CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

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In June 2005, a team of researchers visited Miami to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 65 leaders in the health care market. Miami is one of 12 communities tracked by HSC every two years through site visits. Individual community reports are published for each round of site visits. The first four site visits to Miami, in 1996, 1998, 2000 and 2002, provide trend information against which changes are tracked. The Miami market encompasses Miami-Dade County.

UNINSURED PATIENTS, MALPRACTICE INSURANCE WOES STRESS MIAMI HEALTH CARE MARKET

Exceptionally high health care costs, low levels of health insurance coverage and a difficult medical malpractice insurance environment for physicians and hospitals continue to stress the Miami health care market. Nearly one-third of the population is uninsured, according to one estimate, straining hospital emergency departments and other safety net providers. At the same time, the high cost of medical malpractice insurance has led more physicians to go without coverage, turn down high-risk patients and decline to take call in hospital emergency departments. In addition, because physicians are providing more services in settings other than hospitals, relationships between hospitals and physicians have started to deteriorate. Other key developments in the market over the past two years include:

- Specialist physicians have banded together in single-specialty groups to open physician-owned diagnostic and surgical centers and to enhance negotiating power with health insurers.
- Rising employer demand for lower-cost, less-comprehensive alternatives to the still-dominant health maintenance organization (HMO) products have helped national insurers make inroads over local plans.
- Financial challenges at the county-owned Jackson Memorial Hospital have prompted administrative reforms and program changes designed to preserve the hospital's ability to serve as Miami's primary safety net hospital.

More Physicians Forgo Malpractice Coverage

The persistently high cost of malpractice insurance in Miami has prompted growing numbers of physicians to drop their coverage and avoid high-risk patients and practice settings, threatening to diminish access to physician services for some patients. In some specialties like obstetrics, Miami physicians have long practiced without malpractice coverage, but more recently the problem is affecting larger numbers of physicians in a broader array of specialties. State law allows physicians to practice without coverage if they maintain at least $250,000 in assets to cover the cost of potential malpractice judgments. One Miami hospital system reported that 40 percent of its 2,000 affiliated physicians were practicing without coverage, including all of its orthopedists, neurosurgeons and obstetricians. As a result, many hospitals now waive requirements that physicians maintain such coverage as a condition of granting admitting privileges.

Some physicians in high-demand specialties reportedly have left Miami because of the malpractice insurance problem, leading some hospitals to recruit and employ specialists at considerable expense to maintain specialty clinical service lines. Additionally, the

Miami Demographics

Miami	*Metropolitan Areas 200,000+ Population*
Population[1]	
2,341,167	
Persons Age 65 or Older[2]	
14%#	*10%*
Median Family Income[2]	
*$18,613**	*$31,301*
Unemployment Rate[3]	
7.2%#	*6.0%*
Persons Living in Poverty[2]	
26%#	*13%*
Persons Without Health Insurance[2]	
23%#	*14%*

 # Indicates 12-site high.
** Indicates 12-site low.*

Sources:
[1] U.S. Census Bureau, County Population Estimates, 2003
[2] HSC Community Tracking Study Household Survey, 2003
[3] Bureau of Labor Statistics, average annual unemployment rate, 2003

number of community physicians willing to take call at hospital emergency departments (EDs) reportedly has declined over time, in part because of fears of litigation from the large numbers of uninsured patients who seek care in these settings. At the same time, liability concerns are prompting more community physicians to refer insured patients to hospital emergency departments rather than provide telephone advice or after-hours care. Moreover, a 2003 state law established a $150,000 cap on noneconomic damages in malpractice cases involving care provided in EDs, reportedly creating additional incentives for physicians to refer patients to EDs. As a result, demand for care in EDs has steadily increased, and many hospitals are now paying physicians considerable amounts of money to provide on-call ED coverage—a service that community physicians historically provided without additional compensation from the hospital. One local hospital system reportedly is spending $13 million annually to compensate physicians for taking ED call.

Miami's large number of uninsured physicians reportedly has prompted malpractice attorneys to make hospitals the focus of their litigation, leading to rapidly rising hospital malpractice insurance premiums. One hospital system's annual malpractice premiums jumped from $6 million to $25 million during the late 1990s, leading the system to self-insure against malpractice claims. More recently, this hospital system has developed self-funded malpractice insurance programs to cover physicians who accept assigned patients from the hospital ED and for hospital-based physicians who practice at system hospitals. These new programs were designed to improve the hospital system's ED coverage and strengthen its relationships with hospital-based physicians.

Most recently, Florida voters in November 2004 passed three amendments to the state's medical malpractice law. One of these amendments, supported by physicians, established caps on attorney fees in malpractice cases. A second amendment, supported by trial attorneys, gives patients access to meeting minutes from hospital and physician peer review committees, and a third is designed to revoke the medical licenses of physicians found to be negligent in three or more medical liability suits. The net effects of these new policies remain to be seen, although some observers maintain that the latter two policies are further dissuading physicians from serving on peer-review committees and from practicing in Florida altogether.

Physicians Look for New Revenue Sources

Some physicians are responding to the economic pressures of costly malpractice insurance and other rising practice expenses by developing their own diagnostic and surgical centers to perform profitable outpatient services and procedures. Physician-owned centers are not new to Miami, but they have developed with increasing frequency over the past two years as physicians seek new revenue sources, and they have begun to cause visible reductions in service volume for some hospitals. As one example, an ambulatory surgery center opened by a local orthopedics group in the past year reportedly has caused significant reductions in surgical volume at one of the largest and most prominent hospital systems in the community, Baptist Health South Florida. Two other large hospital systems in the market, Tenet Healthcare Corp. and HCA, reported a 50 percent drop in gastrointestinal endoscopy procedures over the past year as a result of community gastroenterologists opening their own endoscopy centers. While presenting a competitive threat

to hospitals, physician-owned facilities also may fuel increases in health care utilization and costs by creating incentives for physicians to refer more patients for care.

The push to create physician-owned diagnostic and surgery facilities has contributed to recent interest in forming single-specialty medical groups in Miami. Historically, Miami physicians have maintained strong preferences for independent practice, but single-specialty groups have grown in size as more physicians join together. For example, a local hematology/oncology group is doubling in size to 45 physicians, and single-specialty groups in obstetrics/gynecology, pulmonary medicine, neurology, cardiology, orthopedics and urology also have grown steadily. One of the factors motivating these consolidations reportedly is the desire to pool resources and patient volume to better support physician-owned ancillary services and facilities. Larger groups potentially are better able to assemble the capital necessary to develop these facilities and to attract enough patients to make the facilities profitable.

Physicians also are joining single-specialty groups in an effort to gain greater negotiating leverage with health plans. In the past, the lack of physician organizations of any size in Miami has helped health plans constrain payments to physicians. According to health plans, many physicians have responded to low payment rates by increasing the numbers of patients they see and the volume and intensity of services they provide to generate more revenue to offset rising practice expenses. The resulting high levels of health care utilization are one explanation for why per capita health care spending in Miami consistently exceeds that of most other local markets across the country.

Though most groups in Miami are still relatively small, some reportedly are already succeeding in securing higher payment rates, particularly hospital-based specialty groups that are able to control large shares of admissions at popular hospitals.

Strong Hospital Margins Fuel Capacity Expansions

Many of Miami's private hospitals continue to perform well financially despite the difficult malpractice insurance environment, heightened physician competition and the large and growing uninsured population. The area's dominant hospital systems face relatively limited competition from each other because of their geographic segmentation in distinct areas of suburban Miami-Dade County. The local not-for-profit Baptist Health South Florida dominates the southern portion of the county with five hospitals, while two national, for-profit hospital chains, Tenet and HCA, each own multiple facilities in the northern and western parts of the county. Because of this segmentation most health plans find it necessary to contract with all three hospital systems, and these systems reportedly have negotiated payment increases in the high single digits annually. Still, some hospitals that operate in more competitive areas of the county or that serve lower-income populations with fewer privately insured residents have experienced financial troubles over the past two years, including some Tenet-owned facilities and the independent Mount Sinai Medical Center.

The competition that does exist among Miami hospitals has focused on expanding facilities and upgrading technologies to attract additional inpatient admissions from prosperous and growing suburban areas of the market. These expansions have been aided by a 2004 change in the state's certificate-of-need (CON) law that exempts from review hospital bed expansions in areas of high population growth. Baptist's flagship hospital added 100 beds in 2005 and plans to double its emergency depart-

Health System Characteristics

Miami	*Metropolitan Areas 200,000+ Population*
Staffed Hospital Beds per 1,000 Population[1]	
3.3	*3.1*
Physicians per 1,000 Population[2]	
2.9#	*1.9*
HMO Penetration (including Medicare/Medicaid)[3]	
37%	*29%*
Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005[4]	
$986	*$718*

# Indicates a 12-site high.

Sources:

[1] American Hospital Association, 2002

[2] Area Resource File, 2003 (includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists)

[3] Interstudy Competitive Edge, markets with population greater than 250,000

[4] Centers for Medicare and Medicaid Services. Site-level payment rates refer to Medicare Advantage AAPCC Payment Rates by County (Part A + Part B Aged Rates). National figure is actual payment per capita, based on payments for Medicare Coordinated Care Plans and the number of Coordinated Care Plan enrollees in April 2005.

Health Care Utilization

Miami	*Metropolitan Areas 200,000+ Population*
Adjusted Inpatient Admissions per 1,000 Population[1]	
213	*197*
Persons with Any Emergency Room Visit in Past Year[2]	
16%	*18%*
Persons with Any Doctor Visit in Past Year[2]	
73%	*78%*
Persons Who Did Not Get Needed Medical Care During the Last 12 Months[2]	
5.3%	*5.7%*
Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More[2]	
43%	*44%*

Sources:

[1] American Hospital Association, 2002

[2] HSC Community Tracking Study Household Survey, 2003

ment capacity by 2008. Meanwhile, HCA opened a new heart center and expanded overall inpatient capacity at its Aventura Hospital and Medical Center in northern Miami-Dade County in 2004, and it is in the midst of a $100 million expansion project at its facility in the southwestern part of the county. Most recently, HCA received state approval to build a new facility in the West Kendall area of south Miami-Dade County near the site of a new hospital planned by Baptist. Tenet's expansion strategy in Miami has been much less aggressive than its counterparts, reportedly because of heavy financial losses at the national system level.

Emergency departments have become a focal point for hospital competition in Miami because of the increasingly large numbers of patients that receive care from them and the large number of hospital admissions that derive from them. Hospitals have responded by expanding their emergency departments to accommodate more patients and by refurbishing these departments to make them more appealing to patients. While some hospitals are benefiting from the upsurge in demand for emergency care, health plans and employers remain concerned about the escalating cost of this care.

Health Plans Compete to Offer More Affordable Products

Following several years of steep premium increases, health plans in Miami's highly competitive insurance market are now focusing on offering lower-cost products and product features designed to keep health insurance affordable for area employers. Two years ago, premiums were increasing rapidly as health plans corrected for prior financial losses and as more consumers opted for less-restrictive, and more costly, alternatives to the HMO products that have dominated this market in recent years. Since that time, employers have demanded lower-cost health insurance options, and insurers have become concerned about the continued affordability of their products in a market comprised mostly of small and mid-sized employers with middle-income employees. As a consequence, health plans have begun competing to offer lower cost, less comprehensive alternatives to the still-dominant HMO. This trend has helped national insurers gain market share in Miami at the expense of local HMO-based plans.

As in other markets, health plans in Miami have focused most new product development activities on consumer-driven health plan designs that combine a high-deductible insurance product with some type of a spending account that the consumer uses for out-of-pocket expenditures. National plans Aetna, UnitedHealthcare and Humana were the first to introduce these products in the market, and they continue to place more emphasis on these products than their competitors. BlueCross BlueShield of Florida has launched these product designs more recently but has placed less emphasis on them. None of the local Miami-based plans have introduced these products yet.

Observers noted that there is a considerable gap between the product designs that the leading health plans are now emphasizing and the designs that most employers and consumers are actually buying. Enrollment in spending account products has been small to date, a fact that health plans attribute to continuing consumer and employer preferences for HMO product designs with first-dollar coverage. Additionally, the premium differentials currently available between the dominant HMO and preferred provider organization (PPO) plans and high-deductible consumer-driven health plans (CDHPs) are often smaller than many employers expect. To date, most Miami employ-

ers have implemented more modest changes to their health plans, such as increasing employees' share of premium contributions, increasing copayments, and in some cases moving to deductible and coinsurance designs. Some employers have responded to the growth in emergency department utilization by adding incentives for employees to seek care at less expensive urgent care facilities. Others are seeking cost savings by auditing their beneficiary lists to identify ineligible dependents.

As a possible transition from HMO products to CDHP designs, several of Miami's leading health plans have stepped up marketing of more traditional PPO product designs with deductibles and coinsurance requirements. To appeal to consumers accustomed to the first-dollar coverage of HMO products, Humana's Coverage First PPO offers $500 in first-dollar coverage before the deductible requirement begins. UnitedHealthcare of Florida also is transitioning accounts from HMO- to PPO-based products, and BlueCross BlueShield is considering discontinuing its HMO platform altogether to operate all of its products on a PPO platform.

A few Miami health plans have begun to experiment with new provider network and payment designs, led by BlueCross BlueShield of Florida and the tiered-hospital product it launched in South Florida in 2003. BlueCross, however, has been unsuccessful in implementing the product as planned because some major hospitals would not agree to placement in nonpreferred tiers. Most significantly, Baptist Health South Florida refused to participate in the product entirely. As a result, employer interest in the product has been modest, but BlueCross officials continue to view the product as a promising design for the future and expect to introduce a tiered-physician network as a next step.

In a similar vein, both Humana and Cigna reportedly have developed high-performance physician networks and introduced them in the Miami market over the past year. Humana introduced its product in April for the small group market, with the high-performance network having approximately 25 percent fewer doctors than its standard open-access product. The network providers were selected based on a combination of quality and efficiency measures, and employers are offered a discounted premium if they choose the high-performance network. Most recently, BlueCross became the first plan in the market to launch a pay-for-performance incentive program for physicians, which began statewide in March 2005 using incentives linked to measures of quality, efficiency and adoption of information technology. Health plans indicated that it was too early to gauge physician reactions to these new network and incentive arrangements.

Miami has remained an attractive market for Medicare managed care plans because of the large concentration of seniors and relatively high Medicare payment rates for health plans. Payment increases included in the 2003 Medicare Modernization Act (MMA) have allowed many plans to enhance benefits and reduce cost sharing in their Medicare HMO products. Most health plans also have expanded their product lines to include new PPO and prescription drug options established under the MMA law, although two local plans chose instead to sell their Medicare business to competitors seeking to increase their presence in the Medicare market. Health plans expect the new PPO products will help attract higher-income beneficiaries who now opt for the traditional Medicare program and purchase supplemental Medigap coverage.

Miami has remained an attractive market for Medicare managed care plans because of the large concentration of seniors and relatively high Medicare payment rates for health plans.

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Continued Growth of Uninsured Stresses Safety Net Providers

Miami's large uninsured population has continued to grow during the past two years, straining the ability of local health care providers to meet the needs for uncompensated care. The 2004 Florida Health Insurance Study estimates that the uninsured population in Miami-Dade County has reached nearly 29 percent of the population under age 65, or nearly 600,000 people. This increase is attributable to a combination of factors, including immigration, reductions in outreach and enrollment activities for Medicaid and HealthyKids—the Florida version of the State Children's Health Insurance Program (SCHIP)—and loss of employer-sponsored coverage because of the escalating cost of private health insurance. Although Miami has an extensive network of safety net providers, increasing demand for charity care has placed significant pressure on this system.

The most significant pressures on the safety net involve the Jackson Health System, the county's 1,500-bed hospital system. A key source of support for Jackson is a fund generated by a half-cent county sales tax and administered by the Public Health Trust, which serves as the independent governing board for Jackson. While revenues in this fund have increased over the past two years, charity care costs have increased more rapidly. Currently, Jackson is dealing with an annual deficit of $30 million, which is attributed to a growth in uninsured patients, operational inefficiencies and past accounting errors. At the same time, market observers credit Jackson's new CEO, Marvin O'Quinn, for improving the accountability and transparency for how the Public Health Trust dollars are used. Given this change, along with Jackson's financial difficulties and the CEO's efforts to work more collaboratively with other providers, area hospitals have dropped their long-standing attempts to obtain a portion of the Public Health Trust funds for the care they provide to uninsured people.

Jackson's new CEO has turned to a number of strategies to stabilize the system's financial position. To reduce expenses, the system has largely limited care to people living in Miami-Dade County and is considering cutting selected services. To bring in more revenue, Jackson has raised the rates it charges private payers, increased copayments for the uninsured, focused on drawing down more state and federal funding and marketed its services to attract more Medicaid and private pay patients.

At the same time, Jackson is attempting to address growing demand for care. The hospital is opening additional beds and has hired hospitalists to improve patient flow and specialists to reduce waits for specialty care. The system also is working to improve the efficiency of its 12 primary care clinics to reduce financial losses and treat more patients, including the patients who show up in the hospital emergency department for nonurgent care. In addition, Jackson has developed a "Care-A-Van" program to provide basic health care services through mobile units in underserved communities.

Meanwhile, Baptist Health South Florida's healthy financial situation has allowed it to increase its support for safety net care, including new payments for specialists who treat the uninsured at its facilities, an expanded charity care program that now provides free care to uninsured individuals with incomes up to 300 percent of the poverty level, or $58,050 for a family of four in 2005, and a planned new facility for its hospital in Homestead—a low-income area in southern Miami-Dade County.

There have been few expansions in other parts of Miami's safety net over the last two years. For example, though one of Miami's main community health cen-

ters has expanded services for migrant farm workers and school children through new federal grants, it also had to reduce staff and urgent care hours after a cut in Public Health Trust funding in the wake of Jackson's financial troubles.

Several new community efforts have been launched to chip away at Miami's growing uninsurance problem. After years of concern among various stakeholders about the lack of a comprehensive safety net planning structure separate from Jackson Health System and the Public Health Trust, county officials established the Miami-Dade Office for Countywide Healthcare Planning in 2003. In addition, state legislation authorizing the creation of limited-benefit products recently prompted Jackson Health System to introduce the Flex Care Plan, an insurance product aimed at uninsured residents with incomes under 200 percent of the federal poverty level. Flex Care requires significant cost sharing for people between 100 percent and 200 percent of federal poverty, reportedly contributing to lower-than-expected enrollment in the product. And in July 2005, a local consortium of community clinics launched a new program called CareNet to provide discounted health care services to uninsured employees of small businesses. Several commercial vendors also have begun marketing medical discount cards to Miami's uninsured population, making these products a more visible alternative to health insurance. State legislation passed in 2004 to regulate these products.

Meanwhile, in October 2005, the federal government approved Florida's Medicaid reform plan. The plan, which will shift most Medicaid beneficiaries into managed care, will allow the state to contain Medicaid spending by contributing a capped, risk-based amount toward a beneficiary's premium for coverage from commercial health plans, employer-sponsored coverage, provider-sponsored networks or safety net-sponsored plans. Although the state plans to pilot the new model in Broward and Duval counties, market observers in Miami-Dade County are concerned that its eventual implementation in Miami could result in a reduction of services for the Medicaid population and the potential loss of Medicaid patients from safety net providers to private providers.

Issues to Track

Miami's growing uninsured population, high costs of care and difficult medical malpractice environment pose significant barriers to care for many of Miami's most vulnerable residents. Nevertheless, many of Miami's private hospitals remain profitable, even while facing heightened competition from physicians. These developments raise important questions about the future of health care in Miami, including:

- Will the medical malpractice environment lead more physicians to forgo coverage or leave the market, and how will this affect patient access to care?
- Will physician-owned ambulatory facilities and single-specialty groups continue to develop in Miami, and how will they affect the cost and quality of care?
- Will consumer-directed health plan designs and pay-for-performance incentive systems gain ground in the insurance market and help to constrain costs and improve quality of care?
- How will Florida's Medicaid waiver program affect Miami's safety net providers and the low-income populations they serve?

The most significant pressures on the safety net involve the Jackson Health System, the county's 1,500-bed hospital system.

Miami is one of 12 metropolitan communities tracked through site visits by the Center for Studying Health System Change.

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