

Trends in Provider Capitation, 1996-2000
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ABSTRACT

Objective: We examine the extent to which the health care services delivered by physicians and hospitals in public and private health plans are capitated, and how this changed from 1996 to 2000.

Study Design: The data are drawn from the 1996 to 2000 years of the nationally representative Medical Expenditure Panel Survey (MEPS). Information on whether health care use was covered by capitated arrangements was obtained from billing offices of physicians and hospitals, in a follow-back survey of providers used by MEPS household members.

Methods: We compare changes from 1996 to 2000 in the percentage of office-based physician visits, hospital outpatient department (OPD) visits, hospital emergency department (ED) visits, and hospital inpatient stays that are covered by capitation arrangements. We also compare differences by health insurance coverage, including HMO coverage, and selected socio-demographic characteristics. We use standard two-tail tests of significance, which are calculated taking into account the complex survey design of the MEPS.

Results: We find that only 15 percent of visits to office-based physicians were capitated in 1996, declining to 13 percent in 2000. Even among HMO enrollees, visits covered by a provider capitation arrangement represented a minority of all office visits, declining to 25 percent for Private HMO enrollees and 15 percent for Medicaid HMO enrollees in 2000. Even smaller proportions of hospital services were capitated.

Conclusions: Capitation remains relatively rare even among public and private HMO enrollees.

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Introduction

After extraordinary growth through the late 1990s, managed care has clearly lost some momentum. The number of individuals enrolled in Health Maintenance Organizations (HMOs) doubled from 39 million in 1992 to a peak of 80.5 million in 1999, but has since declined to 74 million by 2002.^{1,2} Enrollment in Preferred Provider Organizations (PPOs) grew rapidly between 1990 and 1996 from 38 million to 98 million individuals, but slowed substantially afterwards with approximately 105 million individuals enrolled in 2001.^{3,4}

The growth in managed care brought with it a substantial movement away from traditional charged-based payment arrangements and toward payment based on cost-containing approaches such as capitation, fee schedules, and negotiated rates. Capitation, in particular, once held great promise as a means to contain costs and is often thought of as synonymous with HMOs. However, there is often a great deal of confusion about the distinction between capitation payments to health plans for coverage under a plan, for example, as in Medicare and Medicaid HMOs, and capitation payments to providers for the provision of care, for example, under a risk contract between a health plan and a specific provider. Although capitation is often used to describe both situations, they are fundamentally different. At the plan level, capitation can be thought of as a premium paid for health insurance coverage, but does not necessarily imply a specific method of paying individual providers. At the provider level, capitation is a substitute for fee-for-service payment in which a flat amount, for example, some amount per person per month, is paid to cover all of the services provided. From a theoretical perspective, the promise of capitation in both cases comes from the shifting of risks to the health plan or provider, thus creating strong incentives to restrain health care utilization and costs.^{5,6}

By the late 1990s, the proportion of physicians in practices with any type of managed care contract had reached a peak of 92 percent, and more than one-third of physicians were in practices that had contracts that involved capitation.⁷ However, along with a leveling off of the number of physicians in practices with any type of managed care contract, the average amount of practice revenue derived from these contracts has also leveled off in recent years at about 40 percent according to AMA physician surveys.⁸ Never large, the average amount of physician practice revenue derived from capitated contracts appears to have declined slightly to approximately 7 percent by 2001, according to another physician survey.^{8,9} These physician surveys suggest that capitation of providers is far less common than capitation of health plans. In contrast, a recent Medicare Payment Advisory Commission (MEDPAC) funded study of financing arrangements within HMOs in selected markets concluded that “While capitation arrangements are particularly common in California, they are more common elsewhere than many assume.”¹⁰

We examine the extent to which health care services were actually covered by capitation arrangements and how this changed between 1996 and 2000 using data from the nationally representative Medical Expenditure Panel Survey (MEPS). While previous surveys of physicians have estimated the percent in practices with capitated contracts and the average percentage of practice revenue derived from these contracts, there is little information available nationally on the extent to which individual medical events are provided under capitated reimbursement arrangements. That is, from the consumer’s perspective, how much of their health care use is actually capitated? Unlike most previous studies, we are able to examine how capitation varies among Medicare, Medicaid, and private health insurance enrollees, and, specifically, how much of the health care received by enrollees in HMO plans is capitated. In

addition to physicians visits, we are also able to examine trends in capitation of hospital-provided services. Finally, we are able to examine how the prevalence of capitation varies among individuals by sociodemographic characteristics.

DATA AND METHODS

Data Source

Our data come from years 1996 through 2000 of the MEPS, which is a large ongoing nationally representative survey of the U.S. civilian non-institutionalized population sponsored by the Agency for Healthcare Research and Quality (AHRQ). We combined data on health care use and personal characteristics from the MEPS Household Component (MEPS-HC) with billing and reimbursement data (including capitation) from the Medical Provider Component (MEPS-MPC), a follow-back survey of health care providers identified by MEPS respondents. The MEPS-MPC collects billing data for a sample of all the office-based doctors reported by MEPS respondents in all years, with heavy over-sampling of providers of households with Medicaid or HMO coverage. Billing data were collected for all reported hospitals in 1996, 1999, and 2000 and a sample of hospitals in 1997 and 1998.¹¹

Because the MEPS-MPC was not designed as a standalone survey, sampling weights were never developed by AHRQ to account for the fact that not all providers were contacted to obtain billing information, either because the provider was not sampled or a signed permission form was not obtained from the MEPS respondent. Once contacted the great majority of office based physician's offices (86 percent in 1996) and hospitals (93 percent in 1996) participated in the MEPS-MPC, and virtually all the providers participating provided information on whether

they were capitated or not for the services that were provided to the MEPS household members. For a variety of technical reasons, we did not attempt to construct our own weights to use the MEPS-MPC capitation data. Instead, we used regression-based methods to predict capitation for all health care events reported by MEPS households, so that estimates of capitation could be made for the full, nationally representative MEPS-HC sample with the regular MEPS sampling weights. Our methods are similar to those used in the development of the MEPS expenditure estimates (with the exception that we use regression-based rather than weighted sequential hot-deck methods) as described in the MEPS Public Use File Documentation.¹² Our estimates of capitation prevalence rates are not sensitive to whether the predicted capitation rates for the full MEPS sample or actual capitation rates for the subset of the MEPS sample for which capitation data are available. This, along with additional analyses not reported here, suggests that non-response bias (at least along observable characteristics) is negligible.

Measuring Capitation

We measure the percentage of office-based doctor visits, hospital outpatient department visits, emergency department room visits, and hospital stays, respectively, that were covered by a capitation arrangements. This measure is based on responses to the following question asked in the MEPS-MPC: “Was the facility/practice reimbursed for (this visit/these visits/stay) on a fee-for-service basis or a capitated basis?.” If necessary, interviewers provided the following definitions: “Fee-for-service means that the practice was reimbursed on the basis of the services provided. Capitated basis means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits.” The wording for this and the other MEPS-MPC questions were developed through extensive focus group and field-testing.

We note that for office-based sole-practioners and hospitals, our capitation variable simply measures whether the provider for each visit or stay was reimbursed on a fee-for-service basis by the health plan, or whether the visit or stay was covered by some capitated arrangement. For physician group practices, the capitation variable measures how the group was reimbursed by the health plan for each visit, but not how individual providers were paid within the group. For example, visits to providers in group and staff model HMOs would generally be considered to be capitated, because the physician groups are usually paid on a capitated basis even if individual providers are salaried. Visits to providers in other types of HMOs or Point of Service plans may or may not be covered by capitation arrangements. Similarly, hospital-based services delivered in hospitals owned by HMOs are considered capitated in the MEPS-MPC. Health care services provided by hospitals not-owned by HMOs are considered capitated only if they are provided under a capitation contract between an HMO and the hospital.

Analyses

We compare changes from 1996 to 2000 in the percentage of office-based physician visits, hospital outpatient department (OPD) visits, hospital emergency department (ED) visits, and hospital inpatient stays that are capitated. We include estimates of changes in capitation by Medicaid, Medicare, and private health plans, and specifically within Medicaid and Private HMOs. MEPS data on Medicare HMO enrollment was not considered reliable and was therefore no longer released after 1996. We also examine differences in capitation by sociodemographic characteristics including age, race and ethnicity, sex, health status, family income, census region, and urbanicity. We use standard two-tail tests of significance, which are calculated taking into

account the complex survey design of the MEPS. All results reported in the text are statistically significant at the .05 level unless otherwise noted.

RESULTS

Office-Based Physician Visits

We present descriptive statistics of the percent of visits to office-based physicians by the U.S. community population in Exhibit 1. Capitation of office-based physician visits remained relatively uncommon in the period 1996 through 2000. Only 15.5 percent of all visits to physicians were capitated in 1996 and subsequent years, dipping slightly to 13.0 percent in 2000. The considerable slowdown in overall HMO enrollment during the late 1990s explains in part why capitation did not become more common. More surprising is the level of capitation within HMOs themselves. Capitation arrangements covered only a minority of physician visits by persons who reported HMO coverage. Only one in three visits to physicians by persons enrolled in HMOs with private health insurance coverage were capitated in 1996 declining to one in four visits in 2000. Among those enrolled in Medicaid HMOs, only about one in four physicians visits were capitated in 1996 declining still further in 2000 (14 percent).

Capitation of physician visits was far more common in the West compared to other regions, with about 1 in 4 visits covered by capitated arrangements on average during the 1996-2000 period. This reflects the much greater HMO enrollment in the West, especially in Staff and Group model HMOs. Among HMO enrollees, capitation of visits was also almost twice as common in the West compared with other regions (data not reported). Similarly, physician visits were three times as likely to be capitated for those residing in Metropolitan Statistical Areas

(MSA) compared to those who did not. Only 5 percent of physician visits by those living in non-MSAs were capitated, reflecting much lower managed care penetration in rural areas.

Variations in the percent of physician visits that were capitated by other socioeconomic characteristics tended to be smaller. A somewhat greater percentage of physician visits by children under the age of 18 were capitated in all years. In 2000, 16 percent of visits by those under the age of 18 were capitated compared to 13 percent for adults 18-64 and 11 percent for those 65 and over. This may be due to the greater likelihood of well-child and other visits to pediatricians and other primary care physicians, who are more likely to be capitated, rather than specialists. Physician visits by Hispanics were more likely to be capitated than those by other groups in 2000, reflecting their greater HMO enrollment. Initial differences between Blacks and whites/others in 1996 were narrower and not statistically significant in 2000.

Physician visits by persons with family incomes below or near the poverty line were somewhat less likely to be capitated, in spite of heavy managed care penetration in the Medicaid program. Differences by health status, though statistically significant, were small. About 14 percent of office-based physician visits by those reporting poor or fair health were capitated in 2000 compared to 12 percent by those reporting good to excellent health. These differences by income and health status reflect a combination of differences in HMO enrollment patterns, propensity to use any services, and intensity of health care use.

Hospital-Based Services

Capitation for hospital-based services was even less common in the years 1996 through 2000. We see in Exhibit 2 that in 2000, only 4.5 percent of outpatient department (OPD) visits were covered by capitated arrangements. Capitation for OPD visits was uncommon even in

HMOs; 10 percent of visits by persons enrolled in private HMOs and 2 percent of visits by persons in Medicaid HMOs in 2000. In a pattern consistent with office-based visits, OPD visits by children, Hispanics, those in poor or fair health, and those with family incomes above 125 percent of the poverty line were all associated with a greater likelihood of being capitated. Geography was an even stronger determinant of capitation for OPD visits compared to office-based visits. By 2000, 18 percent of OPD visits by persons living in the West were capitated, compared to less than 3 percent for the rest of the country. The existence of HMO-owned hospitals by staff/group model HMOs in the West, combined with a low prevalence of capitation among HMOs that do not own their own hospitals, likely explains much of this difference. In addition, it is more common for outpatient visits of persons residing in MSAs to be capitated than those visits for those who do not live in MSAs.

The prevalence of capitation for emergency department visits (ED) remained relatively flat from 1996 to 2000 at about 3 to 5 percent, as shown in Exhibit 3. As with OPD visits, capitation of ED visits was uncommon even among HMO enrollees, with only 11 percent of visits by private HMO enrollees covered by capitation arrangements and 6 percent of visits by Medicaid enrollees. The distribution of capitated ED visits by socioeconomic characteristics is remarkably similar to that of OPD visits. The exceptions being that the differences by perceived health status and age for OPD visits were not statistically significant for ED visits. Once again, geography plays the predominant role in explaining patterns of capitation of hospital ED visits.

As shown in Exhibit 4, the prevalence of capitation for hospital inpatient stays (4 percent in 2000) was about the same as for hospital OPD and ED visits. From a theoretical standpoint, inpatient stays are the most difficult hospital service to capitate, because they occur much less frequently than OPD and ER visits and are subject to much higher variability in costs. The most

likely explanation for why the prevalence of capitation for inpatient stays is about the same as other hospital services is that capitation of hospital services exists primarily in HMO-owned hospitals, where all services are considered capitated as defined in the MEPS.

DISCUSSION

Our results provide additional evidence that capitation of providers, as opposed to capitation of health plans, is relatively uncommon in the U.S. health care system. Although some 79 million Americans were enrolled in public and private HMO plans in 2000, the majority of their health care use was covered by fee for service arrangements and not capitation. In fact, the percentage of office-based physician visits covered by capitation arrangements actually declined among those with HMO coverage between 1996 and 2000, as it did for most hospital-based services. Provider capitation within HMOs outside the West was even rarer. It appears that, in spite of the theoretical promise as a cost-containment mechanism, provider capitation never really expanded much beyond staff and group model HMOs. Even with staff and Group model HMOs, individual physicians tend to be salaried, blunting the incentive effects of capitation to the physician group.

Why is provider capitation rare and becoming rarer?

We offer several possible explanations for the low prevalence of provider capitation even within HMO plans. By definition, capitation contracts place risk on providers, but providers likely vary in their willingness to accept risks. Sole or small group practices may be less willing to accept risks than large practices, because they have fewer patients to spread the risks over. Health care expenses are highly concentrated in the United States, with the top 1 percent of health care users accounting for 27 percent of all health care expenses.¹³ A few very sick patients can have a large impact on a small physician practice. The potential for adverse selection of these very sick patients also increases the risks for larger practices. We note that hospital-based services are even less likely than office-based physicians to be reimbursed on a capitated basis because they are lower probability but higher cost events. Furthermore, if providers are risk adverse then they may demand a risk premium to accept capitated contracts, reducing potential cost savings to the plan over fee-for-service arrangements.

Capitated contracts are also administratively more complex than fee for service arrangements likely leading to higher transaction costs for providers and plans alike. This is especially true outside of staff/group model HMOs where the sole practitioner or group may have contracts with many different HMOs and a corresponding mix of patients. These transaction costs may reduce or eliminate any potential cost savings, making capitation less attractive to the plan and further decreasing providers' willingness to accept capitation instead of fee for service contracts. Transaction costs certainly at least partially explain why despite strong theoretical arguments that mixed capitation/fee for service reimbursement arrangements are optimal, they are almost never implemented in practice.

The much talked about push-back against managed care reflected in the slow-down in enrollment, and indeed reduction in HMO enrollment, may signal a shift in bargaining power between physician practices and health plans. If so, physicians may be even less willing to accept capitated contracts that impose greater risks and higher transaction costs.

Finally, the empirical literature on the effectiveness of provider capitation in reducing or restraining health care cost growth is mixed and surprisingly sparse.¹⁴⁻¹⁶ If capitation cannot clearly demonstrate these cost savings in practice, it is little wonder that it has not caught on more widely.

Caveats

We note at least two limitations in our trend analyses. First, our analyses are limited to actual health care events and whether they are covered by capitated and non-capitated arrangements. As a result, we may underestimate the extent of capitation arrangements because we cannot observe these arrangements among HMO enrollees that do not use any health care services. This measure similarly does not reflect the extent to which capitation reduces the intensity of health care use among HMO enrollees those that do use services. However, to the extent that this bias is relatively constant over the period 1996-2000, the trend analyses are unaffected.

Second, our measure of capitation describes how groups are reimbursed by health plans, but not how individual providers are paid within the group (for example, strictly fee for service, salary, and revenue sharing arrangements). Thus, capitation of health care services at the level of the individual provider actually delivering the services is even rarer.

Future Directions

While plan level capitation in the form of HMOs has not grown over the last few years, it is still a significant force in the U.S. health care system. In contrast, capitation of providers remains rare, in spite of the theoretical arguments that have been advanced for either pure or mixed provider capitation reimbursement. As debate over cost-containment mechanisms begins anew with the recent acceleration in health care costs, it is all the more imperative to understand why this once promising cost-containment mechanism has failed to catch on.

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Table 1. Percent of Office-Based Physician Visits That Are Capitated, 1996-2000

| | 1996 | 1997 | 1998 | 1999 | 2000 |
|--------------------------------------------|-------------|-------------------|-------------------|-------------------|---------------------|
| Total | 15.5 | 15.6 | 15.3 | 15.5 | 13.0 ^{a,b} |
| Health Insurance | | | | | |
| Medicare | 9.8 | 11.5 | 11.2 | 12.5 | 10.7 |
| Private Insurance | 20.2 | 20.0 | 19.2 | 17.8 | 15.8 ^{a,b} |
| Private HMO | 33.3 | 29.2 ^a | 30.0 | 27.9 | 25.3 ^{a,b} |
| Medicaid | 11.8 | 10.8 | 12.0 | 17.3 ^a | 10.5 ^a |
| Medicaid HMO | 23.2 | 20.0 | 20.7 | 25.6 ^a | 14.1 ^{a,b} |
| Age in years | | | | | |
| Under 18 | 21.9 | 20.6 | 20.9 | 18.6 ^a | 16.0 ^{a,b} |
| 18-64 | 15.8 | 16.1 | 15.4 | 15.8 | 12.9 ^{a,b} |
| 65 and over | 9.7 | 10.8 | 11.0 | 12.6 | 11.0 |
| Race/ethnicity | | | | | |
| Hispanic | 16.9 | 18.3 | 20.4 ^a | 20.9 | 20.0 |
| Black | 21.7 | 20.3 | 17.6 | 19.8 | 13.6 ^{a,b} |
| White and other | 14.7 | 14.9 | 14.5 | 14.5 | 12.2 ^{a,b} |
| Sex | | | | | |
| Male | 15.8 | 16.7 | 15.3 | 15.3 | 13.2 ^{a,b} |
| Female | 15.2 | 14.9 | 15.3 | 15.6 | 12.8 ^{a,b} |
| Perceived Health Status | | | | | |
| Fair/Poor | 17.4 | 17.5 | 17.3 | 16.3 | 13.8 ^{a,b} |
| Good to Excellent | 13.8 | 14.1 | 13.6 | 14.8 | 12.2 ^a |
| Poverty Status | | | | | |
| Below 125% of poverty line | 9.2 | 10.6 ^a | 11.5 | 16.1 ^a | 10.4 ^a |
| Above 125% of poverty line | 17.0 | 16.7 | 16.1 | 15.4 | 13.5 ^{a,b} |
| Region | | | | | |
| Northeast | 15.5 | 14.7 | 11.5 ^a | 15.5 ^a | 13.3 |
| South | 10.2 | 15.4 ^a | 11.0 ^a | 10.5 | 8.6 ^a |
| Midwest | 12.9 | 12.2 | 9.7 ^a | 9.5 | 9.5 ^b |
| West | 24.8 | 21.7 ^a | 31.9 ^a | 30.9 | 23.2 ^a |
| Metropolitan Statistical Area (MSA) | | | | | |
| MSA | 17.7 | 18.2 | 17.9 | 17.7 | 14.8 ^{a,b} |
| non-MSA | 5.3 | 5.3 | 4.7 | 6.4 ^a | 4.6 ^a |

^aSignificantly different from previous year at .05 level.

^bSignificantly different from 1996 at .05 level.

Table 2. Percent of Hospital Outpatient Department Visits That Are Capitated, 1996-2000

| | 1996 | 1997 | 1998 | 1999 | 2000 |
|--------------------------------------------|-------------|------------------|-------------------|-------------------|--------------------|
| Total | 7.2 | 4.2 ^a | 7.2 ^a | 4.0 ^a | 4.5 ^b |
| Health Insurance | | | | | |
| Medicare | 4.9 | 4.0 | 3.4 | 3.7 | 3.3 |
| Private Insurance | 10.3 | 4.7 ^a | 10.5 ^a | 4.2 ^a | 6.6 ^{a,b} |
| Private HMO | 19.2 | 9.6 ^a | 18.7 ^a | 7.4 ^a | 10.2 ^b |
| Medicaid | 3.1 | 4.2 | 4.6 | 3.9 | 1.3 ^a |
| Medicaid HMO | 6.3 | 6.2 ^a | 14.4 | 6.6 | 1.9 ^{a,b} |
| Age in years | | | | | |
| Under 18 | 10.3 | 5.5 ^a | 12.4 ^a | 4.9 ^a | 6.6 ^b |
| 18-64 | 7.9 | 4.2 ^a | 8.6 ^a | 4.1 ^a | 5.0 ^b |
| 65 and over | 4.9 | 3.8 | 3.2 | 3.7 | 3.6 |
| Race/ethnicity | | | | | |
| Hispanic | 9.4 | 3.8 ^a | 7.2 | 7.9 | 10.4 |
| Black | 4.2 | 5.5 | 4.2 | 3.1 | 5.8 |
| White and other | 7.4 | 4.0 ^a | 7.6 ^a | 3.8 ^a | 3.9 ^b |
| Sex | | | | | |
| Male | 10.5 | 3.5 ^a | 5.2 ^a | 3.8 ^a | 3.9 ^b |
| Female | 4.6 | 4.7 | 9.0 ^a | 4.2 ^a | 5.0 |
| Perceived Health Status | | | | | |
| Fair/Poor | 9.1 | 5.5 ^a | 10.7 ^a | 4.8 ^a | 7.3 ^a |
| Good to Excellent | 5.9 | 3.6 ^a | 5.5 ^a | 3.6 ^a | 3.3 ^a |
| Poverty Status | | | | | |
| Below 125% of poverty line | 5.4 | 3.3 | 4.2 | 5.1 | 2.2 ^a |
| Above 125% of poverty line | 7.7 | 4.4 ^a | 7.9 ^a | 3.8 ^a | 5.0 ^b |
| Region | | | | | |
| Northeast | 4.8 | 3.8 | 3.4 | 2.8 | 3.5 |
| South | 5.4 | 3.3 | 6.9 ^a | 2.4 ^a | 1.2 ^b |
| Midwest | 4.0 | 2.3 ^a | 2.6 | 1.4 | .7 ^{a,b} |
| West | 18.2 | 9.9 ^a | 23.1 ^a | 15.8 ^a | 18.2 |
| Metropolitan Statistical Area (MSA) | | | | | |
| MSA | 8.8 | 4.8 ^a | 8.6 ^a | 4.8 ^a | 5.7 ^b |
| non-MSA | 2.0 | 2.2 | 2.3 | 1.2 ^a | 1.0 ^b |

^aSignificantly different from previous year at .05 level.

^bSignificantly different from 1996 at .05 level.

Table 3. Percent of Hospital Emergency Department Visits That Are Capitated, 1996-2000

| | 1996 | 1997 | 1998 | 1999 | 2000 |
|--------------------------------------------|-------------|------------------|-------------------|------------------|--------------------|
| Total | 4.9 | 3.3 ^a | 4.4 ^a | 4.4 | 4.9 |
| Health Insurance | | | | | |
| Medicare | 6.9 | 4.0 | 3.4 | 5.0 | 5.1 |
| Private Insurance | 6.1 | 3.9 ^a | 5.5 ^a | 5.2 | 6.2 |
| Private HMO | 10.9 | 6.8 ^a | 9.2 ^a | 7.8 | 10.7 ^a |
| Medicaid | 2.2 | 3.5 | 4.9 | 3.2 | 4.1 |
| Medicaid HMO | 5.6 | 7.4 | 10.0 | 5.3 | 5.5 |
| Age in years | | | | | |
| Under 18 | 4.3 | 4.2 | 3.5 | 4.5 ^a | 4.6 |
| 18-64 | 5.1 | 2.6 ^a | 5.2 ^a | 4.2 ^a | 4.7 |
| 65 and over | 5.5 | 4.7 | 3.1 | 5.3 | 6.0 |
| Race/ethnicity | | | | | |
| Hispanic | 7.4 | 4.8 | 10.5 ^a | 5.9 ^a | 9.8 |
| Black | 7.3 | 2.7 ^a | 5.0 | 2.7 | 2.4 ^b |
| White and other | 4.2 | 3.2 | 3.4 | 4.6 | 4.8 |
| Sex | | | | | |
| Male | 5.7 | 3.8 ^a | 4.4 | 4.5 | 3.9 ^b |
| Female | 4.2 | 2.9 | 4.4 ^a | 4.4 | 5.8 |
| Perceived Health Status | | | | | |
| Fair/Poor | 5.0 | 3.8 ^a | 4.7 | 4.9 | 5.0 |
| Good to Excellent | 4.9 | 2.9 ^a | 4.2 ^a | 4.1 | 4.9 |
| Poverty Status | | | | | |
| Below 125% of poverty line | 3.1 | 1.9 | 4.7 ^a | 4.6 | 2.9 |
| Above 125% of poverty line | 5.6 | 3.8 ^a | 4.3 | 4.4 | 5.6 |
| Region | | | | | |
| Northeast | 5.0 | 1.0 ^a | 1.9 | .9 ^a | 2.7 ^{a,b} |
| South | 3.4 | 2.0 ^a | 3.2 | 3.0 | 3.3 |
| Midwest | 3.3 | 2.8 | 1.0 ^a | 1.3 | .4 ^{a,b} |
| West | 10.4 | 8.2 | 15.4 ^a | 17.6 | 17.6 ^b |
| Metropolitan Statistical Area (MSA) | | | | | |
| MSA | 5.8 | 3.8 ^a | 5.3 ^a | 5.4 | 5.6 |
| non-MSA | 1.7 | 1.7 | 1.6 | 1.5 | 2.2 |

^aSignificantly different from previous year at .05 level.

^bSignificantly different from 1996 at .05 level.

**Table 4. Percent of Hospital Inpatient Stays
That Are Capitated, 1996-2000**

| | 1996 | 1997 | 1998 | 1999 | 2000 |
|--------------------------------------------|-------------|------------------|------------------|-----------------|--------------------|
| Total | 5.5 | 3.2 ^a | 2.3 | 3.3 | 4.2 ^{a,b} |
| Health Insurance | | | | | |
| Medicare | 5.6 | 2.7 ^a | 1.5 | 2.0 | 2.5 ^b |
| Private Insurance | 6.5 | 4.5 | 3.7 | 5.4 | 6.9 |
| Private HMO | 9.8 | 7.3 | 6.1 | 9.5 | 11.8 |
| Medicaid | 2.5 | 1.5 | 2.4 | 2.0 | 2.5 |
| Medicaid HMO | 6.4 | 3.5 | 4.6 | 4.3 | 3.5 |
| Age in years | | | | | |
| Under 18 | 3.7 | 3.8 | 1.4 ^a | 2.1 | 2.9 |
| 18-64 | 5.8 | 3.3 ^a | 3.0 | 4.2 | 5.1 |
| 65 and over | 5.6 | 2.8 ^a | 1.7 | 2.3 | 3.0 ^b |
| Race/ethnicity | | | | | |
| Hispanic | 5.8 | 6.0 | 3.4 ^a | 4.2 | 4.7 |
| Black | 8.6 | 1.4 ^a | 1.6 | 2.4 | 2.1 |
| White and other | 5.0 | 3.2 ^a | 2.3 | 3.3 | 4.5 ^{a,b} |
| Sex | | | | | |
| Male | 5.5 | 3.9 ^a | 2.6 | 3.0 | 3.8 ^b |
| Female | 5.5 | 2.7 ^a | 2.2 | 3.5 | 4.5 ^{a,b} |
| Perceived Health Status | | | | | |
| Fair/Poor | 5.0 | 4.4 | 2.7 | 4.6 | 4.4 |
| Good to Excellent | 5.7 | 2.7 ^a | 2.2 | 2.8 | 4.1 ^{a,b} |
| Poverty Status | | | | | |
| Below 125% of poverty line | 4.0 | 2.1 ^a | 2.5 | 2.1 | 3.2 ^b |
| Above 125% of poverty line | 6.0 | 3.6 ^a | 2.3 | 3.6 | 4.5 ^{a,b} |
| Region | | | | | |
| Northeast | 2.4 | .4 ^a | 1.9 ^a | 1.3 | 3.8 ^a |
| South | 3.7 | 1.8 | 1.6 | 1.0 | 1.7 |
| Midwest | 3.7 | 2.5 ^a | .3 ^a | .5 ^a | .9 ^b |
| West | 14.6 | 8.9 ^a | 8.5 | 14.4 | 14.8 |
| Metropolitan Statistical Area (MSA) | | | | | |
| MSA | 6.4 | 3.9 ^a | 3.1 | 4.5 | 5.1 ^b |
| non-MSA | 2.4 | 1.7 | .5 | .5 | .9 |

^aSignificantly different from previous year at .05 level.

^bSignificantly different from 1996 at .05 level.