Florida's Experience with
MEDICAID REFORM

Understanding Florida Medicaid Today
And the Impact of Federal Health Care Reform

Medicaid is a critical part of the health care system in Florida. It covers about 27 percent of the state's children, pays for 51 percent of all deliveries and nearly two-thirds of nursing home days. [1]

Consequently, implementation of the federal Affordable Care Act — which seeks to reduce the number of uninsured in part by moving more low-income persons into Medicaid — could have a substantial impact on large numbers of Florida and important implications for state finances.

However, cost and benefit projections vary widely and should be analyzed carefully.

Florida Medicaid today

Florida Medicaid, including its companion program, KidCare, or CHIP, today insures about 3 million Florida residents. Total federal and state spending to support this program is estimated at about $20.3 billion for fiscal 2010-2011.

In general, only children, their parents, people with disabilities and some seniors are eligible for Medicaid in Florida. Childless adults typically are not eligible unless they qualify on the basis of disabilities.

The thresholds for eligibility are more generous for children than for adults. Children up to age 18 are eligible for either Medicaid or KidCare at income levels up to 200 percent of the federal poverty level. By contrast, eligibility for parents is limited to those with incomes below 20 percent of the poverty level (under $5,000 annually for a family of four).[2]

Adults with disabilities may be eligible with incomes up to 74 percent of the poverty level, and pregnant women are eligible up to 185 percent of poverty.

Growing enrollment, stable per-person costs

Medicaid is a very efficient program, costing significantly less on a per-person basis than private insurance – often because provider reimbursement is low. This is especially true in Florida, which has a low per-person cost – ranking 43rd in the country.

Although total program costs have risen 37 percent from $14.8 billion in fiscal year 2007-2008, spending per person is down marginally.[3] Monthly per-person spending, on average, dropped from $574 in 2007-2008 to $570 in the current fiscal year.

(Per-person costs vary considerably across the different covered populations, with costs for children and parents generally much lower than costs for the elderly or disabled. Overall, per-person costs for children and parents are about $211 per month; for pregnant women, $865; for those with disabilities, $1,482; and for those dually eligible for Medicaid and Medicare, $1,741 per person per month.)

Florida's experience mirrors what is happening nationwide. A recent national survey underscored that Medicaid cost growth is driven almost exclusively by enrollment growth.[4]

Who pays the bill?

Although discussions about Medicaid often focus on the burden its costs place on state budgets, a majority of dollars that support Florida's Medicaid program come from the federal government under a system of matching funds.

Prior to the recession, the federal share of every dollar spent on Medicaid was about 57 percent. In an effort to help states during the recession, the federal government took on a larger share of the costs. The matching rate for Florida was increased during 2010 to more than 67 percent; during 2011, the rate transitions back down to 56 percent. Matching dollars for Florida's CHIP program are higher: the federal share was 69 percent in 2009.

The result of this matching funds system is that every dollar Florida draws from general revenues and other dedicated funding sources provides a much greater value in benefits to those enrolled in Medicaid or CHIP and payments to the state's health care providers. Under the matching funds rate that applies to Medicaid after the temporary increase phases out, $1.00 in state funds yields over $2.30 in benefits, and $1.00 invested in CHIP yields over $3.20 in benefits.

Key Findings

The State of Florida's $6 billion cost projection for implementing the Affordable Care Act is based on unrealistic assumptions.

For example, the state assumes 100% of those eligible will enroll — a feat that has never been achieved in any state in the nation for either Medicaid or Medicare.

And the state fails to take into account any potential savings stemming from implementation.

Using more realistic assumptions and accounting for modest savings results in an estimated cost of no more than $1 billion and perhaps a savings of up to $3 billion.

The Jessie Ball duPont Fund commissioned researchers from Georgetown University's Health Policy Institute to examine the impact of changes to Florida's Medicaid program on beneficiaries in the affected counties, and to identify issues confronting the state under implementation of the Affordable Care Act.

JESSIE BALL DUPONT FUND

What will happen in 2014 as a result of health reform?

The Affordable Care Act seeks to reduce the number of uninsured persons in part by expanding Medicaid programs. The basic design of health reform calls for Medicaid to cover people with low incomes – up to 133 percent of the federal poverty level ($14,484 for a single person or $29,725 for a four-person family in today's dollars).

Beginning Jan. 1, 2014 all adult citizens in Florida with incomes up to 133 percent of the federal poverty level will become eligible for Medicaid – regardless of whether they are parents or qualify based on disabilities.

Furthermore, the federal matching funds rate for these newly eligible populations will be far higher than under today's rules. In fact, from 2014 through 2016, the federal government will pay 100 percent of the new costs. The match rate phases down to 90 percent in 2020, meaning that Florida still pays only 10 percent of the costs for newly eligible adults into the future.

In other words, over the first 10 years of reform, the federal government will pay on average 94 percent of the cost of new Medicaid coverage.

In addition to expanding Medicaid eligibility for low-income persons, the Affordable Care Act allows those with incomes above 133 of the federal poverty level to purchase coverage through new health insurance exchanges. The exchanges, which are scheduled to begin operation in 2014, will subsidize coverage for many people with incomes as high as about 400 percent of poverty or about $89,400 for a family of four.[5]

These subsidies will bring even more dollars to the state. Subsidy and Medicaid dollars will add up to an estimated $437 per nonelderly Florida resident – the third highest rate of the 50 states.[6]

How will reforms affect the number of uninsured Floridians?

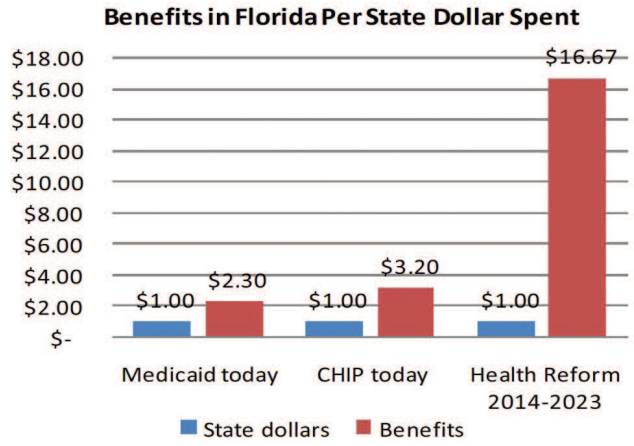
Florida has the third highest rate of uninsurance in the United States, in part because of its relatively ungenerous Medicaid program. In total, about one in 10 Florida residents is uninsured and below 133 percent of the poverty level.[7]

This history of tight eligibility means that Florida has much to gain from the changes coming under health reform.

Today, 54 percent of Florida's nonelderly adults with incomes under 133 percent of the poverty level are uninsured, but only 17 percent receive insurance through Medicaid. The new eligibility rules under health reform will create a significant expansion of Florida's program, primarily for adults, and will increase Medicaid enrollment by an estimated 35 percent to 50 percent depending on the aggressiveness of sign-up efforts.[8]

The vast majority of these new eligibles will come from the ranks of the uninsured, not shifts of people from private coverage. Between 680,000 and 1.1 million Florida residents without insurance today are projected to gain coverage from Medicaid as a result of the new law. [9]

The changes are expected to be much more modest for children because Medicaid and CHIP already have been successful in reducing the number of uninsured children to historically low levels. Florida's children today are much less likely to be uninsured than adults, precisely because they have had Medicaid and CHIP to protect them from the decline in employer-based coverage and the rising costs of insurance.



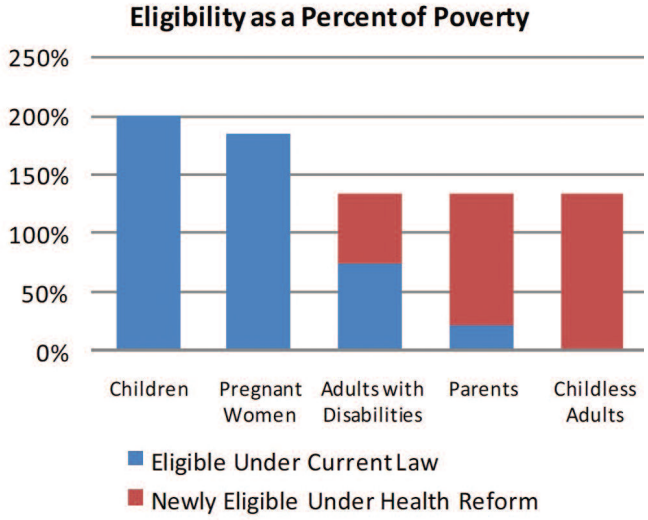
How will reforms affect Florida's budget for health care services?

Medicaid expansion is the source of much of the debate in Florida about the costs of health reform. In thinking about the impact of these changes, it is essential to look at both new costs and potential savings that the state and local governments will incur as a result of substantially expanded insurance coverage.

Under the Affordable Care Act, the Medicaid expansion is financed primarily by the federal government with only a small share of state dollars required. The considerable expansion in coverage and tremendous influx of federal dollars for the years 2014 to 2019 comes at an increase in state funds of only 2 percent to 4 percent over current spending levels, according to estimates by The Urban Institute, a nonpartisan economic and social policy research center. [10]

Under a scenario that assumes enrollment at roughly current rates, the state would incur new spending over six years of $1.2 billion (a 2 percent increase over current levels), enhanced by $20.1 billion in new federal dollars.

Under a second scenario that assumes higher participation from those eligible for new coverage, the increase in new state funds needed is $2.5 billion, 3.8 percent over the state's baseline spending levels.



These cost estimates are significantly lower than those offered by Florida's Agency for Health Care Administration (AHCA), which has estimated new costs at $4.1 billion for new Medicaid enrollment and related changes over essentially the same time period.[11] AHCA also estimates a $2.0 billion cost for higher payment rates for primary care doctors. [12]

Why are the cost estimates so different?

In short, AHCA's estimate assumes the highest possible costs and the least possible savings. Some of these assumptions may be reasonable, but others are unrealistic.

AHCA has assumed that 100 percent of those newly eligible will enroll after a two-year transition – a participation rate that has never been achieved in Medicaid or Medicare programs in any state in the country. AHCA applies this 100-percent-participation assumption both to people who are newly eligible for Medicaid as a result of the new law and those eligible for Medicaid today but who have not enrolled.[13] While the new law does not alter the status of those currently eligible but not enrolled, some believe that marketing aimed at the newly eligible will have a spill-over effect and increase the likelihood of enrollment among those previously eligible but not enrolled.

By contrast, The Urban Institute's analysis suggests that participation levels will be consistent with past program experience around the country — between 57 percent and 75 percent (the latter assuming more ambitious state efforts) of uninsured new eligibles would enroll. A lower estimated enrollment rate will lead to lower state costs because fewer people will receive services.

Florida's current participation rate is low by national standards. For example, enrollment of eligible children in Florida is 70 percent, well below the national average of 82 percent (in fact, the fifth lowest of all states).[14] Even a significant improvement would fall short of 100 percent enrollment.

Enrollment in Medicaid can be challenging today, requiring in-person consultation and paperwork that includes documentation of income and assets. The health reform law calls for simplified eligibility standards and procedures. In addition, providers, who often help their patients get enrolled, will have more incentive to do so in the future.

States, however, will continue to have considerable control over the simplicity of the process and the ambitiousness of outreach efforts. Nevertheless, one expert states, "100 percent is just not a realistic number."[15]

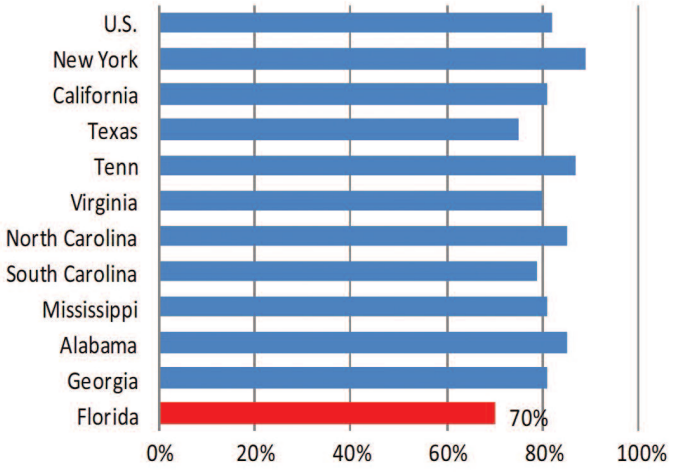
In addition to projecting high enrollment, AHCA's estimates appear to assume that the current average per-person rate of spending will apply to new enrollees.

According to a recent study, adults who enroll in Medicaid under reform are likely to be less expensive than those already enrolled in Medicaid (although more expensive than those who remain uninsured).[16] Why? Because the sickest, most costly beneficiaries are likely already eligible for Medicaid by virtue of a disability or because a health care provider has taken steps to make sure they are enrolled as a way to ensure payment.

Newly enrolled adults should be less expensive than the adults currently in Medicaid. Thus using current per-person costs tends to overestimate future spending.

Although both of these factors may inflate AHCA's estimate, there are a few sources of potential costs that could increase the estimate modestly. For example, state administrative expenses could rise due to having more people in the program, pushing total spending up somewhat. The impact of some other health reform provisions, such as changes to how prescription drugs are paid, is also not considered.

Children's Medicaid/Chip Participation Rates - 2008



Source: Henry J. Kaiser Family Foundation

Could increased insurance coverage create offsetting savings?

Increased insurance coverage will change the nature of the health care safety net.

Today, those without insurance still receive some health services through clinics and safety-net hospitals, even without any means of payment, and a variety of state and local programs help to pay providers for these services. Better insurance coverage should reduce the burden on these programs.

Nationally, an analysis by the Lewin Group found that collectively states will save $106 billion between 2010 and 2019, primarily from a reduced need for safety-net programs.[17] Another study by the Urban Institute projected savings of $70 billion to $80 billion if just half of safety-net costs were eliminated.[18] If true, these savings would dwarf the $21 billion to $45 billion in new state costs throughout the country as identified by the Urban Institute study.

In Florida, like elsewhere, state and local dollars pay a portion of the cost of care for those without health insurance. The largest piece is support for uncompensated care provided by hospitals, especially the safety net hospitals that serve large numbers of uninsured patients. State and local governments also help support local health clinics or sponsor other programs to make primary care and other services available to those without insurance.

Florida's Low Income Pool (LIP), a complex structure created under the current Medicaid waiver pilot program, is one way state and local funds are made available to hospitals and certain other safety-net providers that provide high levels of uncompensated care. The LIP and its related programs provide about $2 billion to these providers. The dollars are primarily intergovernmental transfers from local governments matched by federal funds.[19] In the current year only about $25 million in state general revenues are paid into this fund, while about $750 million come from local governments. State and local governments in Florida should see considerable savings if more insurance coverage means less uncompensated care.

Much of this savings will occur at the county and city level. Twelve Florida counties currently operate 16 independent hospital taxing districts with authority to levy taxes.[20] Typically these districts support local hospitals that care for poor and uninsured county residents.

In 2007, these districts collected about $600 million in taxes, up by 75 percent in just five years. Broward County raises about $205 million per year to support its public hospitals.[21] Palm Beach and Hillsborough counties take a different approach, levying taxes (an estimated $154 million for Palm Beach) to reimburse doctors and hospitals for indigent care, rather than support a single hospital. Miami-Dade County has no taxing district but uses $350 million raised through sales and property taxes to support its local nonprofit hospital – an amount not counted in the total for hospital districts.

If coverage expansions substantially lower the number of uninsured patients, the hospitals, doctors and others who treat them should have less need for support from public dollars. This, in turn, could allow Florida counties to lower these special taxes. During the national debates, the hospital industry's support was premised on the idea that expanded coverage would eliminate the need for some of the subsidies that help pay for services provided to the uninsured. The national studies cited above offer further evidence that savings should be available.

Although hospital care is probably the largest source of offsetting savings, state funds also support many mental health and substance abuse service programs aimed at people with no source of payment. It is likely that many who use these services today will gain coverage through Medicaid or through private insurance that no longer imposes pre-existing condition requirements. The state would have a strong incentive to move people from programs funded entirely by the state to Medicaid or private insurance, where federal or private insurance dollars would cover a portion of the $500 to $600 million in state dollars that currently fund mental health substance and substance abuse service programs.

The 2011 Legislature is debating the future of the Medicaid "medically needy" program, which includes about 45,000 people whose incomes are too high to qualify but who experience catastrophic medical expenses. These individuals have the highest average per-person costs of any group in Medicaid and collectively cost the state $1.2 billion in 2010-11. Many in this group today lack other sources of insurance. Once health insurance exchanges are created and subsidies go into effect in 2014, they should be able to purchase private insurance at a subsidized price. The result could be considerable savings to Medicaid without any loss of access to health services.

Offsetting savings could come from some additional sources, although specific results will depend in part on future policy decisions. One depends on the status of Florida's CHIP program after 2014. AHCA assumes in its estimates that the federal matching funds rate will drop when some children now on CHIP are moved to Medicaid. But some experts believe that there are ways that the state can retain the higher rate of federal funding.

Finally, some experts think that Medicaid has a significant effect on the state economy, generating jobs and other economic activity.[22] From the state's perspective, this effect is accentuated by the presence of matching federal dollars. If true, an expanded Medicaid program should create more jobs and bring in more state and local tax revenues.

What is the bottom line?

Estimates of Florida's cost for Medicaid expansions that will go into effect in 2014 vary because of different assumptions about future decisions by policymakers, providers and individuals.

AHCA's estimate of $6.1 billion in spending over six years emphasizes the highest possible net costs because of high enrollment assumptions, makes high average cost assumptions, includes added costs for primary care payments, but makes no allowance for offsetting savings.

The Urban Institute's estimate of $2.5 billion in new spending is based on aggressive enrollment efforts, but also does not include estimates of offsetting savings.

We believe a more realistic set of assumptions about both costs and savings for the state and counties projects six-year costs that would not exceed $1 billion and, in fact, could yield as much as $3 billion in savings. Specifically, these projections assume:

- A 75 percent enrollment rate;
- Additional spending for higher payments to those who provide primary care;
- At least 25 percent savings in current state and local payments for safety-net care;
- At least 25 percent savings from transfer of medically needy to exchanges.

If a 50 percent savings in safety net payments was realized and a share of current payments for the medically needy segment of Medicaid were eliminated, the state spending on Medicaid expansions would be more than totally offset at the same time that as many as 1 million Florida residents gained new insurance coverage.

In the worst case where new costs were not totally offset, Florida residents and Florida providers would benefit from increased coverage for no more than $1 billion in new state spending.

In the best case, new benefits would be accomplished with no new state and local spending and even the possibility of as much as $3 billion in savings over six years.

ENDNOTES

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2. Martha Heberlein, Tricia Brooks, and Jocelyn Guyer, Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011, Kaiser Commission on Medicaid and the Uninsured, January 2011. For a working parent, there is some allowance for earned income – raising the effective rate to 59 percent of poverty.
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4. John Holohan, et al, *Medicaid Spending Growth Over the Last Decade and the Great Recession 2000-2009*, Kaiser Commission on Medicaid and the Uninsured, February 2011.
5. See Center for Children and Families, Summary of Medicaid, CHIP, and Low-Income Provisions in Health Care Reform (April 2010), for a summary of these and related provisions in the Affordable Care Act.
6. Matthew Buettgens, John Holahan, and Caitlin Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," Urban Institute, March 2011.
7. Randall R. Bovbjerg, Barbara A. Ormond, and Vicki Chen, State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts, Kaiser Commission on Medicaid and the Uninsured, February 2011.
8. John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, Kaiser Commission on Medicaid and the Uninsured, May 2010.
9. Holahan and Headen project that another 270,000-300,000 will switch to Medicaid from other sources of coverage. See also Matthew Broaddus and January Angeles, "Medicaid Expansion in Health Reform Not Likely to "Crowd Out" Private Insurance, Center on Budget and Policy Priorities, June 22, 2010.
10. John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, Kaiser Commission on Medicaid and the Uninsured, May 2010.
11. Agency for Health Care Administration, "Overview of Federal Affordable Care Act as Provided to the Social Services Estimating Conference," January 4, 2011. A minor difference is that AHCA's estimate is based on state fiscal years, whereas the Urban Institute uses calendar years.
12. In an effort to improve access to Medicaid services, the ACA requires that physician fees in 2013 and 2014 for certain primary care services be increased to levels paid by Medicare and provides 100 percent federal matching funds to do so. Although the federal requirement ends after 2014, AHCA assumes that the state will choose to continue to incur these costs to maintain the increases in future years.
13. AHCA assumes a smaller rate (80 percent) for those currently buying individual private insurance and assumes that those not enrolling in Medicaid will retain coverage through their private policies.
14. Genevieve M. Kenney et al., "Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?" Health Affairs 29(10): 1920-1929, October 2010.
15. Alan Weil, "Medicaid Expansion in Health Reform: National and State Estimates of Coverage and Cost," (transcript), Kaiser Family Foundation, May 26, 2010.
16. John Holahan, Genevieve Kenney, and Jennifer Pelletier, "The Health Status of New Medicaid Enrollees Under Health Reform," Urban Institute, August 2010.
17. The Lewin Group, "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers," Staff Working Paper #11, June 8, 2010.
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19. AHCA Low Income Pool Council, "Council Report for State Fiscal Year 2010-11 with Recommendations for State Fiscal Year 2011-12," February 1, 2011.
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21. Estimates for Broward and other counties come from two Miami Herald articles: "Need for public hospitals to be a 'hot topic' for Gov.-elect Rick Scott" (December 30, 2010) and "Debate heats up about hospitals' charity" (February 28, 2011).
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