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NEW GEORGIA AND FLORIDA HEALTH PLANS UNLIKELY TO REDUCE RANKS OF UNINSURED

By Judith Solomon

This year, Georgia and Florida — states in which the percentage of people who are uninsured is well above the national average of 18 percent — have enacted legislation aimed at decreasing the number of uninsured residents. Georgia created new tax breaks for high-deductible health plans, while Florida will allow private insurance companies to sell "bare-bones" policies offering limited benefits. These initiatives, which differ markedly from the comprehensive health reform plans that Massachusetts and Vermont enacted in 2006 (and that 13 other states have been considering),[1] share some key characteristics:

- **Neither approach provides a targeted subsidy to help low-income people, who make up the bulk of the uninsured, afford coverage.** About two-thirds of uninsured Americans have incomes below 200 percent of the poverty line ($35,200 for a family of three); three-quarters have incomes below 300 percent of the poverty line ($52,800 for a family of three).[2] Most of these individuals cannot afford coverage without subsidies to help pay for it.[3]

- **Neither plan is likely to lead to an appreciable increase in the number of people with health coverage,** since neither includes the subsidies needed to make coverage affordable.

- **Many people who do get coverage through these initiatives will be underinsured.** Many could face high out-of-pocket costs and have problems paying their medical bills.

[1] John E. McDonough, *et al.,* "A Progress Report on State Health Access Reform, *Health Affairs* web exclusive, January 20, 2008.

[2] Center on Budget and Policy Priorities analysis of 2007 Current Population Survey data.

[3] See, for example, Linda J. Blumberg *et al.,* "Setting a Standard of Affordability for Health Insurance Coverage," *Health Affairs* web exclusive, June 4, 2007.

Georgia: Costly New Tax Breaks, Mostly for Insurance Companies, That Will Likely Result in Little Coverage Gain

Almost 1.7 million Georgians — 20 percent of all residents under age 65 — are uninsured. Almost two-thirds of them have incomes below 200 percent of the poverty line.[4] Yet in sharp contrast to the recent coverage expansions in Massachusetts and other states, Georgia's plan does not attempt to help these low-income individuals obtain insurance. Instead, as its supporters acknowledge, the plan's main target is uninsured people with incomes over $50,000.[5]

The Georgia law (HB 977) makes a number of changes in the tax treatment of high-deductible health plans that can be used with Health Savings Accounts (HSAs)[6] but does not *require* that the plans be coupled with an HSA. The law is simply a series of tax breaks and other benefits for high-deductible plans:

- High-deductible plans will be exempt from the premium taxes that Georgia and its local governments impose on insurers. (The state premium tax is 2.25 percent of gross premium revenue; counties and municipalities are allowed to charge up to an additional 2.5 percent.)
- Businesses with fewer than 50 employees that offer high-deductible plans and pay at least $250 a year toward the cost of coverage will receive a $250 tax credit for each employee enrolled in a high-deductible plan for a full year.
- Individuals who purchase high-deductible plans in the individual market will be able to deduct their premiums from their income when they determine their state income tax liability.

The bill also establishes a "fast track" process for the state to approve new high-deductible plans for sale in Georgia and allows insurers to offer rebates and incentives to attract purchasers.[7]

A strong advocate for the Georgia law was the Center for Health Transformation (CHT), led by former Speaker of the House Newt Gingrich. According to CHT, the bill will make high-deductible plans less expensive, which in turn will lead more individuals and small businesses to purchase these plans.

CHT claims, on the basis of deeply flawed analysis (see the box on next page), that 500,000 Georgia residents will gain coverage as a result of the new law.[8] An analysis of the state legislature's fiscal note, however, suggests that from 2009 to 2013, the number of high-deductible health policies would increase by only about 65,000 and that many of these policies would likely cover people who

[4] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey.

[5] Ron Bachman, "The Impact of Insuring 500,000 Georgians Previously Uninsured," Center for Health Transformation, June 2008.

[6] In tax year 2008, federal law defines a "high-deductible" health plan as one with a deductible of at least $1,100 for individual coverage and $2,200 for family coverage. An overview of the major flaws with HSAs and high-deductible health plans along with citations to numerous studies and papers is at http://www.cbpp.org/pubs/hsa.htm.

[7] Office of Governor Sonny Perdue, "Governor Perdue Signs Healthcare Reform Bills," May 7, 2008.

[8] Aaron Gould Sheinin, "Perdue signs high-deductible insurance plan bill," *The Atlanta Journal-Constitution,* May 7, 2008.

switched from one type of health insurance to another, rather than people who would otherwise be uninsured. Thus, the number of uninsured people gaining coverage would be small.[9]

This should not be surprising. For an individual, the new state income tax deduction will offset only about 6 percent of the cost of coverage. For small employers, the new $250 tax credit will offset about 5 percent of the cost.[10] It is unlikely that many individuals who would otherwise be uninsured, or many small employers who otherwise would not offer coverage, will purchase health insurance as a result of the new law. It is more likely that some people who already have coverage will switch to high-deductible plans to take advantage of the tax deduction or credit.

CHT and other groups are now promoting the Georgia approach to other states on misleading grounds. For example, a recent op-ed in a New Mexico newspaper claimed that Georgia was on a path to cover 500,000 uninsured individuals and urged New Mexico lawmakers to follow Georgia's lead.[11]

The Georgia legislation also has downsides. The legislature's fiscal note estimates that state and local governments will lose almost $223 million in revenue between 2009 and 2013 from the new tax breaks. Two-thirds (67 percent) of this amount will go to insurance companies; 30 percent will go to employers.[12]

In addition, high-deductible health plans such as those that the Georgia law promotes pose risks to low-income individuals. A recent study by the Government Accountability Office (GAO) confirms that such plans are risky for people who have low incomes and people with significant health problems because of the potential for such people to be left with substantial out-of-pocket costs they cannot afford — and to forgo needed health care as a consequence.[13]

Moreover, another new study finds that *more than half* of the people at all income levels who are "underinsured" — meaning that their out-of-pocket medical costs exceed 10 percent of their income (or 5 percent of income for people below 200 percent of the poverty line) or that their deductibles alone exceed 5 percent of income — went without needed care during the year. Some 45 percent of these people reported problems paying medical bills.[14] These findings raise particular concern about the effects on low- and moderate-income people of the high-deductible plans that the

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[9] See Timothy Sweeney, "Analysis of HB 977," Georgia Budget and Policy Institute, March 2008.

[10] Sweeney.

[11] Paul Gessing, "State should follow Georgia's model on health care, *Las Cruces Sun-News,* June 3, 2008. See also, Ronald E. Bachman, "A Guide for State Legislators: Creating an HSA State," Center for Health Transformation, March 2007.

[12] Georgia Department of Audits and Accounts, letter to Honorable Judson Hill, March 25, 2008. See also Sweeney, note 10. The $223 million projection assumed the local tax changes would take effect in July 2008, not January 2009 as finally enacted, so the actual revenue loss over this five-year period would be somewhat lower.

[13] The GAO study also found that high-income individuals are using HSAs as tax shelters. "Consumer-Directed Health Plans: Small But Growing Enrollment Fueled by Rising Cost of Health Care Coverage," Government Accountability Office, GAO-06-514, April 28, 2006.

[14] Schoen *et al.,* "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* web exclusive, June 10, 2008.

The Unfounded Claim That 500,000 Georgians Would Gain Coverage

The claim that changing the treatment of high-deductible health plans would reduce the number of uninsured Georgia residents by 500,000 first surfaced as a "rough estimate" in a CHT report to the Georgia General Assembly.[1] CHT's estimate, which relied on an outdated 1996 CBO analysis,[2] resulted from the following calculations:

- Without offering any evidence to show how the proposed changes would actually reduce premiums or explaining how it arrived at its estimate, CHT assumed that the cumulative impact of these changes would be a 41 percent decrease in the cost of high-deductible plans.
- CHT next applied the 1996 CBO analysis — despite the fact that most of the effect of the new Georgia law is likely to be in the individual health insurance market rather than the employer health insurance market — which found that every 1 percent increase in premiums for employer-sponsored insurance resulting from a mental health parity requirement would cause 300,000 Americans to lose coverage.
- CHT assumed that each percentage-point decrease in the price of high-deductible plans would raise the number of insured Georgians by 10,000 (the 300,000 national number scaled to Georgia).
- Using all of these questionable assumptions, CHT found that a 41 percent decrease in premiums for high-deductible plans would result in 410,000 more Georgians with coverage.
- CHT then claimed that an additional 90,000 people would gain coverage through other changes the group was promoting. Some of these other changes, including new health clinics and tax credits to providers that adopt health information technology, were *not* enacted into law, but CHT continues to use the 500,000 estimate.

In October 2007, CBO issued a paper explaining its current assumptions regarding how lowering premiums in the individual health insurance market would affect take-up by the uninsured — an analysis with greater relevance to Georgia's new legislation. Under the CBO assumptions, fewer than 100,000 Georgians would become insured under the state's plan, *even if one also accepts the unfounded assumption that the cost of coverage would decline by 41 percent.*[4]

[1] Center for Health Transformation, "Recommendations for Free-Market Solutions to Insure All Georgians for Healthcare," 2008.

[2] Congressional Budget Office, "CBO's Estimate of the Impact on Employers of the Mental Health Parity Amendment in HR 3103," unpublished, May 13, 1996.

[3] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

[4] Congressional Budget Office, "CBO's Health Insurance Simulation Model: A Technical Description," October 2007.

Georgia law favors and suggest that the money Georgia policymakers poured into the new tax breaks could have been spent more effectively in other ways to help low- and moderate-income uninsured individuals gain meaningful coverage.

Florida: "Bare-Bones" Insurance Policies of Little Help to the Uninsured

Florida has an even bigger challenge than Georgia, with 3.7 million uninsured residents — 24 percent of all residents under age 65 — and a budget deficit of over $3 billion for fiscal year 2009. As in Georgia, almost two-thirds of those lacking health coverage have incomes below 200 percent of the poverty line.[15]

Touted as a way to provide "affordable health insurance options" to uninsured Floridians, the recently enacted "Cover Florida" plan allows insurers to offer policies with limited benefit packages.

- Insurers that participate in Cover Florida must offer a choice of at least two different plans. Some plans may not cover hospital or emergency room care, although insurers must offer one option that does include at least some coverage for these services

- Insurers can keep costs down by putting limits on the number of services they offer and capping the amount they pay for benefits;

- While insurers cannot turn people away based on their health status, they can exclude coverage for pre-existing conditions.[16]

Policies will be available to people between the ages of 19 and 64 who have been uninsured for at least six months.[17] Insurers in the state have said that they can offer the policies for about $150 a month, which is about 60 percent below the average cost of a policy for an individual.[18] It is not clear whether coverage at this price would be for a plan that includes inpatient and emergency care, and whether premiums would be higher for people in poor health.[19]

Cover Florida has received considerable attention,[20] but the track record for bare-bones policies suggests that they will not attract many uninsured Floridians, especially when — as with the new state law — premium subsidies for low- and moderate-income consumers are not provided.[21] A review of similar initiatives found that "in states where insurers have . . . begun to sell scaled-back

[15] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey.

[16] Senate Bill 2534, which Governor Crist signed on May 21, 2008. The law does not specify a maximum time period for exclusion of coverage for pre-existing conditions.

[17] There are some exceptions to the six-month requirement, such as people who have exhausted their coverage under COBRA or lost a job that offered health insurance.

[18] Kevin Sack, "New Florida Law Allows Low-Cost Health Policies," *The New York Times,* May 22, 2008.

[19] Like many states, Florida allows insurers selling in the individual health insurance market to vary premiums based on an individual's health status. "Failing Grades: State Consumer Protections in the Individual Health Insurance Market," Families USA, June 2008.

[20] "The Florida Revelation. . . ," *The Wall Street Journal,* May 29, 2008; Sack.

[21] Jonathan Gruber, "Covering the Uninsured in the United States," NBER Working Paper 13758, January 2008.

benefit products, take-up rates have been remarkably low."[22] Researchers have suggested that people do not perceive these plans as being worth the money.[23]

Florida already has experience with another limited-benefits plan, "Health Flex," which has had very low take-up. In 2002, state legislation authorized insurers to offer limited-benefit plans to low-income people.[24] ("Cover Florida" differs in that it will be available to people at all income levels.) Six years later, insurers are currently offering only five Health Flex plans, and the plans are available in just three of Florida's 67 counties. According to Health Flex's 2007 annual report, a total of 2,280 people were enrolled in the five plans at the end of the year; all but 50 of them were in three plans that individual counties are subsidizing, and one of those subsidized plans is shutting down because the county has withdrawn its funding.[25] The annual report concludes that the "future of the Health Flex Program appears to depend largely on the availability of government or private funding sources to subsidize part of the costs."

When low-income people do enroll in bare-bones plans, they face a significant risk of experiencing high out-of-pocket costs. Bare-bones plans provide limited or no coverage for important benefits such as inpatient care, and they often have high deductibles or other cost-sharing charges.[26] A substantial body of research shows that even modest cost-sharing causes low-income people to forgo needed care.[27] Moreover, low-income people who get care through bare-bones plans may go into debt. Medical debt problems contribute to about half of all bankruptcies, and many individuals who declare bankruptcy actually had health coverage for at least part of the time they experienced health problems but the insurance left them with high out-of-pocket expenses.[28]

Conclusion

Because most uninsured people have low incomes, they need subsidies to help them afford coverage. The new Georgia and Florida initiatives lack such subsidies and thus will not benefit most uninsured residents. People who do enroll in Georgia's high-deductible plans or Florida's bare-bones plans will still be at risk for high out-of-pocket costs and unpaid medical bills.

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[22] Isabel Friedenzohn, "Limited-Benefit Policies: Public and Private-Sector Experiences," State Coverage Initiatives, July 2004.

[23] Sack.

[24] The 2008 legislation establishing Cover Florida reauthorizes the Health Flex Plan through 2013 and raises the income limit for participants from 200 to 300 percent of the poverty line.

[25] *Health Flex Plan Program: Annual Report,* Agency for Health Care Administration, January 2008.

[26] Sherry Glied *et al.,* "Bare-Bones Health Plans: Are They Worth the Money?" The Commonwealth Fund, May 2002; Kyung Song, "Bare-bones health plan left family swimming in debts," *The Seattle Times,* February 28, 2008.

[27] The research on cost-sharing and premiums is summarized in Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 7, 2005.

[28] David U. Himmelstein *et al.,* "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* web exclusive, February 2005.