REPORT TO THE SECRETARY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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EXECUTIVE SUMMARY

When planning policy or programs to address the problem of uninsurance, there is a need for precise information about defined segments of the uninsured population. Recognizing this need, the State Planning Grant program of the Health Resources and Services Administration authorized funding for the 2004 Florida Health Insurance Study (FHIS). This study was intended to update findings from a previous 1999 survey and measure any changes that have occurred in that state's health insurance circumstances during the intervening five years. In addition, the planning grant was intended to assist Florida in developing a plan for providing access to affordable health insurance coverage to all its citizens. A second phase of 2004 FHIS was created in order to better understand Florida's health care safety net and assess the potential of safety net providers in forming health plans that could be used in coverage expansion efforts.

Leadership for both phases was provided by the Agency for Health Care Administration (AHCA) with subcontracts to the University of Florida and Health Management Associates.

Since 1999 the number of uninsured Floridians has increased by 700,000 people and the number of employers offering health insurance has dropped so that in some regions less than 50 percent of employees are offered insurance through their place of work. The prevalence of small business, seasonal workers, and a high immigrant population in Florida exacerbates the uninsurance problem, in comparison with other states.

The findings from FHIS 2004 and its Phase II component have resulted in a series of policy recommendations for a new health coverage option for Florida's uninsured. These recommendations suggest that a limited benefit insurance plan focused on providing comprehensive preventive and routine health care benefits at affordable rates in order to keep its members well and out of the hospital might appropriately address the problem of uninsurance in Florida. The plan would be made available in the general market in order to broaden the risk pool and appeal to the desire for market driven changes. The plan's key features would be a low premium and a requirement that the provider network include Federally Qualified Health Centers (FQHCs). The product would be marketed towards the uninsured and families with incomes between 150% and 300% of the FPL.

PROJECT OVERVIEW: OBJECTIVES AND METHODS

Phase 1: 2004 Florida Health Insurance Study

The primary objective of the FHIS Phase I project was to describe the uninsured in Florida and to propose a program or coordinated set of programs to provide all uninsured citizens in Florida with health care coverage. Three core activities are designed to meet this objective.

1. Describing the Uninsured

Survey
A second round of the Florida Health Insurance Survey (FHIS 2004) was fielded in early spring of 2004. The first round of FHIS was fielded in 1999 by researchers at the University of Florida. The survey instrument for full enumeration of each household included questions about various sources of health insurance coverage, items about employment and income, and questions about demographics, health care utilization and health status. The survey was conducted in English and Spanish and sampling ensured adequate representation of respondents throughout the state and included over-samples from African American, Hispanic and low-income populations.

Focus Groups
To augment findings from the health insurance survey, 10 focus groups were conducted throughout the state of Florida. At least two focus groups were conducted in Spanish and/or Haitian Creole. The focus groups provided a community 'voice' to the project. Participants were asked to comment about their experiences with health insurance coverage as well as on possible options to increase coverage.

2. Developing Health Insurance Options

The development of coverage options included several components.

Designing and Fielding Structured Interviews
These interviews elicited information from key decision makers (such as state officials, members of the business community, and health providers) regarding the factors they believe to be essential components of a program designed to expand health coverage to uninsured Floridians.

Review of Current Environment and Existing Options
Findings from FHIS 2004, the analysis of changes from the FHIS 1999, focus groups, as well as a review of existing coverage options, were used to identify, delineate, and prioritize gaps in health insurance coverage.

3. Disseminating Project Results

Dissemination activities included the development and distribution of printed publications. Fact sheets, issue briefs and chart packs were prepared and distributed to key stakeholders throughout the state and posted on the web.

Phase 2: 2004 Florida Health Insurance Study

A primary goal of the FHIS 2004 Phase II project was to explore the ability and feasibility of ambulatory (outpatient) care safety-net providers to organize into health plans to participate in coverage expansion efforts for low-income uninsured Floridians and to accommodate changes to the Medicaid program.

Specific tasks included:

- A survey of safety-net ambulatory care providers in three specific locations throughout the state in order to assess the infrastructure and capacity;
- Assessment of consumer interest in health plans offered by ambulatory care providers; and
- The development of a statewide strategic plan that includes a preliminary set of guidelines for community health centers, other ambulatory care safety net providers and stakeholders.

Safety Net Provider Survey

A survey of all Florida County Health Departments (CHDs) and Community Health Centers (CHCs) who are members of the Florida Association of Community Health Centers (FACHC) was conducted in order to document and describe the ambulatory (outpatient) care safety net in Florida. Overall, both CHDs and CHCs serve a large uninsured population and the major challenge these clinics face is in providing or obtaining specialty care for these individuals.

The objective of the 2004 Survey of Safety Net Providers was to assess the infrastructure and capacity of the health care safety net in Florida with the overall goal of exploring the capacity of CHCs to organize into health plans. Specifically, the survey analysis has described:

- The types of services safety net providers deliver to their uninsured patients; and
- The key challenges faced by these providers in serving Medicaid and uninsured populations.

Although CHDs were included in the survey, the main focus of the project was the CHCs in the State.

Assessment of Consumer and Provider Interest in Health Plans Offered By Ambulatory Care Providers

Five focus groups were conducted by Health Management Associates (HMA) with uninsured consumers in three regions of the state. The purpose of focus groups with the uninsured was to learn more about people who do not have health insurance, the issues and problems they face, and services provided by safety net providers utilized by the uninsured. We wanted to learn where, when, or if individuals without health insurance obtain health care and if they would be interested in insurance programs that could be offered by safety net providers.

In addition, one focus group with representatives from ambulatory care safety-net providers was held. The purpose of the focus group with representatives from ambulatory care safety-net providers was to explore the feasibility and interest of developing health insurance programs that can be implemented and offered by community health clinics. Participants were asked what they thought an ideal benefit package would be, the organizational structure needed to provide such a package, and their interest in adopting practices to improve efficient delivery of health care services. The group was also asked what funding options would best fit their needs in serving the uninsured and if there was any interest in pursuing a range of funding options such as subsidized health insurance and blended funding streams.

FINDINGS AND RESULTS

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

Telephone Survey Findings

Currently, there are over 2.7 million uninsured Floridians under the age of 65, an increase of nearly 700,000 people since 1999. This figure represents 19.2 percent of the state's non-elderly population, or one-fifth of all non-elderly Floridians.

Income: Individuals in families with lower incomes are more likely to be uninsured. More than a third of individuals in families with annual incomes of less than $25,000 are without health insurance, compared to less than five percent of people in families with an annual income of $95,000 or more.

Age: Rates of uninsurance vary by age. Overall, children have lower rates of uninsurance than adults. Preschoolers (age 0—4 years) have the lowest rate at 8.1 percent. Among adults, the highest rate is among young people age 19 to 24; over a third of this group (35.1 percent) lack health insurance coverage. Among adults nearing retirement (age 55—64), 13.3 percent are without health insurance. Generally, 12.1 percent of Floridians

under age 19 years are uninsured compared to 22.2 percent of Floridians between age 19 and 64 years.

Gender: Overall, there are slight differences in rates of uninsurance for women (18.0 percent) and men (20.5 percent). However, there is also regional variation. In District 10 (Hillsborough County), there is a higher rate of uninsurance among women (14.9 percent) than men (13.4 percent). The largest difference is in District 14 (Charlotte, Collier, and Lee Counties) where 21.2 percent of women and 27.4 percent of men lack coverage.

Family Composition/Marital Status: Married individuals have an uninsurance rate of 15.9 percent. By contrast, individuals who are widowed, divorced, separated, never married, or who live with an unmarried partner have strikingly higher uninsurance rates ranging from 23.0 percent to 38.9 percent.

Health Status: A relatively small number of uninsured Floridians (2.6 percent) cited medical problems and/or pre-existing conditions as the 'main reason' for not having health insurance.

Employment status (including seasonal and part-time employment and multiple employers): Looking at employment status for working aged Floridians, the highest rate of uninsurance is among those who are unemployed (out of a job and actively looking for work), almost half of whom (48.1 percent) lack coverage. Of those with jobs, the highest rate of uninsurance is among self-employed people (32.0 percent) followed by part-time employees (26.1 percent). Among full-time employees, 15.7 percent lack coverage. While this pattern generally holds throughout the state, some regional variations for particular employment groups are substantial.

Availability of private coverage (including offered but not accepted): About 13.6 percent of Florida's working uninsured who have insurance available through the workplace are ineligible for coverage that is available to some employees. Additionally, 12.7 percent decline employer-based coverage because it is too expensive, while 4.5 percent decline for other reasons. A very small number of uninsured Floridians (one percent) cite that they 'don't believe in insurance' as the 'main reason' for not having heath insurance. Additionally, 5.8 percent of Floridians assert that they don't need insurance and/or are usually healthy as the main reason for not having health insurance. Less than one percent says that readily available free or inexpensive care is the main reason for not having health insurance.

Availability of public coverage/Medicaid history: Among people who are currently uninsured, 27.3 percent have previously been enrolled in Medicaid. Among uninsured children, about half (49.6 percent) have been enrolled in Medicaid, and among uninsured adults age 19—64 years, 22.2 percent have had some period of enrollment in Medicaid.

Race/ethnicity: Statewide, Hispanic Floridians have the highest rate of uninsurance at 31.8 percent. About 22.6 percent of Blacks are without health insurance, as are 19 percent of those in other racial groups (including American Indians, Alaskan Natives, Pacific

Islanders, and non-Hispanic mixed race). White non-Hispanics have the lowest rate of uninsurance: about 14.3% lack coverage.

Immigration status: Florida adults born outside the United States have a rate of uninsurance double that of those born in the United States (37.9 percent vs. 17.5 percent).

Geographic location (as defined by State -- urban/suburban/rural, county-level, etc.): Miami-Dade County now has the highest rate of uninsurance in the state at 28.7 percent. Most districts stayed the same or had an increase since 1999, with slight decreases in rates being observed in District 3 (Alachua and Marion Counties) which went from 18.3 percent to 17.1 percent and District 13 (the rural counties around Lake Okeechobee) which dropped from 25.5 percent to 24.4 percent. Rates in other parts of the state vary from 13.7 percent to 24.4 percent.

Duration of uninsurance: For Floridians without health coverage, it appears to be a persistent situation. More than half of those without coverage (54.1 percent) report having been uninsured for more than a year, and another 18.9 percent never had insurance.

OTHER:
Firm Size of Employer: There is a strong relationship between employer firm size and uninsurance. Among those working full time for small firms of four or fewer employees, over a third (36.3 percent) lack coverage. (This includes full-time self-employed people). Among those working for large employers, only 5.2 percent are without coverage.

Education: The rate of uninsurance declines with increasing education. Statewide, about half of adults with less than a high school education are uninsured (49.5 percent) compared to only 10.7 percent of those with a bachelor's degree or higher. Uninsurance rates for adults who have less than a high-school diploma vary from a low of 35.3 percent in District 5 (Clay, Flagler, Nassau, St. Johns, and Volusia Counties) to a high of 65.1 percent in District 14 (Charlotte, Collier, and Lee Counties).

Focus Group Findings

When asked about the cost of an affordable health care plan, many participants declined to name a dollar figure, but were quick to point out the trade-offs between costs paid up front as premiums and expense at the time of an office visit or hospital stay. They asked exactly what services would be covered, attempting to weigh the cost-benefit ratio. There was the sense that no matter how affordable the premium may be, hidden costs would always arise in the form of co-pays, drug costs, etc. Some expressed interest in a sliding-scale premium based on the purchaser's income level.

> ***"For one person, $35 for the health insurance."***
> —Tampa Bay Uninsured Group

"Say the insurance costs me $30 a month, how cheap. But what good does it do? Nothing, nothing. Normally a visit costs $100, we will give you $10 off, you have to pay $90….then the doctor…will charge $110 so that they get $100 from you, right?

—Miami Hispanic Uninsured Group

When asked about availability of Medicaid and public programs for which they might qualify, some had applied for Medicaid and been denied or became mired in the paperwork. When it came to public coverage, some participants expressed frustration that each family member had to go through the process of qualifying separately.

"Now I took everything she asked for and now she comes to me like, uh, uh, physical address. I said what do you mean by physical? Where you stay. I gave her the address. Well, we need it on a light bill, or water bill or phone bill, or gas. I said well we have a P.O. Box, so what do I do now?"

—Palm Beach African American Uninsured Group

Those who could get health insurance through their employer or some other means were asked why they do not purchase this insurance. Cost was overwhelmingly the most common reason given for lack of coverage, mentioned spontaneously in every group. Some also reported that they did not feel they had benefited from insurance coverage that they had in the past, and dropped it in order to save money. Some reported that pre-existing medical conditions limited their ability to obtain coverage.

"A member from the [insurance] company came...and they discussed with the bosses there and the problem was that we had to pay $130 quote, I think it was every month…"

—Miami Hispanic Uninsured Group

When asked if the State should require employers to offer health insurance to all employees, most participants gave positive responses. They saw insurance benefits as one of the requirements for a desirable job. They were positive about a state-mandated requirement for employers to offer coverage. There were very mixed responses as to whether state-run programs were preferable. While some participants felt the state was responsible for the health of its people, others felt the state would do a poor job administering a program.

"Yes, that's very important."

"It should be obligated. Just like it's mandated to pay taxes. The company should be encouraged to insure its employees; they should report how many employees are insured."

—Miami Hispanic Uninsured Group

The most positive response to a state-sponsored limited-benefit plan (Health Flex) was that some health insurance was better than no health insurance. Participants also

expressed understanding that this program was targeted to people with jobs, with an eligibility threshold higher than for Medicaid and other public programs.

Participants reported being unable to obtain medical care when they needed it, and seeking care only when pain or other symptoms made treatment mandatory. Forgoing screenings and preventive care was a common strategy for limiting medical costs. For these people, health concerns are just one competing demand on their resources.

Participants reported using various strategies for addressing their urgent medical needs. These included county health departments, hospital emergency rooms, private doctors willing to work out a payment plan, free clinics staffed by volunteers, and WeCare programs. In many cases, participants reported the frustration of long waits and many turn-downs in order to be seen. They described a patchwork of care, seeing different providers at each encounter, with little continuity of care, probably no follow-up after the presenting medical crisis is resolved, and no "medical home." Some complained at having to repeat their entire medical history every time they visit a provider.

The primary complaint about any insurance product, including limited benefit plans was cost, especially co-payments and prescription drug costs. Participants seemed less concerned with exactly which benefits were included as whether they would continue to have to pay out of pocket at each visit. Additionally, participants understood the idea of a "limited benefits" plan, but were unclear about how the benefits would be rationed. Many said that prescription drug benefits were essential to make any package attractive to them. Many said that they wanted comprehensive coverage.

> ***"I think that should include dental care, such as dental hygiene. You know, getting your teeth cleaned and checked, x-rayed, that kind of thing cause your teeth are important."***
>
> —Panama City Uninsured Group
>
> ***"Everything."***
>
> —Miami Hispanic Uninsured Group

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

Across the state of Florida, 73.1 percent of employed individuals report that their employer or union offers health insurance coverage. This ranges from a low of 62.8 percent in Miami-Dade County (District 17) to a high of 81.4 percent in Duval County (District 4).

Telephone Survey Findings

Employer size (including self-employed): Employees of larger firms are more likely to be offered health insurance coverage than employees of smaller firms. Statewide, 95.1 percent of individuals who work for firms with 1,000 or more employees report that their

employer offers health insurance to at least some employees. By contrast, only 17.3 percent of workers in firms with four or fewer employees are offered coverage.

Industry sector: Offers of health insurance vary by the type of industry in which a firm is engaged. The lowest rates of offers of employer-based health insurance are found in hotel/restaurants (59.7 percent), construction (46.8 percent), agriculture (44.2 percent), and other services, such as laundry, beauty or barbershops, and funeral homes (43.6 percent). The highest rates are found in education (88.7 percent), public administration (95.3 percent), and mining/fuel refining (97.2 percent).

Employee income brackets: Workers with annual job earnings of $20,000 or more were most likely to report that their employer offers coverage, with over three-quarters reporting offers of coverage. Among workers with annual job earnings of less than $15,000, rates of offer range from 45.3 percent to 62.8 percent.

Percentage of part-time and seasonal workers: Across the state, 77.2 percent of persons employed full-time (35 hours or more per week) report that their employer or union offers a health insurance plan to at least some of their employees. Only 52.9 percent of persons employed less than full-time report that their employer offers coverage.

Geographic location: The highest rates of employer offers of health insurance (for both full and part-time employees) are in District 4 (Duval County) while the lowest rates are in District 17 (Miami-Dade County).

Eligibility for Coverage: In general, if employers offer a health insurance plan to any employee, they extend that offer to all employees. Among Floridians working for employers who offer health insurance, most (91.6 percent) are eligible to participate.

Family Coverage: When employers offer a health insurance plan as part of employee benefits, most (79.3 percent) provide access to family coverage.

Cost of policies/level of contribution: Among Floridians who participate in employment-based health insurance, the median employee share of premiums is $151.55. Ranking employees by the amount of their share of employment-based premiums reveals that 25 percent of the employees who pay the most spend $280 or more per month for coverage. The 25 percent of employees who pay the least spend $77.94 or less.

Percentage of employees offered coverage who participate: About 13.6 percent of Florida's working uninsured who have insurance available through the workplace are ineligible for coverage that is available to some employees. Additionally, 12.7 percent decline employer-based coverage because it is too expensive, while 4.5 percent decline for other reasons. Participants from the focus group had a difficult time articulating what would be an affordable premium

Focus Group Findings

Price was the primary reason cited by employers for not offering health insurance or discontinuing health insurance. A business owner noted that if you try to price your service to cover the cost of health insurance, then your service price is not competitive. Pre-existing [health] conditions were cited as another barrier to acquiring affordable insurance. Rate increases reported to be up to 20—30 percent a year influenced several employers to stop offering health insurance. One participant mentioned that their company experienced insurance scams for small group/individual insurance.

In the face of economic downturn or increased costs, it can be expected that more employers will drop health insurance as a benefit of employment. Employers expressed interest in tax incentives and a mandate to offer health insurance. Those who currently offer insurance felt that these approaches would ‘level the playing field.’

SECTION 3. HEALTH CARE MARKETPLACE INCLUDING A DESCRIPTION OF THE AMBULATORY CARE SAFETY NET

Florida's Health Care Marketplace

Florida's healthcare marketplace reflects the characteristics of Florida's economy, the size of its businesses and the demographics of its geographic features as well as its retired and ethnic populations. These factors have been well documented in the 1999 FHIS and the 2004 FHIS, but have affected the state's efforts to extend healthcare coverage and policy for many years in the past.

Healthcare has become the largest industry in Florida. In fact, Florida's health care industry is over $92 billion and health care expenditures are about 17.8 percent of the Gross State Product. Florida's population has the nation's highest percentage of elderly, and their Medicare funds have contributed to the increase in the healthcare industry (24.8 percent comes from Medicare). Before healthcare became the largest industry, tourism was the largest component of the economy followed by a strong agricultural segment. Florida's economic history and base does not include the type of large, industrial-based and unionized businesses and workforce that is found in many mid-western states. Instead, small businesses and self employed individuals have been typical and a critical factor in the high level of uninsured.

The primary source for health insurance coverage for working age individuals in Florida has traditionally been the employer and continues to be the employer, but the 2004 FHIS found that the number of employed Floridians who reported that their employer offered health insurance coverage eroded since the 1999 FHIS study, from 62.7 percent in 1999 to 56.4 percent in 2004. In some parts of Florida employment-based health insurance rates are now below 50 percent. Many employers and small businesses have not been able to acquire health insurance at rates comparable to the large employers who can spread risk over larger populations. The nature of the tourism and agricultural industries has introduced many seasonal jobs, part-time, low-wage, transient and migrant employment. The 2004 FHIS found that:

- Employment status is critical with those individuals employed full-time having the lowest rate of uninsurance (15.7 percent), part-time employed (26.1 percent), exclusively self-employed (32.0 percent) and unemployed (48.1 percent).
- Employees of larger firms are more likely to be offered health insurance coverage than employees of smaller firms. Statewide, 95.1 percent of individuals who work for firms with 1,000 or more employees report that their employer offers health insurance to at least some employees. By contrast, only 17.3 percent of workers in firms with four or fewer employees are offered coverage.

Income status is not only related to the percentage of uninsured, it is a critical component of the policy options selected in Florida:

- Rates of uninsurance increased slightly or were stable for people at either end of the income spectrum, but increase markedly for middle income families, especially working families with annual incomes between $15,000 and $45,000.
- Florida's Health Flex program and KidCare programs, for example, have an income limit of 200 percent of the Federal Poverty level. The data suggest questions on the potential need for these programs for people in the next income brackets.

At least two additional factors are important to understanding the Florida marketplace—racial and ethnic factors and the diverse geographic demographics. Racial and ethnic disparities in the rates of health insurance coverage are documented with Hispanic uninsured at 32 percent, Black at 23 percent and Non-Hispanic White at 14 percent. Florida's geography includes high density population areas, but also includes rural areas with fewer traditional health insurance products available. One illustration of this point is the number of health plans in the Medicaid program. While some counties have 8-12 comprehensive HMO's and health plans providing coverage, about half (33 of 67 counties) have no HMO or health plan providing coverage. These rural counties rely on the safety-net providers of county health departments, FQHCs, rural health clinics and hospitals.

One area where Florida achieved progress from 1999 to 2004 was with children under the age of 19. Here the rate of uninsurance dropped from 13.9 percent in 1999 to 12.1 percent in 2004.

Increases in the number of uninsured, rising health care costs, and the uncertainty of any major coverage expansions in the foreseeable future mean that most uninsured Floridians will continue to rely largely on the health care safety net, including the hospital emergency room and health clinics for medical care. Developing new coverage options is crucial, not only to ensuring that individuals are able to access health care, but also to preserve and enhance the health care safety net.

Ambulatory Care Safety Net

This section summarizes findings from the safety net survey.

Organizational Challenges

The main challenge encountered by both CHDs and CHCs was obtaining specialty care for patients, cited by 87 percent of respondents. The top specialty services that organizations had difficulty obtaining included physical therapy, dermatology, endocrinology, orthopedic care, restorative dental care, cardiology, oncology, mental health treatment and counseling, and occupational/vocational therapy. Sixty-six percent of respondents cited patient complexity and social and economic issues as a challenge and 64 percent cited financial issues. In contrast, meeting governmental requirements, physical/plant building issues, and technology needs posed no challenge to either type of organization. Compared to CHCs, a greater percentage of the CHDs reported that they

had “major challenges” with clinical staff recruitment/retention, writing grants/securing non-federal funding, patient transportation, obtaining diagnostic testing for patients, and patient compliance with clinical recommendations.

Percent reporting a major organizational challenge	All Sites N=67	CHC N=16	DOH N=51
Obtaining specialty care for patients	86.6	87.5	86.3
Financial issues	64.2	68.8	62.7
Patient complexity—social and economic issues	65.7	68.8	64.7
Patient complexity—clinical	50.7	56.3	49
Obtaining clinical procedures needed by patients	53.7	56.3	52.9
Physical plant/building issues	35.8	50.0	31.4
Technology needs	20.9	50	11.8
Clinical staff recruitment/retention	53.7	43.8	56.9
Support staff recruitment/retention	35.8	37.5	35.3
Patient transportation	46.3	37.5	49.0
Appointment no-shows	38.8	37.5	39.2
Writing grants/securing non-federal funding	52.2	37.5	56.9
Obtaining diagnostic testing for patients	37.3	31.3	39.2
Patient compliance with clinical recommendations	34.3	25	37.3
Meeting government requirements (e.g. HIPAA, other)	10.4	6.3	11.8

* Percentages do not total 100 because respondents could choose multiple answers.

Disease Management Programs

About 43 percent of the organizations operated a formal disease management program. The most common type of disease management program was diabetes followed by asthma and mental health conditions. CHCs were more likely to operate a formal disease management program than CHD clinics. Disease management is an approach to reducing healthcare costs and improving quality of life for individuals with chronic diseases. This reduction of costs is achieved through the coordination of providers and procedures concerned with the care of an individual enrolled in the program.

Patient Care Access Tools

About 94 percent of the organizations used computer-based systems for scheduling appointments and verifying Medicaid eligibility. Only 3 percent of all organizations utilized a computer-based system for tracking emergency room visits and less than 2 percent had computer-based systems for profiling hospital admissions and emergency department use by primary care physicians. Overall, CHCs have more comprehensive computer-based systems.

Access

Seventy-two percent of CHDs and CHCs accept walk-in patients on a limited or restricted basis, 19 percent always accept walk-ins, and only 3 percent never accept walk-ins. Typical restrictions include full capacity, primary care appointment slots filled, and walk-in slots filled. Only 2 percent based acceptance of walk-ins on insurance status. Sixty-six percent of organizations sometimes turn away care-seeking patients, while 22 percent never turn away patients. On average, both kinds of organizations have about 2,550 appointment slots available each week, and 79 percent reserved some slots specifically for walk-ins. Overall, CHDs are more likely to accept walk-ins than CHCs.

Language

While 87 percent of all organizations indicated that they have patients who prefer to speak a language other than English during their medical visits, only 22 percent of the patient population actually preferred to do so. Spanish was by far the most common language spoken other than English, followed by Haitian Creole. Interestingly, both kinds of organizations did not use formal interpreters during medical visits. Instead, the majority used family or a companion to interpret, or staff and providers without interpretation training. Overall, more CHC patients prefer to speak a language other than English than CHD patients.

Services for the Uninsured

Although 84 percent of all organizations indicated that uninsured patients are required to pay for health care services on a sliding scale, more than half indicated that patients receive services without regard to payment or financial arrangements. Less than 8 percent require patients to pay a deposit prior to their visit. The majority of organizations did not subsidize services for uninsured patients, and if provided, these services were offered through other organizations. The most common subsidized services offered at other organizations are laboratory services (37 percent), followed by radiology services (36 percent) and then specialty medical services (24 percent).

Eighty percent of all organizations indicated that the CHDs, followed by Free/Volunteer clinics and Community Mental Health Centers, are the most common types of programs available that address the issue of uninsurance in their area. Although CHCs have more patient visits and accept more walk-ins, 88 percent of both CHCs and CHDs agree that the CHD is the most common type of health care program for the uninsured in their area.

Summary

In general, the survey showed that both CHDs and CHCs serve a large uninsured population and their major challenge is obtaining specialty care for those individuals. Organizations reported that they had a big problem getting dermatology, endocrinology, orthopedic, and oncology care.

Specifically:

- More CHCs (56 percent) operate a formal disease management program than CHDs (39 percent). The top two types of disease management programs for both are diabetes and asthma.
- Both types of organizations utilize comprehensive computer-based systems to facilitate patient care access.
- Both CHCs and CHDs readily accept patients who walk in without an appointment, but are restricted by capacity limits.
- To serve the high percentage of patients who prefer to speak a language other than English, CHCs (81 percent) mainly utilize physicians who speak the language fluently and CHDs (65 percent) mainly utilize other staff without interpretation training.
- MediPass and Medicaid Health Maintenance Organizations (HMOs) are the top two contractors of both CHCs and CHDs.
- CHCs (63 percent) and CHDs (53 percent) provide uninsured patients with health care services without regard to payment or financial arrangements and CHDs more commonly than CHCs subsidize off-site health care services.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

Recent Health Policy Reforms

Throughout the last two years, Medicaid reform issues have dominated the time of stakeholders and the Legislature. However, these discussions have also involved several safety-net issues involving local governments and their initiatives. Changes were also made to the KidCare program. At the same time, prior efforts on purchasing pools, the Health Flex Program and insurance reforms received less attention.

The Medicaid restructuring, the Section 1115 Research and Demonstration Waiver and subsequent Legislative authorization for implementation did not have an objective to expand coverage for the uninsured. However, one aspect of the waiver, the Low Income Pool (LIP), clearly had major implications for the safety-net hospitals and providers in the state. At the time of waiver application, the Florida Medicaid program was distributing approximately $700 million to local safety-net hospitals and providers through the hospital inpatient Upper Payment Limit (UPL) program, for which the state matching share came from Inter-Governmental Transfers (IGT's) by county and local governments.

The $700 million UPL support to the safety-net providers would have been at risk of being greatly reduced when the Florida Medicaid Reform program placed its population in capitated managed care plans. Federal regulations would not allow a managed care day to be counted towards the UPL amount. The Disproportionate Shares Hospital (DSH) program was not similarly at risk.

Florida sought to continue this funding and negotiated an amount of $1 billion each year for five years for a Low Income Pool (LIP) to continue and improve support for the safety-net services to the indigent and uninsured. The Special Terms and Conditions of the 1115 Waiver allow that "these healthcare expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured."

The Legislature and policy makers have debated the distribution methodology for the LIP funds and provided a plan to CMS and authorized LIP Council to make recommendations to the Legislature. In the recent 2006-2007 Appropriations Act, the non-hospital ambulatory safety-net providers, primarily FQHC's, found significant increases. Last year the FQHC's received $7.27 million in UPL funds. Under the first year of the Medicaid Reform Waiver LIP program, they received the $7.27 million plus an additional $8 million. In addition, there was a $1 million allocation to the St. Johns R.R.H.N. of which $600,000 was for services in Baker, Clay and Nassau counties, the rural component of the pilot for Medicaid Reform. The remainder of the $1 million was to be equally divided between Bradford and Union Counties to expand primary care services to low income, uninsured adults.

The majority of LIP funds distributed to hospitals support and supplement many community-wide hospital and county systems that include out-patient and primary care components, funded through special taxing districts, property taxes or sales taxes. The Hillsborough County Health Plan, North and South Broward Hospital Districts and the Jackson Trust are all examples of extensive safety-net systems, and primary recipients of Low-Income Pool funds.

For the new $8 million non-hospital share, the Agency for Health Care Administration and the FACHC are currently working on the allocation for the new funds to be used for the extension of primary care and preventive services to the uninsured and in rural and underserved areas of Florida.

Other allocations resulted in a $1 million block of LIP funds, divided equally at $200,000 each, specifically going to serve uninsured individuals in Sarasota, Charlotte, Lee, Okaloosa and Walton Counties.

Community Health Centers as a Vehicle for Coverage Expansion

Community health centers and local health department clinics are commonly sited as sources of care within the health care safety net. Both sources are designed to meet the healthcare needs of the medically underserved and as such play an integral role in providing care for the uninsured. A 'Federally Qualified Health Center' (FQHC), or community health center, is a community-based health organization that provides comprehensive primary health, oral, and mental health/substance abuse services to persons in all stages of the life cycle. County health departments often offer clinical services in primary care, family planning, HIV care, maternity care, sexually transmitted diseases, and tuberculosis control. Many of these services are offered as part of publicly funded programs such as WIC Nutrition (Women, Infants, and Children), Healthy Start, MomCare, and Florida KidCare. Community Health Centers (CHCs) are located in medically underserved areas, including many urban neighborhoods with large numbers of poor and minority residents, and receive federal funding to provide care to uninsured patients. But even when safety net providers, such as CHCs, are present, a large number of uninsured people apparently are unaware of them as places to receive affordable medical care, including many uninsured that are poor and have a high need for medical care. Safety-net providers are a critical resource for uninsured individuals and it makes sense to assess their organization, types of services delivered, and their ability to offer and manage limited benefit plans and other potential coverage options. Safety-net providers are an ideal place to start reaching out to low income uninsured individuals who need care and cannot access other providers.

The literature consistently shows that CHCs are excellent health care providers that deliver care that is equivalent or better than the quality of care provided at other provider types. In 2004, 53 percent of the individuals served by Florida CHCs were uninsured.[1] A primary goal of the FHIS 2004 Phase II project is to explore the ability and feasibility of

[1] *Hall, Bell, and Lemack. "Analysis of Survey of Safety Net Providers." March 2006.*

ambulatory care safety-net providers to organize into health plans to participate in coverage expansion efforts for low-income uninsured Floridians and to accommodate changes to the Medicaid program.

On March 3, 2006 a meeting of the FHIS II Statewide Steering committee was held at the Winter Park Health Foundation to unveil the Florida Health Insurance Study 2004 Phase II research results. FHIS II steering committee members invited the Health Council of Central Florida's Orange County Health Planning Partnership (OCHPP) System of Care work group members to join in the discussion. The OCHPP has identified access to affordable healthcare as one of its priority areas, and the members were invited in order to learn and participate in the discussion. The results of the FHIS II were successful in generating a thoughtful and frank conversation about services to the uninsured and the difficulty in marketing solutions.

Of the variety of issues and options that were discussed, one alternative coverage option for the uninsured drew considerable interest from the group. The 'Care Access Health Plan,' Inc. was formed to provide a licensed limited benefit coverage alternative. The plan's goal is to respond to the need for a new managed care solution that delivers defined comprehensive preventive and routine health care benefits at affordable rates; providing care to keep its members well and out of the hospital.

Care Access took a unique approach to Chapter 641, Part II (known as the Prepaid Health Clinic statute) when it applied for its Office of Insurance Regulation (OIR) license. As approved by OIR, Care Access offers a comprehensive list of preventive care services for primary and specialty physician care, urgent care, prescription medication, routine outpatient ambulatory surgery, behavioral health, hearing and vision services, diagnostic treatment, and other preventive health care services by utilizing a large network of credentialed private practice doctors rather than local clinics. By the requirements of the statute, Care Access does not provide inpatient hospital services. Defined insured hospital benefit coverage may be obtained through Care Access' strategic alliance partner Markel Insurance Company, an A-Rated insurance company licensed in Florida; or through other licensed companies that offer stand-alone hospital defined or catastrophic insurance products.

The group decided that one option for coverage expansion would be to create a limited benefit plan to be made available in the general market (similar to the Care Access plan). This will broaden the risk pool and appeal to those who desire market driven changes. Also, this option will not require any special approvals. The plan's benefit package would be determined by the company that administers, markets, and sells the plan. The plan would emphasize culturally (language) appropriate care in the provider network. The plan's premium would be no more than $60 per month, which would clearly limit the benefit package. The provider network would be required to include local community health centers. Outreach efforts for this product would target uninsured individuals and families with incomes between 150% and 300% of the FPL. Using county-based funds, this program would subsidize this offering for those who are uninsured for 6 months or

more, for a limited period of no ore than 3 years, with a phased-out subsidy. The subsidy would be offered directly through the employer if possible or directly to the insurance carrier or broker. Oregon has successfully provided the subsidy directly to uninsured individuals, proving this as a viable option. The subsidy would come from local dollars, possibly matched through funds from the low-income pool described above since a portion of those monies are to be used to support the ambulatory care safety net.

SECTION 5. CONSENSUS BUILDING STRATEGIES

Florida has been a HRSA State Planning Grantee for about three years and during that time there have been several consensus building strategies at the state and community levels. In August, 2003 Florida undertook two initiatives designed to address the various issues associated with lack of access to affordable health insurance. One initiative, the Governor's Task Force on Access to Affordable Health Insurance, which was identified in the proposal application for the current HRSA SPG program grant, was created by Governor Jeb Bush on August 25, 2003 through Executive Order 03-160. The other initiative began when House Speaker Johnnie Byrd created the House Select Committee on Affordable Health Care for Floridians, August 14, 2003, to address the issue of access to employer-based health insurance. Both the Task Force and Select Committee received public input at each of these meetings and heard presentations from experts in the field of health care coverage options.

Both the Task Force and Select Committee produced final recommendations, a number of which were the same or similar. Many of the recommendations were authorized by the 2004 Legislature although the final form of the legislation departed from the recommendations in some instances. Tables 2, 3 and 4 summarize the recommendations and the final outcomes from the 2004 legislative session. Ultimately, eleven recommendations designed to increase access to affordable health insurance or to address factors associated with the increased cost of health insurance were enacted.

Table 2: Health Care Coverage Options and Related Initiatives Recommended by both the Task Force (TF) and Select Committee (SC)

Recommendation	Enacted Legislation
Establish purchasing pools for small employer groups. (TF) Establish purchasing pools for micro- groups. (SC)	HB 1629
Expand the Health Flex Plan Program statewide.	HB 1629
Promote initiatives that increase the use of evidence-based medicine by physicians and health care institutions. (TF) Promote initiatives that increase the use of evidence-based medicine. (SC)	HB 1629
Encourage the development of electronic medical records by providing financial incentives and promoting the use of digital technology and information systems. (TF) Require the use of technology supporting a single medical record. (SC)	HB 1629

Table 2: Health Care Coverage Options and Related Initiatives Recommended by both the Task Force (TF) and Select Committee (SC)	
Create a new, appropriately designed health insurance residual market ("risk-pool".) (TF) Establish a health insurance residual market. (SC)	HB 1629
Utilize licensed agents as frontline educators of consumer protections and contact points for information distribution. (TF – part of the Consumer Protection and Information Recommendation) Allow insurance agents and brokers to act as true insurance consultants serving the consumer's needs. (SC)	HB 1629
Healthcare providers and/or private health coverage carriers should ensure consumers have access to information designed to educate them about health insurance coverage and to assist them in making informed health care purchasing decisions and adopting healthy lifestyles. (TF) Promote the use and development of consumer driven healthcare products: Ensure that consumers have the information they need to make necessary decisions. (SC) Provide consumers with health care information that is needed to make wise spending decisions. (SC) Promote healthy lifestyles. (SC)	HB 1629

Table 3: Health Care Coverage Options and Related Initiatives Recommended by the Task Force (and not by the Select Committee)	
Recommendation	**Enacted Legislation**
Encourage the development of local health care programs for individuals lacking health insurance.	HB 1843 SB 708
Focusing on federal Health Insurance Flexibility and Accountability (HIFA) waivers, explore a comprehensive plan to restructure the Medicaid program to improve access to health care coverage for Florida residents.	Removed from final bill
Determine if there are additional ways, within available resources, to further support the viability of the crucial safety-net providers.	HB 1843 Appropriations Bill – page 48
Develop mechanisms for tracking the success of efforts to reduce the percentage of the uninsured.	No specific legislation
Encourage enrollment in the KidCare program and consider what can be done to fund it in recognition that the program will need to be reauthorized by Congress in three years.	HB 1837 HB 1843 SB 2000

Table 4: Health Care Coverage Options and Related Initiatives Recommended by the Select Committee (and not by the Task Force)	
Recommendation	**Legislation Enacted**
Develop a premium assistance program for employer-sponsored coverage.	No legislation.
Minimize inappropriate utilization of emergency services.	HB 1629
Allow more flexibility in tailoring plans based on individual needs.	No specific legislation

The work of the Task Force and Select Committee completed in early 2004 forms the framework for Florida's ongoing efforts to reduce the rate of uninsurance in the State. The current HRSA grant-funded analysis of coverage options will include an analysis of each of the options selected for expansion or implementation in Florida enacted during the 2004 session. While this analysis will include identification of additional methods to strengthen Florida's "safety-net," readily available data does not include the level of detail necessary to comprehensively assess and analyze this complex system.

Other consensus building activities vary from qualitative data collection such as focus groups, structured interviews and key informant interviews to local community policy development meetings and roundtable discussions during which local stakeholder buy-in was sought. The roundtable discussions allowed health care administrators, advocates, and experts to come together and talk openly about the challenges that will be faced in the effort to create a new coverage option for the uninsured.

Two major barriers in obtaining health insurance coverage previously identified in Phase I of the 2004 FHIS continued to surface during the Phase II focus groups with the uninsured. Premiums that are not affordable and the exclusionary provisions for pre-existing health conditions were issues that were raised in all the Phase II focus groups conducted with the uninsured. Additionally, the need for preventive care, primary care, prescription drugs, diagnostic tests, inpatient hospital care, dental care and eye glasses were consistent topics in each group.

The need and desire for affordable comprehensive health insurance coverage was persistent and perceivably more urgent than in past focus groups with uninsured consumers. Focus group moderators noted that the issues and problems mentioned by the participants in the FHIS Phase II focus groups with the uninsured were very similar and in some cases identical to each other and to the issues and problems stated by the uninsured consumers in focus groups held in 2003.[2] The focus groups provide detailed information which will be valuable to the creation of a new coverage option that reflects the needs and realities of safety net providers and the uninsured in Florida.

[2] *Health Management Associates. "Focus Group Findings" The Florida Health Insurance Phase II Project, December 2005.*

Focus group representatives from the Orange County area ambulatory care safety-net providers were primarily physicians. This group indicated that Health Flex type plans are not the answer for the low-income uninsured. There was agreement that access to health care, not necessarily health insurance, would better motivate their clients to seek preventive and primary health care. Current capacity is being exceeded in many cases and the need already exists for more space, more staff, larger provider networks, and access to specialty care providers. These needs would greatly increase if health insurance programs were offered and implemented by community health clinics, and if premiums and benefits offered were found desirable to the low-income uninsured. However, focus group participants speculated that participation in these new health insurance plans would be low. Safety-net provider representatives suggested that consumer and provider education programs would be necessary to increase consumer awareness and ensure participation in any new project or program. The Federally Qualified Health Center and County Health Department representatives expressed concern about the continuation of cost based reimbursement for their Medicaid clients. In the midst of Medicaid reform these funds that enable clinics to provide care to the uninsured may be put at risk.

The providers were very complementary of the Orange County Primary Care Access Network (PCAN). PCAN is a joint effort between Orange County Government, primary health care centers, community agencies, hospitals and other social services. PCAN's mission is to improve the access, quality and coordination of health care services to the underinsured and uninsured populations of Orange County. The providers that participated in the Orlando focus group advocated the expansion of PCAN to other areas to serve even more of the uninsured, and suggested that PCAN be used as a model for other areas in the state. Partially because of the high regard for PCAN and other community health centers, as well as the involvement of the Florida Association for Community Health Centers, there was strong consensus around using the ambulatory care safety net as a mechanism for coverage expansion.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

Several lessons emerged from the process of implementing both phases of the Florida Health Insurance Study.

First, state specific data proved to be very useful in the development of options for health insurance coverage. However, increasingly officials in counties and other localities wanted to use the data to assist in developing county-based options. Some counties, anticipating the need for such data had paid for additional sample for their respective counties. For counties without sufficient sample, it was difficult if not impossible to provide certain subgroup estimates necessary for planning. Since, increasingly the options for coverage expansions are being developed at a local level, states may wish to design surveys that support county and local subgroup estimates.

Second, to increase response rates from safety net officials and obtain high rates of participation, obtaining buy-in from a senior official (in the case of the local health

departments) or from an industry official (in the case of the community health centers) was crucial.

Third, Florida's health policy agenda has been strongly guided by the introduction of Medicaid Reform. As attention to Medicaid increased in Florida, as is the trend throughout the country, the state ran the risk of losing policy momentum to create programs to address uninsurance. The state of Florida took a unique approach to incorporating a focus on uninsurance within the legislation for Medicaid reform, with the introduction of the 'Low-Income Pool (LIP).' The LIP program was established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low income pool consists of a capped annual allotment of $1 billion. Funds from the pool may be used for health care expenditures which may be incurred by hospitals, clinics, or other provider types for uncompensated medical care costs of medical services for the Medicaid, underinsured and uninsured populations. The LIP program may become a valuable funding source for the policy option created from this grant. A key lesson for other states is the importance of understanding other policy discussions that are occurring and if necessary, adapt the coverage agenda to suit the external environment.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

The number of uninsured Americans continues to grow. According to the Kaiser Family Foundation, 45.8 million individuals lack health insurance. Not having health care coverage is linked to poor access to appropriate health care services and possibly poor health outcomes. Strategies to reduce the number of uninsured have been incremental. More comprehensive and strategic approaches are needed. While it may be necessary to formulate plans at the state and local levels, some funding and guidance must occur at the federal level.

SECTION 8. OVERALL ASSESSMENTS OF SPG PROGRAM ACTIVITY

The process of proposing and then implementing health insurance reforms is labor intensive, requires significant collaborations and consensus building across stakeholders, and is time consuming. In addition, state policy agendas may change midstream forcing changes in approaches to finding solutions to the uninsurance problem. Consequently, multiple years of funding are needed in order for the SPG program to realize its objectives. Funding does not have to be particularly large in certain years, but sufficient to ensure that the state level debates and development of policy options can continue. In Florida, the SPG program facilitated renewed conversations around the uninsured – not just at the state level, but also within county units. And in fact, as a result of these conversations and the availability of data on the uninsured, coverage expansions are being initiated at the county level.

It is of concern that the program is being discontinued. We recommend that the program be revitalized and that new incarnations focus not only on state level efforts, but also on local efforts to improve access to care.