



*A not-for-profit health and tax policy research organization*

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Subcommittee on Health**

**The Honorable Frank Pallone, Jr.,  
Chairman**

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**Hearing on**

**“Living without Health Insurance:  
Why Every American Needs Coverage”**

**By Grace-Marie Turner**

**President**

**Galen Institute**

## ***Executive Summary***

### **“Living without Health Insurance: Why Every American Needs Coverage”**

By Grace-Marie Turner

With the increasing ability of the medical profession to save and improve our lives, Americans value the security of health insurance to cover their health costs. For public policy solutions to be effective in reducing the number of those who do not have the security of health insurance, we must look beneath the numbers to see who is uninsured, why, and what solutions are likely to work to expand coverage.

Analyses show those who are most likely to be uninsured are young adults, those working for small businesses and their dependents, lower-income workers, and minorities. Either we can dramatically expand public programs to cover this population or we can find new ways to help them access private coverage. I would suggest that, with so many competing priorities for taxpayer dollars, we find ways to strengthen access to private health insurance.

Research by Jonathan Gruber of MIT shows that despite an enormous expansion in public health programs over the last 20 years, the number of uninsured continues to grow. Gruber’s research suggests that most of the rise in public insurance comes from a fall in private insurance. He finds that crowd-out is most likely to take place with those in upper income categories – the target category for SCHIP expansion – because they are more likely to have options for private coverage.

Further, it is essential that legislative changes not make it more difficult for employers to provide coverage by inadvertently driving up their premiums. Milliman Actuary Mark Litow argues that expanding government programs puts added pressure on the cost of private health insurance. Public payers pay less to doctors and hospitals, and as these public programs expand, private plans must pay more. Their costs rise, driving up premiums and causing more people, especially individuals and small businesses, to drop out of the market, thereby swelling the ranks of the uninsured.

Changes are needed to our health care system to meet the challenges of a changing workforce and 21<sup>st</sup> century economy. America can lead the way by putting in place new policies that combine a general tax deduction or credit with additional financial assistance for lower-income people, and flexibility to turn SCHIP and Medicaid benefits into defined contributions, thereby retargeting existing funds to increase access to private health insurance. Building on this base of private coverage would both be more economical for taxpayers and also would give workers eligible for public subsidies the dignity of private insurance coverage, with its broader access to private physicians and medical facilities.

# **“Living without Health Insurance: Why Every American Needs Coverage”**

By Grace-Marie Turner

President, Galen Institute

Chairman Pallone and distinguished members of the committee, thank you for the opportunity to speak with you today during this week of national attention on “Covering the Uninsured.” To introduce myself, I am Grace-Marie Turner, president of the Galen Institute, a non-profit public policy research organization that I founded in 1995 to focus on market-based policy solutions to the problems in our health sector.

Our core focus at the Galen Institute is offering solutions to expand private health insurance to the tens of millions of people in this country who are without coverage.

With the increasing ability of the medical profession to save and improve our lives, Americans value the security of health insurance to cover their health costs. When we look at the trend lines for health insurance coverage in the U.S., it is clear that we must chart a new course.

The number of people without health insurance is steadily rising, now 44.8 million, according to recent revised Census Bureau estimates,<sup>1</sup> and the number of people with coverage through the workplace is falling, from 69% in 2000 to 61% in 2006.<sup>2</sup>

If public policy solutions are to be effective in reducing the number of uninsured, it is important to look beneath these numbers to see who is uninsured, why, and what solutions are likely to work to expand coverage.

Analyses show those who are most likely to be uninsured are young adults, those working for small businesses and their dependents, lower-income workers, and minorities. I would like to offer suggestions for new strategies to increase coverage for those who are most likely to be without insurance.

### **A profile of the uninsured**

About 80% of the uninsured are workers or their dependents. These are people who make too much to qualify for public programs, such as Medicaid and the State Children's Health Insurance Program, but don't have the good, higher-paying jobs that come with health insurance. These are the people that are in what we call the "Galen Gap." Our logo is a conceptual depiction of this group that represents our largest public policy challenge.<sup>3</sup>

We have two choices: Either we can dramatically expand public programs to cover this population or we can find new ways to help them access private coverage. I will describe research by Jonathan Gruber of MIT which suggests that the former may not be the best strategy and suggest ways that existing public funds could be used to expand access to private coverage for this target population.

### **Who is most likely to be uninsured?**

- Young adults: Among young adults aged 19-24, 38.2% do not have health insurance.<sup>4</sup> For this population of people who are overwhelmingly healthy and believe in their invulnerability, the cost of insurance is the biggest issue.
- Employees of small businesses: Only 60% of small firms offered coverage in 2006. And the smallest firms are least likely to provide coverage: Only 48% of firms with 3 to 9 workers offer health insurance to their workers. The drop in employment-based health insurance has been primarily among small companies employing 3 to 199 workers. In contrast, 98% of large firms with 200 or more workers offered health insurance in 2006.<sup>5</sup>

The reason firms cite for not offering health insurance is the high cost of coverage,

with 74% saying that the high price of premiums is a “very important” reason they don’t offer health insurance.<sup>6</sup> And some firms are just too small to manage their businesses as well as the complexities of health insurance. The National Restaurant Association says, for example, that some employees may only work for a restaurant for a few days, making it almost impossible to enroll these workers in health plans and for their job to be a stable source of coverage.

- Lower-income Americans: In 2005, 37% of non-elderly people with incomes under 100% of federal poverty were uninsured compared to just 7% of those with incomes of 300% of poverty or above.<sup>7</sup> Lower-income workers need targeted subsidies to help them afford insurance.
- Minorities: An estimated 32.3% of Hispanics are uninsured, compared to 10.7% of whites and 19% of blacks.<sup>8</sup> This suggests that outreach to the Hispanic community with new options and information about those options would be an important component of an effort to increase enrollment in health insurance.

And even though a profile of the uninsured captures these primary categories, the actual faces in this group without coverage are ever-changing. According to the Congressional Budget Office, the uninsured population is constantly shifting as people gain and lose coverage. Furthermore, the length of time that people remain uninsured varies greatly.

Some people are uninsured for long periods of time, but more are uninsured for shorter periods. About 45% are uninsured for four months or less.<sup>9</sup> This is primarily a phenomenon of our system of job-based health insurance where people lose their health insurance when they lose their job and have periods of uninsurance while they wait to get covered again.

And many of the uninsured are eligible for public programs. Twenty-five percent of the uninsured are eligible but not enrolled in public programs. Another 20% have incomes high enough to afford coverage, defined as 300% of poverty or above, according to a report published in *Health Affairs*.<sup>10</sup>

The CBO says that 16% are continually uninsured for more than two years, and they tend to be people with less education, those with low incomes, and Hispanics. These longer-term uninsured would seem to be an important group for Congress' attention as they clearly have fewer opportunities for private coverage.

### **Crowd out**

As Congress focuses on the problem of the uninsured, it would be helpful to look at the success of past strategies in expanding access to public coverage, especially through Medicaid expansions and the creation of the State Children's Health Insurance Program.

Over the past two decades, the number of people without health insurance and the number of people with publicly-supported health insurance both have risen.<sup>11</sup> According to Jonathan Gruber of MIT, from 1984 through 2004, the share of the non-elderly population in the U.S. that is uninsured rose from 13.7% to 17.8%. At the same time, the share of the non-elderly U.S. population that is publicly insured rose from 13.3% to 17.5%. In other words, Gruber shows that despite an enormous expansion in public health programs, the number of uninsured continues to grow.

Gruber's research suggests that most of the rise in public insurance comes from a fall in private insurance. His data show that, between 1984 and 2004, the share of the U.S. non-elderly population with private health insurance fell from 70.1% to 62.4%. His estimates suggest that expansions of public insurance are crowding out private insurance at the rate of 60%. That means, in general, that private insurance coverage is reduced by 60% as much as public insurance rises.

Because there is a great deal of attention to expanding the State Children's Health Insurance Program, it is important to look at these findings to make sure that a program expansion wouldn't simply be replacing private insurance with taxpayer-supported coverage. Gruber finds that crowd-out is most likely to take place with those in upper

income categories – the target category for SCHIP expansion – because they are more likely to have options for private coverage.

It is only logical that people would opt for public coverage if it were offered because taxpayer-supported insurance is almost always less expensive for recipients than private insurance. But it may be worth rethinking this strategy if the goal of the added spending on SCHIP is to reduce the number of uninsured. Gruber's research suggests that expanding SCHIP could add more children to public rolls but not have a significant effect on reducing the number of uninsured children.

According to the Kaiser Commission on Medicaid and the Uninsured, a surprising percentage of poor and near-poor adults – those earning 200% of poverty or below – have employment-based or other private health insurance.<sup>12</sup> The Kaiser study shows that 45% of non-elderly people who earn between 100% and 199% of poverty (up to \$20,420 in 2007) have private health insurance, either coverage they get through work (39%) or individual policies (6%). About a third of lower-income adults are uninsured and one-quarter have public coverage, primarily through Medicaid or SCHIP.

Clearly it would be a mistake, with so many competing priorities for taxpayer dollars, to replace private coverage for those who have it with expanded public health programs.

## **Making private insurance more expensive**

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It also would be helpful to examine the consequences of a major expansion of SCHIP or other public programs on the market for private insurance.

Expansion of government health programs drives up the cost of private health insurance, according to health actuary Mark Litow of Milliman Consultants and Actuaries.

Here's why: He estimates that private health plans pay about 64% of the full charges of doctors, hospitals, labs, etc. Medicare pays about 37% of these "undiscounted" charges. And Medicaid pays only about 30%.<sup>13</sup>

It's only logical that the more of the market that is taken up by programs paying only 30% of a provider's charges, it is going to put more pressure on others to make up at least some of the difference. Litow argues that expanding government programs puts added pressure on the cost of private health insurance. As public programs expand, private plans must pay more. Their costs rise, driving up premiums and causing more people, especially individuals and small businesses, to drop out of the market, thereby swelling the ranks of the uninsured.

With 160 million Americans receiving their health coverage through the workplace, it is essential that legislative changes not make it more difficult for employers to provide coverage by inadvertently driving up their premiums through expansion of public programs.

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Hippocrates' dictate to "First, do no harm"<sup>8</sup> would seem useful guidance.

### **Alternative ideas to expand coverage**

Changes are needed to our health care system to meet the challenges of a changing workforce and 21<sup>st</sup> century economy.

Tying health insurance to the workplace is not meeting the needs of a workforce that is increasingly independent and mobile. The Labor Department reports that four in ten Americans leave their jobs every year, with virtually all of them moving on to a new job.<sup>14</sup> With this kind of job mobility, it is extremely difficult to tie health insurance to the workplace and expect people to have continuity of coverage. We need a system that allows people to have health insurance that is portable, insurance that they can own and control, and insurance that fits the needs of families and their budgets.

Portability of health insurance would help not only those who are uninsured, but also those who are worried they could lose their coverage. It would give new security to millions of workers who are worried that if they lose their jobs, they will lose their health insurance. With the cost of health insurance and health care rising every year, they fear they would not be able to afford coverage on their own. The middle class is increasingly afraid that they are one premium payment away from joining the ranks of the uninsured.

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**America can lead the way** in creating a health care system that fits with our 21<sup>st</sup> century economy by putting in place new policies that respond to consumer demands for more affordable, portable health insurance.

- The first step would be giving favorable tax treatment of health insurance to people whether they buy coverage on their own or get it at work, as President Bush has proposed.
- Congress also could offer refundable tax credits for those in lower-income categories who need additional help in purchasing policies.
- Further, Congress could allow those eligible for public programs to apply the value of the subsidies for which they are eligible toward the purchase of private health insurance. This would mean that citizens could take the value of their

Medicaid benefit and apply it toward employer-offered coverage. Or they could take the value of their SCHIP subsidy to add their children to their policies at work.

- And legislators could create new opportunities for people to purchase group health insurance through organizations that may be more stable forces in their lives than their jobs, such as churches, labor unions, and professional and trade associations.

This combination of a general tax deduction or credit, with additional financial assistance for lower-income people, and flexibility to turn SCHIP and Medicaid benefits into defined contributions would retarget existing funds to increase access to private health insurance.

Building on this base of private coverage would both be more economical for taxpayers and also would give workers eligible for public subsidies the dignity of private insurance coverage, with its broader access to private physicians and medical facilities.

Consumers, not just in the United States but in all developed countries, are demanding a much greater role in decisions involving their health care. Women, especially, believe that they, rather than a corporate human resources director, could make better decisions involving health coverage for their families if only they were given the chance.<sup>15</sup>

Giving people more power and control over their health care and health insurance creates new incentives for people to be more engaged in managing their health. Many companies realize this and are instituting new programs to give employees incentives to better manage their health spending. A number of studies have shown that if people are given the tools, the information, and the incentive to manage their care, outcomes can be dramatically improved. And we could transform our health care system into one that responds to the changes of a 21<sup>st</sup> century workforce and meets the needs of a diverse population of health care consumers.

Thank you for the opportunity to talk with you today about these important issues. I would be happy to answer any questions you might have or to provide additional information.

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#### ENDNOTES

<sup>1</sup> "Census Bureau revised 2004 and 2005 health insurance coverage estimates," U.S. Census Bureau, March 23, 2007. [http://www.census.gov/Press-Release/www/releases/archives/health\\_care\\_insurance/009789.html](http://www.census.gov/Press-Release/www/releases/archives/health_care_insurance/009789.html)

<sup>2</sup> "Health benefits offer rates," *Employer Health Benefits 2006 Annual Survey*, Kaiser Family Foundation, Washington, D.C. September 26, 2006. <http://www.kff.org/insurance/7527/>

<sup>3</sup> The Galen Institute logo is a conceptual depiction of a central problem in the health sector that affects Americans under age 65 without health coverage. The horizontal axis represents a given individual's income. The vertical axis represents the likelihood that individual is eligible for health coverage and the value of taxpayer subsidies for the coverage.

People on the left side of the scale with the very lowest incomes are most likely to qualify for taxpayer-supported health programs, especially Medicaid, although in some states, even the poorest residents may remain uninsured if they don't meet certain qualifications.

As an individual moves up the income scale, the likelihood of qualifying for government health programs declines. Those on the right side of the scale with higher incomes are much more likely to have job-based health coverage, which is generously subsidized through the tax code.

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Working Americans with modest incomes are most likely to be uninsured and are caught in the trough, which we call the Galen Gap. They earn too much to qualify for public programs but are unlikely to have the good jobs that provide health insurance as a tax-free benefit.

<sup>4</sup> “The uninsured in America, first half of 2005: Estimates of the U.S. civilian noninstitutionalized population under age 65,” Statistical Brief #129. June 2006. Jeffrey A. Rhoades, PhD. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.meps.ahrq.gov/papers/st129/stat129.pdf>

<sup>5</sup> “Health benefits offer rates,” *Employer Health Benefits 2006 Annual Survey*, Kaiser Family Foundation, Washington, D.C. September 26, 2006. <http://www.kff.org/insurance/7527/>

<sup>6</sup> “Health benefits offer rates,” *Employer Health Benefits 2006 Annual Survey*, Kaiser Family Foundation, Washington, D.C. September 26, 2006. <http://www.kff.org/insurance/7527/>

<sup>7</sup> “The uninsured: A primer. Key facts about Americans without health insurance,” Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. October 2006. <http://www.kff.org/uninsured/7451.cfm>

<sup>8</sup> “Revised estimates of persons without health insurance: 2005,” U.S. Census Bureau. <http://www.census.gov/hhes/www/hlthins/hlthins.html>

<sup>9</sup> “The Uninsured and Rising Health Insurance Premiums,” testimony by CBO Director Douglas Holtz-Eakin before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 9, 2004. <http://www.cbo.gov/showdoc.cfm?index=5152&sequence=0>

<sup>10</sup> “The uninsured and the affordability of health insurance coverage,” Lisa Dubay, John Holahan and Allison Cook. *Health Affairs*. Nov. 30, 2006. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.1.w22>

<sup>11</sup> “Crowd-out ten years later: Have recent public insurance expansions crowded out private health insurance?” Jonathan Gruber and Kosali Simon. National Bureau of Economic Research Working Paper 12858, January 2007. <http://www.nber.org/papers/w12858>

<sup>12</sup> “The uninsured: A primer. Key facts about Americans without health insurance,” Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. October 2006. <http://www.kff.org/uninsured/7451.cfm>

<sup>13</sup> Release of data pending by Milliman Consultants and Actuaries, Mark Litow, Principal and consulting actuary. Information from private e-mail exchange April 20, 2007. [www.milliman.com](http://www.milliman.com)

<sup>14</sup> “Job openings and labor turnover: November 2006,” Bureau of Labor Statistics, United States Department of Labor, January 10, 2007. [http://www.bls.gov/news.release/archives/jolts\\_01102007.pdf](http://www.bls.gov/news.release/archives/jolts_01102007.pdf)

<sup>15</sup> “In America. Focus on women,” Bob Herbert, *The New York Times*, September 28, 2000.

