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CONTAINMENT OF HOSPITAL AND HEALTH CARE COSTS—THE REGULATED MARKETPLACE

COMMENT BY
LINDA H. RICHEY*

Rising health care costs are a critical problem for Florida's citizens. Hospital care consumes 47% of each health care dollar, by far the largest share. Physicians and dentists consume 28%, nursing homes take 10%, and 15% goes to other providers of health care. Through payroll taxes, general revenues, state funds, and other sources, government and taxpayers pay for 40% of personal health care costs. Another 28% is paid through insurance, both privately purchased and employer-paid, and other sources. The remaining 32% is made up of out-of-pocket payments including deductibles, co-insurance, and noncovered services.\(^1\) Between 1979 and 1984, the average hospital bill rose 118%. Every year, Florida employers have faced 25% to 40% increases in medical insurance premiums.\(^2\)

According to data received by the Hospital Cost Containment Board, health care costs continued to increase in hospital budgets for fiscal 1984. Compared to an increase in the Consumer Price Index of 4.8%, budgeted gross revenue per hospital admission rose 14.4% over fiscal year 1983 while operating expense increased 8.8%.\(^3\) The spiraling cost of hospital-based care is the most highly visible aspect of the problem of health care cost containment faced by the legislature and the citizens of Florida, but it is not the only aspect.

The standard policy arguments for containment, either through rate setting and other regulatory strategies or through marketplace "reform" in the belief that prices can be controlled through traditional supply-demand behavior, tend to obscure rather than illuminate the problem. The meaning of market competition is itself unclear. To disciples of orthodox competitive economic theory, it is the "long-awaited triumph of reason."\(^4\) However, those who look to the state to improve the quality of life fear that the politically pop-

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1. FLA. TASK FORCE ON COMPETITION & CONSUMER CHOICES IN HEALTH CARE, AN OPPORTUNITY FOR LEADERSHIP 56 (Mar. 1984) [hereinafter cited as TASK FORCE].


ular competitive-market language marks government's disappearance from the health care sector and therefore an end to equity. According to the Florida Task Force on Competition and Consumer Choices in Health Care, there is no "pure" model for either strategy. Rather, successful cost containment measures in Florida are those compatible with federal policy incentives and regulation.

Some policymakers question the possibility of ever achieving a rational, streamlined market for medical care. Political pragmatists often subscribe to the belief "that in human affairs reason is occasionally the compass but emotion is always the steam." However, Florida's business community is solidly behind the idea of marketplace reform:

The best opportunity for facilitating fundamental change in the health care marketplace in Florida would seem to be an approach to health care cost containment leading to increased efficiency in health care services delivery which places emphasis on competition and the market as allocator. The major means for promoting market forces is for the providers (via competitive responses and self-restraint), the payers (by offering competitive health care plans) and purchasers (via prudent purchase initiatives) to restrain the rate of increase in hospital prices without a need for public intervention.

The Florida Legislature has previously addressed the problem of hospital and health care cost inflation. In 1979, it created the Hospital Cost Containment Board with the intent of promoting more rational purchase decisions by consumers through dissemination of hospital cost information. The hospital cost containment legislation, known as the Health Care Access Act, invests the Board with regulatory authority. A major piece of legislation, the Act also provides for an extensive combination of competitive and regulatory strategies for health care cost containment.

This Comment discusses several bills that concern health care

5. Id.
6. TASK FORCE, supra note 1, at 6.
7. HEALTH POLITICS AND POLICY, supra note 4, at 61.
8. TASK FORCE, supra note 1, at 119 (quoting the SOUTH FLA. HEALTH ACTION COALITION, INC., PROPOSAL TO THE FLORIDA TASK FORCE ON COMPETITION AND CONSUMER CHOICES IN HEALTH CARE (Jan. 1984)).
10. Ch. 84-35, § 17, 1984 Fla. Laws 52, 66 (current version at FLA. STAT. § 395.504 (Supp. 1984)).
and hospital costs considered by the 1985 Florida Legislature. The expressed intent of most of the bills explicitly reflects Florida's avowed preference for price competition in the health care marketplace. However, beyond the resolving clauses, much of the substantive language is regulatory—a continuation of Florida's dual approach in containing health care costs generally.11 In 1985, the legislature passed a major revision of chapter 641, part II, Florida Statutes, regulating Health Maintenance Organizations (HMOs); adopted legislation requiring that a prospective payment system based on diagnostic related groups be extended to neonatal care units; and passed bills providing for financial disclosure by nursing homes and authorizing health insurers to enter into contracts for alternative rates of payment with pharmacists and pharmacies. The legislature failed to enact measures that would have broadened Medicaid coverage for health care, mandated a second opinion before elective surgery, and strengthened the existing statutory prohibition against "wallet biopsies," that is, requiring patients to prove their ability to pay prior to treatment.

I. NEONATAL CARE GROUP REIMBURSEMENT

To increase income, most private industries share an incentive to reduce costs, thereby increasing profits. Until very recently, an inverse incentive obtained in hospital practices. Hospitals traditionally have been reimbursed on a cost basis, a method believed by many to be inherently inflationary, as it reimburses retrospectively and pays a cost rather than a price. Reimbursement is generated in direct proportion to the expense of the medical procedure. Under such a system, the efficient provider is more often punished than rewarded.

In October 1983, the Federal Government altered the incentive base. It began a prospective payment system under Medicare, using diagnostic related groups (DRGs) as the payment unit.12 A DRG is a category of illness which groups patients according to similar clinical attributes. Within each category there is a fixed payment for medical services rendered. Because physicians can readily distinguish one DRG from another clinically and can asso-

11. Id. § 2, 1984 Fla. Laws at 54 recognizes the duality of legislative intent: "Further, the Legislature finds that although price competition and market forces are the preferred methods for controlling health care costs, in reality, a combination of market forces and government regulation is already in effect."
12. TASK FORCE, supra note 1, at 94.
ciate "particular patient management processes" with each DRG, the categories are considered "medically meaningful."13 The Florida Legislature established a prospective payment arrangement as part of the 1984 Health Care Access Act. The legislature found that such arrangements would "contribute to the deceleration of hospital cost increases while enhancing the adequacy of and access to care so highly valued by consumers."14

For several years, Florida has funded a statewide program of regional perinatal intensive care centers (RPICC). These centers are in-hospital units which provide a full range of medical care to women with high-risk pregnancies and to newborn babies requiring intensive care.15 The Department of Health and Rehabilitative Services (HRS) has administered the funding, which is composed of a minimum support grant and additional cost-based funding for services rendered. As in other health care areas, this system has resulted in reimbursement inequities. Every year, some centers recover a much higher percentage of costs than do others.16 The legislature, long aware of the system's deficiencies, placed proviso language in the 1984-85 Appropriations Act directing HRS to develop a uniform cost-related prospective payment system for the neonatal program. Based on diagnosis and intensity of care, the system should pursue the goals of fund allocation and control of costs.17

The 1985 legislature passed an act that provides, inter alia, for a change in RPICC funding.18 This legislation directs HRS to develop and set up a neonatal care group (NCG) system. Modeled after Medicare DRGs, the NCG system will fund in-center neonatal hospital services by categorizing patients according to various clinical factors, severity of illness, and intensity of care required.19 The Act discontinues equal minimum support grants;20 it directs HRS to adopt criteria to partially charge parents or guardians whose incomes exceed financial eligibility criteria but who could

14. Ch. 84-35, § 26, 1984 Fla. Laws 52, 76 (current version at FLA. STAT. § 395.515 (Supp. 1984)).
15. FLA. STAT. § 383.16(3) (1983).
17. Ch. 84-220, § 1, 1984 Fla. Laws 724, 863.
not pay full charges without extreme hardship. Additionally, the Act specifies that payments for neonatal care provided at affiliated centers may be based on a rate no higher than the center's prevailing Medicaid per diem rate. Finally, the Act permits funding for other related services to be based on operating budgets or rate structures and provides for annual cost reports and development of several studies concerning neonatal intensive care services.

The legislation should result in a more even distribution of available funds to the RPICCs, but the cost of keeping high risk, low-birth-weight infants alive is extraordinarily high. Infant mortality is primarily caused by low birth weight, and Florida has the ninth worst infant mortality rate in the country. The average bill in 1984 was $15 thousand for each of the 5,500 underweight infants born in Florida. The total bill of $82.5 million was shared by taxpayers, insurance companies, and parents. Conversely, the cost-benefit ratio for prenatal care is estimated to be at least three to one—the state will save three dollars for every one dollar spent on preventive health services for pregnant women. If Florida could reduce the number of low-birth-weight babies by one-half, it could save millions of dollars per year in RPICC expenses.

II. PHARMACISTS AND PREFERRED PROVIDER ORGANIZATION ARRANGEMENTS

The legislature further limited the traditional cost reimbursement system by passing legislation extending preferred provider organization arrangements (PPOs) to include pharmacists and pharmacies. A PPO allows a third party payer to contract with health care providers who furnish services for lower than usual fees in return for prompt payment and a higher volume of consumers.

22. Id. § 5 (amending Fla. Stat. § 383.19) (1983)). The original Senate bill more narrowly defined affiliated centers as designed to offer health services to women with mild to moderate risk pregnancies and infants requiring less than the full range of services available at the regional perinatal centers. Compare Fla. SB 708, sec. 1 (1985) with ch. 85-225, § 1, 1985 Fla. Laws 1514, 1514 (amending Fla. Stat. § 383.16 (1983)).
25. Id.
26. Id.
27. Id.
28. TASK FORCE, supra note 1, at 111.
On the consumer side, a PPO encourages the beneficiary to use preferred providers by offering incentives such as a reduction in or waiver of co-insurance requirements or lower deductibles. Within the context of a third party insurance mechanism, the beneficiary gives up a measure of free choice compared to traditional comprehensive coverage but retains more choice than that provided by an HMO.29

In the prefatory clauses of the 1983 enabling legislation for PPOs, there is a clear legislative intent to remove existing legal barriers to effective price competition and to encourage competition and to promote more efficient health care financing.30 Specifically exempted from the scope of the legislation were those licensed health care providers regulated under chapter 465, Florida Statutes—pharmacists and pharmacies. Insurers and self-insurers could otherwise enter into PPO arrangements with licensed health care providers and could, "by agreement with insureds, limit payments under a . . . policy to such alternative rates regardless of the provider chosen by the insured, and offer the benefit of such alternative rates to insureds who select such providers."31

Apparently, at the time the 1983 legislation was enacted, there was a question whether explicit legislative authorization was required for the PPO arrangements under consideration.32 In any case, the specific exclusion of pharmacists and pharmacies indicated an intent to prohibit contracts between them and insurers in a PPO framework. PPO arrangements are new; the enabling legislation is barely two years old. Yet there is a strong and continuing interest in the concept, particularly in Florida's business community, which finds the PPO attractive because of its nonregulatory, competitive-negotiated structure.33

Passage of Senate Bill 427 dissolves the distinction between pharmacists and pharmacies and other licensed health care provid-

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29. Id. at 115.
31. Id. §§ 3, 4, 1983 Fla. Laws 2304, 2305 (current version at Fla. Stat. §§ 627.6375, 627.6695 (1983)). The legislation enacted sections which affect individual and group health insurance policies, respectively. Also enacted was a subsection which provides that nothing in the Unfair Insurance Trade Practices Act prohibits insurers from engaging in PPO arrangements provided that insureds who select designated providers are offered the benefits of the alternative rates.
32. Staff of Fla. H.R. Comm. on Health Care & Ins., HB 748 (1985) Staff Analysis 2 (Apr. 5, 1985) (on file with committee) [hereinafter cited as HCI HB 748 Staff Analysis].
33. TASK FORCE, supra note 1, at 115-16.
ers engaged in PPOs. The Act simply deletes the exclusionary provision from all pertinent sections of the 1983 legislation. The Staff Analysis of the identical House companion bill summarizes this as a "general intent . . . to allow an insurance policy to list pharmacists or pharmacies from which an insured could obtain pharmaceuticals at a negotiated rate . . . [T]he policy could provide for reimbursement or indemnification at a higher rate than if the insured went to a non-preferred pharmacy." 35

As a result of this legislation, governmental entities, as self-insurers, can directly negotiate with pharmacists for discounted rates under group plans. As a third party that controls a sizeable share of the market, governmental entities should be able to negotiate attractive rates for their employees. Whether PPOs actually help to lower overall health care costs in Florida—hospital, physician, pharmaceutical—cannot yet be determined. PPOs are an evolving concept, as yet relatively free of statutory definitions, delineations, or prohibitions. There is presently no statutory prohibition regarding exclusive provider arrangements, nor are permissible differentials in payments defined; if problems occur in these areas, the legislature may then devise statutory solutions.

III. NURSING HOME FINANCIAL DISCLOSURE

Nursing home care is big business in Florida. Almost one-third of the current Medicaid budget, $308 million, will be spent on nursing home care. Virtually the entire cost is paid by individual consumers and by Medicaid; less than five percent of the cost is picked up by private insurance and Medicare. The average cost of care to a private pay Florida resident runs from about $1.5 thousand to more than $2 thousand each month. Those in need of care whose incomes exceed the Medicaid income ceiling of $843 per month and yet do not have sufficient independent funds to reach the private care range may be priced out of the marketplace. No statistics are available showing the number of persons barred from


In the House, the companion measure, Fla. HB 748 (1985), introduced by Rep. Lippman, Dem., Hollywood, was reported favorably out of the House Comm. on Health Care & Ins. and sent to the Comm. on Approp., Fla. H.R. Jour. 209 (Reg. Sess. Apr. 25, 1985), where it was again reported favorably, id. at 245 (Reg. Sess. May 3, 1985). On the floor, the Senate bill was substituted for the House bill and passed without objection. Id. at 686 (Reg. Sess. May 28, 1985).

35. HCI HB 748 Staff Analysis, supra note 32, at 2.
care, nor are there compilations reflecting the amount of charity care, if any, extended by nursing homes. Of the nearly 500 nursing homes in Florida, about eighty percent are Medicaid-certified and are required to give specifically formatted cost information to the HRS Medicaid office. The public does not see the information, which is used to set facility reimbursement levels and ceilings.36

The Hospital Cost Containment Board (HCCB) has the responsibility to monitor and regulate hospital budgets,37 but the HCCB had never previously been authorized to gather information on nursing home revenues and expenditures. Such authorization was proposed in House Bill 261, sponsored by Representative Abrams,38 and in a Senate companion, Senate Bill 235 (1985), sponsored by Senators Malchon39 and Meek.40 As finally passed, the second committee substitute for the Senate bill provides for a systematic gathering and analysis of nursing home financial reports.41

The legislation that passed creates sections 400.341–.346, Florida Statutes. Section 1 of the Act embodies the legislative intent:

[It is] in the best interest of the state that nursing home care be affordable and accessible to all persons requiring these services. Further, the Legislature finds there is a paucity of information on nursing home revenues and growth in those revenues, the equity of the burden in providing charity care, and nursing home rates and charges. The potential for growth in nursing home revenues and the effect of such growth on state and local government budgets and on the ability of persons to purchase nursing home care makes it vital that nursing home revenues and expenditures be documented and analyzed.42

The legislation provides definitions and directs the HCCB to establish a uniform system of financial reporting for nursing homes. The system should maximize existing accounting systems and min-

38. Dem., Miami.
40. Dem., Miami.
42. Ch. 85-298, § 1, 1985 Fla. Laws 1867, 1868.
imize paperwork. However, a uniform system of reporting is distinguished from a uniform accounting system. The HCCB may not require adoption of the latter. Each nursing home must file with the HCCB an annual report of its audited experience, including revenues, expenditures, and statistical measures, and must submit a schedule of charges and variations. The HCCB is authorized to gather other reports as necessary, with all reports open to public inspection except those containing privileged medical information. The HCCB is authorized to inspect and audit nursing home books and records for compliance, including records of individual or corporate ownership.\textsuperscript{43}

The legislation lists several categories and types of data to be documented and monitored: total revenues and annual changes; revenues by source and classification, including family contributions; average patient charges by geographic region, payor, and type of facility ownership; and profit margins and amount of charity care by region and type of ownership.\textsuperscript{44} The HCCB’s findings are to be disseminated through an annual report to the Governor and legislature, through pamphlets and brochures to the general public, and through cooperative efforts with HRS, local health councils, the State and District Nursing Home Council, and Long Term Care Ombudsman Councils.\textsuperscript{45}

The original draft of the bill provided that expenses for administration and operation of the program were to be paid for, subject to legislative approval, by assessments against each nursing home, not to exceed 0.025\% of the home’s annual revenues. A nursing home under new ownership would have been assessed based on annual revenue for the last fiscal year under the previous ownership. A facility in noncompliance with the financial disclosure program would have faced a fine of up to $1 thousand per day for each day in violation.\textsuperscript{46}

The bill was amended in the House Subcommittee on Aging and Mental Health. The Subcommittee added language that permits a nursing home certified under Title XIX of the Social Security Act to file its annual Medicaid cost report and any Medicaid audits instead of the report developed by the HCCB. Those facilities must provide the HCCB with information not already contained in

\textsuperscript{43} Id.  
\textsuperscript{44} Id.  
\textsuperscript{45} Id.  
\textsuperscript{46} Staff of Fla. H.R. Comm. on Health & Rehab. Serv., HB 261 (1985) Staff Analysis 2-4 (Apr. 9, 1985) (on file with committee).
the Medicaid reports. Additional Subcommittee amendments re-
 require companies operating more than one nursing home to report
 for each home and for the company’s home office separately and
 restrict the HCCB’s right to inspect and audit books and records
 to those circumstances where it has reason to believe there is evi-
dence of noncompliance.\textsuperscript{47}

The full HRS Committee further amended the House bill. Its
amendments excluded from the bill’s provisions those continuing
 care facilities licensed under chapter 651, Florida Statutes; de-
scribed more specifically contributions by families as comprising
 expenditures from the patient’s resources and from the family, as
well as expenditures not directed toward any specific patient’s
care; required documentation of patient days by payor category;
required other data concerning revenues and expenditures; and al-
low a facility upon notification to timely file a complete report
before incurring a fine.\textsuperscript{48} A major amendment that came out of
Committee altered the assessment provisions levied against nurs-
ing homes. The capped percentage of annual revenues was dropped
in favor of a far broader, more open-ended assessment “against
each nursing home in an amount set by HRS to cover the board’s
approved budget.”\textsuperscript{49} New homes pay initial assessment on licen-
sure and a home coming under new ownership is assessed based on
its number of beds.\textsuperscript{50}

The House Appropriations Subcommittee on HRS-Criminal Just-
tice substantially increased the amount of resident information to
be tracked and filed by the nursing homes, including date and lo-
cation of admission; patient’s age, primary diagnosis, and source of
financial support at the time of admission; date of conversion to
Medicaid and amount by payor source spent on nursing home care
prior to conversion; and date of discharge, reason for discharge,
and location to which the resident is discharged.\textsuperscript{51} The Florida

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\item \textsuperscript{47} The subcommittee met on April 8 and two days later reported the bill favorably,
with seven amendments, pending ratification by the full committee. \textit{Fla. Legis., History of

\item \textsuperscript{48} See Fla. CS for HB 261 (1985); \textit{Fla. H.R. Jour.} 242, 243 (Reg. Sess. May 2, 1985)
(Reports of Standing Committees).

\item \textsuperscript{49} See id.

\item \textsuperscript{50} Id. On May 1, 1985, the House Comm. on Health & Rehab. Services reported the bill
was then referred to the Comm. on Approp., where it was subreferred to the Subcomm.
son, History of House Bills} at 37, HB 261.

\item \textsuperscript{51} Fla. H.R., Subcomm. on Health & Rehab. Serv.-Crim. Just., tape recording of pro-
ceedings (May 13, 1985).

\end{itemize}
Health Care Association and American Health Care Association suggested gathering the additional information, since the creation of a Long Term Care Insurance Program in the next few years will depend, in part, on having a base of information. Data collected as a result of this amendment will provide such a base.\(^5\)

Other amendments adopted by the Appropriations Subcommittee authorized the HCCB to evaluate and monitor Medicaid conversion, and provided up to ten budgeted positions to assist the board in its implementation of the Act.\(^5\) After adding a title amendment and an amendment providing particulars of the report required of facilities certified under Title XVIII, the full Appropriations Committee reported the bill favorably as a committee substitute for a committee substitute. It was in this form that the legislation ultimately passed.\(^5\)

The House Appropriations Committee estimated that expenses and first-year startup costs to implement the Act will total approximately $317 thousand for fiscal 1985-86.\(^5\) The expense to the state is estimated to decrease in subsequent years.\(^5\) Each nursing home will bear the expenses of filing an audited cost report and paying an increase in its annual licensure fee to offset administrative costs to the HCCB. The Florida Health Care Association estimates that the expense of an audited cost report will be $4 thousand.\(^5\) There will be an additional assessment per licensed nursing home bed of about six dollars the first year.\(^5\) The public sector, in the form of Medicaid, will probably reimburse costs incurred by Medicaid certified homes. Totally private nursing homes will probably pass on the costs to their residents.

The costs of implementing the Act are outweighed by the potential benefits to the public. Nursing homes are being drawn into the

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52. Interview with Susan Turner, Staff Member, Fla. H.R., Comm. on Health & Rehab. Services (June 19, 1985).

53. The Subcommittee met on May 13 and reported the bill favorably as a proposed committee substitute for a committee substitute because of three amendments. FLA. LEGIS., HISTORY OF LEGISLATION, 1985 REGULAR SESSION, HISTORY OF HOUSE BILLS at 37, HB 261.


56. Id.


58. Id.
ongoing argument between those who favor regulation and those who favor competition in the health care market. Yet those who argue either position would have their preferred policies formulated out of an information vacuum. Policy based on factual information is generally more rational than policy borne out of speculation or unfounded assumptions about the nursing home industry. At least in theory, consumers can make more intelligent financial decisions if their choices are based on the best available information concerning the industry and the marketplace. The impact of this Act, in terms of public policymaking and personal choice, will be felt in proportion to the escalating demand from Florida’s aging population for nursing home care.

IV. REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

Health Maintenance Organizations (HMOs) seem to be the one health care delivery mechanism actually capable of reducing the overall cost of care instead of shifting costs to other payers.\(^5\) HMOs are an example of vertical integration in health care. For a fixed, prepaid monthly or annual premium the subscriber receives a full range of ambulatory and inpatient services, and the provider is at risk for the quantity, quality, and cost of care.\(^6\) Since HMOs enjoy a financial reward if their subscribers stay well, the focus is on preventive care. Efforts to avoid unnecessary hospitalization or expensive tertiary care usually result in lower health care costs for HMO enrollees. Subscribers lose a measure of freedom to choose health care providers. Except in a medical emergency, subscribers may see only those providers employed by or under contract with the HMO.\(^7\)

Some industry critics see in the HMO integration of services a valuable model for improving the consistency and quality of health care and consider HMOs an integral part of market-oriented reform.\(^8\) Other critics hold that there are fundamental flaws in the HMO theory; by joining comprehensive delivery and prepaid financing in one organization, a rational, self-regulating entity does not necessarily, or even probably, follow. Nor would the competitive pressures of the organization’s efficiency necessarily force the

59. Task Force, supra note 1, at 110.
60. Health Politics and Policy, supra note 4, at 283.
62. Health Politics and Policy, supra note 4, at 283.
Health care reform is essential for a larger health care system to change its ways, according to this line of argument. These critics contend that key contributors face strong disincentives to form and support HMOs. They further contend that deeply imbedded elements in health care delivery, including consumer psychology, professional culture, and organization makeup, work against HMO development.65

Although the idea of a prepaid group practice was originally dismissed as slightly subversive, conservative critics "substituted a rhetoric of rationalization and competition for the older rhetoric of cooperation and mutual protection. The socialized medicine of one era had become the corporate reform of the next."64 In 1984, the Florida Legislature evidenced an intent that the state foster market reform by encouraging employee enrollment in alternative insurance plans, including HMOs, wherever feasible.65 In slightly more than three years, the number of HMOs in Florida has increased from ten to twenty as of October 31, 1984. Of the approximately 530,000 subscribers, an estimated 46% live in Dade, Broward, and Palm Beach Counties and represent between 6 and 7% of the total area population.66 Blue Cross and Blue Shield of Florida projects that by 1988 about 14% of Florida's population will be enrolled in HMOs.67 The number of HMO subscribers in Florida increased 72% last year.68 Thus, HMOs are a popular alternative to the mainstream fee-for-service system of health care delivery and an increasingly significant factor in Florida's health care marketplace.

An HMO creates unique regulatory problems. By statute, both the Department of Insurance (DOI) and HRS regulate HMOs. HRS ensures quality of care, and DOI ensures fiscal soundness and protects health care consumers from fraud and abuse. Because of the rapid growth and regulatory problems of HMOs, DOI found its current regulatory authority inadequate. It proposed a major reform to part II of chapter 641, Florida Statutes, which regulates HMOs.69

The Insurance Commissioner called together a task force in September 1984, whose participants included members of employer...
groups, consumer groups, the HMO industry, the Florida Medical Association, and the Academy of Florida Trial Lawyers, among others. The recommendations of the task force and those of DOI were heard in the House Health and Life Insurance Subcommittee on April 23, 1985. The Subcommittee heard additional testimony, amended the task force proposals, and voted to favorably recommend the resulting language to the Health Care and Insurance Committee in the form of a proposed committee bill. After the amendments were incorporated, PCB-1 was presented to the Committee, which, in turn, adopted another fourteen amendments and voted the bill out favorably as a committee bill, House Bill 1387. The bill was referred to the Appropriations Committee, which adopted six amendments and voted it out favorably. On the House floor, the bill was read for the second and third times, floor amendments and certain Appropriations amendments were adopted, and the bill was passed as amended. The Senate substituted House Bill 1387 for Committee Substitute for Senate Bill 573, passed the bill, and ordered House Bill 1387 enrolled.

The legislation is comprised of forty-eight sections which substantially expand the existing regulatory authority of DOI and provide for additional duties and responsibilities of HRS in ensuring HMO quality of care. The most significant changes are embodied in approximately fifteen sections, but the legislation as a whole constitutes a major reform of chapter 641, part II, Florida Statutes.

Section 5 of the Act concerns legislative intent, adding that it is state policy to guarantee that high quality health care be delivered by comprehensive health care plans. New section 641.18(6) states that the operation of an HMO without a certificate of authority is a danger to Florida citizens and exposes any enrollee to irreparable loss, damage, or injury. The intent of this language is to make it

71. Staff of Fla. H.R. Comm. on Health Care and Ins., HB 1387 (1985) Staff Analysis 16 (final June 12, 1985) (on file with committee) [hereinafter cited as HCI HB 1387 Staff Analysis].
76. (Supp. 1984).
easier for DOI to obtain an injunction against an unlicensed HMO.\textsuperscript{78}

Section 7 of the Act requires HMOs licensed after October 1, 1985, to be incorporated in Florida.\textsuperscript{79} Seventeen of the twenty existing HMOs are Florida corporations.\textsuperscript{80}

The Act amends the application process for a certification of authority from DOI. Section 8 of the Act requires that the financial statements necessary under current law be certified by an independent CPA. An HMO application must include a description of the HMO's grievance procedures and copies of the proposed certificates and member handbooks to be distributed to subscribers.\textsuperscript{81}

The grievance procedure issue came up in Subcommittee testimony, and at least one business coalition wanted to see DOI set up a standardized grievance procedure.\textsuperscript{82} There was testimony that the bill was too vague on the point,\textsuperscript{83} but, in its final version, the Act still allows each HMO to formulate its own procedure for dealing with consumer dissatisfaction. This section of the Act also delineates acceptable marketing activities prior to certification and exempts from the Act's requirements any provider who contracts with HRS on a prepaid basis to provide social services or health care to those eligible. For those plans, HRS is required to set rules and standards for such aspects as quality, insolvency protection, adequacy of insurance, and actuarial soundness.\textsuperscript{84} Previously, only those HRS contracts covering Medicaid services were exempt.\textsuperscript{85}

Under present law, an HMO, in its initial application, must demonstrate to HRS an ability to offer comprehensive health care services in the geographic area proposed. HRS certification is a condition precedent to DOI licensure. Previously, once the certificate had been granted, no additional approval was required to expand into a new geographic area.\textsuperscript{86} Section 9 of the Act remedies this anomaly by forbidding any change in geographic area unless

\begin{itemize}
\item \textsuperscript{78} HCI HB 1387 Staff Analysis, \textit{supra} note 71, at 3.
\item \textsuperscript{79} Ch. 85-177, § 7, 1985 Fla. Laws 1236, 1247 (to be codified at Fl. Stat. § 641.21).
\item \textsuperscript{80} HCI HB 1387 Staff Analysis, \textit{supra} note 71, at 4.
\item \textsuperscript{81} Ch. 85-177, § 8, 1985 Fla. Laws 1236, 1247 (amending Fl. Stat. § 641.21 (Supp. 1984)).
\item \textsuperscript{82} Fla. H.R., Subcomm. on Health and Life Ins., tape recording of proceedings (Mar. 4, 1985) (on file with committee).
\item \textsuperscript{83} Id.
\item \textsuperscript{84} Ch. 85-177, § 8, 1985 Fla. Laws 1236, 1247; \textit{see also} HCI HB 1387 Staff Analysis, \textit{supra} note 71, at 4.
\item \textsuperscript{85} Fl. Stat. § 409.266(2)(b) (Supp. 1984).
\item \textsuperscript{86} HCI HB 1387 Staff Analysis, \textit{supra} note 71, at 5.
\end{itemize}
an HMO notifies both DOI and HRS of its intent at least sixty days prior to providing health care services in the new area. Before enrolling members, it must submit to HRS a notarized affidavit affirming its existing and projected capability to provide such health care. If HRS determines an HMO is incapable of providing the services, it must notify the DOI, which, in turn, can issue an administrative order prohibiting the expansion.\textsuperscript{87} Additionally, the bill increases to $100 thousand the amount of the required fidelity bond to cover misappropriation of funds by HMO employees. A $25 thousand bond had been required previously.\textsuperscript{88}

Section 11 of the Act adjusts the minimum financial surplus requirements for HMOs. The Act mandates a minimum surplus equal to $100 thousand or five percent of an HMO's total liabilities, whichever is greater. If an HMO can satisfy DOI that the organization has historically generated sufficient net income to assure its financial health for the following year and can meet other conditions, then DOI must lower the surplus requirement to not less than $100 thousand. An HMO may earn an exemption from the requirement if its subscriber claims have been guaranteed by an organization having a surplus of the greater of $2 million or twice the minimum surplus of an HMO.\textsuperscript{89} The new law may result in a shift of surplus. Under the old law, all HMOs were required to maintain a $250 thousand surplus by 1988.\textsuperscript{90} Under the new requirements, larger HMOs may have a greater surplus if their minimum 5 percent of total liabilities exceeds $250 thousand. Similarly, smaller HMOs may have a lower requirement.\textsuperscript{91}

Section 12 of the Act creates a Rehabilitation Administrative Expense Fund requiring every HMO to make a $10 thousand cash deposit with DOI. The fund will pay administrative expenses during a court-ordered rehabilitation of an HMO. If rehabilitated, an HMO must reimburse the fund and, if an HMO is liquidated, the fund will be reimbursed for expenses incurred as provided for in chapter 631, Florida Statutes.\textsuperscript{92}

\textsuperscript{87} Ch. 85-177, § 9, 1985 Fla. Laws 1236, 1249 (amending Fla. Stat. § 641.22(1) (Supp. 1984)).
\textsuperscript{88} Id. (amending Fla. Stat. § 641.22(10) (Supp. 1984)); see also HCI HB 1387 Staff Analysis, supra note 71, at 5.
\textsuperscript{89} Ch. 85-177, § 11, 1985 Fla. Laws 1236, 1250 (amending Fla. Stat. § 641.225 (Supp. 1984)); see also HCI HB 1387 Staff Analysis, supra note 71, at 6.
\textsuperscript{91} Ch. 85-177, § 11, 1985 Fla. Laws 1236, 1250 (amending Fla. Stat. § 641.225 (Supp. 1984)).
\textsuperscript{92} Id. § 12, 1985 Fla. Laws at 1251 (to be codified at Fla. Stat. § 641.227).
Section 15 vests in DOI the power to seek temporary and permanent injunctive relief when an HMO is operated without a certificate of authority, when a licensed HMO has engaged in prohibited activity, or when an HMO is handling health maintenance contracts without a certificate of authority.\(^9\)

Section 17 simplifies the present deposit requirements for insolvency. It requires all HMOs to deposit either twice their reasonably estimated average monthly uncovered expenses or $100 thousand, whichever is greater. DOI may waive the deposit for financially healthy HMOs, for those with guaranteeing organizations, and for those with approved plans to continue benefits in the face of insolvency.\(^9\)

Section 21 of the Act provides for procedural guidelines concerning the content and distribution of HMO contractual materials. The Act requires HMOs to give each subscriber a copy of the applicable HMO contract, certificate, or member handbook.\(^9\) Under present law, any contract or rate change must be filed with DOI, subject to disapproval.\(^9\) Included in this procedure are any changes to an application form, member handbook form, certificate, or grievance procedure. Grounds for disapproval are listed.\(^9\) This section of the Act also amends section 641.31(7) by changing "or" to "and," clarifying that HMOs must offer care provided by osteopaths, chiropractors, and podiatrists. When the Health Care and Insurance Committee heard the May 6th revision of the draft bill, an attempt was made to delete the additional premium currently required by section 641.31(7) to obtain such care. The idea was to spread the cost among all HMOs,\(^9\) but the bill ultimately passed with the premium requirements intact.\(^9\)

The language of section 21 occasioned some bracing debate on the House floor. The debate brought into focus the legislative tension between pursuing a policy of increasing consumer awareness

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93. *Id.* § 15, 1985 Fla. Laws at 1254 (to be codified at Fla. Stat. § 641.281); see also HCI HB 1387 Staff Analysis, *supra* note 71, at 7.


98. See Fla. H.R. Comm. on Health Care & Ins. PCB 85-1, sec. 20 (1985) (proposed amendment to Fla. Stat. 641.31(7)). Amendment 1, by Rep. Kimmel, Repub., West Palm Beach, restored the present statutory language.

and simultaneously protecting burgeoning HMOs in the marketplace. Section 21 of the bill as passed by the House Appropriations Committee had mandated that contracts, certificates, or handbooks "shall" disclose that for certain medical procedures, subscribers may receive care from physician extenders such as nurse practitioners, physician assistants, or other individuals who are not licensed physicians. The House considered an amendment offered by the Appropriations Committee to strike the subsection. House members speaking against the amendment cast the issue as one of consumer protection. They centered on the necessity for truth in advertising and voiced concerns that in south Florida, especially, subscribers are subject to misrepresentation in this area, believing incorrectly that they have been treated by a physician each time they are provided medical care. Those in favor of the amendment argued that disclosure would put HMOs at a competitive disadvantage, since hospitals are not required to similarly disclose. The amendment failed by a narrow margin, was reconsidered, and failed again. A floor amendment then was offered to strike "shall" and insert "may." By adoption of the amendment, the House effectively gutted the subsection, leaving to each HMO the discretion to disclose.

A controversial aspect of section 24 of the Act concerns restrictions on an HMO's ability to expel subscribers from an HMO or the refusal by an HMO to issue or renew a subscriber contract. As passed, the Act distinguishes between refusing to enroll an individual member of a subscriber group and expelling or refusing to reenroll a member of the group. The Act prohibits refusal to enroll based on factors of race, color, creed, marital status, sex, or national origin. Once enrolled, a group member cannot be refused reenrollment or be expelled based on the foregoing factors, or by reason of age, health status, health care needs, or prospective costs of health care services. However, based on health factors, an HMO may refuse to enroll an individual member of a subscriber group.

When the Appropriations amendment allowing HMOs to refuse enrollment based on health factors was offered on the floor, similar

102. Id.
104. Id. 839 (Reg. Sess. May 29, 1985) (Amendment 7).
105. Ch. 85-177, § 24, 1985 Fla. Laws 1236, 1262; see also HCI HB 1387 Staff Analysis, supra note 71, at 10.
Policy tensions surfaced.\(^{106}\) One side argued that the amendment discriminated against individual members, allowing HMOs seeking commercial business to skim the best risks from the group and let the questionable risks fend for themselves; that the amendment vitiated one of the salient points of HMOs—their ability to spread the losses from poor risks among all their members. The opposition responded with a competition argument.\(^{107}\) To meet the goal of greater competition in the health care marketplace, smaller HMOs must be allowed to pick and choose among consumers. The point that smaller HMOs could be wiped out by one catastrophic illness was labeled spurious and rebutted with reminders of the many fiscal safeguards scattered throughout the bill.\(^{108}\)

However, a substitute amendment was adopted, setting up the previously mentioned distinctions for enrollment and allowing HMOs to weed out those potential subscribers most in need of health care services.\(^{109}\) If a small company chooses to shift its entire group coverage from a traditional insurer to an HMO, it would appear that those employees deemed unacceptable risks might lose all coverage. It is problematic whether preexisting medical conditions might prevent their buying coverage, at any price, from an alternative provider.

Section 31 of the Act requires HMOs to keep a current list, by geographic area, of all hospitals and primary care physicians providing medical care. The list must be available to DOI, HRS, and employers and subscribers being solicited for coverage. The list must include hospitals routinely used by the HMO.\(^{110}\)

A statewide subscriber assistance program must be implemented under section 32 of the Act. A review panel is to recommend actions DOI should take concerning unsatisfied grievances, and HMOs are required to submit quarterly reports of unresolved grievances.\(^{111}\)

Section 33 of the Act specifies those investments authorized for HMOs. The Act defines in detail what may be termed assets and liabilities in determining an HMO's financial condition. Furniture

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109. Id. at 839 (Reg. Sess. May 29, 1985) (Substitute Amendment 6).
110. Ch. 85-177, § 31, 1985 Fla. Laws 1236, 1264 (to be codified at F LA STAT. § 641.3109); see also H CI HB 1387 Staff Analysis, supra note 71, at 10.
111. Ch. 85-177, § 32, 1985 Fla. Laws 1236, 1265 (to be codified at F LA STAT. § 641.311); see also H CI HB 1387 Staff Analysis, supra note 71, at 11.
and furnishings, fixtures, vehicles, medical libraries, equipment, and medical supply inventories may be included as assets under specified conditions. The investment authorization provisions supplant those found in the insurance code, currently applicable to HMOs.\textsuperscript{112} The new provisions appear to be both more restrictive and more expansive than the previous ones. The Act excludes many of the generally authorized investments, yet allows a considerably higher concentration of investment in property associated with HMO businesses and in contracts for administrative services and health care than allowed for insurers.\textsuperscript{113}

Sections 35 and 36 of the Act provide a list of prohibited unfair trade practices geared solely to HMOs. Although the Act generally duplicates the unfair insurance trade practice provisions,\textsuperscript{114} certain new provisions have been added concerning additional actions that constitute misrepresentation and false advertising.\textsuperscript{115} Of particular interest is the listing of a new ground constituting an unfair claims settlement practice. The provision prohibits an HMO from failing to provide a subscriber with services unless an HMO reasonably believes it has a legitimate defense for not providing contracted services.\textsuperscript{116}

Sections 43 and 44 concern conversion terms applicable solely to HMOs.\textsuperscript{117} Rather than listing the specific minimum benefits required to be offered to an individual whose group HMO coverage terminates, the Act provides for a converted contract to include a level of benefits substantially similar to the level offered in the group contract.\textsuperscript{118} Under the Act an HMO can discontinue a subscriber for cause and does not have to offer a converted policy.\textsuperscript{119}

Lastly, section 45 of the Act authorizes the issuance of life maintenance contracts that provide comprehensive coverage of the life, health, and disability of the insured. The stated legislative intent is to maximize an insurer’s financial incentives to maintain an in-

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\textsuperscript{112} Ch. 85-177, § 33, 1985 Fla. Laws 1236, 1265 (amending Fla. Stat. § 641.35 (Supp. 1984)).
\textsuperscript{113} Id.; see also HCI HB 1387 Staff Analysis, supra note 71, at 11.
\textsuperscript{114} Fla. Stat. § 626.9541 (Supp. 1984).
\textsuperscript{116} Ch. 85-177, § 35, 1985 Fla. Laws 1236, 1277 (to be codified at Fla. Stat. § 641.3903(5)).
\textsuperscript{117} See generally HCI HB 1387 Staff Analysis, supra note 71, at 13.
\textsuperscript{118} Ch. 85-177, § 43, 1985 Fla. Laws 1236, 1283 (to be codified at Fla. Stat. § 641.3921).
\textsuperscript{119} Id. (to be codified at Fla. Stat. § 641.3921(4)).
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sured's health, life, and employability. The legislature also intends that insurers have the authority to require of their insureds a healthy lifestyle as a condition of entitlement to a life maintenance contract.\textsuperscript{120} The legislation enables a life and health insurer to sell a single policy combining life, health, and disability income insurance. Life insurers may engage in joint ventures with health insurers or HMOs. The Act provides for minimum standards for such a policy and, for those contracts which meet the standards, the insurer may be exempted from all rate regulation of the contract, among other entitlements.\textsuperscript{121}

This regulatory legislation will increase costs for DOI, HRS, and new and existing HMOs. The costs will be borne by HMO subscribers and the taxpayers of Florida. HMOs must pay $10 thousand to the rehabilitation fund, meet increased surplus and deposit requirements, and pay for the HRS triannual quality audits. DOI and HRS will incur additional costs in taking action on HMO geographic expansion and in establishing a grievance review panel. Offsetting these costs is the rationale that the regulations will work to strengthen the solvency of new and existing HMOs and minimize the economic and human costs of substandard or failing HMOs.

V. SECOND SURGICAL OPINION PROGRAM

Unnecessary surgery is seen by many as adding to the spiraling cost of hospital care, another example of excess utilization of hospital services. Intervention in the form of a mandatory or voluntary second surgical opinion program is a comparatively recent, and controversial, form of utilization review.\textsuperscript{122} Some state legislatures have mandated programs for Medicaid recipients, while other programs have originated with unions.\textsuperscript{123}

Whether second opinion programs result in cost savings depends on the credence placed in available studies. According to the Florida Department of Administration (DOA), not only is there no documentation to prove that mandatory second opinions are cost-effective, but higher costs may be incurred by pursuing alternative medical procedures. By delaying surgery, the eventual surgical pro-

\textsuperscript{120} Ch. 85-177, § 45, 1985 Fla. Laws 1236, 1287 (to be codified at Fla. Stat. § 627.9301(1)).

\textsuperscript{121} Id. (to be codified at Fla. Stat. § 627.9303); see also HCI HB 1387 Staff Analysis, supra note 71, at 13.

\textsuperscript{122} HOSPITAL COST CONTAINMENT PROGRAMS 70 (E. Hughes ed. 1978).

\textsuperscript{123} Id.; see also ISSUES IN HEALTH CARE REGULATION 152 (R. Gordon ed. 1980).
procedure is often more expensive. However, at least one study demonstrates that, as a result of steelworker unions establishing a mandatory second-opinion program, the number of surgical claims for reimbursement dropped 9% over a four year period. During the same period, national surgical rates rose 20%.

To resolve cost-effective uncertainties, DOA currently has a pilot project set to begin in January 1986. The project will require a mandatory second opinion in elective surgeries. Employees enrolled under the state's group health plan will participate. Although the project is currently scheduled to be conducted only in select counties, DOA is already authorized under prior appropriation language to set up a statewide program.

On April 2, bills were introduced in the Senate and the House that would have preempted the DOA study and directed DOA to mandate second opinions prior to elective surgery as a condition of coverage by the state's group health insurance plan. Existing state law makes no specific provisions for the benefits or design of the program; those provisions are assigned to DOA, whose Bureau of Insurance is responsible for the program's daily operations. The bills would have defined elective surgery as surgery where other, "less drastic treatments are generally recognized by the medical community as comporting with accepted medical practice in the treatment of the condition," or surgery used for a condition "not generally recognized in the medical community as threatening to life or health." The legislation would have directed DOA to develop a system to identify surgical procedures which could be termed elective. Further, the legislation would have au-

125. HOSPITAL COST CONTAINMENT PROGRAMS, supra note 122, at 71, (quoting 2 NATIONAL COMMISSION ON THE COST OF MEDICAL CARE, SECOND OPINION SURGICAL PROGRAM: A VEHICLE FOR COST CONTAINMENT? REPORT—AMERICAN MEDICAL ASSOCIATION (1978)).
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Authorized DOA to enter into contracts with individual physicians and insurance carriers to provide second opinions. It also would have directed DOA to develop a schedule of fees for obtaining the opinions.131

The bills would have bound DOA to undertake the program, limited the department’s administrative discretion, and limited a collective bargaining agent’s ability to represent employees on the second opinion question.132 Conceivably, the bills might have served as precedent for additional legislative strictures on the collective bargaining process. Perhaps in response to those concerns, by the time the bills were reported favorably out of their respective committees as committee substitutes, neither bill mandated state-wide implementation of the program. Instead, a pilot study would have been made in only three counties: Polk, Pinellas, and Broward, with authority given to DOA to expand the program into more counties, subject to appropriations.133 Sensibly deleted from each bill was authority to set up a second surgical opinion program for HMOs.134

The Senate bill stalled on the calendar for two weeks, but action was livelier in the House. Committee Substitute for House Bill 145 had become a vehicle for House Bill 1378, a controversial Fitness-Wellness Pilot Program from the House Committee on Health Care and Insurance. Parliamentary maneuvering to piggyback the programs proved fatal to both. Although the bill passed the House with the fitness-wellness amendment,135 it was not retrieved by the Senate from messages until the last hours of the final day of the session. The bill was then substituted for Committee Substitute for Senate Bill 467,136 but a floor amendment by Senator Gordon137 that struck the fitness-wellness language138 sent the legislation back to the House, where it died in messages.139

132. Id.
134. See id. The program would have had a negative economic impact by requiring costs over and above the fixed cost to the state of the HMO payment. Ret., Pers’l & Coll. Barg. Staff Analysis, supra note 124, at 2.
137. Dem., Miami Beach.
139. Fla. LEGIS. HISTORY OF LEGISLATION, 1985 REGULAR SESSION, HISTORY OF HOUSE BILLS at 21, HB 145. The question of implementing a fitness-wellness program for state employees will probably recur in the 1986 legislative session. The implementing act for general appropriations for fiscal 1985-86 contains proviso language directing the DOA to pro-
Had the second opinion legislation passed, any cost reduction for elective surgery could have been measured on a statewide basis. As a major employer, the state would have a sizeable pool of enrollees available to participate in a mandatory second opinion program. Implementing the DOA pilot program will result in a substantially smaller sample, but a careful accounting of the direct and indirect costs of a second opinion should still provide useful information. If savings are found to be minimal, similar legislative efforts could be forestalled.

VI. EMERGENCY MEDICAL CARE FOR INDIGENTS

The Hospital Cost Containment Board has noted that “[t]he provision of hospital care to indigents has become a problematic, but important, public policy issue as competitive pressures on Florida hospitals have increased. . . . [T]he provision of indigent care by individual hospitals affects the hospital’s financial needs and stability.”140 According to the Florida Task Force on Competition and Consumer Choices in Health Care, the rise of corporate medicine and the pursuit of cost containment measures combine to aggravate the problem of equitable access to health care for the poor. The Task Force noted a trend in Florida whereby hospitals turning in the best economic performance (investor-owned hospitals) delivered far less charity care and fell behind other hospitals in volume of Medicaid patients.141 According to 1982 data gathered by the Hospital Cost Containment Board, government hospitals provided twelve times more charity care than did Florida’s proprietary hospitals and twenty-five percent more than voluntary hospitals, calculated as a percentage of gross patient revenue.142

Prior to admitting a patient in need of emergency medical care, it is not uncommon for a hospital to conduct a “wallet biopsy.” An individual found to be uninsured, underinsured, or just plain poor runs the risk of being turned away from the emergency room and summarily dumped on the public hospital system. Florida law prohibits any general hospital or specialty hospital with an emergency room from denying anyone treatment for any emergency medical condition that will deteriorate from a failure to provide such treat-

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140. HCCB ANN. REP. supra note 3, at 19.
141. TASK FORCE, supra note 1, at 135.
142. Id.
A hospital with an emergency room may not require payment prior to giving emergency medical care when the patient has shown evidence of adequate health insurance coverage.\footnote{FLA. STAT. § 395.0143 (Supp. 1984).}

Senate Bill 902, sponsored by Senator Gersten,\footnote{FLA. STAT. § 395.0145 (Supp. 1984).} would have amended and toughened the existing statutory requirements. The bill provided that a hospital shall not deny emergency treatment to one in need “for any reason,” nor shall the hospital “transfer any such person to another hospital.”\footnote{Dem., Coral Gables.} Language would have been deleted in section 395.0145 such that a patient treated pursuant to section 395.0143 would no longer have to show adequate insurance coverage either prior to treatment or as a precondition to treatment.\footnote{Fla. SB 902, sec. 1 (1985).} The bill would have prohibited hospitals from making any inquiry into a patient’s financial status before rendering care.\footnote{Id. sec. 2 (1985).}

Senate Bill 776 was sponsored by Senator Mann.\footnote{Fla. SB 902 (1985) was introduced on April 19 and was referred to the Senate Comm. on Health & Rehab. Serv. FLA. S. JOUR. 136 (Reg. Sess. Apr. 19, 1985).} Like Senate Bill 902, but without reference to existing statutes concerning emergency medical care, Senate Bill 776 would have prohibited a hospital from denying a patient admittance based on economic criteria. The bill would have allowed a transfer only if, “in the medical judgment of the licensed hospital physician responsible for emergency room service, the hospital [was] unable to render appropriate treatment.”\footnote{Dem., Ft. Myers.} Further, “no such transfer shall be authorized until the physician considers the patient sufficiently stabilized for transport.”\footnote{Id. sec. 2 (1985).} Total decisionmaking responsibility would have been given to the licensed physician on staff.\footnote{Compare Fla. CS for SB 776 & 902 (1985) with Fla. SB 902 (1985).} Because of their similar intent, both bills were combined into Committee Substitute by the Senate Health and Rehabilitative Services Committee, but the language in Senator Gersten’s bill disappeared.\footnote{Fla. CS for SB 776 & 902, sec. 1 (1985).} The combined legislation additionally would have required hospitals to maintain transfer agreements with appropriate receiving hospitals.\footnote{Fla. CS for SB 776 & 902, sec. 1 (1985).} The committee substitute was reported favorably, read for the first time on May 22, and referred to the Senate Commerce Commit-
TEE,155 where it died.156

Had any of the "wallet biopsy" legislation passed, public hospitals might have seen a decrease in their indigent caseloads, at least theoretically. However, none of the legislation specified a penalty in case of violations157 and voluntary compliance by nonpublic hospitals is scarcely a realistic hope. Considering the problem of indigent patients, one proprietary hospital lobbyist remarked: "Where in the world is it written that the paying medical public has to pay for the medically indigent public?" Like any other for-profit entity, proprietary hospitals seek to minimize losses whenever possible; dumping indigent patients on government hospitals is a crude, but effective, method to contain costs.

The complex question of who will pay for Florida's medically indigent cannot be answered satisfactorily by so simple a response as this legislation. The Health Care Access Act of 1984159 directed the HCCB to contract with a state university system institution to conduct a study which will provide, inter alia, proposals for broader-based funding sources to finance indigent health care. A report of the study must be made to the President of the Senate, the Speaker of the House, and the Governor by February 1, 1986.160 The report may provide legislators with more thoughtful solutions to the problem of emergency medical treatment for Florida's indigents.

VII. EXPANSION OF MEDICAID COVERAGE

Several bills were introduced in the 1985 Regular Session that, if passed, would have expanded or shifted Medicaid coverage of health care. However, all of the bills died in committee. House Bill

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156. FLA. LEGIS. HISTORY OF LEGISLATION, 1985 REGULAR SESSION at 102, SB 776.


159. Ch. 84-35, § 7, 1984 Fla. Laws 52, 57 (current version in scattered sections of FLA. STAT.).

160. Id. § 8, 1984 Fla. Laws at 57.
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642, sponsored by Representative Press, would have established by rule a Medicaid medically needy program to provide emergency medical care for financially eligible persons at any verified trauma center, financial eligibility to be based on Aid to Families with Dependent Children (AFDC) income and resource standards. Currently, only Medicaid eligible people are covered at trauma centers. HRS estimated that if the bill reached an additional population of 51,000 the annual cost would be nearly $74 million. In addition to the high price tag, HRS determined that the bill could not be implemented as written. To implement a medically needy program under Medicaid, Florida must at least provide ambulatory services to medically needy minors and pregnancy related services to medically needy women.

House Bill 402, sponsored by Representatives Grindle, Abrams, and Bell, would have authorized HRS to contract with licensed hospitals for inpatient and outpatient services to Medicaid recipients through a process of negotiations, competitive bidding, or both. While the process might have produced lower prices in the marketplace and some savings for the state, teaching facilities

161. Dem., Delray Beach.


164. Repub., Altamonte Springs.
165. Dem., Ormond Beach.

Sen. Johnson, Repub., Sarasota, sponsored the companion bill, Fla. SB 676 (1985), which was introduced on April 15 and referred to the Senate Comm. on Health & Rehab. Serv. and the Comm. on Approp. No further action was taken. Fla. Legis., History of Legislation, 1985 Regular Session, History of Senate Bills at 91, SB 676.
would have been adversely affected financially. Teaching facilities provide a disproportionate share of Medicaid hospital inpatient days. Because of the high cost of medical education, the facilities have the highest Medicaid per diem rate. The bill would have acted either to redirect care to less expensive facilities or to force the costlier facilities to reduce their Medicaid patient rates. As a result, teaching hospitals probably would have engaged in more cost shifting, making up deficits from private payers.

House Bill 741, sponsored by Representative Metcalf, would have allowed Medicaid reimbursement for inpatient psychiatric services provided by licensed specialty psychiatric hospitals under contract with HRS. Under federal regulations, Florida has the option of reimbursing specialty psychiatric hospitals for services rendered to eligible recipients under age twenty-two and those age sixty-five and over. Currently, the Medicaid program reimburses general hospitals for psychiatric services rendered to eligible recipients of all ages, up to a maximum stay of forty-five days per fiscal year.

The legislation would have made twenty-four specialty psychiatric hospitals eligible Medicaid providers. According to HRS estimates, six areas would have been affected fiscally had the legislation been implemented. The diversion of patients to psychiatric hospitals from general hospitals, state hospitals, and residential care centers would have resulted in increased general revenue costs of about $2 million. The expansion of eligibility and utilization would have cost approximately $5 million in general revenue. There would have been a saving of about $1.1 million in general revenue if eligible clients presently in programs funded by general revenue had elected to shift to psychiatric hospitals. However, HRS estimated the net, negative impact on general revenue to be

168. Dem., Coral Gables.
close to $6 million.\textsuperscript{171} Competition can be costly.

VIII. \textbf{The Mayo Clinic Bill}

The steady incursion of corporate medicine into the traditional medical organization was encouraged on a grand scale by the Florida Legislature this session. The Mayo Clinic of Rochester, Minnesota was the fortunate benefactor of legislation allowing its physician-employees to circumvent the usual medical licensure process, thereby streamlining Mayo's branching efforts in Jacksonville.\textsuperscript{172} The Mayo Clinic is also branching into Arizona, but the Arizona Legislature declined to create an exception to its licensure statutes.\textsuperscript{173}

The legislation provides alternative qualifications for medical licensure by endorsement, one of two methods by which a person may obtain an unrestricted license to practice medicine; provides for a temporary license to practice medicine; and authorizes corporations meeting specific criteria to organize for the purpose of practicing medicine.\textsuperscript{174} The House version of the legislation ultimately passed. The criteria set forth in Committee Substitute for House Bill 1132 effectively limited the number of qualifying corporations to one, the Mayo Clinic, although its name never appeared in the bill.

Florida's medical establishment, including the Florida Medical Association, the state's teaching hospitals, and the Board of Medical Examiners, among others, voiced grave concerns about the bill. There was concern that discipline of physicians practicing with a

\textsuperscript{171} Id.

\textsuperscript{172} Ch. 85-56, 1985 Fla. Laws 292. The original bill, Fla. HB 1132 (1985), was introduced on April 8, 1985 and referred to the H.R. Comm. on Reg'y Reform, FLA. H.R. JOUR. 11, (Reg. Sess. Apr. 8, 1985), then subreferred to the Subcomm. on Prof. Reg., FLA. LEGIS., HISTORY OF LEGISLATION, 1985 REGULAR SESSION, HISTORY OF HOUSE BILLS at 154, HB 1132. The subcommittee reported the bill favorably with amendments. Id. The committee also reported the bill favorably after making it into a committee substitute. FLA. H.R. JOUR. 405 (Reg. Sess. May 16, 1985). The House passed the committee substitute, id. at 575 (Reg. Sess. May 24, 1985), after having approved a single amendment while on second reading, id. at 509 (Reg. Sess. May 22, 1985).


\textsuperscript{173} Feinstein, Florida's Legislature Revives 'Dangerous Doctors', Miami Herald, June 23, 1985, at 3B, col.6.

\textsuperscript{174} Ch. 85-56, § 1, 1985 Fla. Laws 292, 292 (amending FLA. STAT. § 458.313 (Supp. 1984)). Id. § 2, 1985 Fla. Laws at 295 (amending FLA. STAT. § 617.01 (Supp. 1984)).
temporary license provided by section 2 of the bill might be difficult to enforce. Disciplinary sanctions are usually imposed against a license and these physicians would have no permanent license. Also, while the legislation clearly authorizes a corporation to organize for the purpose of conducting the practice of medicine, no government agency in Florida has the authority to regulate or monitor such corporations. The regulatory outlook is murky indeed.

Finally, the licensure by endorsement is tied to the applicant's specialty field; any oral examination is limited to the physician's specialty. Mayo's specialists should be able to rotate in and out of the state with ease, yet Florida has a chronic oversupply and geographic maldistribution of medical specialists. More than sixty percent of the medical students in Florida enter such fields as neurology, surgery, and cardiology, rather than primary care fields. Federal legislation is pending that would require states to meet quotas for internships and residencies in primary care. Failure to comply would result in the loss of Medicare funds which now underwrite one-third of the costs of graduate medical school training. The Mayo Clinic legislation would seem to exacerbate the problem of specialty overcrowding in Florida.

IX. Conclusion

In recent years the Florida Legislature has twice passed major bills dealing with health care cost containment. In the session just ended, the legislature has built on the foundation of the Hospital Cost Containment Act of 1979 and the Health Care Access Act of 1984. Passage of the legislation mandating nursing home financial disclosure invests the Hospital Cost Containment Board with more responsibility. It is possible that the Board may ultimately assume regulatory power over the nursing home industry, if an analysis of their financial data indicates that regulation is in the best interests of the citizens of Florida.

The 1985 Regular Session saw a continuation of the struggle between those who firmly believe that regulation is the best solution to containment of health care costs and those who believe that an

177. Id.
178. Id.
unregulated marketplace is the answer. The government expanded its regulatory role, massively rewriting the law governing HMOs, yet reduced its regulatory role by opening up Florida's health care marketplace to the Mayo Clinic. The legislature's friendly treatment of the Mayo Clinic diminished to some extent the power of the existing medical community to oversee its members and to control entry into the market.

The struggle was visible in other legislation: Neonatal care group payments were further regulated by a prospective payment system, but the competitive marketplace was expanded through inclusion of pharmacists and pharmacies in preferred provider arrangements.

In a session where only a bare bones budget was passed, it was not surprising that the legislature was reluctant to expand Medicaid coverage. However, the problem of who will pick up the cost of caring for the medically indigent is a recurring one which the legislature must eventually face; indeed, it may be the most critical cost containment question before the 1986 legislature.