



214 Massachusetts Ave. N.E Washington D.C. 20002 (202) 546-4400 www.heritage.org

CONGRESSIONAL TESTIMONY

**“Covering the Uninsured Through
the Eyes of a Child”**

**Testimony before
Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives**

February 14, 2007

**Nina Owcharenko
Senior Health Care Policy Analyst
Center for Health Policy Studies
The Heritage Foundation**

Summary of Testimony

Health care coverage for children is important. Without it, children suffer and society pays. Children without coverage seek care in an inefficient and costly manner.

Defining Uninsured

Like adults, the vast majority (over 60 percent) of children obtain coverage through the employer based system. 27 percent receive care through the Medicaid and SCHIP programs. An estimated 11 percent of children are considered uninsured.

There are a variety of ways to count the uninsured: a specific point in time; entire year, or at any time during a year. In considering duration, children are more likely to have shorter periods of uninsurance than adults.

Uninsured Children

By age, children have the lowest uninsurance rate than almost all other age groups (except those 65 and older). Adults between the ages of 18 and 24 have the highest rate with 31 percent.

By family income, the majority of uninsured children are among lower-income families. But, the largest growing segment of uninsured is among middle and upper income families.

By family work status, the majority (68 percent) of uninsured children are in families with a full-time, full-year worker. Only 17 percent of uninsured children have no family member working.

Obstacles to Existing Coverage

The current patchwork system of public and private coverage does not work for everyone, including children.

In the private sector, not all workers (or their dependents) have employer-based coverage. Moreover, coverage outside the place of work can be costly, depending on state regulation.

In the public sector, access to quality care is limited. Second, entitlement approaches, such as Medicaid, are unsustainable. Finally, public program expansions have the unintended consequence of crowding out private coverage for families.

Strategies for Addressing Shortfalls of the Current System

For the private sector:

- Fix the tax treatment of health insurance.
- Promote an alternative to the employer-based system.

For the public sector:

- Add greater choice for enrollees.
- Adopt more patient-centered models.

Federalism

- Support state-based innovations.

My name is Nina Owcharenko. I am Senior Health Policy Analyst at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Children’s Health Insurance Coverage

Health care coverage for children is important. Without it, children suffer and society pays. One study reports that 54 percent of children without coverage have not received any well-child visits and 31 percent have not seen a doctor in the past year, compared to only 9 percent and 26 percent for children with insurance coverage.¹ When an uninsured child does access the health care system, it is usually in a very inefficient and costly manner. The cost of uncompensated care—treating those without coverage— cost taxpayers an estimated \$34.6 billion in federal, state, and local spending in 2004.² Thus, this phenomenon does not just harm children, but impacts society as a whole.

Defining Uninsured

Today’s health care system is a mix of private and public coverage. According to the most recent U.S. Census data, 68 percent of the population receives their health insurance through the private sector—predominately through the place of work—and 27 percent

¹Campaign for Children’s Health Care, “No Shelter from the Storm: America’s Uninsured Children,” September 2006, p. 9, at www.childrenshealthcampaign.org/tools/reports/Uninsured-Kids-report.pdf.

²Jack Hadley and John Holahan, “The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?” Kaiser Commission on Medicaid and the Uninsured *Issue Update*, May 10, 2004, p. 3, at www.kff.org/uninsured/upload/The-Cost-of-Care-for-the-Uninsured-What-Do-We-Spend-Who-Pays-and-What-Would-Full-Coverage-Add-to-Medical-Spending.pdf.

receive their care through the public sector.³ This leaves an estimated 15 percent of people without health care coverage.⁴

The results for children are similar. Over 60 percent obtain coverage through the private sector employer-based system and 5 percent obtain coverage directly through the private market.⁵ 29.7 percent obtain care through the public sector, of which the overwhelming portion (27 percent) receives care through Medicaid and SCHIP.⁶ The remaining 11 percent of children are considered uninsured.⁷

While significant, it is important to note that there are a variety of ways of counting the uninsured. The commonly referenced Census figures reflect an individual's coverage status at a specific point in time. However, there are other ways of counting the uninsured. For example, besides measuring coverage at a specific point in time, other typical and useful measures include the number of people uninsured for the entire year and the number uninsured at any time during the year. According to a Congressional Budget Office analysis of the uninsured, 26.8 percent of children were uninsured "at any time" in 1998, but only 7.3 percent were uninsured "all year."⁸ Moreover, children are more likely to have shorter periods of uninsurance than adults.⁹

³Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," U.S. Department of Commerce, U.S. Census Bureau, August 2006, p. 21, at www.census.gov/prod/2006pubs/p60-231.pdf.

⁴*Ibid.*

⁵*Ibid.*, p. 69.

⁶*Ibid.*

⁷*Ibid.*

⁸Congressional Budget Office, "How Many People Lack Health Insurance and for How Long," May 2003, p. 7, at www.cbo.gov/ftpdocs/42xx/doc4210/05-12-Uninsured.pdf.

⁹*Ibid.*, p. 9.

Uninsured Children

By Age

Interestingly, by age group, uninsured children actually had lower uninsurance rates than other age group. Adults between the ages of 18 and 24 ranked the highest with 31 percent uninsured, followed by those between 25 and 34 with 26 percent uninsured, those between 35 and 44 with 19 percent, and finally those between 45 and 64 percent with 15 percent.¹⁰ As mentioned, 11 percent of children (below 18 years of age) are uninsured.¹¹

By Family Income

According to estimates by Paul Fronstin at the Employer Benefit Research Institute, an estimated 32 percent of uninsured children are in families with income below federal poverty; 33 percent in families with incomes between 100 and 200 percent federal poverty; 19 percent between 200 and 300 percent federal poverty; and 17 percent above 300 percent federal poverty.¹² Of note, the largest growing segments of uninsured are among middle and upper income families.¹³

By Family Work Status

Fronstin analysis also found that of children without coverage, 68 percent were in families with a full-time, full-year worker; 5 percent of uninsured children were in families with a part-time, full-year worker; 6 percent were in families with a full-time,

¹⁰DeNavas-Walt *et al.*, p. 22.

¹¹*Ibid.*

¹²Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey," Employee Benefit Research Institute Issue Brief No. 298, October 2006, p. 23, at www.ebri.org/pdf/briefspdf/EBRI_IB_10a-20061.pdf.

¹³Devon Herrick, "Crisis of the Uninsured: 2006 Update," National Center for Policy Analysis Brief Analysis No. 568, September 6, 2006, www.ncpa.org/pub/ba/ba568.

part-year worker; and 4 percent were in families with a part-time, part-year worker.¹⁴

Only 17 percent of uninsured children were in a family with no worker.¹⁵

Obstacles to Existing Coverage

Obviously, the current patchwork system of public and private health insurance does not work for everyone, including children.

Private Sector Shortfalls

As noted, an overwhelming percent of uninsured children are part of a working household where at least one family member has a job. However, having a job does not guarantee coverage for workers or dependents. An employer may not offer coverage, as is common in the small business sector. A worker may not be eligible for employer coverage due to waiting periods or work status. Finally some workers simply choose not to participate in employer coverage. 64 percent of workers who did not participate in employer coverage cited cost as reason.¹⁶

Obtaining family coverage outside the place of work can also be difficult. The federal tax code discriminates against those who do not obtain coverage through their places of work. Unlike under the employer-based system, where the full value of the health benefit is excluded from a workers' taxable income, individuals purchasing coverage on their own do not receive such a tax break and must use after-tax dollars to buy coverage.

¹⁴Fronstin, p. 24.

¹⁵*Ibid.*

¹⁶*Ibid.*, p. 16.

Moreover, states regulate the individual market, which directly impacts those purchasing coverage in their own. Well-intentioned but costly one-size-fits-all state regulations can make coverage unaffordable, especially for those with limited incomes. The Council of Affordable Health Insurance estimates that mandates, for example, can increase the cost of health insurance by 20 to 50 percent, depending on the mandate and state.¹⁷

Public Sector Shortfalls

The public sector also has its share of shortfalls in reaching uninsured children, as illustrated by the number of children eligible for but not enrolled in Medicaid and SCHIP. The Kaiser Family Foundation estimates that 74 percent of uninsured children are eligible for Medicaid or SCHIP.¹⁸

It is common knowledge that access troubles these public programs. The number of doctors who will see new Medicaid patients continues to decline. In a recent analysis of Medicaid physicians, 15 percent of pediatric physicians were not accepting any new Medicaid patients, an increase from the previous year.¹⁹ Moreover, the implications of limited access to care results in more Medicaid and SCHIP enrollees showing up at the emergency room. Research has found that Medicaid and SCHIP ER visits account for over 80 percent of hospital admissions.²⁰

¹⁷Victoria Craig Bunce, JP Wieske, and Vlasta Prikazsky, "Health Insurance Mandates in the States 2006," Council for Affordable Health Insurance, March 2006, www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf.

¹⁸John Holahan, Allison Cook, and Lisa Dubay, "Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage," Kaiser Commission on Medicaid and the Uninsured, February 2007, p. 4, at www.kff.org/uninsured/upload/7613.pdf.

¹⁹Peter Cunningham and Jessica May, "Medicaid Patients Increasingly Concentrated Among Physicians," Center for Studying Health System Change *Tracking Report* No. 16, August 2006, p. 3, at hschange.org/CONTENT/866/866.pdf.

²⁰John S. O'Shea, MD, "The Crisis in Hospital Emergency Departments: The Burden of Federal Regulation," The Heritage Foundation *Backgrounder*, forthcoming.

Cost is another factor. Federal and state spending on public programs, such as Medicaid, are consuming a greater share of the budget. According to the National Governors Association, Medicaid is now the largest state budget item, surpassing educational, transportation and other key state functions.²¹ At the federal level, federal spending on health care is also increasing at an unmanageable pace. By 2015, health care spending will consume 20 percent GDP, and the government's share will be one-half.²²

Finally, public program expansions also impact the stability of private coverage. Research has shown a direct correlation between the expansion of government public programs and the decline in private health insurance. Most recently, Jonathan Gruber and Kosali Simon found that “the number of privately insured falls by about 60 percent as much as the number of publicly insured rises.”²³ Gruber and Simon also concluded that the “crowd out” phenomenon is far more dramatic when considering the entire family. Thus, expansions reduce private insurance options for family members more rapidly.²⁴

Strategies for Addressing the Shortfalls of the Current System

Policymakers should focus on solutions to improve the function of the private and public sectors that will help families obtain coverage and control their health care decisions.

²¹National Governors Association and National Association of State Budget Officers, “The Fiscal Survey of States,” December 2006, p. 1, at www.nasbo.org/Publications/PDFs/Fall%202006%20Fiscal%20Survey%20of%20States.pdf.

²²Christine Boger *et al.*, “Health Spending Projections Through 2015: Changes on the Horizon,” *Health Affairs Web Exclusive*, March–April 2006, exhibit 3, p. W-64, at content.healthaffairs.org/?cgi/reprint/25/2/w61 (subscription required).

²³Jonathan Gruber and Kosali Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” National Bureau of Economic Research *Working Paper* No. 12858, January 2007, p. 2, at www.nber.org/papers/w12858.

²⁴*Ibid.*, p. 28.

Private Sector

- **Fix the tax treatment of health insurance.** One of the primary roles of the federal government is the federal tax code. President Bush has recently put forth a bold policy initiative to remove the distortion of the tax code with regard to the tax treatment of health insurance. Federal policymakers should seize this unique opportunity and build on the President's proposal by adopting refundable, advanceable tax credits. These tax credits could be designed to assist families in enrolling their children in dependent coverage through the place of work or the non-employer market.

- **Promote an alternative to employer-based coverage.** As noted, not all families fit into the employer-based system. Although insurance reform is primarily the responsibility of state policymakers, there are some federal tools that can expand individual access to affordable coverage. Federal policymakers should look for ways to encourage individuals to obtain health care coverage of their own choice and help to facilitate a more robust non-employer marketplace. Such policies could encourage innovative approaches that preserve the benefits of pooling, but promote more personal and portable coverage.

Public Sector

- **Add greater choice for enrollees.** The traditional public health care design depends on a one-size-fits-all approach. Balancing financing and design can be difficult and undoubtedly results in coverage that does not meet everyone's

needs. The Deficit Reduction Act increased flexibility for states to tailor health care services to enrollees. Federal policymakers should build on this first step by giving enrollees more choices from competing networks and insurers for the delivery of their care. Moreover, individual enrollees should have the freedom to use their existing public program allocation and purchase private coverage through the marketplace, which would help many low-income children mainstream into the private market with their families.

- **Adopt more patient-centered models.** Due to the bureaucratic structure of the public programs, enrollees have little say in the type or way services are delivered, and many are promised a set of benefits but do not always receive them. The Cash and Counseling initiative in Medicaid is a successful example of creating a more patient-centered approach to care in Medicaid. Federal policymakers should use this model to give enrollees greater control in determining the care and services they receive and from whom.

Federalism

- **Support state-based innovations.** In light of the federal gridlock on health care policy, many states have begun to take the lead on health care reform. In some respects, this makes sense. There is great diversity at the state level, and blanket federal policies can have varying impacts and outcomes depending on the state.²⁵ Thus, federal policymakers should encourage state innovation and

²⁵Sherry Glied and Douglas Gould, "Variations in the Impact of Health Coverage Expansion Proposal Across States," *Health Affairs Web Exclusive*, June 7, 2005, at content.healthaffairs.org/cgi/reprint/hlthaff.w5.259v1 (subscription required).

consider providing federal tools to assist states in addressing the unique needs of their states.

Conclusion

Addressing the lack of health insurance among children is important. One of the best ways to begin to tackle the solution is to address the shortfalls in the overall health care system. Policy initiatives should focus on changes to the private and public health care system that increase coverage options and personal control. Such policy solutions will not only address the needs of children, but improve the health of the system for all Americans.

The Heritage Foundation is a public policy, research, and educational organization operating under Section 501(C)(3). It is privately supported, and receives no funds from any government at any level, nor does it perform any government or other contract work.

The Heritage Foundation is the most broadly supported think tank in the United States. During 2004, it had more than 200,000 individual, foundation, and corporate supporters representing every state in the U.S. Its 2004 income came from the following sources:

Individuals	56%
Foundations	24%
Corporations	4%
Investment Income	11%
Publication Sales and Other	5%

The top five corporate givers provided The Heritage Foundation with 2% of its 2004 income. The Heritage Foundation's books are audited annually by the national accounting firm of Deloitte & Touche. A list of major donors is available from The Heritage Foundation upon request.

Members of The Heritage Foundation staff testify as individuals discussing their own independent research. The views expressed are their own, and do not reflect an institutional position for The Heritage Foundation or its board of trustees.