Comparing Medicaid reform pilot benefits from Year 1 to Year 2: Confusion, clarification and a correction

Introduction

The lynch-pin of Florida's experiment with Medicaid reform has been the concept of consumer choice – creating a system that allows consumers to select the coverage plan that best meets their individual health care needs. For this reason, researchers at Georgetown University, throughout their multi-year analysis of Medicaid Reform, have attempted to view and understand reform from the perspective of consumers, and access information in the same manner as consumers.

In April 2008, however, the Georgetown team learned the hard way exactly how confusing the information provided to consumers could be. Charts used to compare the benefits and costs of programs participating in the reform pilot in Year 1, with those participating in Year 2, were inadequately identified, leading to erroneous conclusions about the changes in benefit options and costs between the first two yeas of the pilot.

Document confusion

There are 10 HMO plans participating in Medicaid Reform in Broward County and three in Duval County. Consumers seeking to compare benefits and costs among these providers have three resources:

- Contact a Choice Counselor by telephone for an oral discussion of specific benefit questions. (Some in-persons visits also have been conducted.)
- Consult information on the Choice Counseling web site
- Consult information on the web site of Florida's Agency for Health Care Administration, which oversees the state's Medicaid program.

Georgetown researchers wished to compare data across programs and years. Contacting Choice Counselors was not an option as the counselors will not provide information to anyone without a Medicaid ID. Consequently, in August 2007, the researchers sought data from the two web sites.

Researchers downloaded the benefit comparison chart from the Choice Counseling web site in August 2007 prior to the start of the new benefit year in September 2007. This was used as the basis for Year 1 benefit and cost data.

On the AHCA web site, the researchers found a benefit comparison chart dated July 2007 and labeled "draft." It was different in appearance from charts the researchers had seen before. This chart was used as the basis for Year 2 benefit and cost data.

It was based on these documents that the researchers reported "benefit offerings have become less generous in year two....copayments are rising, and extra services are being reduced," in Medicaid Reform Briefing #4 that was released December 6, 2007.

In April 2008, however, conversations with researchers outside of AHCA led the researchers to realize that their assumptions had been incorrect. In fact, the comparison chart on the Choice Counseling web site in August 2007 reflected Year 2 benefits and costs, though that was not indicated on the document. And the benefit comparison labeled "draft" on the AHCA web site was, in fact, a draft of the Year 2 redesigned comparison chart but with Year 1 data still included. Consequently, the researchers' findings were exactly the opposite of what now appears to be the case.

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How did benefits and costs actually change?

Based on a revised analysis, it appears that most participating HMOs reduced or eliminated most copayments imposed in the first year, while one plan added a copay in a single service category. This is a positive change for beneficiaries who may find even modest copayments a barrier to care.

With respect to benefits, pilot HMOs have some flexibility to change certain Medicaid benefits such as prescription drugs, outpatient therapies and services, and podiatry. HMOs generally loosened or dropped specific existing limits on physical therapy and durable medical equipment, important benefits for people with disabilities (although most plans without limits still display a footnote that "prior authorizations, limits, or exceptions may apply"). Prescription drugs constitute one of the most widely used benefits, and here the changes were mixed. Eight HMO plan offerings raised limits on drugs and six imposed stricter limits. Many of these pharmacy changes occurred in the plans offered by Wellcare, which has the largest market share in each of the original pilot counties. Wellcare's Healthease plan imposed on parents a new limit of nine prescriptions a month where the benefit was previously unlimited, while both Wellcare plans adjusted the limit for people with disabilities from 16 to 17 a month in line with the state's revised sufficiency guidelines.

Plans are able to offer extra services, and over half the reform HMOs made at least some additions to their offerings. The most common improvements were increases in coverage of over-the-counter medications from $10 to $25 per month and, for some plans, the addition of a circumcision benefit.

The bottom line

Georgetown researchers made a significant error in reporting the changes in benefits and costs between Year 1 and Year 2 of Medicaid Reform.

However, information available to consumers online remains inconsistent and potentially confusing. As of May 1, 2008, the AHCA web site carried a July 2007 "Final Draft" of the benefit comparison chart and the Choice Counseling web site posted a benefit choice brochure dated May 2008. There are substantial differences in the two documents.

Copies of this report may be found online at http://www.dupontfund.org/ and at http://www.hpi.georgetown.edu/floridamedicaid> . The report is made possible through the generous support of the Jessie Ball duPont Fund, The Community Foundation in Jacksonville and United Way of Northeast Florida.

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