Community Report
THIRD VISIT
2000-2001

MIAMI • FLA.
Summer 2001

Hospitals Profit from Aggressive Negotiations

In February 2001, a team of researchers visited Miami, Fla., to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 70 leaders in the health care market. Miami is one of 12 communities tracked by HSC every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first two site visits to Miami, in 1996 and 1998, provided baseline and initial trend information against which changes are tracked. The Miami community encompasses Dade County.

The Miami health care market has become more tumultuous over the past two years, as key hospitals pressed health plans for more profitable contracts and, in some cases, threatened to drop out of plan networks if their demands were not met. Health maintenance organizations (HMOs), which dominate the market, experienced financial losses, leading plans to abandon aggressive price competition and increase premiums, hitting small businesses especially hard. Meanwhile, in a market where one in four persons is uninsured, demand for indigent care has grown. Though safety net providers have taken steps to respond, a state health care budget shortfall has created uncertainty about future funding.

Other important developments in Miami since 1998 include:

- Hospital systems dissolved physician ventures and abandoned risk contracting because of disappointing financial performance.
- Health plans introduced less restrictive but costlier products and retooled provider contracting strategies.
- Affordable insurance options for small businesses eroded, as the state struggled with insurance reform.

Miami Demographics

Miami	Metropolitan areas above 200,000 population
Population, July 1, 1999 [1]	
2,175,634	
Population Change, 1990-1999 [2]	
12%	*8.6%*
Median Income [3]	
$19,672	*$27,843*
Persons Living in Poverty [3]	
25%	*14%*
Persons Age 65 or Older [3]	
15%	*11%*

Sources:
1. U.S. Bureau of Census, 1999 Community Population Estimates
2. U.S. Bureau of Census, 1990 & 1999 Community Population Estimates
3. Community Tracking Study Household Survey, 1998-1999

Miami's hospitals have adopted a tougher negotiating stance with health plans and have secured payment increases of 15 percent or more over the past year.

Hospitals Gain Clout

Strengthened by consolidation during the 1990s, Miami's hospitals have adopted a tougher negotiating stance with health plans and have secured payment increases of 15 percent or more over the past year. Two of the area's most prominent hospital systems—Baptist Health System of South Florida and HCA-The Healthcare Company—publicly threatened not to renew contracts with the state's largest insurer, Blue Cross and Blue Shield of Florida, unless their demands for higher payment rates were met. HCA did the same with two other large insurers. Most health plans have yielded to the hospitals' demands to keep provider networks intact.

Hospitals reportedly have sought higher payments from health plans for several reasons—among them Medicare payment reductions resulting from the 1997 Balanced Budget Act (BBA), persistently low payment rates from commercial health plans, rising uncompensated care expenditures and losses on risk contracts and business ventures with physician organizations. In seeking higher payments, several hospital systems have benefited from previous acquisitions and mergers that gave them considerable influence in geographically and demographically distinct market niches within Miami-Dade County. By establishing these niches, hospital systems such as Baptist Health System and Tenet Health System of South Florida have positioned themselves as highly desirable components of health plan networks. Hospitals have gained additional negotiating leverage as excess capacity has declined in the area due to continued population growth, hospital staffing shortages and problems in the state's long-term care industry that have reduced the availability of nursing home beds for hospitalized patients awaiting discharge.

Miami's hospital systems also have used their leverage to abandon unprofitable risk contracts and to establish more favorable contracting terms with health plans. Since 1998, increasing numbers of hospitals have moved to lucrative per diem payment arrangements—often with favorable stop-loss provisions that give a hospital added financial protection against high-cost cases. Furthermore, some hospital systems have convinced plans to discontinue retroactive denials, a change reinforced by new state legislation limiting this practice. In addition, some hospital systems have successfully prevented plans from excluding affiliated hospitals from their networks.

As a result of these changes, as well as steps to strengthen profitable acute care and specialty service lines, all four of Miami's major hospital systems were profitable as of 2001, with both nonprofit Baptist Health System and county-owned Jackson Memorial Hospital rebounding from operating losses in 1999. Some observers indicated that this success has enabled hospitals to become more selective in the types of health plans and contracting arrangements they will accept. Nevertheless, some health plans expected that recent improvements in hospital profitability would ultimately make contracting negotiations between hospitals and plans less contentious.

Few Physician Contracting Organizations Remain

With a few notable exceptions, physician contracting organizations have failed to survive in Miami. Numerous national physician practice management companies had entered the market, and management service organizations (MSOs) had formed to manage physicians' risk contracts with health plans. Hospitals had developed physician-hospital organizations and employed primary care physicians to manage risk contracts and protect referrals. However, most of these ventures quickly proved financially unsuccessful and were abandoned.

The demise of physician practice management companies and hospital-physician ventures in Miami has soured many physicians on joining groups, and a steady erosion of risk contracting has left physicians with fewer reasons to organize. Most physicians

in the area continue to practice solo or in small partnerships. A few small single-specialty physician contracting organizations—including obstetric/gynecological, anesthesiology and oncology networks—have survived and gained some leverage with health plans, but they are notable exceptions. These organizations have secured leverage by controlling large shares of patient volume at specific hospitals or in specific geographic areas.

As a result of oversupply and lack of many contracting organizations, physicians continue to receive low payment rates. For privately insured patients in HMOs, physicians often receive 70 to 80 percent of the Medicare fee schedule. Although their payment rates have risen modestly over the past two years, most Miami physicians have not secured payment increases comparable to those won by hospitals.

A few single-specialty physician organizations have succeeded in creating ambulatory surgery and diagnostic centers that compete with hospitals for these services. But because of hospitals' opposition and lingering concerns about the quality of ambulatory centers, many health plans have been reluctant to contract with these centers.

HMO Losses Prompt Changes

Large financial losses have forced health plans to abandon aggressive price competition and seek profitability and growth through changes in product design. Plans held premiums low through much of the 1990s, despite rising medical care costs, to gain a foothold in Miami's oversaturated HMO market. As a result, annual HMO losses mounted, peaking at $183 million statewide in 1999. Since then, several financially troubled plans dissolved or were acquired by other plans, but the market has remained highly competitive, with at least 16 plans operating in Miami.

Consistent with the insurance underwriting cycle, most plans have raised premiums substantially over the past year to compensate for prior-year losses. Annual premium increases range from 10 percent for large groups to well over 20 percent for groups with fewer than 50 employees. To minimize premium increases, some plans have moved to reduce utilization and costs—including reducing provider networks, strengthening utilization management, using hospitalists to manage inpatient care and increasing consumer cost sharing—despite the objections of some providers and consumers.

Other plans have sought to increase profitability and market share by offering less restrictive health insurance products as alternatives to traditional gatekeeper HMOs that have dominated the market. UnitedHealthcare became Miami's largest and fastest-growing HMO—overtaking plans such as Blue Cross and Blue Shield of Florida, Humana Medical Plan and AvMed Health Plan—after introducing a direct-access HMO product in late 1998. That United's enrollment has continued to grow over the past year—even though premiums for direct-access products have become much higher than those for gatekeeper HMOs—demonstrates the willingness of many purchasers and consumers to pay more for less restrictive products. Several other Miami plans have recently introduced direct-access products in response to United's success.

The growing popularity of direct-access HMOs has contributed to the movement away from risk contracting in Miami because they do not tie patients and payments to a specific physician or medical group. Some primary care physicians reportedly have opposed the move away from capitation, arguing that discounted fee-for-service payments are insufficient to support the full scope of services formerly provided under capitation.

Historically, Miami's HMOs relied either on full-risk contracting with provider organizations or on primary care capitation contracts with individual physicians. Since 1998, however, most hospitals have discontinued risk-bearing contracts and have negotiated more lucrative per

Health Insurance Status

	Miami	*Metropolitan areas above 200,000 population*
Persons under Age 65 with No Health Insurance [1]	*23%*	*15%*
Children under Age 18 with No Health Insurance [1]	*17%*	*11%*
Employees Working for Private Firms that Offer Coverage [2]	*77%*	*84%*
Average Monthly Premium for Self-Only Coverage under Employer-Sponsored Insurance [2]	*$161*	*$181*

Sources:
1. Community Tracking Study Household Survey, 1998-1999
2. Robert Wood Johnson Foundation Employer Health Insurance Survey, 1997

Health System Characteristics

	Miami	*Metropolitan areas above 200,000 population*
Staffed Hospital Beds per 1,000 Population [1]	*3.6*	*2.8*
Physicians per 1,000 Population [2]	*2.7*	*2.3*
HMO Penetration, 1997 [3]	*64%*	*32%*
HMO Penetration, 1999 [4]	*52%*	*36%*

Sources:
1. American Hospital Association, 1998
2. Area Resource File, 1998 (includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists)
3. InterStudy Competitive Edge 8.1
4. InterStudy Competitive Edge 10.1

Medicare has remained a competitive and lucrative business line for Miami's HMOs, but the generosity of benefits offered to Medicare beneficiaries has begun to erode over the past year.

diem payments from health plans. Health plans have retained some risk contracts with nonhospital-based provider organizations (such as MSOs) and most capitated contracts with primary care physicians, but, according to several health plans, levels of service have begun to erode under these arrangements. Consequently, some of the market's largest plans have begun to move back to fee-for-service payment arrangements with primary care physicians and to experiment with limited-risk arrangements (e.g., contact capitation) for specialists.

Medicare has remained a competitive and lucrative business line for Miami's HMOs, but the generosity of benefits offered to Medicare beneficiaries has begun to erode over the past year. The BBA constrained payment levels and introduced stricter accounting rules for Medicare+Choice, causing HMOs' financial margins to decline. Nonetheless, Medicare+Choice payment rates in Miami have remained among the highest in the nation because they are based on the area's historically high per-capita Medicare expenditures.

Consequently, Miami's seniors continue to pay no premiums for these plans and to enjoy a broader choice of plans and a more comprehensive set of benefits than their counterparts in other markets. Over the past year, however, several plans implemented caps on pharmacy benefits for the first time, and some plans added or raised copayments for selected services. Health plans predicted more severe benefit reductions and the possibility of plan withdrawals over the next two years if Medicare+Choice payment increases continue to lag behind the rates of growth in medical and pharmaceutical costs.

Reforms Fail to Prop Up Small Group Market

Affordable insurance options for Miami's smallest businesses have dwindled over the past two years, despite several recent state reform efforts. In 1996, Florida attempted to expand insurance options for small businesses of up to 50 people, including sole proprietors, through legislation that required guaranteed issue (plans offering insurance must sell to any purchaser) and community rating (premiums reflect average health care costs in the community rather than group characteristics and costs).

These reforms, which were expected to lower insurance costs by creating an influx of healthy people to the state's small group insurance market, instead triggered adverse selection by attracting people with significant health care needs. Faced with rising costs from small group policies, health plans responded by raising small group premiums significantly, pulling out of the market altogether or limiting exposure to small groups. Some plans have begun using complex enrollment processes and eliminating broker commissions to avoid groups of fewer than 10 people.

Another state initiative created insurance purchasing associations to make small group insurance more affordable, but they were dissolved in 2000 after several years of unsuccessful operations. This effort, launched in 1994, created insurance purchasing associations, called Community Health Purchasing Alliances (CHPAs), in 11 districts throughout Florida. The CHPAs lost an important political advocate with the 1998 death of Gov. Lawton Chiles, who reportedly used his clout to encourage health plan participation. Before Chiles' death, the Miami-Dade CHPA had as many as 21 health plan offerings, but by April 2000, only two plans remained. Other reasons cited for the CHPAs' failure included:

- lack of authority to negotiate with health plans over product offerings;
- inability to pool members under a single master contract;
- adverse selection stemming from too many plan choices for employees;
- opposition from insurance brokers; and

• administrative problems, including lax standards for screening out individuals representing themselves as businesses.

A new Florida law intended to bolster the small group insurance market allows plans to establish premiums based on age and sex and then adjust these premiums based on health status and prior utilization within a rate band of 15 percent. To address adverse selection problems, the law establishes an enrollment period for one-person businesses. In addition, it provides a structure for private nonprofit purchasing alliances that would have the authority to combine lives from multiple small businesses under a single master policy. The law's impact remains to be seen.

Safety Net Responds to Growing Demand for Care

Continued population growth has fueled the demand for charity care, causing hospitals, community health centers (CHCs) and other safety net providers to experience significant increases in uninsured caseloads. Miami hospitals have been particularly hard hit, reporting double-digit increases in uninsured patients and uncompensated care costs for 1999.

Miami's largest charity care provider is Jackson Memorial Hospital, the only hospital to receive support from two county-funded indigent care subsidies. The subsidies—one funded from general county revenues and the other through a special state-authorized sales tax—are administered by the Public Health Trust of Miami-Dade County, an independent governing board for county health services. Other local hospitals have sought a share of the funding, arguing that indigent care money should follow uninsured patients wherever they seek care in the county, particularly since residents in some areas do not have easy access to Jackson Memorial facilities.

The Florida Legislature weighed in on the controversy in 2000 by passing a law requiring Miami-Dade County to use some of its indigent care dollars to operate a county-wide plan for the uninsured. Asserting that the law violated the county's home rule authority, the Miami-Dade County Commission refused to implement it. In February 2001, seven local hospitals filed a suit against the county seeking to force compliance with the new law, creating continued uncertainty about the distribution of Miami's indigent care funds.

In an effort to enhance its position as a county-wide source of care, Jackson Memorial Hospital—recently renamed Jackson Health System—has strengthened relationships with several CHCs and has pursued acquisition of a community hospital serving southern Dade County, an area where Jackson lacks a strong presence. Jackson also has begun conversations with several community organizations about creating a pilot managed care plan for the uninsured in southern Dade County. Other hospitals argue that Jackson's actions fall far short of the intent of the state's indigent care legislation.

In the midst of this controversy, Miami's CHCs have expanded their infrastructure, services and hours to address the growing demand for community-based charity care. CHCs have obtained funding for these expansions from various sources, including the Public Health Trust, local governments and federal grant programs. They also have developed contracts with Medicaid HMOs and strengthened efforts to enroll uninsured patients in Medicaid and the state's umbrella program for children's health insurance, Florida KidCare. Several community advocacy organizations have augmented CHC efforts by launching intensive outreach and education campaigns to increase access to health care among Miami's large uninsured and immigrant populations.

KidCare's Growing Pains

Recent state initiatives to expand public insurance coverage have helped Miami's safety net providers. But the rapid growth in state health care expenditures has

Continued population growth has fueled the demand for charity care, causing hospitals, CHCs and other safety net providers to experience significant increases in their uninsured caseloads.

With one in four people already uninsured, any erosion in employer-based or public coverage could stretch the safety net beyond its limits.

raised questions about the sustainability of these efforts. Over the past two years, Florida has significantly expanded eligibility for Florida KidCare—an umbrella program supported through joint federal and state funding for Medicaid and the State Children's Health Insurance Program (SCHIP), as well as through separate state appropriations. These eligibility expansions, combined with a recent outreach campaign, have netted KidCare nearly 74,000 additional children in Miami since the beginning of 1999, more than double the 35,000 children originally expected. The massive influx of new enrollees, plus rising pharmaceutical costs, has greatly expanded Florida's health care budget.

Mounting state budget pressures have stimulated efforts to control health care spending. To reduce state expenditures that do not draw down federal matching funds, the Florida Legislature placed a $13.5 million annual limit on state funding in 2000 for Florida KidCare enrollees who are ineligible for coverage under federal Medicaid and SCHIP regulations, including non-citizen children, children of state employees and 19-year-olds. Florida covers these groups with state appropriations—through an initiative that predates SCHIP and KidCare—but because of the state funding limit, enrollment in KidCare was capped for these groups after July 1, 2000. A waiting list of approximately 6,000 enrollees had formed as of February 2001—with residents of Miami-Dade and two other south Florida counties reportedly comprising about 75 percent of those waiting.

While Florida has constrained spending on individuals ineligible for Medicaid or SCHIP coverage, state Medicaid expenditures have continued to grow, resulting in a Medicaid budget shortfall expected to total $1 billion by mid-2001, according to some estimates. This shortfall has generated a variety of proposals to reduce Medicaid spending, including payment cuts to providers and health plans and efforts to increase Medicaid enrollment in HMOs. In view of Florida's mounting budget problems, some observers feared state efforts to expand public insurance coverage in Miami have begun to reach their limits.

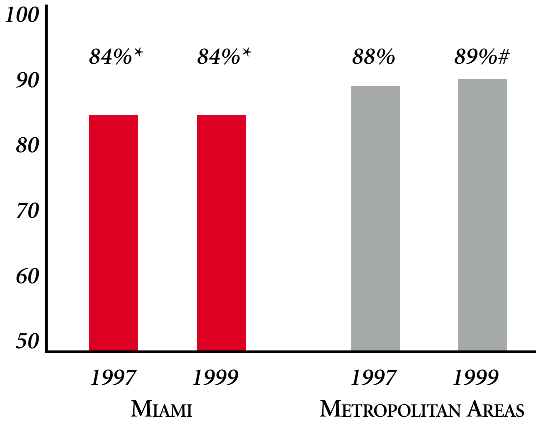
Issues to Track

Growing hospital negotiating power in Miami, combined with health plans' decisions to offer less restrictive and more expensive products, has heightened concerns about the affordability of health insurance for Miami residents. Florida's past efforts to make insurance more affordable for small businesses have failed, and the state's recent public insurance expansions appear vulnerable to budget difficulties. With one in four people already uninsured, any erosion in employer-based or public coverage could stretch the safety net beyond its limits. Together, these developments raise new questions about how health care delivery and health insurance coverage may change in Miami:

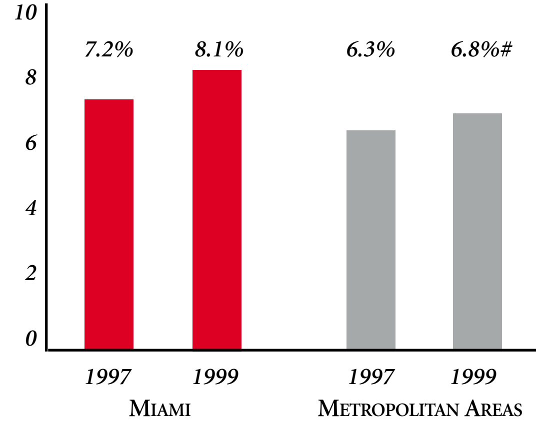
- Will consumers and employers continue to move to direct-access products, despite rising health care costs and premiums?
- How will rising health insurance premiums affect private health insurance coverage, especially for small businesses?
- How will Florida's new small group insurance reforms affect small employers' access to affordable coverage?
- How will hospitals, policy makers and the Public Health Trust resolve the longstanding controversy over public funding for indigent care, and what impact will their decisions have on access to care for the uninsured?
- How will state budget pressures affect benefits and coverage under Florida's Medicaid and SCHIP expansion programs, and how will safety net providers be affected?

Miami's Experience with the Local Health System, 1997 and 1999

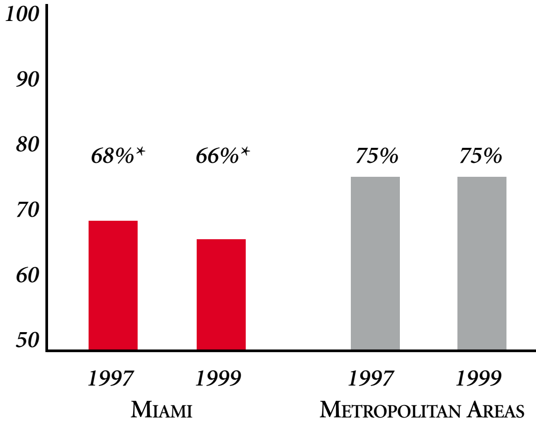
Persons Satisfied with the Health Care They Received in the Last 12 Months



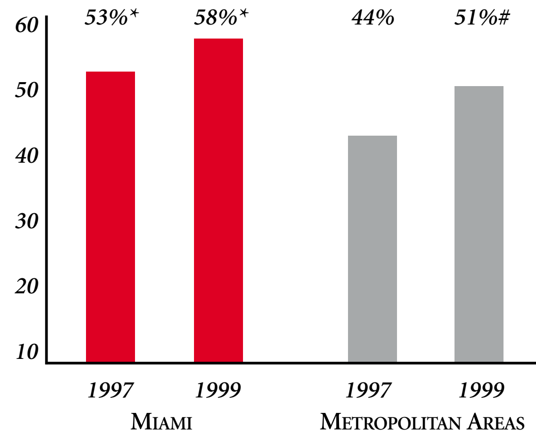
Persons Who Did Not Get Needed Medical Care in the Last 12 Months



Physicians Agreeing that It Is Possible to Provide High-Quality Care to Their Patients



Persons with Insurance that Requires Gatekeeping



** Site value is significantly different from the mean for metropolitan areas over 200,000 population.*
 # Statistically significant difference between 1997 and 1999 at p< .05.

The information in these graphs comes from the Household and Physician Surveys conducted in 1996-1997 and 1998-1999 as part of HSC's Community Tracking Study.

The Community Tracking Study, the major effort of the Center for Studying Health System Change (HSC), tracks changes in the health system in 60 sites that are representative of the nation. Every two years, HSC conducts surveys in all 60 communities and site visits in 12 communities. The Community Report series documents the findings from the third round of site visits. Analyses based on site visit and survey data from the Community Tracking Study are published by HSC in Issue Briefs, Data Bulletins and peer-reviewed journals. These publications are available at www.hschange.org.

Authors of the Miami Community Report:
Glen P. Mays, Mathematica Policy Research, Inc.
Sally Trude, HSC
Lawrence P. Casalino, University of Chicago
Patricia Lichiello, University of Washington
Ashley C. Short, HSC
Andrea Benoit, HSC

Community Reports are published by HSC:
President: Paul B. Ginsburg
Director of Public Affairs: Ann C. Greiner
Director of Site Visits: Cara S. Lesser
Editor: The Stein Group

For additional copies or to get on the mailing list, contact HSC at:
600 Maryland Avenue SW, Suite 550, Washington, DC 20024-2512
Tel: (202) 554-7549 (for publication information)
Tel: (202) 484-5261 (for general information)
Fax: (202) 484-9258
www.hschange.org

HSC, funded exclusively by The Robert Wood Johnson Foundation, is affiliated with Mathematica Policy Research, Inc.