced for special needs populations relative to families in Medicaid. Medicaid-dominated plans served a low percentage of Medicaid families in 59 percent of the mandatory counties in the 15 study states, but they served a low percentage of the disabled/elderly population in even more mandatory counties – 72 percent.

INTRODUCTION

The number of full-risk health plans serving Medicaid enrollees has grown from 196 in 1994 to 339 in 1997, coinciding with the rapid growth of enrollment in fully capitated Medicaid managed care programs (Figure 1). This growth of the number of participating plans occurred as a market response to state interest in pursuing Medicaid managed care. More commercial plans began serving the Medicaid population, and many new plans with a business focus on Medicaid were formed. During 1997 and 1998, however, the growth in the number of participating plans slowed as commercial plans exited from the Medicaid market more frequently than in past years.[1] Several states experiencing an increase in the number of commercial plans exiting the Medicaid market have experienced a shift toward greater enrollment in Medicaid-dominated plans.

Figure 1

Full-Risk Commercial and Medicaid-Dominated Health Plans Participating in Medicaid, 1993-1997



Source: *MPR analysis of InterStudy (1996-1997), GHAA (1993-1995), and HCFA data.*
Note: *Commercial plans are those for which Medicaid enrollment is less than 75% of total enrollment.*

Medicaid-dominated plans – defined as full risk health plans in which at least 75 percent of their enrollment is Medicaid – were historically prohibited from operating for more than three years without a waiver, with some Congressionally mandated exceptions. The "75/25" rule required that at least 25 percent of each Medicaid-serving plan's total enrollment be non-Medicaid and non-Medicare.[2] The rule was viewed as a quality of care protection, under the theory that if a plan

[1] See Suzanne Felt-Lisk, "The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation," the Kaiser Commission on Medicaid and the Uninsured, May 1999.

[2] Medicaid-dominated plans could also form without federal restriction in states that had received waivers allowing this to occur, including several large states pursuing Medicaid managed care under 1115 waivers.

is able to attract at least 25 percent of its enrollees in a competitive, commercial market, then it must be providing adequate quality care. The requirement was controversial, however, and some questioned whether it was associated with any differences in quality of care. The Balanced Budget Act of 1997 added new quality protections for states seeking to pursue Medicaid managed care and eliminated the 75/25 requirement.

Some state policies have provided targeted support for Medicaid-dominated plans, particularly those that are owned by safety-net providers. For example, California pays a 2 1/2 percent premium differential for safety-net plans, and plan-specific rate-setting in Massachusetts permits safety-net plans to seek rates which reflect higher costs (NYS Coalition of PHSPs 1998). While commercial plans offer access to "mainstream" providers and may help improve the provider choices available to Medicaid enrollees, Medicaid-dominated plans may be structured in ways that better meet the often complex health care needs and cultural diversity of the Medicaid population (Fagan and Riley 1998). Also, some believe Medicaid-dominated plans better support safety-net providers who also serve the uninsured.

Little is known about the characteristics of Medicaid-dominated plans, in part because many are not licensed as HMOs. Instead, they often are certified by states under a different set of requirements because of their sole focus on non-commercial clients. Many (but not all) Medicaid-dominated plans are omitted from HMO industry directories that draw upon state insurance department records of licensed HMOs as a major information source. In turn, those HMO directories have formed the basis for most previous Medicaid managed care research. This research, in contrast, includes the full set of plans serving Medicaid beneficiaries.

CHARACTERISTICS OF MEDICAID-DOMINATED PLANS

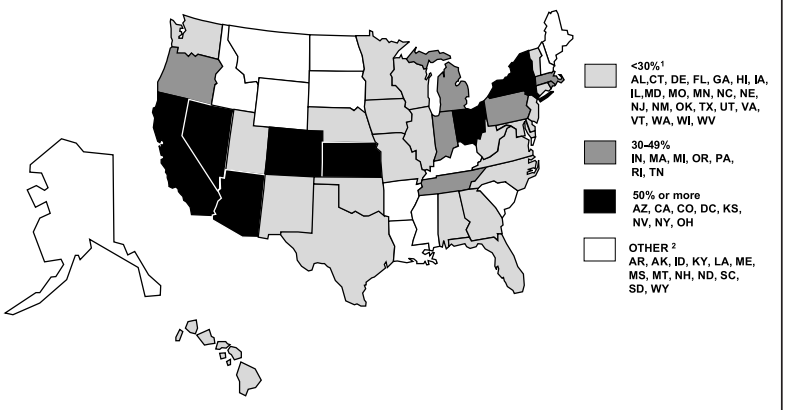
In June 1997, 118 Medicaid-dominated plans served 3.4 million Medicaid enrollees, representing 36 percent of all Medicaid enrollees in full-risk plans (Table 1).[3] Medicaid-dominated plans are widely distributed throughout the states, though to date they have played a much more important role in some states than in others. Just over half (58 percent) of the Medicaid-dominated plans are located in the 5 states that had 5 or more of these plans in 1997: New York (20), California (19), Oregon (9), Arizona (8), and New Jersey (6). Figure 2 shows states by the percentage of full-risk Medicaid managed care enrollment that Medicaid-dominated plans represent. The figure shows some regional pattern in the reliance on Medicaid-dominated plans. Our analysis found no strong association between the share of enrollees in these plans and the age of the Medicaid managed care program. For example, in Florida, Washington, and Hawaii (whose programs all began before 1994), Medicaid-dominated plans play a relatively small role in the Medicaid managed care market. However, in Arizona, another older program, Medicaid-dominated plans play a large role, serving more than 50% of Medicaid managed care enrollees.

Table 1
Distribution of Participating Full-Risk Health Plans and Medicaid Enrollees, 1997

Plan Characteristics	Participating Managed Care Plans		Medicaid Managed Care Enrollees	
	Number	Percent	Number (1,000)	Percent
Total	339	100%	9,334	100%
Medicaid Proportion of Total Enrollment				
Medicaid-Dominated Plans	*118*	*35%*	*3,360*	*36%*
75-89 percent	16	5%	467	5%
90 percent or more	102	30%	2,894	31%
Commercial Plans	*221*	*65%*	*5,974*	*64%*
Medicaid Product*	16	5%	933	10%
<10 percent	77	33%	933	10%
10-24 percent	67	20%	2,053	22%
25-49 percent	38	11%	1,307	14%
50-74 percent	23	7%	747	8%

SOURCE: MPR analysis of data from InterStudy and HCFA.
*Stand-alone Medicaid product offered by commercial firm.

Figure 2
Percentage of Full-Risk Enrollees Served by Medicaid-Dominated Plans, by State, 1997



[1]Six state programs with at least 10,000 enrollees in full-risk plans had no enrollment in Medicaid-dominated plans: Georgia, Iowa, Nebraska, New Mexico, Vermont and West Virginia.
[2] "Other": states with very limited or no fully capitated enrollment (< 10,000 enrollees).
SOURCE: MPR analysis of data from InterStudy and HCFA data.

[3] NOTE: All data are for June 1997, with the exception of financial data, which were for calendar year 1997, except as noted, and accreditation status, which were available for June 1998.

Table 2

Characteristics of Medicaid-Dominated Plans Compared with Other Full-Risk Health Plans, 1997

Characteristics	Medicaid-Dominated Plans	Commercial Plans	All Full-Risk Health Plans
Number of Plans	118	221	709
		Percent Distribution	
Total Plan Enrollment			
<24,999	59%	19%	37%
25-49,999	26	11	19
50-99,999	10	20	17
100-249,999	4	33	19
250,000 or more	1	17	8
Medicaid Enrollment			
0	0	0	52
1-9,999	31	39	17
10-19,999	19	21	10
20-44,999	34	24	13
45,000 or more	16	16	8
Profit Status			
For-Profit	37	63	69
Not-for-Profit	63	37	31
Age in 1997			
<3 years	58	12	26
3 years or more	42	88	74

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

Organizational Characteristics

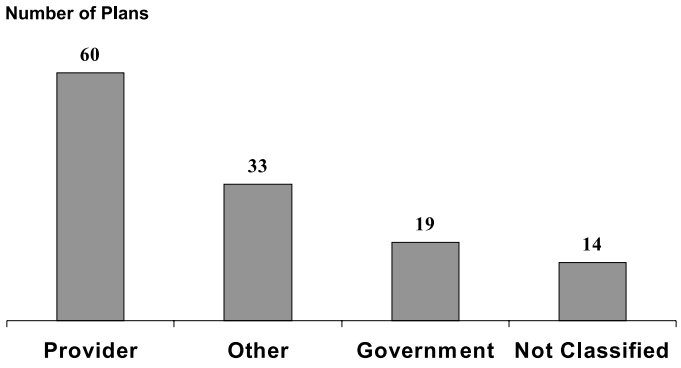
Plan Size. Nearly all Medicaid-dominated plans are small by HMO industry standards – more than half have fewer than 25,000 members (Table 2). Only 15 percent have more than 50,000 members, compared with 70 percent of other Medicaid-serving plans and 44 percent of all full-risk health plans. Small size presents a challenge, as very small plans tend to have higher administrative costs per member and may be unable to generate the volume of revenue needed to make major infrastructure investments (such as information systems). Other data suggest that small plans generally find it more difficult to succeed financially (HCIA 1999).

Medicaid Enrollment. Although they are smaller in total enrollment, Medicaid-dominated plans tend to enroll slightly more Medicaid enrollees per plan than do other Medicaid-serving plans. Half of the Medicaid-dominated plans served at least 20,000 Medicaid enrollees, compared with 40 percent of other Medicaid-serving plans.

Ownership. In general, Medicaid-dominated plans can be classified into four broad ownership categories (Figure 3 and Table 3): provider-owned; other managed care firms (including multi-state and independently owned); government-owned; and not classified. Understanding how these types of plans differ is important because ownership is likely to influence organizational philosophy, operations, access to capital, and other elements that may be important to financial viability and enrollee outcomes for Medicaid-dominated plans.

Figure 3

Medicaid-Dominated Plans by Type of Ownership, 1997



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

NOTE: Because several plans include multiple types of owners, the total number of plans shown here (126) is greater than the total number of Medicaid-dominated plans in 1997 (118).

Table 3
Ownership of Medicaid-Dominated Plans, 1997

	Number of Medicaid-Dominated Plans Including Each Type of Owner	% of All Medicaid-Dominated Plans
Total Medicaid-Dominated Plans	118	100
PROVIDER-BASED PLANS, BY PROVIDER TYPE	60	51
Hospitals (all)	31	
Academic Medical Center	11	
Other Safety Net Hospitals	13	
Other Hospitals or Safety Net Status Unknown	10	
Federally Qualified Health Centers	24	
Physician Organizations	16	
OTHER MANAGED CARE FIRMS	33	28
INDEPENDENT	22	
AFFILIATED WITH A MULTI-STATE MANAGED CARE FIRM	11	
Amerigroup (IL, NJ, TX)	3	
Americhoice (NJ, NY)	2	
Genesis (OH, WI)	2	
Medical Care Mgt. Co. (TN, MS)	2	
Managed Health Services Insurance Corp. (IN, WI)	2	
GOVERNMENT PLANS, BY TYPE OF GOV'T ENTITY	19	16
County Organized Health Systems (CA)	5	
County Government — Other (CA)	8	
County Government — States Other than CA	2	
Local Health Department	3	
State Government	1	
NOT CLASSIFIED[a]	14	12

NOTE: Percentages in the second column do not add to 100% because a few plans (10) include multiple types of owners. Similarly, because many plans were owned by partnerships or coalitions of different types of providers, the numbers of each type of provider-based plan do not add to the total number of provider-based plans.

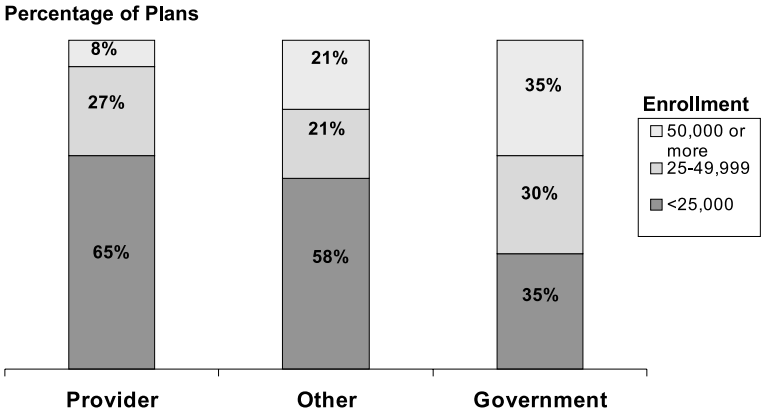
[a]Six of these plans are also included in the provider-based category above because the plan is owned by a partnership between providers and others who are of unknown type.

SOURCE: MPR STAFF RESEARCH.

Provider-owned: Half of all Medicaid-dominated plans are at least partly owned by providers (51 percent). Provider-based plans tend to be smaller than other Medicaid-dominated plans (Figure 4), and most of them (73 percent) are not-for-profit (Figure 5). About half of the provider-based plans (31 of 60) are owned at least in part by a hospital, most of which are safety-net hospitals. Eleven plans (18 percent) are owned at least in part by an academic medical center (AMC) and 13% were owned in part by another safety-net hospital. Federally qualified health

Figure 4

Size of Medicaid-Dominated Plans by Type of Ownership, 1997

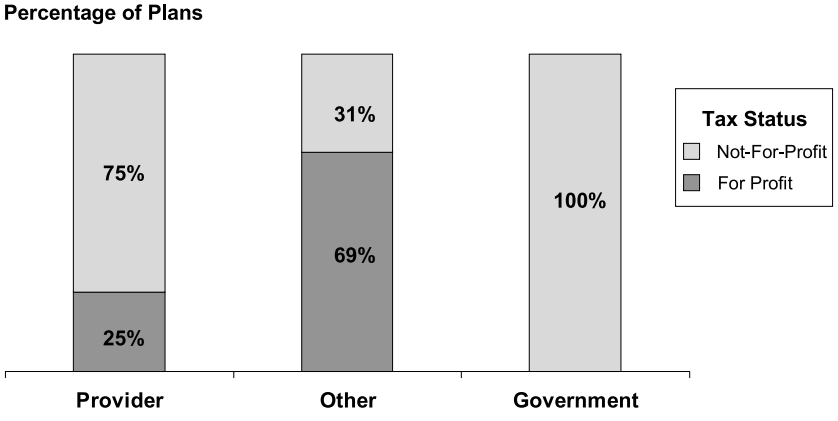


SOURCE: MPR analysis of data from InterStudy and HCFA, supplemented by staff research.

NOTE: Provider-based plans include all Medicaid-dominated plans that are at least partly owned by providers. Other managed care firm plans and government plans are similarly inclusive. Only10 Medicaid-dominated plans (of 118) include multiple types of owners.

Figure 5

Tax Status of Medicaid-Dominated Plans, by Type of Ownership, 1997



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

centers (FQHCs) own 24 of the 60 (40 percent) provider-owned Medicaid-dominated plans in whole or in part (9 of these FQHC plans were partnerships with other entities, usually a hospital). Physician organizations own 16 (26 percent of provider-owned) Medicaid-dominated plans, most of which are located in Oregon. Thus, within the subset of Medicaid-dominated plans that are provider-based, we find large variety in the types of provider organizations that participate as owners.

Other managed care firms: "Other managed care firms" include two types of plans: those that are affiliated with a multi-state managed care firm and those that are independent. Within the group of other managed care firms, multi-state managed care firms own 11 (33 percent) Medicaid-dominated plans. All 5 multi-state firms operated in only 2 or 3 states in 1997. Americaid is one such multi-state firm. Its self-proclaimed mission is "to operate a community-focused managed care company with an emphasis on public-sector health care..."[4] AmeriChoice is another such firm. In addition to owning multiple Medicaid-dominated plans, AmeriChoice has other lines of business, including health care information systems and physicians' practice management.[5]

Government-owned: Governments at least partly own 19 of the 118 Medicaid-dominated plans. This excludes plans owned by public hospitals (which were counted as provider-based plans), but includes plans owned by local health departments, county governments, and one state government. Thirteen of the 19 government-owned plans are located in California. This reflects the scale of California's program, the role of counties in the state, and the fact that California has included local governments as a specific part of its strategy for implementing capitated Medicaid managed care (Verdier 1999; Draper, Gold, and Hudman 1999; The California Association of Health Insuring Organizations 1999). These circumstances in California explain why government-owned plans are on average larger than other Medicaid-dominated plans (Figure 4).

Not classified: We believe that 22 Medicaid-dominated plans are independent firms that are neither provider- nor government-owned, though ownership relationships are difficult to trace; it is likely that several of these plans actually have ownership ties to another type of owner that we did not identify. Further, some of these plans may have originally been formed by providers, even if they are not currently provider-owned.

In contrast to the provider-based and government plans, the other managed care firms (including both independent and affiliated plans) tend to be for-profit plans (72 percent) (see Figure 5). Also of note, while still very small relative to industry standards, these plans tend to be somewhat larger than provider-based plans: twenty percent of the other managed care firms plans have 50,000 or more members.[6]

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[4] http://www.amerigroupcorp.com

[5] AmeriChoice did not operate a significant commercial managed care business at the time of our study. Statement by Oxford Health Plans, announcing plans in November 1998 to transfer its Medicaid business in Brooklyn, NY to a subsidiary of AmeriChoice. Also see http://www.americhoice.com.

[6] Eight Medicaid-dominated plans had ownership types that were not classified. For five of the eight, we identified an affiliate company, but the company did not fit into the above categories or we did not have enough information to classify it. For the other three, our modest attempts to elicit ownership type for each plan did not yield enough information to classify them in another category. These eight plans are excluded from analyses based on ownership type.

Tax Status. Overall, a majority of Medicaid-dominated plans are not-for-profit (63 percent), compared with only 31 percent of all full-risk health plans (see Table 2). Not-for-profit Medicaid-dominated plans enrolled 2.3 million Medicaid recipients, or one-fourth of all full-risk Medicaid enrollees.

Looking more closely within the group of Medicaid-dominated plans, most provider-owned plans and all government-owned plans are not-for-profit, whereas most of the other plans are for-profit. These for-profit independent or multi-state managed care firms enroll 0.6 million enrollees, or 6 percent of all full-risk enrollees.

Note, however, that there is not a completely consistent relationship between profit status and type of ownership. For example, there are several plans owned by safety-net providers that are organized as for-profit plans, and a few independent managed care firms are non-profit plans that originated from community-based organizations. Thus, we should not assume that the underlying mission of all for-profit plans differs from that of non-profit plans, nor should we assume that all provider-based plans are non-profit. For-profit tax status may have been sought by provider-based plans, for example, to ease access to necessary start-up capital.

Age. Over half of Medicaid-dominated plans began operating within the last 5 years (58 percent). In 1997, these newer plans enrolled 1.5 million enrollees, or 16 percent of all Medicaid managed care enrollees. Independent or multi-state managed care plans tend to be somewhat newer than provider-based plans, but not dramatically so. The growth in new Medicaid-dominated plans has come from the formation of a range of plan types – provider-based, government, and other managed care firms. Six states contain three or more of these newer Medicaid-dominated plans: California (10), Michigan (3), Mississippi (3), New York (8), Oregon (4), and Pennsylvania (3).

Accreditation. By mid-1998, only 5 (4 percent) of the Medicaid-dominated plans had received one-year or full accreditation by the National Committee for Quality Assurance (NCQA), and an additional 2 were accredited by the Joint Commission on Accreditation of Healthcare Organizations. In contrast, we estimate that about 34 percent of all full-risk health plans had

one-year or full accreditation from NCQA in mid-1998.[7,8] This gap between Medicaid-dominated plans and other plans is not surprising since state Medicaid agencies have not been requiring accreditation as a condition of certification, as have many large private purchasers. Thus, there is little incentive for Medicaid-dominated plans to undertake the substantial investment required to undergo accreditation. Instead, states set other quality-related requirements and monitor the plans directly and through a contracted external quality review organization. Preparation for accreditation is a costly process, particularly for new plans (Felt-Lisk and St. Peter 1996). States may fear (perhaps with good reason) that Medicaid-dominated plans would not be able to survive financially if they had to invest in the quality improvement structures and processes that NCQA accreditation requires, and they may believe such accreditation is unnecessary given their existing quality requirements.

Financial Status

1997 was a bad year financially for many Medicaid-dominated plans as well as other full-risk plans.[9] The HMO industry as a whole was unprofitable, with substantially more than half the industry losing money; several other financial indicators also worsened (HCIA 1998). Nearly half of the 63 Medicaid-dominated plans for which we have financial data lost money in 1997 (48 percent), and based on a measure of their liquidity, one third were not financially positioned to meet their short-term obligations.[10]

Looking beyond single measures of these plans' short-term finances, we estimate 30 percent are at medium or high financial risk, with 16 percent at high risk. "High risk" is defined as having (1) negative net worth or a net loss in 1997 that is greater than net worth, and (2) negative net income in 1997, and (3) current ratio less than 1, indicating probable inability to cover short-term

[7] It is necessary to estimate this figure because obtaining a more precise one would require matching plan names from the NCQA accreditation status listing to our database- an exercise beyond the scope of this study. To estimate, we simply divided the number of accredited plans on the NCQA list by the total number of plans in our database operating in mid-1997.

[8] Two more Medicaid-dominated plans (less than 2 percent) have provisional accreditation. About the same percentage of all plans have this status, which indicates only partial compliance with NCQA standards.

[9] Financial status indicators are based on 1997 data obtained from state insurance departments and/or Medicaid agencies for Medicaid-only plans in 15 states. We limit the financial analysis to plans where Medicaid comprised 90 to 100 percent of their total enrollment because of concern about consistency and comparability across plans when allocation of expenses between different product lines was required.

[10] These plans' current liabilities are greater than their current assets. In technical terms, their "current ratio" is less than 1.

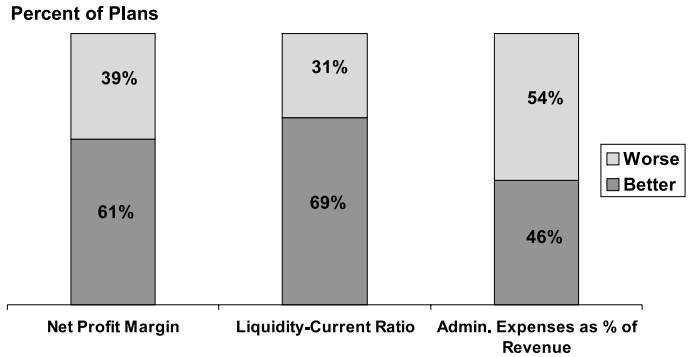
obligations.[11] We define "medium risk" as plans not identified as high risk plans but which have total liabilities greater than total assets (negative net worth). The financial difficulties we identify cut across all types of Medicaid-dominated plans; there are no obvious patterns by tax status, ownership type, age, or number of enrollees. Ten of the 13 states for which we have data on financial status have at least one Medicaid-dominated plan at medium or high risk. New York has 6 at-risk plans (of 13 analyzed); California, Oregon, and Tennessee each have 2; Missouri, Florida, Ohio, Illinois, and Arizona each have 1.

Although most did not fare very well, the Medicaid-dominated plans as a group did not fare any worse than other full-risk plans in 1997. We were able to analyze three financial indicators, comparing the Medicaid-dominated plans for which we had financial data to other plans in the same state that had submitted financial data to Health Care Investment Analysts for the same year and in the same format we used. We found the following (Figure 6 and Table 4):

- Sixty-one percent of the Medicaid-dominated plans have net income that is higher than the average (median) value for other full-risk plans in their state.

Figure 6

Percent of Medicaid-Dominated Plans Faring Better or Worse than Average for Commercial Plans in Same State, 1997



NOTE: The "better" bar on the graph shows the percentage of Medicaid-dominated plans above the median value for commercial plans in the same state, where higher values are desirable (net profit margin, current ratio), and lower than the median where lower values are generally desirable (administrative expenses).

SOURCE: MPR analysis of financial statement of Medicaid-only plans, collected from state Medicaid agencies and insurance departments, and HCIA 1998.

[11] Multiple years of financial data offer a better indication of financial status than the one year of data available to us. We rely heavily on net worth as an indicator of risk, because net worth is a measure of accumulated assets in relation to accumulated obligations and thus is a more stable indicator than net income in any given year.

Table 4

Median Values of Selected Financial Indicators for Medicaid-Dominated Plans Compared with Others, by State, 1997[a]

	Number of Plans[b]		Average Net Profit Margin Surplus of revenues over expenses as a proportion of revenue. A measure of overall profitability. Converted to a percentage; 1.2% indicates 1.2% surplus.		Average Current Ratio Ratio is current assets to total current liabilities. An indicator of a plan's liquidity and its ability to meet short-term (i.e., due within one year) obligations. Higher values are desirable.		Average Administrative Expense as a Percentage of Revenue Indicates what proportion of its revenue a plan is spending on administration, which includes all expenses other than expenses for medical care.	
	Medicaid-Dominated Plans	All Other Plans	Medicaid-Dominated Plans	All Other Plans	Medicaid-Dominated Plans	All Other Plans	Medicaid-Dominated Plans	All Other Plans
All 13 States	61	281	0.3%	-4.0%	1.1	1.0	15.9%	15.9%
Arizona	6	10	0.5%	1.0%	1.0	0.8	10.2%	14.5%
California	9	22	4.0%	0.0%	1.3	1.2	12.2%	14.9%
Connecticut	2	14	2.1%	-5.0%	1.1	1.3	16.4%	19.4%
Florida	2	30	-9.3%	-8.5%	0.1	1.1	34.5%	21.0%
Illinois	1	24	-38.9%	-4.0%	1.6	1.2	84.9%	15.2%
Missouri	3	20	1.4%	-2.5%	1.1	1.1	15.5%	15.4%
New Jersey	5	18	-3.4%	-2.0%	1.1	1.0	22.1%	19.5%
New York	13	33	-3.5%	-5.0%	1.2	0.8	24.4%	15.4%
Ohio	2	23	-4.1%	-5.0%	0.8	0.9	18.8%	15.1%
Oregon	9	5	1.1%	0.0%	1.0	0.4	9.4%	13.5%
Pennsylvania	4	24	-3.0%	-5.0%	1.0	1.0	14.3%	14.3%
Tennessee	4	18	-0.3%	-8.0%	NA	1.1	15.0%	16.1%
Washington	1	7	1.5%	-7.0%	1.8	1.0	5.4%	12.1%

[a] Only those Medicaid-dominated plans with 90-100 percent Medicaid enrollment were included.

[b] This indicates number of plans used in analysis. There are very few Medicaid-dominated plans with missing data except in New York. California's county organized health systems were excluded because of their very different structure.

NOTE: Nationally, the median values for the indicators shown are: net profit margin -5%, current ratio 1.1, administrative expense as a percentage of total revenue 15.6% (HCIA 1998).

SOURCE: MPR ANALYSIS OF FINANCIAL STATEMENT OF MEDICAID-ONLY PLANS, COLLECTED FROM STATE MEDICAID AGENCIES AND INSURANCE DEPARTMENTS, AND HCIA 1998.

- Sixty-nine percent of the Medicaid-dominated plans are "more liquid" than other plans in their state, indicating greater ability to meet short-term obligations, and
- Administrative expenses for Medicaid-dominated plans as a group are not unusually high relative to other plans in the state, despite their small size. (However, see Robinson 1997 for a discussion of the limitations of using the medical loss ratio, and, by extension, the administrative expense ratio used here.)

Financial data for a single year do not offer the power or precision to draw strong conclusions about the financial status of plans or the characteristics associated with financial difficulties. Further, our assessment of risk must be tentative in part because we do not know what level of financial stability or success is required by the plans' owners. Providers who own the provider-owned plans may sometimes be willing to provide additional financial backing when the plan appears to be in poor financial health, for strategic reasons such as maintaining inpatient volume. On the other hand, private investors may have relatively strict criteria for financial success.

ROLES OF MEDICAID-DOMINATED PLANS IN THEIR MARKETS[12]

A county-level analysis for 15 high-volume Medicaid managed care states suggests that Medicaid-dominated plans are rarely the dominant plan in the market. In general:

- Most enrollees are in counties with both Medicaid-dominated and commercial plan choices;

- Medicaid-dominated plans usually enroll a substantial minority (about a third) of the enrollees in the counties they serve;

- Medicaid-dominated plans' service to enrollees is concentrated in counties that present special challenges, such as being poorer, being health professional shortage areas, and having greater concentrations of ethnic minorities.

Table 5 shows the numbers of plans and enrollees included in this analysis.

Four-fifths of enrollees are in counties with both a Medicaid-dominated and commercial plan; one-fifth do not have a choice. Eighty-one percent of enrollees are in counties that are served by both Medicaid-dominated plans and commercial plans, although such choices are offered in only about half (54 percent) of the counties with full-risk Medicaid managed care (Figure 7). About a third of counties have only commercial plans serving Medicaid, but these account for only 10 percent of enrollees. Fewer counties – 15 percent – have only Medicaid-dominated plans; these counties account for 9 percent of enrollees.

[12] Because national data are not available, this section is based on analysis of detailed Medicaid enrollment data for mid-1998 that we collected from the Medicaid agencies of 15 high-volume Medicaid managed care states: AZ, CA, CT, FL, IL, MI, MO, NJ, NY, OH, OR, PA, TN, WA, and WI.

Table 5

Number of Full-Risk Health Plans and Enrollees in 15 High Volume Medicaid Managed Care States (Mid 1998)

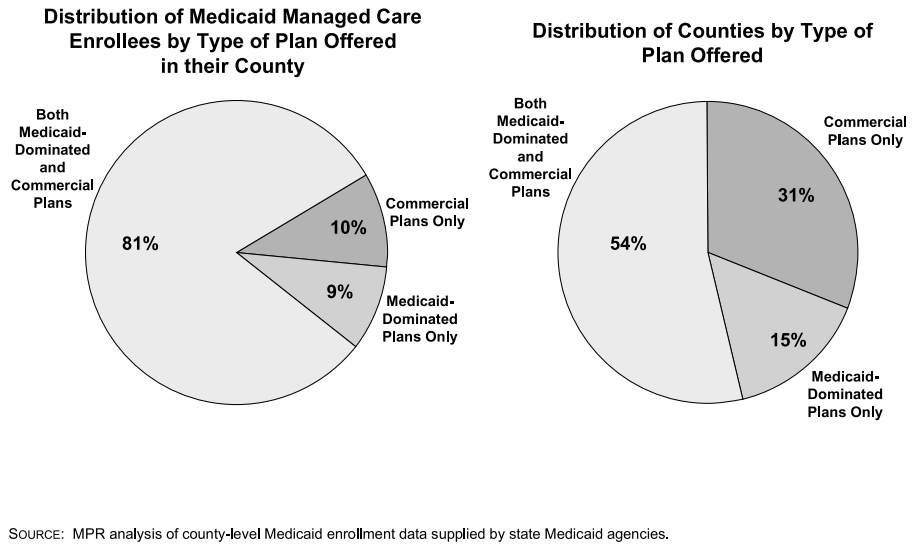
	Full-Risk Health Plans		Medicaid Enrollment in Full-Risk Plans: Total		Families		Disabled/Elderly	
	N	%	N	%	N	%	N	%
All	210	100	8,032,621	100	5,383,709	100	751,375	100
Medicaid-Dominated Plans	82	39	3,460,607	43	2,063,357	38	315,071	42
Commercial Plans	128	61	4,572,014	57	3,320,352	62	436,304	58

SOURCE: MPR analysis of Interstudy data, HCFA data, and Medicaid enrollment data from Medicaid agencies.

NOTE: States included are AZ, CA, CT, FL, IL, MI, MO, NJ, NY, OH, OR, PA, PA, TN, WA, WI. Medicaid enrollment are for mid-1998, but Medicaid-dominated plan or commercial plan type was determined based on 1997 data.

Figure 7

Distribution of Counties and Enrollees by Type of Plan Offered (15 states, 1998)



SOURCE: MPR analysis of county-level Medicaid enrollment data supplied by state Medicaid agencies.

The typically smaller service area of a Medicaid-dominated plan helps explain why commercial plans are offered in a higher percentage of counties than Medicaid-dominated plans. Almost half of the Medicaid-dominated plans serve only one or two counties, compared with only one-fourth of commercial plans that serve Medicaid.

Medicaid-dominated plans usually enroll a substantial minority (less than a third) of total Medicaid enrollees in the counties they serve. In counties where both Medicaid-dominated plans and commercial plans serve Medicaid, Medicaid-dominated plans most often serve fewer than one-third of the enrollees in the county (58 percent of counties). They were heavily predominant (serving two thirds or more of the enrollees) in only 13 percent of these counties. However, certain demographic groups or neighborhoods may be quite dependent upon specific Medicaid-dominated plans even if these plans do not serve a large percentage of the population county-wide.

We also found that Medicaid-dominated plans are more often predominant in voluntary program areas than in mandatory ones. For example, Medicaid-dominated plans served a large majority of the county's enrollees in one quarter of the voluntary counties, but much more rarely in the mandatory counties (only 11 percent). Since service to Medicaid is the sole focus of Medicaid-dominated plans, they may be more interested than commercial plans in actively marketing their services in areas where the total potential number of enrollees for managed care plans may be smaller, such as voluntary counties. Conversely, the lower market share of Medicaid-dominated plans in mandatory counties could reflect greater competition in these counties from commercial plans.

In many states, Medicaid-dominated plans' service is concentrated in counties that present special challenges. The types of counties in which Medicaid-dominated plans serve a high proportion of enrollees[13] ("high MDP counties") vary by state. But in a majority of the states we analyzed, these counties are poorer, have been designated as Health Professional Shortage Areas, and/or have high minority populations relative to other counties (see Appendix A, Table A-1 for the full state-by-state analysis). Some of the most striking state-by-state examples follow:

- In Washington state, an average of 16 percent of the families are below poverty in high MDP counties, compared to 10 percent in other counties. An average of 28 percent of the

[13] Nationally, Medicaid-dominated plans serve 36 percent of Medicaid enrollees in full-risk managed care. Therefore, we classified counties where Medicaid-dominated plans served 36 percent or more of the enrollees in the county as "high MDP counties" (this was 34 percent of counties) and others as "low MDP counties." Counties with no commercial plans were grouped with the high MDP counties, and those with no MDP option were grouped with the low MDP counties.

population identify themselves as a racial or ethnic minority, compared with 7 percent in other counties.

- In Pennsylvania, the population per square mile in high MDP counties is half that of other counties. Per capita income in these counties is 28 percent below the average for other counties, and the average percent of families below poverty is twice that of other counties (10 percent compared with 5 percent).

- In Tennessee, 72 percent of high MDP counties are designated health professional shortage areas, compared with 56 percent of other counties. About 12 percent of the population in these counties identify themselves as a racial or ethnic minority, compared with 3 percent elsewhere.

- In Oregon, the high MDP counties are extremely rural, with an average of only 12 people per square mile compared with 64 people per square mile in other counties.

These results both stress the state-to-state variety in the role Medicaid-dominated plans play in their markets, and also suggest that in many states the Medicaid-dominated plans may be filling a real need since they are operating in areas that are less likely to support commercial managed care plans.[14]

Medicaid-dominated plans serve "their share" of the disabled and elderly Medicaid population, but do not seem to be playing a special role in serving this population in the states that enroll special needs populations into capitated programs.[15] In other words, where included in capitated managed care, the disabled and elderly Medicaid population is enrolled in Medicaid-dominated plans to about the same extent as the remaining Medicaid population. Appendix A, Table A-2 provides a state-by-state analysis of enrollment into Medicaid-dominated plans by the disabled or elderly for the six states in our study with at least 50,000 such enrollees in their state's capitated program. In no state for which we had data did Medicaid-dominated plans serve significantly higher proportion of the disabled or elderly population. However, the analysis does show that patterns vary by state. For example, in Tennessee, 47 percent of families are enrolled in Medicaid-dominated plans compared with 39 percent of the elderly and disabled

[14] While our data are suggestive, data on the demographic characteristics of the health plans' enrolled population would be necessary before strong conclusions could be drawn on this point.

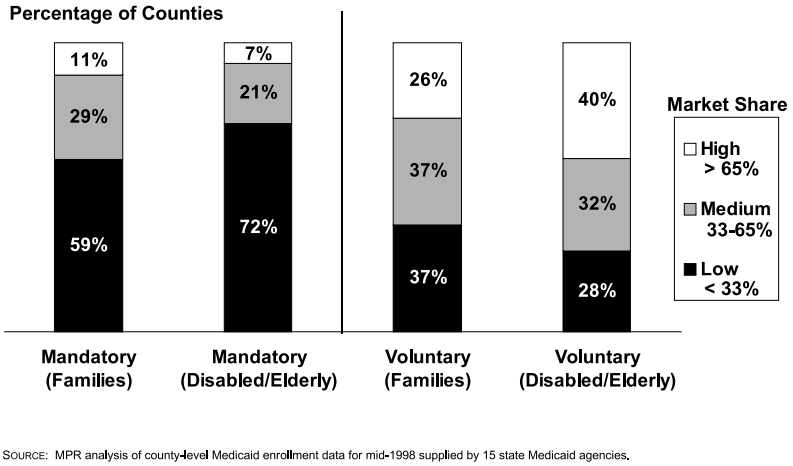
[15] This equivalent distribution of disabled and other enrollees also held true when we looked in more detail within Medicaid-dominated plans and commercial plans by type of ownership.

population. The difference seemed to arise from the Blue Cross Blue Shield (BCBS) plan's enrollment. The BCBS plan, which is statewide and enrolls about half of all Tenncare enrollees, served 34 percent of families in Medicaid, but 41 percent of the disabled/elderly enrollees.[16] Also, in Oregon, 40 percent of Medicaid families enrolled in Medicaid-dominated plans compared with 33 percent of the disabled/elderly population.

Analysis of mandatory versus voluntary program areas also revealed overall similarity in the Medicaid-dominated plans' and other plans' roles in serving disabled/elderly and families in Medicaid. Figure 7 shows that Medicaid-dominated plans tended to serve a relatively low percentage of enrollees in mandatory program areas for both families and special needs populations, and serve a relatively higher percentage for both population groups in voluntary program areas. This pattern was somewhat more pronounced for special needs populations relative to families in Medicaid. Medicaid-dominated plans served a low percentage of Medicaid families in 59 percent of the mandatory counties in our study states, but they served a low percentage of the disabled/elderly population in even more mandatory counties – 72 percent (Figure 8).

Figure 8

Market Share of Medicaid Dominated Plans, 1998



SOURCE: MPR analysis of county-level Medicaid enrollment data for mid-1998 supplied by 15 state Medicaid agencies.

[16] This is not a consistent finding across the states for BCBS plans: the BCBS plan in Pennsylvania also served a somewhat higher percentage of disabled/elderly enrollees than other enrollees (39 versus 35 percent), but the BCBS plans in California and Oregon served about the same percentage of families and disabled/elderly enrollees.

KEY FINDINGS AND DISCUSSION

Each of our four key findings is discussed below.

1. **Medicaid-dominated plans are small plans that vary widely in ownership type, and are a mix of for-profit and not-for-profit entities.**

The variation in the most fundamental organizational characteristics such as ownership type and profit status among Medicaid-dominated plans suggests that there may be variation in how and how well they serve the Medicaid population. This finding seems to suggest caution regarding policies that assume that any health plan focusing mostly on the Medicaid population is worthy of special support. Rather, policies should be designed to support desirable characteristics of health plans more broadly, or within the group of Medicaid-dominated plans.

2. **In many states, Medicaid-dominated plans' service to Medicaid is more concentrated than other plans in areas that present special challenges such as greater concentrations of ethnic minorities, higher levels of poverty, and fewer health care resources.**

Special policy concern for Medicaid-dominated plans may be warranted where their service to Medicaid is both of high quality and concentrated in areas with characteristics that may not support other plans. However, our data did not allow us to analyze the extent to which Medicaid-dominated plans as a group are essential supports to the safety-net for the uninsured in these communities, although we did identify 41 Medicaid-dominated plans that are owned by Federally Qualified Health Centers, academic medical centers, and/or other safety-net hospitals, all of which are usually included in definitions of safety-net providers.

3. **Medicaid-dominated plans currently play a relatively limited role in most markets and are not serving the disabled/elderly Medicaid population in managed care to a greater extent than other plans.**

The small size and limited overall role of Medicaid-dominated plans in their markets to date suggest they will not easily or quickly have the capacity to fully replace the role of commercial plans in Medicaid managed care, should commercial plans continue to exit the Medicaid market. Further, identifying those Medicaid-dominated plans which are able to fill the role of exiting commercial plans is important, given the wide variation in basic characteristics of Medicaid-dominated plans (e.g., non-profit vs. for-profit, provider-based vs. other types of plans). The overall absence of a special role for Medicaid-dominated plans in serving the disabled/elderly population may provide some support to the belief that the disabled/elderly population overall is

becoming integrated into managed care programs in roughly similar patterns to others. However, more detailed analysis using clinical data is needed before we can determine whether enrollees with more complex health needs are enrolling in certain types of plans.

4. Nearly a third of Medicaid-dominated plans appear at financial risk. However, Medicaid-dominated plans did no worse financially in 1997 than other plans in their states, and many fared better.

The results of our financial analysis of Medicaid-dominated plans offer mixed news. On the one hand, our identification of 30 percent of the Medicaid-dominated plans at financial risk in the states we studied seems worrisome. However, without more information it is impossible to interpret the seriousness from a policy perspective, since these plans were widely scattered and varied in ownership type and other characteristics. Also, the available data were limited to several common financial measures for a single year. Nevertheless, the fact that just over half of the Medicaid-dominated plans broke even or made money in 1997 and that many did better than other plans in their state contradicts the perception of some that many of these plans are poorly managed and on the verge of financial collapse.

While filling a need for basic information about Medicaid-dominated plans, our analysis also raises numerous additional questions: How do the different types of Medicaid-dominated plans vary in the ways they serve Medicaid beneficiaries and in the quality of care their members receive? If the Medicaid-dominated plans at financial risk fail, what benefits to Medicaid beneficiaries or safety-net providers will be lost? Will Medicaid-dominated plans play a much increased role in their markets as commercial plans continue to exit, and, if so, what types of Medicaid-dominated plans will become larger and stronger? These are important issues for policymakers to monitor as the Medicaid managed care market continues to evolve.

Appendix A

Detailed Tables

Appendix A-1

Characteristics of Counties with Higher Enrollment (Market Share) in Medicaid-Dominated Plans

(Median Values for Selected Socioeconomic and Environmental Indicators)

State and Market Share of MDPs	Rurality	Health Resources		Income and Employment		
	Pop. per Square Mile	Percent Partial or Whole HPSA* County	Percent Non-White	Median Per Capita Income	Percent Families Below Poverty	Unemployment Rate
Connecticut						
Lower	758	67	11.3	$25,600	4.6	5.3
Higher	300	100	5.1	24,000	4.3	6.0
Michigan						
Lower	116	79	4.1	18,600	9.1	5.5
Higher	43	73	3.6	17,300	11.6	8.2
Missouri						
Lower	28	46	2.4	17,200	11.7	4.8
Higher	56	64	4.7	17,800	8.7	4.0
New Jersey						
Lower	717	60	13.0	25,100	4.7	6.7
Higher	2,362	83	21.9	24,900	4.6	6.8
New York						
Lower	126	77	3.9	19,200	7.3	6.5
Higher	500	67	10.4	21,000	6.6	5.7
Ohio						
Lower	469	38	8.5	20,600	9.0	5.5
Higher	954	88	17.5	20,900	10.1	5.0
Oregon						
Lower	64	86	4.4	18,100	9.4	5.9
Higher	12	86	3.8	17,400	10.1	7.2
Pennsylvania						
Lower	468	67	6.5	23,300	5.0	4.8
Higher	238	75	2.9	18,200	9.9	7.2
Tennessee						
Lower	63	56	2.5	15,400	13.8	5.9
Higher	51	72	11.7	15,900	14.7	5.4
Washington						
Lower	29	89	6.7	18,400	9.5	7.6
Higher	34	100	28.2	17,800	15.6	11.1

* HPSA = Health Professional Shortage Area

SOURCE: Mathematica Policy Research analyses based on the Area Resource File, 1997. Enrollment data provided by State Medicaid agencies.

Appendix A-2

State by State Analysis of Enrollment in Medicaid-Dominated Plans and Commercial Plans, by Plan Ownership

	Tennessee		Pennsylvania		Florida		Arizona		California		Oregon	
Percent of Medicaid Enrollees in:	Families	Disabled/ Elderly	Families	Disabled/ Elderly	Families	Disabled/ Elderly	Families	Disabled/ Elderly	Families	Disabled/ Elderly	Families	Disabled/ Elderly
Number of Enrollees	618,246	335,624	490,231	154,060	317,893	68,545	251,081	59,02	1,271,567	52,768	164,569	52,156
Medicaid-Dominated Plans												
All	47%	39%	56%	52%	2%	1%	88%	85%	38%	40%	40%	33%
Provider Based	5	4	21	19	2%	1%	37	37	4	7	40	33
Other Managed Care Firm	32	28	35	33	0	0	38	34	6	10	0	0
Government	0	0	0	0	0	0	2	2	32	30	1	0
Other	9	8	0	0	0	0	3	34	0	0		
Commercial												
All	53	61	44	48	98	99	12	15	62	60	60	67
BCBS	34	41	35	39	0	0	0	0	20	19	30	31
Other Large or Affil.	18	18	9	9	89	93	7	6	39	40	30	36
Other	1	1	0	0	10	6	6	10	2	2	0	0

NOTE: Of the 15 states that are the focus of our study, this tables includes the six that enrolled 50,000 or more disabled/elderly into their capitated programs.

SOURCE: Mathematica Policy Research analyses.

APPENDIX B: THE DATA

The dataset used in this analysis was developed by Mathematica Policy Research, Inc. The Henry J. Kaiser Family Foundation funded the addition of 1997 national data and 1998 data for 15 states that was used here. This update built on an earlier project, which was sponsored by the Center for Studying Health System Change, that used 1993–1996 data.

Overview of the Creation of the Database. To develop the database, we merged HCFA data on full-risk Medicaid enrollment by plan for June 30 of each year from 1993 to 1997 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 1996–1997 were from InterStudy HMO directories 6.2 and 8.1. The merge process required matching plans that are listed by different names in the HCFA and industry sources. We drew on information from other researchers, called some state Medicaid offices, and sometimes called individual plans to clarify ambiguities and supplement available information. Plans that do not provide comprehensive medical services (e.g., behavioral health and dental managed care plans) were excluded from the database. Though we performed many checks, some errors undoubtedly remain.

Enrollment Data Collected from States. Detailed Medicaid enrollment data by plan, by county, and by Medicaid eligibility category were collected for 15 high-volume Medicaid managed care states from the state Medicaid agencies of those states. The month for which the data were provided differed slightly by state but was a spring/summer month in 1998. We were able to obtain the requested data from all states, except that we were not able to obtain the eligibility group breakdown for Michigan or the five California County Organized Health System counties. Because we did not have non-Medicaid enrollment for 1998, we determined plan characteristics based on 1997 data (supplemented as necessary by telephone calls).

Analysis of Enrollment Pattern of Disabled/Elderly Medicaid Population. To analyze whether special Medicaid populations in managed care are enrolled in Medicaid-dominated plans more or less than in other plans, we collapsed the detailed eligibility group data for each state into three broad categories to create roughly comparable data for analysis across the states. Marilyn Ellwood, a Senior Fellow in Mathematica's Cambridge office and a national expert on Medicaid eligibility, created the algorithm for collapsing the data into "Families," "Disabled or Aged," and "Other" categories. The "Other" category includes, for example, foster children, refugees, and eligibility groups such as state-only general assistance eligibles that likely include both some families and some disabled or elderly enrollees.

Financial Data and Analysis. The financial data we used was extracted from full data in the National Association of Insurance Commissioners' format or a very similar state-defined

format, and was collected from the 15 state Medicaid agencies and insurance departments (as appropriate) for the plans identified as having Medicaid enrollees that comprised at least 90 percent of their total enrollment. Data were for calendar year 1997, which was the most recent year available.[17] The only exception was Tennessee, where we were not able to obtain the audited, full financial reports but did obtain state-maintained financial data drawn from those reports. We were able to obtain the financial data for 62 of the 79 Medicaid-only plans in the 15 states, including plans in all of the targeted states except for Michigan (which had two Medicaid-only plans). New York was the only state with much missing data (7 of 20 plans missing), and we were told that the missing plans' data are just misplaced, rather than being missing for any other reason. Of the other 8 plans for whom we did not receive data, we know that at least 5 went out of business or were sold or merged. Since the HCIA data used for comparison also does not include every health plan that existed in that year, we believe they probably faced the same issues we did and thus do not assume there is any bias introduced by our inability to include these data; rather, both the MPR data and the HCIA data may show somewhat more favorable financial status than is true at any point in time.

The most commonly used financial indicators were evaluated for use based on the insight they could potentially provide about the current profitability, overall financial status, liquidity, and administrative costs of the Medicaid-dominated plans along with whether they were available from our data and/or HCIA data from their Guide to the Managed Care Industry.[18] We only had comparative data (for our plans and HCIA plans) for three indicators: administrative costs as a percentage of total revenue, net profit margin, and current ratio. Absent comparable data, we nevertheless analyzed the total net worth of our plans; when a plan's total liabilities are greater than total assets (meaning the plan has a negative net worth), this is generally recognized as indicative of financial trouble.

County-Based Analysis of Medicaid-Dominated Plans' Roles in their Markets. To compare the characteristics of counties where Medicaid-dominated plans served higher and lower proportions of beneficiaries, we used Area Resource File (ARF) data for 1997 matched by county name to the county-level enrollment data provided by state Medicaid agencies. The county-level data from New York State included New York City (NYC) counties as a group, and we had no methodologically sound way to combine the five individual counties' data that were in the ARF. Therefore, NYC is excluded from this analysis. The five County Organized Health Systems in California were also excluded from this analysis, because the structure of plan participation and enrollment in these counties was pre-determined by state policy, making them very different from other counties.

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[17]About one-fifth of the plans had a 12-month reporting period different from the calendar year. For eleven plans (including 7 of the 11 plans in California), the reporting year ended in June 1997. One plan's year ended in May, and one's ended in September.

[18] Analyzing the full HCIA dataset was beyond the scope of this project.

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