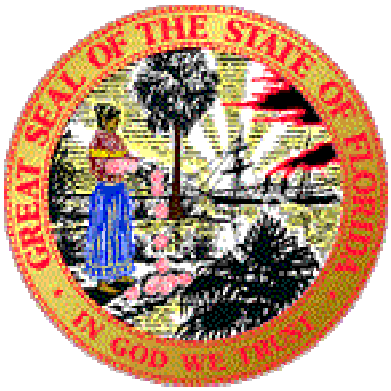
# Governor's Task Force on Access to Affordable Health Insurance


## Final Report
## February 15, 2004

*Lt. Governor*
*Toni Jennings*
*Co-Chair*

*Chief Financial Officer*
*Tom Gallagher*
*Co-Chair*

# Final Report of the Governor's Task Force on Access to Affordable Health Insurance




**Prepared by Health Management Associates, a consulting firm**

**In conjunction with staff from the Agency for Health Care Administration and the Office of Insurance Regulation, Department of Financial Services**

**Tallahassee, Florida**

**February 15, 2004**

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## Executive Summary

The Governor's Task Force on Access to Affordable Health Insurance (Task Force) was created by Governor Jeb Bush on August 25, 2003 through Executive Order 03-160. The Task Force was comprised of seventeen members from varied areas of the state and represented a wide range of expertise including business leaders, health policy experts, health care providers, and consumers. Lieutenant Governor Toni Jennings and Chief Financial Officer Tom Gallagher chaired the Task Force.

The Executive Order noted many factors that impact access to affordable health insurance as well as the consequences of being uninsured, including:

- More than 2.8 million Floridians have no health insurance;
- Fifty-five percent of those who do not have insurance state the reason they don't have insurance is lack of affordability;
- According to the Bureau of the Census, there is a large disparity in the degree of lack of insurance by ethnic group, with twelve percent of non- Hispanic whites being uninsured, compared with twenty-one percent of African Americans and thirty-four percent of Hispanics being uninsured;
- According to studies, the rate of avoidable hospitalization is fifty to seventy percent lower for the insured versus the uninsured;
- An increasing number of employers are opting to cease providing insurance coverage to their employees due to the high cost; and
- An increasing number of employers who continue providing coverage are forced to shift more premium cost to their employees, thus diminishing the value of employee wage increases.

Florida has a long history of implementing health care programs and insurance regulations designed to support the provision of health care coverage and health insurance products, but the need for additional affordable health insurance options in Florida is acute. Governor Bush noted during a news conference in Miami on August 26, 2003: "Clearly we have a significant problem, and it's time for the state, in a substantive way, to come forward with some concrete programs."[1]

Persistent high rates of uninsurance in Florida and other states have been well documented. The Kaiser Family Foundation ranks the state sixth in the nation in terms of the percent of its population without health insurance coverage and third nationally in uninsured children (15.7%).[2] The Kaiser Family Foundation stimates that 18 percent of Floridians of all ages

| State | Uninsured all ages | State | Adults 19-64 |
|---|---|---|---|
| Texas | 23% | New Mexico | 30% |
| New Mexico | 22% | Texas | 27% |
| California | 19% | Louisiana | 25% |
| Louisiana | 19% | California | 24% |
| Oklahoma | 19% | Oklahoma | 24% |
| Alaska | 18% | **Florida** | **23%** |
| **Florida** | **18%** | Alaska | 22% |

Source: The Kaiser Family Foundation, State Health Facts Online. 2000-2001 Data. Retrieved January 2004.

[1] LaMendola, Bob. *Bush Names Panel on Health Insurance: Number Who Lack Coverage Rise Again*. South Florida Sun-Sentinel, 8/26/03.
[2] As cited in the State of Florida, Office of the Governor, Executive Order No. 03-160, 8/25/03.

were uninsured during 2001-2002, with an uninsurance rate of 23 percent for Floridians ages nineteen through sixty-four years of age.[3]

The Task Force goals, as specified in the Executive Order, address the continuum of issues specific to Florida's health insurance status:

**Goal # 1:** Identify the contributing factors to the increasing costs of health insurance and the cost of accessing insurance in Florida.

**Goal # 2:** Identify the major barriers that prevent Floridians from obtaining health insurance coverage.

**Goal # 3:** Identify federal issues regarding health insurance coverage that may contribute to higher health insurance costs, and which may need to be communicated to federal lawmakers.

**Goal # 4:** Investigate pilot and other alternative approaches to traditional health insurance which have been demonstrated to be effective in providing health care coverage to various populations.

**Goal # 5:** Identify potential partnerships the state can utilize to increase available health insurance coverage.

**Goal #6:** Provide policy recommendations to improve access to affordable health insurance and achieve more predictable cost, while maintaining consumer choice.

There were seven meetings held throughout the state:

- September 22, 2003: Coral Gables;
- October 13, 2003: Tallahassee;
- November 17, 2000: Tampa;
- December 3, 2003: Jacksonville;
- December 17, 2003: Miami;
- January 9, 2004: Orlando; and
- February 2, 2004: Tallahassee.

The September 22, 2003 meeting was held in conjunction with the Florida Health Insurance Symposium and served as the organizational meeting for the Task Force. The subsequent three meetings addressed one or more Task Force goals and consisted primarily of presentations from academicians, insurance professionals, health policy experts, and other stakeholders to educate the members on the complexities of the numerous issues. The Task Force established goals, debated issues, formulated their policies and worked to reach consensus on the issues.

[3] *State Health Facts Online,* The Kaiser Family Foundation. Data Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys. Retrieved November 2003. http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi.

The Task Force developed principles for use in choosing among recommendations to improve access to health insurance coverage and ranked these principles in order of priority. The Task Force considered the degree to which policy options were consistent with these principles during the development of Task Force recommendations.

| Rank | Principle |
|---|---|
| 1 | Address the issues of rising healthcare costs. |
| 2 | Ensure that consumers have necessary information to make knowledgeable choices. |
| 3 | Protect the rights of all consumers. |
| 4 | Are cost effective. |
| 5 | Support rather than conflict with existing state reforms and assistance programs. |
| 6 | Are affordable for Floridians at a variety of income levels. |
| 7 | Are realistic. |
| 8 | Protect the position of less healthy individuals. |
| 9 | Are affordable given Florida's budget situation. |
| 10 | Are fair. |
| 11 | Ensure that insurance companies are not created without appropriated oversight. |
| 12 | Do not add to the existing problems of cost shifting. |

The Task Force recommendations were finalized February 2, 2004. The Draft Interim Task Force Report was provided to the Governor, Speaker of the House, and President of Senate, for their review on January 15, 2004, and a final report was presented on February 13, 2004.

Several issues surfaced late in the proceedings of the Task Force Meeting on January 9, 2004 the Task Force members felt were significant and should be addressed in the final report as issues that need further exploration and development. The issues are:

- Identification of viable funding solutions for the maintenance of existing trauma centers and development of new trauma centers in underserved areas;
- Continued strengthening of fraud and abuse prevention and detection initiatives specific to health care;
- Development of viable long-term care (LTC) insurance products that address the needs of all consumers, including consumers with disabling conditions and elders with incapacities of aging; and
- Continued efforts to address medical malpractice insurance concerns.

The eleven Task Force recommendations are included in their entirety in this executive summary. The recommendations and an analysis specific to each recommendation are included in the Task Force Recommendations section of this report. The placement of the recommendations in the following pages does not reflect any ranking or assigned priority.

## Task Force Recommendations

**Pooled Purchasing: Small Employer Access Program**

In order to provide more affordable, traditional health benefit coverages for Florida's small employers and their employees:

A. Establish purchasing pools for small employer groups with two to twenty-five employees to provide more affordable health care coverage for these businesses and to promote options designed to increase the provision of employer sponsored insurance (ESI). These pools should be structured to:

   1. Leverage negotiating power of the pool;
   2. Obtain more stable premiums;
   3. Use established Healthy Kids regions as the geographical areas for these purchasing pools;
   4. Utilize competitive bidding conducted by the Office of Insurance Regulation to select which insurer who will offer coverage for each of these areas. Use the new high risk pool, when operational, to establish the Small Employer Access Program where there are no successful bids;
   5. Offer the standard and basic plans presently required in the small employer market, as well as an option of catastrophic coverage that includes a limited level of primary care coverage;
   6. Allow for waiver of benefit mandates and other similar innovations; and
   7. Allow any appropriately licensed agent with at least one active health carrier appointment to sell Small Employer Access Program policies for fair commission.

B. Eliminate requirement of prior approval of rates for small employer groups with 26-50 employees.

C. Investigate and, if feasible, implement additional incentives designed to increase the provision of ESI.

**Local Initiatives**

Encourage the development of local health care programs for individuals lacking health insurance, in order to provide for the development and expansion of local health care solutions, where such solutions do not negatively impact the traditional insurance market and are not in conflict with insurance code, except as provided by statute (i.e. Health Flex). Specific provisions should support:

A. Increased networking of local communities;

B. Local grants for start-up funds;

C. Creation of public/private partnerships; and

D. The development of new seed money sources, including increased levels of local tax initiative only by referendum and targeted specifically to healthcare issues.

**Evidence Based Medicine**

Promote initiatives that increase the use of evidence based medicine by physicians and health care institutions. Priority should be given to initiatives that improve the quality of health care and provide for a more efficient and effective delivery system. Specific options include:

A. Explore joining or supporting efforts already underway, such as those of the Leapfrog Group, the international group Bandolier, and the Healthy Florida Foundation;

B. Promote university or medical school based research utilizing Medicaid and other data collected by the AHCA to identify and quantify the most cost effective treatment and interventions, including disease management programs;

C. Encourage development of systems to measure and reward providers who implement evidence based medical practices;

D. Evaluate and identify ways to tie a health care provider's use of evidence based medical practice to medical malpractice liability;

E. Routinely review other state and private initiatives and published literature for promising approaches and disseminate information about them to providers; and

F. Encourage the Florida Medical Association and other health care associations to regularly publish findings related to the cost-effectiveness of disease specific evidence based standards.

**Utilization of Electronic Health Care Information**

Encourage the development of electronic medical records by providing financial incentives and promoting the use of digital technology and information systems, including:

A. Supporting Florida-based universities' efforts to obtain grants to test or facilitate adoption of electronic medical records such as those endorsed by the American Academy of Family Physicians;

B. Promoting the use of electronic medical records that allow for the capture of patient clinical data and that facilitate and allow all caregivers and receivers to share medical records and access clinical information;

C. Ensuring that state medical school and continuing education programs include training on use of the Internet and electronic aids, such as personal data assistants (PDA's), in physician offices and other health care settings to access evidence based medicine research findings;

D. Continuing efforts like Florida Medicaid's current initiative to facilitate physician adoption of electronic prescribing using a patient care system that provides point-of-care, patient-specific medication history and comprehensive drug information and interaction reports, integrated with Medicaid's Preferred Drug List; and

E. Encouraging all providers to submit claims electronically.

**Medicaid Restructuring**

Focusing on federal Health Insurance Flexibility and Accountability (HIFA) waivers, explore a comprehensive plan to restructure the Medicaid program to improve access to health care coverage for Florida residents, subject to budget neutrality requirements imposed by federal regulations, sensitive to the local needs of each community. This plan may address:

A. The benefit array;

B. Cost sharing requirements;

C. Cost-effective delivery systems;

D. Coordination with employer sponsored insurance;

E. Additional measures to enhance the cost effective administration of the program; and

F. Continued efforts to reduce fraud and abuse.

**Protection of Safety-Net Providers**

Determine if there are additional ways, within available resources, to further support the viability of the crucial safety-net providers, including emergency rooms and hospitals, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), in order to ensure access to health care for those that lack health insurance.

**Information on the Uninsured**

Develop mechanisms for tracking the success of efforts to reduce the percentage of the uninsured, including the maintenance and periodic gathering of relevant information concerning the number and characteristics of the uninsured.

A. Consider enhancing the 2004 Florida Health Insurance Study and future updates to incorporate the design and implementation of monitoring and evaluation programs;

B. Consider designing and implementing market research studies, such as focus groups and structured interviews, to analyze the uninsured population as part of the health insurance market and to monitor consumer health purchasing patterns; and

C. Strengthen existing annual premium and enrollment data reporting requirements of health insurance carriers.

**The KidCare Program**

A. Encourage enrollment in the KidCare program and consider what can be done to fund it in recognition that the program will need to be reauthorized by Congress in three years. The state shall:

   1. Permit the use of local funding available from counties or other government entities for additional slots, provided there is a commitment that the funding will be continued for a minimum of three years;

   2. Ensure that the KidCare program gives priority enrollment to children who are currently enrolled and are required to move from one program component to another; and

   3. Subject to federal authorization and given it is cost-effective for the State:

      a. Give first priority to children who do not have access to affordable employer sponsored coverage (ESI) and prioritize enrollment for children with access to ESI on the basis of family income, with access being provided to those with lower incomes first;

      b. Provide a subsidy no greater than the KidCare premium to offset the incremental difference between the cost of the employee-only premium and the ESI family premium;

      c. Provide wrap-around benefits to supplement the benefits provided under ESI in order to provide for access to a benefit plan that is actuarially equivalent to the KidCare benefit plan; and

      d. Adjust the waiting list for risk to address those with the most critical needs first.

B. Any recommendations must take current budget constraints into consideration.

**Creation of Health Plans for Uninsurables and HIPAA-Eligibles**

To stabilize Florida's health insurance markets and make them more competitive; to provide access to health coverage to Florida's uninsurables; and to make health insurance more affordable by bringing about reductions in costs to all of Florida's insureds, conservatively estimated to average 2.0 percent for large groups, 4.0 percent for individual policies and 3.0-7.5 percent for small groups:

A. Create a new, appropriately designed health insurance residual market, structured in accordance with the National Association of Insurance Commissioners Model Health Plan for Uninsurables Act, (NAIC Model Act), that accomplishes the following:

   1. Is initially developed by a three-person transition team, appointed by the Governor and headed by the Director of the Office of Insurance Regulation. Upon establishment, be managed by a Board of Directors as outlined in the NAIC Model Act;
   2. Qualifies for federal funding that is available to these types of pools, provided that it is in the best interest of the pool and its financial stability;
   3. Offers insurance that is flexible and designed to meet the needs of enrollees, comprised of the standard and basic plans presently required in the small employer market, as well as an option to provide catastrophic coverage that includes a limited level of primary care coverage;
   4. Uses an administrator who is a duly licensed health insurance carrier or third party administrator selected by a competitive bidding process;
   5. Incorporates effective cost control techniques, including, but not limited to, establishing annual and lifetime maximum benefits, utilizing pre-existing condition limitations, and requiring structured disease management, case management and utilization review programs for all participants;
   6. Makes coverage available to both:
      a. Individuals who are uninsurable, as defined in the NAIC Model Act; and
      b. Individuals eligible for guaranteed issue coverage in the individual health insurance market as a result of federal continuation of coverage requirements, provided in the Health Insurance Portability and Accountability Act (HIPAA).
   7. Utilizes a sliding scale related to the individual's ability to pay in setting plan premiums.

B. Fund the new pool using an appropriation from General Revenue sources including but not limited to a portion of the annual growth in existing net insurance premium taxes. Manage the pool to operate within any caps on available funds.

C. Consider using components of the California risk pool as a model for the new program.

D. Concurrent with the creation of the high-risk pool, eliminate the present requirement that carriers provide guaranteed issue small employer coverage to One-Life Groups.

E. Require a report after the third full year of operation on the success of the pool in accomplishing its objectives.

## Background

Persistent high rates of uninsurance in Florida and other states have been well documented. The Kaiser Family Foundation ranks the state sixth in the nation in terms of the percent of its population without health insurance coverage and third nationally in uninsured children (15.7%).[4] The Foundation estimates that 18 percent of Floridians of all ages were uninsured during 2001-2002, with an uninsurance rate of 23 percent for Floridians ages nineteen through sixty-four years of age.[5]

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Source: The Kaiser Family Foundation, State Health Facts Online. 2000-2001 Data. Retrieved January 2004

Two million eight hundred thousand (2.8 million) Floridians have no health insurance, and 55 percent cite affordability as the primary reason.[6]

Florida has a long history of implementing health care programs and insurance regulations designed to support the provision of health care coverage and health insurance products. Efforts to address the needs of the uninsured began in the 1940s with the creation of public hospital taxing districts, followed by the implementation of the Medicaid program, the passage of the Florida Comprehensive Health Association (FCHA) Act (high-risk pool), the implementation of HealthyKids and the passage of health insurance laws designed to regulate and support the provision of private health insurance, including employer-sponsored insurance (ESI).

**Florida History of Health Care Coverage and Initiatives**

| Year | Program | Services/Coverage |
|---|---|---|
| Between 1940 and 1970 | 20 local public hospital taxing districts established. | Funding for care to the medically indigent and services and facilities for local populations. |
| 1970 - 1987 | Florida Medicaid Program | Initially provided health care coverage to low-income parents and children.<br>• 1986: added the medically needy group (comprised of low-income individuals with high medical expenses).<br>• 1987: added low-income elders and the disabled, children under five with family incomes up to 100% FPL and individuals in need of nursing home care (the institutional care program or ICP).<br>• Additional expansions included coverage for pregnant women, additional children (now covered with family incomes up to 200% FPL), and coverage for low-income Medicare beneficiaries. |

[4] As cited in the State of Florida, Office of the Governor, Executive Order No. 03-160, 8/25/03.
[5] *State Health Facts Online,* The Kaiser Family Foundation. Data Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys. Retrieved November 2003. http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi.
[6] As cited in the State of Florida, Office of the Governor, Executive Order No. 03-160, 8/25/03.

| Year | Program | Services/Coverage |
|---|---|---|
| 1982 | Florida Comprehensive Health Association (FCHA) Act | Established a "last resort" insurance program for high-risk individuals who had lost their coverage or could not obtain coverage elsewhere (the "high-risk" pool). |
| 1984 | Public Medical Assistance Trust Fund (PMATF) established | One percent (rising to 1.5 percent in subsequent years) tax on net incomes of hospitals.<br>Re-funneled these funds to hospitals that served large numbers of uninsured Floridians. |
| Mid 1980's | Local Initiatives | Many safety-net hospitals initiated programs to identify and enroll medically indigent patients in locally funded programs or in Medicaid.<br>The Hillsborough County Health Program was established to translate new, local sales tax revenues into a system of care for employed, uninsured people in the county. |
| 1990 | Florida Healthy Kids Corporation | A public/private partnership option (Healthy Kids) permitting counties to use local funds to provide health insurance to children was established. The funds became eligible for federal matching using a Medicaid waiver. |
| 1992 | The Heath Care Reform Act | The Florida Agency for Health Care Administration (AHCA) was established. |
| 1993 | Health Care and Insurance Reform Act of 1993 | Small Employer health insurance market reformed to require guaranteed issue policies and modified community rating.<br>Created eleven Community Health Purchasing Alliances (CHPAs). |
| 1998 | Florida KidCare Act | Expanded Healthy Kids statewide. |
| 1999 | Statewide local taxing authority | Legislation authorizing up to ½ cent of optional sales tax revenue by referendum to be earmarked exclusively for indigent health care in each county. |
| 2000 - 2003 | Small Employer Health Insurance Market modifications | Various statutory changes were implemented in an effort to strengthen the small employer market and provide more affordable health insurance to small employers, including:<br>• Modified community rating definition expanded to allow +/- 15% rate adjustment for health status, claims history and duration.<br>• CHPAs disbanded.<br>• One-life groups limited to guaranteed issue only one month per year; product offerings limited to Standard and Basic; and modified community rating changed to allow a one-life rate pool with rates up to 150% above other small employer groups.<br>• Any limitations on cost sharing eliminated. |

| Year | Program | Services/Coverage |
|---|---|---|
| 2002 | Health Flex Pilot Program authorized | Provides for the development of alternative approaches to health insurance for individuals with incomes under 200% FPL ineligible for health insurance (including Medicaid). A primary feature is the ability to offer coverage free from Florida's mandated benefits. |

Between 1940 and 1970, the state established 20 local public hospital taxing districts to provide funding for local services and facilities and fund care for the uninsured. Florida established the Medicaid program in 1970 and has continued to expand coverage and eligibility throughout the program's history.

The Florida Medicaid Program was established in 1970 and provided coverage to a select segment of the population. Persons eligible for Medicaid were expanded through a number of legislative modifications to the program in the 1980s.

In 1982, the Florida Comprehensive Health Association (FCHA) Act was passed. FCHA established a "last resort" insurance program (the high-risk pool) for high-risk individuals who had lost their coverage or could not obtain coverage elsewhere. (*The program is currently closed to new enrollment because of budget constraints).*

In 1984, the legislature passed significant legislation that called for a 1.5% tax on hospital incomes, to establish the Public Medical Assistance Trust Fund (PMATF). The PMATF is designed to redistribute these funds to hospitals with above average levels of uncompensated care.

In the mid 1980s, many of the state's safety-net hospitals initiated programs to identify and enroll medically indigent patients in locally funded programs or in Medicaid. Tampa General Hospital, for example, invested in case management staff who followed patients into rural and challenging urban areas in order to obtain eligibility information that would facilitate enrollment in either the county medically indigent program or Medicaid.

In 1988, a local initiative in Tampa, Florida led to what has become another national award winning (Innovations in American Government) program. The Hillsborough County Health Program was established, providing a coordinated system of care for employed, uninsured people in the county.

The Heath Care Reform Act of 1992 was enacted to bring a variety of institutional components addressing health care purchasing and regulation into a newly coherent framework of what was to be called the Florida Agency for Health Care Administration (AHCA). Also in 1992, the Florida legislature passed legislation authorizing special taxing districts for counties with populations of 800,000 or more to collect a half percent sales tax to help cover the cost of indigent care. This taxing authority was used by Hillsborough County to expand their Health Care initiative.

In January 1993, AHCA issued a comprehensive proposal for health care access, *A Blueprint for Health Security*. This proposal ultimately could not gain sufficient consensus in the state Senate. However, certain key elements of the plan were later adopted. Some elements of the plan included: basic benefit standards; Medicaid program expansion including a buy-in component; private health insurance reforms; increasing primary care providers in all parts of the state;

community-based care (for the frail elderly and the physically and mentally disabled); establishment of rural health networks; practice guidelines for health care professionals; outcome measures (to assess the cost and quality aspects of different approaches to treatment); health promotion; and regulation.

In 1993, the Health Care and Insurance Reform Act was enacted. This act brought significant reform to the small employer market ("small groups"), ensuring access to coverage by requiring guaranteed issue of policies. It also facilitated affordable coverage by requiring that carriers pool experience of all small groups together for rate development. The law required "modified community rating', a mechanism in which a group's rate could differ from another group's only based on the composition of the group in regard to age, sex, county, family composition and tobacco use.

The Act also created eleven Community Health Purchasing Alliances (CHPAs). While CHPAs were considered an initial success, their viability could not be sustained. At their peak in 1998, the impact among the state's uninsured population was minimal. Only 23,000 small businesses obtained coverage through the alliances, providing insurance to 93,000 individuals. This limited success was due in part to the inability to attract insurance companies and agents.

During the past several years, the Florida Medicaid program has provided prescription assistance payment services to seniors of various income levels. Some of these programs include Silver Saver and Life Saver Rx.

In 2002, the Florida Legislature, concerned about the affordability issue, authorized the Health Flex Plan Pilot Program, which is designed to encourage insurers, HMOs, health care provider organizations, and other private and public community-based organizations to develop alternative approaches to traditional health insurance for the non-elderly uninsured with income less than 200 percent of the FPL.

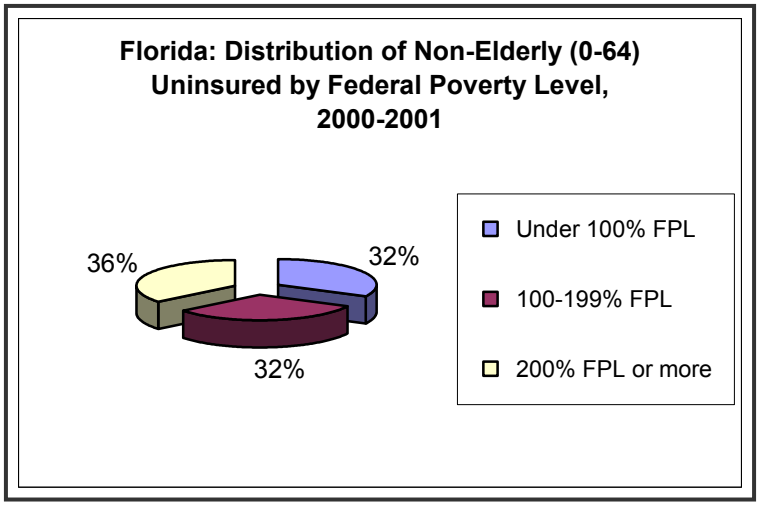
In early October 2003, the Florida Agency for Health Care Administration (AHCA) was awarded a one-year grant to support its efforts to develop options to increase health insurance coverage. As one of seven states receiving the grant, the $975,000 State Planning Grant from the United States Health and Human Services' Health Resources and Services Administration (HRSA) will be used to design a program or coordinated set of programs to increase Florida's health care coverage.

Three core activities have been designed to meet this objective: 1) describing the uninsured; 2) developing health insurance options; and 3) disseminating project results. A current analysis of the uninsured will be obtained through the implementation of a second round of the Florida Health Insurance Study in early Spring 2004. The grant will also build upon the work of the Task Force by completing more extensive analysis relevant to the Task Force recommendations that may be required by the legislature and state agencies. Project results will be disseminated through printed publications and a web-based data query tool. A final report and public release will be issued at the conclusion of the process.

### *Who Are Florida's Uninsured?*

Most of Florida's uninsured are socio-economically disadvantaged. For example, among the non-elderly:

- Sixty-four percent live at or below 200 percent of the FPL;
- Twenty-six percent of African Americans and 36 percent of Hispanics are uninsured compared to 15 percent of whites; and
- Half of all non-citizen non-elderly residents are without coverage.[7]




Source: The Kaiser Family Foundation, 2003 State Health Facts Online.

Analyses of the Florida Health Insurance Study (FHIS) telephone survey indicate that rates of uninsurance vary dramatically throughout the state, reflecting local differences in employer-based and public coverage, as well as in population characteristics.[8] The highest rate of uninsurance by region was in a seven-county rural area (comprised of DeSoto, Glades, Hardee, Hendry, Highlands, Monroe and Okeechobee counties) at 25.5 percent. However, rates of uninsurance were almost as high in Miami-Dade County, with 24.6 percent of non-elderly residents uninsured. In comparison, the rate of uninsurance was 15 percent in nearby Palm Beach County. On a statewide basis, 22 percent of Florida's uninsured live in Miami-Dade County, with another nine percent in Broward County.

### *Employment and Insurance Coverage*

Today, the majority of insured Floridians of all ages obtain health care coverage through their employers. According to analysis from the 2002 CPS, 62 percent of non-elderly residents have employer-sponsored health insurance.[9]

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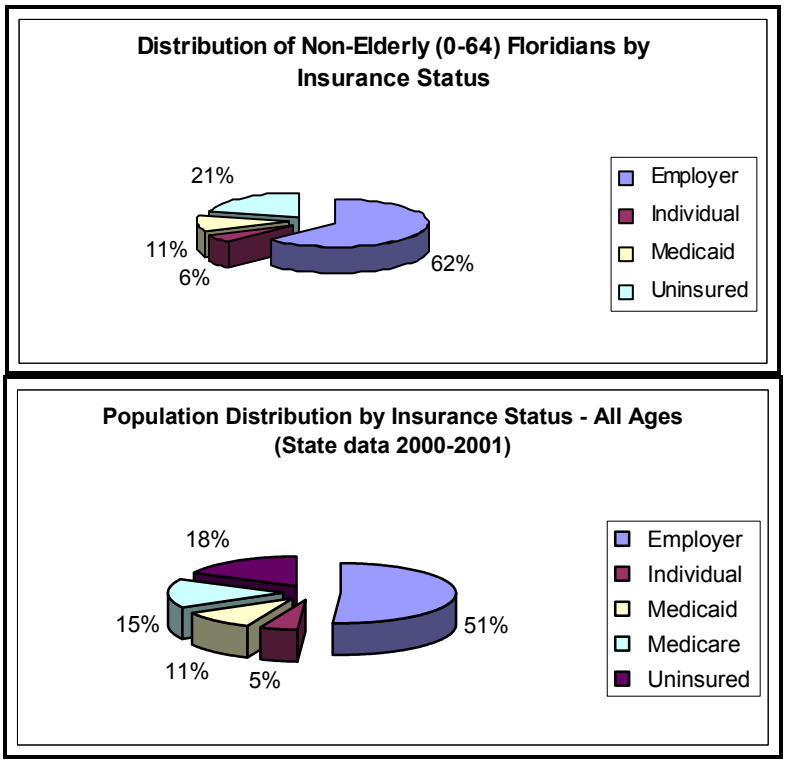
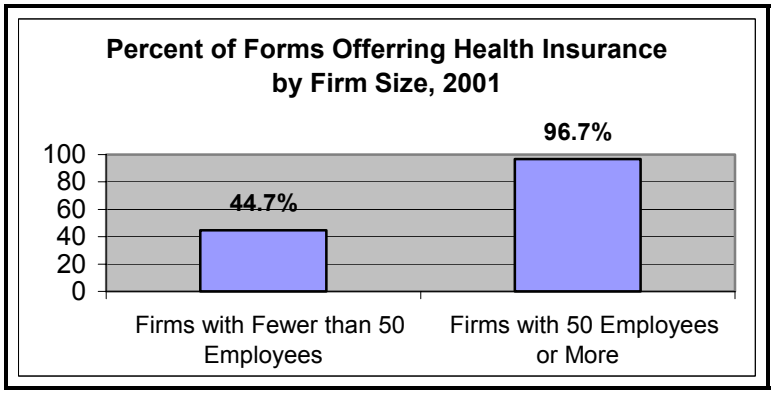
[7] The Kaiser Family Foundation, *State Health Facts Online.*
[8] Duncan et al. The Florida Health Insurance Study Volume 1: The Telephone Survey January 2000. Retrieved January 5, 2004 from the AHCA Website: http://www.fdhc.state.fl.us/Publications/Technical_Reports/fhis_v1_ref_1.pdf.
[9] The Kaiser Family Foundation, *State Health Facts Online.*




Source: The Kaiser Family Foundation, State Health Facts Online 2003.

The ability of a worker to obtain employer-sponsored coverage varies with firm size: smaller companies are less likely to provide coverage than larger organizations.




Source: The Kaiser Family Foundation, State Health Facts Online 2003.

Florida is one of the top five states in the country with the highest proportion of workers in small businesses, with 40 percent of its workers ages eighteen to sixty-five employed in firms with fewer than 25 workers.[10] The 1999 FHIS showed that among employed uninsured Floridians, 65 percent had employers who did not offer health care coverage, and another 15 percent were

[10] *The Uninsured Issue*. Agency for Health Care Administration, August 1, 2003 presentation. http://www.fdhc.state.fl.us/Medicaid/deputy_secretary/recent_presentations/uninsured_issue_081103.pdf.

ineligible to receive coverage even if it was provided. Furthermore, the percent of employed Floridians who were offered health insurance varied significantly by industry type.[11]

In 1999, only 55 percent of those employed in agriculture were offered coverage compared to 94 percent of those in public administration.[12] The low offer rate among agricultural enterprises is one explanation for the high rates of uninsurance in rural counties. It is important to note that the survey also shows that 83 percent of Floridians who are eligible actually enroll in employer-sponsored coverage.

Despite the various legislative changes to the small employer market, small businesses (employers with 1 to 50 employees comprising 26 percent of the employer-sponsored market) face an especially difficult task in affording health insurance coverage for their employees. In 2000, premiums for small employers rose by 16 percent, 24 percent in 2001 and another 30 percent on average in 2002.

Affordability is the main reason that Floridians do not purchase health insurance, including employer-sponsored insurance (ESI). Seventy-four percent of uninsured Floridians responding to the 1999 FHIS, when asked what the main reason was for not having health insurance, selected "Too expensive/can't afford/premium too high". Additional factors cited by employed, uninsured Floridians include ESI not offered by employer (65 percent) and ineligibility for ESI (14.9 percent). Rates of uninsurance vary inversely in relation to the size of the employer. For example, rates of uninsurance are 24.6 percent for employers with one to nine employees, 14.9 percent for employers with ten to twenty-four employees and only 4.8 percent for employers with one hundred employees or more.[13]

Employers also face another barrier in regard to offering health insurance coverage – the number of carriers in the small group market decreased from a peak of 104 in 1997 to 26 by the end of 2001. Consequently, during the same time period, there was a reduction of 600,000 lives in the number of people receiving health insurance coverage in the small group market. In 2001, the small group market covered approximately 1.18 million lives.[14]

In response to the recent concerns about the viability of the small group market, Insurance Commissioner Tom Gallagher appointed a committee to revise the standard benefit plans to make them more affordable to small groups. In April 2003, new benefit plans were announced and are expected to save small companies between 20 and 40 percent in premiums (Florida Small Employer Benefit Plan Committee, 2002).

### *Public Insurance*

The Florida Medicaid program, established in 1970, is one of the country's largest. For FY 2002-03, the number of beneficiaries is expected to be nearly 2.1 million. The Florida Medicaid program covers a number of different eligibility groups primarily comprised of low-income parents and children, disabled adults, low-income elders (who also have access to Medicare), and pregnant women.

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[11] Duncan et al. *The Florida Health Insurance Study, Volume 1: The Telephone Survey*. January 2000.
[12] Ibid.
[13] Ibid.
[14] *Florida Small Employer Benefit Plan Committee Report, November 2002*. Retrieved January 3, 2004 from the DFS Website: http://www.fldfs.com/companies/pdf/Sm_Emp_Grp_Benefit_Comm_Rpt_%20Nov02.pdf.

| Income Eligibility Levels for Medicaid Beneficiaries | | | |
|---|---|---|---|
| **Program** | **Income Limit (% of Poverty)** | **Estimated FY 2002-03 Eligibles** | **FY 2002-03 Expenditures In Millions** |
| TANF | 24.4% | 634,650 | $1,418.8 |
| SSI | 73.75% | 470,725 | $7,683.9 |
| Unemployed Parent | 24.2% | 98,290 | $173.9 |
| Medically Needy | 24.2% | 26,786 | $385.8 |
| SOBRA Aged and Disabled (MEDS-AD) | 88.0% | 96,552 | $651.4 |
| Medicare Beneficiaries | | | |
| – Qualified Medicare Beneficiaries/ QMB | 100% | 22,426 | $33.4 |
| – Specified Low Income Medicare Beneficiaries/SLMB | 120% | 35,607 | $22.1 |
| – Qualified Individuals | QI 1 135% | 15,016 | $9.3 |
| | QI 2 175% | | |
| Pregnant Women | 185% | 52,598 | $345.8 |
| Family Planning Waiver | TANF/SSI Limits | 109,979 | $8.5 |
| Children | | | |
| – Birth to Age One-Above 185% to 200% of Poverty | 200% | 1,366 | $18.4 |
| – Ages One | 185% | 50,001 | $216.6 |
| – Ages One to Six | 133% | 195,155 | $164.4 |
| – Born after 9/30/83 age 6 but not Age 19 | 100% | 279,599 | $269.2 |
| – Born before 10/1/83 but not Age 19 | 100% | 598 | $14.4 |
| – Refugee Assistance Program | TANF/SSI Limits | 7,954 | $14.7 |
| TOTAL | | 2,097,302 | $11,430.7 |

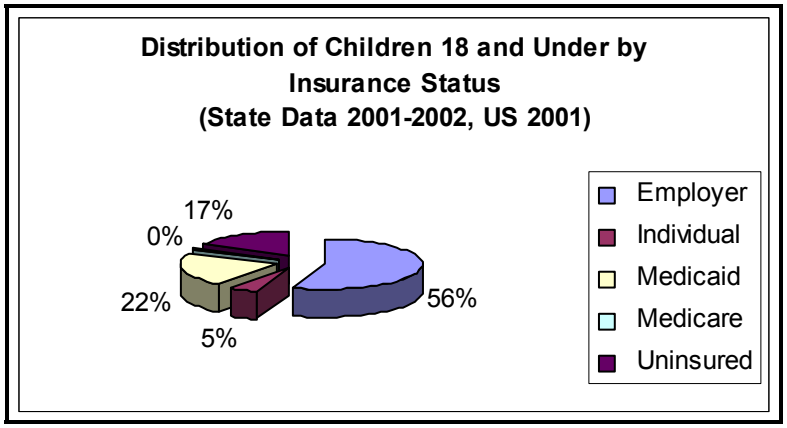
Source: Agency for Health Care Administration 2003

Medicaid provides mandatory benefits, such as physician services, inpatient hospital services and skilled nursing facility services for individuals 21 years of age and older, and a wide array of optional benefits such prescribed medicines, dental, vision and hearing services, intermediate nursing facility services and home and community-based services.

As in other states, considerable effort is needed to ensure that individuals eligible for public health care coverage are actually enrolled. Low-income populations are difficult to reach and the enrollment process is often confusing. This can be particularly problematic in Florida where multiple agencies including the Agency for Health Care Administration, the Department of Children and Families and Florida KidCare, are involved in the process. During the 2002 state

legislative session, Governor Bush signed into law the Health Care Access Bill. A key component of this legislation is the establishment of a pilot program aimed at developing an easily accessible eligibility determination system. The enhanced system would have allowed applicants for Medicaid or Florida KidCare to complete an application over the telephone with a 2-1-1 operator. The pilot was discontinued in 2003 due to lack of funding.

Fifty-seven percent of Medicaid beneficiaries are children, 16 percent are elderly, and 27 percent are adults between ages 21 and 65.[15] Medicaid is an important source of health insurance coverage for children, covering 22 percent of all children from birth to 18 years of age.[16]




Source: The Kaiser Family Foundation, State Health Facts Online 2003.

For over a decade, the nationally recognized and award winning Florida Healthy Kids Corporation, a public-private subsidized health insurance program for school aged children, had been steadily expanding the scope of its influence in providing health insurance for children to an increasing number of counties. In 1998 the Legislature passed the Florida KidCare Act, which expanded the Healthy Kids program statewide and provided health coverage to nearly 256,000 children. The KidCare Act earmarked $245 million, which included $75 million in funding from Florida's historic tobacco victory and federal funds, to expand Medicaid eligibility under federal Title XXI, and was credited with reducing the number of uninsured children by one-third. Uninsured children in Florida were able to receive health care coverage through the Healthy Kids Corporation, MediKids, Children's Medical Services Network and other health insurance plans. Currently, there is a cap on new enrollment in the Title XXI portion of the Florida KidCare program because of budget constraints.

Florida provides coverage for children who live at or less than 200 percent of the FPL through the Florida KidCare program. Federal funding for this program comes from Medicaid (Title XIX of the Social Security Act) and the State Children's Health Insurance Program, also known as SCHIP (Title XXI of the Social Security Act). As of January 2003, Florida KidCare covered 85 percent of children living at or less than 200 percent of the FPL. Overall, however, 17 percent of Florida's children remain uninsured.[17]

Because of budgetary shortfalls, new enrollment in the Title XXI component of Florida KidCare has been suspended. But it is important to note that over the past ten years, the nationally

[15] *The Uninsured Issue*. Agency for Health Care Administration, August 11 Presentation.
[16] *State Health Facts Online,* The Kaiser Family Foundation.
[17] *The Uninsured Issue*. Agency for Health Care Administration, August 11 Presentation.

recognized and award winning Florida Healthy Kids Corporation (FHK), a public-private subsidized health insurance program for school aged children has been steadily expanded through a series of legislative initiatives. Currently, there are over 305,000 children enrolled in FHK and over 1.5 million children enrolled in the Florida KidCare program statewide.[18]

### *Local Initiatives to Provide Health Care Services to the Uninsured*

Uninsured Floridians may turn to local health care programs to obtain health care services in communities that have undertaken local initiatives. Localities have employed a myriad of strategies to address the problem of the uninsured. Palm Beach County, for example, has developed a plan for its uninsured residents through its health care taxing district. The Health Care District of Palm Beach County operates the Coordinated Care Program, for county residents who do not receive and/or cannot afford health insurance. Eligible beneficiaries must have an income equal to or less than 150 percent of the FPL. At present, 25,000 Palm Beach County residents are served through the program. The District and its programs are financed through property taxes. [19]

The Hillsborough County HealthCare Program is a comprehensive managed care program for residents of the Tampa area. The program is funded by a special discretionary sales tax. Currently, the plan has four networks of primary care providers, specialists, and hospitals. Eligible beneficiaries must be county residents whose income is at or below 100 percent of poverty. In 2002, the program served 31,000 individuals.[20]

In Miami-Dade County, the Public Health Trust, funded by a half-cent sales tax passed in 1991, has funneled over $800 million to Jackson Health System to care for the poor and uninsured.

A number of communities also provide services through volunteer efforts, including organized physician referral programs that link uninsured residents with local physicians and other health care providers who donate their services.

JaxCare a public/private partnership, is a nonprofit organization whose mission is to develop effective and cost efficient ways of providing access to health care to the uninsured low-wage workforce who earn too little to afford commercial health insurance but too much to be eligible for Medicaid and other government programs. JaxCare is a resource management corporation that provides a community framework for coordinated, efficient delivery of health care to reduce uncompensated health care costs for medical facilities and other providers while increasing access and improving health outcomes. A two-year pilot test is being conducted before pursuing long-term strategies. JaxCare was conceptualized and developed through the "Communities In Charge" grant initiative of The Robert Wood Johnson Foundation. The technological infrastructure was developed through HRSA Community Access Program (CAP) grants from the Department of Health and Human Services (DHHS).

### *The Health Flex Plan Pilot Program*

The Health Flex Plan Pilot Program (Health Flex) was approved by the 2002 state legislature as a pilot program for four areas of the state: 19 counties in the Florida Panhandle, Hillsborough

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[18] Ibid.
[19] Palm Beach County Health Care District. *Health Programs Summary*. [Retrieved January 13, 2004]. http://www.hcdpbc.org/health_programs/index.html.
[20] *The Uninsured Issue*. Agency for Health Care Administration, August 11.

County, Miami-Dade and Broward Counties, and Indian River. These areas have the highest concentration of uninsured persons.

Health Flex is designed to permit insurers and other designated entities to offer a low-cost form of health care coverage targeted to non-elderly individuals with family incomes of up to 200 percent of poverty, who have not been covered by a private insurance policy for the past 6 months, and who are not eligible for coverage by other public programs. Persons eligible for local indigent health care programs are not excluded from participating in Health Flex.

Health Flex plans can be offered by health insurers, HMOs, a health care provider sponsored organization, local government, a health care district, and other public or private community based organizations. Enrollees agree to make any payments required for participation, including periodic payments due at the time health care services are provided.

Health Flex plans are unique in that they are not subject to licensure under the Florida Insurance Code. As such, they are free from providing all statutorily required health care benefits. AHCA and the Department of Financial Services, Office of Insurance Regulation (formerly, the Department of Insurance) must approve Health Flex plans.

As of December 2003, three plans had been approved to participate in the Health Flex Plan Pilot Program: American Care, a physician group in Miami-Dade County; Preferred Medical Plan, a licensed HMO provider, also located in Miami-Dade County; and JaxCare, in Duval County.

### *Health Care Costs and the Uninsured*

In Florida, as in other states, the implications of being without health insurance are profound. The 1999 FHIS showed Floridians without health insurance were more likely to lack a usual source of care, to have fewer doctor visits, and to delay or not obtain needed care. For example, 63 percent of uninsured Floridians lacked a usual source of care compared to 89 percent of those with health insurance. Uninsured Floridians were also more likely to be in poor health and to report a significant out-of-pocket expense for a doctor's visit.[21]

**Consequences of Being Uninsured in Florida**

- 300-600 "premature" breast cancer deaths;
- 1,400 premature deaths due to under-treated hypertension;
- 50% higher risk of death for breast or colon cancer;
- 25% with diabetes go without checkup

Source: *FHIS 1999*

Floridians with health insurance tend to be in better health than those without health insurance. Among insured Floridians under age 65, about 42.1 percent are reported to be in excellent health. By contrast, only 28.9 percent of uninsured Floridians under age 65 report themselves to be in excellent health.[22]

It is difficult to quantify the cost-savings that might be achieved if all Floridians had access to health insurance, especially health insurance that included preventative care, disease management and other enhanced care management practices.

The cost of providing health care to the uninsured is borne by local, state and federal government sources. At the national level, government sources paid up to 85 percent of the $34-38 billion

[21] Duncan et al. *The Florida Health Insurance Study, Volume 1: The Telephone Survey. January 2000.*
[22] Ibid.

cost of covering the uninsured in 2001. State and local governments appropriated an estimated $3.1 billion to cover hospitals' uncompensated care costs in 2001.[23]

**The Cost of Not Covering the Uninsured**

- The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates.
- A conservative estimate based on the full range of studies is that a reduction in mortality of 5-15% could be expected if the uninsured were to gain continuous health coverage.
- Better health would improve annual earnings by about 10-30 percent and would increase educational attainment.
- On average, the uninsured receive about half as much care as people who are insured all year. In 2001, persons uninsured for the full year used $1,253 per year in medical care compared to $2,484 for persons with private coverage for the full year.
- Total uncompensated care provided in 2001 was estimated to be $35 billion. The primary source of funding for uncompensated care is government, which spent an estimated $30.6 billion for care of the uninsured, two thirds of which is federal.

*Source: The Cost of Not Covering the Uninsured – Project Highlights. The Kaiser Commission on Medicaid and the Uninsured, June 2003. Key Findings.*

[23] NGA Center for Best Practices. *Fact Sheet: The Uninsured, 2003.* http://www.nga.org/cda/files/0903FACTSUNINSURED.pdf.

## Creation of the Task Force

The Governor's Task Force on Access to Affordable Health Insurance (Task Force), was created by Governor Jeb Bush on August 25, 2003 through Executive Order 03-160 (Attachment A). Within the Executive Order, Governor Bush states, "it is of vital importance and in the best interests of the people of the State of Florida, that the needs of the uninsured and the issue of available, affordable health care insurance be addressed in a cohesive and meaningful manner."[24]

The Office of Insurance Regulation (OIR) identified the importance of including the support of existing health care coverage options, including support for traditional "safety-net" providers, as a Task Force priority.

"Clearly we have a significant problem, and it's time for the state, in a substantive way, to come forward with some concrete programs."

Gov. Bush at a news conference in Miami, South Florida Sun-Sentinel, 8/26/03

### *Selection of Task Force Members*

The Task Force was comprised of 17 members representing business leaders, health policy experts, health care providers and consumers. Members of the Task Force were selected by Governor Bush and formally invited to participate on the Task Force through a letter from Co-Chairs Lieutenant Governor Toni Jennings and Chief Financial Officer Tom Gallagher.

### *Task Force Members*

- Lieutenant Governor Toni Jennings, Co-Chair
- Chief Financial Officer Tom Gallagher, Co-Chair
- Dr. Rhonda M. Medows, Secretary, Agency for Health Care Administration
- R. Paul Duncan of Gainesville, Professor and Chair of the Department of Health and Services Administration, University of Florida
- Sue G. Brody of St. Petersburg, President and CEO, Bayfront Health System, Inc.
- John M. Hogan of Tallahassee, CEO, Capital Health Plan
- Anthony Suarez of Orlando, Attorney, A. Suarez & Associates, P.A.
- Nancy P. Keefer, President, Bonita Springs Chamber of Commerce
- Dr. Carlos Buznego of Miami, Center for Excellence in Eye Care
- Marvin O'Quinn of Miami, President & CEO, Jackson Health System
- Ken Stevenson of Tallahassee, Insurance Broker, Earl Bacon Agency
- Richard J. Walsh of Orlando, Senior Vice President, Darden Restaurants, Inc.
- Dr. Fleur Sack of Miami, President, Florida Academy of Family Physicians
- Susan N. Story of Gulf Breeze, President and CEO, Gulf Power
- Rosa B. Ramos of Plantation, Registered Nurse, Miami Children's Hospital
- Frank Farkas, D.C., State Representative, House District 52
- Durell Peaden, Jr., State Senator, District 2

[24] Ibid.

Biographies of each task member are provided in Attachment B.

## *Staff Support to Task Force*

The Task Force was staffed by representatives from the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR). Technical assistance and additional staff support was provided by Health Management Associates, a health policy consulting firm. Staff met weekly to develop meeting agendas, schedule speakers, prepare meeting materials and manage the overall progress of the Task Force.

A web site was established to facilitate communications and provide background information, meeting materials, updates and links to relevant Internet sites for additional information concerning access to health insurance.[25]

The Task Force functioned under the Florida Sunshine Law, which requires all meetings and discussions between Task Force members to be public.

Prior to the first meeting, staff to the Task Force met to develop a work plan and prepare background materials. The work plan was updated and enhanced throughout the meeting process.

## *Task Force Goals and Objectives*

The Task Force was created to identify factors that impact the cost of, and access to, health insurance; investigate alternative health insurance approaches and partnerships that have been demonstrated to be effective in providing health care coverage to various populations; and provide policy recommendations to improve access to affordable health insurance, and achieve more predictable cost, while maintaining consumer choice.

The Task Force was charged with addressing six goals.

**Goal # 1:** Identify the contributing factors to the increasing costs of health insurance and the cost of accessing insurance in Florida.

**Goal # 2:** Identify the major barriers that prevent Floridians from obtaining health insurance coverage.

**Goal # 3:** Identify federal issues regarding health insurance coverage that may contribute to higher health insurance costs, and which may need to be communicated to federal lawmakers.

**Goal # 4:** Investigate pilot and other alternative approaches to traditional health insurance which have been demonstrated to be effective in providing health care coverage to various populations.

**Goal # 5:** Identify potential partnerships the state can utilize to increase available health insurance coverage.

**Goal #6:** Provide policy recommendations to improve access to affordable health insurance and achieve more predictable cost, while maintaining consumer choice.

[25] Task Force web site: www.fdhc.state.fl.us/affordable_health_insurance/index.shtml

### *Task Force Meeting Schedule and Logistics*

The Task Force met monthly from September through February. Meetings were held in different locations across the state to accommodate the geographical diversity of Task Force members and to permit broader public input across the state.

- September 22, 2003
  The Biltmore Hotel
  Coral Gables, FL
- October 13, 2003
  The Knott Building
  Tallahassee, FL
- November 17, 2003
  Airport Marriott Hotel
  Tampa, FL
- December 3, 2003
  Florida Community College
  Jacksonville, FL
- December 17, 2003
  Miami-Dade College
  Miami, FL
- January 9, 2004
  University of Central Florida
  Orlando, FL
- February 2, 2004
  412 Knott Building
  Tallahassee, FL

Meeting content and speakers were based on the Task Force's Work Plan that outlined the six goals of the Task Force and the proposed action steps for meeting each goal. A companion document (the Issues Grid) was also developed and described in greater detail the issues or factors that contribute to each of the six goals. The Work Plan and the Issues Grid are available on the Task Force page of the AHCA's website.

Meeting schedules and agendas were published and posted on the Task Force's web site. In addition to the formal agenda, time was provided at each meeting for public input. Meeting materials were mailed to Task Force members in advance of each meeting. Meeting materials, including speaker materials were also posted on the web site.

Prior to the first meeting, Task Force members received a compilation of articles and reports describing the uninsured in Florida and across the United States.

### *Public Input*

Time was provided during each Task Force meeting for public input and comment. Due to the anticipated number of speakers at each meeting, persons providing remarks were encouraged to submit written comments to ensure that the Task Force received comments in their entirety. Stakeholder presentations were heard at several Task Force meetings. Also, as the Task Force

meeting locations moved across the state, the Task Force received presentations and remarks from significant local programs in the communities.

As interest to provide public input increased, a determination was made to allocate additional time for public comment and stakeholder presentations at the December 3 meeting. A second December meeting was added on December 17 to enable the Task Force to discuss the public input and carry out its other business.

### *Meeting Records*

The proceedings of each Task Force meeting were recorded and transcribed. Transcripts were posted on the Task Force's web site. In addition to the transcripts, individuals serving as staff to the Task Force recorded meeting notes. This report provides a summary of the meetings, both in terms of presentation content and Task Force discussions and deliberations. Agendas for each meeting are provided as attachments to this report (see Attachment D).[26]

[26] All meeting materials can be accessed through the Agency's website at: http://www.fdhc.state.fl.us/affordable_health_insurance/index.shtml.

## First Meeting of the Task Force – September 22, 2003

The first meeting of the Task Force was held on September 22, 2003 in Coral Gables. This meeting was primarily organizational in nature and coincided with the one and one-half day Florida Health Insurance Symposium organized by the Department of Financial Services and the Office of Insurance Regulation.

Task Force members were presented with the Task Force goals, a preview of the Health Insurance Symposium agenda, an overview of the uninsured in Florida, and a review of the Task Force work plan.

### *Trends in Job-Based Insurance*

John Gabel from the Health Research and Educational Trust provided the Task Force with a synopsis of the trends in job-based insurance. He summarized changes in health insurance premiums, changes in the distribution of employee and employer contributions to the cost of health care, and information on the percentage of workers covered by employer-sponsored health insurance. The 2003 Kaiser Family Foundation (KFF)/HRET Employer-Sponsored Health Benefits was the source for much of the information provided in his presentation. In summary, Mr. Gabel forecasts a slight slowing in the underlying costs of health care; double-digit increases in premiums; increased employee contributions, co-payments, deductibles and coinsurance; an increase in consumer-driven care; and an increase in the number of uninsured Americans.

### *Improving the Current Health Care System*

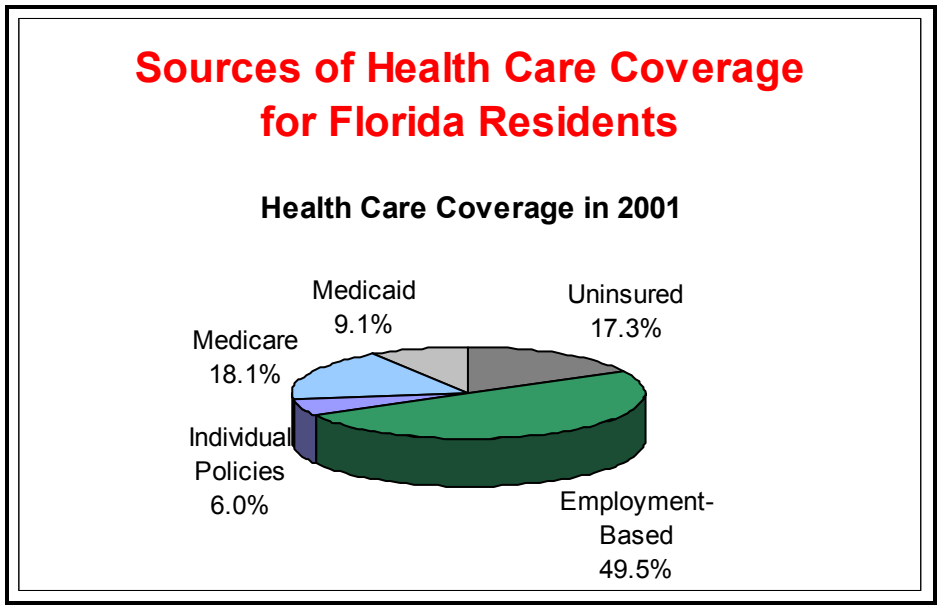
Brian Klepper from The Center for Practical Health Reform (CPHR) described what is broken in the country's current health care system and suggestions for reform. Much of Dr. Klepper's presentation was spent discussing the principles for, and approaches to, change at a national level. These principles fell under four general categories: coverage; private sector orientation; information and quality; and accountability. Dr. Klepper concluded his talk by describing his insights on the approach to change.

In summary, this presentation provided one framework for the Task Force to consider when reviewing and discussing options to address access to health insurance.

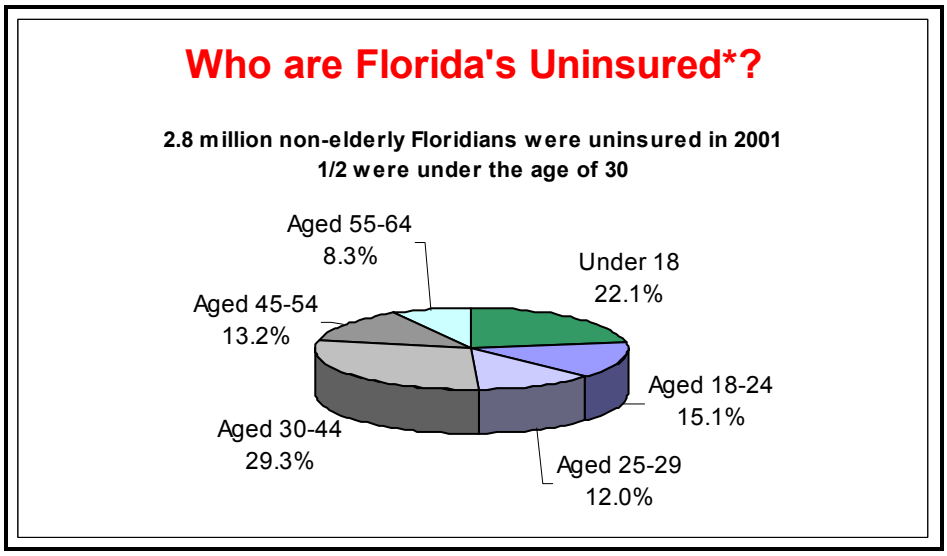
> "It is NOT about finding a way to cover the uninsured. It IS about preventing the rapid erosion of our mainstream coverage vehicles - Employer Coverage and Medicaid - and re-enfranchising the uninsured in the process."
>
> - "Saving American Health Care: Steps To A More Stable, Improved Health System," Brian Klepper, 9/22/03 meeting presentation

### *Overview of the Uninsured in Florida*

Ken Thurston from the Agency for Health Care Administration (AHCA) presented an overview of the uninsured population in Florida. Mr. Thurston described the findings of the 1999 Florida Health Insurance Study, which identified the number and characteristics of the uninsured in Florida. The uninsured can be portrayed by four basic characteristics: income, employment status, geography (residence) and ethnicity. Mr. Thurston also described the health-related consequences of being uninsured.




Source: Employee Benefits Research Institute, Analysis of Florida data from the US Census Bureau's Current Population Survey, March 2002.




Source: Employee Benefits Research Institute, Analysis of Florida data from the US Census Bureau's Current Population Survey, March 2002.

### *Task Force Work Plan*

Marshall Kelley from Health Management Associates introduced the Work Plan to the Task Force. He described how the six goals would drive the meeting agendas and discussions. Mr. Kelley walked through proposed objectives for each meeting in order to reach conclusion in January.

## *Florida Health Insurance Symposium*

Rich Robleto from the Florida Office of Insurance Regulation offered introductory comments on the background of Florida's problem with access to health insurance. His remarks included a preview of the symposium agenda, presentation topics and speakers.

The presentations at the Florida Health Insurance Symposium provided attendees with additional background on the uninsured problem in Florida, as well as the United States. The symposium began with a summary of current market trends. Presentations and panel discussions on affordability, accessibility and consumer-oriented market reform rounded out the symposium's agenda. The symposium agenda, speaker biographies and presentation materials are available on the Task Force web page of the AHCA's website.

> "41 percent [of Americans] are not confident of being able to afford health care in the next 10 years (up from 35% in 2002)."
>
> "Most insured Americans say they are willing to accept some restrictions on health care in exchange for lower costs."
>
> - 2003 Health Confidence Survey, Employee Benefit

In response to the presentations, a discussion ensued on possible initiatives that could be undertaken to provide more affordable and accessible health insurance. Suggestions were recorded by the meeting facilitator and grouped into one of five categories: medical care practice, benefit plan design, market reform, other and emerging issues. The following tables summarize the discussion.

| **Florida Health Insurance Symposium: Medical Care Practice Considerations** |
|---|
| • Redesign medical practices to include improved:<br>– Case management<br>– Coordination of care across multiple providers<br>– Evidence-based practices<br>– Chronic disease prevention and/or management<br>• Address health care industry labor shortages (i.e., nurses, technicians) and the resultant impact on the cost of care<br>• Eliminate or reduce defensive medicine costs (unnecessary testing)<br>• Discourage inappropriate use of high cost trauma centers<br>– Provide alternatives for evenings and weekends<br>– Encourage use of cheaper, more appropriate settings for non-emergency care<br>▪ Educate consumers to appropriate care setting<br>▪ Facilitate additional Health Flex plans<br>▪ Expand Health Flex program eligibility to less than 250% of federal poverty level |

| **Florida Health Insurance Symposium: Benefit Plan Design Considerations** |
|---|
| • Design health care benefit plans that provide incentives for healthy life styles<br>• Encourage expansion of consumer driven health care plans<br>– Medical savings accounts<br>– Health reimbursement accounts<br>• Revisit mandated benefits to avoid conflict with consumer driven health care plans |

**Florida Health Insurance Symposium: Market Reform Considerations**

- Seek balanced market reforms involving all the stakeholders in the decision making process
- Provide a residual market (High Risk Pool) for persons who are uninsurable
  - Learn from Florida's history and the experiences of other states
    - Ensure adequate funding for now and in the future
    - Spread the risk and costs broadly
    - Use appropriate benefit plans
    - Provide consumer choice
    - Evaluate programs and funding mechanisms used by other states
  - Seek concurrence with stakeholders
    - Maintain ongoing communication with carriers
    - Collaborate, not compete with private sector
  - Seek/consider federal funding for risk pool seed money
    - Infrastructure for federal funding is already in place (Trade Act Amendments)
  - Alternative of guaranteed issue individual coverage would need to be considered very carefully to avoid problems encountered in other states
- Require standardized policies to be offered in the individual market
  - Ensure availability of adequate coverage
  - Provide basis of comparison shopping
- Modify the small group market to provide more participation and affordable coverage
  - Require all employers to offer a base plan to all employees to increase the participation of healthier employees
  - Require employers to "pay or play"
    - Provide coverage to employees or
    - Contribute to residual market funding
  - Include all micro-groups (five employees or less) in a reopened risk pool
  - Modify pooling requirements
    - Presently one life vs. all other
    - Consider five or less employees vs. all other
- Use a re-opened risk pool for all persons eligible for guaranteed issue coverage as a result of HIPAA
- Modify Medicaid accessibility requirements to be more inclusive
- Assure appropriate funding levels for good existing public health programs. Use them as models for expanded coverage to the uninsured
- Encourage and enhance full racial and/or ethnic participation
- Do comparison of Florida markets and products to other states with similar demographics

**Florida Health Insurance Symposium: Other Considerations**

- Recognize that consumer behaviors will only change when they are forced or modified by rewards
- Provide consumers with cost and reimbursement data needed to make appropriate choices
- Improve data collection and sharing (within the privacy guidelines) of all stakeholders
- Advocate federal changes to allow rollover of flexible spending account funds from year-to-year
- Educate employees on health insurance options the same way they are educated on retirement options
- Educate consumers and agents on the guarantee issue rights provided by the federal HIPAA laws

| Florida Health Insurance Symposium: Other Considerations |
|---|
| and on the consumer requirements to protect and/or take advantage of those rights<br>• Address variability of hospital charges by payer<br>– The lack of insurance or fact that a service is not covered should not result in higher charges<br>• Study how much government presently spends on health care and where and how it is spent<br>– Is there presently "Universal Health Care?"<br>– Is the public sector in competition with private sector or vice versa?<br>– Should private sector enrollees be encouraged to enroll in public sector programs or vice versa?<br>– Do the government sector actions damage the private sector markets? |

| Florida Health Insurance Symposium: Emerging Issues |
|---|
| • Address the problems associated with "Discount Cards"<br>– Educate consumers to understand what they are purchasing<br>– Provide consumer protection from being misled and/or overcharged<br>– Require certification of the discount card networks<br>– Ensure providers are aware that they are a part of the marketed network<br>• Address the issue of mandatory arbitration clauses in insurance contracts<br>– Balance consumer rights to the court system with the costs and problems resulting from class actions suits<br>– Consider expansion of the HMO Consumer Panel to other lines of insurance<br>– Study actual experience where mandatory arbitration clauses are used<br>• Continue to address unauthorized entities selling insurance<br>– Prosecute offenders in conjunction with new legislation (Pete Orr Act)<br>– Educate consumers to "Never buy insurance from a yard sign" |

Subsequent to the meeting, a final report of the Health Insurance Symposium was published by the Division of Financial Services, Office of Insurance Regulation and provided to the Task Force at its December 3, meeting. The final report included summaries of speaker presentations, suggested initiatives and next steps.[27]

[27] A copy of the full report may be accessed through the following Website: http://www.fldfs.com/companies/insurance_symposium/.

## Second Meeting of the Task Force – October 13, 2003

The Task Force convened for its second meeting on October 13, in Tallahassee. The Task Force was provided with background information on the first three goals. During the meeting, and following each formal presentation, the Task Force had an opportunity to react to and discuss the presentation and insight it provided in addressing the goals of the Task Force.

### *Goal 1: Factors that drive the cost of health insurance*

The factors that contribute to rising costs fall into three general categories: 1) market factors; 2) factors related to how health care services are purchased and reimbursed; and 3) factors outside of the healthcare delivery system.

Market factors include costs related to the scope of coverage, a lack of efficiency, provider pressures, and fraud and abuse. Cost drivers related to healthcare financing include the absence of incentives for insured consumers to control cost, the provider payment methodology, and the lack of accessible and understandable information to educate consumers. Factors outside of the healthcare delivery system include unhealthy lifestyles, population characteristics, consumer attitude, and issues related to access. While some variation across states exists, the factors driving up the cost are common from one state to another. A more detailed description of these cost drivers is provided in the Task Force Issues Grid available on the AHCA's website, Task Force web page.

> "Consumers pay the greatest price, but rising healthcare costs have an impact on other sectors as well. Employers are increasingly facing difficult choices, as they are forced to pass costs along to their employees, reduce salaries, or reduce benefits."
>
> - "The Factors Fueling Rising Healthcare Costs," PriceWaterhouseCoopers, April 2002

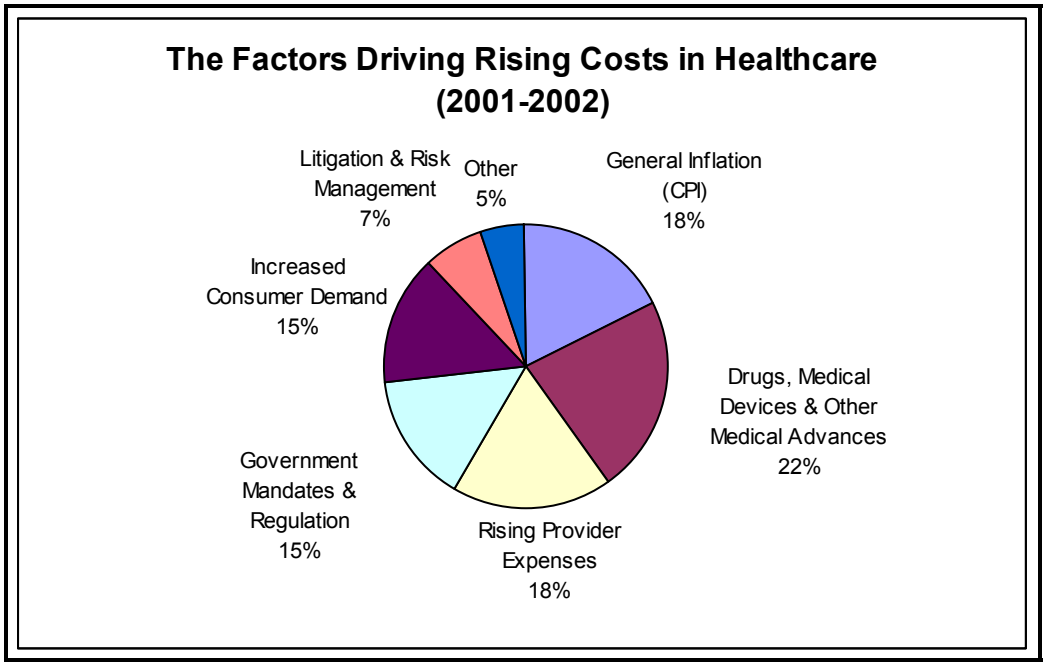
The results of a 2002 study conducted by PriceWaterhouseCoopers examined the cost of healthcare and the factors that are driving it higher.[28] This study provided an historical review of costs and then described the major cost drivers. The primary contributors to rising costs were grouped into seven categories.

Vernon Smith, PhD, a Principal with Health Management Associates, presented the Task Force with a picture of the primary cost drivers impacting the affordability of health insurance. Dr. Smith pointed to the cyclical nature of health care costs, indicating our current high point in the cost cycle. Hospital spending is a primary driver in current cost growth, with prescription drug costs in a close second place.

> "The high rate of premium growth in 2003 appears to have been driven by a combination of rapid inflation in the costs for health care services and insurers' efforts to emphasize profitability in their pricing."
>
> - "Employer Health Benefits: 2003 Annual Survey," The Kaiser Family Foundation and Health Research & Educational Trust, 9/12/03

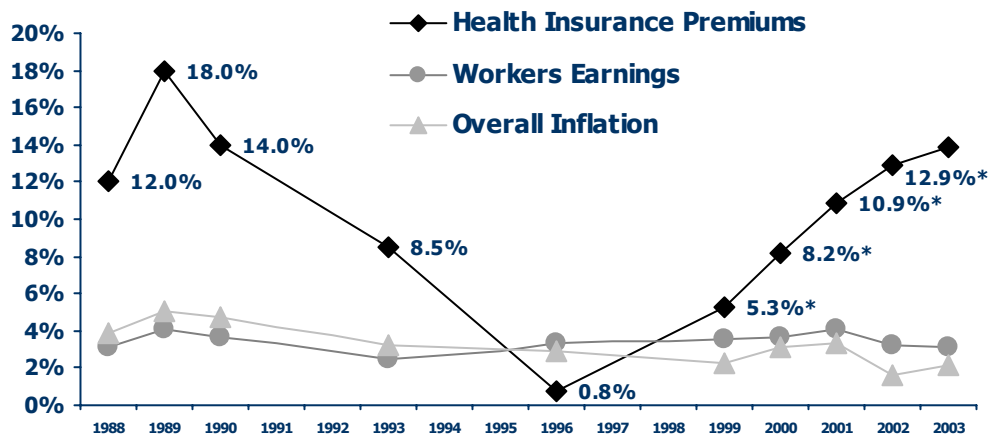
Dr. Smith also described the inter-related set of supply and demand factors that drive costs. These factors include demographics (including the aging U.S. population), affluence, patient demand, lifestyle and health status, new technology, provider capacity, and the surplus or shortage of specific types of providers.

[28] PriceWaterhouseCoopers for the American Association of Health Plans, *The Factors Fueling Rising Healthcare Costs.* April 2002.




One response to these factors has been to back away from managed care, affording patients more choice, more direct access to specialists and fewer utilization controls. A direct effect of these changes has been high rates of premium growth. In recent years, according to Dr. Smith, premium growth has exceeded cost growth. In response to higher costs, employers are shifting health care costs to their employees through higher premiums and cost sharing for more services. The following table displays these increases for the past 15 years.

**Health Insurance Premiums, Earnings and Inflation: Increases 1988-2003**




Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002, 2003;
KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): 1988-2003; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2003.
*Estimate is statistically different from the previous year shown at $p<0.05$: 1996-1999, 1999-2000, 2000-2001, 2001-2002.
^ Estimate is statistically different from the previous year shown at $p<0.1$: 2002-2003.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

### *Goal 2: Major barriers that prevent Floridians from obtaining health insurance*

Unlike the cost drivers, there is more variation from state to state on the barriers that prevent individuals from obtaining health insurance. For example, Florida's predominance of small businesses results in a different picture of the uninsured than a state that has a significant presence of large companies and unionized workforces. Barriers that prevent Floridians from obtaining health insurance coverage fall into one of four categories: 1) individual factors; 2) employer-sponsored coverage; 3) Florida market; and 4) public programs. A more detailed description of these barriers is provided in the Task Force Issues Grid on the AHCA's website, Task Force web page.

> "66% of all firms offered coverage to workers in 2003."
>
> - Kaiser Family Foundation/HRET, 2003 Employer Benefits Survey

Stephanie Lewis, J.D. an Assistant Research Professor at Georgetown University's Health Policy Institute provided the Task Force with an overview of health care coverage in Florida. She described the protections provided by job-based coverage in terms of anti-discrimination, access, adequacy, and affordability. However, for many, job-based coverage is not available, either because coverage is not offered by the employer, the employee is not eligible for coverage, or the employee is unable to pay his/her portion of the premium for the coverage offered. She commented on Florida's guarantee issue provision, but noted the barrier of only being able to access the protections during the month of August, with coverage effective in October.

For an individual without coverage, there is often no viable coverage, and the provider safety-net does not fill the void for needed services. Ms. Lewis described Florida's individual insurance market, both in terms of exclusions and the high cost. Ms. Lewis concluded her presentation with some closing thoughts on possible options for addressing barriers to obtaining insurance. Mr. Gallagher supplemented Ms. Lewis' presentation by providing some additional background on high-risk pools and Florida's experience.

### *Goal 3: Federal issues that may contribute to higher health insurance costs*

On a federal level, issues that contribute to higher health insurance costs center around mandated benefits, the cost of regulation, and public program eligibility/citizenship requirements. The Task Force heard two presentations concerning the federal issues that contribute to increased health insurance costs, as both Dr. Vernon Smith from Health Management Associates and John Cerisano from BlueCross BlueShield Association (BCBSA) addressed these issues.

Dr. Smith focused on the federal laws that define Medicaid, as well as the laws that provide structure and protections in our health system. Medicaid eligibility and income criteria, COBRA, HIPAA, ERISA and EMTALA regulations were among the examples Dr. Smith provided. While the collection of federal laws provides a whole series of protections, they also impose a number of mandates; each law comes at a cost.

Mr. Cerisano began his presentation by summarizing recent healthcare cost trends. He then described current access initiatives at the federal level. The balance of his presentation was spent discussing the Association Health Plans (AHPs) initiative. Intended to control costs and improve access to coverage for small employers and individuals, AHPs would group individuals together to take advantage of economies of scale through group purchasing. Mr. Cerisano noted BCBSA's opposition to AHPs, as BCBSA believes they would have a negative impact on small businesses.

Following the presentations, Gary Crayton from Health Management Associates summarized the federal issues that contribute to health care costs, as described by the previous two speakers: the costs of HIPAA, mandated benefits (amount, duration and scope), citizenship requirements, basic eligibility criteria, and Association Health Plans (AHPs).

Rich Robleto then provided the group with additional information on the high-risk pool and mini-COBRA for businesses with less than 20 employees. He continued with a follow-up report from the Health Insurance Symposium held in September. He reviewed the categories of recommendations that developed during the conference (see the tables on pages 27 and 28).

### *Public Input*

Following the formal presentations, time was provided for public comment.

- County Commissioner (Leon County) and President-Elect of the Florida Association of Counties Cliff Thaell spoke to the Task Force about three issues. He described how the ongoing practice of devolving health care responsibilities for the uninsured to local governments has impacted local governments. He continued by sharing how many counties have risen to the challenge of providing health care for the working poor in their communities. He concluded his remarks by impressing the need for state and local governments to work together and by citing an opportunity of how the State of Florida could help in the larger mission of providing healthcare to those most in need; he suggested a revision in statute regarding the indigent care surtax.
- Leslie Dughi from the Florida Chamber of Commerce addressed the Task Force next. She noted that she was representing the Florida Chamber of Commerce, the National Federation of Independent Business (NFIB), Associated Industries of Florida (AIF) and the Florida Retail Federation, which came together to provide recommendations to the Task Force. She provided comments on employer-sponsored coverage and indicated that this year's annual health insurance study will be launched very soon. In addition to verbal comments, a white paper, summarizing their comments on the first three goals of the Task Force was provided. Comments included their perceptions of the cost drivers, barriers to coverage and federal issues.

  "42% of employers providing insurance reported they would consider dropping it if cost continued to escalate."

  - The State of Health Insurance in Florida, Florida Chamber of Commerce annual report.

  "Almost 85% of small employers indicated they want to provide health benefits if it was affordable, yet more than 22% of the respondents dropped health benefits in the last two years."

  - NFIB Member Survey
- Representing the Home-Based Businesses of Florida, Michael Dobson addressed the Task Force and shared some statistics for this group of businesses. He described the size of this work force and the difficulties these individuals have in seeking affordable health insurance coverage. He concluded by thanking the Task Force for its deliberations.
- Dorothy Johnson, Executive Director of the Community Action Agency, expressed the difficulty her agency had in finding health insurance coverage for its employees a few years ago. She encouraged the Task Force to consider CHPAs or a similar group purchasing option to enable small businesses to be grouped with others for insurance premium rating purposes.

- Bob Wychulis, President, Florida Association of Health Plans, summarized his presentation from the September Health Insurance Symposium. He suggested that the solution to curbing rising health care costs is multi-faceted, as a large portion (33 percent) of the costs are out of the control of health plan management. These costs include general inflation, government mandates and increased consumer demand. He also noted the need for consumer education. Mr. Wychulis indicated his willingness to return at a later meeting with recommended solutions.
- Ralph Gladfelter, representing the Florida Hospital Association, addressed the Task Force next. Mr. Gladfelter made four points. While recognizing that it is a federal issue, he encouraged 100 percent deductibility of health insurance costs for small businesses and the self-employed, as it is for large businesses. He described the costs of under-funding and uncompensated care borne by hospitals. He continued by describing the inappropriate use of emergency rooms and the impact it has on health care costs. Lastly, he described the insulation consumers have from the costs of their health care decisions and the need for hospitals to provide comparative charge and outcome information. He concluded his remarks by reminding the Task Force of the "harm" created by the last Governor's Task Force in 1983-84.
- William Long, Administrator of Campbellton-Graceville Hospital, spoke on behalf of the 29 rural hospitals and eight critical access hospitals spread throughout the state. He described the fiscal challenges facing the hospitals due to rising costs of employees' health insurance. Mr. Long's solution to the problem would be to expand access to the state's health insurance plan to rural hospitals. The lower premiums under the state's plan, according to Mr. Long, would help these hospitals remain in business.
- Chuck Casio, a nursing home manager, provided remarks on behalf of the Florida Healthcare Association as its District President. He requested assistance in bringing back liability insurance for long-term care providers.
- Steve Birtman represented the National Federation of Independent Business. He commented on the health insurance coverage scams, which claim to provide coverage for an outrageously low premium. He also indicated support for Association Health Plans (AHPs).
- Connie Welch from the Florida Institute for Family Involvement spoke next. This agency provides assistance with health care decisions to families with children with special health care needs. She encouraged the Task Force to consider whether access to health care is a social issue, a medical issue, or a combination of the two. She encouraged the maximization of state resources, the expansion of safety-net providers and the creation of options and choices beyond Medicaid.
- Miss Kittendorf shared her personal experience as a disabled, medically needy person. She described the problems she has faced with accessibility to insurance and to medically necessary health care due to cost.
- Ernesto Pichardo, State Director of Consejo de Latinos Unidos, provided remarks on behalf of the Florida State Latinos and National Advocacy Organization, which investigates and provides assistance to the uninsured. Mr. Pichardo submitted a report, *Inferno*, which describes experiences of victims of hospital price gouging. He urged the Task Force to read the report and take action.

- Mark Nemeiser spoke on behalf of the American Federation of State, County, and Municipal Employees (AFSCME). He encouraged expansion of the state's insurance plan to cover school employees and county employees, thereby adding younger, less costly employees, increasing the size of the rating pool, and decreasing the cost of health care (premiums).

### *Meeting Wrap-Up*

Co-chair Gallagher concluded the meeting by describing the objectives for the November 17 meeting, which are to review alternative and effective approaches to traditional health insurance, and Florida initiatives.

### *Task Force Assessment of Cost Drivers and Barriers*

Following the October 13, meeting, Task Force members were asked to rate the factors acknowledged by the speakers and discussed by the Task Force for the first three goals: factors that drive the costs of health insurance and the barriers to health insurance at the state and federal levels. The top factors in these three areas are summarized below. Scores are based on a 5-point scale with a score of 5.0 representing an assessment of an item as "very important". Seven Task Force members responded to the assessment.

#### Goal 1: Cost Drivers

The top six cost drivers, based on seven respondents, were:

| Cost Driver | Average Score |
|---|---|
| Lack of case management, care coordination and evidence-based practice; | 4.7 |
| Quality deficiencies/failure to use best medical practices; | 4.4 |
| Third party payer system provides little incentive to consumer to control costs; | 4.4 |
| Drug costs; | 4.1 |
| Provider costs related to keeping up with best practices; and | 4.0 |
| Labor shortages of some medical professionals. | 4.0 |

#### Goal 2: Barriers That Prevent Floridians From Obtaining Health Insurance

The top six state barriers, based on seven respondents, were:

| Barrier – State Level | Average Score |
|---|---|
| Individual factors – double digit premium increases | 4.3 |
| Employer-sponsored coverage – premiums are unaffordable | 4.3 |
| Individual factors – cost-shifting | 4.0 |
| Individual factors – cost sharing | 4.0 |
| Individual factors – co-payments, deductibles | 4.0 |
| Employer-sponsored coverage – employer eligibility requirements | 4.0 |

### Goal 3: Federal Barriers to Obtaining Health Insurance

The top four federal barriers, based on seven respondents, were:

| Barrier – Federal Level | Average Score |
|---|---|
| Basic eligibility criteria (e.g., income, age, disability) | 3.5 |
| Cost of regulation (e.g., HIPAA privacy and data requirements) | 3.3 |
| Mandated benefits | 3.2 |
| Citizenship requirement | 3.2 |

### *Post-Meeting Activities*

Following the October 13 meeting, staff met to review the meeting discussions and to prepare for the November 17 meeting. During this time, it was determined that an additional meeting, scheduled for December 17 was necessary.

## Third Meeting of the Task Force – November 17, 2003

The Task Force assembled in Tampa on November 17, for its third meeting. This meeting focused on goals four and five, which charged the Task Force with investigating alternative approaches to traditional health insurance that have demonstrated effectiveness, and with identifying potential partnerships to increase health insurance coverage.

Eight broad categories of uninsured were presented to the Task Force in the Issues Grid. Within each category, policy options and potential partners were also provided. The categories are:

- People who can afford coverage but choose not to buy it;
- Higher-risk people who can afford coverage but are unable to access it;
- Higher-risk people who cannot afford risk-adjusted premiums;
- People/employers who cannot afford coverage;
- People who are eligible for public programs, but don't enroll;
- People covered by insurance, but who are at risk of losing it;
- People at risk of purchasing inadequate, misleading or fraudulent coverage; and
- People who are between periods of coverage (e.g., employment waiting period, retired but not yet eligible for Medicare).

National, state and local perspectives were shared with the Task Force during this meeting.

### *Options for Covering the Uninsured – National Perspective*

Elliot Wicks from Health Management Associates and the Economic and Social Research Institute shared his insights concerning the categories of the uninsured and the types of reform initiatives that impact each group. Dr. Wicks groups the uninsured into four categories: 1) those who can afford insurance, but do not buy it; 2) those eligible for subsidized programs, who do not enroll in them; 3) higher-risk people who could afford average-price coverage, but not premiums that reflect their higher risk; and 4) lower-income people who cannot afford average price coverage without subsidies. According to Dr. Wicks, only 33 percent of the uninsured have household incomes less than $25,000 and 17 percent have household incomes that exceed $75,000.[29]

The individual differences and needs among the four categories of the uninsured suggest that a "one size fits all" solution is not likely. Dr. Wicks provided options for each of the four groups.

He then provided the pros and cons of a number of non-traditional approaches that have been tried in recent years. In summary, Dr. Wicks suggested that while comprehensive and far-reaching solutions are likely to require "substantial new money, some compulsion and strong political will", incremental approaches are still beneficial.

### *Florida Initiatives – Past and Present*

A summary of Florida initiatives to address the uninsured was provided by Task Force member Paul Duncan from the Department of Health Services Administration at the University of Florida. Florida's experience with innovative approaches and initiatives spans a 35-year period.

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[29] *Uninsured by Household Income*, U.S., Current Population Survey, 2002.

Demonstrations of the state's actions include insurance and organizational reforms; programs oriented to children; Medicaid expansions; safety-net programs; programs targeted to underserved populations; and local initiatives.

In addition to the efforts of this Task Force, Dr. Duncan noted other current initiatives: hospital efforts to inform consumers and to address historic pricing practices, exploration of options by both houses of the legislature, receipt of a HRSA federal planning grant to replicate the 1999 Florida Health Insurance Study; and the National Governors' Association (NGA) monitoring of the Safety-Net Provider System Grant.

> "Florida is among the more active states in responding to issues regarding access to health care and health insurance."
>
> - "Florida Initiatives Past and Present", Presentation by Paul Duncan at 11/17/03 Task Force meeting

### *Local Initiatives*

Four local initiatives were highlighted during the November 17 meeting: Florida KidCare, Winter Park Health Foundation, Hillsborough County Health Plan, and Lakeland Volunteers in Medicine.

#### Florida KidCare

Ken Thurston, from the Florida Agency for Health Care Administration and Dr. Louis St. Petery from the KidCare Coordinating Council presented summaries of the Florida KidCare program. The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act permitting states to expand Medicaid, to create a separate state program, or to do both. Florida KidCare is funded through the SCHIP.

The presentations focused on financing for the Title XXI program, enrollment trends, ways to maximize federal dollars, and the current status of the program, including the enrollment waiting lists and opportunities to expand KidCare.

#### Winter Park Health Foundation

Patricia Maddox, president and CEO of the Winter Park Health Foundation, discussed the access initiatives currently under development in Orange County. The Foundation's mission is "to create the healthiest community in the United States" by focusing on three populations: children, older adults and the uninsured.

The initiatives under development include provision of a grant to enable increased enrollment of Title XXI eligible children in Orange County; a demonstration program, which would provide subsidies for premium support for employment-based coverage; and a limited benefit coverage option.

#### Hillsborough County HealthCare Program

David Rogoff, director of the Hillsborough County Department of Health and Social Services provided the Task Force with an overview of the goals and strategies for addressing the uninsured and underinsured. He also summarized the Hillsborough County HealthCare Program.

His program provides access to health care for low-income residents of Hillsborough County who do not have private insurance, Medicare or Medicaid. Hillsborough HealthCare funds the state-required local match for Medicaid payments, which brings in additional federal health care dollars to the community.

**Lakeland Volunteers in Medicine Clinic**

The Lakeland Volunteers in Medicine Clinic, as described by its chief administrative officer Bobby Yates, is a free (volunteer-run) clinic in Lakeland that offers primary medical care, dental services and counseling services to the working uninsured in the community.

The high poverty rate in the City of Lakeland and its surrounding county (Polk), coupled with a shortage of primary care providers exacerbates the access problems faced by the uninsured in the community.

In its first year of operation (2001) the clinic saw over 3,800 patients. In 2003, it expects to provide care to over 7,600 individuals. Funding for the clinic comes from local giving campaigns and other fundraising activities. Nearly 186 clinical volunteers and 273 lay volunteers staff the clinic.

## *Public Input*

Public comment was provided by a number of individuals. A summary of each person's remarks is provided below.

- Steve Lesky, from Partnership for a Healthier Pinellas, recommended that Pinellas County be added to the pilot area for Health Flex, and that consideration be given to increasing the Health Flex limit up to 300 percent of the Federal Poverty Level.
- K.B Forbes, Executive Director of Consejo de Latinos Unidos, recommended measures be taken to stop the price gouging of the uninsured, and to enforce the Florida Deceptive and Unfair Trade Practices Act that says unconscionable conduct will be illegal.
- Austin Curry, Florida Silver Haired Legislature, recommended innovation and the implementation of a program like the Hillsborough County Health Plan, which currently serves over 31,000 people at minimal cost in Hillsborough County, across all Florida counties.
- Dena Leavengood represented the Hillsborough County Health Care Coalition and the League of Women Voters. She recommended building upon local investments, and using programs (like that in Hillsborough County) as models to be implemented elsewhere. She also recommended building on businesses, because that is where health insurance is based; removing barriers; and expanding Health Flex.
- Philip Compton, from Florida Consumer Action Network, encouraged the Task Force to protect the existing safety-net programs; not eliminate benefits; reduce mandated benefits; and not cut existing coverage. He encouraged options that would ensure comprehensive coverage, including provisions for mental health and long-term care services. He also recommended maximizing the existing federal and state health care dollars now available, and using the $77 million available from the Federal Relief Act to restore the cuts that have been made and the freezes that put 54,000 children in Florida on the KidCare waiting list. Finally he suggested closing the numerous corporate loopholes and using revenue currently lost through those loopholes to fund programs for the uninsured.
- Mary Figg, from the College of Public Health at the University of South Florida, encouraged removal of the cap on Florida Kidcare enrollment placed by the Florida legislature that is affecting thousands of families in the state.

- Ronna Metcalf, Executive Director, The Life Enrichment Center in Tampa, asked that the nonprofit sector be considered, as well as small businesses, in any recommendations adopted by the Task Force.
- Bruce Hepper, retired from a 40-year career in the health care industry, asked the Task Force to consider a solution that addresses the problem of individuals who could afford coverage but who do not purchase it, but who then access care from sources we all pay for. He also encouraged the Task Force to find solutions for ensuring affordable health care is available to those who are not able to afford it without developing a "two-tiered" system of care (the haves and the have-nots).
- Dale Maloney, State Legislative Chairperson for Florida Association of Health Underwriters, stressed the importance of a well-funded, appropriately functioning high-risk pool that offers the aspects of managed care, as the first step to increase marketplace viability and stability by assisting the otherwise unhealthy and therefore uninsurable Floridians by providing coverage of last resort. He recommended that it be funded by the establishment of a per-head assessment on all health insurance policies, whether individually, partially, or fully funded issued by the state.
- Carl Warren, Sr., Vice President in a Community Health Advocacy Partnership Share and Regional Market Coordinator, Wellcare Health Plans of Florida, recommended that aggressive legislative action be taken to eliminate unfunded mandated costs that are automatically attached to the managed care system, which could be reducing the quality of overall access and care of both Medicaid and Medicaid users of state-sponsored health insurance. He also encouraged the development of public-private partnerships, with a focus on intervention, education and prevention, in addition to access.
- Al Johnson, United Services Association for Health Care, asked the Task Force to consider some of the innovations that are happening with the Association-Based Health Care Plan, and that consideration also be given to returning to a two-tier system, with the first tier being access to routine and basic health care, and the second tier being catastrophic coverage.
- Joyce Smith, small business owner, asked for an expansion of Healthy Kids, the creation of a plan for small business owners, the creation of a plan for part-time workers, and support for the health care plan in Hillsborough County.
- Ken Hoverman, CEO, United Health Care of Florida, expressed support for a two-tier approach, a reduction of mandates within Health Flex, and a more robust approach than what we currently have for medical liability reform. He also recommended that measures be developed to help consumers be better educated about their health care, and about how to take care of themselves.
- Wendy McCoy, TECO Energy, Inc., asked the Task Force to review and consider benefit mandates, that cost shifting to private payers be addressed, that the state be urged to partner with providers to reduce medication errors and improve efficiency through implementation of e-solutions to discourage fraud, abuse and concerns about those who are take drugs inappropriately. She also commented that government-based insurance programs serve as a model for private employers and offer plans that might offer coverage for select over-the-counter medications through the health plans.

- Wesley Hufford, an uninsured resident, hopes the Task Force will do the right thing, and consider all those individuals who are incapable, in wheelchairs, who have been denied coverage, denied health care, when pursuing answers.
- Remarks by Steve Mattingly, a former candidate for state senator in District 11, included a recommendation that a law be passed to protect those people who are forced into filing bankruptcy due to a medical emergency. He also recommended that the government implement price controls to make health insurance affordable.
- Hong Jian He represented The Florida Acupuncture Association and suggested that the state of Florida study and research the health care model of China, and that the use of Oriental and Chiropractic medicine be considered as an option to improve health care and decrease healthcare expenditures.
- Jerri Reita Brenton, Certified Holistic Nurse, recommended support be given to the "Safe Staffing and Quality Care" bill, and that a concerted effort is made to educate people to keep them well.
- Michael Sheedy, Associate for Health, Florida Catholic Conference, stressed that healthcare is an essential social service not a commodity to be allocated based on the ability to pay, and that health reform should respect the religious and ethical values of both individuals and institutions.
- Richard Carrell, a cancer patient, asked the Task Force to consider socialized medicine, if an option, due to the high and continually increasing costs of health care.
- Dr. Francis Kendrick, recommended incorporating health savings accounts as an alternative mechanism to control for over-utilization and for everyone to cover their routine and minor health care costs without interference of a third party.
- Jackie Knight, Executive Director, We Care Services, encouraged the Task Force to examine and consider successful programs throughout the world, and that we stop talking about affordable health insurance and start talking about delivery of health care to the people that need it. She also asked that organizations such as hers, which function as a stop-gap in the community, be funded by the State of Florida.
- Tom Vertich, Independent Agent, Fort Myers, suggested reviewing and reforming regulations and standardizing procedures while keeping their intent intact as a way to lower the high administrative costs associated with health insurance; and providing tax credits to businesses, to insurance plan administrators, health care facilities and doctors.
- Raeclaire Johnson, a consumer and cancer patient, asked the Task Force to take measures to improve administrative processes in the health care system to improve medical error rates and fraud and abuse, and to essentially reduce health care costs.
- Evelyn Bethell, Pinellas County Human Services, asked that the efficiency of the current health care system be closely examined before considering any program expansions.

### *Meeting Wrap-Up*

At the conclusion of the meeting, but prior to adjournment, Task Force members were asked to rank the twelve proposed principles currently under consideration for assessing health care coverage options. Scores were based on a 3-point scale, with rankings of very important (3

points), important (2 points) and less important (1 point). Task Force members were also asked to add additional options as needed. The outcomes of the rankings are summarized below.

| Rank | Principle |
|---|---|
| 1 | Address the issues of rising healthcare costs |
| 2 | Ensure that consumers have necessary information to make knowledgeable choices |
| 3 | Protect the rights of all consumers |
| 4 | Are cost effective |
| 5 | Support rather than conflict with existing state reforms and assistance programs |
| 6 | Are affordable for Floridians at a variety of income levels |
| 7 | Are realistic |
| 8 | Protect the position of less healthy individuals |
| 9 | Are affordable given Florida's budget situation |
| 10 | Are fair |
| 11 | Ensure that insurance companies are not created without appropriated oversight |
| 12 | Do not add to the existing problems of cost shifting |

## Fourth Meeting of the Task Force – December 3, 2003

The meeting on December 3 was held in Jacksonville. Co-chair Gallagher opened the meeting by welcoming everyone; he proceeded by summarizing the meeting's goals and objectives. The meeting was devoted to presentations and recommendations from key stakeholders and the development of initial Task Force recommendations.

Rich Robleto recapped the six goals of the Task Force, the work plan and the goals for the December 3 meeting, the progress and accomplishments of the Task Force to date and the plans for moving forward in the remaining meetings. Mr. Robleto mentioned the "tools" used by the Task Force thus far to gain a deeper understanding of the uninsured problem and the possible approaches to addressing the problem. Written materials, staff research and support, presentations by industry experts and public testimony were acknowledged as the primary contributors in moving the Task Force toward meeting its goals.

The Task Force was provided with a copy of the final summary report from the Health Insurance Symposium held in September. Mr. Robleto commented on the large volume of information and materials provided to and received by the Task Force since its inception and noted that limited time had been available to date to develop the recommendations of the Task Force. He also mentioned that a working draft of the Task Force report was disseminated to Task Force members; this draft contained information on meetings and activities to date. He noted that the report would be expanded to reflect continued activities and deliberations of the Task Force. He informed the Task Force that the December 3 meeting would provide for some additional, more focused presentations and time for Task Force members to offer and discuss initial recommendations.

Mr. Robleto indicated that the December 17 meeting would be devoted to a presentation and discussion of Task Force recommendations, with a draft report of Task Force meetings and deliberations to be distributed at the January 9 meeting.

### *Task Force Discussion*

Florida's Chief Financial Officer Gallagher introduced a session on the direction of the Task Force and a discussion of initial recommendations. Each Task Force member present at the meeting spoke and offered comments regarding their initial recommendations and requests for additional information. Many of the comments were general in nature and will be further developed as additional information is received and processed.

### *Stakeholder Presentations*

At the October 13 meeting of the Task Force, the members heard from a number of key stakeholders on their thoughts regarding the first three goals of the Task Force (factors that contributed to the increasing costs of health insurance; barriers that prevent Floridians from obtaining health insurance coverage; and federal issues that contribute to higher health insurance costs). During that meeting, several of the stakeholders asked for the opportunity to present their recommendations at a future meeting. The December 3 meeting, which was devoted to development of Task Force recommendations, accommodated this request.

The agenda included Task Force discussion and stakeholder presentations from five industries (insurance, business, provider, county government, insurance agents) and one local health coverage program:

- The Florida Association of Health Plans;
- The Florida Chamber of Commerce;
- The Florida Association of Health Underwriters;
- The Florida Hospital Association;
- The Florida Association of Counties; and
- JaxCare Inc.

Each presenter provided the Task Force with their respective organization's recommendations. Written materials summarizing each presentation were provided to the Task Force. Each presentation was followed by a question and answer session.

## Florida Association of Health Plans

The first stakeholder presentation was provided by Bob Wychulis, President and CEO of the Florida Association of Health Plans. Mr. Wychulis described the work of the Florida Employers and Insurers Working Group on Affordable Health Care, a broad-based coalition of insurers and employers. Coalition membership includes: Associated Industries of Florida, Florida Chamber of Commerce, National Federation of Independent Business-Florida, Florida Retail Federation, Florida Insurance Council, Florida Association of Health Plans, AAHP/HIAA, AvMed, Aetna, and Cigna.

> ". . .this group represents the employers who are striving to continue to offer their employees continued access to affordable health insurance policies and the insurance companies that struggle with keeping the premiums affordable."
>
> - Bob Wychulis, presentation at 12/3 Task Force meeting

The coalition's goals and principles and specific policy recommendations were described. In summary, the coalition was formed to help small businesses obtain insurance and provide coverage for their employees. Fourteen policy recommendations were offered. Recommendations included increased patient education and dissemination of comparative information on health care costs; changes in reimbursement; reforms of state insurance regulations; changes in public program requirements; and assistance with funding (e.g. subsidies, tax incentives).

## Florida Chamber of Commerce

Leslie Dughi, Director of Government Affairs for the Florida Chamber of Commerce, introduced the Task Force to the Chamber's *"Let's Get Florida Covered"* campaign. She provided preliminary results of the recently completed annual health insurance survey, which indicated that cost is the primary reason cited by employers who do not offer health insurance coverage for employees. During her presentation, Ms. Dughi offered seventeen recommendations to increase health care coverage. The recommendations were divided into eight categories covering the topics of tax incentives, alternative financing methods, premium assistance, high-risk subsidy program, Health Flex, KidCare, prescription drugs, and quality initiatives and information access.

> "All stakeholders in the health care delivery and payment system – providers, government and consumers – must work together for the common solutions."
>
> - Leslie Dughi, presentation at 12/3 Task Force meeting

## Florida Association of Health Underwriters

John Sinibaldi, president of John Sinibaldi Insurance, Inc. provided the Task Force with recommendations from the Florida Association of Health Underwriters. Mr. Sinibaldi began by painting a picture of the insurance crisis for small group employers. He then summarized the history of small group reform and provided a description of the variables that are exacerbating the insurance crisis. Of the three factors that affect the cost of insurance, the cost of health care, the cost of administration and utilization, Mr. Sinibaldi indicated that utilization increases are the driving force behind the breakdown in small group insurance coverage. After describing the current crisis, Mr. Sinibaldi offered a number of options and proposed recommendations. His suggestions for a "fix" for the small group insurance crisis included four steps: reopen the high-risk pool; move HIPAA eligibles and others into the high-risk pool, along with uninsurable individuals; create a second option for employees that doesn't significantly increase premium costs; and encourage a voluntary mini-medical market under the employer-sponsored catastrophic coverage umbrella. According to Mr. Sinibaldi, the intended result of the implementation of these recommendations would be that every employer voluntarily sponsoring a small group health plan would experience virtually 100 percent participation of all eligible employees, thereby insuring hundreds of thousands of people who currently cannot or will not purchase insurance, even if only with catastrophic coverage.

> "Health insurance premium increases for small businesses in Florida averaged 17% three years ago, 24% two years ago and 30% last year."
>
> - Kevin McCarty, OIR, as quoted by John Sinibaldi during his presentation at the 12/3 Task Force meeting

## Florida Hospital Association

Ralph Glatfelter, Senior Vice President, presented the Florida Hospital Association's recommendations. Mr. Glatfelter prefaced his presentation by indicating that FHA's recommendations are proposed and have yet to be finalized by the FHA Board. Final FHA recommendations will be provided to the Task Force at its December 17, meeting. Mr. Glatfelter summarized approaches that have been tried, noting many have failed.

> ***Suggestions for the Task Force***
>
> "Do no harm."
> "You can't increase access by increasing costs."
> "Learn from the past."
>
> - Ralph Glatfelter, FHA presentation at 12/3 Task Force meeting

Mr. Glatfelter continued by presenting trends on healthcare costs, per capita healthcare spending and premium increases. A considerable portion of his presentation was devoted to a discussion of hospital emergency rooms, the "safety-net" for the uninsured and everyone else." He noted that emergency room (ER) visits increased 16 percent nationally and 24 percent in Florida between 1997 and 2002 according to the Center for Studying Health System Change. Mr. Glatfelter proceeded to provide suggestions for reducing medically unnecessary ER use. His recommendations included: making available comparative hospital charge information for common procedures to better educating consumers and enhancing consumer choice, and increasing broad-based funding for Florida's trauma network, high-risk pool, Medicaid expansion and KidCare expansion.

## Florida Association of Counties

Commissioner Bob Janes (Lee County) represented the Florida Association of Counties (FAC) and provided their recommendations. He began his presentations with a brief overview of the

healthcare services currently being provided at the county level. He described the programs and services counties are mandated to support (e.g., contributions to Medicaid program for portions of inpatient hospital stays and nursing home care, local match for community alcohol and mental health services, health care costs for eligible indigent county residents receiving care at an out-of-county hospital, financial support to county health departments), as well as additional services that are provided on a discretionary basis (e.g., hospice care, services for the disabled and elderly).

The FAC membership has formalized their position on increasing access to affordable health care.

> "Counties support legislation that removes barriers that hinder county governments' ability to maximize discretionary local resources to provide access to health care at the local level. Additionally, counties support federal, state and local partnerships that help promote stability, expansion and flexibility of local health care programs through waivers and legislative proposals."

The Florida Association of Counties offered six recommendations: indigent health care surtax; premium assistance subsidies; local flexibility with Medicaid nursing home dollars; local flexibility to use local funds to fund kids on KidCare waiting list; federal waivers and legislative proposals; and federal, state, and local partnerships.

### *Public Input*

The afternoon portion of the December 3 meeting began with a series of presentations and comments from the public. All individuals who requested to speak made remarks. Twelve persons provided comments to the Task Force. Five individuals were given an extended period (five minutes) to share information with the Task Force.

- Kathy Mankinon, Chair, Healthy Start Coalition, recommended using the 76 million dollars received from the first installment of Medicaid relief to take immediate action to remove the Florida KidCare cap, and fund the children on the Florida KidCare waiting list.
- Dr. Albert Bachnecht, Florida Dental Association, urged the Task Force to ensure that the quality of care not be reduced by the challenge of reducing costs.
- Dr. John Stimer, Florida College of Emergency Physicians (FCEP), Associate faculty, University of Florida Shands in Jacksonville, recommended improving access to health care through increased hours and staffing at public health clinics, and implementing an incentive system for PCPs to see patients after hours. These measures would cut costs and ensure the availability of emergency and trauma care in our state for those who need such care for treatment, not convenience. Dr. Stimer also shared FCEP's principles and recommendations for creating affordable health insurance in Florida. Dr. Stimer reiterated the critical role emergency departments play in the healthcare system, but acknowledged the high costs associated with their inappropriate use. Five recommendations were offered to ameliorate this situation: fund alternate sites of service (e.g., public health clinics) to emergency departments; educate the public on the proper use of the emergency department; explore ways to provide incentives for insurers to more extensively cover preventative care; contain pharmaceutical costs through incentives for efficient coverage and utilization of drugs; and continue steps toward liability reform.

- Jim Cameron, Daytona Beach/Halifax area Chamber of Commerce, recommended measures to assist employers with the provision of health coverage, and to encourage continuation of health coverage. Specific measures recommended included expansion of the federal health care tax credit, expansion of the Health Flex Plan Pilot Program, elimination of the waiting list for the KidCare Program, and further consideration of health care mandates.
- Andrew Cauthen, National Health Corporation, encouraged the Task Force to consider options that would assist small businesses in attaining health insurance for their employees through Association Memberships (Association Health Plans), which can offer lower cost benefits supplemented with high deductible catastrophic health insurance, a more affordable solution. Over 60 percent of America's uninsured are small business owners and their families or the employees of small businesses. If small employers are expected to provide health insurance, better options than they currently have should be made available.
- Reverend Paul Cromwell, Executive Director, ICARE, the Inter-church Coalition for Action, Reconciliation and Empowerment, asked that the "caps" on the KidCare program and other Florida children's health insurance programs be lifted. He also asked that the money for outreach be reinstated, and that the Florida legislature, community groups, and the Governor turn to Washington to ensure that funding continues for these programs.
- Deborah Parsons, Senator Hill's legislative assistant, stressed that all Floridians should be entitled to basic health care, and that communities and state and local government, which are responsible for the delivery of health care, work to contain costs and ensure the highest possible quality of health care to all persons regardless of their race, sex, national origin, age, disability, marital status, education level, income, or geographical location.
- Linda Merrill, Community Health Action Information Network, asked that parity for mental health be included as an issue as recommendations are deliberated. She also recommended removing the cap on KidCare. She remains confident that the funding will be reauthorized and will continue in the future, since this program has strong bi-partisan support.
- An unidentified consumer from Jacksonville noted that access to affordable insurance for his handicapped adult son, who recently lost his group insurance where he works and is unable to afford any other coverage with an $8,000 annual salary, is needed.
- Dave Shaver, Founder, Consumer Support Services, asked that Medicaid buy-ins be reinstated to help people with disabilities and pre-existing conditions get back to work and continue to receive their health benefits.
- Derek Sirmons, FIT Insurance, encouraged inclusion of monitored participation and compliance with required fitness regimens as a way to offer reduced health insurance premiums or increased benefits.
- Paul Whorton, SHANDS, stressed that major medical coverage still needs to include congenital defects or catastrophic conditions.

## JaxCare Inc.

Following the public comment, Dr. Rhonda Davis Poirier, president and CEO of JaxCare provided the Task Force with an overview of the organization. JaxCare is a public-private

partnership designed to finance and deliver health care to Jacksonville's uninsured low-wage workforce. The objectives of the partnership are to: link, integrate and manage healthcare and social service delivery; maximize community resources; track utilization and need; lower administrative and healthcare costs, and evaluate and ensure quality.

The JaxCare pilot was a two-year program that began in 2000. The pilot covered 1,600 workers. Funding for the pilot program came from four sources: City of Jacksonville (31%), hospital contributions (26%), grants and corporate donations (20%), and patients and employers (23%). JaxCare covers physician, hospital and ancillary services, and generic drugs. The success of the program has motivated JaxCare to look for ways to sustain and expand its program.

Plans for sustainability will occur at three levels. At the local level, JaxCare will demonstrate the cost/benefit of the pilot program to garner continued support. At the state level, JaxCare will work to educate the legislature and the state administration on the program and will look for opportunities for expansion/replication across the state. A big accomplishment for JaxCare was AHCA and OIR approval of JaxCare's Health Flex plan on December 3, 2003. At the federal level, JaxCare will continue to look for matching opportunities.

### *Meeting Wrap-up*

Lieutenant Governor Jennings led the Task Force in a discussion of initial recommendations and the identification of additional information requested by Task Force members. As a follow up to their morning presentations, the Task Force asked both Mr. Sinibaldi from the Florida Association of Health Underwriters and Mr. Glatfelter from the Florida Hospital Association additional questions.

The Task Force discussed a range of options and issues of interest to one or more Task Force members. Eleven initial options were agreed upon as of interest to the Task Force for Florida and are summarized in the following table. The list is in no particular order.

| Option | Description |
|---|---|
| KidCare | Maximize enrollment in KidCare fully utilizing all available federal funding, including but not limited to using the entire federal allotment. |
| Mandated Benefits | Provide flexibility for inclusion of policies in the market that do not require mandated benefits. |
| High-Risk Pool | Re-open the pool and establish a continuing source of funding to allow for enrollment at a level sufficient to provide for premium relief in the rest of the insurance market. |
| Employer-Sponsored Insurance (ESI) | Provide incentives for employers to offer health insurance to their employees. |
| Consumer Information | Ensure consumers have access to information designed to assist individuals in making informed health care purchasing decision and adopting healthy lifestyles. |
| Evidence-Based Medicine | Develop and publish information that will provide for more efficient delivery of care to contain costs and health insurance premiums. |

| Option | Description |
|---|---|
| Medicaid | Develop a comprehensive plan to restructure the Medicaid program to allow for additional individuals to be enrolled, without increasing overall state funding requirements. |
| Pooled Purchasing for Businesses | Provide for pooled purchasing arrangements to assist businesses in obtaining the most competitive prices for health insurance. |
| Health Flex | Expand Health Flex policies to all areas of the state. |
| Local Initiatives | Encourage the development of local health coverage programs for individuals lacking health insurance. |
| Safety-Net Providers | Determine if there are additional ways within existing resources to further support the viability of the crucial safety-net providers and ensure that access to those who lack insurance is guaranteed. |

The Task Force members submitted recommended health care coverage options of interest to staff for compilation and follow-up at the December 17 meeting. The Task Force also asked staff to provide additional information on the following topics for the December 17 meeting.

- High-risk pool and funding;
- HealthyKids funding;
- Health Flex;
- Medicaid restructuring;
- Community Health Purchasing Alliances (CHPAs);
- Summary of cost implications of mandates;
- MedAccess;
- Medical Malpractice Task Force recommendations that have not been implemented;
- Ways to control/reduce cost drivers;
- Small group insurance reform options; and
- Programs using evidence-based medicine, purchasing pools, disease management, and use of best practices.

### *Post-Meeting Activities*

Following the meeting, staff met to develop a plan to accomplish the requested assignments made by the Task Force. As directed by the Task Force co-chairs and in consideration of the comments provided by Task Force members during the meeting, staff prepared a document that summarized the draft policy recommendations approved by the Task Force, developed a document that summarized the policy options recommended by speakers during their presentations to the Task Force, and prepared a series of one page white papers on topics for

which additional information was requested. These documents were prepared for discussion at the December 17 meeting.

## Fifth Meeting of the Task Force – December 17, 2003

The Task Force convened in Miami for its December 17 meeting. The primary objective of this meeting was to review, discuss and finalize recommended health insurance coverage approaches. Lieutenant Governor Toni Jennings opened the meeting and introduced Dr. Rolando Montoya from Miami-Dade College who welcomed the Task Force and members of the public to Miami and to the Wolfson Campus of the college.

Rich Robleto provided a summary of outcomes from the December 3 Task Force meeting in Jacksonville. He noted the Task Force heard from a number of stakeholders representing various groups and received general public input from thirteen individuals during the Jacksonville meeting.

Mr. Robleto reviewed the eight topics about which the Task Force members requested additional information. An analysis of each topic was prepared by staff to the Task Force and provided prior to the meeting by e-mail. Copies of the analyses were also included in the Task Force members' December 17 meeting packets. These topics were:

- Addressing cost drivers;
- Best practices;
- Health Flex;
- Mandated benefits;
- Med Access;
- Purchasing pools;
- Restructuring Medicaid;
- Healthy Kids; and
- The Sinibaldi Plan.

### Agency Presentations

Kevin McCarty, Director of the Office of Insurance Regulation reviewed the outcomes from the September 22 Health Insurance Symposium and presented the Office of Insurance Regulation priorities for Florida, and identified protection of the private insurance market as a priority. He noted that 85 percent of insurance costs are for direct claims costs and 15 percent for administration. He urged the Task Force to ensure that any recommendations not increase the proportion of health care spending devoted to administrative costs in order to preserve funds for health care services.

He noted that OIR believes the following areas can assist in improving access to health insurance coverage. These are:

- Availability of a High Risk Pool. The Trade Act of 2002 may provide access to federal matching funds for the pool;
- Removal of the one-life group from the small group market and the option for this group to access a revised high-risk pool;
- Movement of the 2-5 member groups to a purchasing pool and use of a Healthy Kids model;

- Continued development of the pilot projects that are free of mandated benefits;
- Expansion of Health Flex statewide; and
- Provision of electronic access to consumer information.

Mr. McCarty urged the Task Force to adopt principles that support rather than harm the private employer-based insurance model.

**Kevin McCarty –**

"Whenever possible, any proposal that comes before you to deal with the problems of health insurance in Florida, should be addressed by protecting the integrity of the private health insurance market. The solvency and consumer protections that have evolved over the years in this market will bring long-term viability and stability to any programs that we undertake."

Following Mr. McCarty, Mr. Ken Thurston provided the Task Force with the Agency for Health Care Administration's (AHCA's) perspectives on five policy areas: Medicaid restructuring, safety-net providers, local initiatives, evidence-based medicine and consumer information. He asked the Task Force to be cognizant of the continued growth in the Medicaid program and the need to constrain this growth.

Mr. Thurston described the available options for restructuring the Medicaid program. He referenced the flexibility of the HIFA waiver that is specifically designed to expand health care coverage and can be approved faster than a "regular" 1115 waiver. Under a HIFA waiver, a state can offer coverage to individuals up to 200 percent of the Federal Poverty Level. It also provides the state flexibility with the benefit structure. Identifying additional ways to support the viability of safety-net providers were also noted by Mr. Thurston. He also encouraged continued development of local health care coverage programs for individuals lacking health insurance.

The development and dissemination of information concerning evidence-based medicine and the promotion of disease management initiatives were suggested as ways to contain costs and health insurance premiums. Providing consumers with greater access to information designed to assist them in making informed decisions was suggested as an area for consideration.

Mr. Thurston also educated the Task Force on Florida's SCHIP funding balance for the KidCare program.

### *Presentations on Additional Options*

Based on the Task Force's request at previous meetings for additional information on the high-risk pool and Health Flex, presentations on these health coverage options were made. A presentation on Memorial Health Care, the primary safety-net provider in South Broward County, was also given.

## High-Risk Pool

Michelle Robleto from the Florida Comprehensive Health Association provided the Task Force with a description of the role of residual insurance markets, a description of the ripple effects of a high-risk pool and options for future consideration.

Ms. Robleto defined residual markets as "specialty insurance markets or facilities designed to assume risks that are generally unacceptable to the normal insurance market."[30] Residual markets protect markets and provide access. By establishing a residual market through a risk pool, the

[30] Robleto, Michelle. *Something's Missing, Florida's Health Insurance Markets*. Presentation to the Governor's Task Force on Access to Affordable Health Insurance, 12/17/03

burden of uncompensated services is reduced and excessive risk is removed from the commercial market. Ms. Robleto continued by describing the "ripple effects" of a risk pool. A risk pool removes stress on the small group market by removing high-cost, high-risk individuals from the rating structure, thereby enabling businesses to offer more affordable coverage. It also reduces uncompensated care.

Over 60 percent (31) of the states have risk pools. Seven states, including Florida, offer no means of access. Funding is the biggest issue in a risk pool. Ms. Robleto suggested a number of ways to equitably spread the costs: allocation from state funds, assessments with tax credits, service charge on providers or services, assessments on a per covered life basis, and assessments with no tax credits.

***Risk Pools:***

- provide access to coordinated, quality health care.
- protect the market from excessive risk … encourages price competition between carriers.
- increase private market coverage and reduce need for public programs.
- promote affordable commercial coverage and offer interim coverage solutions.

- Michelle Robleto at 12/17/03 Task Force meeting

Ms. Robleto offered two risk pool options for Florida:

- Open a new, qualified risk pool for the medically uninsurable and Trade Act eligibles (funding through assessments with tax credits); and
- Open a risk pool for HIPAA eligibles and Micro groups (funding through assessments on covered lives).

Michelle Robleto responded to extensive questions concerning the high-risk pool including questions concerning the level of liability specific to the pool in 1990-1992 and the projected liability now if the pool had remained open. The Task Force requested that staff provide actuarial information specific to these questions.

## Memorial Health Care

John Benz provided the Task Force with an overview of the facilities and services provided by the Memorial Healthcare System (MHS). As the primary safety-net provider/system in South Broward County, MHS provides 97.5 percent of all uncompensated care. This amounts to approximately $100 million annually. Mr. Benz described the positive impact MHS has made on a number of key health indicators. Impressive statistics for childhood immunization rates, breast and cervical cancer screening rates, and prenatal care visits were among the examples provided. Mr. Benz noted that childhood immunization rates hover around 95 percent, while the benchmark is 65 percent, and the cervical cancer screening rate has averaged 79 percent over the past two years.

Mr. Benz concluded his presentation by indicating MHS' support of the Task Force's mission to provide affordable health insurance. He recommended that the Task Force consider increasing funding to safety-net providers. He also offered support for the development and financing of a high-risk pool and the development of local uninsured/health coverage demonstration programs.

## The Health Flex Plan Pilot Program

Tom Warring from the Bureau of Managed Care, AHCA, described the Health Flex Plan Pilot Program. The intent of the program, which started in 2002, is to offer an alternative to traditional health insurance programs to low-income individuals who cannot afford traditional health insurance products.

The program is restricted to individuals with incomes less than 200 percent of the Federal Poverty Level, who have been uninsured for at least six months, who are under 65 years of age, and who are not eligible for coverage under Medicare, Medicaid or KidCare.

Three programs have been approved for participation:

- JaxCare, a private/public partnership in Duval County;
- AmericanCare, a physician group in Dade County; and
- A plan offered by Preferred Medical Health Plan, a licensed HMO.

Many of the Health Flex requirements mirror the state's HMO requirements. However, there are a few notable differences: there are no mandated benefits, there is no access for participants to an external grievance program, and there are no licensed marketers.

CFO Tom Gallagher recommended that the Health Flex option be expanded statewide, utilizing varying benefit packages in order to determine the impact on the health insurance market. He emphasized the importance of collecting data to evaluate the impact of Health Flex, including variation related to scope of coverage and cost.

### *Public Input*

Following the scheduled presentations, the Task Force received public input and comment.

- Rose Naff, Florida Healthy Kids Corporation, made a presentation on previous efforts, barriers and future possibilities for making Healthy Kids more like an employer-sponsored insurance model. She noted that 93 percent of current Healthy Kids enrollees have been uninsured for more than six months prior to buying into the program.
- Senator Peaden asked how Healthy Kids responds to families who miss premium payments. Ms. Naff responded that families have 60 days to submit a late payment, but noted that 97 percent of families pay on time. Senator Peaden suggested the legislature may need to address the issue of families not electing coverage until a child is ill, then taking coverage only for the period when medical expenses are high.
- Paul Sanford of the Florida Insurance Council presented data concerning the cost to re-open the high-risk pool. Later, Mr. Sanford and Michelle Robleto were asked about the fiscal liability associated with opening the risk pool. Mr. Sanford noted the pool should be funded solely with general revenue dollars.
- Ralph Glatfelter, Florida Hospital Association, provided a follow-up presentation to his initial presentation at the Task Force's December 3 meeting in Jacksonville. He noted that the FHA is developing statewide discount rates that will serve as limits on what providers may charge the uninsured, but this work is not yet completed. He also noted that Medicare regulations place restrictions on what hospitals may do and requires equivalent collection efforts for all patients regardless of whether they are insured or uninsured.
- Gil Amara, Jackson Health System, spoke concerning the uninsured served by Jackson Health Systems.
- Dr. Jose Garcia, a Health Flex Plan founder, spoke concerning the advantages the Health Flex model offers and of the problems with and need for regulation of discount plans. Dr. Garcia later responded in length to Task Force members' questions on regulations and discount plans.

- Frank Hart from the Florida Institute for Family Involvement spoke concerning children with special health care needs.
- Gepsie Metellus, Haitian Neighborhood Center in Miami, thanked the Task Force for being sensitive to the health care concerns of the Haitian community in South Florida and for inviting them to the meeting. This presentation discussed safety-net providers and the lack of access to the more traditional forms of coverage, as well as barriers in communication.
- Daniel Rodriguez, JMF Financial Group, discussed options for the provision of supplemental access coverages (primary care only coverage; catastrophic coverage) combined with association memberships.
- John Sinibaldi made a follow-up presentation to his presentation at the Task Force's December 3 meeting in Jacksonville. He answered questions that had subsequently been raised in the discussions.
- Daniella Levine, Human Services Coalition of Dade County, made an oral and written presentation to the Task Force. She recommended eliminating the KidCare waiting list, restoring Medicaid cuts, and expanding Medicaid coverage to everyone up to 100 percent of the FPL.
- Karen Woodall, KidCare Coordinating Council Finance Group, spoke as an advocate for the uninsured.

### *Update on House Select Committee on Affordable Health Care for Floridians*

Although the December 17 meeting agenda included time for an update on the activities of the House Select Committee on Affordable Health Care for Floridians, a representative for the Committee was unable to attend the meeting. The presentation was rescheduled for the Task Force's January 9 meeting.

### *Discussion on Recommendations*

Co-chair Gallagher led the Task Force through a review of the health insurance coverage recommendations presented to and discussed by the Task Force during the past five meetings (see Attachment C). Task Force members were asked to review and rank eleven preliminary recommendations. Task Force members were also asked to concur that the recommendations accurately reflect Task Force deliberations. Ultimately, the Task Force selected ten recommendations for further analysis and for adoption at the January 9 meeting.

### *Meeting Wrap-Up*

Lieutenant Governor Jennings concluded the meeting with a review of the draft Task Force Recommendations document, a discussion of next steps and the plans for the January 9 meeting. She also noted that the final report of the Task Force would be finalized by the February 2 meeting. This additional meeting was tentatively scheduled, in the event additional time was needed by the Task Force to finalize the report.

### *Post-Meeting Activities*

Staff met after the meeting to further develop the recommendations agreed to by the Task Force.

## Sixth Meeting of the Task Force – January 9, 2004

The Task Force convened on January 9, 2004 in Orlando at the University of Central Florida. The primary objective of this meeting was to enable the Task Force to further develop and discuss and finalize policy recommendations after receiving public input.

Dr. John Hitt, President, and Dr. Belinda McCarthy, Dean of the College of Health and Human Services at the University of Central Florida welcomed the Task Force and extended support for the Task Force's work. Dr. McCarthy presented Lieutenant Governor Jennings and CFO Gallagher with awards for their special efforts in leadership and for making a difference in health and public affairs. CFO Gallagher continued the meeting with a summary of the meeting's agenda. He noted that the majority of the meeting would be devoted to finalization of the Task Force's recommendations.

Rich Robleto then provided the Task Force with a summary of the outcomes from the December 17 meeting and reviewed the materials the Task Force members would be discussing during the afternoon session specific to the Task Force recommendations. He indicated that the draft report would be sent to Task Force members around January 15, at which time Task Force members would have two weeks to review the report and provide comments to staff.

### *Update on House Select Committee on Affordable Health Care for Floridians*

Frank Farkas, DC, Chair of the Select Committee on Affordable Health Care for Floridians, Florida House of Representatives and a Governor's Task Force member, reviewed the Preliminary Report of the Select Committee on Affordable Health Care for Floridians. He also reviewed the similarities and differences between the Task Force Select Committee processes and focus, noting the House Select Committee focused on employer-based insurance solutions and did not address the Medicaid program. Representative Farkas stated a final report with Select Committee recommendations would be forthcoming and noted that he plans to develop legislation to address these recommendations. He also noted he will be working to incorporate the Governor's Task Force recommendations into the Select Committee's recommendations as appropriate.

### *Public Speakers*

- Bill McCollum, President and CEO, The Healthy Florida Foundation, addressed the Task Force on the work of the Healthy Florida Foundation. Mr. McCollum discussed the process of the collaborative effort between health care providers, business people, and community leaders in developing recommendations to improve America's health care delivery system. A written report of 14 recommendations was provided to the Task Force. Mr. McCollum indicated that a final report would be forthcoming. He stated that he found the Governor's Task Forces' preliminary recommendations to be consistent with the Healthy Florida Foundation recommendations, except that he advised inclusion of the Healthy Florida Foundation's first recommendation concerning electronic medical records.
- Becky J. Cherney, President and CEO of the Central Florida Health Care Coalition, made a presentation to the Task Force on evidence-based and outcome-based medicine in the Central Florida area. Her main subject was clinical quality. She spoke concerning the types of important consumer information that are not yet readily available. She recommends information be provided to consumers on health care access, quality, cost

and capacity. Ms. Cherney profiled the most common family practice diagnoses and procedures in order to demonstrate the great variation in cost, etc.

- Larry Jones, Director of the Orange County Health and Family Services, Primary Care Access Network presented concerning "Orange County—A Community Collaborative Addressing the Uninsured." Mr. Jones described the characteristics of the Orange County uninsured and the establishment of the County program to provide primary care access. From the program's inception in 2000, it has served more than 30,000 patients and provided 130,000 visits.
- Leslie Dughi, Director of Governmental Affairs for the Florida Chamber of Commerce, made a follow-up presentation to the committee on the results of an employer survey on affordable insurance. Ms. Dughi included information on the prices and margins for which employers would consider the product affordable. Ms. Dughi had made several previous appearances highlighting the Chamber recommendations, and had been asked to return and report on this survey to the Task Force.

### *Public Input*

The Task Force received comments from several members of the community.

A series of representatives of the insurance industry spoke to the Task Force about their concerns. Most of these individuals also addressed questions from the Task Forces members:

- Joyce Bohl, Senior Actuary for Humana, Inc.;
- John Schwarz, Vice President, Small Group, United Healthcare; and
- Gerald Wester, Aetna.

Most of the discussion with Task Force members centered on the recommendation to remove the +/-15% provision for small group rates, and the effects of other existing and recommended changes to the small group market. The insurance industry speakers did not recommend the removal of this provision. Mr. Wester concluded by stating that the elimination of the health status rate band would not increase access to affordable health insurance and might return Florida to a deteriorating small group market.

- John Sinibaldi, John Sinibaldi Insurance, recommended removal of the provision.
- Steven Smith, Blue Cross and Blue Shield of Florida, was asked for his opinion by the Task Force. Mr. Smith discussed the original difference of opinion between BCBS of Florida actuaries and marketing staff, but concluded that he could concur in removal of the +/-15% provision as they found it did not make much of a difference.
- Dale Maloney, Florida Association of Health Underwriters also spoke on the creation of a new High Risk Pool.
- Harry Stinton, Insurance Agent.

A series of presenters spoke to the Task Force concerning Association Health Plans:

- Melanie Brooks, USA+ member.
- Raini Forrest, USA+ membership Association.
- Nina Howser, Assistant, Dr's Office.
- Charles L. Lewey, USA +.

- Christine Padovan, President, GE Cambell Financial Services.

These association membership presentations made their case to the Task Force members on the advantages of Association memberships. However, they stimulated questions from the Task Forces members on the potential need for additional disclosure, regulation and other consumer issues.

- Jim Kragh, Good Health Network spoke of his contract with the Medicaid electronic prescribing pilot project where 800 physicians use PDAs containing a sixty-day prescription history for each patient. He spoke in support of the Task Force recommendations concerning the use of evidence-based medicine and electronic health care information and innovations.

The following speakers requested that their written materials be provided in members folders and made available to the public:

- Florida Legal Services; and
- Florida Catholic Conference.

### *Finalization of Task Force Recommendations*

The balance of the meeting was spent reviewing, discussing and finalizing the Task Force's recommendations. Lieutenant Governor Jennings facilitated this discussion. Concurrence on each of the ten recommendations was sought. Task Force members were also given the opportunity to propose new options to the formal recommendations. Each of the proposed recommendations was discussed and the wording for some recommendations was revised by the Task Force. Following discussion of the recommendations, the Task Force voted concerning adoption of the recommendations. Each of the ten recommendations was approved, and included a change to the recommendation concerning evidence-based medicine. The Task Force requested that this recommendation be split into two recommendations – one encompassing evidence-based medicine and one encompassing electronic medical records (for a total of eleven recommendations). In addition, four issues not specifically included in the recommendations were discussed:

- Fraud and abuse efforts;
- Long-term care insurance;
- Funding for trauma centers; and
- Medical malpractice issues.

The Task Force members requested that staff include these issues in the Task Force Report as emerging issues that should be developed further.

### *Meeting Wrap-Up*

Prior to adjournment, Lieutenant Governor Jennings reiterated the plans for distribution of the draft report around January 15 and the request for review and comments within two weeks. She also indicated that Task Force members would have a final opportunity to provide comments at the February 2 meeting. The final report is due to the Governor, the President of the Florida Senate and the Speaker of the House of Representatives on February 15, 2004.

### *Post Meeting Activities*

Staff finalized the Task Force Draft Report, including changes to the recommendations, and provided the report to the Task Force members for review by e-mail on January 15, 2004 and by paper copy the following day.

## Seventh and Final Meeting of the Task Force – February 2, 2004

The seventh and final meeting of the Task Force was held on February 2, 2004 in Tallahassee. Co-chair Gallagher opened the meeting and detailed the purpose of the meeting, including the review of comments from Task Force members regarding the draft report, incorporation of those comments into the final report, as appropriate, and formal adoption of the report.

Rich Robleto explained the documents that were contained in the Task Force members' packets of materials and how they were going to be used in the meeting. The documents contained in the packets consisted of: the agenda; the interim draft report; Task Force members' comments concerning the recommendations, Task Force members' comments concerning the report, an errata sheet relating to technical and grammatical changes, and copies of the Governor's press release and the White Paper regarding his proposed programs to increase access to health care insurance.

Lieutenant Governor Jennings facilitated a discussion of the documents regarding task force comments. It was agreed by the Task Force that the changes detailed on the errata sheet be adopted. Comments concerning the report were received from Dr. Fleur Sack and Dr. Paul Duncan. Dr. Sack's comments regarding evidence-based medicine were reviewed and approved with changes for incorporation into the final report. Dr. Duncan's comments primarily dealt with technical corrections and data collection. These were approved for incorporation into the final report.

The discussion then shifted to the comments concerning the recommendations. Comments had been received from Mr. Stevenson, Ms. Story, Ms. Brody, and Ms. Ramos. These comments related to the recommendations specific to: Pooled Purchasing, Health Flex, Local Initiatives, Evidence-Based Medicine, Utilization of Electronic Healthcare Information, Medicaid Restructuring, KidCare, and the Creation of a Residual Pool. Each member explained his or her comments to the Task Force. The majority of the comments were intended to clarify or further explain the recommendation, with one exception. Mr. Stevenson stated he disagreed with the pooled purchasing recommendation as drafted in the report. He expressed concerns regarding the proposed structure of these pools and stated if this recommendation were to remain that the pools be implemented on a pilot basis, as opposed to on a statewide basis. After discussion, it was agreed by the Task Force that the recommendation would remain as written in the report and that Mr. Stevenson would be provided the opportunity to express his reservations concerning the recommendation in the final report. The comments concerning the other recommendations were discussed, and the members agreed on how to address these in the final report.

Lieutenant Governor Jennings then moved for adoption of the report with the additions to the report content discussed by task Force members. The motion was seconded, and approved unanimously by the members. Lieutenant Governor Jennings noted that Mr. Stevenson would be contacted to obtain his comments concerning the pooled purchasing recommendation for inclusion as a "minority" report if he desired.

### *Meeting Wrap-Up*

Lieutenant Governor Jennings and Mr. Gallagher thanked all the members for their service to the Task Force and the meeting was adjourned.

### *Post Meeting Activities*

Subsequent to the meeting, Mr. Stevenson indicated he was satisfied with the Task Force discussion about his concerns regarding the pooled purchasing recommendation and supported the report as written. Staff finalized the Task Force Report, including changes to the content requested by Task Force members and final corrections for grammar and spelling. The Task Force report was issued in its final approved version February 15, 2004 and provided to the Governor, the President of the Florida Senate and the Speaker of the House of Representatives, as well as to Task Force members.

## Task Force Recommendations

Task Force recommendations were developed to address Task Force Goal # 6 contained in the Executive Order:

> *Provide policy recommendations to improve access to affordable health insurance and achieve more predictable cost, while maintaining consumer choice.*

The placement of the recommendations in the following pages does not reflect any ranking or assigned priority. The eleven recommendations encompass the following areas or programs:

- Pooled Purchasing for Businesses;
- Health Flex Plan Pilot Program;
- Consumer Protection and Information;
- Local Initiatives;
- Evidence-Based Medicine;
- Utilization of Electronic Healthcare Information;
- Medicaid Restructuring;
- Protection of Safety-Net Providers;
- Information on the Uninsured;
- KidCare; and
- Creation of a Residual Pool.

### *Emerging Issues*

Several issues surfaced late in the proceedings of the Task Force Meeting on January 9, 2004, and there was insufficient time for them to be analyzed and discussed for inclusion in the final recommendations. However, the Task Force members felt that these topics were significant and should be addressed in the final report as issues that need further exploration and development. It is the hope of the Task Force that the Governor will direct the appropriate state agencies to continue to further develop these issues, make appropriate improvements, and seek additional legislation, if needed.

The issues are:

- Identification of viable funding solutions for the maintenance of existing trauma centers and development of new trauma centers in underserved areas;
- Continued strengthening of fraud and abuse prevention and detection initiatives specific to health care;
- Development of viable long-term care (LTC) insurance products that address the needs of all consumers, including consumers with disabling conditions and elders with incapacities of aging; and
- Continued efforts to address medical malpractice insurance concerns.

## I. *Pooled Purchasing: Small Employer Access Program*

In order to provide more affordable, traditional health benefit coverages for Florida's small employers and their employees:

A. Establish purchasing pools for small employer groups with two to twenty-five employees to provide more affordable health care coverage for these businesses and to promote options designed to increase the provision of employer-sponsored insurance (ESI). These pools should be structured to:

1. Leverage negotiating power of the pool;
2. Obtain more stable premiums;
3. Use established Healthy Kids regions as the geographical areas for these purchasing pools;
4. Utilize competitive bidding conducted by the Office of Insurance Regulation (OIR) to select which insurer will offer coverage for each of these areas. Use the new high-risk pool, when operational, to establish the Small Employer Access Program where there are no successful bids;
5. Offer the standard and basic plans presently required in the small employer market, as well as an option of catastrophic coverage that includes a limited level of primary care coverage;
6. Allow for waiver of benefit mandates and other similar innovations; and
7. Allow any appropriately licensed agent with at least one active health carrier appointment to sell Small Employer Access Program policies for fair commission.

B. Eliminate requirement of prior approval of rates for small employer groups with 26-50 employees.

C. Investigate and, if feasible, implement additional incentives designed to increase the provision of ESI.

### Background

Estimates are that about one-half of uninsured people are employed by small businesses. Small businesses are less likely to offer insurance because small employer financial resources are generally limited. And to make matters worse, policies for the small employer market generally require higher premiums than do policies for large groups.

Although the number of small employers in Florida continues to increase, the enrollment in the small employer health insurance market has decreased significantly. This decrease in enrollment is generally attributed to either employers dropping coverage as it becomes unaffordable, or to the larger of the small employers (generally those with more than 25 employees) moving from the insurance market to a self insured plan in an effort to reduce costs. Although a conversion to a self-insured plan is better than dropping coverage altogether, it adds a new set of issues since small employers are generally not financially prepared for the potential risk associated with self-insurance.

The creation of purchasing pools should have a positive effect on the price of health insurance. Modification of Florida's rate regulation for the larger groups may serve to provide options to keep them in the market.

Pooled purchasing alliances are one approach designed to improve the affordability of small employer coverage. Florida has implemented programs to pool small businesses in the past with limited success. The Community Health Purchasing Alliances (CHPAs) evolved from a pilot project funded by a grant from the Robert Wood Johnson Foundation. In 1992, about 12,700 small business owners, employees and dependents were covered. In 1993, the program went from a pilot project to a statewide program.

At almost the same time the legislature passed sweeping market reforms which included the provision of guaranteed availability of coverage to small employers and a requirement for modified community rating, which requires that carriers pool the experience of all of their small employer groups to determine premium rates. With modified community rating, small groups, for rating purposes, were aggregated together such that they were larger than most "large groups". These reforms rendered the CHPAs somewhat unnecessary. In addition, the fact that the CHPAs included a significant and costly infrastructure by 1997, carriers began to lose interest in CHPAs. They were repealed by the legislature in 2000[31] and replaced with a modification to the statutes to allow the formation of Health Care Alliances. These Alliances are relatively unstructured in the statute and are provided to allow small employers to band together to negotiate discounted administrative fees similar to large groups.[32] Although numerous groups have explored the establishment of one of these new Alliances, to date only one small alliance in South Florida has been established.

Generally, the goals of a purchasing pool are to gain administrative efficiencies, leverage negotiating power for lower premiums, and pool risk to obtain more stable premiums. For a pool to be successful there must be sufficient start-up and marketing dollars, which are generally funded by the members of the pool. Even the most successful pools have had limited success impacting the overall uninsured rates in states where they have been implemented. California has a relatively successful pool with over 106,000 lives and 11,000 firms covered, but still has a high rate of uninsured overall. Pooled purchasing arrangements generally do not become large enough to realize economies of scale or to have bargaining power.

Many small employers attempt to provide coverage to their employees but can only subsidize a small portion (e.g. 50 percent) of the premium. Unless these employers can convince their employees to contribute the remainder of the premium, they are unable to meet carrier participation requirements and they become ineligible for group coverage. One approach, frequently referred to as "The Sinibaldi Plan", proposes to bring these groups into the market by allowing the employer to use the employer's share of the group health insurance premium to purchase an alternative, significantly reduced benefit plan for employees who elect not to participate in the group plan. The alternative benefit plan would be designed such that the employer contribution was adequate to fully fund the plan.

Another option for small businesses is to provide incentives for employers to offer health insurance to their employees. States have tried a number of incentives to increase the provision

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[31] Select Committee on Affordable Health Care for Floridians – *Preliminary Report, Florida House of Representatives*, December 2003.
[32] Ibid.

of employer-sponsored insurance (ESI). These have been comprised mainly of tax credits for small employers and provision of subsidies to individuals and families to offset the cost of the monthly premium. Subsidy programs have been implemented at both the state and local levels.

States have found it administratively difficult to implement ESI subsidies that include federal matching funds, but the availability of the HIFA waiver offers additional flexibility to develop these programs. (See "Medicaid Restructuring" for more information concerning HIFA waivers).

Local subsidy programs have been implemented in a number of states and use local, employer and employee contributions and in some instances, federal funding via the use of the Upper Payment Limit (UPL) and Disproportionate Share (DSH) programs. For example, Wayne County and Lansing, Michigan each cover the working uninsured employed by small businesses (with enrollment of approximately 15,000 individuals). However, similar programs in San Diego and New York eventually closed due to a lack of sustained funding.

Finally, many argue that states can reduce the cost of insurance by exempting policies from some of the 50+ mandated benefits that are included in Florida law and allowing the provision of limited or minimum benefit health insurance packages. Florida has not exempted small employers from mandates, except in the case of local government sponsored arrangements that can offer Health Flex plans targeted to small employers. However, the Health Flex Plan Pilot Program provides an opportunity for insurers and other entities to offer health insurance to individuals free from mandated benefits (although one or more mandated benefits may be included at the insurer's option). (See "Health Flex" for more information concerning the Health Flex Plan Pilot Program).

State tax credits have primarily been of utility in states that, unlike Florida, have an individual income tax. However, according to some industry experts, incremental coverage expansion through federal tax credits may be the most likely policy option to be enacted by Congress. At present, there are approximately 50 proposals in both the House and Senate.

Small businesses have an increasingly difficult time affording health care for their employees. Forty percent of small businesses have dropped their coverage in the past six years. Less than 38 percent of small businesses in Florida currently offer coverage. This compares to the national average of 50 percent.[33]

## Groups Impacted

Individuals who are employed by small businesses and small business owners could benefit from a purchasing pool. Fifty-two percent of Floridians ages eighteen to sixty-five are employed in small business with less than fifty workers. Based on 2000-2001 state and United States Census Data compiled by the Kaiser Family Foundation, 51.3 percent of uninsured Floridians ages eighteen through sixty-four were employed full-time in small businesses with up to 49 employees, equivalent to approximately 400,000 Floridians.[34] The Florida Health Insurance Study (FHIS) estimated 234,000 uninsured Floridians ages eighteen through sixty-four worked part-time. It is not known how many of these uninsured part-time workers are employed in small businesses. The number of children in this group cannot be reliably estimated based on available data.

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[33] Sinibaldi, John. *Florida's Small Group Health Insurance Crisis*. Presentation to the Task Force at December 3, 2003 meeting.

[34] Calculated by Health Management Associates based on data from the Kaiser Family Foundation Website, State Health Facts Online and the 1999 FHIS.

## Considerations

Since Florida's small group laws already require that carriers pool all of their small group experience, a purchasing alliance will not provide an increased spread of risk. In fact, it is important that any purchasing alliance be appropriately structured to avoid or limit further segregation of risk. To address the cost of claims, a purchasing alliance could be considered as a vehicle to explore the elimination of certain benefit mandates. In addition, pools could provide for more administrative efficiencies for small businesses and offer products at reduced rates relative to the standard small group rates. Purchasing Pools could also serve as a vehicle to explore the feasibility of "The Sinibaldi Plan" outlined previously.

Removing the requirement of prior approval of rates for groups of 26 to 50 employees would allow carriers to react faster to changes in the market and to consumer demands. This flexibility could serve to keep some of these groups in the market.

Florida's current corporate tax structure and the make up of businesses in Florida make it difficult to provide any incentives using corporate income tax credits. In addition, corporate tax credits result in a reduction of state revenue. Florida's budget situation would make it difficult to appropriate direct subsidies as an employer incentive to provide health insurance to their employees. The size of the tax credit needed to induce substantial numbers of people who now lack coverage to enter the insurance market is also unknown.

Since most uninsured people are employed, the obvious means for reaching a substantial number is by means of employer sponsored insurance. A focus on ESI also builds on the private, employer-based health insurance system that is our nation's preferred approach to health care coverage. Incentives, financial or non-financial, that successfully encourage employers to offer health insurance could prove to be very useful. Which incentives might be most effective for various types of employers should be studied with care. Potential costs are difficult to estimate.

## Funding

Since this recommendation does not call for state subsidies of premium payments, the only funding that would be needed would be for the administration of the program by the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR). The amount of this funding depends on the type and extent of administration desired by the State.

## II. *Health Flex Pilot Plan Program Expansion*

Expand the Health Flex Plan Pilot Program (Health Flex) statewide in order to offer more flexible, basic, low-cost health care coverage to the low-income working uninsured:

A. Require regulatory oversight of Health Flex advertisement and marketing procedures by the Office of Insurance Regulation;

B. Establish a requirement for standardized consumer grievance procedures similar to those required for HMOs; and

C. Use Health Flex plans to gather more information to evaluate low-income consumer driven benefit packages.

### Background

The 2002 Florida Legislature passed Senate Bill 46-E, which authorized establishment of a Health Flex Plan Pilot Program (Health Flex). Senate Bill 46-E states that: " . . . a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health options for low-income uninsured state residents."

The major provisions of the legislation centered upon exemption of mandated coverage benefits, authority to allow a range of entities to provide coverage, eligible counties for the pilot, and eligible population. The Health Flex Plan Pilot Program legislation exempts these plans from the fifty-one mandated health care benefits governing health plans in Florida, which are found in the Florida Statutes, Chapter 641. Health Flex plans may design their own plan benefits with unique co-payments and limits.

Health Flex providers may design benefit packages that include any combination of benefits, limitations and underwriting criteria. For example, they may include inpatient or outpatient services in any combination. They may or may not include a prescription drug benefit or may limit this benefit to $50 per month of generic drugs, as one Health Flex plan has done. In addition to insurance companies and health maintenance organizations with a Health Care Provider Certificate, Health Flex Plan Pilot Programs may be offered by health care provider sponsored organizations, local governments, health care districts, or other public or private community-based organizations.

| REVIEW CRITERIA<br>Quality of Care Requirements | HEALTH FLEX PLAN REQUIREMENTS | HMO REQUIREMENTS |
|---|---|---|
| Detailed Description of Services | Yes | Yes |
| Mandated Benefits (Ch. 641, F.S.) | None | Yes |
| Listing of Reasons of Denial of Coverage | Yes | Yes |
| Quality Assurance Program | Yes | Yes |
| Utilization Review and Incidence Reporting | Yes | Yes |
| Listing of Quality of Care Indicators | Yes | Yes |
| Physician Credentialing | Yes | Yes |
| Provider Network Adequacy | Yes | Yes |
| Access to Care Standards | Yes | Yes |

| REVIEW CRITERIA<br>Quality of Care Requirements | HEALTH FLEX PLAN REQUIREMENTS | HMO REQUIREMENTS |
|---|---|---|
| Internal Grievance Process | Yes | Yes |
| Access to External Grievance Program | No | Yes |
| Questionnaire | Yes | Yes |
| Licensed Marketers | No | Yes |

Health Flex was authorized for counties identified by the AHCA with high levels of uninsured and for Indian River County. The language regarding the geographic areas eligible to participate in the Health Flex Plan Pilot Program reads:

> "….for eligible participants who reside in three areas of the state that have the highest number of uninsured persons, as identified in the Florida Health Insurance Study conducted by the agency and in Indian River County."

This has resulted in the following areas as potential pilot sites:

- South Florida: Miami-Dade, Broward and Indian River counties
- Central Florida: Hillsborough County; and
- Northern Florida: Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, Gulf, Franklin, Liberty, Gadsden, Leon, Wakulla, Jefferson, Taylor, Hamilton, Suwannee, Lafayette, Dixie, Levy, Citrus, Sumter, Columbia, Baker, Union, Bradford, Putnam, Clay, Duval and Madison counties.

No limitation exists on the number of pilot projects statewide, nor is there a limitation on the number of projects per county. The Health Flex Plan Pilot Program may only be provided to residents who:

- Are 64 years of age or younger;
- Have a family income equal to or less than 200 percent FPL;
- Are not covered by a private insurance policy and are not eligible for coverage through a public health care program, such as Medicaid or KidCare, and have not been covered at any time during the past 6 months; and
- Have applied for health care coverage through an approved health plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

Health Flex plans are exempt from licensure under the Florida Insurance statutes. The Office of Insurance Regulation and the Agency for Health Care Administration must approve a Health Flex plan application. The review is for the purpose of establishing that consumer protections, actuarial certification of rates, and financial solvency requirements are met. The two agencies have developed an application that is available on the AHCA's Internet site.[35]

The statute authorizing the Health Flex Plan Pilot Program was amended during the 2003 session of the Florida Legislature; Senate Bill 22-A, Conference Committee Amendment. This consisted of two changes:

[35] http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/Health_Flex/index.shtml.

- The Health Flex Plan Pilot Program was extended from an expiration date of July 1, 2004 to July 1, 2008.
- Language was added permitting coverage from a Health Flex Plan Pilot Program to be purchased "through a small business purchasing arrangement sponsored by a local government".

As part of the Agency for Health Care Administration's efforts to launch new Health Flex plans in 2003, four focus groups were conducted in three areas of the state: one each in Miami and Tampa, and two in Panama City. Two of the four focus groups were held with potential Health Flex enrollees to discuss possible product designs, benefit packages and pricing. The remaining two were held to discuss possible marketing approaches for Health Flex offerings and are not discussed in this report. A report encompassing Health Flex and the outcomes from the focus groups is expected to be released by the AHCA in early 2004.

Findings from the focus groups included:

- The concept of the Health Flex program was well received by all participants, although some expressed concern over the 6-month uninsured waiting period, and how pre-existing conditions might be handled. Most agreed that oversight by the State of Florida was a positive attribute of the program, and increased the program's perceived credibility.
- In terms of benefit design, participants want a fairly comprehensive plan that covers physician visits, basic diagnostic tests (especially mammograms), prescription drugs, and in-patient hospital stays. Additionally, hearing, vision, and dental coverage are also important.
- Participants understand and accept co-pays for the services used, and were accepting of large co-pays for therapeutic and diagnostic services, and for brand name prescription drugs. But since health care services, especially for uninsured individuals, are inextricably linked with hospitals and hospital emergency rooms, plans without any inpatient hospital coverage were deemed less than satisfactory. A cap on the number of inpatient days covered was not a barrier to acceptance, although a 5-day cap did raise questions as to whether this was "*enough*".
- Participants also expressed concern about premium prices, and overall, premiums above $100 to $120 per month were considered unaffordable. Most participants were willing to pay up to $100 per month, if the plan benefits provided sufficient value.

Health Flex plans offer an opportunity to test the insurance market for health insurance alternatives that offer a range of coverage options free from Florida's fifty-one mandated benefits (although plans can include one or more mandated benefits at their discretion). Because the plans are not required to provide Florida's mandated benefits, they can offer many types of benefit packages such as primary care and related services without inpatient hospital services. Another benefit option could be limited to catastrophic coverage.

This success of Health Flex plans will depend on a number of factors including:

- The willingness of an entity to offer limited benefit plans;
- The pricing structure of these plans in comparison to plans subject to mandated benefits;
- The willingness of providers to participate in these plans; and
- The willingness of consumers (in this limited market niche) to purchase these plans.

The Agency for Health Care Administration and the Office of Insurance Regulation has approved three applications.

*American Care, Inc*. was the first organization approved to participate in the Health Flex Plan Pilot Program. The approval letter provided an effective date of March 7, 2003. Jose E. Garcia, Jr., MD, is the Chief Executive Officer. This plan serves residents of Miami-Dade County. They applied to be a Health Flex plan as a "Health Care Provider Sponsored Organization". The benefit plan offered by American Care, Inc. covers outpatient services only, including many outpatient surgery components with substantial co-payments and limitations. A full copy of the application and details are available upon request. American Care Inc. was reported by the AHCA to have over a thousand inquiries and 130 enrollees as of November 2003.

*Preferred Medical Plan, Inc.* was the second application approved. Preferred Medical Plan, Inc. has been operating for a number of years in Florida as an HMO, participating in the Medicaid program and with individual plans in the commercial market. They will serve members in Miami-Dade County. As of December 2003, they had 21 enrollees. Preferred is offering a primary care and outpatient benefit plan with limited drug coverage, as well as preventative services such as immunizations and mammograms. As an operating HMO in Miami-Dade County, Preferred had the infrastructure in place for eligibility, claims, marketing, network development, and other key activities.

On December 1, 2003 *JaxCare* became the third plan approved. JaxCare is a public/private partnership that includes many of the groups with which outreach has occurred in other areas. It is a managed system of care countywide in Duval County. JaxCare linked many community groups and providers—existing safety-net providers with private sector providers to complete a countywide network. "The backbone of the network is a secure, internet-based data system that shares information about programs, services and patient need." According to the JaxCare presentations, JaxCare was conceptualized and developed through the "Communities in Charge" grant initiative of The Robert Wood Johnson Foundation. The technological infrastructure was developed through the HRSA Community Access Program (CAP) grants from the DHHS.

The Mayor of Miami-Dade County created a task force to look at ways to provide coverage to the working uninsured. While there are many aspects to the work of that task force, a limited benefit plan to those employed uninsured with incomes under 200 percent FPL via the Health Flex Plan Pilot Program authority is a key component to their current planning process. Additionally, Miami-Dade is looking at the possibility of using the county or other public funds to leverage employee, employer and potentially federal funds to create a public/private partnership to serve the working uninsured. This task force is currently meeting to develop a program. The Miami-Dade Commission has given the go ahead for planning this program. County staff are working on the details for an implementation plan.

## Groups Impacted by Recommendation

Families or individual members of families (including children) and childless adults with incomes under 200 percent FPL are impacted by expansion of Health Flex. The exact number of individuals who are likely to access health insurance through the Health Flex option is difficult to estimate because there is insufficient experience with the program to generate estimates of take-up rates.

The number of individuals potentially eligible for Health Flex plans can be grossly estimated using existing data sources, but must be qualified because:

- Existing estimates of uninsured Floridians are not current, including estimates from the FHIS (1999) and the Kaiser Family Foundation (based on 2001 Census Bureau data). However, an update to the FHIS will be conducted in the first half of 2004. It is likely that levels of uninsurance will be found to have increased as a result of both overall population growth and declines in availability and/or affordability of ESI.

| Income Range | Number of Uninsured Floridians Under Age 65 | |
|---|---|---|
| | FHIS[36] | KFF[37] |
| Under 100% FPL | 527,000 | 912,747 |
| 100 – 150% FPL | 411,000 | 899,368 |
| 151 – 200% FPL | 273,000 | |
| **Total** | **1,211,000** | **1,812,115** |
| Number of children estimated potentially eligible for KidCare[38] | 388,902 | 388,902 |
| **Balance of uninsured with incomes under 200% FPL** | **822,098** | **1,423,213** |

- An increasing number of children are uninsured both as a result of overall population growth and the closure of the KidCare program to new enrollments. If the KidCare program is not restored and expanded, the size of the impacted group will grow.

Therefore, the estimate based on the FHIS, adjusted by children eligible for KidCare likely understates the size of the impacted group. The estimate based on census data from 2001 (Kaiser Family Foundation) is likely more accurate. On the other hand, an unknown portion of individuals seeking access to insurance with incomes under 200 percent FPL are eligible for public programs like Medicaid and KidCare, but have chosen not to enroll in these programs. It is not known if such individuals who might become known when applying for a Health Flex plan, would subsequently enroll in an available public program.

## Considerations

This option reduces the overall number of uninsured by providing low income, uninsured individuals, regardless of employment, with an affordable health care product. However, the extent to which the level of uninsured will be reduced is not known, and additional experience with the program is required to measure the effectiveness of this option. It potentially addresses the issue of rising health care costs by providing access to basic health care services that may reduce the use of costlier inpatient and emergency services. Coverage may be limited, however, depending on the specific benefit package – therefore, individuals with more extensive health care needs may continue to seek non-covered services and will contribute to the cost of uncompensated care. In addition, some Health Flex plans will not protect the enrollee from catastrophic health care expenditures.

The Health Flex program can assist local communities in addressing the uninsurance problem in their respective counties by allowing entities other than licensed insurance companies, such as community organizations and local governments, to pool their resources and design and establish programs for low-income individuals. Furthermore, local programs can implement Health Flex plans by contracting with HMOs and other existing licensed networks. The use of HMOs and other licensed entities provides insolvency protection for the local program and substantially

[36] Duncan et al., *The Florida Health Insurance Study Volume 1: The Telephone Survey January 2000*.
[37] The Kaiser Family Foundation, *State Health Facts Online*.
[38] Institute for Child Health Policy, *Florida KidCare Program Evaluation Report*. January 2003

simplifies implementation, since established networks have the infrastructure required to conduct outreach, enrollment, claims payment and reporting.

Health Flex eligibility requirements (e.g. six-month waiting period following loss or termination of coverage) were designed to discourage employees or employers from dropping existing group coverage. Finally, while Health Flex plan provisions include consumer protections and financial solvency requirements, these requirements do not include all of the consumer protections or long-term solvency requirements of a traditional (fully regulated) insurance benefit plan.

## Funding

Health Flex plans do not require any state funds to operate, although funding for outreach could assist in increasing enrollment.

## III. *Consumer Protection and Information*

A. Healthcare providers and/or private health coverage carriers should ensure consumers have access to information designed to educate them about health insurance coverage and to assist them in making informed health care purchasing decisions and adopting healthy lifestyles. This effort shall be designed to:

1. Strengthen the connection between consumers and physicians;
2. Provide meaningful information to consumers by requiring the availability of:
    a. Standardized policy forms for the individual insurance market, similar to those required in the small employer market, to enable an applicant to make an informed comparison among competing individual carriers;
    b. A "transparency in pricing, cost and quality measures" through the standardized collection of data relevant to elective and high volume procedures, tests, pharmaceuticals and durable medical equipment allowing for an apples-to-apples consumer comparison of hospital and other healthcare provider charges and costs for widespread distribution through various media; and
    c. The amount of reimbursement that will be made by a consumer's benefit plan for any specified service(s);
3. Require the Department of Health (DOH), healthcare providers and health coverage carriers to make available to consumers information about appropriate use of healthcare services and about making appropriate decisions regarding their life style choices and personal healthcare needs; and
4. Utilize licensed agents as frontline educators of consumer protections and contact points for information distribution.

B. Develop appropriate regulations and disclosure requirements specific to the expanding market of "Discount" Cards/Plans dealing with the provision of health care services and prescription drugs in order to protect Floridians from unscrupulous business practices.

C. Remove the +/- 15 percent rate adjustment in the small group market, in order to permit small employers to evaluate and compare coverage proposals from competing small employer carriers.

### Background

In response to double-digit increases in health care premiums, individuals and employers are exploring all avenues to find affordable health insurance. Many people today are so desperate for affordable health insurance, they often fall prey to substandard products.

Consumers need information to determine whether their coverage is legitimate, whether the coverage is being offered by an unauthorized entity, or, whether it is in fact not coverage at all but is actually one of the *health discount programs* being marketed around the state. In addition, consumers are generally unable to fully analyze the differences between different legitimate policies and thus make informed purchase decisions.

Many employers faced with significant rate increases find that if they are able to continue to provide coverage at all, they do so by offering a reduced benefit package to their employees.

This has led most carriers to offer reduced benefit options. Many of these new plans include a high deductible and a fund, which is equal to some percentage of the deductible, controlled by the employee to cover some of his/her share of the costs.

There are many variations of these plans that are generally referred to as consumer driven health plans (CDHPs). Premiums for these plans are lower because of the reduction in benefits. In addition, when consumers are spending their own money they may be more efficient in their use of health care services.

As a result of all of the above, interest in comparative information on price and outcomes continues to grow. Two out of five American healthcare consumers in employer-sponsored health plans are interested in enrolling in these CDHPs that give them more control over when, where and how they spend their health care dollars. Half of them are interested in using the Internet to compare costs for medications, insurance, doctor visits and hospital procedures. Contrary to conventional wisdom, most consumers interested in comparative information are thirty-five years of age or older.[39]

It is important that consumers have enough information to make informed decisions. They will need to be able to:

- Compare health care providers on both fees and outcomes;
- Know the expected charges for services and the amount of reimbursement that will be available from their benefit plan;
- Recognize legitimate benefit plans from among the many "discount cards" and plans available from unauthorized entities;
- Compare products offered by different health insurers and HMOs; and
- Choose appropriate treatment plans.

In addition, consumers need information on items such as physician and hospital experience with specific procedures, rather than more global ratings such as accreditation (although global ratings may provide additional helpful information for the consumer). Recent research has found that specific information such as experience by the surgeon and/or the hospital with specific procedures, compliance with best practices or established protocols, and low mortality rates are associated with improved outcomes. Consumers, according to research by the Foundation for Accountability (FACCT), want easy-to-understand information to help them make decisions about quality of care. Consumers were less likely to choose process[40] measures and instead preferred outcome measures.[41] Physician profiling techniques are available, but many rely on claims to a particular purchaser and thus may not be of sufficient volume to be reliable unless consolidated. Many of the profiling techniques are proprietary and there is no consensus on what should be measured or reported to consumers.

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[39] The Dieringer Research Group and Pareto Health Group, *2003 Consumer-directed Health Care Survey*.
[40] Process measures refer to criteria such as number of screenings, number of surgeries completed, compliance with protocols, etc.
[41] *Consumers and Quality. What do they know? What do they want?* Results from FACCT Consumer Research - 1996-2000. Retrieved January 2, 2004 from the FACCT Website: http://www.facct.org/facct/doclibFiles/documentFile_196.pdf.

Information on healthy lifestyles and clinical guidelines has been developed by a number of national groups, but the impact of this information is dependent on the consumer's ability and willingness to adopt suggested lifestyle changes.

The Leapfrog Group is attempting to address the gap in information, but their work is in the development stage. Consideration has been given to developing ZAGAT type guides (consumer-rated restaurant guides) for physicians and other providers, although ZAGAT is currently being sued as the result of a ZAGAT rating of a restaurant.[42]

One area of increasing concern is the sale of health care discount cards in Florida (and across the nation). These cards typically charge a monthly fee in exchange for discounts that specific health care providers agree to provide to cardholders. Unfortunately, while a reputable discount card does offer the consumer an opportunity to receive "discounted" services and/or medication, these cards are not health care insurance. Because discount cards are unregulated, they also may not deliver the promised discounts, or may mislead consumers to believe they are purchasing health insurance. Unlike health insurance, discount plans do not pay claims. According to the Commonwealth Fund, state regulators report that promoters can use discount plans as a subterfuge in one of two ways: by establishing a discount plan that pays claims and therefore should be subject to state insurance law or by collecting monthly fees without actually negotiating discounts with providers.[43] The Commonwealth Fund report recommends that states prosecute purveyors of fraudulent "insurance" cards aggressively.

> "To improve success rates of criminal prosecutions, state policymakers could strengthen criminal penalties by making it a felony to operate and sell unauthorized health plans. Sentencing guidelines for state judges could help ensure that operators of scams are held accountable through mandatory prison terms".
>
> The Commonwealth Fund Issue Brief, August 2003

Florida currently publishes a consumer guide for HMO products based on client satisfaction and other data. Similar information is not available for other insurance products. Not all measures available for HMOs could be obtained for other products, but the client satisfaction data could be provided.

AHCA collects hospital discharge and other data in the Center for Health Statistics. Hospital report cards were prepared by AHCA for a couple of years. Mortality by selected conditions was risk adjusted. However, there were technical difficulties with the report in terms of the reliability and validity of the measures. Given the numerous categories, the guide was difficult to understand and use, and the report was discontinued. Several other states have issued hospital report cards. There is little consensus on which measures should be used or how to report them. Some hospital providers have developed internal quality monitoring tools that could be adapted to a standardized set of measures. The Florida Hospital Association has expressed support for the collection and dissemination of hospital comparative data.

The Department of Financial Services, Office of Insurance Regulation, publishes basic health insurance guides and frequently asked questions (and answers to frequently asked questions). At the present time, this information is limited to basic descriptions, answers or contact information.

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[42] CNNMoney: *Transvestite eatery sues Zagat. Reuters News Service*. December 25, 2003. Retrieved January 2, 2004 from: http://money.cnn.com/2003/12/24/news/funny/transvestite_suit.reut/.

[43] *Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed.* The Commonwealth Fund, Issue Brief. August 2003. Retrieved January 3, 2004 from the Commonwealth Fund Website: http://www.cmwf.org/programs/insurance/kofman_insurancescams_ib_665.pdf.

Florida's small employer market laws require that every carrier offer an applicant a choice of two standardized benefit plans (Basic and Standard Plans). This requirement not only provides applicants with a basis for comparison between carriers, but also ensures that appropriate levels of coverage are available in the market. Presently there is no similar requirement in the individual market.

Currently, when small businesses apply for insurance in the small group market, carriers are allowed to modify the premiums +/- 15 percent from the premium quotes based on the health status, claims experience or duration of the group. This rating factor was added several years ago as a means of increasing both the number of carriers and the enrollment in the small employer pool. It was based on an old NAIC Model Regulation, which had subsequently been updated and the suggested use of the factor eliminated. To date, the number of carriers in the market has declined slightly and small employer enrollment has dropped significantly.

In addition to not having produced the expected results, this new rating factor prevents small businesses from truly knowing what price they will be paying. Eliminating this provision would require the quote to be precise and not subject to any increases, so the small business purchaser would know the exact price of the insurance the business is purchasing.

Consumers generally have no information about the charges for health care services or the amount of reimbursement that will be provided by their carrier until well after treatment takes place. Many attribute a high percentage of personal bankruptcies resulting from insured individuals medical bills to this fact.

In addition, many workers' compensation hospital based out-patient services and in-patient services with charges over $50,000 are paid as a percentage of charges, but self-insured employers and carriers who must pay these bills do not have access to the charge information until after services are rendered. Finally, the Three Member Panel, which by statute (s. 440.13(12), F.S.), must annually set reimbursement levels for all services, does not have access to the charge information either.

## Groups Impacted

All of Florida's citizens are negatively impacted by the lack of comparative information, including both individual consumers and employers who must make business decisions that will affect their bottom line and their employees.

## Considerations

Access to relevant and usable information will enable consumers to make more informed and cost-effective decisions concerning their health care purchasing and help control overall health care costs and insurance premiums. In addition, providers may be encouraged to improve their quality of care if information concerning their practice and outcomes is readily available to the public. California recently passed legislation requiring the disclosure of hospital charge masters.

Some consumer information concerning healthy lifestyles has been developed at the national level and could be made more accessible with a limited investment of resources. Development of new information will require extensive efforts to develop criteria that are agreed to by stakeholders and relevant to consumers.

Obtaining consensus on provider quality measures for the development of consumer information is difficult. Development of new guidelines is costly and takes time. The cost to providers is

higher if everyone has different standards. Development costs would be less if providers joined with national groups. Consumer acceptance is slow and results manifest over the long-term.

There might also be costs that would be borne by providers to gather and report additional information.

Information and standards must be updated on a regular basis.

## Funding

There may be some costs associated with implementing and administering this recommendation that will be incurred by the OIR.

## IV. *Local Initiatives*

Encourage the development of local health care programs for individuals lacking health insurance, in order to provide for the development and expansion of local health care solutions, where such solutions do not negatively impact the traditional insurance market and are not in conflict with insurance code, except as provided by statute (i.e., Health Flex). Specific provisions should support:

A. Increased networking of local communities;

B. Local grants for start-up funds;

C. Creation of public/private partnerships; and

D. The development of new seed money sources, including increased levels of local tax initiative only by referendum and targeted specifically to healthcare issues.

### Background

A number of communities in Florida have designed and implemented coverage models to provide care for the uninsured population in their geographic regions. Some local initiatives can use local taxing authority authorized by Section 212.055(4) Florida Statutes to fund their programs. This section of statute provides the authority for non-consolidated counties with a total population of 800,000 or more to levy the Indigent Care and Trauma Center Surtax at a rate of up to 0.5 percent. This surtax may be imposed by either an extraordinary vote of the county's governing body or voter approval in a countywide referendum. The surtax proceeds are to be used for providing health care services for both indigent persons and the medically poor, including, but not limited to, primary care and preventive care as well as hospital care. This surtax is one of several surtaxes subject to a combined rate limitation. A county eligible to levy this surtax may not levy it along with the Local Government Infrastructure Surtax and/or Small County Surtax in excess of a combined rate of 1 percent. The Indigent Care and Trauma Center Surtax is scheduled for repeal on October 1, 2005.

The following counties are eligible to levy this surtax: Broward, Hillsborough, Palm Beach, and Pinellas. Miami-Dade County is eligible to levy the tax but cannot do so because their existing authority to levy the County Public Hospital Surtax if combined with an Indigent Care and Trauma Center Surtax would exceed the combined rate limitation.

*Palm Beach County* has developed a health care initiative for its indigent residents based on its hospital taxing district status. The hospital district has established a Coordinated Care Program, which is a managed care program for eligible county residents who do not receive or cannot afford health insurance. To be eligible for enrollment in the Health Care District's Coordinated Care Program, applicants must meet basic eligibility criteria by providing documentation for the following:

- Proof of Palm Beach County residency;
- Personal identification;
- Income; and
- Assets.

Qualifying applicants must have an income equal to or less than 150 percent FPL and assets of $5,000 or less for an individual, or $6,000 or less for a family. Three options are available:

- Full Services: Hospitalization, Primary Care, Dental, Prescription Drugs;
- Clinic and Pharmacy: Primary Care, Dental, Prescription Drugs; or
- Pharmacy Only: Prescription Drugs.

*Hillsborough County HealthCare Program* provides comprehensive primary and preventive services to low-income (under 100 percent FPL) residents of Hillsborough County who do not have health care coverage. Hillsborough HealthCare has four networks providing primary care at several clinics strategically located in the county. There are hundreds of participating referral specialists in the networks, as well as a full array of diagnostic and hospital services. Hillsborough HealthCare also covers prescriptions, vision, dental, home health and other medically necessary services. In some cases, citizens with income over 100 percent of the poverty level and no other coverage can qualify under a Medical Crisis Intervention (MCI) Program, with co-payments required based on their income. MCI cases are approved for those conditions that are expensive to treat either because of the severity or the chronicity of the medical condition.

Older citizens who have Medicare, but are within the poverty guidelines, may qualify for limited assistance with items that Medicare does not cover, such as prescriptions and eyeglasses. There are no premium payments for Hillsborough HealthCare; however, there are some member co-payments for certain services such as dental care and eyeglasses. MCI plans have co-payments for services starting at $5, depending on a member's income.

Hillsborough County began collecting a half-cent sales tax along with $26.8 million per year in property taxes as mandated by the State of Florida to fund the program in 1992, and reduced the sales tax to a quarter-cent in 1997. The Hillsborough County Healthcare Program reported serving 31,000 county residents as of November 2003 and more than 70 percent of members have been participating in the program for less than one year. Less than 30 percent of plan members are unemployed. Hillsborough County reports the program has:

- Reduced per-member per-month costs from $600 to $260;
- Reduced the average length of a hospital stay from 10.2 days to 5.1 days;
- Saved more than $10 million in emergency room care;
- Saved more than $90 million in medical expenses; and
- Reached $50 million in annual savings to the county in 2003.[44]

*Miami-Dade County* is in the process of developing a public/private partnership program to make health care coverage available to the working uninsured employed by small businesses. The source of funding is expected to be a combination of funds from the county, employer, employee and provider donations. The program is expected to make coverage available through a Health Flex plan offeror.

The *Memorial Healthcare System* in Broward County has developed a comprehensive health care program for uninsured county residents. The system provides access to primary care, medications, specialist care and hospital services using a sliding fee scale. Individuals with incomes under 200 percent FPL pay a "minimal cost." The Memorial Healthcare System reports

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[44] *Hillsborough Health Care Program.* Hillsborough County Internet site located at: http://www.hillsboroughcounty.org/health_ss/dhc.html.

substantially improved outcomes for participants, including 95 to 100 percent compliance with established health care measures such as completion of childhood immunizations, access to prenatal care and routine screenings (including mammograms, pap tests and diabetic testing). The program is funded by local tax revenues and cost sharing.[45] The Memorial Healthcare System reports provision of 97.5 percent of all uncompensated care in South Broward County, amounting to $100 million in care annually.[46]

*JaxCare* is a public/private partnership designed to provide a county-wide managed system of care in Duval County. According to JaxCare, the program combines the existing safety-net provider services with private sector physicians, hospitals and other health care providers to create a countywide, managed, healthcare network for the uninsured. The backbone of the network is a secure, Internet-based data system that shares information about programs, services and patient needs. This information system allows JaxCare to connect its uninsured workforce with the least costly and most appropriate health care services in Jacksonville.[47]

Volunteer programs exist in many counties and municipalities in Florida. A number of communities, such as Duval, Leon, and Alachua Counties, operate "We Care" programs designed to link uninsured individuals in need of specific health care services with physicians, hospitals and other service providers who donate their time to provide care. These programs are generally operated under the auspices of the local medical society and are a resource for the local health department. Alachua County's "We Care" Program has been operating for more than thirteen years. In 2000, the Alachua County Medical Society reported the cumulative total of volunteer medical and dental services provided over a ten-year period exceeded $12.5 million. In 1998, the Primary Care Component of the program provided almost $400,000 in volunteer medical services to Alachua County residents.[48]

Other volunteer efforts include programs like Lakeland Volunteers in Medicine (LVIM), which began as a project of the Watson Clinic Foundation. LVIM is a free clinic offering high-quality healthcare to the working uninsured of Lakeland, FL. The clinic operates from donations of professional services by physicians and other providers, volunteer hours contributed by over 400 community members, and financial contributions. In 1999, $7.4 million was raised in gifts, in-kind contributions, pledges and grant expectancies to support the clinic. The clinic serves uninsured residents of the greater Lakeland area with incomes up to 150 percent FPL.[49]

These local initiatives provide health care services to address the needs of the diverse populations in their communities, including the linguistic and cultural diversities of the communities. Many of these initiatives form collaborative efforts with Health Care Taxing Districts and safety-net providers, such as Federally Qualified Health Centers (FQHC) and Rural

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[45] Benz, John. *Presentation to the Governor's Task Force on Access to Affordable Health Insurance*. South Broward Hospital District. December 17, 2003. Available online at: http://www.fdhc.state.fl.us/affordable_health_insurance/121703_meeting/memorial_healthcare_system_121703(benz).pdf.

[46] *Ibid*.

[47] Davis Poirier, Rhonda. *What is JaxCare?* Presentation to the Governor's Task Force on Access to Affordable Health Insurance. December 3, 2003. Available online at: http://www.fdhc.state.fl.us/affordable_health_insurance/120303_meeting/jaxcare_handout_120303(poirier).pdf.

[48] *We Care Physician Referral Network,* Alachua County Medical Society. http://www.acms.net/about.asp?page_id=4&n=4.

[49] Yates, Robert. *Case for Support, Lakeland Volunteers In Medicine.* Presentation to the Governor's Task Force on Access to Affordable Health Insurance. November 17, 2003. Available online at: http://www.fdhc.state.fl.us/affordable_health_insurance/111703_meeting/case_for_support.pdf.

Health Clinics (RHC). These collaborative efforts seek to enhance and sustain their programs by leveraging local government, private, and not-for-profit financing mechanisms with federal grants and waivers. While these initiatives provide essential health care services to uninsured individuals, they do not provide access to health insurance and therefore do not reduce the number of uninsured.

However, local initiatives can provide access to health care coverage through three vehicles, two of which are currently available (KidCare and Health Flex):

- Counties can contribute funding (or increase their current contributions) to the KidCare program, thereby making health insurance available to the community's uninsured children residing in families with incomes below 200 percent FPL.
- Counties can become a Health Flex plan or can contract with a Health Flex plan to provide access to health insurance in their community.
- Counties could potentially be included in a Section 1115 waiver submission (including a Health Insurance and Flexibility Act (HIFA waiver) to provide health insurance, either through a waiver expansion benefit plan and/or through premium subsidies, and would leverage federal funds for the county contribution.

## Groups Impacted by the Recommendation

Families or individual members of families (including children), and childless adults with incomes under an amount specified by the local communities are impacted by expansion of local initiatives. In general, local initiatives target individuals with incomes below 150 percent or below 200 percent FPL. If these initiatives were included in a Health Insurance and Flexibility Act (HIFA) waiver, the income limit is required to be uniform on a statewide basis.

## Considerations

Local initiatives help maintain access to health care for the uninsured and are part of Florida's "safety-net". Local initiatives empower local communities and encourage the communities to be responsible and accountable for their uninsured residents. These initiatives offer a number of advantages over statewide public programs (although they could be incorporated into a carefully crafted statewide public program and retain many of these advantages), including:

- They may be perceived as less bureaucratic and be free of the stigmas of state "welfare" programs.
- They can generate funds from a number of sources such as gifts, grants and in-kind donations although a source of recurring revenue is essential.
- Individuals may be more supportive of contributing funds, including tax dollars, to programs where they can see the impact of their money on a more personal basis.

Local initiatives, while valuable resources for their communities, can contribute to a fragmented system of coverage expansion for the uninsured. If a local initiative fails, there may be pressure from the community (or even an expectation) for the State to assume support for the program. In addition, some local initiatives offer health care services that are less than comprehensive and may not reduce the need for high-cost uncompensated care. Finally, local initiatives do not generally offer access to health insurance and do not reduce the number of uninsured (although they do reduce the number of individuals who do not have access to health care services).

## Funding

Local initiatives do not impact Florida's budget. Funding opportunities could be provided through a combination of local, federal and private revenue sources.

## V. *Evidence-Based Medicine*

Promote initiatives that increase the use of evidence-based medicine by physicians and health care institutions. Priority should be given to initiatives that improve the quality of health care and provide for a more efficient and effective delivery system. Specific options include:

A. Explore joining or supporting efforts already underway, such as those of the Leapfrog Group, the international group Bandolier, and the Healthy Florida Foundation;

B. Promote university or medical school based research utilizing Medicaid and other data collected by the AHCA to identify and quantify the most cost effective treatment and interventions, including disease management programs;

C. Encourage development of systems to measure and reward providers who implement evidence-based medical practices;

D. Evaluate and identify ways to tie a health care provider's use of evidence-based medical practice to medical malpractice liability;

E. Routinely review other state and private initiatives and published literature for promising approaches and disseminate information about them to providers; and

F. Encourage the Florida Medical Association and other health care associations to regularly publish findings related to the cost-effectiveness of disease specific evidence-based standards.

### Background

Evidence-based medicine is an explicit approach to problem solving and continual professional learning, which requires the use of current best evidence in making medical decisions about individual patients. To achieve evidence-informed decisions, the health practitioner evaluates published literature and grades trials to form clinical recommendations. This process can include:

- Development of a focused clinical question concerning the patient's problem(s);
- Searching of secondary databases and the primary literature for relevant articles;
- Assessment of the validity and usefulness of those articles;
- Judgement concerning the relevance to the individual patient; and
- Implementation of the findings in patient care.[50]

In order for physicians, health care providers and patients to apply evidence-based medicine to individual health care needs, a variety of resources have been developed, including:

- Systematic Reviews/Meta-Analyses;
- Critically Appraised Topics (e.g., *ACP Journal Club*);
- Practice Guidelines;

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[50] *About the Evidence-based Medicine Resource Center*, Retrieved December 31, 2003 from the New York Academy of Medicine in partnership with the American College of Physicians, New York Chapter.
Evidence-based Medicine Working Group Website: http://www.ebmny.org/.

- Evaluated Bibliographic Databases (e.g., Cochrane Library);
- Consensus Development Reports;
- Decision Analyses; and
- Patient Education/Decision Tools.[51]

Using current evidence, disease management programs for certain chronic illnesses have been designed and implemented by large HMOs such as Kaiser Permanente, and public health and insurance programs, including the Florida Medicaid program. Disease management (DM) is an integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

- Identifying and proactively monitoring high-risk populations;
- Educating patients about their conditions;
- Helping patients and providers adhere to evidence-based treatment protocols;
- Promoting provider coordination; and
- Preventing avoidable medical complications.

DM focuses on the chronically ill, who account for a disproportionately large percentage of all medical expenditures. Twenty-one of the fifty states have implemented one or more DM programs as part of their Medicaid programs, and the federal government has demonstration projects underway to determine the potential efficacy of DM for Medicare enrollees. In Florida, proviso language included in the FY 1997-98 General Appropriations Act (GAA) authorized the AHCA to implement a disease management initiative for asthma, diabetes, HIV/AIDS, and hemophilia. Additional DM programs were authorized in 1998-1999 for hypertension, cancer, heart disease, end-stage renal disease and sickle cell disease. The anticipated savings from these programs was $112.7 million, although these savings have not yet been realized.[54]

**Florida Disease Management (DM) program Enrollment[53]**

| Disease State | Beneficiaries | Providers |
|---|---|---|
| HIV/AIDS | 5,106 | 845 |
| Hemophilia | 93 | 43 |
| Renal disease | 2,712 | 1,153 |
| Congestive Heart Failure | 4,757 | 1,377 |
| Diabetes | 13,791 | 1,951 |
| Asthma | 30,692 | 2,133 |
| Hypertension | 24,436 | 2,174 |
| **Total** | **81,587** | |

Florida Medicaid has experienced success with disease management in controlling costs and is considered an innovator in disease management. In January 2003, the AHCA reported savings of over $6 million over a two-year period for the HIV/AIDS

[51] *Evidence-based Medicine – Finding the Best Clinical Literature*, Retrieved December 31, 2003 from the University of Illinois at Chicago, Library of the Health Sciences Peoria Website: http://www.uic.edu/depts/lib/lhsp/resources/ebm.shtml.
[52] *About the Evidence-based Medicine Resource Center*. Retrieved December 31, 2003 from the New York Academy of Medicine in partnership with the American College of Physicians, New York Chapter. Evidence-based Medicine Working Group Website: http://www.ebmny.org/.
[53] *Disease Management*, Presentation to the Senate Appropriations Subcommittee on Health and Human Services, January 15, 2003 by the Florida AHCA. Retrieved December 31, 2003 from the AHCA Website at: http://www.fdhc.state.fl.us/Medicaid/deputy_secretary/recent_presentations/index.shtml.
[54] *Disease Management*, Presentation to the Senate Appropriations Subcommittee on Health and Human Services, January 15, 2003 by the Florida AHCA. http://www.fdhc.state.fl.us/Medicaid/deputy_secretary/recent_presentations/disease_management_011503.pdf.

DM program, and over $3.5 million for the renal disease DM program.[55] Total savings to date have been over $10.5 million, a fraction of the $112.7 million projected cost savings. Savings have been limited in part by the limited duration of some of the DM programs, and should improve over time. In addition, it appears that programs characterized by very high-cost disease states on a per recipient basis, such as HIV/AIDS and renal disease, yield greater savings than other programs where some or many individuals may have less severe medical conditions.

Disease Management programs are still in their infancy and face the following challenges:

- **Silo Effect.** DM can increase complexity and fragmentation in the delivery system by focusing on a single disease.
- **Co-morbidities.** Although many DM vendors are now able to address more than one disease (e.g., asthma, diabetes, and congestive heart failure), they are still unable to address other co-morbidities, such as mental health conditions and cancer. Many would prefer to see a whole-body approach to chronic care management.
- **Delayed savings.** DM programs require an up-front investment in added care services; savings generally accrue over the longer term. Recent research indicates that it may take up to 10 years before savings from disease management for diabetic patients may be realized.
- **Demonstrated savings.** Because of the challenges associated with projecting health care spending, conflicts have arisen about the true extent of DM savings. However, recent evidence supports cost-savings associated with DM for specific disease states. In September 2003, American Healthways (a DM company) announced that a disease management program for 17 chronic conditions, administered for Blue Cross Blue Shield of Minnesota since 2001, has produced a projected reduction in health care spending of about 2 percent to 3 percent for fully insured, commercial plan sponsors. The plan measured a 14 percent cut in hospital admissions and an 18 percent reduction in emergency department visits for the 130,000 patients in the program.[56]
- **Pharmaceutical interests.** DM is seen by some as a vehicle for pharmaceutical manufacturers to sell more drugs. Pharmaceutical interests have provided seed money for a number of state DM programs.
- **Physician participation.** Provider participation in these programs varies widely (primarily due to the emphasis on adherence to evidence-based protocols).

Other initiatives that facilitate the use of, or contribute to, evidence-based medicine include telemedicine, nurse triage lines and evidence-based medical practice information dissemination programs.

*Telemedicine*

Savings may be obtained by providing specialist services and other services to rural residents via telemedicine. For example, a diabetic's eyes can be examined using a special machine during a routine office visit and the results transmitted to a specialist for review without the necessity for a separate appointment with the specialist. Almost half of state Medicaid programs reimburse

[55] *Disease Management*, Presentation to the Senate Appropriations Subcommittee on Health and Human Services.
[56] Kazel, Robert. *Evidence still out on disease management as cost saver*. *American Medical News* Oct. 27, 2003. Retrieved December 31, 2003. Available from: http://www.ama-assn.org/amednews/2003/10/27/bisb1027.htm.

specialists for telemedicine consultations. Medicare has developed a telemedicine fee schedule. Results are mixed regarding cost savings outside of rural areas.

*Nurse Triage Lines*
Nurse triage lines allow individuals to call a nurse and receive health care advice. Often individuals can be diverted from emergency room use and appointments scheduled with the appropriate provider resulting in potential cost-savings. A study of nurse triage lines conducted from 2000 to 2001 evaluated the medical and financial impact of this line on ER and clinic use at a military hospital. The study results included a reported annual cost savings of $318,123.[57]

*Evidence-Based Medical Practice Information Dissemination Programs*
One of the most successful efforts to disseminate evidence-based medical practice information is being implemented by the Leapfrog Group. The Leapfrog Group works with medical experts throughout the country to identify problems and propose solutions designed to improve hospital systems that could break down and harm patients. Leapfrog was founded by the Business Roundtable in 2000 and has 145 members (120 are Fortune 500 corporations). The Leapfrog Group states:

> "[Leapfrog] was created to help save lives and reduce preventable medical mistakes by mobilizing employer purchasing power to initiate breakthrough improvements in the safety of health care and by giving consumers information to make more informed hospital choices. It is a voluntary program aimed at mobilizing large purchasers to alert the healthcare industry that big leaps in patient safety and customer value will be recognized and rewarded with preferential use and other intensified market reinforcements."[58]

At present, the following three initiatives are targeted, and Leapfrog is in the process of obtaining comments on a fourth.

- Computerized Physician Order Entry (CPOE): Reduces serious prescribing errors by more than 50 percent.
- Staffing Intensive Care Units with Trained Specialists (Intensivists): Reduces the risk of patients dying in the ICU by more than 10 percent.
- Evidenced-based Hospital Referral: Appropriate referrals for high-risk procedures and conditions could reduce a patient's risk of dying by at least 30 percent.[59]

Leapfrog has twenty-two rollout regions including the Atlanta, California, Central Florida, Colorado, Dallas-Forth Worth, Maine, Massachusetts, Metropolitan New York, Michigan, Minnesota. Overall, nearly 40 percent of all regional rollout hospitals have implemented at least one of Leapfrog's recommended patient safety practices. Computerized Physician Order Entry (CPOE) has been implemented in 4.1 percent of the regional rollout hospitals and 17.2 percent plan to implement it by 2005. Of the regional rollout hospitals with ICUs, 22.3 percent have fully

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[57] O'Rourke, Kathleen M. *Using a nursing triage line to schedule ER and clinic appointments in a military managed care setting: Is it cost-effective?* American Public Health Association Abstract #40248. November 2002. Retrieved December 31, 2003 from the APHA Website: http://apha.confex.com/apha/130am/techprogram/paper_40248.htm.
[58] *The Leapfrog Group – About Us.* Retrieved December 31, 2003 from the Leapfrog Website: http://www.leapfroggroup.org/about.htm.
[59] *The Leapfrog Group – Fact Sheets*. Retrieved December 31, 2003 from the Leapfrog Website: http://www.leapfroggroup.org/FactSheets.htm.

implemented ICU physician staffing with intensivists and 4.8 percent plan to implement it by 2004. Leapfrog reports that adoption of its practices and products are also now occurring outside of the rollout area.[60]

Bandolier is a print and Internet journal published by Oxford University (London) about health care, using evidence-based medicine techniques to provide advice about particular treatments or diseases for healthcare professionals and consumers. The content is 'tertiary' publishing, distilling the information from (secondary) reviews of (primary) trials and making it comprehensible. Bandolier began publication in 1994 and initiated free, full text Internet access to materials in 1995. Bandolier was initially funded by the British National Health Service, but funding ended in 2002. Sponsorship and free hosting by Oxford University now support the publication

Bandolier maintains a monthly journal encompassing a wide array of topics, a pain site and a knowledge base of research articles. Bandolier periodically publishes compilations of evidence-based research. For example, Bandolier has published *Bandolier's Little Book of Pain,* a portable guide to evidence-based pain treatments. For each possible treatment, the book provides the evidence supporting the efficacy of the treatment, along with a clinical bottom line, for those requiring immediate information.[61]

While evidence-based medicine is not systematically utilized in clinical practice at present, national efforts are underway to inform health care leaders. For example, the Robert Wood Johnson Foundation is working with the National Health Care Purchasing Initiative to educate 300 top executives in Medicare, Medicaid, and Fortune 500 companies who are collectively responsible for administering $600 million in health care expenditures annually (55 percent of the U.S. total). The Foundation has targeted payors as an important group because they set standards and expectations for care.[62]

Development of guidelines at the state level is expensive and time consuming. The AHCA published some practice guidelines in the 1990s based on medical evidence. However, the development of practice guidelines is difficult as the evidence base is incomplete (for example, many new drugs are not tested against older or alternative drugs) and advances in medicine can occur rapidly. New drugs, technology advances and changes in practice exacerbate the problem of keeping the standards current. More could be accomplished in this area if other purchasers or states worked together.

The use of evidence-based medicine has been demonstrated to reduce the cost of care for individuals with certain high-cost conditions such as HIV/AIDS and renal disease, but has been less conclusive for other conditions.[63] The provision of clinical guidelines to consumers offers the potential for beneficial outcomes, including reductions in cost, with limited investment. Broader adoption of evidence-based guidelines and related practices can assist in reducing the overall cost of health care and the cost of health care insurance.

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[60] *October 13, 2003 News.* Retrieved December 31, 2003 from the Leapfrog Website: http://www.leapfroggroup.org/LeapfrogRelease101403.pdf.

[61] *About Bandolier* and *Bandolier's Little Book of Pain, Bandolier*. Retrieved from the Bandolier Website January 3, 2004. http://www.jr2.ox.ac.uk/bandolier/.

[62] *Better Health Outcomes Possible Using Evidence-Based Medicine*, Advances, Issue 2, 2000. The Robert Wood Johnson Foundation, Retrieved January 3, 2004 from the the RWJ Website: http://www.rwjf.org/publications/publicationsPdfs/Advances_2000_Issue_2.pdf.

[63] *Disease Management*, Presentation to the Senate Appropriations Subcommittee on Health and Human Services.

## Funding

It is difficult to estimate the cost or feasibility of promoting the use of evidence-based medicine, especially with the goal of widespread adoption by health care providers. The greatest promise for widespread adoption is likely the use of a three–fold approach:

- Appealing to a health care provider's desire to achieve greater "success" in treatment;
- Appealing to the scientific base from which the health care profession originates; and
- Demonstrating the financial benefit to providers and, ultimately, consumers.

The infrastructure necessary to implement evidence-based medicine in Florida does not currently exist and will require commitment from the medical community and the Legislature to develop and fund.

## VI. *Utilization of Electronic Health Care Information*

Encourage the development of electronic medical records (EMRs) by providing financial incentives and promoting the use of digital technology and information systems, including;

A. Supporting Florida-based universities' efforts to obtain grants to test or facilitate adoption of electronic medical records such as those endorsed by the American Academy of Family Physicians;

B. Promoting the use of electronic medical records that allow for the capture of patient clinical data and that facilitate and allow all caregivers and receivers to share medical records and access clinical information;

C. Ensuring that state medical school and continuing education programs include training on use of the Internet and electronic aids, such as personal data assistants (PDAs), in physician offices and other health care settings to access evidence-based medicine research findings;

D. Continuing efforts like Florida Medicaid's current initiative to facilitate physician adoption of electronic prescribing using a patient care system that provides point-of-care, patient-specific medication history and comprehensive drug information and interaction reports, integrated with Medicaid's Preferred Drug List; and

E. Encouraging all providers to submit claims electronically.

### Background

Some countries utilize a unified electronic medical record with web-based access by consumers and other individuals authorized to view the record by the consumer. Utilization of an EMR is more common in countries with national health systems, when such systems require use as a condition of payment. In addition, use in a single-payer system is easier because of the uniform format and reporting requirements. While the United States has a more administratively complex medical system than countries that require the use of EMR, this is not the sole reason that EMRs are still in their infancy in the U.S. A recent Medscape article references the lack of a coordinated national effort to identify the required components of the EMR or to provide adequate incentives for its use as important explanations for limited use in the U.S.[64] The article also notes that the American Academy of Family Physicians (AAFP) is leading an effort to form a public-private consortium with a goal of distributing and maintaining an open-source EMR.

Application of information technology has been identified by the Institute of Medicine as one of the principal ways to improve the quality of health care. The Leapfrog Group is considering making use of outpatient electronic medical records its next standard for health care purchasing contracts. In several other countries, use of electronic medical records ranges from 50% to 90%. In the United States only about 7% of physicians use EMRs and cost is often cited as the primary barrier to wider use. A cost-benefit study of the use of EMRs in primary care settings found an estimated net benefit from using an electronic medical record for a 5-year period was $86,400 per provider. Benefits accrue primarily from savings in drug expenditures, improved utilization of radiology tests, better capture of charges, and decreased billing errors. The net benefit varied

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[64] Reider, Jacob MD, *The Electronic Medical Record: Promises and Pitfalls*. Posted August 25, 2003, retrieved December 31, 2003 from the Medscape General Medicine Website: http://www.medscape.com/viewarticle/460247.

from a low of $8,400 to a high of $140,100. A five-way sensitivity analysis with the most pessimistic and optimistic assumptions showed results ranging from a $2,300 net cost to a $330,900 net benefit.[65]

The desire to leverage information technology to facilitate more efficient and effective provision of healthcare is gathering momentum at both the state and national levels. The December 17, 2003 report of Preliminary Findings from the Healthy Florida Foundation chaired by former Congressman Bill McCollum, includes the development of EMRs and the promotion of information systems as Recommendation 1. Furthermore, the recommendation calls for the establishment of a universal electronic medical record system in the State of Florida within five years.[66]

At the national level, Senator Hillary Clinton announced a five-point health care proposal January 12, 2004 to:

1. Increase research on quality of care;
2. Provide the public with a standardized reporting system that allows consumers to reliably compare performance;
3. Build an information technology infrastructure that enables information sharing;
4. Give patients and providers information in real time; and
5. Pay for performance. [67]

The plan includes the establishment of voluntary "interoperability standards" to ensure that different hospital and physician systems can talk to each other, exchange electronic health records, and reduce paperwork.

While implementation is extremely limited, some physicians believe that once adopted, EMRs become essential parts of a medical practice.

> "Electronic medical records (EMR), for those of us who have adopted them, have made practice so much more rewarding and efficient that it is hard to contemplate returning to paper charting. Like other modern tools that have become indispensable - the cell phone, fax machine, or e-mail -once we have started using them, we don't want to give them up."[68]

Electronic health care information initiatives continue to be developed and have become more widely available with increased use of PDAs. The Leapfrog Group is currently developing and testing its Physician Office Clinical Decision Support proposal (PODS). PODS has 3 components:

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[65] Wang, Samual et al. *A Cost-Benefit Analysis of Electronic Medical Records in Primary Care.* The American Journal of Medicine. April 1, 2003. [Retrieved January 13, 2004]. http://www.brighamandwomens.org/gms/News/WangEMRCostBenefit.pdf.

[66] The Healthy Florida Foundation. *Preliminary Findings*. [December 17, 2003. Retrieved January 13, 2004]. http://www.healthyfloridafoundation.org/resources/hff-prelim-findings.pdf.

[67] *Senator Clinton Offers Proposal to Improve Health Care for All Americans*. January 12, 2004 Press Release from the Office of Senator Hilary Rodham Clinton. http://clinton.senate.gov/~clinton/news/2004/2004112649.html.

[68] Avitzur, Orly. *Electronic Medical Records – How Neurologists Go Paperless.American.* Academy of Neurology. Volume 2, Number 5, May 2002. [Retrieved January 13, 2004]. http://www.medsystechnologies.com/Medsys_neuro_today.pdf.

- e-prescribing that provides decision support based on drug reference information and patient specific information;
- e-lab results - a system that tracks whether lab results have been viewed and communicated to the patient and acts as a warehouse to store and retrieve them; and
- e-care reminders - an electronic system linked to a set of nationally recognized care guidelines that will generate periodic reports on care performance and signal deficiencies during patient contacts.

Leapfrog has twenty-two rollout regions for its products including Atlanta, California, Central Florida, Colorado, Dallas-Forth Worth, Maine, Massachusetts, Metropolitan New York, Michigan, Minnesota. Overall, nearly 40 percent of all regional rollout hospitals have implemented at least one of Leapfrog's recommended patient safety practices. Computerized Physician Order Entry (CPOE) has been implemented in 4.1 percent of the regional rollout hospitals and 17.2 percent plan to implement it by 2005.

Electronic claims processing is in use by many providers, but there are no federal or state requirements that providers file claims electronically. While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the use of a uniform format for electronic claims submission nationwide (effective October 13, 2003), it does not mandate submission of claims electronically. The Florida Medicaid program provides free software and training to encourage the submission of claims electronically. Between eighty-five and ninety percent of claims are submitted in this manner. Smaller providers such as individual physicians and case managers generally account for the majority of paper claims.

## Groups Impacted by Recommendations

The utilization of electronic health care information has the potential to impact all consumers, all health care providers and the systems and agencies that regulate or deliver health care services.

## Considerations

While there is much interest in the use of EMRs and other applications of information technology to health care provision, the complexity of the existing health care system, especially the use of multiple payors, is likely to continue to challenge widespread adoption. However, as health care providers and insurers better understand and experience the benefits of technology, especially cost-savings coupled with the potential for improved outcomes, it is likely that efforts to develop standards and applications will gain momentum.

Protecting the privacy of Protected Health Information (PHI) is an important issue that must be considered in the context of this recommendation. Along with the goal of making health records readily accessible to those heath care providers who are seeing the patient, appropriate safeguards are required to prevent these records from being used to deny care or prevent insurance coverage. While the basic privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) would apply to these and all health records, it may be necessary to further increase consumer protections to ensure insurance coverage is not inappropriately denied.

Electronic claims submission requires authorizing legislation. Electronic claims submission can be facilitated by the provision of technical assistance to small providers.

## Funding

It is difficult to estimate the cost of promoting the use of electronic medical records. There are at present no uniform guidelines, standards or definitions regarding what constitutes an EMR and the extent to which an EMR should be maintained and accessed. The implementation of EMR requirements in Florida requires commitment from the medical community and the Legislature to develop and fund.

Implementation of a requirement that claims be submitted electronically does not require State funding.

## VII. *Medicaid Restructuring*

Focusing on federal Health Insurance Flexibility and Accountability (HIFA) waivers, explore a comprehensive plan to restructure the Medicaid program to improve access to health care coverage for Florida residents, subject to budget neutrality requirements imposed by federal regulations, sensitive to the local needs of each community. This plan may address:

A. The benefit array;

B. Cost sharing requirements;

C. Cost-effective delivery systems;

D. Coordination with employer-sponsored insurance;

E. Additional measures to enhance the cost effective administration of the program; and

F. Continued efforts to reduce fraud and abuse.

## Background

*Authority and Funding*

The Medicaid program was established in 1965 under the authority of Title XIX of the Social Security Act. Title XIX permits states to make medical assistance available to individuals and families with low incomes and resources, and is jointly funded by state and federal dollars. States participate in Medicaid because they can share the cost of providing health care services to eligible individuals with the federal government. Florida implemented its Medicaid program on January 1, 1970.

The proportion of funding provided by the federal government varies by state based on a comparison of the state's median income level to the national median income level. Generally, states with more "poor" families receive a higher matching rate from the federal government. The federal government never contributes less than fifty percent or more than seventy-eight percent of the dollars spent on Medicaid services in any state, regardless of the median income level.

Florida's matching rate for 2003 is approximately fifty-nine percent. At present, for every dollar in Medicaid services expended in Florida, the state funds forty-one cents and the federal government fifty-nine cents. In 2002, Florida served over two million Floridians and expenditures were almost $10 billion, making Florida's Medicaid program the fourth largest in the nation based on enrollment and the fifth largest based on total expenditures. In terms of per beneficiary spending, Florida was forty-sixth of fifty states and Washington, D.C. in 2002.[69] Expenditures in FY 2003-04 are budgeted at $12.7 billion.

*Coverage Requirements*

Each state must cover mandatory eligibles (such as low-income families with children and low-income individuals with disabilities) and mandatory services (such as physician, inpatient hospital and skilled nursing facility services) in order to participate in the Medicaid program. Florida also includes an array of optional eligibility groups and services in its Medicaid program. For example, Florida covers the optional eligibility groups "aged, blind and disabled" and the

[69] Based on information from The Kaiser Family Foundation State Health Facts Online data.

"medically needy" and includes optional services such as prescribed medications, durable medical equipment, and skilled nursing care. Florida has consistently expanded Medicaid eligibility for children, and through the combination of Medicaid and the Healthy Kids program, provides access to health insurance for children residing in families who have incomes up to 200 percent FPL.

Florida provides limited access to public health insurance to adults, primarily covering very low-income parents, low-income elders and the disabled. Parents with incomes above 24 percent of FPL and childless adults (regardless of income) have no access to Medicaid (unless they are eligible in a category such as the aged/blind/disabled).

**Florida has consistently expanded Medicaid eligibility for children:**

Children – in families with incomes up to:
1988 – under age 5: 100% FPL
1989 – under age 6: 100% FPL
1990 – under age 6: 133% FPL
– under age 7: 100% FPL
2000 – under age 1: 200% FPL

Pregnant women with children – incomes up to:
1987 – 100% FPL (children under age 2)
1989 – 150% FPL (children under age 1)
1991 – 185% FPL (children under age 1)

*Cost Sharing*

Cost sharing is permitted under existing Medicaid regulations, but is severely limited. Medicaid regulations prohibit the use of co-payments for anyone under age 18 (who comprise 57 percent of Medicaid eligibles), for pregnancy-related services, or for services affecting the pregnancy.

When co-payments are permitted, they must be "nominal," currently defined in federal regulations as not exceeding three dollars for the most expensive services. Finally, services must be provided, regardless of the client's ability to pay the co-payment. Deductibles must also be nominal (not in excess of $2), and premiums may not be required of most Medicaid beneficiaries. While premiums are allowed for some optional groups such as the medically needy, federal regulations establish a sliding-scale schedule for these premiums with a maximum payment of $19 per person per month.

Cost sharing for children under Title XXI (HealthyKids) is less restrictive for some groups of children but is still subject to a number of requirements. Families with incomes at or below 150 percent of the Federal Poverty Level (FPL) may not be required to pay enrollment fees, premiums, or other similar charges that exceed the amounts imposed under Medicaid. When premiums are permitted, they must be based on an income-related sliding scale, and be limited to no more than a specified monthly amount per family. No co-payments are permitted on preventive services, including but not limited to, well-child care, well-baby care, and immunizations. Total cost sharing for families with incomes above 150 percent FPL must not exceed 5 percent of the family income.

*Cost Containment and Quality Initiatives*

Florida Medicaid has pioneered reforms designed to improve health outcomes and/or achieve cost–savings, including the implementation of managed care (both primary care case management through the MediPass program and through Medicaid managed care organizations), disease management, and preferred drug lists. Cost-savings initiatives continue to be explored in response to the continued growth in the Medicaid program coupled with the economic downturn. State Medicaid programs across the country are facing their third consecutive year of budget shortfalls. While spending growth is slowing (reported as 9.3 percent for 2003, down from 12.8

percent in 2002)[70] states, including Florida, are struggling to fund their Medicaid programs. The Kaiser Family Foundation recently completed its third annual survey of the fifty states and reports that:

- Over the past 3 years, 50 states have taken action to control drugs costs, 50 have reduced or frozen provider payments, 34 have reduced or restricted eligibility, 35 have reduced benefits, and 32 have increased co-payments.
- The primary cause of the fiscal crisis is the falloff in state tax revenue, with the decline in revenue collection being $62 billion, while spending increased about $7 billion in FY 2002.
- Medicaid spending growth between 2000 and 2002 has been driven in part by enrollment growth due to the economic downturn, as well as continued increases in hospital and prescription drug costs.
- Despite slower enrollment growth for the elderly and individuals with disabilities, they accounted for almost 60 percent of Medicaid spending growth during 2000-2002, reflecting their greater use of health care services.

A number of states, including Florida, have enhanced their fraud and abuse detection and prevention programs, and have outsourced administrative services such as third party liability recoveries, as a cost-savings measure. Despite these cost-savings initiatives, Florida continues to face a Medicaid deficit.

*Medicaid Restructuring to Accommodate Expansions*

While states are struggling with current Medicaid funding requirements, there is increasing pressure to provide publicly-funded health insurance to the uninsured, while the cost of providing this coverage has escalated, and resources have declined.

Prior to 2001, states that sought to expand access to health insurance, either through access to Medicaid benefits, the use of premium subsidies or both, did so using a "regular" Section 1115 waiver. Section 1115 of the Social Security Act provided authority for the Secretary of the Department of Health and Human Services (DHHS) to waive most (but not all) Medicaid requirements in order to test new programs. "Regular" 1115 waivers are most commonly used to cover groups of individuals not otherwise eligible for Medicaid (such as higher income parents and childless adults), provide unique services not available under any other Medicaid authority, to use a different payment methodology for Medicaid services, to restructure Medicaid benefits, or to impose higher cost sharing requirements on certain groups of Medicaid recipients.

These waivers have traditionally been difficult and time consuming to develop and obtain approval for. "Regular" Section 1115 waivers can be less than statewide and are designed as five-year research and demonstration waivers. "Regular" 1115 waivers must be budget neutral, although budget neutrality can (but may not necessarily) be applied in a less restrictive manner than with a HIFA waiver. Minnesota, Vermont and Tennessee have included Medicaid expansions in their 1115 waivers.

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[70] The Kaiser Family Foundation. *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004 - Results from a 50-State Survey*. Prepared by Vernon Smith, Ph.D., Rekha Ramesh, Kathy Gifford, Eileen Ellis, Health Management Associates and Victoria Wachino, Kaiser Commission on Medicaid and the Uninsured. September 2003. http://www.kff.org/medicaid/kcmu4137report.cfm.

Health Insurance Flexibility and Accountability (HIFA) waivers were initiated by CMS in 2001 to encourage new comprehensive state approaches that increase the number of persons with health insurance coverage within current-level Medicaid and SCHIP resources. In addition, the HIFA waiver was designed to provide for a streamlined application and approval process and to afford states specific flexibility in the benefit design and cost sharing components of an expansion program. To use a HIFA waiver, a state must meet agree to certain program and funding requirements. A HIFA waiver must:

- Be in effect statewide (although geographic phase-in can be authorized);
- Expand coverage to previously uncovered persons;
- Coordinate or encourage private (especially employer-sponsored insurance) and public health insurance coverage for low-income uninsured persons through approaches such as premium assistance and wraparound services;
- Continue to provide the services specified in a state's Medicaid Plan to mandatory populations (such as TANF and SSI recipients);
- In states using SCHIP funds, maintain Medicaid eligibility levels for children that are no more restrictive than were in effect in June 1997;
- Provide specific services to optional populations,[71] including hospital and physician services;
- Provide a basic primary care benefit to expansion populations[72] but may limit the types of providers and types of services and employ cost sharing provisions; and
- Be budget neutral under Medicaid or allotment neutral under SCHIP.

Section 1115 waivers must be budget neutral to ensure that demonstration projects do not increase federal funding over what would have been spent under current law program requirements. Each HIFA waiver operates under a budget neutrality agreement that limits federal financial payments over the life of the demonstration and this limit is negotiated prior to approval of the waiver. Expenditures under a HIFA waiver are limited to all medical assistance (Medicaid) payments for the Medicaid eligibility groups affected by the waiver, a state's DSH funds, and Title XXI (SCHIP) funds (not including future redistributed SCHIP funds since these funds are not available to states on an ongoing basis). However, SCHIP funds used for non-SCHIP eligibles (i.e., childless adults) must be matched at the state's regular Medicaid matching rate rather than the enhanced SCHIP matching rate.

HIFA waivers can be funded by savings resulting from service reductions or eligibility changes, or by redirecting existing funds such as Disproportionate Share Hospital (DSH) payments and previously unmatched state funds (although maintenance of effort is required). States can place an enrollment cap on an expansion population (which can assist a state in meeting budget neutrality requirements).

*HIFA Waivers Approved As of November 2003*

Eight HIFA waivers had been approved as of November 2003 in the states of Arizona, California, Colorado, Illinois, Maine, New Mexico, New Jersey and Oregon.

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[71] Populations such as the Aged/Blind/Disabled and medically needy.

[72] Populations not covered through Medicaid or SCHIP absent an 1115 waiver (e.g. childless adults).

**Approved HIFA Waivers**[73]

| State | Expansion Group(s) | Primary Source of Funding |
|---|---|---|
| Arizona | Parents with incomes between 100% and 200% FPL; non-parents (continuation from previous 1115 waiver) with incomes up to 100% FPL. | SCHIP funds. |
| California | Enroll parents, caretakers and legal guardians with incomes under 200% FPL into state's separate SCHIP program. | SCHIP funds. |
| Colorado | Pregnant women 134% to 185% FPL in SCHIP program. | SCHIP funds. |
| Illinois | Families with incomes less than 185% of FPL. Individuals who are medically uninsurable up to 185% FPL. | SCHIP funds. |
| Maine | Childless adults up to 100% FPL initially, then increased to 125% FPL. | Unspent DSH funds. |
| New Jersey | Parents of SCHIP or Medicaid children with incomes at or below 200% FPL. | Savings from "standardization" of the parent benefit package. |
| New Mexico | Childless working adults 19-64 with incomes up to 200% FPL who do not have access to insurance. Also to parents of Medicaid and SCHIP children from 37% to 200% FPL. | SCHIP funds. |
| Oregon | Creates Oregon Health Plan standard, OHP Plus and the Family Health Insurance Assistance Program (all for individuals up to 185% FPL). | New co-pays from groups previously exempted from co-pays. |

Two of these waivers specifically include ESI:

- **New Mexico** has created a new employer-sponsored insurance plan. The state will contract with a managed care organization to provide a new insurance product for employers to offer to their low-income workers. The policy would be purchased with a combination of state and federal, employer, and employee contributions and would be comparable to a comprehensive commercial benefit package. Employers will be required to contribute at least $75 per employee per month toward premiums. The program has not yet been implemented.
- **Illinois**' HIFA waiver approved September 2002, gives beneficiaries an informed choice between ESI and Medicaid coverage. The State did not include Medicaid wrap-around coverage for ESI, as has been the case with previous 1115 waivers. Insured children and parents will choose between:
  - Premium assistance for private health insurance coverage; or
  - The benefit package specified in the approved Title XIX State Plan and the amendment to Illinois' Title XXI State Plan, whichever is applicable.

[73] Center for Health Services Research and Policy, George Washington Department of Health Policy, February 2003. *State HIFA Waiver Plans*. http://www.gwhealthpolicy.org/downloads/ChartHIFA.pdf.

In addition, Arkansas has a pending HIFA waiver application that proposes to use employer contributions as state share to leverage FFP. Arkansas has submitted a HIFA waiver request (the "Arkansas Employer-Sponsored Insurance Initiative") that funds a "bare bones" policy through employer taxes, federal SCHIP funds and beneficiary cost sharing. Employers that voluntarily choose to participate would pay a "tax" that would be deposited into the state general fund and would be able to purchase a "bare bones" policy. By employing the employer tax approach, Arkansas is hoping to obtain federal SCHIP matching funds on the employer's contribution.

Florida has implemented a number of Medicaid waivers of varying types in the past, and has received authorization from CMS for several section 1115 waivers, such as the Family Planning Waiver and Independence Plus Waiver (consumer directed care). Florida has not developed a HIFA waiver application to date.

While HIFA waivers in general must be budget neutral in relation to federal funding, CMS has approved federal matching funds for some coverage options that were previously funded solely by state dollars. For example, Illinois' HIFA Waiver provides federal matching funds for medically uninsurable individuals enrolled in the State's high-risk pool that was previously state-funded. Oregon's HIFA waiver includes a pre-existing and previously state-funded premium assistance program.

## Groups Impacted by the Recommendation

The groups impacted by restructuring of the Medicaid program will depend entirely on how the restructuring is accomplished. Because budget neutrality requirements must be met, the source of funds for an expansion will be the primary driver in defining the expansion population. In addition, current Medicaid beneficiaries could be impacted if changes are made to current eligibility levels or services in order to fund the expansion.

In accordance with Task Force principles and consistent with prior expansions undertaken by other states, an expansion would be targeted to individuals based on need and would likely impact individuals in the following sequence:

- Children with access to family ESI;
- Parents with incomes over 24 percent FPL (and up to a limit to be determined by the state, but no greater than 200 percent FPL);
- Aged, blind or disabled with incomes over 88 percent FPL (and up to a limit to be determined by the state, but no greater than 200 percent FPL); and
- Childless adults with incomes up to a limit to be determined by the state, but no greater than 200 percent FPL.

Medicaid-enrolled health care providers and the agencies that regulate or deliver Medicaid health care services would also be impacted.

## Considerations

Under a HIFA waiver, a state can offer reduced benefits and cover additional people up to 200 percent FPL. However, advocates have strongly fought reductions in benefits. Providers have strongly fought any reductions in payment or additional utilization controls. Restructuring could include options for catastrophic coverage for individuals for whom this would be appropriate based on income.

Some Medicaid beneficiaries have access to employer-sponsored coverage, yet the state is unable to tap this resource for the program as currently designed. Restructuring of the Medicaid program should emphasize coordination with, and utilization of, ESI.

If the Arkansas HIFA waiver application is approved, Florida could evaluate the Arkansas approach (e.g., use of an employer contribution to draw down federal matching funds) and consider the development of a similar HIFA waiver.

Most states using a HIFA waiver have utilized unexpended SCHIP funds – Florida needs these funds to cover children. State funds are severely limited by the normal growth of Medicaid and other legislated mandates (e.g., class size, high-speed train service).

## Funding

From a budget perspective, a HIFA waiver requires no new state funds because the waiver is subject to federal budget neutrality requirements. However, utilization of existing funding to accommodate an expansion population will be challenging. The following options are possible, although the relationship between the amount of funds that could be made available and the number of individuals that would receive access to Medicaid or premium assistance requires actuarial analysis.

- Since a large portion of Medicaid expenditures are for long-term care services for the elderly and disabled, the State could potentially achieve savings from a substantial restructuring of the Medicaid long-term care programs (and coordination with Medicare) as well as improved care management.
- Funding from local initiatives could be utilized to expand coverage without requiring additional state revenue. However, once an entity accepts federal Medicaid funds, the entity is subject to all state and federal Medicaid regulations. There is likely to be some cost associated with compliance with these regulations.
- Some states have incorporated funds from state-only funded programs into HIFA waivers in order to receive Federal Financial Participation and expand coverage. There may be state-only funded programs in Florida that could be incorporated into a HIFA waiver in order to gain federal matching funds (but this requires further exploration).
- If the Arkansas HIFA waiver is approved, Florida could consider a similar approach using employer contributions to draw down federal funds to subsidize ESI premiums.

Florida Statutes require the AHCA to obtain legislative authorization to develop and submit a HIFA waiver application to CMS.

## VIII. *Protection of Safety-Net Providers*

Determine if there are additional ways, within available resources, to further support the viability of the crucial safety-net providers, including emergency rooms and hospitals, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), in order to ensure access to health care for those that lack health insurance.

### Background

The fallback source of care for people without health insurance is safety-net providers. Included in this group are community clinics, public health centers, hospital clinics, and inpatient hospitals. Community clinics generally operate on a pay-if-you-can basis. The low-income uninsured often pay nothing or a heavily subsidized amount.

Uninsured individuals often seek care in the emergency room for primary care needs that could more effectively be treated in another setting. Government funding cutbacks, welfare reform and the volatility of the Medicaid program have increased the stress on safety-net providers and threatened their ability to continue serving vulnerable populations.[74]

There will continue to be uninsured in Florida who will need health care services and who cannot afford to pay for their care. These individuals routinely use the emergency rooms or other local safety-net providers such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Safety-net providers will need continued financial support from government programs, such as Medicaid, and from local initiatives to maintain their financial viability because of their relatively high levels of uncompensated care.

Medicaid currently manages several programs aimed at maintaining the financial survival of the traditional safety-net providers. The Medicaid program pays hospitals that serve a disproportionate share of the indigent funds above their routine per diems to help compensate for the uncompensated care. FQHCs and RHCs receive relatively higher reimbursement for the services they provide compared to the traditional fee schedule used for physician services. Medicaid continually evaluates reimbursement policies for all provider types and services, including the payments to safety-net providers.

While adequate funding is critical to maintain the safety-net, researchers have identified additional factors as important in helping safety-net providers build capacity and improve care coordination for low-income and uninsured people. The Center for Studying Health System Change reports these factors are:

- Strong political and organizational leadership;
- Community support;
- Collaboration; and
- Business acumen.

[74] Silow-Carroll et al, Economic and Social Research Institute, *Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity.* A Series of Community Voices Publications Prepared for the W.K. Kellogg Foundation, November 2001.

For example, a Seattle community health center improved its finances by focusing on strategies commonly identified among safety-net hospitals and community health centers in all 12 communities studied by researchers. These strategies were:

- Streamline operations and improve productivity by, for example, increasing use of clinical support staff and non-physician clinicians, upgrading information technology and transitioning to same-day patient scheduling;
- Improve payment collection from insurers and patients;
- Leverage economies of scale and share technical expertise with other safety-net providers;
- Enroll uninsured patients in public insurance coverage at the provider site;
- Attract more privately and publicly insured patients to improve payer mix; and
- Raise funds and apply for grants, such as federal expansion grants, particularly to develop mental and dental health services. [75]

On a national level, the Bush administration has expressed support for safety-net providers and has increased the funds available for federal grants for community health centers and clinics that meet the eligibility requirements. President Bush's fiscal year 2004 budget proposes an increase of $122 million in the appropriation for the Consolidated Health Center Program authorized under Section 330 of the Public Health Service (PHS) Act. The increase represents the third installment in the President's multi-year plan to serve an additional 6 million people in 1,200 of the Nation's neediest communities through new or significantly expanded health center access points. Grant awards for new access points are for a three-year time period. For FY 2004, the Bureau of Primary Health Care has established a cap of $650,000 for section 330 support of new access points.[76]

While section 330 grant funding provides a revenue stream for community health centers, applying for grant funding is labor intensive and is a competitive process. Once funding is granted, FQHCs are required to comply with a number of reporting and administrative requirements.

There are a number of barriers to compiling an accurate description of the size and scope of Florida's safety-net. There is no clear definition of exactly what comprises the safety-net. Often, 'safety-net' refers to ambulatory care sites such as clinics and hospital outpatient departments. In this instance the term refers to accessible adequate primary care, which is intended to reduce the need for more expensive services such as emergency room visits and inpatient hospitalizations. In other instances the term 'safety-net' includes the emergency room and inpatient services. The safety-net can also refer to financing mechanisms to support uncompensated services (e.g. disproportionate share payments or local subsidies) or health plans that target previously uninsured individuals.

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[75] Felland LE, Kinner JK, Hoadley JF. *The Health Care Safety-net: Money Matters but Savvy Leadership Counts,* Issue Brief No. 66, August 2003. Retrieved January 3, 2004 from the Center for Studying Health System Change Website: http://www.hschange.org/CONTENT/591/.

[76] *Requirements of Fiscal Year 2004 Funding Opportunity for Health Center New Access Point Grant Applications*, HRSA/BPHC Program Information Notice, 2004-02, September 30, 2003.

Many safety-net programs are vulnerable, relying on governmental, community or foundation support for their continuity. A recent telephone survey of Florida programs in 6 counties revealed that over 40 percent had changed location or services. The number and variety of safety-net providers makes it difficult to assess the number of people served, the scope of services, and the amount of resources used.

Estimating the level of need for safety-net services is also difficult. Typically, need is based on estimates of the uninsured. However, other considerations are important, such as the degree to which individuals are underinsured for services, structural elements such as the availability of primary and specialty providers, and the use of local subsidies and charitable giving to support safety-net services.

There have been several efforts at quantifying and describing Florida's safety-net. In 1998, the Florida legislature authorized the Florida Health Insurance Study (FHIS). In addition to a health insurance survey, the study included a survey of community clinics, programs and other safety-net resources that provide medical care services to poor and uninsured Floridians. Providers were asked to describe the kind of services they provide, the number of visits to their locations, waiting time for services, and sources of funding. The study revealed that the most commonly provided services include primary and preventive health care, family planning and lab work. However, only one-quarter of the sites provided specialty services and one-third provided mental health care. The study also showed that the majority of safety-net institutions in the state are relatively small organizations that rely on some form of federal, state, or local funding to provide care to low-income populations.

In the summer of 2003, Blue Cross Blue Shield of Florida (BCBSF) undertook the development of a database of healthcare programs serving the uninsured throughout the State of Florida. This current listing of 1,450 programs was compiled from agencies, public entities, and planning councils throughout the state, and is considered to be a complete listing of these programs. BCBSF has called to verify the program information concerning all of these programs, which constitute a broadly defined "safety-net" for the uninsured, as well as the underinsured, throughout Florida.

## Groups Impacted

Through increased funding and financial support for safety-net providers, all consumers will benefit, as increased funding translates to increased capability, which means greater access.

## Considerations

There are limited ways to provide additional funding within existing resources beyond grant funding that may be available from the Federal government. These include:

- A revision to the Upper Payment Limit (UPL) program;
- A revision to the distribution of Disproportionate Share Hospital (DSH) funds; and
- A revision to reimbursement policy for basic rates (i.e., per diem payments and fee-for-service schedules).

Medicaid currently has developed some specific measures that address supplemental payment to hospitals for DSH and UPL that target safety-net providers. However, Medicaid could evaluate whether additional measures are needed to further improve funding for safety-net providers. For example, Medicaid could develop specific measures to determine the amount of services

provided by safety-net providers and use these measures in their reimbursement policies to effectively target scarce dollars to those providers serving the highest number of uninsured. While this approach would provide additional funding to help maintain the financial viability of crucial safety-net providers, it creates differential payment schedules or methodologies within the same provider types.

*A Revision to the Upper Payment Limit (UPL) Program*
Federal Medicaid regulations require Medicaid not to pay more than what Medicare would have paid for the same service, known as the Upper Payment Limit (UPL). In most states, including Florida, Medicaid payments are significantly less than Medicare payments for most services. Florida has implemented programs that provide additional reimbursement to hospitals and some nursing homes, in specified classes (i.e., private, public and state) up to what Medicare would have paid and financed the state funding of this with the transfer of local funds to the Medicaid program. There is a Disproportionate Share (DSH) Task Force, established by the Legislature, which makes recommendations on how this program should be structured and financed. The DSH Task Force could include in its review process a method to take into account specific provisions related to those hospitals that are key safety-net providers.

*A Revision to the Distribution of Disproportionate Share Hospital (DSH) Funds*
Federal Medicaid regulations require supplemental payments to be made to hospitals that serve a disproportionate share of the low-income, uninsured. This funding is capped at the federal level and the DSH Task Force also prepares recommendations for the distribution of the DSH funding. The process for DSH funding could include considerations that take into account measures to benefit key safety-net hospitals.

*A Revision to Reimbursement Policy for Basic Rates*[77]
Currently, institutional providers (hospitals, nursing homes, etc.) are paid on a cost based, per diem basis, subject to specific limitations, that have the effect of paying less than actual cost. Most non-institutional providers are paid on a fee-for-service basis that is generally much less than what Medicare would have paid. These policies could be reviewed to create some preference to crucial safety-net providers. However, this may be difficult to implement because of the existing special payments via DSH to safety-net hospitals (which could be viewed as "excessive" special provisions).

## Funding

No new state funding is required to implement this recommendation as proposed. However, seeking federal and local funding opportunities is strongly encouraged.

[77] Basic rates include per diem payments and fee-for-service schedules.

## IX. *Information on the Uninsured*

Develop mechanisms for tracking the success of efforts to reduce the percentage of the uninsured, including the maintenance and periodic gathering of relevant information concerning the number and characteristics of the uninsured.

A. Consider enhancing the 2004 Florida Health Insurance Study and future updates to incorporate the design and implementation of monitoring and evaluation programs;

B. Consider designing and implementing market research studies, such as focus groups and structured interviews, to analyze the uninsured population as part of the health insurance market and to monitor consumer health purchasing patterns; and

C. Strengthen existing annual premium and enrollment data reporting requirements of health insurance carriers.

### Background

Monitoring changes in health expenditures, insurance premiums, and other cost indicators is fundamental to sound policymaking. States need this information to assess the potential impact of new proposals and evaluate current programs. There are several national data sources available to states that provide various health care measures (including insurance status). These sources rely on census data and, while useful, do not have the specificity desired for state-specific detailed analysis. There are two program models, Minnesota and Maine, which have been proven useful to their state governments for collecting and using cost data and related information.

The Health Economics Program (HEP) of the Minnesota Department of Health (DOH) provides analysis of health expenditures and premium changes. The program also supports broader studies of health plan enrollment trends, the uninsured, and other health policy topics. The legislature, interest groups, and others use these program data and analyses. The HEP is funded from a mix of sources, including the general fund, tobacco settlement funds, and provider taxes. Minnesota's health expenditure estimates are used to:

- Inform legislators of the status of the health care market;
- Measure the potential effects of pending bills on health care costs and expenditures for issues such as patient protection, mental health parity, and prescription drugs;
- Determine administrative costs;
- Understand the costs associated with mandated benefits; and
- Evaluate figures and analyses provided by interest groups.

Florida's efforts to systematically track the uninsured have been conducted by the University of Florida under contract to the AHCA through the 1999 Florida Health Insurance Study (FHIS Phase I and II). The 1999 FHIS was a landmark research effort that served as a model for many

other states. In addition, the 1999 FHIS served as the basis for evaluating the Florida KidCare Program and in determining the impact of welfare reform on the uninsured.[78]

Florida's recent HRSA grant award includes funding for development of a Web-based Data Query Tool. Florida's HRSA project staff from the University of Florida, working in conjunction with the AHCA and a project consultant will develop an Internet-based query tool that will enable individuals to interactively explore FHIS survey data. The query tool will be modeled after the *AskCHIS* tool developed at UCLA for the California Health Interview Survey. The *AskCHIS* tool provides estimates in tabular or graphical form. The HRSA grant-funded 2004 update to the 1999 FHIS will be loaded into the database. The FHIS data and U.S. Census Data will be available through the Internet and users will be able to request specific tabulations. The FHIS data will also become a part of the Multi-State Integrated Database developed by the Arkansas State Planning Grant team and housed within the Arkansas Center for Health Improvement.

Another mechanism that can be utilized to assist in the tracking of information relevant to characteristics of Florida's uninsured population is the enhanced analysis of the private insurance market enrollment and premium data. The Office of Insurance Regulation annually gathers information on all health insurance products issued or enforce via an established and fully operational internet-based electronic filing system. This collected information includes:

- Direct premiums earned;
- Direct losses incurred;
- Direct premiums earned for new business issued during the year;
- Number of policies;
- Number of certificates; and
- Number of total covered lives.

Additionally, summaries of typical benefits, exclusions, and limitations, for each type of individual health policy form currently being issued in the state are collected.

Unfortunately, this data is only collected on a voluntary basis from all but those carriers who actively participate in Florida's individual market. Amending Section 627.9175, F.S. to extend this reporting requirement to all insurance-related entities authorized to offer or service accident and health products to Floridians would provide trending information to help forecast and validate other data collections specifically targeted to the uninsured.

## Groups Impacted

Gathering information on the uninsured promotes better monitoring and understanding of the problem and has the potential to impact all consumers, all health care providers and the systems and agencies that deliver health care services and conduct outreach.

[78] Information on this study can be obtained on the website: http://www.fdhc.state.fl.us/Publications/Technical_Reports/index.shtml.

## Considerations

The cost of gathering data on the uninsured is dependent on the scope and frequency of this data collection. For example, the cost for survey fieldwork for the 2004 FHIS update is expected to be $450,000. This does not include the cost for statisticians, analysts and data systems staff required to compile, clean, analyze and prepare data in a useable format for Internet access.

However, expanding existing OIR annual premium and enrollment data reporting requirements of health insurance carriers would not incur any additional state outlays. A fully operational Internet data collection system exists and is currently being used to collect this type of data and provide external parties with prepared data in various downloadable Internet accessible formats.

## Funding

The need for additional funding depends upon the extent to which additional tracking capabilities are desired. Current funding for these research studies comes from philanthropic foundations and federal grants programs. Funding opportunities from the pursuit of additional grants such as the HRSA State Planning Grant Program and The Robert Wood Johnson Foundation State Coverage Initiatives Grant Program for ongoing tracking is strongly encouraged.

## X. *The KidCare Program*

A. Encourage enrollment in the KidCare program and consider what can be done to fund it in recognition that the program will need to be reauthorized by Congress in three years. The state shall:

1. Permit the use of local funding available from counties or other government entities for additional slots, provided there is a commitment that the funding will be continued for a minimum of three years;
2. Ensure that the KidCare program gives priority enrollment to children who are currently enrolled and are required to move from one program component to another; and
3. Subject to federal authorization and given it is cost-effective for the State:
   a. Give first priority to children who do not have access to affordable employer-sponsored insurance (ESI) and prioritize enrollment for children with access to ESI on the basis of family income, with access being provided to those with lower incomes first;
   b. Provide a subsidy no greater than the KidCare premium to offset the incremental difference between the cost of the employee-only premium and the ESI family premium;
   c. Provide wrap-around benefits to supplement the benefits provided under ESI in order to provide for access to a benefit plan that is actuarially equivalent to the KidCare benefit plan; and
   d. Adjust the waiting list for risk to address those with the most critical needs first.

B. Any recommendations must take current budget constraints into consideration.

### Background[79]

The Balanced Budget Act of 1997 created federal funding for a State Children's Health Insurance Program (SCHIP) of the Social Security Act and authorized $47 billion through 2007. SCHIP is designed to provide coverage to children residing in a family with income below 200 percent of the Federal Poverty Level (FPL) or whose family has an income 50 percent higher than the state's Medicaid eligibility threshold. Some states have expanded SCHIP eligibility beyond the 200 percent FPL limit, and others are covering entire families and not just children.

A state can use SHCIP funds to either:

- Expand Medicaid eligibility to previously uninsured children;
- Implement a separate children's health insurance program (independent of Medicaid); or
- Combine both the Medicaid and separate program options.

**Florida's SCHIP Allotment**
Florida did not use its full annual allotments until 2001. Congress allowed the state to retain some of the unused funds, but reallocated $119.7 million.

[79] Federal SCHIP requirements source: Centers for Medicare and Medicaid Services. http://www.cms.hhs.gov/.

Florida chose to combine a Medicaid option (MediKids) with a separate program (HealthyKids) to form KidCare. The state allocation amount is calculated based on 50 percent of the number of low income uninsured children plus 50 percent of the number of low-income children and the state cost factor (based on annual wages in the health care industry for each state).

The state amount is constrained by federally-defined "floors" and "ceilings". Allocations for SCHIP are limited to both a national and state annual allocation. State-specific funds that are unused within 3 years revert to the Treasury and are available for redistribution to other states.

**Florida's Federal Matching Rate**
In Florida, approximately 70% of funding for KidCare is Federal.

The federal matching rate for SCHIP is equal to 70 percent of a state's Medicaid Federal Medical Assistance Percentage (FMAP) for the fiscal year plus 30-percentage points, not to exceed 85 percent. Administrative costs associated with SCHIPs are limited to 10 percent of a state's expenditures specific to SCHIPs per fiscal year.

Florida's KidCare program has five components: MediKids, Florida Healthy Kids, Children's Medical Services Network, Behavioral Health Network and Medicaid for children.

**KidCare Program Component Coverage Level (by FPL)**

| | | |
|---|---|---|
| **Medicaid for Children** | | |
| | Ages 0 to 1 | 200% or below |
| | Ages 1 to 6 | 133% or below |
| | Ages 6 to 19 | 100% or below |
| **MediKids** | | |
| | Ages 1 to 5 | 134% to 200% |
| **Healthy Kids** | | |
| | Age 5 | 134% to 200% |
| | Ages 6 to 19 | 101% to 200% |
| | Ages 3 to 19 | Above 200% - can participate but receive no premium assistance |
| **CMS Network** | | |
| *Physical Health* | Ages 0 to 1 | 186% to 200% |
| | Ages 1 to 6 | 134% to 200% |
| | Ages 6 to 19 | 101% to 200% |
| *Specialized Behavioral Health* | Ages 5 to 19 | 101% to 200% |

Florida Healthy Kids includes some enrollment that is state only funded or full pay.

To be eligible for the Title XXI portion, a child must meet the following criteria:

- Uninsured, under 19, and a United States citizen or qualified non-citizen;
- Not a dependent of a state employee;
- Not eligible for regular Medicaid;
- Not residing in a public institution; and

- Reside in a family with income below 200 percent of the FPL (Florida's KidCare income limit); or no more than 50 points above the state's highest Medicaid income.

Florida also provides for continuous eligibility. This enables a child to maintain a continuous period of coverage even if there are fluctuations in the family's income. Current continuous eligibility periods are twelve months for children from birth to five years of age, and six months for children six years of age through nineteen years of age.

*Cost Sharing Options*
States may impose cost sharing on program participants but may not charge cost sharing for preventive services or immunizations, or impose cost sharing that exceeds 5 percent of a family's gross or net income. Florida cost sharing is calculated on the basis of a family's gross income. American Indian and Alaska Native children who are members of a federally recognized Tribe must not be charged any cost sharing. In Florida, the Miccosukee and Seminole Tribes are federally recognized.

Other cost sharing rules for children residing in families with incomes at or below 150 percent FPL also apply and include:

- States may not impose more than one type of cost sharing for a service;
- States may only impose one cost sharing charge for all services delivered during a single office visit; and
- Families may not be required to pay enrollment fees, premiums, or other similar charges that exceed the amounts imposed under Medicaid.

In Florida, recipients must pay a monthly fee of fifteen to twenty dollars depending upon income. In order to achieve expenditure and enrollment targets, some additional restrictions are being placed on the program such as requiring a six-month wait before being allowed to re-enroll if the premium is not received prior to the first of the month.

*Benefit Package*
States have several options in developing the benefit package for a separate SCHIP. They may use:

- B*enchmark coverage*: a package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; or a health benefits plan that the state offers and makes generally available to its own employees; or a plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.
- *Benchmark equivalent coverage*: coverage with an aggregate actuarial value at least equal to one of the benchmark plans. States must cover inpatient and outpatient hospital services, physician services, surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, including age-appropriate immunizations.
- *Existing state-based comprehensive coverage*: In the states where existing state-based comprehensive coverage existed prior to the enactment of SCHIP (i.e., New York, Pennsylvania and Florida), the existing health benefits package is deemed to be meeting the coverage requirements of the SCHIP program.

- *Secretary approved coverage*: coverage that is the same as the state's Medicaid program; comprehensive coverage for children offered by the state under a Medicaid demonstration project approved by the Secretary; coverage that either includes full Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits or that the state has extended to the entire Medicaid population in the state; coverage that includes benchmark coverage plus any additional coverage; coverage that is the same as the coverage provided by New York, Florida or Pennsylvania; or coverage purchased by the state that is substantially equal to coverage under one of the benchmark plans through the use of benefit-by-benefit comparison.

**Florida's Healthy Kids Benefit Package**
CMS approved Florida's existing state benefit package for the Healthy Kids program.
In February 2001, Florida began implementation of a comprehensive dental benefit for KidCare participants.

States must also:

- Provide coverage for well-baby and well-child care, immunizations and emergency services.
- Provide abortion coverage only to save the life of the mother, or to terminate a pregnancy resulting from an act of rape or incest.

In general, states cannot permit the implementation of preexisting condition exclusions. If SCHIP plans provide coverage through group health plans, preexisting condition exclusions are permitted only in so far as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules allow.

*Premium Assistance Option*
States providing SCHIP coverage through premium assistance for group health plan coverage (such as Florida) must adopt specific protections against substitution of coverage also referred to as "crowd-out". States may require participants to access employer-sponsored insurance (ESI) and provide premium assistance to assist in purchasing this insurance subject to the following SCHIP rules:

- A six-month waiting period is required;
- The premium assistance must be cost-effective as defined at the federal level;
- If the employer plan does not provide all of the benefits available under the public program, the state must provide wraparound coverage; and
- The state must assure that cost sharing amounts paid by the family do not exceed allowable cost sharing under the public programs.

Florida attempted to implement a premium assistance program, but at the time, CMS indicated the employer had to contribute 50 percent of the premium. Prior studies have indicated that Florida employers generally do not provide that level of premium assistance.

To date, three states have implemented premium assistance programs: Massachusetts, Oregon and Wisconsin. Their experience includes:

- Outreach campaigns must include specific efforts to target employers, and involve employers in the design phase to address their concerns and ensure their participation.

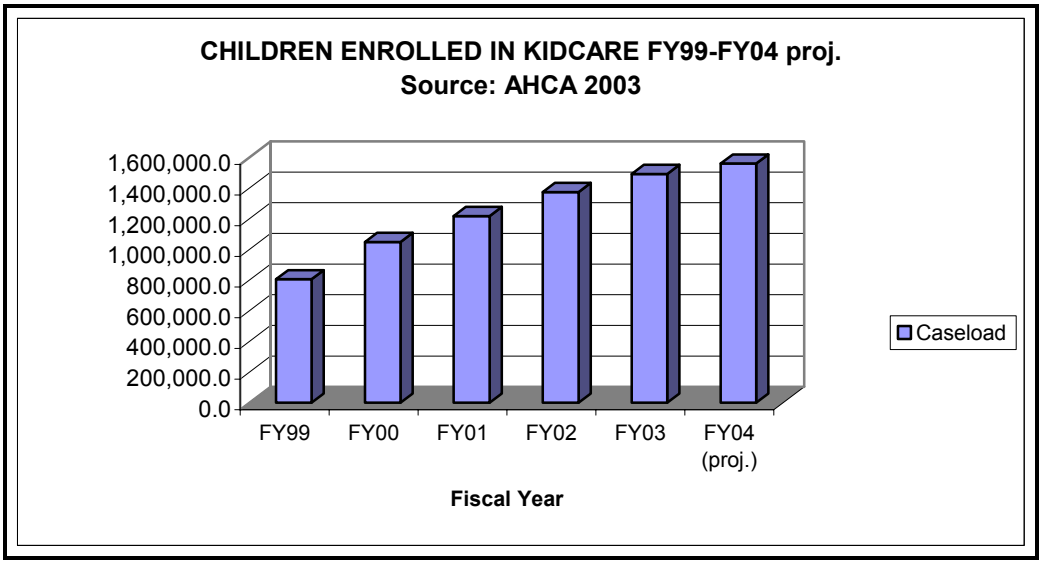
- Enrollment into the premium assistance program is complex, time-consuming, and challenging (Wisconsin and Massachusetts). In particular, state officials noted that the complexity of investigating employer benefit packages and comparing them to the state-selected SCHIP benchmark has resulted in families not qualifying for premium assistance largely due to plans not covering benefits such as dental and vision care.

Massachusetts and Wisconsin believe their premium assistance programs are worthwhile endeavors, but caution other states considering such programs against being overly optimistic about initial enrollment. Enrollment results for 2001 are:

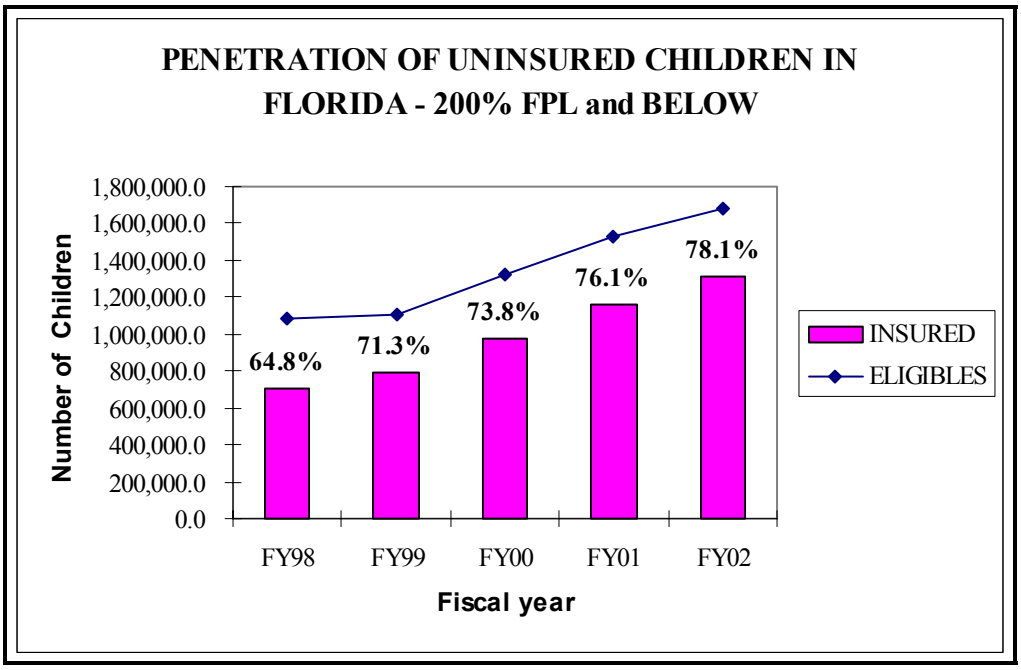
- Wisconsin's Health Insurance Premium Payment (HIPP) program: 47 families (October 31, 2001);
- Massachusetts: 4,433, children but only 16 percent were funded through SCHIP because of the stringency of their SCHIP benefit benchmark with the remainder funded through Medicaid (September 30, 2001). Massachusetts received approval to change its benefit plan in March 2002 and officials believe this may allow greater numbers of children to qualify for SCHIP-funded premium assistance.

Despite relatively small numbers of enrolled families, Massachusetts and Wisconsin officials believe that partnering with the private sector "is the right thing to do" and will have long-term benefits.[80]

Florida's KidCare program grew dramatically during the first three years of operation, with enrollment slowing as the number of uninsured children declined. By 2002, KidCare had increased health insurance coverage of children to 78 percent from a previous coverage rate of 65 percent in 1998.[81]




[80] Westpfahl, Amy and Hill, Ian. *Premium Assistance Programs under SCHIP: Not for the Faint of Heart?* May 16, 2003. Assessing the New Federalism Occasional Paper No. 65. The Urban Institute. http://www.urban.org/.
[81] Information provided by the Agency for Health Care Administration, December 23, 2003.




The Florida Legislature funded a "no growth" policy for FY 2003-04, based on March 2003 KidCare Estimating Conference projections. Spring actual enrollments exceeded these projections, with a significant increase occurring from June 2003 to July 2003. Applications received by the Healthy Kids third party administrator during the spring were processed, with a wait list developed for new applications received on or after July 1, 2003. Currently enrolled children (except for certain Medicaid children) are allowed to transfer between program components, even if the receiving component has a wait list. For example, a MediKids enrolled child who turns age 5 is enrolled into Healthy Kids (provided the premium is paid). Florida KidCare enrollment, including non-title XXI children, was 276,355 as of November 2003, exceeding the legislative cap of 271,267. The waiting list was 66,216 children. As of December 11, 2003, the waiting list grew to 73,992 children and by January 26, 2004, to 110,402 children.

| **KidCare Waiting List by Program Component 1/26/2004**<br>*Source: AHCA January 2004* | |
|---|---|
| Florida Healthy Kids Title XXI and Full Pay | 63,313 |
| MediKids | 18,847 |
| CMS Network | 1,606 |
| Florida Healthy Kids Non-Title XXI | 26,636 |
| Total | 110,402 |

In order to stay within the KidCare budget, the state will have to implement a "hard cap", which would not only prevent new children from enrolling in the program, but would also move to the wait list children ready to transition to another program component if the receiving component is closed. Implementation of a "hard cap" will result in more children becoming uninsured. A number of program changes have been considered including:

- Reduce income eligibility;
- Cancel coverage of the state only subsidy;
- Reintroduce administrative controls;
- Increase cost sharing;
- Reduce benefits;
- Obtain employer participation;
- Eliminate full-pay coverage option;
- Reduce provider and plan payment rates;
- Reduce administration;
- Increase Medicaid eligibility; and
- Introduce waiting periods.

Changes implemented so far are:

- Elimination of KidCare outreach effective July 1, 2003;
- Increase to the family premium effective July 1, 2003 ($20.00);
- Increase to the co-payments for Healthy Kids effective October 1, 2003 (Increased to $5 for most services);
- Reduction of the dental benefit for Healthy Kids to $750 per member, per year; and
- Reduction to plan payment rates to Healthy Kids providers.

In late January 2004, the CMS informed the AHCA that $132,618,000 of unspent SCHIP funds from other states will be redistributed to Florida and must be expended by September 30, 2005. This additional federal funding will allow Florida to reduce the waiting list upon appropriation of state matching funds.

## Groups Impacted by the Recommendation

While the KidCare program has been effective in reducing the rate of uninsurance among children, funding limitations are affecting this progress. Children residing in families with incomes under 200 percent FPL who are ineligible for Medicaid and who are currently uninsured or who are on the waiting list, will be benefited by a funding expansion. The numbers of children potentially impacted include:

- 110,402 children who were on the waiting list as of January, 26, 2004; and
- 74,038 additional children estimated to be uninsured and eligible for Healthy Kids or MediKids.[82]

[82] Institute for Child Health Policy. *Florida KidCare Program Evaluation Report, 2003*.

## Considerations

Expansion of the KidCare program is an attractive option for the State and widely supported by advocates for a number of reasons including the opportunity to match funds at the 70 percent rate and the success of the program in reducing the level of uninsured children. KidCare coverage provides access to primary and preventative care, reducing the need for ER services, out-of-pocket expenses and the cost of uncompensated care.

State funds are significantly limited by the normal growth of the Medicaid program and other legislated mandates. Task Force principles require that recommendations are affordable given Florida's budget situation. This includes minimization of the use of General Revenue (GR) funds, while at the same time allowing for maximization of any federal funds. Therefore, a non-GR source of funding is required in order to draw down the 70 percent federal funding. Some counties and foundations have offered to provide the state portion of the funding. In the past, however, some counties have been unable to honor or extend their commitments. This situation could create pressure to continue the funding through state funds should county funds become unavailable. Also, if expenditures were to result in a need for federal matching funds above the federal allotments amortized over the remaining years until reauthorization, there would still be a need for more general revenue in the out years.

In addition to funding, changes in the design of the existing KidCare program should be explored. The Task Force identified the minimization of replacement of private coverage with public coverage as a component of affordability for the State. "Crowd-out" is reported to be occurring under the current structure. Children are enrolling who have access to their parent's ESI. This increases the cost and risk levels in the commercial markets.

Current federal regulations do not allow enrollment of non-citizens using federal dollars.

## Funding

State funding for Medicaid or SCHIP programs, per federal regulations, can come from three sources: broad based tax revenues (general revenue, cigarette taxes, etc); provider specific taxes (such as the current hospital tax); or transfers from local governments.

Florida is currently spending its federal SCHIP allotment in full. At current spending levels, Florida can utilize its remaining federal SCHIP allotment over a three-year period at $296.2 million a year. This level of spending does not permit program growth. However, there is an anticipated additional, one-time (e.g., non-recurring) redistribution of unspent SCHIP funds from other states that will be available for Florida. The amount and timing of this redistribution to Florida is not currently known.

Based on known data regarding the KidCare waiting list and historic program spending along with adjustments made to constrain spending, the KidCare Coordinating Council estimates that an additional $23.4 million in state funds are required for 2003-2004. Additional state funds will be needed for SFYs through 2006-2007. The amounts are displayed in the table below. It is possible that a portion of the allotment could be accessed using local government funds transferred to the state specifically to fund KidCare.

**KidCare Funding Needs** *In $Millions*

| | Federal | State[+] | Total |
|---|---|---|---|
| **State Fiscal Year 2003-2004** | | | |
| Current Appropriation | $296.2 | $113.0 | $409.2 |
| Additional Appropriation Required* | $57.5 | $23.4 | $80.9 |
| **Total Appropriation** | **$353.7** | **$136.4** | **$490.1** |
| **State Fiscal Year 2004 -2005** | | | |
| Annual Appropriation | $296.2 | $113.0 | $409.2 |
| Additional Appropriation Required* | $90.3 | $36.5 | $126.8 |
| **Total Appropriation** | **$386.5** | **$149.5** | **$536.0** |
| **State Fiscal Year 2005 -2006** | | | |
| Annual Appropriation | $296.2 | $113.0 | $409.2 |
| Additional Appropriation Required* | $125.1 | $50.0 | $175.1 |
| **Total Appropriation** | **$421.3** | **$163.0** | **$584.3** |
| **State Fiscal Year 2006 -2007** | | | |
| Annual Appropriation | $296.2 | $113.0 | $409.2 |
| Additional Appropriation Required* | $163.0 | $65.2 | $228.2 |
| **Total Appropriation** | **$459.2** | **$178.2** | **$637.4** |

**Dependent on availability of additional federal funding*

[+] *State funds may include contributions from County governments*

## XI. *Creation of Health Plans for Uninsurables and HIPAA-Eligibles*

To stabilize Florida's health insurance markets and make them more competitive; to provide access to health coverage to Florida's uninsurables; and to make health insurance more affordable by bringing about reductions in costs to all of Florida's insureds, conservatively estimated to average 2.0 percent for large groups, 4.0 percent for individual policies and 3.0-7.5 percent for small groups:

A. Create a new, appropriately designed health insurance residual market, structured in accordance with the National Association of Insurance Commissioners Model Health Plan for Uninsurables Act, (NAIC Model Act), that accomplishes the following:

   1. Is initially developed by a three-person transition team, appointed by the Governor and headed by the Director of the Office of Insurance Regulation. Upon establishment, be managed by a Board of Directors as outlined in the NAIC Model Act;
   2. Qualifies for federal funding that is available to these types of pools, provided that it is in the best interest of the pool and its financial stability;
   3. Offers insurance that is flexible and designed to meet the needs of enrollees, comprised of the standard and basic plans presently required in the small employer market, as well as an option to provide catastrophic coverage that includes a limited level of primary care coverage;
   4. Uses an administrator who is a duly licensed health insurance carrier or third party administrator selected by a competitive bidding process;
   5. Incorporates effective cost control techniques, including, but not limited to, establishing annual and lifetime maximum benefits, utilizing pre-existing condition limitations, and requiring structured disease management, case management and utilization review programs for all participants;
   6. Makes coverage available to both:
      a. Individuals who are uninsurable, as defined in the NAIC Model Act; and
      b. Individuals eligible for guaranteed issue coverage in the individual health insurance market as a result of federal continuation of coverage requirements, provided in the Health Insurance Portability and Accountability Act (HIPAA).
   7. Utilizes a sliding scale related to the individual's ability to pay in setting plan premiums.

B. Fund the new pool using an appropriation from General Revenue sources including but not limited to a portion of the annual growth in existing net insurance premium taxes. Manage the pool to operate within any caps on available funds.

C. Consider using components of the California risk pool as a model for the new program.

D. Concurrent with the creation of the high-risk pool, eliminate the present requirement that carriers provide guaranteed issue small employer coverage to one-life groups.

E. Require a report after the third full year of operation on the success of the pool in accomplishing its objectives.

## Background

As their cornerstone of a healthy, competitive insurance market, forty-three of the fifty states, including all of the six largest states except Florida, have either provided guaranteed availability of health insurance coverage for all or have established a residual market for individuals who are unable to meet the health standards required by carriers in the market. Twenty-nine states have adopted a residual health insurance market pool (also referred to as a "high-risk" pool), which is a state-created, nonprofit pool that is generally subsidized through an assessment on health insurers and/or paid for with state funds.

In addition, the use of a high-risk pool is the federal governments "preferred" mechanism for state compliance with the health insurance portability requirements under HIPAA. Any other mechanism requires federal approval as a "State Alternative Mechanism". A high-risk pool is not designed to significantly reduce the number of uninsured by offering them coverage directly. Rather, it serves to stabilize the insurance markets and spread the cost of high utilizers of coverage across the broadest base possible. As a result, more affordable coverage becomes available in the market and many of those who are presently uninsured are able to access coverage.

In fact, although high-risk pools are a form of last-resort coverage for people who have medical conditions or other characteristics that make them uninsurable, the premium amounts for these individuals may be a barrier to enrollment. While most states offer coverage at 150 percent of the average premium, this amount may still be too high to attract substantial enrollment.

High-risk pool premium revenues do not cover the costs of providing the medical services that this group uses. The shortfall has to be made up by collecting revenue from sources other than the high-risk people themselves. The National Association of Comprehensive Health Insurance Plans (NASCHIP) reports that all state high-risk pools lose money, with approximately forty percent of overall operating costs requiring subsidy. Subsidy mechanisms vary.

Some states assess all insurance carriers, HMOs and other insurance providers and may provide a tax credit for the assessment; others provide an appropriation from state general tax revenue or use a hospital or health care provider surcharge.[83] Assessments to carriers can be in proportion to the amount of health insurance premiums they write in a state, or can be based on the proportion of individuals covered by each carrier. More states are now using an assessment on health insurers, stop loss, and reinsurance carriers based on the number of covered lives. The NAIC reports this method:

- Provides broad-based assessment and more equitable funding by most if not all of the health insurance industry in the state;
- Requires close coordination with state insurance regulators to make sure all insurers subject to assessment, including stop loss carriers, report and follow through on paying the assessment; and
- Is easier for carriers to budget for, as it is a fixed amount and can be passed through to policyholders.[84]

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[83] National Association of State Comprehensive Health Insurance Plans. *What is a Risk Pool?* Retrieved January 2, 2004 from the NASCHIP Website: http://www.naschip.org/what_is_a_risk_pool.htm

[84] Ibid.

Kentucky, Oregon, Washington, and Wisconsin assess premiums on stop-loss insurers or reinsurers in addition to the traditional assessment on insurers.[85] Federal law (ERISA) prohibits states from requiring self-insured employers to pay such fees.

Other funding options are either not feasible or are politically difficult including:

- Charging higher premiums to cover losses;
- Charging hospitals and surgical centers (viewed as a "tax"); and
- Using settlements and tobacco taxes (tend to be "one-time" funding sources).

Some researchers believe that states that have implemented guaranteed issue individual coverage without a limitation on rates but that also maintain a high-risk pool offers the most promising approach to insuring the otherwise uninsurable.[86] High-risk pools are believed to create a positive "ripple effect" throughout the health insurance market by moving high-risk and/or high cost individuals out of the market and rating structure, thereby reducing the cost for the remaining market. The actuarial analysis provided herein demonstrates and provides an estimate of this effect.

In California's risk pool, the Major Risk Medical Insurance Program (MRMIP), services are delivered through contracts with health insurance plans, which provide for premium sharing between the individual enrollee and the state. In this way the state is fully aware of its cost for each enrollee and can control its overall liability by placing limits on enrollment. Presently, the MRMIP has almost 3,000 fewer enrollees than are provided by the statutory cap on enrollment. The majority of subscribers are between the ages of 40 and 64, and 58 percent are women.

Beginning September 1, 2003 a new law in California (AB1401) requires subscribers to leave the MRMIP after 36 consecutive months in the program, but they leave with a guarantee of coverage from plans selling products in the individual insurance market. MRMIP's subsidy is funded from tobacco tax funds.

| **California Risk Pool (MRMIP) Enrollment Data[87]** | |
|---|---|
| Number enrolled as of October 2003 | 7,088 |
| Statutory Cap on Enrollment | 9,990 |
| Number of 36-month disenrollments to date | 9,336 |

Florida's high-risk pool, the Florida Comprehensive Health Association (FCHA), was created by the Legislature in 1982 and closed to new enrollment during SFY 1989 –1990. At its peak, the program had 7,500 enrollees.

Any excess losses in the FCHA are funded through an assessment of all health insurance carriers and HMOs based on a proportion of premiums earned. The present assessments limited by

[85] *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*. Mathematica Policy Research. August 2001.
[86] Ibid.
[87] *MRMIP Subscriber and Health Plan Data: October 2003 Summary*. Retrieved from the MRMIP Website January 2, 2004: http://www.mrmib.ca.gov/MRMIB/MRMIPRptSum.pdf.

statute cannot exceed 1% of a carrier's premium. Given the current base of approximately $15 billion, this statutory limit is presently about $150 million.

Originally, carriers were able to take a credit against their premium taxes for the FCHA losses. However, this tax offset was taken away in 1990. Then, with estimates of future losses as high as $100 million, the pool was closed to new enrollment after June 30, 1991.

Unfortunately, the loss projections that were provided to the legislature did not recognize policy form and administrative changes that had been implemented by the FCHA. The actual losses were less than a third of the projections at $33 million.

Current enrollment in Florida's closed pool is 521 persons. The average annual premium is $3,700. The program is financed by an assessment levied against insurance companies writing business in Florida and the individual's premium. Florida's inability to re-open the pool is financially driven. Losses for calendar year 2002 were $4.6 million. Part of the funding difficulty is due to the federal law that prohibits states from imposing health insurance assessments and surcharges on the ERISA-qualified plans.

## Groups Impacted

Individuals who cannot get coverage through the private market will be directly impacted. It is estimated that a Florida program for high-risk individuals should cover at least 16,000 persons.[88]

In addition, as a result of the "ripple effect" (mentioned above), a reduction in all health insurance premiums is projected, especially in the small employer market.

A summary of the impact of this "ripple effect" is provided below in the Actuarial Analysis section of this document.

## Considerations

The closure of the high-risk pool to new enrollment is believed to have adversely impacted small employer market premiums. Given that Florida provides guaranteed issue coverage to sole proprietors and other one-person groups, it is generally accepted that many otherwise uninsurable individuals find a way to establish a business and obtain small employer coverage. The inclusion of these high-cost individuals in this market who would have otherwise been enrolled in the high-risk pool means, in essence, that the small employer market is subsidizing much of the cost that would otherwise be incurred by the risk pool and spread across a significantly broader base.

The Federal Trade Act Amendments recognize the value of risk pools to the health insurance markets and include subsidies to establish a new pool or to offset losses incurred by existing pools.

Uninsurable individuals who do not find their way into the small employer market generally find access to health care, but may either present for care at high-cost centers (primarily emergency rooms) when less-expensive primary care would be appropriate or when they have advanced conditions that require emergency room or inpatient hospital care as a result of inadequate access to preventative and primary care.

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[88] *Access to Health Insurance for High Risk Individuals*, Presentation at Florida Health Insurance Symposium, September 22, 2003

While a high-risk pool removes high-cost or potentially high-cost individuals from the market, reducing overall cost to the remaining, comparatively healthy individuals, pools have had limited success in enrolling large numbers of individuals and substantially impacting the level of uninsurance within a state. However, the use of a risk-pool along with other reforms or initiatives would be an important part of a state's efforts to ensure access to affordable health insurance for all the state's citizens.

## Funding

Implementation of a new residual pool requires funding from the state budget (general revenue, etc.); an increase in insurance premiums (limited to not more than 1%); tax credits (a reduction in general revenue, etc.); or some combination of the above. The amount would depend upon the limitations set by the Legislature. The actuarial analysis below provides an estimate of the required funding.

The viability of a new residual pool can be assisted by:

- Securing a dedicated revenue source;
- Controlling enrollment in the pool; and
- Including a sunset provision tied to an outcomes and actuarial analysis of the impact and effectiveness of a new residual pool.

## Actuarial Analysis

The purpose of this analysis is to provide information and insight into the effect of opening a health insurance risk pool in Florida. The current pool, the Florida Comprehensive Health Association (FCHA), has been closed for over ten years and has approximately 500 lives remaining. The analysis and discussion provided below does not utilize the experience of the current pool, but rather attempts to estimate the impact of opening a new pool. The re-opening of the pool will provide for a flow of lives into and out of the pool rather than a stagnant group of high risk lives.

An assumption is made that the current lives in the FCHA pool are not reflective of experience that would be generated by an open pool. This assumption is validated by comparing the current pool's experience with other states' pools, as well as the FCHA's ability to negotiate preferential provider arrangements and spread administrative costs.

*Results*

Based on the analysis provided herein, the results of establishing a new health insurance risk-pool in Florida include:

- Insuring the uninsurable could reduce all health insurance rates by **2 percent** to reflect a reduction to uncompensated care costs.
- Removal of the HIPAA eligible individuals from the individual market could reduce individual rates by up to **2 percent**. Given Florida's premium volume is in excess of $11 billion, this amounts to over $200 million.[89]

[89] Florida Office of Insurance Regulation. CY 2003 collection and analysis of December 31, 2002 data reported by carriers as their "Supplemental Report of Gross Annual Premiums and Enrollment Data for Health Coverages Issued to Florida Residents," on form OIR-B2-1094.

- Removal of the one-life groups from the market could result in a decrease, or reduction to future rate increases in small employer rates of **1.0 to 5.5 percent** and prevent further subsidization of these groups by the employers with 2 – 50 employees as the one-life group experience continues to deteriorate.
- HIPAA individuals would receive nondiscriminatory access to coverage.
- An active pool would be able to negotiate improved provider contracts.
- An active pool would have lower unit costs for administration than realized by regular insurers.
- An open risk pool could provide state access to federal funds.
- A residual market would result in an enhanced health care market, leading to more carriers entering the market, greater competition and greater rate stability.

*Analysis*

The proposal for opening a health insurance risk pool includes providing coverage to not only the present uninsured population, but also to:

- One-life groups currently insured by the small group carriers; and
- HIPAA eligible individuals currently insured by the individual commercial market carriers.

Each of these groups currently has access to guaranteed issue coverage. The chart below demonstrates the results presented to the Governor's Task Force at its Miami meeting. The anticipated result is that charging each category 200 percent of the Standard Risk Rate (SRR) would provide a sufficiency in the one-life and HIPAA groups and a deficiency for the uninsurable individuals. The resulting subsidy requirement for almost 106,000 lives would be just under $30 million.

Details for each category follow.

| Category | Insureds | Premiums | Claims | Loss Ratio | Deficiency* |
|---|---|---|---|---|---|
| Uninsured | 20,000 | $152,477,475 | $186,564,549 | 122% | $49,012,238 |
| One-Life Groups | 80,155 | $315,172,239 | $283,476,797 | 90% | -$9,017298 |
| HIPAA | 5,714 | $57,283,880 | $41,866,329 | 73% | -$12,068,245 |
| | | | | | |
| **Total** | 105,869 | $524,933,594 | $511,907,675 | 98% | $27,926,695 |
| **Per Enrollee** | | $4,958 | $4,835 | | |

**includes administration equal to 8 percent of total claim costs*

*The Uninsured*

If a pool were opened to provide insurance to currently uninsured lives, the Office of Insurance Regulation anticipates that the experience would replicate other state pools similarly situated. (See notes at end of document.) Using this assumption, and based on the average experience realized by California, Texas, Illinois and Minnesota, (other large state risk pools), the pool would reflect a 16 percent anticipated deficiency for 20,000 newly insured lives.

| Insureds | Premiums | Claims | Loss Ratio |
|---|---|---|---|
| 20,000 | $102,659,128 | $111,797,417 | 109% |

Projections from this analysis are better than the results of the group conversion experience of the current carriers. To be more conservative, the figures below assume the conversion level experience. At the 200% SRR, this would generate $49 million in pool deficiency (26 percent of claim costs).

| Insureds | Premiums | Claims | Loss Ratio |
|---|---|---|---|
| 20,000 | $152,477,475 | $186,564,549 | 122% |

*One-Life Groups*

The rates presently charged to one-life groups in the small group market range by carrier, county and gender. For HMOs, these range from 151 percent to 256 percent (average of 201 percent) of the SRR published by the Office of Insurance Regulation (OIR). For commercial insurers, this range is broader, from 149 percent to 536 percent (average 270 percent) of the SRR. This means that, on the average – considering HMO and commercial insurer experience - one-life groups are paying rates 10 percent higher than would be charged in the FCHA (200 percent of the SRR).

| Members | 2002 CY Premium | Adj. Premiums One-Life Surcharge | Max. Premiums | 2002 CY Claims |
|---|---|---|---|---|
| 80,155 | $253,276,602 | $358,257,773 | $379,914,903 | $283,476,797 |

Source: Florida small group market survey.[90]

If a risk pool had insured this market, the rates charged to consumers would be approximately 10 percent less than they are currently being charged. By carrier and category, such revisions would alter insurance rates in a range from a 35 percent rate increase to a 60 percent decrease. This finding is consistent with industry concern over one-life groups terminating group coverage to move to group conversion coverage, which is limited to 200 percent SRR.

The illustrative impact of these lives being written by a risk pool and charging 200 percent SRR is as follows:

| Members | Premium | Claims | Loss Ratio |
|---|---|---|---|
| 80,155 | $325,308,420 | $283,476,797 | 87% |

- When the small group law was changed to allow for a one-life group rate-up, the carriers were able to reduce their 2-50 community rate by up to 6 percent. This reduction reflected the average subsidy that the 2-50 rate had been increased to support the adverse experience realized by the one-life groups.

[90] Florida Office of Insurance Regulation (OIR): Phone survey [requested October 2003] – experience period CY 2002 [20 carriers responding].

- Since the change in the law and the subsequent increase to one-life group rates, enrollment has decreased and experience has deteriorated to the point that the 50% rate-up authorized by legislation is no longer adequate to cover the cost of these groups. Some large carriers report One-Life Group experience that would justify a rate 20% higher than the maximum allowed. This rate shortfall is subsidized by groups of two to fifty employees. If the one-life group experience is removed from the small group market and the 2-50 life experience is permitted to be self sufficient, the market could realize an additional 1.0 - 5.6% percent average rate decrease.

*HIPAA eligible individuals*
Five carriers were surveyed accounting for 5,700 HIPAA lives. The actual experience is:

| Insured lives | Premiums | Claims | Loss Ratio |
|---|---|---|---|
| 5,714 | $43,596,423 | $41,866,329 | 96% |

Source: Survey to larger carriers in the individual market.[91]

The above experience reflects the fact that carriers are charging a premium that exceeds the rate charged individuals meeting their underwriting standards. If these lives had been insured by the FCHA pool and charged a rate of 200 percent SRR, the premium revenue would increase on average 32 percent.

| Insured lives | Adj. Premiums | Claims | Loss Ratio |
|---|---|---|---|
| 5,714 | $57,283,880 | $41,866,329 | 73% |

*Alternate Scenario*
A worst-case scenario of the anticipated experience of the risk pool is provided here.

| Category | Insureds | Premiums | Claims | Loss Ratio | Deficiency* |
|---|---|---|---|---|---|
| One-Life Groups | 40,078 | $162,653,210 | $170,086,078 | 105% | $21,039,754 |

*includes administration equal to 8 percent of total claim costs

In preparing the summary, OIR anticipated that not all 80,000 one-life groups would seek or qualify for insurance in the FCHA pool. OIR has assumed that half of these lives will seek coverage in the pool. OIR also assumed an anti-selection factor of 120 percent. This factor represents the fact that healthier lives will seek coverage elsewhere and the less healthy will qualify for coverage in the pool.

| Category | Insureds | Premiums | Claims | Loss Ratio | Deficiency* |
|---|---|---|---|---|---|
| HIPAA | 5,714 | $57,283,880 | $41,866,329 | 73% | $0 |

[91] Florida Office of Insurance Regulation (OIR): Phone survey. [Requested October, 2003]. Four carriers responding out of five requested. One was unable to isolate HIPAA experience.

| Category | Insureds | Premiums | Claims | Loss Ratio | Deficiency* |
|---|---|---|---|---|---|
| Uninsured | 20,000 | $152,477,475 | $186,564,549 | 122% | $49,012,238 |
| | | | | | |
| Total | 65,792 | $372,414,565 | $398,516,956 | 107% | $70,051,992 |

*includes administration equal to 8 percent of total claim costs

The above illustration reflects the following:

| Per Insured Life | Dollars |
|---|---|
| Average Premium | $5,922 |
| Average Claim | $6,119 |
| Average Deficiency | $1,249 |

It is also important to note that federal funds are available to qualifying pools. One condition currently required for access to such funds is that the plan rate cannot exceed 150 percent SRR. The impact of reducing the rate from 200 percent SRR to 150 percent SRR is that the $94,788,468 pool deficiency would increase to $137,704,496.

## Notes

*State High Risk Pools*[92]

A review was conducted of four states' high-risk pools in order to determine the average experience being realized by other states where the pool is currently accepting new risks. The four states reviewed were: California, Illinois, Minnesota and Texas. The combined experience of these four states represents over 85,000 current insureds with the average premium and claim per insured being $3,600 and $5,600 respectively. Overall, the four pools average slightly over 40 percent of the claims costs being supported by external income, i.e., industry assessment or other funding mechanism. The specific 2002 CY experience of the noted pools is illustrated below:

| State | Insureds | Premium | Claims | LR | %SRR | Deficiency* |
|---|---|---|---|---|---|---|
| California | 16,288 | $73,957,652 | $99,324,651 | 134% | 125% | $30,688,962 |
| Illinois | 14,791 | $64,593,074 | $95,980,035 | 149% | 125% | $37,313,270 |
| Minnesota | 31,088 | $77,281,946 | $145,747,695 | 189% | 125% | $77,018,821 |
| Texas | 23,360 | $93,674,088 | $137,032,503 | 146% | 200% | $54,955,335 |
| | | | | | | |
| **Total** | **85,527** | **$309,506,760** | **$478,084,884** | **154%** | | **$199,976,388** |

*includes administrative costs

Note that three of the above four pools charge their insureds less than the 200 percent of the Standard Risk Rate (SRR). The SRR is published by the OIR annually to represent the average rate of the individual market for those carriers currently offering individual insurance coverage.

[92] Comprehensive Health Insurance for High Risk Individuals, 17th Edition 2003/2004. SelfEmployedCountry.org. http://www.selfemployedcountry.org/riskpools/manual.html.

Current Florida Statutes provide that the maximum FCHA rate is 200 percent - 250 percent SRR. If the experience of the reviewed pools were adjusted to be at the 200 percent SRR limit, California and Illinois would be self-sufficient and Minnesota would reduce the $77 million deficiency to $30 million (a reduction of 53 percent of claim costs to 21 percent of claim costs). This is illustrated below:

| State | Insureds | Adj. Premium | Claims | LR | %SRR | Deficiency* |
|---|---|---|---|---|---|---|
| California | 16,288 | $118,332,243 | $99,324,651 | 84% | 200% | $0 |
| Illinois | 14,791 | $103,348,918 | $95,980,035 | 93% | 200% | $0 |
| Minnesota | 31,088 | $123,651,114 | $145,747,695 | 118% | 200% | $30,649,653 |
| Texas | 23,360 | $93,674,088 | $137,032,503 | 146% | 200% | $54,955,335 |
| | | | | | | |
| **Total** | **85,527** | **$439,006,363** | **$478,084,884** | **109%** | | **$85,604,988** |

**includes administrative*

*High Risk Pool Utilization*

It is a fallacy that all policyholders in a high-risk pool are high utilizers of health care. Reviewing data of the current FCHA pool as well as group conversion experience of other insurers and HMOs, approximately 95 percent of all cumulative lifetime claims of in-force policies fall between $0 and $99,999.99. Additionally, approximately 12 percent of conversion lives have not filed any claims, with 84 percent of conversion lives filing claims between $1 and $24,999. Looking at this differently, cumulative claims represent between 0 percent and 9 percent of the available lifetime policy limits for 88.4 percent of the in-force business reviewed. This information indicates that individuals do not enter the conversion pool because they are high risk for large immediate claims, but rather that they may be uninsurable, i.e., do not meet industry underwriting standards. An uninsurable individual is not synonymous with a high-risk individual.[93]

[93] Florida Office of Insurance Regulation (OIR): Phone survey [Requested June 2003] and OIR rate filing data. Nine carriers reviewed.

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# Attachment A: Executive Order

STATE OF FLORIDA
OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NO. 03-160

WHEREAS, more than 38 million Americans have no health insurance; and

WHEREAS, according to the Kaiser Family Foundation, eight out of ten uninsured Americans are workers or dependents of workers and nearly eight out of ten uninsured Americans have family incomes above the poverty level; and

WHEREAS, more than 2.8 million Floridians have no health insurance; and

WHEREAS, fifty-five percent of those who do not have insurance state the reason they don't have insurance is lack of affordability; and

WHEREAS, according to the Bureau of the Census, there is a large disparity in the degree of lack of insurance by ethnic group, with twelve percent of non- Hispanic whites being uninsured, compared with twenty-one percent of African Americans and thirty-four percent of Hispanics being uninsured; and

WHEREAS, an increasing number of employers are opting to cease providing insurance coverage to their employees due to the high cost; and

WHEREAS, an increasing number of employers who continue providing coverage are forced to shift more premium cost to their employees, thus diminishing the value of employee wage increases; and

WHEREAS, according to studies, the rate of avoidable hospitalization is fifty to seventy percent lower for the insured versus the uninsured; and

WHEREAS, according to Florida Cancer Registry data, the uninsured have a seventy percent greater chance of a late diagnosis, thus decreasing the chances of a positive health outcome; and

WHEREAS, according to the Agency for Health Care Administration's 2002 financial data, uncompensated care in Florida's hospitals is growing at the rate of twelve to thirteen percent per year. At $4.3 billion in 2001, this cost, when shifted to Floridians who remain insured, is not sustainable; and

WHEREAS, Medicaid caseloads grew almost seven percent in the last fiscal year, and the costs of the Medicaid program continues to grow at an alarming rate; and

WHEREAS, average health insurance premium increases for the last two years have been in the range of ten to twenty percent for Florida's employers; and

WHEREAS, the Florida Legislature, through the creation of Health Flex, has already identified the need for lower cost alternatives; and

WHEREAS, some communities in Florida and throughout the nation have established local initiatives to address the problem of the uninsured; and

WHEREAS, the Governor's office, in cooperation with the Department of Financial Services, has planned a symposium on the uninsured for September 21-22, 2003; and

WHEREAS, it is of vital importance and in the best interests of the people of the State of Florida, that the needs of the uninsured and the issue of available, affordable health care insurance be addressed in a cohesive and meaningful manner; and

WHEREAS, there is general recognition that the issues surrounding the problem of access to affordable health insurance are complicated and multifaceted.

NOW THEREFORE, I, JEB BUSH, Governor of the State of Florida, by the powers vested in me by the Constitution and laws of the State of Florida, do hereby promulgate the following Executive Order, effective immediately:

Section 1.

A. There is hereby created the Governor's Task Force on Access to Affordable Health Insurance (the "Task Force").

B. I hereby appoint Lieutenant Governor Toni Jennings and Chief Financial Officer Tom Gallagher to Co-Chair the Task Force. The Task Force will be comprised of business leaders, health policy experts, health care providers and consumers.

C. The Task Force shall be composed of the following members:

(1) Lieutenant Governor Toni Jennings, Co-Chair
(2) Chief Financial Officer Tom Gallagher, Co-Chair
(3) Dr. Rhonda Medows, Secretary, Agency for Health Care Administration
(4) R. Paul Duncan of Gainesville, Professor and Chair of the Department of Health and Services Administration, University of Florida
(5) Sue G. Brody of St. Petersburg, President & CEO, Bayfront Health System, Inc.
(6) John M. Hogan of Tallahassee, CEO, Capital Health Plan
(7) Anthony Suarez of Orlando, Attorney, A. Suarez & Associates, P.A.
(8) Nancy P. Keefer, President, Bonita Springs Chamber of Commerce
(9) Dr. Lazaro Hernandez of Tampa, Obstetrician & Gynecologist
(10) Marvin O'Quinn of Miami, President & CEO, Jackson Health System
(11) Ken Stevenson of Tallahassee, Insurance Broker, Earl Bacon Agency
(12) Rick Walsh of Orlando, Senior Vice President, Darden Restaurants, Inc.
(13) Fleur Sack of Miami, President, Florida Academy of Family Physicians
(14) Sue Story of Gulf Breeze, President & CEO, Gulf Power
(15) Rosa B. Ramos of Plantation, Registered Nurse, Miami Children's Hospital

D. Task Force members shall receive no compensation, but shall be entitled to per diem and travel expenses while attending meetings of the Task Force to the extent allowed by Section 112.061, Florida Statutes. Per diem and travel expenses shall be paid in accordance with Chapter 112, Florida Statutes. The Task Force will be staffed and supported with all available resources of the Agency for Health Care Administration and the Office of Insurance Regulation.

E. The Task Force shall meet at the call of the chairpersons. The Task Force shall act by a vote of the majority of its members present, either in person or via communication technology. No member may grant a proxy for his or her vote to any other member or member designee, except with the prior approval of the chairpersons. I will fill by appointment any vacancy that occurs on the Task Force.

Section 2.

A. The Task Force shall be advisory in nature and is created for the purpose of:

1. Identifying the contributing factors to the increasing costs of health insurance and the cost of accessing insurance in Florida;
2. Identifying the major barriers that prevent Floridians from obtaining health insurance coverage;

3. Identifying federal issues regarding health insurance coverage that may contribute to higher health insurance costs, and which may need to be communicated to federal lawmakers;
4. Investigating pilot and other alternative approaches to traditional health insurance which have been demonstrated to be effective in providing health care coverage to various populations;
5. Identifying potential partnerships the state can utilize to increase available health insurance coverage; and
6. Providing policy recommendations to improve access to affordable health insurance, and achieve more predictable cost, while maintaining consumer choice.

Section 3.

To aid its study of the issues and the development of its recommendations, the Task Force may take public testimony from experts and stakeholders. In addition, the Task Force is encouraged to take whatever other steps are necessary to gain a full understanding of the medical, legal, insurance and other issues involved.

Section 4.

The Task Force shall submit an interim report setting forth recommendations, including any recommendations for legislative action, to the Governor, the President of the Florida Senate and the Speaker of the House of Representatives by January 15, 2004. The Task Force shall submit a final report setting forth the recommendations, including any recommendations for legislative action, to the Governor, the President of the Florida Senate and the Speaker of the House of Representatives by February 15, 2004.

Section 5.

All agencies within the authority of the Executive Office of the Governor are directed, and all other agencies are requested, to render full assistance and cooperation to the Task Force on Access to Affordable Health Insurance.

Section 6.

The Task Force shall continue in existence only until its objectives are achieved, but its existence shall terminate in any event no later than May 30, 2004, unless extended by further Executive Order.
IN TESTIMONY WHEREOF, I have hereunto set my hand and have caused the Great Seal of the State of Florida to be affixed this 25th day of August, 2003.

_____
GOVERNOR

ATTEST:

_____
SECRETARY OF STATE

# Attachment B: Task Force Member Biographies

# Task Force Member Biographies

*(Note: Senator Peaden and Representative Farkas were added to the Task Force at its first meeting. Dr. Buznego replaced Dr. Hernandez, who was identified in the Executive Order.)*

## Lieutenant Governor Toni Jennings, Co-Chair

Toni Jennings, the 16th Lieutenant Governor of Florida, is the first woman to hold the office. A native of Orlando, Lt. Governor Jennings is a successful businesswoman and a dedicated public servant.

Prior to her current role, Lt. Governor Jennings served as Florida's first two-term State Senate president. As Senate leader, she distinguished herself as a skilled consensus builder. She also used her background as a business leader and former fifth-grade teacher to champion workforce development initiatives in Florida and created the state's school readiness program in 1993. While in the Senate, Lt. Governor Jennings helped create a system of accountability in public education and led the development of effective solutions for the crisis created by rising workers' compensation rates.

Lt. Governor Jennings also was a driving force behind the state's successful program to move citizens from welfare to self-sufficiency, and later chaired Workforce Florida, Inc. from 2000-2002. In this role, she successfully balanced the training needs of Florida's workers with the skills required by Florida's employers. Additionally, Lt. Governor Jennings is committed to civic leadership. Before accepting the responsibilities of Lt. Governor in March 2003, Lt. Governor Jennings served on the Florida Chamber of Commerce, the Rollins College Board of Directors, the Florida Tax Watch Board, the National Advisory Council of the Arnold Palmer Children's Hospital and the University of Central Florida Foundation Board.

In 2002, Lt. Governor Jennings was named to the Florida Women's Hall of Fame. She received a number of awards during her legislative tenure including "Florida Guardian of Small Business" by the National Federation of Independent Businesses, Florida Wildlife Association/National Wildlife Association "Conservation Legislator of the Year," and the Florida School Boards Association "Friend of Education Award." Additionally, she twice earned distinction as a "Friend of the First Amendment" by the First Amendment Foundation.

A native Floridian, Jennings is a product of the public school system and is a graduate of Wesleyan College. She has dedicated more than 24 years to serving the people of Florida. She has also earned respect in the construction industry, leading Jack Jennings and Sons, a family-owned construction company, into its 55th anniversary in 2003. For more than 20 years as a corporate officer, she negotiated purchase of health insurance coverage for employees of the construction company.

## Chief Financial Officer Tom Gallagher, Co-Chair

Tom Gallagher's life in public service began in 1974 when he was elected to the Florida House of Representatives. He served for 13 years in the House, seven of which were spent as the only republican from the Miami-Dade delegation.

In 1987, Governor Bob Martinez appointed him Secretary of the Department of Professional Regulation, and in 1988, he was first elected to the Cabinet position of State Treasurer, Insurance Commissioner and Fire Marshal. As Insurance Commissioner, Gallagher is best known for his leadership in the aftermath of Florida's most devastating and costly natural disaster - Hurricane Andrew. Also during his tenure, Gallagher spearheaded the creation of the Healthy Kids Corporation, a program that offers health insurance to more than 500,000 uninsured children in Florida.

After serving as Education Commissioner from 1998-2000, Gallagher was again elected State Treasurer in November 2000. During the 2002 legislative session, Gallagher was instrumental in the passage of a bill creating Citizens Property Insurance Corporation, designed to be exempt from federal taxes, saving Floridians nearly $100 million annually.

In 2003, Gallagher was sworn in as Florida's first Chief Financial Officer. During the 2003 legislative session, Gallagher persuaded lawmakers to enact legislation putting an end to predatory rating practices used by out-of-state insurance companies. Under the new law, companies that target policyholders for drastic rate increases when they become ill could lose their insurance licenses.

As the Chief Financial Officer, Gallagher has been tasked with monitoring the state's fiscal health. In order to provide the legislature with information to better prioritize existing resources and track trends in how state funds are spent, Gallagher is proposing improvements to Florida's statewide accounting system.

Gallagher is married to the former Laura Wilson, a sixth generation Floridian from Madison, Florida. Laura received her bachelor's degree from Wheaton College and her law degree from Notre Dame. Tom and Laura are the proud parents of a 4-year old son, Charlie.

### Rhonda Medows, MD, FAAFP, Secretary, Agency for Health Care Administration

Governor Jeb Bush appointed Dr. Rhonda M. Medows Secretary for the Agency for Health Care Administration (AHCA) on July 10, 2001, and she assumed her post on August 6, 2001.

Immediately prior to joining the Agency, she was a Medical Director at Blue Cross Blue Shield of Florida in Jacksonville, from March 2000, and was responsible for the Health Plan Quality Compliance division and the Medical Coverage Guideline Development Area. She served on the Board of Directors of the Florida Blue Charitable Foundation.

From 1993 to 2000, Dr. Medows was in private practice at the Mayo Clinic in Jacksonville, specializing in Family Medicine which includes adult medicine, pediatrics, office gynecology, minor surgery and procedures and urgent care.

From 1989 to 1993, she was associated with Kaiser Permanente, in Atlanta as a family physician.

Dr. Medows graduated from Cornell University in Ithaca, NY, with a degree in biology and business management, and received her medical degree from Morehouse School of Medicine in Atlanta. She completed her internship and residency at University Hospital at Stony Brook Family Practice Residency Program in Stony Brook, NY.

She has been a member of the American Academy of Family Physicians, the National Medical Association, the American College of Physician Executives, the Florida Medical Association, the Florida Academy of Family Physicians, and the National Association of Managed care Physicians.

In addition, she has been active in the We Care Jacksonville Volunteer Physician program, a member of the Florida Commission on Excellence in Health Care (2000), on the Board of Directors of the Hubbard House Women's Crisis Center inJacksonville (1997-2001), the Mayor's Commission on the Status of Women in Jacksonville (1998-Present) and on the Board of Directors of the Ponte Vedra Beach Chamber of Commerce (1998-2000).

She is married to Dr. Wells and the couple has three children. They live in Tallahassee, FL.

### R. Paul Duncan, Ph.D., of Gainesville, Louis C. and Jane Gapenski Professor of Health Services Administration; Chairman, Department of Health Services Administration; Director, Ph.D. Program in Health Services Research; Director, Master of Public Health Program; University of Florida Professor

Paul Duncan has been a faculty member at the University of Florida for just under twenty-five years. His appointment is in the Department of Health Services Administration, College of Health Professions, where he also serves as Chairman. Duncan's teaching assignments are targeted to the training of health services administration professionals focused on the challenges of administrative leadership in health care organizations, as well as doctoral level trainees focused on studying and understanding how the health care system works.

Author of nearly 100 published articles and dozens of health policy reports, the primary focus of Duncan's research is access to health care, including health insurance coverage. From 1998 until the present, he has been responsible for the design and implementation of major surveys of health insurance coverage in Florida, Kansas, Indiana and elsewhere.

When not teaching or doing research, Duncan takes his interests into the community. He has been a member and chair of the Health Care Board of Alachua County, Florida. For almost ten years, he served on the Board of Directors, and has twice been elected President of the ACORN Clinic, an award winning medical and dental care clinic that serves poor and uninsured rural residents in the areas north of his home in Gainesville, Florida.

### Sue G. Brody of St. Petersburg, President & CEO, Bayfront Health System, Inc.

Sue Brody serves as president and chief executive officer of Bayfront Medical Center, a private, not-for-profit, 502-bed trauma center and community teaching hospital in St. Petersburg, Florida. Bayfront also operates the four-helicopter Bayflite air-medical program. Since joining Bayfront in 1995 as chief operating officer, Ms. Brody has increased the hospital's market share and implemented a $100 million capital improvement program, including the addition of high-tech services such as gamma knife, deep-brain stimulation and cardiac catheterization. She has created a family-friendly workplace, including on-site childcare, a K-4 partnership school for children of employees and care for sick children. During Ms. Brody's tenure, Bayfront's financial commitment to providing charitable care has grown to an annual level of nearly $15 million.

### John M. Hogan of Tallahassee, CEO, Capital Health Plan

Mr. Hogan has served as the Chief Executive Officer for Capital Health Plan throughout its 25 year history. The plan today serves 109,000 residents of the Tallahassee area. CHP is a national leader in health plan circles, having been selected in 2002 by the National Committee on Quality Assurance as one of the most effective programs in the country. CHP was the only health plan receiving such a recognition in the southeast.

CHP has been an innovator in affordable health care delivery in Tallahassee, developing the area's first HMO, first and most extensive urgent care services, first hospitalist program, and first center for chronic care services. The health plan has served the small business community since the 1980's and today has over 20,000 members drawn from small employers. The health plan is an affiliate of Blue Cross and Blue Shield of Florida, a relationship initiated in 1981.

Capital Health Plan is an active partner with the Robert Wood Johnson Foundation sponsored Pursuing Perfection program at Tallahassee Memorial and is a training site for the FSU College of Medicine. Mr. Hogan serves on the advisory board for the medical college. He holds a bachelor's degree from the University of North Carolina (1972), an MA from the University of Virginia (1976), and an MBA from Florida State University (1984).

### Anthony Suarez of Orlando, Attorney, A. Suarez & Associates, P.A.

Anthony Suarez graduated from St. John's University School of Law in 1977. He was admitted to the bar in the States of New York and Florida as well as the Federal District Courts throughout the country. Mr. Suarez is currently an adjunct law professor at the Barry University School of Law, and President of A. Suarez and Associates.

Mr. Suarez is also a former member of the Florida House of Representatives. He served as a Captain in the United States Army reserves from 1974 to 1988, and was appointed by Governor Chiles to the Judicial Nominating Commission, 18th Judicial District in 1997, and appointed by Governor Bush to the Educational Opportunities Task Force in 1999 as a trial attorney and small business owner.

Mr. Suarez is familiar with the issues facing consumers of health products and of the providers of such. He knows that a legislative solution is delicate due to the complex nature of the industry and consumer expectations.

## Nancy P. Keefer, President, Bonita Springs Chamber of Commerce

Nancy Keefer joined the Bonita Springs Area Chamber of Commerce in January 1997 as their President. Prior to Bonita Springs, Keefer was the Executive Vice President of the Chemung County Chamber of Commerce in the Finger Lakes Region of Upstate NY for nine years. Included in her current responsibilities is the day to day operations of the 1200 member business organization. Under Keefer's leadership, the Bonita Springs Area Chamber of Commerce was named Chamber of the Year for the State of Florida in July 2000 and received Accreditation by the U.S. Chamber of Commerce in 2002. Statewide and Nationally, Keefer serves on the Executive Board for the Florida Chamber of Commerce Executives, the Board of Governors for the Florida Chamber and is a member of the Board of Regents for the U.S. Chamber Institute Program at the University of Georgia. Keefer was named "Citizen of the Year" by the Bonita Springs Lions Club for 1997-98, named a "Woman of Style" by N Magazine in March 2001 and named by Gulfshore Business Magazine as one of the "40 top community leaders under 40" in southwest Florida in September 2003.

## Carlos Buznego, M.D., Center for Excellence in Eye Care

Dr. Carlos Buznego is proud to serve his "hometown" community of Miami. Born in Havana Cuba, his family moved to the United State in 1962. Dr. Buznego attended local schools in Miami and graduated Valedictorian from Southwest High School in 1979. At Washington University in St. Louis, Dr. Buznego was a "Scholar in Medicine" accumulating various honors while earning his Bachelors and Medical degrees. Dr. Buznego was awarded "Grand Prize in Ophthalmology" for his accomplishments at the Washington University Medical School. He completed his training in Ophthalmology at Bascom Palmer Eye Institute in 1991.

Dr. Buznego's specialty is micro surgery including LASIK, cataract, and glaucoma surgery. He is board certified by the American Board of Ophthalmology and certified by VISX to perform laser vision correction procedures for treatment of nearsightedness, farsightedness and astigmatism. Dr. Buznego is a voluntary assistant professor of ophthalmology at the University of Miami's Bascom Palmer Eye Institute Baptist and South Miami Hospitals.

Highly respected by his papers, Dr. Buznego has been named one of the "Best Doctors in South Florida" in *Miami Metro* magazine's poll of physicians. Dr. Buznego served as president of the Dade County Medical Association in 2002, as the youngest president in history of the DCMA. He also served as the president of the Florida Society of Ophthalmology among Florida's Eye Physicians and Surgeons. In 1996, the FSO named Dr. Buznego "Young Ophthalmologist of the Year." He is active on the board of directors for several other medical and ophthalmology organization.

Dr. Buznego is married with two children and is an avid professional and collegiate sports fan. He enjoys skiing, biking and politics.

## Marvin O'Quinn of Miami, President of the Public Health Trust; President & CEO, Jackson Health System

Marvin O'Quinn was recently named president of the Public Health Trust and chief executive officer of Jackson Health System, a countywide, integrated network that has the 1,757-bed Jackson Memorial Hospital as its centerpiece. Jackson Memorial is the largest charity care and Medicaid provider in the state. With more than 55,000 discharges and 500,000 patient visits annually, Jackson is one of the busiest hospitals in the nation, and also serves as the teaching hospital for the University of Miami School of Medicine. Prior to coming to Miami, O'Quinn was the executive vice president of operations for the Atlantic Health System in Florham Park, New Jersey, which, like Jackson, is a medical school teaching affiliate. Before the Atlantic Health System, one of the largest nonprofit systems in central and northern New Jersey, he was the senior vice president/chief operating officer for New York Presbyterian Hospital, which resulted from a merger between Columbia Presbyterian Medical Center and New York Hospital-Cornell Medical Center.

## Ken Stevenson of Tallahassee, Insurance Broker, Earl Bacon Agency

Ken Stevenson has spent most of his 20-year career in the insurance industry as an agent and sales manager. He has won top producer awards on numerous occasions as well as Team Performance Awards. His career includes

serving as an Administrator for the Office of Insurance Regulation and also several years as a National Sales Trainer and Consultant. Now Ken concentrates exclusively on employee benefits as an agent for the Earl Bacon Agency, in Tallahassee. Ken is a Graduate of Furman University and lives with his wife Connie and their two children in Tallahassee, Florida. Professional designations include CPCU, AAI, CPM. Ken is also the Statewide Agent Representative for the Florida Association of Health Underwriters.

### Richard J. Walsh of Orlando, Senior Vice President of Corporate Affairs, Darden Restaurants, Inc.

Darden Restaurants, Inc., (NYSE) is the world's largest publicly traded casual dining restaurant organization and one of the 50 largest employers in the United States. Headquartered in Orlando, Darden owns and operates Red Lobster, Olive Garden, Bahama Breeze, Smokey Bones BBQ Sports Bar and the most recent test restaurant, Seasons 52. He joined General Mills in 1984 and currently serves as senior vice president, Corporate Affairs, and is a member of the Darden Executive Management Team. He received a BA in political science in 1977 and a master's in public policy in 1983 from the University of Central Florida. Locally, he serves on the University of Central Florida Board of Trustees and College of Business Advisory Council of the University. He also serves as immediate past-chairman of the Florida Chamber of Commerce; the SunTrust Bank Administrative Board; Orange County Arts and Cultural Affairs Council and the Orange County Mobility 20/20 initiative.

His interests include collecting Native American and Western art, reading, horses and climbing.

### Fleur Sack of Miami, President, Florida Academy of Family Physicians

Dr Fleur Sack is a Board Certified Family Physician who has been practiced in the South Miami area for 20 years. She was born in 1948 in South Africa where she graduated from the University of Witwatersrand in 1972. After immigrating to America in 1976, she completed a residency in Family Practice at the University of Miami and Jackson Memorial Hospital in 1982.

Dr Sack is presently the President of the Florida Academy of Family Physicians. In 2001 she was the recipient of the prestigious Florida Family Physician of the Year and a nominee for the American Academy of Family Physicians of the Year Award. Her leadership in addressing Florida Legislators and decision makers displays her deep commitment that patients maintain access to excellent health care. She is the author of a book, Romance to Die For. Published in three languages it is about HIV prevention for women. As a crusader for the improvement of health in her community she has been the recipient of numerous patient awards including the Weizmann Institute "Women of Vision Award" and the "Doctor's Day Award" from the Dade County Medical Association Alliance.

Her diverse appointments at Baptist Health Systems of South Florida, where she is affiliated, have included: Chairman of the Department of Family Medicine, Member of the Medical Board, Chairman of the Physicians' Advisory Council, Medical Director of Women's Health for the Center for Health and Fitness Miami , Collaborative Medicine Task Force, Quality Assurance Committee , Ethics Committee, Education Committee and Bioterrorism Task Force.

She has been actively involved in the Florida Academy of Family Physicians serving on the Board, on the Government Affairs Committee and the Quality Practice Managemnt Committee. Nationally she served on the Committee on Women in Medicine.

Dr Sack is married to Anesthesiologist Simon Frank and they have two married sons and one grandchild.

### Susan N. Story of Gulf Breeze, President & CEO, Gulf Power

Ms. Susan N. Story is President and CEO of Gulf Power Company, which is a subsidiary of Southern Company, one of the largest electric utilities in the United States. Susan is responsible for the overall direction and operations of Gulf Power, which provides electricity to 10 counties in Northwest Florida. She has worked for Southern Company for 21 years in a number of capacities, beginning her career as a nuclear power plant engineer, and serving in various managerial and officer positions, including Director of Human Resources and Executive

Vice-President of Engineering and Construction for Southern Company. In her role as Director of Human Resources in the early 1990s, she was responsible for Compensation and Benefits programs for Southern Company Services, dealing with complex market and employee issues in health care delivery and capital accumulation (pensions, 401K, etc.) plans. In her current role as President and CEO, she deals with the challenges of financial predictability and affordability of health care for the 1400 employees who work for Gulf Power in Northwest Florida.

Susan has a B.S. in Industrial Engineering from Auburn University and an MBA from the University of Alabama in Birmingham. She has attended executive management and leadership programs at Duke University, Oxford and Cambridge Universities in England, and Harvard University. She has also done post-graduate work in financial options and derivatives at the University of Alabama, and tort, contracts, and criminal law at the Birmingham School of Law.

### Rosa B. Ramos of Plantation, Registered Nurse, Miami Children's Hospital

Ms. Ramos graduated from Miami Dade Community College with a degree in nursing. She is currently the Chair of the Florida Board of Nursing, and has been on the Board for the 3 1/2 years. Ms. Ramos has been working in health care for 18 years, most of it at Miami Children's Hospital. Her main experience is surgery, trauma and triage. She also has experience working with diabetic patients at South Miami Hospital, asthma patients and in physician's offices. She is currently a part time nursing school instructor at Atlantic Vocational Technical School. She also is a member of the AHCA Risk Management Council of Florida.

### Frank Farkas, D.C. State Representative, House District 52

First elected to the Florida House of Representatives in 1998 and re-elected subsequently in 2000 and 2002, Frank Farkas has distinguished himself as a state lawmaker and community leader.

He currently serves as Chairman of the Health Care Committee and Vice-Chairman of the Health Appropriations Subcommittee. He is also a member of the Business Regulation Committee, Education K-20 Committee, Higher Education Subcommittee, Procedures Committee, Rules Subcommittee, Select Committee on Medical Liability Insurance, Policy Committee, and Coordinating Committee on Public Security. In addition, he has served on the House Budget Conference Committee every session since 1999.

Representative Farkas' legislative effectiveness and leadership have been recognized by citizen groups throughout the state. He has been presented with the Beacon of Hope Award - Carlton Manor, Inc. (2003), Florida Chamber of Commerce 2002 "A" Honor Roll, Pinellas County Osteopathic Medical Society's Legislator of the Year Award (2002), Florida Dietetic Association Legislative Appreciation Award (2002), Florida Association of Chamber Professionals' Legislative Appreciation Award (2002), Florida Optometric Association Legislator of the Year Award (2001), the Florida Association of Counties' County Champion Award (2001), the Florida Society of Health-System Pharmacists Legislator of the Year Award (2001), the Florida Dental Association Representative of the Year Award (2001), the Salvation Army "Children's Village" Development Recognition Award (2001), the Florida Massage Therapy Association Legislative Appreciation Award (2001), the Florida Holocaust Museum Appreciation Award (2001), the Florida Podiatric Medical Association Appreciation Award (2001), the Healthy Start Coalition Appreciation Award (2001), the Citizens for Health Freedom Appreciation Award (2001), the Florida Association of Homes for the Aging and the Residents of Palm Shores Legislator Appreciation Award (2001), the Suncoast Epilepsy Association Appreciation Award (2001), the Florida Association of Insurance and Finance Advisors Representative of the Year Award (2000), the National Federation of Independent Businesses' Guardian of Small Business Award (2000), the D.I. Rainey Legislative Award (2000), the Florida Assisted Living Association Legislative Appreciation Award (2000), the Florida Department of Juvenile Justice "Bridge Builder" Appreciation Award (2000), the American Heart Association Appreciation Award (2000), the American Cancer Society Appreciation Award (2000), the Friend of Massage Therapy Award (1999) and the American Cancer Society Appreciation Award (1999). In addition, Representative Farkas was selected as one of the Florida Chamber of Commerce's Top 40 legislators for the 2001 session, and in 2000, and 2003, surveys conducted by the Miami Herald, ranked as one of the most effective legislators, placing in the top quartile among House members.

Beyond his legislative work, Frank's community involvement includes service as the past president of the St. Petersburg Jaycees, the Snell Isle Neighborhood Property Owners Association, the St. Petersburg Rotary Club, the Pinellas County Chiropractic Society and the Florida Chiropractic Association. He has been Chairman of the St. Petersburg Small Business Council and Nina Harris Boy Scout Troop 350. His professional awards include Small Business Person of the Year (1988) by the St. Petersburg Chamber of Commerce and the Florida Chiropractic Association Kudos Award (1995 & 1998). In 1999, Frank received the Annie Award from Brookwood for his outstanding community service.

Born in Milwaukee, Wisconsin, Frank moved with his family to St. Petersburg in 1972. He is a graduate of St. Petersburg Catholic High School, St. Petersburg Junior College, Eckerd College and Palmer College of Chiropractic, from where he received his Doctorate of Chiropractic. In 1979, Frank opened his own chiropractic clinic and has been in active practice since then. Frank and his wife Toni have been married 25 years and have two children, Brian, 17, and Stephanie, 12.

## Senator Durell Peaden, Jr., State Senate, District 2

Senator Peaden was initially elected to the Senate in 2000, and was subsequently reelected. Her has also served in the House of Representatives from 1994 - 2000. He also practiced as a General Practice physician. His committee membership includes the following:

- Appropriations Subcommittee on Health and Human Services, Chair
- Appropriations
- Banking and Insurance
- Children and Families
- Health, Aging, and Long-Term Care
- Home Defense, Public Security, and Ports
- Judiciary

Senator Peaden is married to Nancy Green and has three children, Durell III (Trey), Tyler and Taylen. Senator Peaden received a B.A. from Tulane University in 1968, an M.D. from Universidad Autonoma de Guadalajara in 1973 and a J.D. from the Jones School of Law at Faulkner University in 1987.

Senator Peaden is from a family of elected officials:

- John Wilkinson, cousin, (Whig), Legislative Council House, Santa Rosa, 1844, and House, Santa Rosa, 1848-1850 and 1860
- John Wilkinson, Jr., cousin (Democrat), House, Santa Rosa, 1885, and Senate, District 1, 1889
- J. Peaden, cousin, (Democrat), House, Santa Rosa, 1905, 1907, 1909
- R. W. Peaden, cousin, (Democrat), House, District 2, 1972-1976
- John W. Kennedy, grandfather, Chair, Okaloosa County Commission

# Attachment C: Summary of Speaker Recommendations

| Speaker Recommendations |
|---|
| ***Healthy Kids/KidCare*** |
| 1. Expand/restore/maximize KidCare enrollment |
| • Restore funding without caps. |
| • Expand Healthy Kids/KidCare. |
| 2. Identify new funding |
| • Identify funding to expand KidCare and eliminate the waiting list. |
| • Enable counties to provide financial assistance to kids on the waiting list for KidCare. |
| • Use federal Medicaid relief [e.g. the temporary enhanced FMAP] to eliminate the KidCare waiting list and continue enrollment in this program. |
| 3. Expand eligibility |
| • Modify KidCare eligibility requirement to allow only those children whose parents do not have access to employer-sponsored coverage to enroll. |
| • Adopt 12 months of continuous eligibility for all KidCare components |
| • Implement presumptive eligibility |
| • Use a medical income disregard for children with catastrophic illnesses otherwise eligible for Title XXI subsidies |
| • Cover non-Title XXI-eligible children (i.e. non-citizens) using state and local funds in the same proportion as the current Federal and State share. |
| 4. Coordination with ESI |
| • Redesign the Florida KidCare program to provide premium assistance to families to allow them to be insured under the same employer-sponsored policy and to provide greater choice of plans. |
| • Allow KidCare funds to be used by low-income parents to purchase employer-sponsored coverage without any new mandates. |
| 5. Revise administration - Use a single entity to determine eligibility |
| 6. Establish and fund Florida KidCare community coordination, health and family education functions. |
| 7. Contract for a study that will include the costs and benefits of implementing strategies to further improve the KidCare program. |
| ***Medicaid Program*** |
| 8. Evaluate and implement a HIFA Waiver |
| • Evaluate and pursue, if appropriate, HIFA waivers and sub-regional waivers. |
| • Develop a HIFA waiver for pilot programs. |
| • Seek/obtain HIFA waiver to provide premium assistance to low-income employees for the purchase of employer-sponsored health insurance. |
| 9. Identify new funding |
| • Identify funding to expand Medicaid and include small employers without coverage. |
| • Enable selected counties the opportunity to invest their nursing home dollars in home and community-based care programs. |
| • Maximize revenue by taking advantage of matching opportunities |
| 10. Expand eligibility |
| • Support initiatives to allow families who are ineligible due to income to buy-in to the Medicaid program. |
| 11. Evaluate ways to sustain current program and implement improvements |
| • Identify ways to increase the state's flexibility for providing care to Medicaid recipients. |

| **Speaker Recommendations** |
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| • Evaluate current Medicaid program and implement/expand programs that ensure quality care is provided in the most cost-effective manner possible. |
| • Protect/maintain state subsidy programs. |
| ***High-Risk Pool*** |
| 12. Reopen the high-risk pool |
| • [Use] risk pooling arrangements, including *high-risk pool*. |
| • Identify funding to *re-open* the high-risk pool. |
| • *Reopen* the high-risk pool; make sure it is funded adequately. |
| 13. Revise funding design and sources |
| • Fund any high-risk subsidy program in the broadest possible manner. |
| • Do not fund high-risk subsidy programs in a manner that would contribute to the unaffordability of employer-sponsored health insurance. |
| • If a high-risk subsidy program for the chronically ill is re-established, fund it through recurring general revenue dollars. |
| • Identify *funding* to re-open the high-risk pool. |
| • Reopen the high-risk pool; make sure it is *funded* adequately |
| 14. Revise eligibility requirements - move HIPAA eligibles, group conversions and one-life groups into the high-risk pool, along with uninsurable individuals. |
| ***Health Flex*** |
| 15. Expand Health Flex program to develop an affordable coverage option for working, low-income individuals who are unable to access coverage in the group market. |
| 16. Revise licensure requirements - require Health Flex plans to be licensed as insurers and subject to the same solvency, claims payment and consumer protection provisions. |
| 17. Encourage Health Flex plans to be marketed to employer groups to provide more coverage choices. |
| 18. Target Health Flex and similar programs at specific geographies and populations. |
| ***Other Flexible Employer Coverage Plans*** |
| 19. Create a second option for employees that doesn't significantly increase premium costs for the employer, but *provides catastrophic coverage* to the employee (and affordable catastrophic coverage to the dependents). |
| 20. Encourage a voluntary *mini-medical market* under the umbrella of employer-sponsored catastrophic coverage; the more choices, the better for the employee and dependents. |
| ***Industry Standards/Requirements*** |
| 21. Require all providers to *submit claims electronically.* |
| 22. Require all third party payers to be *licensed* by the OIR, as insurers and HMOs are licensed, to ensure adequate protection for all Florida consumers. |
| 23. Examine the cost impacts mandated benefits have on health insurance policies. |
| 24. Revise mandated benefits |
| • Review mandates regarding payment for ER services without adequate means to control costs. |
| • Reduce regulatory requirements on insurers and HMOs to the extent necessary to permit the offering of innovative benefit plans to persons currently uninsured. |
| • Allow insurers and HMOs regulated by the Office of Insurance Regulation to offer lower cost flexible benefit policies designed to meet Floridians' health care needs and budget constraints. |

| **Speaker Recommendations** |
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| • Minimize state and federal mandates that hinder counties' ability to provide local options to affordable health care. |
| 25. Revise provider payment collection requirements |
| • HMOs and insurers should be required to collect the co-payment for ER care. |
| • Require insurers to honor assignment of benefits. |
| 26. Work to remove barriers to new programs (e.g., state regulations such as risk pool constraints, expanded sovereign immunity). |
| 27. Expand risk-pooling arrangements – local ability to mix businesses into a risk pool (would require insurance code change). |
| 28. Remove +/- 15% rate up in small group market. |
| ***Funding*** |
| 29. Seek new funding sources |
| • Obtain private sector funding for use as seed money and conceptual development (not sustained funding) |
| • Seek new sources of State funding – i.e. increased moving violation fines, registration surcharges, etc. |
| • Maximize revenue by taking advantage of matching opportunities. |
| • Alternative funding sources and options should be sought to insure funding of indigent, Medicaid and Workers' compensation care rendered in EDs and trauma centers. |
| 30. Protect and maximize existing funding Sources |
| • Maximize and protect matching opportunities (SCHIP, DSH, FQHC, UPL) |
| • Protect current State funding (and don't pass more costs to local government). |
| 31. Impose higher co-payments for non-urgent, non-emergency or out-of-network ER use. |
| ***Cost Drivers*** |
| 32. Develop alternatives to high-cost services (i.e. ER) |
| • State should consider investing in public health clinics to provider alternative to emergency departments, thereby reducing long-term costs. |
| • Help patients get the appropriate health care in the appropriate setting and at the appropriate time. |
| • Adopt measures to reduce medically unnecessary ER use |
| 33. Do not limit innovative tiering programs used by employers to rein in *pharmacy costs*. |
| 34. Encourage the use of, or implement, evidence based medicine/disease management |
| • Use evidence-based medicine to ensure appropriate medical care is provided in the private and public sector. |
| • Expand disease management programs in the public sector to increase the quality of life and lower the cost of care. |
| • Support the work of organizations such as Leapfrog Group that promote quality care based on scientific data. |
| (Information concerning the cost of health care services – see consumer education/information). |
| 35. Improve accessibility of all health care data to practitioners to reduce need for duplicate diagnostic testing, treatment and prescriptions. |

| Speaker Recommendations |
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| 36. Explore ways to provide incentives for insurers to more extensively cover appropriate preventative care. |
| ***Premium Assistance/Subsidies*** |
| 37. Develop new premium assistance programs. |
| • Seek/obtain HIFA waiver to provide premium assistance to low-income employees for the purchase of employer-sponsored health insurance. |
| • Create a premium assistance program for employer-sponsored coverage. |
| • May be opportunities for some counties to assist individuals through subsidized premiums. |
| • Complete the demonstration program, to provide subsidies to low-income persons who are offered employer-sponsored coverage, but don't accept it, as a HIFA waiver project. |
| • Develop "3-shared premium" program where premiums are shared by employers, provider, government. |
| 38. Protect or expand existing subsidy programs |
| • Protect and maintain existing state subsidy programs (i.e. medically needy, silver saver). |
| • Pick up the Medically Needy share of cost. |
| ***Local Reforms and Initiatives*** |
| 39. Build on and leverage investments in local programs such as Hillsborough County. |
| 40. Support legislative proposals that promote flexibility at the local level. |
| 41. Allow counties the discretion of levying an indigent health care surtax by an extraordinary vote of the county commission. |
| 42. Assist local governments in obtaining federal matching funds. |
| (Minimize state and federal mandates that hinder counties' ability to provide local options to affordable health care) – see mandates. |
| ***State Reforms and Initiatives*** |
| 43. Encourage increased patient responsibility through consumer-driven health plans. |
| 44. Build on strengths and assets of individual players and existing assets to partner to minimize costs, maximize revenue and meet expectations. |
| 45. Encourage legislature to continue down road toward reform. |
| 46. Develop and implement mechanisms for tracking the success of efforts to reduce the numbers of the uninsured. |
| ***Federal Reforms and Initiatives*** |
| 47. Support the Federal initiative – Association Health Plans |
| 48. Encourage expediting the approval process for federal waivers. |
| 49. Change the Federal Title XXI law to allow use of Federal funds for health care coverage provided to legal immigrant children who would otherwise qualify for subsidies. |
| 50. Encourage Congress to expand the health care tax credit. |
| 51. Encourage Congress to allow rollover of flexible spending accounts (FSAs) from year to year. |
| 52. Encourage Congress to ensure HRA and FSA funds can be used electronically to avoid unnecessary expense of paper claims. |

| Speaker Recommendations |
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| ***Access to Information/Consumer Education*** |
| 53. Strengthen the connection between consumers and physicians |
| • Promote patient education services that strengthen the connection between patients and their physicians. |
| • Promote services, such as MDHUB.com, that strengthen the connection between patients and their physicians. |
| 54. Provide information concerning the cost of health care services |
| • Make available current comparative charge information for common- non-emergency inpatient and outpatient procedures. |
| • Expand efforts to develop and disseminate information that health care consumers need to make wise spending decisions. |
| 55. Provide information concerning appropriate use of health care services and health promotion |
| • Educate public about, and use incentives for, proper use of emergency department. |
| • Develop a task force to develop a list designed for use by consumers of appropriate uses of ER services. |
| • Use health literacy and other education programs used by the private and public sector to provide consumers with information to make appropriate health care decisions and live healthier lives. |
| 56. Provide reference information to improve access to quality services. |
| • Authorize the Agency for Health Care Administration to produce a reader-friendly hospital report card that includes pertinent information such as mortality, readmission rates, and lengths of stay. |
| • Enhance role of County Social Services as source of information and link to options. |
| ***Health Information Systems*** |
| 57. Expand representation on the CHIS advisory council to include employer associations to ensure major health care purchasers in Florida are included in health information discussions. |
| 58. Expand government and private sector initiatives that increase quality health care data available to the public. |
| 59. Develop information systems support – county-based, provider-based |
| 60. Develop a methodology that makes valid comparable outcomes data available and is risk-adjusted. |
| ***New or Expanded Programs/Services*** |
| 61. Establish programs that provide prescription drugs to citizens with chronic diseases who enter care management programs. |
| 62. Develop additional State or Federal programs for prescription drug coverage, grants, waivers and other services. |
| 63. Look for ways to provide incentives for coverage and efficient utilization of drugs. |
| 64. Identify funding to expand Florida's trauma network. |
| 65. Provide a reasonable level of reimbursement for non-contracted emergency services and providers to help abate increasing health care costs and to protect consumers who ultimately absorb those increases through higher premiums and out-of-pocket costs. |
| 66. Establish limits on charge levels for indigent patients in the ER (i.e. a sliding scale of allowable charges or percentage of charges based on Medicaid or Medicare charges or best price levels). |
| ***Tax Incentives*** |
| 67. Establish tax incentives to expand health care. |

# Attachment D: Task Force Meeting Agendas

# Governor's Task Force on Access to Affordable Health Insurance

*Lt. Governor*
*Toni Jennings*
*Co-Chair*

*Chief Financial Officer*
*Tom Gallagher*
*Co-Chair*

**Governor's Task Force on Access to Affordable Health Insurance**

**September 22, 2003**

**10:45 am to 12:15 pm**

**Granada Room**

**Biltmore Hotel, Coral Gables**

**AGENDA**

| | | |
|---|---|---|
| **10:45 – 10:55** | **Welcome and Introduction of Task Force Members** | Lieutenant Governor Toni Jennings and Chief Financial Officer Tom Gallagher, co-chairs |
| **10:55 – 11:00** | **Administrative Functions** | Co-chairs |
| **11:00 – 11:10** | **Review of Task Force Goals** | Co-chairs |
| **11:10 – 11:30** | **How the Health Insurance Symposium Addresses Task Force Goals** | Rich Robleto, Office of Insurance Regulation |
| | **Overview of Florida Uninsured** | Ken Thurston, Agency for Health Care Administration |
| **11:30 – 11:45** | **Review of Preliminary Work Plan** | Staff |
| **11:45 – 12:00** | **Summary of Outcomes from Today's Meeting** | Co-chairs |
| **12:00 – 12:15** | **Plans for Next Meeting** | Co-chairs |
| **12:15** | **Meeting Adjourn** | |

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# Governor's Task Force on Access to Affordable Health Insurance

*Lt. Governor*
*Toni Jennings*
*Co-Chair*

*Chief Financial Officer*
*Tom Gallagher*
*Co-Chair*

**MEETING AGENDA**

**October 13, 2003**
**10:00 AM – 4:00 PM**
**Room 412, The Knott Building – Tallahassee**

**Topic: Presentation and Discussion of Goals 1, 2 and 3**

| | | |
|---|---|---|
| **10:00 am – 10:15 am** | Welcome/Introduction | Chief Financial Officer Tom Gallagher |
| | Administrative Functions | |
| **10:15 am – 11:15 am** | Task Force Goal 1: Factors that drive the cost of health insurance. | |
| | Speaker | Vernon Smith |
| | Issues summary | Marshall Kelley |
| | Discussion | Secretary Rhonda Medows |
| **11:15 am – 12:15 pm** | Task Force Goal 2: Major barriers that prevent Floridians from obtaining health insurance. | |
| | Speaker | Stephanie Lewis |
| | Issues summary | Marshall Kelley |
| | Discussion | Chief Financial Officer Tom Gallagher |
| **12:15 pm – 1:15 pm** | Lunch | |
| **1:15 pm – 2:15 pm** | Task Force Goal 3: Federal Issues that may contribute to higher health insurance costs. | |
| | Speakers | Vernon Smith/John Cerisano |
| | Issues summary | Gary Crayton |
| | Discussion | Secretary Rhonda Medows |
| **2:15 pm – 2:30 pm** | Summary of Symposium Information | Rich Robleto |
| **2:30 pm – 3:30 pm** | Public Input* | Chief Financial Officer Tom Gallagher |
| **3:30 pm – 4:00 pm** | Discussion/wrap-up and plans for next meeting | Chief Financial Officer Tom Gallagher |
| **4:00 pm** | Adjourn | |

* Because of the anticipated number of speakers, time will be limited for each individual providing public input. You are encouraged to submit your comments in writing in order to ensure they are received in their entirety by the Task Force

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# Governor's Task Force on Access to Affordable Health Insurance

*Lt. Governor*
*Toni Jennings*
*Co-Chair*

*Chief Financial Officer*
*Tom Gallagher*
*Co-Chair*

**Governor's Task Force on Access to Affordable Health Insurance**
**November 17, 2003**
**10:00 AM to 4:00 PM**
**Airport Marriott Hotel, Grand Ballroom East, Tampa**

**AGENDA**

**Topic: Presentations and Discussion of Goals 4 and 5**

| | | |
|---|---|---|
| **10:00 am – 10:05 am** | Welcome and Administrative Functions | Lieutenant Governor Toni Jennings<br>Chief Financial Officer Tom Gallagher |
| **10:05 am– 11:15 am** | Task Force Goals 4 and 5: Investigate pilot and other alternative approaches to traditional health insurance which have been demonstrated to be effective and identify potential partnerships to increase health insurance coverage. | |
| | • Speaker: The Range of Options | Elliot Wicks |
| | • Speaker: Florida Initiatives Past and Present | Paul Duncan |
| | • Discussion | Lieutenant Governor Toni Jennings |
| **11:15 am – 12:45 pm** | **Public Input** | Chief Financial Officer Tom Gallagher |
| **12:45 pm– 1:15 pm** | Lunch | |
| **1:15 pm – 2:45 pm** | **Presentations:** | |
| | • SCHIP Funding | Meta Calder |
| | • Florida KidCare Coordinating Council | Dr. Louis St. Petery |
| | • Winter Park Health Foundation | Patty Maddox |
| | • Hillsborough County Health Plan | Dave Rogoff |
| | • Lakeland Volunteers in Medicine | Bobby Yates |
| **2:45 pm – 3:45 pm** | Discussion and Development of Task Force Policy Statements | Lieutenant Governor Toni Jennings |
| **3:45 pm – 4:00 pm** | Completion of feedback forms, wrap-up and plans for next meeting | Chief Financial Officer Tom Gallagher |
| **4:00 pm** | Meeting Adjourn | |

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# Governor's Task Force on Access to Affordable Health Insurance

*Lt. Governor*
*Toni Jennings*
*Co-Chair*

*Chief Financial Officer*
*Tom Gallagher*
*Co-Chair*

**Governor's Task Force on Access to Affordable Health Insurance**
**December 3, 2003**
**10:00 AM -- 4:00 PM**
**Florida Community College at Jacksonville**
**Downtown Campus Auditorium**
**101 West State Street**

**AGENDA**

**Topics: Task Force Discussion and Development of Initial Recommendations**
**Presentation of Recommendations from Key Stakeholders**

| | | |
|---|---|---|
| **10:00 am – 10:10 am** | • Welcome/introduction<br>• Administrative Functions<br>• Accomplishments to Date<br>• Goals for Today's Meeting | Lieutenant Governor Toni Jennings<br>Chief Financial Officer Tom Gallagher<br>Rich Robleto |
| **10:10 am – 11:30 am** | Task Force Discussion<br>• Direction concerning the Task Force process<br>• Suggestions/ideas from the Task Force<br>• Issues about which the Task Force needs additional information | Lieutenant Governor Toni Jennings |
| **11:39 am – 1:00 pm** | Stakeholder Presentation of Recommendations | |
| 11:30 – 11:45 | Florida Chamber of Commerce | Leslie Dughi |
| 11:45 – 12:00 | Florida Association of Health Plans | Bob Wychulis |
| 12:00 – 12:15 | Florida Association of Health Underwriters | John Sinibaldi |
| 12:15 – 12:30 | Florida Hospital Association | Ralph Glatfelter |
| 12:45 – 1:00 | Florida Association of Counties | Bob Janes |
| | JAXCARE, Inc. | Rhonda Davis Poirier |
| **1:00 pm– 1:30 pm** | Lunch | |
| **1:30 pm – 2:30 pm** | Public Input | Lieutenant Governor Toni Jennings |
| **2:30 pm – 3:45 pm** | Task Force Discussion<br>• Questions for stakeholders<br>• Identification of Initial recommendations<br>• Task Force requests for additional information | Chief Financial Officer Tom Gallagher |
| **3:45 pm – 4:00 pm** | Goals and Assignments for 12/17 Meeting and Wrap-up | Chief Financial Officer Tom Gallagher |
| **4:00 pm** | Adjourn | |

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# Governor's Task Force on Access to Affordable Health Insurance

*Lt. Governor*
*Toni Jennings*
*Co-Chair*

*Chief Financial Officer*
*Tom Gallagher*
*Co-Chair*

**Governor's Task Force on Access to Affordable Health Insurance**
**December 17, 2003**
**10:00 AM – 4:00 PM**
**Miami-Dade Community College**
**Wolfson Campus Auditorium**

**AGENDA**

**Topic: Goal 6 - Provide policy recommendations to improve access to affordable health insurance, and achieve more predictable cost, while maintaining consumer choice.**

| | | |
|---|---|---|
| **10:00 am – 10:05 am** | • Welcome/Introduction<br>• Administrative Functions | Lieutenant Governor Toni Jennings<br>Chief Financial Officer Tom Gallagher |
| **10:05 am – 10:25 am** | • Summary of Outcomes from December 3rd Meeting<br>• Review materials for the Task Force<br>• Review process for the Meeting | Rich Robleto |
| **10:25 am – 11:00 am** | • Agency Presentations | Kevin McCarty<br>Ken Thurston |
| **11:00 am – 11:45 am** | Speakers<br>• High-risk pool<br>• Memorial Health Care<br>• Health Flex Presentation | Chief Financial Officer Tom Gallagher<br>Michelle Robleto<br>John Benz<br>TBD |
| **11:45 am – 1:15 pm** | **Public Input** | Lieutenant Governor Toni Jennings |
| **12:30 pm – 1:15 pm** | Working Lunch | |
| **1:15 pm – 1:30 pm** | Update on the House Select Committee on Affordable Health Care for Floridians | Committee representative |
| **1:30 pm – 3:45 pm** | • Review, discuss and finalize Task Force recommended health insurance coverage approaches for Florida<br>• Rank approaches | Chief Financial Officer Tom Gallagher |
| **3:45 pm – 4:00 pm** | Wrap-up and plans for next meeting | Lieutenant Governor Toni Jennings |
| **4:00 pm** | Adjourn | |

**Because of the anticipated number of speakers, time will be limited for each individual providing public input. You are encouraged to submit your comments in writing in order to ensure they are received in their entirety by the Task Force.*

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# Governor's Task Force on Access to Affordable Health Insurance

*Lt. Governor*
*Toni Jennings*
*Co-Chair*

*Chief Financial Officer*
*Tom Gallagher*
*Co-Chair*

**Governor's Task Force on Access to Affordable Health Insurance**
**January 9, 2004**
**10:00 AM – 4:00 PM**
**University of Central Florida: Pegasus Ballroom**
**4000 Central Florida Boulevard**
**Orlando, FL 32516**

## AGENDA

**Topic: Goal 6 - Provide policy recommendations to improve access to affordable health insurance, and achieve more predictable cost, while maintaining consumer choice.**

| | | |
|---|---|---|
| **10:00 am – 10:10 am** | • Welcome<br>• Administrative Functions | University of Central Florida President Dr. John Hitt<br>Chief Financial Officer Tom Gallagher |
| **10:10 am – 10:20 am** | • Summary of Outcomes from December 17th Meeting<br>• Review materials for the Task Force<br>• Review process for the Meeting | Rich Robleto |
| **10:20 am – 11:30 am** | **Public Input** | Chief Financial Officer Tom Gallagher |
| **11:30 am – 12:15 pm** | Lunch | |
| **12:15 pm – 3:45 pm** | • Review, discuss and finalize Task Force recommendations<br>• Identify additional recommendations | Lieutenant Governor Toni Jennings |
| **3:45 pm – 4:00 pm** | Wrap-up and plans for next meeting | Chief Financial Officer Tom Gallagher |
| **4:00 pm** | Adjourn | |

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# Governor's Task Force on Access to Affordable Health Insurance

*Lt. Governor*
*Toni Jennings*
*Co-Chair*

*Chief Financial Officer*
*Tom Gallagher*
*Co-Chair*

**Governor's Task Force on Access to Affordable Health Insurance**

**February 2, 2004**

**10:00 AM – 1:00 PM**
**Knott Building**
**Tallahassee**

## AGENDA

**Topic: Goal 6 - Provide policy recommendations to improve access to affordable health insurance, and achieve more predictable cost, while maintaining consumer choice.**

| | | |
|---|---|---|
| **10:00 – 10:10** | Welcome<br>Administrative Functions | Chief Financial Officer Tom Gallagher |
| **10:10 – 10:20** | Status Update | Rich Robleto |
| **10:20 – 12:30** | Review of Task Force Comments<br>Review of Errata Sheet<br>Adoption of Task Force Report | Lieutenant Governor Toni Jennings<br><br>Chief Financial Officer Tom Gallagher |
| **12:30 – 1:00** | Wrap-up and thanks | Lieutenant Governor Toni Jennings<br>Chief Financial Officer Tom Gallagher |

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# Attachment E: Website Links to Meeting Materials

# Website Links to Meeting Materials

Meeting materials for each of the Task Force's meetings are available on the Task Force's website. Materials include:

- Meeting agendas
- Speaker presentation materials
- Meeting transcripts
- Information provided by public speakers
- Other supporting materials

Task Force Website:

http://www.fdhc.state.fl.us/affordable_health_insurance/index.shtml.

**State of Florida**
**Jeb Bush, Governor**

**Prepared by Health Management Associates,**
**a consulting firm**
**in conjunction with staff from**


**2727 Mahan Drive**
**Tallahassee, FL 32308**
**1-888-419-3456**
**http://www.fdhc.state.fl.us/affordable_health_insurance/**


**and**


**Office of Insurance Regulations**
**200 Gaines Street**
**Tallahassee, FL 32301**
**http://www.fldfs.com/companies/**