

File: Florida Waiver

THE WHITE HOUSE  
WASHINGTON

23 June 1994

MEMORANDUM TO THE PRESIDENT

FROM: Harold Ickes *(Handwritten initials)*

SUBJECT: Florida's application for a section 1115 waiver for its proposed managed competition health insurance plan for 1.1 million low income residents

You are meeting with Governor Lawton Chiles this afternoon. He will press Florida's case to have HHS grant Florida's request for a waiver in connection with its proposed managed competition health insurance plan for some 1.1 million low income residents.

You will be briefed immediately prior to your meeting with Governor Chiles.

Attached is a copy of a memorandum, dated 22 June 1994, to Kevin Thurm, Chief of Staff to Secretary Shalala, from Bruce Vladeck, Administrator of HCFA, outlining the issues.

According to Mr. Vladeck, substantial progress has been made in negotiating an agreement, but a number of problems remain, including the fact that this is not a revenue neutral proposal.

You should listen to the Governor, refer to the progress of the negotiations, but urge that those negotiations must continue. Any signal from you that the waiver might be granted until the Florida - HHS negotiations are successfully concluded would very much undercut HHS at this point, when considerable progress is being made.

cc: Mack McLarty  
Carol Rasco  
Marcia Hale  
John Hart



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

JUN 22 1994

To: Kevin Thurm  
Chief of Staff

From: Bruce Vladeck  
Administrator

Subject: Update on Florida's Section 1115 Waiver Application

**Purpose**

This note provides an up-to-date summary of our discussions with the State of Florida on their proposed 1115 Medicaid waiver.

**Proposal**

The Florida Health Security (FHS) Program, submitted on February 10, uses a managed competition model to provide health insurance for 1.1 million low-income Floridians. The Florida waiver differs from other previously approved State-wide 1115 health care reform waivers in that the Florida Medicaid program, except for coverage of the medically needy, remains intact. FHS is a voluntary program for the non-Medicaid uninsured that allows employers and individuals with incomes below 250 percent of the poverty level to buy modified community rated insurance which is subsidized by the State and Federal government. Particular features include:

- o Any family unit with gross annual income below 250 percent of poverty, irrespective of the value of their assets, will be eligible to apply.
- o Insurance will be provided through Community Health Purchasing Alliances (CHPAs) that currently provide policies for the small employer market.
- o Individuals and firms must be uninsured for 12 months prior to joining the CHPA.
- o Purchase is entirely voluntary both on the part of the individual and employer.
- o Medicaid eligibles, except for the medically needy who will be grandfathered into FHS, are ineligible for FHS and will remain in Medicaid.
- o Licensed agents sell insurance policies through the CHPAs and receive commissions from the Accountable Health Partnerships.
- o The benefit package is the Florida Department of Insurance (DOI) package used in the small employer market. It contains both managed care and indemnity packages, which contain significant cost sharing and fewer benefits than Medicaid.

The Florida legislature has not given final legislative approval to the proposal as the Senate is deadlocked 20-20 along party lines. Governor Chiles has already called one inconclusive special legislative session this summer and plans to call another shortly. Resolution of outstanding issues in the waiver application would presumably give the legislature additional impetus to act.

One unusual feature of FHS has made the evaluation of this waiver application more difficult than usual. FHS would use Medicaid savings to subsidize what the State considers a private sector program. Since our statutory authority is designed "...to assist in promoting the objectives of title XIX...", and FHS is designed for an uninsured low-income population, a major issue is the extent to which FHS must contain Medicaid-type features. The State wants FHS to mirror the small employer market and include many features of that market, including limited benefits and high cost-sharing to guard against inappropriate use and unfavorable risk selection. Nevertheless, Federal Medicaid funds must be used for a program that is consistent with the purposes of Medicaid, provides Medicaid-type protections for enrollees, and does not in effect become a block grant.

While we have managed to reach agreement with the State in several areas in reconciling these apparently conflicting objectives, several of the remaining unresolved issues stem from this conundrum. For example, as a general policy, managed care plans that enroll Medicaid beneficiaries must have no more than 75% Medicare/Medicaid enrollees. If we consider the FHS population to be Medicaid, some current Medicaid managed care plans may no longer meet this test. Approval could also create a precedent for subsequent State waivers.

#### Progress to Date

We are now actively engaged in negotiations with the State on the remaining outstanding issues, and are hopeful that we will ultimately reach agreement on a waiver provided the State is prepared to meet us halfway on some of the remaining issues. We have made substantial progress in supporting the State's policy goals while at the same time assuring access, quality, and financial protections given both our statutory authorities and our goals on health care reform. We have reached agreement on several issues ranging from protecting certain vulnerable populations to the basic methodology for calculating budget neutrality. We continue to meet to establish key final baseline estimates that will guarantee appropriate federal contributions.

#### Major Outstanding Issues

##### 1. Matching of Premiums

Whenever private premiums have been collected on behalf of Medicaid beneficiaries, our longstanding policy prior to the Tennessee

waiver was to provide Federal match on total premiums minus employer and individual payments; that is, we only match State contributions. Florida is requesting that Federal matching payments be based on gross premiums including a combination of employer, employee, and State contribution. This proposal would have the State share diminish as income class increases. For example, at 200% to 250% of the Federal poverty level, an individual and employer would each contribute \$25, the State \$1, and the federal government \$65. The State proposes to cap the number of enrollees at this higher income level.

In the case of the Tennessee waiver, we agreed to match individual premiums on a limited basis. Until recently we took the position in the negotiations that we would not agree to a Tennessee-like solution, because of our concern about reinforcing that precedent. However, we are now discussing an option that would limit federal exposure and assure reasonable matching shares by adjusting Florida's cap on higher income enrollees. It remains to be seen whether the State will accept this approach. One question is whether we should match employer premiums, which might set a new precedent at a time when we have additional pending waiver requests to do so, some of which are far more extensive (e.g. Massachusetts). We are attempting to structure the terms and conditions in a way that will minimize this issue.

## 2. Insurance Brokers

Under FHS, insurance brokers, not alliances as under HSA, market policies to individuals and receive commissions from the AHPs. We believe that this practice may contain incentives for agents to enroll healthy individuals or individuals receiving minimal State subsidies in plans, and to stay away from such populations as the medically needy. The State has indicated that this provision reflected a difficult political compromise with insurance brokers within the State. General Counsel has informed the State that this practice would violate Federal fraud and abuse laws, which bar commissions and kickbacks in Medicaid-related programs. This is still an open issue pending a meeting with the State and the Justice Department to obtain further clarification. Nevertheless, even if such a policy is not technically illegal, we feel it would be damaging to permit Federal matching funds for this purpose. We have informed the State of our position, and they are attempting to accommodate our concerns by ensuring that Federal funds are not used for this purpose.

## 3. Encounter Data

In all State-wide Medicaid waivers, we have required 100 percent encounter data in order to track and evaluate the demonstrations, especially to ensure access and quality for vulnerable populations. For Florida, we would use these data to estimate the impact of FHS on individuals who were insured through the demonstration, and to compare FHS's impact with those of other state-wide demonstrations.

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Florida is opposed to providing 100 percent encounter data for physician services. They argue that such a requirement is extremely burdensome for managed care organizations and would undermine physician support for FHS. The State has offered to provide a one percent sample of physician encounters and says it is amenable to some increase in sample size. However, much of this data is already available, since most physicians, including many in managed care plans, are paid on an encounter basis.

We continue to believe that 100 percent encounter data is essential for several reasons. First, managed care arrangements create incentives for plans to restrict use of services. Second, such incentives are reinforced in the managed care and indemnity plans in FHS due to the high copayments. Third, because we are concerned about the impact of FHS on at-risk individuals located in various geographic areas and treated by different providers, we cannot specify all the samples we might need a priori. For example, it is possible that the underlying structure of FHS may deter appropriate levels of utilization for some groups (e.g., children with asthma living in underserved areas, pregnant women, persons with mental illness). Without 100% encounter data, we cannot evaluate such impacts. We are especially concerned with the civil rights dimension of a project such as Florida's, and we don't believe we can assure adequate compliance with civil rights laws without complete data. We are now attempting to write language for the terms and conditions of the waiver that would give beneficiaries necessary protection but also afford the State the appearance of a victory on this issue. We do not propose to make any substantive concessions on this issue at this time.

#### 4. Premium Rating Bands

As in the small employer market, premiums under FHS are differentiated on the basis of age and sex. This will result in large differentials in premium rates by age (e.g. 5 to 1) and sex (e.g. 3 to 1). Since Federal and State premium subsidies are limited to a fixed percentage of a \$116 benchmark premium, individuals in high premium bands (e.g. males 50-60) will face substantial out-of-pocket premium payments.

The State is willing to work with the Legislature to try to eliminate the rating factor by gender, but is not willing to drop the age factor. They argue that if they eliminate the age factor higher risk individuals will opt in while healthier younger people will not purchase FHS coverage. This will result in an increase in the baseline premium with the concomitant result of fewer individuals and employers buying coverage through FHS. The State is willing to consider narrowing the premium bands based on age over time. We believe that creating a disincentive for higher risk persons to obtain insurance is inconsistent with the principles of health care reform. We recommend a special term and condition that commits the State to a specific narrowing of the premium bands on

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age, starting in the second year, be included as part of the waiver.

#### 5. Copayments and Benefits

The high copayments in the managed care plans (\$100 a day for the first five days of hospital care, \$100 per visit for emergency care, and \$10 per visit for prenatal and postnatal care) and indemnity plans (20 percent coinsurance) could create barriers to care. In a similar vein, benefits under FHS are far more limited than under Medicaid, especially with regard to EPSDT medically necessary follow-up services for children.

These features result from the FHS benefit package being conformed to the DOI small employer market package. The State has indicated that children in families with incomes below the poverty level will receive all necessary services through other State-sponsored programs, while women with infants who have incomes below 185 percent of poverty will be covered by Medicaid. Nevertheless, we still believe that these copayments and benefit limitations are inappropriate in a Medicaid demonstration where at least 60 percent of the enrollees will have incomes below 150% of the poverty level. We are attempting to structure a compromise whereby the State could subsidize some of the more egregious copayment and benefit gaps, especially for the traditionally high priority populations in the Medicaid program, e.g., the lowest-income enrollees, pregnant women, infants, and children.

#### Summary

We have made substantial progress to date. The State is now pushing hard to see draft final terms and conditions. We must proceed cautiously given the fact that any waivers provided to one State are immediately seen by all other states as a precedential minimum, and applications that are either already in house and impending contain very expensive expansions of these precedents. Further, Congressional unhappiness with the waiver process carries the risk of legislative restrictions on our authority under 1115 (if the District Court, in the NACHC lawsuit, doesn't impose such restrictions first). Nevertheless, we are still hopeful that we will be able to construct an agreement that will satisfy both parties.

cc: Ken Apfel  
Judy Feder  
Jerry Klopner  
John Monahan