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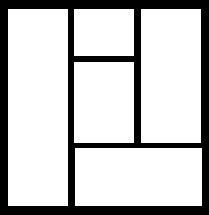

NEW FEDERALISM
HIGHLIGHTS FROM STATE REPORTS

A product of "Assessing the New Federalism," *an Urban Institute Program to Assess Changing Social Policies*

Health Policy for Low-Income People in Florida

Debra J. Lipson, Stephen Norton, and Lisa Dubay

Like many other states, Florida attempted to significantly reform its health care system in the early to mid-1990s but had only limited success. The state has since turned its focus to mandatory enrollment in managed care for Medicaid beneficiaries; health insurance purchasing cooperatives to increase insurance affordability in the small-group market; and the Healthy Kids Program, a school-based program of subsidized insurance for low-income children. While Governor Lawton Chiles's policy priorities reflect a concern for the needs of low-income people, the state has built-in limits on tax revenues, a state expenditure cap, and a fiscally conservative legislature, limiting support for expansions in health insurance coverage and state support of the safety net. As a result, Florida counties have been a significant source of support for the indigent. For example, local taxes help support the Healthy Kids Program, public hospitals, and the Hillsborough County Health Plan.

Florida faces a number of major challenges in the near future. Of primary concern are the size and scope of the Medicaid program and the size of the uninsured population.

State Characteristics

Florida has one of the largest, fastest-growing, and most diverse populations of all the states. From 1990 to 1995, Florida's population increased by 9.5 percent (1.7 times the national average), reaching 14.1 million. The state's elderly population, in particular, is one of the largest and most rapidly growing in the country. As of 1995, 16.7 percent of the population was over the age of 65—substantially higher than the national average of 12.1 percent and higher than in any other state. Noncitizen immigrants comprised 10.0 percent of the state's population in 1995, compared with 6.4 percent for the nation (table 1)*.

Florida's economy is healthy and growing more rapidly than that of the country overall. The state's projected job growth in FY 1997-98 is 2.9 percent, more than double the national rate of 1.3 percent. Per capita income in 1995 ($23,061) was about on a par with the national average, as was the increase in per capita income during the period 1990–95—20.7 percent (table 1).

In part because of the strong economy, AFDC caseloads have declined in each of the last three fiscal years, including a significant drop from 220,500 families in October 1995 to 186,600 families in December 1996. Average monthly Medicaid cases fell from a high of 1.6 million in FY 1993-94 to 1.5 million in FY 1996-97.

Despite a positive economic picture, the state has one of the highest uninsured rates in the country—19.2 percent of the nonelderly population versus 15.5 percent for the nation (table 1). This high rate may be attributable to the state's high poverty rate, its relatively limit-

Table 1
State Characteristics

Sociodemographic	Florida	U. S.
Population (1994–95) (in thousands)	14,103	260,202
Percent under 18 (1994–95)	24.6%	26.8%
Percent 65+ (1994–95)	16.7%	12.1%
Percent Hispanic (1994–95)	16.5%	10.7%
Percent Non-Hispanic Black (1994–95)	15.4%	12.5%
Percent Non-Hispanic White (1994–95)	66.5%	72.6%
Percent Non-Hispanic Other (1994–95)	1.6%	4.2%
Percent Noncitizen Immigrant (1996)*	10.0%	6.4%
Percent Nonmetropolitan (1994–95)	6.9%	21.8%
Population Growth (1990–95)	9.5%	5.6%
Economic		
Per Capita Income (1995)	$ 23,061	$ 23,208
Percent Change in Per Capita Personal Income (1990–95)	20.7%	21.2%
Unemployment Rate (1996)	5.1%	5.4%
Percent below Poverty (1994)	16.2%	14.3%
Percent Children below Poverty (1994)	25.9%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	19.2%	15.5%
Percent Medicaid—Nonelderly (1994–95)	13.2%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	59.2%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	8.5%	6.2%
Smokers among Adult Population (1993)	22.0%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	7.7%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	7.5	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	59.6	54.4
Violent Crimes per 100,000 (1995)	1,071.0	684.6
AIDS Cases Reported per 100,000 (1995)	56.9	27.8

Source: Complete list of sources is available in *Health Policy for Low-Income People in Florida* (The Urban Institute, 1997).
* Three-year average of the Current Population Survey (CPS) (March 1996–March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship. Please note that these numbers have been corrected since the original printing of this report.

ed Medicaid program, and the importance of small employers, which are less likely to offer health coverage, in the economy.

Politics and Health Policy

Governor Lawton Chiles, a Democrat, has been in office since 1991 and won reelection in 1994; his term expires in 1998, and Florida law prohibits him from running for a third term. Florida's legislature has historically been led by Democrats, but this has changed recently. In 1996, Republicans gained majority control of the House, with a two-seat lead (61 to 59). Republicans gained control of the Senate in 1994 and maintained it in 1996; they currently have a six-seat margin over Democrats (23 to 17).

Health policy issues have been a high priority of Governor Chiles and other state leaders, evidence of which is the state's passage of the Health Care Reform Act of 1992 and the Health Care and Insurance Reform Act of 1993, which reformed aspects of the small-group market and implemented insurance reform but failed to expand Medicaid eligibility as planned. The recent legislative agenda has been dominated by a debate over funding priorities, which has been cast as a tradeoff between social and health services versus education and corrections. In FY 1996-97, the legislature explicitly took funds from Medicaid and transferred them to education and corrections. Funding priorities for FY 1997-98 were expected to be similar.

State Medicaid Expenditures

Florida's Medicaid program accounted for 17 percent of the state budget (federal and state dollars) in 1995—an increase from 11 percent in 1990. State general revenues comprised 70.5 percent of the nonfederal share of the program in 1995. (About 72 percent of Florida's general revenue comes from sales tax collections; the state does not have an income tax.) The remainder of state support for Medicaid comes primarily from a 1.5-percent assessment on hospitals' and other health care providers' revenue and a portion of the state's cigarette tax receipts.

In the early 1990s, Florida's Medicaid expenditures increased at a rate equal to that at the national level—27 percent average annual growth between 1990 and 1992 (table 2). Expanded enrollment, especially among children, and double-digit increases in expenditures per disabled and child enrollee were largely responsible for the growth observed in Florida (table 3). Florida's disproportionate share hospital (DSH) program also grew rapidly from 1990 to 1992; however, DSH is a small fraction of total expenditures.

Between 1992 and 1995, Medicaid enrollment growth moderated—with the exception of that of the blind and disabled—and growth in expenditures per enrollee also decelerated (table 3). During this period, the state's average annual rate of expenditure growth dropped significantly to 13 percent on average, although it was still in excess of the national average of 10 percent. Florida's higher-than-average spending growth was linked to greater increases in its long-term care spending (14.7 percent per year growth versus 8.3 percent in the nation) (table 2).

Although its long-term care expenditures have been growing more rapidly than in the nation as a whole, Florida spent proportionately less of its Medicaid budget on long-term care

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
Florida and United States
(Expenditures in Millions)

	Florida			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Total	**$6,273.7**	**27.2%**	**13.4%**	**$157,872.5**	**27.1%**	**9.9%**
Benefits						
Benefits by Service	$5,799.9	26.1%	13.6%	$133,434.6	18.8%	11.0%
Acute Care	4,030.7	30.9%	13.1%	79,438.5	22.1%	13.0%
Long-Term Care	1,769.3	16.5%	14.7%	53,996.1	14.8%	8.3%
Benefits by Group	$5,799.9	26.1%	13.6%	$133,434.6	18.8%	11.0%
Elderly	$1,755.0	17.7%	12.6%	$40,087.4	16.7%	8.1%
Acute Care	637.5	18.5%	13.8%	9,673.7	18.5%	11.9%
Long-Term Care	1,117.5	17.3%	11.9%	30,413.7	16.2%	7.0%
Blind and Disabled	$1,908.6	27.8%	14.5%	$51,379.4	17.7%	12.9%
Acute Care	1,276.1	35.2%	12.0%	29,760.7	22.8%	15.2%
Long-Term Care	632.5	13.5%	20.3%	21,618.7	12.3%	10.1%
Adults	$505.9	8.6%	5.0%	$16,556.9	20.4%	9.2%
Children	$1,630.5	49.9%	16.9%	$25,410.9	24.3%	13.3%
Disproportionate Share Hospital	$334.2	107.9%	20.4%	$18,988.4	261.5%	2.7%
Administration	$140.6	10.1%	-1.8%	$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: 1995 data for the United States are preliminary.

than the national average in 1995 (28 percent versus 34 percent). It spent more on acute care (64 percent versus 50 percent) and less on DSH payments (5 percent versus 12 percent). Mainly because of its below-average spending on long-term care, Florida's expenditures per elderly and disabled enrollee were, respectively, 20.0 percent and 28.1 percent below the national average in 1995. In contrast, spending per child enrollee was 15.4 percent above the national average.

Medicaid Eligibility

Although Florida's Medicaid eligibility criteria are not as generous as those in many other states, program rolls swelled in the early 1990s. Between 1990 and 1992, enrollment expanded by 23.3 percent annually, with growth slowing dramatically to 6.2 percent per year between 1992 and 1995. The high growth rate between 1990 and 1992 is attributed to recession-induced increases in AFDC caseloads and large increases in the "expanded-eligibility" groups, including pregnant women and infants up to 185 percent of the federal poverty level (FPL). Despite its eligibility expansions, Florida's Medicaid program ranks in the bottom 10 states in percentage of low-income population covered: In 1994, 39.6 percent of the population below 150 percent of the FPL had Medicaid coverage, compared with 51 percent nationally.

Recent federal legislation has implications for legal immigrants' eligibility for Medicaid. Under the 1996 federal welfare reform law, an estimated 54,000 current legal immigrants receiving Supplemental Security Income (SSI) in Florida would lose their SSI and Medicaid benefits. Another 3,000 immigrants receiving Medicaid were also expected to lose coverage. Legislation to maintain coverage for these individuals at an estimated cost to state or local governments of more than $200 million was introduced by the Dade County delegation. With the passage of the Balanced Budget Act of 1997, most immigrants will retain their benefits; new immigrants, however, will not be covered during their first five years in the country.

Medicaid Managed Care

Managed care is the cornerstone of the state's efforts to control Medicaid acute care expenditures. Florida now contracts with 19 health maintenance organizations (HMOs) and has implemented a primary care case management program (MediPass) throughout the state. The state requires mandatory enrollment in managed care for most recipients—two-thirds of Medicaid beneficiaries participate in either MediPass or capitated managed care plans. Florida's history of marketing and enrollment abuses and problems with quality of care in managed care programs led the state to prohibit direct marketing, increase resources for beneficiary education, and add staff to monitor quality of care. It has also enacted a competitive bidding system to drive down capitation rates, hoping to reduce rates to 92 percent of fee-for-service rates.

Table 3
Medicaid Enrollment and Expenditures per Enrollee: Contributions to Total Expenditure Growth

	Florida			United States		
		Average Annual Growth			Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Elderly						
Total expenditures on benefits (millions)	$1,755.0	17.7%	12.6%	$40,087.4	16.7%	8.1%
Enrollment (thousands)	225.2	8.2%	4.8%	4,116.6	5.1%	3.0%
Expenditures per enrollee	$7,793	8.8%	7.5%	$9,738	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	$1,908.6	27.8%	14.5%	$51,379.4	17.7%	12.9%
Enrollment (thousands)	330.9	12.6%	12.5%	6,405.2	9.8%	9.5%
Expenditures per enrollee	$5,767	13.5%	1.8%	$8,022	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	$505.0	8.6%	5.0%	$16,556.9	20.4%	9.2%
Enrollment (thousands)	404.6	15.5%	5.1%	9,584.2	11.5%	4.6%
Expenditures per enrollee	$1,250	–6.0%	0.0%	$1,728	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	$1,630.5	49.9%	16.9%	$25,410.9	24.3%	13.3%
Enrollment (thousands)	1,198.6	33.7%	5.3%	21,566.0	13.1%	4.8%
Expenditures per enrollee	$1,360	12.1%	11.0%	$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

Efforts to Expand Insurance Coverage

The Healthy Kids Program is a school-enrollment-based program that provides comprehensive health insurance to school-aged children and their younger siblings. Operating in 16 counties, the program covered approximately 26,400 children as of February 1997. The legislature recently provided additional state funding to increase the number of children in the program to 60,000. It also granted the Agency for Health Care Administration the authority to seek a Section 1115 waiver to cover children in households with incomes up to 185 percent of the FPL through the Healthy Kids Program.

Florida enacted a series of insurance reforms designed to increase coverage in the private market as part of its 1992 and 1993 health care reform laws. The reforms require insurers offering policies in the small-group market to guarantee issue of policies without regard to health status or preexisting conditions, provide for portability of plans between employers, and require the use of modified community rating. The legislation did not affect the individual insurance market. Florida also created 11 regional community health purchasing alliances (CHPAs). As of 1997, 18,000 small businesses, representing 76,000 lives, received coverage through the CHPAs. Slightly fewer than half of the 76,000 enrollees were previously uninsured. It appears that CHPAs are experiencing some adverse selection, meaning their enrollees have greater medical needs than the population in general. CHPAs are also prohibited from negotiating rates with insurers, which limits their ability to take advantage of their market power. As a result, premiums for CHPA-sponsored insurance plans are reportedly only about 6 percent lower than premiums for the same plans offered outside of the CHPAs, which is less than the cost advantage expected for group purchasing.

The Health Care Market

Florida's health care market is one of the most competitive and entrepreneurial in the country. Managed care has been growing rapidly in the private market in Florida. As of 1995, 25 percent of the state's population was enrolled in an HMO. State policy has generally been supportive of the growth of managed care: Although a number of bills to regulate managed care have been introduced in the legislature, the few that have been enacted do not represent serious restrictions on the activities of managed care organizations. Most HMOs are for-profit, and mergers and acquisitions are occurring at a rapid pace.

The competitive pressures placed on hospitals by managed care plans have forced hospitals to change rapidly. Despite significant consolidation in the hospital market, industry officials indicate that the hospital market has considerable excess capacity; in 1996, hospitals averaged only a 51-percent occupancy rate. As a result, managed care organizations have been able to negotiate deep discounts, forcing hospitals to assess their cost structure and market position. Thus far, competitive pressures have had little impact on the number of hospitals and beds, and hospitals are faring relatively well, perhaps because of the large Medicare market.

The considerable growth in for-profit hospital systems has raised concerns about the quality of care and the provision of charity care, yet no action has been taken by the state. The emergence of alliances between public hospitals and investor-owned organizations and the potential conversion of some of the bigger public hospitals to private ownership are likely to create more interest in this issue.

The Safety Net

The safety net institutions visited are in relatively good financial health, in large part because of local financing arrangements that exist in many of the metropolitan areas with large low-income populations. The success of safety net providers also stems from their ability to adapt to the requirements of a competitive managed care environment. Hospitals and community health centers have developed their own managed care plans, partnered with other plans, and developed networks with other health care providers to achieve greater efficiencies.

Florida has allowed localities to establish special health care taxing districts. How the funds raised by the taxing districts are distributed is an important determinant of the success of safety net providers. In Hillsborough County, where funds are distributed across several types of providers through the county's insurance program, Tampa General Hospital is facing some financial stress and considering a change in ownership status. In Dade County, where, as in most districts in the state, local revenues are targeted at the major public hospital, the major safety net provider, Jackson Memorial Hospital, is faring relatively well.

Local funding in Dade and Hillsborough Counties has risen considerably as a result of increases in their sales tax. The infusion of new local funds in these two counties has helped safety net providers offset losses in Medicaid revenues brought about by the increased interest of private hospitals in the Medicaid market. An important question is whether local revenues will remain adequate to support care for the indigent.

Long-Term Care

Despite its large and growing elderly population, Florida has relatively low Medicaid expenditures on long-term care, largely because its nursing home bed supply is one of the lowest in the country and the state has been slow to expand home and community-based services. In addition, the elderly population in Florida has a lower rate of poverty than the national average and, thus, may have less need for public support for nursing home care. This dearth of nursing home beds has raised concerns about access now and for the future.

The overall strategy for providing services to the developmentally disabled and mentally ill populations has been to reduce the reliance on institutional settings and increase community-based care. However, the need for both institutional and community-based services outpaces the supply of such services or state resources to purchase them. A recently filed lawsuit will test whether long-term care services for the disabled are entitlements.

Challenges for the Future

Florida faces a number of major challenges in the near future. Of primary concern are the size and scope of the Medicaid program and the size of the uninsured population. Governor Chiles has proposed expanding Medicaid coverage to children under age three with household incomes up to 185 percent of the FPL, and increasing the number of children covered by the Healthy Kids Program to more than 100,000. The legislature will likely have to balance its ongoing efforts to curb Medicaid spending with policy initiatives to take advantage of new federal matching funds for children's health insurance.

The state faces other challenges, including welfare reform provisions that will bar new legal immigrants from Medicaid for five years; an expected rise in demand for long-term care; and the shortcomings of the CHPAs. There is also concern about the competitive pressures facing safety net providers. The growth in Medicaid managed care, which has increased competition for Medicaid patients, coupled with the large uninsured population, places a burden on safety net providers and the local governments that support them.

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* Please note that these numbers have been corrected since the original printing of this report.

About the Authors

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There are two *Highlights* for each state. The *Highlights* that focus on health cover Medicaid, other public insurance programs, the health care marketplace, and the role of public providers. The income support and social services *Highlights* look at basic income support programs, employment and training programs, child care, child support enforcement, and the last-resort safety net. The *Highlights* capture policies in place and planned in 1996 and early 1997. To receive the full-length reports on which the *Highlights* are based, contact the Urban Institute.

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