Enrollment and Disenrollment in Medicaid Managed Care Program Management

Prepared by
Jane Horvath
Neva Kaye

December
1996
Acknowledgements

We would like to thank The Pew Charitable Trusts for support of this effort. In particular, we thank Harriet Dichter and Linda Rich of the Trusts for their support of projects intended to help states improve the capacity of Medicaid managed care to serve women and children. We also thank Robert E. Hurley of the Medical College of Virginia/Virginia Commonwealth University and John Couter of Cornell for inviting us to join them in this study and for their insights into the interpretation of the findings.

The following state Medicaid officials took time to complete the survey which became the basis of this paper and we would like to thank them: Judy Bergeron, Murray Brown, Cynthia Burnell, Barbara Christensen, Angie Dombrowicki, Sharon Donovan, Betty Ferdinand, Brenda Goldstein, Joanne Grundman, David Harrison, Kay Holmes, Stacy Hull, Brenda Jackson, Maryann Keriazes, Sue Madson, Lynn Martinez, Tom McGraw, Craig Miller, Judith Muck, Philip Shimer, Sharon Steadman, Katherine Tvaronas, Paul Wallace-Brodie, Daniel Walsky, Pat Williams, and Judith Wilson.

Finally, we would like to thank the following people for discussing with us their enrollment and disenrollment systems and their use of data for program management: Rick Potter and Laurie Montgomery of the AHCCCS; Pat Williams of Georgia Medicaid; Sharon Steadman, Lisa Alexander, Ken Kubisti, Terry Seung, and Jean Terrell of Indiana Medicaid; Tricia Leddy, John Andrews, and Murray Brown of Rhode Island Medicaid; Sharon Edmonds of Harvard Pilgrim Healthplan; Jack Knock of Arizona Physicians IPA; and Monsignor Ryle of the Arizona Catholic Conference.
# Enrollment and Disenrollment in Medicaid Managed Care Program Management

## TABLE OF CONTENTS

**BACKGROUND** ................................................................. 1

**GENERAL FINDINGS** .......................................................... 3

**SURVEY RESULTS** .............................................................. 4
  - Disenrollment Levels ..................................................... 5
  - Data Formats ................................................................... 8
  - Enrollment Policies .......................................................... 10
    - Voluntary Enrollment .................................................. 11
    - Voluntary and Mandatory Enrollment ............................. 11
    - Mandatory Enrollment ................................................ 11
    - Choice Period ............................................................. 12
    - Auto-Assignment .......................................................... 12
  - Health Plan Monitoring ................................................... 14
  - Enrollee Satisfaction ....................................................... 15
  - Health Benefit Manager Performance Monitoring ............... 16

**SURVEY OBSERVATIONS** ...................................................... 18

**ENROLLMENT AND DISENROLLMENT CASE STUDIES** .............. 19
  - Methodology .................................................................. 20
  - Enrollment and Disenrollment Systems .............................. 21
    - Arizona ................................................................... 21
    - Georgia .................................................................. 23
Indiana ................................................................. 24
Rhode Island ......................................................... 26

Relationship of Enrollment and Disenrollment Systems to Automatic
Assignments and Disenrollment Rates .......................... 28
State Analysis of the Reasons Behind the Variation in Rates .................. 31
Data Collection .......................................................... 34
Data Collected ............................................................ 34
Data Sources ............................................................. 35
Reporting Frequency .................................................... 36
Data Aggregation ....................................................... 36
Data Uses ................................................................. 37
Disenrollment Surveys .................................................. 40

CASE STUDY OBSERVATIONS .............................................. 40

CONCLUSIONS .................................................................. 42

List of Appendices

Appendix A: Program Characteristics and Rates of Auto-Enrollment and
Voluntary Disenrollment ................................................. 44

Appendix B: Disenrollment Data Uses, Formats, and Availability .......... 47

Appendix C: Survey Questions and Complete State Responses ............ 50
Enrollment and Disenrollment in Medicaid Managed Care Program Management

BACKGROUND

How do Medicaid managed care program managers use enrollment and disenrollment information to manage their programs? What does a low disenrollment rate imply about health plan (and enrollment broker) performance? Are people who select a health plan less likely to disenroll than those who are assigned to a plan? What elements of an enrollment system lead to a higher level of voluntary selection and/or lower level of disenrollment? This paper seeks to answer these questions, among others.

This paper is part of a larger project undertaken by Cornell University and funded by The Pew Charitable Trusts to examine beneficiary choice in Medicaid managed care from the perspective of the disenrollment process. The overall project is managed by Robert E. Hurley of the Virginia Commonwealth University and John Couter of Cornell. It will include an in-depth look at Medicaid managed care enrollment and disenrollment practices in Philadelphia and several other metropolitan areas. This work on policies and disenrollment rates across several states has two purposes. The first is to determine if there is a link between a state’s Medicaid managed care enrollment policies and its rates of voluntary enrollment and disenrollment from capitated health plans. The second is to determine if and how states use information about disenrollment and enrollment to manage their managed care contractors and their programs. The overarching goal is to provide state policymakers with information that will enable them to craft better enrollment systems and to better manage their programs.

The National Academy for State Health Policy conducted a mail survey of state Medicaid programs in May and June 1996 to learn more about managed care
disenrollment processes and levels. The survey was mailed to 27 Medicaid programs, which had previously indicated that they tracked disenrollment from Medicaid managed care plans.\(^1\) However, we learned in this survey that all 27 do not have operational systems; some had reported affirmatively if they planned to track disenrollment.

This National Academy for State Health Policy survey provides general information about how those states that reported tracking disenrollments from capitated managed care plans used disenrollment data. In addition to questioning how states use information about disenrollment in administering their managed care programs, the survey asked directly about the levels of both total AFDC and AFDC-related disenrollment and voluntary disenrollment from capitated health care plans.\(^2\) Finally, part of the survey contained questions concerning characteristics of the respondent state’s Medicaid managed care program enrollment policies and procedures that affect the enrolling AFDC eligibility group.

In addition to the survey, the National Academy for State Health Policy conducted telephone interviews — speaking with Medicaid officials, health plan representatives, and consumer representatives in four states to discuss in greater detail the merits of particular disenrollment processes and policies. Those states are: Arizona, Georgia, Indiana, and Rhode Island.

---

\(^1\) State programs surveyed included Arizona, California, Delaware, Georgia, Illinois, Indiana, Kansas, Maryland, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Virginia, Washington, Wisconsin and West Virginia. Illinois did not respond. These states indicated that they tracked disenrollment in an earlier survey, the complete results of which are available in: Emerging Challenges in State Regulation of Managed Care: Report on a Survey of Agency Regulation of Prepaid Managed Care Entities. Portland, ME: National Academy for State Health Policy, 1996.

\(^2\) For purposes of this study voluntary disenrollment includes any member-initiated termination of health plan enrollment — regardless of cause. In other words, voluntary disenrollment includes those who disenroll from one health plan to enroll into another and those who voluntarily disenroll from a plan to fee-for-service (when permitted). The larger category of disenrollment includes all voluntary disenrollments as well as those who involuntarily disenroll from a plan to fee-for-service at the initiation of the health plan and those who are disenrolled due to loss of Medicaid eligibility.
This paper is presented in two main sections. The first summarizes and analyzes information obtained from the surveys. The second section presents case study information of how disenrollment information is used for program and health plan management in four states.

GENERAL FINDINGS

This project was initiated to determine if a correlation existed between state Medicaid enrollment policies and disenrollment rates and to learn if the types of data states collect impact upon how they manage their programs. The most surprising finding of this survey and the case studies was the remarkable lack of meaningful correlation between AFDC disenrollment and auto-assignment rates and particular state enrollment policies. The same policies can produce very different outcomes across states. For example, we found no evidence that enrollment systems that use a variety of outreach methods result in less voluntary disenrollment than those that use fewer approaches. Further, there is little correlation between a state’s program characteristics and the type of enrollment and disenrollment data they reported collecting.

A second finding, from both the survey and the case studies, was the extreme lack of consistency in how states define automatic assignments and disenrollments. In fact this lack of consistency is so extreme that it makes cross-state comparison of these numbers extremely difficult.

In the area of auto-assignment of the AFDC population, there is significant variation. For example, one state does not count as assigned those AFDC beneficiaries who are automatically enrolled with a provider they had previously

---

3 Automatic assignment refers to the process used in mandatory enrollment programs whereby people are automatically enrolled with a health plan or a provider when they do not voluntarily select one in a given time period. This process is sometimes called auto-assignment or involuntary enrollment.
used, while other states do consider this an assignment. Regarding voluntary disenrollment, some states count those people who disenroll from one plan to join another (also known as "switching") as a voluntary disenrollment, others count them as a separate category of "plan switching." In states that count plan switching separately from voluntary disenrollment, the AFDC voluntary disenrollment rate is very low because it typically includes only program exemptions or terminated eligibility cases. The survey attempted to address these situations by asking states to produce data using the definitions included in the survey. Unfortunately, as will be discussed later, states may have had difficulty producing the rates requested because of different program structures. Comparing rates across states was difficult because of different definitions and reporting periods, which made rates incomparable.

A final significant finding was the limited extent to which states use aggregate disenrollment data — disenrollment information grouped across all health plans — as a program management tool. Even though most of the surveyed states indicated that disenrollments were tracked, only about half of those states know the rate of voluntary disenrollments from capitated health plans. Therefore, the concept of tracking disenrollment is significantly different than what was anticipated.

**SURVEY RESULTS**

Twenty-six of the 27 states surveyed responded. Of these 26, all but Michigan indicated that disenrollments from capitated Medicaid managed care contractors are tracked. Two of the 25 that responded affirmatively, Vermont and West Virginia, indicated that their Medicaid managed care programs were not yet operational.

---

4 Illinois did not respond.
Disenrollment Levels

One of the main purposes of this survey was to look at levels of voluntary disenrollment across states and ascertain if there are relationships between levels of disenrollment and other features of a particular Medicaid managed care program. To that end, states were asked to report on disenrollment from capitated health plans in the metropolitan area within the state that had the greatest enrollment of AFDC beneficiaries.\(^5\) Disenrollment from capitated health plans could include switching plans and/or disenrollment from a plan into fee-for-service. The survey did not make a distinction.

States were asked to report two disenrollment rates for the AFDC and AFDC-related population: the total rate and the voluntary rate. Total disenrollment should include all disenrollments from health plans in the region — loss of eligibility, health plan initiated, and beneficiary initiated — among the AFDC and related groups. Voluntary disenrollments for the same population should include only those that are initiated by the beneficiary and include disenrollments that occur at open enrollment periods or those that occur outside any scheduled enrollment periods ("for cause" disenrollments\(^6\)). Voluntary disenrollments should further include disenrollments from one capitated plan to another and disenrollments from a capitated health plan to the fee-for-service system.

Unfortunately, there was confusion among some respondent states regarding voluntary disenrollments. For example, information was provided about voluntary disenrollments from a mandatory managed care program but all information about voluntary disenrollments from one health plan to another was omitted because it

---

\(^5\) States were asked to provide this information for a metropolitan area of a state, or a county, or other geographic area which they would identify on the survey. Questions about the program characteristics (mandatory, voluntary, degree of choice, etc.) were also to be answered based on a geographic area selected by the state respondent.

\(^6\) "For cause" disenrollments are those where the beneficiary provides a reason for the requested disenrollment to the state or its representative that is evaluated and a decision rendered about whether to permit the disenrollment. Depending on the managed care program, the disenrollment can be from the entire risk-based managed care program or a disenrollment from one plan to enroll in another.
was not considered voluntary disenrollment but rather, plan switching. Contributing to this confusion was the fact that many states have a 6 or 12 month lock-in for AFDC and AFDC related enrollees. This means that voluntary disenrollments from the program for cause can occur any time; while voluntary disenrollments from one plan to another can only occur during a one month open enrollment period every 6 or 12 months. These differences make the two types of voluntary disenrollment rates difficult to combine in a meaningful way, at least in states that restrict plan switching through lock-ins.

Ten states could report a number/rate for total disenrollments for AFDC and related groups while 14 states could report on the rate of voluntary disenrollments. The ten states that could report on the rate of total disenrollment also reported on the rate of voluntary disenrollment. Four of the states that could report on the voluntary disenrollment rate (Delaware, Kansas, New Hampshire, and New Jersey) were not able to report the rate of total disenrollment. There is no apparent correlation between program characteristics among these four states that might lead to the similarity in data reporting/report formats. For example, one state has voluntary enrollment (New Hampshire) and the others have mandatory enrollment (Delaware, Kansas, and New Jersey). Also, auto-assignment rates among the three mandatory programs range from under 11% to 44%.

It is interesting that more states apparently track voluntary disenrollments than track total disenrollments. Voluntary disenrollment is potentially a more meaningful measure by which to assess the quality of health plan services than total disenrollment. However, total disenrollment can be helpful in ratesetting and evaluating health plan outcomes and preventive treatment in the context of sporadic Medicaid eligibility (although methods for making such adjustments are

---

7 States that could report on total disenrollment rates from capitated plans are: Arizona, Georgia, Indiana, Ohio, Oregon, Rhode Island, Texas, Utah, Virginia, and Washington. States that could report on voluntary disenrollment rates are: Arizona, Delaware, Georgia, Indiana, Kansas, New Hampshire, New Jersey, Ohio, Oregon, Rhode Island, Texas, Utah, Virginia, and Washington.
still evolving). Further, the total disenrollment rate can be used as a proxy for the voluntary disenrollment rate — if the rate of involuntary disenrollment (e.g. enrollee moves or loses Medicaid eligibility) is assumed to be the same for all health plans. Using that assumption, any variation in the total disenrollment rates between health plans can be ascribed solely to variations in the voluntary disenrollment rate.

Total disenrollment rates for the AFDC and related groups among the ten reporting states varied from a low of .8% in Utah (with an auto-assignment rate of 1% or less) to a high of 13% in Indiana\(^8\) (with an auto-assignment rate of 38%). Georgia was the only voluntary enrollment state that could report a total disenrollment rate.

Voluntary disenrollment rates among the 14 reporting states ranged from a low of .15% in Rhode Island (with an auto-assignment rate of 8.7%) to a high of 10% in Texas (with an auto-assignment rate of 50%). Most of the rates of voluntary disenrollment were much lower than 10% and were in fact clustered around 1%.

There was no apparent correlation between disenrollment rates and rates of auto-assignment to capitated plans. For example, Virginia reported a voluntary disenrollment rate of 1% with an auto-assignment rate of 48%. While Oregon, reported a voluntary disenrollment rate of 5% with an auto-assignment rate of 5-7%.

Of the 23 respondent states with operational programs that reporting tracking disenrollments, nine could not report on the rates for either total or voluntary disenrollment of AFDC and related groups from capitated health plans. This would

\(^8\) This was a rough estimate from Indiana since the Medicaid agency does not routinely look at disenrollment from capitated health plans. The way the program is structured, the more meaningful disenrollment information concerns switching from and to primary care physicians; the beneficiary’s choice of doctor determines if he or she will be in a health plan (and which one) or in the state PCCM network.

The National Academy for State Health Policy ♦ 7
indicate one of two things. The first possibility is that these states ‘track’
disenrollments by processing the requests and do not compile the information.
(Although of the nine, only Wisconsin really fits into this category because the state
indicated that while disenrollments are tracked, the information is not used for
health plan monitoring or health benefit manager performance assessment.) The
second possibility is that these states monitor disenrollments on a case-by-case basis,
so the disenrollment system functions like a grievance/complaint system in terms
of providing a warning about potential problems.

Data Formats

The survey contained questions concerning the type of data states have
available in order to learn more about the potential of any particular state to track or
monitor health plan disenrollment (particularly voluntary disenrollments). Data
format questions were also aimed at learning about relationships between the types
of data states used and program characteristics. (For example, is knowledge of
voluntary disenrollment rates correlated with programs that require enrollment
into capitated health plans, or with programs that use disenrollment information to
monitor health plan performance?)

Of the 25 states that track disenrollments from capitated risk contractors
(including two states whose programs are not yet operational), 23 have
disenrollment data available on a plan specific basis (i.e. the state can identify
disenrollments from individual contractors). Only North Carolina indicated that
this capability is not available, while Kansas reported that plan specific
disenrollment information is available only from some plans. All 25 states can
obtain disenrollment information that is aggregated across health plans for a
program-wide look at disenrollment activity.
Ten states indicated that voluntary disenrollment data is reported separately from other types of disenrollment data. This indicates that information on voluntary disenrollment levels should be readily available and usable. Two other states, (Ohio and Virginia) indicated that voluntary disenrollment information is available apart from other disenrollment data and, in addition, is included in other report formats. This is likely the case in more states but the survey did not consistently identify this.

In addition to asking about whether voluntary disenrollments are reported separately from other disenrollment information, states were also asked if they aggregated voluntary disenrollments with other types of disenrollments for reporting purposes. This question was intended to explain why a state might not be able to provide a voluntary disenrollment rate separate from a total disenrollment rate. However, there appears to be no correlation between a yes or no response to this question and whether a state provided a voluntary disenrollment rate.

It was expected that a state that indicated the availability of discrete, separately reported information about voluntary disenrollments (distinct from total disenrollment) would know the rate of such voluntary disenrollments. Of the ten states with operational programs that indicated voluntary disenrollment data is reported separately from other disenrollment information, eight\(^9\) met this expectation.

Nebraska and Pennsylvania did not know the rate of voluntary AFDC disenrollment even though they have separately reported data about voluntary disenrollments. These two states also did not know the rate of total AFDC and AFDC related disenrollments from capitiated health plans. In the case of Nebraska, the state does not separate out eligibility categories for disenrollment reporting. For

---

\(^9\) The states are: Georgia, Maryland, New Hampshire, New Jersey, Ohio, Utah, Virginia, and Washington.
Pennsylvania, this could indicate that disenrollments are not tracked systematically but rather on a case-by-case basis.

It was also expected that a state that did not have discrete information about voluntary enrollments would not be able to provide a voluntary disenrollment rate separate from a total disenrollment rate. There were six states (California, Missouri, Montana, Nevada, North Carolina, and Wisconsin) that met this expectation.

Seven other states\(^\text{10}\) that report voluntary disenrollment data with other disenrollment data were also able to report the rate of voluntary disenrollments. This would indicate that information on voluntary disenrollments is also available as discrete information, but that the survey failed to clearly pick up on this possibility.

*Enrollment Policies*

The survey collected information about program design in order to examine any correlations between enrollment/disenrollment levels and program enrollment policies. States were asked to provide details such as whether the program was voluntary or mandatory, the auto-assignment rate, and some information about the enrollment and disenrollment processes. Because program policies and characteristics can vary within a state, respondents were asked to complete the survey based upon a metropolitan (or other geographic) area where the greatest proportion of the AFDC population was enrolled.\(^\text{11}\)

---

\(^{10}\) States that aggregate voluntary disenrollment data with other disenrollment data are: Arizona, Delaware, Indiana, Kansas, Oregon, Rhode Island, and Wisconsin

\(^{11}\) If a state could not meet that standard with respect to providing disenrollment rates, they were asked to provide what information they had and indicate the geographic region covered by the data and the population, if other than AFDC.

The National Academy for State Health Policy • 10
Voluntary Enrollment

Of the 26 respondent state agencies, only four operate programs where enrollment into a capitated program is voluntary in the geographic region of the state for which they chose to respond (Georgia, Maryland, Nevada, and New Hampshire). Each of these four states offered a choice of two or more HMOs$^{12}$ and a fee-for-service alternative program (which could include a PCCM program$^{13}$). None of these four programs auto-assigned to capitated health plans.

Voluntary and Mandatory Enrollment

Two states — Montana and Pennsylvania — operate both voluntary and mandatory HMO enrollment programs within a given geographic area (metropolitan region or county) and included information about each type of program (see Appendices for details). Both these states included HMOs and PCCM networks in their voluntary and mandatory programs. In Montana the program is voluntary for children but mandatory for adults. In Pennsylvania, the program is mandatory only in parts of the Philadelphia metropolitan area and remains voluntary in other parts.

Mandatory Enrollment

Four states — Indiana, Kansas, Michigan, and Nebraska — have programs where enrollment into either PCCM or a capitated plan is mandatory. Individuals who do not select either a health plan or primary care case manager can be auto-assigned to either. The auto-assignment is based on a computer algorithm that

---

$^{12}$ Applying strict Medicaid definitions, Nevada technically does not contract with HMOs which are fully capitated entities contracting for a comprehensive set of services. Nevada contracts for less than a comprehensive set of Medicaid services, which is technically defined as a Prepaid Health Plan (PHP) in Medicaid terminology. For purposes of this paper, and the underlying survey to which Nevada responded, the term HMO is used since the PHP/HMO distinction is not relevant to this discussion.

$^{13}$ PCCM stands for Primary Care Case Management. Many states operate these types of managed care programs that do not require providers to accept financial risk for provision of care to enrollees. Instead, providers are paid a small (usually $3/ enrollee-month) case management fee and also continue to be paid fee-for-service for all services provided to enrollees. Since this paper focuses on enrollment into capitated plans it considers those states that offer health plans as a voluntary alternative to a mandatory PCCM program (Such as Massachusetts) to be voluntary programs.
generates the assignment. All four of these states offer a choice of at least two capitated health plans and a PCCM network.

There are 16 respondent states where enrollment into capitation is mandatory (excluding Pennsylvania and Montana discussed above). Of these, three offer a PCCM enrollment alternative and a choice of at least two capitated health plans. If an individual fails to choose an HMO or a PCCM provider, the individual is assigned to a capitated health plan. The remaining thirteen states offer only HMO choices and an individual who fails to make a selection is automatically assigned to an HMO.

Choice Period

Almost half the states with mandatory enrollment programs give the beneficiary one month to make a selection before auto-assignment occurs. Five states provide more than one month and six others provide less than one month. There is no apparent correlation between the length of time permitted to make a selection and the rate of auto-assignment for AFDC and related groups: Rhode Island permits 30 days and auto-assigns 8.7% of cases while New Jersey permits four months with an assignment rate of 11%. Nebraska allows 15 days and has a rate of 8.1% while Utah allows 10 days and has an assignment rate of under 1% (estimated). Four states with operational programs (North Carolina, Pennsylvania, Michigan, and Washington) reported that they did not know the auto-assignment rate.

Auto-Assignment

AFDC auto-assignment rates can vary tremendously among the states for a variety of reasons. One such reason could be the length of time a program has been in operation. For example, Virginia believes its assignment rate (48%) was affected

---

14 These states are California, North Carolina, and Oregon.
by the fact that the program was only six months old at the time of the survey;\textsuperscript{15} however, the Arizona program began in 1981 but its auto-assignment rate is also high (approximately 41%).

Another factor in the variation in rates among states is how a state assigns and who is counted in the rate calculation. Whether an entire family is assigned as a unit or as individuals can affect the assignment rate, for example. Rhode Island counts whole families (including newborns). This practice will lower its rate relative to other states where each family member is counted as an auto-assignment, even if the member is a new member joining a family which is already enrolled with a managed care provider. Also, a state may or may not count reassignments as auto-assignments, such as where an individual who loses eligibility temporarily is automatically re-enrolled in the health plan she had previously chosen.

Finally, there are states like Wisconsin, which automatically assigns everyone to a health plan and gives everyone 5 - 12 weeks to decide if they would like to make an alternative selection; the resulting Wisconsin assignment rate is 100%. Delaware operates in a similar fashion but reported an assignment rate well under 100% — 44%. The difference in the rate, despite the similarity in the process, is because Delaware does not count as assigned all those who make a choice different from the original assignment.

Obviously, a state's policy on when people are assigned and which types of enrollments are actually counted as assignments will affect the rates. Significantly different policies make assignment rates extremely difficult and even erroneous to compare without adjustments that account for differing policies.

\textsuperscript{15} Virginia also believes that the rate of auto-assignment results from pre-assignment, which is done in other states such as Delaware and Wisconsin, wherein a new enrollee is informed in advance of the HMO to which he or she will be assigned if the enrollee does not make an alternate choice.
Health Plan Monitoring

Seventeen states with operational programs reported using disenrollment data to monitor health plan performance. There are potentially two ways to ‘track’ disenrollments for purposes of health plan monitoring using plan-specific disenrollment data. (Twenty-four of the reporting 26 states currently have or plan to have access to plan-specific disenrollment information.) One method is to track it on a case-by-case basis – as each disenrollment request is filed, it is examined for approval or rejection and subsequent processing. Another method is to review disenrollment reports for overall program trends and trends within individual plans.

With regard to tracking on a case specific basis, a disenrollment request resulting from dissatisfaction with health plan operation or service might trigger some oversight activity or otherwise feed into the state’s quality monitoring system, much like a complaint/grievance system. Using disenrollment reports that are generated periodically and after open enrollment periods (where such exist in mandatory enrollment systems) oversight activity would involve reviewing the data for trends and outliers which might then trigger further investigation. In order to detect trends and outliers, a report should present plan-specific disenrollment data in formats such as a rates, ratios, or proportions that allow states to analyze the voluntary disenrollments relative to: 1) the total Medicaid enrollment of the contractor; 2) other contracted health plans; or 3) a threshold the state may have established.

The survey questions do not provide information about specific state data formats. The survey shows only whether or not disenrollment data is available by health plan and whether a state can report a voluntary disenrollment rate by a geographic area. The survey did not gather information about the use of disenrollment data for health plan monitoring.
Of the 17 states with operational programs that reported using disenrollment data for health plan monitoring, 11 reported knowledge of the rate of voluntary disenrollments from capitated health plan contractors and reported having plan specific disenrollment data.\textsuperscript{16} Five states that monitor health plan performance using disenrollment information reported having access to plan specific disenrollment data even if they could not report a voluntary disenrollment rate by county or other geographic region. Finally, of the original 17 states, North Carolina could not report a disenrollment rate and did not have access to disenrollment data by plan.

Use of disenrollment data for health plan performance monitoring could be limited without access to plan-specific disenrollment rates. Indeed, the case studies presented in the second half of this report indicate that, despite the availability of the data, states in general make little use of disenrollment rates in health plan performance monitoring. (Please see the section on “Data Uses” in the case studies for a more complete discussion of this issue.)

\textit{Enrollee Satisfaction}

Of the 25 states that reported tracking disenrollments from capitated health plan contractors, 20 also reported surveying enrollees for their reasons for disenrollment.\textsuperscript{17} In 11 of these states, each disenrollee is contacted. In eight others, surveys of disenrollees are conducted on a sample basis. Virginia reported using both methods: a sample basis for the AFDC population, and contacting each SSI-related disenrollee.

\textsuperscript{16} The 11 states that reported a voluntary disenrollment rate and have plan specific disenrollment data and monitor health plan performance using disenrollment information are: Delaware, Georgia, Indiana, Maryland, New Hampshire, New Jersey, Ohio, Oregon, Rhode Island, Utah, and Virginia.

\textsuperscript{17} The five that did not report surveying reasons for disenrollment were: Missouri, Nevada, North Carolina, Texas, and Washington.
Arizona surveys reasons for disenrollment as a component of enrollee satisfaction monitoring. Because the Arizona system is mandatory for enrollees and the only enrollment option is risk-based health plans, a survey of current enrollees can capture information about plan switching and the reasons for such switching. California does not do a separate survey of disenrollees but captures disenrollment reasons on the disenrollment request form which is filed with the Medicaid agency. Based on case studies discussed later, it appears that many states capture reasons for disenrollment in ways similar to California and Arizona rather than conducting a separate survey.

Twelve states reported that disenrollment surveys are done by both the state and health plan. Seven states reported that these surveys are done solely by the state or its designee/contractor, and only one state, Kansas, reported that the survey is done exclusively by the health plan contractors.

Health Benefit Manager Performance Monitoring

Disenrollment data also can be used to monitor the performance of independent enrollment brokers. While states can and do use auto-assignment rates to measure broker performance, disenrollment rates can be used as another measurement tool.\(^\text{18}\)

Low disenrollment rates may indicate that brokers are doing a good job of informing beneficiaries of their choices and helping them select plans that meet beneficiary needs. Low rates can also mean that brokers do well at educating beneficiaries about how to make the best use of managed care systems — make

\(^{18}\) Please refer to the “Data Use” section of the case studies for a more complete discussion of the types of enrollment and disenrollment data states may use to monitor enrollment brokers.
appointments, change doctors within plans if necessary, obtain referrals to specialists.

States need to be cautious in how, and to what extent, disenrollment rates are used to evaluate enrollment broker performance. High or low disenrollment rates could have a variety of causes. For example, high disenrollment rates in the presence of an enrollment broker system could mean poor broker performance; however, the high rates could have little to do with the effectiveness of the broker, and everything to do with the operation and quality of one or more of the health plan contractors.

While low rates of voluntary disenrollment would generally be viewed as a positive reflection on broker performance, states need to be attentive to the effect of different performance incentives. For example, if brokers are evaluated on the basis of disenrollment rates, and the brokers are responsible for some part of the disenrollment process (as is the case in 16 respondent states\textsuperscript{19}), a broker could make it difficult for someone to disenroll because it will affect the performance rating of the broker. Similarly, low disenrollment rates may reflect lack of knowledge among beneficiaries that disenrollment is an option — it could be that the plans, the brokers, or both are doing a poor job of informing enrollees. States need to strike a balance in how they use disenrollment data in this context.

Two survey questions regarding enrollment brokers/health benefit managers identified 16 of the responding states that use or plan to use the services of independent enrollment brokers.\textsuperscript{20} Six of these states use (or intend to use in the

\textsuperscript{19} In response to the question, "The first step in the disenrollment process is for the beneficiary to contact (check all that apply):", 16 states indicated the enrollment brokers could be the first step. See Appendix C.

\textsuperscript{20} One question was where can a beneficiary go to disenroll from a health plan. There were 16 states that indicated a beneficiary could go to an enrollment broker. Those states are assumed, then, to utilize the services of independent health benefits counselors (except in the case of Utah, which uses state workers dedicated to the benefits counselor function). Another survey question was whether the state uses disenrollment data to measure the performance of enrollment brokers. The 6 states that answered yes to this question (as opposed to those that answered ‘no’ or ‘not applicable’) are assumed to use enrollment brokers. Between the two questions, there are 16 states that seem to employ these brokers, including Vermont and West Virginia which must intend to use them when the program is
case of West Virginia) disenrollment data as a measure of broker performance. All six of these states collect plan specific disenrollment data and aggregate that data across all health plans. All six states are also able to identify voluntary disenrollment rates by geographic areas, all of which would be important sources of information with which to monitor enrollment brokers.

SURVEY OBSERVATIONS

The National Academy For State Health Policy survey highlights several important issues for state policymakers and researchers. First, there is considerable disparity among states in their definitions and terms describing enrollments and disenrollments. The variation in terms can and does affect the rates, and makes it difficult to compare across states.

Second, the survey responses show that there is no simple set or combination of program features that consistently affect rates of voluntary disenrollments and auto-assignments. There were no clear correlations between rates of disenrollment and program features such as voluntary/mandatory enrollment, period of choice prior to enrollment, use of enrollment brokers, and various outreach methods. Nor was there an obvious correlation between levels of disenrollment and rates of auto-assignment in mandatory states. Therefore, it would seem that in order to determine just what affects rates of auto-assignment and voluntary disenrollment will require more in-depth study of program policies.

---

21 States responding affirmatively that disenrollment data is used to monitor enrollment broker performance are: Delaware, Georgia, Indiana, New Jersey, and Utah. West Virginia includes this as part of their program design but the program was not implemented at the time of the survey.
ENROLLMENT AND DISENROLLMENT CASE STUDIES

Using telephone interviews, this section of the paper examines how four representative states manage their Medicaid managed care enrollment and disenrollment systems. Particular emphasis is placed on how these states use enrollment and disenrollment rates and surveys of disenrolling beneficiaries to manage their managed care programs.

In theory, disenrollment has the potential to provide important information about program performance, plan performance, and enrollment broker performance. Of course, identifying a high or low rate is only the first step in effectively using this information for program management. States must then investigate to find the reasons behind a high or low rate, as the same rate could have many causes — both good and bad. High disenrollment rates could mean that the enrollment broker and/or health plan is not educating enrollees about how to use the health plan, or that access barriers exist within the health plan or that one health plan’s marketing program is more effective. Low disenrollment rates could mean that enrollees are satisfied with their health plan or that they do not know how to disenroll from the plan.

Despite the theoretical usefulness of disenrollment data, these case studies show that program managers do not generally use aggregate disenrollment data to evaluate performance. Most have found that disenrollment rates are too small to make any reliable judgements. Therefore, state program managers rely more on enrollment (rather than disenrollment) and net plan change22 data for managing programs and health plans.

---

22 Net plan changes refers to the net increase and/or decrease in total enrollment that occurs during the reporting period. This number is not an enrollment or a disenrollment rate. For example, if during the reporting period, a health plan with 1,000 enrollees had 100 people enroll and 25 people disenroll, that health plan would have a net plan change of +75 people and a net rate of plan change of 7.5%. This plan would also have an enrollment rate of 10% and a disenrollment rate of 2.5% during the reporting period.

The National Academy for State Health Policy ♦ 19
Methodology

Four of the twenty-six respondent states (see discussion in previous section) were selected for more in-depth telephone interviews. These interviews elicited more information about the type of information collected and how it is used by states to manage their Medicaid managed care programs. Additional information was also collected about each state’s enrollment/disenrollment system. Besides state staff, several plan and advocate representatives were interviewed. The four states were selected based on two criteria:

- Each state provided survey responses concerning voluntary and involuntary\textsuperscript{23} enrollment rates, and voluntary and involuntary disenrollment rates. The provision of all the rates denoted the potential existence of a more extensive enrollment/disenrollment tracking system.

- Each state represents one of four broad categories of enrollment/disenrollment models found in the survey. Specifically:

  Georgia represents the voluntary risk-based managed care states — those that offer beneficiaries the choice of joining a health plan or remaining in fee-for-service Medicaid and do not assign to a health plan those beneficiaries who do not choose one (although some states in this category assign beneficiaries to a PCCM provider);

  Indiana represents the mandatory managed care states — those that require a beneficiary to either join a health plan or participate in the PCCM

\textsuperscript{23} In mandatory programs, involuntary enrollment refers to the process used to assign those people who do not choose a managed care provider to such a provider. This process is frequently called automatic assignment and the resulting rate is spoken of as an automatic assignment rate.
program and assign beneficiaries who do not choose to both types of managed care programs;

Arizona represents the mandatory risk-based managed care states with high automatic assignment rates — mandatory risk-based managed care states are those that require beneficiaries to join a health plan and assign beneficiaries who do not choose to a capitated health plan; and

Rhode Island represents the mandatory risk-based managed care states with low automatic assignment rates.

Enrollment and Disenrollment Systems

Case study information generally supports the findings of the survey: similar enrollment and disenrollment system structures produce very different automatic assignment rates while different structures can produce similar disenrollment rates. Below is detailed information about each state’s system.

Arizona

The mandatory program in Arizona provides beneficiaries a choice of at least two health plans in each county and uses a 12-month enrollee lock-in. This State’s estimated monthly automatic assignment rate for the AFDC population is 40%, while the total disenrollment rate is 8.9% for this group, and voluntary disenrollment rate is .33%. Less than 5% of enrollees change health plans during the annual open enrollment period. (Arizona defines voluntary disenrollment for the AFDC group as occurring typically outside the open enrollment period where a beneficiary disenrolls from the AFDC program, thereby losing Medicaid eligibility

24 A 12 month lock-in means that enrollees may only switch to another health plan once each year. Other states have 6 month lock-ins under which enrollees may not switch health plans for six months after enrollment.

25 These numbers are based on enrollment activity during a one-month sample time period.
and thus being disenrolled from the health plan. The State counts disenrollments from one plan to another during open enrollment in a separate category labeled “plan changes.” This analysis defines both of these disenrollment types as voluntary disenrollments. The two rates provided by Arizona cannot be combined. Therefore, this analysis uses the 5% figure both because it makes up the bulk of the voluntary disenrollments and is the rate that is most similar in nature (even if not identical) to the disenrollment figures provided by those states that do not use an enrollee lock-in.)

Arizona’s program is older than many, if not most, state Medicaid managed care programs; it began operation in 1982. New beneficiaries must choose a health plan within 16 days of establishing Medicaid eligibility and all enrollees may voluntarily choose to change health plans during a month-long annual open enrollment period. Finally, Arizona does not limit the number of Medicaid beneficiaries an individual health plan may enroll.

The State has sole responsibility for the enrollment/disenrollment process. Enrollment brokers are not used and health plans do not play an active role in enrollment. The State depends primarily on written materials to inform beneficiaries of their health plan alternatives. These materials are sent to enrollees before the annual open enrollment period and to new beneficiaries after Medicaid eligibility is established. The material sent to new beneficiaries contains a State prepared cover letter explaining the enrollee’s right to select a health plan and how to do so, and information produced to state specifications by each plan that describes the plan. The State randomly assigns new beneficiaries who do not choose a health plan. Arizona’s assignment algorithm ensures that all health plans receive at least

26 These two numbers cannot be combined because the rate of .33% is a per month number, while the less than 5% number reflects an annual event. Since one cannot estimate the monthly equivalent of the annual event the two rates cannot be accurately combined. (One cannot assume that dividing the 5% by 12 yields an equivalent monthly rate; because, if given the opportunity, some enrollees would switch more than once each year. Also one cannot assume that, if given the opportunity, the rate of plan changes would be 5% each month, because many enrollees would not change each month.)
5% of the automatically assigned enrollees, but favors those health plans that offer the State a lower price.

Arizona severely restricts plan marketing activities to ensure that capitation payments pay for medical services rather than marketing. This strict control forces at least some health plans to combine marketing and service provision. For example, one health plan (Arizona IPA or “APIPA”) simultaneously creates incentives for enrollees to get preventive care, provides needed clothing to enrollees, and advertises the health plan. APIPA collects, cleans and sorts used clothing by size. Enrolled women who bring their children in for EPSDT screens or come in for prenatal care receive four coupons per visit that they can then trade to receive clothing at plan sponsored “swap meets.” APIPA also arranges for organizations such as Headstart and Job Service to attend the swap meets to provide information to attending enrollees.

Finally, one health plan felt that the strict state control over the enrollment process reduces confusion among new enrollees about what each health plan offers. However, this health plan also felt that members need more information than that provided through the current system to make an informed decision.

Georgia

Georgia’s voluntary program provides beneficiaries the choice of fee-for-service or a health plan. (Currently only one health plan participates, but Georgia Medicaid staff are processing applications from two more plans.) Because the program is voluntary, Georgia has no automatic assignment program. The total disenrollment rate is 6.6% and its voluntary disenrollment rate is 2.46%. This program is very new (enrollment began in February 1996). Unlike Arizona, this program has no lock-in (Georgia allows enrollees to disenroll at the end of any month). Because the program is voluntary, no limits are placed on the length of
time an enrollee has to choose a health plan. Finally, Georgia limits the number of Medicaid beneficiaries a contracted health plan may enroll based on the health plan’s provider network.

In Georgia, an enrollment broker is primarily responsible for enrollment and disenrollment activities. This enrollment broker uses mail, face-to-face meetings, and the telephone to inform potential enrollees about their health plan option. Georgia requires the enrollment broker to speak to each beneficiary in person or over the telephone before enrollment. Finally, Georgia, like Arizona, strictly controls plan marketing. Plans may not market directly to beneficiaries before enrollment. The State does however, allow plans to use mass marketing not directed specifically at Medicaid beneficiaries.

Indiana

Indiana, unlike Arizona and Georgia, requires that beneficiaries join either an HMO or the PCCM program. Indiana has an automatic assignment rate of 38%,27 a total disenrollment rate of 13% and an estimated voluntary disenrollment rate of 7%.28 Like Georgia, Indiana’s program is relatively new — a voluntary program began in 1994 and was converted to a mandatory program in July 1996 — and uses a month-to-month lock-in. This State allows newly eligible beneficiaries one month to select a managed care provider (compared to 16 days in Arizona).

Indiana (like Georgia) uses an enrollment broker for informing beneficiaries of their health plan options. This enrollment broker relies on mail, telephone, and

27 38% is the average percent of beneficiaries who were assigned each month to a Primary Medical Provider (PMP) because they failed to select a PMP after counseling by the enrollment broker and could not be assigned based on an existing (fee-for-service or managed care) provider relationship. The reporting period for this rate is FY 1997 (7/95-6/96).

28 Indiana generally regards voluntary disenrollments as disenrollments from the program — which are almost non-existent. For purposes of responding to the survey they aggregated their plan changes with their program disenrollments to estimate the total voluntary disenrollment rate. In other words, the 7% figure represents primarily changes between plans and not program disenrollments.
face-to-face outreach methods to inform beneficiaries and requires the broker to provide either a face-to-face or telephone contact with enrollees before enrollment. Indiana also uses a videotape in the enrollment process. Finally, Indiana, unlike either Arizona and Georgia, does not restrict health plan marketing; instead the ability to enroll is restricted. In other words, health plans may market in any way they choose — including door-to-door marketing — but only the enrollment broker may enroll the beneficiary into the health plan. This policy ensures the enrollment broker an opportunity to explain all beneficiary health plan choices before every enrollment. Even though health plan marketing is not restricted, all marketing plans and materials are subject to state review and approval.

Indiana is unique in that it requires beneficiaries to choose or be assigned to a primary medical provider (PMP), which determines whether a beneficiary will be in a health plan or the state PCCM program. Instead, PMPs must predetermine whether they will accept new enrollees as a PCCM or as a health plan provider. Then, if the selected (assigned or chosen) PMP is accepting new enrollees through the PCCM program, the beneficiary joins the PCCM program; or, if the PMP is accepting new enrollees through a health plan, the beneficiary joins that health plan.

Indiana's assignment algorithm shares many features used by the other states and is designed to assure that: 1) people stay with the PMP they have had in the past; 2) the PMP has an appropriate specialty (adults are not assigned to pediatricians for example); 3) the family is assigned as one unit; 4) people are assigned to a provider near their home (zip code or county); (5) automatic assignments are split fifty/fifty between risk and PCCM; and 6) more people are assigned to PMPs whose practices have the greatest percentage of openings for new patients. Finally, Indiana does not place any limits on the number of Medicaid beneficiaries a health plan may
enroll. Instead it places a limit on the number of beneficiaries an individual PMP may enroll.

Rhode Island

Rhode Island's mandatory program provides beneficiaries a choice of two or more health plans. Like Arizona, beneficiaries have no fee-for-service or PCCM option. Rhode Island's average monthly automatic assignment rate is 8.7%, the total disenrollment rate is 3.2%, and the voluntary disenrollment rate is .15%. Like Arizona, Rhode Island uses a 12 month enrollee lock-in and reported a separate open enrollment plan change rate of .72%. For the reasons discussed in the Arizona section, this analysis will use the open enrollment change rate (.72%) as the voluntary disenrollment rate.

The program is relatively new, having begun operation in 1994. New enrollees are allowed 30 days to select a plan. (This compares to the 16 days offered by Arizona and the 30 days offered by Indiana.) Finally, Rhode Island does not limit the number of beneficiaries most health plans may enroll. However, the State will impose a limit on a health plan, if the plan's proposed network is not sufficient to serve the population.

Rhode Island, unlike the other three states, places heavy reliance on a contracted administrative entity for both general managed care program development and oversight. Although Rhode Island does not use an enrollment broker it does use State staff who are solely dedicated to enrollment and outreach and located in local offices. These enrollment counselors, like Georgia's and Indiana's enrollment brokers, use mail, telephone, and face-to-face methods to inform beneficiaries about their health plan options. Unlike both Georgia and Indiana, this State does not require face-to-face or telephone contact before beneficiary enrollment.
In Rhode Island, new beneficiaries are offered group and individual counseling at the time of Medicaid application. A ten minute professionally produced video explains the managed care program. The State follows-up these more interactive activities with a mailing in Spanish and English. Beneficiaries have one month from the date of the mailing to select a health plan. Beneficiaries that do not select a health plan\textsuperscript{29} within 30 days, are assigned as a family unit to a health plan using an algorithm identical to Arizona's (that randomly assigns beneficiaries so that all plans receive at least 5\% of beneficiaries and the plans that offer the state lower rates receive a higher percentage).

During the 30 day period, beneficiaries may call the enrollment counselors or the health plan (both maintain toll-free lines for this purpose) for more information. Health plans, however, may not initiate contact with the beneficiary until after the beneficiary is offered a counseling session by the state enrollment counselors. These counselors maintain lists of available primary care providers organized by plan and by town so that beneficiaries can easily choose a health plan based on a specific provider's health plan affiliation. Lists of affiliated pharmacies and specialists are also maintained, which the counselor updates (together with primary care provider lists) twice each month. Surprisingly, State staff found that pharmacy affiliation is a particularly important factor in beneficiary choice of health plan.

One health plan believes the State's enrollment/disenrollment system is very good. In particular, the information transmitted from the State to the plan (primary care provider, head of household, telephone number, date-of-birth) is very useful. The health plan also praised the collaborative process the State used to

\textsuperscript{29} It is worth noting that to preserve existing relationships Arizona, Indiana, and Rhode Island re-assign beneficiaries who lose Medicaid eligibility to the same managed care provider if the beneficiary regains eligibility within a specified time. However, these states do not count these events as automatic assignments.
develop the system, including making changes requested by plans after a trial period. However, the health plan expressed concerns similar to those expressed by an Arizona plan about the strict control of contacting potential new enrollees.

Relationship of Enrollment and Disenrollment Systems to Automatic Assignments and Disenrollment Rates

As stated in the introduction to this section, very similar structures and processes produce very different automatic assignment rates while very different structures and processes can produce similar disenrollment rates. States have very different definitions for these rates. (e.g. some states count as an auto-assignment those who lose Medicaid eligibility, subsequently regain it and are re-assigned to the previous health plan, other states do not). Nonetheless, not all of the differences in rates can be ascribed to the differing definitions. This section of the paper examines the relationships between these rates and the enrollment or disenrollment systems used by the four states interviewed.

Arizona and Rhode Island have very different automatic assignment rates (41% and 8.7% respectively). Yet, these states' program structures are similar. Both states are mandatory, use a 12 month lock-in, strictly control plan marketing, and use the same automatic assignment algorithm. The differences among these state programs are: the length of time beneficiaries have to select a plan (Arizona allows 16 days compared to 30 in Rhode Island); the entity responsible for enrollment (Arizona retains the responsibility while Rhode Island contracts out); and the techniques used to reach beneficiaries (Arizona relies on mailed material only. Rhode Island uses face-to-face counseling sessions, telephone, mail, and videotape).

However, these program differences alone do not account for different automatic assignment rates because similar features result in completely different outcomes in other states. For example, the mandatory program in Indiana uses the
same outreach methods as Rhode Island and provides an enrollee choice period identical to Rhode Island's, yet the Indiana automatic assignment rate (38%) is much higher than Rhode Island's (8.7%).

Indeed, Indiana seems to go to greater lengths than Rhode Island to inform enrollees, at least in some areas. This State (due to the nature of their enrollment system – choice of a primary medical provider rather than a health plan) maintains continually updated lists of primary care providers and requires that each enrollee speak to the enrollment broker (either in person or over the telephone) before enrollment. Rhode Island's list of primary care providers is updated twice each month and beneficiaries are offered in-person or telephone counseling before enrollment. But, Rhode Island does not require beneficiaries to obtain this counseling before enrollment.

The Rhode Island program does go further than Indiana in that it maintains lists identifying specialist and pharmacy affiliations, besides those identifying primary care provider affiliations. This may be a particularly significant difference—Rhode Island staff found that pharmacy affiliation is a surprisingly important factor in beneficiary choice of health plan.

Rates of voluntary disenrollment also exhibit some confusing relationships to enrollment features. Georgia and Rhode Island reported very low voluntary disenrollment rates (2.46%, and 0.72% respectively) compared to the rates for Arizona and Indiana (5% and 7%).30 While one might expect a low voluntary disenrollment rate in a voluntary program like Georgia because people made a free and conscious choice to enroll, a similar rate in a mandatory program like Rhode Island would not necessarily be expected. Finally, it is interesting that the total

---

30 Again, for the reasons previously discussed the voluntary disenrollment rates for Arizona and Rhode Island represent the percent of enrollees who change health plans during the annual open enrollment period.
dismal enrollment rate in Rhode Island is less than half that of Arizona’s (3.2% v. 8.9%). This implies that the involuntary disenrollment rate is higher in Arizona than in Rhode Island – a rate that is not affected by the automatic assignment rate but could be affected by state eligibility policies. Indeed, Rhode Island has more generous eligibility thresholds than Arizona for poverty-related coverage and AFDC coverage, which apparently lead to greater stability in the Medicaid roles generally and a much lower involuntary disenrollment rate.

The case studies did find one potential relationship among state rates. Both Arizona’s and Indiana’s automatic assignment rate is roughly 4 times higher than Rhode Island’s (40%, 38%, and 8.7%, respectively) which is on par with the amount of difference in the voluntary disenrollment rates: (5%, 7%, and .72%). This finding is one of the few expected relationships that were actually confirmed — someone assigned to a plan would seemingly be more likely to disenroll from a health plan than someone who selected the health plan.31

Therefore, it appears that the elements of program structure examined in this study, both by the survey discussed in the first section and the telephone interviews, do not greatly impact automatic assignment and voluntary disenrollment rates. Further in-depth study would be needed to understand this relationship and to examine whether in fact there is any link between enrollment policies and voluntary disenrollment rates.

Based on the case study comparison between Indiana and Rhode Island, a future study might examine how, as a requirement of enrollment, face-to-face or telephone contact by a neutral party affects disenrollment rates relative to programs where there is no such requirement. A future study might also examine the utility

31 The survey did not find this relationship in all states. However, perhaps a more in-depth analysis of the other states would explain the difference in findings.

The National Academy for State Health Policy ◈ 30
of having other aspects of plan networks than primary care provider affiliation (e.g. pharmacy affiliations) available during enrollment choice counseling. Finally, a future study might investigate how differences in the format and language of the outreach material (including the language used by those responsible for informing beneficiaries during face-to-face or telephone contacts) affect disenrollment rates.

*State Analysis of the Reasons Behind the Variation in Rates*

The telephone interview provided another avenue for examining the relationship between program structure and enrollment and disenrollment rates — state staff were asked to explain why they felt their program's rate was low or high.

Rhode Island felt that their program achieved a low automatic assignment rate by using a combination of methods (face-to-face, telephone, and written) to inform beneficiaries of their choices and by providing enough time up front for people to make a decision.

Arizona and Indiana both pointed out that an automatic assignment is not necessarily a failure. If the beneficiary understands the managed care program and his or her choices, but still chooses not to select a plan or provider, an automatic assignment may simply mean that the beneficiary has no preference. The beneficiary may choose not to select a health plan if he or she has no regular doctor or is not satisfied with the care provided by the doctor. In that case, an automatic assignment to a health plan or provider results in an improvement for the enrollee because that enrollee now has a “medical home” and improved access to the health care system.

Arizona backs its interpretation with the results of a focus group study that found that most people did not mind being automatically assigned because it gave them a doctor when they did not have a doctor before. In some sense, Rhode
Island’s experience also supports this interpretation: they found that pharmacy affiliation was a very important factor in choice of health plan which suggests that people are not choosing health plans based on physician affiliation.

Arizona also felt that the reading level of the informing material may contribute to the high automatic assignment rate. Although the material prepared by each health plan is written at the sixth grade reading level, the letter prepared by the State is written at the 11th grade level. The State is currently redrafting the letter to the 6th grade level and will see if there is a reduction in the automatic assignment rate.

As far as state analyses of disenrollment rates are concerned, Arizona and Rhode Island both said that the managed care program disenrollment rates (.33% and .15% respectively)\(^{32}\) were low because these states operate mandatory enrollment managed care programs. In other words, these states severely restrict the reasons for which someone can voluntarily disenroll from the managed care program, as distinct from disenrolling from one health plan to another (and in the case of Arizona, there is no fee-for-service alternative program to be exempted into, as there is in many other states, including Rhode Island). Georgia officials believe that the low disenrollment rate\(^{33}\) shows the program’s newness (enrollees have not yet made up their minds whether or not to disenroll), and enrollee satisfaction with the participating health plan. Finally, Rhode Island, which had both a very low “for cause” disenrollment rate and a very low plan switching rate, believes that the State’s emphasis on enrollee choice during the enrollment process prevents disenrollments.

\(^{32}\) These are the average monthly voluntary disenrollment rates. Since both these states use a 12-month lock-in, the average monthly voluntary disenrollment rate represents “for cause” disenrollment from the program—not voluntary changing of health plans. These are the only two states in these case studies that provided a specific rate of for cause disenrollments. (Indiana, while not providing a specific number, also indicated that their program disenrollment rate was very low for similar reasons.)

\(^{33}\) Since only one health plan currently participates in Georgia’s program their rate does not include plan changes. It does include voluntary disenrollments from the plan that were not “for cause.”

The National Academy for State Health Policy ♦ 32
Both Arizona and Indiana discussed enrollee changes between health plans (Arizona) and managed care providers (Indiana). Arizona’s focus groups found that not all health plan enrollees clearly understood that they could change health plans. (As with the automatic assignment rate, this finding is probably at least partially driven by the grade level of the letter from the State included in the enrollment packet.)

On the other hand, Indiana, which had a higher voluntary disenrollment rate (about 7%) than Arizona (about 5%)\(^{34}\) believes that facilitating an enrollee’s right to “vote with their feet” is a good way to manage contracted health plans. In other words, Indiana believes that health plans will compete to do a better job of delivering care to retain enrollees. Therefore, this State designed a system that makes changing providers extremely easy (e.g., Indiana uses a month to month lock-in; Arizona uses a 12 month lock-in) and makes sure that all enrollees are aware of their right to change health plans.

In Arizona, enrollees who switch plans during the open enrollment period are asked why they made this decision to change. Arizona has found that many of those who change health plans do so for reasons that could have been resolved without changing plans. For example, some people changed health plans because they wanted to change primary providers, or because they thought that another health plan offered an additional service, although all plans are required to offer the same set of services. This suggests that those who change health plans in Arizona may do so because they do not fully understand how to access care within the plan or even what services their plan offers. An Arizona advocate also substantiated this

---

\(^{34}\) Again, this is a difficult comparison since Arizona’s rate is for an annual open enrollment period (12 month lock-in) and Indiana’s rate is for the voluntary switches that occur each month (monthly lock-in). An argument can be made that if Arizona allowed monthly changes, that State’s monthly disenrollment rate would be lower than the 5% reported because those people who switch plans would be able to do so during the year instead of being concentrated into a one month period. But there is no way to predict exactly how much lower the rate would be.
finding by stating that “changing health plans is more indicative of dissatisfaction with the primary care provider than the health plan.” In response to this, Arizona intends to produce a video to inform people during the open enrollment period of “frequently encountered problems that may be addressed without changing health plans.”

**Data Collection**

All four states collect very similar enrollment and disenrollment data. The similarities occur in what data they collect, when they collect it, and how they aggregate it.

**Data Collected**

All four states collect information about enrollment. All collect the total number of new enrollees by health plan. The mandatory enrollment states (Arizona, Indiana, and Rhode Island) also collect the number of new enrollees assigned to health plans which is a subset of the number of total new enrollees.

In addition, Indiana collects the number of people automatically assigned to a provider they used in the past while Arizona collects information about the number of people who are re-enrolled into a health plan after a lapse in Medicaid eligibility. Neither state considers these enrollments true automatic assignments since they are based on previous choice of provider or plan. The additional enrollment data collected by each state is different because Indiana looks at previous provider use, even if that use occurred in the fee-for-service system, while Arizona uses previous health plan membership only. Also, Indiana’s data is based on all new enrollees, while Arizona’s is based on those new enrollees who had previous Medicaid eligibility.
Georgia, Indiana, and Rhode Island collect data about disenrollments. While all three collect the number of people who disenroll this information is not grouped by voluntary or involuntary disenrollment. Rather, they capture the specific, case by case reason for disenrollment (e.g. wanted a different primary care provider (PCP), lack of access to non-emergency transportation, currently under treatment by a provider not affiliated with the program) during the disenrollment process. Georgia aggregates this information on a regular basis so that the State may routinely track voluntary and involuntary disenrollment rates. Indiana and Rhode Island do not routinely aggregate this information. Instead, these states maintain the individual’s reason for disenrollment within their information management system. Finally, Indiana collects the number of people who change PMPs as distinct from disenrollments from health plans discussed above.

As previously implied, Arizona does not collect data about disenrollments other than whether Medicaid eligibility was terminated, resulting in health plan disenrollment. Instead, it collects data about the net change in health plan enrollment that occurs during the annual open enrollment period. Strictly speaking this data is neither enrollment nor disenrollment data. Rather it is the net result of all enrollments and disenrollments for a particular health plan.

Data Sources

All four of the states generate enrollment, disenrollment and plan change data from their internal data processing systems rather than relying on health plan reporting. In addition, of the two states that delegate the enrollment function to a contractor (Georgia and Indiana), only Indiana obtains information from the contractor.
Reporting Frequency

All four states generate monthly reports showing individual enrollments and disenrollments on a monthly basis. And while all four produce monthly aggregate enrollment reports, only Georgia produces aggregate disenrollment monthly reports. Arizona also collects detailed information (net change for each plan by rate category) about enrollment changes that occur during the open enrollment period on an annual basis. Finally, Indiana’s system is capable of producing ad hoc reports with various aggregations of enrollment and disenrollment data.

Data Aggregation

The four states all produce routine reports identifying individual enrollments and disenrollments. As previously discussed, Georgia is the only state that routinely produces reports showing aggregate enrollment and disenrollment rates. All four states can aggregate the disenrollment, enrollment and net plan change information at both the plan and program levels and can organize the data in a variety of ways that are pertinent to the way their programs operate.

Arizona’s annual net plan change and Rhode Island’s monthly enrollment information are aggregated by enrollee rate category and health plan. Rate categories usually reflect enrollee age, sex, and residence, but may also reflect enrollee health status. For example, Arizona has a code specifically for pregnant women. Georgia aggregates both enrollment and disenrollment information by health plan and aid category. This State also aggregates its disenrollment information by reason for disenrollment. Indiana’s system is designed to produce ad hoc reports on an as needed basis and allows data aggregation on many variables so that the State can review and analyze the data in the way that best answers a specific question. For example, Indiana recently produced a report aggregating automatic assignments by county.
Data Uses

Georgia is the only state interviewed which has a system that identifies potential problems of individual plans or the enrollment broker based on aggregate disenrollment numbers. As discussed earlier, this State collects both voluntary and involuntary disenrollment rates. State staff operate a system that automatically tracks those rates and staff investigate any time a health plan’s voluntary disenrollment rate exceeds 5%. (This event has not yet occurred.) They feel that a 5% rate indicates a strong possibility that the plan is not adequately serving enrollees, although the disenrollment rate could be the result of many different causes, including poor performance by the enrollment broker. The Georgia data system is also designed to compare plans with each other, a function that will be utilized after the program expands to include more than one health plan.

The other three states appear to focus on individual disenrollment, and aggregate enrollment and net plan change rates, rather than on aggregate disenrollment rates. State staff and participating health plan staff believe the greatest value of disenrollment information is not the rate of disenrollments, but the reasons behind each individual disenrollment and that enrollee specific complaints can be used to better health plan performance.

Arizona, Indiana, and Rhode Island do not rely on aggregate disenrollment data to manage their plans, enrollment broker or program. Both Indiana and Rhode Island have examined the enrollment and disenrollment numbers for trends. However, they, along with Arizona, decided not to use the aggregate disenrollment rates because they found the rates were too low to be reliable indicators of program and/or enrollment broker performance and were certainly too low to be a useful tool in evaluating individual plan performance.
Instead, Arizona, Indiana and Rhode Island rely mostly on information regarding enrollment rates (voluntary and involuntary). Arizona also relies heavily on information about net health plan changes. (This is neither an enrollment nor disenrollment rate, but rather the net effect of all individual enrollments and disenrollments during open enrollment periods.) All four states do, however, routinely examine individual cases of disenrollment for possible referrals to quality oversight committees or potential program improvements.

Besides the fact that disenrollment rates are thought to be too low to be useful or predictive, state staff expressed a common commitment to management by positive goals. This attitude results in the use of enrollment rather than disenrollment data to manage their programs. As one state official said “...we focus on what the plan of choice is doing right.” And, as another official expressed it “...we rely on the competition between plans to retain enrollees to ensure that they provide good service.” This attitude was also expressed by an advocate who said that “...enrollment is more important than disenrollment for managing plans – the focus should be on who does a good job and why so that the whole industry can move forward.”

While the states are not using rates of disenrollment for program management, they are using case specific disenrollment information and enrollment and net plan change rate information for many program management purposes such as:

- Arizona meets with health plan Chief Executive Officers (CEOs) each month and with CEOs and Medical Directors each quarter to go over the enrollment (rather than disenrollment) figures. They use these meetings to find out what each health plan does to attract (or discourage) enrollment into their plan. The state may then decide to share the “good”

The National Academy for State Health Policy ♦ 38
ideas with other plans or feed the “bad reasons” into their health plan performance monitoring system. For example, the state found that some beneficiaries select a particular health plan because the plan provides a separate ID card from the Medicaid card, so the enrollees feel like they have “real insurance,” not Medicaid. Conversely, some beneficiaries said they did not select another plan because they know other enrollees that belong to that plan that have had to wait a long time for appointments.

- Arizona uses the aggregate net plan change data from the open enrollment period as a check to see if a plan is cherry-picking\textsuperscript{35} enrollment. For example, the state may take a closer look at a health plan whose net enrollment of pregnant women drops significantly during the open enrollment period. (Since Arizona pays a separate rate for pregnant women they can find this information by examining the net plan changes by rate code report.)

- Indiana and Rhode Island use the rate of voluntary selection of health plans to judge the performance of the enrollment broker (Indiana) or enrollment counselors (Rhode Island) in enrollee education. These states assume that a high voluntary enrollment rate shows that the entity responsible for enrollment is doing a good job.

- Indiana’s enrollment broker targeted those counties with high automatic assignment rates for provider recruitment into the managed care program. This State assumed that enrollees were choosing not to select a PMP because their current providers were not participating in the program.

\textsuperscript{35} Cherry-picking refers to any practices a health plan might use to encourage enrollment of relatively low cost people and/or discourage enrollment of relatively high cost people.
• Indiana also uses information about why people changed plans (collected as part of the enrollment/disenrollment process) to identify program improvements. For example, many people changed due to emergency transportation problems, so now Indiana is working with health plans to develop a solution for the program as a whole.

• Rhode Island provides monthly reports showing the individual reasons for disenrolling from the program (as opposed to changing plans) to their quality assurance team.

Disenrollment Surveys

None of the states interviewed surveyed disenrollees about plan satisfaction or reasons for disenrollment apart from the enrollment/disenrollment process. However, all four states find out why people are disenrolling as part of the process itself. Additionally, Arizona performed both a survey and focus groups with health plan enrollees and identified the reasons enrollees leave plans through these activities.

CASE STUDY OBSERVATIONS

Similar to the findings of the survey reported earlier in this paper, these case studies found very little relation between the structure of the enrollment or disenrollment process, and the enrollment or disenrollment rates reported by each state. Perhaps a study examining differences between the specific materials (written, video, and verbal) used in the process might find stronger causal relationships.

The case study findings do, at least partially, explain the findings about state “tracking” of disenrollments. The survey suggested that while many states tracked disenrollments, slightly over half of the respondents track disenrollment rates, even
though a slim majority of states surveyed had access to rates of voluntary disenrollments. The case studies found that at least among four states, there was greater interest and perceived utility in tracking the reasons for individual disenrollments, instead of aggregate disenrollment rates, even where states had aggregate disenrollment rate information. The states interviewed used the individual reasons to identify areas for improvement in both program and plan operation.

Although only one of the four case study states relies on voluntary disenrollment rates, they all rely on enrollment rates (voluntary and involuntary) for plan, program, and enrollment broker management. Enrollment rates have several advantages over disenrollment rates. First, larger numbers permit easier distinctions between plans and produce more reliable trend analysis. (To illustrate, a change in the automatic assignment rate from 25% to 50% is more significant than a change in disenrollment from 0.15% to 0.30% — although the degree of change is the same.) Also, focusing on enrollment encourages health plans to strive to be the best, rather than avoid being the worst.
CONCLUSIONS

States as a group place less emphasis on the aggregate disenrollment numbers as a tool to monitor or measure the quality of specific health plan contractors than they do on case specific disenrollment monitoring. States that could report disenrollment numbers typically had low rates of disenrollment and low rates make meaningful quality and performance measurement difficult.

Low rates of voluntary disenrollment and the underlying infrequent occurrences can make policy development problematic. For example, low rates of voluntary disenrollment can be either positive or negative when viewed in the aggregate. Low rates can mean that enrollees are completely satisfied with their care and have no desire to change plans, or it can mean that enrollees are not properly informed of their options to switch plans or seek exemption from the program. The rates themselves do not reveal whether a low rate is positive or negative. (Conversely, the significance of high voluntary disenrollment rates could also be debated.) A low voluntary disenrollment rate can be difficult for use in accurately assessing health plan contractor performance. Finally, as the survey results show, a low disenrollment rate is not easily correlated with any particular policy or programmatic feature, so it is not easy to focus on a rate where it is not known exactly what it means nor what really influences that rate.

Although states do not rely on disenrollment rates, they do rely on enrollment rates (voluntary and involuntary) for plan, program, and enrollment broker management. As previously discussed, this rate has several advantages over disenrollment rates. First, because the numbers are larger, it is easier to make distinctions between plans and produce more reliable trend analysis. Also, focusing on enrollment encourages health plans to strive to be the best, rather than avoid being the worst.
Case study information seems to indicate that states find enrollee-specific disenrollment information more helpful in program and plan management than aggregate voluntary disenrollment rates. While overall voluntary disenrollment levels are low, regardless of data format/source, the individualized information is detailed with regard to issues, and as such may have more predictive power to identify specific potential problems.
Appendix A: Program Characteristics and Rates of Auto-Enrollment and Voluntary Disenrollment
### Appendix A: Program Characteristics and Rates of Auto-Enrollment and Voluntary Disenrollment

<table>
<thead>
<tr>
<th>State</th>
<th>Voluntary into Capitation in Specified Metro Area or County</th>
<th>Auto-Assignment into Capitation?</th>
<th>Length of Time Before Assignment</th>
<th>Auto-Assignment Rate into Capitation</th>
<th>Voluntary Disenrollment Rate</th>
<th>Face to Face or Telephone Req'd Before Enrollment</th>
<th>Enrollment Broker Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>2+ HMO/ffs or PCCM</td>
<td>N</td>
<td>n/a</td>
<td>n/a</td>
<td>2.46%</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>MD</td>
<td>2+ HMO/ffs or PCCM</td>
<td>N</td>
<td>n/a</td>
<td>n/a</td>
<td>.97%</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>MT (children)</td>
<td>1+ HMO/ffs or PCCM</td>
<td>N</td>
<td>n/a</td>
<td>n/a</td>
<td>unknown</td>
<td>O</td>
<td>Y</td>
</tr>
<tr>
<td>NV</td>
<td>2+ HMO/ffs or PCCM</td>
<td>N</td>
<td>n/a</td>
<td>n/a</td>
<td>unknown</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>NH</td>
<td>2+ HMO/ffs or PCCM</td>
<td>N</td>
<td>n/a</td>
<td>n/a</td>
<td>2%</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>PA-volun.</td>
<td>2+ HMO/ffs or PCCM</td>
<td>N</td>
<td>n/a</td>
<td>n/a</td>
<td>unknown</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>IN</td>
<td>2+ HMO/ffs or PCCM</td>
<td>assign to HMO &amp; PCCM</td>
<td>1 mo</td>
<td>38%</td>
<td>7%</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>KS</td>
<td>2+ HMO/ffs or PCCM</td>
<td>assign to HMO &amp; PCCM</td>
<td>1 mo</td>
<td>38%</td>
<td>3.1%</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>MI</td>
<td>2+ HMO/ffs or PCCM</td>
<td>assign to HMO &amp; PCCM</td>
<td>1.5 mo</td>
<td>unknown</td>
<td>unknown</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>NE</td>
<td>2+ HMO/ffs or PCCM</td>
<td>assign to HMO &amp; PCCM</td>
<td>15 days</td>
<td>8.1%</td>
<td>unknown</td>
<td>O</td>
<td>Y</td>
</tr>
<tr>
<td>AZ</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>16 days</td>
<td>40.9%</td>
<td>.33% b 5%</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>CA</td>
<td>2+ HMO/ffs or PCCM</td>
<td>Y</td>
<td>1 mo</td>
<td>25%</td>
<td>unknown</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>DE</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>1 mo</td>
<td>44%</td>
<td>2</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

1| Mandatory into Capitation in Specified Metro Area or County

The National Academy for State Health Policy ✰ Page 45
### Appendix A: Program Characteristics and Rates of Auto-Enrollment and Voluntary Disenrollment

<table>
<thead>
<tr>
<th>State</th>
<th>Voluntary into Capitation in Specified Metro Area or County</th>
<th>Auto-Assignment into Capitation?</th>
<th>Length of Time Before Assignment</th>
<th>Auto-Assignment Rate into Capitation</th>
<th>Voluntary Disenrollment Rate</th>
<th>Face to Face or Telephone Req'd Before Enrollment</th>
<th>Enrollment Broker Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>?</td>
<td>15% _e</td>
<td>unknown</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>MT</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>2 mo</td>
<td>20% _e</td>
<td>unknown</td>
<td>O</td>
<td>Y</td>
</tr>
<tr>
<td>NJ</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>4 mo</td>
<td>11% _e</td>
<td>.3%</td>
<td>O</td>
<td>Y</td>
</tr>
<tr>
<td>NC</td>
<td>2+ HMO/ffs or PCCM</td>
<td>Y</td>
<td>10 days</td>
<td>unknown</td>
<td>unknown</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>OH</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>1 mo</td>
<td>20% _e</td>
<td>.65%</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>OR</td>
<td>2+ HMO/ffs or PCCM</td>
<td>Y</td>
<td>1 mo</td>
<td>5-7% _e</td>
<td>5%</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>PA-mand.</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>2-4 wks</td>
<td>unknown</td>
<td>unknown</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>RI</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>14/30 days</td>
<td>8.7% _e</td>
<td>.15% _b, .72% _p</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>TX</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>1 mo</td>
<td>50% _e</td>
<td>10%</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>UT</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>10 days</td>
<td>&lt;1% _e</td>
<td>.8%</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>VT</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>1mo</td>
<td>unknown*</td>
<td>unknown*</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>VA</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>2 mos</td>
<td>48% _e</td>
<td>1%</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>1 mo</td>
<td>unknown</td>
<td>1.27% _b, 1.8% _p</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>WV</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>1 mo</td>
<td>unknown*</td>
<td>unknown*</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>WI</td>
<td>2+ HMO only</td>
<td>Y</td>
<td>5-12 wks</td>
<td>100% _e</td>
<td>unknown</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

n/a = not applicable  
O = not if efforts to contact have failed  
* = program not implemented  
ffs = fee-for-service  
PCCM = Primary Care Case Management

1 CA fee for service is available in mandatory county only for people exempt from risk program.  
_e = estimated  
_b = program exemptions only  
_p = plan switching/voluntary plan disenrollments to another plan during annual open enrollment, except in WA which is monthly.  
_s = statewide rate  
^ = Nevada contracts with entities other than Medicaid-defined HMOs although the term HMO is used here.

The National Academy for State Health Policy ♦ Page 46
Appendix B: Disenrollment Data Uses, Formats, and Availability
Appendix B: Disenrollment Data Uses, Formats, and Availability

<table>
<thead>
<tr>
<th>State</th>
<th>Voluntary or Mandatory in Specified Metro Area or Country</th>
<th>Disenrollment Data Used for Health Plan Monitoring</th>
<th>Disenrollment Data Used for Enrollment Broker Performance</th>
<th>Total AFDC Disenrollment Rate Known</th>
<th>Voluntary AFDC Disenrollment Rate Known</th>
<th>Voluntary Disenrollment Data Aggregated w/ Other Disenrollment Data</th>
<th>Plan-Specific Disenrollment Data Available</th>
<th>Aggregated Plan Disenrollment Data Available</th>
<th>Auto-Assignment Rate Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZ</td>
<td>M</td>
<td>n/a</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>CA</td>
<td>M</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>DE</td>
<td>M</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>GA</td>
<td>V</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n/a</td>
</tr>
<tr>
<td>IN</td>
<td>M</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>KS</td>
<td>V</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y-some</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>MD</td>
<td>V</td>
<td>y</td>
<td>n/a</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n/a</td>
</tr>
<tr>
<td>MO</td>
<td>M</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>MT</td>
<td>M/V</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>NE</td>
<td>M</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>NV</td>
<td>V</td>
<td>y</td>
<td>n/a</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n/a</td>
</tr>
<tr>
<td>NH</td>
<td>V</td>
<td>y</td>
<td>n/a</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n/a</td>
</tr>
<tr>
<td>NJ</td>
<td>M</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>NC</td>
<td>M</td>
<td>y</td>
<td>y</td>
<td>y &amp; n</td>
<td>y</td>
<td>y &amp; n</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>OH</td>
<td>M</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>OR</td>
<td>M</td>
<td>y</td>
<td>n/a</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>PA</td>
<td>M/V</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
</tbody>
</table>
## Appendix B: Disenrollment Data Uses, Formats, and Availability

<table>
<thead>
<tr>
<th>State</th>
<th>Voluntary or Mandatory in Specified Metro Area or Country</th>
<th>Disenrollment Data Used for Health Plan Monitoring</th>
<th>Disenrollment Data Used for Enrollment Broker Performance</th>
<th>Total AFDC Disenrollment Rate Known</th>
<th>Voluntary AFDC Disenrollment Rate Known</th>
<th>Voluntary Disenrollment Data Aggregated w/ Other Disenrollment Data</th>
<th>Plan-Specific Disenrollment Data Available</th>
<th>Aggregated Plan Disenrollment Data Available</th>
<th>Auto-Assignment Rate Known</th>
</tr>
</thead>
<tbody>
<tr>
<td>RI</td>
<td>M</td>
<td>y</td>
<td>n/a</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>TX</td>
<td>M</td>
<td>n/r</td>
<td>n/r</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>UT</td>
<td>M</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>VT*</td>
<td>M</td>
<td>y</td>
<td></td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>VA</td>
<td>M</td>
<td>y</td>
<td>n/a</td>
<td>y</td>
<td>y &amp; n</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>WA</td>
<td>M</td>
<td>y</td>
<td></td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>WV*</td>
<td>M</td>
<td>y</td>
<td></td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
<tr>
<td>WI</td>
<td>M</td>
<td></td>
<td></td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
</tr>
</tbody>
</table>

* = program not implemented yet

y = yes

blank = no

n/a = not applicable

n/r = no response

M = mandatory

V = Voluntary
Appendix C: Survey Questions and Complete State Responses
National Academy for State Health Policy
Medicaid Managed Care Disenrollment Survey
26 respondents of 27 surveyed states
25 responding states track disenrollment

I. Monitoring Disenrollment

1. Are disenrollments from capitated Medicaid managed care contractors tracked?
   yes: 25 AZ, CA, DE, GA, IN, KS, MD, MO, MT, NE, NV, NH, NJ, NC, OH, OR, PA, RI, TX, UT, VT, VA, WA, WV, WI
   no: 1 MI

1a. Can the state identify voluntary disenrollments (beneficiary/enrollee initiated) from capitated health plans?
   yes: 24
   no: 1 MI
   no response: 1 CA

1b. Are voluntary disenrollments aggregated w/other types of disenrollments for reporting purposes?
   yes: 15 AZ, CA, DE, IN, KS, MO, MT, NV, NC, OH1, OR, RI, TX, VA2, WI
   no: 10 GA, MD, NE, NH, NJ, PA, UT, VT, WA, WV

1c. Is disenrollment data available on a capitated health plan specific basis?
   yes: 23 AZ, CA, DE, GA, IN, MD, MO, MT, NE, NV, NH, NJ, OH, OR, PA, RI, TX, UT, VA, VT, WA, WV, WI
   no: 1 NC
   in some cases: 1 KS

1d. Is disenrollment data available aggregated across health plans?
   yes: 25 AZ, CA, DE, GA, IN, KS, MD, MO, MT, NE, NV, NH, NJ, NC, OH, OR, PA, RI, TX, UT, VT, VA, WA, WV, WI
   no: 0

2. Does the state use disenrollment data for quality assurance or other plan performance measurement?
   yes: 19 CA, DE, GA, IN, MD, MO, MT, NE, NV, NH, NJ, NC, OH3, OR, RI4, UT, VT, VA, WV
   no: 5 AZ, KS, PA5, WA, WI
   no response: 1 TX

3. Does the state use disenrollment data to measure health benefits counselor/enrollment broker performance?
   yes: 6 DE, GA, IN, NJ, UT6, WV

---

1 Available both aggregated and disaggregated.
2 Available both aggregated and disaggregated.
3 Beginning 7/96.
4 On a case-specific basis.
5 Planned for future.
6 Benefit managers in Utah are actually state employees whose jobs are exclusively benefit counselors located in each eligibility office.
4. Are disenrollees surveyed or questioned about their reason for disenrollment?
   yes: 20 AZ, CA, DE, GA, IN, KS, MD, MT, NE, NH, NJ, OH, OR, PA, RI, VT, VA, WV, WI
   no: 5 MO, NV, NC, TX, WA

4a. Who surveys/questions disenrollees?
   the state or its contractor: 7 AZ, GA, MT, NE, OR, UT, VA
   the health plan(s): 1 KS
   state or contractor & health plan: 12 CA, DE, IN, MD, NH, NJ, OH, PA, RI, VT, WV, WI

4b. How are disenrollees selected for survey?
   sample basis: 9 AZ, GA, MD, OH, OR, VT, VA (for afdc), WV, WI
   each disenrollee is contacted: 12 CA, DE, IN, KS, NE, MT, NH, NJ, PA, RI, UT, VA (for abd)

II. Program Characteristics

1. Enrollment of the AFDC and related groups into capitated Medicaid managed care in a specified metropolitan area is:
   voluntary: 6 GA, KS, MD, MT (children), NV, NH
   mandatory: 21 AZ, CA, DE, IN, MI, MO, MT (adults), NE, NJ, NC, OH, OR, PA, RI, TX, UT, VA, VT, WA, WV, WI

2. AFDC and AFDC related beneficiaries have:
   a choice of two or more capitated health plans with no fee for service alternative choice
   15: AZ, DE, MO, MT (adult), NJ, OH, PA (mand. areas only), RI, TX, UT, VT, VA, WA, WV, WI

---

7 Planned for future.
8 Survey done as part of satisfaction survey, conducted on non-routine basis.
9 Enrollees are not surveyed for plan changes/plan switching during annual open enrollment.
10 The disenrollment request form asks the reason for the request.
11 Default enrollment to either health plan or PCCM program.
12 Default enrollment is to either health plan or PCCM program.
13 Default enrollment is to either health plan or PCCM program.
14 Default enrollment is to either health plan or PCCM program.
15 Some parts of Philadelphia are mandatory, while others are voluntary.
16 1115 waiver permits mandatory enrollment into one health plan.
a choice of **two or more** capitated health plans and a fee for service alternative choice (either PCCM or traditional fee for service)

12: CA\(^{17}\), GA, IN, KS, MD, MI, NE, NV, NH, NC, OR, PA (vol. areas only)

a choice of **one** capitated health plan and the non-capitated Primary Care Case Management (fee for service) Program

1: MT (for children)

a choice of **one** capitated health plan and unmanaged traditional fee for service

0

3. AFDC and related enrollees who do not make a choice of a capitated health plan are assigned to a **capitated health plan**.

   yes: 21 AZ, CA, DE, KS\(^{19}\), IN\(^{19}\), MO, NE, MT(adults), NJ, NC, OH, OR, PA, RI, TX, UT, VT, VA, WA WV, WI

   no: 5 GA, MD, MI\(^{20}\), NV, NH

3a. How long a time is someone given to choose a plan before auto-assignment occurs?

   1 mo.: 9 CA, DE, IN, KS, OH, OR, TX, VT, WA, WV

   45 days: 1 MI

   2 mos: 3 MT, VA

   3 mos: 0

   4 mos: 1 NJ

   other: 8 AZ 16 days; MO ?; NE 15 days; NC 10 days; PA 2-4 wks; RI 14 days from enroll. session or 30 days from enroll letter; UT 10 days; WI 5-12 wks

3b. What is the percentage of enrollments that are auto-assigned to **capitated health plans**?

   not applicable: 4 GA, MD, NV, NH,

   don’t know: 6 MI, NC, PA, VT\(^{21}\), WA, WV\(^{22}\)

   known: 16 AZ: 40.9% act., CA-25% est., DE-44% act., IN-38% est., KS-38% act., MO-15% est., MT-20% est., NE-8.1% act., NJ-11% act., OH-30% act., OR-5-7% est., RI-8.7% act., TX-50% est., UT<1% est., VA-48% act., WI-100% act.

4. Enrollment/Outreach of AFDC and related groups is done by (check all that apply):

   mail 22: AZ, CA, DE, GA, IN, KS, MI, MO, MT, NE, NH, NJ, NC, OH, PA, RI, TX, VT, VA, WA, WV, WI

   telephone: 18 CA , DE, GA, IN, KS, MI, MO, MT, NE, NJ, NC, RI, TX, VT, VA, WA, WV, WI

   face to face: 20 CA, DE, GA, IN, KS, MO, NE, NH, NJ, NC, OH, PA, RI, TX,

---

\(^{17}\) For the county to which the response applies, Sacramento, the fee-for-service alternative is only available for exempted cases. Unless there are specific predefined circumstances which apply to a beneficiary, the beneficiary is expected to enroll with an HMO, so this is not really an 'alternative' choice for beneficiaries generally.

\(^{18}\) Default enrollment is to either a health plan or the PCCM program.

\(^{19}\) Default enrollment is to either a health plan or the PCCM program.

\(^{20}\) Default enrollment is to either a health plan or the PCCM program.

\(^{21}\) Program not implemented yet.

\(^{22}\) Program not implemented yet.
enrollment brokers: 15 CA, DE, GA, IN, KS, MO, NE, NJ, NC, OH, TX, UT24, VT, WV, WI
government workers (state or local): 8 KS NV NH OR RI UT VA WA
door to door recruitment by health plans: 3 MD25, MI, PA
other: 2 MT26, VA27

4a. Face to face or telephone contact with the beneficiary is required in the enrollment process.
  yes: 9 GA, IN, MD, NH, NC, OH28, OR, PA,29 UT30
  no: 14 CA, DE, KS, MI, MO, NV, PA31, RI, TX, VT, VA, WA, WV, WI
  not if efforts to contact have failed: 4 AZ, MT, NE, NJ

5. The first step in the disenrollment process is for the beneficiary to contact (ck all that apply):
  Medicaid agency: 10 DE, GA, KS, MI32, NV, NH, OR, UT, WA, WI
  health plan: 11 DE, GA, IN, KS, MD, MI, NV, NJ, PA, RI, VA
  enrollment broker: 16 CA, DE, GA, IN, KS, MO, MT, NE, NJ, NC, OH, TX, UT33,
  VT, WV, WI
  other: 1 AZ (elig. office)

6. Are other eligibility groups treated the same as AFDC in terms of enrollment and disenrollment rules and outreach?
  yes: 17 DE, GA, KS, MD, MI, MO, NE, NV, OR34, PA, RI, TX, UT, VT, VA, WA, WV
  no: 9 AZ35, CA, IN, MT, NJ, NC, OH, OR, WI
  not applicable: 1 NH

7. Capitated Medicaid managed care risk contracts in this metropolitan area or county are:
  let to all qualified bidders: 20 GA, KS, MD36, MI, MO, MT, NE, NV, NH, NJ,
  NC, OH, OR, PA, RI, UT, VT, WA37, WV, WI,
  let to a limited number of qualified bidders: 6 AZ, CA, DE, IN, TX, VA

23 Only during implementation.
24 UT brokers are state employees who work exclusively as benefit counselors in eligibility offices.
25 Door to door recruitment by health plans was halted in October, 1996.
26 Plans market (not door to door).
27 Plans market (not door to door).
28 Unless request for mail enrollment is made.
29 For voluntary groups.
30 For initial enrollment.
31 For mandatory groups.
32 Initial step in disenrollment depends on type of program enrollment (PCCM or health plan).
33 Enrollment broker is state employee.
34 Re: disenrollment.
35 State-only groups are treated differently.
36 Let to all qualified 'applicants'.
37 Changing to limited number soon.
8. What is the AFDC (and AFDC related) total disenrollment (voluntary and involuntary) in the specified metropolitan area or other specified area?
   not known: 15 CA, DE, KS, MI, MO, MT, NE, NV, NH, NJ, NC, PA, VT\textsuperscript{38}, WV\textsuperscript{39}, WI
   known: 11 AZ-8.9\%, GA-6.6\%, IN-13\% est., MD-5.69\%, OH-8.29\%, OR-9\%, RI-3.26\%, TX-10\%, UT-8\%, VA-6\%, WA-7.2\%

8a. What is the voluntary AFDC (and AFDC related) disenrollment rate from capitated plans in this metropolitan area or county?
   not known 11 CA, MI, MO, MT, NE, NV, NC, PA, VT\textsuperscript{40}, WV\textsuperscript{41}, WI
   known: 15 AZ-33\%\textsuperscript{42}, DE-2\%, GA-2.46\%, IN-7\% est., KS-3.1\% statewide, MD-.97\%, NH-2\% statewide, NJ-.3\%, OH-.65\%, OR-5\%, RI-.15\%\textsuperscript{43}, TX-10\%, UT-8\%, VA-1\%, WA-1.27\%\textsuperscript{44}

\textsuperscript{38} Program not yet implemented.
\textsuperscript{39} Program not yet implemented.
\textsuperscript{40} Program not yet implemented.
\textsuperscript{41} Program not yet implemented.
\textsuperscript{42} This rate represents monthly withdrawals from risk-based program participation based on loss of eligibility for AFDC. Voluntary disenrollment from one plan to another, "plan switching," occurring at annual open enrollment is approximately 5\%.
\textsuperscript{43} This rate represents monthly program exemptions. The rate of plan switching during annual open enrollment is .72\%.
\textsuperscript{44} This rate represents monthly program exemptions. The average monthly rate of plan switching is approximately 1.8\%.