

Florida's Medicaid Reform: Ideology, Rhetoric, and the Needs of Medicaid Beneficiaries

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Florida received approval from the Centers for Medicare & Medicaid Services (“CMS”) late last year to make sweeping changes to the state’s Medicaid system under a Medicaid waiver. In so doing, Florida’s own relation to Medicaid changed: Rather than providing coverage to most Florida Medicaid recipients through state programs, the state will now merely purchase or fund coverage for most recipients via an array of private health plans. This situation may be cause for celebration by those who believe that the government should get out of the business of providing health coverage to the public. However, it remains to be seen whether the new responsibility for selecting a plan and covering increased costs will in fact profit the ostensible beneficiaries of this change – the Medicaid recipients themselves.

Most Florida Medicaid beneficiaries will be required to participate in Florida’s Medicaid program under the waiver (“Medicaid Reform”) although the plan phases certain populations in over time. The first people to participate will be impoverished families and children, as well as aged and disabled adults and children receiving Supplemental Security Income (“SSI”) cash assistance who are new Medicaid applicants.¹ Other populations, such as individuals eligible for both Medicare and Medicaid, institutionalized individuals, foster care children, and others, will be phased in over time.²

Florida’s Medicaid Reform fits neatly with the market-based philosophy and emphasis on choice above all other values that characterize changes made to other benefit programs in recent years. Medicaid Reform requires most beneficiaries to enroll in a privately operated, capitated managed care plan.³ In its application for its section 1115 waiver, Florida touted the flexibility of private plans under its proposal “to develop customized benefit packages that better fit and are more appropriate for Medicaid enrollees” than the “one-size-fits-all” benefit package offered by traditional Medicaid.⁴ Under Medicaid Reform, each beneficiary will be able to choose among a variety of plans, all of which (other than employment-based plans) must be at least actuarially equivalent to the Medicaid benefit package offered in Florida prior to approval of the waiver, but which notably may offer differing benefits.⁵ This will ostensibly allow beneficiaries to choose a plan that will “best meet their needs.”⁶

¹ FLA. AGENCY FOR HEALTHCARE ADMIN., FLORIDA MEDICAID REFORM: APPLICATION FOR 1115 RESEARCH AND DEMONSTRATION WAIVER 7, 9 (2005), *available at* <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGL/> (last visited May 6, 2006). Current beneficiaries in those groups will be enrolled as they reapply for benefits. *Id.* at 9.

² *Id.* at 8.

³ *Id.* at 9, 17-18. Provider service networks may receive fee-for-service payments in lieu of capitation for up to three years following the start date of the program. *Id.* at 34.

⁴ *Id.* at 16.

⁵ *Id.*

⁶ *Id.*

Despite the rhetoric, it is far from certain whether choice of the sort touted by Florida's Medicaid Reform is quite what the state's Medicaid recipients need. On the one hand, it might be beneficial if, for example, a family with Medicaid coverage can choose a plan that offers certain increased prescription drug and wellness benefits in lieu of long-term care coverage. If plans offer benefit packages that genuinely make better sense for certain Medicaid populations than others, and if beneficiaries can take the time and have the diligence to wade through each plan offered in their area to determine which one makes the most sense for them, then perhaps this change will yield a net gain for Florida's Medicaid population. However, painstakingly determining the details of one's health coverage benefits and having the stamina to thoroughly compare them with other potential coverage options are activities that many people have difficulty with, if anecdotes and other evidence are any guide.⁷ The ongoing issues many seniors are experiencing with respect to signing up for Medicare Part D are instructive in this regard.⁸ To expect Florida's Medicaid beneficiaries to do significantly better may be expecting too much.

While choosing between various insurance options, Florida Medicaid beneficiaries will have no health coverage except for emergency services.⁹ After undergoing the Medicaid application process, individuals who have been approved for benefits then have 30 days to decide either to enroll in an established Medicaid managed care plan or to opt out of Medicaid and instead use a fixed sum of money from the state to contribute towards a private, capitated managed care plan or, if one is available to them, an employment-based plan.¹⁰ If they fail to decide among these options within 30 days, the state will automatically assign them to a plan.¹¹ Because of the lack of coverage while making a decision, Medicaid beneficiaries who need services immediately may be prematurely forced into a plan that fails to meet their needs. Additionally, others who are unaware of the coverage gap may unwittingly incur medical expenses during the first 30 days that they must pay for themselves. If coverage were retroactive to the date of approval rather than to the date of plan choice, this problem could be resolved.

Florida's Medicaid Reform institutes certain other features presently common in employment-based health insurance. Under Medicaid Reform, non-employment-based plans may impose limited cost-sharing requirements.¹² If a beneficiary has the option to

⁷ In this regard, many Americans with employment-based health insurance value the role their employers take in choosing their health insurance plans and do not want them to abdicate that role. *See, e.g.*, EMP. BENEFIT RES. INST., HEALTH CONFIDENCE SURVEY, HEALTH INSURANCE: EMPLOYER INVOLVEMENT AND DEFINED CONTRIBUTIONS (Oct. 2001), available at <http://www.ebri.org/pdf/surveys/hcs/2001/dchltfs.pdf> (last visited Jan. 31, 2006); LISA DUCHON ET AL., HENRY J. KAISER FAM. FOUND., LISTENING TO WORKERS 9 (2000).

⁸ For attitudes about the number of drug plans from which to choose under Medicare Part D, *see, e.g.*, Kaiser Fam. Found., *Jan./Feb. 2006 Health Poll Report Survey: Selected Findings on Seniors' View of the Medicare Prescription Drug Benefit* 4–6 (2006), available at <http://www.kff.org/kaiserpolls/upload/7462.pdf> (last visited Mar. 15, 2006).

⁹ FLA. AGENCY FOR HEALTHCARE ADMIN., *supra* note 1, at 16.

¹⁰ *Id.* at 9.

¹¹ *Id.*

¹² *Id.* at 24–25. Children under age 19, pregnant women and institutionalized individuals are exempt from cost-sharing requirements. *Id.* at 25. Additionally, a plan may not impose cost-sharing requirements for emergency services and family planning services and supplies. *Id.*

participate in an employment-based plan and chooses to do so, however, these limits do not apply.¹³

Federal law generally prohibits most cost-sharing in the Medicaid program because most beneficiaries are impoverished and, in fact, must be impoverished in order to qualify for benefits at all.¹⁴ While the cost-sharing permitted under Florida's Medicaid Reform by non-employment-based plans is admittedly minimal (e.g., two dollars for a physician visit), there rarely are any funds to spare in the budget of an individual living below the federal poverty level. Because Florida's Medicaid Reform places no limits on the ability of employment-based plans to impose cost-sharing amounts on Medicaid beneficiaries opting to choose a work-based policy, this option may ultimately prove unsustainable for many beneficiaries.¹⁵ Additionally, because a Medicaid beneficiary is prohibited from changing the chosen plan 90 days after opting into it, some Medicaid recipients may be faced with a Hobson's choice when confronting a need for treatment and a concordant need to pay a high deductible, co-payment, and/or co-insurance amount.¹⁶

There is something to be said for providing one or, at most, a handful of plans that offer the coverage most beneficiaries within a given Medicaid population need, such as that provided under traditional Medicaid or, possibly, as envisioned by a proposal now under consideration in Idaho.¹⁷ Medicaid exists in large part because the individuals served by it fall outside the population traditionally served by employment-based health insurance.¹⁸ Frequently, they fall outside this population not because of any fault of their own, but rather because they are too young to work, or they are elderly or disabled. Often, they are poor candidates for private coverage through the individual market because they are pregnant or have serious health problems. The private market considers such individuals undesirable because they often have significant, predictable, and unavoidable health needs. Hence, traditional Medicaid functions differently from insurance offered on the private market.¹⁹ Attempting to reshape Medicaid coverage so it resembles that offered through the private market, often through employment, is misguided when it seeks to do so not because it better serves the health needs of beneficiaries, but rather for ideological or economic reasons that have little to do with the original goals of the Medicaid program.

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¹³ *Id.* at 33.

¹⁴ 42 U.S.C. § 1396o(a)(2) (West 2006).

¹⁵ FLA. AGENCY FOR HEALTHCARE ADMIN., *supra* note 1, at 33.

¹⁶ *See* FLA. AGENCY FOR HEALTHCARE ADMIN., *supra* note 1, at 32.

¹⁷ *See* H.B. 776, 58th Leg., 2nd Reg. Sess. (Idaho 2006). While I believe some of the stated goals of the Idaho bill miss the point of Medicaid coverage in general, it may make sense to follow Idaho's lead by evaluating the needs of the disparate populations served by Medicaid and tailor the benefits offered to them accordingly.

¹⁸ For more on this subject, *see* Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 12–13 (2001).

¹⁹ *See id.*