



Medicaid Reform: Few Beneficiaries Have Participated in the Opt-Out Program

at a glance

The Medicaid opt-out program is a component of Florida's Medicaid Reform initiative administered by the Agency for Health Care Administration. The program allows eligible beneficiaries to participate in their employer-sponsored health insurance plan as an alternative to enrolling in a Medicaid Reform plan. Beneficiaries choosing this alternative use their Medicaid premiums to purchase individual or family health insurance.

To date, the opt-out program has not been widely used. As of the end of March 2008, only 19 beneficiaries were enrolled in the opt-out program while a total of 30 beneficiaries had enrolled since September 2006. Eleven beneficiaries had disenrolled because they were no longer eligible for Medicaid or lost access to employer-sponsored insurance.

Medicaid Reform

The 2005 Legislature authorized the Agency for Health Care Administration (AHCA) to reform the state Medicaid program with the intent of improving health outcomes of Medicaid beneficiaries and achieving budget predictability.¹ AHCA obtained a federal waiver and legislative approval to implement a managed care pilot program, which began providing services to Medicaid beneficiaries in Broward and Duval

counties in September 2006. AHCA expanded the pilot to Baker, Clay, and Nassau counties in September 2007.² AHCA will need legislative approval to expand Medicaid Reform beyond these five counties.³

The major premise of Medicaid Reform is to improve health care delivery services by giving managed care health plans flexibility to better meet the specific needs of Medicaid beneficiaries and to promote competition among these plans. Under Medicaid Reform, health plans can develop customized benefits packages for different beneficiary groups. Medicaid Reform is intended to empower beneficiaries by offering them more managed care options and encouraging them to take an active role in their health care. Medicaid Reform beneficiaries receive detailed information on their health plan choices and assistance from specially trained choice counselors to help them select a Reform plan that best fits their needs. Beneficiaries can earn monetary credits for participating in certain healthy behaviors that they can use to purchase health-related products.

¹ Chapter 2005-133, *Laws of Florida*.

² AHCA received approval to implement an 1115 Research and Demonstration Waiver application from the Centers for Medicare and Medicaid Services in October 2005. The Legislature approved implementation of the waiver in December 2005 (Chapter 2005-358, *Laws of Florida*).

³ Chapter 2005-358, *Laws of Florida*, established a goal of statewide implementation by June 2011 in accordance with waiver requirements but requires AHCA to obtain legislative approval to expand implementation beyond the pilot sites.

Participation in Medicaid Reform in the pilot counties is mandatory for certain low income children and families and aged and disabled beneficiaries. These include families who have incomes at or below 23% of the federal poverty level, children who live in families that earn up to 200% of the federal poverty level (depending on the children’s ages), and individuals who are age 65 and older or disabled and receive federal Supplemental Security Income.⁴ Other beneficiaries may choose to participate in Medicaid Reform, including children in foster care, individuals with developmental disabilities, and Medicare beneficiaries who are also eligible for Medicaid (dual eligibles).

As required by Ch. 2005-133, *Laws of Florida*, this is one of a series of reports presenting the results of OPPAGA’s evaluation of the Medicaid Reform managed care pilot programs. This report addresses three questions regarding the Medicaid Reform opt-out program.

- What is the opt-out program?
- How do beneficiaries learn about and enroll in the program?
- How many beneficiaries have enrolled in the program?

Questions and Answers —

What is the opt-out program?

The opt-out program is a component of Florida Medicaid Reform intended to give beneficiaries more choice and provide a bridge between public and private health care coverage. The opt-out program allows eligible beneficiaries to participate in employer-sponsored health plans as an alternative to enrolling themselves or their dependents in a Medicaid Reform plan. Eligible beneficiaries can use the money that Medicaid would have paid if they enrolled in a Reform plan to pay their portion of the employer’s health plan

premium.⁵ Beneficiaries with multiple family members who are Medicaid-eligible can pool together Medicaid premiums to pay their share of the premium for a family plan. Beneficiaries can also use their Medicaid premiums to purchase supplemental plans offered by their employers, such as dental and vision plans.

To be eligible for the opt-out program, Medicaid beneficiaries, or their parents or legal guardians, must be employed and eligible for their employers’ health plans. Beneficiaries can also have private health insurance or be COBRA-eligible.⁶ The Medicaid Reform waiver requires that employer-sponsored health plans meet minimum state licensure standards to participate in the opt-out program. Beneficiaries who participate in the opt-out program waive their rights to Medicaid benefits offered under Reform plans.⁷ They must also agree to the terms and conditions of their employers’ health plans, which could include a year-long commitment to the plan; health benefits that differ from Medicaid Reform plans; and additional costs, such as deductibles, co-payments, and co-insurance. Beneficiaries who enroll in the opt-out program can switch to a Reform plan within 90 days, at Medicaid re-determination, during the employer’s health plan enrollment period, at other qualifying events that allow changes to the employer’s health plan, or upon losing eligibility for the plan.⁸

⁵ The amount that Medicaid would have paid is a Medicaid Reform premium rate based on a beneficiary’s age, eligibility category, gender, and county of residence.

⁶ The 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA) provides continuation of group health coverage that otherwise might be terminated. COBRA allows certain former employees, retirees, spouses, former spouses, and dependent children to temporarily continue health coverage at group rates. However, COBRA applies only when group coverage is lost due to certain events, such as leaving a job for reasons other than gross misconduct or a reduction in the number of hours of employment.

⁷ For example, opt-out enrollees forfeit earning enhanced benefit credits of up to \$125 a year for engaging in healthy behaviors. However, according to the Medicaid Reform waiver, opt-out enrollees who previously earned but did not spend their enhanced benefit credits can spend them while enrolled in the opt-out program.

⁸ Medicaid will pay premiums for only one health plan—either an employer-sponsored plan or a Medicaid Reform plan. Therefore, if beneficiaries decide to switch to a Reform plan, they must do so during the employer’s open enrollment period; otherwise they might have to continue paying employee premiums.

⁴ In 2008, 23% of the federal poverty level is \$4,048 per year for a family of three; 100% of the federal poverty level is \$17,600 for a family of three; and 200% of the federal poverty level for a family of three is \$35,200.

Since July 2006, AHCA has contracted with its third-party liability vendor, Health Management Systems, Inc. (HMS), to administer the opt-out program. The contract required that HMS enroll beneficiaries in the opt-out program and process the premium payments to either reimburse beneficiaries or directly pay premiums to employers.⁹ The contract provided HMS a \$5,000 monthly fixed fee to maintain the opt-out accounting system and a \$50 monthly per enrollee fee to process premium payments. The contract stipulated that AHCA pay HMS no more than \$150,000 to operate the program.¹⁰ As shown in Exhibit 1, as of the end of March 2008, AHCA had paid HMS \$110,050 to administer the opt-out program, resulting in an average administrative cost per enrollee of \$3,668.

**Exhibit 1
Through March 2008, AHCA Paid HMS \$110,050 to Administer the Opt-Out Program**

HMS Payments from July 2006 through February 2008	
Monthly fees for accounting system	\$105,000
Monthly processing fees	5,050
Total	\$110,050

Source: AHCA contract expenditure data.

However, in March 2008, AHCA began negotiating a new contract for administering its third-party liability and opt-out programs. The new contract will not include the \$5,000 monthly fee to maintain the opt-out accounting system. In addition, the new contract will pay the vendor a significantly lower monthly per enrollee processing fee. AHCA staff told us that the lower payment level reflects including Medicaid third-party liability recovery services in the contract,

which can be highly profitable for vendors.^{11,12} Although AHCA awarded the new contract to a vendor in May 2008, the award is under challenge. HMS will continue to administer the opt-out program until AHCA settles the challenge and finalizes the new contract.

How do beneficiaries learn about and enroll in the program?

Beneficiaries initially learn about the opt-out program from Medicaid Reform choice counselors who help them to enroll in a Medicaid Reform health plan.¹³ However, choice counselors cannot directly enroll beneficiaries in the opt-out program. Instead, choice counselors refer interested beneficiaries to HMS, the vendor responsible for enrolling qualified beneficiaries and/or their dependents into the opt-out program.

As shown in Exhibit 2, choice counselors describe the opt-out program to employed beneficiaries explaining that health plan benefits and providers, share of costs, and enrollment periods may differ from Medicaid. If beneficiaries are interested in the opt-out program, choice counselors advise them to gather additional information about their employers' health plans, such as the benefits provided and out-of-pocket payments. Choice counselors also give these beneficiaries the HMS toll-free telephone number and tell them that HMS staff will explain more about the opt-out program.

⁹ HMS reimburses beneficiaries or pays health plan carriers or employers directly on a weekly, biweekly, or monthly basis, depending on the premium payment schedule. Beneficiaries submit paycheck stubs to HMS to show proof of premium payment.

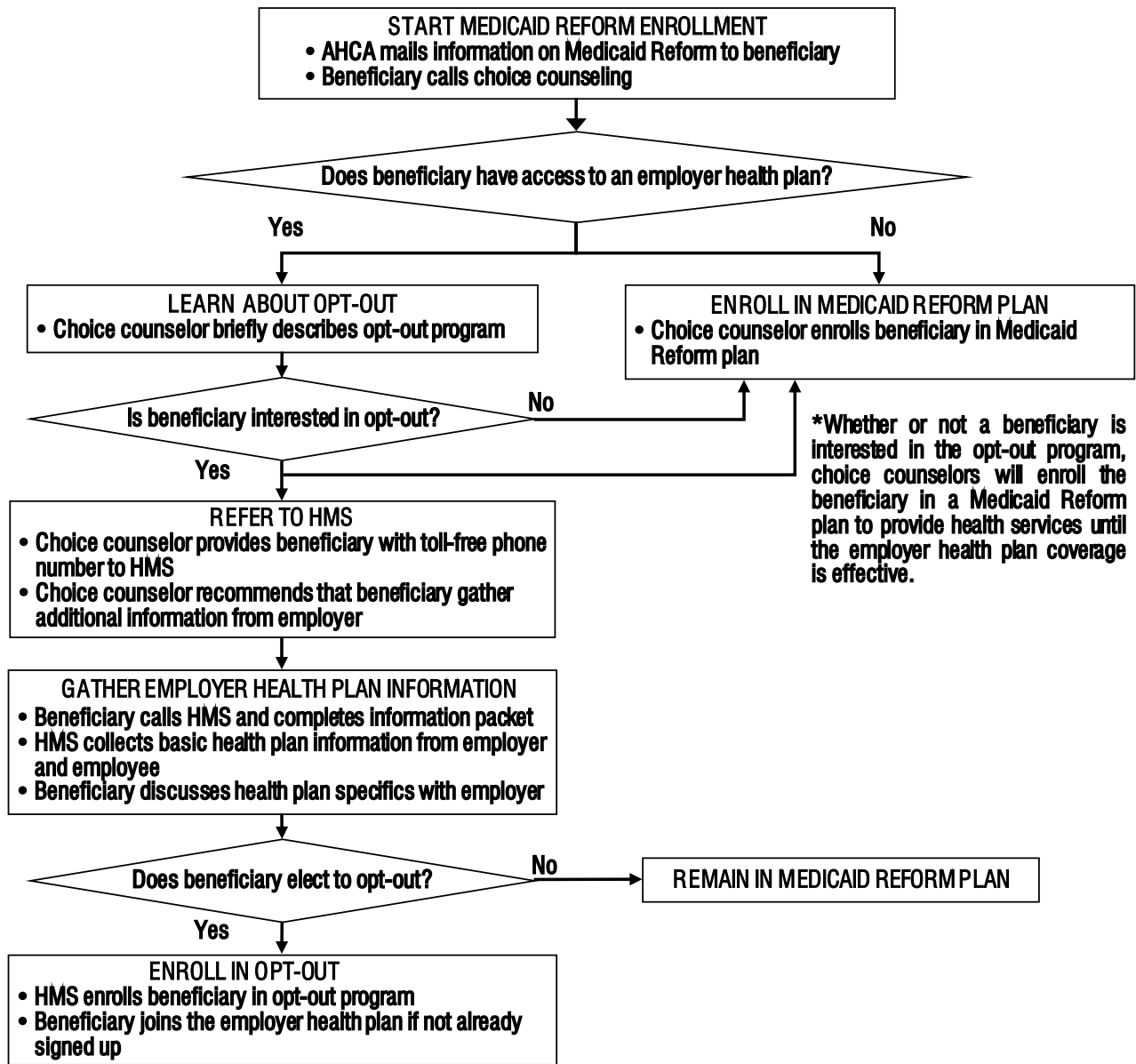
¹⁰ The initial contract period was from July 2006 through December 2007. In August 2007, AHCA amended its contract with HMS, extending it to April 30, 2008; however, it did not increase the contract amount. AHCA granted HMS an extension of up to six additional months, as the new third-party liability/opt-out contract was not awarded before April 30, 2008.

¹¹ AHCA staff indicated that the third-party liability program can produce several million dollars in vendor profits annually. The contract period is for five years from May 1, 2008, through April 30, 2013.

¹² At the time that AHCA contracted with HMS for providing opt-out program services, AHCA could not amend its already-existing third-party liability contract with HMS to include opt-out services. That coupled with no experience by either AHCA or HMS related to the cost of providing these services resulted in contracting for these services at a higher cost than anticipated in the new contract.

¹³ Choice counselors are individuals certified by AHCA to assist beneficiaries in reviewing their Medicaid Reform plan choices, either by phone or at in-person counseling sessions.

Exhibit 2
Some Medicaid Reform Beneficiaries Qualify to Participate in the Opt-Out Program



Source: OPPAGA schematic based on interviews with AHCA and HMS staff and review of opt-out program documents.

HMS staff explain to callers how the opt-out program works and help beneficiaries gather information about their employers’ health plans. HMS staff tell beneficiaries that Medicaid will pay their premiums for individual, family, and supplemental plans up to the amount that Medicaid would pay if they chose a Medicaid Reform plan. HMS staff note that multiple family members who are Medicaid-eligible can pool beneficiary premiums to pay for a family plan.

HMS staff also explain that beneficiaries are responsible for paying any co-payments, deductibles, or services not covered by their employers’ health plans as well as any amount of their employee premiums that exceed the Medicaid premium. Because they are not licensed insurance agents, state law prohibits HMS staff from advising beneficiaries about whether to choose their employers’ health plans or a

Medicaid Reform plan.¹⁴ Thus, beneficiaries are responsible for learning about their employers' health plans' covered services, limits on services, participating providers and facilities, and cost-sharing arrangements and for comparing this information to Medicaid Reform plans. HMS staff encourages beneficiaries to discuss health plan specifics with their employers' human resource managers.

If a beneficiary is interested in enrolling in the opt-out program, HMS mails an enrollment packet to the beneficiary that requests information about the employer and its health plan. The packet also includes a release form that gives HMS permission to contact the employer. Upon receiving the signed release form, HMS contacts the employer to verify the beneficiary's eligibility for the employer's health plan and gathers basic information about the health plan, such as the coverage type (e.g., individual or family), policy type (e.g., major medical and/or catastrophic), open enrollment periods, and employee contribution.¹⁵ HMS staff verify that the employer's health plan is licensed by Florida's Office of Insurance Regulation, enroll the beneficiary into the opt-out program, and arrange with the beneficiary or the employer to pay the employee's portion of the employer-sponsored insurance premium.¹⁶

How many beneficiaries have enrolled in the program?

Beneficiaries have not widely used the opt-out program, with only 30 beneficiaries having enrolled in the program since September 2006. Since that time, HMS has received calls from or on behalf of 91 beneficiaries interested in the opt-out program. Of these, HMS determined that the opt-out program was not an option for 15 callers; 59 callers were determined eligible but chose not to

enroll in the opt-out program.¹⁷ Seventeen calls were from or on behalf of beneficiaries that resulted in HMS enrolling 30 individuals, representing 16 households. Exhibit 3 profiles two of these households. (See Appendix A for details on all households that have enrolled in the opt-out program.)

**Exhibit 3
Profile of Opt-Out Program Participants Demonstrates How Households May Enroll in the Same Health Plan**

One household that participated in the opt-out program included a mother and three children eligible for Medicaid. The mother was already enrolled in her employer-sponsored health plan through her job with a large fast food restaurant chain. In October 2006, she enrolled in the opt-out program and used her Medicaid premium to pay the employee premium for her employer's health plan, which provides major medical, dental, and critical illness benefits. Her children remained enrolled in a Medicaid Reform plan. However, in March 2007, the mother lost her job and left the opt-out program. At that time, AHCA mailed her a Medicaid enrollment package so that she could select a Reform plan.

A second household that participated in the opt-out program included six family members with four children who were Medicaid eligible. All family members were already enrolled in an employer-sponsored health plan through the father's job with a large religious organization, and Medicaid was serving as the secondary payer for the children. In February 2007, the father enrolled the children in the opt-out program to pool the children's Medicaid premiums and pay the employee premium for the family plan sponsored by his employer. The employer's health plan provides major medical insurance for all family members. In December 2007, the family disenrolled from the opt-out program because the children were no longer eligible for Medicaid.

Source: OPPAGA scenarios based on AHCA information.

As of the end of March 2008, 11 beneficiaries had disenrolled from the opt-out program. These beneficiaries were no longer eligible for Medicaid or lost access to employer-sponsored insurance. (See Exhibit 4.) The 19 remaining beneficiaries represent 13 households. All but one of these households are in the children and families eligibility category.

¹⁴ Section 626.8305, F.S.

¹⁵ If the employer health plan's enrollment period precludes the beneficiary from enrolling at this time, HMS will contact the beneficiary during the employer's next open enrollment period to see if the beneficiary is still interested.

¹⁶ Beneficiaries are responsible for signing up to receive benefits through their employers' plans.

¹⁷ Of the 59 callers who were eligible for the program but chose not to participate, one caller cited financial risks as the reason that they chose not to enroll, and three callers stated that they decided they were not interested in the opt-out program. The remaining 55 callers did not provide a response as to why they chose not to participate.

**Exhibit 4
Opt-Out Program Enrollment Remains Low**

Year	Month	New Enrollees	Disenrollments	Net Enrollment
2006	September	0	0	0
	October	1	0	1
	November	0	0	1
	December	0	0	1
2007	January	5	0	6
	February	4	0	10
	March	0	6	4
	April	0	0	4
	May	0	0	4
	June	4	0	8
	July	0	0	8
	August	1	0	9
	September	1	0	10
	October	5	0	15
	November	2	0	17
	December	0	4	13
2008	January	2	0	15
	February	2	0	17
	March	3	1	19
Total		30	11	19

Source: OPPAGA analysis of AHCA data.

Since Reform was first implemented in September 2006, less than 1% of Medicaid Reform beneficiaries have enrolled or even expressed interest in participating in the opt-out program. While a large proportion of Medicaid beneficiaries would not qualify for the program because they lack access to employer-sponsored insurance or cannot afford out-of-pocket expenses, AHCA does not have information about why participation in

the program has been low. Based on data collected at the time that households enroll in Medicaid, approximately 36% of Medicaid households in Broward and Duval counties reported earned income.¹⁸ However, AHCA has not determined if these beneficiaries continue to earn income or have access to affordable employer-sponsored health insurance. AHCA should determine the reasons for low participation in the opt-out program, including determining beneficiary access to employer-sponsored insurance, and identify ways to address barriers in order to increase program enrollment.

Agency Response

In accordance with the provision s. 11.51(5), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Agency for Health Care Administration for his review and response.

The Secretary's written response has been reproduced in Appendix B.

¹⁸This percentage is based on information collected by the Department of Children and Families for beneficiaries that were determined Medicaid eligible during January, February, and March 2008.

OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). Cover photo by Mark Foley.

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Gary R. VanLandingham, Ph.D., OPPAGA Director

Appendix A

Thirty Individuals Representing 16 Households Have Participated in Medicaid Reform's Opt-Out Program

Since enrolling in Medicaid Reform, a total of 30 individuals representing 16 households have participated in the opt-out program. All but one of these households is in the children and families eligibility category. As of the end of March 2008, 11 individuals had disenrolled from the opt-out program because they either lost their job or Medicaid eligibility. Thus, 19 Medicaid beneficiaries representing 13 households were enrolled in the opt-out program at that time.

Table A-1
From September 2006 Through March 2008, 16 Households Participated in the Opt-Out Program

Household	Eligibility Category	Number of Beneficiaries Enrolled (Age of Beneficiaries)	Months Enrolled	Employer Type	Policy Type	Total Premiums Paid ¹	Currently Enrolled?	Reason for Disenrollment
1	Children and Families	1 (23)	October 2006-March 2007	Large Fast Food Chain Restaurant	Single	\$ 764.12	N	Loss of job
2	Children and Families	5 (1, 3, 5, 8, and 12)	January 2007-March 2007	Large Grocery Store Chain	Family	522.31	N	Loss of Medicaid eligibility
3	Children and Families	4 (1, 3, 5, and 7)	February 2007-December 2007	Large Religious Organization	Family	1,987.38	N	Loss of Medicaid eligibility
4	Children and Families	2 (12 and 14)	June 2007-Current ²	Large Pharmaceutical Corporation	Family	368.88	Y	Disenrolled then re-enrolled
5	Children and Families	2 (4 and 8)	June 2007-Current	Large Pharmacy Chain Store	Family	1,466.80	Y	n/a
6	Children and Families	1 (6 mos.)	August 2007-Current	County School Board	Family	1,083.41	Y	n/a
7	Children and Families	1 (12)	September 2007-Current	Small Private Automotive Repair Business	Family	675.53	Y	n/a
8	Children and Families	3 (4, 8, and 13)	October 2007-Current	Large Hospital	Family	1,450.00	Y	n/a
9	Children and Families	2 (6 and 8)	October 2007-Current	County School Board	Family	1,111.94	Y	n/a
10	Children and Families	2 (4 and 7)	November 2007-Current	Large Hospital	Family	356.76	Y	n/a
11	Children and Families	2 (1 and 5)	January 2008-March 2008	Large Insurance Agency	Family	358.45	Y ³	n/a
12	Children and Families	1 (61)	February 2008-Current	Large Medical Technology Company	Family	†	Y	n/a
13	Aged and Disabled	1 (18)	February 2008-Current	Large Private Bank	Family	198.94	Y	n/a
14	Children and Families	1 (1)	March 2008-Current	Large Private Consulting Group	Family	†	Y	
15	Children and Families	1 (6 mos.)	March 2008-Current	Large Private Business	Family	107.56	Y	n/a
16	Children and Families	1 (50)	March 2008-Current	County Health Department	Family	†	Y	n/a
Total Households Enrolled: 16			Total Individuals Enrolled: 30		Total Premiums Paid: \$10,452.00			
Total Households Currently Enrolled: 13			Total Individuals Currently Enrolled: 19					

† To date, AHCA has not provided premium payment information for these families.

¹ Beneficiary premiums reimbursed through March 2008.

² This family initially enrolled in the opt-out program in June 2007, and then disenrolled in December 2007 due to loss of employment. The beneficiary then gained new employment in January 2008, and subsequently reenrolled in the opt-out program. However, to date, HMS has paid premiums only for January 2008. HMS will retroactively reimburse the enrollee for premiums paid while eligible for opt-out so long as the employee provides appropriate documentation.

³ As of March 2008, the younger child had lost Medicaid eligibility, but the older was still Medicaid-eligible and remains enrolled in the program.

Source: OPPAGA analysis of AHCA and HMS enrollee data.

Appendix B



CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

May 30, 2008

Mr. Gary VanLandingham, Director
Office of Program Policy Analysis
and Government Accountability
111 West Madison Street, Suite 312
Tallahassee, FL 32399

RE: Medicaid Reform: Few Beneficiaries Have Participated in the Opt-Out Program

Dear Mr. VanLandingham:

Thank you for the opportunity to review and comment on the Office of Program Policy Analysis and Government Accountability (OPPAGA) draft report entitled "Medicaid Reform: Few Beneficiaries Have Participated in the Opt-Out Program." We appreciate OPPAGA's factual and comprehensive review of the Opt-Out Program and concur with your summary.

Please let us know if you have any questions regarding the Opt-Out component of Medicaid Reform.

Sincerely,

A handwritten signature in black ink, appearing to read "Holly Benson", is written over a light blue circular stamp.

Secretary
Holly Benson

HB/jb

cc: Carlton D. Snipes, Deputy Secretary for Medicaid

