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Problems Cited by State Leaders as Justification for Rejecting Health Expansion Are Either Problems of Their Own Making or Already Addressed

For the past several years, leadership in the Florida House of Representatives has repeatedly rejected the opportunity to extend health coverage to non-elderly, uninsured adults with family incomes up to 138 percent of the Federal Poverty Level through Medicaid or an alternative as provided under the Affordable Care Act (ACA). This would include, for example, a single parent of two children with annual income between $6,930 and $27,720, as well as a single adult with income below $16,240.

In attempting to justify its refusal, Florida House leaders in particular have ignored or selectively interpreted almost every relevant fact pertaining to expansion and its implications for Florida. A review of those facts and implications are beyond the scope of this brief, but they include misrepresentations of the fiscal and economic impacts of expansion, the extent of available federal flexibility to deviate from traditional Medicaid rules, the nature of both the Medicaid program and the expansion population, and the effectiveness of the Medicaid program in providing health coverage, to name a few.

The reality, however, is that not only have leaders misrepresented the fundamental characteristics of Florida's Medicaid program, many of the threats they identify as primary exist as a direct result of or have already been addressed as a result of deliberate choices made by the legislature. Three examples of such choices they made and then proceeded to use in the effort to discredit Medicaid and expansion include: 1) choices that eroded the adequacy of provider reimbursement rates in the Medicaid program, 2) choices that restricted eligibility for the Medicaid program, and 3) choices that required most Medicaid recipients to enroll in health plans administered by privately administered managed care organizations. The fact that these conscious decisions have created or addressed many of the issues cited as impediments to expansion serves to directly discredit opponents' arguments.

1. Choices Made by Florida Leaders Regarding Provider Participation and Reimbursement Rates in Medicaid Have Directly Given Rise to the Very Criticisms They Levy Against It

Low provider participation rates in Medicaid are often cited as purported evidence of a fatal deficiency in the program. To the extent that the effectiveness of Medicaid is hampered by lower provider participation rates, however, this is a direct result of choices made by the Florida Legislature and Governor.

In 2012, Florida's Medicaid reimbursement rates in the aggregate[i] were just 57% of the corresponding Medicare rates, 45th among all states. They were also just 86% of the U.S. average Medicaid rates.[ii] Florida fared even worse with regard to reimbursement rates for primary care, which were less than half (49%) of the corresponding Medicare rates. Only five states had lower primary care rates, and these rates were only 83% of the nationwide average. [iii]

Equally significant, the competitiveness of Florida's low provider reimbursement rates has eroded over time. A decade ago, Florida's aggregate Medicaid rates were significantly higher in comparison with Medicare: 65% overall and 60% for primary care.[iv] Furthermore, these rates were far closer to the national average then (95% and 96%, respectively).[v] Although Florida *did* increase Medicaid provider rates between 2008 and 2012, it did so by only 1.1% in the aggregate, far less than 4.9% national average.[vi] Moreover, 20 states raised their primary care rates during the same period, while Florida's remained unchanged.[vii]

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Inadequate and eroding provider reimbursement rates in the Medicaid program are particularly problematic because they are understood to be inextricably related to low provider participation rates, a criticism continuously levied by opponents of expansion. Among the 24 states for which reliable participation rates could be determined, Florida's ranked 20th, with 59.3% of American Medical Association member physicians serving Medicaid enrollees.[viii] By contrast, a third of these states had corresponding participation rates that were greater than 80%, and even the national average of 66.9%[ix] was significantly higher than Florida's.

The centrality of the Legislature's role in influencing provider participation was confirmed most recently in the findings issued by a federal judge as a result of litigation filed against the state by pediatricians over inadequate rates and their detrimental impact on children enrolled in Florida's Medicaid program.[x] In his December 2014 order, the court found that "Florida's structure for setting physician reimbursement fails to account for statutorily mandated factors in the [federal] Medicaid Act, including the level of compensation needed to assure an adequate supply of physicians so as to…set rates at a level that will promote quality of care or equal access to care as required by [federal law]…Florida's…mandates result in artificially set rates for many services without any consideration of physician incurred costs or what is needed for competitive rates that are sufficient to attract medical providers."[xi]

The severity of this concern was reinforced again this month by the federal Centers for Medicare and Medicaid Services (CMS) in its negotiations with Florida over the extension of Florida's Low Income Pool (LIP). The LIP is the special dispensation negotiated under the federal waiver authority granted to Florida as part of the effort to implement the Legislature's directive Medicaid managed care statewide. The funding provided through the LIP was intended to offset the cost of uncompensated care for the uninsured and underinsured, but the Governor and the House have insisted that the LIP be continued in

full, even as they reject the permanent, comprehensive alternative available through coverage for the Medicaid expansion-eligible population.[xii] In its letter of May 21, CMS expressed its "concern that provider payment rates be sufficient to promote provider participation and access, and to support plans in managing and coordinating care," citing the case and noting that the findings raise questions as to whether or not Florida reimbursement rates comply with federal law.[xiii]

2. Choices Made by Florida Leaders Regarding Medicaid Expansion Have Left Floridians Worse Off Than Their Counterparts in Many States Were *Before* the Affordable Care Act

Long before the Affordable Care Act's (ACA's) expansion of Medicaid became an option for extending coverage to hundreds of thousands of the lowest-income Floridians without other access to quality coverage in January 2014, the Florida Legislature could have followed the lead of other states and covered many of them regardless. Furthermore, these states provided coverage despite receiving the usual federal Medicaid match rate (currently 60 percent in Florida) rather than the federal match rate available under expansion (100 percent through 2016 and never lower than 90 percent) available through the ACA. In essence, Florida is not only among the minority of states that have yet to close the so-called "coverage gap," Florida's gap started out wider than it ever was most other states.

The current Medicaid income limit for parents of children under age 19 in Florida is just 35 percent of the Federal Poverty Level (FPL) ($579 per month for a family of three). Even prior to January 2014, however, when the ACA's Medicaid expansion increased the income limit for most uninsured and non-elderly adults in participating states to 138% FPL, most states (43 in 2012, for example) had Medicaid income limits for jobless parents that were higher than Florida's limit of 20% FPL.

Given that leaders have lamented the purported cost of the expansion of Medicaid or an alternative[xiv], it must be noted that many of those costs are only relevant because the Legislature set and maintained such restrictive eligibility criteria for Medicaid.

Specifically, the current Medicaid income limit for parents of children under age 19 in Florida is just 35 percent of the Federal Poverty Level (FPL) ($579 per month for a family of three).[xv] Even prior to January 2014, however, when the ACA's Medicaid expansion increased the income limit for most uninsured and non-elderly adults in participating states to 138% FPL, most states (43 in 2012, for example) had Medicaid income limits for jobless parents that were higher than Florida's limit of 20% FPL.[xvi] In 15 states, that limit was set at 100% FPL or higher.[xvii] In other words, the coverage gap that the Florida Legislature has so persistently declined to close was already irrelevant in 15 states long before any ACA coverage expansion took effect.

Florida's income limit for working parents was considerably higher than for jobless parents (50% FPL[xviii]), but that limit was higher still in 30 other states, and was at least 100% FPL in 18 of them.[xix] Furthermore, as of 2012, for example, 25 states provided some form of coverage to certain low-income, non-disabled adults without children, including 8 that provided the equivalent of full Medicaid.[xx] (As 2014 approached, some states scaled back eligibility or restricted enrollment where permitted by the ACA in anticipation of transition to a health coverage landscape that included Medicaid expansion and the Marketplace.)

3. Choices Made by Florida Leaders to Shift Medicaid to a Managed Care Environment Run by Private Sector Entities Render Criticisms Regarding Issues Addressed by the Implementation of Statewide Medicaid Managed Care Moot

In their persistent opposition to expansion, leaders have repeatedly referred to Medicaid as a "broken system", citing – albeit inaccurately or misleadingly - spiraling costs, overly restrictive federal requirements and poor health outcomes. Despite the problematic nature of these claims, they are identical to assertions employed throughout the past decade in justifying their push for mandatory enrollment of Medicaid recipients in risk-bearing managed care plans administered by managed care organizations operating in the private sector. Most importantly, their aim was realized as of September 2014, when the state completed the implementation of Statewide Medicaid Managed Care in a form and manner that, by all official accounts, addressed the previously raised concerns.

Statewide Medicaid Managed Care (SMMC), a recasting of the Medicaid Reform experiment, was pushed through the 2011 Florida Legislature by the Republican leadership and signed into law by Governor Scott, both of whom again praised Medicaid managed care as the remedy for the problems they identified in Medicaid.

The push by state leaders for a statewide program of Medicaid managed care in which the financial risk associated with the responsibility for providing/regulating the delivery of care would be transferred to private companies began more than a decade ago. In his 2005 proposal, then-Governor Jeb Bush insisted that skyrocketing Medicaid spending made reform essential, claiming that Medicaid would absorb 59% of the state budget by 2015 if the state were not granted broad relief from traditional federal Medicaid requirements, including the flexibility to establish a system of mandatory enrollment in managed care plans operated by private companies.[xxi] The Governor described his proposal as "put[ting] the focus back on the patient by encouraging strong patient-doctor relationships and allowing competition in the market to drive access and quality of care."[xxii]

By the end of 2005, the federal Centers for Medicare and Medicaid Services (CMS) had approved Governor Bush's request for a five-year, federal Section 1115 Medicaid Demonstration Waiver to implement the Medicaid Reform Pilot Program in two (and later five) counties. Under an 1115 waiver and the broad flexibility it provides, the state and CMS negotiated "Special Terms and Conditions" that supersede the usual Medicaid rules. Perhaps most notably, recipients in the Medicaid Reform experiment were required to enroll in an HMO or related managed care plan that agreed to receive a fixed payment in exchange for bearing the financial risk for providing their enrollees' care. This mandatory enrollment in risk-based, capitated managed care and other unprecedented free market elements were described as essential to reining in "unsustainable" Medicaid costs.[xxiii]

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recipients in all 67 Florida counties to enroll in a private sector HMO or similar plan paid on a capitated (i.e., fixed amount per enrollee per month) basis.[xxiv] Upon passage of the SMMC legislation, then-House Speaker Dean Cannon described Medicaid as a "federal entitlement program run amok that has become the single-largest cost driver in our state's budget," adding that "the transformational [SMMC] legislation will reform our state's broken Medicaid system."[xxv] For his part, Governor Rick Scott offered that "[r]eforming health care for Medicaid recipients (through a waiver)…will lower the cost of health care, increase choice of health plans, and save taxpayers $1.8 billion."[xxvi]

SMMC was implemented across the state during the spring and summer of 2014. Since then, state Medicaid officials have consistently reported to the Legislature and others that the rollout of Statewide Medicaid Managed Care was completed smoothly, and that many of the problems they had identified in the former (fee-for-service) Medicaid system and the Medicaid Reform experiment have been remedied or significantly ameliorated under SMMC. In short, the position of the State Medicaid Director, who reports directly to Governor Scott, is that Medicaid is no longer the "broken system" leaders had insisted it was when they demanded that Medicaid decisions be turned over to managed care plans.[xxvii]

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Yet it is precisely these same managed care plans or their analogs - administered by precisely the same entities based in the private sector (managed care organizations) - that would operate under Medicaid expansion or any alternative ultimately approved by the Legislature.

For a third consecutive legislative session, the Florida Senate has offered a proposal to draw down the 100% federal funding currently available through the Affordable Care Act for Medicaid expansion or an alternative. In 2013 and 2014, the Senate proposed expansion via Healthy Florida, a program that would have built directly onto the structure of the Florida Healthy Kids Corporation, the successful, public-private partnership which, like Statewide Medicaid Managed Care, relies solely on managed care organizations for the delivery of care, albeit in the CHIP program rather than Medicaid.[xxviii]

The Senate's 2015 expansion proposal, which differs from its predecessors, would create the Florida Health Insurance Affordability Exchange program (FHIX). The FHIX would be even more of a free market-driven, private sector-based approach than Statewide Medicaid Managed Care, essentially providing the newly eligible with vouchers that would allow choice from among a range of plans and products offered by insurers and vendors, including some that might not meet ACA requirements.[xxix] If an enrollee did not spend his or her full voucher amount on monthly premiums would funnel the unspent balance to a health savings account. The FHIX proposal is as distinct from traditional Medicaid as a proposal could be while still laying serious claim to the ACA "Medicaid expansion" funding, using the flexibility provided under a federal 1115 waiver and perhaps other waivers and making use of all of the forms of free market flexibility previously sought.

In opposing expansion, the House leadership argues against their own reformed Medicaid system, responsibility for which has been turned over to managed care organizations that ultimately report to shareholders or investors, and which was made possible through the flexibility granted by the federal government in response to their prior demands.

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These and other examples reveal a clear pattern on the part of state leaders opposed to expansion of characterizing the Medicaid program not only as problematic, but as problematic as a result of inflexible federal requirements. Most of these characterizations are inaccurate, or at best highly misleading. To the extent that any have or had merit, however, either they are a product of the state's own deliberate use (or misuse) of federal flexibility, or they were already addressed in response to prior mischaracterizations.

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Endnotes

[i] As encapsulated using a "Medicaid-to-Medicare Fee Index." See Stephen Zuckerman and Dana Goin, "How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees," Urban Institute and Kaiser Commission on Medicaid and the Uninsured, December 2012, p.4

[ii] Id., p.14

[iii] Ibid.

[iv] Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols; Changes in Medicaid Physician Fees, 1998-2003: Implications For Physician Participation; Health Affairs, June 2004, p.6

[v] Ibid.

[vi] Zuckerman and Goin, p.16

[vii] Ibid.

[viii] David Baugh and Shinu Verghese;; Physician Service Use and Participation in Medicaid, 2009; Mathematica Policy Research, October 2012, p.7

[ix] Ibid.

[x] Although the case and the court's findings pertain exclusively to children, the same issues undoubtedly pertain to adults as well.

[xi] *Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics, et al., v. Liz Dudek, et al.*; No. 05-23037 (Southern District of Florida, December 30, 2014)(Findings of Fact and Conclusions of Law); p.144

[xii] See *Rick Scott v. HHS*, No. 15-00193 (Northern District of Florida,. May 7, 2015)(Plaintiffs' Mem. Supp. Prelim. Inj.)

[xiii] Vikki Wachino, CMS; Letter to Justin Senior, Deputy Secretary for Florida Medicaid; May 21, 2015, p.3

[xiv] Legislative forecasters have in fact projected that the net cost to the state of expansion would in fact be negative (i.e., the cost of expansion would be more than fully offset by cost savings in existing programs and services. See Florida Legislature, Bureau of Economic and Demographic Research; LIP, IGTs and SB 2512 (Presentation to Florida Senate, Committee on Appropriations); April 21, 2015; p.15

[xv] Based on the amount shown at Centers for Medicare and Medicaid Services (CMS), State Medicaid and CHIP Income Standards – Household Size of Three, October 2014, adjusted by 5 percent of the Federal Poverty Level (FPL)

[xvi] Martha Heberlein, Tricia Brooks, Jocelyn Guyer, et al, Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012; Kaiser Commission on Medicaid and the Uninsured; January 2012; p.40

[xvii] Id.

[xviii] 50% FPL is well-established to have been the income limit for a family of three at this time, using the now obsolete method of disregarding a portion of earned income. The reported 58% FPL statistic may pertain to the income limit for a 1-person household, which is unrealistic for the working parent scenario.

[xix] Ibid.

[xx] Id., p.42

[xxi] Governor Jeb Bush, Florida Medicaid Modernization Proposal, January 11, 2005

[xxii] Rick Lyman, "Florida Offers a Bold Stroke to Fight Medicaid Cost", New York Times, January 23, 2005

[xxiii] Agency for Health Care Administration, Florida Medicaid Reform: Application for 1115 Medicaid Research and Demonstration Waiver, October 2005, pp.3-7

[xxiv] For example, staff analysis for CS/HB 7107 (2011) states: "All Medicaid recipients shall receive covered services through a managed care program except for populations which receive limited Medicaid services… Medicaid managed care must be provided by an eligible plan. Eligible plans include health insurers, exclusive provider organizations, health maintenance organizations, and provider service networks."

[xxv] Florida House of Representatives, Office of the Speaker; "Medicaid Reform Passes the Legislature" (press release; May 6, 2011.

[xxvi] Rick Scott for Governor, **Rick Scott's Plan to Turn Florida Around**, p. 13, 2010

[xxvii] Elizabeth Dudek, Agency for Health Care Administration: An Overview (presentation to Florida Senate Subcommittee on Health and Human Services Appropriations); January 26, 2015.

[xxviii] For example, staff analysis for CS/SB 1816 (2013) states: "Delivery of services under Healthy Florida is provided for under s. 624.917(5), F.S. The FHKC is directed to contract with authorized insurers licensed under ch. 627, F.S., managed care organizations authorized under ch. 641, F.S., and provider service networks authorized under ss. 409.912(4)(d) and 409.962(13) that are prepaid plans meeting standards established by the FHKC to deliver services to enrollees."

[xxix] For example, see Section 5 of CS/SB 7044 (2015).