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Model of Stability:
Measured Growth in Both the Overall Medicaid Budget and of Managed Care Plan Payment Rates Will Constrain Costs of Medicaid Expansion

General Background:

In the most recent round of debate by the Florida Legislature over whether or not to extend coverage to hundreds of thousands of the lowest-income Floridians though the Medicaid program (or an alternative that meets the requirements of the Affordable Care Act), opponents invoked many familiar and long-debunked arguments. Perhaps the oldest and most often cited of these claims is the assertion that the current Medicaid program is "spiraling out of control" and "swallowing the state budget." These precise claims were invoked again as purportedly central to the House majority's opposition to the Senate's proposed coverage expansion by creating the Florida Health Insurance Affordability Exchange Program (FHIX) during the recent special session.

These assertions about the fiscal burden of Medicaid in the aggregate, in all of their various incarnations, have repeatedly been shown at best to be entirely skewed or devoid of context. As misleading as those claims are, however, the broad and diverse nature of the Medicaid program and its enrollees masks equally compelling additional information about how effectively Medicaid has controlled costs at the individual level. In particular, the shift to a system of capitated (i.e., fixed payment per enrollee), risk-based managed care as deliberately set in motion by Republican legislative leaders through the Statewide Medicaid Managed Care initiative has by their own admission resulted in cost savings.

Although the expected $23.5 billion in total Medicaid projected spending for 2014-15 amounts to 30% of the total state budget, the state's share is far less, at $10.5 billion. More importantly, a significant portion of the state share ($5.4 billion) is generated through other sources, leaving the portion funded through state general revenue at $5.1 billion. In short, only 22% of the current Medicaid budget is appropriated using funds – state general revenue (GR) - that the legislature is directly responsible for making available.

Most importantly in this context, base payment amounts made to managed care plans for the demographic groups that most closely match those who would be newly eligible under some form of coverage expansion have increased very slowly over time. In fact, these rates have increased more slowly than both the general rate of inflation and rate of state general revenue collections.

As a result, and in direct contradiction to critics' portrayals, **Medicaid is a cost-effective coverage safety net for the poorest and sickest Floridians. Further, the program's budget trajectory has been one of**

constrained and sustainable growth, deviating only from that trajectory to any significant degree due to income and coverage losses resulting from the recession**. Extending Medicaid or alternative coverage to the newly eligible** – namely, non-elderly adults with family incomes at or below 138 percent of the Federal Poverty Level who cannot qualify for Medicaid under current rules (for example, a single parent of two children with family incomes between $578 and $2,310 per month[1]) - **would not alter that trajectory or threaten the program's sustainability.**

The Myth of Spiraling Medicaid Costs…in the Aggregate

Most discussions about Medicaid spending trends have logically focused on the program as a whole and its relationship to the overall state budget. Critics of the program in particular have been intent on making the case that Medicaid is absorbing an unsustainably large and rapidly increasing share of the state budget. The aim, as described in detail in a number of previous briefs, has been to make Medicaid the scapegoat for a host of purported problems in an effort to justify finance- and tax-related policy decisions and priorities that make any significant state spending on Medicaid and other safety net programs a hindrance.

First, Medicaid is often characterized by critics in such a way as to make its impact on the state budget appear as onerous as possible. For example, they consistently present Medicaid spending in terms of the percentage that total spending absorbs of the overall budget. However, for each dollar in the Medicaid budget, the state must only furnish approximately 40 cents, with the federal government automatically providing the other 60.[2]

Thus, although the $23.5 billion in total expected Medicaid spending for 2014-15 amounts to 30% of the total state budget, the state's share of that amount is far less, at $10.5 billion.[3,4] More importantly, a significant portion of the state share ($5.4 billion) is generated through other sources (e.g., local governments, provider assessments, recipient cost-sharing), leaving the portion funded through state general revenue at $5.1 billion.[5] In short, only 22% of the most recent Medicaid budget is appropriated using funds – state general revenue (GR) - that the legislature is directly responsible for making available.

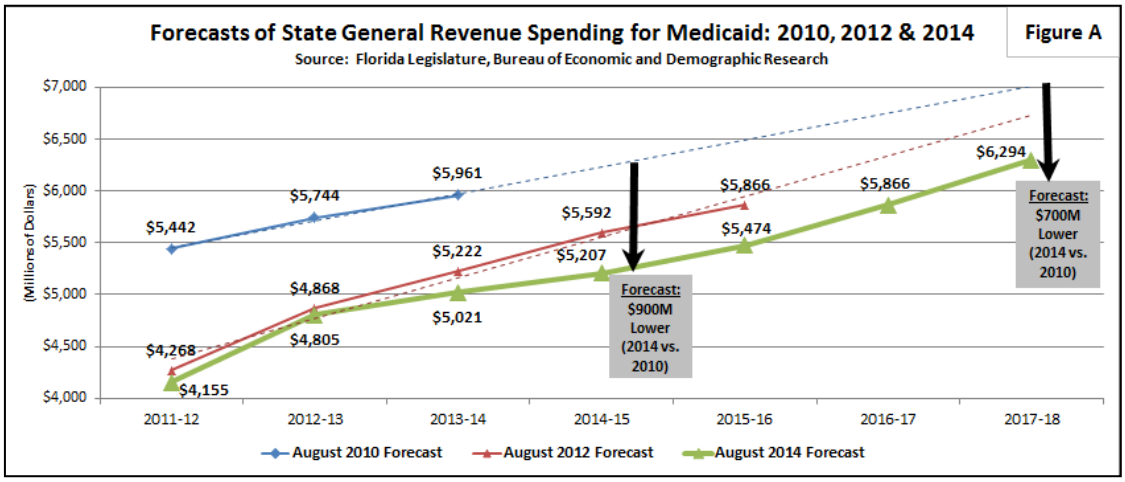
The only reasonable frame of reference for evaluating the extent to which Medicaid spending impacts the state must therefore be in terms of state GR, and such a comparison reveals a picture much different than the one painted by critics. Specifically:

- The amount of state GR absorbed by the Medicaid program has increased by an average of 2.5% per year over the past seven years, more slowly than the general rate of inflation.[6]

- The percentage of available state GR absorbed by Medicaid has not significantly increased since the start of the recession, remaining steady at about 19%.[7] This stability persisted in spite of significant enrollment increases, first from income and coverage losses in the recession and later, to a lesser extent, from the so-called "welcome mat" effect accompanying open enrollment in the federal Health Insurance Marketplace.

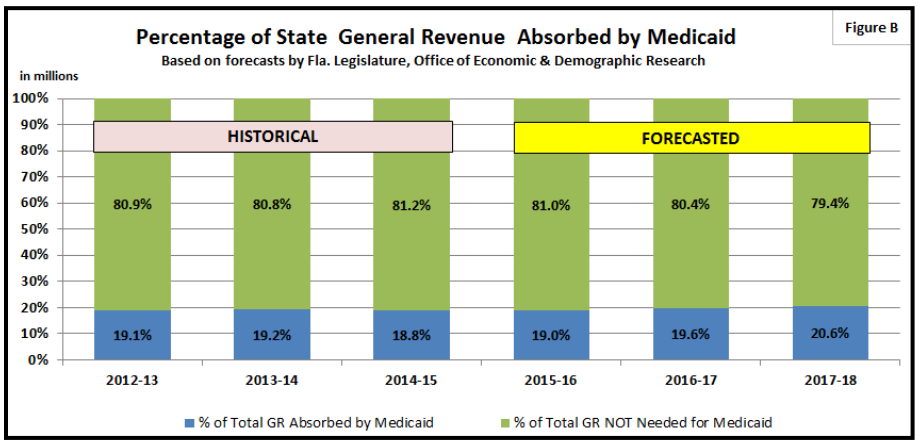
- Official state forecasts of the amount of state GR that would be absorbed by Medicaid have been far higher than the actual amounts ultimately spent. Forecasters most recently projected that Florida would spend $1.3 billion less over the five-year period ending June 2016 than it expected to spend during that period just two years earlier.[8]

- State forecasts of the amount of GR that would be spent on Medicaid in the future have consistently fallen over time. For example, for every five GR dollars that the state's 2010 forecast expected would be spent on Medicaid during the following three fiscal years (July 2011 – June 2014), it only spent four.[9] See Figure A.



- Forecasts have repeatedly pushed back the year in which the percentage of total GR collections absorbed by Medicaid was expected to increase to just 20 percent. For four consecutive years (2010 through 2013), forecasters projected that the 20 percent threshold would be reached within the next one or two fiscal years. In each case, however, that threshold was never reached. In the 2014 forecast, the date was pushed back yet again - this time by *four* years - to 2017-18.[10] See Figure B below.

- A full coverage expansion via traditional managed care would absorb a very small amount and percentage of additional state GR. Specifically, the most recent official forecasts are that expansion would require $867 million in GR spending over the next five years.[11] That amount is just one-half of a percent of total projected GR collections over that period, and would constitute an increase in projected GR spending for Medicaid of less than three percent.[12]



This is not remotely the full story, however. After factoring in the directly offsetting savings associated that would result from providing real coverage to recipients currently receiving very sporadic Medicaid coverage through the Medically Needy program[13], expansion would yield a net state *savings* of $163 million over the next five years.[14]

The Myth of Spiraling Medicaid Costs on a Per Enrollee Basis

The upshot of the above discussion and a review of related indicators of the magnitude of and growth in aggregate Medicaid spending is that Florida's Medicaid program is in fact neither unsustainable nor spiraling out of control. Yet these big picture trends mask an equally important fact about Florida Medicaid: per-recipient spending is stable and well controlled, particularly as relates to the set of recipients that most closely resemble the group who would gain coverage under expansion. This stability is most apparent for those Medicaid recipients enrolled in health maintenance organizations (HMOs), which are paid a fixed amount per enrollee per month (PMPM) to ensure appropriate access to all covered and medically necessary services. With the implementation of Statewide Medicaid Managed Care, the legislature seeks to translate cost predictability from the level of the individual HMO enrollee to the Medicaid system level.

Managed care has been part of Florida Medicaid for more than two decades. However, "managed care" is a general term that refers to a potentially wide range of arrangements in which the payer (in this case, the state) contracts with an intermediary charged with facilitating or regulating access to services by enrollees. Although improved health outcomes remain a central stated aim of managed care, the primary emphasis, particularly in the Florida experience, has been on achieving spending predictability and containing costs. The intermediaries most clearly suited to realize those aims are the aforementioned Medicaid HMOs[15], corporate entities with a financial incentive to regulate or restrict access to care, particularly for the vast majority that ultimately report to shareholders or investors. Such efforts can take a variety of forms, both direct (e.g., "utilization review" used to deny requests for services) and indirect (e.g., "narrow" or even inadequate provider networks), any of which can be used to justify delays or denials of necessary care.

Proposed rate increases in private health insurance are considered potentially unreasonable only if they exceed 10 percent under the Affordable Care Act. Annual rate increases of 10 percent or more in private insurance were commonplace prior to the ACA and are not unheard of today. Yet for only one subgroup of enrollees did rate increases average more than 2 percent over the course of the entire period.

Medicaid HMOs function most effectively as a cost controlling mechanism when a maximum number of Medicaid recipients are required to enroll (rather than remain in some form of fee-for-service arrangement) and when these plans assume a maximum amount of financial risk for the care their enrollees receive. This is precisely the aim of Florida's Statewide Medicaid Managed Care (SMMC) initiative, first formulated under then-governor Jeb Bush as the Medicaid Reform Pilot Program in 2005, reconstituted as SMMC in 2011, and implemented statewide in 2014 under Governor Rick Scott.[16] Under SMMC, and in particular under its Managed Medical Assistance component, almost all recipients with full Medicaid coverage are now required

to enroll in an HMO or similar plan that assume the financial risk for providing care in exchange for a fixed payment. Base monthly payment amounts (PMPM) are based on factors related to age, gender, region and eligibility category, with adjustments made using a proxy for expected level of service known as risk adjustment.

Prior to the rollout of SMMC, however, HMOs had a prominent presence in Florida Medicaid. Nevertheless, recipients in many eligibility categories were either excluded from or not required to enroll in managed care plans[17], and further, managed care plans were not required to operate like HMOs. Recipients in the children and families-related eligibility group, the group that most closely corresponds to the vast majority of the potentially newly eligible under expansion, were required to participate in some form of managed care. However, a large segment of these recipients were enrolled in the MediPass program, a form of managed care known as primary care case management. MediPass allowed for the coordination of enrollees' care without restricting access to care. From a cost containment perspective then, MediPass more closely resembled traditional fee-for-service Medicaid than capitated Medicaid managed care.

For recipients who were enrolled in Medicaid HMOs, plans received a base PMPM payment for each enrollee based on age, gender, region, and eligibility category. The calculation of these rates was grounded in service utilization among recipients in fee-for-service Medicaid. Historical payments received by HMOs for non-elderly, non-disabled adults in three very different regions of the state is summarized in Tables I, II and III, and Figures C, D and E below.[18] Region 3 consists of one mid-sized county and several largely rural counties, while Region 5 includes urban, suburban and rural areas and Region 11 contains the largest urban county in the state.

Table I - PMPM Payments to HMOs Region 3: Alachua and North Central Florida			
Age and Gender Category	**2006-07 PMPM**	**2013-14 PMPM**	**Average Annual % Change**
Ages 14-20 (F)	$ 143	$ 125	-1.7%
Ages 14-20 (M)	$ 76	$ 73	-0.5%
Ages 21-54 (F)	$ 277	$ 280	0.1%
Ages 21-54 (M)	$ 178	$ 153	-2.0%
Ages 55+ (F & M)	$ 374	$ 348	-1.0%

Figure C

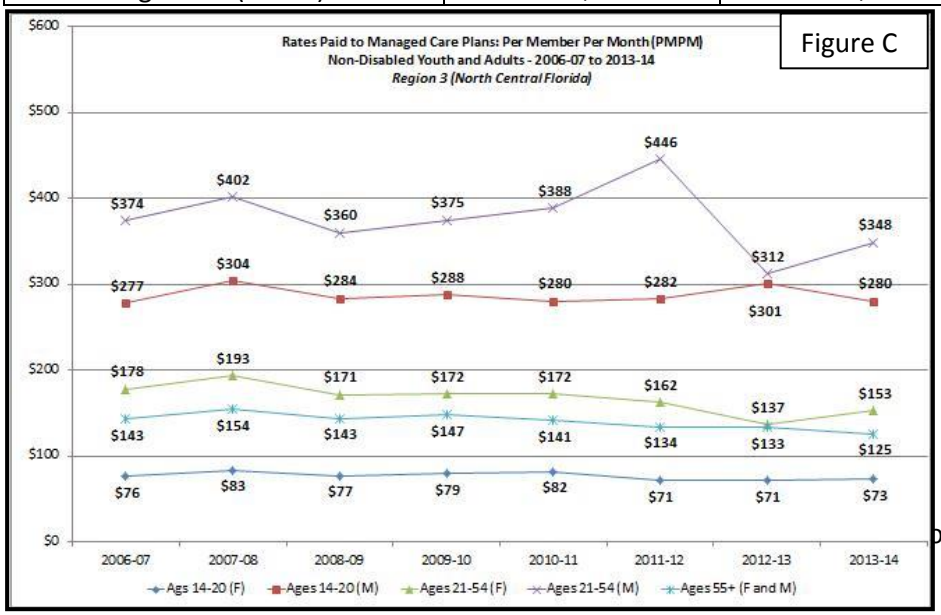


Table II - PMPM Payments to HMOs Region 5: Pinellas and Pasco Counties			
Age and Gender Category	**2006-07 PMPM**	**2013-14 PMPM**	**Average Annual % Change**
Ages 14-20 (F)	$ 137	$ 144	0.8%
Ages 14-20 (M)	$ 73	$ 83	2.1%
Ages 21-54 (F)	$ 266	$ 325	3.2%
Ages 21-54 (M)	$ 171	$ 177	0.5%
Ages 55+ (F & M)	$ 360	$ 405	1.8%

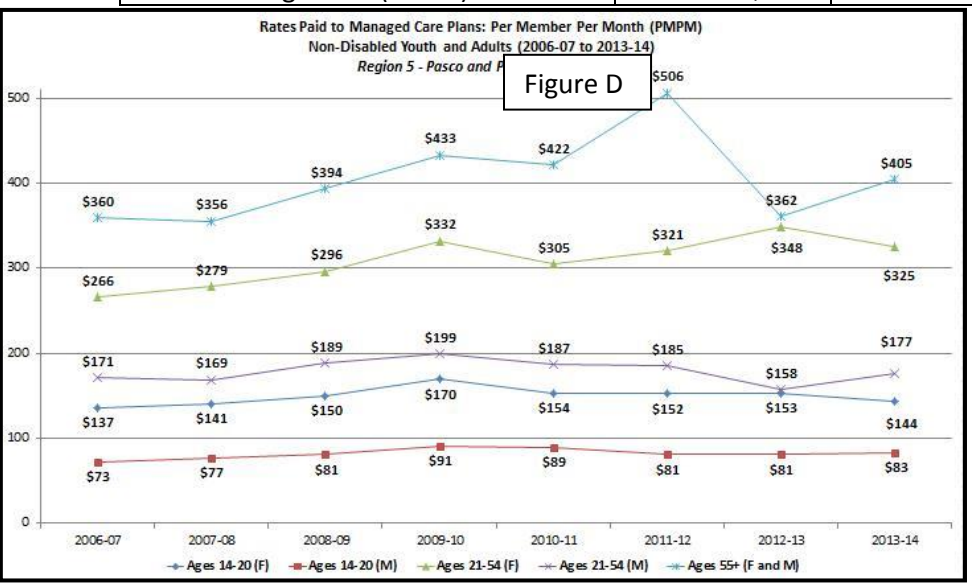
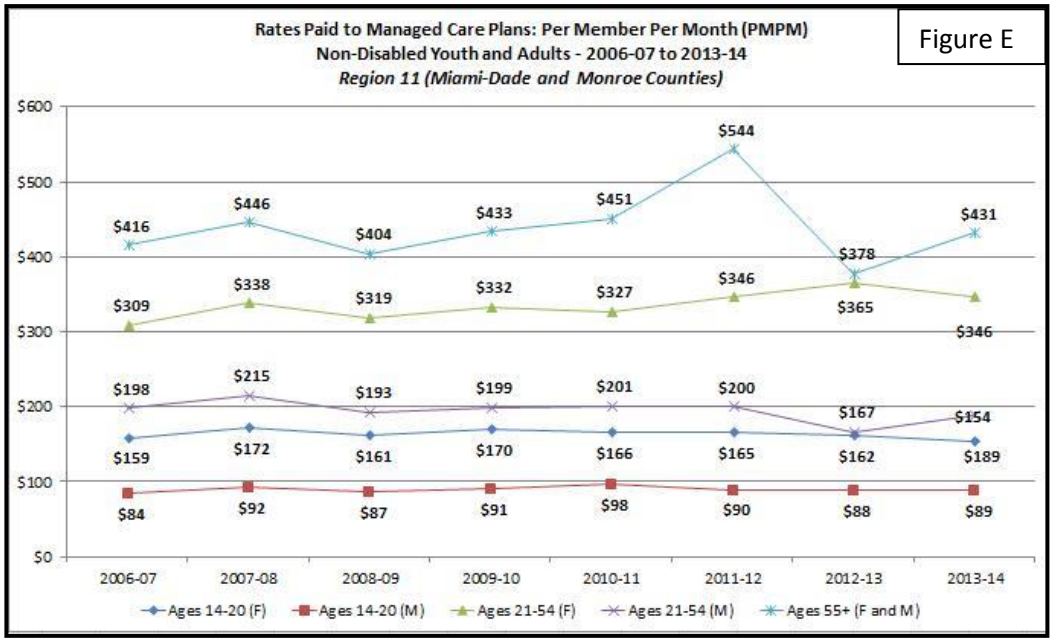


Table III PMPM Payments to HMOs in Region 11 – Miami-Dade and Monroe Counties			
Age and Gender Category	**2006-07 PMPM**	**2013-14 PMPM**	**Average Annual % Change**
Ages 14-20 (F)	$ 159	$ 154	-0.4%
Ages 14-20 (M)	$ 84	$ 89	0.9%
Ages 21-54 (F)	$ 309	$ 346	1.8%
Ages 21-54 (M)	$ 198	$ 189	-0.7%
Ages 55+ (F & M)	$ 416	$ 431	0.5%



Over the seven-year period, base payment rates to HMOs across the demographic subgroups most relevant to the expansion of coverage through Medicaid or an alternative increased at a very slow rate in all these very diverse regions. In fact, in Region 3, rates for four of the five demographic subgroups were *lower* in 2013-14 than they were seven full years earlier.

By way of comparison, under the Affordable are Act, proposed rate increases in private health insurance are considered potentially unreasonable only if they exceed 10 percent. Annual rate increases of 10 percent or more in private insurance were commonplace prior to the ACA and remain today. Yet in only one subgroup in one region (women ages 21-54 in Region 5) did rate increases *average* more than *2* percent per year over the course of the entire period. Moreover, given that the Consumer Price Index increased at an average of about 2.2% per year during this period, it is fair to conclude that capitation rates increased more slowly than the general rate of inflation.

Note Regarding the Comparison of SMMC and Pre-SMMC Rates

One additional consideration: the above comparison does not extend to the current year (2014-15), because historical PMPM rates in the three regions are not directly comparable due to the rollout of Statewide Medicaid Managed Care. For one, with the end of the MediPass program, all of these recipients formerly in fee-for-service Medicaid were folded in for rate setting purposes. Furthermore, with far fewer recipients exempted from or permitted to opt out of managed care under SMMC, a different set of recipients may be in the children and families category than previously. Other factors may be at work.

For another, the rate cells themselves are not directly comparable. For 2014-15, rates in the children- and families-related category are blended for the 14-20 and 21-54 age brackets into a single bracket spanning ages 14 to 54. Without the underlying actuarial data, it is not possible to divide the blended rates into their constituent parts, but any reasonable estimate based on what is known about the age distribution and rate disparity of the recipients makes it clear that the PMPM amounts themselves increased significantly over pre-SMMC levels.

Conclusion

As most recipients in the current Medicaid program are required to participate in a system of capitated, risk-based managed care going forward, the already sustainable Medicaid budget can only be expected to further stabilize, barring monumental changes in Florida's economic landscape well beyond the control of policymakers. Indeed, such constancy was the explicit aim of Republican state leaders in seeking and obtaining a federal Medicaid demonstration waiver from federal CMS to require such participation by most recipients under Florida's Statewide Medicaid Managed Care experiment.

Most relevant to the legislative debate over coverage expansion, in addition to the fact that expansion would *reduce* state general revenue spending for Medicaid in the short term, **the primary components of future spending growth for those recipients most similar to the potentially newly eligible appear poised to remain well-constrained over time as well.**

In short, examination of both the bigger and smaller spending pictures make it clear that not only is Medicaid a manageable and sustainable component of the state budget, expansion as called for in the Affordable Care Act would do nothing to alter that reality, while providing tremendous benefits to Florida in the form of real coverage for hundreds of thousands who could not otherwise obtain it.

At the same time, the remarkably moderated growth in the capitation rates paid to managed care plans over time reaffirms longstanding questions about whether plans are inappropriately restricting access to care. However, the persistent lack of publicly available utilization data has to date precluded scrutiny of any such effects.

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Endnotes

1 For a more detailed description of the Floridians who would be newly eligible for coverage under some form of Medicaid expansion or an alternative, see FCFEP, Characteristics of Floridians Newly Eligible for Coverage, June 2015

2 See, e.g., 79 Federal Register 71427

3 2014-15 General Appropriations Act (Chapter 2014-51, Laws of Florida), p.431

4 Florida Legislature, Bureau of Economic and Demographic Research (EDR), Social Services Estimating Conference (SSEC), Medicaid Long-Term Medicaid Forecast, March 2015, p.2

5 Ibid.

6 Derived using EDR Medicaid Long-Term Forecasts from 2010 through 2014

7 Derived using EDR Medicaid Long-Term Forecasts from 2010 through 2014, and EDR, Revenue Estimating Conference, Long-Term Revenue Forecast, Fall 2014

8 Calculated as the difference between amounts taken from EDR Medicaid Long-Term Forecasts of July 2012 and March 2015

9 Based on comparisons between amounts found in the EDR Medicaid Long-Term Forecasts of July 2010 and August 2014

10 Percentages derived using information found in EDR Medicaid Long-Term Forecasts from 2010 through 2014 and Long-Term Revenue Forecast from Fall 2014

11 EDR, Impact Analysis: LIP, IGTs and SB 2512 (Presentation to Florida Senate Appropriations Committee), April 21, 2015, p.15

12 Derived using information taken from various EDR forecasts.

13 Estimates of savings to be achieved through sunset of the Medically Needy program pertain only to those recipients who would access full coverage via coverage expansion (i.e., direct offsets).

14 EDR, Impact Analysis: LIP, IGTs and SB 2512, p.15

15 In this context, Medicaid HMOs include other managed care entities that adapt a similar business model

16 For a more detailed explanation and history of mandatory Medicaid managed care, see FCFEP, Medicaid Managed Care, the Low Income Pool and Medicaid Expansion, May 2015

17 Some recipients continue to be excluded from or eligible for exemption from participation in managed care. However, fewer recipients can be excluded or exempted, and the MediPass program has ended.

18 PMPM rates for capitated managed care plans are set annually by the Agency for Health Care Administration.