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The Complicated State of Medicaid in the United States

Stability amidst considerable future uncertainty

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2017 marked the year that Medicaid moved to the forefront of the national conversation, as perception - and politics - caught up with the reality that no other social welfare program touches more Americans. While the robust debate remains unsettled, it's clear that the future of Medicaid coverage, and resulting expenditure impacts, will remain in the spotlight for the foreseeable future, dominating the headlines and permeating the nation's debate.

As has been posited in this report in prior years, the Affordable Care Act's most significant and enduring impact has been the expansion of Medicaid eligibility, which along with increased emphasis on health coverage and the creation of Health Insurance Marketplaces, has surged enrollment in Medicaid. With nearly 75 million Americans enrolled in Medicaid as of the Summer of 2017[1], and millions more at some point over the past year, Medicaid has dramatic consequences on the health of our nation, across physical, behavioral, and fiscal dimensions.

Yet, of all health programs in America, in many ways Medicaid is the most complicated – and is poised to become ever more so. Unlike Individual coverage on the Exchanges with a single primary funding source, the Federal government, Medicaid is funded at both the Federal and State Level. Unlike Commercial Group coverage with a single class of covered individuals – employees and their dependents - Medicaid covers a range of individuals from children, to the blind and disabled, to refugees, to pregnant women and working adults. Unlike Medicare with a single national set of standards, Medicaid programs vary widely from state-to-state. And, unlike TRICARE with coverage for life for beneficiaries, Medicaid programs redetermine eligibility for coverage frequently.

Despite this complexity and significance, detail on the composition of the Medicaid market, growth drivers, and trends is often elusive relative to other health programs. This analysis, the fifth annual on the State of Medicaid, aims to fill that gap by providing a detailed view of the Medicaid market, including the rapid growth of private Medicaid health plans and key considerations for Medicaid health plans and organizations involved in Medicaid markets going forward, powered by the proprietary collection and analysis of state Medicaid data.

[1] *A note on the data: all data is based on state reporting of current membership publicly disclosed or provided under Freedom of Information Act (FOIA) requests. Data is from June – September 2017,* aside from California Fee for Service (May 2017) and Connecticut (January 2017). *All reported figures are at the prime contract level, sub-contracts not represented. Membership aggregated at parent entity. Private Managed Care requires the administration of beneficiary health benefits, excludes ACOs, excludes state-owned assets (such as Green Mountain Care in Vermont), but includes non-state run public entities (such as LA Care in California), as well as licensed provider-sponsored networks and other reported entities. The scope of inquiry was limited to physical health; behavioral, dental, drugs, etc. were excluded from analysis. Finally, membership in Medicaid programs was defined by each state, including in most cases full-benefit TANF, CHIP, ABD, and MLTC populations receiving Medicaid benefits; in many cases, though, beneficiaries receiving family planning services exclusively have been excluded from analysis. Year-over-year comparisons are from PwC's The Still Expanding State of Medicaid in the United States, Summer 2015 and five-year comparisons are from PwC's The State of Medicaid in the United States, Summer 2013.*

The Complicated State of Medicaid

Medicaid enrollment

For the first time in four years, overall enrollment in Medicaid did not grow materially as no new states elected to expand coverage, the economy continued to strengthen, and a number of states sought to more aggressively redetermine eligibility status. Total enrollment increased by a nominal 98,000 Americans (or 0.13%) to end with ***74.8*** million covered by a physical health Medicaid program, translating to ***23.2%*** of the US population.

One of the key factors leading to the lack of any material increase in total enrollment was California, historically the largest driver of enrollment growth and the largest Medicaid program, shrinking by 250,000 beneficiaries to end with total enrollment of 13.3 million. This decline of not even 2% of total enrollment, to put it in perspective, is as large as each of the ten smallest Medicaid programs! Still, since 2013, 5.4 million Californians have been added to Medicaid. Wyoming, the nation's least populated state, still has the fewest beneficiaries enrolled, with only 61,000, while Alaska, powered by expansion, dropped out of the five smallest Medicaid states, replaced by New Hampshire.

This year, the District of Columbia overtook New Mexico as the jurisdiction with the greatest proportion of residents enrolled in Medicaid at **37.0%** (the highest proportion achieved in any state since the program's inception), followed closely by New Mexico at 36.5% and California at 33.9%. The bottom five remained unchanged with Utah maintaining the lowest share of residents covered at just 9.1%.

Figure 1: State Medicaid enrollment highlights[2]

Largest enrollment		Smallest enrollment		Largest share of population		Smallest share of population	
California	13.5M	Wyoming	61K	District of Columbia	37.0%	Utah	9.1%
New York	6.1M	North Dakota	92K	New Mexico	36.5%	Wyoming	10.4%
Texas	4.5M	South Dakota	119K	California	33.9%	Virginia	11.5%
Florida	3.5M	Vermont	170K	Arkansas	32.6%	North Dakota	12.1%
Illinois	3.2M	New Hampshire	183K	Kentucky	32.1%	Nebraska	13.0%

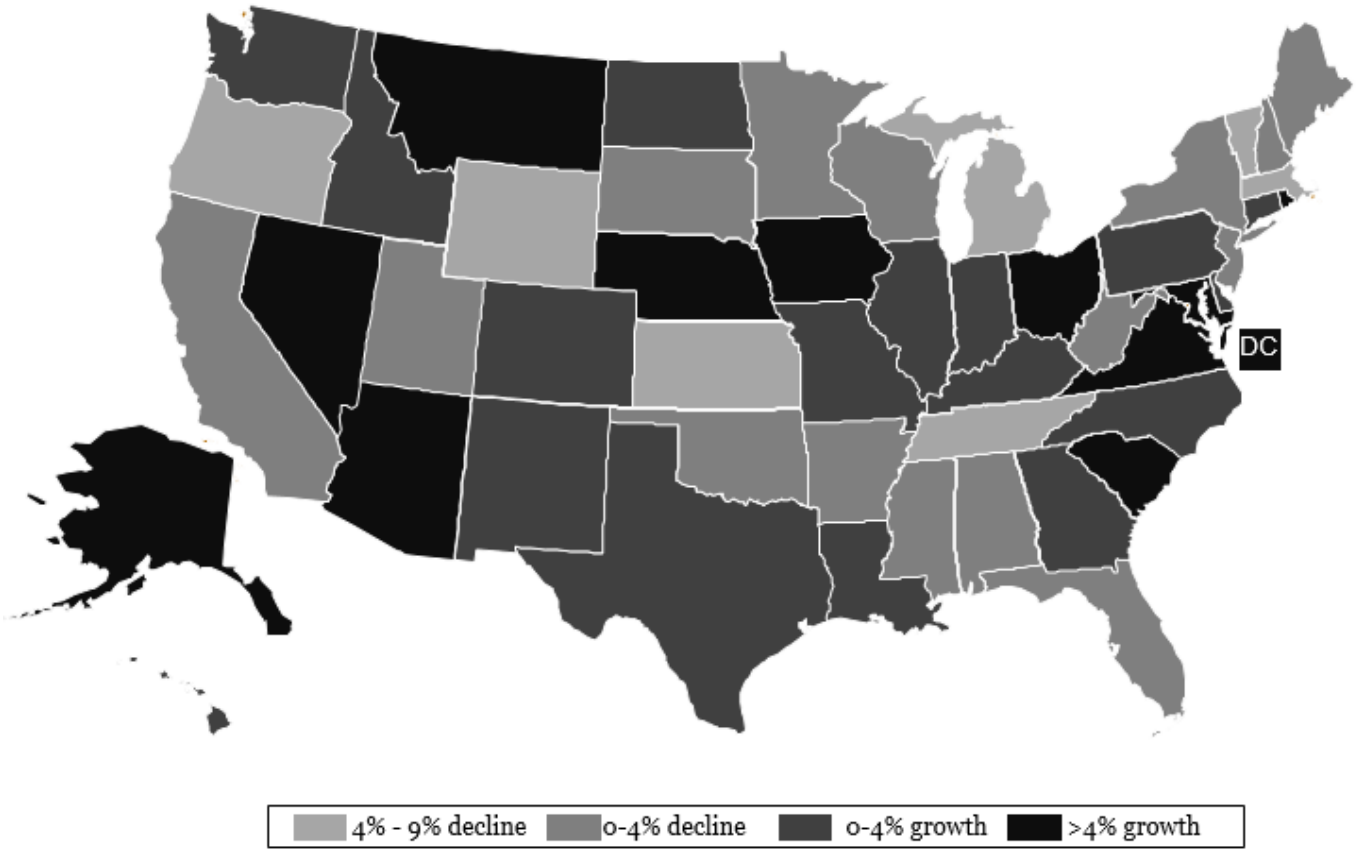
State-level enrollment changes in 2017 were more mixed than in prior years, with the headline national number belying much more significant moves at the state-level. 18 states and the District of Columbia had enrollment changes greater than plus or minus 4%.

22 states reported declines in total enrollment, ranging from substantial declines of 9% in Kansas and Tennessee to the insignificant decline of 2 members in Utah. 28 states and the District of Columbia posted increases in enrollment over the past year. Alaska and Montana posted the largest gains, at 23% and 20%, respectively, as their late expansion of Medicaid continued to drive enrollment growth, a trend seen previously in other expansion states. Rhode Island also posted double digit gains growing by 11%.

[2] ***Appendix A*** *contains additional details on Medicaid market size and structure by state.*

Not surprisingly given the significant enrollment increases, Alaska and Montana experienced the largest increase in the share of population enrolled, with an additional 4.8% of Alaskans and 3.6% of Montanans receiving Medicaid benefits in the past year. Over the past two years, nearly one in eleven Alaskans (9.1%) and one in twelve Montanans (8.6%) have been added to Medicaid, largely as a result of expansion.

Figure 2: Growth in enrollment from 2016 to 2017



While the story was one of relative stability, a look back to 2013, immediately before the ACA's Medicaid expansion took hold, shows a dramatically different picture. Medicaid enrollment has increased by ***17.8 million*** Americans (from 57.1 million in 2013), or ***31%.*** One in twenty Americans have been added to Medicaid coverage since 2013 as the share of the US population on Medicaid has increased by 5.0%. 44 states and the District of Columbia have increased Medicaid enrollment over that time, while 6 states, including one expansion state have fewer enrollees today than in 2013.

Two states, Montana and Nevada, have more than doubled their Medicaid populations since 2013. In Big Sky Country, Medicaid enrollment has increased by a staggering 118% (or 124,000 Montanans, 11.5% of the state's population). And, the Silver State is not far behind, growing by 105% (343,000 Nevadans, 10.9% of the state's population). Other states posting significant growth in enrollment include Colorado (+94%), Rhode Island and Kentucky (+77% each), and California (+68%).

The Commonwealth of Kentucky increased the share of population covered by Medicaid more than any other state, with one in seven residents (13.7%) covered since 2013, with California close behind at 13.1%.

Among the six states lower enrollment today than in 2013, Maine posted the largest decline (18%) with 50,000, or 3.8% of Mainers, no longer on Medicaid. Wyoming's enrollment declined by 9%, while the other four states posted more minimal declines of less than 4%.

Figure 3: Enrollment change from 2013 to 2017

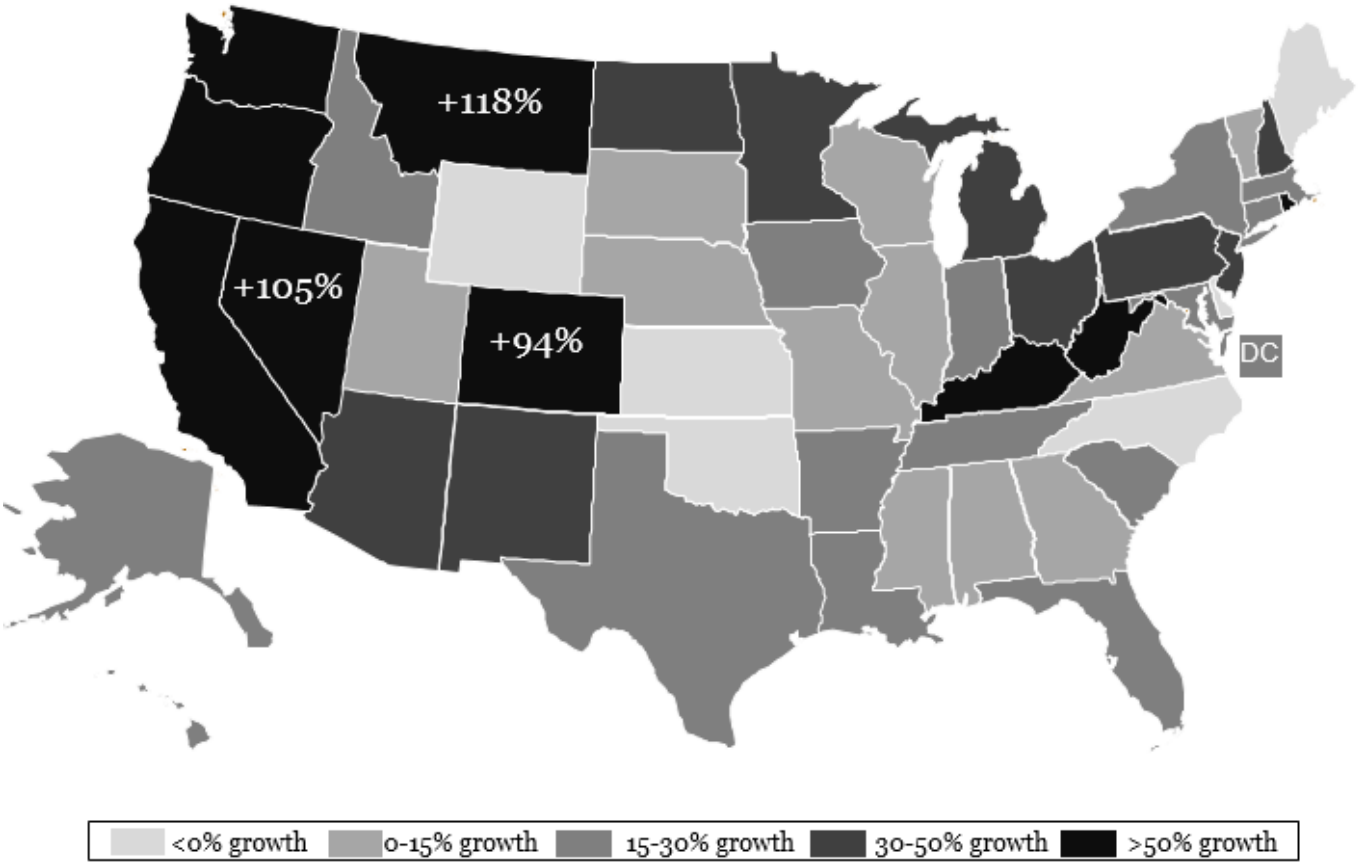
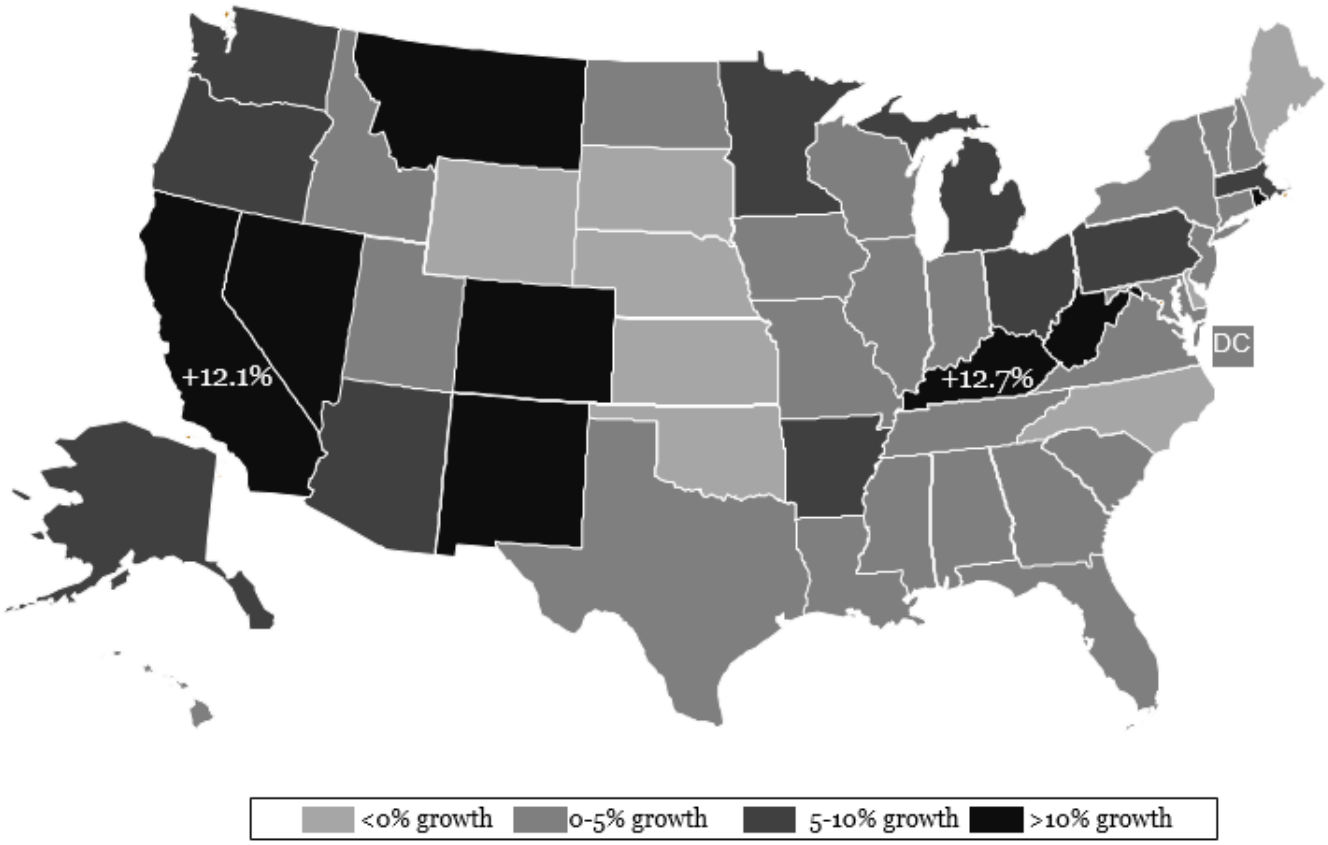


Figure 4: Population share covered change from 2013 to 2017



The Power of Local Influence – Nevada versus Maine

While much of the conversation has focused on the Federal intervention in Medicaid markets, it is increasingly important to acknowledge the significant power and influence of state-level policies in determining the ultimate trajectory of enrollment in a Medicaid program. Over the past five years this has been well illustrated by the differences in enrollment between Nevada and Maine.

In 2010, voters in both Nevada and Maine elected new Governors, both Republicans. In 2013, a year before Medicaid expansion took hold, Nevada's Medicaid program had relatively stringent eligibility standards; as a result, only 11.8% of Nevadans were enrolled in Medicaid, the 7th lowest in the nation. Maine, conversely, had relatively generous eligibility standards; 21.3% of Mainers were enrolled in Medicaid, the 10th highest in the nation.

Following passage of the ACA, Nevada's Governor embraced the additional coverage options afforded by the law. Nevada approved Medicaid expansion to take place on the first possible day in 2014. The state also launched a state-based Marketplace for individual coverage and took steps to aggressively promote health coverage. As a result, by 2017, Nevada's Medicaid program has grown by 105% as 343,000 Nevadans have been added to Medicaid. Medicaid today covers 22.7% of the population of the state and the Nevada uninsured rate has declined by over 8 points, far in excess of the national average[3].

On the other hand, Maine's Governor has declined to expand Medicaid and advocated withdrawing from the ACA. The state relied on the Federal Marketplace and Federal dollars to encourage sign-ups. And, the Governor has acted several times to restrict eligibility to Medicaid from the previously generous standards. Adults with and without dependents have been eliminated from Medicaid, and the Governor has tried to restrict eligibility to young adults as well. As a result, Medicaid enrollment in Maine has declined by 18% since 2013, now covering only 17.5% of the state's population, well below the US average. The uninsured rate in Maine has only declined by 4 points, although in 2013 it was decidedly less than the US average[4].

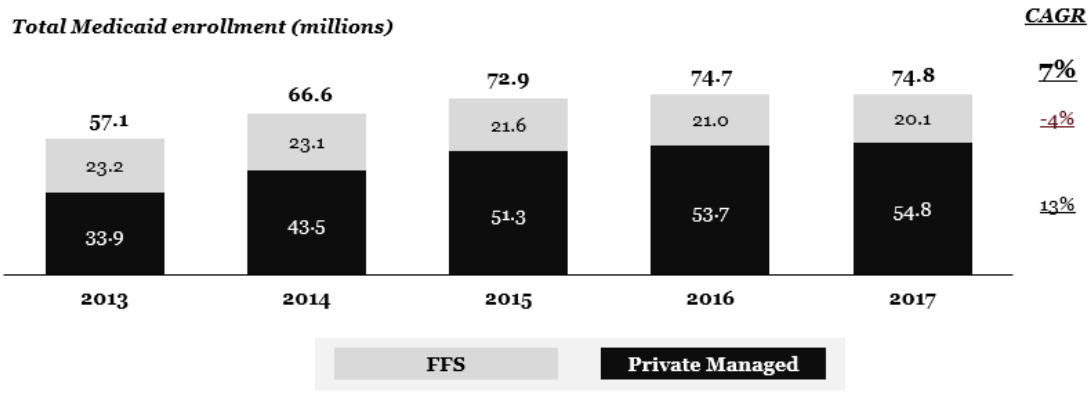
The differences in Medicaid enrollment between Nevada and Maine illustrate the power of local decision making on the program and coverage of citizens. Despite the considerable uncertainty emanating from Washington DC, interested stakeholders must also focus on the meaningful decisions made in state capitols across the country.

[3] Kaiser Family Foundation, *Medicaid's Role in Nevada*, July 21, 2017
[4] Kaiser Family Foundation, *Medicaid in Maine*, June 2017

Medicaid managed care

As has been the case in each of the past three years, private Medicaid health plans grew in 2017. The overall number of beneficiaries in private managed care increased ***by 1.5 points to 73% of total beneficiaries, meaning an additional 1 million Americans*** are today covered by a private Medicaid health plan. This represents 1.9% growth from last year, with 54.8 million Americans served by such plans.

Since 2013, the gains in private Medicaid health plans have been even more significant than the overall increase in enrollment. An **additional 20.9 million** Americans, or one in 16 (6.5%), are now served by a private Medicaid health plan, **while 3.1 million fewer** are served by fee-for-service or public managed care than were in 2013.



No state added private managed care in the past year, leaving 42 states with some form of private managed Medicaid. Of the remaining states without private managed care, North Carolina continues to move forward with an expected 2019 implementation of a statewide program, while Oklahoma issued, then withdrew, a request for proposal for managed care to cover aged, blind, and disabled Medicaid members.

The notable change over the past year, however, was the number of states that significantly increased their population covered by private plans.

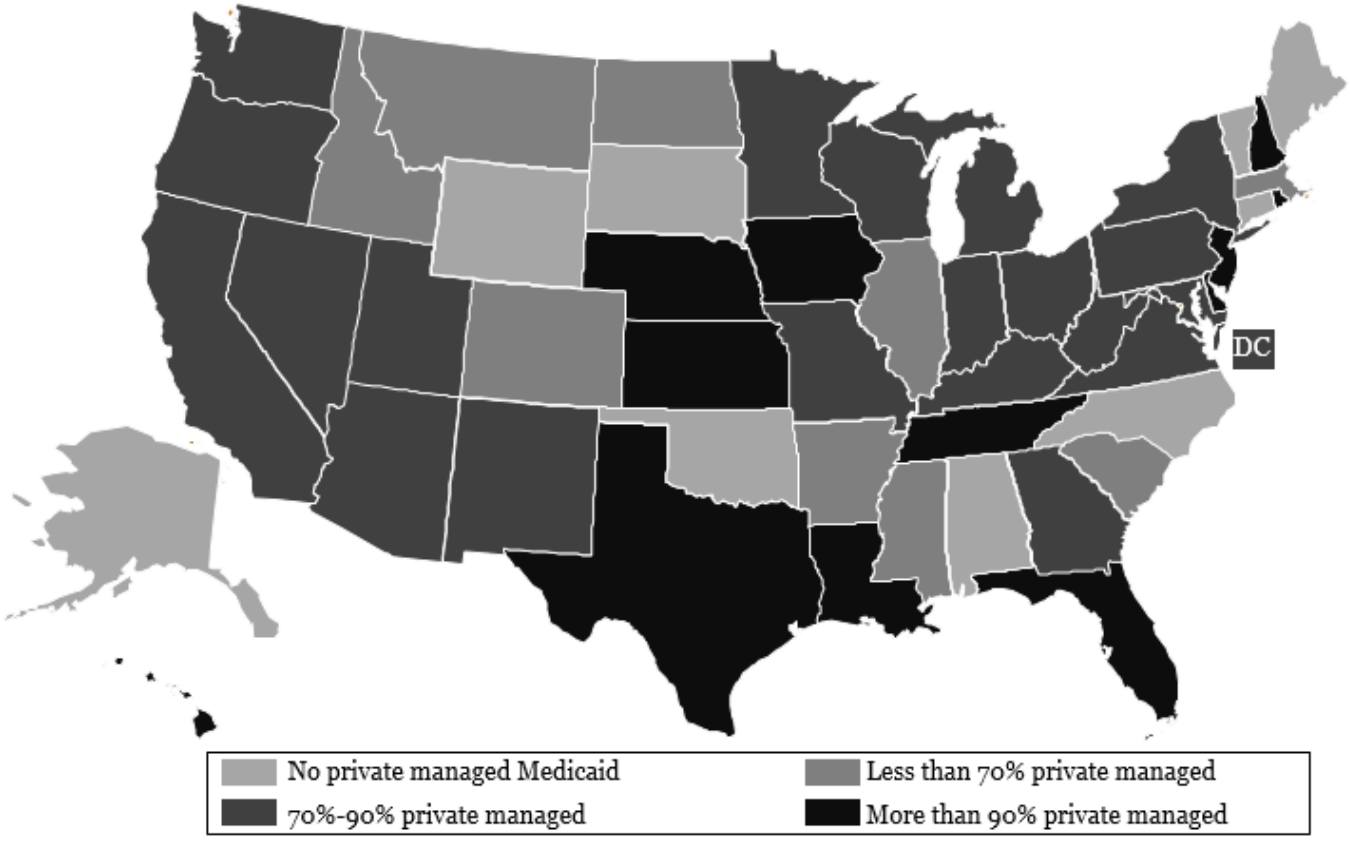
Today, 12 states have at least 90% of Medicaid populations covered by private plans, up from nine last year, and only four in 2013. And, five states have 99% or more of their beneficiaries in a private plan, up from only two last year. Sizable increases in private share include Missouri, which expanded managed care statewide and moved to 74% managed, and West Virginia, which moved Social Security Income (SSI) recipients to managed care and went to 81% managed. Nevada also expanded managed Medicaid into additional (rural) counties in the summer of 2017.

Figure 5: Share of private managed Medicaid (as % of overall Medicaid population[5])

Largest share		Smallest share	
Tennessee	100%	Idaho	1%
Hawai'i	100%	Colorado	10%
Nebraska	100%	North Dakota	22%
Louisiana	99%	Arkansas	27%
Kansas	99%	Montana	35%

[5] *Only includes states with some form of private managed Medicaid.*

Figure 6: Private managed care enrollment share, by state



Private managed Medicaid health plans

For the second year in a row, the number of private Medicaid health plans[6] declined, from 179 last year to 171 today. This net decline of eight plans is largely a result of plans being acquired or ceasing operations. Only three plans joined the list this year, the fewest number of new plans in five years.

Only two health plans exited the Medicaid market: Health Alliance in Illinois, which retains a commercial and Medicare presence, and Maine Community Health Options, which is one of the few remaining CO-OPs and previously had been operating in New Hampshire Medicaid.

As was the case last year, a considerable amount of consolidation was present in the market, as smaller plans, often owned or sponsored by care delivery organizations, were acquired by larger plans with the scale necessary to effectively operate. In Arizona, WellCare acquired Tenet's Phoenix Health Plan and UnitedHealthcare acquired Maricopa Integrated's local plan. Trusted, a private equity-funded, District of Columbia-based health plan acquired Harbor Health Plan in Michigan from Tenet. And, in the managed long-term care space, Centers Plan for Healthy Living acquired CenterLight in New York and Inclusa was formed in Wisconsin, consolidating three smaller entities.

Illinois continued to experience consolidation from the Accountable Care Entity (ACE) experiment of past years with both Meridian and Family Health Network acquiring failed ACEs. United also completed the acquisition of Rocky Mountain in Colorado and WellCare acquired the Arizona assets of Care1st from Blue Shield of California.

More consolidation is expected in the year ahead. In September 2017, Centene announced its intention to acquire Fidelis Care, a 1.25 million-member Medicaid-focused plan in New York, which, if consummated, will only further cement Centene's position as the nation's largest Medicaid plan.

The three new Medicaid plans this year were all provider-sponsored health plans - Kalos Health and Crystal Run, in New York, and Children's Medical Center in Texas.

Among existing Medicaid plans, a number of multi-state plans won or lost contracts in the prior year. Centene was the big winner, adding Nebraska and Nevada to their portfolio. CareSource was added as a plan in Indiana, United in Missouri, and WellCare in Nebraska.

Interestingly, in Nevada, Aetna was also awarded a contract but exited the state's Medicaid program only two months after entering. Aetna was also the only plan to lose a contract in both Missouri and Nebraska.

Similarly to prior years, Medicaid remains a local business, with the vast majority of plans operating in only one state. 151 or 88% of all plans are single-state Medicaid plans, down from 90% last year. Consistent with last year, nine plans operate across four or more states, while ten plans operate in two states and one plan in three states.

The 11 plans with greater than 1 million members remained unchanged this year, reflecting the relative stability in the market**.** *72* plans have fewer than 50,000 members, down from 76 last year, illustrating the bifurcated nature of the Medicaid market and the consolidation focus at the low end of the membership spectrum. The average Medicaid plan, excluding the 11 jumbo plans with greater than 1 million members and the managed long-term care plans (which generally have fewer than 10,000 members), increased modestly this year to 159,000, up 3% from last year, again reflecting the slow but steady trend towards scale through consolidation.

[6] Plans with greater than 1,000 members; plans are grouped at the parent company-level

The complicated questions around Expansion

The status of Medicaid expansion dominated the headlines throughout the course of 2017. A number of states that expanded Medicaid saw potential executive and legislative action and rhetoric that could reverse the massive enrollment gains of the past five years. Many of the remaining 19 states that have not yet elected to expand Medicaid saw the lack of Federal action as a potential impetus to capture the additional funding through expansion.

The result was that the number of states with expanded Medicaid coverage remained steady, as no new state elected to expand and no expansion state opted to rescind such coverage. However, some movement was present at the state-level on both fronts. In Kansas, the Governor vetoed legislation, which was narrowly sustained, that would have expanded Medicaid. Maine voters will decide in November 2017 on Medicaid expansion through a ballot initiative. And, in Ohio, the legislature voted to substantially curtail Medicaid eligibility; however, the Governor, an outspoken advocate for increased Medicaid coverage, vetoed the legislation.

Going forward, given the policy uncertainty around Medicaid coverage and funding, state policy makers (and, in Maine, voters) will have to address a complicated fact pattern to best decide how to balance health coverage and financial considerations relating to Medicaid.

With regards to Medicaid enrollment over the past year, expansion states continued to post greater growth in enrollment than non-expansion states. Across the 31 states and the District of Columbia that expanded Medicaid, total enrollment grew by 0.3%, while non-expansion states posted a decline in Medicaid enrollment of 0.4%.

The difference in enrollment change between expansion states and non-expansion states over the past five years is more pronounced. Expansion states have grown by 15.2 million beneficiaries, or 40%, over the past five years, while non-expansion states have still grown by 2.6 million individuals, albeit only 14%.

While the term “Medicaid Expansion” has been used to describe states that have elected to modify eligibility levels to those defined in the Affordable Care Act, under-discussed is the overall expansion of Medicaid coverage as a result of the ACA. In many ways, Medicaid expansion is broader than Medicaid expansion.

As previously mentioned, growth in Medicaid enrollment in non-expansion states over the past five years was brisk, even in the face of improved economic conditions. In Texas, Medicaid has grown by nearly 900,000, or 26%, despite the state not expanding eligibility levels. And, a similar story is at play in other non-expansion states like South Carolina (+26%), Florida (+25%), and Idaho (+18%).

Even within expansion states, a significant portion of the growth in Medicaid enrollment has come from outside of the expansion populations. In Montana, the expansion population added 81,000 out of total program growth of 124,000 – meaning 43,000 additional Montanans enrolled in legacy Medicaid programs. In Colorado, 375,000 newly eligibles joined Medicaid under the ACA, out of nearly 675,000 Coloradans added to the Medicaid rolls.

This phenomenon suggests that a number of individuals are seeking health coverage, often with the support of an enrollment counselor or Navigator, and realizing they are eligible for traditional Medicaid categories.

Given the propensity to utilize private managed care for expansion enrollees, it should not be surprising that over the past five years enrollment in Medicaid managed care in expansion states surged by 68% or 16.2 million, while in non-expansion states the growth in managed care was a still substantial 45%, or 4.6 million enrollees.

Since 2014, this report has sought to estimate the *Medicaid Expansion Gap* – the number of additional individuals that would be covered if all states expanded eligibility, using an archetype analysis related to initial coverage limits and Medicaid expansion election. With the modest difference in growth between expansion status, the Medicaid Expansion Gap increased nominally in 2017 to 5.1 million, suggesting that if the remaining 19 states expanded Medicaid coverage, the Medicaid program would be estimated to cover roughly 80 million Americans.

The complicated market ahead

Over the past five years, Medicaid has experienced explosive growth followed by a period of relative stability. But one need only to consume the news on any given day to see that the future of Medicaid is complicated. Such complications will pose challenges to existing Medicaid plans, vendors, and service providers, while at the same time offering new opportunities. And, with Medicaid expenditures on a path to reach $1 Trillion by 2025[7], the opportunities will be significant.

To best realize that opportunity, health plans, vendors, and service providers should consider a set of key factors around best managing through the complications of today while setting the foundation to succeed in the Medicaid market of tomorrow:

- **Managing complexity around participation**– Approaching the start of annual open enrollment period, the Federal government announced significant reductions in spend around marketing and support to designed to drive traffic to Marketplaces. Coupled with a shortened open enrollment period and scheduled maintenance on nearly every Sunday during the six week period, and the perceptions of impacts from the elimination of cost-sharing reduction payments to health plans, many industry observers are expecting a significant reduction in the number of Americans visiting the Marketplaces and signing up for Individual health insurance.

  What may be less appreciated, however, is the impact that the diminished traffic will have on Medicaid, given the significant populations, both expansion and traditional, enrolling in Medicaid as a result of increased emphasis on health benefits and enrollment support. This added complexity has the potential to adversely impact Medicaid enrollment in the coming years, especially given the churn prevalence of the Medicaid population. To maximize enrollment, plans should consider their current and future strategies to support enrollment counselors, Navigators, and marketing to drive additional consumers to sign-up for health coverage.

- **Managing complexity around product design** – While many health policy questions remain unanswered, a number of the recent proposals sought to drive greater deregulation of healthcare products and markets. Through the use of waivers, plans and service providers can expect a devolution of product and benefit requirements to the states, offering more flexibility, and complexity, in Medicaid. Moves to add beneficiary cost sharing and savings accounts appear to be likely. Benefits previously mandated may be made optional, requiring service providers to more adroitly make a compelling case for the value of their solutions. And, Medicaid agencies are continuing to advance initiatives that attempt to lift up quality, seeking to tie plan and provider incentives to delivering healthcare value. Plans should prepare to administer a more complex, and changing, set of benefits. And, with greater variability in benefit offerings, health plans should begin to think about non-mandated offerings to enhance competitiveness and drive enrollment or reduce costs.

[7] Centers for Medicare and Medicaid Services, *National Health Expenditures 2015-2025*, March 21, 2017

- **Managing complexity around new populations** – As Medicaid has grown to cover nearly a quarter of Americans, the need for additional population-specific programs, targeted at the most medically needy and complex individuals, has grown. At the same time, states and localities are increasingly looking to private managed care plans to assume financial responsibility for populations such as the Severely Mental Ill, individuals with Substance Use Disorder, and those requiring Long-Term Services and Supports. Growth opportunities for Medicaid health plans increasingly will fall in such corners of the market.

  To successfully, and profitably, compete health plans will need to ascertain the additional capabilities necessary for managing the most complex populations, including considering procuring such capabilities externally and evaluating the benefits of build-versus-buy. Plans will likely also need to contend with extreme variations within population categories, as the delivery of care and coverage may vary on a state-by-state or even county-by-county basis, necessitating both institutional and local knowledge. Service providers are recognizing the high costs and significant opportunity associated with these populations, and developing a robust suite of offerings. Such providers should strive to be diligent in identifying target segments, geographies, and customers, and structuring viable business models that deliver value to the service provider, health plans, local stakeholders, and beneficiaries.

- **Managing complexity around political changes –** With the politics around healthcare changing daily, and definitive solutions appearing to be put off, identifying future strategies and positioning in the Medicaid space is challenging. In addition to the uncertainty around eligibility and funding at the Federal-level, Medicaid's status as a joint Federal-state program introduces an equally uncertain path forward at the state-level. While ascertaining the ultimate direction of policy is challenging, plans and service providers should first endeavor to isolate facts from noise. Medicaid's status as the key government-sponsored healthcare program, and the complexity involved in administering the program, should insulate it from drastic, immediate change. Plans and service providers, though, should look to craft strategies that meet the enduring goals of any health program – high quality outcomes at a high level of value - to best weather any political change, while also allowing for adaptability in the future across a changing market.

- **Managing complexity around the playing field –** As if all of the above were not significant enough, the Medicaid landscape continues to evolve. Consolidation of sub-scale plans continues in an effort to optimize the administrative base, while larger plans look to increase growth and geographic expansion by acquiring attractive assets. While Medicaid has historically been an active space for provider-sponsored health plans, increasing uncertainty around the Individual market and a realization of the lack of scale efficiencies across the book may encourage additional providers to exit from the administration of health benefits.

  The continued growth of private managed care plans and the increase in the number of states with nearly all populations covered by private managed care limits greenfield growth opportunities. Aside from the increase in medically complex populations, plans will increasingly win the future through active reprocurement cycles, often at the expense of incumbent plans. To thrive across an increasingly complex playing field, plans will need to make difficult determinations around their ability to effectively compete in the future at current scale, as well as make the necessary investments to serve increasingly complex populations and achieve differentiated, proven value positions to successfully win. Service providers will need to adapt to larger, more sophisticated purchasers by strengthening their value proposition to enable their customers to succeed and achieving the scale to serve plans across states and regions.

The complicated state of Medicaid

Recent events have illuminated that Medicaid, and surrounding issues, are complicated. While much of the discourse has focused on Federal changes to health policy, including the roll-back of Medicaid expansion and modifications to Medicaid funding, the future of Medicaid is more complicated than just anticipating and reacting to Federal actions. The significant divergence between states this year illustrates the impact that state-level actions, policies, and intentions have on future growth. And, with the recent Executive branch actions targeting key pillars of the Affordable Care Act, the resulting impact on future enrollment in Medicaid remains unclear. All in all, a complicated policy environment will continue to drive uncertainty in Medicaid.

Regardless of the policy outcomes, though, the future opportunity in Medicaid will be in managing and serving the most complicated populations. With 73% of all beneficiaries in private managed care, and the number of states with full managed care increasing, the remaining growth will skew towards populations that require the greatest level of care and coordination. With significant challenge comes great opportunity, as the per member fee-for-service spend is nearly twice that of managed care.

Plans, vendors, and service providers will need to adapt in the face of considerable market and policy uncertainty. Despite considerable noise emanating from Washington, the near-term outlook for Medicaid remains strong, as state procurement cycles continue to move more members to private managed care and the market stabilizes with nearly one in four Americans covered. At the same time, identifying and designing a longer-term strategy will be critical to ensure one's position in what may be a dramatically different market in the future.

The current state of Medicaid is substantial and consequential. And, the future state promises to be even more so, only more complicated.

Appendix A – Detailed state data[8]

State	Total Medicaid beneficiaries (Thousands)	Growth from 2016 (%)	Growth from 2013 (%)	Private managed Medicaid beneficiaries (Thousands)	Non-private managed Medicaid beneficiaries (Thousands)
Alabama	817	(1%)	12%	0	817
Alaska	192	23%	28%	0	192
Arizona	1,748	5%	37%	1,555	193
Arkansas	973	(1%)	25%	261	712
California	13,298	(2%)	68%	10,729	2,569
Colorado	1,367	3%	94%	128	1,239
Connecticut	773	2%	24%	0	773
Delaware	207	0%	(4%)	197	10
District of Columbia	252	6%	17%	196	56
Florida	3,469	(1%)	25%	3,179	289
Georgia	1,954	0%	11%	1,369	586
Hawaii	353	1%	22%	353	0
Idaho	300	2%	18%	2	298
Illinois	3,186	2%	12%	1,820	1,366
Indiana	1,353	1%	27%	1,125	228
Iowa	655	5%	27%	600	55
Kansas	386	(9%)	(3%)	381	5
Kentucky	1,423	2%	77%	1,273	150
Louisiana	1,479	3%	20%	1,465	14
Maine	233	(3%)	(18%)	0	233
Maryland	1,373	6%	29%	1,168	205
Massachusetts	1,747	(6%)	28%	816	930
Michigan	2,417	(5%)	37%	1,813	604
Minnesota	1,186	(0%)	35%	944	241
Mississippi	732	(3%)	6%	483	248
Missouri	986	0%	14%	730	256

[8] *Source: PwC analysis of state Medicaid enrollment, Summer 2017.*

State	Total Medicaid beneficiaries (Thousands)	Growth from 2016 (%)	Growth from 2013 (%)	Private managed Medicaid beneficiaries (Thousands)	Non-private managed Medicaid beneficiaries (Thousands)
Montana	228	20%	118%	81	147
Nebraska	249	7%	1%	248	1
Nevada	669	4%	105%	474	195
New Hampshire	183	(1%)	42%	175	8
New Jersey	1,757	(0%)	35%	1,671	86
New Mexico	761	1%	45%	678	82
New York	6,052	(0%)	16%	4,672	1,381
North Carolina	1,825	2%	(1%)	0	1,825
North Dakota	92	3%	39%	20	72
Ohio	2,965	4%	40%	2,540	425
Oklahoma	772	(2%)	(1%)	0	772
Oregon	980	(5)	56%	839	141
Pennsylvania	2,869	4%	30%	2,302	567
Rhode Island	317	11%	77%	285	32
South Carolina	1,216	5%	26%	762	455
South Dakota	119	(1%)	2%	0	119
Tennessee	1,423	(9%)	19%	1,423	0
Texas	4,499	1%	24%	4,239	260
Utah	276	0%	11%	232	44
Vermont	170	(5%)	14%	0	170
Virginia	970	4%	8%	791	179
Washington	1,861	0%	55%	1,534	327
West Virginia	523	(2%)	54%	422	101
Wisconsin	1,146	(1%)	3%	797	349
Wyoming	61	(5%)	(9%)	0	61

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Ari is a Director with PwC's Health practice, supporting health plans and health services organizations primarily around growth and deals strategy. Ari leads client engagements across all lines of business (including Medicaid, Medicare, and Commercial) and a variety of focus areas (such as PBM/specialty pharmacy, behavioral health, specialty networks, and digital). Aside from client work, Ari authors an annual report on Medicaid markets in the United States and perspectives of the current state of the payer market and resulting growth implications for health plans and health services businesses.