

HealthFlex: Potential Policy Barriers

The Health Flex Plan Program was established in 2002 by the Florida Legislature. Its goal was to unite a variety of entities, including HMOs, governmental programs, health care providers, nonprofit organizations and other community resources in order to provide primary and preventative health care coverage to low-income, uninsured workers. The plans can be obtained directly from the provider (HMO, local government, private or nonprofit organization, etc.) or through an employer's purchasing arrangement with the provider. Participation in the program is limited to Florida residents under age 65 who have been uninsured for at least six months, who are not eligible for any public insurance program, and who earn less than 200% of the federal poverty limit¹ (\$20,000 for a family of 4 in 2006).² The plans have either low-cost or completely subsidized premiums, in order to remove the financial barrier to obtaining coverage.

Currently, there are five state-approved plans in operation. American Care, Inc., a private physician group, and Preferred Medical Plan, Inc., a licensed HMO, operate privately in Miami-Dade County and provide limited benefits. Vita Health Plan is operated by Healthy Palm Beach, Inc., a licensed HMO, and its premiums are partially subsidized by the Health Care District of Palm Beach County. JMH Health Plan is operated by the Public Health Trust of Miami-Dade County. JaxCare, which operates in Duval County, is financed through a partnership between the City of Jacksonville, area hospitals, private and corporate donations, and premiums paid by enrollees and their employers. Enrollment is offered only through employers, and while enrollment has remained below the maximum of 1,650, participation has grown substantially.¹

Ultimately, four parties (the state, local entities, employers and beneficiaries) play a role in the Health Flex program. A number of factors have been identified at each level that may be accountable for the low enrollment.

The State

The State is responsible for setting the requirements for the program, reviewing provider applications, and publicizing the program to plan providers and employers. Potential shortcomings include:

- Not enough publicity generated among potential providers, employers, and beneficiaries
- Lack of support with implementation
- Some fundamental flaw in the design of the program

Under a grant from the Robert Wood Johnson Foundation, AHCA partnered with the University of Florida and several other entities to market Health Flex to both providers and consumers. After this initial marketing period, several local entities expressed interest in the program, though after conducting feasibility studies, not all decided to pursue it.¹

Plan Providers

The providers of Health Flex plans are responsible for partnering with existing community organizations in order to provide coverage at a reduced cost while still remaining financially sound. They are expected to adhere to state-mandated quality standards and are subject to financial audits.

Table 1: HealthFlex Plan Summary as of September 30, 2006

Plan	County of operation	Enrollment as of 9/30/06	Hospital coverage provided?	Calendar year net income (loss) as of 9/30/06
American Care, Inc.	Miami-Dade	37	no	\$8,919
JaxCare, Inc.	Duval	690	yes	\$167,483
Preferred Medical Plan, Inc.	Miami-Dade	21	no	(\$8,055)
JMH Health Plan	Miami-Dade	797	yes	(\$411,488)
Vita Health Plan	Palm Beach	231	yes	(\$424,959)

Potential provider shortfalls include:

- No incentive to initiate a program
- Lack of support from the community
- Lack of financial incentive
- Lack of hospital care in two of the five plans

The two plans that do not cover hospital care have by far the lowest enrollment, 21 for Preferred Medical Plan, Inc. and 37 for American Care, Inc. These two plans also rely solely on premiums, rather than community partnerships, for their funding.

A grievance procedure is in place for beneficiaries who feel that their coverage is inadequate; however, as of January 2007, not a single grievance had been filed. While it is optimistic to believe that the programs are operating perfectly, it seems more probable that this is due to a lack of information on the part of beneficiaries. They might not be well informed of the existence of the grievance process, or their expectations may be low due to limited exposure to the health insurance field. In either case, more education would be needed to teach beneficiaries about what a health plan entails.

Employers

Employers are eligible to arrange coverage for their low-income workers under HealthFlex, and in such an arrangement they would pay at least part of the premium. Several factors leading to businesses' limited adoption of plans include:

- Income limits that prevent all employees from being enrolled
- High turnover means little incentive to keep employees healthy over the long term
- Expense is too much for small businesses already operating on a narrow margin

The January 2007 Health Flex annual report identifies the income limits placed on plans as a significant issue for employers. If only some employees qualify for coverage, many employers would prefer to cover nobody rather than create perceptions of unequal treatment among their workers. A 2007 study out of Case Western Reserve University identified worker turnover as another reason that employers may not provide insurance. Because an employee may only be with the company for a few years, there is little incentive for the employer to ensure that they receive preventative care for their long-term health, and thus insurance is deemed an unnecessary expense.³ This is particularly true among small businesses, whose employees are much less likely to be insured than workers at large companies.⁴

Beneficiaries

Certain demographic factors are associated with not seeking primary health care or insurance coverage. Among those relevant in this case are:

- Minority status (particularly Hispanic)
- Foreign-born, especially recent immigrants
- Low income
- Youth
- Non-English speakers

Miami-Dade County is the location of the two lowest-enrollment plans. It also has a very large Hispanic population (61.3%) and significant foreign-born population (50.3%).⁵ A 2001 study sponsored by the Robert Wood Johnson Foundation found that Hispanics are often “unaware of available health services or fearful of providers.” Hispanics are also much less likely than other races to accept employer-sponsored insurance if it is offered to them. This could lead to low enrollment of Hispanics, as well as a lack of participation among Hispanic-owned businesses. A 2004 study by the Agency for Healthcare Quality and Research found that Hispanics were more likely than other races to view insurance as not worth the cost, and to believe that they are healthy enough that they do not need it.⁶ Duval County, with a Hispanic population of just 5.7%, saw more success with its program.⁵ This may be a coincidence, but it is certainly a factor worth considering. It should also be noted that those working in low-income positions without insurance are often young and healthy, and may view coverage as unnecessary or not worth the cost.

The language barrier may also be a significant impediment to the uptake of these plans. In Miami-Dade County, 71.1% of the population speaks a language other than English at home. Institutional barriers, particularly a lack of translators, are often an impediment to obtaining coverage and care. The Robert Wood Johnson Foundation’s report recommends that more health-related interventions be targeted to speakers of other languages, and that non-print media be used in order to reach those of low literacy.⁷

Other factors that may also contribute to the low enrollment in these plans:

- The six-month waiting period
- Maximum income requirements
- Illegal immigrant status
- No desire for insurance

In order to qualify for Health Flex, beneficiaries must not have had insurance for six months prior to enrollment. This could be potentially disastrous for some, particularly those with chronic conditions. Another requirement is that enrollees earn no more than 200% of the federal poverty limit, which was \$20,000 for a family of four in 2006. The median household income in Miami-Dade County in 2006 was \$46,731, just above this threshold. Several of the plans expressed a desire to raise the maximum income to 220% of the FPL, which would broaden the eligibility for these plans considerably. It is worth noting that under JMH Health Plan, only four of the 797 enrollees fell into the highest income category. The vast majority of beneficiaries have incomes of less than 100% of the FPL, which qualifies them to have their premiums completely subsidized.¹ Table 2 shows the percentage of each poverty level who are uninsured for each of the HealthFlex counties.

Table 2: Uninsured rates by income level (% of FPL)

County/FPL	<100%	100-150%	151-200%	201-250%	>250%
Duval	26.5%	25.9%	24.1%	14.6%	7.5%
Palm Beach	50.0%	44.1%	37.5%	16.7%	7.7%
Dade	43.8%	48.9%	33.6%	33.0%	11.5%

Source: 2005 FHIS report

For 2006, the Office of Immigration Statistics estimated there were 980,000 undocumented immigrants living in Florida, two thirds of whom have been here less than ten years. These workers are disproportionately employed in the construction and service industries, which typically pay low salaries.⁸ The nature of their work, their illegal status, and their recent immigration are all factors which would cause them to not seek out health insurance, particularly a plan associated with state government.

The 2004 AHRQ study found that the uninsured were twice as likely as the insured to view coverage as simply unnecessary. Low educational attainment is another factor associated with no desire for insurance, and many of the low-income uninsured have a limited education. They may also be put off by the paperwork needed to enroll, or simply be intimidated by the prospect of obtaining insurance.⁶

Conclusion

There are three key weaknesses in the Health Flex program:

- Despite expansion of the program to all 67 counties, as well an extension of the deadline to create new plans until 2008, very little interest has been expressed by potential plan providers. This could be due to ineffective communication by the state or a fundamental flaw in the nature of the program which makes it unfeasible in practice.

- Enrollment in all of the existing plans is lower than anticipated. This may be due to a variety of demographic factors among potential enrollees, as well as a lack of interest among employers and failure to market the plans effectively.
- Of the five plans, two in particular are suffering from very low enrollment. A lack of hospital coverage and no community partnerships are the distinguishing characteristics of these plans.

Of the five plans, only JaxCare, Inc. has significant enrollment as well as being financially solvent. A variety of factors are responsible for its relative success, including hospital partnerships, nonprofit support, and possibly demographic characteristics that distinguish Duval County from South Florida.

In Miami-Dade County, the vast majority of Health Flex participants have incomes less than 100% of the FPL, which qualifies them for complete subsidization of their premiums. This suggests that, although many desire health insurance, they are either unwilling or unable to pay for it, and therefore, raising the income cap would be unlikely to result in greater enrollment.

¹ “Health Flex Plan Program Annual Report.” January 2007. Florida Agency for Health Care Administration.

² “The 2006 HHS Federal Poverty Guidelines.” U.S. Department of Health and Human Services. <<http://aspe.hhs.gov/poverty/06poverty.shtml>>

³ Cebul, Randall et al. “Employer-Based Insurance Markets and Investments in Health.” School of Medicine and Center for Health Care Research and Policy, Case Western Reserve University. July 2007.

⁴ Banja, John D. “The Improbable Future of Employment-Based Insurance.” *The Hastings Center Report*, Vol. 30, No. 3. (May - Jun., 2000), pp. 17-25.

⁵ United States Census Bureau, American Community Survey 2006. <<http://www.census.gov/acs/www/>>

⁶ Cohen, S. B. *Attitudes toward Health Insurance and Their Persistence over Time, Adults 2003–2004*. Statistical Brief #161. February 2007. Agency for Healthcare Research and Quality, Rockville, Md. <http://www.meps.ahrq.gov/mepsweb/data_files/publications/st161/stat161.pdf>

⁷ “Spanish Media Can Help Latino Children the Health Care They Need.” Robert Wood Johnson Foundation, December 2006.

⁸ Passel, Jeffrey S. “The Size and Characteristics of the Unauthorized Migrant Population in the U.S.” Pew Hispanic Center, 7 March 2006.