

### **THE PROBLEM**

According to the 1999 Florida Health Insurance Study (FHIS), 24.6 percent of the nonelderly population of Miami-Dade County—nearly one-half million persons—are uninsured.<sup>1</sup> This is well above the national average of 16 percent,<sup>2</sup> ranking fourth among selected metropolitan areas (MSAs)(see Table 2.1).<sup>3</sup> Within Florida itself, Miami-Dade’s uninsured rate is exceeded only by that of the rural midstate counties<sup>4</sup> (25.5 percent for those counties, taken together). Lack of health insurance is disproportionately high among ethnic minorities in Miami-Dade (see Figure 2.1) and thus also among immigrants, most of whom are ethnic minorities.

People with lower incomes in Miami-Dade are also less likely to have health insurance. The FHIS found that nearly one-third of those with incomes of less than 150 percent of the federal poverty level (FPL) lacked health insurance. In stark contrast, less than 20 percent of those with family incomes between 200 and 250 percent of the FPL lack health insurance, and less than 10 percent of those with family incomes over 250 percent of the FPL are uninsured. This supports

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<sup>1</sup>Agency for Health Care Administration (AHCA) (2000).

<sup>2</sup>Moyer (1999).

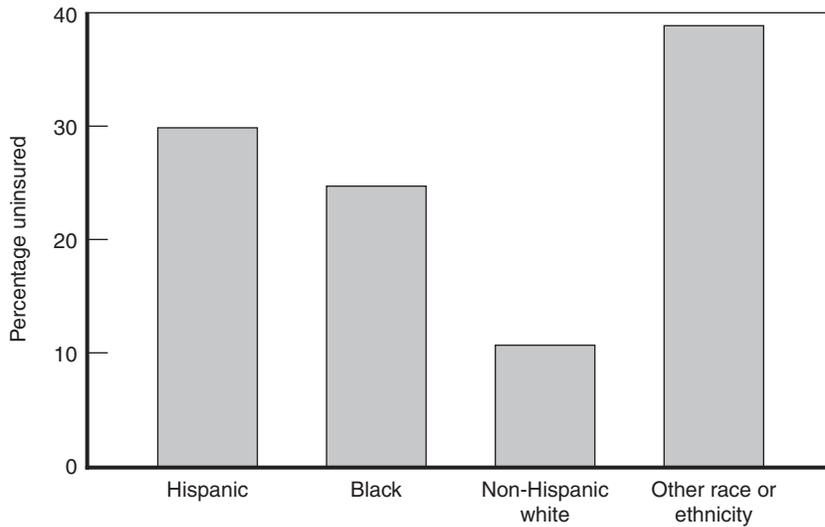
<sup>3</sup>The MSAs were selected to be comparable to Miami—that is, they were either in Florida or had significant Hispanic populations.

<sup>4</sup>De Soto, Glades, Hardee, Hendry, Highlands, Monroe, and Okeechobee Counties (Florida Health Insurance Study, AHCA, 2000).

**Table 2.1**  
**Selected MSAs with High Uninsured Rates,**  
**All Income Levels, Ages 0–64, 1997**

MSA	Percent Uninsured
El Paso, TX	37
Los Angeles, CA	31
West Palm Beach, FL	29
Miami, FL	27
Tucson, AZ	26
Fort Lauderdale, FL	26
Tampa, FL	25

Source: Bureau of the Census, *Current Population Survey*, March 1998, adapted from Brown et al. (2000).

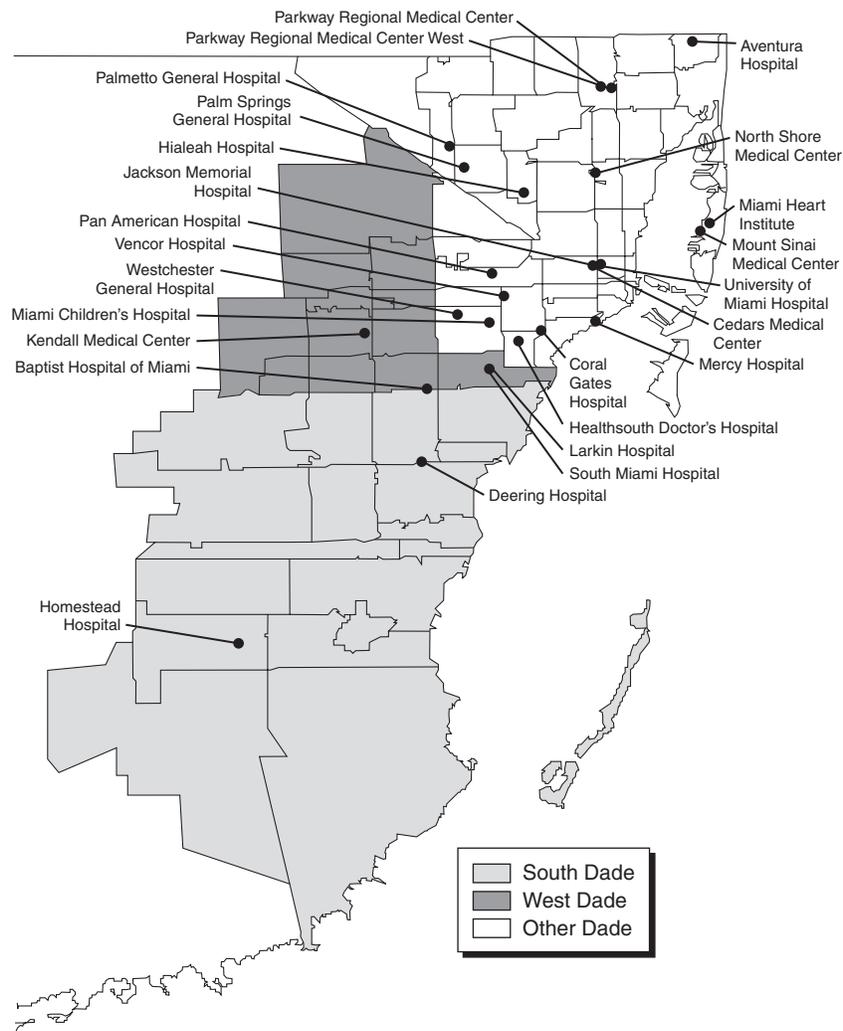


NOTE: The FHIS did not distinguish between African-Americans and Haitians.

**Figure 2.1—Racial/Ethnic Minorities in Miami-Dade Are Disproportionately Uninsured**



are concentrated in the Miami urban center and in the county's more rural south. However, most of the hospitals are located in the urban center of the county, as shown in Figure 2.3, including JM. Thus, people living outside the urban center may need to travel when they seek hospital care.



**Figure 2.3—Most of the Hospitals in Miami-Dade Are Located in the Metropolitan Area of the County**

## RECENT ATTEMPTS TO ADDRESS THE PROBLEM

In the past ten years, a variety of local and state efforts have been made to address the problem of the uninsured in Miami-Dade County. These efforts have included planning, legislation, and litigation. The process has been contentious, with different parties motivated by different views as to which institutional arrangements best serve the uninsured.

In 1991, Florida passed legislation permitting local taxing districts to hold referenda for approval of tax levies to finance health care for the indigent.<sup>5</sup> In September of that year, Miami-Dade County voters approved a surtax of 0.5 percent on sales, the proceeds of which were earmarked “for the operation, maintenance and administration of Jackson Memorial Hospital to improve health care services.”<sup>6</sup> Polls taken shortly before the vote revealed that voters of all ethnicities supported the measure, largely because they believed it would cut waiting lists for poor patients.<sup>7</sup> At the time the surtax was initiated, Jackson Memorial Hospital (JMH) was operating at a loss. The tax provided the funds needed to stabilize the hospital and allowed it to grow and improve. These funds helped expand hours at Jackson satellite clinics and, at least anecdotally, reduced waiting times and no-show rates.<sup>8</sup> Today, JMH receives over \$140 million annually from the surtax<sup>9</sup> and is a well-respected tertiary-care hospital.<sup>10</sup>

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<sup>5</sup>Title XIV, Taxation and Finance, Chapter 212, Tax on Sales, Use and Other Transactions. For Miami-Dade County, the law assigned all surtax revenues to the sole public hospital with no requirement that the funds be dedicated to providing indigent care. The surtaxes applying to other large counties and to small counties were designated for indigent care, not assigned to the local county hospital.

<sup>6</sup>Language on the referendum ballot.

<sup>7</sup>Petchel (1991).

<sup>8</sup>Rogers (1993).

<sup>9</sup>Public Health Trust (2000).

<sup>10</sup>Tertiary care involves the most complex services (including open heart surgery, burn treatment, and transplantation) and is provided in inpatient hospital facilities. Primary care is oriented toward the daily, routine needs of patients (such as initial diagnosis and continuing treatment of common illnesses) and is provided in outpatient facilities. Secondary care includes “routine” hospitalization and specialized outpatient care.

JMH is ranked in the top 25 hospitals in the nation in treating eye disorders; among the top 25 hospitals in pediatrics; and among the second 25 in gynecology and in treating kidney disease, ear-nose-throat disorders, and digestive disorders (2000 *U.S.*

The surtax accomplished the goal of supplying funds to stabilize JMH and improve its health-care services. As the sole county hospital, JMH continued to provide quality care to the uninsured in Miami-Dade County. However, JMH was not the only health-care provider serving the uninsured. By 1993, other hospitals in the Miami-Dade County area that cared for the indigent had begun to voice concerns that they deserved a share of the surtax revenue.<sup>11</sup> These facilities argued that they were more cost-effective than JMH, and a distribution of surtax dollars to other hospitals would allow indigent patients to receive care closer to their homes.<sup>12</sup>

Meanwhile, controversy had also arisen over the mechanism for the planning of indigent health care. In 1991, the Miami-Dade County Commission created an Indigent Health Care Task Force to develop mechanisms to improve the delivery of health care to the uninsured. This task force included representatives from various community associations and from the Miami-Dade County Public Health Trust, a county-appointed board of community-member volunteers that had been established to oversee JMH. (The board has included as *ex officio* members administrators and staff from JMH as well as the University of Miami.) The task force produced an extensive plan for improving care for the uninsured and underinsured, which included 39 goals and specific recommendations for ways to achieve them.<sup>13</sup> Among the recommendations were the following:

- Establish an independent board to plan, control financing, and monitor the indigent-health-care system.
- Develop a system that is decentralized and reflects a community-based responsibility for indigent health care.

The County Commission did not officially accept the task force report, but action eventually was taken on the first of the two recommendations. In 1995, County Commissioner Maurice Ferré advanced

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*News and World Report* hospital rankings, <http://www.usnews.com/usnews/nycu/health>, February 9, 2001, update).

<sup>11</sup>Nancy Ancrum, member of editing board of the *Miami Herald* (personal communication, 2001).

<sup>12</sup>Guber (1993).

<sup>13</sup>Dade County Indigent Health Care Task Force (1992).

an ordinance to create an independent authority that would submit to the County Commission unbiased recommendations on county-wide indigent-health-care planning. A semiautonomous entity was ultimately approved (Ordinance 95-71), and the Dade County Health Policy Authority was created to advise the County Commission *through* the Public Health Trust.<sup>14</sup> One-third of the Authority board members are also board members of the Public Health Trust (which oversees JMH), so it is not a fully independent entity. The Public Health Trust Board of Trustees passed a resolution on December 14, 2000, requesting the Health Policy Authority to simultaneously submit all reports to the Trust and to the Board of County Commissioners to “eliminate a perception that the Trust is filtering reports and not moving forward on reports submitted by the Authority.”<sup>15</sup> However, only the Trust—not the Authority—is able to request that the reports become agenda items at Commission meetings (where they are acted upon).

The following example illustrates the restrictions and limitations of the Health Policy Authority on expeditiously and efficiently affecting health-care policy in Miami-Dade. From 1997 to 1998, the Authority, together with the Health Council of South Florida and many community partners, conducted the South Dade Community Health Initiative. This multiagency effort produced a report<sup>16</sup> that contained a series of recommendations to the County Commissioners (via the Public Health Trust) on ways to improve access to health care for the uninsured and underserved in South Dade, the most remote area of the county.<sup>17</sup> In February 1999, the Public Health Trust issued a Staff Response to the Community Health Initiative Report.<sup>18</sup> The Trust stated that its own planning initiatives were addressing issues similar to those raised in the report. Those initiatives included the Dade County Five-Year Plan for 1993–1998, which covered primary, secondary, and tertiary health-care services in the county. The Trust also stated that it should not bear full responsibility for addressing at

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<sup>14</sup>Hoo-you (2000).

<sup>15</sup>Public Health Trust Board of Trustees Meeting minutes, December 14, 2000.

<sup>16</sup>South Dade Community Health Initiative Final Report, October 1998.

<sup>17</sup>South Dade is the southern part of Miami-Dade County, beginning at Kendall Drive (also known as SW 88th Street).

<sup>18</sup>Hoo-you and Lucia (1999).

a loss the unmet need for health services in all of Miami-Dade County. The Trust requested that the Health Policy Authority collect additional data to identify and quantify the voluntary contributions of not-for-profit providers toward addressing unmet needs in South Dade and to indicate how these providers could contribute toward the recommendations in the Initiative report.<sup>19</sup> The Trust's rationale was that these providers receive a certain financial benefit from their tax-exempt status, and therefore they should provide uncompensated care commensurate with this benefit. This rationale is consistent with the point made by some policy analysts that the level of uncompensated care provided by many institutions is not commensurate with the value of their tax exemption: Hospitals in the poorest communities tend to provide more than average uncompensated care, while those in more affluent communities often provide less than average.<sup>20</sup>

The South Dade Community Health Initiative Report was ultimately approved by the County Commission. In fall 2000, the Chairman of the Public Health Trust requested that the Health Policy Authority write a document, "Elaboration of Recommendations Related to the Public Health Trust as Derived from the South Dade Community Health Initiative," to enable the Trust to develop implementation plans for the recommendations. As of December 2000, the Trust had several public media initiatives under way or planned that were consistent with recommendations in the South Dade report.<sup>21</sup> The Trust also passed two resolutions directing staff to complete further analysis, including recommendations for implementation, related to transportation and access to primary care in South Dade.<sup>22</sup>

Nonetheless, the controversy surrounding the health-care surtax became even more contentious amid reports that JMH had substantial cash reserves, reported to be as much as \$470 million.<sup>23</sup> Trust offi-

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<sup>19</sup>Ibid.

<sup>20</sup>Kane and Wubbenhorst (2000).

<sup>21</sup>Public Health Trust Program Planning and Primary Care Committee minutes, December 22, 2000.

<sup>22</sup>Public Health Trust Program Planning and Primary Care Committee minutes, January 26, 2001.

<sup>23</sup>Balmaseda (1999).

cials contended that referring to all of these funds as reserves is misleading, since substantial amounts are legally restricted by bond issue terms, have been committed to construction programs by approved contracts, support employee-benefit programs, or have been escrowed for self-insurance liabilities based on actuary reports.<sup>24</sup> Moreover, it is common practice for hospitals to accumulate reserves to provide capital for expansion and renovation.<sup>25</sup> In 1999, Trust representatives estimated that the unrestricted funds in reserve amounted to \$300 million.<sup>26</sup> In the midst of these community debates about JMHS's cash reserves, on May 5, 2000, the Florida Legislature amended the Florida Surtax Statute to make it possible for providers other than the county hospital (JMHS in Miami-Dade) to receive county funding for indigent health care.<sup>27</sup> However, on September 19, 2000, the Miami-Dade Board of County Commissioners declared through Ordinance 00-111 that this amendment violated Miami-Dade County's Home Rule Charter and refused to comply with it. As a result, several hospitals filed a lawsuit on February 8, 2001, to require the county to implement the surtax amendment (and thereby remit the required funds to an independent authority to fund a plan for indigent-health-care services). The lawsuit was dismissed without prejudice on July 24, 2001. The private hospitals filed an amended complaint on September 26, 2001, which has also since been dismissed.

### COMMUNITY VOICES—MIAMI

The Community Voices—Miami project was thus conceived in a community that had experienced considerable debate over how to provide health care to the uninsured. The lack of major systemwide

<sup>24</sup>Conchita Ruiz-Topinka, Public Health Trust, personal communication (October 12, 2001).

<sup>25</sup>See, for example, Lisa Gibbs, special to the *Miami Herald*, October 22, 2001.

<sup>26</sup>Public Health Trust Executive Committee Meeting minutes, September 27, 1999.

<sup>27</sup>The 1991 Florida surtax statute stated that the county must, in addition to the surtax, continue to fund the county hospital to the extent of at least 80 percent of the prior county funding (a "maintenance of effort" (MOE) requirement). The 2000 Florida surtax amendment modified the 80 percent MOE, earmarking up to 25 percent of the MOE funding for a special fund to be administered by a board independent from the board that runs the county public hospital, against which all eligible hospitals within the county could make claims (for reimbursement in proportion to the uncompensated care provided).

change motivated the project's initiators at Camillus House to establish a structure that might prove more successful at turning concepts into action. To this end, project leaders sought to establish consensus by bringing together as broad an array of community representatives and health-care providers as possible. These individuals were distributed among three standing committees with different purposes:

- The Oversight Team, composed of representatives of Camillus House, United Way, and RAND, as well as community leaders, was charged with providing administrative oversight for Community Voices.
- The Multi-Agency Consortium (MAC), composed of health-care and social-service providers, community leaders, regulatory policymakers, and other "stakeholders," was organized to create a long-term strategic plan for improving health care for the underserved and to design implementation strategies.
- The Leadership Council, composed of community leaders, was created to mobilize political and economic support for the strategic plan.

Community Voices was aware that the size, geographical layout, and economic and ethnic diversity of Miami-Dade County presented significant challenges to improving access to health care by the underserved. In addition, changes in health-care funding brought about by managed care also appeared to be eroding the ability of the county's hospitals to provide care to this group. At the second meeting of the MAC in July 1999, RAND was asked to conduct the funds-flow analysis described in the remainder of this report.

## **SUMMARY**

- The proportion of uninsured persons in Miami-Dade County is high relative to national averages and to the proportion in other areas of Florida. Many of the uninsured live in Miami's urban center and in the southern area of the county. However, those living in the south also live far away from most hospitals.
- Local and state efforts to address the problem have achieved some success in funding care for the uninsured, primarily

through a surtax. However, the allocation of the surtax (100 percent to JMH) and the mechanism for planning indigent health care remain controversial.

- Community Voices–Miami convened an array of community representatives and health-care providers to establish a structure for improving access to care for the uninsured and asked RAND to conduct the analyses presented in this report.