

# Is Medicaid Reform good for taxpayers?



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# Is Medicaid Reform good for taxpayers?

## Executive Summary

Earlier this year, Florida lawmakers passed legislation (HB 7107 & HB 7109) that would radically alter the way Medicaid services are delivered throughout Florida by pushing over 2 million Floridians into managed care plans.

The current Medicaid reform is directly based on controversial Medicaid experiments that have taken place over the last five years in five pilot counties (Duval, Nassau, Baker, Clay and Broward). However, this new proposal expands the concept greatly by creating a Statewide Medicaid Managed Care system (SMMC) that would take place in all 67 counties. With insufficient new protections being put into place to change the behavior of bad actors, this Medicaid reform plan is a recipe for a massive taxpayer rip-off.

To date, there is no credible research or data indicating that the pilots have been effective at achieving their goals. It is unclear whether they have saved money, and if so, whether that was at the expense of needed care.

For-profit Medicaid managed care plans also have a horrific track record of defrauding the state and denying care in order to increase profits. This report looks critically at that track record while asking why the state is forging ahead to aggressively expand a pilot program that has not been proven to work.

According to Sean J. Hellien the corporate whistleblower that exposed Wellcare's many Medicaid Fraud schemes, the company cheated the state out of \$300 to \$600 million dollars. It is clear that the HMO illegally pocketed well over \$100 million in taxpayer dollars but the full extent of WellCare's fraud has yet to be fully determined and documented.

The WellCare whistleblower suit gives us a peek behind the corporate curtain to look at the many schemes HMO used to maximize profits by defrauding the state, taxpayers and by denying services.

- The WellCare whistleblower complaint reveals that Amerigroup, Valueoptions, Humana, United Healthcare and Vista, all used similar tactics to WellCare, such as false statements to illegally retain overpayments from the state. Hellain's complaint also shines a light on collaborative efforts among companies to defraud the state and avoid being detected.

- In January of 2011, Amerigroup Community Care and United Healthcare were fined close to \$4 million for the denial or improper reduction of speech-therapy services for children in the state's Medicaid program.
- Earlier this year, it was discovered that four private health insurers who participated in the state Medicaid privatization pilots, AmeriGroup Florida, Inc., Vista Health Plan, United Healthcare and WellCare, falsely reported spending millions of dollars on patient care in the State Children's Health Insurance Program, costing the state \$3.1 million between 2003 and 2007.
- Last month, Humana Inc., was fined \$3.3 million by the state for failing to promptly report Medicaid fraud or abuse to state investigators as the law requires.
- Total Medicaid HMO fines by AHCA from 2006-2011 amounted to \$6,186,300.

Medicaid HMOs stand to make a fortune if the state is given a green light by CMS (U.S. Center for Medicare & Medicaid Services) to move forward with the current Medicaid proposal. This is clear when looking at the money they are spending in political contributions and on lobbyist. Companies are looking to make billions by investing millions in the political process. The report found that Medicaid & Commercial HMOs (some of which will enter the Medicaid market if the SMMC moves ahead) paid:

- \$4,673,145.25 to political parties
- \$971,660 to political committees and ECO's
- \$378,750 to individual candidates
- \$98,000 to cabinet positions

It is clear that HMOs plan to make a great deal of money if the SMMC moves forward. However, the SMMC reform proposal is a bad deal for Florida's taxpayers. It is essentially taking a failed five county experiment that was rife with fraud and expanding it to all sixty-seven Florida counties.

The Medicaid Managed Care Pilot Program should not be expanded unless there is convincing evidence from an independent evaluation conducted by an organization with a reputation for unbiased research that an expansion would result in cost savings to the State of Florida and improve the health care services received by Medicaid enrollees. To date, all objective research and a great deal of anecdotal evidence suggest that the pilot projects have not been effective.

CMS should deny the state's request for a waiver to create the SMMC. However, without changes to greater protect against fraud and abuse, and guarantees like an MLR that taxpayers will not get ripped off, this proposal could funnel billions from Florida's citizens to big HMO corporations.

## Background

Earlier this year, Florida lawmakers passed legislation (HB 7107 & HB 7109) that would radically alter the way Medicaid services are delivered throughout Florida. This proposal would create the State Medicaid Managed Care system (SMMC) which would turn the state's entire Medicaid program over to managed care organizations. Most of these managed care plans are private for-profit health maintenance organizations (HMO). Before the SMMC can be implemented the federal Center for Medicaid & Medicare Services (CMS) must approve a request by the state for a waiver. At stake are billions of tax dollars and the health of millions of poor and elderly Floridians.

Medicaid is a health care safety-net program, created in 1965. It is funded and regulated through a state and federal partnership, which is administered at the state level by the Florida's Agency for Healthcare Administration (AHCA). Medicaid provides health care services to over 3 million enrolled Floridians, including: low-income children, pregnant women, and adults who are elderly or have a disability. The Patient Protection and Affordable Care Act, passed by Congress in 2010, will eventually require Medicaid to cover all adults below 133 percent of the poverty level. (1)

The Medicaid reform bill passed in May would do away with the existing fee-for-service system, in which the state pays providers for each service, and move to a capitated system, where all plans collect a per-client stipend from the state. This is troubling in that many for-profit plans would have an economic incentive to increase their profits by reducing the cost of treating clients. In this proposal, managed-care companies would also have unprecedented flexibility to vary the amount, duration and scope of benefits in confusing and risky ways.

This Medicaid reform is directly based on controversial Medicaid experiments that have taken place over the last five years in five pilot counties (Duval, Nassau, Baker, Clay and Broward). Proponents of the current proposal have consistently tried to distance the new plan from the pilot counties. However, the current reform is fundamentally similar outside of the fact that the current reform expands this experiment from not five, but all sixty seven counties.

This plan, would force over two million Floridians into managed care networks without counting those who would be newly eligible in 2014 under the Patient Protection and Affordable Care Act. Many of these plans would be for-profit and are expected to receive billions of state dollars.

Proponents argue that HMOs can provide a better coordinated care that lowers healthcare costs for the state. Unfortunately, there is no credible research or data indicating that the pilots have been effective at achieving these goals.

A report produced by The Health Policy Institute at Georgetown University was released in April while the legislature was debating the current proposal. The reports main findings were that:

- “There is no clear evidence that the managed care pilot programs are saving money, and if they are whether it is through efficiencies or at the expense of needed care.
- Little data is available to assess whether access to care has improved or worsened under the pilot program.
- Children, parents and people with disabilities who rely on Medicaid have experienced enormous disruption as a result of plan turnover in Broward, Duval and surrounding counties. Patients appear to be “voting with their feet” and moving from HMO’s to Provider Sponsored Networks.
- Special features of the pilot program – enhanced benefit programs designed to stimulate more healthy behaviors, and the opt-out program allowing beneficiaries to take advantage of employer-sponsored insurance – have had negligible impact. Only 21 beneficiaries are currently enrolled in the opt-out program. (2)

The five-year Medicaid pilot program was spearheaded by Governor Jeb Bush and launched in 2006 as an effort to replace traditional Medicaid with a managed-care model.

The Georgetown research on the pilots highlighted a number of concerns in those counties including declining provider participation, more restrictive drug formularies, high administrative costs and an absence of clear evidence that the changes were saving money. But most pointedly the researchers found, both 2008 and 2011 reports, that there was little data to assess whether access to care was improving or worsening. Similarly, there was insufficient data to draw conclusions about whether the pilots were saving money.

Research released in 2009 by the University of Florida (UF), who contracted with the state to evaluate the pilots, said that after two years the program was saving money. However, UF did not account for the costs of the enhanced benefits program or increased administrative costs. The UF study also could not assess whether the declines in cost that they found were the result of a decrease in access to care or more efficiency in the program. (3)

The Georgetown study did find that several insurers with a substantial share in the market were reducing benefits such as durable medical equipment, home health services, physical and respiratory therapies, chiropractor and podiatry services for adults. With significant pressure on the Medicaid budget and no increase for in-person spending researchers expressed concern about downward pressure on the benefits package, especially if the statewide expansion moved forward. (4)

A great deal of research is still needed to determine whether the pilots have indeed saved money, and if so, whether that was at the expense of needed care.

The expansion of the pilot projects, given the surprising lack of evidence that they have been successful, raises serious questions as to whether the state's transition to a Medicaid system that is completely reliant on for-profit managed care providers is a wise use of state health dollars.

The reform proposal becomes even more suspect when we look at the infamous track record of many of these companies when it comes to defrauding the state. One must ask whether the state's transition to a Medicaid system that uses for-profit managed care providers extensively (not solely) is a wise decision given the track record of many of these companies defrauding the state and unjustifiably denying care.

While several reports have looked at the question of whether the pilots have achieved their goals no Florida report has stepped back to look at the pattern of bad behavior among Medicaid HMO's that has consumed billions of state dollars. Starting with the WellCare whistleblower lawsuit, this report looks critically at the track record of Medicaid HMOs defrauding the state while asking why the state is forging ahead to aggressively expand a pilot program that has not been proven to work. With a demonstrated track record of massive fraud, and insufficient new protections being put into place to change the behavior of bad actors, this Medicaid plan is a recipe for a taxpayer rip-off of epic proportions.

The report ends by briefly looking at HMO state political contributions to candidates, parties and committees along with lobbyist expenditures. It is clear how eager HMO's are to enrich themselves on the taxpayers' dime by all the money they are throwing into lobbying and campaign contributions. These companies are looking to make billions by investing millions in the political process.

### WellCare: A case study of Corporate Greed

From 2002 to 2007, Sean J. Hellein worked for WellCare as a Senior Financial Analyst. WellCare is the largest Medicaid HMO in Florida, where they have been active for over fifteen years. They describe themselves on their website as a provider of government-sponsored health plans including Medicare, Medicare PDP, Medicaid, State Children's Health Insurance Programs and others. (5)

Sean J. Helleine was the quintessential corporate insider, meeting regularly with the company's CEO and head executives who entrusted him with top secret information. During his time at WellCare, the company saw earnings triple, pleasing shareholders and impressing industry observers. Company executives publically credited their success to hard work, an eye on costs and good customer service.

Unfortunately, for WellCare, Sean Hellein had a conscience, knew too much information, and revealed the true secrets of WellCare's success. In 2006, Mr. Hellein filed a whistleblower complaint alleging that more than a dozen WellCare managers and executives participated in various schemes to defraud the state of Florida, along with six other states. Hellein's lawsuit

estimated that WellCare illegally siphoned \$400 million to \$600 million from state health insurance programs for the poor through a laundry list of fraud schemes. (6)

According to the whistleblower WellCare has illegally siphoned \$400 million to \$600 million from state health insurance programs for the poor.

During the following eighteen months, Hellein worked undercover with federal investigators to capture over one thousand hours of audio & video during sensitive meetings with high level co-workers by using a wire, miniature cameras and other devices. This led to a raid of WellCare's headquarters in Tampa, FL in October, of 2007, by federal investigators who seized thousands of documents.

“Cherry Picking”: Dumping Patients that Aren't Profitable

The sixty page whistleblower complaint that kicked off the investigation detailed how WellCare executives, like CEO Todd Farha and others, met monthly between 2003 and 2005 to discuss powerpoint presentations detailing how much the company could save by disenrolling “high cost” members. The presentations detailed how the company could save \$20,000 per disenrolled neonatal baby, and \$11,500 per disenrolled terminally ill-patients. (7) With a concern only for profits and no concern for the well being of patients, the company then developed strategies and teams to systematically disenroll these members. Each team was given a target number of neonatal babies or terminally ill-patients to disenroll.

If this is true, the company lied to the government when saying they would provide services for beneficiaries. It also means that taxpayers failed to get what they paid for in Medicaid dollars while also being forced to compensate for higher medical costs resulting from high cost trips to the emergency room by those who were no longer insured. Alternatively, some of those patients may have found coverage by less unscrupulous plans or found coverage through traditional fee for service Medicaid.

According to Hellein, team leaders were rewarded when they did a “good job” of disenrolling these patients. For example, the neonatal babies disenrollment team was recognized in 2004 at a celebratory dinner for successfully disenrolling 425 premature infants from the companies rolls. The team leader was given a promotion and recognized as one of Wellcare's top Health Services employees in 2004. An internal document called the “Hospice Conversion Plan” anticipated a cost savings of \$3 million for disenrolling terminally-ill patients. (8)

According to the whistleblower complaint presentations by senior management detailed how the company could save \$20,000 per disenrolled neonatal baby and \$11,500 per disenrolled terminally ill-patients.



In the complaint Hellein recounts a meeting with one of WellCare's top officers who felt that WellCare needed to be more careful about their shady practices due to a case against Amerigroup Corporation in another state for engaging in similar tactics. According to Hellein, the officer said that WellCare would prefer that members die because it's cheaper.

In another similar instance, illustrating the company's emphasis on the needs of shareholders over patients, WellCare determined that mothers and babies who received help through the Temporary Assistance for Needy Families program (TANF) were less profitable than disabled members who received funds through SSI, the Supplemental Security Income program. WellCare then developed a strategy to systematically discourage TANF members from joining while recruiting more SSI members who would generate greater higher investor profits for the company. Unfortunately for many mothers receiving TANF benefits, WellCare's strategy was effective.

### Accounting Games

The whistleblower complaint describes numerous schemes devised by WellCare executives to defraud the government by using creative accounting tricks or false data to minimize what the company owed the state. One way they avoided paying the state what they owed was to create their own reinsurance subsidiary based in the Caymen Islands.

WellCare overpaid their Caymen Island reinsurance subsidiary with a rate nearly five times higher than it paid other reinsurers. The company evaded regulations explicitly denying their reimbursement if the costs of self-reinsurance exceeded the cost of comparable commercial reinsurance premiums by categorizing these payments as "unrelated activities."

A whistleblower complaint revealed that Todd Farha, CEO of Wellcare, (right) approved plans to strategically disenroll neonatal babies and terminally ill patients to boost Wellcare's profits.



In numerous other instances, the company committed fraud by simply taking advantage of the states mistakes. According to Hellein, WellCare was receiving overpayments totaling \$2 million per year from the Florida Medicaid program due to mistakes the state made in premium coding. WellCare would then devise accounting schemes to support the bogus state numbers in order to avoid paying money back to the state in subsequent years. The company intentionally failed to notify Florida Medicaid officials when they were overpaid or when the state's actuarial consultants miscalculated WellCare's expenses.

In the initial settlement with the state that followed the raid on WellCare's corporate headquarters it came to light that WellCare had used a "phantom" subsidiary, Harmony Behavioral Health, to hide the fact that the company's Medicaid HMOs, HealthEase and StayWell, weren't spending as much money as they were supposed to on patients' treatment.

#### WELLCARE FRAUD TIMELINE

- 2004 to 2006 – WellCare sees earnings triple.
- 2006 – Senior financial analyst files whistleblower complaint.
- For 18 months whistleblower works undercover with investigators
- October 2007 – Investigators raid Wellcare headquarters
- May 2009 -- WellCare agrees to pay state \$80 million to avoid criminal charges.
- May 2009 - WellCare reaches a separate \$10 million settlement with the Securities and Exchange Commission (SEC) for securities fraud.
- June 30, 2010 – Two more Wellcare whistleblower complaints revealed.
- June, 2010 – A tentative \$137.5 million settlement with Government announced.
- July, 2010 - Florida CFO announces independent audit showing WellCare overcharged the state by \$2.1 million above overpayments already identified.
- June 28, 2011 – Whistleblower continues suit despite settlement arguing that the fraud amounts to between \$300 and \$400 million dollars. Federal judge orders government to turn over company documents to whistleblower and his attorney who believe settlement is far too low and that WellCare has the ability to pay.

Under the terms of their contracts with Medicaid and Florida Healthy Kids Corp., the HMOs were supposed to pay the unspent money back. Harmony was created specifically to disguise what WellCare actually spent, according to investigators. (9)

#### Costs to Taxpayers

In June of 2010, WellCare released details of a tentative \$137.5 million settlement with state and federal authorities. A month later in July, 2010, Florida's Chief Financial Officer announced that an independent audit of payments to WellCare concluded that the company overcharged the state by \$2.1 million beyond overpayments identified in previous investigations. Hellein, who had worked in the finance department at WellCare, estimates their theft to Florida to be near \$300 million, far more than the settlement amount. In addition, the Government could

recoup double or triple damages under The False Claims Act. In addition, WellCare paid the state \$80 million in a 2009 settlement to avoid criminal charges for intentionally underpaying \$40 million in refunds owed to the state. Several weeks after the announcement of the \$80 million settlement, it was announced that WellCare had entered another \$10 million settlement with the U.S. Securities and Exchange Commission for securities fraud. (10)

Although the full extent of WellCare's fraud has yet to be fully determined and documented, it is clear that the HMO illegally pocketed well over \$100 million in taxpayer dollars. WellCare persuaded state and federal prosecutors to adopt a tentative settlement that's millions of dollars less than their real and potential punitive damages, based on their limited ability to pay.

However, Hellein and his attorney, much to the chagrin of the federal and state government, continue to challenge and demand proof of their inability to pay. On June 28, 2010, a federal judge in Tampa ordered the government to turn over company documents to Hellein and his attorney and allowed 60 days to examine the documents. The judge also said they could depose an unnamed executive from WellCare. This suit is ongoing. (11)

Incidentally, WellCare remains the largest Medicaid HMO in Florida, with 25% of market share in Medicaid managed care today. On a proportionate basis, they stand to gain hundreds of thousands of new enrollees under SMMC. (12)

### More Than One Bad Apple

The story of the WellCare whistleblower suit not only gives us a peek behind the corporate curtain to look at the many schemes one HMO used to maximize profits by defrauding the state, taxpayers and by denying services. Most importantly, this complaint illustrates that WellCare was not alone by a long shot. According to Hellein, other Medicaid HMOs such as: Amerigroup, Valueoptions, Humana, United Healthcare and Vista, all used similar tactics to retain overpayments from the state, which HMOs are required to return by law.

Kerri Fritsch was Senior Director of Finance for Harmony Behavioral Health Inc., and formerly worked for Amerigroup where she was responsible for creating scenarios to underreport the company's true payback obligation to the state. In a 2007 conversation between Hellein and Ms. Fritsch, she recounted another conversation between herself and the CEO of Amerigroup. When the CEO asked her why they did not submit actual costs in their reporting to the state, Ms Fritsch explained that if they did, it would cost Amerigroup millions. Instead Amerigroup falsified their reporting and it allegedly cost taxpayers millions. (13)

Hellein's complaint also shines a light on disturbing collaborative efforts by companies to defraud the state. While WellCare, Amerigroup, Valueoptions all compete for business they also cooperate with each other in their reporting to reduce the likelihood that the state detects any one of their individual false claims. Hellein's accusations are supported by numerous stories in the news. (14)

## Medicaid HMOs & Commercial HMOs

The pattern of fraud and bad behavior alleged by Hellain is further illustrated by the millions of dollars of fines Medicaid HMOs have been assessed in recent years. Data collected by a public record's request of fines the Florida Agency for Healthcare Administration AHCA had assessed on Medicaid and Commercial HMO over the last five years revealed that Medicaid HMOs get fined far more often than commercial HMOs by AHCA. This analysis does not include fines that the Florida Office of Insurance Regulation (OIR) imposed on commercial HMOs.

Total Medicaid HMO fines from 2006-2011 amounted to \$6,186,300 while the total commercial HMO fines by AHCA during the same period were nineteen times lower, at \$323,300. But when looking at the Medicaid HMO fines, it becomes clear that these companies typically pay a fraction of the original fine. (15)

The following chart illustrates how the original fines, when looked at annually, are in some cases three to five times higher than the final amount actually paid. There was only one year where the amount paid was more than the initial fines.

### Total Amount of Fines Imposed by AHCA on Medicaid HMOs Between 2006 - 2011

Year	Original Fine	Fine Assessed	Final Amount Paid
2010-2011	\$4,101,200	\$2,768,900	\$1,458,900
2009-2010	\$126,000	\$121,000	\$120,600
2008-2009	\$154,700	\$135,100	\$634,100
2007-2008	\$830,800	\$796,400	\$140,200
2006-2007	\$1,008,000	\$842,525	\$274,573
Total	\$6,220,700	\$4,663,925	\$2,628,373

The highest fines were for more substantive offenses such as marketing violations, contract violations, unregistered agents marketing, failure to file encounter data, using non-approved forms, failure to notify the state of fraud in a timely manner, and the denial of speech therapy services, to name a few.

The highest individual fines over the last five years were imposed on United Healthcare, \$1,305,000, and Amerigroup, \$2,655,000, in 2011 for the denial of speech therapy services. Other groups, such as Staywell Health Plan (a WellCare subsidiary) received a number of high fines for marketing violations. Staywell (a WellCare subsidiary) was fined \$500,000 in 2010 for unregistered agent marketing and in 2006 was fined \$504,700 for marketing violations. Over the five year period Staywell was fined \$1,203,500 for various reasons. Other groups like Amerigroup and Humana also received large fines for marketing violations. In addition, there were a high number of smaller fines, primarily for late filings, ranging from \$200 to \$6500.

This high number of late filings suggests that regulators are having a difficult time receiving timely financial information from HMO's making it difficult for AHCA to detect potential fraud

and enforce regulations. The fact that there are so many repeated fines also suggests that the penalties are not high enough to disincentivize the bad behavior.

#### United & Amerigroup: Making Profits by Denying Speech Therapy Services to Children

In January of 2011, Amerigroup Community Care and United Healthcare were fined close to \$4 million for the denial, or improper reduction, of speech-therapy services for children in the state's Medicaid program. The agency determined that Amerigroup inappropriately denied or reduced services to 531 children and fined United for 522 violations. This was a violation of state law as well as a state contract that required the insurers to offer these services to people in need. (16)

In January of 2011, Amerigroup Community Care and United Healthcare were fined close to \$4 million for the denial or improper reduction of speech-therapy services for children...

AHCA discovered that the company and a subcontractor, Therapy Review Systems (TRS), were calling legitimate therapy needs educational, rather than medical in order to deny services and then refer children to services provided by schools. An analysis of Amerigroup's records revealed that services were denied inappropriately or reduced to 121 children while 410 children were inappropriately denied or reduced treatment due to "educational goals". (17)

#### Amerigroup and WellCare Fined For Failing to Cover Pregnant Mothers

In 2010, AHCA discovered that for years HMOs had not been following requirements to enroll babies in their mothers' health plans soon after birth. This failure by companies to follow guidelines led to \$34 million in additional costs to the state for infant care. The lion share of the fraud, totaling \$20.9 million, was committed by two HMOs that were run by WellCare. The second largest fine of \$6 million was imposed on Amerigroup.

In the Amerigroup case, AHCA sought to impose \$2,500 fines for 2,427 children. The agency reported that it had paid \$6.9 million in "fee for service" payments to hospitals and doctors and other providers, which is about \$3.2 million more than would have gone to Amerigroup if the children had been properly enrolled on time.

Other HMOs with smaller potential fines are Humana, United Healthcare, Vista, Citrus Health Care, JMH Health Plan, Preferred Medical Plan, Universal Health Care and Total Health Choice. Healthy Palm Beaches has paid a \$90,000 fine. (18)

Humana fined \$3.3 million for failing to notify state of fraud

Humana and its CarePlus subsidiary together make up Florida's largest and most profitable HMO with 568,000 members and 2010 profits of \$330 million. Last month, Humana Inc., was fined \$3.3 million by the state for failing to promptly report Medicaid fraud or abuse to state investigators as the law requires.(19) Companies who detect fraud are required to report it within 15 days of its discovery. In this case, the state fined the company \$2.7 million for failing to disclose the fraud and a second fine of \$660,000 for violating the terms of its contract as a Medicaid HMO. At the time this report was written, Medicaid officials and Humana had not disclosed how the fraud came to light.

Defrauding the State Children's Health Insurance Program

Earlier this year, in a separate investigation, it was discovered that four private health insurers who participated in the state Medicaid privatization pilots had falsely reported spending millions of dollars on patient care in the State Children's Health Insurance Program, also known as Kidcare. The fraud by these four insurers cost the state \$3.1 million in refunds between 2003 and 2007. AmeriGroup Florida, Inc., Vista Health Plan, United Healthcare and WellCare were all required to spend at least 85 percent on medical services rather than administrative costs and profits. If an insurer spends less, it must refund 50 percent of the shortfall to the state. (20)

### Medicaid HMO Fraud: Beyond WellCare

- The WellCare whistleblower complaint reveals that Amerigroup, Valueoptions, Humana, United Healthcare and Vista, all used similar tactics to WellCare, such as false statements to illegally retain overpayments from the state. Hellain's complaint also shines a light on collaborative efforts among companies to defraud the state and avoid being detected.
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- Last month, Humana Inc., was fined \$3.3 million by the state for failing to promptly report Medicaid fraud or abuse to state investigators as the law requires.

These stories illustrate a pattern of fraudulent or deceptive behavior among Medicaid HMO's that should cause the state great concern when looking to expand the role of managed care in the Medicaid program statewide.

The willingness of Medicaid HMO to bend, break or ignore the rules and the incentives to do so in order to increase profits are far too great while the penalties appear to be too low.

This pattern of fraudulent behavior raises serious questions as to whether dramatically expanding the role of these companies in the state Medicaid system can make the system more efficient and less expensive as proponents have claimed. The 2011 Medicaid reform proposal is essentially rewarding these companies for bad behavior, without instituting any additional safeguards to make sure this epidemic of fraud doesn't repeat itself.

#### Medicaid Reform Equals Big Bucks for HMOs

Managed care is generally profitable. The Florida Office of Insurance Regulation (OIR) released a quarterly report (21) earlier this year showing that "profits for Florida HMOs (Medicaid and Commercial) leaped sixteen percent, to close-record levels, at a time when clients saw their premiums and co-pays rise. The 3.5 million HMO members in Florida paid \$19.2 billion in premiums last year, up 3.6 percent (while) HMO costs went down by an average of 1.2 percent. It was the second straight year of double-digit profit evolution for HMOs and pushed the industry's total revenue close to the 2004 record of about \$710 million." (22)

Medicaid HMOs stand to make a fortune if the state is given a green light by CMS (U.S. Center for Medicare & Medicaid Services) to move forward with the current Medicaid proposal. Millions, and perhaps billions, of tax dollars would be paid to these managed care providers who would then pay direct providers of services while retaining funds for profits. This makes little sense when reports have shown that "historical data reveals that, on a per-person basis, Medicaid has contained costs more effectively than private health insurance." (23) Profits stand to be so great that Florida managed care PPO giant Blue Cross & Blue Shield has even shown their intention to get in the game. Last May, Blue Cross announced that they would begin enrolling Medicaid recipients in 2012. (24)

#### Medical Loss Ratio vs Profit Sharing

Taxpayers should have some guarantees or protections in place to ensure that private HMOs whom the state is contracting with actually deliver the care they have agreed to provide rather than just shoveling taxpayer dollars into private investor profits. The best way to ensure that taxpayers are protected is to require insurers to spend at least 85% of tax dollars on actual medical care...

One of the more controversial debates over the SMMC Medicaid proposal during the 2011 state legislative session arose around the question of how to prevent Medicaid HMOs from lining the pockets of shareholders and executives at taxpayer's expense.

One solution involved requiring insurers to comply with a medical loss ratio (MLR) limiting the percentage of each tax dollar that Medicaid HMO's can keep for profits and administrative costs. The second proposal involved a profit sharing system called an achieved savings rebate (ASR). This plan creates an arrangement between HMO's and the state allowing the managed-care organizations to keep the first 5 percent of any profits and then split profits between 5 and 10 percent with the state. All profits over 10 percent would be returned to the state. (25)

The MLR proposal, backed by consumer advocacy groups, was defeated due to fierce opposition from managed care companies. Instead legislators approved an HMO backed ASR, profit sharing plan. While, the MLR and ASR are both improvements on the current system by adding an additional accountability mechanism the ASR which was included is inferior in several key ways.

According to a recent issue brief (26) released by the Florida Center for Fiscal and Economic Policy (FCFEP), the ASR lacks a crucial feature of the MLR. The MLR requires the direct reporting of the percentage of taxpayers' investment in Medicaid that is spent on direct patient care and what percentage is spent on administrative costs. In contrast, the ASR allows plans to evade reporting their patient care spending. Additionally, under the ASR, the percentage of tax dollars spent on administrative costs such as executive compensation would be decided by actuaries behind closed doors rather than by decision-makers who are made accountable to the public via a transparent process. According to FCFEP's analysis the use of the version of the ASR approved by the Florida Legislature would also allow HMO's to divert up to \$9 billion more from patient care to their own pockets during first 5 yrs of statewide experiment than if MLR had been used.

Another potential problem with this plan is that it could create a perverse incentive for the cash-strapped state to view HMO profitability as a funding stream and possibly even look the other way when fraud may be at hand. Similarly, the state would have a disincentive to pursue policies like stronger penalties against persistently unethical contractors.

The issue of whether the Medicaid reform will contain an ASR or MLR continues to be relevant as the state seeks permission by the federal government to waive a number of basic federal Medicaid laws. Many expect the Center for Medicare and Medicaid Services (CMS) to require the state to include an MLR as a condition for approving the waiver request.

While making sure tax dollars are being used efficiently by insurers is a huge concern, an even greater concern is how the drive for profits has and could impact patient care. One clear example of this is the disruption of plans caused by the withdrawal of Wellcare, Amerigroup, United Healthcare, Vista and Buena Vista in Broward County when they feared they would not turn a profit. While the new Medicaid reform proposal contains provisions that would discourage this from happening in the future, the incident stands as an illustration of where companies priorities lie – shareholders, not patients or taxpayers.



## Money & politics: More Profits Equal More Influence Equal More Profits equal....

The lack of evidence that the Medicaid pilot projects were successful raises a question as to why the state is rushing to expand the role of managed care statewide. It is still unclear whether the pilot projects or the current plan will lower costs while maintaining the quality of care beneficiaries receive. Moreover, with plenty of evidence that Medicaid HMO fraud is costing taxpayers hundreds of millions of dollars while companies generate profits by denying or reducing care, one must ask, why would state lawmakers so aggressively push to expand the role of managed care providers in the Medicaid system at this point?

### HMO Political Influence

According to the Division of Election's Campaign Finance database contributions Medicaid HMO's spent \$1,862,044.00 in the 2010 election cycle. This number is likely to be conservative given the variety of ways that money flows through political committees, subsidiaries and individuals who have an interest in companies. (28)

As it is still very early in the 2012 election cycle, the data are taken from the 2010 cycle. We looked at both Medicaid and non-Medicaid HMOs as it is useful to look at the overall contributions by the industry and some non-Medicaid HMOs will create Medicaid plans if the current proposal moves forward.

Direct contributions by HMOs (Medicaid & Commercial) to legislative candidates amounted to \$378,750 while direct contributions to candidates for Florida cabinet positions totaled at a \$98,000. More contributions were made to political committees and Electioneering Communications Organizations (ECO's) which totaled \$971,660. (see chart below for a list of political committees) . While these amounts are significant, the bulk of the contributions from HMO's went to the two major political parties, which came to \$4,673,145.25.

Special interest groups and high donors will often contribute money to political parties who can receive unlimited contribution and then redistribute that money to committees and candidates. This is one of the most common loopholes in Florida's campaign finance laws that special interests exploit to evade the \$500 limitation on direct contribution to candidates.



## HMO Contributions for 2010 Election Cycle

Insurers	Republican Party	Democratic Party	Political Committees	Legislative Candidates	Cabinet Candidates	Total
Aetna	47,500	28,000	100.00	20,500	4,000	100,100
Amerigroup	117,000	50,000	17,500	57,000	1,000	193,000
Avmed	19,000	3,000	0	6,250	1,000	29,250
BC/BS	1,965,000	1,022,201.25	780,210	69,500	9,000	3,845,911.25
Buena Vista	0	0	0	0	0	0
Capital Health Plan	0	0	0	1,500	0	1,500
Carefloirda	0	0	0	0	0	0
Florida Health Plan	50,000	30,000	4,000	7,000	2,000	93,000
Freedom Health	0	0	0	0	0	0
Health First	0	0	2,500	0	0	2,500
Health Options	65,000	22,500	15,000	16,500	7,000	126,000
Healthease	0	0	0	500	0	500
Humana	115,000	90,000	38,100	94,500	4,500	342,100
Jackson Memorial Health Plan	0	0	0	0	0	0
Medica Health Plans of Florida	0	0	0	0	0	0
Molina	0	0	10,000	14,500	0	24,500
Personal Health Plan	0	0	0	0	0	0
Positive Health care	0	0	0	0	0	0
Preferred Medical	135,000	35,000	36,500	33,000	3,500	243,500
Simply Health	0	0	0	500	500	1000
Staywell Health Plan	0	0	0	0	0	0
Sunshine State Health Plan	0	0	0	0	0	0
Time Insurance	0	0	750	0	0	750
Trustmark	0	0	2,000	0	0	2,000
United	215,000	45,000	2,500	10,000	0	305,000
Universal Health	385,000	20,000	0	13,500	9,500	428,000
Value Options	30,000	6,000	0	6,000	0	42,000
Vista	444	0	0	25,500	6,500	32,444
Wellcare	150,000	27,500	62,500	2,500	49,500	292,000
Totals	3,293,944	1,379,201.25	971,660	378,750	98,000	6,105,055.25

- Total contributions from Medicaid HMO's = \$1,862,044.00
- Medicaid HMO's are boldface, all others are commercial HMOs.
- Campaign finance data was collected from Florida Division of Election's Contribution Database Medicaid HMO's are boldface

Significant industry contributions also went to ECOs which spent on behalf candidates:

### **Top 15 Political Committee Contributions**

- Let's Get to Work – ECO – \$315,000
- Freedom First Committee – ECO - \$105,000
- Responsible Leadership Committee, inc., – ECO – \$85,000
- Florida Mainstream Democratic Forum – ECO – \$60,000
- Florida Chamber of Commerce \* - CCE(s) - \$54,500
- Florida First Initiative CCE – \$50,000
- Florida Jobs PAC – CCE – \$50,000
- Florida Association of Health Plans – CCE - \$40,000
- Jax Biz – CCE = \$35,000
- Innovate FL – CCE – \$22,500
- Citizens For an Enterprising Democracy – CCE - \$22,500
- Creating Possibilities – CCE – \$20,000
- Florida Leadership Alliance – CCE – \$20,000
- Saving Florirda's Heartland – CCE – \$17,000
- FIC PAC –CCE- \$14,000

HMO Contributions to political committees in the 2010 election cycle = \$1,072,510.00. The largest contributions were to ECO's .

*\* FL Chamber had three different committees whose contributions are totaled above. Florida Chamber Free Enterprice cce, Florida Chamber of Commerce cce, and the Florida Chamber of commerce Alliance cce.*

\* Source: Florida Division of Elections Contribution Database

While the numbers in the charts above are significant they are likely conservative and only tell part of the story as to how HMOs influence the political process.

A Sun-Sentinel article in early April looked at those working the legislature to influence the Medicaid proposals outcome. With an analysis of the state lobbyist registration database in early April the paper counted 30 lobbyists representing HMO's. The analysis found that the Florida Association of Health Plans alone had 18 lobbyists which they paid an average of \$55,000 in the first quarter. These numbers are likely conservative as the article was written in early April and some lobbyist are contracted late in the session as tensions mount and stakes get higher. (29)

Although only a snapshot from the most recent election, the pervasiveness of industry campaign contributions just prior to legislative negotiations raises serious questions about the integrity of the decision making process around health care policy in Florida.

## Conclusion

This report documents a small sampling of HMO Medicaid fraud occurring in recent years. There is probably much more that we do not know about. It is important to note that the fraud we are aware of is largely due to a whistleblower testimony rather than internal investigative or any sort of accountability system. However, the instances detailed here are intended to show that billions of taxpayer dollars have been lost in a healthcare delivery system that was supposed to more efficiently serve our Medicaid population while saving the state money.

Florida PIRG, along with over 100 other advocacy groups and providers, including the Florida Medical Association FMA, are currently urging CMS to deny the state's request for a waiver which would allow them to move forward with the SMMC. The Medicaid Managed Care Pilot Program should not be expanded unless there is convincing evidence from an independent evaluation conducted by an organization with a reputation for unbiased research that an expansion would result in cost savings to the State of Florida and improve the health care services received by Medicaid enrollees. To date, all objective research and a great deal of anecdotal evidence suggest that the pilot projects have not been effective.

The SMMC reform proposal is a bad deal for Florida's taxpayers. It is essentially taking a failed five county experiment that was rife with fraud and expanding it to all sixty-seven Florida counties.

We can only speculate as to why lawmakers have moved forward with such a dramatic expansion of a program that has not been proven to be effective. However, it is clear that Florida HMOs invested millions of dollars influencing the political process in the election cycle leading up to last session. They also have shown strong support for the reform proposal which they likely had a hand in crafting. These companies stand to make a great deal of money from the new system.

Along with fraud, there is a legitimate concern that companies will put more of the public dollars they receive towards profits than actual care. While some improvements were made in the areas of accountability and transparency, they are likely to fall short of what is needed to keep companies in check and protect the public's purse. While the Achieved Savings Rebate (ASR), does add more accountability and transparency to the system than what currently exists, it will not provide as much accountability as a strong Medical Loss Ratio would have. (30)

CMS should deny the state's request for a waiver to create the SMMC. However, without changes to greater protect against fraud and abuse, and guarantees like an MLR that taxpayers will not get ripped off, this proposal could funnel billions from Florida's citizens to big HMO corporations.

The End

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