



# findings brief

## Managed Care Mandates Fall Short of Curbing California Medicaid Costs

---

“Managed care contracting reduced the efficiency of the Medicaid program in California. In fact, Medicaid spending appeared to increase by almost 20 percent following the shift to managed care.”

— Mark Duggan,  
*University of Maryland*

---

Over the past several years, growth in Medicaid spending has far outpaced the growth in state tax revenues and now accounts for nearly 22 percent of total state government spending. Rapid health care cost increases during the 1990s led many state governments to shift Medicaid recipients into managed care plans in an effort to control costs. The conventional wisdom at the time suggested that states would save money as a result. Like many other states, California sought relief through managed care; it passed legislation to foster enrollment and county by county, Medicaid recipients moved from a fee-for-service (FFS) system to managed care plans.

To shed light on the effects of transitioning beneficiaries from FFS Medicaid to Medicaid managed care, Mark Duggan, Ph.D., and colleagues from the University of Maryland and the National Bureau of Economic Research examined how mandatory enrollment in managed care has affected both spending and health outcomes for California Medicaid recipients. They found that despite a dramatic increase in Medicaid managed care

enrollment—from less than 12 percent in 1993 to 51 percent in 1999—there was neither a significant reduction in spending nor improved health outcomes.

“Our findings suggest that managed care contracting reduced the efficiency of the Medicaid program in California,” says Duggan. “In fact, Medicaid spending appeared to increase by almost 20 percent following the shift to managed care and persisted long after the mandates first took effect.” Sacramento was the earliest county to mandate managed care enrollment in 1994, with Monterey instituting its Medicaid mandates in October 1999.

### Background

Duggan and colleagues estimated the effect of switching recipients from FFS to managed care, focusing on government spending, medical treatments, and health outcomes. They examined 20 county-level mandates that California put into place during the 1990s that required certain categories of Medicaid recipients to enroll in managed care. The state paid managed care organizations a fixed amount per recipient-



**AcademyHealth**

Advancing Research, Policy and Practice

AcademyHealth is the national program office for HCFO, an initiative of The Robert Wood Johnson Foundation.

The switch from FFS to managed care did not lead to significant improvements in health outcomes. The hospitalization rate for avoidable conditions declined, but no more than for other conditions that would not be affected by the quality of medical care.

month and the plans paid the hospitals, physicians, pharmacies, and other health care providers. Medicaid recipients had no out-of-pocket costs.

The researchers began by estimating the average effect of the shift to managed care. Using the existence of a county-level mandate as an instrumental variable for Medicaid managed care enrollment, they found that Medicaid spending increased by an average of 17 percent following the shift to managed care plans. This effect persisted long after the mandates were first introduced, suggesting that they are not simply driven by startup costs of a new plan.

They then explored differences across three types of managed care being used in the 20 study counties: 1) Geographic Managed Care (GMC)—several commercial plans compete; 2) county-organized health system (COHS)—one not-for-profit, community-based HMO plan; and 3) two-plan—one commercial plan competes with one private, not-for-profit Medicaid only plan. The study focused on a random 20 percent sample of Medicaid recipients, in large part from the Aid to Families with Dependent Children population (now known as CalWORKS). Using complete claims and eligibility data, Duggan calculated individual-level Medicaid spending in six-month intervals from 1993–1999 for a sample of approximately 1.2 million program participants.

“We were able to follow the same individuals as they shifted into managed care from fee-for-service and see whether costs rose or declined as a result,” says Duggan. “The spending increases in counties with just one managed care plan were significantly greater than in other counties, suggesting that there is some benefit to competition between plans. Still, spending increased by a significant amount in counties using all three types of managed care arrangements.”

### Health Outcomes

The researchers also found that the switch from FFS to managed care did not lead to significant improvements in health outcomes. The hospitalization rate for avoidable conditions declined, but no more than for other conditions that would not be affected by the quality of

medical care (e.g., accidents). “This leads us to believe that Medicaid managed care plans did not improve health; they were simply less likely to hospitalize individuals with a certain condition,” Duggan says.

The project’s findings for infant health outcomes also showed little change resulting from the move to managed care, but Duggan notes that measuring health is difficult given the multitude of observed and unobserved health outcome dimensions. Accordingly, he points out that his results on health outcomes should be interpreted with caution, as the results from California may not be generalizable to other Medicaid recipients, to Medicaid programs in other states, or to the federal Medicare program. Still, he says, policy-makers should be more skeptical about the potential for managed care plans to reduce government spending on medical care.

Although the burden of administrative costs on the health care system is enormous, Duggan did not have data on these costs. Nevertheless, anecdotal evidence suggests that the shift from FFS to Medicaid managed care contracts resulted in increased administrative costs for the state. Therefore, the increase in Medicaid spending resulting from the shift to Medicaid managed care in this project may be understated.

### Implications for Policy

Both the private and public sectors have looked to managed care to improve incentives to use an appropriate and efficient amount of medical care. FFS plans generate few incentives to limit health care utilization. Managed care plans, on the other hand, should be able to lower expenditures by reducing utilization of inefficient services. Instead, while the plans may have reduced utilization, they led to increases in Medicaid spending.

According to Duggan, there are a number of possible explanations. First, anecdotal evidence suggests that managed care plans had to pay hospitals, physicians, and other health care providers significantly more because of their lower market share. Second, commercial plans will contract with Medicaid only if they believe that they can earn a profit, thus driving a wedge between Medicaid and plan expenditures.

Finally, there may be economies of scale in managing the Medicaid program, thus administrative costs per enrollee may be much higher in small managed care plans than in the much larger FFS plan.

Moreover, unlike FFS, managed care reimbursement does not increase with changes in health status, therefore, there is an incentive to keep beneficiaries healthy. Information about quality of providers from managed care plans should promote healthy outcomes. Duggan's findings on health outcomes, however, do not support these theories.

Clearly, California's goal of reducing Medicaid expenditures by shifting beneficiaries from FFS

to managed care plans was not successful. While these results may not apply across the board, policymakers should consider the possibility that managed care may not be the mechanism through which to curb budget shortfalls.

*For more information, contact Mark Duggan, Ph.D., at 301.405.3266.*

### **About the Author**

Bonnie J. Austin, J.D., is a senior manager at AcademyHealth ([www.academyhealth.org](http://www.academyhealth.org)) with the Changes in Health Care Financing and Organization (HCFO) initiative ([www.hcfo.net](http://www.hcfo.net)). She can be reached at 202.292.6700 or [bonnie.austin@academyhealth.org](mailto:bonnie.austin@academyhealth.org).