FLORIDA CENTER FOR FISCAL AND ECONOMIC POLICY

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Bogus Bonus: Legislature's Choice of Accountability Mechanisms Delivers Unearned Billions to Medicaid HMOs

Summary

Legislation passed during the 2011 regular session aims to expand an experimental form of Medicaid managed care statewide. One of the most controversial issues debated was the question of what standards should be used to regulate how much managed care plans can profit from their contracts to manage the taxpayer-funded Medicaid system. Although the use of both "medical loss ratio (MLR)" and "achieved savings rebate (ASR)" as accountability mechanisms was discussed, the final legislation incorporated a version of the ASR only.

The use of the version of the ASR approved by the Florida Legislature is problematic, particularly in comparison with the version of the MLR they rejected. In particular, using this ASR will:

- Allow Medicaid HMOs and mostly for-profit managed care plans to divert up to $9 billion dollars more from patient care to their own pockets during the first 5 years of the statewide managed care experiment than would have been possible had the proposed MLR been used.

- Divert up to an estimated $240 annually in taxes paid by every Florida household from statewide priorities such as education and public safety to provide this extra subsidy to managed care plans, but not benefit Medicaid patients or providers in any way.

- Provide some accountability that has been lacking in Medicaid managed care in Florida, but without the essential elements of transparency and public accountability inherent in the MLR.

- Deliver a massive and inappropriate bonus to managed care plans and their frequently out-of-state executives and investors at the expense of the most vulnerable patients and Florida taxpayers.

Background

In response to leaders' repeated but spurious claims that Medicaid spending is spiraling out of control, the Florida Legislature enacted legislation[i] during its 2011 regular session that calls for statewide implementation of a Medicaid managed care experiment built directly on the foundation of the 5-county, problematic Medicaid Reform Pilot Program. Like Medicaid Reform, although expanded to include every county and almost every patient group, recipients would be required to enroll in capitated managed care plans. Furthermore, those plans would have unprecedented flexibility to vary benefits and other aspects of their operation.

Requiring recipients to enroll in managed care plans paid on a capitated basis (i.e., plans receive a fixed payment per recipient per month) is one key method that the legislature intends to use to contain Medicaid spending. Capitated payment rates are arbitrarily reduced ("discounted") below the fee-for-service arrangement used in traditional Medicaid. Even Medicaid fee-for-service rates, however, are far lower than their counterparts in the federally administered Medicare program.

The excessive diversion of tax dollars from patient care for uses such as executive pay and profit can be effectively prevented only through the establishment and enforcement of strong accountability measures.

As a result, plans will in turn seek individually to reduce their spending on patient care. (For-profit plans, which dominate Florida's Medicaid managed care market, obviously already have a strong incentive of their own to spend less on care.) The experiment allows plans to use a number of tools in their efforts to achieve those reductions: unprecedented flexibility to vary their benefit packages in unique and confusing ways, aggressive utilization management practices, and payment rate negotiations with providers in which the plans have the upper hand.

The excessive diversion of tax dollars from patient care for uses such as executive pay and profit can be effectively prevented only through the establishment and enforcement of strong accountability measures. This question of how to regulate the extent to which managed care plans can benefit from their contracts to manage the taxpayer-funded Medicaid system was among the most controversial issues included in last session's debate over the Medicaid managed care experiment. Although the use of both "medical loss ratio (MLR)" and "achieved savings rebate (ASR)" mechanisms were debated, the final legislation incorporated a version of the ASR.

The ASR vs. MLR question remains relevant, however, as the legislature does not have the only say in the matter. Medicaid is a state-federal partnership, with the federal government providing the majority of program funding. Although approved by the legislature and signed into law by the governor, the experiment has another significant hurdle to clear. Because implementing the experiment requires that the state be granted a waiver from a number of basic federal Medicaid laws, the federal Centers for Medicare and Medicaid Services (CMS) must approve Florida's proposal. Although Florida can elect not

to include an MLR requirement in its Medicaid managed care program without a federal waiver, CMS could insist that an MLR requirement be included to ensure accountability as a condition of waiver approval. The issue has already been a focal point in the state's negotiations with CMS.

About the Medical Loss Ratio

The MLR concept has been prominent in the news recently, as a version of the MLR requirement for private health insurance plans was included in the federal Patient Protection and Affordable Care Act and went into effect this year.[2] The health law includes no such requirement for Medicaid managed care plans, however.

In general, under an MLR requirement imposed on any form of health coverage, managed care plans are required to spend no less than a set minimum percentage of the premiums they receive on patient care, in contrast with: 1) spending for administration, overhead and marketing, or 2) retention of unspent premiums as profit. In the event that a plan spends less than the required minimum percentage of premiums on patient care, it must refund the shortfall.

In the context of Medicaid managed care, taxpayers provide the premiums that fund patient care as well as managed care plans' executive compensation and profits. Earlier versions of the managed care experiment considered during the 2011 legislative session incorporated the use of an MLR.

Although problematic in many other ways, the Senate bill[3] called for an MLR standard of 90 percent (i.e., each Medicaid managed care plan would have been required to spend at least 90 percent of Medicaid payments received on "medical services and direct care management."[4]) Equivalently, plans would have been permitted to retain up to 10 percent of premiums received for administrative spending, marketing costs, and profit.

That standard included an adjustment, however, that would have allowed a plan reporting an MLR between 87 and 90 percent to retain half of the up to 3 percent extra that would have otherwise been due back to the state.[5,6] Therefore, from a plan's perspective, the amount of Medicaid funding available for uses such as executive compensation and returns distributed to investors is maximized by spending 87 percent of premiums on patient care because, under that scenario, the plan would retain its first 10 percent as well as half of the next 3 percent. As a result, the true MLR standard proposed under the Senate version was 87 percent.

The Achieved Savings Rebate

Leaders ultimately rejected the MLR in favor of the different but related "achieved savings rebate[7]" (ASR). The ASR has been described informally as a form of profit-sharing. Under the form of ASR ultimately passed by the full legislature, plans are initially permitted to retain up to 7 percent[8] of *total*

plan revenue (which includes not only premiums but other sources of Medicaid-related revenue as well[9]) as profit.

Under the ASR, allowable profit is calculated as total revenues less total eligible expenditures. Eligible expenditures, for example, include administrative costs up to a certain percentage of revenue that is to be determined by state-contracted actuaries who are heavily insulated from public scrutiny and accountability. Then, if plan administrative spending exceeds that percentage, any profit the plan expected to claim would be reduced by that excess amount.

A key purpose of the MLR is direct reporting of the percentage of taxpayers' investment in Medicaid that is spent on direct patient care, which is the reason the investment was made in the first place. Using the ASR allows plans to evade reporting their patient care spending.

In addition, the definition of the approved ASR includes an adjustment similar to the one proposed for the MLR. For every two dollars in profit earned in excess of 7 percent[10] of revenue, one dollar must be returned to the state. In addition, all profits in excess of 10 percent must be returned to the state in full. Thus, a plan maximizes its profit at 10 percent of income, with the plan retaining most of that (8.5 percent of income[11]).

Although it may seem that these limits on profit retention are simply codified in an abundance of caution and that 10 percent annual profit levels are unattainable, there are recent examples of plans reporting even higher rates of return. For example, for the fourth quarter of 2008, Healthease, one of the two plans in Florida Medicaid operated by HMO giant WellCare, reported a $14.3 million return on total revenues of $126.2 million, an 11.3 percent return.[12]

Comparing the MLR and ASR

The MLR and ASR are related mechanisms, and it should be noted that both would serve as an additional accountability mechanism for Medicaid managed care beyond what is in place currently. Moreover, both tools are subject to the same abuses. The ASR is more limited in terms of its usefulness as a tool for ensuring plan accountability, however. For one, a key purpose of the MLR is direct reporting of the percentage of taxpayers' investment in Medicaid that is spent on direct patient care, which is the reason the investment was made in the first place. Using the ASR allows plans to evade reporting their patient care spending as that amount need not be directly reported. More substantially, the percentage spent on administrative costs such as executive compensation would be decided by actuaries behind closed doors rather than by decision-makers who are made accountable to the public via a transparent process.

Beyond these general differences in approach, the more significant concern is the weakness of the standards that will be imposed using this particular version of the ASR rather than the proposed version of the MLR. During the rate-setting process, for example, the target percentage of administrative costs to be built into managed care plan payment rates is likely to be approximately 12 percent of premiums

received.[13] However, the state has certainly permitted considerably higher allocations to administrative costs by individual plans in the past. A conservative estimate, based on a review of recent plan profit-loss reports, is that administrative loads of 15 percent will be permitted.

The table below summarizes and compares several characteristics of the versions of the MLR and ASR under consideration:

MLR vs. ASR (versions considered during the 2011 legislative session)				
Component or Aspect	**Medical Loss Ratio** ***(proposed but not adopted)***	**MLR Scenario: Managed Care Plan - $100M contract**	**Achieved Savings Rebate** ***(included in final legislation***	**ASR Scenario: Managed Care Plan - $100M contract**
Revenues Included in Calculation	Medicaid premium payments to plans only	$100.0M	All Medicaid-related revenue (includes for example, interest earned)	$101.0M
Maximum Retained by Plans for Administrative Costs	A *total* of 13% may be retained for purposes other than direct patient care, such as admin, marketing and profit (plus additional Medicaid-related income)	$13.0M	15%	$15.2M
Maximum Retained by Plans as Profit			8½%	$8.6M
Refunded to State by Plan in Scenario Above	1½%	$1.5M	1½%	$1.5M
Maximum Total Retained by Plan	11½%	$12.5M[14]	22%	$22.2M
Minimum Used for Patient Care	87%	$87.0M	76½%	$77.3M

How Much Using the ASR Will Cost Patients and Taxpayers

We can estimate how much more managed care plans would be permitted to retain as a result of the legislature's decision to use this version of the ASR rather than the proposed MLR. State projections indicate that by 2013-14, when the statewide Medicaid managed care assistance is to be implemented, a bare minimum of $18 billion in total (including federal and state) Medicaid spending will be in categories contracted to plans for the management of their enrollees' care. Additional information regarding the portion of 2013-14 Medicaid spending not assigned to managed care plans can be found in the Appendix.

With the ASR, as seen in the table above, plans would be permitted to retain up to 22 percent of their Medicaid-related income for administration, profit and certain other types of expenditures. Under the proposed MLR, by contrast, plans would have been permitted to divert only 11½ percent of their Medicaid payments from patient care-related activity for their own use.

Using the proposed MLR would have resulted in estimated spending of $15.7 billion on patient care in 2013-14, as compared with $13.7 billion using the ASR, allowing plans access to $2.0 billion in additional revenue.

Medicaid plans historically have little income other than the premiums they receive.[15] Those additional sources historically account for at most 1 to 2 percent of total plan income. Furthermore, earned interest is the only one of these sources that is not tied to direct outlays by plans connected to the provision of care.

All other things being equal, the ASR could therefore better promote accountability, as all sources of income are considered in its calculation. (The ASR would nevertheless remain the less transparent measure.) However, in the case of the approved version of the ASR, all things are not equal, as it allows far more spending on administration and retention of profit than the alternative MLR proposal.

Under the above assumptions, using the proposed MLR would have resulted in estimated spending of $15.7 billion on patient care in 2013-14, as compared with $13.7 billion using the ASR, allowing plans access to $2.0 billion in additional revenue. Put another way, the ASR will have the effect of diverting more than $600 in care per recipient.[16] Furthermore, because some patient groups (recipients with chronic medical conditions, for example) use a disproportionate share of medical resources, using the ASR rather than the MLR will result in the diversion of thousands of dollars worth of care for those patients each year.

Of this $2.0 billion, however, slightly less than $200 million will revert to the state, allowing these plans to ultimately retain $1.8 billion more than they otherwise would have. In effect, $240[17] of the taxes paid by every Florida household would be shifted from essential spending on items such as education and public safety to fund extra subsidies for managed care plans – mostly for-profit HMOs – as a result of the state's use of this version of the ASR instead of the MLR.

Additional Considerations

It should be noted that this $1.8 billion subsidy is what is authorized by the legislation, but the amount of subsidy could be more limited if plans are required to forego some profit in order to provide required levels of care and meet other contract requirements. To the extent that state Medicaid managed care contracts require that plans meet strict performance requirements, and the Agency for Health Care Administration enforces them, it may not be feasible for all plans to claim maximum allowable profit.

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Further, the 87 percent MLR standard proposed by the Senate is similar to but slightly more stringent than the 85 percent standard (with no portion of the remaining 15 percent to be retained by the plan) discussed in the state's negotiations with federal CMS.[18] Assuming the state's and CMS' methods of calculating the MLR are aligned, use of the 85 percent standard would reduce the total amount diverted from patient care in 2013-14 from $2.0 billion to $1.8 billion.

Finally, with the expansion of Medicaid coverage under the Patient Protection and Affordable Care Act (PPACA) in 2014, well over a million Floridians will become Medicaid-eligible for the first time. Although estimates of the cost of Medicaid expansion produced by the Agency for Health Care Administration are grossly inflated, refutation of those estimates is beyond the scope of this report. Taking those estimates (5-year cost: $29.1 billion total, $3.5 billion state share[19]) at face value, Medicaid managed care plans will be able to retain an average of more than $400 million per year in additional taxpayer subsidies simply as a result of the decision to use the ASR instead of the MLR.

Appendix
Supplemental Information Regarding the Estimation of the ASR and MLR

The estimates of ASRs and MLRs are based on the amount of Medicaid funding to be contracted with managed care plans. With almost all patient care proposed for delivery through managed care plans, only three types of Medicaid spending would not be associated with a managed care contract:

1. spending pertaining to recipients who are excluded from enrollment in managed care plans.
2. spending pertaining to recipients who are exempt from mandatory participation in managed care and do not opt to enroll.
3. spending not associated with the care of specific patients which is therefore not included in the calculation of the capitated rates paid to managed care plans.

1. Excluded from Managed Care

The legislation excludes four groups of recipients[20], all of which are small in number:

- **Women eligible only for family planning services** - Through Florida's Medicaid Family Planning Waiver, women who lose Medicaid eligibility can continue to receive family planning services for up to 2 years.[21] Spending under the Family Planning Waiver for 2010-11 was expected to be less than a half-million dollars.[22]

- **Women eligible only for breast and cervical cancer treatment** - Women with incomes below 185 percent of the federal poverty level who are screened through a program operated the Department of Health and diagnosed with breast or cervical cancer can receive Medicaid-funded treatment for their condition.[23] The amount spent on this program is sufficiently small that no separate estimates of program costs are published.

- **Certain undocumented immigrants in need of emergency care** - Undocumented immigrants who meet all other Medicaid eligibility criteria except for their immigration status can only receive care for life-threatening emergencies through Medicaid.[24] In other words, their Medicaid eligibility lasts only for the duration of their life-threatening emergency. Of the almost 3 million Floridians enrolled in the Medicaid program in June 2011, a total of 844 were classified as undocumented immigrants.[25]

- **Children receiving services in a prescribed pediatric extended care center (PPEC) -** PPECs are non-residential health care centers for medically fragile children from birth through age 20 who require continuous therapeutic or skilled nursing supervision. PPECs include an array of services focused on meeting the medical, developmental, physical, nutritional, and social needs of the children who require short, long-term, or intermittent services.[26] There are currently 39 licensed PPECs in Florida, with capacity to serve almost 1,500 medically fragile children.[27] Although PPECs receive Medicaid funding, children served by PPECs receive other Medicaid services not provided through the PPECs.

The total number of recipients in the four excluded categories is very small, totaling no more than a few thousand among the almost 3 million recipients. Furthermore, recipients in the first three categories are eligible for only limited services, and it does not make economic sense for plans to enroll them.

2. Exempt from Managed Care

Exempt recipients may choose to enroll in a managed care plan, but are not required to do so. These include recipients who:

- have another form of coverage, excluding Medicare;
- have been placed in residential juvenile justice or mental health treatment facilities;
- are eligible for refugee assistance;
- reside in a "developmental disability center", namely Sunland Center in Marianna or Tacachale in Gainesville; or
- receive services through the Developmental Disabilities (DD) Waiver or are on the waiting list for such services.[28]

The number of exempt recipients is also small, and although it is not clear how many will be able and willing to participate in Medicaid managed care programs, the spending associated with the exempt recipients will be limited. For example:

According to the Department of Juvenile Justice, only youth residing in "low- or moderate- risk" residential programs that are not directly operated by the state may be Medicaid-eligible.[29] At most 2,500 such youth are in such facilities, and annualized Medicaid expenditures incurred on their behalf total about $4 million.[30]

According to legislative staff, only 622 residents will reside in Development Disabilities facilities, although the cost is a higher $112.5 million.[31]

The largest group of exempt recipients includes individuals with developmental disabilities who receive services through the so-called "DD Waiver" or who are on the waiting list for DD Waiver services.[32] Spending on the Waiver services is expected to total $810 million in 2013-14[33], which will actually dwarf the other care-related spending for these recipients.

3. Non-Recipient-Specific Spending

Expenditures in this category are expected to total $1.5 billion in 2013-14 and consist mainly of hospital-related funding, including the Low Income Pool and components of the federal Disproportionate Share for Hospitals (DSH) program.[34] This spending will begin to decrease beginning in 2014 as a result of PPACA.

This report was researched and written by Greg Mellowe. The report and its findings do not necessarily reflect the views of the FCFEP Board of Directors.

Endnotes

1 CS/HB 7107 and CS/HB 7109 (Chapters 2011-134 and 2011-135, Laws of Florida)
2 See section 1001, Patient Protection and Affordable Care Act
3 CS/CS/CS/SB 1972 (2011)
4 "Direct care management" means "care management activities that involve direct interaction between providers and patients." See Id., section 35
5 See Id., section 40
6 Specifically, for every two Medicaid premium dollars that a plan fails to spend on patient care in excess of the 10% threshold, one dollar must be repaid to the state, until the total of all funds either retained or returned reaches 13%. If the amount not spent on patient care exceeds 13% of Medicaid premiums received, all of the excess amount must be repaid to the state.
7 See section 409.967(3), Florida Statutes
8 The legislation allows plans to retain 5% of income, half of the amount between 5% and 10% of income, and an additional 1% of income for exceeding pre-defined quality standards. Applied in the order specified in

statute, this equates to allowing plans to retain up to 7% of income without being required to return any funds.

[9] Examples of additional sources of Medicaid-related gross revenue include interest income, subrogation and reinsurance recoveries.

[10] Plans that do not meet pre-defined quality standards will lose one dollar of profit for every two dollars in excess of 5% of income. See section 409.967(3)(g), F.S.

[11] The plan may retain up to 7% + ½ of 3% = 8.5%.

[12] Agency for Health Care Administration (AHCA), Medicaid Prepaid Plans: Quarterly Profit and Loss Report, December 2008

[13] Based, e.g., on correspondence from the Florida Association of Health Plans to AHCA, August 2010

[14] Amount includes an additional $1.0M in non-premium revenue not shown elsewhere in the column.

[15] Based on review of AHCA, Medicaid Prepaid Plans: Quarterly Profit and Loss Reports, 2008-2010

[16] Calculated using 2013-14 Medicaid caseload forecast. See Florida Legislature, Office of Economic and Demographic Research (EDR), Social Services Estimating Conference (SSEC), Medicaid Caseloads, July 2011, p.2

[17] Calculated using projection of 2013-14 Florida households. See EDR, Florida Demographic Estimating Conference, Intercensal Population and Household Estimates, July 2011, p.2

[18] Florida Current, *Federal government insists Medicaid overhaul must include medical loss ratios*, August 31, 2011

[19] Derived from AHCA, Overview of Federal Affordable Care Act, August 2011, p.11

[20] Section 409.965, F.S.

[21] Section 409.904(5), Florida Statutes

[22] AHCA, Presentation to House Health and Human Services Committee, 13 January 2011, p.18

[23] Section 409.904(9), F.S.

[24] Section 409.904(4), F.S.

[25] AHCA, Number of Medicaid Eligibles by Age and Assistance Category, May 2011, pp.2,4

[26] AHCA, Special Needs Children in Florida: A Report to the Florida Legislature, February 2003

[27] AHCA, Active Health Care Providers Summary, August 2011

[28] Section 409.972, F.S.

[29] Department of Juvenile Justice, Frequently Asked Questions, August 2011

[30] Estimated costs based on Per Member Per Month (PMPM) spending, using assumptions about the demographic characteristics of residents of DJJ-sponsored facilities

[31] EDR, Social Services Estimating Conference (SSEC), Long-Term Medicaid Forecast, July 2011, p.14

[32] Id., p.20

[33] Id., p.18

[34] Id., pp.2-3