The Impact of Assignment to Different Managed Care Organizations on Medicaid Spending and Health Care Use in the United States

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Sector(s): Health

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Location: South Carolina, United States of America

Sample: An estimated 60,000 individuals expected to be randomly assigned to Medicaid Managed Care Organizations in 2017.

Target group: Health care providers

Outcome of interest: Mortality Health outcomes Take-up of program/social service/healthy behavior

Intervention type: Health care delivery

AEA RCT registration number: AEARCTR-0002762

Partner organization(s): South Carolina Department of Health and Human Services

Most low-income households enrolled in Medicaid receive their health care through Managed Care Organizations (MCOs), which vary in terms of their financial and provider network coverage. Researchers are conducting a randomized evaluation to test the relative impact of assignment to different MCOs on health care utilization and expenditure.

Policy issue

The primary source of public health insurance for low-income individuals in the United States is Medicaid, a program administered by the states according to federal government regulations. Many state Medicaid agencies contract with Managed Care Organizations (MCOs), which offer different health care plans and services in return for fixed payments per Medicaid beneficiary.[1], Managed care has become the most common form of health care delivery in the Medicaid program, with MCOs enrolling more than 70 percent of Medicaid beneficiaries in 2013, up from about 10 percent in 1991.[2]

The managed care plans offered by MCOs have different characteristics, such as deductibles and provider networks. An important question is whether enrolling in a particular managed care plan affects beneficiaries' health care use and spending. For example, does enrolling in a plan with a lower deductible and a broader network of providers result in more health care use and higher spending, compared to enrolling in a less generous plan? Alternatively, do differences in health care use and spending across plans reflect pre-existing differences in the individuals who select into different plans?

In an ongoing evaluation in South Carolina, researchers will analyze the relative impact of different managed care plans on health care use, health care spending, and health outcomes. This evaluation will take advantage of the random assignment of Medicaid recipients who have not made an active plan choice (and who are not assigned to a plan based on a past active choice or the choices of their family members) to different MCOs.

Context of the evaluation

In South Carolina, all Medicaid beneficiaries must enroll in a managed care plan, and the state ranks each managed care plan by issuing star ratings based on various metrics. This system of managed care plans is designed to offer choice to Medicaid beneficiaries and to encourage plans to compete for beneficiaries. Plan ratings are shown to new or current beneficiaries who are choosing a managed care plan, which could influence beneficiaries to choose more highly rated plans. Additionally, when beneficiaries do not actively choose a plan and cannot be matched to plan based on their previous plan choice or the plan choices made by their family members, the state automatically assigns them to a plan. Plans with higher star ratings receive a larger share of these auto-assigned beneficiaries, which creates further incentive for plans to achieve higher star ratings.

An important policy question is whether these star ratings reflect actual differences between the plans or pre-existing differences between plan enrollees. For example, one aim of the star ratings is to incentivize plans to promote preventive health behaviors. A plan may achieve a higher star rating by encouraging its enrollees to seek preventive care or by enrolling individuals who would be more likely to seek preventive care regardless of their plan's features. Another goal of the managed care system is to limit health care costs by providing MCOs with a fixed payment per beneficiary, rather than reimbursing for each service delivered. This payment system provides an incentive for MCOs to enroll individuals who are likely to have lower health care costs.

An insurance benefits plan.

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Details of the intervention

Researchers are conducting a randomized evaluation to test the relative impact of assignment to different MCOs on health care use, health care spending, and health outcomes. Prior to 2017, the state automatically assigned Medicaid beneficiaries to

different managed care plans using a quasi-random, “round robin” procedure. Beginning in 2017, the state will automatically assign beneficiaries using an explicitly random procedure. Researchers estimate that roughly 60,000 beneficiaries will be randomly assigned each year.

Researchers will analyze the effect of being randomly assigned to different managed care plans by matching records of beneficiaries’ plan assignments to various sources of administrative data, including data from Medicaid claims, the Department of Mental Health, the Department of Alcohol and Drug Abuse Services, and vital records.

Results and policy lessons

Project ongoing; results forthcoming.

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1. Centers for Medicare & Medicaid Services. 2017. “Home>Medicaid.”
2. Mark Duggan, “The Impact of Contracting Out on Medicare and Medicaid,” NBER Reporter, no.1 (March 2017): 23. http://www.nber.org/reporter/2017number1/duggan.html