Florida Medicaid

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Medicaid

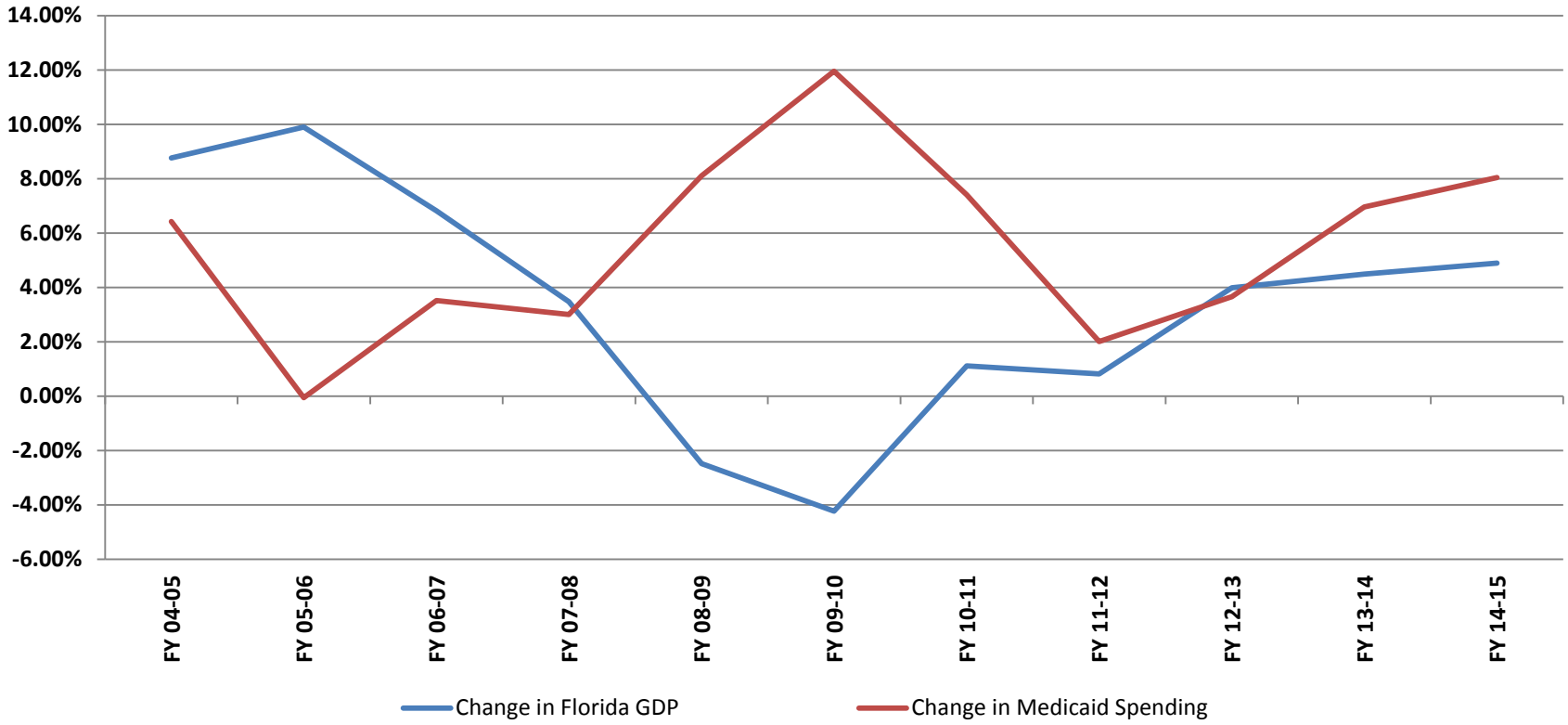
- Federal law requires the coverage of certain eligibility groups and services, and states have the option of covering additional eligibility groups and services.
- State legislatures may change Medicaid eligibility, services, and/or reimbursement at any time, within the federal parameters.
  - Must maintain minimum mandatory eligibility groups and services.
  - Must provide all medically necessary services to children and pregnant women.

Medicaid

- States cannot stop providing services or freeze eligibility based on an expenditure cap.
- For 2015-2016 State Fiscal Year (7/1/15 – 6/30/16) the federal share (FMAP) of Florida Medicaid expenditures is approximately 60.5% and the state share is 39.5%.

Medicaid: Counter-Cyclical Program

Florida Change in GDP Versus Change in Medicaid Spending, 2005-2014



* Source: GDP data are calendar year ending in the shown state fiscal year. Obtained from the U.S. Bureau of Economic Analysis, http://bea.gov/iTable/index_regional.cfm
* Source: Medicaid Expenditures are from the final year end budgets for FY 2013-14 and prior; Medicaid Expenditures are from the March 4, 2015 Medicaid Expenditure SSEC for FY 2014-15

Controlling Medicaid Program Costs

- States have several main ways to control program costs:
  - Reduce reimbursements to providers,
  - Eliminate optional services for adults,
  - Eliminate optional eligibility groups, and/or
  - Implement delivery system reform.
- Florida most recently has implemented delivery system reform through the Statewide Medicaid Managed Care program.

Estimated Medicaid Expenditures: 2016-2017

- Caseload Estimate: 4.2 Million
- August 2015 Estimate: $24.9 Billion Total
- Estimated Budget Need: $762 Million Total
- August 2015 Estimate: $6.4 Billion GR Only
- Estimated Budget Need: $600 Million GR Only

Note: Consensed upon on at August 2015 SSEC.

Estimated Medicaid Expenditures: 2016-2017

- Growth in the overall Medicaid projections between FY 2015-16 and FY 2016-17 is mostly influenced by the relatively high Medicaid caseloads adopted at the July 21, 2015 caseload SSEC.
- The caseloads adopted for FY 2016-17 were 4.24% higher than those adopted for FY 2015-16.
  - Average Monthly Caseload FY 2015-16: 4,002,644
  - Average Monthly Caseload FY 2016-17: 4,172,190
- The Agency estimates that $883.8 million of the total August 2015 SSEC forecast growth between FY 2015-16 and FY 2016-17 is related to the adopted caseload. Of this amount $343 million is the estimated GR impact.

Estimated Medicaid Expenditures 2016-2017: Impact of ACA

- Much of the caseload growth in the 2016-2017 estimate is attributable to the implementation of the Affordable Care Act (ACA):
  - Eligible but not enrolled,
  - Changes in eligibility determination,
  - New income level for children (133% FPL), and
  - Coverage for former foster care (up to age 26).

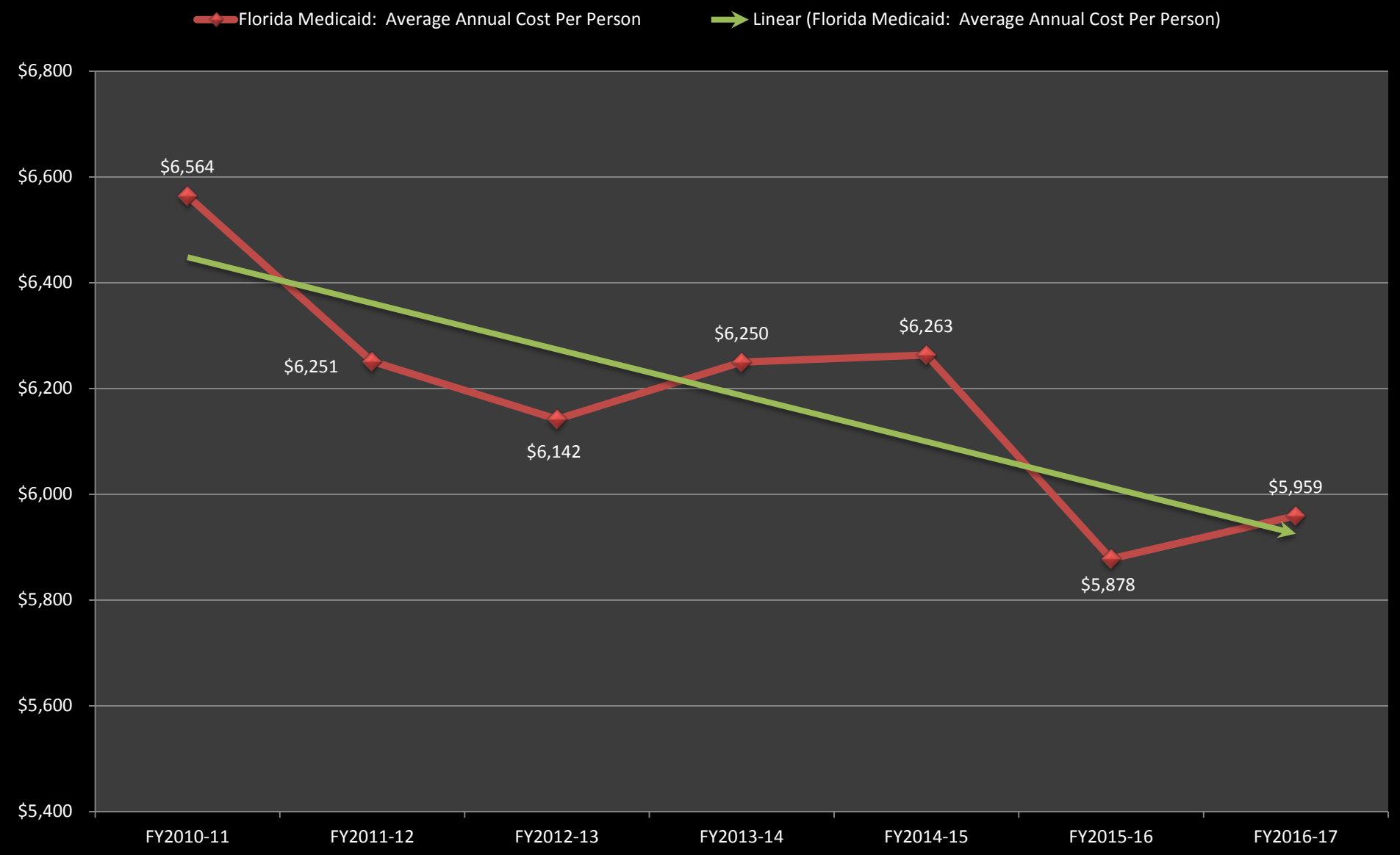
Estimated Medicaid Expenditures: 2016-2017

- In addition to the increased caseload, several other factors are driving the budget need for 2016-17:
  - Projected health care inflationary increases, particularly for pharmacy,
  - Projected health insurance provider fee funding,
  - Projected additional utilization of applied behavioral analysis services, and
  - Projected reduced revenue/collections
    - Tobacco Tax Component of the Health Care Trust Fund and Public Medical Assistance Trust Fund.

Estimated Medicaid Expenditures: 2016-2017

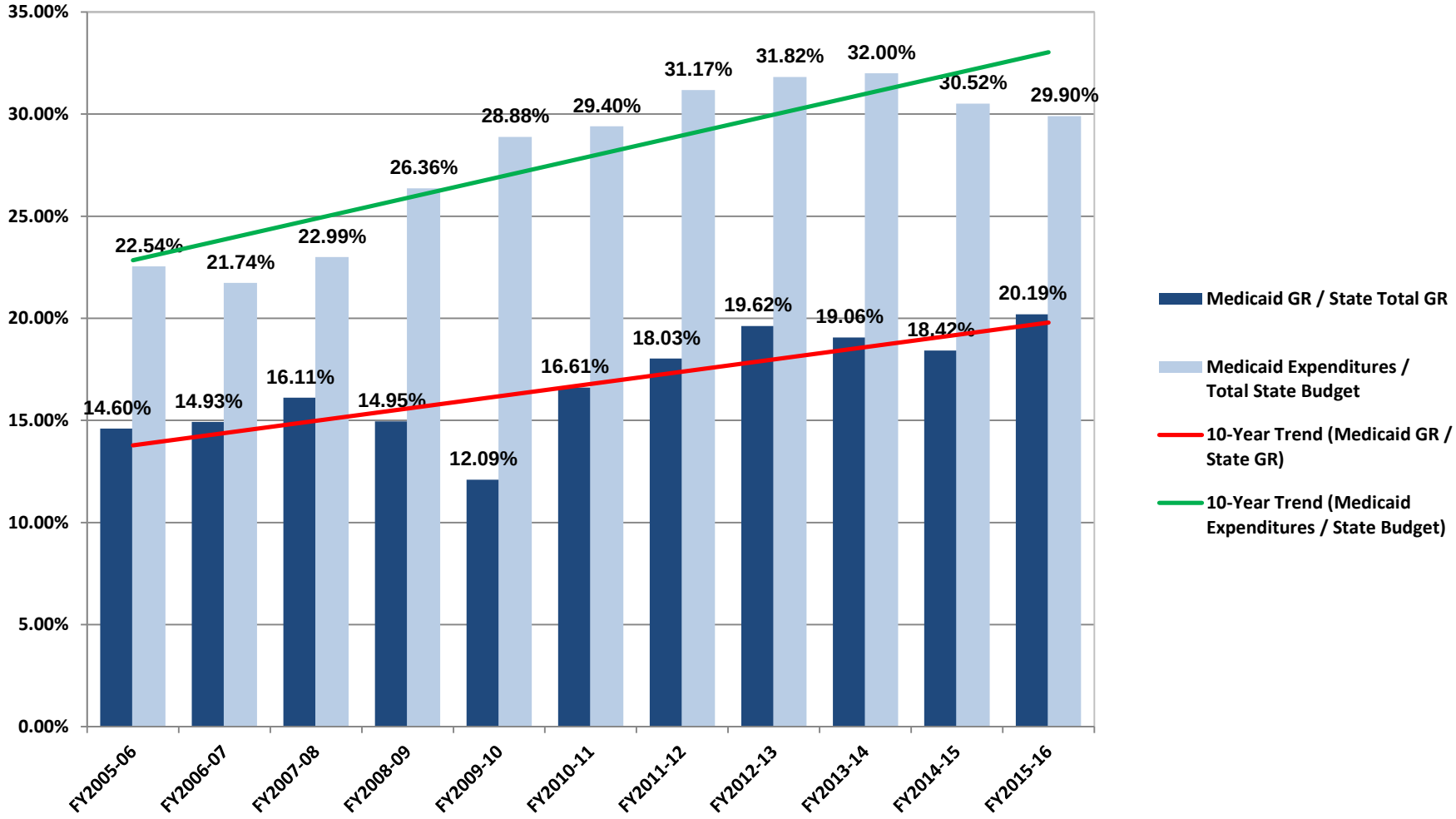
- All other forces, other than caseload, project to increase the total cost of the program by less than 2%.
- In fact, the yearly cost per person (PMPY) of the program has dropped steadily and consistently over the last several years.
- This has occurred while the Medicaid population as a percent of the total Florida population has increased, pushing up the Medicaid Budget as a percent of total state budget.

Florida Medicaid: Average Annual Cost Per Person



FY 2013-14 and prior data is from the final year end budgets.
FY 2014-15 Medicaid Expenditures data are from the March 4, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC
FY 2015-16 Medicaid Expenditures data are from the August 28, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC
FY 2016-17 Medicaid Expenditures data are from the August 28, 2015 Medicaid Expenditure SSEC and Caseload is from July 21, 2015 Medicaid Caseload SSEC

Medicaid Expenditures as a Percentage of Total State Budget, FY 2005-06 through FY2015-16



Florida GR and Florida Budget for FY 1998-99 through FY 2013-14 is from the Final Budget Reports posted on the Florida Fiscal Portal
Medicaid GR and Medicaid Services Expenditures for FY 2005-06 through FY 2013-14 are AHCA reconciled expenditures
Medicaid Expenditures for SFY 14-15 are from the March 4, 2015 Medicaid Expenditure SSEC
Medicaid Expenditures are for SFY 2015-16 are from the August 28, 2015 Medicaid Expenditure SSEC
Florida GR and Florida Budget for FY 2014-15 are the estimated expenditures from the Final Budget Reports posted on the Florida Fiscal Portal
Florida GR and Florida Budget for FY 2015-16 are the appropriations from the Laws of Florida

Statewide Medicaid Managed Care Program

- Most Florida Medicaid recipients are enrolled in one or both of the components of the Statewide Medicaid Managed Care (SMMC) program:
  - Long-term Care program.
  - Managed Medical Assistance program.
- Implemented during 2013 and 2014.
- Designed to incentivize higher quality without causing inflation.

SMMC and Projected 2016-2017 Program Costs

- As of October 1, 2015, there were 3,072,561 people enrolled in the MMA program.
  - 80% of total Medicaid program. Most of the remaining 20% are not eligible for full Medicaid.
- Changes that impact Medicaid as a whole are reflected in the MMA program, and in its rates. For example:
  - Increased pharmacy expenditures:
    - Hepatitis C and Cystic Fibrosis drugs.
  - Shift in hospital funding:
    - Replaced IGT distributions with $400 million GR which includes additional GR for a rate increase.
- These increases are not specifically attributable to managed care, but reflect changes to the health care system or Medicaid program as a whole.

SMMC and Projected 2016-2017 Program Costs

- Managed Care is still only one component of Florida Medicaid program and an increase in capitation rate does not directly correlate to that percent increase in overall program costs.
- Not all program expenditures can be controlled through delivery system changes or cost controls:
  - Medicare part D "Clawback",
  - Supplemental insurance payments (for dual eligibles),
  - Low Income Pool, and
  - Disproportionate Share hospital payments.

SMMC First Year Program Cost

- Statute required that, for the first year of the first contract term, the agency negotiate capitation rates or fee for service payments with each plan in order to guarantee aggregate savings of at least 5 percent.
- The five percent savings was calculated prior to the release of the competitive procurement by projecting forward the current capitated rate and FFS expenditures and reducing the resulting projected rate by 5%.
- Savings were negotiated with the plans during the competitive procurement and secured for year one of the contract.

SMMC First Year Program Costs

- Competitive procurement required.
- "Best value" to the state included negotiated capitation rates for first year of the contract.
  - Detailed Data Book & sample methodology in ITN
  - Bidders submitted cost proposals, methodology, and actuarial certification.
  - Negotiations resulting in a rate schedule of common rates for all awarded standard plans in each region.

SMMC First Year Program Costs

- Rate-related negotiation goals:
  - Actuarially sound.
  - Take advantage of competitive process; listen to industry.
  - Achieve savings target established in statute.
  - Establish common base rates for all selected standard plans in each region.

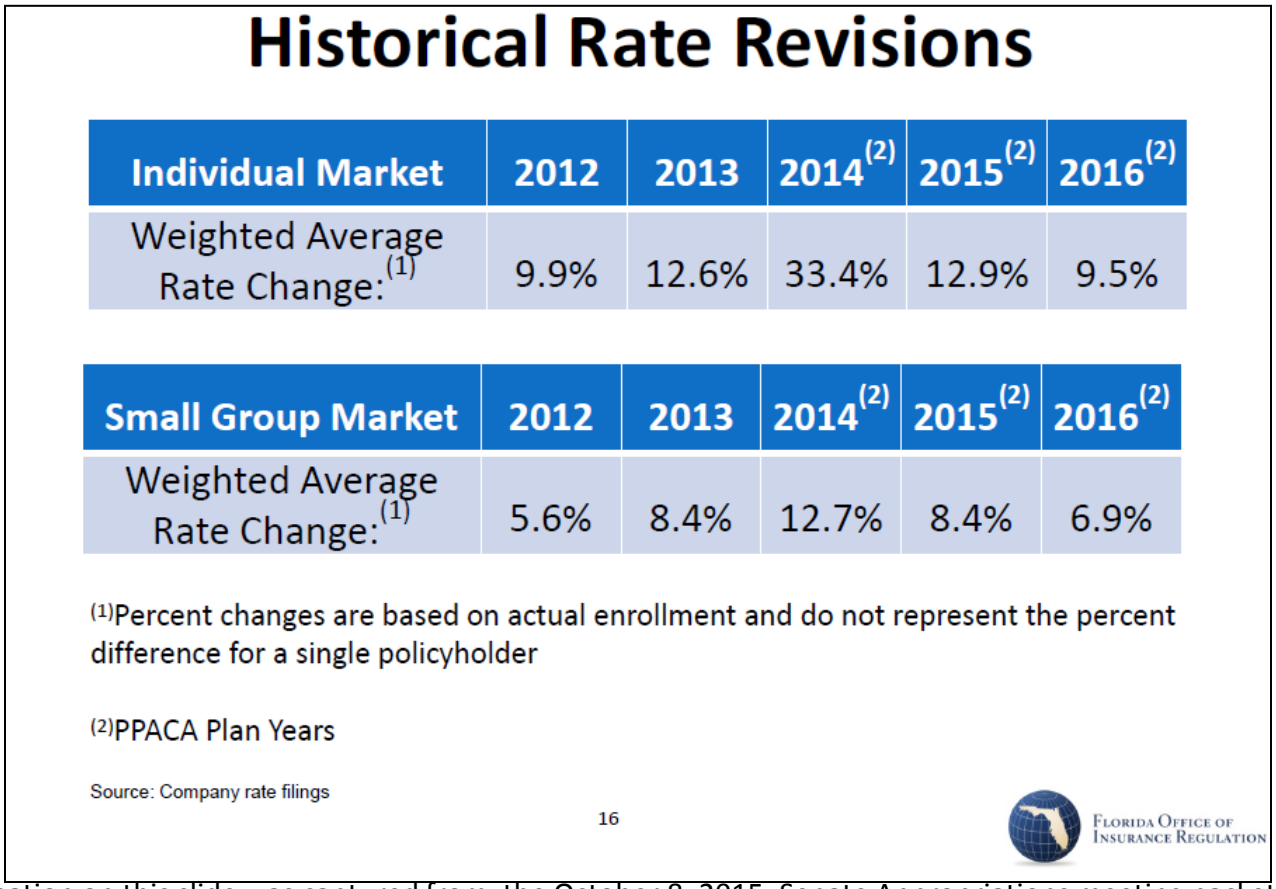
SMMC Projected 2016-2017 Program Costs

- The overall average capitation rate increase for MMA program rates from 2014-2015 to 2015-2016 projects to 7.7%, but the budget impact is actually significantly lower.
  - This was applied for the August 2015 SSEC.
  - Included impact of shift of expenditures from the FFS program to the MMA program:
    - Hospital rate increase.
    - Move from FFS Kick Payment for Hepatitis C drugs to inclusion in the capitated rate.

SMMC Projected 2016-2017 Program Costs

- The overall average rate increase for LTC program rates from 2014-2015 to 2015-2016 was 2.5%
  - This was applied for the August 2015 SSEC.
- Percent of rate change for both MMA and LTC varied by Region and the new capitated rates were effective September 1, 2015.

For Comparison: Private Market Historical Rate Revisions



Historical Rate Revisions

Individual Market	2012	2013	2014[2]	2015[2]	2016[2]
Weighted Average Rate Change:[1]	9.9%	12.6%	33.4%	12.9%	9.5%

Small Group Market	2012	2013	2014[2]	2015[2]	2016[2]
Weighted Average Rate Change:[1]	5.6%	8.4%	12.7%	8.4%	6.9%

[1]Percent changes are based on actual enrollment and do not represent the percent difference for a single policyholder

[2]PPACA Plan Years

Source: Company rate filings

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Florida Office of Insurance Regulation

The information on this slide was captured from the October 8, 2015, Senate Appropriations meeting packet containing a presentation presented by Rich Robleto with the Office of Insurance Regulation.

SMMC Projected 2016-2017 Program Costs

- Unique Plan Experience During Year 1 of MMA:
  - Negotiated Rates,
  - Costs associated with SMMC roll out and transition.
- Assumed vs. Actual hospital contracting rates.
- Failure to anticipate RX trend,
  - Note: AT RISK CONTRACTS.

SMMC Plan Financial Status

- Plans participating in the SMMC program projected a Medical Loss Ratio (MLR) as part of their initial bid.
- The MLRs submitted with the bids were reviewed by our actuaries as part of the rate certification and found to be sound.
- The MLR statewide average bid by plans for the MMA component was roughly 89%.
- The MLR bid by plans for the LTC component was nearer to 95%.

SMMC Plan Financial Status

- Health plans are contractually required to submit financial statements and the Achieved Savings Rebate (ASR) Financial report both quarterly and annually.
  - Quarterly reports are unaudited.
  - Annual reports are audited.

SMMC Plan Financial Status

- ASR Financial reports include reporting of expenditures for the quarter or year that are anticipated but have not yet occurred (ex: claims for services during the period that have not yet been submitted). These are "Incurred But Not Reported" costs or IBNR.
  - IBNR estimates can be restated as additional time passes and claims move out of IBNR estimates and into actual paid claims.
  - For the entire MMA program, the Q1 2015 State Plan MLR decreased from 95.78% on the initial Q1 Reports to 94.38% once Q1 was restated on the Q2 2015 reports.

SMMC Plan Financial Status

- Audited Financial Statements prepared using Statutory Accounting Principles (SAP) are due to the Agency by April 1.
- Audited Annual ASR Financial Reports are due to the Agency by July 1 and include a claims runout period through March 31.
    - In 2014, MLRs reflected by audited reports continued the downward trend seen in the "restated" quarterly reports.

Insolvency Requirements

- Plans are required to maintain a surplus
  - (Assets – Liabilities = Surplus)
- The Agency monitors contractual surplus requirements through quarterly and annual financial statements
- If a plan fails to maintain minimum surplus requirements:
  - the Agency can prohibit marketing activities,
  - freeze enrollment,
  - impose liquidated damages, and/or
  - terminate the contract statewide.

Insolvency Requirements

- Plans are required to open an insolvency protection account and deposit an amount equal to 2% of the annual contract value.
- Requirements apply to both HMOs and PSNs.

Agency Responsibilities for Insolvency/Bankruptcy

- If an HMO regulated by the Office of Insurance Regulation (OIR) is declared insolvent the Agency assists the Division of Rehabilitation and Liquidation, in their capacity as Receiver, per Chapter 631, Florida Statutes, with:
  - Transfer of funds in the health plan's insolvency protection account for satisfying outstanding obligations
  - Review of the legitimacy of health care-related claims
  - Health care-related reporting that may be required of the insolvent entity

Agency Responsibilities for Insolvency/Bankruptcy

- PSNs are not regulated by Florida Office of Insurance Regulation. The Agency serves as the lead Agency in overseeing the insolvency.
- In all cases, the Agency will work with the insolvent plan to ensure a smooth exit from the SMMC program. This includes ensuring recipients are notified of their options for future plan enrollment and continuity of care provisions are in place before transition.

Questions?