

Health Care Access in Palm Beach County:

A Review of Available Data

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Background

In 2001, the Quantum Foundation contracted with The Access Project to conduct an assessment of health access issues in Palm Beach County. The results of the assessment, which was based on a review of secondary data and interviews with 28 key informants, was published in February 2002 in a report entitled *Health Care Access Issues in Palm Beach County*.

Since that date, the Quantum Foundation and other local health care funders and providers have joined together as Access Palm Beach County (APBC), a coalition whose mission is to coordinate health care for uninsured residents of the county and expand the capacity of local facilities to serve them. At the request of APBC members and with funding from the Quantum Foundation, The Access Project has prepared the following report to assist APBC in setting goals and measuring the progress of its efforts. This report updates the secondary data included in the February 2002 report, and also summarizes data provided by several APBC members and other healthcare providers and agencies that sponsor health coverage programs.

Secondary Data Findings

1. Population Growth

Palm Beach County continues to experience a rate of population growth exceeding that of the state. Between April 2000 and July 2003, Palm Beach County's population grew by 7.5%, compared to 6.5% for the state. For the county as a whole in 2003, of people reporting one race, 74% were white and 16% were black. Fifteen percent of the population was Hispanic (of any race).¹ Compared to 2000, when 78% of the county population was white, 15% black, and 17% Hispanic,² the white population continued to decrease while the minority population remained relatively stable. However, in the West Palm Beach-Boca Raton Metropolitan Statistical Area (MSA), between 2000 and 2003, the white population (single race) declined from 80% to 73.5%, while the black (single race) population increased from 13.9% to 15.8%, and the Hispanic (any race) population increased from 12.5% to 15%.³

The growth of the Hispanic and other linguistic minority populations was reflected in an increase in the estimated percentage of the population 5 years of age and over that speaks English less than "very well." Between 2000 and 2003, the percentage of this population in the West Palm Beach-Boca Raton MSA rose from 7.7% to 13%.⁴ The growth in populations that typically have disproportionately high rates of uninsurance, as well as those that face linguistic barriers to accessing care, will continue to challenge facilities in the county that treat uninsured and non-English speaking patients.

2. Health Insurance Coverage

Prevalence. 1999 data indicated extremely high rates of uninsurance among specific groups in Palm Beach County, in particular people with incomes below 100% of the Federal Poverty Level (FPL) (47%) and between 100% and 150% of FPL (27%), and Hispanics (40%).⁵

In most respects, the situation in 2004 is worse.

According to *The 2004 Florida Health Insurance Study: Palm Beach County Augmentation*, the rate of uninsured in the county rose from 15.1% in 1999 to 18.9% in 2004, a 25% increase. By comparison, the rate for the state rose from 16.8% to 19.2%, a 14% increase.⁶

The survey, which was conducted by the Florida Agency for Health Care Administration (AHCA), does not translate percentages into numbers. The U.S. Census reported that in 2003, Palm Beach County had 1,196,071 residents.⁷ Applying the 18.9% uninsured rate from the 2004 AHCA study produces an estimate of 226,057 uninsured residents. This figure is conservative, as the county population almost certainly increased between 2003 and 2004.

The rate of uninsurance among low-income people in Palm Beach County is particularly noteworthy. Among people with incomes below 100% of FPL, 50% of Palm Beach County residents are uninsured, compared to 38.8% in the state.⁸ This figure also far exceeds that for any of the other counties in which augmentation studies were conducted (Brevard, Duval, Orange, Osceola, and Seminole), none of which had rates above 37%. The U.S. Census Department estimated that in 2003, 122,276 residents of Palm Beach County were below the poverty level; this represented just under 13% of the county population.⁹ Using the Census estimate, 61,138 residents under the poverty level in Palm Beach County are uninsured. (Again,

this figure is conservative because of the differing time periods of the population and uninsurance estimates.)

Rates of uninsurance in Palm Beach County were also high among low-income people above the poverty line. Among those with incomes between 100% and 150% FPL, 44.1% are uninsured in the County compared to 38% in the state (and 27% in the County in 1999). Among those with incomes between 151% and 200% of FPL, 37.5% are uninsured in the County compared to 28.3% in the state.¹⁰

As in 1999, rates of uninsurance among minorities in the County were higher than the rate for whites. In 2004, 31.6% of Hispanics and 34.5% of African-Americans were uninsured, compared to 11.8% of whites. These figures differ significantly from those in 1999, when 40% of Hispanics and 16.6% of African Americans were uninsured. However, comparisons between the two surveys with respect to race and ethnicity must be regarded with great caution, as the methodology for specifying race and ethnicity in 2004 was different than in 1999.¹¹ Using the 2003 Census figures for the number of African-Americans (single race) and Hispanics (any race) in Palm Beach County, one could conservatively estimate that in 2004 there were 65,362 uninsured African-Americans and 56,521 uninsured Hispanics in the County.¹²

The county showed improvement among children ages 0-4, where the rate of uninsurance dropped from over 10% in 1999 to 8.6% in 2004 (or approximately 6,257 children). However among children ages 5-9, the rate rose from under 10% to 15.9% (approximately 11,025 children), and for children ages 10-18, the rate rose from about 12% to 17.6%. (Census age groupings don't directly correspond to these latter age groupings, so population estimates can't be given.) There was also a large increase for adults ages 19-24, from 20.9% to 31.7%, and among adults ages 45-54, where the rate rose from just under 10% to 17.1% (approximately 27,225 adults).^{13,14}

Most of the uninsured in the county are long term uninsured; more than two thirds (68.2%) have not had coverage for more than a year, and almost half (48.6%) have not had coverage for more than two years.¹⁵

Impact. The data indicate that lack of coverage has had a definite impact on people's ability to access care. In 2004, half of the uninsured in the county (50%) said they had delayed or not obtained needed medical care in the last 12 months because they could not afford it, compared to 11.2% of the insured, with over two thirds (68.3%) of the uninsured reporting that they didn't have insurance because they couldn't afford it. Less than 1% said they didn't have insurance because free or inexpensive care is available.¹⁶

Research The Access Project conducted in late 2003 in collaboration with three local organizations suggests that lack of coverage also results in significant medical debt.¹⁷ In a survey of clients of Florida Rural Legal Services, the Urban League of Palm Beach County, and the Haitian Center for Family Services, over half of the 81 respondents (52%) said they had medical bills they couldn't afford to pay. In households where none or only some family members were covered by health insurance, 65% and 62% respectively had medical debt. (However, even in households where all members were covered, almost 4 in 10 respondents had medical debt (39%).) The amount of debt varied widely; the lowest amount mentioned was

\$50, and the highest was \$20,000, with the median amount at \$3,116. The most common source of medical debt was hospitals: among respondents who had debt, 9 in 10 (91%) said they owed money to hospitals. Other sources that contributed to people's medical debt included physicians, prescription medications, and ambulance services.

Among respondents with debt, few said health care providers had informed them about the availability of charity care (5%), or about public programs to help them pay for their care (17%). Only 12% said providers had discounted their bills, while 24% said providers had charged them interest on their debt. A large percentage of respondents with debt said they had been contacted by a collection agency about their medical bills (67%), and a small number said they had taken out a loan to help pay them. It should be noted, however, that few reported facing legal action, such as being sued in small claims court or having their wages attached.

3. Health Indicators

As in 2000, Palm Beach County's rates for most basic health indicators in 2003 were equal to or better than the state's. For example, 3-year age-adjusted death rates in 2001-3 for heart disease, cancer, stroke, and diabetes were all below state averages. However, major racial disparities exist. For all these diseases, the death rate for blacks was significantly higher than for whites; in the case of stroke it was almost twice as high (73.0 vs. 34.5 per 100,000) and in the case of diabetes three and half times as high (51.2 vs. 14.1 per 100,000). The rate of black infant deaths per 1,000 births was 13.7 in the County, compared to 5.7 for whites, while for neonatal deaths the rate was 8.6 for blacks vs. 3.7 for whites.¹⁸

The 2000 assessment highlighted two indicators in which Palm Beach County rates were significantly worse than state averages: HIV/AIDS and access to prenatal care. These indicators remain a significant source of concern within the county.

The death rate in the county from HIV/AIDS for 2001-3 was 13.5 per 100,000, compared to 10.3 for the state. However, the rate of death for blacks was an astounding 18 times higher for blacks in the county than for whites (71 vs. 3.9). Moreover, the black death rate from HIV/AIDS in the county is close to twice the rate for blacks in the state (71 vs. 44.2). The average three-year rate of new cases per 100,000 in 2001-2003 was 45 for the county compared to 30.2 for the state.¹⁹

The percentage of residents in the county having access to first trimester prenatal care in 2001-03 was 78.8%, compared to 85% for the state. The county's rate was almost identical to its rate in 1998-2000. Again, racial disparities exist, with only 66.8% of blacks and 64.9% of Hispanics having access to first trimester care, compared to 83.8% of whites. Conversely, the percentage of births with late or no prenatal care was 5.9 in the county, almost twice the 3% rate for the state. The rate for blacks in the county was 8.5%, and for Hispanics 11.7%, compared to 4.6% for whites.²⁰ According to Palm Beach County Health Department figures, only 31% of the prenatal patients treated at Health Department clinics got care in the first trimester; 27% did not get care until the third trimester.²¹

One other indicator for which the Palm Beach County rate was worse than the state's was the prevalence of tuberculosis (7.4 vs. 6.5 per 100,000).²²

Provider and Agency Information

1. Clinic Information

Information about the use of clinics that provide treatment to the uninsured was received from the Caridad Health Clinic, Samaritan Gardens Community Health Center, and the Health Department clinics. While information was also received from the Comprehensive AIDS clinic, the clinic had been in operation for less than a month and the data were too limited to include in this report. The Wellness Centers were only able to provide information about referrals, but are in the process of improving their data collection and reporting abilities.

In the previous year, Caridad Health Clinic reported treating 11,206 patients and Samaritan Gardens Community Health Center approximately 4000 patients; all of the patients at both clinics were uninsured. The Health Department reported that its clinics treated 51,344 patients in the first eight months of 2004, and projected a total for the year of 77,016. Slightly over half of these patients (approximately 54%) are uninsured. Almost all of these patients are very low income – all of the patients at the Caridad and Samaritan Gardens clinics and 89% at the Health Department clinics have incomes below 150% of the Federal Poverty Level. (Approximately 18% of the Health Department patients have coverage through the Health Care District and approximately 18% are covered by Medicaid.)

Caridad's patient population is almost entirely Hispanic, while Samaritan Gardens and the Health Department clinics treat a mix of whites, African-Americans, Hispanics, Haitians, and other minorities.

None of the clinics report having waiting lists, but all have certain types of services for which there are longer waits for care. These include gynecology and surgery at the Caridad, dentistry (3-4 weeks) and podiatry and optometry (3 months) at Samaritan Gardens, and well checkups (2-3 months) at the Health Department clinics.

All of the clinics report specialties for which they have difficulty finding providers to whom they can refer their patients. These include:

- Caridad: pediatric cardiology, ophthalmology, neurology, endocrinology
- Samaritan Gardens: cardiology, ophthalmology, neurology, oral surgery, dermatology
- Health Department: pediatric gastroenterology, pediatric HIV oncology, some cancer subspecialties, pediatric ENT, pain management

Caridad Health Clinic refers approximately 25 patients a month to specialists. The Samaritan Gardens Community Health Center says it rarely refers patients because there is such limited availability of specialists. However, if care were available, the clinic conservatively estimates that it could refer 20-30 patients a week.

Samaritan Gardens assists about 75% of its patients with applications for Health Care District coverage, and about 90% of these patients qualify for Option 2. It does not assist with Medicaid applications. Caridad Health Clinic refers people to the Health Care District and the Department of Children and Families to apply for public coverage programs, but does not assist them in filling out applications. For people requiring hospitalization, the Clinic works through

physician contacts on a case-by-case basis to try to obtain free medical care. Obtaining free hospital services is also done in an ad hoc manner. The Wellness Centers refer patients to the Health Care District, Medicaid, and KidCare to apply for health coverage (they referred 1508 patients in the first 8 months of 2003).

2. Hospital Information

Three of the APBC member hospitals or hospital systems provided data for this report. However, the data were not consistent across the hospitals, so it is not possible to make comparisons or accurately aggregate the data.

Two of the hospitals/hospital systems reported seeing about 3,934 uninsured patients a month, representing between about 9% and 12% of their total patient population. By far the largest grouping was uninsured patients treated and discharged from their emergency rooms; between 17% and 25% of all ER patients treated and discharged were uninsured. By comparison, approximately 5% of outpatients were uninsured at the reporting hospitals, and 6% to 8% of inpatients.

According to one hospital, 70% of uninsured who come to the ER have non-emergent conditions, compared to only 7% of the insured. Other hospitals were unable to provide this information. Hospitals were also unable to provide information about the percentage of uninsured and insured admissions for ambulatory-care sensitive conditions (that is, conditions for which hospitalization could be prevented by timely primary care).

The hospitals screen only a portion of their uninsured patients for public programs and charity care – for example, they may not screen outpatients or patients whose bills are below a certain dollar threshold. Two of the reporting hospitals said they screen between one third and two-thirds of their uninsured patients, mostly for public programs; combined, this translates to about 1,775 uninsured patients a month, or about 45% of their uninsured patients overall. One of the hospitals reported that most of those screened for public programs are pregnant undocumented immigrants applying for Emergency Medicaid, about 85% of whom qualify. The other hospital reported that of those referred for Medicaid and HCD screening, about a quarter (24%) were actually enrolled. The two hospitals reported screening about 8-9% of their uninsured patients for charity care, or about 366 patients; the percentages that actually qualify for charity care were not provided.

A third hospital did not provide the overall numbers of patients it treated in its inpatient, outpatient, and emergency department, or the percentage of those patients that was uninsured, so estimates of the percentage of uninsured patients screened for public and charity programs could not be made. It did provide data on numbers screened and qualified for these programs for two months, October and November 2004. These data indicate that the hospital screened between 166 and 362 patients per month, with the largest number being uninsured patients who presented at the emergency room. The bulk of these patients were screened for Medicaid eligibility (19 and 61 patients), with 50% and 63% qualifying for the program in the two reported months. The next largest number was screened for HCD eligibility (10 and 19 patients), with 54% and 61% qualifying. The smallest number was screened for the hospital's charity care program (2 and 11 patients), with 75% and 100% qualifying.

3. Public Health Care Coverage Programs

According to the Department of Children and Families (DCF)²³, in November 2003 81,988 county residents were covered by Medicaid, and 12,450 by KidCare. As of August 2004, The Health Care District covered 6,767 residents under Option 1 (the only coverage option that includes inpatient care) of its Coordinated Care program, and 11,015 residents under all three options combined.²⁴

Both agencies reported receiving about 7,000 applications a month. However, there is a large discrepancy in the number of eligibility workers screening the applications. DCF reported having 129.5 FTE eligibility workers, or approximately 1 for every 59 applications, while HCD reported having 19, or 1 per 368 applications. It should be noted, however, that DCF workers also screen applicants for AFDC and Food Stamps and do periodic reviews of their cases.

While DCF said that figures fluctuate, in the month of August 2004 it approved approximately 80% of Medicaid applicants processed that month. HCD did not give a specific time period, but said that it approves only 16% to 20% of applicants for its Coordinated Care program. Of those applicants it disqualifies, HCD reports that 6 to 8% are found to be eligible for Medicaid, while 78% fail to submit complete applications with all necessary supporting documentation. Of those who are denied Medicaid coverage, DCF reports that only about 12% are denied because of incomplete applications.

Both HCD and DCD report implementing improvements designed to simplify their application process over the last year. For example, HCD reports revising the application form to ensure it is at an appropriate level of readability, expanding the types of documentation acceptable to establish identity and prove residency, accepting photocopies as well as original documents, revising its asset criteria, reducing the number of bank statements that have to be submitted, and expanding the number of agencies that can assist residents with applications for expedited Option 2 (clinic and pharmacy) benefits. DCF reports having streamlined its application process, reduced the level of required verification, and reduced the required number of face-to-face contacts with applicants.

Conclusions and Recommendations

The data on local facilities and public programs come from APBC members and others, and in some cases are estimates. For that reason, the findings are not definitive. However, this review of both the primary and secondary data suggests the following conclusions and recommendations.

1. The relatively high percentage of women in Palm Beach County who do not receive early prenatal care, particularly those who belong to ethnic or racial minorities, continues to represent a serious health access issue. One benchmark of progress for APBC is reducing this rate. Reducing the rates of AIDS/HIV incidence and death, especially among African-Americans, is also an important priority.
2. High rates of uninsured presenting in hospital emergency rooms with non-emergent or ambulatory-care sensitive conditions suggest lack of availability of affordable and accessible primary care. (Ambulatory-care sensitive conditions are those for which hospitalization might have been avoided if patients received appropriate primary care.)

One hospital in Palm Beach County reported a very high percentage of uninsured patients who presented in its emergency room for non-emergent conditions compared to insured patients. Other hospitals were unable to provide these data. Hospitals were also unable to provide percentages of uninsured patients who are either treated in emergency rooms or admitted as inpatients for ambulatory-care sensitive conditions.

These rates might also be appropriate benchmarks of progress and APBC member hospitals should consider establishing measures for tracking them. John Billings of New York University has created an algorithm for calculating these rates. It is currently used by the Indigent Care Collaborative in Austin and could be utilized by APBC as well.

3. The high percentage of low-income residents in Palm Beach County who are uninsured suggests that many people eligible for public and private programs are either unaware of these programs or are finding it difficult to apply for them.

This conclusion is reinforced by the primary data. The large percentage of applicants for HCD coverage who are denied because of incomplete applications suggests that, in spite of changes in the application process, significant barriers remain. Local clinics that treat primarily uninsured people often lack the resources to help their clients apply for all programs for which they may be eligible, including the HCD program and Medicaid. While the hospitals that provided data vary in the percentages of uninsured patients they screen for public programs, not all categories of uninsured patients are screened (for example, in some cases outpatients or those whose bills fall below a threshold amount are not screened) and many fail to complete the application process. Only 8% to 9% of uninsured patients at the reporting hospitals were screened for the hospitals' own charity care programs. In addition, The Access Project's research on medical debt in Palm Beach County found that few of the survey respondents who had unaffordable medical bills said that health care providers had informed them about the availability of public or charity care programs to help them pay for their care.

The common eligibility initiative that APBC has undertaken may greatly improve this situation. However, developing software that screens people for eligibility for a range of programs may be a necessary but not a sufficient response. It may be important to review application processes themselves to identify remaining obstacles, and to provide significant support for individuals who are attempting to enroll in these programs. Two programs that provide extensive support for applicants in navigating the enrollment process have demonstrated that they can enroll increased numbers of patients into public programs, resulting in savings for both patients and facilities. Advocacy & Benefits Counseling for Health in Madison WI reports generating over ten dollars in third party payments for each dollar spent on health benefits counseling, while Cooley-Dickinson Hospital in Northampton MA has significantly increased its staffing for Hampshire Health Connect, a screening and enrollment assistance program for uninsured patients, based on the savings to the hospital resulting from increased reimbursements. In addition, the Indigent Care Collaborative in Austin TX found that merely having staff to screen patients using the Medicaider software program was insufficient for ensuring that eligible patients actually enrolled in available programs; it thus added outreach workers to assist patients in completing the application process. Moreover, a recent study conducted in the emergency department of an inner-city academic children's hospital showed that ED-based insurance outreach programs can successfully increase enrollment of uninsured children in Medicaid and the State Children's Health Insurance Program.²⁵

To measure progress in this area, APBC should establish methods for tracking the numbers of clients screened for Medicaid, KidCare, the HCD Coordinated Care program, and hospital charity care programs, both at common eligibility sites and at member organizations, the number likely to be eligible, and the number actually enrolled to determine whether the common eligibility and/or other initiatives are improving the rate of enrollment in public health coverage programs. APBC should also work on identifying remaining barriers to enrollment for these programs and consider the importance of making personnel available to applicants to assist them in navigating the enrollment process.

4. Palm Beach County hospitals and clinics that provided data for this report gave information on the number of uninsured patients they treat. However, it is impossible to calculate the unduplicated number of uninsured patients treated or to identify patient utilization patterns. Implementing a shared health record, as was done by the Indigent Care Collaborative, would allow for the collection of data that would greatly improve APBC's ability to monitor and analyze uninsured patients' use of the County's health care facilities.
5. While data on the quantity and quality of medical interpreters and other forms of language assistance services were not collected for this report, the growth of the Palm Beach County population that speaks English less than "very well" suggests that providing adequate language assistance services remains an important priority for APBC. In conjunction with the language assistance subcommittee, APBC should consider measures to track the availability and adequacy of language assistance services for consumers in clinical care settings, patient financial services departments, and agencies that provide health coverage for the uninsured.
6. APBC should consider creating a subcommittee on data to determine what data members should collect and report on to measure the progress of the coalition's initiatives and to

establish common definitions and standards across member agencies for collecting these data. This work should be done in collaboration with the common eligibility subcommittee, so the Benefit Bank software can be programmed to collect as much of the desired data as possible.

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- ¹ U.S. Census Bureau, American Community Survey Profile 2003, *Population and Housing Profile: Palm Beach County, Florida*.
- ² U.S. Census Bureau, *Profile of General Demographic Characteristics 2000*.
- ³ U.S. Census Bureau, American Community Survey 2003 Multi-Year Profile, *West Palm Beach – Boca Raton, FL MSA, General Demographic Characteristics*.
- ⁴ U.S. Census Bureau, American Community Survey 2003 Multi-Year Profile, *West Palm Beach – Boca Raton, FL MSA, Selected Social Characteristics*.
- ⁵ Agency for Health Care Administration, *Florida Health Insurance Study*, January 2000.
- ⁶ Agency for Health Care Administration, *Highlights from the 2004 Florida Health Insurance Study: Palm Beach County Augmentation*, 2004.
- ⁷ U.S. Census Bureau, American Community Survey 2003 Data Profile, *Palm Beach County, General Demographic Characteristics*.
- ⁸ *Palm Beach County Augmentation, op.cit.*
- ⁹ U.S. Census Bureau, American Community Survey 2003 Data Profile, *Palm Beach County, Selected Economic Characteristics*.
- ¹⁰ *Palm Beach County Augmentation, op.cit.*
- ¹¹ *Ibid.*
- ¹² U.S. Census Bureau, American Community Survey 2003 Data Profile, *Palm Beach County, General Demographic Characteristics*.
- ¹³ Rates of uninsurance are from the *Palm Beach County Augmentation, op.cit.*
- ¹⁴ Numbers of uninsured are estimates based on *Palm Beach County, General Demographic Characteristics, op.cit.*
- ¹⁵ *Ibid.*
- ¹⁶ *Ibid.*
- ¹⁷ The Access Project, *Unpublished data*, 2003.
- ¹⁸ Palm Beach County Health Profile Report, <http://www.floridacharts.com/charts/chart.aspx>.
- ¹⁹ *Ibid.*
- ²⁰ *Ibid.*
- ²¹ Information provided by Dr. Alina Alonso, Palm Beach County Health Department.
- ²² Palm Beach County Health Profile Report, *op.cit.*
- ²³ All information on Medicaid and KidCare provided by Melanie Swager, Department of Children and Families, OMC Manager, Economic Self-sufficiency Services, South Zone – West Palm Beach, FL.
- ²⁴ Information on the Health Care District program provided by Debi Gavras, Palm Beach County Health Care District.
- ²⁵ The study is scheduled to be published in the *Annals of Emergency Medicine*. The lead author is Prashant Mahajan, M.D. of Children’s Hospital of Michigan in Detroit.