In an overheated, politicized debate, straight talk about Florida Medicaid

In the fall of 2006, as Jeb Bush was winding down his term as governor, Florida launched an experimental Medicaid program in Duval and Broward counties. The five-year pilot program replaced traditional Medicaid with a managed-care model, with the goal of improving efficiency and reducing costs.

Now, five years, two governors, one president and a Great Recession later, the Florida Legislature faces the expiration of the pilot program and the challenge of charting the next course for Medicaid — a challenge made more complex by a host of factors:

» The five-year pilot program has yielded little in the way of concrete evidence of either efficiencies or cost reductions. In fact, the pilot has raised significant questions about the ability of its managed care model to effectively meet the needs of beneficiaries, particularly in a turbulent market.

» Nevertheless, the Legislature generally envisions a future where the pilot program’s model is expanded statewide. However, the current administration in Washington D.C. is unlikely to be as accommodating as its predecessor in approving such a request.

» Meanwhile, the number of Floridians enrolled in Medicaid increased by 30 percent between June 2008 and June 2010, as the Great Recession triggered record unemployment and erosion of employer-provided health insurance. Though per-person costs have remained flat, the overall cost of the program has risen, driven by this increased enrollment.

» Federal health reform legislation, passed in 2010, creates a new set of overlays for Florida Medicaid that must be factored into future planning. The law broadens eligibility for Florida Medicaid in a way that is primarily funded with federal dollars. Added state costs are likely to be offset by savings that should result from reduced costs for safety-net providers.

» But anti-Washington sentiment in Tallahassee leaves many Legislators hostile toward health reform and expansion of Medicaid eligibility, concerned about increased state costs and disinterested in increased federal support. And the state’s projections of the cost of health reform are based on some unrealistic assumptions.

In light of this chaotic but critical situation, the Jessie Ball duPont Fund asked researchers at the Health Policy Institute at Georgetown University to examine two key components of the debate:

What can be said about the impact of the Medicaid managed care pilot on beneficiaries in the affected counties? What lessons have been learned during the last five years that should inform public policy decisions in Tallahassee?

What impact will federal health reform have on Florida’s Medicaid program? Are current budget projections realistic or not, and if not, why not?

Their findings:

The lessons from Medicaid Reform:
There is no clear evidence that the managed care pilot programs are saving money, and if they are whether it is through efficiencies or at the expense of needed care. Little data is available to assess whether access to care has improved or worsened under the pilot program.

Children, parents and people with disabilities who rely on Medicaid have experienced enormous disruption as a result of plan turnover in Broward, Duval and surrounding counties. Patients appear to be “voting with their feet” and moving from HMOs to Provider Sponsored Networks.

Special features of the pilot program — enhanced benefit programs designed to stimulate more healthy behaviors, and the opt-out program allowing beneficiaries to take advantage of employer-sponsored insurance — have had negligible impact. Only 21 beneficiaries are currently enrolled in the opt-out program.

The impact of federal health reform:
State estimates on the financial impact of federal health reform are based on unrealistic assumptions and appear overstated. More realistic assumptions suggest costs will be at most 1/6 of state estimates and may, in fact, yield substantial savings for the state.

The researchers’ reports on both of these topics follow.
Florida’s Experience with Medicaid Reform

As Legislators Wrestle to Define Next Generation of Florida Medicaid, Benefits of Reform Effort Are Far From Clear

More than four years into Florida Medicaid’s managed care pilot program, the benefits of what is commonly called “Medicaid reform” remain far from clear.

Meanwhile, the state’s ability to expand and/or alter the pilot is dependent on negotiations with the federal government and those negotiations may be complicated by ideas under consideration by the 2011 Legislature, now in session.

Background

On Sept. 1, 2006 the State of Florida began enrolling Medicaid beneficiaries in Broward and Duval counties into a new managed care pilot program – a controversial and unique approach that gives insurers unprecedented flexibility to determine which benefits adult beneficiaries receive. Because of this level of flexibility and other aspects of the pilot, a Section 1115 Research and Demonstration waiver from the federal government was required. Section 1115 waivers are initially authorized for a period of five years, and Florida’s Section 1115 waiver is scheduled to expire on June 30, 2011.

Despite significant controversy, the initial waiver application was granted in record time by the Bush administration. Subsequent investigations by the U.S. Government Accountability Office found that public participation in the development of the proposal was inadequate, and that the federal Secretary of Health and Human Services likely overstepped his authority in granting certain aspects of the waiver. For these reasons, and because significant federal funding is at stake, it is unlikely that the Obama administration would renew the waiver without some changes.

On June 30, 2010 the State of Florida submitted an application for renewal of the waiver after the 2010 Legislature deadlocked on whether to expand the pilot statewide. Negotiations between the state and the federal Centers for Medicare and Medicaid Services about the terms and conditions of a waiver renewal are ongoing at the time of this publication. A temporary extension is possible while negotiations continue.

Key Findings

» There is no clear evidence that the pilot programs are saving money, and if they are whether it is through efficiencies or at the expense of needed care.

» Little data is available to assess whether access to care has improved or worsened under the pilot program.

» Children, parents and people with disabilities who rely on Medicaid have experienced enormous disruption as a result of plan turnover in Broward, Duval and surrounding counties. Patients appear to be “voting with their feet” and moving from HMOs to Provider Sponsored Networks.

» Certain features of Medicaid reform, such as the opt-out program designed to encourage the use of employer-sponsored insurance and the Enhanced Benefits program designed to encourage healthy behaviors, lack evidence to suggest they are achieving their goals and may be an inefficient use of scarce funds.

The current Legislature also is considering taking the pilot statewide as well as making more extensive changes to the Medicaid program (such as expanding managed care to long-term care and requiring premiums of everyone enrolled in Medicaid regardless of income), many of which would require additional waiver authority from the federal government. New waivers or a significant overhaul of the existing waiver application could slow the process of approval significantly.

What is happening in the affected counties?

Georgetown University’s previous research into the impact of Florida’s Medicaid changes highlighted a number of concerns, including declining provider participation, more restrictive drug formularies, high administrative costs and an absence of clear evidence that the changes were saving money. This report provides a brief update on what has happened in the pilot counties since the final report was issued in October 2008.

Enrollment in the five participating counties (Broward, Duval, Baker, Clay and Nassau) has grown to 275,856 in February 2011, a 40 percent increase over enrollment of 196,860 in August 2008. The growth reflects an overall increase in Medicaid enrollment in Florida and nationwide due to the effects of the recession.
Enrollment in the pilots currently constitutes just less than 10 percent of Florida’s statewide Medicaid enrollment. The single largest group of beneficiaries enrolled in the pilot counties continues to be children.

Beneficiaries may choose to enroll in any available plan, including both capitated managed care plans (HMOs) and provider-sponsored networks (PSNs).

PSNs are networks that are operated by a health care provider or groups of providers. Medicaid reform rules treat PSNs somewhat differently than HMOs. PSNs do not have the flexibility to limit benefits or deviate from the state’s drug formulary in the same way that HMOs do until they go “at-risk.” (Networks operating at-risk are paid on a risk-adjusted, per-enrollee basis, rather than reimbursed for actual services provided. They are “at-risk” because they will lose money if they provide more in services than they are paid.)

The 2008 report found concerns among PSNs about moving to an “at-risk” form of payment as the state planned to do in the fall of 2009. PSNs at that time enrolled a disproportionate number of persons with disabilities who typically have higher medical needs and thus are more expensive. However, today PSNs continue to receive reimbursement from the state for the actual costs of their enrollees after the Legislature extended the deadline to 2011.

High levels of market disruption
Since 2008, there has been significant turnover in participating plans in all counties.

As the charts below show, the vast majority of beneficiaries in Duval County likely have changed plans since 2008. The withdrawal of Wellcare in 2009, which had 55 percent of market share in 2008, was a significant disruption. A new HMO – Sunshine – covers 43 percent of enrollees today. The PSN operated by Shands Jacksonville has picked up significant market share and now enrolls 46 percent of beneficiaries in Duval County.

In Broward County, a similar picture emerges. The withdrawal of Wellcare, Amerigroup, United Healthcare, Vista and Buena Vista means that plans representing two-thirds of the market share in 2008 are no longer participating in Broward today.

Changes on the PSN side suggest that the vast share of Medicaid beneficiaries in Broward as well have been required to change plans at least once over the past few years – leading to possible disruptions in care and lack of continuity in providers.

Movement to PSNs
It appears that beneficiaries have reacted to this significant turmoil in the market by moving in large numbers away from managed care to the PSN options available to them.

As the chart above shows, the percentage of beneficiaries in all reform counties choosing a PSN has increased significantly since 2008 and now stands at 45 percent.

The importance of the PSN option is even more pronounced for people with disabilities, who have greater health care needs. In 2008, 41 percent were enrolled in PSNs and today a slight majority – 51 percent – are enrolled in PSNs.

The question of adequate care and benefit limits
Unfortunately little data is available to assess whether access to care is improving or worsening. Anecdotal evidence suggests that concerns still exist.
Information about the benefits packages that plans are offering provided by the state to the federal government reports that most HMOs are not limiting benefits, although those that are – Sunshine, United Healthcare, and Medica – have substantial market share. These plans have used the flexibility in the waiver to limit durable medical equipment, home health services, physical and respiratory therapies, chiropractor and podiatry services for adults. Plans also have added a few benefits such as a credit for over-the-counter medications. (Children must continue to receive the full Medicaid benefits package in all plans under the terms of the waiver unless they are in the opt-out program.)

Given that there is significant pressure on the Medicaid budget, and that there is no increase in per-person spending on average in Florida’s Medicaid program, concern arises about additional downward pressure on the benefits package, especially if budget pressures continue and the state is permitted to expand the waiver managed care program to new counties.

Enhanced benefits accounts
This component of the waiver was designed to encourage healthy behaviors on the part of Medicaid beneficiaries.

Previous research found a lack of knowledge about the program on the part of beneficiaries and providers contributing to low take-up rates, high administrative costs and scant evidence of impact on behavior.

Today it appears that redemption of the credits awarded to beneficiaries has improved substantially – suggesting that awareness has improved – but little evidence that behavior has changed as a result of the program.

Most credits continue to be awarded for keeping well-child and other doctor’s appointments; virtually none are being awarded for more complex behavioral changes such as participation in smoking cessation, diabetes management or weight loss programs.\(^{(13)}\)

The “opt out” provision
The “opt out” provision gives beneficiaries the choice of enrolling in employer-sponsored insurance if it is available to them but requires families to pay all applicable coinsurance and cost sharing. Evaluating this component of Florida’s demonstration is important because some legislative proposals advocate an expansion of this approach.

In general, premium assistance programs have had low enrollment nationwide, especially when eligible populations have very low incomes. These groups tend not to have access to employer-sponsored insurance, and if they do, premiums and cost-sharing can be unaffordable. In addition, Florida’s program in particular has had extraordinarily high administrative costs in the past in part because of the low enrollment.

According to the latest data submitted by the state, there are currently 21 persons enrolled in the “opt-out” program – less than .01 percent of current pilot participants.\(^{(14)}\) As a result, per capita administrative costs likely will continue to be extremely high and the program most likely is not cost-effective.

Has the pilot program saved money?
The 2008 report noted that there was insufficient data available to draw conclusions. That still appears to be the case.

The University of Florida, which has a contract with the state to evaluate the waiver, released a study in July 2009 that examined the first two years of the reform pilot. This study concluded that the pilots were saving money, but did not account for the cost of the enhanced benefits program and increased administrative costs associated with the pilot.

The study also concluded that it was not possible to assess whether these savings were a result of reduced access to care or more efficient provision of services.\(^{(15)}\)

No further analysis or data has been forthcoming.

Conclusion
Much critical information is still lacking about the impact of Florida’s Medicaid pilots, including whether or not the pilots have saved money – and if they have whether the savings came at the expense of needed care.

Certain features of the waiver, such as the “opt-out” program being considered for expansion, have not been successful.

Market instability and plan turnover have resulted in significant changes in beneficiary plan assignments over the past three years, which is likely to have caused disruptions in care for children, people with disabilities and other vulnerable populations. Provider sponsored networks which have not yet been capitated have become more popular with beneficiaries.
ENDNOTES


2. It is worth noting that states do not need a federal waiver to enroll the majority of Medicaid beneficiaries in managed care (i.e. children and parents who are eligible as a result of their incomes, adults receiving Supplemental Security Income for a disability) as long as certain consumer protections are observed; Florida’s changes required a waiver because it sought to go further by enrolling additional populations and allowing managed care companies to limit benefits as well as to establish the Low Income Pool and limit children’s benefits in certain circumstances.


4. Many Medicaid beneficiaries can be enrolled in managed care without a waiver as long as they have a choice of plans and other consumer protections. Children receiving disability payments and persons also receiving Medicare are among the exceptions. Premiums for children and other low income persons are expressly prohibited by federal law.


10. Per capita spending from State Health Notes, Kaiser Family Foundation.


Florida’s Experience with Medicaid Reform

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

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

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

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

Florida Medicaid today

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

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

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

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

Growing enrollment, stable per-person costs

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

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

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

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

Who pays the bill?

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

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

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

Key Findings

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

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

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

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

The Jessie Ball duPont Fund commissioned researchers from Georgetown University’s Health Policy Institute to examine the impact of changes to Florida’s Medicaid program on beneficiaries in the affected counties, and to identify issues confronting the state under implementation of the Affordable Care Act.
What will happen in 2014 as a result of health reform?

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

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

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

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

In addition to expanding Medicaid eligibility for low-income persons, the Affordable Care Act allows those with incomes above 133 of the federal poverty level to purchase coverage through new health insurance exchanges. The exchanges, which are scheduled to begin operation in 2014, will subsidize coverage for many people with incomes as high as about 400 percent of poverty or about $89,400 for a family of four. These subsidies will bring even more dollars to the state. Subsidy and Medicaid dollars will add up to an estimated $437 per nonelderly Florida resident – the third highest rate of the 50 states.

How will reforms affect the number of uninsured Floridians?

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

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

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

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

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

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

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

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

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

Under a second scenario that assumes higher participation from those eligible for new coverage, the increase in new state funds needed is $2.5 billion, 3.8 percent over the state’s baseline spending levels.
These cost estimates are significantly lower than those offered by Florida’s Agency for Health Care Administration (AHCA), which has estimated new costs at $4.1 billion for new Medicaid enrollment and related changes over essentially the same time period. AHCA also estimates a $2.0 billion cost for higher payment rates for primary care doctors.

Why are the cost estimates so different?

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

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

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

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

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

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

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

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

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

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

Could increased insurance coverage create offsetting savings?

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

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

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

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

Florida’s Low Income Pool (LIP), a complex structure created under the current Medicaid waiver pilot program, is one way state and local funds are made available to hospitals and certain other safety-net providers that provide high levels of uncompensated care. The LIP and its related programs provide about $2 billion to these providers. The dollars are primarily intergovernmental transfers from local governments matched by federal funds. In the current year only about $25 million in state general revenues are paid into this fund, while about $750 million come from local governments. State and local governments in Florida should see considerable savings if more insurance coverage means less uncompensated care.
Much of this savings will occur at the county and city level. Twelve Florida counties currently operate 16 independent hospital taxing districts with authority to levy taxes. Typically these districts support local hospitals that care for poor and uninsured county residents.

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

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

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

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

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

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

What is the bottom line?

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

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

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

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

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

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

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

In the best case, new benefits would be accomplished with no new state and local spending and even the possibility of as much as $3 billion in savings over six years.
ENDNOTES
5. See Center for Children and Families, Summary of Medicaid, CHIP, and Low-Income Provisions in Health Care Reform (April 2010), for a summary of these and related provisions in the Affordable Care Act.
8. John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, Kaiser Commission on Medicaid and the Uninsured, May 2010.
9. Holahan and Headen project that another 270,000-300,000 will switch to Medicaid from other sources of coverage. See also Matthew Broaddus and January Angeles, “Medicaid Expansion in Health Reform Not Likely to ‘Crowd Out’ Private Insurance, Center on Budget and Policy Priorities, June 22, 2010.
11. Agency for Health Care Administration, “Overview of Federal Affordable Care Act as Provided to the Social Services Estimating Conference,” January 4, 2011. A minor difference is that AHCAs estimate is based on state fiscal years, whereas the Urban Institute uses calendar years.
12. In an effort to improve access to Medicaid services, the ACA requires that physician fees in 2013 and 2014 for certain primary care services be increased to levels paid by Medicare and provides 100 percent federal matching funds to do so. Although the federal requirement ends after 2014, ACA assumes that the state will choose to continue to incur these costs to maintain the increases in future years.
13. ACA assumes a smaller rate (80 percent) for those currently buying individual private insurance and assumes that those not enrolling in Medicaid will retain coverage through their private policies.
21. Florida for Broward and other counties come from two Miami Herald articles: “Need for public hospitals to be a ‘hot topic’ for Gov.-elect Rick Scott” (December 30, 2010) and “Debate heats up about hospitals’ charity” (February 28, 2011).

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