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Recent Changes in Health Policy for Low-Income People in Florida

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While the last few years have seen clear innovations in state policymaking, there is a great deal of uncertainty about the effects of these innovations on Florida's health care system.

Overview

Through the early and mid-1990s, the state of Florida could be described as an innovator in health policy. Under the creative leadership of both executive and legislative branch officials, Florida proposed and/or implemented a wide array of initiatives, including expanding health insurance coverage through the Florida Health Security Act, implementing managed competition in the small group insurance market through the Community Health Purchasing Alliances, increasing health coverage of low-income children through the Title XXI–supported KidCare program, reducing infant mortality through the Healthy Start program, and improving efficiency and cost management in the Medicaid health system through the aggressive expansion of Medicaid managed care. Many of these efforts were viewed as "models" and were emulated by other states.

In more recent years, important and sometimes subtle shifts in this role have occurred. With the passing of the gubernatorial reins from Democrat Lawton Chiles to Republican Jeb Bush, and with Republican majorities elected to both houses of the legislature in 1998, Florida for the first time in recent history saw the complete political alignment of its executive and legislative branches within the Republican party. This development, along with a slowing economy, have helped create an environment that is more fiscally conservative, that embraces a less expansionary view of the role of state government, and that sees solutions to health policy challenges involving the cooperative partnering of state and local governments and the private sector. Within this philosophical construct, innovations continue to emerge in the state as it works to better serve vulnerable populations.

This report assesses changes and continuities in the past five years, building on an earlier baseline study.[1] In brief, our case study revealed that budget shortfalls emerged in Florida in the past year, fueled by a combination of dramatic growth in Medicaid spending due to increases in enrollment, home- and community-based program funding and health care costs (in particular, prescription drugs), and declines in general revenue funds due in part to the recent implementation of large tax cuts. Interestingly, however, despite facing an estimated Medicaid shortfall of $1.5 billion, state officials were able to avoid implementing significant program cuts as a way of reconciling the budget shortfalls during the regular 2001 legislative session.[2] Instead, the state adopted policies that sought to control spending growth rates and find more efficiencies in current operations. Principal among the state's strategies was the adoption of a new Medicaid prescription drug formulary that would allow Florida to restrict beneficiaries' use of prescription drugs to medicines for which it has successfully negotiated the receipt of "supplemental manufacturer rebates"—that is, rebates that go beyond the federally mandated discounts Florida currently receives from manufacturers.[3]

The catastrophic events of September 11, 2001, however, precipitated a significant downturn in the state's economy that created huge unexpected deficits in the state's

fiscal year (FY) 2002 budget. As a result, the governor was forced to convene two special sessions of the legislature late in 2001 where they enacted several cost-cutting measures, including reductions in Medicaid eligibility and services for adults. It remains to be seen whether the cost efficiencies the state has invested in will prevent future cuts to Medicaid and other health care programs in the event of a prolonged economic slump.

Problems of uninsurance continued to loom large, fueled by historically low rates of employer-sponsored health insurance and very low Medicaid income eligibility levels for adults. But by the end of the regular 2001 session, policymakers had no plans to pursue public coverage expansions through such avenues as Section 1931 Medicaid expansions or State Children's Health Insurance Program (SCHIP) "family coverage" waivers. Rather, the state promoted expanded private sector coverage through such strategies as the creation of the Small Health Alliance (to replace the defunct Community Health Employer Purchasing Alliances and permit group pooling/purchasing by small employers). There have also been proposals to create bare-bones policies that would increase the affordability of insurance for low-income populations, but state officials admit that the potential for these proposals to significantly decrease the uninsurance rate is limited. The recent Medicaid program cutbacks and the persistence of weak economic conditions will likely aggravate the state's problem with uninsurance.

Acute care systems—primarily managed care organizations and hospitals—have weathered turbulent times. In the managed care sector, intense competition, coupled with tighter regulations in the aftermath of quality-of-care scandals, have caused numerous plans to leave the state entirely and other plans to stop participating in Medicaid. Yet many policymakers describe the managed care market as "healthier" in light of these developments, with financially sound plans and better state oversight more firmly in place. At the same time, recent years have seen the development of an alternative Medicaid managed care model (the Provider Service Network) that is built around provider groups that traditionally serve low-income and vulnerable populations.

As with the health maintenance organization (HMO) industry, the hospital sector has experienced financial difficulty in the past few years. Significant reductions in Medicare reimbursement mandated by the Balanced Budget Act of 1997, coupled with steady increases in the provision of uncompensated care, have weakened the financial position of hospitals. More recently, however, hospitals' financial circumstances have improved, partly due to the numerous mergers and acquisitions that have strengthened their market position when negotiating payment arrangements with insurers. Additionally, while Florida had a relatively small disproportionate share hospital (DSH) program throughout the 1990s, state plans call for increasing the state's drawdown of federal matching dollars through Upper Payment Limit (UPL) initiatives, an effort that could potentially bolster hospital operations.

A full-blown crisis has emerged within Florida's long-term care system, one that threatens to further undermine the quality of the nursing home system. A complex set of interrelated factors have "domino-ed" to create this situation: chronic staffing shortages led to an erosion in quality of care, which in turn led to lawsuits that resulted in extremely large awards for complainants and skyrocketing liability insurance rates for the industry. The situation will be further compounded in the long term by the lack of home- and community-based alternatives to nursing home care in a state that already has a very high proportion of older people, one that is projected to increase in the future.

In contrast to the state of home- and community-based services programs for the elderly, the state has made tremendous strides in its efforts to implement community-based alternatives for younger Floridians with developmental disabilities. Governor Bush has surprised many with his efforts to focus resources on this population and, using the U.S. Supreme Court's *Olmstead* decision (which provided a limited right to home- and community-based services) as leverage, his administration has successfully argued with federal officials for the approval of pending Medicaid waivers and state plan amendments to expand long-term care alternatives in community settings.

TABLE 1. *Selected Florida Characteristics*

	Florida	United States
Population Characteristics		
Population (2000) (in thousands)[a]	15,982	281,422
Percent under age 18 (1999)[a]	22.8%	25.7%
Percent Hispanic (1999)[b]	16.7%	12.5%
Percent black (1999)[b]	16.6%	12.8%
Percent Asian (1999)[b]	2.7%	4.1%
Percent nonmetropolitan (1999)[b]	7.1%	20.3%
State Economic Characteristics		
Per capita income (2000)[c]	$28,146	$29,676
Percent change per capita income (1995–1999)[d]	8.1%	10.8%
Unemployment rate (2001)[e]	3.9%	4.5%
Family Profile		
Percent children in poverty (1998)[f]	18.8%	17.5%
Percent change children in poverty (1996–1998)[f]	–14.9%	–15.0%
Percent adults in poverty (1998)[f]	11.7%	11.2%
Percent change adults in poverty (1996–1998)[f]	–7.1%	–10.4%
Political		
Governor's affiliation (2001)[g]	Republican	NA
Party composition of senate (2001)[h]	15D-25R	NA
Party composition of house (2001)[h]	43D-77R	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC)[i]	50.4%	59.3%
1998 (TANF)[i]	30.3%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996[j,k]	113%	124%
1998[j,l]	200%	178%
2000[j,m]	200%	205%

Table 1 notes begin on page 28.

Finally, the state's response to budget shortfalls has put a strain on the relationship between state and local governments. Last year, $89 million in local taxes and state graduate medical education funds were used to leverage $135 million in federal matching funds through the UPL program—all of which were directed back to local hospitals. The legislature passed legislation for FY 2002 that calls for almost tripling the local contribution, but the legislature has required that some of the local monies raised for the UPL program be channeled into state general revenue accounts, a move that could threaten local participation in the program. In addition, the opposition of Governor Bush to a bill that would waive the local match requirement for participation in the state's SCHIP program was also a source of tension between state and local governments.

To better understand how states have responded to both federal constraints and state flexibility during the last half decade, this study of Florida, along with 12 separate studies of other states, examines state priority setting and program operations in health policy affecting the low-income population.[4] Five major sets of issues are addressed in this set of reports. First, how have the political and fiscal circumstances of the state changed over the last several years? Second, has the state expanded public or private health insurance coverage, through Medicaid, SCHIP, Medicaid research and demonstration waivers, or state-funded programs? Third, how have Medicaid managed care and other acute care issues changed? For example, has access been affected by managed care plan withdrawals from Medicaid or backlash against plans by providers or beneficiaries? How are states coping with federal DSH cuts? Fourth, how are states responding to pressures to expand home-

and community-based services for disabled persons, their new freedom to set reimbursement rates, and the labor shortage? Fifth, what other issues were prominent?

Information for this report came from in-person interviews on site in late March 2001, sometimes supplemented by telephone and written responses. Interviewees included state officials, provider associations, and other knowledgeable observers. Secondary sources included publicly available documents, newspaper articles, and Web sites. Interviewees were given the opportunity to comment on a draft, and policy changes were tracked through the end of the December 2001 special session that was called to address unanticipated budget deficits.

Background

Demographics and Insurance

Florida's population has grown from 12.9 million people in 1990 to nearly 16 million residents in 2000 (see table 1), which represents a growth rate of 23.4 percent, almost double the growth rate for the nation as a whole (not shown).[5] The demographic makeup of Florida's population is also among the most racially and ethnically diverse in the country. According to Census estimates, the black and Hispanic populations make up 16.6 percent and 16.7 percent of the Florida population, respectively (versus 12.8 percent and 12.5 percent, respectively, for the nation), and the foreign-born population makes up 17 percent of the Florida population (versus 11.2 percent of the total U.S. population, not shown).[6] Florida is also an overwhelmingly urban state, with approximately 93 percent of its population residing in a metropolitan area.[7]

Demographic trends in Florida underline the rapid aging of Florida's population, with the 85 and older population—the population most likely to need long-term care services—exhibiting one of the fastest growth rates. According to estimates, this population grew 58.1 percent from 1990 to 2000 and is expected to grow by another 44.2 percent by 2010. The increase in the elderly population is coupled with a disconcerting trend: the decline in the growth rate of the population age 25 through 44, a major component of the labor force. The growth rate for this group declined from 60 percent between 1980 and 1990 to 16.5 percent between 1990 and 2000 and is expected to decrease to -3.0 percent between 2000 and 2010.[8]

Children and nonelderly adults in Florida have a significantly lower rate of employer-sponsored insurance coverage and a higher rate of uninsurance relative to the national average (see table 2). These disparities between Florida and the United States are evident even among children and adults above 200 percent of the poverty level, suggesting that the problem of uninsurance exists beyond the extremely low-income populations. One of the contributing factors to Florida's high uninsurance rate is the nature of its economy. In 2000, 54.6 percent of Florida's workforce was employed in the service or retail trade industries,[9] which typically have high uninsurance rates. Florida's economy is also dominated by small firms that are less likely to offer insurance. According to a state-level evaluation of the health insurance status of Florida residents, nearly 65.2 percent of uninsured employed Floridians age 18 to 64 report that their employers do not offer health insurance.[10] With employers facing a weak economy and rising health care costs, there is a concern that more workers will become uninsured due to their employers' inability to afford employee health care coverage.

Political Developments

Jeb Bush was elected governor in November 1998, replacing Governor Lawton Chiles (D). Like former Governor Chiles, health-related initiatives rank high on Bush's agenda. There are, however, noticeable differences in policy focus and development between the two administrations.

One example of the differences between the two administrations is the relative focus of health policy initiatives. The expansive nature of health policy initiatives under the Chiles administration—for example, the Florida Health Security, a program that sought to

TABLE 2. *Health Insurance Coverage, by Family Income and Type of Insurance, Florida and the United States, 1999*

	Children (Ages 0–18)[a] (%)		Adults (Ages 19–64)[b] (%)	
	Florida	United States	Florida	United States
Below 200% FPL				
Employer-sponsored	34.8	38.7	41.6	41.7
Medicaid/SCHIP/state	35.3	35.2	12.6	14.7
Other coverage	4.4	3.8	10.1	8.8
Uninsured	25.5	22.4	35.8	34.9
Above 200% FPL				
Employer-sponsored	**76.4**	85.3	**77.7**	83.7
Medicaid/SCHIP/state	**6.5**	3.8	0.8	1.1
Other coverage	**8.2**	4.9	**9.5**	5.8
Uninsured	**8.9**	6.0	**12.0**	9.4
All Incomes				
Employer-sponsored	**57.9**	66.7	**67.4**	72.3
Medicaid/SCHIP/state	**19.3**	16.4	4.2	4.8
Other coverage	**6.5**	4.5	**9.7**	6.6
Uninsured	**16.3**	12.5	**18.8**	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children: Findings from the National Survey of America's Families." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.
b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults: Findings from the National Survey of America's Families." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.
Note: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.
FPL = federal poverty level
SCHIP = State Children's Health Insurance Program

subsidize health insurance premiums for the entire low-income uninsured population—has been replaced with a more focused policy objective of improving services for vulnerable groups within this population, that is, low-income children, persons with disabilities, and the elderly.

Consistent with the narrowing of health policy objectives, limiting the government's role in implementing policy initiatives is another new development in the political environment since Bush took office. Officials describe the government under the Bush administration as one that seeks to incorporate the private sector when developing the state's health policy agenda. The Bush administration directly incorporates the private sector by creating partnerships with businesses to deliver services traditionally provided by the government (for example, contracts with private companies to deliver disease management services to Medicaid recipients, and the increase in HMO participation in Medicaid managed care). State legislators and the governor also indirectly use businesses to further health policy goals by creating a regulatory environment that encourages businesses to provide services that the government could otherwise provide (for example, small group market reform to make insurance more affordable for the uninsured). Initiatives that focus on reducing the size of government and increasing its efficiency occupy a large portion of the governor's political agenda. Even the management style of the governor and administration officials reflects a more business-minded atmosphere.

While health care initiatives are a high priority in the Bush administration, there are other issues that play a prominent role in his policy agenda. As a candidate, tax relief and education were the driving forces of his campaign and, as governor, are high priorities in his administration. In his first year as governor, he enacted a $1 billion tax reduction, the largest tax cut in the state's history.[11] The level of prominence of other issues creates a cer-

tain amount of competition for health policy initiatives that did not exist in the previous administration.

Another major development that occurred with the election of Governor Bush was the rare Republican party alignment of the governor's office and the two houses of the state legislature, an event that has not occurred since the Reconstruction era. This unique event has had a direct impact on policy development relative to the Chiles administration. Officials state that there is a willingness to compromise when there are disagreements between the executive and legislative branches. Evidence of this can be seen in the legislature's support of the governor's substantial interest in funding programs for vulnerable populations.

Despite the more conciliatory atmosphere, there are still tensions that exist within the legislature and between the governor's office and the legislature. One big point of contention during the regular and special 2001 legislative sessions was whether to proceed with proposed tax cuts despite deteriorating economic conditions: during the regular session, the senate supported scaling back tax cuts for the year, while the governor and house supported full implementation of the cuts; during the first special session, the governor and senate were in favor of delaying the tax cuts, while the house still fervidly supported full implementation. Another long-standing point of contention between Bush and the legislature is the governor's policy of significantly reducing or eliminating state funding of local projects that are not relevant to the state as a whole.

Health Care Market Developments

Florida's HMO industry has had substantial financial problems in recent years. Between 1997 and 1999, HMOs generally reported negative profit margins, with the extent of the losses nearly tripling between 1997 and 1999.[12] According to industry representatives, the ailing health of the HMO industry was due in part to the undercapitalization of health plans and skyrocketing growth rates in health care costs, especially prescription drug costs. Also, the ability of HMOs to negotiate discounts slowly eroded because consolidation strengthened the market position of hospitals. Using their newfound bargaining power, hospitals have begun to demand increases in provider payments. HMO industry representatives also contend that the extreme competitiveness of the market and the extensive list of mandated benefits required under Florida law have worked against the financial stability of the industry.

In addition to the recent financial woes of the HMO industry, plans have had to deal with an increasingly strict regulatory environment that resulted from allegations of poor business practices by HMOs. One of Governor Bush's major initiatives was to impose tougher state sanctions against delinquent HMOs and aggressively expand the state's independent review panel that resolves disputed health plan medical and coverage decisions.

The increased attention given to HMOs by the administration is reflected in the actions of the insurance regulatory agencies and state legislature. In 1999, the Agency for Health Care Administration and the Department of Insurance launched a major investigation of the HMO industry after a dramatic increase in complaints against HMOs. In addition, the practice of making late payments to providers resulted in the Department of Insurance imposing substantial fines for flagrant violations of the state's prompt payment laws. The Florida legislature passed legislation in 2000 that strengthened prompt payment laws in the state. Industry representatives reported that the increased attention to ensuring that HMOs meet standards of profitability and to identifying insolvent and poorly managed HMOs seems to have improved the health of the market. Recent reports of higher first quarter profits for 2001 support their conclusions.[13]

During the late 1990s, Florida's hospital systems experienced financial difficulties. In 1999, total net income for the state's 194 hospitals reached its lowest point in seven years, and nearly one-third of hospitals in Florida incurred losses.[14] According to hospital industry representatives, the strained financial situation of Florida hospitals was due in large part to federal cutbacks in Medicare reimbursement. With Florida having the second largest Medicare population in the country (2.9 million Floridians receive Medicare),

Medicare is the largest contributor to hospital revenue.[15] As a result of Medicare payment cutbacks in the Balanced Budget Act of 1997, industry representatives estimate that hospitals will lose $3.3 billion in revenue between 1998 and 2002 (after accounting for givebacks provided for in the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000).[16] Another factor affecting the financial status of hospitals was the rising burden of providing uncompensated care. Hospitals have experienced a decrease in their ability to cross-subsidize uncompensated care through payments from insurers because of the high penetration of managed care and its discounted payment rates. The precarious financial circumstances of hospitals contributed to seven hospital closures between 1997 and 1999 as well as numerous mergers and acquisitions.[17]

More recent news about the financial position of hospitals suggests that the situation is improving somewhat. For example, as a result of the consolidation of the hospital market, a number of hospitals were able to negotiate more favorable payment arrangements with insurers. Nonetheless, with the increases in costly hospital emergency room use and the persistence of labor shortages that threaten to increase the cost of labor, hospitals are still cautious about their financial outlook.[18]

Fiscal Circumstances of the State

General Strength of the Economy

During the late 1990s, Florida, like the rest of the nation, experienced a healthy economy. For much of the 1990s, the annual growth rate for new jobs exceeded the U.S. average, and the unemployment rate was slightly lower than the U.S. average.[19] In 2000, per capita income was about on par with the national average, although the growth rate in per capita income between 1995 and 1999 was lower than the U.S. average (see table 1). Among these generally healthy economic indicators, there were some dim spots. Florida had a higher rate of children in poverty than the United States as a whole, but the rate of decline of children in poverty between 1996 and 1998 matched that of the nation. Conversely, the proportion of adults in Florida living in poverty matched the national average, while the rate of decline in Florida's adults living in poverty from 1996 to 1998 was slower than that of the nation. Despite these issues, the overall health of the economy and the implementation of the state's welfare-to-work program caused Florida to experience a rapid decrease in welfare caseloads between 1996 and 1998 relative to the national average (20.1 percentage point decline in Florida versus 9.4 percentage point decline nationwide).

Budget Trends

The health of the economy in recent years has made funds available for state spending. Historical budget trends presented in table 3 suggest that education is a top priority in the state. Educational expenditures experienced the highest growth rates in state expenditures between 1995 and 2000, especially higher education, where average annual growth rates are more than twice the national average.

Spending on entitlement programs was pretty much kept in check during the late 1990s. In keeping with the huge decreases seen in Florida's welfare caseload relative to the national average, the decrease in total spending for Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF) programs between 1995 and 2000 outpaced the national average. The modest growth rates in Medicaid spending reflected national growth rates during this time.

Recent Budget Issues

Florida's economic health in FY 2000–2001 continued to be strong, but by the end of the 2001 legislative session, there were signs that the economy would slow down in FY 2001–2002. Job growth, consumer spending, and business investments were all expected to continue their current deceleration in growth. Consequently, the fiscal landscape for Florida has become more tenuous than it had been in recent years. According to March 2001 estimates, net general revenue growth declined from 5.2 percent in FY 2000 to 2.6 per-

TABLE 3. *Florida Spending by Category, 1995 and 2000 ($ in Millions)*

	State General-Fund Expenditures[a]				Total Expenditures[b]			
	Actual	Estimated	Annual Growth (%)		Actual	Estimated	Annual Growth (%)	
Program	**1995**	**2000**	**FL**	**U.S.**	**1995**	**2000**	**FL**	**U.S.**
Total	$13,950	$18,705	6	5	$37,561	$48,653	5	6
Medicaid[c,d]	$1,921	$2,480	5	5	$5,931	$7,338	4	4
% of Total	14%	13%			16%	15%		
K–12 Education	$5,207	$7,179	7	7	$6,715	$9,126	6	7
% of Total	37%	38%			18%	19%		
Higher Education	$1,663	$3,038	13	5	$2,682	$4,674	12	5
% of Total	12%	16%			7%	10%		
Public Assistance	$334	$258	–5	–6	$838	$258	–21	–5
% of Total	2%	1%			2%	1%		
AFDC/TANF	*$312*	*$258*	*–4*	*–9*	*$782*	*$258*	*–20*	*–7*
% of Total	*2%*	*1%*			*2%*	*1%*		
Corrections	$1,398	$1,567	2	6	$1,472	$1,681	3	6
% of Total	10%	8%			4%	3%		
Transportation	$–	$–	–	5	$4,656	$4,489	–1	6
% of Total					12%	9%		
All Other[e]	$3,427	$4,182	4	5	$15,267	$21,086	7	8
% of Total	25%	22%			41%	43%		

Source: National Association of State Budget Officers (NASBO), 1996 State Expenditure Report (April 1997), and 1999 State Expenditure Report (June 2000).
a. State general-fund expenditures exclude other state funds and bond expenditures.
b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.
c. States are requested by the National Association of State Budget Officers to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, and so forth are included in state spending because states cannot separate them.
d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA 64.
e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

cent in FY 2001, although the growth rate was expected to rebound to 3.5 percent for FY 2002.[20] Furthermore, increases in Medicaid and SCHIP spending alone had reached 18.1 percent in FY 2002,[21] causing the costs of these health care programs to place the largest amount of stress on the budget. Funding increases for education programs also placed a great deal of burden on the budget.

One tool used to reconcile looming budget shortfalls was revenue generated by the tobacco settlement. In FY 2001, the legislature appropriated the majority of settlement payments to fund the state's SCHIP program, assisted living services, home- and community-based programs, and other existing programs within the Department of Children and Family Services (DCFS) through the Lawton Chiles Endowment Fund. In FY 2002, settlement funds increased by an additional $396 million, giving the state a total of $860 million that is available for spending.[22] Originally, Governor Bush recommended designating most of the increase in settlement payments to the Chiles Endowment Fund and contingency reserves, permitting a net spending increase of only $33 million for other programs. By the end of the regular legislative session, however, more of the tobacco settlement revenue was tapped in order to maintain or enhance other health and human services programmatic operations as well as provide additional tax cuts.

In the aftermath of September 11, 2001, however, Florida's economy, which is heavily dependent on the state's tourism industry, took a turn for the worse, devastating the state's delicate fiscal position. By October 2001, the original general revenue estimates that were used to appropriate funds in FY 2002 had been reduced by $1.3 billion (6.6 percent), leaving the state with a projected year-end deficit of $928.5 million.[23] Since Florida's constitution requires a balanced budget, the governor called two special sessions of the legislature to resolve the budget deficit. Two sessions were needed because the first essentially ended in a deadlock between the senate and the house, with the legislature unable to compromise on a viable solution. Before the second session, however, the governor was able to broker a compromise that enabled the legislature to develop a fiscal plan to balance the state's budget. In the end, more than $1 billion in cuts were made to the state's original FY 2002 budget, and a delay in implementing a previously enacted tax cut was approved.

Medicaid Enrollment and Expenditures

Enrollment Trends

Between 1995 and 1998, Florida's Medicaid program experienced a decrease in enrollment, reflecting national trends of declining Medicaid participation (see table 4). Children on Medicaid experienced the greatest decline in this period, with an annual average negative growth rate that was more than four times the national average (-6.7 percent versus -1.5 percent). The relatively higher rate of decline in elderly Medicaid enrollment was driven by declines in noncash enrollees. The blind and disabled populations and adult noncash enrollees were the only groups to experience an increase in enrollment, which is consistent with national trends.

More recent data from Florida's Agency of Health Care Administration indicate that this trend of declining Medicaid enrollment is reversing. According to the Agency, Medicaid enrollment increased 9.5 percent between December 1998 and December 1999.[24] The largest part of this increase is due to increased enrollment by poverty-related children, which accounted for 55 percent of the total increase during this period. This substantial increase can be attributed, in part, to the state's SCHIP-related outreach efforts. Another large contributor to the Medicaid enrollment increase is women covered by the state's family planning waiver (37 percent of the increase). This program extends Medicaid coverage for family planning services to women who have received a Medicaid-financed pregnancy-related service in the past two years. The program was created to encourage low-income women to increase the time between births, a practice that the state hopes will improve the quality of life for low-income women and their families and reduce the pregnancy-related costs incurred by the state's Medicaid program. State Medicaid officials also report that the recent increase in the number of former welfare beneficiaries that are receiving transitional Medicaid benefits has also contributed to the increase in Medicaid enrollment.

Expenditures Trends

The overall trend for Medicaid expenditures in Florida between 1995 and 1998 mirrored the national trend of modest growth in spending. A breakdown of the growth rate trends by type of service, however, reveals considerable disparities between Florida and the nation. The growth rate for acute care expenditures was less than half the national growth rate. The main exception to this phenomenon of lower Medicaid spending growth during this period was the significantly higher growth rate for Florida's prescription drug expenditures (18.7 percent for Florida versus 11.2 percent for the nation).[25]

While acute care spending per enrollee in 1998 was comparable to the rest of the United States, Florida's long-term care expenditures per enrollee were well below the national average.[26] The lower long-term care expenditures have been attributed in part to the surprisingly low supply of institutional long-term care providers and the limited development of home- and community-based programs in the state.[27]

TABLE 4. Medicaid Enrollment and Expenditures in Florida, 1998

	Florida, 1998			Average Annual Growth (%), 1995–1998					
				Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee	
	Total Annual Expenditures (in billions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Florida	United States	Florida	United States	Florida	United States
Total Expenditures	**$6,863**	**–**	**–**	**3.0**	**3.9**	**–**	**–**	**–**	**–**
Medical Services									
By Eligible Group	**$6,246**	**1,466**	**$4,262**	**2.5**	**5.1**	**–2.9**	**–1.0**	**5.6**	**6.1**
Elderly	$1,792	179	$10,038	–0.2	4.3	–2.1	0.1	2.0	4.2
Blind and disabled	$2,848	364	$7,816	11.5	8.5	7.7	3.6	3.6	4.7
Adults	**$607**	**216**	$2,810	–3.8	–1.4	–4.9	–4.4	1.2	3.1
Cash assistance	$303	150	$2,022	–13.8	–10.4	–7.9	–14.9	–6.4	5.3
Other enrollees	$304	66	$4,589	13.5	7.8	3.6	9.3	9.6	–1.4
Children	**$999**	**707**	$1,414	–7.5	2.7	–6.7	–1.5	–0.9	4.3
Cash assistance	$450	373	$1,207	–9.4	–8.8	–9.8	–12.2	0.5	3.9
Other enrollees	$550	334	$1,645	–5.8	12.4	–2.6	9.8	–3.3	2.4
By Type of Service	**$6,246**	**–**	**–**	**2.5**	**5.1**	**–**	**–**	**–**	**–**
Acute care	$4,176	–	–	1.2	4.0	–	–	–	–
Long-term care	$2,070	–	–	5.4	6.5	–	–	–	–
DSH	**$371**	**–**	**–**	**3.5**	**–7.3**	**–**	**–**	**–**	**–**
Administration	**$246**	**–**	**–**	**20.5**	**8.5**	**–**	**–**	**–**	**–**

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Note: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. "Cash assistance" refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. "Other enrollees" include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. "Acute care" services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), and payments to Medicare. "Long-term care" services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. "DSH" stands for disproportionate share hospital payments.

As in other states, more recent data on Medicaid expenditures illustrate the considerable strain the state's Medicaid budget now faces. Increases in Medicaid spending have produced a budget shortfall of $546 million in FY 2001; the shortfall rose to $1.5 billion in FY 2002.[28] Three main factors contributed to the unexpected increases in expenditures. The first was the dramatic increase in funding for home- and community-based services that serve as alternatives to institutional care for elderly persons and younger persons with disabilities. From FY 1998 to FY 2001, funding levels more than doubled, going from $282.4 million to $603.7 million.[29] The majority of the increased funding went to home- and community-based service programs for the developmentally disabled.

The second factor was the substantial increase in health care expenditures, with prescription drug prices one of the biggest catalysts. As noted above, prescription drug expenditures in Florida have always had higher-than-average growth rates, even in times of relatively stable growth for Medicaid expenditures. More recently, prescription drug services have become the most expensive item in the state's Medicaid program, surpassing even nursing home care costs to consume a projected 20 percent of the state's Medicaid budget in FY 2001–2002.[30] Relative to other states, Florida has one of the highest annual fee-for-service prescription drug expenditures per recipient, even though it pays relatively low unit prices for prescription drugs (only five states had lower costs than Florida during FY 1999).[31] According to a report published by the Office of Program Policy Analysis and Government Accountability, the rise in prescription drug expenditures was largely due to a lack of aggressive cost control measures. Between FY 1996 and FY 2000, 67.4 percent of the increase in prescription drug costs was due to increases in doctors prescribing more costly drugs.[32]

The third factor was the unanticipated increase in Medicaid caseloads, which was a result of (1) the extensive outreach effort to enroll children in Florida's SCHIP program, which resulted in identifying and enrolling Medicaid-eligible children, and (2) provisions for transitional Medicaid coverage for welfare leavers that allowed families to stay on the program after they no longer qualified for cash benefits. The use of transitional benefits is likely to increase due to a law that was passed in the 2000 legislative session that seeks to increase the use of transitional benefits by welfare leavers.

Despite the unintended budgetary consequences of expansions, Florida continued to expand eligibility for Medicaid. By the end of the regular 2001 legislative session, Florida had expanded eligibility for uninsured women who have been diagnosed with breast and cervical cancer and had authorized the creation of an insurance premium subsidy program for privately insured Medicaid-eligible persons.

While factors outside the control of policymakers have contributed to some of the current hardships, the state's past fiscal policy is partly to blame for the current budget woes. Some observers expressed the concern that there was a philosophical contradiction in the policymaking of the Florida government that embraced fiscally conservative policies such as tax cuts while simultaneously promoting program expansion policies.

State Responses to Medicaid Budget Pressures

In response to the recent growth in state Medicaid expenditures, the Florida legislature attempted to institute cost-control measures, with a particular focus on containing prescription drug costs. In the 2000 legislative session, the governor and legislature made efforts to curtail prescription drug spending by enacting a bill that would limit the number of brand-name prescription drugs that Medicaid recipients can receive per month without prior authorization,[33] reduce the reimbursement levels for pharmacies that dispense drugs to Medicaid patients, and require generic drug manufacturers to offer the state a rebate. These provisions, however, were apparently not enough to curb the growth of prescription drug costs.

When the financial strain of the Medicaid budget spilled over into the 2001 regular legislative session, the initial response of the state legislature was to propose making several cuts to health care programs. Most notably, the senate appropriations subcommittee

on Health and Human Services voted to eliminate the Medically Needy program, which they predicted would produce a cost savings of $100 million in the next year's budget. They also voted to reduce the number of pregnant women eligible for the state's Medicaid poverty-related expansion program by reducing the income threshold from 185 percent of the federal poverty level (FPL) to 145 percent of FPL, which would save an additional $37 million.[34,35]

By the end of the regular legislative session, the governor and state legislature avoided the implementation of program cuts, preferring the continued use of cost-containment measures to resolve the budget shortfall. The most notable was the creation of a state Medicaid preferred drug list program that would restrict the types of drugs beneficiaries can use without prior authorization. Antiretroviral drugs, drugs used to treat mental illness, and drugs for nursing home and other institutional residents would be exempted from prior authorization. Florida's Medicaid drug formulary, which was approved by the U.S. Department of Health and Human Services in September 2001, allows the state to directly negotiate rebates with drug manufacturers in exchange for placing the manufacturers' drugs on the state's preferred drug list. The state-negotiated rebates would supplement the manufacturer rebates that are already provided to states under federal law.

Florida is the first state to take advantage of a 1993 law that allows states to negotiate with drug companies outside of the federal drug rebate program.[36] The proposal for a drug formulary first surfaced during the 1999 legislative session, but it was defeated under pressure from pharmaceutical industry lobbyists and beneficiary advocates. The move by Florida to supplement the savings it receives through the federal rebate program may establish a trend for other large states that are also facing substantial increases in prescription drug costs and have the bargaining power to engage in direct negotiations with drug companies.

In addition to establishing a pioneering Medicaid drug formulary, Florida has set an important precedent by using formulary negotiations to solicit drug companies to provide funding for services that could bolster the administration of the Medicaid program while producing cost savings for the state, instead of just simply requiring them to provide supplemental cash rebates. This cost-containment initiative is an example of the principles of public-private partnerships and market-oriented solutions that have guided the development of Florida health policy in recent years.

In a deal with Pfizer, the Agency for Health Care Administration agreed to include drugs produced by Pfizer on the formulary, purchased at full price, in exchange for Pfizer providing financial and operational assistance to initiatives that the Agency believes will produce cost savings for the state's Medicaid disease management program (discussed later in this report). Pfizer has guaranteed a savings of $33 million over two years; if the initiatives fail to meet that goal, the drug company will pay the difference. The Agency has negotiated a similar deal with the Bristol-Myers Squibb Company to provide funds to improve the health care of certain Medicaid populations and address the language and cultural barriers that prevent them from receiving care. State officials believe that the deals with Pfizer and Bristol-Myers Squibb signify a unique and attractive opportunity to combine the state's cost-containment goals with improved benefits for Medicaid participants.

While the state is optimistic about its Medicaid drug formulary program, opponents of the state's Medicaid drug formulary are concerned that the program will negatively impact the fee-for-service clients that it covers.[37,38] Even though drug formularies have been successfully used by commercial insurance plans, opponents contend that this population (comprised largely of elderly persons and persons with disabilities) is generally sicker than the privately insured population and, consequently, has a higher demand for prescription drugs; they also lack the financial means available to most privately insured patients to obtain drugs that are denied to them. There is also a concern about the lack of an adequate communication system between AHCA and Medicaid beneficiaries that will inform clients of their rights and allow the state to effectively monitor the experience of vulnerable populations in the program.[39]

The first major challenge to the state's formulary came in August 2001 in the form of a lawsuit filed by the pharmaceutical industry's lobbying organization, Pharmaceutical Research and Manufacturers of America (PhRMA). Principal among its objections was the claim that Florida's program is in violation of federal law because it disregards a provision that requires states to ensure that drugs that are not included in the formulary have *no* "significant, clinically meaningful therapeutic advantage over other drugs in the formulary."[40] In January 2002, a federal judge denied PhRMA's claim and let the program stand, citing as his reason for the decision the fact that Florida allowed access to nonformulary drugs through the prior authorization process. PhRMA plans to appeal the decision.

Florida has instituted other prescription drug reforms, including the development of a drug benefit management program that intends to manage more efficiently the drug therapies of HIV/AIDS patients and other patients that have large demands for prescription medicines. All told, the state expects a savings of $214 million from the drug reforms it has instituted in FY 2002.[41]

The efforts to control Medicaid spending have gone beyond the prescription drug cost control measures discussed above. Florida has developed other cost-cutting programs that include the use of competitive bidding processes to establish contracts with providers and suppliers for various health care services and products (home health[42] and independent laboratory services and medical supplies and apparatuses) and the development of a prior-authorization policy for nonemergency Medicaid inpatient admissions. Inpatient hospital services represented the third largest contributor to the Medicaid shortfall in FY 2002 after prescription drugs and nursing home care.[43] The state has also used Medicaid managed care enrollment policies to divert more participants into capitated HMO plans so as to take advantage of the perceived cost benefits of this managed care arrangement.

In theory, the combined effect of these cost controls could produce the desired outcome of controlling Medicaid expenditures, but a November 2001 report on the effectiveness of Medicaid cost-control measures released by the Office of Program Policy Analysis and Government Accountability suggests that the success of cost-control initiatives is hampered by the way these measures are currently implemented and evaluated.[44] The report analyzed initiatives implemented between FY 1997–1998 and FY 1999–2000 and found that one-third of the expected $297 million in savings has not materialized, largely due to implementation delays. The Office also estimated that only 38 percent of the savings anticipated from FY 2000–2001 prescription drug control measures were realized (reports on other cost-control measures were not yet available). The report concluded that inadequate reporting to the legislature on the progress of implementation and actual achieved savings negatively affects its ability to evaluate the fiscal impact of the policies that have been adopted.

In light of the current state of Florida's economy, the efficacy of these policy initiatives is even more of a concern. As a result of the budget deficits that appeared after September 11, the state had to adopt more aggressive measures to balance its budget. At the end of the second special legislative session, the state enacted several cuts in funding for Medicaid programs and services. The cutbacks included adopting a similar version of an earlier proposal to eliminate the Medically Needy program for adults, effectively ending coverage for almost 19,000 Medicaid beneficiaries.[45,46] The state also reduced the income eligibility threshold for the state's elderly and disabled Medicaid expansion program, ending coverage for an additional 1,500, and eliminated Medicaid coverage of dental, visual, and hearing services for adults, restricting access for approximately 190,000 beneficiaries who use at least one of those services.[47] Another earlier proposal to eliminate Medicaid eligibility for pregnant women with incomes between 150 percent and 185 percent of FPL was enacted in the first session but later repealed in the second. The ability of the state to efficiently realize cost savings from the cost-control measures it has implemented could play a role in determining whether future cuts to the Medicaid program will be necessary.

Health Insurance

Due in part to the nature of Florida's economy, the uninsurance rate among children and nonelderly adults in Florida is relatively high when compared to the national average (see table 2). With the declines in welfare caseloads in the late 1990s, one major concern of the Florida state government was the potential of welfare reform to aggravate the problem of uninsurance in the state. In 1999, the Florida Agency for Health Care Administration published a report on the effect of the state's welfare reform program on the uninsured, which found that only 41 percent of people who left welfare between October 1997 and March 1999 maintained Medicaid coverage, while another 11 percent obtained health insurance from an alternative source.[48] The report did not distinguish between the number of people receiving transitional benefits and those eligible for the Section 1931 or Title XXI programs. The study reported that children were more likely to retain Medicaid coverage during the study period, due in part to the higher levels of income eligibility for children.

Medicaid income thresholds for low-income parents are relatively low compared to the Medicaid and SCHIP thresholds for children. Even after the state attempted to expand eligibility for parents after welfare reform by increasing the income eligibility rules and removing restrictions on the eligibility of two-parent families, a low-income parent in a family of three still must have income below 68 percent of FPL in order to qualify for Medicaid, and the income threshold decreases as family size increases.[49] Children, however, can qualify for public insurance coverage with family income up to 200 percent of FPL, regardless of family size. In addition to the limits on adult income eligibility, parents face other administrative obstacles to maintaining coverage after welfare. In 1999, former welfare recipients filed a class-action lawsuit alleging that Florida state agencies were illegally denying coverage to former welfare recipients by virtue of their failing to inform them of their right to receive assistance. Since the lawsuit, the state has made efforts to increase staff training on how to inform former welfare recipients of their right to continued Medicaid benefits. The state has also increased public outreach that attempts to correct the misperception that the loss of welfare translates into the loss of Medicaid and encourage the take-up of Transitional Medicaid Assistance for recipients that are no longer eligible for Medicaid. Nevertheless, a report published by Families USA found that the income and administrative barriers confronting adults who go off welfare contributed to the loss of coverage for more than 80,000 parents (37 percent decline of Medicaid parents) between 1996 and 1999.[50]

Outside of the administrative improvements made by the state, there have been no concrete discussions on expanding eligibility for low-income parents under Medicaid using Section 1931 provisions included in the Balanced Budget Act of 1997 that allow states to expand eligibility for parents without obtaining a waiver from the federal government. While recent budget constraints are largely to blame for the lack of Section 1931 expansions, members of the state government also have a negative view of expanding entitlement programs.

Conversely, there was some support in the legislature for expanding the state SCHIP program for low-income children to their parents, but financing the enrollment of noncitizen children that are ineligible for Medicaid or SCHIP due to federal rules was likely to be a higher priority.

State Children's Health Insurance Program

Addressing the problem of uninsurance among Florida's children has been a policy priority for the state. The higher rates of public coverage among Florida's children relative to adults (see table 2) suggest that the state's public insurance programs have made some headway in dealing with this problem. Positive gains in coverage are attributable to the state's ambitious implementation of KidCare, Florida's Title XXI/SCHIP program.

Officially established in 1998, KidCare's roots date back to 1990 and the creation of the school-based child health insurance initiative called Healthy Kids, a joint venture between the Florida government and private industry. Today, the program represents a relatively

complex "combination program"; that is, it comprises both Medicaid and separate state program components. The Medicaid component consists of a program expansion that extends Medicaid coverage to infants with family incomes between 185 percent and 200 percent of FPL and teens age 15 through 18 with family incomes below 100 percent of FPL. The separate state program component is comprised of (1) the MediKids program, which is a nonentitlement Medicaid "look-alike" program that offers Medicaid benefits to children age 1 through 4 with family incomes between 133 percent and 200 percent of FPL, and (2) the Florida Healthy Kids program, which was grandfathered into the Title XXI program to provide coverage for children age 5 through 6 with family incomes between 133 percent and 200 percent of FPL and children age 7 through 18 with family incomes between 100 percent and 200 percent of FPL. Florida's SCHIP program also includes the Children's Medical Services program, a separate and specialized health care delivery system that is extended to all SCHIP-eligible children with special health care needs.

The complex structure of the KidCare program is the result of strong political sentiment against a pure Medicaid expansion and the desire to implement a program utilizing the existing infrastructure. The state legislature, particularly the house, was very opposed to using Title XXI authority to further expand Medicaid, given the very large expenditure increases that occurred under Medicaid throughout the 1980s and more general resistance to expansion of entitlement programs. Moreover, there was strong political and private sector support for the existing Healthy Kids program and a desire to implement SCHIP as expeditiously as possible. As a result, policymakers chose to maintain the Healthy Kids administrative, enrollment, and service delivery structures already in place, and to incorporate a relatively limited expansion of Medicaid for older children living in poverty that simply accelerated the phase-in of mandatory federal rules that would have made these children eligible for Medicaid by October 2001. The MediKids component was the result of a compromise between the legislature and the outgoing Chiles administration, which had pushed for Medicaid-equivalent coverage for Florida's youngest uninsured children. Finally, the Children's Medical Services program component was incorporated, because it was already a well-run and well-respected alternative system available to Medicaid enrollees, and policymakers judged that the system should be made available to children with special health care needs who are eligible for SCHIP.

The complex structure of Florida's KidCare program has left some families confused about how the program works and who's eligible for which component. Administratively, the multifaceted model has also led to coordination challenges between the Florida Agency for Health Care Administration, which oversees Medicaid and MediKids; the Department of Health, which oversees the Children's Medical Services program; the Department of Children and Families, which oversees the eligibility determination for Medicaid; and the not-for-profit Healthy Kids Corporation, which manages Healthy Kids components and the eligibility determination for the KidCare program.[51]

Perhaps the most direct outcome of these coordination challenges has occurred in the area of program enrollment. While KidCare has generally achieved high rates of enrollment—Florida has the third largest SCHIP program in the nation—participation in the program was initially slowed by backlogs and delays in the enrollment process and, more recently, due to shortfalls in some counties that could not provide the local match resources required by the Healthy Kids model. State officials report that a number of steps have been taken to streamline the application process and expedite enrollment, including building more sophisticated linkages between the state Department of Children and Families and the Healthy Kids eligibility systems. Solving the local match issue, however, has proven more challenging.

Initially, the requirement that local governments contribute to the cost of covering children under Healthy Kids was a guiding principle of the initiative; state officials who viewed local communities as best equipped to solve local problems—and financially responsible for doing so—embraced devolution. The local match requirement started at 5 percent of total funding for the first year, but was slated to increase by 5 percent each year

until it reached a cap of 20 percent of total funding. Over time, however, many counties found it difficult to meet the match requirement. As a result, thousands of eligible children across the state were put on waiting lists during 1999 and 2000 while counties raised the monies necessary to meet matching requirements. In 2001, the state legislature responded to this barrier by removing the requirement for the local match, but Governor Bush, who strongly believes in the participation of local government in providing programs to the public, sought to void the language in the bill through legal action. The issue became moot when, during the December 2001 special session, the legislature revised the statute to waive the local match requirement for one year, effectively resolving the governor's challenge.[52]

Despite these problems, KidCare is widely viewed as a very successful program. As of May 2001, 1.2 million Florida children were covered under KidCare, which represents an estimated 81 percent of all children eligible for the program. The state was expected to expand KidCare's capacity for enrollment even further with additional funding provided by the 2000 state legislature, but the recent economic downturn may weaken the state's ability to sustain enrollment increases.

In addition to its past enrollment success, the Healthy Kids component of KidCare has broadened the scope of its coverage with the approval from the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) in 2001 to include comprehensive dental services to its benefit package. (Originally, coverage of dental benefits was quite limited and only included cleanings and X rays.) Unfortunately, however, this added benefit will only be available to counties that contribute at least $4,000 annually in local matching funds. In addition, the ability of the state to successfully implement the dental benefit is questionable given the overall shortage of dentists that practice in Florida and their general unwillingness to participate in public insurance programs. There is also concern that the expansion of dental coverage will lead to premium increases in the program (estimated in the amount of $3 to $12 per child per month) while not necessarily improving children's access to dental care.

Small Group Market Reform and Other Employer/Private-Based Health Care Coverage Initiatives

Florida's approach to covering low-income adults has focused mostly on promoting affordable employer-sponsored coverage for the small group market. As stated previously, there is a preponderance of small employers in Florida's economy that are faced with a limited selection of high-cost coverage options.[53]

To make coverage more accessible for small firms, the legislature and former Governor Chiles passed a host of small group market reforms that tried to regulate the insurance market into offering more affordable plans. The major objectives of the legislative reform were to require insurers participating in the small group market to guarantee coverage under all small group products without regard to health status, preexisting conditions, or claims history, and to replace the practice of setting rates based on health status with a "modified community rating" system.[54,55] Some observers believe that these reforms had the effect of driving up premiums for the small group market. As a result, Governor Bush signed a health reform bill in June 2000 that limits some of the guarantee-issue and rate variation provisions outlined in the health reform laws of 1992 through 1994, believing that the loosening of these regulations will make the small group market more affordable to employers. Specifically, the 2000 health reform bill gave insurers the "limited ability" to look at health status or claims history when issuing small group policies. It also allows small group insurers to adjust rates by ±15 percent based on health status, claims history, and duration of coverage.

A small group reform law passed in 1993 also sought to expand coverage to small-firm employees by creating 11 health care purchasing cooperatives called Community Health Purchasing Alliances (CHPA). The CHPA system was a public-private venture based on a model of managed competition that sought to pool groups of small-firm employees so as

to reduce premium prices and increase consumers' health plan choices, but the program did not live up to expectations. According to a 1998 report by the Florida Office of Program Policy Analysis and Government Accountability, the CHPA program did little to reduce the state's uninsurance rate.[56] The report found that CHPAs covered 45,000 previously uninsured Floridians, which represented only 1.6 percent of the state's uninsured. A key factor in the failure of the CHPA system was the program's lack of authority to negotiate lower insurance rates with health plans. Another drawback to Florida's managed competition model is that CHPAs are prevented from pooling individual contracts, which limits their ability to benefit financially from economies of scale. In 2000, legislation passed to disband the CHPAs and replace them with a consortium of private, nonprofit corporations known as the Small Employer Health Alliance. Interviews with HMO industry lobbyists indicate that there is little interest in CHPA's successor.

The governor and members of the legislature have also considered programs that would have a more direct impact on increasing the level of private sponsored insurance among low-income adults. The first measure, proposed by a state representative, involves relaxing the various mandated benefits requirements to allow insurers to offer a less expensive "no frills" plan. The theory behind this proposal is that mandated benefits have contributed to the high cost of premiums. The second measure, called HealthFlex, proposed by the governor, would allow insurers, HMOs, and community-based organizations to offer bare-bones policies on a pilot basis in selected portions of the state with relatively high uninsurance rates that would cover major medical and preventative services, much like the first proposal. The first proposal, however, is geared more toward increasing employer-based insurance, while the second broadly focuses on the low-income population as a whole. State officials, however, admit that both proposals would have only a marginal effect on the uninsurance rate.

Acute Care Issues

Medicaid Managed Care

Enrollment. Mandatory managed care programs are an integral part of Florida's Medicaid policy. As of August 2001, 63 percent of all Medicaid recipients were enrolled in managed care.[57] Temporary Assistance for Needy Families (TANF), poverty-related, and Supplemental Security Income (SSI) populations are required to enroll in managed care. Pregnant women eligible through poverty expansions, Medicare and Medicaid dual eligibles, and people receiving care through the Medically Needy program or a home- or community-based care waiver program are excluded from the state's Medicaid managed care program.[58]

Populations that are mandated to enroll in managed care have a choice between enrolling in the primary care case management program (PCCM), Medicaid Provider Access System (MediPass), one of the participating HMOs, or, for recipients in southern Florida, the Provider Service Network (PSN), a relatively new alternative that is an extension of the MediPass program. Until recently, Medicaid policy automatically enrolled all eligible recipients that failed to voluntarily enroll in a plan into one of the available Medicaid managed care options based on the voluntary choice patterns of recipients for the previous quarter. For example, if 60 percent of recipients who made voluntary managed care selections chose to enroll in MediPass, then MediPass would receive 60 percent of the mandatory assignments and the HMOs would receive the remaining 40 percent. Due to the Medicaid budget overruns, however, Medicaid autoenrollment policies have been targeted as a mechanism to achieve cost savings for the program since autoenrollment represents more than 50 percent of all Medicaid enrollment in managed care. Specifically, the state implemented a change to the autoenrollment policy that mandates that 100 percent of nonvoluntary enrollees be assigned to HMOs until HMO and MediPass/PSN enrollments are equal.[59] The move toward increased enrollment in HMO plans reflects the state's perceptions regarding the cost-efficiencies of the HMO managed care arrangements. At one point during the legislative session, Governor Bush proposed to

require all Medicaid beneficiaries to enroll in Medicaid HMOs (with exemptions for those who have special health care needs or live in a county with fewer than two HMOs), drastically reducing the size of MediPass, but it was too successful a program to sacrifice.

Another Medicaid managed care policy that has come under review due to the budget shortfalls is managed care choice counseling. In 1997, only 26 percent of Medicaid managed care participants voluntarily enrolled in plans. The low voluntary enrollment rate was attributed to the problems beneficiaries have historically faced during the enrollment process: HMO marketing abuses, insufficient monitoring of HMO enrollment practices by the state, and limited state outreach and education for beneficiaries. In 1998, Florida contracted with an enrollment broker to provide choice counseling and, according to officials, the program was beginning to have a positive effect on the enrollment process: as of FY 1999–2000 the voluntary enrollment rate had climbed to 49 percent. By the end of the 2001 special legislative sessions, however, the legislature chose to cancel contracts with enrollment brokers and, instead, use informational brochures to educate beneficiaries—a move that some state officials feel may reverse the gains made in recent years.

Medicaid Contracted Plans. As previously stated, the state is attempting to increase the role of capitated plans in its Medicaid managed care program by promoting the expanded use of HMOs. Florida's history with HMOs has been somewhat tumultuous. When the state first began contracting with HMO programs, there was little monitoring or oversight by the state. In 1994, a series of media investigations revealed that widespread marketing abuses and substandard quality of care existed within the loosely regulated Medicaid HMO system. This prompted the state legislature to pass a slew of reforms in 1996 tightening regulations that govern the administration of care by HMOs. The regulations required that HMOs obtain a commercial license and national accreditation, improve grievance procedures and patients' access to information on the plan, and limit physicians' caseloads.

In addition to implementing regulations to improve the performance of Medicaid HMOs, the 1996 legislation also cut capitation rates for HMO plans in order to produce more cost savings from the program. A 1999 study of Medicaid managed care capitation payment levels found that Florida's rates were some of the lowest in the country.[60]

In the face of stricter regulations, lower rates, and general market instability, the number of Medicaid participating plans fell from 26 in 1995 to 14 in 2001.[61] The state reports that, despite the exit of plans from the program, there is still adequate participation in Medicaid managed care. The continued involvement of the remaining plans can probably be attributed to the competitiveness of the overall market (Florida Medicaid HMOs are largely commercial plans); but recent reductions in HMO capitation rates coupled with the precarious financial position of the HMO industry could potentially weaken their ability to participate in Medicaid.

One consequence of the dominant presence of HMOs is the weakening of the financial base of community health centers (CHCs). CHCs played an important role in the Medicaid program before managed care and continued to play a role as providers in the MediPass program. With the increased use of HMO plans for Medicaid managed care, CHCs were beginning to experience a decline in Medicaid reimbursement due to the diversion of Medicaid clients to private HMO networks. State officials, however, report that the situation is changing. More and more CHCs are being included as providers in HMOs' Medicaid managed care networks, a practice the Bush administration strongly encourages.

The Provider Service Network operating in south Florida is a more recent addition to the managed care options available to Medicaid recipients. The PSN is a "risk-sharing partnership between the Medicaid program and high-volume Medicaid providers."[62] The demonstration project was instituted in 1997 to see whether safety net providers can provide health care for Medicaid recipients while offering the state competitive prices for rendered services. This new Medicaid managed care arrangement is seen as one way to protect the viability of safety net providers at a time when Medicaid HMO penetration is increasing.

Since its inclusion into the Medicaid program, the PSN has had some difficulty establishing itself as a financially stable entity. The biggest impediment thus far is its inability to attract enough Medicaid enrollees to remain solvent. In its first year of operation, providers wanted an agreement from the Agency for Health Care Administration to refer 25,000 Medicaid enrollees to the network in order to stay financially viable.[63] The state has said that it cannot guarantee a specific number of enrollees because network selection is a consumer choice. The Agency initially declined to include the PSN as an autoenrollment option but has since reversed its position. As a result, the PSN has attracted over 22,000 recipients to its network as of August 2001, which has put it closer to its original goal of 25,000.[64] With the recent change in autoenrollment policies, however, the PSN may again experience difficulties in attracting new enrollees.

MediPass and the Disabled Population. Florida is unique in its efforts to mandate managed care enrollment for its non-dual-eligible SSI population; typically, states have focused their Medicaid managed care initiatives on the relatively healthier AFDC/TANF and poverty-related populations. When Florida first began mandating enrollment for the SSI population in 1996, it took several steps to smooth transition of SSI recipients into the MediPass program. Specifically, it consulted advocacy groups on the best way to accommodate the SSI population, it developed training programs designed to prepare primary care providers to serve the SSI population, and it attempted to recruit specialists that had experience in treating persons with disabilities. Florida also incorporated the Children's Medicaid Services Network—a preexisting primary care program for children with special health care needs—as a separate managed care option in conjunction with the MediPass program.[65]

In 1997 and 1998, Florida expanded its initiatives for persons with disabilities enrolled in MediPass by creating pioneering disease management programs. The programs were created to help improve health care outcomes and reduce the cost of care for chronically ill individuals by improving the management of care. The state contracted with private disease management organizations to provide services to providers and clients to help them better manage the course of a client's illness (for example, helping clients follow treatment plans and monitor their illness). The Agency for Health Care Administration pays disease management organizations in advance for their coordinating services with the expectation of savings for the MediPass program. If savings are achieved, the Agency for Health Care Administration shares a portion of the savings with the disease management organizations; if costs exceed expected savings, then the disease management organizations must refund the advance payments. The legislature estimated that the Medicaid program would save $112.7 million during the four years of the program's operation (FY 1998–99 to FY 2000–01) and reduced budget appropriations accordingly.[66]

While the idea behind the disease management program has promise, in practice the program has problems. A 2001 report by the Office of Program Policy Analysis and Government Accountability revealed that slow implementation of the program, limited participation of eligible participants in existing programs, and the limited involvement of providers have compromised the program's ability to improve outcomes while reducing costs.[67] Another problem with the program is its fragmented disease-oriented design: clients are only allowed to enroll in one of nine disease management programs even if they suffer from more than one chronic condition. Furthermore, the evaluation reports that there have been many obstacles impeding the Agency's ability to evaluate the effectiveness of the program with respect to cost savings and improved health outcomes. As a result of these problems of program implementation and evaluation, the Office of Program Policy Analysis and Government Accountability concludes that it is highly unlikely that the program has achieved the expected cost savings.

In light of the report's findings, members of the legislature have concerns that the aforementioned deal with Pfizer—where the company provides financial and operational support for the disease management program in exchange for the inclusion of Pfizer drugs in the state's new Medicaid drug formulary—will compromise the cost-containment goals of the Medicaid program. Of particular concern is the questionable ability of the Agency to

determine the cost-effectiveness of the program. As one state representative commented, "If [the Agency for Health Care Administration] can't measure whether [disease management] is saving us money, how are they going to measure the value of services [proposed by Pfizer]?"[68]

The questions surrounding disease management aside, advocates and providers are generally pleased with MediPass's performance in caring for the disabled population. Relative to the MediPass program, few special accommodations were made for SSI beneficiaries under the HMO system. Historically, the majority of SSI beneficiaries have been enrolled in the MediPass program, but with the recent shift in autoenrollment policies, there is a concern among advocates about the increased importance of HMOs in Medicaid managed care and their potential to weaken the MediPass program.[69]

Medicaid Disproportionate Share Hospital and Upper Payment Limit Programs

The Medicaid Disproportionate Share Hospital (DSH) program was designed to provide supplemental payments to safety net hospitals that serve a disproportionate share of Medicaid and low-income uninsured patients. Florida's DSH program began in 1988 and was funded primarily by provider taxes deposited in the Public Medical Assistance Trust Fund and general revenues. In response to changes in DSH rules enacted by the federal Omnibus Budget Reconciliation Act (OBRA) of 1993,[70] the state created intergovernmental transfer programs to help finance DSH payments and aggressively expanded its mental health DSH program.

A 1997 national survey of DSH programs, however, found that Florida's DSH program was relatively modest compared with the rest of the nation. In FY 1997–1998, Florida spent only 6 percent of its Medicaid spending on DSH expenditures, compared with the national average of 10 percent.[71] The annual average growth rates for DSH payments between 1995 and 1998, however, have exceeded the national average (see table 4: 3.5 percent for Florida versus -7.3 percent for the nation), which probably reflects the expansion in DSH payments to institutions for mental diseases. The survey on state DSH programs revealed that more than 50 percent of all Florida DSH payments went to institutions for mental diseases.[72]

The practice of including institutions for mental diseases as recipients of DSH payments was a major concern for federal policymakers because health care provided by mental hospitals for persons age 22 to 64 is not covered by Medicaid. They believed that payments to these providers were an indication of states' intention to use DSH payments for purposes other than supporting safety net health programs. Consequently, Congress included provisions in the Balanced Budget Act of 1997 that limit the amount of DSH funding that can go to institutions for mental diseases to no more than 33 percent of a state's federal DSH allotment, a measure that has caused Florida to significantly reduce its DSH funding for institutions for mental diseases.

Another mechanism for extending financial support to hospitals that provide high levels of uncompensated care to Medicaid enrollees is the Supplemental Provider Payment program, also known as the Upper Payment Limit (UPL) program. Under UPL programs, certain providers can receive from the state additional funding that exceeds regular Medicaid reimbursements but is less than 150 percent of the amount the Medicare program would pay for the same services. These additional payments are not included in a state's DSH expenditure cap, which makes the development of UPL programs an attractive alternative for expanding funding for safety net providers. In the 2000 session, the legislature approved funding through a UPL program in Florida, and local and provider taxes raised $89 million that were used to draw down an additional $135 million in federal matching funds.

The future ability of the program to directly support safety net hospitals, however, is somewhat in question. Given the observed success of UPL during its first year, the legislature has required localities to raise roughly three times as much money through provider taxation—$300 million. Importantly, however, they have also announced that $45 million

of the local funds raised would be redirected to state general revenue coffers, essentially establishing a type of "administrative fee" localities would have to pay in order to participate in the UPL program. The fears of some hospital industry officials that this redirection may undermine federal support for UPL—much as support for DSH eroded when states used the program to support non-DSH spending—have materialized with the new guidelines on the UPL program issued by CMS that lower the maximum amount the state can pay nonstate public hospitals from 150 percent to 100 percent of Medicare payment for the same services.

Senior Prescription Affordability Act

In addition to other expansions related to the Medicaid and CHIP programs, the legislature has sought to develop a pharmaceutical expense assistance program for Florida's senior citizens who are eligible for both Medicaid and Medicare. In 2000, the legislature passed the Senior Prescription Affordability Act (SPAA), which will provide assistance for dually eligible low-income seniors in the amount of an $80 monthly benefit for prescription drugs with a 10 percent copayment requirement. Eligible recipients must have incomes between 90 and 120 percent of FPL and not be enrolled in a Medicare HMO with a pharmacy benefit.

The SPAA also includes provisions that will allow Medicare recipients, regardless of income, to receive discounts on prescription drug orders at Medicaid-participating pharmacies. As a condition of participating in the Medicaid or SPPA low-income assistance programs, pharmacies must agree to cap drug prices for Medicare beneficiaries at the average wholesale price minus 9 percent with a dispensing fee of $4.50. Recent news about this phase of the program suggests that in some cases the pharmacies' standard senior discount rates are lower than the wholesale-based rate participants are required to pay under this program. The Florida Agency for Health Care Administration has recommended that consumers comparison shop, but that would require obtaining information on typically inaccessible wholesale prices.[73]

Issues in Long-Term Care for Older People and Younger Persons with Disabilities

Florida has one of the largest elderly populations in the country, yet its long-term care expenditures are relatively modest. As in most states, the Medicaid program is the biggest financer of the long-term care system, and long-term care expenditures represent a significant portion of expenditures, but per capita expenditures for long-term care services as well as growth rates for total expenditures between 1995 and 1998 are well below the national average (see table 4).[74] One explanation for the lower than average long-term care expenditures may be the low supply of long-term care providers in the state relative to the size of Florida's elderly population. In 1998, there were 24.8 beds in residential care facilities and 30.3 nursing facility beds per 1,000 persons age 65 and older, compared to the national average of 25.5 and 52.3, respectively.[75] State officials also attributed lower expenditures to the fact that the elderly population in Florida is healthier and more affluent than in the nation as a whole and therefore requires less long-term care. Finally, the fact that Florida's Medicaid system has relied heavily on institutional settings to provide long-term care, and had not developed extensive home- and community-based initiatives, may also explain why Florida has spent less on long-term care than other states. Recently, though, the state's dependence on institutional care has waned, primarily for the developmentally disabled population.

The immediate concern of policymakers is the implementation of several reforms to help ensure the preservation of an increasingly unstable nursing home industry. But beyond addressing the urgent matters surrounding institutional care, policymakers are also dealing with long-term projections that forewarn of the rapid growth in Florida's aged population and the deleterious effect that will have on the state's Medicaid budget if an institutional-based system continues. Consequently, Florida has made an effort to

develop more cost-effective home- and community-based service programs for the elderly, but more work is needed.

Nursing Home Care Market Reform

Improving Quality of Care. Quality of care in nursing homes is a major issue, a fact that is evident in the increase in the number of nursing homes with poor ratings from state evaluations and the frequency with which personal injury lawsuits are brought against nursing homes. In response to quality of care issues, the Agency for Health Care Administration stepped up its monitoring of nursing homes that exhibit chronic compliance problems and imposed increased sanctions against those providing substandard care. In addition to investigating and sanctioning nursing home facilities, the Agency also developed the "Nursing Home Guide Watch" in 1997 to help consumers evaluate the quality of nursing homes in their area by informing them of nursing homes that have been assigned a poor rating by the state. Despite the Agency's efforts, a 2001 Office of Program Policy Analysis and Government Accountability report found that the Agency for Health Care Administration's use of disciplinary actions against delinquent nursing home facilities was not strong enough and that its methods for informing consumers of nursing home quality were deficient.[76]

With the signing of a long-term care bill (SB 1202) into law in 2001, the governor and legislature sought to implement more fundamental changes in the level of care being delivered in nursing homes by instituting a number of reforms. The major provisions in that bill included a measure that strengthens the Agency for Health Care Administration's regulatory authority to monitor the quality of care for facilities and to impose tougher penalties on delinquent facilities. The bill also placed stricter requirements on the treatment and reporting of resident care and the development of formal grievance procedures to address the complaints of residents and their families.

In addition to tackling these general administrative regulations, the long-term care bill also addressed quality-of-care issues by increasing the minimum staffing levels in the nursing home industry. It is too soon to tell how the new staffing requirements will affect nursing homes in light of the current labor shortage that Florida is experiencing, especially with respect to certified nursing assistants, who provide up to 90 percent of the care for residents of Florida's nursing homes. In 1999, the Florida legislature commissioned a task force that produced an evaluation of the certified nursing assistant labor crisis. The task force study found that Florida's nursing homes had a high certified nursing assistant turnover rate (86 percent) that probably created a high level of discontinuity in the care of nursing home residents. The study cited low compensation due to limited nursing home funding along with a competitive labor market as the primary causes of low certified nursing assistant retention.[77]

The low level of Medicaid reimbursement and its effects on staff retention and other quality of care issues were also addressed in SB 1202. During the early to mid-1990s Medicaid institutional provider payments were the object of perennial budget cuts. Between FY 1991–1992 and FY 1996–1997, the legislature made a total of $81 million in cuts to the reimbursement levels for institutional care. The nursing home industry has attributed the quality of care problems of nursing homes to the low levels of reimbursement, especially in "high Medicaid homes," which are four times as likely as "low Medicaid homes" to have a poor rating.[78] With the institution of these broad quality of care reforms, the Florida legislature has provided an additional $76.6 million in funding to nursing homes, including $24 million for re-basing the direct and indirect patient care component of the Medicaid per diem rate and $42.5 million for increased staffing requirements.[79]

Tort Reform. While policymakers added more pressure on the nursing home industry to improve the quality of services rendered to the community, they also sought to rescue nursing homes from the financial burden of skyrocketing liability insurance costs. Due to cases of nursing home misconduct, the nursing home industry has been the target of numerous civil lawsuits in recent years. The industry claims that the huge damage awards

to plaintiffs and the subsequent increases in liability coverage costs have crippled them financially, but others point to mismanagement. In a study on nursing home liability costs funded by the industry, the average liability claim in Florida in 2000 was nearly three times the average for the rest of the country and liability coverage costs were more than 12 times the national average.[80] As a result, there has been a dramatic decrease in the availability of liability insurers willing to underwrite policies for Florida nursing home facilities.

The most controversial provision in SB 1202 addresses the litigation issues of the nursing home industry, with substantial revisions to the laws governing civil proceedings against nursing homes. The tort reform passed in Florida caps punitive damages at either three times compensatory damages or $1 million, whichever is greater, if the defendant is found guilty of intentional misconduct or gross negligence; or the greater of $4 million or four times compensatory damages if the defendant's actions were motivated by an "unreasonable financial gain." There is no cap if the defendant had a "specific intent to harm the client."[81] While lobbyists for the nursing home industry assert that tort reform will help redirect resources from litigation to patient care, other observers question whether the quality of care improvements provided for in the 2001 long-term care bill will compensate for the loss of what some see as a powerful incentive to maintain high quality of care.

Home- and Community-Based Services

During the mid-1990s, Florida's Medicaid long-term care system was greatly dependent on institutional care, with 88 percent of all Medicaid long-term care dollars going to nursing homes (80.8 percent) and intermediary care facilities and mental hospitals (7.3 percent), and only 12 percent going to home- and community-based programs in FY 1996.[82,83] By FY 2001, however, the proportion of Medicaid long-term care funding going to home- and community-based programs had increased 10 percentage points to 22 percent of total Medicaid long-term care expenditures. While this shift in the distribution of long-term care expenditures reflects the rise of home- and community-based programs as a long-term care policy priority, there are questions as to whether there are still inequities in the development of home- and community-based services alternatives between certain populations, namely the developmentally disabled and the elderly.

Considerable budgetary and policy attention has been given to creating alternative community-based care for the developmentally disabled. Between FY 1997–1998 and FY 2000–2001, funding for community-based care more than doubled, increasing from $282.4 million to $603.7 million.[84] These funding increases have resulted in 88 percent of developmentally disabled clients being served in the community with the majority of those clients participating in the Medicaid home- and community-based services waiver program.[85]

Long waiting lists for home- and community-based programs have also been significantly reduced, motivated by an increased commitment to funding by Governor Bush. In 1999, Florida developed a two-year plan to eliminate existing waiting lists. The reduction in the home- and community-based services program waiting list was also partly motivated by the terms of a lawsuit settlement agreement. In June 2000, the state of Florida reached a settlement in a class-action lawsuit, *Wolf Prado Steiman v. Bush*, in which it agreed to enroll eligible individuals into the waiver program with reasonable promptness, to the extent that a waiver slot and funding for that slot are provided for by legislative appropriations. At the time of interviews with officials from the Department of Children and Families, people placed on waiting lists prior to July 1, 1999, have all been placed in programs, and the state continues to work on eliminating waiting lists generated after that date. The settlement of the class-action lawsuit aside, interviewees felt that in light of the state's commitment to home- and community-based alternatives for the developmentally disabled community, state officials did not feel pressure to develop initiatives that explicitly addressed issues presented by the U.S. Supreme Court's decision in *Olmstead v. L.C.* In fact, officials cite the *Olmstead* decision as an effective tool in counteracting delays the state has experienced in the federal waiver approval process.

While there has been increased development of home- and community-based services programs for persons with disabilities, state officials and advocates claim that less priority has been placed on funding and developing similar programs for the elderly population.[86] In 1998, only 5.3 percent of individuals age 65 and over who were living in poverty were placed in aged/disabled waiver programs compared to 10.5 percent for the nation as a whole.[87] One possible reason cited by advocates for the underdeveloped home- and community-based services initiatives for the elderly was that the extensive use of the Medicare home health program served as a substitute for developing Medicaid home- and community-based services for the frail elderly. In 1996, expenditures for the Medicare home health care program reached $1.49 billion, more than the amount of total Medicaid long-term care expenditures in the state and more than any other state in the country for that year except for Texas.[88] With the restrictions placed on Medicare home health care spending in the 1997 Balanced Budget Act and the limited development of home- and community-based initiatives for the elderly, Florida runs an even greater risk of increasing the use of nursing home care for the elderly, especially as it faces high growth rates in the population most likely to enter nursing homes, elderly persons age 85 and older.

Although home- and community-based program policy for the elderly is criticized as underdeveloped, Florida has made some efforts to develop services. For example, in 1997 Florida started the Long-Term Care Community Diversion Pilot Waiver Program with the objective of using managed care plans to provide home- and community-based care to dual-eligible elderly persons who are at risk for nursing home admission. Advocates and policymakers point out that the program is very limited in scope and that the waiting list for community services far outruns the program's average monthly capacity of 815 cases.[89] Initially, the program had problems attracting managed care plans, but it overcame this hurdle and has recently received funding in FY 2001–2002 to serve an additional 185 persons. Although the program is small, officials from the Department of Elder Affairs claim that the program has resulted in over $12 million in avoided nursing home expenditures.

In addition to developing the long-term care managed care program, the legislature has taken a significant step to increase the amount of money that is available for home- and community-based services programs for the elderly by placing a moratorium on the approval of Certificates of Need applications for the construction of new nursing home beds.[90] With the moratorium, Florida hopes to increase occupancy rates, which will allow nursing home facilities to spread operating costs over a larger number of residents. The economies of scale experienced by the nursing homes will translate into lower Medicaid reimbursement rates and more available funds for home- and community-based services.

The state also hopes to see an improvement in the ability of policymakers to shift future demand for long-term care services from nursing homes to home- and community-based services. Under the Certificates of Need regulations, facilities had up to three years from the time of issuance to build new nursing home beds. This lag time combined with the entitlement of Medicaid recipients to nursing home care had the effect of limiting the state's ability to control demand for nursing home care once new beds became available. The ability to direct demand for long-term care services will also help ensure that home- and community-based programs reach people who are at risk for nursing home care placement in addition to reaching people who will benefit from the services but would otherwise not enter nursing home care. The realization of these potential benefits will hopefully help Florida develop an effective home- and community-based system for the elderly that will keep future long-term care costs under control.

Conclusion

The state of Florida's health care system during the late 1990s can be characterized by relatively stable expansion of the government's health care budget and policy priorities despite turbulence in the private market. It was not until late 1999 and early 2000 that the downturn of the economy and other external market forces (for example, the rise of prescription drug costs) began to affect the fiscal health of the state budget.

While the past few years have seen clear innovation in state policymaking, a lot of uncertainty about the effects of these innovations remains. As the state of Florida's budget reaches crisis levels due in part to the tragic events of September 11, 2001, it remains to be seen whether the current policies of cost containment will be able to minimize the need for future budget cuts to health programs for low-income populations in the event of a prolonged economic slowdown. Although the size and scope of problems with the uninsured have stabilized, the limited potential for "public/private partnership" proposals, such as Small Employer Health Alliances and HealthFlex, to significantly reduce rates of uninsurance as well as the problems experienced in local SCHIP funding that have inhibited program enrollment could cause Florida to lose the gains it has made in reducing its uninsurance rate. Questions also surround the ability of recent long-term care reforms to improve the quality of care received by patients and control the state's long-term care costs.

Finally, the strain between state and local governments is an area of concern for the future of health policy in Florida since the state and local partnership is so central to the financing and implementation of state programs. As one policymaker put it, "Devolution is great when the economy is strong—state flexibility permits enormous creativity and innovation. But in lean times, things get much tougher."

Endnotes

1. The prior study's site visit interviews occurred in February 1997. See Lipson, Debra J., Steven Norton, and Lisa Dubay. 1997. *Health Policy for Low-Income People in Florida*. Washington, D.C.: The Urban Institute. *Assessing the New Federalism* State Reports.

2. Florida's regular legislative session usually takes place between March and May.

3. There are some limitations on the extent to which Florida can restrict beneficiaries' use of drugs to those medicines on the preferred drug list. These limitations are discussed later in the report.

4. The other 12 states are Alabama, California, Colorado, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. The 13 states studied were selected to present a balanced view of state activity and its impact on low-income families. See Kondratas, Anna, Alan Weil, and Naomi Goldstein. 1998. "Assessing the New Federalism: An Introduction." *Health Affairs* 17(3): 17–24.

5. The estimate for 1990 total state population comes from U.S. Census Bureau. 1990. "1990 Census of Population and Housing." http://factfinder.census.gov/servlet/BasicFactsTable?_lang=en&_vt_name=DEC_1990_STF1_DP1&_geo_id=04000US12. [date accessed: January 2002].

6. The estimate for the U.S. and Florida foreign-born population comes from the U.S. Census Bureau. 2000. "2000 Supplemental Survey." http://factfinder.census.gov/home/en/c2ss.html. [date accessed: January 2002].

7. Urban Institute calculation derived from the 1999 National Survey of America's Families. Only includes residents under age 65.

8. Florida Office of Economic and Demographic Research (EDR). "Florida Census Day Population, 1970–2010." http://www.state.fl.us/edr/Population/table1-4.xls. [date accessed: February 2002].

9. Enterprise Florida, Inc. 2001. "Florida Economy at a Glance." http://www.eflorida.com/all_facts.html. [date accessed: January 2002].

10. Florida Agency for Health Care Administration (AHCA). "Florida Health Insurance Study Summary Report: 1999 Health Insurance Survey and the Impact of WAGES on the Uninsured." http://www.fdhc.state.fl.us/Publications/FHIS/index.shtml. [date accessed: July 2001].

11. Governor Jeb Bush's State of the State Address. March 7, 2000. http://sun6.dms.state.fl.us/eog_new/eog/library/releases/2000/march/state_of_state_2000.html. [date accessed: March 2001].

12. Florida Hospital Association. 2000. "Managed Care Trends in Florida." http://www.fha.org/acrobat/mgtrends.pdf. [date accessed: March 2001].

13. Galewitz, Phil. 2001. "HMOs' Outlook Improves Slightly." *Palm Beach Post* (online edition). 6 July.

14. Gibbs, Lisa. 2001. "Strong Recovery: Miami Hospitals Work Their Way Back to Financial Health." *Miami Herald*. 22 October.

15. Florida Hospital Association. 2001. *Federal Health Policy and Florida's Hospitals 2001.* Tallahassee.

16. Ibid.

17. U.S. Department of Health and Human Services, Office of Inspector General. *Hospital Closure Reports, 1990–1999.*

18. Gibbs, Lisa. 2001. "Strong Recovery: Miami Hospitals Work Their Way Back to Financial Health." *Miami Herald*. 22 October.

19. Urban Institute analysis of data from the U.S. Bureau of Labor Statistics.

20. Urban Institute analysis of data presented in the Florida House of Representative, Fiscal Responsibility Council. 2001. *Florida Fiscal Analysis in Brief for FY 2001–2002*. http://www.leg.state.fl.us/data/publications/2002/house/reports/fab.pdf. [date accessed: October 2001].

21. The 18.1 percent increase is relative to base FY 2000–2001 appropriations. Florida Office of Economic and Demographic Research (EDR). "Agency for Health Care Administration, Health Care Services, Summary of the General Appropriations Act for FY 2001– 2002 and Related Substantive Laws"from http://www.state.fl.us/edr/Conferences/Medicaid/medlegis.pdf. [date accessed: September 2001].

22. Florida's e-budget for FY 2001–2002. "Governor's Priorities: Smaller, More Efficient Government, Reducing Budget Growth." http://www.ebudget.state.fl.us/priorities/reducingbudget.asp. [date accessed: March 2001].

23. Revenue estimates come from the EDR, Revenue Estimating Conference Web site, http://www.state.fl.us/edr/Conferences/GR/grconference.htm. [date accessed: October 2001].

24. Figures on enrollment growth between 1998 and 1999 are based on Urban Institute calculations of enrollment data from the Florida Agency for Health Care Administration not shown here.

25. Urban Institute estimates based on CMS-2082 data (not shown here).

26. Ibid.

27. Wiener, Joshua M., and David G. Stevenson. 1998. *Long-Term Care for the Elderly: Profiles of Thirteen States*. Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Occasional Paper No. 12.

28. Florida Office of Economic and Demographic Research. 2001. Results from Social Services Estimating Conference (Medicaid Services Expenditures), February 19.

29. National Association of State Budget Officers. 2001. *The Fiscal Survey of States: June 2001*. Washington, D.C.

30. Florida Office of Economic and Demographic Research. 2001. Results from the Social Services Estimating Conference (Medicaid Expenditures), February 19.

31. Florida Office of Program Policy Analysis and Government Accountability. 2001. *Growth in Medicaid Prescription Drug Costs Indicates Additional Prudent Purchasing Practices Are Needed.* Report No. 01-10. Tallahassee.

32. Ibid.

33. The 2000 legislation included exemptions for children, adults in institutional care, and persons using anti-retroviral drugs or certain mental illness drugs from the proposed limitations on brand-name prescription drug use. In 2001, the exemption for adults in institutional care was eliminated.

34. Gruskin, Shana. 2001. "Proposals for State Budget Cuts Hurt Poor, Needy." *South Florida Sun-Sentinel*. 11 March.

35. Officials from the Agency for Health Care Administration noted that federal requirements would have allowed Florida to only reduce the percentage to 150 percent of FPL, which was the state's established standard in December 1989.

36. In 1990, the federal government passed a law that established the Medicaid drug rebate program requiring drug manufacturers to offer states rebates that were based on the average wholesale price. In return for offering rebates to states, states were required to cover the costs of all drugs produced by the manufacturer (California was the only state exempted from the 1990 law, because it had already established discounts with drug companies). In 1993, this law was amended to allow states to develop formularies that restricted access to prescription drugs as long as they developed a prior authorization process to allow access to drugs excluded from the state's formulary.

37. The Medicaid drug formulary and the brand-name drug limit programs only apply to recipients in the state's Medicaid fee-for-service program, that is, people who are in the traditional FFS Medicaid program or people who are in the state's FFS managed care program (the primary care case management program, MediPass). Capitated Medicaid managed care organizations can only implement these reforms after obtaining approval from the state (Bernasek et al. 2002).

38. Bernasek, Cathy, Catherine Harrington, Rajeev Ramchand, and Dan Mendleson. 2002. *Florida's Medicaid Prescription Drug Benefit: A Case Study*. Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured. Publication No. 4031.

39. Ibid.

40. Pharmaceutical Research and Manufacturers of America (PhRMA). 2001. "PhRMA v. Medows Fact Sheet." http://www.phrma.org/publications/documents/backgrounders/2001-08-07.256.phtm.l[date accessed: November 19, 2001].

41. Florida Office of Economic and Demographic Research. "Agency for Health Care Administration, Health Care Services, Summary of the General Appropriations Act for FY 2001–2002 and Related Substantive Laws." http://www.state.fl.us/edr/Conferences/Medicaid/medlegis.pdf. [date accessed: September 2001].

42. The development of competitive bidding processes for home health services is for private duty nursing services for children with special needs.

43. Florida Office of Economic and Demographic Research. 2001. Results from Social Services Estimating Conference (Medicaid Services Expenditures), February 19.

44. Florida Office of Program Policy Analysis and Government Accountability. 2001. *Expected Medicaid Saving Unrealized; Performance Cost Information Not Timely for Legislative Purposes*. Report No. 01-16. Tallahassee. This report evaluated four categories of cost-control measures: economized prescription drug spending, Medicaid financing adjustments (for example, competitive bidding policies and adjustments to Medicare and nursing home financing), disease management programs, and improved methods of identifying other insurers responsible for payment and overpayments due to fraud and abuse.

45. Florida State Legislature, Office of the Senate Secretary. 2001. *2001 Special Session "C": Summary of Legislation Passed*. Tallahassee.

46. All cuts will be restored until July 1, 2002, with nonrecurring general revenue funds. Cost savings from the implementation of these cuts, therefore, pertain to the FY 2002–2003 budget.

47. Florida State Legislature, Office of the Senate Secretary. 2001. *2001 Special Session "C": Summary of Legislation Passed*. Tallahassee.

48. Florida Agency for Health Care Administration, Office of Health Policy. 2000. *Florida Health Insurance Study Vol. 4: The Impact of Wages on the Uninsured*.
http://www.fdhc.state.fl.us/Publications/Technical_Reports/index.shtml. [date accessed: March 2001].

49. Families USA. 2000. *Clouds Over the Sunshine State: Florida's Working Parents Lose Health Coverage.* Washington, D.C.

50. Ibid.

51. Since a child that is eligible for Medicaid cannot enroll in the state's SCHIP program, the Healthy Kids Corporation refers children that it discovers qualify for Medicaid to the Department of Children and Families for Medicaid eligibility determination.

52. Since the local match exemption provision of the appropriations bill SB 2000 does not contain a dollar amount, it cannot be vetoed by the governor. Therefore, Bush instructed his legal office to seek a judicial void of this proviso language on the grounds that it attempts to change or amend current Florida law and is therefore in violation of the state's constitution. The legislature, however, enacted a statute that eliminates the local match requirement for FY 2001–2002.

53. Feldheim, Mary A. 2000. "Managed Competition in Florida Health Care: Its strengths and Weaknesses." *Policy Studies Review* 17(4).

54. It is designated as a "modified" community rating system, as opposed to a pure community rating system, because age and gender are taken into account when setting rates.

55. Hall, Mark. A., and Elliot Wicks. 1998. *An Evaluation of Florida's Small Group Health Insurance Reform Laws.* Winston-Salem, N.C.: Wake Forest University School of Medicine, Department of Public Health Sciences.

56. Office of Program Policy Analysis and Government Accountability. 1998. *Follow-Up Report on the Status of Community Health Purchasing Alliances in Florida*. Report No. 98-14. Tallahassee.

57. Florida Agency for Health Care Administration. 2001. *MediPass/HMO Enrollment Report*. Tallahassee.

58. Not excluded are persons in the Long-Term Care Community Diversion Pilot Waiver program, which uses managed care plans to provide care to elderly Medicaid recipients in their communities. (This program is discussed more in the "Issues in Long-Term Care for Older People and Younger Persons with Disabilities" section.)

59. Technically, the state has required 100 percent enrollment in HMOs and Exclusive Provider Organizations (EPOs), but the EPO plans have not yet been contracted. Therefore, the discussion of capitated plans is limited to HMOs.

60. Holahan, John, Suresh Rangarajan, and Matthew Schirmer. 1999. *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey.* Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Occasional Paper No. 26.

61. Center for Medicare and Medicaid Services (CMS). 1995. "Medicaid Managed Care Plans Type and Enrollment, by State." http://www.hcfa.gov/medicaid/statesum.pdf. [date accessed: March 2001]. Florida Agency for Health Care Administration. "Listing of Current Florida Medicaid Health Maintenance Organizations." http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/MHMO/docs/MCAID/hmolist1001.pdf. [date accessed: March 2001].

62. Health Care Financing Organization (HCFO). 2000. "Evaluating Florida's Medicaid Provider Service Network Demonstration Project." *HCFO News and Progress.*

63. *American Health Line*. 1998. "Florida: Unique Medicaid Pilot in Works." 5 November.

64. Data on Provider Service Network enrollment are from the Florida Agency for Health Care Administration. 2001. *MediPass/HMO Enrollment Report*. Tallahassee.

65. Regenstein, Marsha, Christy Schroer, and Jack A. Meyer. 2000. *Medicaid Managed Care for Persons with Disabilities: Case Studies of Programs in Florida, Kentucky, Michigan and New Mexico.* Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured. Publication No. 2163.

66. Florida Office of Program Policy Analysis and Government Accountability. 2001. *Medicaid Disease Management Initiative Sluggish, Cost Savings Not Determined, Design Changes Needed*. Report No. 01-27. Tallahassee.

67. Ibid.

68. *American Health Line*. 2001. "Florida: Medicaid Disease Management Program Is No Benefit." 23 May.

69. Regenstein, Marsha, Christy Schroer, and Jack A. Meyer. 2000. *Medicaid Managed Care for Persons with Disabilities: Case Studies of Programs in Florida, Kentucky, Michigan and New Mexico.* Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured. Publication No. 2163.

70. OBRA 1993 tried to rectify what was seen as states' use of DSH for state financing, which is outside the intended use of DHS payments as a financial support system for safety net providers. Provisions in OBRA 1993 include limiting the appropriation of DSH funds to hospitals that had a Medicaid use rate greater than or equal to 1 percent and requiring that DSH payments be no greater than the unreimbursed care for Medicaid recipients and the uninsured.

71. Urban Institute analysis of data from the Urban Institute DSH Program Survey.

72. Coughlin, Teresa A., Leighton Ku, and Johnny Kim. 2000. "Reforming the Medicaid Disproportionate Share Hospital Program." *Health Care Financing Review* 22(2): 137–57.

73. American Health Line. 2001. "Florida: Pharmacies Offer Seniors Lower Rx than the State." 4 January.

74. Urban Institute estimates of long-term care per capita expenditures are from CMS-2082 data (not shown here).

75. Nawrocki, Heather, and Steven Gregory. 2000. *Across the States 2000: Profiles of Long-Term Care Systems*. Washington, D.C.: AARP Public Policy Institute.

76. Florida Office of Program Policy Analysis and Government Accountability. 2001. *Justification Review: Health Care Regulation Program, Agency for Health Care Administration*. Report No. 01-24. Tallahassee.

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90. Sheltered beds in continuing care retirement communities are exempted from the ban.

Table 1 Notes

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i. Two Urban Institute calculations: (1) Average monthly number of AFDC 1996 recipient children divided by number of children in poverty in 1996: U.S. Department of Health and Human Services. Administration for Children and Families. 1997. *Characteristics and Financial Circumstances of AFDC Recipients FY 1996*. Table 18. "Percent Distribution of AFDC Recipient Children by Age (October 1995–September 1996)"; (2) Average monthly number of TANF 1998 recipient children divided by number of children in poverty in 1998: U.S. Department of Health and Human Services. Administration for Children and Families. 1999. *Second Annual Report to Congress August 1999*. Table 9:22. "Percent Distribution of TANF Recipient Children by Age Group (October 1997–September 1998)." The numbers of children in poverty in 1996 and 1998 are Urban Institute calculations from the National Survey of America's Families II.

j. Based on three sources: (1) Urban Institute's TRIM [Transfer Income Model]; (2) Smith, Vernon K. 1999. "Enrollment Increases in State CHIP Programs: December 1998 to June 1999." Health Management Associates, July; (3) Urban Institute analysis of *1999 SCHIP [State Children's Health Insurance Program] Annual Report*. Rules for 1996 and 1998 are policies in place the majority of the year. Rules for 2000 represent plans approved as of January 1, 2000.

k. In 1996, the threshold represents the state Medicaid threshold for poverty-related eligibility or AFDC-related eligibility. Higher thresholds for separate state-financed programs (such as in New York) are not represented here.

l. The figure for 1998 represents the higher of the state threshold for Medicaid eligibility, or the state threshold for Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.

m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

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