

Commercial Health Plan Exits and Involuntary Plan Switching Among Children in Medicaid

Significant changes in the composition of health plans serving public health insurance programs have occurred in recent years. In Medicaid, for example, while the number of health plans that provide health care services exclusively to Medicaid beneficiaries has remained relatively steady, the number of commercial health plans serving both Medicaid and commercial populations has declined. Specifically, there were 22% fewer commercial health plans serving Medicaid beneficiaries nationally in 2003 than in 2000.¹ Since 2000, many of the enrollees of commercial health plans that exited the Medicaid market transferred to health plans that provide health care services exclusively to Medicaid beneficiaries. As a result, membership in these Medicaid-only health plans increased from 4 million in 2000 to almost 7 million in 2003.² Transfers to Medicaid-only health plans include many children and youth because more than 50% of Medicaid managed care enrollment consists of beneficiaries under the age of twenty-one.³ Health plans that these children and youth are transferring to, on the other hand, are concerned that financial losses due to caring for a disproportionately large number of children with special health care needs (CSHCN) might have caused the exiting health plans to withdraw from the public health insurance markets.^{4,5} However, little is actually known about

either the health status of children and youth who have been required to transfer to new health plans or the short term impact of these transfers on their health care expenditures.

“Little information is available on the experience of enrollees involuntarily switching plans...”

Departure of commercial health plans from Medicaid markets has added a new layer to the turnover experienced in public health insurance programs. Results from several studies show that enrollee turnover could be quite high in Medicaid programs.^{6,7,8} Specifically, new enrollees constitute about 30 to 60 percent of Medicaid populations.⁹ Typically, a new enrollee pool in a Medicaid managed care program consists of three groups. First, beneficiaries completely new to the public health insurance system comprise a proportion of this pool. A second group in the new enrollee pool consists of transfers from fee-for-service or primary care case management programs to Medicaid managed care.¹⁰ This group

has expanded drastically in the last decade as Medicaid programs increasingly rely on managed care arrangements both to contain costs and to provide better access to care.¹¹ A third group in the new enrollee pool consists of beneficiaries who voluntarily transfer between health plans within the Medicaid managed care program. Commercial health plan exits from Medicaid markets have added a new group to this pool that we call the ‘enrollees involuntarily switching plans’. These children are forced to transfer to a new health plan due to the withdrawal of their existing plan, hence their transfer is involuntary. The health plans assuming the care for these children view them as new enrollees because they have no prior history with them. However, these children are not new to the Medicaid managed care program. In this study, we focus on enrollees involuntarily switching plans to examine their health status and health care expenditures in the short term after they transfer to one of the existing health plans in the Medicaid market.

Little information is available on the experience of enrollees involuntarily switching plans as they transfer to existing health plans in Medicaid markets. Earlier studies on commercial health plan exits from Medicaid markets mostly focused on issues related to the quality of care.¹² While information

about quality of care is very important, we take a different approach and examine enrollees' health status and health care expenditures one year prior to and one year post their transfer.¹³ Their health status and expenditures are compared to those of children enrolled in the plan receiving the transferring children for 12 months or longer.

Our analysis shows that enrollees transferring from one health plan exiting the Medicaid market did not disproportionately have special health care needs when compared to a group of established enrollees in the plans receiving the transferring children. A second finding from our analysis is that enrollees who involuntarily switch to a new health plan incur relatively higher total expenditures immediately following their transfer than those incurred by established enrollees, even after considering the enrollees' health status. The examination of different components of health care expenditures revealed that expenditures related to emergency department and outpatient visits were contributing to the relatively higher post-transfer expenditures for children involuntarily switching plans. Health care expenditures incurred in the inpatient settings, however, were not different for those involuntarily switching plans and established enrollees.

As discussed later in this issue brief, one possible explanation for the observed differences in emergency department and outpatient expenditures may be related to the children changing their usual source of care in addition to changing their health plan. The emergency department may serve as the only access to the system for the immediate health care needs of children while the families try to identify a new primary

care provider (PCP) and learn procedures for accessing health care services that the new plan and/or provider may use. After the child and family identifies a usual source of care, the new PCP may order additional health care services to assess the child and/or to address any unmet needs leading to higher outpatient expenditures.

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Study Setting

This study was conducted using data from one state's Medicaid Managed Care Program. A health plan serving both commercial and Medicaid enrollees exited the market in this particular state. When the health plan exited, the children transferred to one of six remaining plans.

The Study Design

To assess the effect of commercial health plan exit from Medicaid markets, we relied on comparisons between a treatment and a control group. Enrollees involuntarily switching plans, the treatment group in our study, consisted of children who had to transfer because their old plan exited the Medicaid market. The established enrollees, the control group in our study, consisted of children who were enrolled in the health plans receiving the transferring chil-

dren. We compared the changes in health care expenditures for the treatment group one year pre and one year post the commercial plan exit with those of the control group.

Health care markets are dynamic and many changes (such as introduction of a new drug, implementation of a disease management program or improvements in medical technology) occur that could potentially result in changes in health care expenditure patterns. The primary focus of this study, that is, changes in health care expenditures related to commercial plan exit, is just one of these dynamics. This study uses a treatment and a control group in a pre-post design to isolate changes in health care expenditures that specifically pertain to a commercial plan exit. The methodology used in determining changes in health care expenditures due to commercial plan exit relies on the notion that other changes in the health care market would have similar effects on both groups.

The Data

Two data sources from a state's Medicaid managed care program were used for this study.¹⁴ First, enrollment files containing information about the children's age, gender, number of months enrolled in the program and health plan affiliation were used to identify enrollees who involuntarily switched health plans and those who stayed with the receiving health plan throughout the study period.

Second, we used person-level health care use data provided by the health plans. We used this information in several different ways. First, to estimate the expenditures for the health care



services rendered, Current Procedure Terminology (CPT) codes found in these files were linked to the state's Medicaid fee schedule. Second, International Classification of Disease, 9th Revision, Clinical Modification (ICD-9CM) and CPT codes were used to categorize enrollees into Clinical Risk Groups (CRGs) health status categories.

The CRGs are a clinical system that classifies individuals into mutually exclusive health status categories.¹⁵ The nine core CRG health status categories are hierarchically ordered from least to most complex conditions: healthy, significant acute, single minor chronic, multiple minor chronic, single dominant or moderate chronic, dominant or moderate chronic pairs, dominant or moderate chronic triplets, metastatic malignancies and catastrophic conditions. In this study, nine CRG health status categories were regrouped as follows: (1) healthy, (2) significant acute, (3) CSHCN-minor (single and multiple minor chronic conditions), (4) CSHCN-moderate (single dominant or moderate chronic conditions) and (5) CSHCN-major (chronic pairs, chronic triplets, metastatic malignancies and catastrophic conditions).^{16,17}

Two time periods were assessed for this study. First, the dates that each child transferred from the exiting health plan was determined using enrollment files. Based on these dates, information in the enrollment and encounter files for a 12-month horizon before and after the health plan transfer was used to characterize health care expenditure patterns. Due to varying transfer dates, information from the enrollment and encounter files between September 1, 2001 and May 31, 2004 were employed for this study.

The Sample

We searched the enrollment files between June 1, 2002 and May 31, 2003 to identify enrollees who switched health plans due to the commercial plan exit from the Medicaid market. The same time frame was used to identify established enrollees or those children enrolled for 12 months or longer in the health plans receiving the transferring children. To ensure the stability of CRG health status assignments, we restricted our sample to children who were enrolled in the program for at least 6 months in both the pre and post study periods. We excluded newborns from the analyses since they have unique health care needs and distinctive expenditures that accrue in the pre health plan exit period without a corresponding set of health care needs and expenditures in the post health plan exit period. Consequently, our sample consisted of 127,185 children enrolled in the Medicaid managed care program. Of these children, 9,924 were identified as those involuntarily switching from one health

plan that exited the market to one of the six existing health plans in the Medicaid market. The remaining 117,261 children in our sample were established enrollees of these six existing health plans that assumed the membership of the health plan that exited the market.

The Established and Involuntary Plan Switching Enrollee Health Status and Demographic Characteristics

As shown in **Table 1**, approximately 50% of the children in the established and involuntary plan switching enrollee groups were males. The children were predominantly Hispanic making up 55% of the established enrollees and 63% of those involuntarily switching plans. A substantial percentage of children (i.e., 87% of both established enrollees and those switching plans) were younger than 13 years old. During the post plan exit period, 85% of both the established enrollees and those involuntarily switching plans were health care users.

Table 1: Selected Demographic Characteristics of Established Enrollees and Those Involuntarily Switching Plans

Characteristic	Established Enrollees (N=117,261)	Enrollees Involuntarily Switching Plans (N=9,924)
Child Gender		
Male	50.44%	49.98%
Female	49.56%	50.02%
Child Race/Ethnicity		
White Non-Hispanic	14.96%	17.04%
Black Non-Hispanic	27.33%	18.22%
Hispanic	55.17%	62.57%
Other	2.53%	2.18%
Age		
4 years and younger	41.25%	42.93%
5-13 years	45.80%	44.48%
14-20 years	12.95%	12.60%
Percent Using Health Care in the Post Plan Exit Time Period	85.13%	85.38%



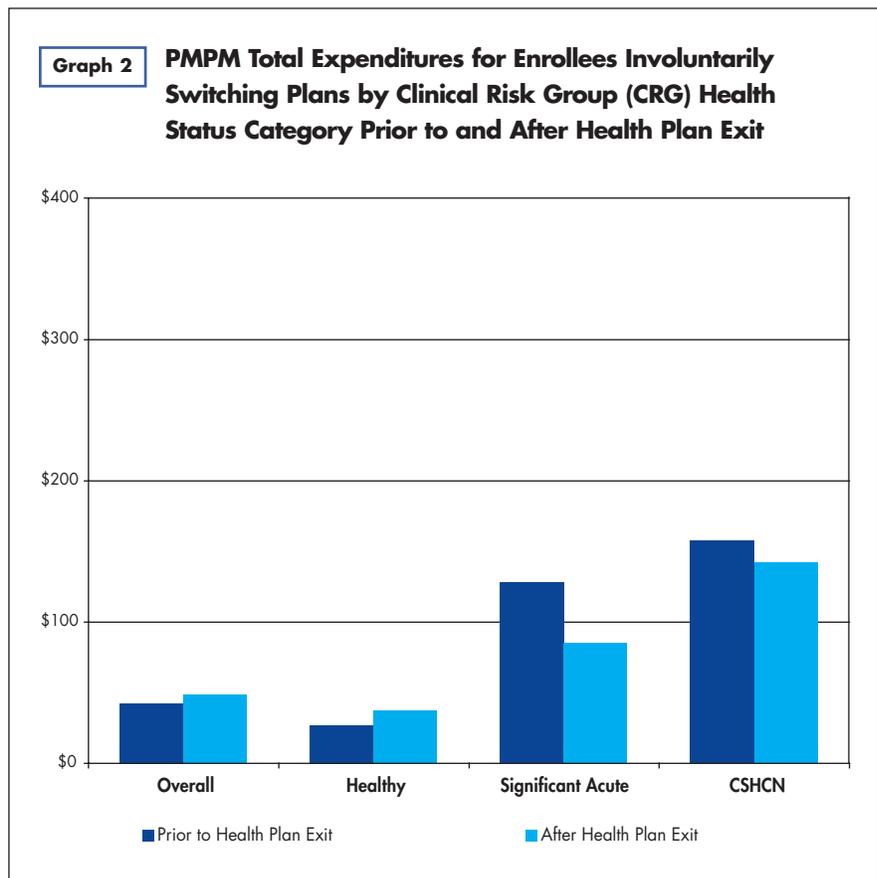
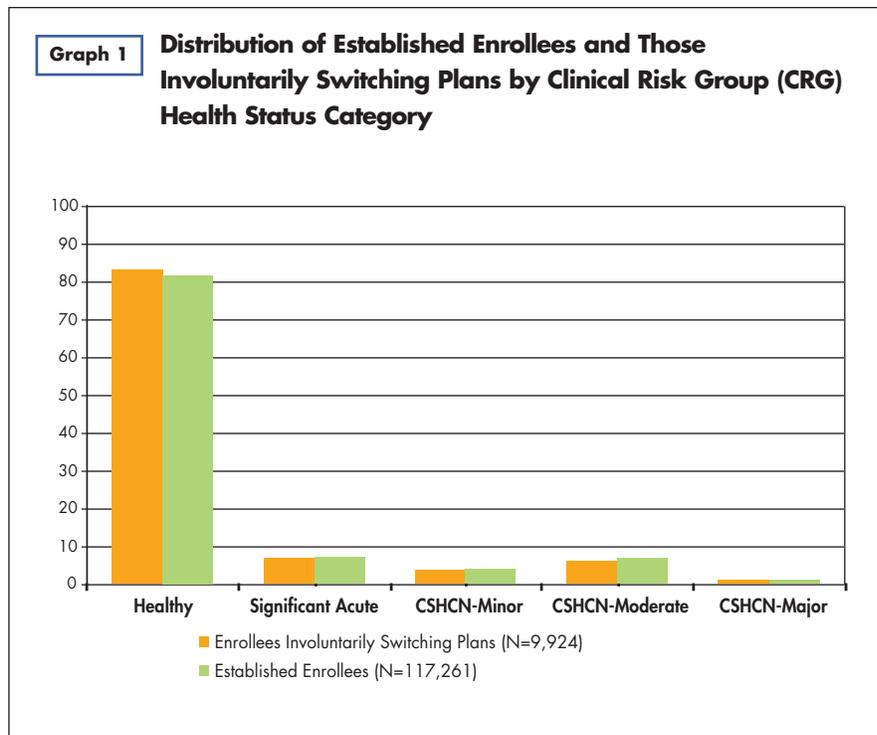
Graph 1 shows the CRG distribution for established enrollees and for those involuntarily switching plans post commercial plan exit from the Medicaid market. The majority of children in the involuntarily plan switching enrollee group were healthy (83%), approximately 7% had significant acute conditions, and 10% had chronic conditions. In comparison, a slightly smaller percentage (81%) of children was healthy in the established enrollee group and close to 12% had chronic conditions. About 7% of established enrollees had significant acute conditions.

Health Care Expenditures Before and After Commercial Plan Exit

Total Expenditures

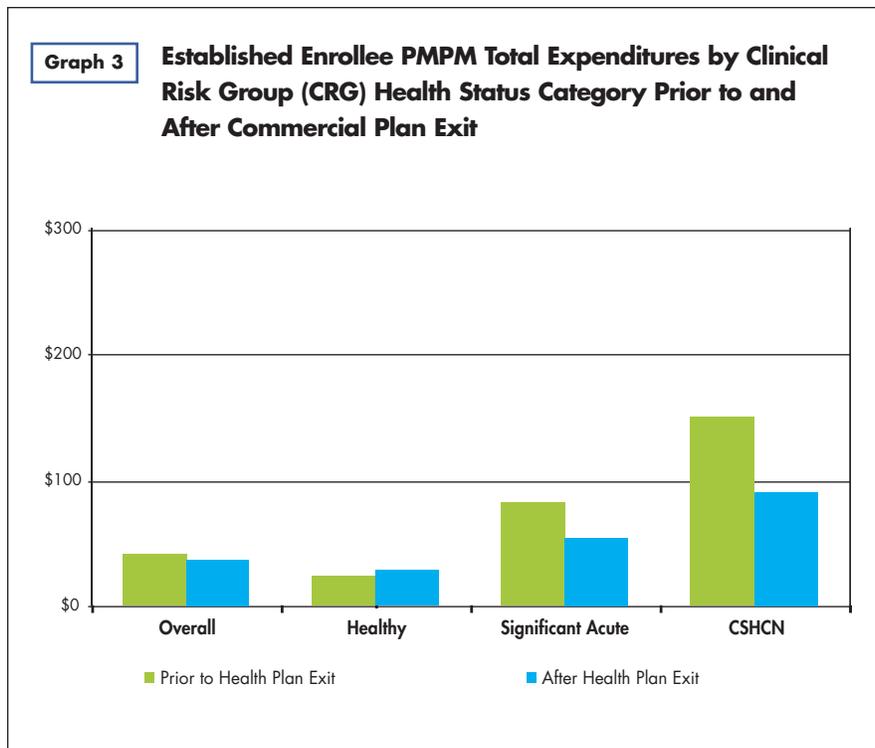
In our multivariate model, we adjusted for time trends in health care expenditures and for beneficiary characteristics such as age, gender, race/ethnicity, number of months in the program, health plan affiliation, and health status as measured by the CRGs. Results for the average per member per month (PMPM) total health care expenditures derived from this model are shown in **Graphs 2 and 3**.¹⁸ Results for average PMPM health care expenditures partitioned as outpatient, emergency department, and inpatient expenditures are presented in the following subsection.

Adjusted average PMPM total expenditures for enrollees involuntarily switching plans prior to and after their transfer are shown in **Graph 2**. Overall PMPM total expenditures for the children transferring health plans were lower, on average,



while they were in their old health plan (\$42.03) than when they were in their new plan (\$48.39). Average PMPM total expenditures varied across CRG health status categories for both periods. Average PMPM total expenditures for those identified as CSHCN by CRGs and for those with significant acute conditions were lower in the post plan switch time period than they were before the plan switch. This difference is more pronounced for those with significant acute conditions. Those children who were categorized as healthy by the CRGs had higher PMPM total expenditures post-transfer than they did before transfer.

Graph 3 shows the average PMPM total expenditures for established enrollees in the plans receiving the transferring children before and after commercial plan withdrawal from the Medicaid market. Specifically, overall PMPM total expenditures, on average, were higher (\$40.48) for established enrollees in the year prior to the commercial plan exit than in the year after the health plan exit (\$36.78). Average PMPM total expenditures for those identified as CSHCN by CRGs and for those with significant acute conditions were lower in the year post the health plan exiting the market than they were before the plan exit. Those children who were categorized as healthy by the CRGs, on the other hand, had higher PMPM total expenditures in the time period after commercial plan exit than they did in the time period before commercial plan exit.



Key findings about total expenditures from the multivariate analysis are:

- Children switching health plans had significantly higher post-transfer expenditures (\$48.39 PMPM) compared to the receiving plans' established enrollee expenditures (\$36.78 PMPM).
- Among children switching health plans, those identified by CRGs as CSHCN have experienced larger relative changes in post-transfer expenditures than children who are healthy.

Outpatient, Emergency Department, and Inpatient Expenditures

Total health care expenditures were partitioned into outpatient, emergency

department, and inpatient expenditures for further analyses. Multivariate models for outpatient, emergency department, and inpatient expenditures were adjusted for time trends in health care expenditures and for beneficiary characteristics such as age, gender, race/ethnicity, number of months in the program, health plan affiliation, and health status as measured by the CRGs.

Key findings on outpatient, emergency department, and inpatient expenditures are:

- Children switching health plans had significantly higher post-transfer expenditures in the outpatient settings (\$32.89 PMPM) compared to the receiving plans' established enrollee expenditures in the outpatient settings (\$23.81 PMPM).

- Health plan switching children's post-transfer emergency department expenditures (\$5.96 PMPM) were relatively higher than the receiving plans' established enrollee emergency department expenditures during the post-transfer time period (\$3.89 PMPM).
- Post-transfer inpatient expenditures for children switching health plans (\$10.80 PMPM) were not different than the receiving plans' established enrollee expenditures in the inpatient settings (\$10.29 PMPM).

emergency department and outpatient expenditures. Health plan switching children's post transfer emergency department and outpatient expenditures were significantly higher when compared to the corresponding expenditures for established enrollees. Health plan switching children's inpatient expenditures were not significantly different than the inpatient expenditures incurred by established enrollees.

Future work is needed to examine the impact of health plan exits on children's long-term expenditures and on families' experiences in obtaining a new usual source of care for their children.

Policy Implications

Our analyses show that enrollees who involuntarily switched health plans did not disproportionately have special health care needs relative to the group of established enrollees in the health plans accepting the transferring children. However, our analyses also show that those involuntarily switching plans incurred total expenditures immediately following their transfer that exceeded the corresponding expenditures of established enrollees even after taking health status into consideration. Among children involuntarily switching health plans, relative changes in post-transfer expenditures were larger for children identified by CRGs as CSHCN than they were for healthy children. This differential impact of plan exit on CSHCN shows how vulnerable these children may be to any disruption in the provision of health care services.

We also examined the impact commercial plan exit had on different components of health care expenditures such as inpatient,

high percentage of children switching health plans were Hispanic might have further complicated the transition process since existing literature suggests an overall lack of familiarity with the United States health care system and language barriers among Hispanic populations.¹⁹ The emergency department visits may become the point of access for immediate health care needs during this transition period. In this case, states experiencing health plan exits could implement processes and policies that will ease the transition during plan switching.

Relatively higher health care expenditures in the outpatient settings for children changing health plans during the post health plan exit period may again be related to the changes in their usual source of care. The degree of overlap in the provider networks in this state between the exiting plan and the remaining health plans is not known. Further it is not known how many children had to change their usual source of care. One study of plan exits in another state found that almost one-half of children involuntarily transferring to new health plans obtained a new PCP.²⁰ If children obtain a new PCP when transferring to another plan, the PCP may order additional health care services to assess the child.

Future work is needed to examine the impact of health plan exits on children's long-term expenditures and on families' experiences in obtaining a new usual source of care for their children with a special emphasis on Hispanic populations' experiences during transitions from one health plan to another.



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- ⁴ Children with special health care needs are defined as children "who have or are at elevated risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount not usually required by children." Maternal and Child Health Bureau. (1995). *Definition of children with special health care needs*. Rockville, MD: Division of Services for Children with Special Health Care Needs. In 2001, an estimated 12.8% of children in the United States had a special health care need. Blumberg, S. (2003). *Comparing states using survey data on health care services for children with special health care needs*. Centers for Disease Control and Prevention, National Center for Health Statistics.
- ⁵ This issue brief focuses on children who switched plans involuntarily due to commercial plan exits from Medicaid markets. In a companion issue brief, results from a similar analysis focusing on adults and children will be presented.
- ⁶ Ellwood, M., Kell, M. (2003). *Using MSIS data to analyze Medicaid eligibility and managed care enrollment patterns in 1999*. Washington, DC: US Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy. Retrieved September 22, 2004, from <http://aspe.hhs.gov/daltcp/reports/msisdata.htm>
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- ⁹ Shenkman, E., Aydede, S., Dick, A., et al. (2004). *The Development of financing and reimbursement strategies for children with special health care needs*. Gainesville, Florida: The Institute for Child Health Policy, University of Florida.
- ¹⁰ This group may include other types of transfers within the public health insurance system. Consider, for example, the states with a separate State Children's Health Insurance Program (SCHIP). Due to downward fluctuations in family earnings, children may be transferring from SCHIP to Medicaid managed care. A completely separate group in this pool consists of re-enrollees who have experienced an interruption in their coverage during coverage renewal.
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- ¹³ In this study, established enrollees are defined as children who have not switched plans throughout the study period. The established enrollees were also those children enrolled in the health plans who assumed the care for those involuntarily switching health plans.
- ¹⁴ The state is not identified here, to help preserve confidentiality of data.
- ¹⁵ Neff, J.M., Sharp, V., Muldoon, J., Graham, J., Popalisky, J., Gay, J. (2001). Identifying and classifying children with chronic conditions using administrative data with the clinical risk group classification system. *Journal of Ambulatory Pediatrics*, 2(1), 72-79.
- ¹⁶ A separate regrouping of the nine CRG health status categories were used in the multivariate part of this study: (1) healthy, (2) significant acute, (3) CSHCN (single and multiple minor chronic conditions, single dominant or moderate chronic conditions, chronic pairs, chronic triplets, metastatic malignancies and catastrophic conditions).
- ¹⁷ The Center for Medicare and Medicaid Services (CMS) protocol was used in the validation of person-level health care use data. All of the use data met the CMS recommended standards for filled and valid data fields. In addition, the contents of the use data were compared to the children's medical records. On average, there was about a 12% underreporting of encounters in the use data compared to the medical record.
- ¹⁸ In the state considered for this study, pharmacy expenditures are carved-out and reimbursed separately on a fee-for-service basis. As a result, health plans do not assume risk for pharmacy expenditures in this state. To reflect the risk the existing plans are assuming when they enroll exiting plan's membership, we focused on inpatient, emergency department, and outpatient expenditures; and excluded pharmacy expenditures from the analyses.
- ¹⁹ Weinick, R.M., Jacobs, E.A., et al. (2004). Hispanic healthcare disparities: Challenging the myth of a monolithic hispanic population. *Medical Care*, 42(4), 313-320; Fiscella, K., Franks, P., et al. (2002). Disparities in health care by race, ethnicity, and language among the insured. *Medical Care*, 40(1), 52-59; Weinick, R.M., Zuvekas, S.H., et al. (2000). Racial and ethnic differences in access to and use of health care services, 1977 to 1996. *Medical Care Research and Review*, 57(1 Supplement), 36-54.; and Weinick, R.M., Krauss, N.A. (2000). Racial/ethnic differences in children's access to care. *American Journal of Public Health*, 90(11), 1771-1774.
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