ARIZONA HEALTH FUTURES

health bullets

December 2004

Health Care Coverage

Averages and Trends

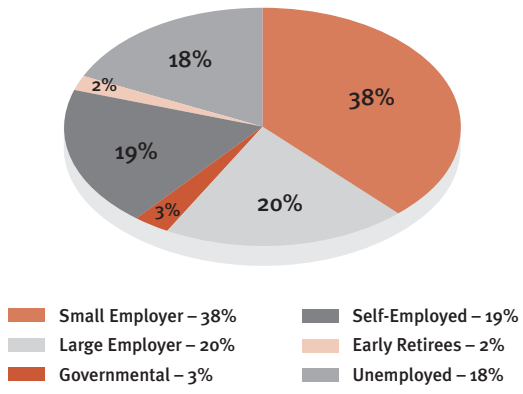
I. Health Insurance Coverage

- The percentage of persons with health insurance coverage is slipping:[1]
  - The rate of uninsured Americans rose from 14.6% in 2001 to 15.6% in 2003, or approximately 45 million people.
  - The rate of uninsured Arizonans dipped slightly from 2001 to 2003 (17.9% to 17%), but is still above the national average.
- Rising health care costs and premiums have precipitated a decline in employer-based coverage and a simultaneous growth in public insurance programs:
  - Nationally, employer-based health insurance covered 63.6% of citizens in 2000, but fell to 60.4% in 2003 – a 5% drop. In Arizona, workplace coverage slipped from 59.1% in 2000 to 54.8% in 2003 – a 7.2% drop.[2]
  - According to the U.S. Census Bureau, national Medicaid enrollment went from 10.6% in 2000 to 12.4% in 2003 – a 14.5% increase. With the advent of Prop. 204, AHCCCS enrollment in Arizona as of October 2004 has increased to approximately 18% of the population, or over one million people. This is almost double the 2000 enrollment figures.
  - Nationally, Medicare enrollment grew from 13.5% of the population in 2000 to 13.7% in 2003. Comparable Arizona figures are 12.9% and 13.6% respectively.[3]

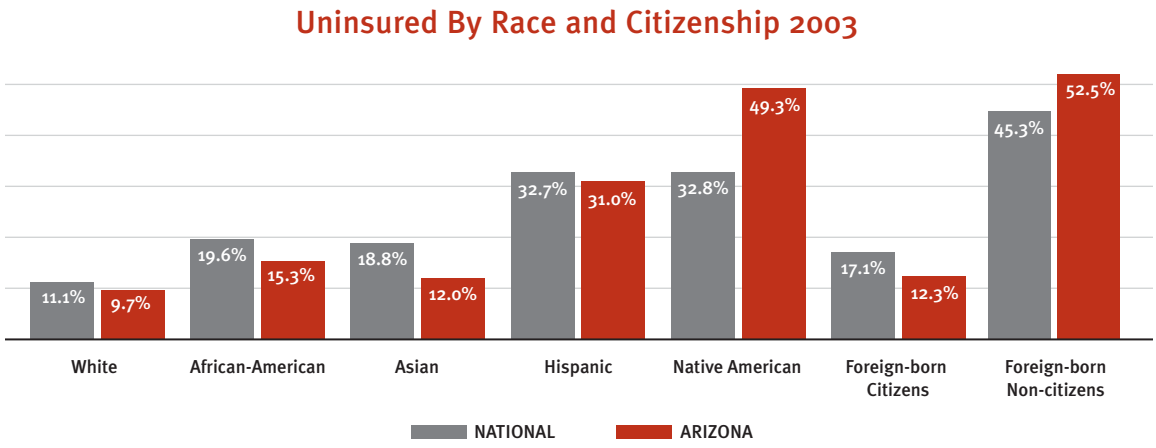
II. The Uninsured

- A recent study projects the number of uninsured in Arizona in 2004 at 17.2%, or 994,000.[4] Of these:
  - About 80% are employed.
  - 267,000 uninsured in the small employer market – 71% of the total – make under 200% of the federal poverty limit (FPL – $17,960 for an individual, or $36,800 for a family of four).
  - Among all uninsured, approximately 386,000 persons – 39% – earn less than 100% FPL and are conceivably eligible for public insurance programs. Some portion of the 322,000 people who earn between 100-200% FPL might be eligible under more targeted programs such as SCHIP.

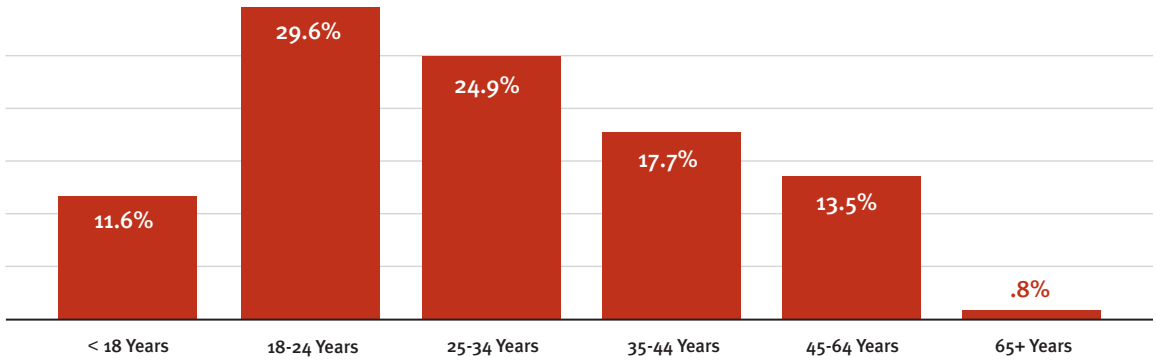
Employment Status of Arizona Uninsured



- Uninsured rates vary by race and citizenship:[5]



- Uninsured rates vary by age:



III. Small Business/Individual Market

- Nationally, 30.8% of small business employees were uninsured in 2003, compared to 13.4% of large business employees.
  - In the same time period, 26.7% of small business employees in Arizona lacked coverage, compared to 16.5% in large businesses.[6]
- Many small business employees, who are less likely to have access to employer-sponsored health insurance, purchase coverage in the individual market. Individually purchased private health insurance covered 9.5% of Americans in 2000, and dipped slightly to 9.2% in 2003.
  - Arizonans covered in the individual market rose from 8.3% to 9.2% in the same time period.[7]

IV. Consumer-Driven Health Plans (CDHPs)

- Consumer-Driven Health Plans (CDHPs) are receiving significant attention from employers and insurers as a way to increase access to care, lower costs and improve system efficiency. The early evidence on CDHP efficacy is equivocal. According to observers, it's either:

- The transformation of American health care. A rocket about to take off.
- A house of cards that is destined to collapse.

- CDHPs utilize a cost-sharing model to enable consumers to make informed choices about using health care services. The general model combines an individual health savings account coupled with a high deductible insurance plan.[8] Some examples include:
  - **Medical Savings Accounts.** MSAs require a high-deductible insurance plan with an employee-owned savings account into which the employee or employer (but not both) contribute on a tax-favored basis. MSAs failed to gain popularity because of tax and eligibility limitations.
  - **Flexibile Spending Accounts.** FSAs were among the first incarnations of the consumer-driven model. They allow employees to set aside untaxed earnings to pay for out-of-pocket medical and other qualifying expenses, such as child care. They have proven to be less popular because of complex provisions and the requirement that unused funds are forfeited at the year's end.
  - **Health Reimbursement Accounts.** HRAs can only be established by employers. They are not portable, and once funds are exhausted, the employee is responsible for any additional costs until the deductible is met.
  - **Health Savings Accounts.** HSAs combine a high-deductible plan with a portable HRA that belongs to the employee. Contributions may come from employers, employees, the self-employed and others. Premiums are not taxed and can be deducted on tax returns. The accounts also earn tax-free interest; unused funds may accrue on an annual basis, but can only be used for qualified medical and health-related expenses.

V. Other Models for Expanding Coverage

- **Purchasing Cooperatives** leverage the economies of scale to reduce premiums for small businesses. They increase small employers' negotiating power while minimizing high administrative costs associated with small group plans. Co-ops have experienced problems with adverse selection (less healthy persons enroll), high premiums and lack of health plan participation.[9]
  - In Arizona, AHCCCS has recently revamped Healthcare Group, a state-sponsored plan for small businesses and the self-employed.[10]
  - The Bush administration has proposed allowing small businesses to form Association Health Plans (AHPs) to increase marketing power on behalf of their employees. AHPs would be exempt from state benefit mandates and solvency rules, much as large, self-insured employers are.[11]
- **Buy-in Plans** allow those who lack access to affordable health care insurance to "buy-in" to large state employee plans or to the state's Medicaid program on a sliding scale basis.
  - SLHI estimates that implementing a sliding scale buy-in for the AHCCCS program in Arizona would increase coverage by about 14%, or 134,000 persons.[12]
- **High Risk Pools** are available in 30 states for chronically ill residents who do not qualify for private coverage. Because premiums are often costly, low-wage earners cannot always afford to buy into such pools, while others who were rejected by the standard market have been able to take advantage of them.[13]
- **Tax Credits** are available in several states for small businesses that provide health plans, or for individually purchased coverage. For example, Kansas gives small companies a $35 tax credit per covered employee per month; Colorado deducts $200 per insured employee for certain businesses in existence less than two years; and North Carolina grants families with children an annual deduction of $100-$300 for non-employer-based insurance.[14]

- **Employer Mandates** require all companies to secure and subsidize an employee medical plan:
  - Hawaii sets forth such a requirement, but exempts small, family-run businesses.
  - California recently passed – and then repealed – a "pay or play" mandate, which prescribes that employers either provide health insurance or pay into a fund for uninsured employees. California's mandate would have included only businesses with more than 50 workers.
  - In Arizona, an employer mandate would cover an additional 480,000 employees – almost 50% of the uninsured population. However, if the small business sector were excluded, like California's proposed mandate, the estimated coverage increase would drop to 19%, or 187,000 employees.

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1 U.S. Census Bureau, Current Population Survey, 1988 to 2003 Annual Social and Economic Supplements. www.census.gov/hhes/hlthins/historic/hihistt4.html.

2 Ibid.

3 Ibid. Projections completed by Mercer Government Human Services Consulting (Mercer) for SLHI,s Arizona CAN report (2004), put the state's Medicare population at 12% in 2004.

4 *Arizona CAN: Coverage and Access Now*, St. Luke's Health Initiatives, Winter 2004. Projections by Mercer.

5 U.S. Census Bureau, op. cit. www.census.gov/hhes/hlthins/hlthino3/hio3t5.pdf. Arizona breakdown is from additional data supplied from U.S. Dept. of Health and Human Services, Assistant Secretary for Planning and Evaluation, Robert Stewart, Dec. 2, 2003.

6 U.S. Census Bureau, http://ferret.bls.census.gov/macro/032004/health/ho1_001.htm. Additional Arizona data obtained from Robert Stewart, Ibid.

7 U.S. Census Bureau, op.cit. (footnote 1)

8 Details on CDHPs are complex and outside the scope of this cursory summary. For views both pro and con, see Greg Scandlen, *Consumer Driven Health Care: New Tools for a New Paradigm*, Galen Institute, March 2003; Mila Kofman, "Health Savings Accounts: Issues and Implementation Decisions for States," *Academy Health Issue Brief*, Vol. V., No. 3, pp. 1-5, Sept. 2004; Karen Davis, *Will Consumer-Directed Health Care Improve System Performance?* The Commonwealth Fund, Aug. 2004, among many other articles.

9 Elliot Wicks, *Health Insurance Purchasing Cooperatives*, Commonwealth Fund Task Force on the Future of Health Insurance, pp. 1-5, Nov. 2002.

10 For more information on Healthcare Group, see www.healthcaregroupaz.com

11 John Shiels, *Bush and Kerry Health Care Proposals: Costs and Coverage Compared*, The Lewin Group, Sept. 2004.

12 *Arizona CAN: Coverage and Access Now*, op. cit.

13 T. Scott Bently, et. al., *Issue Paper on High Risk Pools*, Arizona Health Care Cost Containment System, Aug. 2001.

14 Thomas Snook, AHCCCS *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage*, p. 13, 2001.

15 *Arizona CAN: Coverage and Access Now*, op. cit.

St. Luke's Health Initiatives
A Catalyst for Community Health

Our Mission

To improve the health of people and their communities in Arizona, with an emphasis on helping people in need and building the capacity of communities to help themselves.

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2375 E Camelback Rd
Suite 200
Phoenix Arizona 85016

www.slhi.org
info@slhi.org

602.385.6500
602.385.6510 fax