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# GEORGIA HEALTHCARE COVERAGE PROJECT

## ***Insuring the Uninsured: Three Models for Financing Healthcare Coverage***

### **Who is uninsured – and at what cost?**

More than 1 million people in Georgia age 64 and younger, or 13% of the population under age 65, are currently uninsured.

68% of the currently uninsured population in Georgia are either employed or self-employed or the dependent of a worker. Over half of the working uninsured live in families with incomes below 200% of the federal poverty level.

60% of Georgia's employers offer health benefits, and 88% of Georgia's employees work in establishments that offer health benefits. Smaller firms, rural firms, and firms that have existed for a short time are least likely to offer coverage.

The annual cost to Georgia of not taking action to address the problem of the uninsured has been projected to be:

- \$1.2 billion for the reported cost of care provided; and
- At least \$300 million for the cost of care not received and excess days absent from work.

Added to this is the less quantifiable, but significant, cost of personal suffering due to unattended illness and increased severity of illnesses when treated.

**F**ollowing up on a year of data collection and analysis, the Georgia Healthcare Coverage Project sponsored a series of consensus building events with stakeholders statewide to understand the policy options for reducing the number of uninsured Georgians. These events, held in the fall 2003, included an August meeting of the Healthcare Access Forum, support to the Georgia House Taskforce on Small Business and the Uninsured, a December session with the Atlanta Regional Health Forum, and additional focus groups with small business owners who currently do not offer insurance coverage.

*A common issue emerged from these discussions: **How can we make insurance more available and affordable to the high percentage of working Georgians who do not currently have coverage – particularly those employed in small businesses?** To begin to address this important issue, the Healthcare Coverage Project evaluated several options for expanding coverage that are currently being examined at the national level and projected the impact they might have on Georgians. This paper describes three of these options: Health Savings Accounts, Tax Credits, and High Risk Pools.*

### **Health Savings Accounts**

Health savings accounts (HSAs) are very similar to individual retirement accounts (IRAs) and medical savings accounts (MSAs). They are set up and “owned” by the employee, who agrees to set aside a percentage of his or her salary to cover certain medical expenses. These expenses typically include:

- Health insurance deductibles
- Co-payments for medical services, prescriptions, or products
- Over-the-counter drugs
- Long-term care insurance, and
- Health insurance premiums during any period of unemployment.

HSAs are available to all individuals, provided they have a health insurance plan with a high annual deductible of at least \$1,000 for individual coverage (or at least \$2,000 for family coverage).

Employers can make additional contributions to an employee's HSA. However, like an IRA, the HSA is portable; if an individual changes jobs or retires, the HSA goes with him or her. In addition, there is no time limit within which employees must spend the funds in their HSAs.



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**Health Savings Accounts (HSAs) benefit individuals at high income levels who are relatively healthy. They can potentially fill a niche for individual and small group markets. If HSAs become more popular, however, low deductible insurance would gradually become more costly or even nonexistent. Such a trend would hurt the low income and the sick.**

Contributions by an employer are not included in the individual's taxable income, and contributions by the individual are tax deductible. No taxes are levied on interest and investment earnings generated by the account, or on distributions from the account used to cover qualified medical expenses. Any contributions, however, that are not used to pay for qualified medical expenses are subject to a penalty tax of up to ten percent. Individuals over age 55 may be able to make extra contributions to their HSAs and still enjoy the same tax advantages.

## GEORGIA EXAMPLE: HEALTH SAVINGS ACCOUNTS

**Who would be eligible?** Almost all Georgians not covered by Medicaid or Medicare are eligible to create an HSA.

**How many would be covered?** The number of Georgians covered by the more limited Archer Medical Savings Accounts was quite small. While HSAs have a broader eligibility, it is not clear that they would be any more attractive in the short run. For employers now offering more generous coverage, switching to an HSA may not save them any money in the short run if they want to keep their employee insurance benefits roughly the same. More problematic is whether they would save any money in the long run.

**Who would pay?** Federal and state revenues would be reduced as some income would become non-taxable through contributions to an HSA. This impact could become quite large over time if the deductible limits on the affiliate insurance plans are not increased to keep pace with medical inflation. To the extent that employers switch to HSAs, some low income and less healthy employees may find that they pay more in the form of out-of-pocket expenses and have reduced access to care.

**What is the potential impact?** Based on data about the types of health plans offered in Georgia and their respective participation rates, it is likely that less than 100,000 Georgians will elect to use an HSA for their insurance plan in the near future. Over a much longer period of time, if the limits remain stable, the \$1,000 deductible will become much more common and HSAs will look more like traditional insurance. At that point, use of HSAs will be more widespread, although their effectiveness as a cost management tool will be reduced or completely eliminated.

The theory behind HSAs is that they save money by altering consumers' spending habits. Under this theory, consumers faced with the true costs of healthcare services would become more cost conscious. The reality is that the largest part of an insurer's claims payouts are for high cost cases – episodes of care where the total costs are well beyond the deductible in an HSA plan. Therefore, the cost savings to an employer for switching to an HSA may be minimal. In addition, the best way to reduce high costs,



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**Tax Credits benefit low income individuals who currently purchase health insurance or would be likely to purchase coverage with a subsidy. A little over one million Georgians would be directly impacted by tax credits. An estimated 126,000 uninsured Georgians would purchase coverage under the tax credit plan, and another 900,000 Georgians who currently have coverage would also be eligible for the subsidy. The cost to the Federal government in lost tax revenue for Georgians is estimated to be \$870 million annually.**

**Figure 1:  
Projected Cost of Tax Credits**

Current Coverage	Number Getting Subsidy	Cost of Subsidy
Uninsured	138,345	\$113,442,629
Private	924,329	\$757,949,780
<b>Total</b>	<b>1,062,674</b>	<b>\$871,392,409</b>

particularly for the chronically ill, is to provide early, frequent access to care. However, because there is no time limit within which HSA contributions must be spent, employees may opt to save these funds for later use rather than spend them in the short term for preventive services. Finally, HSAs are most attractive to healthy, higher income individuals. If employers offer HSAs as an option, they may find that the cost of their more traditional plan rises as healthy employees elect HSAs, while employees at higher risk remain in the traditional plan.

## Tax Credits

Tax credits are a type of subsidy which would be available to individuals at low income levels. President Bush has proposed a refundable tax credit as part of the Administration’s Fiscal Year 2004 budget. This approach gives refundable tax credits of up to \$1,000 to individuals and \$3,000 to families to use in the non-group market or for employer-sponsored coverage. It has been estimated that this plan would insure an estimated 3-6 million people nationally who currently have no insurance.

One of the issues with a tax credit is that it is a “blunt” instrument: it is difficult or impossible to offer a subsidy to the currently uninsured without offering that same subsidy to similarly situated people who are already covered. As a result, the costs of a tax credit program may be relatively expensive per newly insured individual.

### GEORGIA EXAMPLE: TAX CREDITS

**Who would be eligible?** All Georgians who live in families with incomes under \$30,000 for individuals and \$60,000 for families are eligible.

**How many would be covered?** An estimated 126,000 uninsured Georgians would gain coverage. Another 900,000 would benefit directly from the subsidy, although they already have coverage. The subsidy in that case may lead to the purchase of more generous health plans.

**Who would pay?** The costs would be borne by taxpayers. Conversely, however, increasing coverage may decrease state and local taxpayer burdens if the amounts they have to pay to provide care to the uninsured decreases.

**What is the potential impact?** The expected impact is depicted in Figure 1.

## High Risk Pools

High risk pools are designed to provide coverage to individuals who have been deemed by the insurance industry as “medically uninsurable.” Typically, these individuals have a chronic health condition and have either been rejected for coverage because of that condition or can only get coverage with exclusions or at



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a higher cost. The pool serves as a risk-spreading mechanism whereby the few high risk, high cost persons in a market are guaranteed a source from which to purchase insurance, and the purchase is subsidized through some public funds.

Coverage offered through high risk pools tends to mirror that of individual market plans. Persons who enroll pay more for coverage, but there is a cap on premiums, usually 25-50% more than comparable private coverage.<sup>1</sup> Once admitted to a high risk pool, an individual is guaranteed access to the same set of services as others in the same insurance plan.

States have been experimenting with high risk pools since 1976, using a variety of structures and funding mechanisms. Premiums paid to pools typically cover about half of the costs, with the balance covered by: state general revenues, specially designated state funds, service charges to hospitals, premium taxes, and/or health insurer assessments that may be based on premiums or the number of covered lives.

Successful pools tend to be those that

- Spread risk and loss equitably to all members.
- Avoid promises of positive return to members from pool operations (since claims will exceed premiums).
- Have a good return from better outcomes of care management (due to integrated techniques and sophisticated predictive models) and cost-effective administration (if systems and staff are tailored to the special needs of the risk pool and its unique population).

## GEORGIA EXAMPLE: HIGH RISK POOLS

**Who would be eligible?** Eligible individuals are those who

- Were denied coverage from two private insurers,
- Were quoted a rate that was higher than the rate at which they could purchase coverage through the pool, or
- Had a prior diagnosis of a serious chronic illness.

**How many would be covered?** Approximately 3,400 Georgians who are currently uninsured would receive coverage from the high risk pool. Although over 5,000 Georgians lack health insurance because they are uninsurable, a portion of them would not participate in the high risk pool because of its expense. Other states have found that high risk pools attract about 1% of the individual market. In Georgia, the number of individuals who are uninsurable and live in families



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***High Risk Pools benefit the “medically uninsurable.” If offered to the uninsurable, these high risk pools may act to stabilize the small group and individual insurance markets.***

with incomes above 300% of the Federal poverty level is almost equal to 1% of Georgia’s individual market.

**Who would pay?** The high risk pool would be funded by assessing insurers and re-insurers at a rate of \$1 per insured per month. The benefits package (with a \$500 deductible, an 80% coinsurance rate, a \$2,000 out-of-pocket maximum, and a \$2 million lifetime maximum benefit) would cost \$5,706 per year for an eligible 50-year-old male – approximately 50% more than comparable coverage outside of the high risk pool.

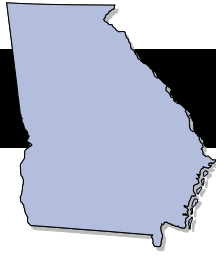
**What is the potential impact?** Based on other states’ experience, the number of individuals in the pool is likely to grow over the first few years of operation as individuals become aware of its existence. If we assume:

- An assessment of \$1 per insured individual per month
- Initial coverage of 40% of the individual market
- Enrollment that builds over the first three years, rising ultimately in Year 3 to 80% of those eligible with incomes over 300% of the Federal Poverty level
- Healthcare cost inflation at levels projected by the Federal Government;

Then we can project:

- A 5-fold increase in enrollees
- A comparable 5-fold increase in premiums, claims and administrative costs
- A relatively stable level of revenue.

Thus, under this scenario (see Figure 2), a high risk pool in Georgia would potentially be viable and sustainable. While the number of people potentially covered would be small relative to the total number of uninsured in Georgia, these individuals are some of the state’s most vulnerable residents. Moreover, the high risk pool has the potential to help stabilize the individual and small group insurance markets in Georgia and thereby increase access to health insurance coverage for an even larger pool of Georgians.



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**Figure 2:  
Five-year Projected Costs for a High Risk Pool**

	Year 1	Year 2	Year 3	Year 4	Year 5
<b>Enrollees</b>	850	1,700	3,399	3,875	4,417
<b>Premiums (Millions)</b>	\$6.33	\$12.65	\$25.31	\$28.85	\$32.89
<b>Revenues (Millions)</b>	\$24.75	\$25.74	\$26.77	\$27.85	\$28.96
<b>Administrative Costs (Millions)</b>	(\$0.32)	(\$0.64)	(\$1.28)	(\$1.33)	(\$1.39)
<b>Claims (Millions)</b>	(\$11.07)	(\$23.00)	(\$45.99)	(\$50.36)	(\$55.26)
<b>Addition to Reserves* (Millions)</b>	\$19.69	\$14.76	\$4.80	\$5.00	\$5.20
<b>Cumulative Reserves (Millions)</b>	\$19.69	\$34.45	\$39.25	\$44.25	\$49.44

*\*Ignores interest income*

***The goal of any effort to make health insurance more available and affordable to working Georgians is to enable them to access care that will improve their health status.***

## Keys to Success

The goal is not to make healthcare free for all, nor is it to totally eliminate the number of uninsured individuals. Rather, it is to help Georgians acquire or improve their health insurance coverage. According to the Rand Corporation, which recently studied the effects of five kinds of state experiments to expand health insurance coverage,<sup>2</sup> a successful approach toward this goal would likely involve:

- Multiple strategies.
- New federal expenditures or innovative public-private approaches to financing. States will be unable to solve the problem of the uninsured on their own.
- Maintaining a strong safety net to ensure that those individuals who remain uninsured (even with substantial public subsidies) will retain access to healthcare.

<sup>1</sup>Abbe Bruce. *Using tax credits and state high-risk pools to expand health insurance coverage.* *Health Affairs* October 23, 2002. pp 345-348.

<sup>2</sup>Rand Corporation website  
<http://www.rand.org/publications/randreview/issues/fall2003/reform.html>

For more information, please contact: The Governor's Office of the Consumers' Insurance Advocate 404-463-1010  
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