South Florida

Site Visit Report

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▼ ▲ ▼ Overview

The south Florida health care market, known for an aggressive for-profit culture, an excess of providers, and large elderly and Hispanic populations, is changing rapidly. Over half of the insured market is enrolled in managed care; coverage is very high among Medicare and Medicaid beneficiaries compared to other markets. The market is, by many accounts, at a tipping point for hospitals and insurers to become much more consolidated. Players in the health system are engaged in a deal-making frenzy that is likely to become even more intense in the future. Although the market spans three counties—Dade, (where Miami is located), Broward (Ft. Lauderdale), and Palm Beach—and sometimes extends into Monroe County (the Keys) and counties to the west as well—the site visit was limited to Dade and Broward counties. Over the past four years, health maintenance organization (HMO) enrollment in this area experienced tremendous growth; between 1993 and 1994 alone, HMO enrollment rose 30 percent, with most of the growth occurring in HMO point-of-service (POS) products.[1] There are 26 competing HMOs and numerous preferred provider organizations (PPOs), none of which have more than 15 percent market share and all of which are vying for new enrollees. Competition among these plans is intense. Due to the potential for increased market share as well as the profitability of current Medicare and Medicaid contracts, the Miami market has become increasingly attractive to out-of-state investor-owned health plans. Consolidation among the many health plans has begun to occur, mostly in the form of large plans acquiring smaller local plans to buy their way into the market or to increase market share.

Payers generally, and insurers in particular, are in the driver's seat because south Florida is a classic buyer's market. The market is oversaturated with providers of all kinds—hospitals, primary care doctors, medical equipment suppliers, and home health agencies. With such excess supply, health plans are able to bargain for lower prices, capitate physicians, and pay hospitals relatively low per diem rates. However, the plethora of providers and health plans often means that no one is ever really in charge. Pacesetters within each sector change frequently, especially as leaders within organizations change frequently.

As the power of insurers and managed care plans in particular has increased, providers of all types—hospitals, physicians, safety net providers—have responded in different ways. In order to strengthen their negotiating

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[1] A POS plan is a health plan with a network of providers whose services are available to enrollees at a lower cost than the services of non-network providers. POS enrollees must receive authorization from a primary care physician to use network services. POS plans typically do not pay for out-of-network referrals for primary care services.

position with insurers, most hospitals have merged into one of four major systems. Three of the four major hospital systems are for-profit (Columbia/ HCA, OrNda, Tenet) and one is nonprofit (Dimension). Public and private hospitals that remain independent are seeking partnerships with other providers and health plans.

Hospitals are fueling the development of physician-hospital organizations (PHOs) as part of their efforts to bolster their market power. Most hospitals are forming alliances with or purchasing physician groups and outpatient clinics to enhance their outpatient service capacity. Although in the past physicians have been fervently independent, multispecialty group practices are becoming more common in the market. In addition to joining physician-hospital organizations (PHOs), physicians are trying to diversify their HMO contracts and take on capitation to assure continued revenue. Despite these trends, there remains very little real vertical integration between hospitals and physicians or between providers and insurers.

In their search for relief from high health care costs, employers and consumers are contributing to the trend toward increased managed care. Neither large nor small purchasers negotiate health benefits collectively, suggesting they have little market power. However, competition among health plans is such that organized purchasing is not necessary to get good deals. Several large employers have negotiated substantial premium discounts. The state-sponsored community health purchasing alliances (CHPAs) have also increased awareness among small businesses that lower premium prices are possible. However, it is unclear whether the CHPAs or the state's small group insurance reforms have had direct impact on premium rates available to small firms.

State and federal policy do not play a significant role in the south Florida market, except through efforts to enroll Medicaid and Medicare beneficiaries in managed care plans. Both levels of government pay relatively generous rates, which explains much of their attractiveness to health plans. The state has also made it easy for Medicaid-only plans to get started by granting them exemptions from normal licensing and quality-of-care requirements. Despite their popularity, the quality of care delivered by such plans has come under increased scrutiny.

The publicly supported safety net providers, including public hospitals, federally funded community health centers, and community mental health centers, appear to be holding their own by adopting business-oriented strategies. However, these providers remain vulnerable to large public sector funding cuts. Safety net providers are experiencing increasing financial pressure. Some of them may perish if Medicaid and state funding cutbacks occur as expected and the proportion of the uninsured—24 percent—remains the same or increases.

Over the next two to three years, the market is expected to change rapidly as managed care growth continues. As long as price competition among plans and providers keeps annual increases in health plan premium rates low, purchasers will have little motivation to organize. Smaller HMOs are expected to leave the market or merge with larger ones, leaving fewer health plans covering the region. Additional hospital alliances or mergers are also anticipated, and the number and size of physician groups is likely to increase. More vertical integration between hospitals and physicians is predicted. But it remains less certain that insurers will seek financial integration with providers.

▼ ▲ ▼ Community and Health System Background
Demographics and the Economy

South Florida is a rapidly expanding metropolitan area that spans three counties—Dade, Broward, and Palm Beach.[2] In 1990 Broward County had 1.3 million residents, Dade County had 1.9 million, and Palm Beach County had 860,000, making up a metropolitan area of 4 million. By 1995, the tri-county areas reached 4.3 million, and it is expected to increase to 4.6 million residents by the year 2000. Miami remains the business and cultural center of the region.

As in other large urban population centers, Miami's ethnically and economically diverse residents tend to have lower incomes than those in Broward and Palm Beach counties. Dade County's average per capita income ($18,000) is lower than either Broward's ($22,000) or Palm Beach's ($27,000). Dade County has a more ethnically and culturally diverse population than the rest of the region; 73 percent of the population is white, compared to 85 percent in Palm Beach and Broward counties. During the 1980s, the Hispanic population experienced substantial growth; in Dade County, over 50 percent are of Hispanic origin, and 65 percent of Miami city residents are Cuban or of Cuban descent.

Seniors represent more than 20 percent of the population of Broward and Palm Beach due to the presence of large retirement communities; they only account for 14 percent of Dade County's population. Indeed, the Miami metropolitan area has a younger population than most of Florida, largely due to the high proportion of immigrants. Although there are many retirement communities in the region, the greatest population growth is occurring in the 25 to 44 age cohort.

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[2]Because Palm Beach County is small in comparison to the other two counties and was beyond the scope of the site visit, this report focuses on Broward and Dade counties.

Services, trade, manufacturing, transportation, and communications are the dominant businesses in the tri-county area. About 64,000 firms are located in Dade County alone. The largest employers in the region are public; for example, in Dade County, the largest employers include the Dade County Public Schools (29,700 employees), Dade County (28,000), and the state of Florida (16,000). The largest private employers include American Airlines, the University of Miami, and BellSouth Telecommunications. The health care industry, including hospitals, nursing homes, adult living facilities, and home health care services, employs 34,000 people in Dade County alone.

Almost 95 percent of the region's firms have fewer than 50 employees, and very few firms in the region have over 1,000. Of firms with fewer than 50 workers, 47 percent do not offer insurance to their employees. This factor contributes to the region's high uninsured rate, which is around 24 percent.

Health System History

Since the early 1980s, the south Florida market has had an oversupply of health care providers. Many of them were drawn by the high elderly population, the climate, and a growing economy. In 1989, it had an expansive hospital sector (64 hospitals, 18,000 beds) and a specialist-dominated physician community, many of whom had relocated their practices from the Northeast. In Dade County alone there were almost 5,000 physicians, or 300 physicians per 100,000 people, compared to 203 per 100,000 for the nation as a whole. Utilization levels were also high; the region's hospitals averaged 1,483 inpatient days per 1,000 versus the U.S. average of 884 to 1000. In 1980, managed care barely had a foothold in this market, with 120,000 enrollees, mainly in the Miami area.

Around 1985, numerous for-profit HMOs began marketing more aggressively in the Miami area. By 1990, HMO enrollment figures had reached nearly 850,000 throughout the tri-county region. Concern over rising health care costs and a desire by out-of-state companies to enroll their employees in HMOs or PPOs contributed to managed care enrollment increases. Another reason for the growth of managed care was the region's Cuban-American community's clinica tradition. Cuban doctors have historically organized into small clinicas that accepted capitated payments from patients. HMOs like CAC and Pasteur, managed care organizations based in Cuban-American communities, prospered largely due to first-generation immigrant clientele and doctors comfortable with an HMO style of medicine.

The late 1980s also saw the introduction of Medicare HMOs, led by International Medical Centers (IMC), which was later bought by Humana. Medicare HMOs flourished, largely due to the substantial elderly population and inviting adjusted average per capita cost (AAPCC) rates, which rank

among the highest in the nation.[3] A temporary drop in the popularity of Medicare HMOs occurred when IMC was convicted of Medicare fraud and abuse in the 1980s.

Over the past four years, heightened competition among insurers led to tremendous growth in HMO enrollment, particularly in plans serving mostly Medicaid and Medicare patients. Medicaid HMO growth was stimulated by state policies in the early 1990s that made it easy for HMOs to enter the market, leading to the proliferation of numerous small HMOs. Fierce competition for Medicaid enrollees quickly brought into the market new players from out of state, who got their start by acquiring smaller Medicaid-only HMOs. Despite the IMC scandal, Medicare products continued to be popular as AAPCC rates lured HMOs into the profitable market.

By reducing provider reimbursement rates and instituting capitated payments, managed care threatened hospitals and physicians who were used to fee-for-service payments. They were threatened even more by Columbia's entrance into the market, which brought HCA hospitals to the region in 1992. To compete with Columbia/HCA, other hospitals began to merge into systems and form alliances with one another. To strengthen their negotiating position with insurers, many hospitals began aligning with physicians through PHOs and other networks. Six of the premier nonprofit hospitals came together in 1985 to form Dimension Health and developed their own PPO network. Physicians, at this point largely unorganized, welcomed allies in the hospital sector but also began to develop indemnity practice association (IPA) networks of their own.

Despite these efforts, the hospital sector has been hit hard by this onslaught of managed care. Insurer/health plan discounts have taken their toll. Inpatient days declined 14 percent between 1980 and 1990, largely due to decreasing lengths of stay. In the past year, commercial HMO days per 1,000 have decreased from 248 to 224, Medicare days have decreased from 1,486 to 1,322, and Medicaid days per 1,000 have declined from 475 to 421.[4]

However, by most accounts, little downsizing has occurred yet. There are 63 hospitals and about 16,000 inpatient beds in the region, 2,000 fewer than in 1980 but far more than managed care plans need. There is still an oversupply of physicians, particularly in Dade where the ratio of physicians per 100,000 actually increased in the past few years. Specialist physicians dominate the market; in the tri-county area, the ratio of specialists to generalists is approximately two to one.

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[3]For example, Dade County AAPCC Part A rate for 1994 was $574.65.
[4]Presentation by CAC Ramsey, Florida Health Care Environment 1995.

▼ ▲ ▼ Health System Changes

Public Policymakers

Since 1992 and 1993 when the state enacted major health care reform legislation, state public policy has had very little impact on the market. The reform laws, which were structured around a voluntary managed competition strategy, had two major components: (1) state-chartered CHPAs and small-group insurance reforms intended to make coverage more available to small groups and (2) the Florida Health Security Program, which was designed to provide subsidized insurance coverage to as many as one million low-income uninsured people.

The state's 11 CHPAs began offering health plans in May 1994 to firms with 50 or fewer employees. The CHPAs must permit all state-certified health plans in their area to offer coverage, and CHPAs must distribute information to help small firms compare the quality and price of each plan. However, CHPAs can neither negotiate premiums with health plans nor directly contract with them. In 1993, the state also enacted a set of small-group market reforms, which apply to all insurers selling to groups of 50 or fewer employees both in and outside the CHPAs.[5]

As of August 1995, nearly 55,000 lives in 12,000 firms were covered through the CHPAs, less than 2 percent of all eligible firms. Just over half of all firms had not had health coverage before. Although rates for small groups were reported to have dropped in the past year or two, there is considerable debate about whether the CHPAs were responsible. The state Agency for Health Care Administration (AHCA) believes the CHPAs, in combination with small-group market reforms, have contributed to the decline. Others believe that the rate reductions were part of a broader trend. Several interviewees stated that CHPA rates were similar to those offered in the private sector to groups of similar size. Blue Cross and Blue Shield (which opposed the CHPA legislation) noted that their HMO and PPO products are not much cheaper when offered through the CHPAs. Many small groups preferred to buy plans outside the CHPAs for their richer benefit packages. There are also allegations that insurers lowered rates outside the CHPAs to undermine them.

Under the Florida Health Security Program, the state had intended to finance subsidies to low-income people (those who make less than 250 percent of the federal poverty level) using savings derived from the requirement that

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[5]The reforms require (1) guaranteed issue, without regard to health status, preexisting conditions, or claims history; (2) a 12-month limit on preexisting-condition exclusions; (3) modified community rating with adjustments allowed only for age, gender, family composition, tobacco usage, and geographic location; and (4) availability of two standardized benefits packages.

all Medicaid recipients enroll in managed care plans. But the legislature denied AHCA authority to implement the waiver program in both the 1994 and 1995 legislative sessions, based on concerns that managed care savings might not be sufficient to cover all those eligible for the subsidies and based on political opposition.[6]

Purchasers

Employers and Employer Coalitions

Purchasers, who are largely unorganized and have no clear strategy—have taken advantage of the changes occurring in the south Florida health care market. But they have not driven it. By showing that they were willing to change plans, a few large public and private purchasers acting individually have fostered price competition and accelerated the development of HMO and POS products. Although employers are price conscious, they have not pushed for information and accountability on quality issues. Employers are interested in direct contracting with providers, but HMOs are pressuring for state legislation to prevent this from occurring.

Several factors impede the development of a collective purchasing strategy among employers. First, many of the region's employers are small firms that are unlikely to offer insurance at all. In addition, both small and large firms are concentrated in service industries whose workforce is largely part-time and who are also unlikely to offer insurance. Second, many large private employers, particularly in the tourism and finance industries, have out-of-state head-quarters that purchase insurance from national firms. Third, many of the region's large employers are public organizations whose ability to conduct joint purchasing is restricted.

Earlier attempts to organize large businesses in a purchasing coalition have had disappointing results. The South Florida Health Coalition, which began in 1985, now has just 15 large business members employing a total of 250,000 employees. In recent years, the group lost several of the original members who found they could be more effective driving down costs on their own. The coalition's activities have shifted focus from joint purchasing to sharing premium information and quality promotion initiatives.

In individual negotiations, large public and private purchasers have flexed their muscle with insurance plans to keep premium rate increases low. After a

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[6]One of the most contentious issues was an "any willing provider" (AWP) clause, advocated by the Florida Medical Association but opposed by the governor. As of August 1995, the governor was going to call a special session of the legislature to debate the waiver issue again. Some believed the state would be in a stronger position to withstand federal Medicaid cuts if its 1115 waiver program were in effect before Congress made its final decisions on the Medicaid budget this fall. A compromise on AWP was also possible.

period of double-digit premium rate increases in south Florida in the late 1980s and early 1990s, large employers have obtained three years of flat or declining premiums and two- or three-year rate guarantees. Some speculate these steady rates reflect health plans' ability to squeeze larger discounts from hospitals and physicians. Others attribute it to the price wars that health plans will wage to maintain large contracts or secure new ones that increase their market share.

Public employers have led the development of aggressive negotiating strategies in Metropolitan Dade County, one of the region's largest employers with 28,000 employees and 2,500 retirees. The county claims that during the first six months of 1995 it saved $32 million (mostly from its POS plan) through its negotiations. For the past two years, the state of Florida, with 11,000 employees in Dade and 7,000 in Broward, told HMOs that it would renew contracts only if the plans did not raise their rates. This netted the state a savings of $7 million and $30 million in each of the past two fiscal years. Several large private firms also obtained steady premium rates because they were willing to switch out of plans that did not give them the requested rates or share the risk for claims higher than those expected.

Over the past couple of years, south Florida's large employers, particularly those in the public sector, have pushed insurers to offer a choice of managed care options. POS products are increasingly popular because they help to reduce employer costs while preserving choice for employees. For many low-income employees, however, HMOs remain more popular because of lower out-of-pocket costs.

Choices are more limited for those in small firms. Small employers generally offer their employees only one plan. The creation of the state-sponsored CHPAs, small-group reforms, and the availability of insurance through local chambers of commerce have helped to increase the options for these employers. But small firms appear to save more if they are willing to restrict plan options.

State and Local Government as Purchaser for Low-Income People

Although neither of the state's major health care reforms has had much impact on the market, the state has had tremendous influence through its Medicaid managed care policies. In April 1993, the legislature passed a law stating its desire to expand enrollment in Medicaid managed care plans. The state Medicaid agency began to do this with two separate but complementary strategies. First, it developed a plan to expand MediPass, the state's primary

care case management program, to all areas of the state.[7] Second, it launched a separate effort to increase voluntary enrollment of AFDC-related Medicaid recipients into HMOs. It did so primarily by loosening the rules that Medicaid HMOs had to meet to qualify. Most important, Medicaid HMO's were given three years to meet licensing standards required of commercial HMOs and allowed to put up very low reserve thresholds (only $250,000). In addition, rates were not age-adjusted and marketing standards were lenient. As a result, Medicaid enrollment into managed care plans increased from 383,000 statewide in June 1993 to more than 600,000 in January 1995. In south Florida, most enrollees are in HMOs. MediPass enrollees are primarily in Broward County because the state has not yet brought Dade County into that program.

The rapid growth in Medicaid managed care, however, came at some cost. In December 1994, a year-long investigation into Medicaid HMOs in south Florida led to a week-long series of articles in the *Ft. Lauderdale Sun Sentinel* that exposed poor-quality care and flagrant marketing abuses. In response to public outcry, in January 1995 the state placed a moratorium on the licensing of any new Medicaid HMOs. It also froze enrollment in the 28 Medicaid HMOs that were already licensed until the AHCA could conduct on-site visits to assess plan compliance with patient medical records requirements, quality-of-care standards, and marketing practices.[8] The state also made substantial modifications to Medicaid HMO contracts commencing after July 1995 and announced rate rollbacks of between 8 and 18 percent, based on findings that the state may have been paying too much. As a result of the enrollment freezes and rate reductions, Medicaid managed care enrollment growth is likely to slow down.

These developments occurred at the same time AHCA was trying to obtain legislative approval to implement the Florida Health Security Program. The state's Section 1115 waiver application had been approved by the federal government in September 1994, but the legislature balked on giving it the green light. In addition to political opposition to the plan, the highly publicized problems with certain Medicaid HMOs contributed to reservations about a substantial expansion of Medicaid managed care. The state's Healthy Kids program, which provides low-cost coverage to uninsured children, has been

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[7]The state's 1915(b) waiver proposing to expand the MediPass program was later approved by HCFA.

[8]In April 1995, the state dropped the enrollment caps for eight Medicaid HMOs that were found to meet at least 90 percent of all 46 contract standards. The HMOs that met less than 90 percent of the quality-of-care standards were subject to fines and penalties, enrollment caps at previous levels, and/or a halt on expansion into new counties.

implemented in about 15 counties (including Broward), but the number of children enrolled is still low compared to the total uninsured. Thus, expansion of coverage to the uninsured remains on hold.

Insurers and Health Plans

With 26 competing HMOs and too many PPOs to count, managed care is clearly flourishing and highly fragmented with enrollment at significant levels. About a third of privately insured people are in managed care plans, as are over 40 percent of all elderly individuals and about 30 percent of the Medicaid population. Competition among plans is intense, particularly for Medicaid and Medicare enrollees. One of the most popular strategies for gaining market share is to buy out smaller competitors; merger frenzy prevails.

Several trends appear to be converging that suggest even stronger growth in managed care and more consolidation among plans in the future. First, competition among health plans for commercial, Medicare, and Medicaid enrollees is accelerating due to purchaser and consumer pressures. Second, hardly a week goes by without news of another merger or acquisition of a local plan by an out-of-state company. Third, managed care organizations appear to have the upper hand in rate negotiations with providers and are able to forge alliances with selected providers.

Between 1993 and 1994, regional HMO enrollment increased by 270,000, a net increase of almost 30 percent. Medicare and Medicaid HMOs continue to be the fastest-growing segments of the market, but PPOs are not far behind, with a 24 percent rise in enrollment from 1993 to 1994.

As plans struggle to gain market share, competition has become increasingly fierce. As one interviewee noted, any managed care organization with enrollment under 70,000 in January 1996 will "see their train leave the state." To secure enrollees and enlarge their buying power, managed care organizations offer low rates to commercial enrollees. Several sources suggested that some HMOs are using profits from their Medicare and Medicaid business to provide these lower rates to the commercial population.[9]

Traditional indemnity insurers have tried to break into this market, by converting their indemnity products to PPOs and HMOs, but they find the competition difficult. John Alden, one of the few insurance companies with national headquarters in Miami, is struggling to remake itself into a managed care organization. In 1991, it was one of the first insurers to enter into a joint venture with a provider system to offer a managed care product (called Neighborhood Health Plan). American Medical Security (AMS), a third-party administrator that formerly offered just indemnity products to small businesses,

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[9]Federal law mandates that HMOs cannot earn more profit in their Medicare HMO product than in their commercial plans.

now offers several PPO products and two exclusive provider organizations (EPOs) and is developing an HMO option as well. Some say the market has proven hard to crack for traditional carriers such as Cigna and Prudential because of their resistance to Medicaid and small businesses—two big targets in this market. But it has been easy pickings for large managed care organizations (MCOs) such as PacifiCare and United Health Care.

Health plans are merging and consolidating rapidly. Those buying other plans are seeking greater market share. Those selling plans want to cash in their gains before competition with even bigger players squeezes their profit margins. Physicians Corporation of America (PCA) is a prime example of the acquisition-oriented market. Its strategy has been to expand its geographic regional presence primarily by adding Medicaid-based HMOs. PCA entered the south Florida market in 1990 from Kansas by acquiring several financially distressed HMOs, including Century Medical Health Plan, Inc. (a Cuban-run staff model HMO and Florida's fourth largest HMO at the time), and Better Health Plan (the state's largest prepaid Medicaid plan). It later bought Family Health Plan, Inc., the largest HMO in the state, and in 1994 and 1995 bought Max-a-Med and Lourdes Health Plan, which had enrollees throughout the tri-county area.

There have been other prominent buyouts by national for-profit companies. PacifiCare has recently bought several local HMOs, including Pasteur. Foundation Health Corporation recently bought CareFlorida. United Health Care bought CAC Ramsey in May 1994 and continues to expand. One interviewee noted that United will need one million enrollees to break even for what they paid to enter the market, a factor that suggests that United is targeting other local plans. Despite these trends, there are still many HMOs in both the commercial and publicly sponsored markets. Consolidation may go much faster and further before it ebbs.

Managed care organizations are gaining increased control over costs through several provider payment strategies: aggressive rate negotiations, selective contracting with providers, and purchase of physician practices. Interviewees believed that until excess provider capacity is reduced or eliminated, these trends will accelerate.

Most health plans use some capitation to pay primary care physicians, and to a lesser extent specialists. Some describe this as "throwing risk" at physicians, because many doctors are not prepared to manage the financial responsibilities involved. Informants suggest that some HMOs view capitation more as a means of increasing dependency of physicians on the plans than of controlling utilization. Because of the oversupply of providers, physicians will accept low capitation rates in exchange for the security of a reliable flow of patients. Only 5 to 20 percent of insurance dollars are capitated, but only because hospitals are not capitated yet. Capitation of primary care doctors appears to be more prevalent in the Ft. Lauderdale area than in Miami, pos-

sibly because Humana has a very large enrollment in Broward and all of its network physicians are capitated.

HMOs and PPOs have started dropping solo practitioners in favor of contracting with large group practices. They are loath to contract with most of the physician-sponsored IPAs, because the IPAs do little to control costs. Managed care plans are also dropping from their networks high-cost hospitals, specialists, and even primary care doctors if their hospital admission rate is too high.

In one of the newer developments, insurers are also courting providers to enter into joint ventures in order to attract enrollees drawn to particular providers. Health plans, however, have little motivation to develop closely integrated systems with one set of providers unless it offers a unique advantage. For their part, hospitals are seeking such alliances to hang on to their patients while trying to make sure their participation does not preclude opportunities to do business with other insurers. Because this joint venture activity is recent and still not widespread, it may or may not become more prevalent as a marketing strategy.

HMOs are getting more sophisticated about medical management and outcomes measurement, and most are seeking National Committee for Quality Assurance (NCQA) accreditation due to state requirements. But concerted efforts by the HMO sector to impose quality standards on providers or establish disease management mechanisms have not begun in earnest. One managed care representative remarked that HMOs are improving the quality of care by weeding out marginal providers and reducing unnecessary care. Despite these efforts, the state's release of information on Medicaid HMOs' performance has left many questioning HMO quality standards. With new resources being invested in state oversight of plans and a consumer report card under development by the state AHCA, managed care organizations should have greater incentives in the future to invest in quality improvement initiatives.

Providers

For the majority of providers in the market, the rise of managed care has challenged their institutional viability and traditional modes of operation. Hospitals have responded to this challenge mainly by consolidating or forming other partnerships that can help improve their negotiating strength vis-à-vis insurers. Hospitals are also joining with and/or purchasing physician groups (mostly through PHOs) to assure a continued source of referrals and bargain collectively with managed care plans. For the same reasons, physicians are actively seeking to join with other physicians and with hospitals. PHOs, however, have not been very successful; few contracts between PHOs and insurers have been signed.

Safety net providers are trying to strengthen their competitive positions too. Public hospitals are seeking partnerships with private HMOs and private hospitals and expanding outpatient services in order to maintain their patient bases. Community health centers (CHCs) have been forced to adopt the same competitive strategies as private sector outpatient providers in order to ensure a continued revenue stream.

Hospitals

For several years, hospitals have aligned into systems to attain greater control over the market, implement efficiencies, and improve their negotiating power with managed care organizations. Hospitals have found that they need to expand their geographic reach into all three counties and provide an extensive array of services if they want to be included in a health plan provider network.

At this time, there are four main hospital systems, three of which are for-profit (Columbia/HCA, OrNda, and Tenet). With 12 hospitals in the tri-county area and approximately 24 percent of the market's beds, Columbia/HCA is a strong presence in the market. The OrNda system has four hospitals in Dade and Broward, and the Tenet system maintains six hospitals, mainly in Broward and Palm Beach counties.[10] The fourth hospital system, Dimension, consists of six not-for-profit hospitals in Dade County: Hialeah, Mt. Sinai Medical Center, Mercy Hospital, the South Miami Health System (which recently merged with Baptist), Miami Children's, and the North Shore Medical Center.

Though it would be difficult to identify a clear leader among these four systems, Columbia/HCA seems to have greater advantages in this market because it acts more like a real system than the others. Nationally, Columbia/HCA typically buys into a market, closes unprofitable and/or inefficient institutions, and consolidates operations to improve efficiency. This mirrors the strategy in south Florida, where Columbia acquired nearly a dozen hospitals when it merged with HCA, closed two (and may be closing another soon), and is leasing another. Now it is concentrating on improving the efficiency of the remaining hospitals in its system, giving administrators incentives to work together, and centralizing as many operations as possible. For example, Columbia/HCA has its regional office negotiate contracts with insurers locally to gain more leverage from having a hospital network.

In the face of such competition, the remaining independent hospitals are also trying to consolidate and/or find partners. The free-standing not-for-

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[10]Tenet is the new entity formed from the merger of American Medical International (AMI) and National Medical Enterprises (NME).

profits include the University of Miami Hospital and Clinics and Pan American Hospital, an institution that primarily serves Miami's Cuban community. The University of Miami recently announced its participation in a PCA-sponsored HMO. Pan American has developed alliances with South Miami Health System for certain services and is also seeking to merge with another hospital or system of hospitals.

After prompting other hospitals to align into hospital networks, Columbia/HCA has also spurred competing hospitals and hospital systems to become more efficient. Nearly all hospitals have expanded outpatient services and have sought to improve clinical quality by implementing critical pathways,[11] reducing lengths of stay, or lowering C-section rates (among the highest in the country). Hospitals gradually have reduced personnel, staffed fewer of their licensed beds, lowered cost per adjusted patient day, and turned to outside management firms for assistance.

Hospitals are also joining with physician groups in various ways to assure a continued source of referrals and bargain collectively with managed care plans. PHOs are flourishing, and in south Florida PHOs are "heavy on the H, light on the P," meaning that they have been developed and capitalized by hospitals. But PHOs have not had great success; they have signed just a few contracts with insurers. Insurers can easily negotiate with individual hospitals and providers and apparently prefer to do so—a "divide and conquer" strategy one hospital administrator noted wryly. One investor-owned MedConnect PHO (owned jointly by OrNda and Tenet) recently fell apart. Should the state give the green light to direct contracting between PHOs and self-insured plans, PHOs may be able to improve their ability to negotiate contracts.

Physicians

Physicians have been forced to respond to changes occurring in the marketplace. To retain patients and revenue, physicians are joining IPAs and PHOs, seeking a variety of HMO contracts, and taking on capitation.

The physician sector has not historically been organized, except for the clinics in the Cuban American community. In fact, a few years ago there was active opposition to the formation of large group practices. The Broward County Medical Society opposed the Cleveland Clinic when it started a branch office of its multispecialty group there several years ago.

More recently, multispecialty group practices began to form, prompted by HMOs' and PPOs' preference for contracting with large groups. There are at least 14 networks for specialty physician services. In addition, independent

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[11]Critical pathways are treatment protocols that reduce variation and cost by optimizing the order, timing, and components of clinical processes designed to affect patient outcomes.

specialty physicians are beginning to form their own IPAs, some with the help of the Florida State Medical Association, which has organized Florida IPAs in conjunction with most county medical societies. Like PHOs, these groups have not negotiated many contracts because they are, in essence, loose affiliations between physicians that do not actively control utilization.

Despite fears about accepting capitation and lower rates, many physicians have done so to retain access to patients. As one interviewee said, "Everyone feels their survival is at stake, so they trade price for volume." A hospital representative alleged that health plans have lured physicians into these arrangements with high rates and then cut the rates back without warning, especially if the health plan gained a sizable portion of the doctor's practice. To survive in this environment, physicians try to contract with multiple health plans so as not to be beholden to one plan.

Observers mentioned other side-effects of the changes as well. More physicians are enrolling in business administration programs, getting on-line capabilities for their offices, cutting office expenses, laying off staff, and streamlining operations in order to operate in an increasingly business-oriented environment.

Safety Net Providers

The safety net of publicly supported providers, including public hospitals, federally funded CHCs, county public health units (CPHUs), and community mental health centers (CMHCs), has been threatened by recent changes in health care funding and by the need to compete in a more market-driven system.

The biggest threat has been loss of Medicaid and Medicare patients to private HMOs, proprietary clinics, and home health agencies, causing declines in Medicaid and Medicare revenue. At the same time, the state's allocation of funds to counties to support primary care services has declined significantly in the past year. Long-standing rifts between the public hospitals and community health centers seem to have grown, as the hospitals begin to compete directly with CHCs in the delivery of outpatient care. Uncompensated care charges, capitated managed care contracts that pay less than costs, and fears that federal Medicaid changes will reduce their subsidies even more all jeopardize the financial position of these providers.

Publicly supported institutions are in a period of retrenchment. Two to three years ago, they had hopes of an expanded pie that would result from increased coverage of the uninsured through federal and/or state programs. Now they seem resigned to having to become smaller, leaner, and more focused in their missions (given shrinking dollars), even as they become more savvy about operating in a competitive market.

Public Hospitals

There are several public tax-assisted hospitals, including Jackson Memorial Hospital (in Dade), four hospitals in the North Broward Hospital District, and two hospitals in the South Broward Hospital District. Dade County and North and South Broward each have their own hospital taxing districts.[12]

It is instructive to examine the effects of system changes on Jackson Memorial Hospital, one of the largest public hospitals in the country. In certain services, patient load has dropped precipitously (e.g., deliveries dropped from a high of 15,000 per year in 1989–90 to 8,900 in 1994–95), with a corresponding drop in Medicaid revenues. Ironically, Medicaid has become one of the best payers, making Medicaid obstetrical patients attractive to private hospitals (e.g., Medicaid pays $700 for a normal delivery vs. $450 from commercial HMOs) and encouraging Jackson to hold on to as many of these women as possible.

The hospital districts have been protected from some financial pressures due to their local tax support. For example, a referendum passed by Dade County voters in 1991 allocated an extra half-cent sales tax to support services at Jackson, amounting to $96 million in 1993–94, which together with county property tax funds made up 23 percent of the hospital's budget that year. In Broward, property taxes also represent the bulk of public funds dedicated to the hospital, which amount to about 15 percent of the district's gross revenues.

Both counties have dealt with increasing competition primarily by seeking partnerships with private HMOs and private hospitals and expanding outpatient services in order to maintain their patient bases. Jackson Memorial Hospital was fortunate to have obtained an HMO license in 1985. The JMH Health Plan was not actively marketed until 1994, when Jackson decided to use the HMO as a platform on which to maintain its patient base. Enrollment in the plan grew from 3,400 to 12,000 last year, and plan managers expect to have 15,000 by the end of the year, 60 percent of whom will be commercial enrollees (mostly county and hospital employees).

At the same time, Jackson is developing another HMO product in collaboration with PCA and the University of Miami (along with 26 community-based hospitals, whose role remains unclear). The HMO will use PCA's network of primary care physicians and clinics, Jackson's neighborhood primary care clinics (managed by PCA), and staff physicians from the University of Miami. For PCA, the deal expands its Medicaid provider network and improves its reputation through affiliation with Jackson's and

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[12]Neighboring Palm Beach County (not covered in this site visit) also has a taxing district, but it is for health care generally not limited to hospitals. Unlike the other two counties, Palm Beach tends to purchase care from private sector providers rather than operate its own facilities.

University of Miami's premiere doctors. The university gets sites in which to train its family practice residents. And Jackson increases the likelihood of retaining some Medicaid patients. According to a hospital representative, Jackson expects this new joint venture to earn profits that can be used to upgrade facilities or build new ones that in turn will help assure Jackson's position as a preeminent tertiary care center.

The two Broward County Hospital districts have also expanded their outpatient capacity, which will help to lower inappropriate emergency room use and steer patients needing inpatient care to their hospitals. In South Broward's case, the hospital district is considering leasing another hospital from Columbia/HCA rather than building a new facility as it originally planned. This action, in addition to other "expansionist behaviors," has raised concerns about whether a public system should be competing so aggressively with private providers and whether the system really needs additional inpatient capacity.

Local Health Departments

Both Dade and Broward County health departments, which are technically branches of state government, have shifted focus in the past two years. They have given up responsibility for directly providing primary and personal health services in order to concentrate on essential public health functions, such as environmental protection and communicable disease control. Dade County made this change most recently, spurred both by the Clinton administration vision for "reformed" public health agencies and by epidemics of typhoid and hanta virus—extremely contagious diseases that required more resources to control than the county had previously allocated. In June, four public health clinics were transferred to the Dade County Public Health Trust (the governing entity of Jackson Memorial Hospital) to be included in the new venture with PCA and University of Miami. The department will use the funds that formerly supported these clinics (about $3 million) to support environmental health services, HIV prevention and education programs, and monitoring of TB patients, among other critical needs. Broward County did something similar 18 months ago when it sold its clinics to the South Broward Hospital District. Turning over the clinics to the public hospitals gives all who seek service, including the estimated 150,000 undocumented immigrants who have few other places to turn, a better chance at continued access to care.

Community Health/Mental Health Centers

As community health centers have experienced increased competition from private clinics and HMOs for Medicaid patients and dollars, CHCs and CMHCs have been forced to adopt the same competitive strategies used by

the private sector. These include upgrading information systems and streamlining operations to increase efficiency, contracting with HMOs, creating networks among centers to broaden geographic coverage and increase negotiating leverage with HMOs, and in a few cases, becoming partners in or developing their own HMOs.

For example, a network of three Dade County CHCs have formed a network and negotiated contracts with several HMOs. The three jointly purchase supplies and services (including a new information system) and are beginning to develop an HMO. One health center found that it experienced so many problems with its HMO contract that it decided to create its own HMO. Most of the state's CHCs are in the process of trying to create a network that can negotiate for managed care contracts on a statewide level.

Several CMHCs in the tri-county area also created a joint venture and won a contract with an HMO, but they lost it two years later to a lower bid from a competitor. The network is now trying to market its unique ability to deliver care to hard-to-serve dual-diagnosis clients (e.g., those who have mental health problems combined with substance abuse, or mental health problems and mental retardation).

Consumers

The consensus among interviewees was that the majority of consumers are benefitting from price competition among health plans and the resulting slowdown in health care price increases. However, Medicare and Medicaid enrollees in managed care are not well protected from shady marketing and questionable quality of care in MCOs.

Consumer group representatives report that consumers like the lower premiums they pay for managed care plans, and low- to moderate-income elderly people on fixed incomes appreciate the extra benefits they get through Medicare risk contracts without having to pay monthly premiums. However, it was unclear whether or to what extent consumers' total out-of-pocket expenses were affected (e.g., deductibles, copayments). Many believed that pressure from voters was driving many of the public policy changes that promoted lower costs, such as the CHPAs and use of managed care for Medicaid patients, even though their cost-saving effect has yet to be proven.

Most nonconsumer interviewees agreed that care was improved as a result of managed care and competition. For example, one person said, "Competition is making doctors pay more attention to patient needs," and another said, "hospitals are becoming more patient- and customer-focused," yet another believed "patients are getting more efficient care, getting in and out of hospitals quicker, and [are] less likely to have unnecessary procedures." There were a few providers, however, who seriously questioned whether some of the low-end HMOs, paying less than $60 per member per month in medical costs, could be delivering high-quality care.

Consumer group representatives agreed that access to primary care seemed to have improved but were less convinced that quality of care overall was better as a result of the rapid movement toward managed care, especially for those who have greater-than-average needs. Consumer advocates believe those most at risk of underservice in managed care plans are people with Alzheimer's disease and others who need long-term care, pregnant women with substance abuse problems, and the elderly in general whose primary care physicians are not necessarily trained in gerontology. At the same time, consumer group representatives believed that improvements of the past few years, such as declining rates of low-birth-weight babies and increasing immunization rates for two-year-olds, were in danger of being reversed as a result of the shift to managed care.

The most serious concerns were raised by those familiar with Medicaid HMOs, who are well aware that some HMO marketing practices were misleading or even fraudulent. Every day, staff in state Health and Rehabilitative Services offices, children's or community centers, and food stamp offices see HMO marketing representatives crowd their lobbies and parking lots, dangling Nike shoes, diapers, and other "free gifts" before people to induce them to sign a piece of paper "agreeing to receive information," when in fact they are signing up to enroll with the HMO. The situation may not be much better with Medicare HMOs, though it is harder to observe because marketing takes the form of aggressive door-to-door sales.

Once enrolled in an HMO, Medicaid and Medicare beneficiaries remain uninformed about what they are entitled to receive. Observers reported that neither the HMOs nor the federal or state government adequately explained what benefits are covered or how to obtain referrals to special services. Consumer advocates expressed frustration with their inability to get a bill passed by the state legislature that would set up an HMO ombudsman program. These concerns may not be limited to publicly sponsored enrollees; a private insurance representative believed that in the view of individual patients, care has become more complicated and bureaucratic and choice has been reduced.

There are some recent signs of improvement. Most believed that the state's 1995 crackdown on Medicaid HMO marketing practices was overdue. A few people were pleased by the attempts of a few HMOs to integrate health and social services for low-income enrollees and those needing long-term care. The Dade County school system has been reaching out to hospitals and clinics to help them set up school-based clinics, but the effort is still small compared to the need. Some believed that as more hospital beds become empty, some of them may be converted to long-term care for HIV patients.

Though few insurers or providers spoke of it, consumer organization representatives reported that the numbers of uninsured people are rising, especially the number of young families, and that they are having a harder time gaining

access to care. Examples were numerous. Those representing immigrant groups reported that more Hispanics were being asked about their immigration status at area hospitals' emergency rooms and that access to care had diminished for them. Those involved in programs that seek volunteer physicians to serve the uninsured report that fewer doctors are willing to provide free services to uninsured people. Uninsured children with special health care needs have few alternatives. Cuts on the order of $40 million for children's mental health services were already being felt in reduced availability of services. The homeless have fewer places than before to turn for help. The Dade County Public Health Trust has a limited range of drugs available to uninsured people, and that list is getting shorter.

▼ ▲ ▼ Future Developments

The Miami/Ft. Lauderdale market is at a crucial juncture. With managed care (HMO and PPO) penetration reaching nearly 60 percent, an oversupply of providers, and a multitude of health plans vying for enrollees, rapid change is almost inevitable. Smaller HMOs are expected to leave the market or be purchased by large ones, leaving fewer plans covering the region. Hospital alliances are predicted to strengthen, mergers to increase, and the number and size of physician groups to grow. Columbia/HCA's influence will continue to be felt as the organization proceeds with its strategy of buying and closing hospitals. More vertical integration will occur between hospitals and physicians; however, there is little evidence that insurers will adopt this strategy with providers, at least not until excess capacity has been squeezed out of the market.

As long as price competition among managed care plans keeps annual premium rate increases low, purchasers will continue to have little motivation to organize. Should premium rates begin to rise again, however, business coalitions may revive. The large public employers, already pushing the managed care organizations to offer lower prices and better products, may begin to insist on more accountability from health plans.

Safety net providers will continue to come under financial pressure, particularly if federal Medicaid and state funding cutbacks occur. Public hospitals will be forced to become leaner and, to survive, will be forced to behave like their private sector competitors. While Dade and Broward counties retain the authority to distribute state primary care dollars, the extent to which those dollars (reduced by 33 percent from previous years) go to the hospitals and/or to community health centers will no doubt continue to be a controversial issue, just as it was when each county had to decide how many of these dollars to retain for its own primary care clinics.

There is concern about the impact of Medicaid block grants and Medicare cuts on consumers. Everyone in the south Florida health care community seemed acutely aware that the state could lose out in the formulas currently under consideration, given the increasing numbers of elderly and poor in the state. And in an area repeatedly threatened by hurricanes, all seemed wary of the strain a severe storm could place on the shaky safety net of health and human services.