Florida to restructure Medicaid to benefit insurance industry

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Florida lawmakers voted to put a cap on Medicaid payments to health care providers Friday, replacing the system of fee-for-service reimbursements. The legislation will radically alter both the quality and availability of medical care for the state's 2.9 million Medicaid recipients.

The move is the most radical plan proposed by any state so far in the drive by the ruling elite to liquidate Medicaid, the joint state- and federal-funded health insurance program for the poor. Proponents of the bill make the absurd claim that the new system will save the state $1.1 billion without affecting quality or availability of care.

Florida currently spends around $22 billion annually on Medicaid payments, out of a total budget of $69.7 billion. While the federal government presently pays nearly 60 percent of all reimbursements, this figure will almost certainly shrink in the near future. The program covers nearly one third, or 27 percent, of the state's children.

The bill was modeled on a pilot program initiated in 2006 in which five counties forced most Medicaid recipients into for-profit HMOs (Health Maintenance Organizations) and provider networks. Patients were no longer able to seek out the medical provider of their choosing, to be reimbursed by the program. Instead, they had to choose from one or another network or HMO and only had access to service providers, including specialists, within the network. This severely limited access to medical care generally, and in particular to doctors specializing in certain diseases and disorders.

A study on the pilot program by Georgetown University in April found that the program curtailed access to care and did not in fact save money. For example, one single parent told the *New York Times* that the pilot program rendered her unable to care for her 16-year-old son, who suffered from muscular dystrophy, spinal injuries and chronic pain. The pilot program forced her instead to choose among private, for-profit plans that included none of her son's original doctors and therapists, and excluded coverage for necessary treatments.

The Georgetown study found that many HMOs, doctors and service providers simply left the state altogether due to low reimbursement rates. When one major HMO left Duval county, home to Jacksonville, Florida, some 55 percent of county Medicaid recipients were left temporarily without any medical plan at all, before being moved into other low-quality, low-access HMOs. The pilot program will expire June 30.

The bills recently approved by the Florida legislature would divide the state into 11 regions where HMOs and managed-care providers would compete with one another for enrollees.

Most of the projected savings, and the estimates vary widely, would come from capping payments to providers, replacing the fee-for-service system. The capping of accounts is effectively moving medical decision-making from the doctor's office to company boardrooms.

Other Medicaid recipients who will be adversely affected are residents of nursing homes and other live-in care facilities. The current proposal could shift as many as two thirds of these patients into home care programs with fewer resources and available services.

Other likely inclusions include some by Governor Rick Scott to require a $10 monthly premium for Medicaid recipients, and another to require a $100 co-pay for "non-emergency" visits to the emergency room.

The latter proposal is ostensibly designed to discourage the use of the emergency room, and encourage routine checkups. The result will be an untold number of deaths resulting from poverty, as the poor are far more likely to put off medical care because of fees, the burden of keeping appointments without adequate transportation or flexible job hours. Consequently, the poor look to emergency rooms as providers of first and last resort.

These proposals and others along the same lines will ultimately require approval by the federal government's Center for Medicare and Medicaid Services (CMS). Virtually since his inauguration this January, Governor Rick Scott has been exchanging letters with CMS and Health and Human Services Secretary Kathleen Sebelius, arguing his case for slashing services in the name of "choice" and cost savings.

The Medicaid program is funded by state money that is matched by federal dollars. In order for states to receive federal funds, they must meet certain criteria for providing access to care. The Obama administration, like the Bush administration, has to a great extent depended on state governments to restructure how public health care programs are administered in order to realize cuts to federal disbursements. For this reason, the Florida legislation is a guide for states throughout the country. Over the past decade, virtually every state in the nation has introduced some measures to curtail medical services, tighten eligibility rules, and privatize case management.

It is now expected that Governor Scott will sign the bills into law, as he presents himself as businessman, supporter of the for-profit health care industry and proponent of privatization. The exact details of the program, which remain to be finalized in collaboration with the federal government, will without doubt serve to funnel tax dollars into the coffers of health care companies while limiting access to care for the most vulnerable sections of the population.

As with the current federal overhaul of health care, the financial elite are insisting that they receive a greater portion of social wealth even if it condemns whole segments of the population to an unhealthy life and an early death.