

# Women's Policy Education Fund Issue Paper

## Transforming Georgia Health Care? 2007 Health Reform Proposals

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### INTRODUCTION

The term “health transformation” is shorthand for a specific set of health care reforms that attempt to steer health care policy using a strictly market-based framework. Like many other reform ideas, the stated goals are to control costs, increase the number of people with insurance, and to improve health.

Many of the tenets behind this line of thinking involve applying free market principles of a product-oriented economy to the funding and provision of health care services. Ideas like *increasing personal responsibility for utilization* boil down to increasing consumer exposure to health care costs. Consumer health care advocates are increasingly concerned that these policies will result in a large scale cost shift to patients and leave more people with coverage underinsured, while yielding little increase in the numbers of people who gain coverage. They may merely trade group coverage for less comprehensive individual health policies, migrating even farther away from the principle of spreading risk widely.

**Impetus for some kind of reform stems from growth in the number of uninsured, declines in workplace coverage, and the additional pressure related health care costs place on families, individuals, businesses and government.**

According to recent data from the Census Bureau, nineteen percent of Georgians (1.7 million) lack health insurance.<sup>1</sup> Trends show an increasing number of uninsured nationwide, a decline in employer-sponsored coverage<sup>2</sup>, and an increasing reliance on government sponsored health care coverage primarily in the form of Medicaid and the State Child Health Insurance Program (SCHIP, which is known as PeachCare for Kids in Georgia). These trends reflect the reality in Georgia where more than sixty percent of children are enrolled in either PeachCare or Medicaid (13.3% and 49.5% respectively).<sup>3</sup>

Health insurance coverage in Georgia is significantly lower than in the rest of the United States. Sixty-two percent of Georgians have private health insurance compared with 67.7%

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<sup>1</sup> Custer, William et al. Sources of Health Insurance Coverage in Georgia 2005, *Center for Health Services Research at Georgia State University* (2006).

<sup>2</sup> The Number of Uninsured Americans Is at an All-Time High, *Center for Budget and Policy Priorities* (August 2006). 46.6 million Americans do not have health insurance. The percentage of nonelderly individuals without health insurance coverage was 17.9 percent in 2005, up slightly from 17.6 percent in 2004.

<sup>3</sup> Minyard, Karen J. et al. Analysis of Access to Care Service Trends and Patterns provided through Medicaid and PeachCare (SCHIP) CY2000/SFY2001 through CY2005/SFY2006. *Georgia Health Policy Center at Georgia State University*.

nationally, the bulk of those securing it through an employer.<sup>4</sup> Nationally employment-based coverage remains the dominant source of health coverage for nonpoor, nonelderly (those below age 65) individuals and workers.<sup>5</sup> Of workers without employment-based coverage in 2005, half worked for firms that did not offer health benefits to any of their workers. Nearly one-third were offered benefits but chose not to participate. Affordability is a underlying major factor as the cost of providing health benefits increased 3.5 times the rate of inflation between 2000-2006.<sup>6</sup>

Given the erosion of employer health coverage while the costs are rising and the number of uninsured increases, a number of proposals to address health care coverage have emerged at the national and state levels. They range from single-payer or “Medicare for All” approaches to those that would make the purchase of health care coverage an individual requirement and create incentives and subsidies for the purchase of private insurance.

In the run up to the 2007 General Assembly a transformation task force convened, providing a public forum for ideas originating with Newt Gingrich’s Center for Health Transformation. Georgia is one of several states the Center has selected to try to enact their ideas. Insurance companies and underwriters that sell individual policies are also enthusiastic supporters of reform proposals from this genre.

Before moving to the merits of the various proposals to “transform health care” it is necessary a closer look at the health insurance vehicle these measures are built upon.

## **PROPOSED GEORGIA HEALTH “TRANSFORMATION” LEGISLATION**

During 2007, more than a dozen bills including core concepts from the health transformation agenda were introduced this session. Below is a brief summary of these proposals and how each fared. Although most did not become law, they remain on the table for consideration during the second half of the biennium.

**Senate Bill 28: the Omnibus Health Transformation Bill.** Senator Judson Hill (R-Marietta) spearheaded most of these bills, beginning with an omnibus bill dropped the second week of session ([Senate Bill 28](#)). SB 28 came out of the 2006 task force and spells out every major provision of the health transformation agenda. All these concepts are tied into a relatively new federal law that allows preferred tax treatment for contributions to a Health Savings Account (HSA). Fewer employers can afford to offer health insurance in the post-managed care era. With health care costs rising, employers seek ways to shift this burden downstream to employees. Enter Health Savings Accounts (HSAs). HSAs are tax-free

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<sup>4</sup> Custer, William. *Ibid.*

<sup>5</sup> [Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey](#), *Employee Benefit Research Institute* (October 2006). Less than 6% purchased an individual health insurance policy.

<sup>6</sup> [Employment-Based Health Benefits: Access and Coverage 1988 – 2005](#), *Employee Benefit Research Institute*, (March 2007). Among workers not eligible for benefits, 56.8% were employed part time, 18.3% had not completed the required waiting period, and 9.4% were employed on a contract or temporary basis. Slightly more than 62% of workers who declined coverage had other coverage, and 23% declined it because it was too costly.

investment accounts that can be used in conjunction with qualifying high-deductible health plans (HDHPs). Individuals can make tax-free contributions in an HSA and later use these funds to pay for out of pocket health care expenses. These accounts go one better than other pre-tax investment accounts, since neither the investment earnings used to cover health care expenses or withdrawals are taxable.<sup>7</sup> Under federal law annual HSA deposits cannot exceed the HDHP annual deductible.

High-deductible health plans which qualify for use with HSAs must have deductibles of at least \$1,050 for individuals and \$2,100 for families, however higher deductibles are possible. With high deductibles come lower monthly premiums. HDHPs may offer limited first-dollar coverage for preventive care (i.e. exclude preventive care from the deductible) however the idea is that individuals pay out of pocket for most of their medical needs until they reach the yearly deductible while paying lower monthly premiums than are offered in comprehensive plans. After reaching the deductible the HDHP applies although individuals are still responsible for required co-payments at the point of service. Federal law does cap total in-network out of pocket medical costs for covered services at \$5,250 per year for individual/\$10,500 for families, and the insurer is responsible for all care costs thereafter. When used in concert, a HSA and a HDHP combine to form what is commonly referred to as a “Consumer Directed Health Plan.”

The health transformation legislative package aims to make Georgia the first state with law and policy officially endorsing the high deductible health insurance products. Only 3.5 million HDHPs exist nationwide; with 2.5 of them sold by a single vendor. Senate Bill 28 did not pass.<sup>8</sup>

**Progeny of Senate Bill 28.** Within a matter of weeks, SB 28 splintered into other bills constituting a legislative package sponsored by Judson Hill in the Senate and Reps. Knox and Channell in the House. Centerpieces of the Georgia proposal include:

- Giving consumers more “skin in the game” by increasing their exposure to health care costs
- Limiting insurer liability by exempting HDHPs and CDHPs from state legal mandates to provide certain basic health benefits
- Establishing a state-run Health Insurance Connector to help consumers compare products and prices in a single forum
- Providing tax incentives for individuals who opt for high deductible health insurance policies over group plans
- Establishing a state-run searchable database available online so consumers can compare costs and outcomes for specific providers and procedures
- Replacing the existing high risk benefits and assignment systems which guarantee otherwise uninsurable persons the ability to buy health insurance with more expensive options that provide fewer benefits and

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<sup>7</sup>[Reforming Healthcare Brief #1: Taking a Closer Look at Health Savings Accounts.](#) *Georgia Budget & Policy Institute* (March 9, 2006).

<sup>8</sup> See similar bill prefled by Rep. Tom Knox, chair of the House Insurance Committee. [HB 27](#) promotes high deductible health plans but was never formally introduced during the 2007 session.

- Developing a new, quasi-governmental healthcare oversight body to monitor adverse patient events, coordinate with hospitals to facilitate improving patient safety, educate providers as well as the public, and keep a database of pharmacy and vaccination records.

**Senate Bill 151: Replacing Insurance of Last Resort.** If passed, [SB 151](#) replaces the existing state health insurance and benefits assignment system with an insurer-friendly model containing few consumer protections. The purpose of the system is to ensure a person at risk of becoming uninsured may obtain alternate comprehensive coverage quickly. Under SB 151 a person must be rejected by two insurers (rejection of coverage outright is less common than offering coverage at unaffordable rates to persons with health problems). Preexisting conditions are not covered for 12 months. This bill is in the Senate Insurance & Labor Committee.<sup>9</sup> See also [HB 752](#).

**Senate Bill 150: Threats to Mandated Services.** [SB 150](#) contains a serious threat to mandated services covered by insurance. It creates a dangerous loophole permitting out-of-state insurance companies to sell policies in Georgia that do not comply with existing insurance coverage mandates.<sup>10</sup> Other provisions:

- Change the PPO coinsurance provisions and makes it more expensive for a beneficiary to see an out of network provider for covered services. SB 150 raises the amount the plan can charge for these services received out of network from a 30-40% differential to 40-50% differential.
- Allow a parent to cover dependents up to age 25 or until two years after ceasing to be a dependent, whichever is earlier, under a group accident and sickness policy to address the risk that newly employed individuals may not yet be eligible for their own coverage
- Set up a central database for electronic medical records and incentives for electronic claims submissions to reduce provider costs and delays associated with paper
- Direct the Department of Community Health to collect provider data for use in a Medicare.gov-like website to help consumers shop for healthcare under the theory that free market principles will steer people away from more expensive or substandard care

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<sup>9</sup> See similar bill prefiled but never formally introduced by Rep. Tom Knox, Chair of the House Insurance Committee.

<sup>10</sup> High deductible health insurance policies would be exempt from providing most mandated benefits required by state law, but not usually by federal law, in all other Georgia health insurance policies including coverage of newborn or adopted children; coverage for victims of domestic violence; outpatient treatment for substance abuse and most mental disorders; Chlamydia screening tests; coverage for complications of pregnancy; reimbursement for psychologists, chiropractors, optometrists, athletic trainers, hospitals specializing in alcohol and drug addiction, general anesthesia for dental in hospital or ambulatory surgery centers; direct access to dermatologists; newborn baby and mother protection (48 hour stay after delivery); direct access to obstetricians and gynecologists; contraceptive drugs and services; prescription inhalers; use of RNs as assistants in surgery; coverage for autism; coverage of child wellness services; provisions for medical and surgical services; coverage of TMJ and other jaw deformities; utilization of mail order pharmacies; coverage in group policies for medical and surgical services generally and coverage of drugs not specifically approved for treatment of cancer].

- Establish patient ownership of medical records
- Create a quasi-governmental entity known as the Patient Safety Corp. to track the incidence of adverse events in hospital settings and maintain a database of pharmacy and vaccination records and
- Form a health insurance connector known as the “Exchange.”

This bill remains in the Senate Health & Human Services Committee, however in the final days of session, transparency language attached to Rep. Steve Tumlin’s [HB 24](#) (simplifying Advance Directives for Health Care) did pass requiring collection of price/outcome data on certain health care procedures be available on a state website. See also [SB 241](#).

**Senate Bill 153: Consumer Driven Health Plans That Cut Mandated Services.** [SB 153](#) was endorsed in committee by the Georgia Insurance Commissioner, who seeks the fact that it gives consumers some “skin in the game,” as a positive feature. The bill authorizes high-deductible individual health insurance policies that do not cover preventive care and can impose “reasonable maximum lifetime benefit” caps with no guaranteed dollar value. SB 153 permits the sale of HDHPs in-state that do not cover contraceptives, newborns for first 10 days of life, well child services, a 48 hour hospital stay after newborn delivery, and other services mandated under state law.<sup>11</sup> Because these policies are far less comprehensive than traditional employer-sponsored group health plans, they also cost less. Consumers must absorb costs associated with uncovered services out of pocket. Such plans are likely to entice healthier individuals out of group plans and thus erode an employer’s pool. Costs are likely to increase for individuals who remain in the pool because they will not be spread as widely over healthy individuals and those with health conditions.

Senate Bill 153 passed the Senate and is in the House Insurance Committee.<sup>12</sup> Language threatening health mandates almost passed as a part of the Conference Committee Report to [HB 330](#), but was stripped from the bill at the last minute.

**Creating State Tax Incentives Benefiting Those Who Use HDHPs with an HSA.**

Constitutionally, all tax legislation must originate in the House Ways & Means Committee. On these grounds all provisions dealing with tax credits and exemptions contained in Senate Bill 28 were stripped from the bill before the Senate Insurance Committee would consider it on the merits. Rep. Tom Knox, Chair of the House Insurance Committee, then introduced [House Bill 242](#) providing tax exemptions that would apply to individuals’ personal income taxes and the State’s premium tax paid by insurers on HDHPs. Surprisingly, Governor Perdue vetoed the bill. After stating comprehensive health care transformation is needed and implying that the premium tax may warrant review the Governor disapproved of the cost (\$61 million over six years).

Another bill creating incentives for the use of HDHPs moved through the House Ways and Means Committee. [House Bill 404](#) introduced by Rep. Mickey Channell offers preferred tax status for contributions to and premiums for health savings accounts in combination with a substantive change in policy. It includes a Massachusetts-like provision requiring all Georgia residents to demonstrate they have health insurance adequate to cover themselves and their

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<sup>11</sup> *Ibid.*

<sup>12</sup> by a vote of 45 - 8

dependents or post \$10,000 in escrow with the state. Failure to do so can prevent one from claiming certain exemptions and receiving future tax refunds. This concept also surfaced in SB 28, and is another plank in the “health transformation” platform. It remains in the House Ways and Means Committee.

**Health Transformation Initiatives Passed in 2007.** Sen. Judson Hill’s resolution ([SR 139](#)) urging Congress to increase the tax-free Health Savings Account contribution threshold and the transparency language amended to HB 24 were the only substantive planks in the "health transformation" platform to pass this session. Although legislation establishing a joint study committee ([SR 355](#)) on transforming health care stalled in the House Health & Human Services Committee, a Senate study committee will convene and may issue legislative recommendations in December as pursuant to Senate Resolution 637.

## ANALYSIS

### **A Consumer-centered view on High-deductible and Consumer Driven Health Plans**

This analysis takes a consumer-centered approach. Judging any health care reform solely from the perspective of whether new conveniences were realized for the system administrator or some short-term savings accrued to a contracted vendor is inadequate. Accordingly, this analysis will focus on how proposed legislation impacts consumers overall, the experience of those who choose high-deductible options, and whether this model can indeed provide coverage to more previously uninsured persons.

**Impact on Consumers in Group Health Plans & Affordability Issues.** Introducing HDHPs into the health insurance marketplace erodes traditional employer-sponsored group coverage. More than offering just another choice on the health insurance buffet, these individual policies further segregate the pool of potential health care consumers based on their ability to pay and secure another policy that will cover any pre-existing conditions. This approach to health care financing drives up costs for those remaining in traditional, employer-sponsored group plans as the healthiest and wealthiest participants opt out. Many health and tax policy analysts suspected that Health Savings Accounts (HSAs) would be used as tax shelters for high-income individuals and new research confirms this is true.<sup>13</sup>

Moreover, promoting HDHPs and CDHPs as an alternative to comprehensive coverage is misleading. It is inherently impossible to rank any three health insurance options as good, better, and best at the time of purchase because individuals and families have no way of predicting what their future needs will be. A “good” policy may be one that meets current needs and would appear to meet a future need at the point of injury or illness. In the wake of a devastating injury or illness, though, a policy will be judged by the number of rehabilitation days it pays and whether it covers all inpatient hospitalization costs and physician recommended therapies, home care, drugs, and supplies without putting a family into medical

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<sup>13</sup> [GAO Study Confirms Health Savings Accounts Primarily Benefit High-Income Individuals](#) indicates that HSAs are disproportionately used by affluent individuals. The report also explains how HSAs and high-deductible plans reduce costs for healthy people while increasing out-of-pocket costs for less healthy people. *Center for Budget and Policy Priorities* (September 2006).

bankruptcy. A byproduct of appropriate, comprehensive coverage is a reduction of indigent care costs.

With insurance premiums increasing more than twice as fast as workers' wages and overall inflation<sup>14</sup>, claims about the affordability of HDHPs and their potential to solve the uninsured problem seem doubtful. Most of Georgia's 1.7 million uninsured struggle with affordability issues.<sup>15</sup> The risk is that consumers, when faced with \$1,050-\$5,250 worth of out of pocket costs for an individual (\$2,100-\$10,500 for a family), are no more likely to seek care than they are if uninsured.

**What is the Experience of Consumers in HDHPs and CDHPs?** Individuals in consumer-driven health plans and HDHPs continue to be less satisfied with their health plan than individuals in more comprehensive health plans. Employees who use a consumer driven health plan are less likely to be given a choice of plans. Also, employers pay approximately the same amount for employees' CDHPs as they do for traditional plans, but employees in CDHPs are faced with much higher out-of-pocket costs than those in traditional plans.<sup>16</sup>

Users of HDHP or CDHP often find preventive care is not excluded from deductible. While the law that created HSAs allows high-deductible health plans to cover preventive services, more than one-half of individuals in CDHPs are in plans with deductibles that apply to all health care services. Research shows more missed care among individuals in CDHPs and HDHPs. These consumers report that they are more likely to delay or avoid needed care because of cost. Alternatively, cash strapped families turn to high interest credit cards to meet necessary medical expenses.<sup>17</sup>

Yet few differences were found among adults in the three plan types in reported use of health services and preventive care. It appears that having some "skin in the game" is no more effective at achieving cost-conscious behavior than comprehensive coverage. Individuals in CDHPs and HDHPs exhibit more cost-conscious behavior in their health care decision-making than individuals with more comprehensive health insurance. However, in many questions that addressed this issue, those in more comprehensive plans were just as likely to report such behavior as adults in consumer-driven or high-deductible health plans.<sup>18</sup> Despite the emphasis on informed choice in consumer-driven health care, research shows people in

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<sup>14</sup> [Employer Health Benefits 2006 Annual Survey](#) investigates trends in employer-sponsored health coverage, including changes in premiums, cost-sharing, employee contributions, and the prevalence of high-deductible health plans. (September 2006)

<sup>15</sup> [Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families](#) examines the implications of rising out-of-pocket costs for all privately insured Americans. *The Commonwealth Fund* (September 2006).

<sup>16</sup> Gabel, Jon et al. [Behind the Slow Growth of Employer-Based Consumer-Driven Health Plans](#) *Center for Studying Health System Change* (December 2006).

<sup>17</sup> [Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses](#) As health care costs continue to rise faster than incomes, families are turning to credit cards to pay for medical care, according to new research by Demos and the Access Project.

<sup>18</sup> ["The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans."](#) The online survey of 3,158 privately insured adults ages 21–64 was conducted to provide nationally representative data regarding the growth of consumer-directed health plans (CDHPs) and high-deductible health plans (HDHPs), and their impact on the behavior and attitudes of health care consumers. *Employee Benefit Research Institute* (December 2006).

CDHPs and HDHPs were less likely to report that their health plans provided information on the cost and quality of providers than those in more comprehensive plans.

Research shows requiring out-of-pocket expenditures by the patient does reduce costs by lowering health care utilization — with some undesirable consequences. As compared with the provision of free care, cost sharing reduced the percentage of low-income adults who sought "highly effective care for acute conditions" by nearly 40% and was associated with worse blood-pressure control and less reliable use of preventive care measures such as Pap smears. Cost-sensitive consumers did not appear to be able to differentiate necessary from unnecessary care.<sup>19</sup> Those with chronic disease, asthma, diabetes, high blood pressure need priority service to maximize limited health care resources.

**Do HDHPs and CDHPs Help the Uninsured?** Survey data finds that adults in CDHPs are no more likely to have been uninsured prior to enrolling in their plans than are those in more comprehensive plans. Nationally, ten percent of CDHP enrollees were uninsured prior to being covered by their current plan, compared with 20% of HDHP enrollees and 24% of individuals with more comprehensive plans. Despite expectations that high-deductible plans would experience rapid growth enrollment in CDHPs and HDHPs is virtually unchanged from 2005. One percent of the privately insured population ages 21–64 are currently enrolled in CDHPs, representing 1.3 million individuals ages 21–64. Another 7%, representing 8.5 million individuals ages 21–64, were enrolled in plans with deductibles high enough to meet the threshold that would qualify to make tax-preferred contributions to a health savings account, but do not have such an account.<sup>20</sup>

## CONCLUSION

If experimenting with these various proposals can only be achieved at the expense of eroding group health plans offered in the same marketplace then this approach to health care reform may not be worth the collective risk involved. Applying free market principles in this context is unproven. It may well backfire as the lowest income consumers have no incentive/ability to participate in the system, while middle income consumers who are increasingly squeezed by medical costs are also less able to shoulder their own healthcare costs and pile up high cost debt as they assume responsibility more costs in preventive care and catastrophic care.

Some theories simply do not translate well into practice. For example, regulating transparency does not always change consumer behavior. A case in point, in 2002 the National Committee for Quality Assessment rolled out a "Nursing Home Compare" feature on its Medicare.gov website. This portal offers a searchable database displaying quality/regulatory violations (number and severity) for all federally funded nursing homes in the United States. No mass exodus from these substandard nursing homes has occurred. Five years later, even the consistently poor performers are still competing in the marketplace with relatively stable occupancy levels. A straight economic analysis of this situation would have predicted a very

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<sup>19</sup> Lee, Thomas & Zapert, Kinga MDs. *New England Journal of Medicine*. "Do High-Deductible Health Plans Threaten Quality of Care?" Sept. 22, 2005.

<sup>20</sup> ["The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans."](#) *Employee Benefit Research Institute* (December 2006).

different outcome. Interestingly, this approach overlooks the role economies of convenience (and similar other transaction costs) play in shaping health care systems. In the nursing home example, the theory that perfect information will drive consumers away from poor care was foiled by the reality that most new nursing home placements are not consumer-centered choices. Where an informed family member motivated by quality and price might reach one decision, a hospital discharge planner working down a list of patient discharges in need of rehabilitation care in 24-hour skilled nursing facilities on a Friday afternoon may well reach another conclusion. When time is of the essence, the first place with an open bed is often the “best placement.” Where third party actors control decision making the availability of provider quality assessment data will not result in the selection of better or less expensive care. Because of the nature of health care, the likelihood is that most choices will continue to be influenced largely by health care practitioners, availability of services, and by geographical and other considerations.

Health care reform is an open subject in Georgia. The conversation will be shaped at least, in part, by what happens over the next six months in the Senate Study Committee.

A “Healthy Georgia” is measured by the wellness of individual citizens. Policy makers must use this yardstick when assessing where the health transformation principles will take us. Government must continue seeking solutions that can provide quality health care at affordable prices, however there is scant evidence that high deductible health plans and consumer driven health plans are likely to be effective strategies for getting affordable, quality health care to more Georgians.

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The opinions expressed are those of the authors.*