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Key Points

Approximately 21 percent of non-elderly Floridians are without health insurance coverage.

Options for improving health insurance coverage in Florida must consider:

- The large number of small employers in the state
- The considerable variability of rates of uninsurance across Florida's communities
- The increasing financial pressures facing Florida Medicaid and KidCare

Tax credits, insurance pools, and health savings accounts, while not perfect solutions, offer potential for improving rates of coverage throughout the state.

Improving Healthcare Coverage in Florida

Introduction

Despite repeated calls for reform, large numbers of people in the United States continue to be without health insurance. Recent estimates for 2002 put the number of uninsured under age 65 in the United States at about 43.3 million, reflecting an increase of 2.4 million since 2001 (Kaiser Family Foundation, September 2003).

The consequences of being uninsured are well documented. We know that those without coverage have greater difficulty gaining access to health care.

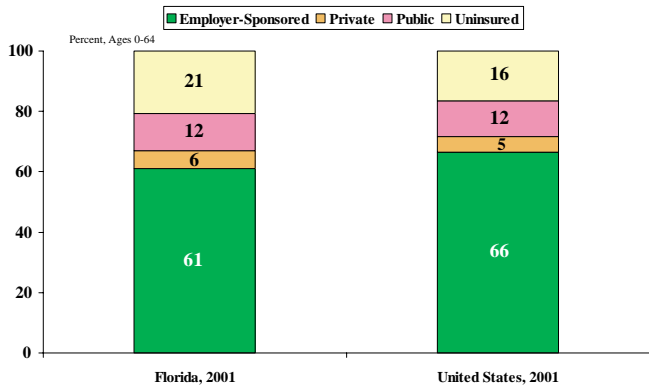
For example, the uninsured are more likely to postpone care or not fill a needed prescription because of cost. They are also more likely to have problems paying medical bills, as well as being contacted by a collection agency about their bills (Kaiser Family Foundation, September 2003).

High rates of uninsurance also have societal and community implications. An Institute of Medicine (IOM) report concluded that a community's high uninsurance rate had adverse consequences on the community's health care institutions (Institute of

Medicine (a), 2003). A study commissioned by the IOM found that within large metropolitan statistical areas (MSAs), as the rate of uninsurance increased, the availability of certain hospital services decreased (Gaskin and Needleman, 2003). Furthermore, the level of speciality services such as trauma, psychiatric, and alcohol and chemical dependence treatment services are lower in MSAs with high rates of uninsurance.

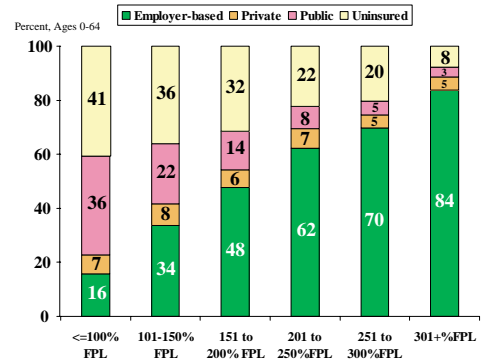
Having health insurance is also linked to better health outcomes. The IOM estimates that the value of a healthier

Figure 1: Health Insurance Coverage United States and Florida, 2001



Analysis of the 1996 and 2002 March Supplement to the Current Population Survey

Figure 2: Health Insurance Coverage by Poverty Level¹ Florida, 2001



¹ In 2001, 100 percent of the Federal Poverty Level was \$8,590 for an individual. Analysis of the 1996 and 2002 March Supplement to the Current Population Survey

life that an uninsured child or adult forgoes because of the lack of health insurance is between \$1,645 and \$3,280 for each year without coverage (Vigdor, 2003). This translates into an aggregate annualized estimate of between \$65 and \$130 billion for the nation for each year of insurance foregone (Institute Of Medicine (b), 2003).

health care coverage for all uninsured citizens in the state.

Florida's Uninsured: Who are They?

Persistent high rates of uninsurance in Florida have been well documented. The Kaiser Family Foundation ranks the state of Florida sixth in the nation in terms of the percent of its population without health insurance coverage. Estimates from the 2000-2001 Current Population Survey indicate that about 18 percent of Florida's population is uninsured (Kaiser Family Foundation Online State Health Facts). Other analyses show that about 21 percent of non-elderly Floridians are without coverage (Figure 1).

Individuals in Florida, who are socioeconomically disadvantaged, are more likely to be without health care coverage (Figure 2). Among the non-elderly who live below 100 percent of the federal poverty level, 41 percent are without coverage compared to approximately 20 percent of individuals between 201 and 300 percent of the poverty level.

Racial and ethnic non-elderly minorities are also more likely to be without health insurance: 14 percent of non-Hispanic whites, 25 percent of non-Hispanic blacks, and 37 percent of Hispanics living in Florida are uninsured. Foreign-born residents of the state are particularly vulnerable: almost 50 percent of non-citizens do not have coverage compared

to 17 percent of citizens (Figure 3).

The 1999 Florida Health Insurance Study (FHIS) showed dramatic variations across communities (Duncan et al, 2000). For example, the study showed that in Miami-Dade County, 25 percent of the non-elderly were uninsured, compared to about 15 percent in Palm Beach County. A more recent analysis from the 2002 March Supplement of the Current Population Survey demonstrated that this significant variation in communities continues to occur. Among major metropolitan areas within the state, Jacksonville has the lowest rate of uninsurance (13 percent) compared to rates in West Palm Beach /Boca Raton (22 percent) and Miami (29 percent) (Figure 4).

The 1999 FHIS also provides insight into the situation in Florida's rural areas. Although only three percent of Florida's non-elderly reside in rural areas, roughly 25 percent of these residents are uninsured.

Incremental Options for Reform

The various options for reform proposed by state and national policymakers and opinion leaders share some common themes: the reform proposals build on the current system of employer-sponsored coverage, most of the proposals advocate for an expanded public-sector role and focus on individual responsibility.

Options for reforms must be mindful of regional socioeconomic differences. Strategies that improve coverage in one part of the country may not work in another part.

The window of opportunity to improve health care coverage in the United States and in Florida appears to be opening. Both Democrats and Republicans are making health insurance reform a key issue in the 2004 presidential campaign. In Florida, two task forces have deliberated and made recommendations to the Governor and the Legislature on this issue. Furthermore, Florida was recently awarded a grant from the federal government to provide an up-to-date estimate of the number of uninsured and to make recommendations for providing

Building on the Employer Base

There are advantages to building on the existing employer based system. Obtaining health insurance from an employer is the way most people get coverage. Over the last century, Americans have come to accept employer-sponsored health insurance as the norm. (Duchon et al, 2000) Furthermore, employer coverage permits health risk pooling, automatic enrollment and payroll withholds for premium payments, and experienced benefit plan managers (Davis and Schoen, 2003).

Rates of uninsurance in Florida vary significantly across communities reflecting local differences in employer-based and public coverage, as well as in population characteristics.

Strategies that build on the current employer-based system of health insurance must be cognizant of the structure and composition of the employers, particularly those in the private sector.

In Florida, the majority of private sector establishments have a small number of employees. In 2001, almost three-quarters of all private sector firms had fewer than 25 employees (Figure 5). That is, about 1.3 million workers statewide, or about 21 percent of private sector workers, are in firms with fewer than 25 workers.

Small firms are less likely to provide coverage compared to larger firms. For example, only 40 percent of firms with fewer than 10 employees offer coverage, while close to 100 percent of firms with more than 1,000 employees offer coverage (Figure 6). However, workers in large firms are also at risk for being uninsured. Recent national estimates indicate that

the number of uninsured workers in large firms is increasing (Glied, 2003).

Small employers tend not to offer health care coverage because it is expensive. Premiums for small employers tend to be higher because (a) costs of marketing and administration must be spread over fewer enrollees, (b) small firms are at greater risk for adverse selection, and (c) small establishments lack the bargaining power of larger employers in negotiating with insurers. As a consequence, workers in smaller firms have higher average employee contributions relative to workers in firms with over 1,000 employees (Figure 7).

It is important to note that when small firms do offer coverage, a high percentage of their employees are eligible (Figure 8) and are enrolled in health plans (Figure 9).

Proposals from various sectors including the White House, Congress, former Democratic presidential candidates, and from Florida's Governor and Lieutenant Governor all place emphasis on small employer groups. In his 2004 State of the Union Address, President Bush noted "small businesses should be able to band together and negotiate for lower insurance rates, so they can cover more workers with health insurance."

Purchasing Pools: Several Democratic candidates (Collins et al, 2003) and other

Figure 3: Health Insurance Coverage by Race/Ethnicity and Citizenship, Florida, 2001

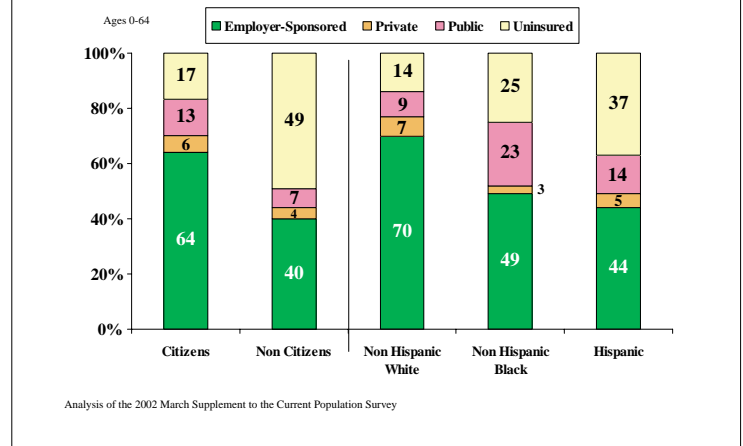
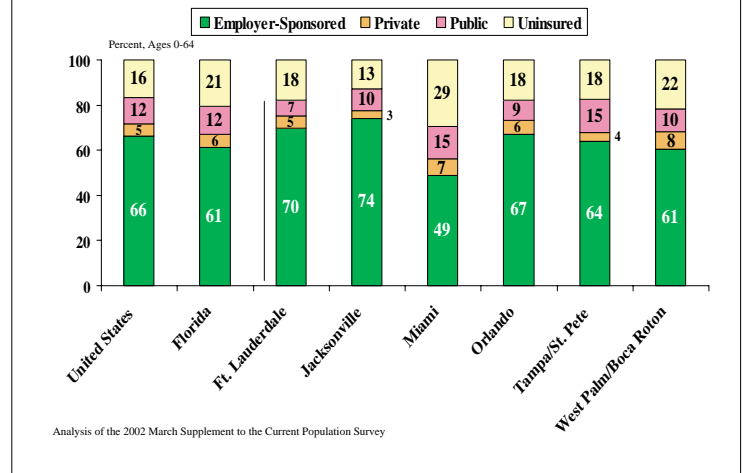


Figure 4: Health Insurance Coverage, Florida, 2001



policy-makers (Davis and Schoen, 2003) have proposed the establishment of a new group insurance option for small businesses and individuals modeled after the Federal Employee Health Benefits Program. One example is S. 39 (Promoting Health Care Purchasing Cooperatives Act) introduced in the US Senate. This bill promotes the development of health care cooperatives that will aid small businesses in pooling their purchasing power. In Florida, the Governor and the Lieutenant Governor propose creating purchasing pools, which will be available to small employers with two to 25 employees. These pools will offer several 'levels' of plan benefit designs.

The main advantage of purchasing pools is that small establishments will have access to the larger risk pools and increased purchasing power leverage

leading to lower overall premiums. An often cited disadvantage is that purchasing pools can be used only for the healthiest patients, leaving the high-risk patients uninsured or enrolled in public insurance programs.

Building on the Existing Public System

A number of proposals also recommend expanding eligibility in publicly funded programs. Recommendations generally involve either allowing individuals and families the option to buy into public programs or expanding eligibility to additional low-income groups.

State Programs: In Florida, publicly funded health insurance is a significant source of health care coverage. The Florida Medicaid program was established in 1970 and is one of the country's largest. Currently, Medicaid enrolls more than two million people (Agency for Health Care Administration, 2004).

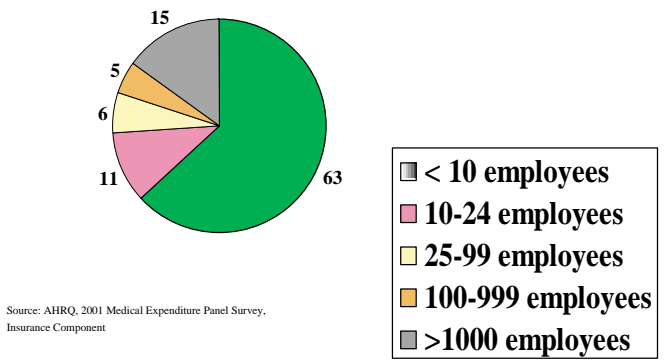
Florida's KidCare program combines Federal and state funding along with family contributions to provide health coverage for children who live at less than 200 percent of the poverty level. Federal funding comes from Medicaid and the State Children's Health Insurance Program (Title XXI). As of June 2003, roughly 1.7 million children were enrolled in KidCare.

Expanding eligibility for public programs statewide will be difficult. Florida, relative to other states, ended the 2002-2003 fiscal year in a respectable financial position (Holahan et al, 2004). Nevertheless, the state completed that year with a \$1 billion shortfall. Consequently, public programs, including Medicaid and KidCare are facing increasing budgetary pressure. Medicaid's budget, at \$14 billion, represents about 23 percent of the total state budget. Lawmakers are searching for ways to curtail Medicaid expenditures through elimination of certain components of the program. For example, during the 2002-2003 legislative session, the medically needy program was slated for elimination. The program survived as a result of strong lobbying on the part of advocates.

Similarly, KidCare, because of decreases in its Title XXI annual allotment, had been forced to create a waiting list for new enrollment in the program (Holahan, 2004). In March 2004, the Florida House and Senate approved a measure to increase funding to the program by \$25 million and provided coverage to about 90,000 children on the waiting list.

However, this new legislation calls for stricter eligibility requirements starting June 30, 2004. Critics of the legislation argue that this will exclude roughly 20,000 children from the program. However, proponents of the bill say that stricter eligibility requirements are necessary to control the program's explosive (and

Figure 5: Percent of Private Sector Establishments by Firm Size, Florida, 2001



Source: AHRQ, 2001 Medical Expenditure Panel Survey, Insurance Component

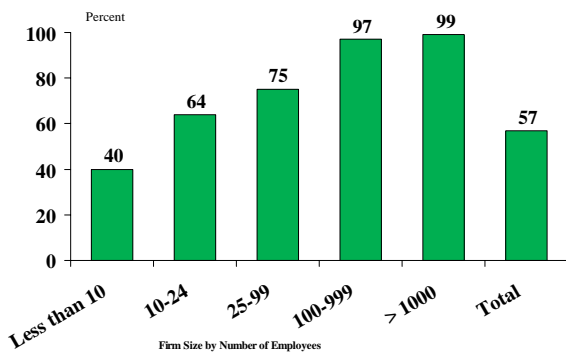
Building on the employer-based system of coverage really means strengthening the ability of small and mid-size employers to offer affordable health care coverage to their employees.

expensive) growth (Hollis, 2004).

HIFA Waivers: Florida, like other states, may wish to pursue a Health Insurance Flexibility and Accountability (HIFA) waiver to expand eligibility in its public programs. Under HIFA, states are permitted to adopt some flexibility in benefit design for expansion populations (but not mandatory populations) and implement cost-sharing requirements. HIFA programs must also have a public-private coordination component and must meet a test of budget neutrality (for Medicaid funds) or allotment neutrality (for SCHIP funds) (Sachs, 2003). Disproportionate Share Hospital Payments (DSH) can also be used to finance increased coverage.

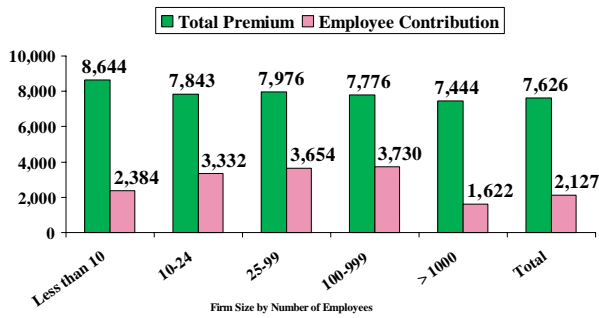
Since its inception in 2002, eight states have received approval to operate HIFA demonstrations. Six of those states (Arizona, Colorado, Illinois, Maine, New Jersey and Oregon) have implemented

Figure 6: Private Sector Establishments Offering Health Insurance by Firm Size, Florida, 2001



Source: AHRQ, 2001 Medical Expenditure Panel Survey, Insurance Component

Figure 7: Average Total Family Premium and Contributions for Family Coverage at Private-sector Firms That Offer Health Insurance, Florida, 2001



Source: AHRQ, 2001 Medical Expenditure Panel Survey, Insurance Component

their waivers.

Community Initiatives: While expansions in statewide programs are fairly unlikely, local communities are beginning to employ a myriad of strategies to address the problem of the uninsured. Palm Beach County, for example, has developed a plan for its uninsured residents through its health care taxing district. Another example is the Hillsborough County HealthCare Program, a managed care program for residents of the Tampa area. Hillsborough's program is funded by a special discretionary sales tax. Finally, JaxCare is a local public-private partnership that provides care for low-income workers in Duval county.

The development of local initiatives has received considerable support from Florida's lawmakers. In 2002, the state legislature implemented Health Flex, a pilot program designed to improve health insurance coverage in areas with the highest concentration of uninsured persons. Non-elderly individuals, with incomes up to 200 percent of poverty and who have not been covered by a private health plan in the last six months, are eligible. Health Flex plans are unique in that they are not subject to licensure under the Florida Insurance code. Consequently, health insurers, provider-sponsored organizations, local governments, health care districts or other public or community-based organizations can design health insurance options that meet the needs of local communities. Recently, the Governor

and the Lieutenant Governor recommended that the Health Flex program be expanded to all counties in the state (Bush and Jennings, 2004).

Focusing on Individuals

President Bush and others advocate for increased personal responsibility in the

selection and use of health insurance. Tax credits and medical or health savings accounts are touted as ways in which consumers can have increased choice in purchasing health insurance.

Tax Credits: To reduce the number of uninsured Americans, both Democratic and Republican policymakers, including the Bush administration, are sponsoring legislation that would allow individuals to receive tax credits toward buying health insurance (Gabel et al, 2002).

A tax credit is not the same as a tax deduction. With a deduction, individuals subtract the amount of money spent on a deductible item from their income. In this case, individuals pay taxes on a smaller income. In contrast, tax credits subtract the allowable amount directly from the amount of taxes owed. Thus, in order for a tax credit to help low-income workers, it has to be "refundable," which means the worker still receives the full value of the credit even if he doesn't owe income taxes (Council for Affordable Health Insurance, 2003).

There are several

appealing aspects of tax credits including the fact that both workers and non-workers can take advantage of tax credits. However, administrative issues are a concern, especially in states such as Florida that do not have a state income tax system to build on. Other critics argue that the value of the tax credit is typically too low to make health insurance affordable. These critics maintain that there are very few low- and moderate-income families that are likely to find room in their tight budgets to pay for health insurance if it still consumes 10 to 20 percent of gross income (Lav and Friedman, 2001). Finally, critics also note that an existing tax credit program has gotten off to a slow start. A component of the Trade Adjustment Assistance Act, enacted in August 2002, is designed to provide tax credits to workers who have lost their jobs due to foreign trade. The tax credits are designed to provide these workers with 65 percent of the cost of health insurance premiums. Estimates indicated that this program could help more than 500,000 workers. However, by the end of 2003 only 5 percent of eligible workers had participated in the program (Pear, 2003).

Consumer Choice Strategies: Increasingly, private industry is enrolling its employees into consumer-directed or consumer-driven health plans (Hewitt Associates, 2004). These plans are designed to

Key HIFA Components

- Enrollment limits for existing beneficiary groups and groups covered by the expansion (based on a first-come first served)
- Flexibility in benefit design
- Cost-sharing requirements can be imposed
- Single adults and childless couples can become eligible by allowing states to redirect federal SCHIP money
- Encourages expansion through premium assistance for the purchase of employer-sponsored coverage

Health Savings Accounts Provisions

- Can only be used in conjunction with health insurance plans that have high deductibles (\$1,000 for individuals, \$2,000 for families)
- Participants can deduct from their gross income contributions equal to 100 percent of their policy deductible. The maximum amounts for 2004 are \$2,600 per individual and \$5,150 per family.
- Unused funds can be carried over each year and transferred from job to job
- Both employers and employees can contribute to the account

Governor view the program as a means by which patients have an "incentive to be good stewards of their health care dollars" (Bush and Jennings, 2004). Furthermore, HSAs are viewed as a way for small employers to contribute to health insurance coverage for their employees. In Florida, the Governor proposes to permit small employers who participate in purchasing pools to choose to contribute

to HSAs rather than traditional health insurance programs. Vermont's governor proposes to use tax credits to encourage small employers to contribute to HSAs on behalf of their employees.

However, critics note, that the healthier, more affluent workers will be attracted to HSAs. Low wage, sicker workers would remain in traditional health insurance programs. As a result, premiums in these traditional programs would increase, ultimately making health insurance coverage unaffordable for low-wage workers (Park et al, 2003).

The Way Forward

For many individuals and their families, the lack of health insurance will continue to be a significant barrier to accessing quality health care. Significant reductions in health insurance are unlikely to occur without major incremental reforms. Many advocate for a complete overhaul of the health care system with an emphasis on providing universal health care coverage using the single payer model. However, given political, ideological, and fiscal realities, it appears as though approaches to covering the uninsured must be incremental in nature and designed to meet the varied needs of individuals and their families. The various reform proposals, if enacted, all have the potential to significantly reduce the number of uninsured in Florida and around the nation. Immediate action in some areas can lay the groundwork for future reforms that collectively lead to significant reductions in the number of uninsured in the longer-term.



provide employees with more choice and flexibility in the selection of benefits and/or out-of-pocket expenditures associated with health insurance.

Perhaps the most frequently discussed form of consumer-directed health plans is medical or health savings accounts. The recent Medicare prescription drug legislation included a provision to establish Health Savings Accounts (HSAs). The Medicare legislation essentially rewrites the 1996 law that established Medical Savings Accounts by making HSAs far less restrictive.

Proponents of HSAs argue that these programs are attractive because they allow patients to have greater control over their health care decisions. For example, Florida's Governor and Lieutenant

Figure 8: Percent of Private-sector Employees Eligible for Health Insurance, (at Firms that Offer Coverage) Florida, 2001



Source: AHRQ, 2001 Medical Expenditure Panel Survey, Insurance Component

Figure 9: Percent of Private-sector Employees Who are Eligible and Enrolled in Health Insurance (at Firms That Offer Coverage) Florida, 2001



Source: AHRQ, 2001 Medical Expenditure Panel Survey, Insurance Component

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Established in 2000, the Florida Center for Medicaid and the Uninsured is dedicated to the improvement of health care in Florida through multidisciplinary collaboration of academic and policy-making experts. The center is located at the University of Florida within the College of Public Health Professions.

The primary mission of the Center is to foster and develop research and analysis on issues related to access to quality health care for Florida's low-income populations. Center faculty and staff study issues related to the Medicaid program and other delivery systems for vulnerable populations. Critical to the Center's mission is the timely dissemination of information to policy makers, providers, and health care advocates.

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