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COMMISSIONS, CLUBS, AND CONSENSUS: FLORIDA REORGANIZES FOR HEALTH REFORM

by Lawrence D. Brown

Prologue: When it comes to medical care and health insurance, Florida is a state of extremes. It has a very large population of uninsured residents; it has a very large population of elderly Americans, virtually all of whom are insured by Medicare; and its Medicare expenditures per eligible beneficiary are the highest in the nation. The magnitude of the problems Florida's health care system faces, not to mention the influence wielded there by a staggering array of private interests, suggests that the Sunshine State might lag behind other jurisdictions in pursuing reform. But as Lawrence Brown points out in our lead essay, such is not the case. Florida has taken several important reform steps over the past decade, the most recent of which Brown discusses in detail. Brown underscores the important role played by Governor Lawton Chiles in the search for policy reforms. Assuming office with big plans for improving Florida’s physical infrastructure and social services, Chiles soon recognized that health care was eating up much of the money he had hoped to use for his own priorities. Chiles’s determination to act gained force when he attended a meeting of the National Governors’ Association and eloquently argued that states could not afford to wait to pursue health care reform. Having articulated the goal, he returned home with a new commitment to make it happen. Brown, a political scientist, received his doctorate in political science from Harvard University. He is a professor and head of the Division of Health Policy and Management at the Columbia University School of Public Health. Brown has written on a variety of subjects for Health Affairs, including the political evolution of federal health care regulation (Winter 1992) and a review of Oregon’s Medicaid rationing plan (Summer 1991).
Abstract: This paper explores the political dynamics by which a health reform leader state-Florida-engineered an ambitious reorganization of state health agencies as an expected prelude to bolder policy measures before the end of 1994. Demographic and fiscal pressures spurred the state to action, but its success at innovation demands a political explanation. This narrative highlights Florida’s patient quest, by means of commissions and task forces, for common ground among parties of diverse dispositions; the sagacity of would-be innovators in wielding a potent policy “club”—the prospect of a single-payer system—to encourage a search for common centrist ground; and the consensus- and coalition-building skills of the state’s leading executive and legislative figures. Florida’s political skill has sustained impressive departures, but the hardest questions—how to finance universal coverage, how to secure universal access, and how to keep it all affordable—remain to be answered.

As pressures for health care reform began to intensify in the mid-1980s, devotees of devolution would have been hard-pressed to argue that the states were a credible source of leadership. Sensing that bold efforts to repair the system would antagonize powerful provider and payer groups without yielding commensurate gratitude in the electorate, most state leaders lacked the political will to enter the fray. Constrained by pledges of “no new taxes” and pressured by myriad spending arenas in addition to health, states also lacked the fiscal capacity to subsidize the quest for universal coverage. Reform leadership, many concluded at the time, would come from Washington or not at all.

By 1990 the potential for state-initiated health reform looked very different. In 1988 Massachusetts became the first state to legislate a statewide play-or-pay plan. (Hawaii had enacted employer mandates, with no “pay” option, in 1974.) In 1989 Oregon won headlines with its plan to ration (“prioritize”) health procedures for part of the Medicaid population and then to use that list of covered services as a minimum benefit package binding on employers. In the early 1990s Minnesota, Vermont, Washington, and Florida joined the ranks of states with legislation designed to move toward universal coverage, and many more states had such measures under earnest discussion. The states had by no means solved the problem of fiscal capacity, but clearly the earlier negative verdict on their political will had been exaggerated and premature.

As might be expected—and presumably desired—in the laboratory of federalism, the states leading the charge for change differ considerably in their preferred strategies and in the routes by which they reached them. This paper examines one of the most intriguing innovators, Florida, which in March 1992 created an Agency for Health Care Administration (AHCA) as a means explicitly expected to achieve affordable universal coverage for all Floridians by the end of 1994. In essence, Florida set off to find a consensus on the substantive problems of cost and access only to discover that none existed and that no one was sure what to do next. Convinced that fragmentation of public authority in the health policy
sphere both defeated coherent control of the larger system and impaired the best efforts of the principal players-public and private-to hold a sensible, sustained discussion about reform. Florida has put its faith in reorganization. The hope is that a rational administrative structure that brings all (or most) of the players in the financing and regulatory games within a common organizational framework, in an agency that works under a skillful director who reports to the governor and stands accountable to the legislature, is a necessary-and perhaps even sufficient-condition for building agreement on reformist means and ends. This paper tries to explain how Florida came to enter the class of leading state health policy innovators and why it embraced the approach that it did.

An Early Innovator

Judged by surface data and impressions, Florida is an improbable source of "progressive" health policy departures. Despite strong liberal enclaves in and around Miami, much of the state is rural, Southern, and politically and culturally conservative. Lacking a personal income tax, and tenaciously committed to that omission as a spur to the growth on which it relies for revenues, Florida tends to rank "near the bottom of the states in almost every indicator of government effort." The state has long displayed the usual package of problems of poorer southern states: high rates of infant mortality and low-birthweight babies, low Medicaid eligibility (24 percent of federal poverty in 1984, 31 percent today), and low rates of payment and provider participation in Medicaid. Gaps in private-sector coverage mirror the public. Ninety-five percent of Florida firms employ fewer than twenty-five people. Also, much of the economy depends on agriculture, construction, tourism, and other service industries that often fail to cover their workers. In consequence, 18.5 percent of Florida's population-and fully 22.9 percent of its nonaged citizens-lack health insurance. The very magnitude of the problem seems itself to inhibit innovation: For example, Hawaii, Massachusetts, and Minnesota had about half of Florida's percentage of uninsured population when they moved toward universal coverage.

Appearances can deceive, however: Florida was one of the first and boldest innovators in state health policy. The pattern commenced in 1984, when Florida enacted the nation's first state-based revenue assessment ("sick tax") on hospitals, to create a trust fund to finance the expansion of Medicaid and primary care services. The visible deficiencies of Medicaid and the tribulations of the uninsured were significant stimuli to action, but those familiar features of the federalist scene do not explain why, much less how, Florida chose to pioneer a new funding strategy for the poor. A fuller explanation requires a look at particular features of Florida’s health policies.
and how political leaders chose to manage them.

Roots of reform. In the early 1980s both the organized elderly and business coalitions were ardently petitioning the legislature for relief from rising health costs; both targeted hospital spending as the logical locus of intervention. Competition was in the air, but few knew what it meant concretely, and those who were not seduced by its allure countered by pressing the case for tough rate regulation of hospitals. Meanwhile, about 40 percent of Florida's hospitals had become for-profit, generating behavior patterns that had fans of competition and regulation alike crying out for a leveling of the playing field. The for-profits were allegedly shirking their fair share of the state's sizable burden of uncompensated care. An observer recalled in an interview that "a two-class system of care was developing and everyone knew it. The for-profits would give the uninsured guy who showed up in the ER fifteen dollars for a taxi and send him to the nearest public hospital." In a potent and unusual split within "the industry," the voluntary and public hospitals pressed their common case for fiscal relief.

Three-part strategy. As state leaders sought to reconcile these diverse concerns, they devised a three-part strategy that served them well in the early 1980s and again a decade later. First, they appointed commissions to explore problems, canvass solutions, and—probably most important—educate dozens of prominent public and private players about what might be done and who wanted what. In 1981 a task force headed by former state legislator Buddy Mackay set the stage by pondering competitive and regulatory issues. Then in 1983 the Task Force on Competition and Consumer Choice, headed by former state senator Bob MCKnight, began drafting "a blueprint for state-wide policy changes." The group became a central focus for group presentations, for ventilation of issues before the press and the public, and, in time, for legislative recommendations.

Second, political leaders adroitly wielded policy "clubs"—the threat of firm intervention that groups wanted to avoid—to win acceptance of more modest measures. As the field-leveling revenue assessment began to gather support, the for-profit hospitals threatened to try to block it. Legislators responded by swinging the (credible) club of a hospital rate-setting system and thus got the revenue assessment plan back on track.

Third, clubs notwithstanding, Florida policymakers assumed that workable reforms required complex bargains that blended benefits with costs in ways that gave all major participants some victory to take away from the table. In 1986 Gary J. Clarke (now the state's director of Medicaid and an important figure in the 1992 reforms) captured well a political style that worked in 1984 and recurred in 1992:

The provisions of the law reflect both the comprehensive nature of the approach as well as the compromises and consensus of all concerned. Businesses were assured an upper limit on
hospital cost increases but were left free to negotiate their own best deals with hospitals. Hospitals escaped the dreaded burdens of either full-fledged budget/rate regulation or mandated charity care requirements. Voluntary hospitals, and especially public hospitals, were guaranteed that their increased burden of Medicaid care would be relieved in direct proportion to the amount of such care they provide—more than offsetting the increased tax to which they were subjected. Advocates for the poor and Medicaid program expansion were able to increase overall revenue by at least a third, without resorting to any apparent increase in direct citizen taxation (sales or income tax). And issues that were too complicated or for which there was insufficient time were left for further study. As the 38 to 0 and 112 to 0 votes in the Senate and House respectively demonstrate, the hard-fought program was in the end supported by all interested parties in the state, and most legislators and lobbyists (except those from some individual hospitals) left the capital that spring well-pleased with their efforts.6

The Health Care Access Act of 1984 created (among other provisions) a Public Medical Assistance Trust Fund initially sustained by a tax of 1 percent of net hospital operating revenues (rising to 1.5 percent in subsequent years). At the state’s Medicaid federal matching rate of 56 percent, Florida envisioned about $200 million annually of new monies with which to expand and improve Medicaid and enhance primary care.7

Commissions Continued: Moving Beyond Medicaid

As the 1980s advanced, it became clear to most health care leaders in Florida that extra hospital-derived revenues to expand Medicaid and primary care services were but a modest first step toward effective reform of a system that staggered under multiple burdens. After an early spell of confusion in which new Medicaid enrollments, and drawdowns on the new trust fund, were much smaller and slower than anticipated, the innovations of 1984 did enable the state to improve markedly its payments to hospitals and physicians. But simultaneous developments reduced this progress to a drop in the bucket. Trust fund-assisted payments to Medicaid providers increased, but between 1985 and 1991 the program’s enrollment doubled, and overall spending soared.

The increases reflected some fairly intractable trends: The recession swelled the ranks of the unemployed, the uninsured, and those on welfare; federal mandates added new groups to the program; immigration to Florida swelled; and various pathologies (acquired immunodeficiency syndrome [AIDS], drug abuse, mental illness, and others) got medicalized and “Medicaidized,” driving up utilization. Meanwhile, Florida continued to add jobs in sectors that typically did not extend health coverage to workers; Medicare (and Medicaid) shifted costs more aggressively as their fiscal worries worsened; business watched its health spending grow and cried for help; the numbers of elderly in Florida and their anxiety about the rising costs of care increased; uncompensated care grew more burdensome, the trust fund notwithstanding; and suspicions about unnecessary treatments
and other sources of waste in the system deepened. By the end of the decade voices rose in every corner of the system and the state urging state policymakers to propose solutions.

Some of these pressures were aggravated by Florida’s demographics and economic infrastructure, but none was unique to the state; as in 1984, these insistent sources of demand for change did not, themselves, explain the state’s capacity to supply it. An adequate answer lies again in the realms of political choice and conflict management, and its first element is (again) the state’s creative use of commissions to set a reform agenda.

In July 1989 the Florida legislature created two multimember task forces—one on Private-Sector Health Care Responsibilities, the other on Government-Financed Health Care—and instructed them to report their findings by March 1991. Over nearly two years the two groups held meetings and worked to forge agreement on the nature of the problems and preferred avenues for change among a wide range of interests. Not surprisingly, the two converged rather closely in their indictment of the usual suspects for the system’s problems: unhealthy lifestyles, excessive utilization, cost shifting, insurers’ preferred risk selection, and more. The two also seemed to be in harmony on a broad division of labor in the public/private partnership: The public sector should secure cost containment and coverage for the unemployed, and the private sector should contrive to insure all its workers. There was also significant agreement on general strategic directions. Both embraced extensive reform of health insurance practices, the promotion of prevention and primary care, and hard choices about what basic benefits public and private insurers should be expected to cover.

In three respects, however, the public-sector group sketched an agenda with sharper policy teeth and more visible political sponsorship than did its private-sector counterpart. First, the Task Force on Government-Financed Health Care boldly proposed ambitious goals with short time horizons. It flatly recommended that (1) all citizens of the state should enjoy universal access, meaning “readily available access to primary care and a means of paying for that care;” (2) 95 percent of employees and dependents should have primary care coverage, or employer mandates should be adopted; and (3) per capita health care costs should increase by no more than the overall rate of inflation—and all this by 1996.

Second, the public-sector group’s willingness to cut to the chase by 1996 came accompanied by a blunt prescription about how to make the cut: “A single state agency, either existing or to be established, shall be given responsibility for the reform of the health care system.” The importance of this recommendation may be gauged by the insistence of eight of the group’s seventeen members (including all three of its hospital representatives) on filing dissenting views and opinions blasting it.
Third, the public-sector task force’s vision of bold goals, tight time lines, and concentrated public authority became identified with its chairman, C. Fred Jones, a widely respected veteran Democratic legislator from central Florida and a conservative. Jones’s standing assured that when he talked about the need for an “800-pound gorilla–someone to sit all you interests down to get your attention and get you to negotiate in good faith”—a broad audience within the public and private sectors and within the liberal and conservative camps took respectful notice.\(^{12}\)

As early facilitators of change, the task forces had worked well. The systemic nature and multiple elements of the problems had been laid out for all to see. A broad range of interest-group leaders had received a two-year education in policy pros and cons and in the values and interests of their task force colleagues, and had been equipped to argue the case for change within their various sectors. The urgency and legitimacy of a continuing quest by both the public and private sectors for reforms had been established. Some pointed and controversial suggestions about what to do here and now had entered the public and private agendas. The challenge now was to turn up the heat to move those suggestions (or substitutes for them) higher on those agendas and closer to legislative enactment.

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**The Canadian Club: Legislative Momentum From Miami**

Florida is a southern conservative state with a major twist: the presence of sizable numbers of seniors, often emigres from the Northeast and Midwest, many of whom bring and retain liberal, activist expectations of government that distinguish them from younger, more conservative Floridians. Especially salient and cohesive is the concentration of liberal Democratic, largely Jewish ex-New Yorkers in and around Miami and Miami Beach. From one perspective (for instance, that of the uninsured), Medicare coverage should make these seniors some of the health care system’s most satisfied customers. From another viewpoint (their own), however, they too are hapless victims of the system: Muddling through on fixed incomes, they watch out-of-pocket medical costs and Medigap premiums soar, and any protracted demand for long-term care could exhaust their assets. Many seniors, therefore, tune in assiduously to the debates about health care reform and expect (probably wrongly) that change will mean lower medical costs for them as well as for the uninsured and the working insured. In pondering reform, this group, many of whom formed their political attitudes in the New Deal era, tend to be more accepting of government-centered solutions than are younger cohorts. The mention of single-payer, Canadian-style schemes strikes no fear in their hearts. Quite the contrary, they—like the national American Association of Retired
Persons (AARP), whose “line” they generally echo-profess not to understand why the U.S. government should not assign itself a leading role in securing affordable universal coverage, and insistently press the question, “Why can’t we have a health system as good as the Canadians have?”

These liberal views found practical expression in 1988 (and thereafter) with the introduction of House Bill (HB) 1, the Florida Universal Health Access Plan, by Rep. Elaine Gordon of North Miami. The bill, strongly backed by the AARP, would give Florida a Canadian-style plan, that is, a publicly financed, single-payer system without employer mandates, copayments, or deductibles. A commission would set statewide global budgets for all providers, negotiate fee schedules with providers within the global budget limits, and set fair premiums for comprehensive benefits. The bill had little short-term prospect for passage. But, precisely because its potential political appeal (should more incremental alternatives falter) was unknown, it tossed a weighty gauntlet before other legislators. If they truly favored reform but would not endorse Gordon’s Canadian-inspired version, what better ideas might they care to offer? HB 1 was, in short, a potent club that providers and policymakers could not ignore. Gordon herself called it “a two-by-four between the eyes of the system.”

In 1991 a prominent Miami Beach liberal, Rep. Mike Abrams, offered a promising alternative. Abrams would establish a public utility-style commission to canvass reform alternatives—a single-payer system would be one among several and to propose detailed plans for a major overhaul of the system. This approach appealed to both Dade County liberals and conservatives who thought it a reasonable facsimile of Jones’s 800-pound gorilla.

A participant later described in an interview the political alignment emerging in support of reform. Business, alarmed at health care spending, could perhaps be persuaded to endorse mandates so long as they followed a decent interval of voluntary efforts to expand coverage and were attached to firm government assurance of cost containment. The hospitals remained skeptical of consolidated government controls but might wax lukewarm if physicians were tightly regulated too. The Department of Health and Rehabilitative Services was even prepared to yield some health functions to the proposed commission. This skittish coalition carried the commission bill through the solidly Democratic House, but the Senate, where Democrats held a narrow 21-19 majority, then balked. Governor Lawton Chiles, newly installed in office and still composing his health reform agenda, did not fight for the bill, while the Florida Medical Association (FMA), fearful of what a commission might do to physician incomes and practice patterns, opposed it aggressively and successfully.

From the ashes of the commission bill in 1991 rose a clear and increasingly hopeful prognosis for the next round. If business stayed in the reform
fold, the main challenges were, first, to split provider opposition by enticing the ambivalent hospitals to the side of change and, second, to convince Governor Chiles to throw his formidable political weight into the struggle. The hospitals were remarkably obliging. A spokesman recalled a soul-searching retreat in 1991 from which the nonprofit and public hospitals emerged with a new dedication to reform. The 1991 legislative session had produced results that hospitals did not like. But, the spokesman said, “It made us rethink our position. The system was broken, it needs fixing, the legislature would continue to pursue change. We saw that we’d better be proactive.” Their reappraisal cleared the strategic field. Now, if the governor came out swinging, the physician lobby might be isolated and quite possibly overcome.

Crafting Consensus: Along Comes Chiles

In most states major health reforms are difficult to achieve in the legislature alone, which is usually riven by factions and limited in the scope and powers of its leadership. Generally, strong executive commitment to and participation in major policy departures are essential to their progress, and in this respect Florida was no exception. When Governor Chiles joined the search for policy reforms, the prospects for a happy legislative outcome increased markedly.

In 1990 Chiles, a veteran of eighteen years as a Democrat in the U.S. Senate, wrested the Florida governor’s office from incumbent Bob Martinez, a Republican who had largely stayed on the sidelines of health reform. While in Washington Chiles had paid sustained attention to maternal and child health issues but had not joined the swelling ranks of self-proclaimed “health leaders.” Once he settled into Tallahassee, however, health reform quickly shot to the top of his agenda, for reasons much like those driving other governors.

Entering office with big plans for improving Florida’s physical infrastructure and social services, Chiles quickly discovered that health care was eating up most of the money he hoped to use for his varied priorities; that is, projected growth in Medicaid spending consumed much of the estimated growth in the state’s public revenues. Meanwhile, the recession, immigration, cost shifting, the growth of the uninsured population, and other factors were pushing the program’s enrollment and costs ever higher, with no relief in view. Something had to be done, and because Medicaid costs were in so many ways driven from without, internal repairs to the program would not suffice. Decrying the “outrageous cycle” and the fiscal and political “mess” it produced, Chiles appointed a twenty-one-member health care working group and told it to return with recommendations within
three months.

The governor’s situational commitment to reform gained extra force and urgency when he attended a meeting of the National Governors’ Association (NGA) in Seattle and joined a debate about the hows and whens of universal coverage. The assembled chief executives were debating a resolution that exhorted the nation to achieve universal coverage by the year 2000. Proposing an amendment to the measure, Chiles eloquently argued that the goal could not wait that long. For one thing, rising costs would demolish state budgets well before that deadline; for another, postponing universal coverage into the tenure of incumbents’ political successors was no profile in courage. The NGA might do as it pleased, declared Chiles, but he for one was determined to see universal coverage achieved in Florida before the end of his current term in December 1994. As bemused aides shook their heads and meditated on how they might deliver on this ambitious pledge, Chiles returned to Tallahassee resolved to do something big, and sooner rather than later.

The unanswered question, of course, was what exactly to do. Administration strategists began bumping into what members of the two task forces of 1989-1991 and the legislative innovators in the House had already encountered: the inexhaustible political blame shifting that parallels and legitimates the economic cost shifting that thwarts health reform. General agreement held that private employers should cover their workers, but mandates were tricky. Business intimated that it could perhaps accept them if honest voluntary efforts failed in the private sector and if insurance costs were properly contained by the public sector. Insurance reform was broadly appealing (even the industry itself endorsed many versions of it), but it was the beginning of workable reform, not the end. Insurers contended, with some merit, that they did not run the larger system and could do little directly to check costs unless hospitals were better disciplined. The hospitals were, as noted above, increasingly receptive to reform, but they insisted as a matter of equity and economics that physicians—those captains of the medical team and dominant allocators of resources—be subjected to the regulation they had so far largely escaped. Physicians, represented by the influential FMA, opposed initiatives that could invite assaults on their incomes and practices. (They were even then sinking heavy political capital into a fight to defeat legislation that would curb widely criticized physician referrals of patients to facilities in which physicians held ownership shares.) If society wants universal coverage, said the doctors, let society make employers offer it.

All of these positions were self-serving, of course, but both logic and politics demanded that they be given their due. Reform would have to be “comprehensive” and “systematic,” but these estimable cliches merely
underscored the complexity of the problem: What model might improve matters and still win widespread political agreement? In Florida, as elsewhere, consensus on the need for change was well advanced; but each major faction wanted to settle the costs of reform anywhere but on itself. Yet light did glimmer down the tunnel. To be sure, Gordon’s single-payer system violated Chiles’s preference for a public/private partnership, and Abrams’s commission proposal created a new authority too detached from the executive branch (already riddled with cabinet agencies whose heads were chosen by statewide election) to suit the governor. But Chiles’s twenty-one-member working group had recommended a new unified health care agency, and the government financing task force had suggested something similar (Fred Jones’s 800-pound gorilla). Chiles himself had been promising to get on with a badly needed reorganization of state government. Health care might be just the place to start.

Crafting Consensus: Bills And Bargains

As 1992 arrived, the elements of reform legislation were rapidly falling into place. Although agreement on such deep-reaching substantive departures as mandates and global budgets remained as elusive as before, virtually all public leaders and private groups (except physicians) embraced the notion that a new public-sector entity was surely necessary and perhaps even sufficient to improve the system by 1995. This agreement drew force from many streams of thought that had come to converge under the pressure of costs. A legislative staffer explained: “Consolidation of health functions is an old idea. We here have been working on it for ten years, in fact. But the stars were never aligned right before. Some powerful legislators would want it, but they’d lose office or whatever, and we’d fail short. Various health gurus around Tallahassee wanted it, but they couldn’t pull it off.” In early 1992 consolidated authority seemed at last to be written in the stars, for reasons summed up by an interest-group participant: “We don’t have the answers, but we see we need a process that will help evolution take place.” Yet in many ways the consolidated authority remained vague and metaphorical; settling on a structure and bringing it to life in legislation acceptable to House, Senate, governor, and interest groups would require political finesse.

The last stages of consensus crafting and legislative drafting got under way when Rep. Elaine Bloom, a Miami Beach Democrat who chaired the House Health Committee, and her staff began negotiating intensively with other political notables over the details of a bill. On the new authority’s general mission most parties concurred. Health policymakers needed a better decision-making structure and process. They should have enhanced
capacity to diagnose the workings and failings of the system and to consider
the practical implications of change in an integrated context now pre-
cluded by organizational fragmentation (Health and Rehabilitative Ser-
vices was far too diffuse and multifunctional to focus effectively on health or
to offer sustained leadership). And they wanted stronger means of concen-
trating leadership to devise reform plans, work with the governor and
legislature to advance them, and explain and define them before the media,
the public, and special groups. Most players agreed too that all of the blame-
and cost-shifting interests should be given notice that the days of voluntar-
ism and privatism would be numbered if the next round of public, private,
and public/private efforts to contain costs and extend access fizzled. Perhaps
an explicit “or else” could not be incorporated into legislation (at least not
yet), but the bill creating a new authority should leave an “or else” hovering
ominously if implicitly in the political air. Broad consensus held that
“public/private partnerships” should be the signature of the piece, and this
was the truest form of partnership. To those (for instance, the doctors) who
groused that “the state was taking over the health system,” reformers could
rejoin that a better-coordinated public system was the only effective way to
get the private system fixed and was (therefore) the only way to save that
system.

Against this backdrop, Bloom, a legislator much respected for intellect
and negotiating skill, took up the concept of a new public authority and the
diverse blueprints for it that important parties entertained and worked to
fashion a package that would be acceptable to all. In seeking consent Bloom
honored the productive political norm of 1984. As she put it in an inter-
view, “I tried to meet everyone’s most important needs.” For example, to
satisfy business the bill dropped proposed language that would have trig-
gerated mandates had the private sector not achieved 95 percent coverage by
a certain date. The doctors were sure to object to a reorganization that
moved their professional overseers, narrowly focused on credentialing, into
a setting that viewed physicians along with everyone else in the big picture
of finance and regulation, but some bile might be mitigated by dropping
legislative references to fee schedules. Chiles did not want a commission or
other administrative species outside the direct line of accountability to his
office; the public authority thus would be an executive agency.

The bill produced by Bloom and her colleagues aimed to bring as many
as possible of the public institutional fragments addressing health care
purchasing and regulation into the newly coherent framework of what
came to be called the Agency for Health Care Administration (AHCA).
(Florida’s constitutional limits on the number of departments in the execu-
tive branch blocked that exalted status for the new entity.) All of the
animals would be in one tank, as participants were wont to say. The agency
would help state policymakers to get the big picture, decide how to fix the system, and then move more directly and forcefully to do it.

The most skillful accommodation could not render the strategy altogether painless. As noted, the FMA would resist a revised regulatory focus; special groups—for instance, the developmentally disabled and the mentally ill—who used Medicaid funds would be less than thrilled to see Medicaid subsumed by a new agency with a focus on financing and regulation; and Florida Health Access, a small-business purchasing cooperative launched in the mid-1980s with Robert Wood Johnson Foundation support and subsidized by state appropriations, would lose a measure of its autonomy. Nonetheless, one protagonist concluded, “The bill was easy to pass because the only giving-up was done by the agencies giving up jurisdiction. No lobbyist or legislators lost anything really.” (This verdict may understate the grievances of the FMA, but at this stage it was a less potent political force than one might have expected because it was busy shooting itself in the foot over the “black hat” issue of physician self-referrals.)

The bill sailed unanimously (109-0) through the House, but in 1992 the Senate remained as much a force to be reckoned with as it had been in rejecting the commission bill a year earlier. The FMA carried considerable clout, especially with Senate Republicans, and in any case the Senate had been absorbed mainly in initiatives that emphasized insurance market reform, pooled purchasing, and managed care, not public-sector reorganization. As the Senate began picking the bill apart, supporters of the agency approach grew nervous. It then grew clear how Bloom’s meticulous consensus building might pay off. Supporters of the bill contacted the interest groups they had labored to accommodate and called in their chips. Each group was assigned a senator, whom they lobbied for passage. Aided by strong lobbying from the governor, the bill’s proponents performed quick and adroit surgery, grafting the Senate’s insurance market reform measures onto the agency initiative and winning Senate passage (35-2) of the amalgamated package, the Health Care Reform Act of 1992.

Consensus For What?

By 1990 the states faced growing pressure for health care reform from three powerful sources. First, the uninsured, estimated at about 15 percent of the nonaged U.S. population (about 23 percent in Florida), continued to be a moral embarrassment and an economic burden for institutions beset by cost shifting and uncompensated care. Second, Medicaid spending was raging out of control, increasing at double-digit rates annually and draining scarce resources from other well-defended policy arenas. Third, the nation’s continued failure at cost containment had produced an insurance cost crisis...
that directly hit millions of “uneasily insured” middle-class voters in their (or their employers’) pocketbooks. The latter two factors struck with special force in the late 1980s and riveted high-level state political attention on health policy as never before. Politicians heard a chorus of grievances from their constituents and knew they had no choice but to respond.

Although most states confronted these more or less generic forces of political economy, only a half-dozen or so have (to date) marshalled the political will to pass legislation that takes a plausible stab at solutions. (The papers that follow in this volume describe the efforts and results in seven other states.) As in other unhappy families, each leader state proceeded in its own fashion. Part of the explanation for Florida’s activism lies in “objective conditions,” especially (1) a politically portentous split between voluntary and public hospitals and their for-profit competitors; (2) decidedly non-Southern support for governmental activism among the state’s numerous liberal senior citizens; (3) a governor willing to extend himself farther than most of his peers in promising state reform and in working to advance it; and (4) a nexus of “blue-chip” (senior and savvy) legislators and staffs committed to forcing action and forging compromise.

Even as problems generic to the states cannot explain why a small subset mobilized for action, however, neither can these demographic, economic, and political conditions entirely account for Florida’s success in making the political wish the father of the policy deed. To close the explanatory circle, one must give strategic choice due credit. Specifically, a near-decade of state activism spotlights three political gambits that served Florida well. These, as noted above, are the use of commissions and task forces to build awareness and agreement among a wide range of public policymakers and private group representatives; the deployment of policy “clubs” (for example, HB 1) to enhance the relative appeal of more moderate reforms and thereby improve their political prospects; and an emphasis on consensus, on fashioning legislation that tries to honor each group’s top priorities and lets each emerge as something of a winner. These strategies effected the practical translation of conditions specific to Florida and of problems common to Florida and other states into the Health Care Access Act of 1984 and the Health Care Reform Act of 1992.

These political dynamics allowed Florida to join the select ranks of leading innovators among the states, but celebration over this undeniable progress should not obscure the limits on what the state found it possible to do in 1992. In early 1993, for example, several smoldering conflicts over structural rearrangements ignited anew. The FMA was (as expected) fighting to rescind the shift of state oversight of physicians from the Department of Professional Regulation to the new agency. Legislators had second thoughts about moving the state employees’ health insurance program into
the AHCA, its new and presumably proper home. And elements within the Department of Health and Rehabilitative Services and within the special populations it serves continued to wonder whether the Medicaid program would be as sympathetic to their needs in a health care financing and regulatory agency as it had been in a human services setting.

Between the fine intentions proclaimed in the bill and embodied in the AHCA and the achievement of universal coverage and reasonable costs by 1995, moreover, stand many massive obstacles. First, from where and from whom will the money come to secure universal access? New public-sector coverage for the unemployed will demand new public revenues, as presumably will too the subsidies needed to help small business meet the costs of such mandates as may be adopted. Nothing in the law resolves the fiscal dilemmas of a high-growth, small-business, low-tax state.

Second, the implications of the AHCA’s reform for the wonderful world of private health insurance remain unclear. Health insurance regulation in Florida falls under the purview not of the agency but rather of a separate, cabinet-level insurance commission headed by an elected Republican. A player in the legislative struggles explained: “Insurance is not in the tank because it was politically impossible with an elected Republican insurance commissioner. Ideally you’d want to carve health insurance out, but not all insurance. But it’s hard to carve out just health insurance and anyhow it would have mobilized Republican opposition and it wasn’t worthwhile to try to do it.” An important source of policy fragmentation lives on, with what consequences time will tell.

Third, the state is by no means the sole captain of its fate in steering toward a new system. Its plans will require federal waivers under Medicare, Medicaid, and the Employee Retirement Income Security Act (ERISA). Whether pursued as individual exceptions or as part of new national policies, these will not come easily, yet fundamental reform cannot advance without them. Fourth, the agency may report to the governor, but none of its plans can be adopted without the approval of the legislature, a body subject to continual flux (for instance, Jones has left office and Bloom no longer chairs the House Health Care Committee) and beset by growing partisan rivalry now that Democrats and Republicans have equal representation in the Senate.

Fifth, the agency has an enormous and possibly unmanageable agenda. One price of consensus on reorganization is to devolve and defer to the new entity all of the tough questions whose tenacity in eluding legislative resolution made it tempting to buy time by means of reorganization in the first place. A quick scan of the agency’s menu of obligations shows (1) securing for each Floridian a “medical home” (a reliable source of primary care); (2) encouraging managed care; (3) pondering reforms in payment
systems; (4) proposing a basic benefits list; (5) developing Medicaid buy-ins for the uninsured and a subsidy scheme for hard-pressed small businesses; (6) figuring out what to do about purchaser cooperatives and such; (7) convening research on health outcomes and medical practice parameters; (8) offering recommendations on utilization controls; (9) using the data and recommendations to induce rank-and-file physicians to accept utilization review techniques that control the volume of services; (10) exploring the extension of certificate-of-need (CON) controls to doctors’ offices and outpatient facilities; and (11) crafting suggestions for tort reform.

Managing so broad an agenda is a prodigious organizational challenge; not surprisingly, participants and kibitzers differ on how best to proceed. A high-level AHCA official argued, “We’ve got to look at the big picture. We need fundamental change. It sounds overwhelming, and the key is you can’t get killed by details.” A hospital representative countered that the big picture is too diffuse and invites fragmentation and dissipation of agency effort. Better, he said, to concentrate on one or two major goals and take on one or two major groups, moving incrementally. Still others recall that the inspiration for the agency is the interconnectedness of health policy problems, which demands both seeing the big picture and doing many big and little things—well and in detail—simultaneously. The public will be watching and expecting great things in 1993 and 1994, proponents contend, but the law, after all, pledges that all Floridians will have access to a package of basic health care benefits by the end of 1994—and this will give the agency great clout. But suppose the public does not like what it sees?

Beneath the hardscrabble surface of these tough managerial choices lies political bedrock: Everyone favors universal coverage and cost containment but wants other public or private players to bear the major costs of achieving them. Nothing in the Florida reform reconfigures this political geology. The reform is “merely” the legislative expression of an hypothesis—that reorganization (or, as Alan Maynard would have it, redisorganization) of the public structures and processes that govern health care financing and regulation will enable the state to find the will and the way to major reform. The next two years will presumably test this hypothesis rigorously.

**Managed Competition In Florida**

In January 1993 testing began in earnest as the AHCA unveiled its preferred general model for reform: the selfsame managed competition that President Bill Clinton also proposed as a national stratagem. On 4 January the agency issued A Blueprint for Health Security, which, among other recommendations, urged that Florida build on such pooled-purchasing prototypes as the Employer Purchasing Alliance, the Florida Healthcare
Purchasing Cooperative, and the Florida Health Access Corporation by establishing community health purchasing alliances to concert the market leverage of small groups and individuals. The proposal, said the agency's director, Douglas Cook, was "a market-based partnership which will empower purchasers through the sheer volume of their activities." The premise was that "provider groups, health insurers, and managed care companies must take the initiative to reorganize the health care system at the community level."15

After colorful legislative debates, Governor Chiles signed on 29 April the Health Care and Insurance Reform Act of 1993 (consecrated by national coverage on the CBS Evening News). It created eleven Community Health Purchasing Alliances (CHPAs) and imposed significant insurance reforms on the small-group market. The law won wide notice not only because it was the first major product of the reorganization act of March 1992 but also because Florida had become the first state to adopt the reform framework favored by the Clinton administration and has thus made itself a "national model" of sorts.

The Health Care Reform Act of March 1992 put its faith in administrative reorganization. Its progeny, delivered in April 1993, expects big things of economic reorganization in the health insurance market. The newer law, like its predecessor, evokes images of glasses half full and half empty. Florida’s version of managed competition is purely voluntary: The CPHAs are available to small businesses, individual purchasers, and the state (acting on behalf of its employees and Medicaid clients) should these buyers find them useful. A legislative staffer observed that progress toward affordable universal coverage requires answers to three questions—how to control costs, how to secure access for everyone, and how to help people who cannot afford coverage—but that the recent legislation directly answers none of them. The 1993 law, like its 1992 antecedent, brought all of the major interests on board (the only significant potential losers are small insurers, whose risk-averting tactics drew near-universal disfavor in Florida, as elsewhere, and arguably physicians, whose prices may face downward pressure) and did so by imposing substantial sacrifices on no one. The law underscores the limits of state health policy innovation: Behind the heroic political crafting and drafting lies the states’ inability to decide how broader coverage will be financed and to designate the losses and losers intrinsic to successful cost containment.

On the other hand, managed competition, like the creation of the agency that promoted it, can be viewed as a crucial evolutionary step toward a consensus that probably cannot be constructed for tough measures (for instance, employer mandates or a single-payer system) until less threatening ones have been tried first. It is doubtful whether Florida’s voluntary
arrangements are a fair test of a theory that (according to Alain Enthoven) requires universal coverage and standard benefits, among other stringent field-leveling rules, in order to stand a chance of working.\textsuperscript{16} Moreover, evidence from The Robert Wood Johnson Foundation’s Health Care for the Uninsured Program (which helped to launch the Florida Health Access Corporation, among other demonstrations) suggests that voluntary efforts tend to be hobbled by very weak penetration into the small-group market, even for discounted products.\textsuperscript{17} But it may not be possible to bypass intermediate measures and go directly to a more “governmentalized” system; one can only hope—at least for now—that federalism plus incrementalism may yet constitute an evolutionary formula for affordable universal coverage.

In the meantime, onlookers understandably disagree about the significance and likely benefits of the legislation of 1992-1993. Some dismiss the measures as pseudo-reform, little more than rearrangements of the deck chairs on the Titanic. One gentle version of this position holds that “this is not a great leap forward but rather Florida positioning itself at the starting blocks for reform.” Others contend that the legislation speaks squarely to the realities of health policy today: Consensus on change remains vague, so it has to be focused; the only practical way to do so is to give policymakers and purchasers the institutional tools they need to get to work. The process may be evolutionary, noted one supporter, but both the agency’s charge and the implications of managed competition are “pretty radical.”

Florida’s reforms could turn out to be the boldest or the most timid of the leading innovator states. They could generate macrolevel change on a scale no state has yet dared, or they could end by reflecting and magnifying the many conflicts that impede reform without disclosing reliable means of resolving them. As with the other innovators (save Hawaii), it is as yet impossible to judge whether Florida’s dynamics are sound and fury that signify little or nothing or the indispensable structural and procedural preconditions of bold policy change. It would be premature indeed to dismiss the states as leaders in U.S. health policy. It would be equally hasty to pin great expectations on the policymakers now testing new political chemistry in the mysterious laboratory of federalism.

The Blurred Big Picture: Political Patterns And Policy Lessons

What, if anything, does the Florida case imply for those who want to understand and accelerate state health policy innovations, or to distill from it lessons for national policy making? An answer must be speculative because the careful comparative work needed to answer the basic question—are Florida and other leading innovators idiosyncratic individual cases, a small set whose members share properties with each other but with
few other states, or exemplars of trends that will soon be sweeping the
country?—has not been done. In the politically heady summer of 1993 the
lure of facile generalization is irresistible, however, so it is argued here that
the political patterns that sustained policy advances in Florida are also
visible in other reform leaders (notably Hawaii, Massachusetts, Vermont,
Minnesota, Washington, and Oregon) and may even offer insights about
the requisites of successful reform politics in Washington, D.C.  

First, most of the leading reform states prefaced their policy work with
numerous and protracted inquiries by commissions and task forces. These
colleges performed the same valuable roles as they did in Florida: They
educated a wide range of key actors of diverse partisan, ideological, regional,
and economic orientations in the complexities of health care reform; cre-
ated a shared vocabulary and set of foci; and laid personal and intellectual
foundations for the legislative process. Along the way, most of these states
were accused of substituting talk for action; only in hindsight is it clear how
much leisurely conversation promoted confident action in due course.

Second, the most vigorous reform states harbor enough “progressive”
sentiment to make credible the deployment of policy clubs (especially a
single-payer system) should opponents derail more moderate proposals.
Vermont, Washington, and the rest are not necessarily “liberal” places, but
they, like Florida, had liberal forces of sufficient strength to put and keep
“fundamental” reforms on the policy agenda and thereby force a steady
search for middle ground. States that have no sentiment for a whole loaf of
reform may be unable to concoct half a loaf either.

Third, the leading states were all adroit practitioners of the elusive art of
legislative-executive relations. All had governors who worked hard to
move the reform process along, and all drew strength from the work of
astute legislative leaders who mediated differences within and among the
ranks of fellow lawmakers, executive branch personnel, and interest-group
representatives. The Elaine Bloom role in Florida was played by Nadao
Yoshinaga (Hawaii), John Kitzhaber (Oregon), Patricia McGovern (Massa-
chusetts), the “Gang of Seven” (Minnesota), Ralph Wright (Vermont),
and Phil Talmadge (Washington), although these were of course leading
lights, not solo performers. This is a serendipitous variable that depends on
both the supply of legislative/executive skill in high places and the amount
of accommodation and cooperation the state’s political culture can sustain.

These modest “lessons” may have something to say about national as well
as state reform efforts. The contributions of such exploratory bodies as the
Pepper Commission and Hillary Rodham Clinton’s task force may have less
to do with arriving at airtight analytical strategies than with educating
important players of diverse values and interests and thus helping to dis-
cover ever-broader common ground in the debate about change. The most
reliable way to forge consensus on moderate reforms may be to keep alive and well the plausible threat of such “radical” steps as a single-payer system. Certainly the rising sense that such a system might be desirable and feasible as a national reform model helped powerfully to concentrate the minds of myriad interest groups and market advocates on managed competition as an alternative. Without strong presidential commitment, reform may falter, but without the deep support of well-placed legislative leaders who are willing and able to build coalitions that embrace groups as well as legislative peers, executive leadership will stall.

Florida and other creative denizens of the federal system also, however, illustrate the limits of such political lessons for policy outcomes. To date, all of the leading states except Hawaii (and perhaps Washington State) have largely dodged the toughest, truly central questions—how to finance universal coverage and keep it affordable over time. A day of political reckoning will presumably come soon. It is no more—but no less—than a hopeful conjecture that the heroic leaps of strategic faith in Florida and elsewhere will eventually prove to be preludes to affordable universal coverage.

NOTES

3. Ibid.
5. Ibid., 12.
6. Ibid., 15.
7. Ibid.
10. Ibid., 7.
11. Ibid., 38-39.
12. The quotation is an interviewee’s paraphrase of Jones’s position.
18. These reflections on patterns in the federal system owe much to conversations with Michael Sparer of Columbia University.