BREAKING BARRIERS

Improving Health Insurance Enrollment and Access to Health Care in Florida

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RECENT PRESS REPORTS CREDIT FLORIDA WITH ENROLLING 1.3 MILLION state residents (6.5 percent of the state's population) in Affordable Care Act (ACA) marketplace health insurance, with nine out of 10 of the new enrollees eligible for tax credits.[1] These recent figures are even more impressive given the state's recent resistance to expanding efforts to enroll the 22.1 percent of the state's population who, before the ACA took effect, were uninsured. The Florida legislature twice rejected Medicaid expansion, leaving an estimated 670,000 Floridians in a health care-less limbo, unable to qualify for Medicaid or for any tax subsidies to purchase health insurance. At the same time, the state spent $900 million to develop Florida Health Choices, a website advocated and supported by Republican U.S. Senator Marco Rubio that was supposed to give uninsured Floridians a health care alternative. As of August 2014, the site had enrolled 30 people.[2] In addition, during the first enrollment period, doctors complained that hundreds of Medicaid and CHIP patients came to their offices only to find that they had been switched into a new health plan and charity care programs were sued for failing to publicize their programs and instituting "unduly burdensome" verification requirements. Complaints from those who did qualify for Medicaid ranged from general confusion about whom to contact for health coverage information to the state arbitrarily disenrolling people and failing to give new enrollees timely notice that their doctor had changed. In the face of these daunting obstacles, advocacy groups, armies of navigators, and outreach by volunteers still managed to enroll almost 984,000 people in the initial enrollment period, second only to California.

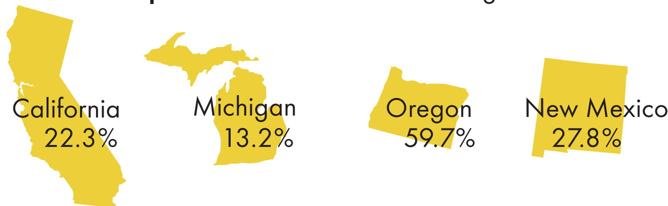
This report, part of a 10-state study, reviews Florida's enrollment efforts and consumers' attempts to access health care in the state's low-income African-American, white, Latino, and, where applicable, Asian-Pacific Islander and Native American communities. The methodology includes key actor interviews with Florida-based navigators, policy and health care professionals, and advocates, as well as 151 surveys in Spanish and English with low-income community residents at food pantries, health clinics, and homeless service centers. The report compares and contrasts the enrollment and "coverage-to-care" trends shown through the interviews and surveys to reported Florida outcomes and, when appropriate, to national trends. Analyses of these results serve as the basis for the report's recommendations.

ENROLLMENT

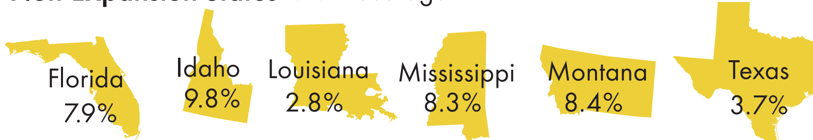
THE PROPORTION OF UNINSURED STATE RESIDENTS went from 22.1 percent in 2013 to 18.9 percent in mid-2014, a decrease of 3.2 percentage points. Medicaid and CHIP enrollment increased by 7.9 percent, more than the average among other states in this study that rejected Medicaid expansion, but still far below the average increase in the Medicaid expansion states studied.

Percent Medicaid and CHIP Enrollment Increase from 2013 Pre-Enrollment to August 2014[3]

Medicaid Expansion States 30.8% average



Non-Expansion States 6.8% average



Access to health care for people of color was a key. Significantly, 81 percent of uninsured Latino adults and 32 percent of uninsured African American adults who fall into the "Medicaid coverage gap" live in two southern states: Texas and Florida.In Florida, 26.4 percent of African Americans, 30 percent of Latinos, and 21.9 percent of Asian-Pacific Islanders were uninsured before the first ACA open enrollment period, as were 18 percent of whites. (People in the "Medicaid coverage gap" are those who would have been eligible for Medicaid had their state opted for Medicaid expansion but whose incomes are too low to qualify them for premium subsidies in the state's health insurance marketplace.)

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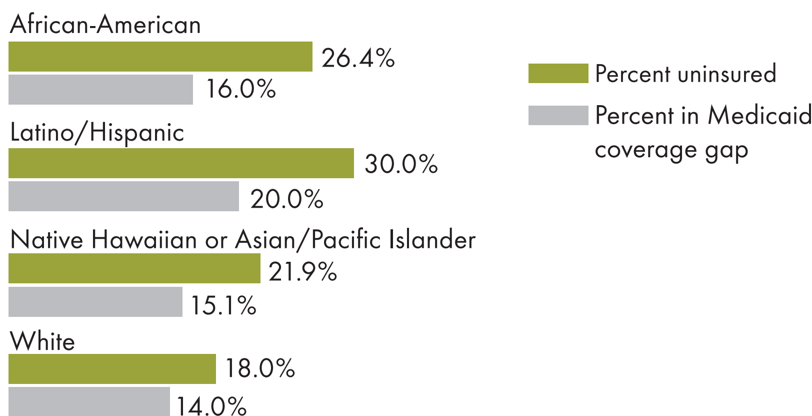
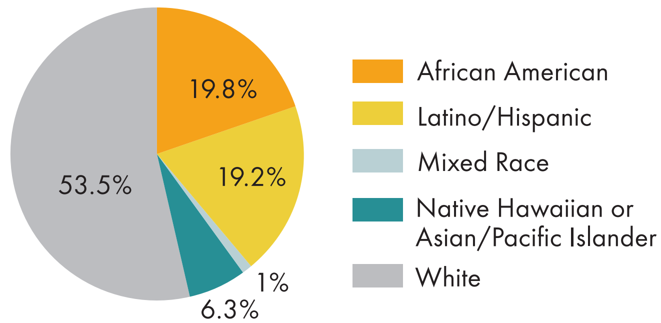
Florida Uninsured Rates, by Race

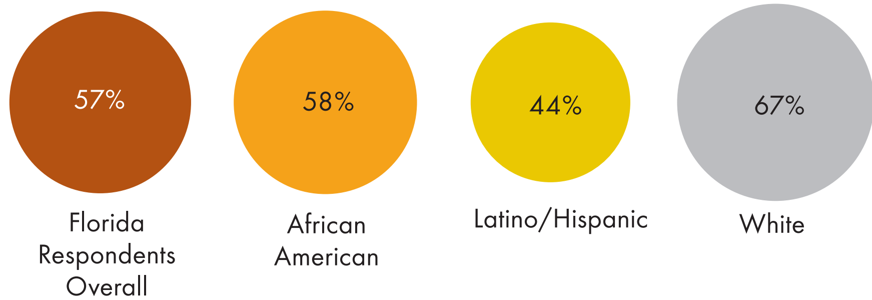


Given the higher percentages of people of color who are uninsured, efficient outreach planning would target those populations for enrollment—but Florida's outcomes suggest that no such targeting was done.

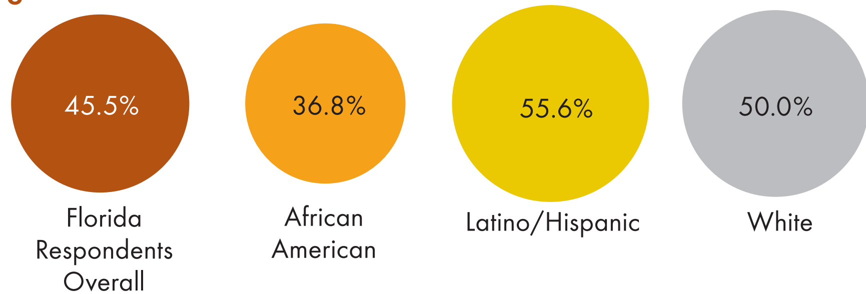
Demographic breakdown of Florida marketplace enrollees through April 2014, by race



Percent of survey respondents with coverage



Percent of survey respondents with medical coverage who got it in the last 12 months



Given the higher percentages of people of color who are uninsured, efficient outreach planning would target those populations for enrollment—but Florida's outcomes suggest that no such targeting was done. African Americans and Latinos, the groups with the highest uninsured rates, each accounted for a little over 19 percent of enrollees, while whites accounted for nearly 54 percent of marketplace enrollees. For our survey respondents, a little over half (57 percent) had medical coverage. Fifty-six percent of Latino respondents, 50 percent of whites, and 37 percent of African Americans with insurance coverage got it in the last twelve months.

Latino Enrollment

Percent of state population	23.6%
Percent of marketplace enrollees	19.2%
Percent of Latino survey respondents with coverage who are new enrollees	55.6%

Almost one of three Latinos in Florida is uninsured, the highest percentage of any racial group. Yet Latinos, who constitute almost a quarter of the state's population, made up only 19.2 percent of marketplace enrollees. In part, this reflects a host of problems during the first round of enrollment. Although the federal website healthcare.gov launched on October 1, 2013, cuidadodesalud.gov, the website for Spanish-speaking applicants, didn't launch until December. Moreover, many Latino families are mixed-status, i.e., include both legally present and undocumented family members. "It complicates the process," says Jody Ray, director of the nonprofit Florida Covering Kids and Families. "The biggest challenge we face is trying to enroll immigrant families, mainly because they come from generations where there has been no expectation of insurance. We have to educate them as to why they should spend any of their precious financial resources on non-emergency medical care."[4] Ann Swerlick, Deputy Director of Florida Legal Services in Tallahassee, adds, "there's also an income barrier for the working poor—when you take $150-200 a month from them for insurance."[5] A third barrier, often unstated, is fear. Although HHS has issued multiple assurances that information obtained from enrollment applications will not be released to the Department of Homeland Security, one survey respondent told us, "my father and my oldest sister are undocumented. We don't want to take a chance on applying for insurance and getting challenged for being here." Paola Pierre, an administrator with the Florida Immigrant Rights Coalition (FIRC), observed, "immigration reform is our main focus … and right now it's hard to see how the ACA actually works for our constituency."[6] Notably, only 44 percent of our Latino survey respondents had medical insurance.

White Enrollment

Percent of state population	56.4%
Percent of marketplace enrollees	53.5%
Percent of white survey respondents with coverage who are new enrollees	50.0%

Over fifty-three percent of Florida's enrollees were white—slightly lower than their percentage of the population (56.4 percent) but greater than their share of the uninsured in the state. White respondents to our survey were insured at a higher rate (67 percent) than either African American (58 percent) or Latino respondents (44 percent). Jessica Lowe-Minor of the League of Women Voters noted a barrier that, she said, affected enrollment efforts all over the state: "misinformation is rampant. There is a lack of understanding of what the ACA actually is and does and the general population is totally confused."[7] For low-income whites this problem was acute. With Florida's move to privatize Medicaid, many already in the program were shifted, often without a choice, to an insurance company where their doctor was not part of the network. In addition to Medicaid, there were other barriers. Website glitches and unfamiliarity with complex medical and insurance terms often led to delays, some of which had disastrous consequences. As Jerston Tubalado of *Focus* in Orlando recalls, "one woman that we were working with was told she was eligible but had a stroke. Now she has medical debt; if she had been able to enroll she would have had coverage."[8]

"The biggest challenge we face is trying to enroll immigrant families, mainly because they come from generations where there has been no expectation of insurance. We have to educate them as to why they should spend any of their precious financial resources on non-emergency medical care."[4]

“It’s not just getting people on health insurance.... we are having to educate people about their options ...how to *use* their insurance.”

African American Enrollment

Percent of state population	16.7%
Percent of marketplace enrollees	19.8%
Percent of African American survey respondents with coverage who are new enrollees	36.8%

Almost 20 percent of new marketplace enrollees in Florida were African Americans, a proportion slightly higher than their 17 percent of the state population. However, with more than a quarter of the state’s African American population uninsured, these initial efforts did not match the need for medical insurance in the African American community. As one advocate observed, in terms of outreach, “African Americans are not part of the narrative.” At 36.8 percent, low-income African American survey respondents had the lowest percentage of new enrollees among the state’s major population groups. One African American survey respondent in Orlando who had assistance with enrollment still found the process “hard to figure out.” He continued, “I signed up for a cheap plan, but I’m not really sure what I get. I do know that I have to pay something for medication, but I’m not sure how the copayment works.” This sentiment was not unusual. As one advocate noted, “It’s not just getting people on health insurance…. we are having to educate people about their options …how to *use* their insurance.”[9]

BARRIERS TO ENROLLMENT

ONLY 44 PERCENT OF OUR RESPONDENTS RECEIVED HELP IN ENROLLMENT; whites received the least assistance (27 percent) and Latinos the most (70 percent), with African Americans in the middle at 42 percent. Barriers included:

ELECTRONIC BARRIERS

General website difficulties and particular failures on the Spanish language website headed the list. In addition, the electronic identity verification process, according to one respondent, “left me hanging. I had to wait two weeks for a call, THEN I wasn’t verified. I just gave up.” In addition, one-third of all respondents did not have an email address, which is a necessary component of the enrollment process. Although relatively easy to get, *not* having an email address suggests that the potential enrollee has minimal familiarity with Internet communications. As the figures below indicate, the racial divide is significant. Whites have an email address at a rate 10 percentage points higher than African Americans and 15 percentage points more than Latinos.

Email Address

Do you have an email address?

	Percent of respondents who have an email address
Florida Respondents Overall	**67.0%**
African American	63.4%
Latino/Hispanic	58.1%
White	73.9%

LANGUAGE AND CULTURAL BARRIERS

In addition to difficulties with the Spanish language website, several advocates pointed to other language barriers. As one community organizer reported, "I am Asian myself – I didn't see anyone helping out the API community – navigators or assistors."[10]

IMMIGRATION STATUS

In addition to the fear of reprisal from the Department of Homeland Security and the complication of enrolling mixed status families, there are also financial barriers to enrolling immigrant families. As Santra Denis, Community Health Director at Miami-based Catalyst, observed, "many poor families, especially immigrant families, simply feel they cannot afford time or money to be proactive in this way."[11]

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LITERACY

Advocates and survey respondents both expressed confusion and frustration about the enrollment process. "The terminology was not straightforward. What's a deductible, a health maintenance organization, co-insurance, a health savings account, an out of pocket limit? First you have to explain the individual mandate, THEN when you help people pick a plan it's difficult to get people to see that they are not necessarily best off with the cheapest option."

COVERAGE GAP

Without a doubt, the biggest barrier to enrollment is the state's rejection of Medicaid expansion and the resulting coverage gap. Without Medicaid expansion, an estimated 670,000 Floridians fall into the gap, making too much to qualify for Medicaid but too little to qualify for subsidies to purchase insurance on the federal exchange. "We are meeting with people on the coverage gap every single day and there is nothing we can do for them," says Leah Barber-Heinz, Chief Executive Officer of Florida CHAIN.[12] Estimates suggest that Florida will lose $66.1 billion in federal Medicaid funding between 2013 and 2022. Linda Quick, President of the South Florida Hospital and Healthcare Association, points out, "Trying to convince legislators with economic arguments has NOT persuaded the supposedly 'business-oriented' chambers-of-commerce-backed legislators about Medicaid expansion. Their objection is clearly ideological, not practical. 'Florida is losing $7 million a day' etc. did not move one legislator."[13] Jodi Ray, Program Director of Florida Covering Kids & Families, sums the problem up: "The failure to accept Medicaid expansion leaves the state with tens of thousands of people who simply will not be covered by any insurance, which will be a financial drain on the state."[14]

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COVERAGE TO CARE

OVERALL ENROLLMENT DATA POINTS to mixed results in expanding health insurance coverage in Florida. Beyond the enrollment question, however, insurance coverage does not necessarily translate into quality care, which includes access to providers, a relationship with a personal doctor, and access to both medication and other forms of treatment. Although the ACA infrastructure is still developing, in this section we examine some key issues related to access and treatment.

State of Health

Do you have one or more medical conditions that have affected you for more than 3 months?

Race/Ethnicity	Percent with chronic conditions by race
Florida Respondents Overall	**52.3%**
African American	47.7%
Latino/Hispanic	53.8%
White	58.3%

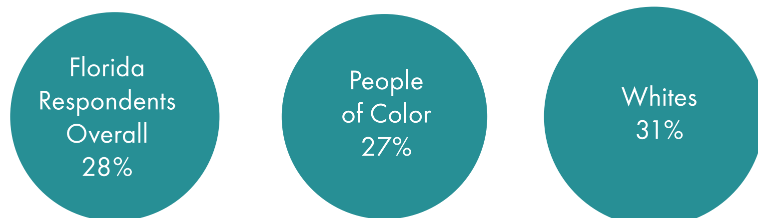
If the incidence of chronic conditions is any indication, the ACA may have arrived just in time. Chronic diseases cause seven of every ten deaths. In addition, health care costs for an individual with one or more chronic diseases are five times the costs for an individual without chronic disease.[15] In this context, it is significant that almost six in ten whites reported one or more chronic illnesses, as did more than half of Latino respondents and almost half of African American respondents.

Access to Health Care

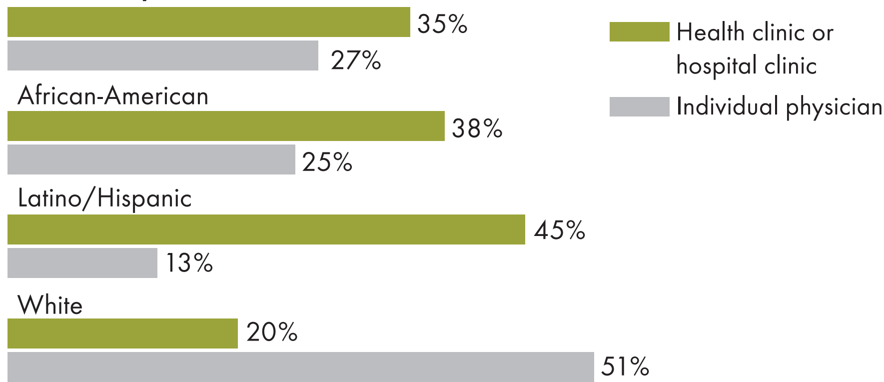
Do you have a personal doctor?

Race/Ethnicity	Percent Yes
Florida Respondents Overall	**74%**
African American	76%
Latino/Hispanic	65%
White	83%

Last time you saw a doctor?
More than a year ago



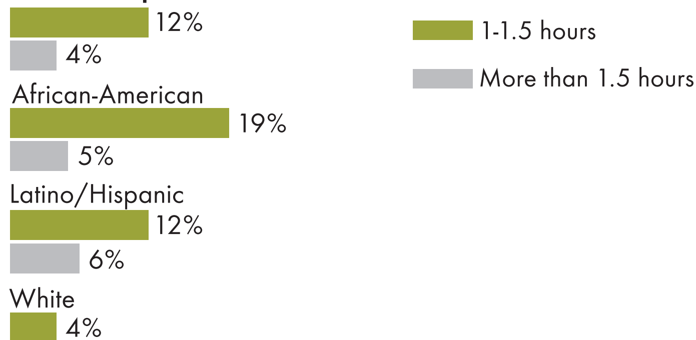
Where do you go for primary health care needs?



	Hospital ER or "no regular place to go"
Florida Respondents Overall	**37%**
African American	37%
Latino/Hispanic	43%
White	28%

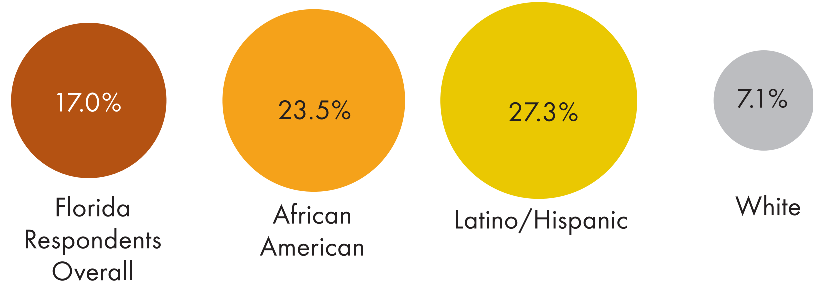
Although three of four survey respondents (83 percent of whites, 76 percent of African Americans and 65 percent of Latinos) say they have a personal doctor, only 27 percent visit that doctor regularly for their primary health needs and more than a quarter (28 percent) have not seen their doctor in more than a year. Significantly, 51 percent of whites compared to 25 percent of African Americans and 13 percent of Latinos see an individual physician for primary health care, while 43 percent of Latinos, 37 percent of African Americans, and 28 percent of whites use the emergency room for their primary health care needs or "have no regular place to go."

Travel time to provider



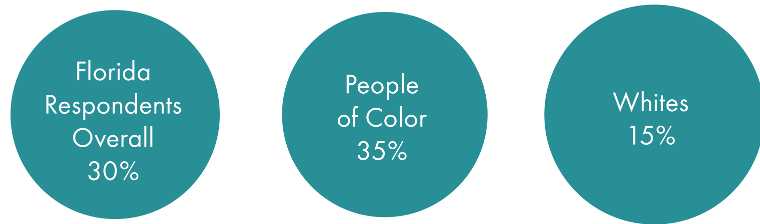
In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed it?

Percent sometimes/never



In the last six months, when you tried to get an appointment for care you needed right away, how long did you usually have to wait to see someone?

Percent waiting more than 7 days



Issues of access to care reflect a number of dimensions of racial stratification. First, 24 percent of African Americans and 18 percent of Latinos had to spend more than an hour's travel time to see their provider, in contrast to only 4 percent of whites. Whites do not get care as soon as they think they need it only 7.1 percent of the time, compared to 27.3 percent for Latinos and 23.5 percent for African Americans. Finally, the percentage of people of color who wait more than 7 days for an appointment (35 percent) is more than twice the 15 percent rate for whites.

Extra Payments

When you enrolled in a health plan, were you informed that financial support was available for low-income people?

	Percent Yes
Florida Respondents Overall	**39%**
African American	26%
Latino/Hispanic	56%
White	43%

Not including copayments, have you ever had to pay extra for doctor visits or medicines that your plan doesn't cover?

	Percent who have had to pay extra
Florida Respondents Overall	**47.5%**
African American	48.6%
Latino/Hispanic	46.7%
White	43.5%

Fewer than four in 10 respondents were informed about subsidies at the time of enrollment. Significant portions of all populations (47.5 percent) had to pay extra for doctor visits or medicines. African Americans and Latino respondents were more likely to have paid extra by a small margin.

Access to Alternative Medical Modalities

In the last 6 months, how often did your doctor or health care provider talk with you about non-medical things like diet, exercise, meditation, or chiropractic care to treat or prevent illness?

	Percent Always/usually
African American	50.0%
Latino/Hispanic	56.2%
White	30.0%

If your doctor discussed non-medical methods and strategies, which ones did he/she discuss?

	Percent of doctors who discussed only diet and/or exercise
Florida Respondents Overall	**65%**
African American	71%
Latino/Hispanic	69%
White	55%

The ACA makes provision for insurance networks to include coverage of alternative modalities, however fewer than half of our survey respondents had a discussion with their health provider about non-medical modalities like acupuncture, chiropractic care, meditation, diet, or exercise. However, of those that did, two-thirds focused solely on the "eat-your-vegetables" self-care strategies of diet and exercise. Although our Florida sample size of respondents to the specific approaches discussed by their physicians is small, the trend is similar to the responses in our national survey, which shows that only 21.6 percent of respondents of all races had doctors who discussed non-medical treatments other than diet and exercise.

Electronic Access

Use the Internet to communicate with provider or insurer

Race/Ethnicity	Percent Yes
African American	18%
Latino/Hispanic	35%
White	50%

A comparatively small percentage of survey respondents from communities of color use the Internet to communicate with providers or their insurance company. This underscores the digital divide—whites are more than two and a half times as likely as African Americans and a third more likely than Latinos to use the Internet to communicate with providers and insurance companies. Internet use will play a role in reenrolling and will be a factor in obtaining tax credits or certification that taxpayers do not make sufficient income to avoid an individual mandate penalty.

SUMMARY OF FINDINGS

Enrollment efforts in Florida did not attempt to target uninsured populations in a strategic way, particularly in communities of color. Florida has an estimated 670,000 people in the coverage gap, a significant portion of whom are African American and Latino.

Nearly one of three Latinos in Florida is uninsured, yet Latinos made up only 19.2 percent of marketplace enrollees. Two factors account for this outcome: **1) The digital divide**, evidenced by the fact that white survey respondents communicate with insurers or health providers a third more than Latino respondents and twice as much as African American respondents, and have email addresses (73.9 percent) at a rate 10 percentage points higher than African Americans (63.4 percent) and 16 percentage points higher than Latinos (58.1 percent); **2) Legal, language, and cultural barriers:** the combination of limited language access, fear of legal reprisals for mixed-status families, and lack of familiarity with culturally-specific insurance and medical terms adds up to significant obstacles to enrollment.

Survey respondents had high levels of chronic illnesses, with over half reporting one or more. Although three-quarters of survey respondents have personal doctors, 31 percent of whites and 27 percent of people of color have not visited them within a year; 28 percent of white respondents, 37 percent of African American respondents and 43 percent of Latino respondents either use the hospital emergency room or “have no place to go” for their medical home. Urgent care was particularly hard to get for people of color, a third of whom had to wait more than seven days. Of those who have sought urgent care service, 23.5 percent of African Americans, 27.3 percent of Latinos, and 7.1 percent of whites thought that they “sometimes or never” got care when they thought they needed it.

The pathway from coverage to care has many obstacles. In a state where 52 percent of survey respondents suffer from ongoing chronic conditions, 16 percent of respondents had to travel more than an hour to obtain care, only 17 percent got care when they thought they needed it, and 30 percent waited more than a week for an urgent appointment. These problems were significantly more prevalent in communities of color; travel time, urgent care, and appointment wait times were two to three times more acute in African American and Latino communities.

Pathways to alternative health modalities are highly limited, with just over half of doctors talking with patients about non-medical approaches to health. When doctors do mention alternatives, 65 percent of the time the emphasis is on the standard patient self-help recommendations—diet and exercise.

In order to improve enrollment and care options, we recommend the following:

I. SAFEGUARDING ACCESS TO HEALTH INSURANCE

Increase enrollment and federal funding by expanding Medicaid. The current enrollment process has reached too few people and Medicaid privatization has not facilitated desired outcomes for either doctors or patients. At this point, the rational policy alternative is to increase enrollment eligibility for an estimated 670,000 low-income uninsured Floridians by taking advantage of federal funds available for Medicaid expansion.

Target for enrollment low-income residents already enrolled in income-based programs. The state should immediately increase low-income health insurance enrollment by automatically enrolling in Medicaid people who already receive need-based benefits like SNAP (food stamps), Supplemental Security Income (SSI), WIC, or free or reduced-price school meals, as well as people released from incarceration with no immediate source of income or assets.

Improve language access. Asian-Pacific Islanders and Latinos have uninsured rates that are significantly higher than whites, and culturally appropriate language access is still not an everyday reality. Complete multilingual application materials and website access are not readily available. To address these issues, Florida should establish a right to enroll in health coverage in the enrollee's primary language. Implementing this policy would require multilingual applications, literature, websites, and interpreters, consistent with the requirement in § 1311(i)(3)(E) of the Act to "provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges." The state should require plans to give enrollees notice of their right to language services, as California does (Cal. Code Regs. tit. 10 § 2538.3), and regularly assess plans' compliance with language access requirements, as New York mandates (N.Y. Pub. Health Law § 4403). Florida should expand its pool of interpreters and require plans to continually update information about which providers are in their networks. Provider directories must be available in multiple languages and list addresses, phone numbers, languages spoken, hospital affiliations, and specialties.

Simplify the insurance-shopping experience and keep provider information current. The state should simplify print and electronic descriptions of plans and benefits, especially deductibles, co-pays, preventive services available at no cost, and the significance of providers being in- or out-of-network, making costs transparent and ensuring easy comparison of services available with no co-pay. It should also require plans to continually update information about which providers are in their networks.

Make faster decisions on enrollment applications. The state should require decisions on ACA and Medicaid applications within two weeks of filing.

II. MOVING CONSUMERS FROM COVERAGE TO CARE

Expand and extend the role of navigators. Many enrollees are new to health insurance coverage. Not only are they unfamiliar with medical terminology, they have had little interaction with the medical system or the insurance system and may need both an introduction and an acclimation. Navigators are in an ideal position to perform this role. The state should extend the role of navigators to encompass teaching new enrollees how to use insurance coverage and recruiting enrollees to participate in marketplace-sponsored evening and weekend clinics focusing on health education, specific mobile services (exams, immunizations, etc.), and access to different medical modalities (e.g., acupuncture, chiropractic care).

Address racial health disparities. Florida should enforce ACA statutory provisions that require insurers to act to reduce racial disparities and continually monitor implementation of insurers' disparity-reduction plans and programs, especially outreach and outcomes. The state should impose penalties, including exclusion from exchanges, against plans that do not succeed in reducing disparities within established target timeframes.

Require plans to include in their networks at least one full-time primary care provider for every 2,000 patients and ensure that enrollees are able to make appointments with their primary care providers within 10 business days of seeking an appointment, as do California and Washington.

Increase payment rates to primary care physicians. Federal support for increased Medicaid payment levels ended on Dec. 31, 2014. Since payment levels strongly affect providers' willingness to see Medicaid patients, Florida should use state funds to continue Medicare-level payments to primary care physicians who serve Medicaid beneficiaries as 15 states (AK, AL, CO, CT, DE, HA, IA, MD, ME, MI, MS, NE, NM, NV, SC) plan to do.

Require that new enrollees have the opportunity for a free physical exam and appropriate screening tests within 60 days of enrollment.
Require plans to adopt geographic access standards ensuring that, for at least 90 percent of enrollees, primary care providers are available within 10 miles or 30 minutes average driving or public transit time and specialists within 45 miles or one hour, whichever is less, as New Jersey does (N.J. Admin. Code § 11:24A–4.10). Vermont imposes similar requirements. Enrollees who live farther from providers should be offered free transportation.

Reinforce the ACA-mandated women's right to no-cost "well-woman preventive" care by ensuring that all plans available through the marketplace include reproductive health care services, including all FDA-approved forms of contraception.

Expand and standardize preventive services, ensuring that non-grandfathered plans offer preventive services (yearly check-ups, immunizations, counseling, and screenings) at *no out-of-pocket cost* and penalize plans in which fewer than 70 percent of enrollees receive these services.

Require plans to track health outcomes, disaggregated by race, ethnicity, primary language, gender, disability, and sexual orientation.

III. BUILDING AN INFRASTRUCTURE TO PROMOTE PREVENTIVE HEALTH CARE

Offer incentives to plans that adopt a broad view of health benefits and tackle underlying social determinants of health. Florida is a poor state with 17 percent of its residents living in poverty. Insurance is one step toward better health but in order to address the prevalence of chronic diseases, the state must encourage innovation and experimentation to address the underlying causes of poor health—particularly in poor rural communities.

Expand medical-legal partnerships as an avenue toward the broad array of issues that lead to poor health in low-income communities (e.g., mold in housing, domestic violence). While three-quarters of states and seven of the ten states studied already have at least one such partnership, through which medical and legal professionals collaborate to look holistically at barriers to health and wellness and work jointly to remove the barriers, the partnerships already in place cannot begin to meet the need.

Invest in school-based health centers. Seek funds from HHS' Health Resources and Services Administration or use state funds to expand school-based health centers, especially in medically-underserved communities (where 14.9 percent of state residents reside), to mitigate the lack of other health care options (Section 4101 of the ACA, 42 U.S.C. § 280h-4).

1. Florida leading U.S. in ACA signups Herald-Tribune, February 4, 2014 accessed at: http://health.heraldtribune.com/2015/02/04/florida-leading-nation-aca-enrollment/
2. Florida website aimed at the uninsured draws little interest Tia Mitchell Tampa Bay Times April 28, 2014 http://www.tampabay.com/news/politics/stateroundup/florida-website-aimed-at-the-uninsured-draws-little-interest/2195173

ENDNOTES

3. http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/august-2014-enrollment-report.pdf Table 1: Medicaid and CHIP: July and August 2014 Preliminary Monthly Enrollment

4. Interview with AJS staff, July, 2014.

5. Interview with AJS staff, July, 2014.

6. Interview with AJS staff, July, 2014.

7. Interview with AJS staff, July, 2014.

8. Interview with AJS staff, July, 2014.

9. Interview with AJS staff, July, 2014.

10. Interview with AJS staff, July, 2014.

11. Interview with AJS staff, July, 2014.

12. Interview with AJS staff, June, 2014.

13. Interview with AJS staff, July, 2014.

14. Interview with AJS staff, July, 2014.

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