FLORIDA'S HEALTH AT RISK

Third in a series of educational briefs on issues impacting Florida's families

Issues to Consider in Governor Bush's "Florida Medicaid Modernization Proposal"

KEY FINDINGS

- There are many key questions left unanswered by the Medicaid Modernization Proposal—including precisely how the changes will impact the state's Medicaid budget and how much money the state will spend per person.
- The proposed expansion of managed care in the governor's proposal is fundamentally different from the way Medicaid managed care currently operates in Florida and nationwide. Private insurance carriers and other managed care networks would have unprecedented flexibility to determine the benefits that Floridians enrolled in Medicaid receive.
- The concept of relying on competition among private insurers to save money without compromising beneficiaries' access to services is untested. Available evidence suggests that Medicaid delivers care more cost-effectively than private insurance.

Introduction:

Like most states, Florida's state budget has faced fiscal pressures due to declining revenues and rising Medicaid costs. These fiscal pressures have prompted most states to enact cost-containment measures. On January 11, 2005 Governor Bush released an outline of a plan to restructure the Florida Medicaid program. The document suggests a far-reaching and radical restructuring of the Florida Medicaid program, although it lacks many important details. Many of the concepts proposed have not been tested anywhere in the country, even on a pilot basis, and many key questions are left unanswered by the document.

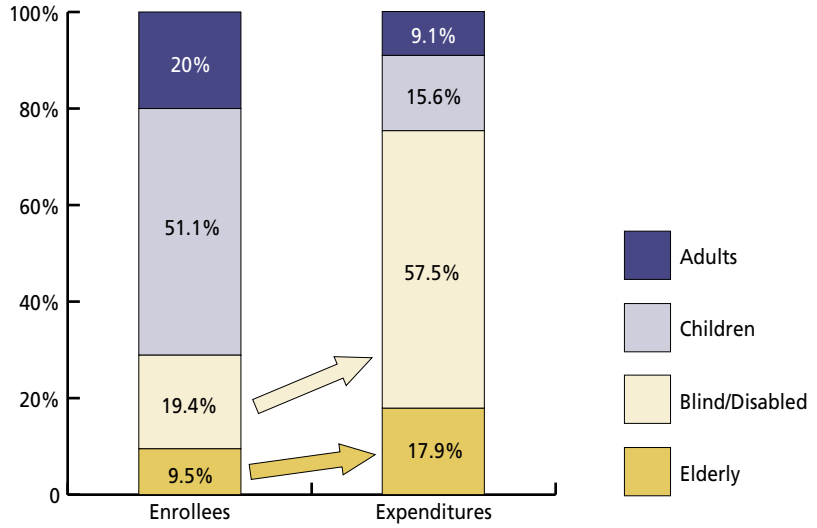
The Governor's proposal is premised on the notion that fostering competition among private insurance carriers and provider networks that seek to assume the risk of providing services, will save the state money without compromising the quality and scope of services that Medicaid beneficiaries receive. As the proposal states: "The vision for the future of Florida Medicaid relies on competition among vendors of coverage and services to inspire innovation and efficiency."[1] The state seeks to guarantee cost savings by placing caps on the amount of money that will be spent per Medicaid beneficiary, as well as an overall cap on state spending.[2]

Without further information on the state's budget assumptions it is impossible to develop precise estimates of who will be impacted and how. Yet even without precise cost estimates, the concepts in the proposal raise many important questions about its impact that should be fully addressed as the plan moves forward.

Why is Medicaid reform important?

Large-scale changes to Florida Medicaid will have enormous implications for Florida's most vulnerable citizens. Florida Medicaid serves approximately 2.2 million persons.[3] Over half of these beneficiaries are children – more than one out of four of Florida's children receive their health care services through Medicaid. In addition, 44 percent of pregnant women receive their prenatal care through Medicaid. Finally, Medicaid is a critical source of coverage for the elderly and

Figure 1: Elderly and People with Disabilities Account for More than Two-Thirds of Florida's Medicaid Expenditures



Source: Georgetown Health Policy Institute/Center on Budget and Policy Priorities analysis of CMS MSIS 2002 data.

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people with disabilities – covering among other things two-thirds of all nursing home days.[4]

In addition, because of its federal matching structure, the Florida Medicaid program is a critical source of funding for Florida's health care infrastructure – in particular hospitals, nursing homes, as well as urban and rural community clinics. Medicaid is also the largest source of federal funds coming into the state. In federal fiscal year 2005, the state expects to receive over $8.1 billion in federal matching funds.[5] These funds have an important economic multiplier effect on the state's economy.[6] One study estimates that if Florida reduces Medicaid spending by just one hundred million dollars, the state would lose $303 million in business activity and cut 3,123 jobs.[7] Thus major changes to Medicaid can be expected to impact Florida's economy as well as providers, counties and other local government entities which play an important role in the delivery of health care to vulnerable populations.

How does the plan envision that Medicaid costs will be reduced?

One of the primary goals of the Governor's reform effort is to achieve "predictability" in Medicaid costs. Increases in health care costs due to new technologies and treatments, the growing cost of prescription drugs and other services, and unexpected epidemics such as HIV/AIDS all make healthcare costs unpredictable and it is difficult to predict how much Medicaid in its current form will cost in any given year. Also, in exchange for open-ended federal financing, Medicaid provides a guarantee of coverage for those children, parents, seniors and persons with disabilities who meet the eligibility requirements and enroll in the program. Increases in enrollment which occur in times of economic downturn or as a result of changes in a state's population all contribute to cost growth in the program.

As in other states, Florida's Medicaid budget has been rising – an average of 12.5 percent over a recent five-year period. Why have these costs been going up? Over the past five years our analysis shows that *enrollment increases account for, on average, 62 percent of Florida's Medicaid cost increases.*[11] In addition, Florida's low-income elderly population is growing at eight times the national average,[12] and enrollment among this population has increased sharply as well. This group is the most expensive to serve because of their complex health care needs. However, the rate of increase in Medicaid spending, both nationally and in Florida, is slowing down both because enrollment growth is slowing and because health care cost growth has decreased somewhat.

Because Medicaid is an entitlement program that guarantees coverage, it is impossible to predict precisely how much will be spent without fundamentally changing the nature of the program. This unpredictability is undertaken in one of the most important features of the Governor's proposal – a cap. The proposal appears to establish two kinds of caps – a per person or "per capita" cap that would operate within an overall or "global" cap on state spending.[13] According to the proposal:

"In the transformed Medicaid program, *setting the spending level is the primary governmental function. From this aggregate budget* funding is earmarked for the three components of the benefits structure … *Each Medicaid participant is entitled to a specific share of the budgeted amount.*"[14] (Emphases added)

Caps on spending have many implications —some of which are discussed in the next section.[15]

How would the new system work?

Beneficiaries would receive a set premium amount that would be risk-adjusted. According to the proposal, there would be a three-tiered benefit system: Comprehensive Care, "Enhanced Benefits" and Catastrophic Care. *These tiers would not be defined by the types of benefits but rather by the amount of money that is allotted to each person in each category.* As the proposal says:

"These components are not defined by the type of services covered – any service may be covered in any category. Rather, they are

What is the difference between the Governor's proposal and a federal "Section 1115" Medicaid waiver?

The Governor's proposal is not a formal Section 1115 federal Medicaid waiver application. However, such a waiver will be needed to implement much of the proposal. Section 1115 waivers are the broadest type of waiver from requirements of federal Medicaid law that states can request.[8] A Section 1115 waiver application by the state will include more specifics such as a proposed budget and a list of the exact provisions of federal law that the state wishes to put aside – for example, the state may seek a waiver of certain federal benefits requirements. The Florida State legislature must approve changes to Florida law that are required to implement the Section 1115 waiver; the state is seeking the legislature's approval prior to submission of a waiver application.

All Section 1115 waivers must be "budget neutral" to the federal government – that is the federal government will not agree to spend more federal dollars under such a waiver agreement than it would have in the absence of such an agreement. To enforce this "budget neutrality" requirement all waivers include some kind of cap on federal dollars.[9] This cap is negotiated privately between the state and federal executive branches as the waiver approval process moves forward.[10] Thus when the state submits a waiver application it will be impossible to evaluate what the fiscal impact of such an agreement will be until a final waiver agreement is reached between the federal and state government.

defined by explicit expenditure thresholds that are based on historic utilization experience."[16]

Because the amount of money is the determinative factor rather than any set of benefits, it appears that the proposal would eliminate a guaranteed benefits package as it is currently constructed.[17]

Managed care plans and other vendors would compete for beneficiaries by offering them different choices for the "Comprehensive Care" services. Beneficiaries could then use their fixed sum to decide which plan to purchase. Once beneficiaries reach a minimum dollar threshold and require more healthcare services they would move into the catastrophic coverage category. It is not clear how this source of funding will function, but it is clear that there will be a maximum benefit limit for catastrophic coverage.

Finally, Medicaid beneficiaries who "exercise personal responsibility" and participate in "established healthy practices" will be eligible for "enhanced benefits." This would be money in a flexible spending account that can be used to purchase additional services.

Florida already has managed care in its Medicaid program. Is the Governor's proposal designed just to expand the current system?

The vast majority of states, including Florida, already use managed care as a way to deliver services, especially to children and families. Florida has 41 percent of its Medicaid population in fully capitated managed care – lower than the national average of 52 percent but still a significant proportion.[18] Florida, like other states, has primarily capitated care for its healthier beneficiaries – children and their parents. Moving to capitated care for other populations with often complex health care needs such as seniors and persons with disabilities – poses more challenges and greater risks.[19]

For those beneficiaries already in managed care, as well as any additional populations that would be moved into managed care, *the Governor's proposal is fundamentally different from the way that Medicaid managed care operates in Florida and nationwide for the following reason:* It appears that private insurers and other provider networks would have extraordinarily broad flexibility under the proposal to determine what benefits Medicaid beneficiaries would receive. According to the proposal:

"The amount, duration and scope of services will be determined by each plan or provider-based system, with government oversight to assure that the amount of coverage offered is sufficient to meet patients' medical needs."[20]

Allowing plans to determine the scope of services is a radical restructuring of the way Medicaid works.

"We know states are struggling with Medicaid spending and the pressure it puts on other state priorities, but.....Medicaid costs actually grew at a slower rate than private insurance costs. The real problem is rising health care costs and the states' ability to pay the bill, and not that Medicaid spending is out of control."

Diane Rowland, executive director of Kaiser Commission on Medicaid and the Uninsured

What do these changes mean for beneficiaries and providers?

The two key concepts that underpin the Governor's proposal described above should be considered together. First, spending will be limited by capping the amount spent for each Medicaid beneficiary. Second, private insurance carriers and provider networks will have unprecedented flexibility to determine what services are provided for this capped amount of funding. *Taken together the new proposed structure raises many questions including:*

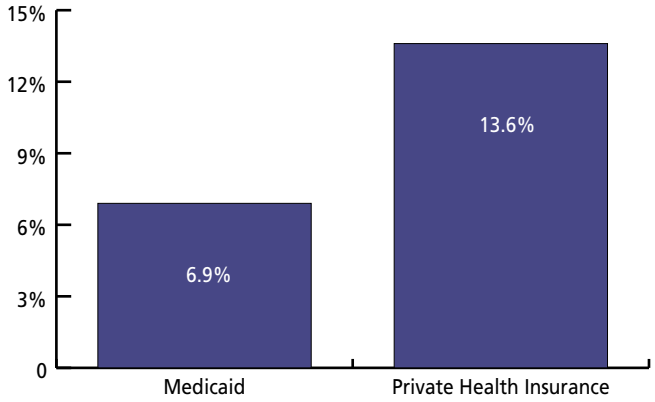
- What will happen when individual beneficiaries reach their cap? If individual caps are based on past claims, who will pay the additional costs of a previously healthy child who develops leukemia?
- Will plans structure their benefits in a way as to maximize profit by attracting the healthier segments of the Medicaid population?
- What will happen to Medicaid beneficiaries when the amount, duration and scope of service are inadequate to meet their medical needs? Will providers end up providing more uncompensated care? Will families be expected to pick up the additional costs? This is of particular concern for those groups with complex medical needs such as seniors and people with disabilities. Medicaid beneficiaries have very low incomes and have few resources available to cover services not covered by the plan.
- What happens to a child whose parent chooses an inadequate plan either because the child has previously been healthy and becomes sick or because the parent wants to save as much money as possible in the enhanced benefits account?

Is reliance on competition among private insurers to save money and improve service a realistic premise?

The Governor's proposal relies on the notion that fostering competition among private vendors will result in reduced costs without reduced access to needed services. Can private insurance truly save money? Or will plans use their new found flexibility to reduce benefits

Figure 2: Administrative Expenditures in Medicaid Are Lower than in Private Health Insurance, U.S. 2003

Administrative costs as a percent of total expenditures



Source: Georgetown Health Policy Institute analysis based on Smith C, et. al. "Health Spending Growth Slows in 2003." Health Affairs 24 (Jan./Feb. 2005), 1: 185-194.

in ways that will severely compromise the available health care services for the children, parents, seniors and persons with disabilities who rely on Florida Medicaid.

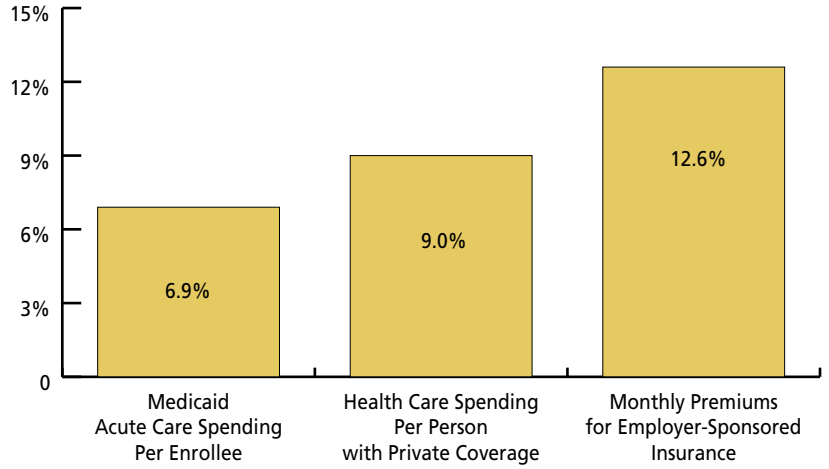
One of the first questions to examine is whether or not Medicaid is a more expensive way to deliver health care services than private insurance. If this were so, then "privatizing" the system could be a good way to save money without compromising services. Available evidence suggests, however, that the opposite is true – Medicaid tends to provide comparable services more cheaply than private insurance. A study done by researchers at the Urban Institute found that *children covered by the Medicaid program cost about 69 percent of what it would cost to cover similar children in private insurance.*[21] This included the costs of covering all children – even those with disabilities – through Medicaid. Non-disabled adults served by Medicaid, cost approximately 78 percent of what it costs to serve adults through private insurance.[22] The same study found that transferring people from Medicaid to private insurance would increase the costs of their care significantly.[23]

Medicaid has low administrative costs. One of the reasons that Medicaid costs are lower than costs in the private insurance market is that Medicaid typically has low administrative costs and does not incur many of the costs associated with private insurance – including profits, advertising, and more generous salaries. Florida reported to the federal government that its administrative costs for federal fiscal year 2005 in Medicaid would be just under 5 percent.[24] While this likely understates the amount Florida Medicaid spends on administrative costs,[25] it is still likely to be significantly less than administrative costs for private health insurance plans. According to a recent national study, *administrative costs for Medicaid are just under seven percent while private insurance administrative costs were almost double that – 13.6 percent.*[26]

The bulk of health care spending in any insurance model is of course for payments to providers. The primary reason for Medicaid's relatively low cost is the lower level of provider reimbursement it pays as compared to both Medicare and private insurance. This is particularly true in Florida. A recent study found that Medicaid on average pays physicians 69 percent of what Medicare pays – in Florida this ratio is 65 percent.[27] Perhaps more disturbing is that, when compared to other states, *Florida ranked 39th in its overall Medicaid physician payment fee index.*[28] This suggests that provider reimbursement levels in Florida Medicaid are already relatively low.

While research is clear that Medicaid improves access to care,[29] it is also the case that low reimbursement levels discourage provider participation. To the extent that the Governor's proposal encourages private insurers to cut costs by reducing provider reimbursement levels this could discourage more providers from participating in the program. Providers may lose growing amounts of money on Medicaid patients, and beneficiaries could face reduced access to care – especially cost-effective primary and preventive care.

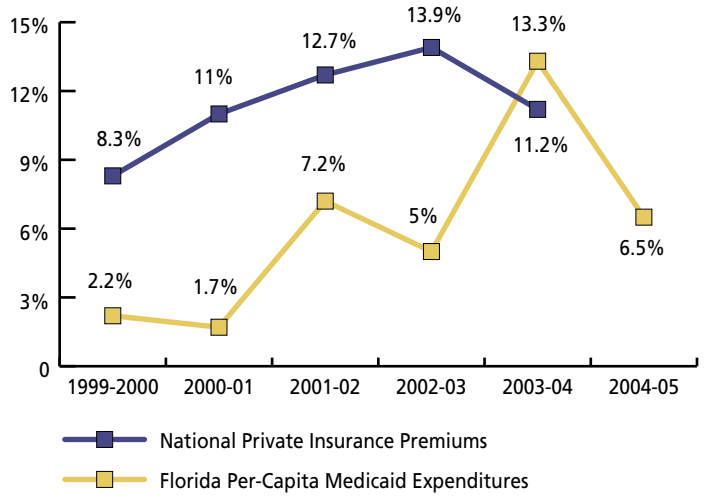
Figure 3: Medicaid Spending Growth is Slower than Growth in Private Health Spending, 2000-2003



Source: Holahan J, Ghosh A. "Understanding the Recent Growth in Medicaid Spending: 2000-2003." (Presentation) The Urban Institute, January 26, 2005.

Figure 4: Private Insurance Premium Increases vs. Florida's Medicaid Expenditures

Florida's Per-Capita Medicaid Expenditures are Projected to Grow 1.9% in 2005-06



Source: Georgetown Health Policy Institute analysis based on Kaiser HRET 2004 Annual Survey; Florida Social Services Estimating Conference Medicaid Caseload data, 2/4/05; Social Services Estimating Conference Medicaid Services Expenditures data, 2/25/05; 1999-00 and 2000-01 Medicaid expenditure data from AHCA Bureau of Program Analysis, June 2004. Expenditure data represents Medicaid expenditures for July 1-June 30th of that fiscal year.

Costs in the private sector are increasing more rapidly than in Medicaid. As described above costs tend to be higher in the private sector, but they are also increasing more rapidly than costs in the Medicaid program. As Figure 3 shows, Medicaid spending on health care services in the U.S. has been growing at a much slower rate than both private insurance premiums and actual spending on health care services in the private sector.[30]

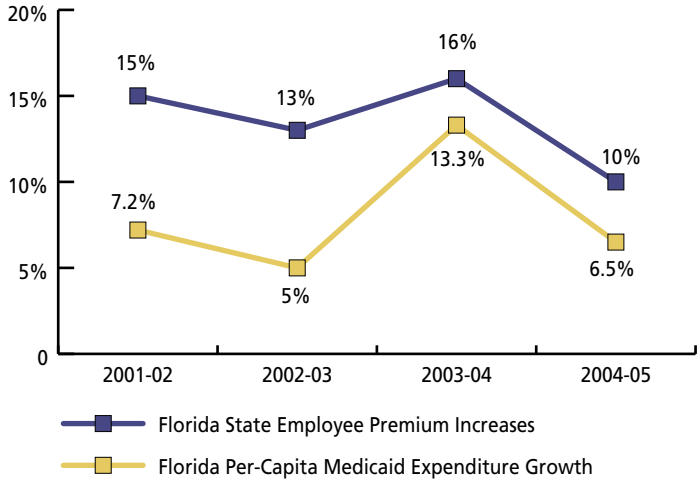
As mentioned above, much of the recent growth in Florida's Medicaid costs -- 62 percent – can be explained by enrollment increases.[31] When Florida's Medicaid costs are compared on a per capita basis to account for this enrollment growth, for the most part, *Florida Medicaid has actually done a much better job of containing costs than private insurance.* This can be considered in two ways. As detailed in a previous policy brief, Florida's Medicaid per person expenditures have grown much more slowly than national private insurance premium costs.[32] Figure 4 updates this analysis with the most recent data available. In addition, Florida's per-capita Medicaid expenditures are projected to grow 1.9 percent in 2005-2006.

State-specific data on private insurance premium costs is hard to come by because of the diversity of insurance markets within Florida and the confidentiality of much of the information. However, one good proxy to examine is how much the state of Florida has been paying to purchase its own employees' health insurance. Figure 5 looks at recent increases in premiums for state employees and compares them to increases in per capita Medicaid costs over the same period.[33] Our analysis finds *that the state of Florida has done a much better job of containing costs on a per person basis in its Medicaid program than in its bargaining with private insurers to purchase insurance for its own employees.*

Conclusion

Available evidence on the cost-effectiveness of Medicaid as compared to private insurance is clear. Medicaid is a more cost-effective way to provide health care services than comparable private insurance. These findings raise many questions about the ability of the Governor's plan to succeed in saving money without serious reductions in services – reductions that HMOs and other insurers would be permitted to make under the terms of the proposal by reducing the amount, duration and scope of the benefits provided.

Figure 5: Florida State Employee Premium Increases vs. Florida's Per-Person Medicaid Expenditure Increases



Source: Georgetown Health Policy Institute analysis based on Florida Social Services Estimating Conference Medicaid Caseload data, 2/4/05; Social Services Estimating Conference Medicaid Services Expenditures data, 2/25/05. State employee premium data from the Florida State Senate Committee on Health and Human Services Appropriations.

Endnotes

[1] See Florida Medicaid Modernization Proposal, January 11, 2005, Proposal, p. 3. Also, for more information on the governors plan go to www.empoweredcare.com.

[2] See Florida Medicaid Modernization Proposal, January 11, 2005, Proposal, p. 5.

[3] Social Services Estimating Conference, February 4, 2005 caseload estimates.

[4] "Florida's Medicaid Program" Presentation of Thomas W. Arnold, Deputy Secretary of Medicaid to the Senate Select Committee on Medicaid Reform. February 7, 2005.

[5] Form CMS-37 Medicaid and SCHIP budget estimates February 2004 submission.

[6] See Sampath, P. *"Penny Wise and Pound Foolish: Why Cuts to Medicaid's Economy Hurt Florida's Economy"* (Miami: Human Services Coalition), October 2003.

[7] *Medicaid: Good Medicine for State Economies, 2004 Update* (Washington, DC: Families USA), May 2004.

[8] For more information on Section 1115 waivers, see *"Medicaid Section 1115 Waivers: Current Issues"* a factsheet from the Kaiser Commission on Medicaid and the Uninsured (Washington, DC), January 2005. Also see Alker, J. and Portelli, L. *"What Could a Waiver to Restructure Medicaid Mean for Florida?"* (Orlando: Winter Park Health Foundation Policy Brief) April 2004, available at www.wphf.org.

[9] For more information, see Alker, J. and Portelli, L. Ibid.

[10] The Centers for Medicare and Medicaid Services (CMS), which is part of the federal Department of Health and Human Services, as well as the Office of Management and Budget (OMB) located in the White House negotiate the terms of the budget neutrality agreement on behalf of the federal government.

[11] Georgetown Health Policy Institute analysis based on enrollment data from the Social Services Estimating Conference "Basic Medicaid Caseloads, Historical and Forecasted: Average Monthly Caseloads by Fiscal Year FY 1995-96 to FY 2004-05," February 6, 2004.; Medicaid expenditure data from AHCA Bureau of Program Analysis (Tony Swinson, Senior Management Analyst Supervisor), 6/28/04.

[12] Joan Alker, and Lisa Portelli, *What Could a Waiver to Restructure Medicaid Mean for Florida?* (Orlando: Winter Park Health Foundation, April 2004).

[13] For more information on these terms see Alker, J and Portelli, L. Ibid.

[14] Florida Medicaid Modernization Proposal, p. 5.

[15] See Alker, J. and Portelli, L op cit.

[16] Proposal p. 7.

[17] See American Academy of Pediatrics: Medicaid Policy Statement *Pediatrics* Vol. 104, No. 2, August 1999, pp. 344-347.

[18] Calculated from the FY 2002 MSIS State Summary, created 1/19/05, available on the CMS website.

[19] In the Balanced Budget Act of 1997 Congress required the Department of Health and Human Services to conduct a study on the challenges of moving people with chronic conditions and special health care needs into managed care. For a good summary of the issues and the study, see Crowley, J. and Lewis, S. *"Pieces of the Puzzle"* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) October, 2001, pp. 5-6.

[20] Proposal, p. 8.

[21] Calculation based on Hadley, J and Holahan, J. "Is Health Care Spending Under Medicaid Higher than in Private Insurance?" *Inquiry* Winter 2003-2004 (40) pp. 323-342.

[22] Ibid.

[23] Ibid, p. 337.

[24] Calculation based on February 2004 submission to CMS Form CMS-37.

[25] Some administrative functions are likely included in the benefit costs through capitated payments.

[26] Cynthia Smith, et al. "Health Spending Growth Slows in 2003," *Health Affairs,* 24(1): 185-194, Jan./Feb. 2005.

[27] Exhibit 2 from Zuckerman, S. "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation" *Health Affairs* 23 June 2004.

[28] Ibid.

[29] See for example Dubay, L. and Kenney, G. "Health Care Access and Use Among Low-Income Children: Who Fares Best?" *Health Affairs* Volume 20, Number 1 pp. 112-121. See also Yu, S. et al "Factors that Influence Receipt of Recommended Preventive Pediatric Health and Dental Care" *Pediatrics* Volume 110, Number 6 December 2002.

[30] Holahan J, Ghosh A. "Understanding the Recent Growth in Medicaid Spending: 2000-2003." (Presentation) The Urban Institute, January 26, 2005.

[31] Alker, J and Portelli, L. *"Florida's Medicaid Budget: Why are Costs Going Up?"* (Orlando: Winter Park Health Foundation) July 2004.

[32] Ibid.

[33] The state purchases insurance for approximately 170,000 employees. The vast majority of these employees pay a share of the premium. However approximately one-fifth of these employees – senior management level staff – have the entire premium costs paid for by the state.

FLORIDA'S MEDICAID BUDGET: WHY ARE COSTS GOING UP?

Third in a series of educational briefs on issues impacting Florida's families – Florida's Health at Risk. Published by the Winter Park Health Foundation.

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