



Summary of the Organizational Meeting

More than 70 supporters of the manufacturing industry (35 manufacturers and 38 support organization representatives) convened at the Hyatt Regency Orlando International Airport on December 2, 2003. Sponsored by CSX and Progress Energy, this first meeting of the Enterprise Florida Manufacturing Advisory Council (EFMAC) allowed manufacturers, economic and workforce development groups and regional support organizations to plan for an improved business climate and increased support services for Florida manufacturers.

Introductory Remarks

Darrell Kelley, President and CEO of Enterprise Florida, addressed the group, explaining that the council had been formed to address concerns of Florida's manufacturing industry: "We agree that while Florida is a great state with a positive business climate, there are issues that are critical to your success that need to be addressed." Kelley urged cooperation among manufacturers and the various support organizations represented. "We must work together to educate our policy makers about the issues Florida manufacturers face. Together, we need to make sure manufacturers are as visible in our capital as, for example, trial lawyers, teachers, insurers, retailers and the hospitality industry have been."

Comments by Participants

Attendees made self-introductions, commenting on priority issues the group should address. Comments included concerns about issues impacting manufacturers' competitiveness in Florida—workers' compensation costs, healthcare, labor issues, taxes on equipment and governmental regulation. Others issued calls to action for benchmarking against manufacturing in other states and establishing a stronger, unified voice for the industry. Generally, the issues raised mirrored those expressed in the brief survey that was sent to participating manufacturers prior to the EFMAC meeting.

Overview of Survey Results

Steve Mayberry, Senior Vice President of Business Retention and Recruitment for Enterprise Florida, summarized the findings of the three-question survey of participating manufacturers:

Q: Why is your manufacturing plant located in Florida?

A: The majority of respondents indicated: the business started here (38%), proximity to customers (20%), or labor (15%).

Q: What do you like most about doing business in Florida?

A: Business climate (33%), Quality of life (23%), Labor (16%), Taxes (12%)

Q: List three issues of concern that relate to the business climate in Florida and/or your community.

A: Insurance (26%), State and local (24%), Workforce (19%), Taxes and incentives (15%), General Business Costs (9%), and Visibility (4%).

For more detail, please see the Powerpoint presentation of survey results.

Issue Discussions and Reports

Based on the issues of concern identified by the survey, participants selected and participated in the following working groups : Visibility, Workforce, Taxes and Incentives, General Business Costs, Insurance, and State and Local. During a working lunch, meeting participants identified and explored business climate and support service issues within the six working groups. Each working group elected an issue leader and a facilitator to record and convene future meetings of the working group. Following the working group discussions , group leaders reported to the group at large the various issues raised during the breakout sessions. (Summaries of each issue group discussion are provided later in this document.)

Plans are underway for each working group to meet by teleconference prior to the next meeting of the Steering Committee on January 28, 2004. These meetings will allow the working groups to refine and prioritize their list of issues.

Steering Committee Response

Members of the steering committee moved, by consensus, to expand the EFMAC Steering Committee to include the newly-elected issue leaders.

The Steering Committee will meet next on Wednesday, January 28, 3 to 5 PM Eastern time in Tallahassee at the Doubletree Hotel, where Enterprise Florida will be conducting a series of board committee meetings that day. Following that meeting, the EFMAC Steering Committee has been invited to attend the Enterprise Florida Board reception, hosted by Governor Bush at the Governor's Mansion from 5:30 to 7:00 PM.

Closing Comments

Citing the cover article of *Fortune* magazine's November 24, 2003, edition, "*Will 'Made in USA' Fade Away?*" Darrell Kelley challenged Florida's manufacturing industry to following the survival strategy of the United States farming industry—"adapt, innovate and create". Kelley urged the group to establish an agenda for the next three years to articulate the impact of manufacturing in Florida and the critical business climate and support services improvements necessary for its success in the global economy.



Visibility – Public Relations Working Group

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David Mihalik, Engelhard Corporation
Valerie Pianta, Hernando County
Sharon Watley, General Scientific Manufacturing, Inc.

Issue Discussion

Develop marketing tool to promote manufacturing – why manufacturing matters in Florida.

- Economic impact of 100 manufacturing jobs on the State.
- A manufacturing job is a high-tech job.

Designate a Florida Manufacturers Day during Industry Appreciation Week. Recommend Governor's proclamation of the day. Open up manufacturing facilities for tours and invite legislators, educators and students. The working group requested volunteers willing to open their facilities for these types of tours.

Develop communications strategies for five key audiences:

1. Legislators and public policy decision makers
 - (host a manufacturer's reception in Tallahassee;
 - include 1-2 legislators as ex-officio members of the Steering Committee)
Sena Black to create a list of state senators and representatives and the member manufacturers in each district.
2. Public
 - (increase public awareness through media)
3. Florida manufacturers
 - (create a statewide Florida EFMAC newsletter to educate them on: existing resources available to grow and expand their business; need to create a unified voice)
4. Educators
 - (involve educational institutions to grow workforce of the future)
5. Manufacturers outside the state
 - (national marketing: Florida for business image)



Workforce Working Group

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Gene Johnson
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Joan McGill, Sarasota County Committee for Economic Development
John Pelc, Exactech, Inc.
Gary Tarr, Pepperidge Farm

Issue Discussion

Resource Materials

Develop a standard education package for economic developers and manufacturers regarding incentives, training, and other programs available to Florida manufacturers.

Utilize Retirees as a Resource for Small Businesses

Develop a plan to utilize retired skilled workers as resources for small businesses (70% of all Florida manufacturing employment). Retirees could provide mentoring, training, and/or fill experienced positions.

Better Utilization of Government Training Funds

Invest in more “business-related” training (e.g., teamwork, communication skills, entrepreneurship, problem solving) at the K-20 level versus welfare to work programs. If we train them in school we will not have to use taxpayers' money to train them again.

Targeted Marketing to Students

Develop a marketing campaign targeted to high school students that informs them of the benefits the manufacturing industry has to offer:

- Tuition reimbursement (can work and go to school at the same time)
- Benefits (health, 401(k), ESOP, etc.)
- Availability of jobs (variety of jobs, job vacancies)

Start Training at K-12 Level

Add business skills and manufacturing opportunities to general education curriculum. (see above)

- Expose students in the K-12 system to business leaders – have business leaders go into schools and/or have students tour manufacturing facilities.

Offer specialized training at the high school level through vo-tech and/or apprenticeship programs.

Defined Manufacturing Skill Set

Have manufacturers define what types of skill sets they will be looking for in their workforce over the next five to ten years. This information can be used to develop appropriate education/training programs.

Next Meeting January 7, 2004
10:00 a.m.
Teleconference



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Issue Discussion

1. Eliminate sales tax on manufacturing equipment. Extend semiconductor, defense and space exemption to R&D equipment for all industries as a first step in the goal to exempt manufacturing from sales tax on all new equipment.
2. Identify a reliable way to estimate manufacturing tax impacts (costs and benefits).
3. Pursue a State tax policy that is not regressive.
4. Eliminate the intangible taxes in Florida.
5. Review Florida's corporate tax code to promote location of corporate headquarters (use Delaware, Nevada as examples).
6. Review tangible personal property tax rates. The application of this tax is not uniform from county to county and is punitive for new investments. Compare tax rates and depreciation schedules against those from other states. Have the state set a max rate and suggested depreciation schedules.
7. Repeal use tax on exports.
8. Promote buying from Florida manufacturers.
9. Consider breaks for Florida veteran manufacturers.
10. Establish maximum use tax on electric consumption. Need consistency between counties. Benchmark competition in other states.
11. Alleviate impact fees on plant construction.
12. Provide incentives for capital investments; existing incentives are largely job-based.

13. Create a one-stop shop for manufacturers so that information regarding incentives available from county to county is provided by a single source.
14. Encourage payment in lieu of taxes (PILOT) or property tax abatements on new expansions in areas that don't offer them.
15. Tie incentives to jobs; not people. (Enterprise Zone incentives were examples.)
16. Protect the existing sales and us tax exemptions.
17. Do more to prevent closing of current businesses, less to recruit new ones.
18. Provide closing funds.
19. More incentives!
20. Need incentives at front end of expansion, not later.
21. Maintain gross receipts natural gas tax exemption.
22. Power companies should give incentives for increasing energy efficiencies.
23. Concern that unemployment compensation costs are increasing (hidden tax) as a result of raids of the unemployment trust fund.
24. Increase training funds.
25. Manufacturing newsletter to keep Florida manufacturers informed on legislation and policies that will impact their operations.



General Business Costs Working Group

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Issue Discussion

Energy

Cost of fuel, electricity, natural gas

- tax on natural gas is retroactive
- elimination of natural gas gross receipts tax
 - improve upon the bill that was introduced last session
- power costs increased 25% in one year
- Inability to choose electricity provider, need a way to negotiate lower rates
- Deregulation of electricity (GridFlorida RTO – The Business Cost Issue Group can utilize their individual memberships in outside groups dedicated to energy issues (e.g. FIPUG, etc.) to keep the general membership of the EFMAC informed periodically. Also, we can make membership information in these outside energy groups available to interested companies. Finally, Progress Energy Florida may be willing to provide information about the issue periodically.)
- Individual electric utilities often offer free site surveys to review a company's power cost structure, efficiency issues, etc. to help the company reduce their power costs.

Reliability

- Different tiers of reliability exist. Smaller manufacturers do not have in-house resources to have utility managers. Perhaps small manufactures can utilize these resources within larger manufacturing companies.
- Smaller manufacturers may want to avail themselves of the Florida industrial power users group.

Availability of suppliers

- "Buy Florida" campaign or event, possibility to be cross-promoted with a "Florida Manufacturing Day" mentioned by one of the other EFMAC table groups. There could be an expo that would be sponsored solely by companies with manufacturing capabilities in Florida. As a tie-in to one of our other issues (lack of utility managers in smaller companies), we could invite power management consultants to set up displays at the event.

Green Energy

- Is there a market for, or incentive to use, "green" energy created by excess power generation?
- Make it a law to buy renewable energy in Florida, from Florida co-generators, before going out of state.

Transportation

Rail

- There is currently a lack of availability of rail cars. Availability has been scaled back recently due to economic conditions.
- On time is critical.
- They are spending money on rail car upgrades.
- Rail is a semi-monopoly and less competition means higher rates.

Trucking

- Out-of-state competitors are paying less in truck fares (up to 50% less). Is there a way to support long-distance hauling?
 - Suggested competitive "back-haul" trucking rates.

Local Roads

- Workforce commutes from Seminole County to Lake County, because schools are better in Seminole, how can these county roads be widened?
 - Suggested this is a county/MPO issue

Affordable housing

- Housing costs in some areas make it difficult to find/afford workers.

Capital access

- There may be some in-house resources, particularly within Enterprise Florida, that can be pulled together and shared.

Next Meeting Group will organize a meeting in January upon receiving notes.



Insurance Working Group

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Issue Discussion

Health Insurance

The group immediately seized on the cost and availability of health insurance as the paramount issue. All participants reported continuing, large increases in premiums, and some reported a continuing reduction in coverages was necessary for their business to afford any coverage at all, and such reduced coverage still required escalating premiums.

Leslie Dughi, Florida Chamber, was very informed on health Insurance issues, and is completing an issues and proposals paper, which will be released after presentation to Florida Chamber management and Board. The committee should review and consider this information as soon as it is available. [ATTACHED]

The following discussion points summarized potential actions that could ameliorate insurance premium increases and improve coverage for manufacturing businesses, most of which are considered small business with less than 50 employees.

- Require insurance companies to market to small business as well as to large business. Most insurance companies focus on larger groups in their marketing efforts, for such groups are most profitable for their sales agents and are easier to administer for the insurer. Requiring attention to small business will improve options for most manufacturers.
- Allow flexibility on coverage and allow negotiated coverage for small business. Such flexibility usually comes to groups of 50 or more. Eliminating mandated coverages for small business and allowing negotiation of coverage by small business with less than 50 employees will expand options and allow some employers to provide catastrophic healthcare and/or hospitalization coverage, which is still better than dropping employer provided health insurance entirely.
- Eliminate the requirement that at least 75% of employees must participate if group coverage is to be provided.

- Consider a requirement implemented in New Mexico. If an employer covers at least 80% of health insurance premiums, employees must take the coverage unless covered elsewhere. This prevents young, healthy employees from opting out of coverage to augment their beer money. Group experience usually is improved when the group universe includes all employees, both young and old.

The group discussed “Presumptive Cause” as an issue with growing potential impact. This is the legal theory that ailments incurred after employment are presumptively caused by the prior employment. For example, a policeman suffers a heart attack, which is attributed to his prior stressful employment as a law officer. The theory is apparently becoming more prevalent beyond law enforcement and fire fighting. There was no consensus on the immediate impact of this expanding legal theory, but the group agreed that it should be monitored as a factor that could greatly affect overall cost of operations and liability exposure.

Workers Compensation Insurance

It was agreed that with the extensive changes recently approved by the legislature no additional change proposals are appropriate at this time. The new law needs to be digested and implemented. It is appropriate to defend the changes; to be sure legal fee limitations are implemented and not weakened; and to attack any fraud by users of the system. Stability must return to the system to attract additional insurers back to the Florida workers compensation market.

Tort Reform

There is little likelihood of legislative action on tort reform, and the committee does not recommend action other than to monitor the issue of “premises liability.” Again this is an evolving legal theory that builds on “somebody has to pay” and sues the owner of property, even when no negligence exists. For example, assume a woman is attacked after hours in a well lighted, properly maintained grocery store parking lot. The perpetrator of the crime likely has little or no resources, and the search for the deep pocket leads to a suit against the grocery owner. Curtailing premises liability should be a goal for future legislative action.

Next Meeting The committee will try and meet again in January to review Florida Chamber recommendations and to better define and prioritize action items on insurance.



ADDRESSING FLORIDA'S UNINSURED

THE FACTORS AFFECTING OUR CITIZENS' HEALTH CARE COVERAGE

OVERVIEW.

Health care is the largest sector of our nation's economy with consumer health care spending making up 14.8% of our nation's Gross Domestic Product (GDP).¹ Ranking a distant second is housing with 10.3% and spending on food with 9.9% of the GDP. Although Congress and state legislatures have tried to stop the hemorrhaging of out-of-control health care costs, all stakeholders acknowledge there is no one "silver bullet" to fix this growing problem.

Florida's four largest employer associations, the Florida Chamber, NFIB, AIF, and the Florida Retail Federation, have joined forces to identify sources of the problem and provide recommendations for consideration by Florida's policymakers.

EMPLOYER DILEMMA.

In 2003, Florida employers faced yet another year of double-digit premium increases and more of the same is predicted for 2004 as the average premium increase is expected to be 11%.² Undoubtedly, skyrocketing premiums have led to increases in the number of uninsured employees and the time has come to address the issues that are driving the costs. Many employers elect to provide their employees health insurance and 62% of non-elderly insured Floridians are covered through employer-sponsored plans.³ As a result, health insurance has become an extremely important recruitment and retention tool for employers and a recent survey indicated 74% of employees would rather have health insurance than a salary increase.⁴ However, the future of employer-sponsored health insurance is at risk.

To gauge employers' opinions, the Florida Chamber and NFIB conducted member surveys reaching, in total, more than 6,000 large and small employers in Florida. The Chamber's annual report, *"The State of Health Insurance in Florida"* found that while most employers offer health insurance, the number quickly is eroding. In the three years this survey was conducted, a significant dip was found from 1999 when 91% of employers offered employee coverage to 2002, when 77% offered coverage. Equally troubling is that 42% of employers providing insurance reported they would consider dropping it if costs continued to escalate. The NFIB study found most small employers pay more than \$2,500 per employee each year for health insurance benefits. Almost 85% of small employers indicated they want to provide health benefits if it was affordable, yet more than 22% of the respondents dropped health benefits in the last two years. Both surveys found that 75% of employers, large and small, experienced more than 10% premium increases last year.

These troubling trends could devastate Florida's economy as an employee's health can have a significant economic impact on a business, especially a small business. Among insured Floridians under age 65, approximately 42% reported being in excellent health while only 28.9%

¹ United States Bureau of Economic Analysis, 2003

² Towers Perrin Health Care Survey, 2004

³ Florida Agency for Health Care Administration, *The Working Uninsured in Florida*, March, 2003

⁴ *Health Pulse of America* by Stony Brook University Center for Survey Research, August 2003

of *uninsured* Floridians under 65 described their health as excellent. Simply put, citizens with insurance tend to be healthier than those without insurance.⁵ Further an unhealthy workforce can negatively affect Florida's economy and derail economic development initiatives.

COST DRIVERS.

To abate the rising costs of insurance, specific cost drivers must be identified and eliminated. Although there has been much discussion on which factors drive costs, disagreement remains. Some blame insurers for increasing premiums, yet the Kaiser Family Foundation found that costs for self-insured plans have increased "at roughly the same rate as premiums for insured plans."⁶ Further, the report found that "insurers' decisions about premiums are being influenced more by cost trends than by catch-up pricing associated with the underwriting cycle."

To protect employer-sponsored health coverage, insurers must remain solvent. And, like any other business, insurers make a reasonable profit to continue operating. According to the Office of Insurance Regulation, Florida HMOs currently average a 2.9% profit margin and over the last five years, have averaged a 2.4% profit margin. OIR also reports that 85% of a premium dollar pays for health services.

- **Hospital costs.** The Center for Health Systems Change (CHSC) reports that hospital spending, for the second consecutive year, accounted for the largest portion of the increase (51%) in total health care spending. In 2001, per capita hospital spending increased 14.6% for outpatient care - including emergency services - and 5.6% for inpatient services. Medicare spending on hospital inpatient services grew 53% from 1992 to 2002, with a 6.7% growth between 2001-02 alone. Further, inpatient care accounts for 40% of all Medicare spending.⁷

Confusion remains on the adequacy of hospital service reimbursements. While Jackson Health System reported it makes 14% on every Medicare patient served⁸, Florida Hospital reported Medicare reimbursement was .5% and 1.1 % below costs in 2001 and 2002 respectively. Further, in order to cover shortfalls in Medicare, Medicaid and self-pay patients, Florida Hospital assesses a \$1,690 surcharge per hospital admission on privately insured patients.⁹ We believe the Task Force should study government reimbursement levels for both Medicare and Medicaid to ensure pertinent information is available to make recommendations for solving the problem of a growing uninsured population.

- **Benefit Mandates.** Mandated benefits are state and federal laws that require private insurers to cover specific treatments, conditions, and providers. Between 1970-1996, state mandates increased 25 fold and despite health insurance costs, over 800 new mandates were considered by state Legislatures in 2002.¹⁰ A 2001 House committee determined our state currently subjects 51 mandates on health insurers.¹¹ The only state with a higher number is Maryland.

⁵ Agency for Health Care Administration, 2003

⁶ Kaiser Family Foundation and Health Research and Educational Trust, 2002

⁷ MedPac is 17-member independent group made up of providers, health care professionals, employers, third-party payors, researchers, and consumer and elderly representatives who advise Congress on Medicare issues.

⁸ Marvin O'Quinn, President & CEO of Jackson Health System, OIR Health Symposium, September 2003

⁹ Rich Morrison, Florida Hospital, House Select Committee on Affordable Health Care for Floridians, October 2003

¹⁰ American Association of Health Plans (AAHP)

¹¹ Florida House Committee on Insurance, *Managing Mandated Health Benefits*, January 2000

Admittedly, a single mandate's cost is difficult to quantify, but one study estimated mandates are responsible for increasing costs by 15%.¹² A survey of six states' claims costs found that increases for mandated benefits were between 5.4% (Iowa) and 22% (Maryland).¹³ In 1987, the Legislature required a "systematic review of current and proposed" mandated benefits and at that time only 16 mandates were in law. Since then an additional 35 mandates have been approved, most *without* the systematic review. In 2001 and 2002, legislators appropriated funds to study the cost of mandates, but ultimately a study has not been conducted.

- *Any Willing Provider (AWP) Mandate.* This term refers to making insurers contract with any health care provider willing to meet certain terms, such as contracting and reimbursement. This type of mandate was found to increase administrative costs by 34% and claims costs by 8.8%.¹⁴ AWP laws may appear innocuous, but the restrict insurers' ability to contract with the highest quality providers and erode the quality of services provided. Further, the primary reason providers negotiate discounts with insurers is to receive guaranteed patient volume. If all providers must be allowed in networks, an appropriate patient load cannot be assured and an insurer's ability to negotiate cost saving discounts is eliminated.
- *Prescription Drug Costs.* Spending on prescription drugs per privately insured person rose 13.2% in 2002, but has decelerated for three years in a row. Some of the factors leading to this growth slowdown include development of a three-tier payment structure for policies and increased co-payment differences between these tiers. Also, the Food and Drug Administration (FDA) approved only 15 new drugs in 2002 compared to 31 each year for the previous 5 years and a number of costly drugs have recently gone off patent.¹⁵ Finally, direct to consumer marketing increases use further increasing prescription drug costs.
- *Labor shortages.* Labor costs in Florida hospitals grew 11% in 2002, fueled by higher salaries due to workforce shortages. Florida has one of the highest vacancy rates for Registered Nurses (RNs) in the U.S. and also suffers from a shortage of radiology technicians and pharmacists. In 2002, Florida hospitals spent more than \$300 million for overtime, temporary or contract staff.¹⁶
- *Fraud and Abuse.* A major financial burden on third party payors – be it a private insurer or the government - is reimbursing providers and facilities for fraudulent health claims. Over the last several years, Florida has aggressively cracked down on fraud and abuse in the Medicaid Program but estimates still indicate fraud and abuse in Medicaid costs taxpayers between 3 and 10% of the Medicaid budget. This translates into between \$261 and \$870 million annually.¹⁷
- *Unhealthy Lifestyles.* Poor lifestyle choices, such as smoking, drinking, over-eating and lack of exercise contribute to lost wages and ultimately increase health care costs. Overweight or obese people have an increased risk for high blood pressure, type 2 diabetes, coronary heart disease, stroke, gall bladder disease, osteoarthritis, sleep apnea, respiratory problems and some types of cancer. Direct and indirect medical costs associated with treating those conditions cost \$117 billion annually.¹⁸ Additionally, studies have shown that obesity is

¹² PriceWaterhouse Coopers, "The Factors Fueling Rising Healthcare Costs", April 2002

¹³ U.S. General Accounting Office, State Mandated Benefits, GAO/HEHS-96-125R, April 1996

¹⁴ Watson Wyatt Company, August 1991

¹⁵ Center for Studying Health System Change, June 2003

¹⁶ Agency of Health Care Administration, 1990-2001 Financial Data

¹⁷ Office of Program Policy Analysis and Government Accountability, Report 01-39, September, 2001

¹⁸ The President's Council on Physical Fitness and Sports *Fact Sheet*

directly related to increased incidences of diabetes.¹⁹ Based on health data of 360,000 Americans from 1984 to 2000, the number of people suffering from diabetes is estimated to increase to over 28 million in 50 years.

BARRIERS TO COVERAGE.

Florida continues to grapple with its uninsured population as evidenced by the recent U.S. Census report that our state has the fourth largest uninsured population in the nation, following California, Texas, and New York. Specifically, the number of uninsured Floridians grew by more than 20% in 11 years, from almost 2.4 million in 1990 to over 2.8 million in 2001.²⁰ Florida employers with one to nine employees have the highest rate (24. %) of uninsurance compared to 4.78 % for those with 100 or more employees. Other startling statistics of uninsured Floridians are that one half are under age 30 and half work full or part time. Further, Hispanics make up nearly one fourth of our uninsured and the uninsured rate for Hispanics is more than twice the rate for white non-Hispanics and almost 50% more than African Americans.

*Cost is the most important factor affecting access to health insurance as more than 1.5 million uninsured Floridians say they don't have coverage because they can't afford it.*²¹ The employer groups who prepared this document support providing insurers more flexibility to develop lower-cost plans to meet the special needs of an employer's workforce. In 2002, increased flexibility allowed OIR to update the standard and basic health plan offerings required for small groups resulting in 20 to 40% premium reductions.²²

In 2003, the Legislature gave employers the ability to choose more appropriate cost-sharing arrangements to reduce premiums. *Now, policymakers must allow insurers to offer a variety of benefit and provider network configurations to further reduce costs and meet consumer needs.* The lessons we learned from the Health Flex Pilot Project allowing benefit flexibility should be applied to employer-sponsored health plans regulated under state and federal law. Outlined below are other factors that can keep Floridians from gaining health insurance.

- *Entitlements.* Florida's Medicaid system provides health services to our state's most needy citizens. Although most agree this is good public policy, a 2002 study found that regardless of the support received by the uninsured, those efforts could not eliminate or even narrow access barriers to the same extent as insurance.²³ This is an important finding indicates that *recommendations to lower the number of uninsured Floridians should be based on private market incentives and expansions not increased government regulations or new costly public programs.*

Clearly, the best way to reduce uncompensated care is to insure more people. In order to reach that goal, market inequities through inappropriate cross-subsidies must be eliminated. As noted before, we recommend an in-depth evaluation of the rules and regulations for Medicaid and Medicare to determine if these programs are unknowingly impeding access to coverage.

¹⁹ K.M. Venkat Narayan, Centers for Disease Control and Prevention, Atlanta, Georgia

²⁰ Agency for Health Care Administration, 2003

²¹ Report on Florida's Uninsured, Agency for Health Care Administration

²² Report of the Florida Small Employer Benefit Plan Committee, November 2002.

²³ Urban Institute Health Care Access for Uninsured Adults: *A Strong Safety Net Is Not the Same as Insurance*, January 2002

- *Economy*. A downturn in the economy may also contribute increase uninsured numbers. When employers experience reduced revenues they must make difficult decisions to ensure the business survives. When faced a tight budget, employers may discontinue health insurance coverage or lay off employees both of which increases the rolls of Florida's uninsured.

FEDERAL ISSUES TO ADDRESS

Although health care is considered a state and local issue, programs at the federal level must be examined to create more affordable alternatives. Employers have identified a number of federal programs that could be altered to help Florida reach its goal of lowering the number of uninsured.

- *Flexible Spending Accounts (FSA)*. FSAs that allow employees to use pre-tax dollars to pay their health-related bills encourages employees to take personal responsibility for planning their health care needs.
- *State Children's Health Insurance Programs*. This highly successful program provides access for uninsured children to health insurance. Employers believe this program can be improved if families and children were given more choice of plans. Also, care should be taken to ensure the most needy children, those without any access to coverage, are assisted first.
- *Health Coverage Tax Credit (HCTC) Program*. This recently established federal pilot project could teach us how tax credits can be used to subsidize former employees' premiums. If successful, Congress' expansion of this program could ultimately assist over 13,000 Floridians with the purchase of health insurance.
- *Trade Adjustment Assistance Act*. This federal legislation provides states up to \$1 million in "seed money" to establish high-risk subsidy programs for the chronically ill that meet certain criteria. Chronically ill citizens are a societal problem and employers believe the state should not open (or re-open) a high-risk subsidy program until a *broad-based, long-term funding source* is identified. An assessment on insurance policies previously funded the Florida Comprehensive Health Association (FCHA) that has been closed to new enrollment since 1991. Ultimately, this assessment was passed to employer premiums.

SUMMARY

Florida's four major employer organizations are aware that this report is only the first step in a long road to decreasing the cost of employer-sponsored health insurance and the number of Florida's uninsured. However, it is imperative that all stakeholders work together with the Task Force to ensure appropriate reforms are developed and ultimately implemented. The Florida Chamber, NFIB, AIF and the Florida Retail Federation pledge our commitment to this goal.



ADDRESSING FLORIDA'S UNINSURED

RECOMMENDATIONS TO INCREASE HEALTH CARE COVERAGE

THE ROAD TO REFORM – THE “LET’S GET FLORIDA COVERED” CAMPAIGN.

Almost half of Florida’s citizens receive health insurance through their employer; thus, the road to reducing our uninsured must travel through the private market and maximize employer-sponsored coverage. The other alternative is expanding our state government’s role as a health insurance provider and while the state plays an important role of providing health care dollars to our poorest citizens, the Florida Chamber believes this role should promote not erode privately sponsored health insurance coverage.

Florida is at a crossroads. Will we continue expanding taxpayer-funded health care, or will we advance policies that reinvigorate employer-sponsored coverage system and free Floridians from the uncertainty of rationing and spending cuts? Until this question is answered, we cannot begin to ensure Floridians have access to the care they need. To advance public policies that promote private market expansion, the following guiding principles remain at the forefront as recommendations are formulated:

GUIDING PRINCIPLES FOR HEALTH INSURANCE REFORM

- **FOCUS EFFORTS ON INCREASING THE NUMBER OF EMPLOYERS ABLE TO PROVIDE HEALTH INSURANCE TO THEIR EMPLOYEES AND THE NUMBER OF EMPLOYEES ABLE TO AFFORD TO PARTICIPATE IN THEIR EMPLOYER-SPONSORED COVERAGE**
- **THE PROVISION OF BASIC HEALTH INSURANCE COVERAGE SHOULD BE FAVORED OVER THE RISK OF GOING COMPLETELY UNINSURED.**
- **ALL SEGMENTS OF THE HEALTH CARE SYSTEM SHOULD TAKE PART IN LESSENING WASTE IN THE SYSTEM.**
- **TAXPAYER-FUNDED HEALTH CARE PROGRAMS SHOULD NOT COMPETE WITH THE PRIVATE MARKET.**
- **ALL HEALTH CARE CONSUMERS - EMPLOYERS, EMPLOYEES AND GOVERNMENT - MUST HAVE ACCESS TO THE INFORMATION AND TOOLS NEEDED TO MAKE INTELLIGENT AND INFORMED CHOICES WHEN SPENDING HEALTH CARE DOLLARS.**

PILOT PROJECTS AND ALTERNATIVE APPROACHES

- **TAX INCENTIVES.** Florida is highly limited in the types of tax incentives it can provide to employers and individuals to encourage their purchase of health insurance. The state’s main tax source, the sales tax, is not easily adapted into a health insurance purchasing incentive. One tax that could reach all Florida employers is the local ad valorem tax on real and personal property, which taxes any property used for business purposes. However, this tax is reserved for local governments, so their cooperation would be imperative and they would

expect some alternative state funding to replace the lost revenue. Therefore, if Florida decides to pursue tax incentives to encourage employment-based insurance, the Chamber suggests a partnership with the federal government.

Expansion of the Health Care Tax Credit Program, a partnership between the federal and state government and health plan administrators, could assist approximately 13,000 Florida families.¹ The tax credit, which is equal to 65 percent of the cost of the insurance premium, would assist two groups:

- Workers who have lost their jobs due to the effects of international trade, are eligible for certain Trade Adjustment Assistance (TAA) benefits; or are eligible for benefits under the Alternative Trade Adjustment Assistance (ATAA) program; and
- Individuals who receive benefits from the Pension Benefit Guaranty Corporation (PBGC) and are at least 55 years old.²

RECOMMENDATION

STATE POLICYMAKERS MUST ENCOURAGE THE U.S. CONGRESS TO EXPAND THE HEALTH CARE TAX CREDIT

ALTERNATIVE HEALTH CARE FINANCING METHODS. Ever rising health insurance premiums have increased the popularity of flexible spending accounts (FSAs) and health reimbursement accounts (HRAs) as another way to pay for health care costs. FSAs and HRAs are potential powerhouses in the effort to reform the health delivery system. Both mechanisms give employees the responsibility and authority to manage their health care dollars in the manner that is most effective for their families while retaining the popular employment-based funding of our existing health care system.

FSAs are employer-established benefit plans that reimburse employee medical expenses not covered by health insurance. There is no maximum contribution cap and they are funded with voluntary, pre-tax employee contributions, although employers may also provide funds. Since FSA contributions are made on a pre-tax basis, that portion of the employee's salary is not subject to income or employment taxes. The one drawback to FSAs is that an employee must forfeit any contribution unused at the end of the year.

HRAs have been compared to tax-free IRAs, because they allow employers to contribute funds in order to reimburse employees for a wide range of medical expenses. COBRA eligibles and retirees can use these funds to pay for health insurance and long-term care premiums. Like FSAs, HRAs do not have a maximum contribution cap and deposits are not subject to income or employment taxes. Yet HRS fund balances may be carried over from year to year.

RECOMMENDATION

ENCOURAGE CONGRESS TO ALLOW ROLLOVER OF FSA FUNDS FROM YEAR TO YEAR.

ENSURE CONGRESS ALLOWS HRA AND FSA FUNDS TO BE SPENT ELECTRONICALLY TO AVOID UNNECESSARY PAPER CLAIMS EXPENSE.

¹ Agency for Workforce Innovation, Implementing the Federal Health Coverage Tax Credit Program (HCTC), October 2003

² IRS.gov

- FLORIDA'S MEDICAID PROGRAM – The Medicaid Program is a state and federal partnership providing health coverage to certain low-income people who may otherwise go without care for themselves and their children. The federal government provides 58 percent of Medicaid funding; the state provides 42 percent. If left unchecked, Florida's \$12.5 billion Medicaid program is projected to have a \$205 million deficit by mid-year 2004 and could hit \$1.4 billion the following year. To ward off these deficits, Florida must re-evaluate its Medicaid Program to ensure the state and its recipients get the best “bang for the buck.”

Block Grants. President Bush has proposed major changes to the Medicaid Program that would provide flexibility to states through block grants. Specifically, states that voluntarily accept a set amount of federal funds, instead of the current open-ended matching funds for Medicaid, would receive allotments that increase by about 8.5 percent each year. Further, these states would receive two percent more funds in 2004 and one percent more between 2004 and 2010. Most important is the fact that states using this method would be authorized to change coverage provided to Medicaid and SCHIP recipients and allowed to set limits on the number of enrollees in the program.

Consumer Directed Care. Almost 70 percent of Medicaid expenditures are spent on care for the elderly, blind and disabled; therefore, special attention should be given to maximize funds used for these populations.³ The Consumer Directed Care program, which strives to defer institutionalization and maintain personal independence, may prove to save Medicaid dollars over the long term. This federal demonstration program, operating in three states, serves 3,488 of the allowed 6000 Florida participants who direct their own care and manage funds allocated for their needs. A monthly cash allotment is provided to participants to purchase services under the personal care benefit yet the individual determines which services they need, from whom they receive it and pay for it from state-established personal account. Florida's demonstration project has yet to receive a final evaluation. However, a report on the Arkansas program found 88 percent of participants said it improved their quality of life⁴ by allowing them to choose their caregivers, obtain the right kind of personal assistance and obtain enough or timely care.

The Arkansas report found the induced demand for personal care service spending was offset during the first year by lower spending for other long-term care services, such as nursing facilities, and offset almost completely during the second year. The report estimated savings would grow over time.

RECOMMENDATION

EVALUATE ALL ASPECTS OF FLORIDA'S CURRENT MEDICAID PROGRAM AND IMPLEMENT OR EXPAND PROGRAMS THAT ENSURE QUALITY CARE IS PROVIDED IN THE MOST COST-EFFECTIVE MANNER POSSIBLE.

IDENTIFY WAYS TO INCREASE THE STATE'S FLEXIBILITY FOR PROVIDING CARE TO MEDICAID RECIPIENTS.

- THE CHRONICALLY UNINSURED. There are individuals in every community who are “medically uninsurable,” meaning they are chronically ill or have a condition that keep them from obtaining individual health insurance in the voluntary market. There has been much debate on who is responsible for funding the expensive care required by these individuals.

³ The Heritage Foundation, A new direction for Medicaid, Owcharenko, Webmemo #355, 10/22/2003

⁴ The Effects Of Cash And Counseling On Personal Care Services And Medicaid Costs In Arkansas 11/2003

Florida's high-risk subsidy program, the Florida Comprehensive Health Association (FCHA), was created in 1983 to provide health insurance to these individuals. In the early years, FCHA enrollment and losses remained low, but in 1989, the trend changed dramatically when tax credits funding the program's assessments were ended. As a result, the Legislature prohibited the FCHA from issuing new policies after July 1, 1991. From that time, enrollment dropped from 7500 covered lives to 570 in 2003. There was an unsuccessful attempt in 2000 to reopen the FCHA and fund deficits with assessments on all health insurance companies, HMOs, prepaid health clinics, fraternal benefit societies, and multiple employer welfare arrangements (MEWAs). Self-funded employers and governmental entities were not subject to the assessment.

Florida's employer organizations historically have opposed reopening this program, because the limited funding mechanism through insurers is passed on to the health policies purchased by employers. Employers believe the cost of caring for these individuals is a responsibility of the state and should, therefore, be paid for in the broadest manner possible.

RECOMMENDATION

FUND ANY HIGH-RISK SUBSIDY PROGRAM ON THE BROADEST POSSIBLE MANNER.

DO NOT FUND HIGH-RISK SUBSIDY PROGRAMS IN A MANNER THAT WOULD CONTRIBUTE TO THE UNAFFORDABILITY OF HEALTH INSURANCE FOR EMPLOYERS AND EMPLOYEES.

PARTNERSHIPS TO INCREASE AVAILABLE HEALTH INSURANCE COVERAGE

- **HEALTH FLEX PILOT PROJECT.** The Health Flex Pilot Project was established in 2002 to assist those individuals who do not have access to employer-sponsored coverage and are not eligible for Medicaid. This pilot was set up to test the viability of delivering basic health care services through public/private partnerships not subjected to the Florida Insurance Code or laws that regulate HMOs and insurance plans. Proponents argue that by releasing these partnerships from stringent regulation such as benefit mandates, gives plans the flexibility to craft low-cost policies that the working poor could afford.

To participate in Health Flex, an individual must be a Florida resident under age 65 and have a family income of up to 200 percent of the federal poverty level (FPL). Additionally, the person must have been without private coverage for the past six months and cannot be eligible for a public health care program. The benefit package is less comprehensive than traditional health insurance policies and provides basic outpatient health care services, such as primary care, lab services and mammograms. Although the plans are not subject to insurance regulation, the Agency for Health Care Administration (AHCA) and the Department of Financial Services (DFS) monitor the quality of care and financial solvency of the plans respectively. Currently, 180 persons participate in the project through two plans within the Miami-Dade area. Duval County is being considered for a project in the coming months.

Employers support allowing basic coverage to be offered and, in fact, have advanced similar legislation to allow private insurers to craft such policies for employers who cannot afford more substantial coverage. Currently, five other states permit insurers to offer policies that do not include all of those states' mandated benefits.⁵ Employers do have concerns about

⁵ National Governor's Association, 2003

Health Flex providers not being subject to licensure under the Florida Insurance Code. This means they are exempt from the following important provisions:

- Consumer protections should a plan become insolvent;
- Consumer protections that prohibit loss of coverage from losing a job, moving from dependent to adult or the specific program ceasing to exist;
- Consumer grievance procedures providing recourse for consumers who disagree with their plan's provisions;
- Prompt payment of claims; and
- Small group market underwriting restrictions such as guarantee issues and modified community rating.

RECOMMENDATION

REQUIRE HEALTH FLEX PLANS TO BE LICENSED AS INSURERS SUBJECT TO THE SAME SOLVENCY, CLAIMS PAYMENT AND CONSUMER PROTECTION PROVISIONS.

ENCOURAGE FLEX PLANS TO BE MARKETED TO EMPLOYER GROUPS TO PROVIDE MORE COVERAGE CHOICES.

- **INTEGRITY OF THE KIDCARE PROGRAM.** In 1998, Florida implemented KidCare, a statewide program that provides health insurance to uninsured children ages 0 to 18. As of June 2003, there were over 1.4 million children enrolled in all four following KidCare components:
 - *MediKids* - Ages one to four who are not Medicaid eligible
 - *Florida Healthy Kids* - Ages five to 18 who are not Medicaid eligible
 - *Children's Medical Services* - Ages 0-18 with special health care needs
 - *Medicaid* - Ages 0-18, no cost health care coverage for those within income guidelines.

Employer organizations applaud the federal, state and local partnership, but believe some fine-tuning is warranted to maintain the integrity of the program. A 2003 report on Miami's health delivery system and its effect on consumers raised a number of concerns with KidCare.⁶ The report stated that, as a result of rapidly rising health insurance premiums, some employers were urging employees to enroll their children in KidCare. This report outlines employers' concerns of "crowd out," the erosion of employer-sponsored health care coverage stimulated by the availability of KidCare funds.

These concerns were confirmed in the latest KidCare evaluation that reported the number of children with access to employer-based coverage prior to entering KidCare has steadily increased in the last four years.⁷ The evaluation found the majority of children (80 percent) who left Kidcare to receive other coverage in FY 2000-01 moved into employer-sponsored coverage while only seven percent moved into Medicaid. One year later, the majority of children who left Kidcare went to Medicaid while only 30 percent moved into employer-sponsored coverage.

⁶ Center for Health System Change (CHSC)

⁷ Kidcare Program – Evaluation 2003

RECOMMENDATION

MODIFY THE KIDCARE ELIGIBILITY REQUIREMENT TO ENSURE ONLY THOSE CHILDREN WHOSE PARENTS HAVE NO ACCESS TO EMPLOYER-SPONSORED COVERAGE MAY PARTICIPATE.

ALLOW KIDCARE FUNDS TO BE USED BY LOW-INCOME PARENTS TO PURCHASE EMPLOYER-SPONSORED COVERAGE WITHOUT ANY NEW MANDATES.

- PREMIUM ASSISTANCE FOR EMPLOYER-SPONSORED COVERAGE. Nationally, more than one-fifth of uninsured employees work for an employer who offers coverage, but the employee does not participate.⁸ Further, more than 85 percent of group health insurance premiums are spent on health care services compared with approximately 65 percent spent from individual premiums.⁹ To lower the number of working poor, states have looked to premium assistance programs for help. According to an Institute for Health Policy Solutions study, premium assistance can constructively link public and employer benefits to maximize the number of low-income working families covered by health insurance, especially in an environment of budgetary constraints.¹⁰ Premium assistance can also:
 - Serve more uninsured citizens with public funds by maximizing employer contributions;
 - Reach more uninsured children whose parents, due to stigma, would not enroll them in a separate public program;
 - Encourage self-sufficiency and strengthen a parent's attachment to the labor force; and
 - Discourage employees from dropping employer-sponsored coverage when their eligibility for public programs expands above the poverty level.

Several states have initiated pilot projects to help uninsured workers purchase employer-sponsored coverage by obtaining a Health Insurance Flexibility and Accountability (HIFA) waiver. This report focuses on the efforts and experiences of two states, New Mexico and Wisconsin.

New Mexico's wage-based program allows low-income employees to purchase insurance with a combination of state and federal dollars and employer and employee contributions. Employees with incomes up to 100 percent of FPL do not pay a premium, but those with incomes above 100 percent of FPL pay a monthly premium of \$20-\$35. There are also \$5 to \$20 co-payments for frequently used primary care services and out-of-pocket charges that are limited to five percent of the family income. This benefit package is similar to commercial ones but excludes several optional Medicaid benefits. The package is priced slightly less than what is offered for commercial plans to prevent employers from shifting down to this coverage. To avoid "crowd out," individuals are not eligible unless they have been without insurance for at least 6 months. Further, incentives are given to managed care organizations to market their commercial plan *first* and then market this new plan as a supplemental plan for low-income employees who do not take up the commercial plans.

⁸ S. Collins, et al, One the Edge: The Health Insurance Coverage of Low-Wage Workers Findings from the 2001 Commonwealth Fund Health Insurance Survey.

⁹ Florida Office of Insurance Regulation

¹⁰ Institute for Health Policy Solutions, Premium Assistance: What Works? What Doesn't?; April 2003

Wisconsin's Badgercare is very similar to New Mexico's program, except families are ineligible for public programs if their employer offers family coverage and pays 80 percent or more of the cost. If an employer contributes less than 80 percent, families must enroll in Badgercare and premium assistance is provided to pay their share of the employer-sponsored coverage. Further, Wisconsin found a critical key to success was verification of an employee's access to employer-sponsored coverage as part of the eligibility process.

RECOMMENDATION

OBTAIN A HIFA WAIVER TO ESTABLISH A PROGRAM TO PROVIDE PREMIUM ASSISTANCE TO LOW-INCOME EMPLOYEES FOR THE PURCHASE OF EMPLOYER-SPONSORED HEALTH INSURANCE.

POLICIES TO IMPROVE ACCESS, PREDICT COSTS AND MAINTAIN CONSUMER CHOICE

- **ACCESS TO INFORMATION.** Across the country, a great deal of information reported to government agencies by health care providers on cost and quality data. The problem lies with the inability of the main purchasers of health care – employers, employees and the government - to easily access this information. One Florida program is already in place that could be used to ensure consumers receive information necessary to make well-informed health care decisions. The Comprehensive Health Information Systems Advisory Council currently works with AHCA to review and improve the state's health insurance system. Some of the information already gathered by this group includes:
 - Health resources by specialty and type of practice and the quality of care provided by various health care providers;
 - Services provided by health facilities;
 - Health care costs and financing, including price and cost trends, payment sources, and federal, state, and local expenditures;
 - Report cards for health maintenance organizations (HMOs) and nursing homes; and
 - The extent of public and private health insurance coverage in Florida.

The Chamber believes increased access to information will ultimately increase the quality of care provided to Floridians. A number of programs are outlined below that focus on the collections and provision of important data to assist health care consumers.

National Voluntary Hospital Reporting Initiative. The Center for Medicaid and Medicare (CMS) maintains a website - www.medicare.gov - that is intended to make critical information about hospital performance accessible to the public and to expand efforts to improve quality. This is a collaborative effort between CMS, the American Hospital Association (AHA), the Federation of American Hospitals (FAH), the Association of American Medical Colleges (AAMC), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF), the Agency for Healthcare Research and Quality (AHRQ), consumer advocates and other stakeholders.

Consumer-Driven Health Plans. Approximately 17 percent of U.S. employers with 5,000 or more employees offer high-deductible policies including consumer-driven health plans¹¹, and another 40 percent say they are likely to offer the plans next year. Conceptually, these plans seek to empower employers and employees to take control and responsibility of their health care. Further, the plans offer education and assistance through Internet sites that allow patients to research cost-effective health care options. Medical savings accounts (MSAs) usually accompany consumer-driven plans for small employers with traditional insurance and FSAs or HRAs accompany all-sized employers using health plans to pay for costs that are not covered.

Transforming Healthcare Through Information Technology Grant Program. In July 2003, the AHRQ convened a group of 50 experts to identify gaps in knowledge relating to the use of health care information (HIT) technology. The group identified the following needs:

- Increased research on important health-related outcomes and diverse health care settings;
- Support for local and regional HIT projects that would lead to standards-based data sharing across health care delivery sites;
- Demonstrations that show the value of HIT in improving patient safety and quality of care;
- Review of incentives and disincentives for adopting and using HIT; and
- Development of evidence-based knowledge and decision-support tools to support clinical decision-making.

AHRQ is now seeking applications for 100 grants across the U.S. totaling \$41 million to plan, implement, and demonstrate HIT's value for improving patient safety and quality of care. These grants may be submitted by public and private non-profit organizations, including universities, clinics, hospitals, and state and local governments and should emphasize community partnerships. An estimated \$14 million will fund projects in rural and small hospitals and communities.¹²

RECOMMENDATION

EXPAND REPRESENTATION ON THE CHIS ADVISORY COUNCIL TO INCLUDE EMPLOYER ASSOCIATIONS TO ENSURE MAJOR HEALTH CARE PURCHASERS IN FLORIDA ARE INCLUDED IN HEALTH INFORMATION DISCUSSIONS.

PROMOTE EXPANSION OF GOVERNMENT AND PRIVATE SECTOR INITIATIVES THAT INCREASE THE LEVEL OF DATA ON QUALITY HEALTH CARE AVAILABLE TO THE PUBLIC.

ENCOURAGE INCREASED PATIENT RESPONSIBILITY THROUGH CONSUMER-DRIVEN HEALTH PLANS.

¹¹ Gary Claxton, Health Policy Analyst, Kaiser Family Foundation, 2003

¹² NIH Guide at <http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-04-011.html>.

- PATIENT ASSISTANCE. Education must be the cornerstone of any reform efforts to lower the cost of coverage and the number of uninsured citizens. It is imperative all health care consumers are educated on basic health information to increase better decision making. Health literary programs advanced by pharmaceutical manufacturers, AHCA, the University of South Florida and federally qualified community health centers are working to identify the most effective way to educate the public on proper health care options and treatments.

Several websites already exist that can educate patients about certain medical conditions and their most efficient treatments. WorldDoc.com provides interactive on-line health decision support to empower people to make better health care choices and has current information on over 90 percent of common medical conditions. For example, this website can help people decide what they may have in terms of a cold or flu and what they should do for medical problems like high blood pressure or asthma.

A recent study found that almost 4 million households have visited their physician's website. Thirty percent did so to request a prescription refill and 21 percent to schedule an appointment.¹³ Mdhub.com was developed to ensure fast and accurate communication between patients and their physicians. This website connects patients to their personal physician's website and allows them, for no cost, to request a prescription refill or schedule an appointment. By allowing the patient to make a request by email, the patient and the office staff's time is maximized and unnecessary delay is avoided. Patients may also complete or update their personal health information online prior to their appointment.

RECOMMENDATION

ENCOURAGE EXPANSION OF HEALTH LITERACY AND OTHER EDUCATION PROGRAMS, USED BY THE PRIVATE AND PUBLIC SECTOR THAT PROVIDE CONSUMERS INFORMATION TO MAKE APPROPRIATE HEALTH CARE DECISIONS AND ENOCOURAGE HEALTHY LIFESTYLES.

PROMOTE SERVICES, SUCH AS MDHUB.COM, THAT STRENGTHENS THE CONNECTION BETWEEN PATIENTS AND THEIR PHYSICIANS.

- EMERGENCY ROOMS. Emergency rooms (ERs) are the most expensive setting for receiving care, and according to the Florida Hospital Association (FHA), ER use has increased 24 percent in the last six years. FHA reports that uninsured patients use ERs for primary care services as well as for more severe medical problems. Further, insured patients incorrectly use ERs when they are unable to get an appointment with their physician.

In the study that showed why people visited their physician's website, more than 35 percent did so to look up health information, and 23 percent did so to ask a question about treatment.¹⁴ Several health plans currently provide a 24-hour 1-800 phone line staffed by a nurse that allow patients, at no cost to ask health questions. Employers believe expansion of these programs could abate overuse of ERs and increase consumer satisfaction by being able to talk to a "live person."

While ER misuse must be curtailed, employers believe health plans and insurers must be provided opportunities to lower the cost of ER services. Currently, insurers are mandated to cover all costs associated with emergency room visits without being given any means to

¹³ Forrester Research, 2003

¹⁴ Forrester Research, 2003

control those costs. This component of emergency services ultimately increases the cost of employer-sponsored coverage.

Another issue that drives ER abuse is fear of liability. In 2003, the Legislature enacted an important package of reforms to curtail unnecessary medical liability lawsuits; however, the success of these reforms remains to be seen. As a result of fear of litigation, physicians tend to refer higher risk patients to ERs.¹⁵ Further some physicians unwittingly drive up use of ERs as their after-hours office message directs patients to the ER if they believe their problem is an emergency.

RECOMMENDATION

CREATE A TASK FORCE OF THE OIR, AHCA, AND THE DOH COMPRISED OF EMPLOYERS, THIRD PARTY PAYORS, PHYSICIANS AND HOSPITALS TO DEVELOP A LIST OF APPROPRIATE ER USES TO ENSURE CONSUMERS ARE GIVEN CONSISTENT INFORMATION ON THIS SERVICE.

REVIEW THE CURRENT MANDATE FOR HEALTH PLANS AND INSURERS (AND THEREFORE EMPLOYERS), TO PAY FOR ALL ER SERVICES WITHOUT SUFFICIENT MEANS TO CONTROL COSTS.

- **EVIDENCED-BASED MEDICINE AND QUALITY INITIATIVES.** An AHRQ study recently found preventable medical errors nationwide contributed to 2.4 million extra hospital patient days and more than \$9 billion in extra costs annually. Other studies document that procedures, such as hysterectomy and hernias, are performed more frequently in some areas than others with no difference in underlying disease rates. Historically, clinicians rely on traditional measures such laboratory tests to determine whether intervention is necessary and whether it is successful.¹⁶ Much of AHRQ's outcomes research has become part of report cards used by consumers to assess the quality of care in health plans. Public programs, such as Medicaid and Medicare, should also use outcomes as a way to monitor and improve quality.

Many health plans analyze physician and hospital practice patterns to ensure patients receive the best care based on current scientific evidence. Yet presently, important health care decisions continue to be made based on incomplete information and over-utilization, under-utilization, and mis-utilization result in poor quality of care for consumers.¹⁷ Clearly, evidenced-based medicine is the future for ensuring quality and appropriate care is provided to Floridians.

The Leapfrog Group, comprised of more than 145 public and private organizations representing 34 million health care consumers in all 50 states, was formed to work with medical experts to identify problems and propose solutions to improve hospital systems. This group identified the three hospital safety measures that could avoid 500,000 serious medication errors and save approximately \$9.7 billion annually:

→ Computer physician order entry – Reduces serious prescribing errors in hospitals by more than 50 percent;

¹⁵ Center for Studying Health System Change, October 2003.

¹⁶ Agency for Healthcare Research and Quality, *Research to Reduce Cost and Improve the Quality of Health Care*. Publication No. 02-P024, April 2002; <http://www.ahrq.gov/research/costqual.htm>

¹⁷ Center for Practical Health Reform – Dr. Brian Klepper

- Evidence-based hospital referral – Sends patients needing complex medical procedures to hospitals with the best survival odds and reduces a patient's risk of dying by more than 30 percent;
- Intensive care unit staffing by critical care medicine physicians – Reduces the risk of a patient dying by more than 10 percent.

Currently, over 1000 hospitals nationwide voluntarily reported their progress towards implementing Leapfrog's recommended practices. Five percent of hospitals working with the group have implemented the computer physician order entry system and an additional 17 percent will implement it by 2005. Twenty-one percent of hospitals have implemented the ICU staffing measure, and an additional 5.4 percent will implement it by 2004. And finally, 80 percent of U.S. health care consumers now have access to vital patient safety data for one or more hospitals in their area

RECOMMENDATION

PROMOTE USE OF EVIDENCE-BASED MEDICINE TO ENSURE APPROPRIATE MEDICAL CARE IS PROVIDED IN BOTH THE PRIVATE AND PUBLIC SECTOR.

SUPPORT THE EFFORTS OF ORGANIZATIONS SUCH AS THE LEAPFROG GROUP THAT PROMOTES QUALITY CARE INITIATIVES BASED ON SCIENTIFIC DATA.

- DISEASE MANAGEMENT PROGRAMS. Integrated disease management programs (DM) apply scientific and medical advances to assure quality-based care is delivered to those with chronic disease. These programs are currently used in both the private and public sector. Successful DM programs must embrace physician collaboration, use of information technology and individual empowerment. The Association of Health Plans/Health Insurance Association of America found that enrollees in health plan DM programs had fewer hospital admissions, fewer ER visits and lower overall health care costs. Further studies have shown that DM for congestive health failure can reduce ER visits and inpatient admissions by one-third.

RECOMMENDATION

EXPAND THE USE OF DISEASE MANAGEMENT PROGRAMS IN THE PUBLIC SECTOR TO: INCREASE THE QUALITY OF LIFE OF PERSONS WITH THESE CONDITIONS AND LOWER THE COST OF PROVIDING THIS CARE.

- PRESCRIPTION DRUGS Prescription drugs provide benefits to society through increased quality of life and decreased surgeries and deaths. Current estimates say an \$18 new drug cost increase saves \$80 in inpatient costs, \$24 in office visits, \$12 in home health; \$10 in outpatient and \$3 in emergency room visits. Overall, a ratio of \$7 is saved for every \$1 invested.¹⁸ But we cannot ignore the fact that bringing a new drug to market costs over \$800 million. This overall cost of developing a new drug must be weighed against its overall benefit to society

The search for lower prescription drug coverage costs has led employers to tiered pharmacy benefit programs. These programs do not lower the cost of drugs, but lower utilization, which reflects approximately 77 percent of spending.¹⁹ Tiered programs require consumers

¹⁸ Prof. F. Lichtenberg, "Benefits and Cost of Newer Drugs: An Update", NBER working paper, 8996, June 2003

¹⁹ Centers for Medicaid and Medicare Services, 2003

to pay, for example, \$5 for generic drugs, \$10 for preferred brand name drugs and \$25 for non-preferred name brand drugs.

Several programs in operation lower prescription drug spending. For example, North Carolina grants free access to prescription drugs and other services for diabetics that enroll in a care management program. In five years, sick days decreased from 12.6 to 5.7 for enrollees.²⁰ Another program secured over \$630,000 in medications from one pharmaceutical, at no charge, for Florida Medicaid patients receiving primary care at one of the 47 federally qualified health centers in our state²¹. If these kinds of programs were expanded, substantial Medicaid funds could be saved on the four most prevalent and high cost conditions in Florida - asthma, hypertension, heart failure, and diabetes.

RECOMMENDATION

EXPAND OR ESTABLISH PROGRAMS THAT PROVIDE PRESCRIPTION DRUGS TO CITIZENS WITH CHRONIC DISEASES WHO ENTER CARE MANAGEMENT PROGRAMS.

DO NOT INSTITUTE NEW LIMITS ON INNOVATIVE TIERING PROGRAMS USED BY EMPLOYERS TO REIN IN PHARMACY COSTS.

LET'S GET FLORIDA COVERED - ACHIEVING THE GOAL. The recommendations outlined in this report are admittedly, only a small sampling of ideas to lower the cost of health insurance and increase the number of insured Floridians. Further, many of these recommendations must go through a cost benefit analysis to determine the possibility for success.

The Florida Chamber believes now is the time that all stakeholders in the health care delivery and payment system – providers, government and consumers – must work together for the common goal of developing solutions to our health care crisis. The Chamber stands ready to assist in the efforts put forth by the Governor's Task Force and other groups to ensure this goal becomes a reality.

²⁰ The Asheville Project", Presentation by John Miall, November 14, 2001

²¹ Pfizer, Inc. 2003



State & Local Working Group

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Eddie Pollock, CSX Transportation
John Ray, Enterprise Florida
Barret Rea, Waste Away Systems
Dave Williams, Exceletech

Issue Discussion

Support and encourage Florida's Department of Environmental Protection (DEP) to adopt EPA's revised New Source Review (NSR) guidelines as part of the Federal Clean Air Act.

Improve the regulatory interface between Florida manufacturers and local, state, regional and federal agencies.

- "Regulatory costs represent six percent (6%) of the pre-tax earnings of Florida manufacturers."
- One-stop permitting for Florida manufacturers.
- Florida needs one source (e.g., state office / manufacturing guru) for Florida manufacturers to go to for assistance: one-stop shopping. Information about Florida incentives and services. "There's no one in Florida government that has a manufacturing background."
- Increase flexibility within DEP permitting process. For example, do not fine manufacturers if they miss a deadline by a couple days.
- Work with and educate agency officials so that they understand the issues and importance of Florida manufacturers.

Buy Florida Campaign: Encourage and educate Florida manufacturers about in-state supplier opportunities. More data collection is required to identify and categorize Florida suppliers.

State Procurement: Make it easier for Florida manufacturers to do business with the State. Give Florida manufacturers preference when competing for State business.

Continuing investing in key infrastructure and quality of life issues (i.e., roads, schools, environment) to ensure Florida continues to be a desirable place to live and do business.

Tax Issues (to be communicated to Taxes & Incentives Working Group)

- Tax incentives for re-tooling.
- Tax incentives to retrain employees.
- Eliminate intangibles tax. This tax discourages corporate headquarters because it taxes authorized by un-issued stock.