

THE UNINSURED AND AFFORDABLE HEALTH CARE COVERAGE

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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THURSDAY, FEBRUARY 28, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 334, Cannon House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Burr, Whitfield, Ganske, Wilson, Bryant, Waxman, Strickland, Capps, Towns, Wynn, Green, and Dingell (ex officio).

Staff present: Nandan Kenkeremath, majority counsel; Yong Choe, legislative clerk; and Amy Hall, minority professional staff member.

Mr. BILIRAKIS. I call this hearing to order. I would like to welcome our witnesses and our audience to this important hearing on the uninsured. And first I would like to thank the Veterans Affairs Committee for allowing us to use this hearing room while our main hearing room, the Energy and Commerce Hearing Room, as you know is being renovated.

And I am proud to be a member of the leadership of both committees. Before we begin today, I would like to take a moment to offer my thoughts and prayers to Dr. John Eisenberg and his family.

As many of you know, Dr. Eisenberg is the Director of the Agency for Health Care Research Equality. I know that Ranking Member Brown and I, as well as all members of this committee, have worked with Dr. Eisenberg over the years in his role of AHRQ, as a founding commissioner of the Physician Payment Review Commission, one of the precursors as you know of MEDPAC.

And as principal Deputy Assistant Health Secretary for Health, John's contribution to government and to health services research has been of immeasurable value, and did not go unnoticed when President Bush decided to retain his expertise during his administration.

For some time now Dr. Eisenberg has been bravely battling a brain tumor, while continuing to lead AHRQ with the same dedication and passion for which he has always been known.

He continues to be one of the top government experts in quality, appropriateness, and effectiveness of health care services, and I know that I speak for myself, for Chairman Tauzin, and all members of this committee when I say their thoughts and prayers are

with John, his family, and his AHRQ family during this very difficult time.

While the number of uninsured individuals in America has remained at an unacceptably high level, despite a strong economy and record levels of employment, the Census Bureau estimates that last year over 38 million people went the whole year without health insurance.

Although this figure does represent an improvement from the 43.4 million Americans that lacked coverage in 1997, there is still real concern with the fact that rising health care costs and the recent economic downturn could and probably will increase the number of uninsured.

In the past, we have acted to create systems that expand health coverage. We have a system that allows employers to offer health benefits to employees without counting these benefits as income.

Medicare and Medicaid, and S-CHIP, represents substantial public investments in providing health coverage to our Nation's most needy. Federally funded community health centers provide health care to individuals without regard to their ability to pay.

State governments have implemented innovative programs, such as high risk pools, to help with the problem of the uninsured. Despite these successes the plain fact is that we must do more.

I believe that it is safe to say that no one solution will completely solve this problem. In order to significantly reduce the number of uninsured, we must look at innovative and flexible solutions that will increase access to health care.

The President has proposed \$89 billion over 10 years as a refundable—and I underline that—refundable tax credit for the purchase of health insurance. One of the most attractive components of this benefit is that it is completely portable, and would be in the hands of the individual to use in a manner that best suits their family.

I believe that it is important for Congress to examine this proposal, and certainly not to turn away from it, but to examine the proposal, and refine it where needed. But it no doubt demonstrates—and I feel very strongly about this, it does demonstrate the administration's commitment to addressing the problem of the uninsured.

The President's budget also recognizes the important role of the health care safety net. The budget proposal would allow States to use an estimated \$3.2 billion in unspent S-CHIP funds to expand S-CHIP, and Medicaid, by enrolling more low income children and their parents.

The administration's proposal also proposes \$1.5 billion for community health centers, something that is very warm to my heart, which is a \$114 million increase over last year's funding level.

And last the budget request proposes expanding the medical savings account and flexible spending account programs. These are real solutions that we should explore, and they can make a real difference in reducing the number of uninsured in America.

But—and I do again emphasize—for the benefit of all of my colleagues up here, not completely solving the problem by any means, but as has happened in the past, hopefully a partial fix, which will go toward at least reducing the number of uninsured.

This year, Congress has a tremendous opportunity, particularly with the President's interests, to improve the quality and availability of health care for all Americans. Our challenge is to enact legislation that will expand access to care for a significant number of Americans in a fiscally responsible manner.

And again I would like to thank our witnesses for being here today, and I look forward to their testimony. And I know would yield to Mr. Brown.

[The prepared statement of Hon. Michael Bilirakis follows:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS, CHAIRMAN, SUBCOMMITTEE ON
HEALTH

Good morning, I now call this hearing to order. I'd like to welcome our witnesses and our audience to this important hearing on the uninsured. First, I would like to thank the Veterans Affairs Committee for allowing us to use their hearing room while our main Energy and Commerce Committee hearing room is being renovated. I'm proud to be a member of the leadership of both these important Committees.

Before we begin today, I'd like to take a moment to offer my thoughts and prayers to Dr. John Eisenberg and his family. As many of you know, Dr. Eisenberg is the Director of the Agency for Healthcare Research and Quality (AHRQ). I know Ranking Member Brown and myself, as well as the Members of this Committee, have worked with Dr. Eisenberg over the years in his role at AHRQ, as a founding Commissioner of the Physician Payment Review Commission (one of the precursors of MedPAC), and as Principal Deputy Assistant Secretary for Health. John's contribution to government and to health services research has been of immeasurable value, and did not go unnoticed when President Bush decided to retain John's expertise during his Administration.

For some time now, Dr. Eisenberg has been bravely battling a brain tumor while continuing to lead AHRQ with the same dedication and passion for which he has always been known. He continues to be one of the top government experts in quality, appropriateness, and effectiveness of health care services. I know I speak for myself, Chairman Tauzin, and all the Members of this Committee when I say that our thoughts and prayers are with John, his family and his AHRQ family during this difficult time.

The number of uninsured individuals in America has remained at an unacceptably high level, despite a strong economy and record levels of employment. The Census Bureau estimates that last year over 38 million people went the whole year without health insurance. Although this figure represents an improvement from the 43.4 million Americans that lacked coverage in 1997, there is still real concern with the fact that rising health care costs and the recent economic downturn could increase the number of uninsured.

In the past we have acted to create systems that expand health coverage. We have a system that allows employers to offer health benefits to employees without counting these benefits as income. Medicare, Medicaid and S-CHIP represent substantial public investments in providing health coverage to our Nation's most needy. Federally funded Community Health Centers provide health care to individuals without regard to their ability to pay. State governments have implemented innovative programs, such as high risk pools, to help with the problem of the uninsured. Despite these successes, the plain fact is that we must do more.

I believe it is safe to say that no one solution will completely solve this problem. In order to significantly reduce the number of uninsured, we must look at innovative and flexible solutions that will increase access to health care. The President has proposed \$89 Billion over ten years as a refundable tax credit for the purchase of health insurance. One of the most attractive components of this benefit is that it is completely portable and would be in the hands of the individual to use in a manner that best suits their family. I believe it is important for Congress to examine this proposal and refine it where needed, but it no doubt demonstrates the Administration's commitment to addressing the problem of the uninsured.

The President's budget also recognizes the important role of the health care safety net. The budget proposal would allow States to use an estimated \$3.2 Billion in unspent S-CHIP funds to expand S-CHIP and Medicaid by enrolling more low-income children and their parents. The Administration's proposal also proposes \$1.5 Billion for Community Health Centers, which is a \$114 million dollar increase over last years funding level. Lastly, the budget request proposes expanding the medical savings account and flexible spending account programs. These are real solutions

that we should explore, and they can make a real difference in reducing the number of uninsured in America.

This year, Congress has a tremendous opportunity to improve the quality and availability of health care for all Americans. Our challenge is to enact legislation that will expand access to care for a significant number of Americans in a fiscally responsible manner. Again, I would like to thank our witnesses for being here today and I look forward to their testimony.

Mr. BROWN. I thank you, Mr. Chairman. I want to echo the Chairman's remarks, first, about John Eisenberg. As a physician, a teacher, a researcher, and a leader in the health care policy area, John has dedicated himself to making our health care system more responsive, and more efficient, and more inclusive.

I was fortunate to work closely with John during the reauthorization of HRQ a couple of years ago, and know that one of this personal priorities has been to ensure the independence and the scientific integrity of the Agency's products.

He has fought hard in his career to deliver objective, timely, and scientifically valid research, in what can sometimes be a politically supercharged environment. And that endeavor, as in so many others, John has been wholly successful.

I want to thank him for his contribution and my thoughts and prayers are with him during his illness and with his family.

I want to thank the witnesses for joining us this morning, especially considering the hearing room in which we sit, and what this committee in Congress that normally sits in this room, with Mr. Bilirakis and others, has done in the area of Veterans Administration health.

And when you look very quantifiably at results, at medical errors, at outcomes, the VA is performing these days an untold story, but one to celebrate. The VA is performing these days according to quantifiable outcome results better than the private health care system in many, many ways in this country.

And from that I think we could learn something. There was an interesting op ed in the Cleveland Plain Dealer the other day. Tom Brizatis, an writer for the Plain Dealer, was arguing for a single payer system. It is not to be confused as opponents often do with the government run health care system, where the government actually provides care.

Single payer means that the financing of health care is centralized, which puts an end to the gaps and the inconsistencies that inevitably arise when you have a patchwork of private and public financing mechanisms.

Implementing such a system would save about a \$100 billion in administrative costs out of the U.S. health care system, dollars that could be used to actually provide care. We know that the administrative costs of Medicare, which is a single payer system by and large, that the administrative costs are less than 2 percent.

And the administrative costs of private insurance are five times that, eight times that, ten times that, depending on the kind of individual or group plan. More importantly under single payer, insurance could function like insurance.

Everyone would pay into the pool, and everyone would know that should they become ill that their costs would be covered. Individuals with health conditions wouldn't be shunned off as we do now into high risk pools, and they would not be denied insurance or

face coverage, exclusions, and gaps because they actually had the occasion to fall ill.

Small businesses wouldn't be forced to drop coverage because their premiums spike upward when one employee gets sick.

People in the individual insurance market would not face an impossible tradeoff, unaffordable premiums, or deductibles so high that health care remains out of reach with or without insurance.

Steelworkers in my district, for example, and throughout the U.S., wouldn't be left without health insurance when their companies go under, or are sold, or declare bankruptcy, as well LTV, and RTI, and others have recently.

Economic downturns would not automatically under single payer swell the ranks of the uninsured. I am not minimizing the potential pitfalls associated with single payer. The public sector, the private sector, consumers, would have to work closely to ensure high quality care and promote continued medical innovation.

We could work through those issues. I am not as optimistic as my friend, Jim McDermott, who is quoted in that op ed that I cited earlier. He believes that the U.S. will see beyond the stigma, recognizing that anything short of a single payer system is just another temporary quick fix.

My guess is that the word, the term, single payer, sends chills down the spine of my colleagues on the other side of the aisle, not to mention probably several of our witnesses.

I think we are going to keep filling holes, unfortunately just keep filling holes in this institution, our health care system, for some time.

But if we are left with incremental solutions, let's establish some ground rules. I will start with the most obvious one. Let's not spend money on a proposal that ultimately reduces access to coverage. My concern about MSAs and association plans, is that by skimming healthier individuals and groups into separate risk pools, these approaches could increase premiums for everyone else.

What happens when premiums increase? So does the number of uninsured. While we are at it, let's not encourage the proliferation of high deductible plans. When an individual faces a high deductible, what kind of care do they avoid?

They avoid, of course, routine and preventive care. Do we really want to discourage the use of routine and preventive care and what that means to costs, and what that means to human health. Strike Two for MSAs.

Let's not spend money on a proposal that creates a two-tiered system; one for healthy people, and one for sick people. Insurance is supposed to be there when you get sick, not until you get sick.

While current high risk pools of filled the gap for some individuals, premiums are exceptionally high and participation is relatively low for the very risk that the risk pool is not balanced.

Again, for insurance to remain stable and to remain affordable, you have to buy in when you are healthy as protection in the event that you get sick. Taken to its extreme, the risk pool says that you would relegate all of those who might become ill into one pool, and all of those who definitely won't become ill into another.

All of us would be in the high risk pool. That's why all of us need insurance, and that's why those of us who are fortunate enough to

stay healthy can't abandon those who become ill. Tomorrow your luck might change. Let's not spend money on a proposal that is not well targeted.

My concern with tax credits is to help low income families who comprise the bulk of the uninsured, these credits would have to be huge. I checked out premiums in the individual markets in my home State of Ohio.

Unless you want a plan with a \$5,000 deductible, the premiums are outrageous, upwards of \$10,000 per year per family in some cases. I understand the administrative load on a typical insurance policy in the individual market—and keep in mind what I said about Medicare—are 2 percent administrative costs.

The administrative load on a typical insurance policy in the individual market can be as high as 40 percent. Is that the best way to spend limited Federal dollars? We would get more bang for our buck by expanding existing public programs like Medicaid, like S-CHIP, like Medicare.

My colleague, Mr. Stark and I, have introduced legislation that would enable uninsured individuals 55 to 64 to buy into Medicare. That is the fastest growing segment of the uninsured population, and the segment with the greatest risk for catastrophic health event.

I have joined Mr. Dingell and Mr. Pallone, and others on this subcommittee on legislation that provides States additional funding so they can get low income parents and other groups into Medicaid and S-CHIP.

We should look seriously at both of those proposals. I want to talk about one more principle, which is the most important of all, and that is let's not expand coverage by taking away from current Medicaid beneficiaries.

We are the world's wealthiest Nation, and we don't need to make deals with the devil. As the committee with jurisdiction over Medicaid, we have a responsibility to ensure that the beneficiaries of that program are receiving the benefits to which they are entitled.

Those beneficiaries remember Medicaid. They live in poverty. Many are disabled severely and most are children. I am concerned that the administration is promoting tradeoffs through the HIFA waiver process that could easily undercut access to care for current Medicaid beneficiaries. I will wrap up, Mr. Chairman.

Some States have asked for waiver authorities to impose significant cost sharing, even enrollment fees, on very low income beneficiaries, using the savings to offer coverage to higher income individuals.

Imagine charging more for the poor so we can offer more benefits to higher income people. I hope, Mr. Chairman, because this committee has a responsibility to Medicaid beneficiaries, that we can work together on a bipartisan basis to monitor the HIFA waiver process and take action to ensure that current beneficiaries maintain access to the coverage that they have now and absolutely need. Thank you, Mr. Chairman.

[The prepared statement of Hon. Sherrod Brown follows:]

PREPARED STATEMENT OF HON. SHERROD BROWN, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF OHIO

Thank you, Mr. Chairman.

First I want to echo the Chairman's comments about John Eisenberg. As a physician, a researcher, and a leader in the health care policy arena, John has dedicated himself to making our health care system more responsive, more efficient, and more inclusive.

I was fortunate to work closely with John during the reauthorization of AHRQ, and I know that one of his personal priorities has been to ensure the independence and scientific integrity of the agency's products. He has fought hard to deliver objective, timely, and scientifically valid research in what can sometimes be a politically charged environment.

In that endeavor, as in so many others, John has been wholly successful. I want to commend and thank him for his contribution. My thoughts and prayers are with John and his family.

I want to thank our witnesses for joining us this morning.

There was an interesting op-ed in the Cleveland Plain Dealer on Sunday. Tom Brazaitis was arguing for a single-payer system.

That's not to be confused, as it often is, with a government-run health care system, where the government actually provides care.

A single payer system means that the *financing* of health care is centralized, which puts an end to the gaps and inconsistencies that inevitably arise when you have a patchwork of public and private financing mechanisms.

Implementing such a system could cut about \$100 billion in administrative costs out of the US health care system, dollars that could be used to actually provide care.

More importantly, under a single payer system, insurance could function like insurance again. Everyone would pay into the pool, and everyone would know that, should they become ill, their costs would be covered.

Individuals with health conditions wouldn't be shunted off into high risk pools, and they wouldn't be denied insurance or face coverage exclusions because they had the audacity to actually fall ill.

Small businesses wouldn't be forced to drop coverage because their premiums spike upward when one employee becomes sick.

People in the individual insurance market would not face an impossible trade-off, unaffordable premiums or a deductible so high that health care remains out-of-reach with or without insurance.

Steelworkers in my district and throughout the US would not be left without health insurance when their companies go under or are sold. Economic downturns wouldn't swell the ranks of the uninsured.

I'm not minimizing the potential pitfalls associated with single payer systems.

The public sector, the private sector, and consumers would have to work closely together to ensure high quality care and promote continued medical innovation.

We could work through those issues. But I'm not as optimistic as my friend, Jim McDermott, who is quoted in the op-ed. He believes the US will see beyond the stigma and recognize that anything short of a single payer system is a temporary fix.

My guess is that the word "single-payer" sends chills down the spine of my colleagues on the other side of the aisle, not to mention several of our witnesses.

I think we're going to keep filling holes for awhile yet. So, if we're left with incremental solutions, let's establish some ground rules.

I'll start with the most obvious one: Let's not spend money on a proposal that ultimately reduces access to coverage.

My concern about MSAs and association plans is that, by skimming healthier individuals and groups into separate risk pools, these approaches could increase premiums for everyone else.

What happens when premiums increase? So does the number of uninsured.

While we're at it, let's not encourage the proliferation of high deductible plans. When an individual faces a high deductible, what kind of care do you think they avoid? Routine and preventive services. Do we really want to discourage the use of routine and preventive services?

Strike two for MSAs.

Let's not spend money on a proposal that creates a two-tiered system, one for healthy people and one for sick people. Insurance is supposed to be there *when* you get sick, not until you get sick.

While current high risk pools have filled a gap for some individuals, premiums are exceptionally high and participation is relatively low, for the very reason that the risk pool is not balanced. Again, for insurance to remain stable and affordable, you have to buy in when you're healthy as protection in the event you get sick.

Taken to its extreme, the risk pool concept says you would relegate all those who might become ill into one pool, and all those who definitely won't become ill into another. All of us would be in the high risk pool. That's why all of us need insurance, and that's why those of us who are fortunate enough to stay healthy cannot abandon those who become ill. Tomorrow your luck could change.

Let's not spend money on a proposal that is not well targeted.

My concern with tax credits is that to help the low income families who comprise the bulk of the uninsured, these credits would have to be huge. I checked out premiums in the individual market in Ohio.

Unless you want a plan with a \$5,000 deductible, the premiums are outrageous. Upwards of \$10,000 per year in some cases. I understand the administrative load on a typical insurance policy in the individual market can be as high as 40%.

Is that the best way to spend limited federal dollars?

We would get more bang for our buck by expanding existing public programs like Medicaid, SCHIP, and Medicare.

My colleague Mr. Stark and I have introduced legislation that would enable uninsured individuals in the 55-65 age group to buy into Medicare. That's the fastest growing segment of the uninsured population, and the segment at the greatest risk for a catastrophic health event.

I've also joined Mr. Dingell and others on this subcommittee on legislation that would provide states additional funding so they can get low income parents and other groups into Medicaid and SCHIP.

I think we should look seriously at both proposals.

I want to offer one more principle, and it is the most important of them all: let's not expand coverage by taking away care from current Medicaid beneficiaries.

We are the wealthiest nation in the world. We don't need to make deals with the devil.

As the committee with jurisdiction over the Medicaid program, we have a responsibility to ensure that the beneficiaries of that program are receiving the benefits to which they are entitled.

Remember, these beneficiaries live in poverty. Many are severely disabled, most are children.

I am concerned that the Administration is promoting tradeoffs through the "HIFFA" waiver process that could easily undercut access to care for current Medicaid beneficiaries.

Some states have asked for waiver authority to impose significant cost sharing, even "enrollment fees," on very low income beneficiaries, using the savings to offer coverage to higher income individuals.

Think that through: is there that much difference between imposing cost sharing on a person with no resources, and abandoning that individual altogether? At what point are we breaking our promise?

This subcommittee has a responsibility to Medicaid beneficiaries. We cannot ignore any action, administrative or legislative, that jeopardizes their access to care.

Mr. Chairman, I hope we can work together on a bipartisan basis to monitor the HIFFA waiver process and take action if necessary to ensure that current beneficiaries maintain access to the coverage they so clearly need.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. All right. I thank the Chairman for his remarks.

Mr. Bryant.

Mr. BRYANT. I want to thank the Chairman for holding this hearing, and I know that is almost a tradition up here. We always start out by thanking the Chairman for having this hearing.

But I especially mean this today because I don't think that anyone disagrees with the problem out there being so many people that are uninsured, and you focusing on this, and how to reach some realistic solutions to this problem, and bringing in the talented people and experts that you have brought in today, I think certainly will help us along that way.

And particularly as we move into a situation with the economy where we realistically, even though we have seen a decline, a slight decline over the last year in uninsured, we likely will see an increase unfortunately.

And I like your idea, too, that we remain open to all opportunities out there, whether they be from the administration, or Mr. Brown, and others, that we look at all possibilities.

And it may not be one comprehensive plan. It may be a series of different ideas that we are able to reduce this number of uninsureds. Before I go too much further in this, I want to also join in with my colleagues that have spoken so far in recognizing John Eisenberg.

I met John—he is a Tennessean by the way, and that’s what I think makes him extra special. Were he still in Tennessee, I would probably be his Congressman, and I actually met him the day that this situation occurred with him.

We were at the conference together in Florida, the health care conference, and I met him that morning. And immediately—he still had a little bit of that southern accent, and so I picked up on that very quickly, and liked he right away.

And we talked, and actually I was on the tennis court next to him when he went down at that unfortunate time. And so I followed him and got to know his wife, Dee Dee, and we share, all of us share, that love for tennis that we have, and we are really all pulling for him.

And I know that this is a difficult time for him, and I am not sure what all was said before I arrived here, but I just wanted to add the fact that I have grown to know him and his reputation, and the fact that he has been so committed to his work here.

And I want to add my thanks, along with those others that have spoken, and our best wishes as a committee for his continued health and recovery.

And back to the issue at hand. I want to apologize for being late. Like so many Members, every Member in Congress, we are bouncing around between hearings all the time, and I was at the TRED Act before I came over here, but this is where my heart is.

I really have an interest in this, and want to see us come to some conclusions here. My State of Tennessee has a waiver, and we are operating under a program called TIN Care, and Tenn care is—we have added—we probably provide health coverage to more people than any other State in the country on a per capita basis. I think we are No. 1.

Almost 1 in 4 in Tennessee, and so about 24. something percent of our folks are on Tenn Care, and it is breaking our back financially. And I am not sure that we want a whole lot more dropped on us if you start talking about expanding the Medicaid, and things like that, that would impact us.

And I am sure that other States are the same way. It is kind of an unfunded mandate to some extent, and we have to be careful as we look at going down those types of roads to get there.

I can just tell you again that Tenn Care is really financially strapping our case right now to the point that we are considering some ways to raise revenue that we have never thought about in the past, including an income tax. We are one of the few States that still does not have an income tax, State income tax.

But I will tell you, too, also that we talk a lot about prescription drugs here, and how are we going to make those available, not just

to senior citizens, which certainly need prescription drug benefits, but to others out there.

I mean, it is not just the older folks that are paying high costs for their drugs, and absolutely, the best answer—well, not the only, but the best answer to this is that we provide health insurance that would incorporate a prescription drug benefit.

We provide better access somehow to coverage which would help solve that problem of prescription drugs. I think the way to do this, and I would agree with my Chairman, would be incentives out there, and all these different issues that we have talked about, all these different programs.

I see them in a more positive light than some on this committee do. I think there are real opportunities out there to do some good. And I also today want to hear from the witnesses—and I know that it is probably part or some of your testimony, and I will close with this—this issue of uninsurable pools.

Now, I come out of a defense law practice where I represented insurance companies, and I know that in most States they have at the insurance level of automobile casualty an uninsurable pool.

I mean, these are the folks that can't get insurance. They have a bad record. Now, they have the ability to limit the amount of coverage, and do other things that can allow them to do it. But if you write car insurance in Tennessee, you have to be a part of that pool, and take your assigned number.

I don't know how that would work with health insurance. It is not the same thing. Obviously, you can't limit your liability very effectively, but I would be interested in hearing how other States handle these uninsurable pools, and with that, I again thank you, and yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Dingell.

Mr. DINGELL. I want to thank the Chairman and the others for making it possible for us to hear from the fine witness panel that we have today. Years ago, Congress passed the Medicare program as a response to the appalling lack of health insurance among the elderly.

Today it is the most popular and successful health insurance program in the country. It guarantees virtually every senior citizen affordable health care coverage. Millions of other Americans, however, do not enjoy a similar guarantee.

I think they should, and so in every Congress I have introduced H.R. 16, a bill that will provide meaningful health care coverage for all Americans. An incremental solution to provide health care insurance to more Americans must be designed carefully so that the current fabric of health care coverage is not undone.

This means protecting existing employer-sponsored coverage from erosion, and ensuring that those with public insurance can continue to count on that coverage being both adequate and affordable.

On the latter point the health insurance flexibility and accountable HIFA waivers initiated by this administration cause me great concern, and I do not believe will meet the test of the light of the day, because the waivers erode coverage for the poorest, most vul-

nerable Americans, in order to finance coverage for higher income individuals.

That makes no sense, I suspect, except to those in the higher income brackets, because where the need lies is with those who have the least, and usually also have the greatest needs.

No solution then can be successful unless it adequately addresses the needs of low income families, even the healthiest of whom are unlikely to be able to afford adequate health coverage on their own, and the needs of those with severe health conditions, even the wealthiest of whom may find no coverage available, due to exclusions and restrictions on coverage in the private insurance market.

In the current budget context, we may prefer to undertake incremental coverage expansions rather than comprehensive universal reform. If that is one of the tests we must meet, then so be it.

But our response should be wise. Therefore, it is particularly important that the efforts to help the uninsured focus on solutions that will get us the most bang for the buck.

Some, improperly designed, spend billions of precious taxpayer dollars on subsidies to those who are already insured, or to insurance companies. There are a number of bipartisan bills on both the House and Senate side that would target coverage to the uninsured without eroding existing coverage and misdirecting Federal funds.

While these approaches, such as the Family Care Act of 2001, the Family Opportunity Act, the Legal Immigrant Children's Health Improvement Act, would not provide coverage to every single one of 40 million uninsured Americans, they would make substantial progress by extending coverage to some of the most vulnerable groups of our uninsured people, and would in that process use taxpayers dollars wisely and well.

Finally, lack of insurance coverage is not the only health care problem Americans are facing. Many Americans currently insured find their coverage lacking some of the basic protections that make health insurance meaningful: access to specialty care; and access to emergency care; and access to independent external appeals procedures to resolve disputes; care provided according to good medical practices and reliable accounting principles; and a mechanism to assure that these mechanisms and protections are enforceable. We need then to pass a meaningful patient's bill of rights to provide these basic protections.

I am still hopeful that we will, and I look forward to working with all who will assist me in that undertaking. I look forward also to hearing from our expert witnesses on options to promote meaningful health care coverage for more Americans.

I hope that this committee and the Congress will soon move forward on the issue, and I thank you for your courtesy to me, Mr. Chairman.

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF MICHIGAN

Today the Health Subcommittee is discussing an issue that is of great importance to me: providing health care coverage for the uninsured. I thank the majority for holding a hearing on this crucial topic and I look forward to hearing from our expert witnesses.

What motivated Congress to propose the Medicare program nearly half a century ago was an appalling lack of health insurance among the elderly. Today Medicare is the most popular and most successful health insurance program in the country, guaranteeing virtually every senior citizen affordable health care coverage. But millions of other Americans do not enjoy a similar guarantee. I think they should, so in every Congress I have introduced H.R. 16, a bill that would provide meaningful health care coverage to all Americans.

Any incremental solution to provide health insurance to more Americans must be designed carefully so that the current fabric of health care coverage is not undone. This means both protecting existing employer-sponsored coverage from erosion and ensuring that those with public insurance can continue to count on that coverage being adequate and affordable. On the latter point, the "Health Insurance Flexibility and Accountability" (HIFA) waivers initiated by the Bush Administration cause me great concern, because these waivers erode coverage for the poorest, most vulnerable Americans in order to finance coverage for higher-income individuals. That makes no sense.

No solution can be successful unless it adequately addresses the needs of low-income families, even the healthiest of whom are unlikely to be able to afford adequate health coverage on their own, and the needs of those with severe health conditions, even the wealthiest of whom may find no coverage available or exclusions and restrictions on coverage in the private insurance market.

In the current budget context, we may prefer to undertake incremental coverage expansions rather than comprehensive, universal reform. Therefore, it is particularly important that efforts to help the uninsured focus on solutions that get us the most "bang for the buck." Some improperly designed approaches spend billions of precious taxpayer dollars on subsidies to those who are already insured.

There are a number of bipartisan bills in both the House and Senate that would target coverage to the uninsured without eroding existing coverage and misdirecting federal funds. While these approaches, such as the FamilyCare Act of 2001, the Family Opportunity Act, and the Legal Immigrant Children's Health Improvement Act, would not provide coverage to every single one of the 40 million uninsured Americans, they would make substantial progress by extending coverage to some of the most vulnerable groups of uninsured people, and would use taxpayer dollars wisely.

Finally, lack of insurance coverage is not the only health care problem Americans are facing. Many Americans who are currently insured find their coverage lacking some of the basic protections that make health insurance meaningful: access to specialty care; access to emergency care; an independent external appeals procedure to resolve disputes; care provided according to good medical practice; reliable accounting principles; and a mechanism to ensure that these protections are enforceable. We need to pass a meaningful Patients' Bill of Rights to provide these basic protections, and I am still hopeful that we will.

I look forward to hearing from our expert witnesses on options to promote meaningful health care coverage for more Americans. I hope that our Committee, and the Congress, will soon move forward on this issue.

Mr. BILIRAKIS. Thank you, and the Chair now recognizes the gentleman from Kentucky, Mr. Whitfield.

Mr. WHITFIELD. Mr. Chairman, thank you very much, and obviously this is a very complex issue that we are dealing with, but I can't think of a more important issue for this hearing to focus on.

I know in the State of Kentucky, I'm sure like many other States, this is one of the major problems facing people who are uninsured. We are really in a dilemma, because if your income is X-dollars and below, then you are covered by Medicaid.

If you are a senior citizen, then you are covered by Medicare. And, of course, we want to expand that to include a prescription drug benefit.

But we have lots of people whose employer does not provide health insurance, or they run their own business. And while they are paying payroll tax that helps support Medicare and Medicaid, they cannot afford to buy health insurance for their own families.

And that's why I am anxious to hear from these experts today to help us come up with a plan, and develop a plan, in which we

can provide meaningful health care coverage. We have talked about this, and we have talked about this, and we continue to talk about this.

But I think it is imperative that we take some action. Now, we have expanded the coverage for young children under the Medicaid program, and under the CHIPS program, and we have increased funding for the community health centers that provides health care to anybody who wants to come in and receive it.

But community health centers are certainly not available everywhere, and I agree that we certainly want to place emphasis on those on Medicaid, as well as those on Medicare, but we also need to start emphasizing those people who are paying payroll tax, but cannot afford to pay health coverage for themselves.

Now, in Kentucky, 6 or 7 years ago, mandates were placed on companies that sold health insurance in Kentucky, and every insurance company left Kentucky with the exception of one.

And as a result rates skyrocketed, and more people became uninsured than before those mandates went into effect. So I think we have to move very carefully and explore any option that is out there, but I do think it is imperative that we start taking some action to try to solve this problem, and I yield back the balance of my time.

Mr. BILIRAKIS. I thank you, and the Chair recognizes the gentleman from New Jersey for his opening statement, Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman. Let me say right at the beginning that I believe in universal health care, and I think that the government has an obligation to provide health insurance for everyone.

I realize that is not a position that we can obtain a majority for in the Congress, in either House probably, but I think ultimately that should be the goal. The problem that we have had in the last few years is since the demise I guess of the Clinton health care proposal is that the number of uninsured continue to rise until we in Congress started to take some steps, like the Children's Health Insurance Program, that would try in a sort of case-by-case or area-by-area situation to reach out to those large groups of uninsured.

And once we put the S-CHIP program in place, and within the last few years until this recession, we started to see a stabilization of the numbers of uninsured, and I guess at about 40 million.

But with the recession, and with September 11, those numbers now are rising again. So I think it is important to have this hearing today. The concern that I have with regard to displaced workers, and workers that lost their jobs or have an inability to find jobs because of the recession, is that we just really haven't dealt with their problem effectively.

The economic stimulus package, which of course has never been passed, should have included COBRA extension, and should include expansion of Medicaid to deal with the problem of displaced workers, and so far that hasn't occurred.

But beyond that a lot of the workers out there are not eligible for COBRA, and so an extension does not necessarily help them. We need to look at innovative ways to deal with their problems, whether it is expansion of Medicaid or some other suggestions, some of which have been made today.

The other problem is that the States face a real crisis with Medicaid. My own State of New Jersey is in a terrible situation. We have a budget deficit that we have to make up, and it is about 12 percent of our budget.

And when our Governor was down here a few weeks ago, he explained that a big part of that is Medicaid costs. If he could deal with Medicaid costs in an effective way with Federal help, he could probably cut back on half of the deficit that he now faces.

My problem with the President's proposal is that he announced essentially in the State of the Union his budget, and that he is addressing this problem primarily through tax credits, \$1,000 or \$2,000.

I just don't think that those are going to work. If they are designed to deal with people who don't have health insurance, and the idea is that they are going to go out in the individual market and buy health insurance, we all know—Mr. Brown mentioned the costs are way up.

A thousand dollars or \$2,000 for couples is just not going to cut it. You are not going to be able to buy that insurance. All you are doing with the President's tax credit is probably helping people that already have insurance, and not the problem that we are trying to address today with the uninsured.

I think that we need to—if we are going to take this approach of just dealing with one sector at a time, rather than dealing with universal health care, then I think we have to address the problem of the uninsured essentially with government programs.

An expansion of the CHIP program to cover the adults has been mentioned, and expansion of Medicaid, and having the near-elderly, which is another large group, be able to buy into Medicare, perhaps with some sort of subsidy on a sliding scale.

These are the types of things that need to be done, and I am afraid—and I will be partisan now in saying this—that I don't see much effort on the part of the President, or even the Republican leadership, to move in that direction.

They seem to be fixated on the Republican side, and these free-market approaches, and the tax credits, which are not going to solve the problem of the uninsured.

And I would simply ask that my colleagues on the other side of the aisle, let's be a little less ideological. I am sure that we are going to hear today about the problems. I think if we are a little less ideological, and we get together behind government programs that maybe go back to the States, like S-CHIP, and expansion of S-CHIP, this is the way this is going to go to make a difference right now for people that don't have health insurance.

And we just have to keep in mind that people are suffering. When I go out and I have my forums, and I had a few the last few weeks, this is the major issue. It is this, and it is prescription drugs.

And we just can't sit around here for another year until the end of this session and pretend that this problem is going to go away. It's not and it is getting worse. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, and the Chair recognizes the gentleman from Iowa, Dr. Ganske, for his opening statement.

Mr. GANSKE. Thank you, Mr. Chairman. We have about 40 million uninsured, and that is the usual figure that is given, in this country. Here are some quick ideas that I have just jotted down on how we can help.

No. 1, we need to get the economy moving. When there is a recession, people lose their health insurance coverage. It is hard for people to get jobs, and if you don't get jobs, you don't get benefits from your employers. We should extend the health care benefits to those who have lost their jobs in this recession.

No. 2. We need to get those who already qualify for existing programs enrolled. There are many, many States that put up impediments to enrolling the uninsured. My own home State of Iowa is an example of this. You have to re-up every month for Medicaid.

Other States have 25 or 30 page forms you fill out, and other States may have one office every 200 miles on the second floor.

No. 3. We need to get signed into law the Ganske-Dingell Patient's Bill of Rights, because there are some very good access provisions in that bill. For instance, the expansion of medical savings accounts, tax deductibility for the self-employed, 100 percent; tax credit for uninsured small employers; private foundation grants to purchasing co-ops.

There are all sorts of things in that bill. I think it would help.

No. 4, the money that the States are receiving for the tobacco settlement should be used for health care.

It is being siphoned off for other uses. Iowa is one of the few States in the country that is devoting 100 percent, or at least nearly 100 percent of the tobacco money, to health care. Other States are using it for many other different purposes.

No. 5. The Governors are asking for ways to deal with the high cost of prescription drugs in their Medicaid programs. We need to address that issue.

No. 6. We need to address the issue of the high cost of prescription drugs, and why this country is paying a premium, the citizens in this country, and basically subsidizing the rest of the world.

We passed a reimportation bill by huge bipartisan majorities in both the House and the Senate. It has not been implemented and we should do so. There are many, many ways that we can address this.

I am glad that the Chairman is dealing with and has called for this hearing, and I look forward to reviewing the testimony of our witnesses, and thank you for coming.

Mr. BILIRAKIS. Thank you.

The Chair recognizes the gentlelady from California, Ms. Capps, for her opening statement.

Ms. CAPPS. Thank you, Mr. Chairman. I appreciate the decision to hold this hearing and the witnesses who will testify. As was just said by my colleague, Mr. Ganske, nearly one-seventh of all Americans, somewhere around 40 million people, cannot get access to routine health care because they lack health insurance.

They either cannot afford insurance, or are not insurable for some medical reason, and this is a terrible problem for our country. These people are being forced to gamble with their health and with their livelihoods. They have to bet that they will stay healthy and not require health care.

Each day they wonder if this is the day that their luck will run out, and is the day that they, or a dependent loved one, contract a terrible disease. Will today be the day that they or their family are stricken by something that will fill their life with pain and bankrupt them.

These people should not have to face such fears without the security that insurance can provide. And beyond the potential suffering of individuals and families, this is a problem that is very costly for the American public as a whole.

Today as we are so preoccupied, and rightly so, with national security, this is a national security issue. It is easy for many Americans who are insured to think that this is not their problem, but it is. Because the uninsured cannot easily get routine care, they end up in the emergency rooms for more severe and more costly conditions. But since they cannot pay for their care, the taxpayers and other patients will pay for them, and it will cost more than if the government or some insurance program had helped the uninsured in the first place.

This simply does not make any sense. We need to find a better way to help the uninsured. These are not deadbeats. They are not people trying to take advantage of the system. They are hard-working people, whose employers cannot or will not help them.

They are good Americans who have been laid off because of the economy and cannot pay premiums, deductibles, or co-payments. They are men and women who are taking care of a family on their own, and need health insurance. They deserve our help.

For many of us, these are numbers, and staggering numbers. But for me, who spent two decades as a school nurse, they are faces, because school nurses spend a disproportionate amount of their time finding solutions, or helping families cope with problems because they can't find insurance.

When you can call the parent of a sick child who has insurance, it makes your job really easy, but I came face-to-face and worked on a daily basis with those parents, anguished, and who struggled to find access to health care for the dearest possessions they owned.

And they felt ashamed and defeated when they could not do such. Some have suggested that we can solve this problem with tax credits for health care, but this would be a very expensive approach and frankly I am doubtful that credits would go very far.

A credit of \$1,000 or even \$3,000 for a family would not even cover the average premium, and does nothing for deductibles or cost-sharing, meaning that most of the uninsured still would not be able to afford coverage.

Now, there is a proposal to expand the State high risk pools, but this might create insurance ghettos of the sickest and poorest, making it even more expensive to provide them with health coverage.

The administration wants to give the States more flexibility to expand their Medicaid and S-CHIP programs to include more people. Some innovative changes might be worth looking at, but there is a real possibility that the States would provide questionable coverage for the poor by reducing benefits or imposing increased cost-sharing on those who are even poorer.

This would undermine the point of such an effort. Some of my colleagues on this side of the aisle suggest that we might better address the problem by enabling more people to access Medicaid and CHIP benefits as they are now.

My colleagues, Mr. Dingell, and Mr Waxman, in particular have championed this approach, and I have been proud to support their efforts. In this time of budgetary limits and competing national priorities it is important that we make sure that Federal dollars are spent wisely.

We need to make sure that we do not throw money away on approaches, as has been mentioned already, that will not work. Instead, we need to make sure that resources are focused on legitimate proposals with positive outcomes.

So I look forward to hearing the witnesses perspectives on these proposals, and the issue as a whole. Their expertise will be useful in making these judgments, and enacting solutions. I think this committee needs to listen very carefully, and make a truly informed decision to address this problem.

So I am glad, Mr. Chairman, that you have called this hearing, and I look forward to working with you on it. I yield back my time. [The prepared statement of Hon. Lois Capps follows:]

PREPARED STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF CALIFORNIA

Thank you Mr. Chairman. I appreciate your decision to hold this hearing.

Nearly 1/7th of all Americans, somewhere around 40 million people, cannot get access to routine health care because they lack health insurance.

They either cannot afford insurance or are not insurable for some medical reason. This is a terrible problem for our country.

These people are being forced to gamble with their health and with their livelihoods. They have to bet that they will stay healthy and not require health care.

Each day, they wonder if today is the day that their luck will run out. Is today the day that they or a dependent loved one contract a terrible disease? Will today be the day that they or their family are stricken by something that will fill their life with pain and bankrupt them? These people should not have to face these fears without the security that insurance can provide.

And beyond the potential suffering of individuals and families, this is a problem that is very costly for the American public as a whole.

It is easy for many Americans who are insured to think that this is not their problem. But it is. Because the uninsured cannot easily get routine care, they end up in the emergency rooms for more severe and more costly conditions.

But since they cannot pay for their care, the taxpayers and other patients will pay for them. And it will cost more than if the government had helped the uninsured in the first place.

This simply does not make sense. We need to find a better way to help the uninsured. These are not deadbeats. They are not people trying to take advantage of the system.

They are hardworking people whose employers cannot or will not help them. They are good Americans who have been laid off because of the economy and cannot pay premiums, deductibles, or copayments. They are men and women who are taking care of a family on their own and need health insurance. They deserve our help.

Some have suggested that we can solve this problem with tax credits for health care. But this would be a very expensive approach, and frankly I am doubtful that the credits would go very far.

A credit of \$1000, or \$3000 for a family, would not even cover the average premium and does nothing for deductibles or cost sharing, meaning that most of the uninsured would still not be able to afford coverage.

Another proposal is to expand the state high-risk pools. But this might create insurance ghettos of the sickest and poorest, making it even more expensive to provide them with health coverage.

The Administration wants to give the states more flexibility to expand their Medicaid and S-CHIP programs to include more people. Some innovative changes might

be worth looking at. But there is a real possibility that the states would provide questionable coverage for the poor by reducing benefits or imposing increased cost sharing on those who are even poorer. This would undermine the point of such an effort.

Some of my colleagues on this side of the aisle suggest that we might better address this problem by enabling more people to access Medicaid and SCHIP benefits as they are now. My colleagues, Mr. Dingell and Mr. Waxman in particular, have championed this approach, and I have been proud to support their efforts.

In this time of budgetary limits and competing national priorities it is important that we make sure that federal dollars are spent wisely. We need to make sure we do not throw money away on approaches that will not work. Instead we need to make sure resources are focused on legitimate proposals with positive outcomes.

So I look forward to hearing the witnesses' perspectives on these proposals and the issue as a whole. Their expertise will be useful in making these judgements and enacting solutions.

I think this committee needs to listen carefully and make a truly informed decision to address this problem.

So I am glad that you have called this hearing today Mr. Chairman, and I look forward to working with you on it.

Mr. BILIRAKIS. Thank you. The Chair recognizes the gentle lady from New Mexico, Ms. Wilson.

Ms. WILSON. Thank you, Mr. Chairman. I know that we have a vote pending, and I will keep my remarks short. By most estimates, New Mexico leads the Nation in uninsured citizens. In the year 2000, 24 percent of New Mexicans did not have health insurance, compared to a national average of 14 percent.

It is a huge problem, and it has only gotten worse in the last few years. For a poor State like New Mexico, I think it is highly unlikely that we will be able to solve this problem ourselves without some help from the Federal Government.

And I also don't believe that there is a single bullet solution. I suspect that there will be a pattern of things that we may be able to put together at the State level, and from the private sector, from the Federal Government, to reduce the number of people who are uninsured, and need health insurance.

The most common reasons for a lack of coverage are costs or unavailability, but what really strikes me is the number of people who have a job that offers health care who decline that health care, often because of costs.

Of the about 42 million people who are uninsured, 16.7 million, or 40 percent, are families with an employer offeror of insurance, but the insurance was declined. In addition, 17.3 million people are in families connected with the work force, but have received no offer of insurance.

In other words, they work for a business, a small business employer, or self-employed, and they don't have health insurance coverage offered to them. So really a little bit over 80 percent of the uninsured are in families connected with the work force.

These are in many cases the working poor. I think there is a tremendous opportunity to improve our employer-based system, as well as to improve the safety net systems that help those who cannot make it just on their own to provide health care for their families.

I very much thank the Chairman for holding this hearing, and giving us an opportunity to look at a variety of different solutions, and how they might work together, because as I say, I don't think there is one answer to this problem. Thank you, Mr. Chairman.

Mr. BILIRAKIS. And I thank you.

We are in a vote, and about halfway through that, and we have at least one more vote after that, or two votes, and so I am wondering if the gentleman from Ohio, Mr. Strickland, would you like to move forward, or would you like to come back?

Mr. STRICKLAND. I think I would like to give my statement.

Mr. BILIRAKIS. Well, let's go ahead and recognize you for your statement.

Mr. STRICKLAND. Mr. Chairman, I attended a funeral recently, a funeral of a young woman by the name of Patsy Haines, and I have talked about Patsy before this committee over the months.

She had chronic leukemia, and she was in need of a bone marrow transport, and her insurance company refused to pay for that transplant, and finally we got her qualified under Medicare, 2 years after her surgery should have been performed.

She received her surgery, and a few days later died, and I wonder as I sit here would Patsy Haines be alive today if she had received this surgery when her physician first said she needed it.

And I point out this issue of Patsy Haines because I think we need to remember that we are talking about real people, and it is shameful that in this country today we do not have a patient's bill of rights which protects people like Patsy Haines and her family from the mistreatment they receive from insurance companies, who are more concerned with the bottom line than with patient care.

Mr. Chairman, the majority of the uninsured today are a part of working families who do not have access to employer sponsored insurance benefits, or whose benefits are inexpensive and provide only bare bones coverage.

Furthermore, about 10 million children are uninsured, and that is particularly tragic since so much of a child's pediatric health care is crucial to ensuring that he or she can live a healthy adult life.

The State Children's Health Insurance Program does much to reduce the number of uninsured kids, providing important basic and cost effective health care to millions.

However, the program has gaps that include not providing for pre-natal care for expectant mothers, or ensuring that children are not forced to wait until coverage is provided.

It is for these reasons that I have introduced H.R. 3729, the Start Healthy, Stay Healthy, Act. This bipartisan bill seeks to expand the S-CHIP program by giving States incentives to cover pre-natal care for pregnant women, increasing the eligibility age through the age of 20, and prohibiting waiting periods for pregnant women, and reducing administrative barriers to the program.

It also provides coverage to any pregnant woman, regardless of her age, if she meets the income guidelines. But regardless of what approach that we take to reducing the ranks of the uninsured, I hope that we do not simply attempt to placate those who are calling for action by offering an inadequate benefit that fails to address the real problem of a lack of a comprehensive health care service.

Such an approach would not only hurt the currently uninsured beneficiaries by giving them something that they cannot really use, it could devastate our current employer-based system of health insurance coverage.

We must make a strong commitment if we are going to provide benefits that will truly help those who are currently without ready access to health care. And in closing I would just like to associate myself with remarks of Representative Pallone.

The real answer is a comprehensive, complete, universal health care system in this country that does not let American citizens like Patsy Haines or some 10 million children go without the health care that they need. And I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. We have one vote, and Mr. Green tells me that he can get his statement in very quickly. So, the gentleman from Texas is recognized.

Mr. GREEN. Thank you, Mr. Chairman. I would like to put my total statement in, but let me reiterate what Ms. Wilson said from New Mexico, and myself from Texas; the uninsured is a serious problem, particularly with the Latino community.

Even though Latinos only comprise 12 percent of the United States population, they have one quarter of the uninsured. Like my colleagues, I support the Family Care Act sponsored by our Ranking Member, John Dingell, to expand Medicaid and S-CHIP coverage, low income adults, and a particular project that we have been working on, and I appreciate the help of the chairman of our subcommittee on the Community Access Program, the CAP Program, to make grants, and how we can make the current system work more efficiently.

And we have had some success with that over the last 2 years, and we have the authorization bill, H.R. 3450, and I appreciate any support on that. My last concern before we go vote is that last August the Department of HHS provided administrative guidance to help States expand the number of individuals eligible for Medicaid or S-CHIP coverage.

It sounded really good, but the problem is that it had to be budget neutral, and it is hard to expand some of these programs and make it budget neutral, because you are trying to serve more folks.

But, again, Mr. Chairman, I thank you for letting me talk as fast as I could coming from Texas.

[The prepared statement of Hon. Gene Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF TEXAS

Thank you Mr. Chairman for holding a hearing today on what is one of the most pressing issues this subcommittee will consider—how best to expand health care coverage to uninsured Americans.

More than 39 million Americans do not have health insurance. With the downturn in the economy, this number is expected to increase significantly.

The uninsured are hard working Americans. Eighty percent of the uninsured come from working families.

Not surprisingly, though, these individuals are working in low-earning jobs. Nearly two-thirds of the uninsured are individuals who make less than 200% of the federal poverty level.

While all Americans are struggling to find affordable health insurance, minorities are much more likely to be uninsured. For example, Latinos comprise only 12 percent of the U.S. population, but nearly one quarter of the uninsured.

The problem of the uninsured is serious in Texas, where 4 million individuals, or 26.8 percent of our non-elderly population, are without health insurance.

Mr. Chairman, uninsured adults are far more likely than the insured to postpone or forgo health care altogether and are less able to afford prescription drugs or follow through with recommended treatments.

According to one report, nearly 40% of uninsured adults skip a recommended medical test or treatment, and 20% say they have needed but did not received care for a serious problem in the past year.

Because the uninsured don't have access to primary or preventive health care, they are more likely to be hospitalized for avoidable health problems such as hypertension and diabetes.

Our nation's health care safety net is in dire need of repair.

I am a strong supporter of legislation such as the Family Care Act, sponsored by Ranking Member Dingell, which would expand Medicaid and S-CHIP coverage to low-income adults.

I also support efforts to double the funding for our core safety-net providers, such as Community Health Centers, public hospitals, and state departments of health, and private hospitals.

These providers have been working together in cities and towns all over the country, developing community-based programs to address the problem of the uninsured.

These coalitions use funding through the Community Access Program (CAP) demonstration project to identify ways to better tend to the uninsured.

Funding under CAP can be used to support a variety of projects to improve access for all levels of care for the uninsured and under-insured.

Each community designs a program that best addresses the needs of its uninsured and under insured and its providers.

I am a strong supporter of this program, having seen how well it has worked in my hometown of Houston, Texas.

Their project aims to improve the interagency communication and referral infrastructure of major health care systems in the city, which will improve their ability to provide preventive, primary and emergency clinical health services in an integrated and coordinated manner.

Mr. Chairman, the CAP demonstration project has worked well in more than 75 communities across the country. We should fully authorize this program so that more communities can develop plans that will help us provide health care to all Americans.

I have introduced legislation, the Community Access to Health Care Act, which has seventy-six bipartisan cosponsors, several of whom are members of this committee.

I know we have worked with your office to see this program included in H.R. 3450, and I appreciate your efforts in that regard. I hope we can see movement of this bill so that we can authorize this important program.

Mr. Chairman, I'd like to shift gears for a moment now to discuss another important issue, one that I have serious concerns about.

Last August, the Department of Health and Human Services (HHS) provided administrative guidance to help states expand the number of individuals eligible for Medicaid or S-CHIP coverage.

On the surface this sounds like a good idea, and something I would support.

Unfortunately, the Administration's requirement that these expansions be "budget neutral" poses a serious problem for current Medicaid populations.

Some of the pending waivers would cut benefits for current Medicaid enrollees in order to expand the program to other populations. This is a classic example of robbing Peter to pay Paul.

The problem is that current Medicaid enrollees are THE most vulnerable populations in our country.

Medicaid serves low income seniors, children, and the disabled. These are individuals who rely on Medicaid to get essential, critical health care.

I have grave concerns that these waivers could cause harm to the very people Medicaid was designed to serve.

I also doubt that we can truly expand these programs without providing commensurate increases in funding.

Finally, I am disturbed that the Secretary will be able to negotiate these waivers without any public comment or input.

This proposal leaves Medicaid enrollees without a seat at the bargaining table, without a say, and without representation. That is not what this country was founded on.

Mr. Chairman, this is obviously a complex issue, and I look forward to hearing from our witnesses about these issues and others.

Thank you, and I yield back the balance of my time.

Mr. BILIRAKIS. Well, we have another offer from Mr. Towns, who is also going to talk very fast also and get his statement in before the vote.

Mr. TOWNS. Mr. Chair, I would like to ask that my statement be entered in the record.

Mr. BILIRAKIS. Granted.

Mr. TOWNS. I hope that this hearing will encourage the Congress to act in a positive way. This is a shame that we have allowed this to occur in this country, and I am hoping that we would take some action and take it real soon, because they have over 40 million people who are uninsured. So, Mr. Chairman, I yield back.

[The prepared statement of Hon. Ed Towns follows:]

PREPARED STATEMENT OF HON. ED TOWNS, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF NEW YORK

Chairman Bilirakis. Thank you for holding this very important hearing today. The United States has one of the best health care systems in the world in terms of access and health care choices. The majority of the U.S. population receives health care coverage through employment-based plans. However there is a growing population of more than 40 million uninsured Americans. Most uninsured Americans are minorities, low to moderate incomes level, adults between the ages of 18-24 and worker's who are not offered or can not afford insurance through the work place. As a result, their ability to take advantage of our advanced medical systems is limited the emergency room because of lack their of health insurance.

The U.S. Census Bureau conducted a survey in March 2001. The survey found that one out of seven Americans went without health insurance for the entire calendar year of 2000. Yet, over half of all uninsured people were full-time, workers or their dependents. In addition, more than 25 percent of those who worked less than full-time, or who were not employed for the full year, were without coverage.

The issue of the uninsured is not only an individual issue but also one that impacts small businesses. Many small businesses are unable to provide employee coverage because small group health insurance coverage is too costly for most businesses and lacks the ability to design affordable health care packages.

I have addressed many issues that the witnesses will make recommendations on today, but I would also like to bring to this committee's attention a specific ethnic group's uninsured plight. Once again, using the information from the U.S. Census, the largest uninsured group in the U.S. are people of Hispanic origin. The data shows that Hispanics have the highest percentage of working uninsured people. Many Hispanics like my constituents, are unable to secure health insurance because low wages, employment migration or insurance are not offered.

Hopefully, today's hearing will begin to provoke the needed action in Congress to formulate legislation on this critical issue. I look forward to hearing from today's witnesses.

Mr. BILIRAKIS. Thank you.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding today's hearing on the uninsured and alternatives for addressing this serious gap in our nation's health care system. Nearly ten percent of Michiganders have no health insurance, and nationally, 14 percent of our population is without coverage.

As Members of Congress responsive to our constituents, every day we see in letters and in our casework the often very poignant faces behind these statistics. Recently, for example, I heard from a family member of a 60-year-old widow suffering from congestive heart failure. She had no private health insurance, and because she had a small piece of rental property, she did not qualify for Medicaid. She already owed bills from prior hospitalizations, and because she could not pay these in full, she was refusing to seek further health care. In increasing desperation, her family went from agency to agency, but found no help for her. While we were able to provide some help and hope for her, how many more individuals and families are going through similarly desperate experiences?

A nation's greatness is measured not only in the might of its armies or the size of its economy. It is measured as well, and perhaps in the end most significantly, in its care for those who most need a helping hand—the sick, the disabled, and the less fortunate. I believe that most people in this nation believe that access to afford-

able basic health care is a fundamental human right and that individuals and families should not be denied care because they cannot afford to pay for that care.

And there are practical reasons, as well, that we must tackle the problem of the uninsured. The uninsured population's overall health status may be lower, and individuals' overall productivity may be lower. The uninsured are less likely to receive basic health care services than insured individuals, and as a result are more likely to seek care in costly emergency room settings. We all pay for these costs in terms of higher premiums and greater demands on publicly funded programs. At some point, we create a vicious cycle—higher premiums push insurance out of the reach of increasing numbers of individuals, employees, and employers.

Mr. Chairman, we have a proud tradition in this Subcommittee of expanding access to health care and health care coverage through our nation's community health centers, the National Health Service Corps, Medicaid, Medicare, and the State Children's Health Program. In this Congress, I want us to continue this tradition by working together on bipartisan ways to extend health care coverage to the nearly 40 million Americans—most of whom are in working families—who have no health insurance coverage.

PREPARED STATEMENT OF HON. BARBARA CUBIN, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF WYOMING

Thank you, Mr. Chairman.

We are confronted with many different variables in trying to understand the plight of the uninsured in this country.

Factors like employment status, industry sectors, age, family, race, income, and geography all play a role in whether or not an individual may have health insurance.

So much of what we face in my home state of Wyoming, in terms of the uninsured, comes down to our rural status.

Wyoming has roughly 480,000 people, and 100,000 square miles of rugged terrain.

Access to medical care and facilities is limited, and folks often travel hundreds of miles across the state, in adverse climate conditions, just to see a doctor.

In 2000, Wyoming had roughly 70,000 people under the age of 65 who were uninsured. Competition among health insurers in the state is scarce as there are only 3 main companies that control the lion's share of the market.

Without competition, health insurers have no incentive to keep premiums down, which in turn leads to an increase in the number of uninsured.

Wyoming does not have an adequate population size to bring in new health insurers, and I believe that is the case with the majority of rural states. Another issue we face with the uninsured in Wyoming is our large small business contingency.

My state has nearly 15,000 businesses with under 100 employees each, and the majority of those businesses do not offer health insurance to their employees because it is too expensive, and choices are limited.

In fact, I was alarmed to learn that 60 percent of small businesses nationwide do not offer health insurance to their employees. That is very substantial considering the small business community represents 99.7 percent of all employers.

It stands to reason that if we can help small businesses gain access to health insurance, this could be a giant step toward vastly reducing the number of uninsured in this country.

I also believe tax incentives could induce greater competition in the health care market, which could then encourage insurers to come into remote areas of the country.

Again, getting our hands around this whole issue is very challenging because of the many variables. However, bit by bit, we can incorporate real, positive changes that can help the private health insurance industry function more efficiently.

Thank you. I yield back my time.

PREPARED STATEMENT OF HON. ROBERT L. EHRLICH, JR., A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, thank you for holding this important hearing today on one of the most significant public health problems in the United States: nearly one out of seven Americans today, or almost 40 million people, are without health insurance. In Maryland, there are approximately 750,000 citizens who are uninsured.

What's left to the uninsured is a health care safety net of inpatient and ambulatory health care providers that are *legally obligated* to provide care for those who cannot afford to pay for it. This safety net includes public and private nonprofit hos-

pitals (often teaching hospitals), public health departments, and community health clinics (CHCs), including federally qualified health centers (FQHCs). In Maryland, due to the unique nature of health care delivery, our critical care hospitals' Emergency Rooms have taken on the role of being de facto primary care providers. As you can imagine, this system is neither cost effective for hospitals nor desirable for patients long-term.

Clearly, steps Congress can take to assist the employer-based health system as well as reduce the number of uninsured are critical to the health of our citizens. I am pleased to consider President Bush's Fiscal Year 2003 budget, which includes a refundable tax credit for health insurance for individuals under age 65. For low-income taxpayers, the credit would equal 90% of the premium and would be decreased for higher incomes; the credit would be phased out at \$30,000 for individuals and at \$60,000 for families. The amount of the credit is limited to \$1,000 for an adult covered by a policy and \$500 for each child, up to two children. The Administration's tax credit proposal may allow 6 million or more Americans who would otherwise be uninsured to gain coverage.

Mr. Chairman, I agree with the President that tax incentives greatly assist people with the cost of insurance—and will increase the number of insured Americans. For the past two Congresses, I have joined Congressman John Cooksey (R-LA), a physician, and Majority Leader Dick Armey (R-TX) to introduce the Patient Access, Choice, and Equity (PACE) Act. H.R. 2250 uses the tax code to give the subsidy directly to the individual to reduce the number of uninsured, improve choice, portability, eliminate tax inequity, and increase efficiency in our health care coverage system. On our subcommittee, Congressmen Bryant (R-TN) and Shadegg (R-AZ) as well as Congresswoman Cubin (R-WY) and Chairman Tauzin are also original co-sponsors of the PACE Act, which I encourage my colleagues to consider to help expand access to health insurance.

Mr. Chairman, thank your holding this important hearing. I look forward to hearing from our witnesses to discuss steps we may take to increase the number of Americans with health insurance.

PREPARED STATEMENT OF HON. CHAIRMAN W.J. "BILLY" TAUZIN, CHAIRMAN,
COMMITTEE ON ENERGY AND COMMERCE

Thank you Mr. Chairman: I want to commend you for holding this important hearing. The problem of the approximately 40 million uninsured in America has been a persistent one. For a few years, the strong economy and low health care cost inflation seemed to make a dent in the problem of the uninsured with the overall number lowered by as many as 3 million. Now I fear that rising health care costs and a weaker economy jeopardize these gains. Employers and particularly small businesses face increasing pressures, which make provision of health insurance benefits difficult. Public programs like Medicaid and SCHIP are also under pressure as Governors must face tightening budgets and falling State revenues.

A strong and growing economy is the engine that allows us to make progress on social problems like access to affordable health care. Mandates that increase private sector health care costs and policies which do not promote economic growth can leave us helpless to address other issues. At this time, and always, we must temper our desire to spend more resources with our need to enact smart policies. We need smart policy to address those who are left in the gaps between public programs, like Medicaid and SCHIP, and those who have health benefits through their employers or the individual market.

WHO ARE THE UNINSURED? These are people generally above the official poverty level, and sometimes several times above that level. Nonetheless, they have difficulty finding low-cost affordable health insurance. As a result, this group experiences reduced access to care. They are also more likely to delay seeking care. Often the uninsured must receive their health care services in a more costly emergency room setting. Providers of health care, especially hospitals, but also physicians, are often uncompensated for the care that they provide to uninsured individuals, and may seek to shift the cost of that care to other private and public payers.

The President has provided thoughtful leadership on this subject which deserves our support. He has proposed a refundable tax credit, which would be available to anyone under 65 without employer-sponsored or public insurance. The President's proposal provides up to \$1,000 for a single person and up to \$3,000 for a family with two or more children. For lower-income Americans, the proposed health insurance credit generally covers more than half of the premium the purchaser would face, and almost always covers more than a third of the premium. In addition, those workers who lose their jobs and health insurance would still be able to take advan-

tage of this credit regardless of whether or not COBRA continuation coverage was available to them. This is particularly important to those part-time and seasonal workers because they would be able to retain the coverage they purchase with the tax credit even if their jobs change. The Administration estimates at least 6 million uninsured Americans would gain health coverage under this proposal.

This policy emphasizes a number of values and marries smart policy with additional resources. These values include individual choice of insurance plans, portability, strengthening of the private sector insurance mechanisms, and accountability. Changes to Medicaid often require passage of further state law provisions which can take time and involve extended bureaucracy. The President's proposal, on the other hand, can be implemented quickly. There is much to commend it. I know it won't solve all the problems of the uninsured but it would make a difference to millions.

I think we can also learn from the history of state initiatives over the past few years. We have seen experiment in mandates which undermine the integrity of the insurance market. Clearly, we need to learn from the mistakes of several states and avoid pernicious mandates and focus more of our attention on how we can improve the individual market through market reforms. One such idea that our Committee has focused on is the promotion of high-risk pools. In the recently passed stimulus bill, we set aside \$100 million expressly for that purpose. Our legislation provides states which currently do not have high-risk pools with seed money to start new programs. Additionally, that bill give states matching funds if they are willing to cap the premium amounts that individuals pay in the pool to 150% of the average policy rate. I am not going to say that the consolidation of individual tax credit, along with vibrant high-risk pools, is the answer to the problem of the uninsured. But it is certainly a good start.

Our Committee will be working on additional legislation in the future to ensure that some key reforms in the insurance market are implemented. Reforms such as finding a new, more stable revenue source for the States, so they can offer high-quality, affordable coverage; and policies that may allow more families to take advantage of SCHIP if they utilize private health insurance. Families should not be forced into public programs against their will. The private insurance market works. We should apply it in our effort to solve this critical problem.

Finally, I want to emphasize that these initiatives should not be partisan. Let me stress: we would be using considerable public resources to help address an important issue; that is a far cry from where both parties stood on this issue over the past few years.

There is much to be done, and I am pleased our President is showing leadership on ideas that focus on individual choice. I look forward to hearing from today's witnesses on this important topic.

PREPARED STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF CALIFORNIA

I just want to make a brief comment today.

First, I am glad, of course, that this Subcommittee is focusing once again on the serious problem we have in this country of some 40 million people who are uninsured. We all know this problem is severe. We all know it has existed for years and years, and we have failed to address it adequately. We all know that it is inexcusable for a country like ours to allow this problem to persist.

And yet, over and over again, we have failed to take action. That has to change.

This shouldn't be about ideology. This shouldn't be about partisanship. This should be about devising a system that works, and getting people the coverage they need.

It is our responsibility to act. But it is also our responsibility to pass a program that will work:

That means we have to have a plan that doesn't only reduce the number of uninsured but that also assures that people who really need medical services are included in the ranks of people who get coverage. If what we do results in coverage that is affordable only for the young and healthy who are unlikely to need much service, but leaves behind people who are less healthy, people who have medical conditions, people who are older—then we will have taken a step in exactly the wrong direction.

I fear a system of individual tax credits will do exactly that. It can never work without radical reform of the individual health insurance market. And that means not only guaranteed issue and no preexisting condition requirements, *it also means that the rates for the coverage must be affordable.* That means affordable for people

who have medical problems. That part is always the missing piece in this debate. Surely we should have learned that lesson from our experience with the Health Insurance Portability Act (HIPA)

We also have to be sure that what we do does not result in a deterioration of the coverage that is already out there. Anything that results in employers dropping the group coverage that is already there will not only move us backward, it risks undermining the very core of our existing coverage system.

Finally, I would just note that we do know that there are programs out there that can work. Medicaid is certainly one. I am proud to note that this year, as a result of the legislation we passed in the late 80s, we now will have every child below poverty covered in the Medicaid program. Many said then that could not be done. But it has been, one year at a time. And it has provided a base for the expansions that have occurred with the CHIP program.

This is significant progress, and we should build on it.

I look forward to hearing from our witnesses today, and to working with my colleagues on both sides of the aisle to bring real health insurance coverage to the millions of Americans who are uninsured today.

PREPARED STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding this important hearing today. The ongoing issue of America's uninsured is of paramount importance.

To our credit, we have had extraordinary success in getting people insured with Medicare and the Children's Health Insurance Program or CHIPs.

Very few senior citizens are uninsured—about 1 percent, or 420,000. The quality of this coverage is a subject for another hearing.

By September 30, 2002 all children under 18 will be required to be covered under Medicaid, up to 100% of the federal poverty level.

The majority of uninsured—approximately 32 million—are those Americans between 19 and 65.

We currently have approximately 43 million uninsured, about 15% of the total population.

This number is growing daily.

Last week during President's Day recess I toured my district.

Not a day went past that I did not have a constituent coming up to me to voice their concern over the high rate of health insurance premiums, in some cases up to 50% over the past two years.

The Administration proposes a tax credit to help cover the uninsured.

Let's say this credit is for \$3000 per family.

Let's say a person can actually qualify for this credit, and wait a year for his tax return to be credited for this amount.

Most programs you can use this credit on cost about \$7300, with a deductible of \$1000.

This means the family receiving this voucher has to pay out of pocket \$4300 per year, with higher optional coverage for prescription drugs, pre-existing health conditions, etc.

Because the majority of the uninsured are from low-income families, do we really think this approach is really going to work?

Mr. Chairman, if you think we have an uninsured problem now, wait until the insurance premiums go up even further.

I have to ask—is it time to institute government price controls on insurance premiums for health insurance?

Thank you, and I yield back the balance of my time.

PREPARED STATEMENT OF HON. ELIOT ENGEL, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF NEW YORK

Mr. Chairman, thank you for holding this hearing on the uninsured. It is certainly an issue that we in Congress need to address. I hope this Committee will take a good hard look at the problem and work to improve this terrible situation.

I find it ludicrous that almost 40 million Americans currently have no health insurance whatsoever. We cannot allow this situation to continue. The President has included \$29 billion over 10 years in his budget proposal for tax credits for low-income individuals to help purchase private health insurance. While I welcome efforts to assist the uninsured, this approach is simply inadequate and misguided. In fact, the President's Economic Report estimated that the tax credit would help only 6

million individuals obtain coverage, leaving more than 34 million people out in the cold. Other estimates suggest that the tax credit will reach far fewer uninsured individuals than the President's estimate of 6 million. I am concerned that the tax credit will simply assist those already with insurance and do little for the ranks of the uninsured. I believe it is clear that the tax credit is far from a solution and will absorb much needed resources with little, if any, benefit.

There are a number of current programs in our health care safety net that are in need of additional funding. I think that short of a comprehensive fix to the problem, we should bolster those existing programs and not simply patch another hole in what is clearly a broken system. The CHIP program, for instance, has been a tremendous success in New York, and we would welcome the opportunity to expand services if additional funding were available. However, estimates suggest that, due to decreased funding, about 900,000 people will lose their CHIP eligibility between 2003 and 2006. CHIP is a proven success, however, it is unclear if the proposed tax credit will provide any benefit to the uninsured whatsoever. Furthermore, states are going to face severe budget constraints due to the economic downturn. As a result, Medicaid and CHIP beneficiaries may experience a reduction of benefits or increased out-of-pocket expenses, forcing many to the ranks of the uninsured.

Mr. Chairman, as we move forward to address the problem of the uninsured I hope that we will consider other options than the President's tax credit. I look forward to the testimony from our panelists and hope we work in a bi-partisan effort to help all uninsured Americans.

Mr. BILIRAKIS. We have a vote, and so we will adjourn and return for those statements from the witnesses.

[Brief recess.]

Mr. BILIRAKIS. The hearing will come to order. The first panel consists of Dr. Arthur L. Kellermann, Co-Chair of the Committee on the Study of the Consequences of Uninsurance, with the Institute of Medicine; Ms. Mary R. Grealy, President of the Healthcare Leadership Council; and Dr. Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation.

As you know, your written statements are a part of the record. We would hope that you compliment them orally. I will turn the clock on to 5 minutes, and I would appreciate it if you would try to keep it as close to that as you can, and if you can't, we will certainly let you finish up.

Let's see. Dr. Kellermann, why don't we just start off with you, sir.

STATEMENTS OF ARTHUR L. KELLERMANN, CO-CHAIR OF THE COMMITTEE ON THE STUDY OF THE CONSEQUENCES OF UNINSURANCE, INSTITUTE OF MEDICINE; MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL; AND DIANE ROWLAND, EXECUTIVE VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION

Mr. KELLERMANN. Thank you, Mr. Chairman. Before I start, I do want to thank you and all your colleagues about your kind words about John Eisenberg. John is an old friend of mind, and a fellow Tennessean, a mentor who played a pivotal role in my career, and he really has dedicated his life to the health of all Americans.

And personally it meant a great deal to me to hear you say what you said.

Mr. BILIRAKIS. I hope that his ears are ringing this morning. They should be, but we are all very sincere in our thoughts for the doctor.

Mr. KELLERMANN. My name is Arthur Kellermann, and I am a practicing emergency physician, and I chair the Department of Emergency Medicine at the Emory University School of Medicine,

and I currently serve as co-chair of the Committee on the Consequences of Uninsurance for the Institute of Medicine.

Two years ago the IOM Council identified the issue of uninsured Americans as a priority for a major analytic initiative. The Robert Wood Johnson Foundation asked the IOM to conduct an extended study of the consequences of uninsurance, not only for individuals and their families, but for the Nation as a whole.

I am here today to discuss our committee's initial findings. They are presented in our introductory report, Coverage Matters, Insurance and Health Care, which was released this past October.

Five additional reports will follow over the next 2 years. The number of Americans without health insurance dipped slightly in 1999 and 2000, but the overall trend for the last 25 years has been one of steady growth.

The trend has been upward in good times, as well as bad, and it has persisted, despite incremental reforms. Now, much of the information that our committee synthesized in coverage matters is known within health policy circles, but it is not well understood by the American public.

Here is some of the misconceptions our report attempts to dispel. Myth Number 1. People without health insurance get the medical care they need. In reality, studies show that the uninsured are less likely to see a doctor, receive fewer preventive services, and are less likely to identify a regular source of medical care.

Myth Number 2. Most people without health insurance are young, healthy adults. The reality is that while it is true that young adults are more likely than persons of other ages to be uninsured, it is largely because they are ineligible for workplace health insurance.

Many are too new in their job, or they work in businesses that don't provide insurance to their employees. Only 4 percent of all workers, age 18 to 44, about 3 million people, are uninsured because they decline available workplace health insurance. And most who do, do it because they can't afford their share of the premium.

And Myth 3, most of the uninsured don't work, or live in families where no one works. As members of the committee have already observed, over 80 percent of uninsured children and adults under the age of 65 live and work in families. Even members of families with two full-time wage earners have almost a one in ten chance of being uninsured.

Myth 4. Recent immigration has been a major source of the increase in the uninsured population. The reality is that over a recent 4 year period more than 80 percent of the growth in the size of the uninsured population consisted of United States citizens.

Recent immigrants, those who have been in this country for 6 years or less, comprise only 6 percent of the uninsured population. Now, folks who can't get insurance through their workplace, or lose their coverage as a result of losing their job, have two options for obtaining coverage.

They can purchase an individual policy or attempt to qualify for public insurance, such as Medicaid. Individual policies have gotten so expensive that they are out of reach for many people, particularly those with low paying jobs.

The full premium for an employment-based package for a family, the same cost-based by an ex-employee who tries to avail themselves of COBRA coverage, averages now more than \$7,000 a year.

Since the median income of an American family in 2000 was just under \$41,000 and the incomes of those without insurance are much lower, it is no wonder that people can't afford to pay that kind of premium.

If private insurance is unavailable or unaffordable, the only alternative for most people is public insurance, such as Medicaid. Unfortunately, strict eligibility requirements, and complex enrollment procedures, make Medicaid difficult to obtain and even harder to keep.

Coverage under Medicaid lasts on average about 5 months. At the end of any given year, approximately two-thirds of people who are insured by Medicaid at the start of the year are no longer covered.

In closing, I would like to emphasize four key points. First, the rising cost of health care, and therefore the rising cost of health insurance, is outpacing the purchasing power of many employers, as well as consumers.

Unless health care is made more affordable, this trend will continue until it becomes unsustainable. Two, while health insurance is a voluntary matter in the United States, many people are involuntarily shut out of the system.

Eighty percent of the uninsured are members of working families. These are the folks who wait on our tables, fix our cars, service consultants to business and start small businesses of their own.

I know this because I take care of them in my emergency room. They show up there in serious or even life-threatening condition, with problems that could have been readily treated at an earlier point in time if they had had access to care.

And even after my ER colleagues stabilized them, we often can't get them follow-up medical care to manage that condition and keep them out of the hospital. It just makes no sense.

Third, having health insurance is not a permanent state of affairs. In any given year, millions of Americans move in or out of the population of uninsured. As the events of the last 6 months have demonstrated, none of us under 65 can assume that we will always have health insurance, no matter what happens.

My own brother learned this 3 months ago when he lost his health insurance. Finally, people without health insurance do go without needed medical care, including doctors' visits and medications, far more often than people with coverage.

The health consequences of the lack of insurance are the focus of our second IOM report, which is due out this May. I commend the committee for holding this hearing, and for attempting to come to grips with this problem. I will look forward to answering your questions.

[The prepared statement of Arthur L. Kellermann follows:]

PREPARED STATEMENT OF ARTHUR L. KELLERMANN, CO-CHAIR OF THE CONSEQUENCES OF UNINSURANCE COMMITTEE, INSTITUTE OF MEDICINE/THE NATIONAL ACADEMIES AND CHAIR, DEPARTMENT OF EMERGENCY MEDICINE, EMORY UNIVERSITY SCHOOL OF MEDICINE, DIRECTOR, CENTER FOR INJURY CONTROL, ROLLINS SCHOOL OF PUBLIC HEALTH, EMORY UNIVERSITY

Good morning, Mr. Chairman and members of the Subcommittee. My name is Arthur Kellermann. I am Chair of the Department of Emergency Medicine, Emory University School of Medicine and Director of the Center for Injury Control, Rollins School of Public Health, Emory University. I serve as Co-Chair of the Committee on the Consequences of Uninsurance of the Institute of Medicine. The IOM is part of the National Academies, originally chartered as the National Academy of Sciences by Congress in 1863 to advise the government on matters of science and technology.

Two years ago the IOM Council identified the issue of the large and growing population of uninsured Americans as a priority for a major analytic initiative. The Robert Wood Johnson Foundation shared this interest and asked the IOM to conduct an extended study of significant consequences of uninsurance. The study will also identify strategies to address these consequences. I am here today to discuss our Committee's initial findings. They are presented in our introductory report, *Coverage Matters: Insurance and Health Care*, which was released this past October. Our Committee will issue five more reports between May of this year and September 2003. They will explore the impact of a lack of health insurance, not only for individuals and their families, but for our local communities and American society in general.

The tragic events of last fall have refocused Americans' attention on our shared personal concerns, our collective fate, and our well-being as a nation. Health insurance, the principal mechanism by which we finance health care in the United States, is critical to ensuring the financial security of American families as well as their access to needed health care. Once again our nation faces a growing population of uninsured Americans after a brief stabilization in the number of uninsured. These circumstances deserve our thoughtful consideration even—perhaps especially—in these exceptional times.

The past 25 years have seen a growing number of uninsured. This trend has held despite incremental reforms in the regulation of private health insurance such as COBRA and HIPAA that have increased opportunities for maintaining coverage (if one already has it). This trend has held despite substantial expansions in Medicaid eligibility, beginning in the late 1980s and continuing through the enactment of the Children's Health Insurance Program in 1997. Although the number of Americans without health insurance dipped slightly in 1999 and again in 2000, after several years of an exceptionally vigorous economy in the mid-to-late 1990s, by the fall of last year (after *Coverage Matters* went to press) it was clear that the economy was softening. This economic downturn, coupled with rising health care costs and insurance premiums and stagnant or declining state tax revenues, has already established that the longer-term trend of growth in the numbers of uninsured Americans will continue.

What does this 25-year trend mean? The Committee's report, *Coverage Matters*, documents

- the persistence of the problem of uninsurance, regardless of whether the economy is weak or strong,
- the inherent instability of insurance coverage for all but the elderly in the United States, stemming both from the structure of our employment-based health system and from the conditions of eligibility for coverage under programs like Medicaid and SCHIP, and
- the reduced access to health care of Americans who lack health insurance.

Each of these findings has important implications for the Congress, for state legislatures, and for others as they design public policies to address the issue of affordable health care for the uninsured.

While much of the information that the Committee has synthesized in *Coverage Matters* is known within health policy circles, it is not widely understood by the American public. In fact, much of what Americans think they know about the uninsured is wrong. Misunderstandings about the causes and consequences of uninsurance have impeded the formulation of effective public policies to solve the problem. Our Committee recognizes that one of its principal tasks must be to broaden and deepen the American public's understanding of issues related to health insurance and the lack or loss of it.

Coverage Matters addresses some of the most persistent myths about the uninsured and the implications of lacking coverage. We have tried to answer the "Who, what, where, and why" of this issue in order to replace *misinformation* with *good*

information. Consider the following examples, drawn from public opinion polls and focus group research:

Myth: “People without health insurance get the medical care they need.”

Reality: In any given year, the uninsured are much more likely to lack needed medical care. They are less likely to see a doctor, receive fewer preventive services such as blood pressure checks, mammograms and screening for colorectal cancer, and are less likely to have a regular source of medical care. As will be further documented in our next report, routine health care, particularly for those with chronic conditions such as diabetes and high blood pressure, can result in improved quality of life, prevent long-term disability and lead to longer life. Health insurance is a critical link in obtaining such care.

Myth: “Most people without health insurance are young, healthy adults who decline coverage offered in the workplace because they feel they don’t need it.”

Reality: Young adults are more likely than persons of other ages to be uninsured largely because they are *ineligible* for workplace health insurance—many are too new in their jobs, or they work for a business that does not provide health insurance coverage to its employees. Only 4 percent of all workers ages 18-44, or about 3 million people, are uninsured because they declined available workplace health insurance. Many of these do so because they can’t afford their share of the premium. Nearly *four times* as many workers in the same age group, approximately 11 million people, are uninsured because their employer does not offer health insurance, and they cannot afford to purchase insurance elsewhere. Purchasing coverage outside of work is not an option for many, because individually purchased insurance policies are frequently expensive, often exclude preexisting conditions, or are simply unavailable.

Myth: “Most of the uninsured don’t work, or live in families where no one works.”

Reality: More than eighty percent of uninsured children and adults under the age of 65 live in working families. While working improves the chances that both the worker and his or her family will be insured, it is not a guarantee. Even members of families with two full-time wage earners have almost a one-in-ten chance of being uninsured.

Myth: “Recent immigration has been a major source of the increase in the uninsured population.”

Reality: Between 1994 and 1998, over 80 percent of the growth in the size of the uninsured population consisted of U.S. citizens. Recent immigrants (those who have resided in the U.S. for fewer than 6 years) are about three times as likely as members of the general population to be uninsured, but they comprise only about 6 percent of the uninsured population.

In the remainder of my testimony, I would like to fill in the picture of Americans most vulnerable to being uninsured and expand on the factors that contribute to this.

In the United States, health insurance is a voluntary matter, yet many people do not choose to be uninsured. There is no guarantee for most people under the age of 65 years that they are eligible for or able to afford health insurance.

Almost seven out of every ten Americans under age 65 are covered by employment-based health insurance, either through their job or through the job of a parent or their spouse. Three-fourths of U.S. workers are offered health insurance by their employers, and 83 percent of those who are offered health insurance accept the offer of coverage. About 18 million Americans live in families whose head works for a company—often a small one—that does not offer health insurance.

People who cannot get insurance through the workplace and who are under age 65, too young to qualify for Medicare, have two potential options to secure coverage—purchase an individual policy or attempt to qualify for public insurance, primarily Medicaid. These two options account for 21 percent of all coverage among persons under age 65.

Individual coverage is expensive and may be priced out of reach for many people, particularly those who are in poor health. The full premium for employment-based coverage for a family—which is the cost faced by former employees who might avail themselves of COBRA coverage—now averages more than \$7,000 per year. Individual policies are either more expensive than these group plans, less extensive in their benefits, or both. As noted in our report, the median family income in 2000 was just under \$41,000, and the incomes of most of those without health insurance was much lower than that—two-thirds of uninsured Americans live in families with incomes below 200 percent of the federal poverty level, about \$34,000 for a family of four in 2000.

For individuals and families, the expense of insurance premiums and competing demands on their income are the main reasons why some workers decline employment-based insurance. Workers who accept an employer’s offer of subsidized health

insurance typically pay between one-quarter and one-third of the total cost of the premium for family coverage. In addition, they may pay substantial deductibles, co-payments, and even pay out of pocket for the costs of health services that are not covered by their health plan. Among lower-income families, those earning less than 200 percent of the federal poverty level, health-related expenses may easily consume 10 percent or more of their annual income.

It isn't easy to foot the bill for health insurance, given its high cost. Employers' willingness to subsidize coverage is strongly influenced by the scarcity or availability of workers, insurance underwriting practices, the cost of health care, and the patchwork of public policies that encourage (or discourage) firms to offer insurance as a benefit.

The kind of job a person holds, and where they live, are strongly related to their chances of having health insurance. Full-time, full-year employment offers families the best chances of having health insurance, as does an annual income above 200 percent of the federal poverty level. The employment mix and strength of the economy, along with eligibility and benefits for public programs like Medicaid and SCHIP, vary across states and geographic regions, with the result that opportunities for obtaining any kind of health insurance coverage and the risk of being uninsured also vary regionally. Roughly a quarter of the populations of Florida, Texas, Arizona, New Mexico and California are uninsured, while less than 12 percent of the populations of Rhode Island, Pennsylvania, Minnesota, Iowa, Nebraska and Hawaii lack coverage. These disparities in rates of insurance coverage reflect very different challenges facing individual states, employers, and the federal government in addressing the persistent problem of uninsurance across the nation.

Many find the opportunities for public coverage too limited. The combination of strict eligibility requirements and enrollment procedures makes public coverage difficult to obtain and even harder to keep. The median length of time that someone under the age of 65 keeps Medicaid coverage is about 5 months. At the end of any given year, about two-thirds of the people who were insured by Medicaid at the start of the year have lost their coverage for any number of reasons.

There are as many ways to lose health insurance as there are to gain it. These include an increase in insurance premiums or a change in terms, loss of a job or a drop in personal income, new terms of employment, a change in health or in marital status, reaching adulthood, or a change in public policy. For some, being uninsured is a long-term or recurrent state of affairs. The median amount of time without insurance is between 5 and 6 months. However, uninsured persons living in low-income families and those with less education on average experience longer periods without insurance.

Non-Hispanic whites make up about half of all uninsured persons. African Americans, however, are twice as likely as non-Hispanic whites to be uninsured, and Hispanics are three times as likely as non-Hispanic whites to be uninsured. Foreign-born U.S. residents are three times as likely to be uninsured as people born in this country. Among the foreign born, non-citizens are more than twice as likely to lack coverage as naturalized citizens.

The greater likelihood of being uninsured among racial and ethnic minorities and recent immigrants reflects, on average, their lower rates of employment-based coverage, which primarily reflects fewer *offers* of employment-based coverage, rather than lower take-up rates. Minority groups and recent immigrants also have, on average, lower family incomes than non-Hispanic whites and U.S.-born residents, which is associated both with employment that does not carry an offer of health insurance and a lesser ability to afford an employer's offer of coverage.

In closing, I want to emphasize several points:

- Since the mid 1970s, the rising cost of health care, and therefore the cost of health insurance, has outpaced the purchasing power of many employers and consumers. Some of the most recent economic data released since *Coverage Matters* was completed shows a resumption of double-digit inflation in health care costs, contributing to a growing gap in affordability. This gap between costs and purchasing power, probably more than any other factor, has fueled the steady growth in the ranks of the uninsured. Unless health insurance becomes more affordable, this trend is expected to continue.
- While health insurance is a voluntary matter in the United States, many people are involuntarily excluded from the system. Among those excluded, the poor and members of certain minority groups are disproportionately represented. However, the uninsured include members of all racial and ethnic groups, persons who live in rural as well as urban settings, and wage earners from a wide variety of occupations. More than 80 percent of the uninsured are members of working families. They wait on tables, fix cars, serve as consultants to businesses,

and start businesses of their own. They contribute in countless ways to the U.S. economy and our society's well-being.

- Having health insurance is not a permanent state of affairs. Many life transitions can result in the gain or loss of health insurance. In any given year, millions of Americans move into (or out of) the ranks of the uninsured. As the job layoffs over the past 6 months have vividly demonstrated, few of us under the age of 65 can assume that we will always have health insurance, no matter what happens.
- Finally, people without health insurance go without needed care, including doctors' visits and medications, far more often than do people with coverage.

Thank you for inviting me to present the work of the IOM and the Committee on the Consequences of Uninsurance. I would be happy to answer any questions that you may have about the Committee or our report.

Mr. BILIRAKIS. Ms. Grealy.

STATEMENT OF MARY R. GREALY

Ms. GREALY. Mr. Chairman, Congressman Brown, and members of the subcommittee, I want to thank you for the opportunity to testify today, and I also want to applaud you for the attention that you are devoting to the most important health care issue facing our Nation.

I testify today on behalf of the members of the Health Care Leadership Council, chief executives of the Nation's leading health care companies and institutions, representing all sectors of health care; from hospitals, to physician groups, health plans, pharmaceutical manufacturers, medical device manufacturers, just to name a few of our rather eclectic membership.

Last summer the members of the Health Care Leadership Council initiated a nationwide campaign called Health Access America. And they are devoting their energy and resources to the challenge presented by the nearly 40 million uninsured Americans.

As part of our Health Access America Campaign, we are conducting research to better understand the varying needs and circumstances of the people who make up the uninsured population.

We are using the internet and our HLC website to link people with health coverage and safety net programs in their States. We are seeking out innovative local and regional programs across the country that are successfully making health care coverage more accessible for working families and for small business owners.

Programs like the Wayne County, Michigan Healthy Choice Initiative in Congressman Dingell's district, and we are also talking to the people who are uninsured. People from all over the country, like Lisa Crowley, a single mother, and self-employed construction worker, from Fort Wayne, Indiana.

Ms. Crowley reached out to us because she works hard, long hours, but she can't obtain insurance to pay for the medication that she needs for her dangerous hypertension condition.

Lisa Crowley and millions of others like her are the focus of the uninsured. They are the faces that we see when we now know who are the uninsured. Are research as you have heard time and again now, and it has really become part of the lexicon of describing the uninsured, that 8 out of 10 of the uninsured are in working families.

America's working class uninsured are to a large degree people who work for small businesses, and these small businesses want to

offer coverage, but they can't make it happen with their tight operating margins.

They are people also who receive an offer of insurance from their employer, but they are not taking that offer because they can't afford the premium. Sometimes they can for themselves, but they can't afford the family coverage for their families.

The HLC believes that successfully addressing this challenge will require a mix of public and private solutions. It is not a question of public versus private. That is a false choice.

There is not a single solution that will solve this problem. We must be flexible and address the challenges of the uninsured in a variety of ways with all the tools available. I have addressed some of these possible solutions in detailing my written testimony, but let me touch briefly on just a few.

If our goal is to significantly reduce the uninsured as quickly and as efficiently as possible, then we need to focus on the workplace, where the vast majority of the uninsured can be found.

It makes enormous sense to utilize a prefunded advanceable, refundable tax subsidy that could be advanced to the individual and used immediately for their monthly premiums.

The combination of a refundable tax subsidy, the lower cost of group health insurance, and the natural outreach opportunities that exist in the employment setting create a very promising environment for expanding coverage to many more Americans.

We have found in programs like Healthy Choice in Wayne County, Michigan, the Focus Program in San Diego, and FAMIS in the State of Virginia, that a relatively small helping hand can bridge that premium gap between what an employer is able to subsidize, and what an employee is able to pay.

We also need to examine the most effective role for our public programs like Medicaid and the State Children's Health Insurance Program. These programs are extremely valuable in providing health care to citizens with very low incomes. When we discuss these programs though, we have to do it in the context of current State budget situations and restraints.

According to the National Conference of State Legislatures, 28 States will consider cutting their Medicaid benefit packages this year. Most States have balanced budget requirements, and given that fact that Medicaid and S-CHIP represent the largest line items in most of these State budgets, Governors will have little choice but to take that direction when looking for savings.

Given this environment, a logical approach would be to use those Medicaid and those S-CHIP dollars to supplement employer health benefit contributions. The administration has launched a demonstration initiative, HIPAA, and that encourages this direction.

It makes good sense in terms of stretching those limited health care dollars. Mr. Chairman, the high number of uninsured Americans is a problem that has perplexed our Nation for far too long.

I believe though that we are seeing an unprecedented determination to find and achieve solutions. Members of this committee have introduced and co-sponsored legislation that would make health insurance more accessible.

And the President has included in his budget more than \$90 billion that would among other things provide a refundable,

advanceable health tax credit to help families purchase health insurance.

The Health Care Leadership Council appreciates and applauds all of your ongoing efforts to help the Lisa Crowleys of the country to solve this most pressing and serious health care issue.

We look forward to working with Congress, and working with the White House on a variety of approaches that will be required to get more Americans health insurance coverage. Thank you.

[The prepared statement of Mary R. Grealy follows:]

PREPARED STATEMENT OF MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

Mr. Chairman, Congressman Brown, and members of the subcommittee. I am Mary Grealy, President of the Healthcare Leadership Council. On behalf of the members of the HLC, I would like to thank you for focusing today's hearing on the very important issue of uninsured Americans. I welcome and appreciate this opportunity to discuss the views of HLC members.

The Healthcare Leadership Council (HLC) is a coalition of chief executives of the nation's leading health care companies and organizations, representing all sectors of health care. Our members are committed to advancing a market-based health care system that values innovation and provides affordable, high-quality care.

The HLC believes there is no greater health care priority in this nation than the approximate 40 million individuals who are without health care coverage. The health consequences experienced by those without health insurance are well documented. People without coverage tend to get sick more often because they do not receive the preventive and diagnostic care that so many of us take for granted. They miss more time on the job. They are absent from school more frequently, and statistics tell us they will die too early.

In addition, our nation as a whole is affected when such a large segment of our population is uninsured. Our productivity suffers, and our health providers absorb a tremendous economic strain caused by uncompensated care. Hospitals alone are absorbing over \$19 billion per year in care provided to those who do not have adequate coverage.

Concern regarding this issue is increasing, and the greater attention being given to the uninsured is both welcomed and necessary. The President and the Congress, including this subcommittee, should be highly commended for their recent efforts to initiate action on behalf of uninsured Americans. As well, a number of private organizations have begun devoting tremendous energy to this issue and should also be commended.

I would like to particularly applaud the members of this committee who have introduced and co-sponsored legislation that would make health insurance coverage more accessible to greater numbers of Americans.

In passing the economic stimulus bill this month, the House of Representatives highlighted the need to find ways to ensure that laid off workers do not join the ranks of the uninsured. We support provisions in that bill which would give those losing coverage a number of options for extending their health care benefits or obtaining new benefits. In particular, we support efforts to help hard-to-insure individuals by providing funding for state high risk pools.

The members of the HLC also support the President's inclusion of more than \$90 billion in his recent budget to begin mapping the way to coverage for a significant number of the uninsured. The majority of this funding would provide a refundable health tax credit that could be advanced to families to help them purchase insurance plans in the non-group insurance market. The HLC believes this is an important step toward providing easier access to health care coverage for the millions of working Americans who are without it.

It is our goal to work with the Administration and Congress to encourage the development and expansion of this proposal. This initiative, as well as the Administration's proposals to increase funding for community health centers, to assist hard-to-insure families and individuals in purchasing coverage from state risk pools, and to maximize use of existing State Children's Health Insurance Program (S-CHIP) funds, exemplifies the Administration's resolve to strip away the diverse array of barriers that keep people uninsured.

It is critical to point out that there is no single answer, no one policy solution that will address the needs of more than 40 million uninsured Americans. Taking on this issue requires flexibility and a mix of targeted public and private solutions.

The HLC supports a three-pronged approach to reduce the number of uninsured Americans: (1) refundable tax incentives to encourage the purchase of insurance, including employer-offered coverage; (2) improvements to the current Medicaid program and S-CHIP, including improved outreach to enroll those currently eligible and the flexibility to use program dollars to expand private coverage; and (3) increased efforts to facilitate awareness of the importance and availability of health insurance, especially among the nation's small businesses.

The members of HLC are committed to this effort—to raising awareness of the national problem of the uninsured and advancing solutions to put health coverage within the reach of uninsured Americans. Last year, we formed the national Health Access America campaign because we believe that all Americans should have access to today's modern medical miracles and life-enhancing technologies and treatments.

Under this campaign, HLC members have pledged their leadership, energies and resources to help solve the nation's uninsured crisis. We are spotlighting local and regional programs throughout the country that are developing successful, innovative approaches to help provide coverage. We are using our Web page to provide uninsured Americans with one-click access to information about coverage and safety net programs in their states. We are conducting research studies on the most effective ways to address this crisis. And, we are talking to people who don't have health coverage, listening to their stories and telling them to a wider audience to underscore the cost that will continue to be paid if we don't solve this problem.

Our work in highlighting model programs throughout the country that promote health coverage and access has been particularly valuable. We spotlight these programs with the HLC "Honor Roll for Coverage" award. In 2000, we presented awards to the Wayne County, Michigan HealthChoice program as well as the FOCUS program in San Diego. Both of these programs provide subsidies to help small businesses and their employees afford health insurance. In 2001, we recognized Virginia's exemplary waiver program that allows S-CHIP funds to be used to help expand employer health coverage, and South Carolina's Commun-I-Care program, which provides care, health care services and products to individuals who are not eligible for public assistance or employer-based insurance.

This year, HLC will present its Honor Roll Award to a new program in Sacramento County, California, called SACAdvantage. Modeled after the San Diego FOCUS program, SACAdvantage will work with small employers to increase access to coverage for their employees.

We believe these and similar state and local programs, small business and association purchasing pools, and other creative ways to encourage health care coverage merit national attention. There are a number of different causes that lead to millions of people being without health insurance, and each of these local programs has analyzed the unique needs and potential solutions for their uninsured populations.

These initiatives are not only providing coverage for a growing number of individuals, families and small businesses, but they are providing us with a critical road map leading toward workable solutions that may encourage small employers and individuals to participate in coverage programs. For example, Wayne County's HealthChoice program, found that it was difficult to entice businesses to participate as long as subsidies to those businesses were less than one-third of their insurance premium costs. The premium formula that eventually made the program a success was one-third paid by the employer, one-third paid by the employee, and one-third subsidized by the county government.

In addition, these small employers received the benefit of the pooling arrangement created by the county, which offered a negotiated price as well as a subsidy. This mirrors some of the advantages enjoyed by large employers and other types of purchasing pool arrangements.

Finally, in an effort to increase awareness about the importance of health care coverage, HLC has worked with Congresswoman Wilson on the introduction of H.Con.R. 271, *The Importance of Health Care Coverage Month*, and securing bipartisan cosponsors for that resolution. Concurrently, our grassroots organization is coordinating events around the country with cosponsors of the resolution to help educate individuals and small business of the importance and availability of health care coverage.

I would now like to share with the Committee information from several research projects that we have undertaken at HLC. These studies are helping us to better understand the characteristics of the uninsured and potential solutions to the significant challenges before us.

Characteristics of the Uninsured

Four out of every five uninsured persons are in families with at least one employed family member. This is the dominant picture of the uninsured—hard-working

people who are not offered or cannot afford health insurance. Of the 33 million uninsured in working families, 13 million are in families where an offer of insurance from an employer is turned down, usually because the family cannot afford it. Twenty million of the uninsured in working households are not offered employer insurance.

It is not surprising that affordability is the most significant of the various barriers to having health coverage. A recent analysis commissioned by HLC shows that 16 percent of those in families with incomes under the federal poverty level with an offer of insurance are uninsured, compared to six percent of those in families with incomes over three times the poverty level.

Cost is a barrier to insurance enrollment for low-income workers and their dependents, in part because their share of premiums consumes a higher percentage of their income than is the case for workers with higher incomes. Also, workers in middle and upper-income brackets tend to work for employers who subsidize a larger portion of their health insurance premiums, whereas low-wage firms offer a smaller subsidy to their employees.

These characteristics suggest that pre-funded, refundable tax incentives to lower income workers could serve to bridge the premium gap that exists between what an employer and employee are each able to contribute toward a health insurance policy. Such tax incentives could encourage many employers not now offering coverage to do so, and also will aid those workers who are not offered health insurance by their employers.

Limitations of S-CHIP and Medicaid

S-CHIP and Medicaid have proven extremely valuable for providing health care to very low income populations, and must play a role in the package of solutions that will reduce America's uninsured population.

However, evidence suggests that we are reaching the limits of effectiveness in reducing the number of uninsured through these programs, as they currently function. Only about half of the individuals currently eligible for Medicaid and S-CHIP actually participate in the programs, suggesting that eligibility alone—without considerable investment to remove existing barriers to participation—does not and will not efficiently increase the number of people receiving coverage.

A number of reasons have been cited for low participation in these programs, including the fact that participation rates in means-tested public insurance programs decline as incomes rise. A large number of those electing not to participate are families with higher income levels who were offered public insurance upon the inception of S-CHIP.

This pattern of lower participation among higher income persons is also evident in other government health care subsidy programs, including the Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) programs. Forty-five percent of QMBs who have incomes at or below 100 percent of poverty do not participate in the QMB program. Among SLMBs, who have slightly higher incomes than QMBs at 100 to 120 percent of poverty, 84 percent of those eligible fail to participate. Obviously, substantial outreach is necessary to overcome barriers to participation, such as the stigma many associate with public programs.

Any discussion of expanding S-CHIP or Medicaid eligibility must also take into consideration the deteriorating fiscal health of many of our states. Medicaid and S-CHIP account for the largest line item in most state budgets. And, unlike the federal government, virtually all of the states do not have the option of deficit spending, meaning that budget cuts will have to occur. The National Conference of State Legislatures's annual Health Priorities Survey for 2002 found that 28 states will consider cutting Medicaid benefit packages this year. At the recent Governor's meeting in Washington, several state chief executives made it clear that Medicaid spending is one of the greatest problems they face.

This challenging environment requires innovative approaches. For example, using S-CHIP funds to supplement employer premium contributions, as the Administration's new Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative waiver encourages, is a logical way to stretch scarce health care dollars. Virginia's FAMIS program, which I mentioned previously, is one of the first programs in the nation to combine its S-CHIP funding with employer-offered coverage. This program is now enrolling thousands of uninsured children into their parents' health plans in the work place.

This idea should be examined closely by other states as well as the Federal government. Many eligible individuals in the higher income categories of Medicaid and S-CHIP, as well as income categories under consideration for Medicaid and S-CHIP expansions, are connected to the workforce through at least one family member. Therefore, solutions involving ways to supplement employer insurance may be high-

ly effective in increasing coverage rates for these populations, providing coverage without the stigma of government dependence. There are steps that must be taken, though, to make this approach work better. There are administrative complexities within the Medicaid and S-CHIP programs that discourage states from opting to coordinate with employer health plans. HHS currently does not have the authority to eliminate all of these barriers. Congress must address them legislatively. The HLC would appreciate the opportunity to work with this committee to help identify and overcome these obstacles.

Targeted, Refundable Tax Incentives

HLC members are committed to forging a health care system characterized by innovation and constantly improving quality. Choice, which drives competition, is essential to such a system. Health coverage tax credits have the potential for providing consumers with a great amount of flexibility for choosing health coverage options that best suit their needs. They also can act as a stimulus to create new and wider coverage choices in the marketplace.

The HLC believes tax credits should be refundable for persons with little or no tax liability, and they should be paid in advance so that individuals with limited or no savings can take advantage of them to pay monthly premiums before the end of the tax year. Risk adjusting tax credits for those with chronic diseases and other health conditions, as well as facilitating the development of state high risk pools toward which credits can be applied, can also help to ensure that the majority of the uninsured are served by this approach.

While we are pleased to see proposals moving forward to use tax credits to address the needs of individuals who do not have an offer of employer insurance, it is our hope that these proposals will be expanded to include others in the workplace who face health coverage challenges. The HLC's strong advocacy for tax incentives to subsidize the purchase of employer-offered insurance stems from the compelling fact that over 80 percent of the uninsured are connected to the workforce. The combination of a refundable tax subsidy, the lower cost of group health insurance and the natural outreach opportunities within an employment setting creates the most promising environment for increasing coverage for families and individuals.

Assessing Cost and Value of Tax Incentives

Our tax code provides tremendous benefits to those who receive their health insurance through their place of employment. Health insurance premiums paid by the employer are not counted as taxable income to the employee. However, this tax exclusion has less value for low-income workers than for their better-paid counterparts.

For families with income levels between 200 to 300 percent of the federal poverty level (\$35,000 to \$53,000 for a family of four), the tax exclusion for employer-paid health insurance is worth only about \$661. For families between 300 and 400 percent of poverty, the exclusion has a value of about \$801. Thus, a refundable tax credit of \$2,000 to \$3,000 per family, the most commonly discussed level, would be particularly valuable for low-income workers, including those who are offered insurance by their employers.

The cost of tax incentive proposals, as with any proposals to reduce the number of uninsured, presents a financial challenge to policy makers. The cost of legislation, of course, must be determined before legislation is acted upon, and the price tags have been notably high. This is particularly true for proposals that allow tax incentives to be used for workers who already have an offer of insurance from an employer. This is, in part, due to the fact that the Joint Tax Committee, on whom Congress must rely for determining the cost of tax legislation before it is passed, incorporates assumptions that many workers already receiving employer-based insurance will be "bought out" with federal dollars and current employer subsidies will cease.

A look at the real world of employer benefits leads to a different conclusion. The extent to which employers will reduce their contributions toward health insurance for employees when a subsidy such as a tax credit is offered can be discerned by looking at economic studies examining actual experiences with other types of wage subsidies. In two such studies examined by HLC (Katz, 1996 and Witte et. al, 1998), general wage subsidies and child care subsidies from the government did not reduce overall employee benefit spending by employers.

Additionally, we can project expected employer behavior if tax credits are focused exclusively toward lower-income employees. It is highly unlikely that an employer would discriminate by reducing premium contributions for low-income workers receiving a tax subsidy, while maintaining current contributions for higher-income workers not eligible for the subsidy.

We would recommend that policymakers utilize these real world examples and fair assumptions regarding marketplace behavior in determining the likely impact of new tax incentive policies.

Phasing in a Tax Credit Approach

All Americans deserve access to affordable health coverage. However, current budget constraints may require us to move in incremental steps toward that goal. For example, targeting tax credits toward populations less likely to already have coverage, such as low-income families or workers in small businesses, can help to reduce the cost of such an approach while still reaching many currently-uninsured persons. The HLC is modeling a number of targeted tax incentive policies and we would be happy to share our findings with the committee.

Another segment of the population that should receive high priority in targeting tax incentives includes dependents of lower-income workers not eligible for S-CHIP or Medicaid. Small and medium sized businesses offering health insurance to their employees contribute, on average, 48 percent of the premium amount for employees, but only 24 percent for their dependents. Not surprisingly, in many cases, workers acquire insurance for themselves, but cannot afford it for their family members. In designing targeted tax incentive policies for the uninsured, we should strive to assist all members of working families.

Conclusion

Mr. Chairman, the Healthcare Leadership Council appreciates your efforts on the uninsured over this past year, and applauds you and your colleagues for your ongoing work to find ways to solve this nation's most pressing health care issue. The uninsured must be our national health care priority for 2002. This multi-faceted problem will require a variety of public and private approaches and we look forward to working with you and the Administration to develop constructive solutions.

Mr. BILIRAKIS. Thank you, Ms. Grealy.
Dr. Rowland.

STATEMENT OF DIANE ROWLAND

Ms. ROWLAND. Thank you, Mr. Chairman, Mr. Brown, and members of the subcommittee for this opportunity to testify today on how to extend coverage to our Nation's uninsured. At last count in 2000, 38.4 million Americans were uninsured; 9.2 million children, and 29.2 million adults.

The profile of the uninsured as you have heard today is a consistent one. They are predominantly low income working families. Two-thirds have income below 200 percent of poverty, and income of less than \$30,000 for a family of three.

And, yes, 8 in 10 are from families with one or more workers. Most are uninsured in fact because they do not obtain coverage in the workplace. Only 60 percent of workers earning less than \$7 per hour have coverage through their own or a spouse's job, compared to 96 percent of workers earning at least \$15 an hour.

Low wage workers are 10 times as likely to not be offered coverage in the workplace as higher wage workers. In fact, low wage employment equals lack of health benefits. When coverage is offered in the workplace the cost is often beyond the reach of low income workers.

In 2001, the average employer premium for family coverage was \$7,000 and the employee's share of that premium was 26 percent, or \$1,800 a year. For a low wage worker earning \$15,000 a year, the premium share equals 12 percent of that individual's family income.

Most would consider that an unaffordable price, even to obtain health coverage. The non-group market offers no bargains for low wage workers. Cheap policies with high deductibles afford little protection.

Better policies are too costly, but still often exclude health conditions, limit benefits, require substantial co-payments, and adjusted high premiums for those with health problems.

Public programs, most notably Medicaid and CHIP, do help fill in the gaps, especially for children. Today, 21 million children, 1 in 5 American children, rely on Medicaid for coverage, and another 4 million have been assisted by CHIP.

Medicaid and CHIP provide coverage for primary care, preventive services, immunizations, and pre-natal care, without financial barriers. They are not just catastrophic health insurance plans.

But public coverage has been broadened primarily for children, and leaves millions of low income adults behind, and 34 percent of low income women and 41 percent of low income men are uninsured.

Medicaid's reach for these adults is extremely limited. Income levels for eligibility of parents in most States remains substantially below that of the levels that Congress has mandated for children; well below poverty in 33 States.

Low income childless adults, who constitute one-half of the low income uninsured population, are excluded from Medicaid coverage unless disabled, no matter how poor. Clearly, broadening coverage to parents and extending Medicaid to childless adults at low incomes would be important steps in addressing the low income uninsured.

Without public expansions, the poorest among the uninsured, and the most chronically uninsured, are likely to remain without coverage. But strategies to address the uninsured must recognize the need economic realities.

As we sit here today, the situation has grown bleaker since the 2000 snapshot. The recent economic downturn and the return of double-digit inflation and health care costs now places health insurance coverage for working families in jeopardy, both from loss of employer sponsored coverage, and limits on the availability and scope of Medicaid due to State physical constraints.

We face the prospect of seeing coverage erode, not expand, for millions of Americans. The combination of rising health care costs and State fiscal constraints, puts the low income population relying on Medicaid and CHIP at particular risk.

We must be careful to not strip benefits and impose additional cost sharing burdens on America's poorest population in order to provide minimal expansions to other groups. This will worsen, not improve, health insurance coverage, and undermine much of the progress that has been made in recent years.

Maintaining the gains in public coverage over the last decade, especially for children, may in fact require additional Federal financing assistance to the States in return for a commitment to maintain coverage for the existing low income population.

Health insurance matters for the millions of Americans who lack coverage. It influences when and whether they get necessary medical care, the financial burdens that they face in obtaining care, and ultimately their health and health outcomes.

Extending coverage to the millions of Americans without health insurance and securing coverage for those who have it today, is both an important policy and health objective for this Nation.

I look forward to working with the committee to help achieve these objectives for our Nation. Thank you very much.
[The prepared statement of Diane Rowland follows:]

PREPARED STATEMENT OF DIANE ROWLAND, EXECUTIVE VICE PRESIDENT, THE HENRY J. KAISER FAMILY FOUNDATION

Thank you for the opportunity to offer testimony this morning on the critical issue of how to extend health coverage to our nation's over 38 million uninsured. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. The national bi-partisan commission serves as a policy institute and forum for analyzing health care coverage and access for low-income populations and assessing options for reform.

Combined with notable expansion in coverage, especially through public coverage of low-income children, the strong economy and sustained economic growth over the last decade helped to bring about the first decline in the number of uninsured in over a decade. However, the downturn in our economy, coupled with increased pressure on state budgets and rising health care costs, now place that progress in jeopardy. My testimony today will focus on the characteristics of the uninsured population, the factors that contribute to their lack of insurance, and the challenge of broadening coverage in the current fiscal environment.

The Uninsured Population

Today, two out of three nonelderly Americans receive their health insurance coverage through an employer-sponsored health plan offered through the workplace. However, for millions of working families such coverage is either not offered or is financially out of reach. Medicaid and the State Children's Health Insurance Program (CHIP) help fill in the gaps for some of the lowest income people, but this publicly sponsored coverage is directed primarily at children and varies in availability across the states. While 20 percent of children are covered by Medicaid or CHIP, only 6 percent of adults are covered, resulting in a greater likelihood of being uninsured for adults (Figure 1). Of the 38.4 million Americans who were uninsured in 2000, 9.2 million were children and 29.3 million were adults. While young adults ages 19 through 24 have the highest rate of uninsurance of any age group, they represent only 17 percent of the uninsured population (see Table 1).

Low-income individuals are disproportionately represented among the uninsured. Because poor and near-poor families have a greater chance of being uninsured, nearly two-thirds (64%) of the uninsured come from low-income families earning less than 200 percent of the poverty level (Figures 2). [In 2002, an income of \$27,476 per year places a family of three at 200% of poverty.] Over a third (36%) of the uninsured come from families living below the poverty level.

The likelihood of being uninsured decreases substantially as income rises (Figure 3). Over a third (36%) of the poor and 26 percent of the near-poor are uninsured in contrast to 6 percent of people with incomes at or above 300 percent of poverty, or roughly \$41,000 a year for a family of three. Employer-sponsored coverage is extremely limited for the low-income population; only 18 percent of the poor and 47 percent of the near-poor receive coverage through their employer. Medicaid helps to offset the lower levels of private insurance for over a third (37%) of the poor and 17 percent of the near-poor. The near-poor run a high risk of being uninsured because with their higher incomes they are less likely to be eligible for Medicaid than the poor, but also less likely than higher income families to have access to employer sponsored health insurance.

This confluence of factors relating to the characteristics of the uninsured places low-income adults at the center of the issue. In 2000, 47% of the 38.4 million uninsured Americans were low-income adults—16 percent parents of low-income children and 31 percent low-income adults without children (Figure 4). The higher level of uninsurance among low-income adults reflects both the lack of insurance coverage in many low wage workplaces and the exclusion of coverage for childless adults in most Medicaid programs. Medicaid coverage, and the availability of federal matching funds to states for coverage, has historically not been available for childless non-disabled adults, no matter how poor. Assuring coverage for this group, as well as the parents of low-income children who are now largely eligible for public coverage, poses the next challenge in coverage expansions.

Limits to Private Insurance

While most Americans rely on employer-sponsored coverage to provide group insurance coverage for themselves and their families, many working families fall out-

side the scope of workplace coverage. Eight in ten of the uninsured come from working families—72 percent come from families where at least one person works full-time outside the home and another 11 percent come from families with part-time employment. Among the low-income uninsured, 58 percent of the poor and 96 percent of the near-poor are working or have workers in their families.

Most uninsured workers (over 70%), and consequently their dependents, are not offered job-based health coverage, either through their own or a family member's job. Lack of access to employer-sponsored coverage is particularly a problem for low-wage workers (Figure 5). Only 60 percent of low-wage workers (those earning less than \$7 per hour) have access to job-based coverage through their own or a family member's job, compared to 96 percent of high-wage workers (those earning at least \$15 per hour). For 40 percent of low-wage workers, in contrast to only 4 percent of high-wage workers, health benefits were not offered.

The likelihood of being offered coverage in the workplace depends largely on where one works, including the size, industry, and wage level of the firm. Most large firms offer coverage, but many smaller firms do not. Small firms face particular challenges in offering their employees coverage due to high turnover rates and small risk pools, which may lead to high premiums for group coverage. Low wage workers often work in small businesses, particularly in retail and service industries where health insurance is not widely offered as a fringe benefit. Low wage workers who are "typical" employees in a firm are also less likely to be offered coverage: surveys and research have shown that the more low wage workers an employer has, the less likely they are to offer health coverage.

When health insurance is offered in the workplace, most employees opt for coverage even though the share of the premium borne by the employee can be substantial, especially for low-wage workers. In 2001, the average annual family premium for employer sponsored group coverage was \$7,053 (Figure 6). The worker's contribution to that premium was, on average, 26 percent, or \$1,801 for the year. For a full-year, full-time worker earning \$7 an hour, the employee share of premiums represents 12 percent of the family's \$14,500 annual income. However, for many low wage workers, the employer covers less than half of the premium, making the cost of coverage even more unaffordable. As a result, even when coverage is offered, many low wage workers are unable to finance their share of the premiums.

If health insurance coverage is not available through a group policy from an employer, families are hard pressed to be able to find and pay for a policy in the individual insurance market. Most directly purchased policies are expensive and have more limited benefits and more out-of-pocket costs than group coverage plans. Moreover, the cost of these policies is based on age and health risk, and any preexisting health conditions are generally excluded from coverage. For the average low-income family, a \$6,000 family policy in the individual market would consume a quarter or more of their income, provide only limited protection, and could exclude coverage for any family members with health problems.

The limits of employer-sponsored and privately purchased health insurance leave millions of low-income children and adults at risk for being uninsured. While on average 16 percent of nonelderly people are without insurance today, uninsured rates vary widely across the country, reflecting the economic environment and employment structure in different states. States with more agriculture and small business and retail industry and less manufacturing have higher rates of uninsurance. From 1999 to 2000, 17 states and the District of Columbia had 16 percent or more of their nonelderly population uninsured (Figure 7).

Public Coverage for the Low Income Population

The lack of employer-sponsored coverage leaves millions of low-income families without private coverage; for many, Medicaid, and most recently CHIP for low-income children, helps to fill the gap. Medicaid now covers one in five of America's children, providing health insurance coverage with limited cost sharing and comprehensive benefits to 21 million low-income children and 8 million low-income parents. CHIP has extended coverage to another 4 million children.

Together, Medicaid and CHIP already play a strong role in reducing uninsured rates among low-income children, with over half (52%) of poor children and nearly a third (30%) of near-poor children now receiving coverage through these programs. With the decoupling of Medicaid and welfare as part of welfare reform in 1996 and the enactment of CHIP in 1997, states have substantially expanded the income limits to extend eligibility to millions of poor and near poor uninsured children. By 2002, 39 states and the District of Columbia had raised their income eligibility levels to at least 200 percent of poverty (Figure 8).

However, the potential to cover almost all uninsured low-income children will only be realized if steps are taken to make enrollment easier for the eligible population.

Often, eligible children remain uninsured because their parents are not aware of the coverage available or find the hurdles to establish eligibility and enroll too cumbersome. Long application forms with extensive questions on work history, assets, and personal information, coupled with use of welfare offices and personnel for processing enrollment, have discouraged many applicants from initiating or completing the process. The steps that states are now taking to simplify enrollment and reduce the burden of enrolling on families are essential to make public coverage work effectively for low-income working families.

While much more progress can be made in improving how Medicaid works for children, Medicaid's current reach among low-income families is compromised by limitations in coverage of parents of eligible children. Medicaid originally covered low-income families by including both children and parents receiving welfare assistance. However, over time, as eligibility expansions focused on children and pregnant women, coverage of parents lagged behind, often remaining at state welfare levels. As a result, millions of low-income children have gained eligibility while their parents, unless pregnant or disabled, remain uninsured. In addition, many families who are eligible for Medicaid but not enrolled lost coverage in the wake of welfare reform, as confusion and computer systems problems erroneously dropped many from Medicaid coverage when they left cash assistance. Moreover, welfare reform also restricted public coverage for many immigrants.

Nearly one-third of low-income parents are uninsured, and of these 5.3 million uninsured parents, less than a third (31%) are potentially eligible for Medicaid but not enrolled. The bulk of uninsured parents (69%) do not currently qualify for Medicaid coverage because their limited income or assets make them ineligible under the stringent eligibility standards for adults. One of the key strategies for improving coverage of the low-income population is to raise parents' eligibility levels to those of their children to achieve coverage for the whole family. This step would not only cover more low-income adults, it would also provide an additional incentive to parents to enroll their children.

While welfare reform contributed to increasing the number of low-income uninsured parents, the changes enacted along with the welfare legislation under Section 1931 of the Social Security Act also offered states new opportunities to substantially expand family coverage. States were granted greater flexibility in family composition rules and the counting of income and resources, enabling them to extend coverage to single- and two-parent households and more low-income, working parents. Using either this new authority or Section 1115 waivers from the Secretary of Health and Human Services, 18 states now provide some Medicaid coverage to parents up to and above 100 percent of the poverty level (Figure 9). However, in 15 states, coverage for parents remains at or below 50 percent of poverty.

The most glaring omission in Medicaid coverage, however, is the exclusion of coverage for low-income childless adults. Nearly half of the uninsured low-income population falls outside Medicaid's reach because they are adults without children. Low-income adults without children have the highest rates of lack of insurance—45 percent of poor and 35 percent of near-poor childless adults are uninsured. Unless they become totally and permanently disabled and can qualify for disability assistance under the Supplemental Security Income cash assistance program, they are generally ineligible for Medicaid. Eight states have used Medicaid waivers to provide Medicaid to low-income childless adults, but coverage remains limited.

Clearly, Medicaid plays a crucial role as an insurer of low-income children and adults, but coverage for the low-income population remains limited by restrictive eligibility and policies and procedures that have carried over from Medicaid's welfare heritage. Converting Medicaid from a welfare assistance program to a health insurer for low-income people and building on Medicaid and CHIP offer an opportunity to bring broader-based coverage to the low-income population and fill the gaps left by employer-based coverage.

Health Coverage in the New Economy

Extending coverage through employer-sponsored and public coverage faces additional challenges as our weaker economy puts new stress on the system. In recent years, the thriving economy helped to moderate growth of the uninsured population as employers used health care benefits as a way to attract and retain workers in a competitive market. At the same time, states expanded Medicaid and CHIP coverage of children. The economic downturn now places health insurance coverage for working families in jeopardy from both loss of employer-sponsored coverage and limits on the availability and scope of Medicaid as a fallback.

Both employer-sponsored coverage and Medicaid (and, as a result, the number of uninsured) are sensitive to economic conditions. In times of recession, employer-sponsored coverage declines, and while Medicaid absorbs some of the loss in coverage,

many more people go uninsured. It is estimated that for every 100 workers added to the unemployment rolls, 85 people will join the ranks of the uninsured. When our national unemployment rate rose from 4.0% in December 2000 to 5.8% in December 2001, we estimate that the number of uninsured increased by 2.2 million (Figure 10).

In addition, the changing economy also poses other threats to coverage for workers. Employers who began to offer coverage to lure workers in a tight labor market are likely to cut back on those offers. Employees' hours may be cut back, making them ineligible for health benefits as part-time workers. As employers face shrinking profits, they may also look to health insurance as a way to cut costs, either by cutting eligibility for some workers, cutting back benefits, or passing a larger share of the cost of insurance on to employees.

All of these scenarios are made even more likely by the fact that the cost of employer-sponsored coverage is rising again after several years of decline (Figure 11). Our recent survey of employer-sponsored health benefits found that from 2000 to 2001, premium costs increased on average 11 percent. However, even more troubling, most employers, especially large employers who are most likely to offer coverage, reported it was likely that these increased costs would be passed along to their employees by increasing their premium share or reducing plan benefits. For workers with marginal incomes, such actions could make maintaining coverage for themselves and their families unaffordable.

Just as the slowdown in the economy could bring a return to the erosion in job-based coverage, the weakened economy and the return of rising health costs could severely compromise public coverage for the low-income population. Declining tax revenues and growing budgetary concerns will undoubtedly drive many states to reduce Medicaid spending and limit expansions of coverage to new populations if additional state spending is required.

During difficult economic times, Medicaid programs get caught in the crossfire between the need for increased coverage and spending and the erosion of state revenues and constraints on state budgets. Rising unemployment drives Medicaid enrollment upward. Using Congressional Budget Office estimates of Medicaid enrollment in 2002, simulations by the Urban Institute predict Medicaid enrollment for children and non-elderly adults at 44.7 million when unemployment is at 4.5%, but rising to 47.9 million if unemployment rises to 6.5%, assuming no other changes than those directly attributable to increases in unemployment (Figure 12). Such increases in Medicaid enrollment have fiscal implications for federal and state Medicaid spending.

Open-ended federal matching funds through Medicaid allow spending to increase automatically in response to higher enrollment levels, but states must provide matching funds to avail themselves of the federal assistance. Reduced state revenues are now placing severe strains on many state budgets. The strong economic growth during the mid- to late-1990s allowed states to build up significant balances, but at the end of 2000 states began to see their tax collections fall and their spending exceed expectations. Many states had to dip deeply into their year-end balances to cope with budget pressures. By the end of December 2001, 39 states were reporting budget shortfalls for fiscal year 2002.

The return of health care cost escalation, as reflected both in employer premiums and rising Medicaid payments, makes both maintaining and expanding coverage more difficult. Cost increases in the private market put pressure on Medicaid programs to keep pace as a major purchaser of care. In order to maintain access to care for its beneficiaries, Medicaid programs are being pushed to raise payment rates for health plans and providers and pay for the escalating cost of prescription drugs. In a recent survey, state Medicaid officials reported that the top reasons for Medicaid expenditure growth in FY2001 were pharmacy costs (48 states); provider rate increases (31 states); enrollment increases from eligibility expansions and growth of the disabled population (27 states), and increased costs for long-term care (24 states) (Figure 13). Given Medicaid's role as a provider of health and long-term care services for the nation's sickest and most disadvantaged populations, these cost pressures are only likely to grow over time.

The challenge for states and their Medicaid programs is how to meet the growing demand for coverage when fiscal resources are constrained. Some states are trying to hold the line and not reduce funding this year, but others have already initiated budget reduction actions for fiscal 2002. States are considering, and some have implemented, reductions in provider payments, eligibility and/or benefits; capping enrollment in the SCHIP program; or putting planned expansions on hold. Others are planning to use the new waiver authority (the Health Insurance Flexibility and Accountability Demonstration Initiative, or HIFA) to alter eligibility and benefits under Medicaid to address budget problems.

State budgetary problems coupled with the pressure to restrain health care spending portend difficult times ahead for health coverage of the low-income population. As health care costs rise, there will be increased pressure on states to cut back on spending and reduce services and/or coverage. If states respond to their difficult fiscal situations by cutting Medicaid in the months ahead, it will not only make it more difficult for newly unemployed workers to secure coverage, but could also reduce coverage for those currently enrolled. Limitations in public coverage would further exacerbate our nation's uninsured problem.

Conclusion

While the profile of the uninsured population and the factors contributing to their lack of coverage remain the same as in earlier years, the prospects for reducing the number of uninsured Americans have dimmed in light of the changes in our economy. Given the recent economic downturn and the renewed growth in health care costs, it appears we are facing the potential of seeing health care coverage erode, not expand, for millions on Americans.

Health care is expensive—beyond the reach of most American families to purchase on their own. As health costs grow and the premiums for insurance rise, health coverage through the workplace is likely to become less available and more unaffordable for working families. Clearly, efforts to control health care spending and make coverage more affordable for employers and employees alike is an essential part of any strategy to maintain and broaden coverage over the long term.

Rising health costs and state fiscal constraints put the low-income population relying on Medicaid and CHIP particularly at risk. Maintaining the gains in public coverage over the last decade, especially for children, may require additional federal financing assistance to the states in return for a commitment to maintain coverage at current levels. Increasing the federal matching rate for Medicaid for low-income children and families would both provide additional resources to states to maintain coverage and even provide an incentive to states to extend coverage. Supplementing and retaining CHIP dollars would also help stabilize coverage for low-income children in the short-run.

I commend the Committee for its efforts to highlight the plight of the 38 million Americans without health insurance coverage and to look at options that could help address this growing problem. I look forward to working with the Committee to meet the challenge of making health care coverage a reality for all Americans.

Thank you for the opportunity to testify today. I welcome any questions.

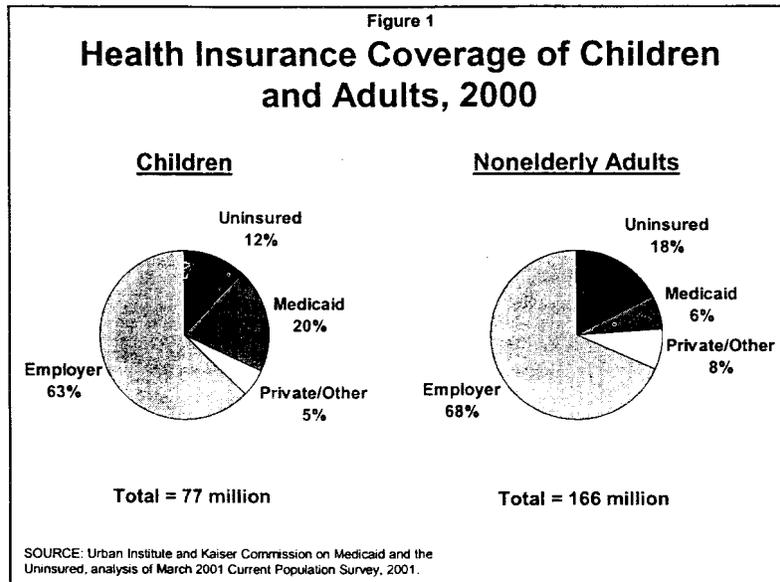
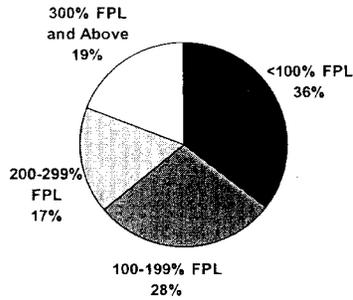


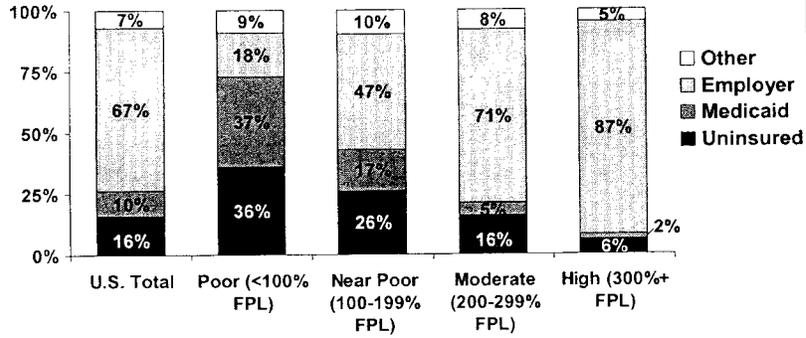
Figure 2
The Nonelderly Uninsured
by Poverty Level, 2000



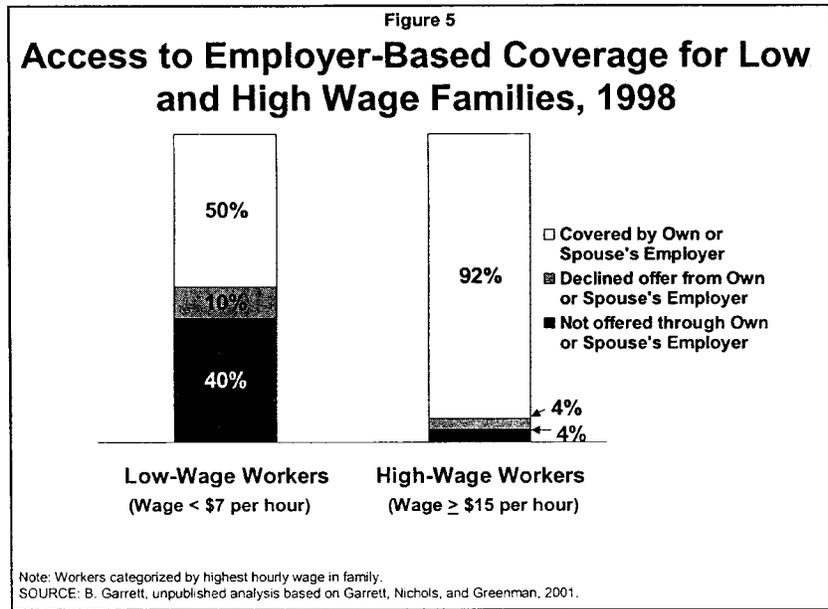
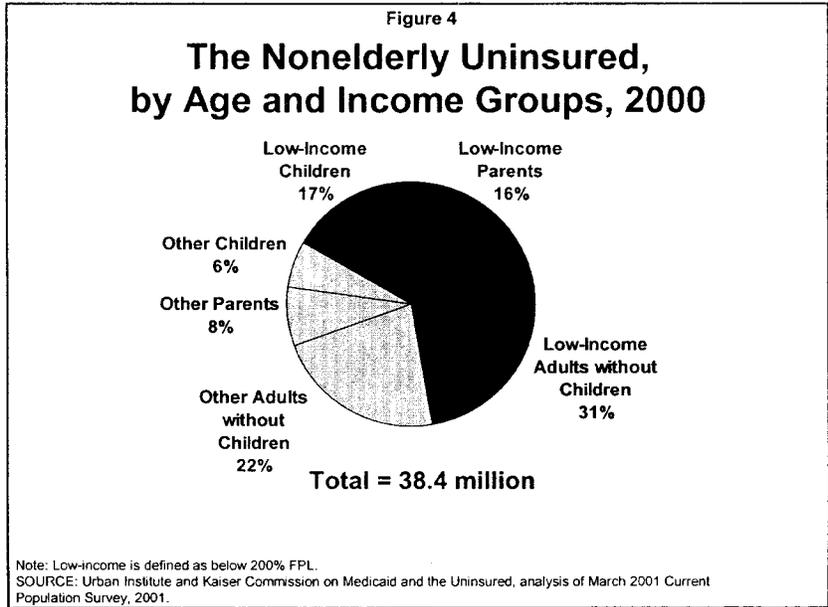
Total = 38.4 million uninsured

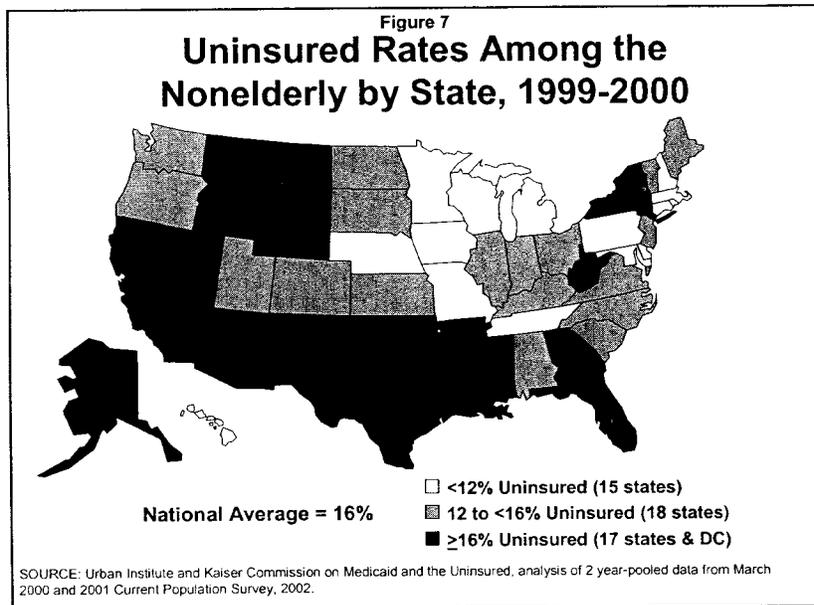
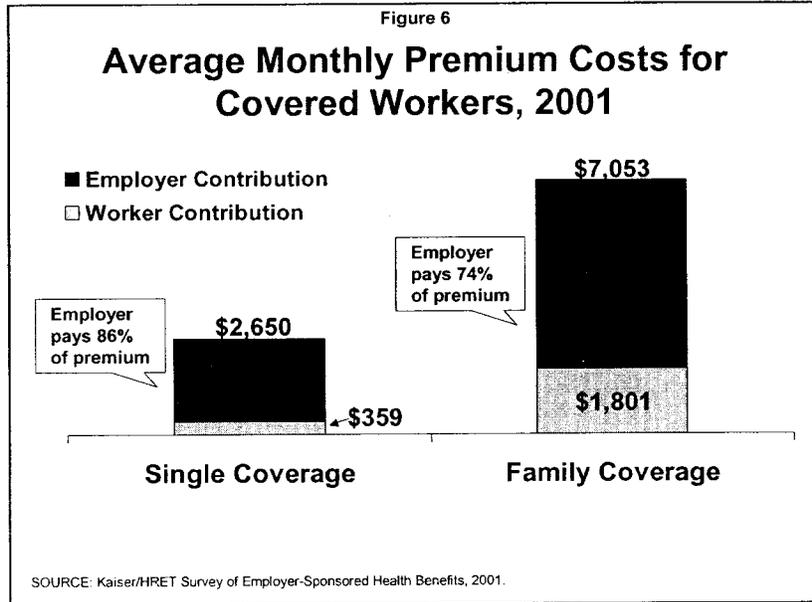
Note: The federal poverty level was \$13,738 for a family of three in 2000.
 SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2001 Current Population Survey, 2001.

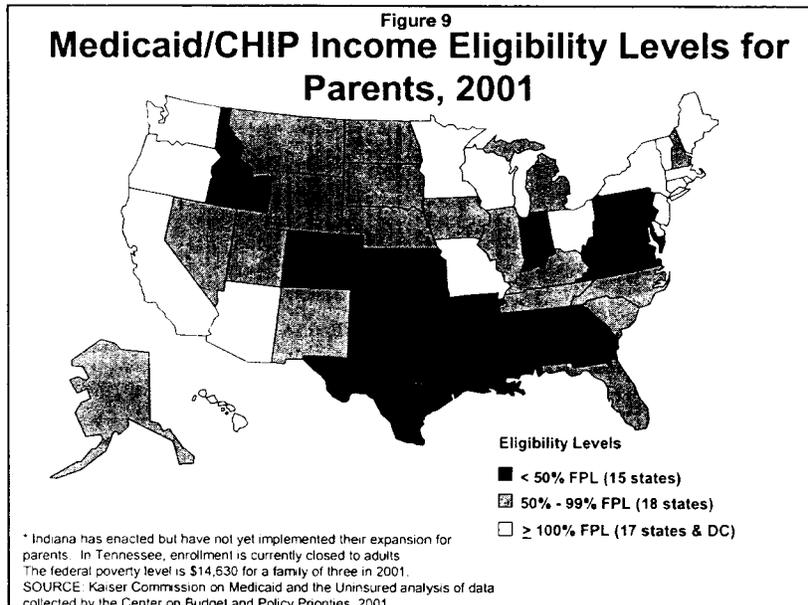
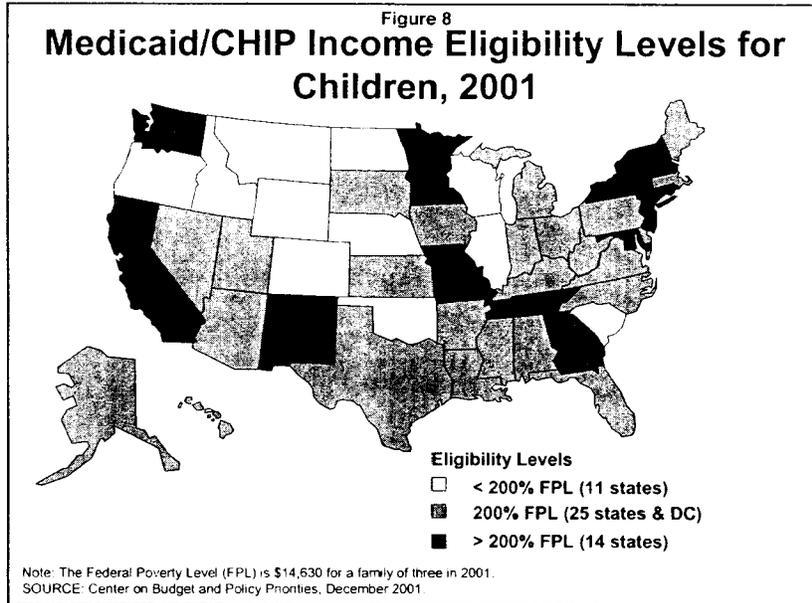
Figure 3
Health Insurance Coverage
by Poverty Level, 2000

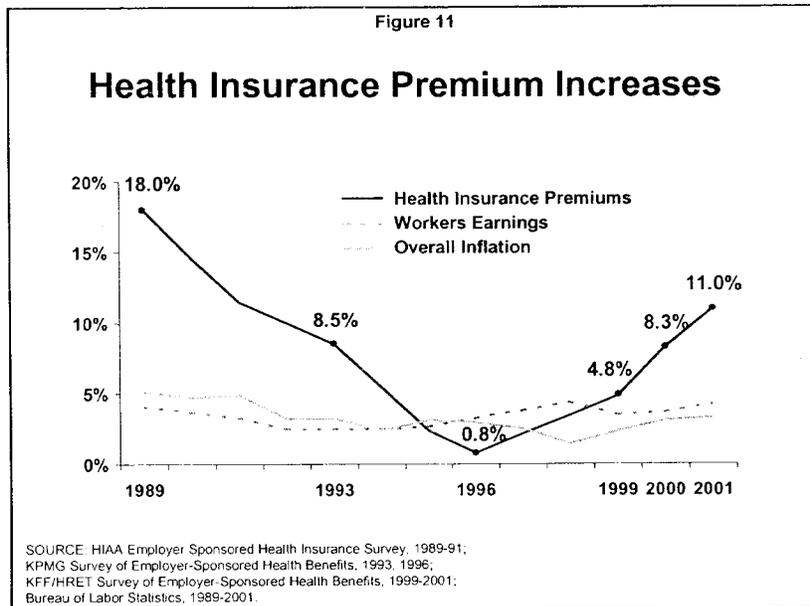
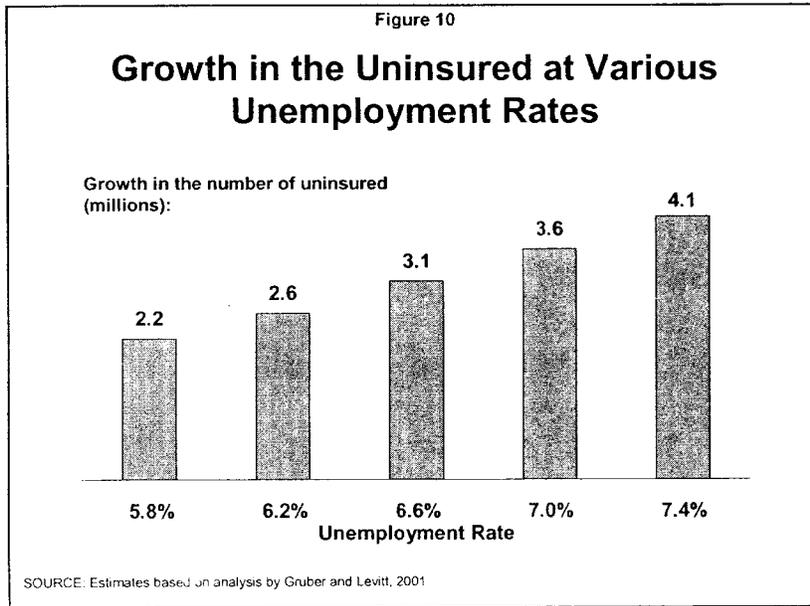


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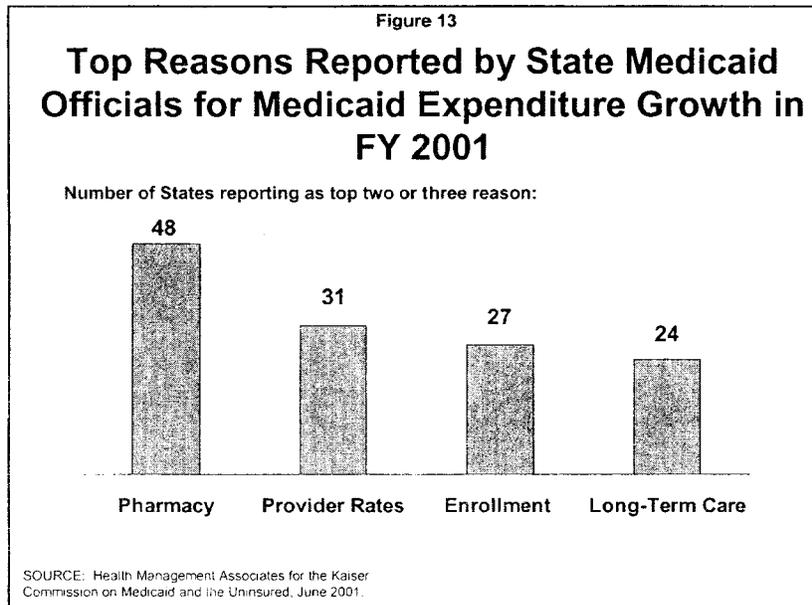
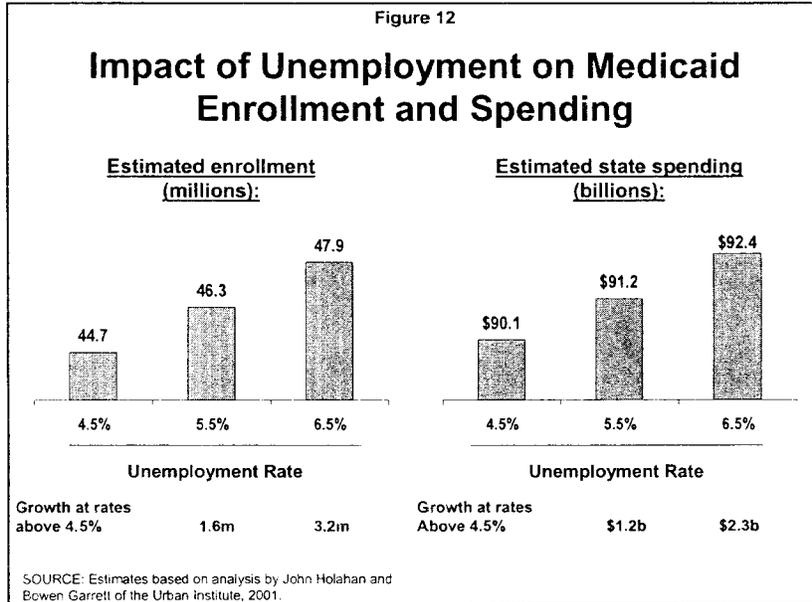


Table 1
Characteristics of the Nonelderly Uninsured, 2000

	Nonelderly Population (millions)	% Distribution of Nonelderly Population	Uninsured (millions)	% Distribution of Uninsured	% Uninsured (Rate)
Total - Nonelderly	242.8	100.0%	38.4	100.0%	15.8%
Age					
Children - Total	76.6	31.6%	9.2	23.9%	12.0%
Adults - Total	166.2	68.4%	29.3	76.1%	17.6%
Adults 19-24	22.8	9.4%	6.6	17.1%	28.9%
Adults 25-34	37.2	15.3%	7.9	20.6%	21.3%
Adults 35-44	44.5	18.3%	6.9	18.0%	15.6%
Adults 45-54	38.0	15.6%	4.6	11.9%	12.0%
Adults 55-64	23.8	9.8%	3.2	8.5%	13.7%
Income (Poverty Level)					
<100%	38.1	15.7%	13.7	35.6%	35.8%
100-199%	41.3	17.0%	10.9	28.3%	26.3%
...100-149%	20.7	8.5%	6.2	16.1%	29.8%
...150-199%	20.6	8.5%	4.7	12.2%	22.8%
200-299%	40.4	16.6%	6.5	16.9%	16.0%
...200-249%	20.9	8.6%	3.9	10.3%	18.9%
...250-299%	19.5	8.0%	2.5	6.6%	13.0%
300%+	122.9	50.6%	7.4	19.3%	6.0%
Family Work Status					
2 Full-time	73.8	30.4%	6.0	15.6%	8.1%
1 Full-time	130.7	53.8%	21.6	56.1%	16.5%
Only Part-time	15.3	6.3%	4.4	11.5%	28.8%
Non-Workers	23.0	9.5%	6.5	16.8%	28.1%
Race/Ethnicity					
White(non-Hispanic)	166.3	68.5%	18.8	48.9%	11.3%
Black(non-Hispanic)	31.9	13.2%	6.3	16.4%	19.7%
Hispanic	31.9	13.1%	10.7	27.9%	33.6%
Asian/S. Pacific Islander	10.3	4.2%	1.9	5.0%	18.7%
Am. Indian/Aleut. Eskimo	2.3	1.0%	0.7	1.8%	29.4%
Citizenship					
U.S. citizen - native	216.1	89.0%	29.1	75.7%	13.5%
U.S. citizen - naturalized	9.0	3.7%	1.8	4.6%	19.8%
Non-U.S. citizen, resident for < 6 years	6.2	2.6%	3.0	7.9%	48.8%
Non-U.S. citizen, resident for 6+ years	11.4	4.7%	4.5	11.8%	39.6%
Health Status					
Excellent/Very Good	170.4	70.2%	23.2	60.3%	13.6%
Good	53.6	22.1%	11.8	30.7%	22.0%
Fair/Poor	18.7	7.7%	3.5	9.0%	18.5%

The 2000 federal poverty level for a family of 3 was \$13,736. Part-time workers were defined as working < 35 hours per week.

Mr. BILIRAKIS. Thank you very much, Dr. Rowland. Well, the Chair recognizes himself. Dr. Kellermann, you state that the combination of strict eligibility requirements and enrollment procedures make public coverage—well, you have given us some staggering facts I might add, but make public coverage difficult to obtain, and even harder to keep.

And then you go on and state that the medium length of time for someone under the age of 65 that keeps Medicaid coverage is about half-a-year, 5 months, 6 months, whatever.

And at the end of any given year, about two-thirds of the people who were insured by Medicaid at the start of the year have lost their coverage for any number of reasons. Those are all staggering facts, and it seems to me that before we can complete our work in terms of whatever it is that we might ultimately decide might be the solution, we are going to have to really look into these facts.

I wonder if you can elaborate a little bit on why all of these things might take place.

Mr. KELLERMANN. Our report gives a fairly detailed breakdown of these issues. I think the theme in my mind is that our system is just incredibly complex, and it is complex in a way that changes and evolves almost in a month to month or year to year basis.

It is as if we have a target that we want people to hit, but we move it whenever we can just to make sure that they miss, whether it is an uninsured family trying to qualify for Medicaid, or it an ER doctor trying to fill out the paperwork properly to get paid for the care they have given.

Or any of the other issues in the system, and regardless of the direction we go in, I think we have to understand that systems have to be simple and understandable if our true goal is to ensure that we get medical care to people who need it.

And complexity alone, independent of financing and other issues, is a tremendous obstacle to getting people insured, and keeping people insured.

Ms. ROWLAND. Mr. Chairman, if I could add that much of the work that the committee has done around children and around improving the retention of children in both Medicaid and CHIP has been an incredible step in the right direction from the studies that Dr. Kellermann was stating.

We now help to keep children enrolled throughout the course of a year, and have tremendously simplified the enrollment, and I think the committee should be quite pleased with the progress that has been made in most States at improving the enrollment process for both Medicaid and CHIP at your direction.

Mr. BILIRAKIS. Are you saying then that we should possibly hitch-hike upon the S-CHIP program as a partial solution?

Ms. ROWLAND. Well, Medicaid has certainly already begun to hitch-hike on the S-CHIP program, in terms of coverage of children, and I think the ground has been laid in many States for really improving the way enrollment is handled and participation is maintained. But we still have a ways to go clearly.

Ms. GREALY. Well, Mr. Chairman, I think there is a way that we could also reduce that complexity for employers and those States that are using this new demonstration authority to leverage those

State dollars and help purchase coverage for the parents, as well as the children, through the employer.

So it is a way that we can leverage the dollars, but the employer certainly could be helped, as well as the beneficiaries of these programs, by making it much less complex for them being able to do that coverage.

Mr. BILIRAKIS. Well, let me—and I would like to get back into that if my time doesn't run out, but let me ask—I am sure that you are all familiar with the President's plan. We don't really have all of the details yet.

He calls it a refundable tax credit approach, and I would like to look at it more as a voucher if you will, or a certificate, or something like that. Maybe not even call it a tax credit quite frankly.

How do you feel—if that were to talk place, how would you feel this might work, and would it work, and to what degree might it work?

Mr. GREALY. I will start. I think the key here is flexibility. That it is something that could be used in a variety of settings. If one is able to find something in the marketplace where those products are available, my guess is that every time we make modifications in the tax code, we see the market develop and respond to those new incentives.

But another approach would be, and as we heard Diane comment, that families are having trouble bridging that premium gap. For low income workers, if they are paying \$1,800 out of their paycheck, that is a big amount.

If we could take that tax credit and allow them to use it to offset their premium costs for that private coverage through their employer, that would be something that would be extremely useful.

So I think again being flexible in using this tax subsidy, voucher, whatever you want to call it, in a variety of ways would really be key here.

Mr. BILIRAKIS. Anyone else in that regard?

Ms. ROWLAND. Clearly, one of the issues with a voucher or a tax credit is where you can utilize that credit. And one of the concerns about a credit that must go into the non-group market is that it is very difficult to purchase reasonable coverage, especially for low income people unless the voucher is tremendously generous.

And so I think the key issue there is what is the generosity of the voucher, and where can you utilize it. What you gain from public coverage is that the State is then responsible for linking you up to coverage, and when you get with a voucher is the individual has to look into where they can it in the market.

Mr. BILIRAKIS. Dr. Kellermann.

Mr. KELLERMANN. I think commenting on a specific policy is beyond the scope of at least the first IOM report. Our second report will look a bit at different features of the impact of uninsurance on people's health.

Two of the major benefits of health insurance are catastrophic coverage in the event that you wrap your car around a phone pole or have a heart attack. The other is encouraging access to preventive care and primary care.

So I think whatever solution we do, I hope will include a mechanism that will encourage people to get medical care early and ap-

propriately so that I will see fewer of those patients in the emergency room with a costly condition.

Mr. BILIRAKIS. All right. My time has expired. Mr. Brown, to inquire.

Mr. BROWN. Thank you, Mr. Chairman. I thank all three of you on the panel. Ms. Rowland, you talked about people in low wage jobs are obviously much less likely to have insurance in your response to the Chairman about the vouchers or tax credits.

We hear talk about insurance, and we hear talk about coverage. Would you make the distinction, Ms. Rowland, on what that means when we all brag about, well, maybe with tax credits we can give insurance to people. What does that really mean in contrast to coverage?

Ms. ROWLAND. Well, I think that really is highlighted by the comment just made by Dr. Kellerman; that what I think of as health insurance coverage is access to primary care, to preventive services, to immunizations, to pre-natal care, as well as coverage for more intensive hospitalization, chemotherapy, and other services.

So it is really assistance at gaining access to the whole range of health care services. What I think about in terms of insurance coverage is that often we end up more looking at kind of covering after the initial primary care is paid for out of pocket.

So I think a policy in which there is a \$1,000 deductible before the policy begins to cover any services is not going to promote the kind of access to primary care and preventive services that we feel are so important, especially for the low income population.

Mr. BROWN. I would like to switch to Medicaid for a moment. Ms. Rowland, you talked about the health insurance flexibility waivers. Proponents suggest that the waivers allow flexibility, more flexibility with respect to cost sharing for optional Medicaid groups.

They also say that proponents also say that they give States flexibility with respect to optional benefits. Would you describe what some of those options are, and what that means, and what some of those optional groups are, and what some of those optional benefits are?

And would you also in this same answer talk about what Utah did, and what Michigan is considering doing?

Ms. ROWLAND. Well, the Medicaid statute obviously has requirements in the Federal statute on what populations and services States must cover. And then it gives States the option to receive Federal matching funds for other groups of individuals and other services.

So the optional groups are those for which Federal matching is available, but there is no Federal statute requiring coverage. Children up to the poverty level are now mandatory covered by Medicaid because Federal statute requires all States to cover them. People who, for example, are medically needy, and have large medical expenses, and spend down to Medicaid coverage, are optional because they are offered at the option of the State.

Or even the parent of a child at 50 percent of poverty is optional because the State is not required to cover parents of Medicaid eligible children. So the concept of optional really depends on whether the State has elected to cover them or not.

Most of them we would consider to still be among the poorest part of our population, and in need of the same kind of services as the mandated populations. The kinds of benefits that are optional include most of the long term care spending for the elderly, for example, under Medicaid.

So when States are looking at these waivers, the dollars that they spend are mostly on optional groups for optional services, but this means for elderly and disabled people getting their long term care services.

And when they look at this waiver, the waiver requires budget neutrality. They can't spend any more money on Medicaid to expand coverage than they would in the absence of the waiver.

So there are going to have to be real tradeoffs within the program of how you stretch benefits for one group of poor people to cover additional groups of low income people. And that is one of the concerns that has come up around the Utah waiver, where people at 50 percent of poverty, who are parents, who are optional groups, earning probably around \$8,000 for a family of three, are being asked to pay up front a \$50 enrollment fee to get coverage, would have a \$100 deductible before they could get hospital care, and would have substantial cost sharing.

And the question is whether that kind of coverage is really going to provide them to the kind of health services that we have previously talked about, and whether that is a good way to finance a minimal expansion of coverage to other populations.

Mr. BROWN. In Michigan?

Ms. ROWLAND. I am not familiar with the Michigan program.

Mr. BROWN. We on this committee a couple of 3 years ago passed the Breast and Cervical Cancer Treatment Act as you remember. We had done the program several years before for the screening.

What does the waiver policy mean for those groups—the disabled and the people that have, say, breast cancer, cervical cancer, low income women—that are eligible for those programs?

What does the waiver policy mean for Medicaid and CHIP beneficiaries there? Well, I think the key in the waiver policy is that no new money is put on the table. So it means that any expansion of services has to take place within the same dollar levels as the State is currently spending.

So you need to reduce benefits for some groups in order to have available dollars to expand coverage to other groups, groups like those being treated for cervical and breast cancer, and the disabled are among the most expensive, because they use the most health services on Medicaid's roles.

That's where the dollars are that you can really try and cut back on in order to finance additional care. So I think what the waivers mean is we will be covering a few new people at the expense of some of the sick and low income people on the program.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentlemen. Mr. Burr to inquire.

Mr. BURR. I thank the Chair and I thank our witnesses today. I just have one question and I will get all three of you to address it. If the Federal Government were to raise the minimum wage, and let's say just for simplicity sake \$1 an hour, what would your

position be if we gave employers the option of providing it in pay or in similar health benefits? Let me start with you, Ms. Rowland.

Ms. ROWLAND. Well, I think raising the minimum wage and giving the employers the choice would do very little to alleviate our uninsured problem, because the minimum wage workers are the ones in which insurance is not offered generally now.

And I think that most workers obviously think that getting health insurance is important, but the minimum wage workers don't have that coverage.

Mr. BURR. Maybe you misunderstood. If an employer chose rather than to pass the \$1 on in a wage increase, and to use that if it were a 40 hour week, \$2,080, in-turn to purchase an insurance policy for that employee or partially for the family under a group negotiated plan, which would for the first time provide insurance coverage to the minimum wage worker, what would your position be?

Should an employer have that option if in fact they chose to do that?

Ms. ROWLAND. Well, I would certainly think employers should be encouraged in every way to offer health insurance coverage, though I still think raising the minimum wage may be a more effective way for low income families to go than getting the health insurance coverage partially supported by their employer.

Mr. BURR. Your belief would be that the individual would take that dollar and would use it for health care?

Ms. ROWLAND. I believe the individual at a minimum wage level would probably take that dollar and use it for living expenses, which could include health care, but might not.

Mr. BURR. But health care would be down the list?

Ms. ROWLAND. Generally, I think for the lowest wage people, there are other demands on their family budget before they get to affording health care.

Mr. BURR. Thank you. Ms. Grealy.

Ms. GREALY. I think anything we can do to help those small employers offer health insurance is a good thing, and if that is an option that would be presented, I think that would be a very positive thing.

Again, I just keep coming back to flexibility. But also sort of referring back to Congressman Brown's comments about the Medicaid program, and how stretched they are, and how they are shifting benefits and dollars around.

How can we best leverage those limited dollars? I think what you are talking about with the minimum wage, what would be the best way to use those dollars. With the Medicaid program, is there some way we can leverage. And what those employers who do offer insurance, or those that would like to offer insurance, and use our limited dollars and add those employer dollars.

Because employers are willing to put a lot of money on the table for health care, and they aren't doing it. So I think any way we can aid them in enhancing that would be a very positive thing.

Mr. BURR. Doctor.

Mr. KELLERMANN. Again, our committee has spoken specifically about policy options. I will tell you as a doctor and as a brother, my brother is living on top of a mountain in East Tennessee.

He is 2 months behind on his mortgage, and he doesn't know how he is going to buy his groceries next week. You ask him if he can make a little extra money on a minimum wage job, and he is going to probably opt for groceries and the mortgage before he opts for insurance. Anything is better than nothing. So I would encourage you and your fellow members to struggle with the issue, but I think we are going to have to really analyze those choices in a very careful way before we lay policies out for folks.

Mr. BURR. Well, let me just add as a commentary for any of us to determine arbitrarily what any individual needs to meet their living expenses really is to guess what their living expenses are.

And if they rent, or they own, or wherever they are. The question that I was really trying to get in is how important is it that we provide a health care benefit, and that we find a mechanism to get coverage to individuals?

And when we talk about a dollar increase or an increase in the minimum wage, there is a real opportunity—it may not be the employee's first choice, and we may all agree that the minimum wage level should be higher than where it is.

But if the objective is to provide coverage, do we have a mechanism through employers, and based upon their group plans, where they negotiate more extensive coverage with less money, and money that we have mandated that they put on the table.

And I think it is something that we all need to think about, because it is a mechanism for some percentage of those individuals out there today that are uninsured, and I have yet to hear a plan where we wipe out the uninsured population in America with one silver bullet.

This will take a number of initiatives, and this may be one of them, and I hope that you will put some thought to it. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Would the gentleman yield?

Mr. BURR. I would be happy to.

Mr. BILIRAKIS. I appreciate that. Are there advantages to covering the uninsured through employer programs, versus the S-CHIP and Medicaid programs, public programs?

Ms. GREALY. Well, I think we have heard several reasons as to why that might be the better approach. Let's look at what the likely benefit package is going to be in an employer-based insurance market.

It probably is going to have those preventive services that Dr. Kellermann feels is so important. And it is probably likely to be more stable. It is something that is going to last for a year, and not something that you have to qualify for every month.

So I think there are definitely advantages, and we also find that as income rises, there is less participation in some of the public programs, whether it be Medicaid, S-CHIPS, SLIMB, QUIMB, or whatever.

So if we are looking at expanding those programs, we might want to take a look at is there some way we can help employers offer medical coverage.

Mr. BILIRAKIS. Dr. Kellermann, do you agree?

Mr. KELLERMANN. Well, one of the complexities that I think we have, particularly when we are dealing with small businesses—and

I come from a small business family—is that the very economic times when folks need health insurance the most is when small businesses are least able to afford it, and have more workers than they have positions to offer.

And so they don't need health insurance as a benefit to attract them. So there is some real—the problem with the system right now is when we need it to work the best, it typically works the poorest. And it is a real challenge for small businesses, as well as for workers.

Mr. BILIRAKIS. But you agree that if that challenge were somehow met that there would be advantages to go that route?

Mr. KELLERMANN. Well, the devil is in the somehow, but I think if we can work together, and there is a feasible way to make it happen, anything we can do to make it—I will take any improvement that we can get on the short term.

On the long term, I think we have to look at a 25 year trend, and realize that we have to understand this very fundamental level, and not making decisions itself is going to create enormous problems.

Mr. BILIRAKIS. Dr. Rowland, very briefly.

Ms. ROWLAND. I think we really need to look at combination strategies, and for the very lowest income population, and especially for those with severe disability who now rely on Medicaid, I think the public program approach is very important and should be maintained.

But obviously as one goes up the income spectrum, one needs to deal more with the employer-based system and try and shore that up. The saddest fact to me is that in the best economy we have had with the lowest health insurance premiums, we made so little progress in getting a higher pick-up rate in the employer-based system.

And I think that really shows that in harder economic times that the lower end of the income spectrum, always public programs will be an important safety net.

Mr. BILIRAKIS. Thank you. Mr. Strickland, to inquire.

Mr. STRICKLAND. Thank you, Mr. Chairman. Ms. Rowland, you made a good point there; in the best of economic times. We went in the wrong direction of having more of our citizens insured; isn't that correct?

Ms. ROWLAND. We did make a little modest progress in the best of economic times in-part because of the expanded public coverage under the S-CHIP program, and along with Medicaid and in-part because there was an increase in employer offerings, and people at the higher incomes did get some health insurance through the employers.

But it was a modest dip in light of a very robust economy and low premiums.

Mr. STRICKLAND. So are you telling me that in terms of raw numbers there were fewer people uninsured 5 years ago than there are now?

Ms. ROWLAND. In 1999 and 2000, we saw the first dip in a decade in the number of uninsured, but it was about a million to 2 million dip.

We are now expecting because of the decline in the economy that the next snapshot that we take will show a rise of maybe 2 or 3 million more uninsured just over the course of this year. Obviously, the Census numbers always lag behind the economic reality of today.

Mr. STRICKLAND. Thank you. Ms. Rowland, one way to measure the success or failure of any policy to cover the uninsured is to look at how it addresses the needs of those with above average health risks, like the disabled and the chronically ill.

And I think that is especially the case when we think of giving someone a voucher to go out and look for insurance. Now, I know the Kaiser Foundation, and in particular the Commission on Medicaid and the Uninsured, has done work on the issue of the disabled and their insurance coverage.

Could you please provide us some background about who the disabled or the chronically ill are, and what their particular health needs may be?

Ms. ROWLAND. Well, the Medicaid disability population is one that generally qualifies for supplemental security income, cash assistance, from the Federal Government, along with having severe enough disabilities to make them permanently and totally disabled.

They include the developmentally disabled, people with mental retardation, children with spinal bifida and other special health care needs, and people with HIV and AIDS.

So the disability population within Medicaid is a very high risk population, one that virtually no private insurer would want to see enter upon their roles.

That population is among the most expensive on the Medicaid program. They consume 80 percent of all the prescription drug spending under Medicaid today, and have very high acute care costs, and very high long term care costs.

In addition, among Medicaid's more disabled populations, they take care of 5 million of low income Medicare beneficiaries who count on Medicaid to provide drugs, long term care, and other issues to supplement Medicare.

So the most expensive, the 73 percent of the dollars spent in Medicaid, go for the disabled and the elderly, as opposed to the children, who make up 51 percent of the beneficiaries, but only about 15 percent of the expenditures.

Mr. STRICKLAND. What success do you think these individuals would have if they were provided with a voucher and asked to go out into the market and find coverage?

Ms. ROWLAND. I don't think they could find any coverage that would be both affordable, and that would also cover the kinds of services that Medicaid covers, because here Medicaid is not an insurance policy.

It is really a coverage policy, providing not only acute care, hospital, and physician services, but rehab services, institutional care for the mentally retarded. And I think that is where we have to be very clear about what the Medicaid program is.

It is not a health insurance program for low income families. It is a complex set of multiple services for the elderly, the disabled, including long term care, mental health services, and other bene-

fits, generally not available through any private health insurance plan.

Mr. STRICKLAND. The disabled community has recently successfully supported Medicaid expansion. For example, the Ticket to Work Act, which Congress passed in 1999, which allows the working disabled to buy into or continue Medicaid coverage as their income increased.

Also, the Family Opportunity Act, which we hope will pass this year, would allow disabled children to receive coverage through Medicaid. Could you talk about why the Medicaid program is so successful in providing coverage for this population?

Ms. ROWLAND. Well, because the Medicaid program has to provide coverage for this population that it does. The employers of these individuals are reluctant to hire them if they think they are going to be adding this disabled person into their employer risk pool, because it will influence the premiums that they as an employer have to pay.

So one of the things that the Ticket to Work Act really does is helps make those individuals employable because their health insurance costs and coverage are still provided by the Medicaid program.

So again that is Medicaid's role as a safety net, compensating and making public or private insurance through the employer not become unduly expensive because of the hire of a severely disabled individual.

Mr. STRICKLAND. So the Medicaid program—and I think this is important for us to understand. The Medicaid program does not discriminate against people on the basis of their illness like the individual market discriminates. Is that a correct statement?

Ms. ROWLAND. No, the Medicaid program is set up to cover the sickest and the illest people in our society who cannot otherwise get coverage elsewhere. You might remember years ago that this committee dealt with a young woman named Katie Beckett, who was hospitalized with a severe respiratory illness, and on a respirator, and unable to be released from the hospital.

Private insurance wouldn't cover her, or let her go home, and her mother successfully argued for Medicaid waivers, where Medicaid now covers such individuals, and allows them to return home.

And one of the success stories of Katie Beckett is that she has now graduated from college instead of living in an institution for her whole life thanks to the kinds of coverage Medicaid gives.

Mr. STRICKLAND. Thank god for Medicaid. Thank you.

Mr. BILIRAKIS. The gentleman's time has expired. The gentleman from Kentucky, Mr. Whitfield, to inquire.

Mr. WHITFIELD. Dr. Kellermann, you had indicated that you were going to have five more studies coming out; is that correct?

Mr. KELLERMANN. Yes, sir.

Mr. WHITFIELD. And will one of those studies go into more detail on options available to expand?

Mr. KELLERMANN. It will. The second report in May is going to deal with the individual health consequences of uninsurance. The third will examine children and families. The fourth—and very important one—is going to look at the effect of large numbers of unin-

sured on ERs, trauma centers, and public institutions that care for everyone.

The fifth report is going to look at how much are we paying, and how are we paying for the uninsured. And the final report will examine what private business, communities, State governments, and the Federal Government are doing that may offer us some insights into effective strategies.

I don't suggest you wait to deal with this problem, but that is the basic sequence the committee has mapped out for its work.

Mr. WHITFIELD. You are the Chairman of the Emergency Medicine Department at Emory University; is that correct?

Mr. KELLERMANN. Yes, sir.

Mr. WHITFIELD. Let me give you a hypothetical. If a person comes into the emergency room at Emory University Hospital, and they have been in a car accident, and they do not have any insurance whatsoever, you treat them; is that correct?

Mr. KELLERMANN. Yes, sir. We treat them both as a matter of ethics, and also as a matter of Federal law. The only health care in America to which every American is legally entitled is care in an emergency department.

Mr. WHITFIELD. Okay. When you finish at the emergency room and if they need hospitalization, what do you do?

Mr. KELLERMANN. We hospitalize them, and we eat that cost, and that has implications for everybody in the country.

Mr. WHITFIELD. And how much was that cost last year? Do you have any idea?

Mr. KELLERMANN. Well, it would be more accurate to say for Grady Hospital, which is Atlanta's only level one trauma center, 60 percent of my patients at Grady are uninsured.

Grady carries tens of millions of dollars in unreimbursed costs every year, and at the same time State and Federal funding are being dwindled every year. So there are issues here not only of access of care for the uninsured, but everyone in the country involved in these sorts of issues.

Mr. WHITFIELD. And obviously those costs raises the costs of health care for everyone, too?

Mr. KELLERMANN. Absolutely. Every time somebody talks about emergency department care being so expensive, they forget that we give out enormous amounts of, quote, free care, although we know it is not free, because we are the only place that people are legally entitled to go to.

And when you have to go to get medical care, we are the one place where we have got to take you in. The problem we have today is that this is a system that everyone takes for granted, and assumes that I can always go to the ER if I have chest pain, or I have a bad headache, or I am injured.

But as hospitals have gotten whittled and whittled, and have cut back on beds, and closed, and cut back on staff, we now have not only in public and teaching hospitals, but private hospitals as well, emergency rooms full of seriously ill and injured patients who can't get upstairs because there are no vacant beds.

Mr. WHITFIELD. Well, I might also add at this point that you are very familiar with Medicaid Dish payments, and of course there is a cap on that right now, and we are trying to raise that cap to

make more money available for those hospitals that are dealing with Medicaid patients.

Mr. KELLERMANN. Yes, sir.

Mr. WHITFIELD. And receiving a disproportionate share of payments.

Mr. KELLERMANN. If that doesn't happen, we could be in a world of hurt.

Mr. WHITFIELD. Right. And as you mentioned, people come to an emergency room—and it doesn't make any difference whether they have been in an accident. Many people come because they have a headache, or they have chest pains, or any number of things, and they will come, because they don't have any other place to go; is that correct?

Mr. KELLERMANN. They don't know where else to go, and they often don't have any where else to go.

Mr. WHITFIELD. Now, all of you are familiar with these community health centers; is that correct?

Mr. KELLERMANN. Yes, sir.

Mr. WHITFIELD. And I noticed that the President is increasing the amount of money for community health centers, which raises the whole question in my mind that most people are saying—which is probably correct, that the only way that you are going to solve this problem is you are going to have to have a fragmented approach.

I mean, you have the public health system, Medicaid, Medicare, and then they say that 80 percent of the uninsured come from working families, or in working families. So obviously anything that we could do to assist employers be able to afford health insurance, or even sole proprietors, would be something worth exploring. But another option would be to simply expand community health centers so they would be available to everyone. Now do any of you advocate that or—

Mr. KELLERMANN. Providing people access to care that can provide preventive and primary care is important, and I know in our report that we observed that currently community health centers only provide access to about 3.5 of the some 39 to 40 million uninsured. So there is a major gap there.

Mr. WHITFIELD. Right. Absolutely.

Ms. GREALY. Mr. Whitfield, I think we definitely want to get insurance coverage for me, but the community health coverage do form an important part of the safety net. And until we can get as most coverage and insurances that we would like to see, I think it is important to have that resource available for people to access.

Mr. WHITFIELD. Right. Now, Dr. Rowland, you had mentioned that Medicaid is not a health insurance program, but the effect is the same isn't it? I provides—I mean, do you feel that the Medicaid Program is adequate?

Ms. ROWLAND. Well, the Medicaid program is more than a health insurance program was really what I was trying to say. That it provides far more than access to basic primary care.

With regard to your community health centers, too, I think that they provide a very important source of access for primary and preventive care, but they really don't help with the hospitalization and some of the follow-up care that Dr. Kellermann mentioned.

And certainly there are lots of rural uninsured people who really have no access to the kind of services that a community health center would provide. So the problem is that they can't be everywhere for a very disparate uninsured population.

Mr. WHITFIELD. Well, we have a community health center in my district, and which is very rural district, and if you had the primary preventive care covered in some way, and then you had insurance for hospitalization, that probably would significantly reduce health insurance I am assuming.

If I may ask one other question. Ms. Grealy, you had mentioned in your testimony something about a program in San Diego, and one in Sacramento, California that they are now looking at as well. Could you elaborate on this little bit?

Ms. GREALY. Well, these are modeled after the FAMIS program and actually the Wayne County, Michigan as well. And the idea here is that we know that there are employers out there that are offering health insurance or their employees.

And we also know that there are other small businesses that would like to do it. And in studying these programs, what we found is that if the employer could get help with about one-third of the premium from some program, whether it be Medicaid, S-CHIP, a local government that is willing to do it, and if the employee could come up with about a third of the premium, then that small business employer could come up with the other third.

And that's what I mean when we talk about how can we leverage these limited dollars in the best way. So we now see under the S-CHIP, and Medicaid waiver demonstration authorities, more and more localities are looking at these programs as a way to work with the employers.

And instead of bringing the parents on to Medicaid, what they are trying to do is bring the whole family into the private employer based coverage.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Green to inquire.

Mr. GREEN. Thank you, Mr. Chairman, and I would like to thank our panel, and even the next panel, because this is such an important hearing on our uninsured. Dr. Rowland and Dr. Kellermann, let me ask my first question.

The Iowa IOM study points out that national immigrants are a small part of the overall population, although it is growing nationally, but in some States like Texas, and my colleague, Ms. Wilson, from New Mexico, mentioned that there are a high number of immigrants. Do you agree with that?

Mr. KELLERMANN. Yes.

Mr. GREEN. These immigrants are likely to work in jobs where they aren't offered or cannot afford the coverage, and as you know, they also don't qualify for the public coverage because the States are banned from covering legal illegal immigrants under the Medicaid and CHIP.

And it seems that lifting this ban and giving the States the option to cover illegal immigrants would be one small, yet helpful, step, and particularly with the States with high immigrant populations. Would you comment on that, on lifting that ban on legal immigrants?

Ms. ROWLAND. Well, certainly that ban has been one of the contributing factors to the very high rates of uninsurance in those States, and also to the problems faced by a large part of the immigrant community.

I think it would be very helpful to lift those bans so that we could provide health care access to them through the Medicaid program, and through the S-CHIP program. It would certainly be a great benefit to the States with the largest immigrant population.

But there is a lot of other States that are now seeing a large growth in the number of immigrants, and they are seeing similar problems.

Mr. GREEN. Dr. Kellermann.

Mr. KELLERMANN. I would encourage all of you if you want to get a window into both the complexities and at times the absurdity of the situation, is when you go back to your district, call up one of your mission critical hospitals, public teaching, or community, and spend a couple of hours in the emergency room and see who comes in, and talk to them.

I know that in Arizona that a colleague of mine has pointed out that with the immigrant population there that they have very limited or no access to care. Their answer is that they go to the emergency room.

And they have Ers in Arizona that are dialysing patients three times a week when they come to the emergency room. They are legally obligated, mandated to do that, with no provision to pay for that care.

So that gets passed on to everyone else. We should not only be worried today about access to care for 40 million Americans. We need to be worried about the fact that the most critical elements of our health care system are collapsing under the strain of the burden of care, and the care for 280 million Americans is being jeopardized.

So we have to be smart, as well as compassionate, and I think anything that can provide care in the most efficient and timely manner for the people that we know are going to end up taking care of anyway is going to make more sense in the long run.

Mr. GREEN. And that is true not just for immigrant populations, and just as you said, the uninsured show up at the emergency rooms, because I have seen it in Houston, and our emergency rooms there, and frankly even for profit hospitals.

Ms. Rowland, in your testimony you said that 2 out of 3 of the non-elderly receive insurance through employer sponsored insurance?

Ms. ROWLAND. Yes.

Mr. GREEN. I keep hearing in the last couple of years a proposal to—there is a goal of eliminating employer-based insurance in our country. It seems by like maybe a small minority, but I hear it on Talk Radio and things like that.

When you have two-thirds of our non-elderly receive insurance through employer-sponsored insurance, is that really rational?

Ms. ROWLAND. Well, I think having two-thirds of our population get coverage through employer-based coverage means if we wanted to address the uninsured that we should not unravel what we have before we find new solutions for those that don't have it.

And which is why I think looking at maintaining and stabilizing the coverage through public programs, as well as trying to shore up what is available in the employer-based system today are important strategies.

Moving people out of employers and refinancing the whole system is going to be extremely disruptive, and I think will both increase the number of uninsured in the process, not decrease it.

Mr. GREEN. Thank you. Both in the testimony of this panel, as well as the next panel, the \$1,000 tax credit is talked about as something that would be beneficial, and I think the goal of my colleagues on at least this side of the aisle was universal coverage, and we realize that we can't get to that.

And so we have to take the good in the system we have, where two-thirds are covered by employers, and take care of that third in the uninsured and immigrant. So we are actually nickel and diming to get to that uniform or universal coverage in different ways.

And so that's why CHIP was created, and that's why we are looking at expanding CHIP, we hope, and so I know that we have a lot of estimates on what the private sector can offer, and I know in the next panel there is—in the testimony there is a cost that is given for an on-line insurance of \$159 per month per person.

And about \$1,900 a year, and Dr. Kellermann, in your testimony you say that it is about \$7,000 a year. And \$1,900 a year for a family plan and yours is about \$7,000, and the next panel will talk about that. Why do we have that disparity?

Is that \$1,900 a \$5,000 deductible or something like that?

Mr. KELLERMANN. I wouldn't know. I would have to ask. I would say show me the policy and what are the terms. How large are the co-payments, and what services am I entitled to receive, to know.

I mean, we can buy very cheap cars or very expensive cars. The devil is in the details. I would have to know what specifically was being offered in that plan to know whether it is value or not.

Mr. KELLERMANN. And I guess what worries me is that we can find a low quote, but it would be a high deductible, and for trying to get the uninsured who are either moderate or poor, they are not going to have \$5,000 or \$10,000 to pay before they even go into a hospital anyway.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. Let me address this panel, and I am not sure anyone has any direct expertise on this, but you probably have opinions on both panels about what I alluded to in my opening statement about what I call the uninsurable, and not just the uninsurable, the high risk.

And I tried to compare it to automobile insurance, and again there is a much different environment there. I don't think there is any way that you could limit your exposure there, and I am still talking about bringing insurance companies in to this type of thing.

And if you write in that State, you have to insure health insurance for this and take your share. But I think the more traditional approach on high risk is the State pool. And I am wondering if any of you had experience with that, and how much the State has.

Because obviously if your pool is high risk, and even if they pay a premium in excess of the normal premium, and if they pay high rates, I can't imagine that would still be sufficient with such a high risk pool to cover, that that would be sufficient money to cover the expenses of the high risk population in that pool.

So I guess the State stands behind it. Does anyone have any experience or is that a loser in terms of huge amounts of money, or is that a reasonable solution to some of this higher uninsured problem, or uninsurable problem. High risk.

Ms. GREALY. I would say it is part of the solution, and I think that is what we have to keep coming back to when we are talking about the \$1,000 tax credit. That may not be the answer for everyone.

But there may well be a segment of the population that does have the income to purchase that type of policy. So, let's put that aside and address your high risk pools. We are hearing from the States that again if they can get some help from the Federal Government, and I believe there is some funding within the President's budget proposal, that that is a mechanism that can address some of the problems.

And that that is probably a better way to go than trying to do the guaranteed issue, which we saw did result in either insurers leaving a particular locality, or resulting in very high insurance premiums.

So you are exactly right. Getting the State and perhaps the Federal Government to some extent to stand behind and fund that risk pool. Again, it is not the solution, but it certainly is part of the solution.

Mr. BRYANT. The insurance companies you find will if forced to do that, they will leave the State?

Ms. GREALY. On the guaranteed issue, yes. You must write a policy for absolutely everyone.

Ms. ROWLAND. There has been some limited experience in some of the States with high risk pools that they haven't been very highly utilized, and have not really emerged as a major strategy.

I think one of the concerns though that you would want to have is whether you are taking all of the high risk people out of the general insurance pool. That would make insurance fairly cheap for everyone else, but it would put tremendous costs in that high risk pool.

And so I would be quite concerned that you would be sort of tiering our health care to where we have the highest and most expensive people in a pool that will be extremely difficult to finance.

Because what helps us finance insurance today is having the sick in the same pool as the healthy to spread the cost over the whole population.

Mr. BRYANT. But my experience though is that some companies aren't going to write those uninsurable high risk people.

Ms. GREALY. That's right. I think you do need a safety valve mechanism to deal there as long as you don't have guaranteed issue.

Mr. BRYANT. Dr. Kellermann, do you have a comment?

Mr. KELLERMANN. I am sure our committee is going to look at that in detail in its final report, but in fairness to the process, I

would rather have my co-chair come back and give you that information once we have had a chance to really go through it in a very methodical way.

Mr. BRYANT. I am intrigued by the issue that was mentioned earlier, and I think it was either Mr. Whitfield or Mr. Green's questioning about the exclusion in Federal law about legal immigrants being treated in the community hospitals.

And so obviously they are all ending up in the emergency rooms, and there is no limitation under COBRA provisions. You have to, no matter who walks in—legal, illegal, whatever—you have to treat that person or be subject to the law?

Mr. KELLERMANN. Yes, sir. We have to treat that person and there is absolutely no mechanism to pay for that care. It is a totally unfunded mandate. Completely.

Ms. GREALY. It is about \$19 billion a year for hospitals at this point in uncompensated care. And that is a very hidden cost, and one that I don't think we focus on enough. Someone is paying for that, and so if we could address and get coverage for a broader population, it certainly would reduced that burden.

Mr. KELLERMANN. The other half of that issue that I am very personally quite concerned about as an emergency physician or as hospitals have cut back on beds, and we have a shortage of nurses, we can't get sick and injured patients, insured or uninsured, out of the ER and up into the hospital.

I held this up a moment earlier. This was an issue of the U.S. News and World Report earlier this fall that is titled, "Crisis In the E.R. Turnaways and Huge Delays are a Sure Fire Receipt for Disaster. What You Can Do." I want to point out that the issue date for this was September 10, and nothing has happened to change this reality with the increasing potential now for mass casualty events.

So as an emergency physician, irrespective of my role in the committee, I am deeply concerned about access to emergency care for everyone in this country, insured or uninsured today.

Mr. BRYANT. Well, I thank the panel and yield back my time.

Mr. BILIRAKIS. And that is the September 10 issue?

Mr. KELLERMANN. Of U.S. News and World Report.

Mr. BILIRAKIS. I just wanted to get that into the record. Mr. Wynn.

Mr. WYNN. Thank you, Mr. Chairman. There is a lot of talk about insurance and standard of care, and my first question is do you believe that Medicaid is the appropriate standard for coverage or care, and that if we talk insurance, we ought to be talking about policies that address that standard of care?

Ms. ROWLAND. I think there are various standards of care. I think what we talked about a little today is that the Medicaid population is in fact a very diverse population, including some very highly disabled individuals, as well as the elderly.

And so the benefit package in Medicaid is very broad to take care of individuals at that level who would not get coverage. But I think the basic protections in Medicaid, and the coverage for the low income populations are in fact a standard that we should hold for looking at further expansions of coverage, or insurance coverage for the low income. Basic benefits and low cost sharing.

Mr. WYNN. Then should we be talking about insurance policies that provide that standard of care as a policy matter?

Ms. ROWLAND. I think we should look at insurance policies to be comprehensive and to promote primary and preventive care, as well as hospitalization and other care.

So I think it is important that we not just provide catastrophic care with high deductibles.

Ms. GREALY. I think it is important that we have a variety of options. Probably a great model to look at is the Federal Employees Health Benefit Plan, where the individual makes the decision about what type of cost sharing that they might want to do.

We have a vast array and variety, and so I think it is hard to say we would want a kind of one size fits all package for any extension.

Mr. WYNN. Well, I was speaking in terms of if we are paying for it, and we are subsidizing it. The Federal Employees Health Benefits Package has been described as a Cadillac of health insurance plans.

I am not sure in the worlds of Mr. Kellermann we can afford the most expensive car. Let me ask another question. On the benefits side, there is a question of whether or not children can get, for example, dental care.

In an insurance package that is being touted as accessible to the uninsured, what are the consequences of that if you are talking about insurance policies that don't provide dental care for young people?

Ms. ROWLAND. Well, certainly under the Medicaid program children, especially those covered mandatorily because of the early periodic screening and diagnosis, and treatment program, or better know as EPSDT, are guaranteed that for anything they are diagnosed for that they should be treated, and which would include dental care.

So that that has been a very comprehensive package for children. So when children talk about the Medicaid benefit package, they are talking about providing any health care service that a child needs, subject to virtually no cost sharing for those under the poverty level.

What I think is harder is when you start looking at the sort of expanding coverage to adults, and at higher income levels what should be in those benefit packages. So that we really need to look at what level can cost sharing be introduced and not be an impediment.

And at what level should some of these additional benefits, like dental care, be included in what is a standard health insurance plan.

Mr. WYNN. Do you have a recommendation?

Ms. ROWLAND. Well, I certainly think for the case of children, especially low income children, dental care has proven to be as important a part of their health care services as basically medical care.

And mental health services, which are often excluded from some of the private health insurance plans, are also a critical part of the benefit package for many of Medicaid.

Mr. WYNN. So if we are designing a program—

Ms. ROWLAND. I think Dr. Kellermann has a comment here, too.

Mr. WYNN. I just wanted to pose this as a question. So we are talking about insuring people in private health insurance, your argument, and don't let me state it for you, but it seems to be that it ought to include dental care. Is that a fair summation of where you are?

Ms. ROWLAND. I think for the low income population, especially dental care, is very important.

Mr. KELLERMANN. And you made the comment about Cadillac care. I would only respond and say that if the car is a beater and you have to spend a lot of money every week to keep it on the road, that's not necessarily a bargain either.

I will never forget a woman I took care of several years ago who came in, a working mother who came in with a massive stroke, and I learned as we were trying to save her life that she had stopped taking her blood pressure medication because she felt that she needed to pay the money to buy food for her kids.

We spent more money in a unsuccessful attempt to save her life in the space of 2 hours in one of the leading academic medical centers in the country than it would have cost to have taken care of her blood pressure and kept her working for the next 25 years. That is no bargain, for her or for us.

Mr. WYNN. Okay. I think that is a good point. This issue of deductibility. Is there a level at which deductibility becomes a problem and where is that?

Ms. ROWLAND. Well, the question there is at what income does the individual start. So that if I am earning \$50,000 a year, for me a \$100 deductible is not probably a problem.

But if I am earning \$15,000 a year, and I have three children to feed, and housing to pay for, a \$100 deductible is really a financial barrier that I would think twice about going to get medical care before I paid for the food or other things for my children.

So I think the issue really is that for someone who is relatively young, and relatively healthy, insurance policies with higher deductibles are probably okay, because they don't assume they are going to get sick.

But we never know when we are going to get sick, and for those at the lowest incomes we don't want people to defer care because they can't afford to access early primary care.

Ms. GREALY. But I think that Diane makes a very important point here, and I think that we need to not look only at the individual, in terms of their income. But if we are looking to expand private coverage, we also need to look at what can the employers do.

And we don't want to put it out of their reach, as well as out of their employee's reach. So I think we really have to be again flexible, and not try to mandate that this is the only way to go, and that is the only way you are going to get the subsidy.

Mr. WYNN. If we are talking about subsidizing employers in order to expand an employer-based program, what would we have to do on an average to enable them to provide care without deductibles being a barrier, and that would include a sufficiently comprehensive benefit package to cover dental care?

Ms. ROWLAND. Well, I think the problem is that you have a lot of employers who don't offer coverage today, and many of them would argue that unless you almost fully subsidize the cost of the insurance premium that they are not going to be able to offer coverage.

And what we know from studies we do of employer coverage, is that the average group payment rate today in the country for a policy for a family is \$7,000 and for an individual, it is \$3,000.

So it is going to cost a lot of money to subsidize employers directly for providing them insurance. And then we get back into what strategy works most effectively. Some partial subsidies to employers, combined with subsidies to individuals, combined with expansions of public programs.

And that is why we are in such a mix of options, because the cost of any one option is substantial.

Mr. WYNN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. It is a question that if we had had a second round, and we are not going to have one, that I wanted to really go into. I would like to excuse this panel, but to first of all ask you if you would be willing—I know that you would be—to respond in writing to questions that the committee staff will send to you.

But I am particularly concerned about the question that Mr. Wynn went into, the fact that—and I believe it was Ms. Grealy that said that 8 out of 10 of the uninsured aren't working families. What can we do.

I mean, it seems like that that is something that we can maybe grab a hold of and it certainly would go a long, long way toward maybe solving the overall problem. So I would love to hear from you all in writing any answers that you may have, and what do you suggest that we might be able to do to try to get to all of those people or a substantial number of them at least covered by their employers.

And so having said that, unless there is anything further, we will excuse you and thank you with much gratitude, as you have helped an awful lot. The Chair now calls the second panel forward.

And they are Ms. Grace Marie Turner, President, of the Galen Institute; Mr. Robert de Posada, President of the Latino Coalition; The Honorable Thomas R. Donnelly, Junior, Board Member, of the Coalition of Affordable Health Care Coverage; Ms. Judy Feder, Dean of Public Policy, Georgetown University; and Mr. Alan Weil, Center Director, Assessing the New federalism, with The Urban Institute.

Thank you, ladies and gentlemen, for your willingness to be here. We apologize for the break that we had to take because of the vote, a very important vote. And again your written statement is a part of the record, and we would hope that what you would do is sort of compliment it if you would, orally. And we will start out with Ms. Turner, President of the Galen Institute. Ms. Turner, please proceed.

STATEMENTS OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE, INC.; ROBERT de POSADA, PRESIDENT, THE LATINO COALITION; HON. THOMAS R. DONNELLY, JR., BOARD MEMBER, COALITION FOR AFFORDABLE HEALTH CARE COVERAGE; JUDITH FEDER, DEAN OF PUBLIC POLICY, GEORGETOWN UNIVERSITY; AND ALAN WEIL, CENTER DIRECTOR, ASSESSING THE NEW FEDERALISM, THE URBAN INSTITUTE

Ms. TURNER. Thank you, Mr. Chairman, and members of the committee for inviting me to testify today. My name is Grace-Marie Turner, and I am President of the Galen Institute, a not-for-profit organization that focuses on health policy.

The problems of the uninsured are serious and a continuing concern to us as they are to this committee as you demonstrate once again in holding this hearing today. Thank you.

I would like to begin with a brief overview of who the uninsured are, and why getting health insurance is so difficult for them. I am encouraged that some new options are being considered to provide help.

As we have heard the uninsured are primarily minorities, especially hispanics, young adults, workers who are not offered or can't afford to buy health insurance at work for themselves or their families, and workers who are between jobs.

The Census Bureau finds that the uninsured are most likely to be in families earning less than \$25,000 a year, to be self-employed, and working in small companies. The likelihood of someone having health insurance is closely tied to income, and to whether or not their job provides health insurance.

Only one-third of those earning under 200 percent of poverty have coverage at work, while three-quarters of those with incomes above that level get insurance through their jobs.

Most of the uninsured make too much to qualify for public programs, and they don't have higher paying jobs that provide coverage. They have fallen through the cracks of the current system.

Several options are being discussed to help them. One is expansion of Medicaid. But State and Medicaid budgets are stressed to the limit, and threatening higher taxes, benefit cuts, or cuts in other programs.

Adding millions to the working Americans to Medicaid roles appears neither politically nor financially feasible in this climate. For example, New Mexico has the highest uninsured rate in the country, yet the State is about \$50 million short in being able to provide coverage next year just for those who are currently on Medicaid.

What about mandates in insurance regulations? Forcing an employer to provide health coverage, especially now, would cause many marginal businesses to lay off workers and even go under.

Insurance regulations also would likely backfire. A recent study by E-Health Insurance shows that States with community rating and guaranteed issue laws had premium prices that were 2 or 3 times higher than States that did not employ these market reforms.

Another option is to provide tangible support through a fundable, sensible tax credits. President Bush has proposed health credits of up to \$1,000 for individuals, \$3,000 for families, and the credits

phaseout, ending in income levels of \$30,000 for individuals and \$60,000 for families.

These credits would likely be targeted to those who are most likely to be uninsured and least likely to have job based coverage. The credits would be refundable so that people would get the same amount of money, no matter how much they owed in taxes.

The President's plan also would be advanceable, meaning that people would get the subsidy up front. The White House estimates that under its proposal that 6 million of the uninsured would get coverage.

The uninsured are getting a bad break from the tax code now, and tax credits would help to level that playing field. Workers can get their health insurance tax free as long as their employer writes the check for the premium.

That means that an executive earning \$100,000 gets a \$2,600 tax break for health insurance at work, while a waiter serving her lunch, and making \$1,500 a year, gets \$79 a year in tax help for the subsidies.

This is clearly a system we would have designed if we were starting from scratch. A study by respected Wharton School economist Mark Pauly says that a refundable tax credit would provide a powerful incentive for the uninsured to purchase coverage.

One of his studies showed that up to two-thirds of the uninsured would buy coverage if they received a subsidy worth just half the value of a good policy. Pauly also found that the individual market is stronger than it is reputed to be.

Achieving universal coverage would require a mosaic of solutions as we have discussed all morning. Tax credits are not the answer for everyone. Older, sicker citizens may find that they still cannot afford or get coverage and safety net programs will continue to be important.

But the fact that credits won't work for some people doesn't seem to me justification for not extending this meaningful help to millions of Americans who would benefit. Others are concerned that tax credits would damage the employment based system by draining younger, healthier, workers from their pool.

However, I would argue that most of those who have coverage at work receive a more generous subsidy than the credits would offer, and they would opt to stay where they are.

The administration estimates that only 15 percent of tax credit users would previously have had employer coverage. Finally, almost any plan you create would have some crowd-out. The question is do you want more people moving into government programs or private health insurance.

In every other sector of the economy, competition forces prices down, and quality up, and the health insurance market would be no different. If you were to provide tax credits for the uninsured or vouchers, the market place would respond by making more affordable, more diverse, more appropriate health insurance available so that people could be deciding what coverage works for them and their families.

That would strengthen the health insurance market place and provide citizens with more coverage and more choices. Most importantly, tax credits tell hard working Americans who are left out of

the current system that they count, too. Thank you for the opportunity to present this testimony, and I would look forward to your questions.

[The prepared statement of Grace-Marie Turner follows:]

PREPARED STATEMENT OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

Introduction

Thank you Mr. Chairman and members of the committee for inviting me to provide testimony today on the important issue of "The Uninsured and Affordable Health Coverage." My name is Grace-Marie Turner, and I am president of the Galen Institute, a not-for-profit research and educational organization that focuses on health policy.

The problems of the uninsured are of serious and continuing concern to this committee, and I commend you for holding this hearing to keep the spotlight on the importance of action to address the needs of a population that is as large as it is diverse. I am encouraged that some new options are being considered to provide them with help and look forward to discussing them with you today.

In my testimony today, I would like to present a very brief overview of who the uninsured are and explain some of the key reasons that obtaining health insurance is so difficult for them. I will briefly explore several of the options under consideration to extend health coverage to the uninsured. And finally, I will describe why I believe that providing refundable tax credits for the uninsured is the best solution to extend meaningful, viable help to millions of uninsured Americans.

Who are the uninsured?

More than 38 million Americans were uninsured at the last official count, but the number surely has risen during the current recession. While the numbers change, the profile of the uninsured remains quite constant.

The uninsured are primarily: 1) minorities, especially Hispanics; 2) lower and lower-middle income Americans; 3) young adults between ages 18 and 24; 4) workers or dependents of workers who are not offered or cannot afford to purchase health insurance through the workplace; and 5) workers who are between jobs.

The Census Bureau finds that the uninsured are most likely to be in families with annual incomes of less than \$25,000, to be self-employed or employees of small companies, and/or to work in service-industry jobs, such as hotels and retail stores.

The Commonwealth Fund, a respected health coverage research organization, conducted a survey between April 27 and July 29, 2001, and confirmed that family income is one of the strongest predictors of being uninsured.¹ The Commonwealth Fund 2001 Health Insurance Survey found that 75 percent of the uninsured had annual incomes below \$35,000, while only two percent had incomes of \$60,000 or more.

The likelihood of someone having health insurance is closely tied not only to higher income but also to whether the worker's job provides health insurance. Only 36 percent of those under age 65 with incomes below 200 percent of the federal poverty level have employment-based insurance coverage, while 77 percent of those above do.²

The uninsured are overwhelmingly working Americans. The Kaiser Commission reported that more than 80 percent of those who are uninsured either are working themselves or live in families headed by a person in the workforce,³ a finding confirmed by Paul Fronstin of the Employee Benefit Research Institute.

More than half (52%) of employees working in firms with fewer than 100 workers and with earnings of under \$20,000 were not offered or were ineligible for employer-sponsored health plans.⁴

Small businesses with fewer than 50 workers account for 94.7 percent of businesses in the United States and employ more than 40 percent of the workforce.⁵ Forty percent of these small businesses do not offer health insurance coverage to

¹ Lisa Duchon, et al. *Security Matters: How Instability in Health Insurance Puts U.S. Workers At Risk*. Findings from the Commonwealth Fund 2001 Health Insurance Survey. New York. December, 2001.

² White House Council of Economic Advisors. *Health Insurance Tax Credits*. February 14, 2002.

³ Kaiser Commission on Medicaid and the Uninsured. *Health Insurance Coverage in America. 1999 Data Update*. Washington, D.C., December, 2000.

⁴ Lisa Duchon, et al. *Listening to Workers*. Findings from Commonwealth Fund 1999 National Survey of Workers' Health Insurance. New York, January, 2000.

⁵ U.S. Bureau of the Census. *1998 County Business Pattern Data*, Table 2.

their workers.⁶ A key reason is the high cost of health insurance and the fact that small firms lack the advantages of large companies in designing and purchasing affordable health care packages.

One-quarter of uninsured workers are self-employed.⁷ While Congress has enacted legislation that will provide full tax deductibility of health insurance for the self-employed as of next year, a tax deduction is worth only as much as the individual's tax bracket. If someone is in the 15 percent tax bracket, even full deductibility means just a 15 percent reduction in price. For many, this is simply not enough of a price break for them to afford coverage.

Minorities are also disproportionately likely to be uninsured. Hispanics are more likely to be employed in blue collar jobs which are much less likely to provide health insurance coverage, but whatever their income, Hispanics are less likely to be offered job-based health coverage than non-Hispanic whites.⁸

Profiles of the uninsured

For most of those who are uninsured, obtaining health insurance through the traditional channel of the workplace is not an option. For example:

1) An Hispanic woman who works two jobs to feed and house her family is likely to fall through the cracks of the U.S. "system" of health coverage. She makes too much to qualify for Medicaid, is not offered health insurance through either of her jobs, and cannot afford to purchase health insurance on her own and still meet her other responsibilities to pay for housing, clothing, transportation, and food for her children.

2) Lower and lower-middle income adults, such as a cab driver making \$25,000 a year, are unlikely to qualify for any public or private health insurance. The cab driver is often much more worried about a major car accident or family illness that not only would destroy his livelihood but also his finances to pay for medical care. But he cannot afford to purchase insurance for himself or his family and still meet his other obligations.

3) College students and young adults working at their first job often do not place health insurance as a top financial priority and often go without.

4) A man working as a mechanic at an automobile garage or a waiter at a restaurant is unlikely to be offered health insurance through his job. The owners of the business are so busy trying to run the business and keep it afloat that organizing and paying for health insurance are too difficult and expensive. As a result, as much as the owners may want to provide health insurance, they simply can't afford it.

5) Finally, a worker who has lost his job generally loses health coverage in the process. A federal program instituted as part COBRA (Consolidated Omnibus Budget Reconciliation Act) allows workers who have left their job-based coverage to continue their insurance by paying 102% of the premium. This coverage is generally very expensive, and only 19% of eligible employees continue COBRA coverage.⁹ While the workers may get another job in a few months, the four or five months between jobs also means that he and his family likely will have no health insurance during that time.

What is life like for the uninsured?

The uninsured are more likely to wait to get the medical care they need, putting off tests and treatment until illnesses are at more advanced stages. They are more likely to face difficulties in paying for the care they do get. And they live in constant fear that they or their children will have an illness or accident and that the family will not be able to afford needed medical care.¹⁰

Unfortunately, those who do not get their health insurance through the workplace or who do not qualify for government programs have few options in obtaining coverage. Either they purchase health insurance on their own, most often with after tax dollars that make the policy even more expensive, or they take the risk of going without.

⁶Larry Levitt et al., *Employer Health Benefits: 1999 Annual Survey*, Henry J. Kaiser Family Foundation and Health Research and Educational Trust, 1999.

⁷Duchon, et al. *Listening to Workers*. The Commonwealth Fund.

⁸Claudia Schur and Jacob Feldman, *Running in Place: How job characteristics, immigrant status, and family structure keep Hispanics Uninsured*, The Commonwealth Fund. May 2001.

⁹Becca Mader. "Few ex-employees choose COBRA: But those who do are heavy users, study finds." *The Business Journal*, November 2, 2001.

¹⁰Connecticut Department of Public Health, Office of Policy, Planning, and Evaluation, Looking toward 2000: *State Health Assessment*, available at http://www.state.ct.us/dph/OPPE/sha99/uninsured_and_underinsured_popul.htm

One of the leading causes of bankruptcies in the United States is medical bills.¹¹ Being without health insurance is not only a problem for 38 million Americans and counting, but also for society as a whole. Those who do not have predictable access to medical treatment often wait until an illness becomes acute before seeking treatment. Not only is the cost of treatment then generally higher, but also at least part of the cost is more likely to be borne by the taxpayer through any of the various channels hospitals and doctors are compensated and through higher premiums for those with private insurance. Most importantly, the person may suffer long-term consequences of going without needed medical treatment.

Economic pressures on these families and on society would be reduced if the uninsured were protected by providing options for them to obtain affordable health coverage.

Medicaid expansion, more regulation, or employer mandates?

Several options are being discussed:

Public program expansion: Many policy makers are recommending expanding coverage to the uninsured through Medicaid and S-CHIP. But the costs of public programs, especially Medicaid, already are consuming up to a third of state government budgets, threatening higher taxes, benefit cuts, or reduced spending on other state programs.¹² State Medicaid budgets are stressed to the limit, and adding millions of working Americans to their rolls appears neither politically nor financially feasible.

For example, New Mexico has the highest uninsured rate in the country, yet the state is \$50 billion short in being able to finance Medicaid for current recipients in the upcoming fiscal year.

The nation's governors were in Washington just this week pleading with Washington to help them with their skyrocketing Medicaid expenses.

Expanding Medicaid to millions more working Americans would mean restricting care to those currently on the program, especially the poor and elderly, or further reducing payments to providers. Already, the program pays doctors so little that many physicians say they lose money when they treat Medicaid patients.

Low Medicaid payment rates in many states already are compromising access to care for those who have Medicaid coverage. For example, the California HealthCare Foundation, an independent philanthropic organization, surveyed almost 1,700 physicians in the state's largest urban counties, and found that only 55 percent of primary-care physicians said they treated Medi-Cal—California Medicaid—patients.¹³

Medicaid recipients often wind up waiting in long lines in hospital emergency rooms to receive even routine care. This drives up costs of this entitlement program even higher.

Employer mandate: Many small employers want very much to provide health insurance for their employees, but they are especially vulnerable to the rising cost of health insurance. Nationwide, more than 200,000 Americans lose their coverage every time the cost of health insurance rises by one percent, according to the Congressional Budget Office. It is almost always small businesses operating closest to the margin that are forced out of the market first. Forcing employers to offer insurance is not a viable option for many marginal businesses that are struggling just to survive, much less to provide health insurance with costs rising at double-digit rates.

Insurance regulations: Evidence has shown that trying to force employers or health insurers to provide coverage through mandates and regulation creates a series of unintended consequences. In 1998, the Galen Institute produced a study based upon GAO studies that highlighted this problem. Our results showed that 16 states that had been most aggressive in regulating their health insurance markets through guaranteed issue, community rating, and other directives, had uninsured rates that rose eight times faster than the 34 states that were less regulatory.¹⁴

A very recent study by the on-line health insurance brokerage, e-HealthInsurance, showed also that states that employ community rating and guaranteed issue had premium prices that were two or three times higher than states that did not employ

¹¹ Ian Domowitz and Robert Sartain. *Determinants of the Consumer Bankruptcy Decision*. National Bureau of Economic Research. 1997.

¹² Vernon Smith, and Eileen Ellis, *Medicaid Budgets Under Stress: Survey Findings for State Fiscal Years 2000, 2001, and 2002*. Kaiser Commission on Medicaid and the Uninsured. October 2001.

¹³ Tony Fong, "Nearly half of physicians shun Medi-Cal," *San Diego Union-Tribune*, February 15, 2002.

¹⁴ Melinda Schriver and Grace-Marie Arnett. *Uninsured Rates Rise Dramatically in States With Strictest Health Insurance Regulations*. The Heritage Foundation. 1998.

this type of insurance market “reform.”¹⁵ While there are likely other factors involved, the average single monthly premium in New York, for example, is \$266. California, which does not employ community rating and guarantee issue, has an average monthly premium of \$143.¹⁶

Another option: Equalize the subsidies

Another policy option is to provide the uninsured with tangible financial support through refundable, advanceable tax credits to help them purchase private health insurance.

The U.S. tax code provides a generous tax benefit to workers if their employer purchases health coverage for them. This system of protecting job-based health coverage from taxation has provided a powerful incentive for workers to get their health coverage at work. But the tax benefits are skewed to favor higher-income individuals and to provide much less help to those with lower incomes. Millions of workers simply are being left behind by this system. Tax credits would provide meaningful help to millions of uninsured families to obtain coverage.

The employment-based system in the United States that serves approximately 175 million workers, dependents, and retirees is not an option for many uninsured workers. Providing tax credits would be a small step to begin to give them subsidies much like those who have job-based coverage so they can obtain their own health insurance.

President Bush has proposed a set of incentives for the uninsured with “health credits” of up to \$1,000 for individuals and \$3,000 for families. He proposes phasing out the credits on a sliding income scale, with subsidies ending at \$30,000 for individuals and \$60,000 for families.

This system of tax credits would be targeted to those who are most likely to be uninsured and least likely to have the option of employment-based health insurance.

The Council of Economic Advisers’ February 14, 2002, white paper on Health Insurance Credits provides additional details on how the administration’s credit would be structured and administered and the anticipated market response.

The idea of providing health credits has tri-partisan backing with bills introduced by House Majority Leader Dick Armey (R-TX) and Ways and Means Chairman Bill Thomas (R-CA), and in the Senate by Sen. John Breaux (D-LA), Sen. James Jeffords (I-VT), and Sen. Bill Frist (R-TN), among others.

Under virtually all of the proposals, the credits would be refundable if taxpayers owed few or no taxes. Many, including the president’s, would also provide “advanceable” tax credits—meaning people wouldn’t have to wait until they file their taxes to get the subsidy.

How the current tax preference works

The main reason that health insurance is so tightly tied to the workplace in the United States is the highly favorable tax treatment it receives. The system of providing health insurance through the workplace in the United States dates to early in the 20th century.

The tax benefit to workers is provided in the form of a tax exclusion. That means that the full value of the health insurance policy is “excluded” from the worker’s income before federal, state, and payroll taxes are calculated. As a result, the value of the health insurance policy and the generous tax break for health insurance are invisible to the employee.

What workers often don’t realize is that their health insurance actually is part of their full compensation package—a form of non-cash (and non-taxable) wages. The tax code explicitly allows the non-wage income they receive in the form of health insurance to be free from taxation.

But workers may receive this tax-favored benefit only if their employers write the checks for the premiums. Because of this invisible tax benefit, the value of the health insurance policy, the tax benefit employees receive, and the cost in forgone wages are largely invisible to workers.

In 1999, tax subsidies for job-based health insurance were worth \$130 billion.¹⁷ But it is a very regressive subsidy, favoring the rich over the poor. A taxpayer earn-

¹⁵ Statement of Vip Patel, Founder and Chairman, eHealthinsurance, Inc., Sunnyvale, California. Testimony before the House Committee on Ways and Means Hearing on Health Care Tax Credits to Decrease the Number of Uninsured. February 13, 2002.

¹⁶ eHealthInsurance, Inc. *The Cost and Benefits of Individual Health Insurance Plans*. January 2002.

¹⁷ John Sheils, Paul Hogan, Randall Haught. *Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy*. National Coalition on Health Care 1999.

ing \$100,000 a year or more gets an annual subsidy worth \$2,638 while one earning \$15,000 gets only \$79 a year in assistance toward the purchase of health insurance.

What that means is that the executive with a high-paying job gets a generous tax subsidy for health insurance from the taxpayer while the waiter serving her lunch gets little or no help in purchasing health insurance.

Clearly, this is not a system we would have designed if we were starting from scratch. Instead, it has evolved as a relic of World War II wage and price controls.

An increasingly mobile society

In our increasingly mobile society, millions of Americans are constantly moving from one job to another and, for the fortunate ones, from one job-based health plan to another. But this job mobility is another reason that so many people lose their health insurance when they lose or change jobs.

According to the U.S. Bureau of Labor Statistics, 13 million workers change their employment status in a typical month.¹⁸ On average, that means 13 million Americans leave home or school to enter the labor force, exit the labor force without looking for new work, find new work after a spell of unemployment or search for work after they quit or are dismissed or laid off—every month.

Tax credits would provide these workers with more stability by giving them subsidies for health insurance that they could keep.

The impact

Wharton economist Mark Pauly, et al, (2001) find that a refundable tax credit would provide a powerful incentive for the uninsured to purchase health coverage. One study showed that 48 to 66 percent of the uninsured would buy coverage if they received a subsidy worth half of the value of the policy. And the uptake rate increases as the subsidy rises: 74 percent of the uninsured would buy a policy if they received a credit worth 75 percent of the premium cost.¹⁹

Pauly, et al, also have studied the market for individual health insurance. They found that the individual market “appears to be improving, in both administrative costs and protection against high premiums associated with high risk.”²⁰

Validating their research, eHealthInsurance, the on-line health insurance brokerage, recently pulled a sample of 20,000 individual policies sold from its database of customers. The company found that the average individual policy cost \$159 a month and the average premium for individual and family policies purchased through the company ranged from \$1,200 to \$1,900 a year per person. Eighty-seven percent of policies purchased by individuals can be considered “comprehensive.”²¹

The Health Policy Consensus Group, composed of experts from many market-based think tanks and academic institutions, developed a vision statement explaining why we believe that tax credits would be beneficial.²² Here are some highlights of the statement:

Every American should be able to obtain needed medical care. Reforming the tax treatment of health insurance is central to achieving this goal.

Congress could begin by providing a new set of incentives for people who do not have health insurance. These incentives should be properly structured to create an opportunity to purchase coverage in an open and competitive market.

We recommend providing credits or other comparable fixed incentives, explicitly determined by legislation, to assist people in obtaining private health insurance.

The size of the incentives will depend on how much taxpayer money lawmakers deem to be available. It can be structured in different ways.

Options

Credits or other fixed incentives could be used to purchase private group or individual health coverage. If credits are provided, they could be refundable.

The size of the credit or alternate financial incentive could be adjusted to reflect risk or need, or it could be used to buy into a high-risk pool. These adjustments should be made while minimizing their effect on marginal tax rates.

¹⁸Michael M. Weinstein, “Economic Scene: Cream in Labor Market’s Churn.” *The New York Times*, July 22, 1999.

¹⁹Mark Pauly, and Bradley Herring. “Expanding Coverage Via Tax Credits: Trade-offs and Outcomes,” *Health Affairs*, Jan-Feb, 2001.

²⁰Mark Pauly, Allison Percy, and Bradley Herring. “Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons,” *Health Affairs*, Nov/Dec, 1999.

²¹Statement of Vip Patel in testimony before the House Committee on Ways and Means. February 13, 2002.

²²The Health Policy Consensus Group. *A Vision for Consumer-Driven Health Care Reform*. The Galen Institute 1999.

To expand access to coverage, states could relax mandated benefit laws for insurance purchased with federal assistance, thus allowing a broader range of more affordable insurance products.

Benefits of this approach

Millions of Americans not eligible for the current tax subsidy would receive help in purchasing health insurance.

Assistance can be targeted to those who do not have health insurance.

It can be targeted to those in specific age, income, or other categories which legislators deem most worthy of the assistance.

It gives individuals more choice as to where they obtain health insurance.

It allows individuals the opportunity to select the kind of health coverage that best suits their needs.

It helps to minimize distortions in the marketplace.

It is more equitable across income groups.

It is available whether an individual's insurance is organized through employment-based groups or elsewhere. The role of employers in assisting employees to obtain health insurance could be maintained by each employer, if the company so desired.²³

Application and benefits

Tax credits for the purchase of private health insurance would provide today's uninsured workers and their families with financial help in purchasing coverage to begin to equalize the subsidies that employees with job-based insurance receive.

Some have proposed only allowing the credits to be used for job-based coverage. But for too many of the uninsured, this would continue to shut them out of the system. Allowing the credit to be used only for job-based insurance would mean that it would be of little or no use to an estimated 20 million Americans for whom job based coverage is simply not an option.

If the tax credit approach is to be successful, it is imperative that those eligible be allowed to use the credits to purchase insurance outside the workplace—such as through church groups, professional or trade associations, labor unions, or other groups that citizens trust to negotiate in their best interest.

Offering tax credits to the uninsured is an important solution for many reasons.

First, by giving people tax credits, they can choose the health plan that best suits their needs and the needs of their families.

Second, tax credits are portable. Because the subsidies for health insurance are not tied to the workplace, people can keep their health insurance even if they lose their jobs or don't have the option of job-based coverage.

Third, this army of newly empowered consumers will inject renewed energy into the fragile market for privately purchased health insurance. This market has been suffocated by state insurance regulations and mandates that have made individual and small group health insurance policies prohibitively expensive in many states and have driven many insurers out of the market. Tax credits would improve the market for private health insurance by giving consumers and insurers an incentive to strengthen the market for private health insurance.

Fourth, the cost of the insurance would be visible, and consumers would be more motivated to shop for the best coverage for the money, reversing the current trend for workers with job-based coverage to demand more and more insurance coverage because the full cost of the policy and the services they consume is hidden from them.

But most importantly, tax credits tell these hardworking Americans who are left out of the current system that they count, too.

A step in the right direction

As this committee, this Congress, and this country have learned, achieving universal coverage will require a mosaic of solutions. Tax credits for the uninsured will create a new system of subsidies that would be the best way, I believe, to reach millions of people who are falling through the cracks of the current system. But they are not an answer for everyone. Older, sicker citizens may find that they still cannot afford or get coverage, even with the credits, and safety net programs will continue to be an important part of the solution.

But the fact that credits will not work for some people does not seem to me to be justification for not extending this meaningful help to millions of Americans who would benefit.

²³ For further information, see *Empowering Health Care Consumers through Tax Reform*, Grace-Marie Arnett, ed, University of Michigan Press, 1999.

Others are concerned that tax credits would damage the employment-based system by draining younger, healthier workers from their pools. However, I would argue that most of those who have employment-based coverage receive a more generous subsidy than the credit, and they would opt to stay where they are. Also, many employers who offer health insurance feel strongly their obligation to their employees and would find ways to encourage them to stay with the company plan. And if many of the newly insured purchasing coverage with the tax credit are indeed healthier, their expenses are likely to be lower, and they will help reduce premiums for everyone in the pool.

Finally, the health insurance market is showing its ability to respond to changing demands by creating new options, like eHealthInsurance, for the uninsured to obtain affordable coverage on their own. If billions of dollars in subsidies were available to millions more workers, the market would be transformed to provide many more options than are available today.

In every other sector of the economy, competition forces prices down and quality up, and health insurance is no different.²⁴ If the federal government were to provide tax credits for the uninsured, the marketplace would respond by making more affordable, more diverse, more appropriate health insurance available. That would strengthen the health insurance market and would provide citizens with more choices for coverage. If state governments were to provide complementary tax incentives, they could expand health coverage to even more uninsured citizens.

Refundable tax credits would encourage the marketplace to be more responsive to their demands. Further, it takes an important step toward a system that provides health coverage for all and which still provides the freedom for the health care industry to innovate so it can continue to provide the world's best medical care.

Thank you for the opportunity to present this testimony. I would be happy to answer any questions you may have and to provide additional information.

Mr. BILIRAKIS. Thank you very much, Ms. Turner. Let's see. Mr. Robert de Posada, President of the Latino Coalition.

Mr. Posada, please proceed.

STATEMENT OF ROBERT DE POSADA

Mr. POSADA. Thank you, Mr. Chairman, and thank you, Mr. Brown, and members of the committee, my name is Robert de Posada, and I am the President of the Latino Coalition, which was created in 1995 to address those issues that directly affect the well-being of hispanics in the U.S.

Some of our members include the Inner-American College of Physicians and Surgeons, and the Hispanic Business Roundtable, among others. When it comes to health insurance according to the U.S. Census Bureau, the highest uninsured rate in the U.S. is among people of hispanic origin.

Over one-third of hispanics were uninsured, compared to only 12 percent for non-hispanic whites. Foreign born immigrants are even worse, with more than half without health insurance.

The main reason why so many hispanics do not have health insurance is that generally they have lower incomes and they work for smaller firms than in the service industry. Employment and income levels are the leading indicators of health insurance coverage in this country, and the lower the income, the more likely that the worker will not have coverage.

We have held health care conferences all around the country to try to figure out what can we do to address this crisis, and we have come to the conclusion that no one has all the answers like everybody has said here.

²⁴ Hixson, Jesse. *Six-Questions Everyone Should Ask about Health System Reform: An Application of Basic Economics*, Galen Institute, March, 2002.

It will take several different ideas, which together if enacted, will help address this crisis. However, we strongly believe that we must focus our resources on the working poor. We call them the too poor, but not poor enough; too poor to afford health insurance, yet not poor enough to qualify for Medicaid.

And these are predominantly low income workers who do not have access to health insurance through their employer. That's why we strongly believe that the most important issue that this Congress can take at this session is to pass a refundable tax credit to help workers who do not get insurance from their jobs.

And adding additional provisions to help reduce prices and promote a real outreach to undeserved communities. But as Mark Twain said, get your facts first, and then you can distort them as you please.

Instead of trying to make good ideas even better, opponents of a refundable tax credit will just say about anything to shoot this idea down. The fact is that in most of the concerns addressed by these opponents are already addressed by the leading tax credit legislation sponsored by Congressman Arney and Congressman Lipinski.

For instance, tightened policies won't reach low income workers. Most hispanic groups in this country or around the country, including the League of United Latin Americans, have come to the conclusion that the past expansions of Medicaid and CHIP did little to reduce the number of uninsured hispanics.

The fact is that these programs have failed to reach the undeserved and uninsured in our communities. Even during boon economic times there has been no real incentive for State workers to go out to these undeserved communities to expand these programs.

And we know because we have been there at the State level fighting these cuts in services to Medicaid even during this boon economic period. We believe the tax credit will help address the situation because with a well crafted refundable tax credit, most insurance companies will develop special products to reach out to these new markets as potentially new clients.

Also, something like the Shadegg-Lipinski bill from last year, which established individual membership associations, would allow community-based groups, churches, and other associations to offer mandates of free health insurance coverage to their friends and members.

And having community-based organizations and churches directly involved in the outreach process will be the most effective way to reach out to low income and undeserved families.

Tax credits offer too few dollars. Well, a quick surge into some of the health insurance costs in the District of some of the members here today shows that people can find health insurance for a married couple with two children for less than the amount available in the tax credit.

Let me give you an example. In Leery, Ohio, for \$1,800, you can get a PPO with a \$1,000 deductible. In L.A., for \$2,600, you can get a PPO with a \$500 deductible.

In Springdale, Maryland, for \$2,300, with a \$1,000 deductible, and the list goes on for insurance available for the amount of the

credit. To go even further, the individual members of the association would help low income workers pull together and get mandate free insurance at much lower prices.

And next these employers will decide to drop their coverage offering. Well, in our conversation with small business owners from across the country, we do not expect this massive drop out.

However, we do believe that any kind of tax credit legislation should include provisions to make sure that this doesn't happen. There has been talk about including provisions that employers who drop health insurance for their employees will lose their health insurance deduction retroactively to the date that the tax credit becomes available, and maybe this is the answer.

I believe that a well-crafted bill that is refundable will be a great boost to addressing this crisis. There is not a single magic bullet that will solve this crisis. It will take several different approaches, and we hope that rather than shooting down ideas, we can work together to implement tax credits, strengthen access to Medicaid and CHIP, promote pooling among individuals and associations, expand our community health centers, and make sure that we encourage more businesses to offer health insurance for their workers.

We are ready to help this committee achieving these goals and thank you very much for inviting me here again and for your commitment to this issue.

[The prepared statement of Robert de Posada follows:]

PREPARED STATEMENT OF ROBERT GARCIA DE POSADA, PRESIDENT, THE LATINO COALITION

My name is Robert Garcia de Posada and I am the President of The Latino Coalition. The Latino Coalition was established in 1995 to address policy issues that directly affect the well-being of Hispanics in the U.S. The Coalition's agenda is to develop and promote policies that will enhance overall business, economic and social development of Hispanics.

When it comes to health insurance, according to the U.S. Census Bureau, the highest uninsured rate in the U.S. is among people of Hispanic origin. Over one third, or 34.2% of Hispanics were uninsured compared with only 12% for non-Hispanic whites. U.S. Hispanics also have the largest percentage of the working uninsured at 37.9% compared to only 14.9% for non-Hispanic whites. Foreign-born immigrants were even worse off with more than half without health insurance. According to the Commonwealth Fund, in small- to medium-sized companies with fewer than 100 workers, 63 percent of white workers have health benefits compared with 38 percent of Hispanic workers.

There is a strong relationship between un-insurance and the kind of employment a person has. The reason is simple: Most Americans get their health insurance through their place of work. Moreover, in getting their health insurance through the workplace, they are also eligible to get large and, under current law, unlimited federal tax breaks for the purchase of health insurance. There is no such tax relief for workers who get health insurance outside the workplace or for workers and their families who cannot get employer-based health insurance.

Today, 65 percent of the uninsured are in working families where the breadwinner works full time. Because Hispanic workers are heavily concentrated in the service industry and in small businesses—working for firms that do not or cannot offer them health insurance coverage—they are disproportionately found outside of the normal channels of health insurance in the United States.

People who are working should not be discriminated against by the federal tax code in their purchase of health insurance simply because they buy a policy outside of their place of employment. There is a better policy. The best option to expand health insurance for Hispanic workers is to give them direct tax relief, either in the form of tax credits, if they are paying taxes, or vouchers—in effect, refundable tax credits—if they do not have taxable income. This will establish equity in the tax code and the health insurance market, reduce the need for these families to depend

on government insurance programs like Medicaid or other forms of public assistance, expand health insurance coverage, and mainstream millions of uninsured Hispanic workers into America's private insurance market.

The health insurance market in the United States is uniquely job based. All Americans, both employers and employees, get tax relief if and only if they get their health insurance coverage through their place of employment. If the employer offers health insurance, the employer gets unlimited tax relief in the form of a tax deduction as part of the cost of doing business. Likewise, under this arrangement, employees also get unlimited tax relief for purchasing health insurance through their employer. But, instead of a tax deduction, an employee gets what is technically called a "tax exclusion" on the value of the job's health benefits. If an employee does not get his health insurance through the place of work, he gets little or no tax relief; indeed, the federal tax code punishes workers who buy health insurance outside the workplace by making that worker buy health benefits with after-tax dollars. For most workers, this cost is a huge disincentive for obtaining health insurance on their own.

The main reasons so many Hispanics do not have health insurance are they generally have lower incomes and they work for smaller firms. Employment and income level are the leading indicators of health insurance coverage in this country. The lower the income, the more likely a worker will not have coverage. If they are working independently or with a firm that does not provide health insurance, they simply do not have coverage because they cannot afford it. Small firms with fewer than 25 employees are the least likely to provide employment-based health insurance. Based on the 1990 Census, odds are that Hispanic workers—with a per capita income of only \$10,773 and a solid majority employed by small businesses, particularly the service industry—will not be offered health insurance at the workplace and will not be able to afford it on their own.

If a worker is employed by a large corporation, the chances are that both the benefits package and the tax benefits are very generous. However, if a worker is middle- or low-income and is employed by a smaller company, the tax benefits are less generous. Low-skilled workers often do not work for large companies or command a wage that enables them to buy health insurance, and they get little if any government assistance in purchasing it. If a worker decides to purchase individual policies, they will soon realize it is prohibitively expensive. This is the problem facing America's working poor. At The Latino Coalition, we strongly support policies to promote equality and equity between employer-based health insurance coverage and consumer-based coverage. We are here to call on Congress to end the discrimination that exists against people who buy health insurance outside the place of business.

Most Americans are personally familiar with such cases. But, for purposes of illustration, consider Martha Sanchez, a single mother of two in Miami. Martha works as a receptionist for a small law firm, earning approximately \$10 per hour. Her employer does not provide health insurance, and she cannot afford to buy an individual health insurance policy.

This is the case for many Hispanic workers. They are not poor enough to qualify for Medicaid, but are too poor to afford private health insurance. In addition, there is a high degree of mobility in the Hispanic workforce. And, as noted, the current system of employment-based health insurance is simply leaving too many working people who have families and are willing to work without affordable insurance.

There is another angle to all of this, one that never crossed our minds until we read the results of a recent study commissioned by Consejo de Latinos Unidos. This study found that public and private hospitals are taking advantage of self-paying uninsured Latinos throughout the Greater Los Angeles area. After a careful analysis of their hospital bills, the study found that these uninsured group was being charged almost five times the amount that hospitals would charge health maintenance organizations (HMO). When you read the testimonials and the findings of this study, you truly understand why groups like our have focused most of our efforts in trying to address the uninsured crisis in this country, and particularly in the Latino community.

So what can Congress do to help someone like Ms. Sanchez get health insurance?

First, enhance tax incentives for individuals without access to employer-sponsored coverage. You can enact refundable tax credits or vouchers to help low-income workers purchase health insurance. In order to make these tax credits truly accessible to low-income workers and small businesses, we believe that these tax breaks could be blended into the withholding system. In other words, allow the worker to withhold the cost of health insurance from the payroll tax, in order to afford insurance. We should also offer employers the authority to pay this premium if they wish. We salute President Bush and the bipartisan group of senators and representatives who

have signed on to support refundable tax credits for the uninsured. This is without a doubt the most important initiative that Congress can undertake if they seriously want to improve access to affordable health insurance.

Second, Congress should support the President's initiative to expand our Community Health Centers. These centers are in many cases the first line of defense for many uninsured Latinos across the country. However, while we expand the network of community health centers, we should also develop a stronger public education campaign to promote the existence of these centers, particularly in underserved communities.

Third, Congress can equalize the tax laws so that associations and community-based organizations have the same tax breaks as large businesses, when they provide health insurance. This would promote a more community-based insurance system that would have a better understanding of the community they serve. Don't forget that health patterns in our population are not the same. For instance, in the U.S. Hispanic community, there is an instance of diabetes, three times the level of the population at large. Having organizations and doctors who understand these differences are critical to provide cost-effective services to their customers.

Last year we strongly supported the bipartisan efforts of Congressmen Lipinski and Shadegg to permit Individual Membership Associations to offer mandate-free health insurance (H.R. 4119). This effort would allow community-based groups, churches and advocacy organizations to offer individual health insurance to its members. This legislation required that these IMAs offer at least two health insurance choices to its members, including one that is mandate-free. According to the Council for Affordable Health Insurance, we can expect a reduction in price of approximately 20-25% with this initiative. But aside from the reduction in cost, what makes this plan so attractive is the ability of community-based groups and churches to reach out to underserved communities in a much more effective way than current government health programs.

Fourth, Congress should eliminate the obstacles to pooling. This will help promote more affordable, accessible and accountable coverage for consumers. The Latino Coalition strongly supports Association Health Plans, as a way to reduce the cost of health insurance and offer small business a mechanism to pool together to increase their bargaining power.

Fifth, Congress should allocate additional funds for Medicaid programs in states that have been disproportionately affected by the current recession. We salute the efforts by Congressmen Brown and King to increase Medicaid spending. We would encourage Representatives Brown and King to include provisions in their bill to guarantee that doctors have the necessary flexibility to take the best care of their Medicaid patients, particularly in the area of prescription drugs.

However, we oppose current legislative efforts to expand Medicaid as a main tool to address the uninsured crisis. For the past three years, The Latino Coalition has been battling severe cuts in Medicaid services at State legislatures across the country. At a time when most states are gutting the services available to Medicaid patients, it would not be financially responsible to add millions of new patients into this program. This would make the program less stable financially and would force more severe restrictions on much needed services for our most vulnerable citizens.

Sixth, Policymakers must make health insurance affordable for people who can't qualify for health insurance because they have a preexisting condition. The Latino Coalition believes sick people cannot be left out of the world's greatest health care system and must have access to affordable health insurance.

Yet, there are only two ways to provide coverage to uninsurable individuals: (1) guaranteed issue or (2) health insurance safety nets. One works, the other doesn't.

- *Guaranteed issue.* Guaranteed issue means that anyone can get health insurance at anytime regardless of their health condition. This means that people can actually wait until they are sick before they buy health insurance, giving people an incentive to opt out of the health insurance pool. When people opt out and are guaranteed coverage at any point, rates escalate in an actuarial death spiral. This is what happened in New Jersey after the state legislature enacted guaranteed issue. *According to the New Jersey Department of Insurance, family rates for a \$500 deductible plan now range from \$3,170 a month to \$17,550 a month!*

Guaranteed issue has not succeeded in making rates affordable for families, especially those who need access to our health care system.

- *High Risk Pools.* Health Insurance Safety Nets, or high risk pools as some refer to them, are the best and most affordable way to provide coverage for individuals who are otherwise uninsurable. A Health Insurance Safety Net is a special state-based, privately funded comprehensive health insurance plan. Currently, 29 states have safety net plans, and approximately 127,000 people were covered

by these plans last year. The way they work is pretty simple: The enrollees pay a premium, and these premiums are usually capped so the enrollee has price protection. To help fund the safety net plan, the state usually assesses insurance companies based on the amount of business they conduct in that state.

On February 14, Republicans and Democrats voted to send \$120 million to the states to help existing safety nets plans and to establish one in those states that currently do not have one. The Latino Coalition supports that initiative and applauds those members of Congress who voted to help sick people get affordable health insurance.

Seventh, Congress can promote changes in our tax laws to help low-income workers and small businesses have access to affordable health insurance. For example,

- Small businesses could get a tax credit that could be phased-in beginning with the smallest firms of fewer than 10 employees;
- Individual purchasers of health insurance and the self-employed should be able to fully deduct the cost of premiums;
- Employee contributions for health insurance should not be considered taxable income; and,
- Tax credits should be made available for risk pools sponsored by the private industry.

Finally, we cannot ignore the fact that reducing regulatory burden and government mandates, reforming liability laws, and promoting personal responsibility are also key components of any solution to this problem.

Access to affordable health insurance is a problem that disproportionately affects the U.S. Hispanic community. The Latino Coalition strongly commends this committee for addressing this issue, and we look forward to working with you to break down the barriers and build the necessary bridges to improve the access to affordable health coverage for the uninsured.

Thank you.

Mr. BILIRAKIS. Thank you very much, sir.

Mr. Donnelly, please proceed.

STATEMENT OF HON. THOMAS R. DONNELLY, JR.

Mr. DONNELLY. Mr. Chairman, and Congressman Brown, thank you very much for the opportunity to be with you. I hope that my voice holds out today, but thank god for microphones.

I also want to associate myself with your remarks regarding Dr. Eisenberg, a dear friend, and someone with whom we have worked on patient safety. We thank you for this opportunity to show with you today our ideas about solutions for the growing problem of the uninsured.

The Coalition for Affordable Health Coverage is a broad based group that came together because of a strong common desire to address the issue of the uninsured. Our members include physician groups, like the AMA, business groups, the insurance carriers, and insurance brokers, consumer groups, and others who believe that affordability of coverage is a basic component of access to health care.

The focus of my testimony today will be on why we believe that the implementation of market oriented efforts, including tax credits, will make health insurance more accessible and more affordable to a significant portion of the uninsured.

Mr. Chairman, we start from the premise that it is critical for as many as possible of the uninsured to be covered for their health care. We are convinced that this is best accomplished by enhanced access to the private health insurance marketplace.

In the private marketplace, individuals and families can evaluate their variety of options available to them and decide what is best for their personal and unique needs. Additionally, without in-

creased private sector payments for health care, the cost of both health care and health insurance will continue to escalate.

If we increase public payment for health services by relying on Medicaid expansion as the primary solution for the uninsured, costs shifting to the private sector will only continue to push the cost of private coverage higher.

Further, new private sector options for the uninsured would encourage more healthy individuals to apply for coverage, and which will lower health insurance costs for everyone.

One of the solutions that will help the uninsured who pay income taxes, afford private health insurance coverage, is increased deductibility for health insurance premiums.

Therefore, other individuals who have no tax liability, the refundable, advanceable tax credit we have discussed will provide better assistance with monthly health insurance premiums when they are due, and directly to the insurance companies.

It will also reduce adverse selection to COBRA, and State continuation plans by providing funding so that all terminating employees would have the incentive to continue coverage, and not just those with serious health conditions.

Now, opponents of insurance tax credits claim that current health credit proposals provide too little cost assistance relative to the premium. I am reminded of Mr. Green's comments, and I would love to engage you on that when the time comes.

Research reveals, however, that a credit in the range of \$1,000 for individuals, and \$2,000 to \$3,000 for families contained in several of the bipartisan proposals in the House and in the Senate, provide significant financial assistance toward the purchase of private health insurance coverage without creating an incentive for employers to stop providing coverage for their employees.

There exists a robust individual market that offers a variety of policy coverage options in many States, and most people can find a policy suitable for their needs. Contrary to the analysis that accompanied it, a recent Kaiser Family Foundation report actually showed that 6 out of 7 individuals in less than perfect health were able to obtain health insurance in every one of the geographic markets tested.

Further analysis of the markets compared in the Kaiser study reveals that costs for the policies in more highly regulated States with guaranteed issue requirements and community rating were significantly higher than in other States for most of the Kaiser applicants.

Additionally, experience at the State level with guaranteed issue and community rating reveals that several States that had previously mandated guaranteed issue in the individual market have since repealed it.

I believe that Mr. Whitfield spoke about Kentucky, and now provide access to health insurance for people with serious or chronic health conditions through high risk pools.

These States found that the cost and availability of health insurance coverage in the individual market was severely restricted by guaranteed issue requirements.

A refundable health insurance tax credit would help eligible individuals afford the cost of health insurance coverage in high risk

pools in the same way it would be used for those to purchase coverage through regular individual health insurance markets.

So for this reason, we are very encouraged by the recent action of the House to provide Federal funding to help States with costs associated with high risk pools. Funding of this type should be a high priority for Congress to ensure that everyone has access to health insurance coverage, and will provide much more stability for existing health insurance markets than costly new guaranteed issue requirements.

Mr. Chairman, I should also mention that a number of members of our coalition are very concerned about the large number of uninsured people who have access to employer sponsored coverage, but are unable to afford their share of the employer sponsored premiums.

A health insurance tax credit designed to be used either to buy coverage in the individual health insurance markets, or to help a low income employee pay his or her share of the premiums would address this concern.

To keep the issue in perspective, we should remember that individuals without employer sponsored health insurance currently must purchase coverage in the individual health market entirely on their own.

This is particularly hard for low-income employees who may have to decide between health insurance and groceries, and tax credits should be considered a base from which to build on the financing of health insurance coverage.

It is not designed to take away the role of the employer in the financing of health insurance coverage, or to replace personal responsibility. The Coalition of Affordable Health Coverage believes that it will take these and other creative solutions to achieve affordable health insurance coverage for uninsured Americans.

We are pleased that the Congress and the administration are aggressively addressing the problem of the uninsured and believe it is important to take action now on this very important issue. Congress should not go home having done nothing because it decided to wait until it could do everything.

I appreciate this opportunity to testify, and I would be delighted to answer any of your questions.

[The prepared statement of Hon. Thomas R. Donnelly, Jr. follows:]

PREPARED STATEMENT OF HON. THOMAS R. DONNELLY, JR., REPRESENTING THE
COALITION FOR AFFORDABLE HEALTH COVERAGE

Mr. Chairman, Congressman Brown, and distinguished members of the committee, we thank you for this opportunity to share with you today our ideas about solutions for the growing problem of the uninsured. The Coalition for Affordable Health Coverage is a broad-based coalition that came together because of a strong common desire to address the issue of the uninsured by increasing access to private sector health insurance options. Our members include physician groups, business groups, insurance carriers, insurance brokers, consumer groups and others who believe that affordability of coverage is the most basic component of access to health care. We believe this Committee, and this Congress, have a unique opportunity to take action to significantly reduce the number of the uninsured, and we hope to serve as a resource to you in your efforts to do so.

The members of our Coalition believe, as has been expertly demonstrated, that the number of Americans lacking health insurance is simply too high. As has also been demonstrated, these Americans are often uninsured for different reasons. Con-

sequently, our members believe that a variety of approaches will be necessary in order to address these different causes. The focus of my testimony today will be on why we believe, based on how the marketplace works and the characteristics of those who are uninsured, that the implementation of tax credits and other market-oriented efforts will make health insurance more accessible and affordable to a significant portion of the uninsured.

Mr. Chairman, we start from the premise that it is critical for as many as possible of the uninsured to be provided with access to the private health insurance marketplace. The private marketplace allows individuals and families to evaluate the variety of options available to them and decide what is best for their personal and unique needs. Additionally, without increased private sector payment for health care, the cost of both health care and health insurance will continue to escalate. Providers faced with increasing numbers of Medicaid patients must address the issue of losses from low Medicaid reimbursements, and they do this by cost shifting to private payers. If we rely on Medicaid expansion as the primary solution for decreasing the number of uninsured, we will increase the percentage of public payment for health services. The cost shifting that occurs as a result will only push the cost of private coverage higher, and eventually will drive some providers out of business. Bringing newly insured people into the system through the private sector greatly reduces cost shifting. Further, private sector options for the uninsured will encourage healthy individuals to apply for coverage, which will decrease the losses experienced by health insurance pools in both the group and individual health insurance markets. This will lower health insurance costs for everyone that is insured.

Over half of the 40 million uninsured Americans are the working poor or near poor. These workers may work one or more part time jobs but not enough hours at any one job to qualify for health insurance benefits, or they may be seasonal or temporary and move from one employer to another. Still other low or moderate wage workers work for employers who don't offer coverage at all, regardless of employment status. Some have access to an employer-sponsored plan, but are unable to afford their share of the premium, or have employer-paid coverage for themselves but are unable to afford dependent coverage for their families. The problem in all of these situations boils down to one thing—affordability. Although individual or group coverage may be available, it is beyond their reach due to their inability to pay for it.

One of the solutions that will help the uninsured pay for private health insurance coverage is increased deductibility of health plan premiums. Increasing health insurance premium deductibility for people who owe income taxes puts coverage for those who don't have employer based coverage available on the same par with those who obtain their coverage through an employer-sponsored plan. However, deductibility does nothing for the many working poor who have no or very low tax liability.

People with no tax liability don't benefit from a deduction because they don't owe taxes to start with, and more important, because a deduction is only available at the end of the year. Financial assistance that is only available at the end of the year is of no value to the low-income uninsured because without advance payment, they are unable to pay their monthly premiums when they are due. They can't wait a year to be reimbursed, so they remain uninsured.

For these individuals, a refundable, advanceable tax credit would provide assistance with health insurance premiums monthly, when their premiums are due. This type of credit, advanced monthly and administered through the insurance company, would be available when needed and would be difficult to abuse, since the insurance company would certify that coverage was purchased. It would also reduce adverse selection in COBRA and state continuation plans by providing funding so that all terminating employees would have the incentive to continue coverage, not just those with serious health conditions.

Opponents of health insurance tax credits claim that current health credit proposals such as the one proposed by the Bush administration provide too little cost assistance relative to the premium. Research reveals, however, that a credit in the range of \$1,000 for individuals and \$2,000-\$3,000 for families provides significant financial assistance towards the purchase of private health insurance coverage without creating an incentive for employers to stop providing coverage for their employees.¹

The individual market offers a variety of policy coverage options in many states for individuals who don't have access to employer-sponsored coverage. Policies are

¹To get an idea what is available in the individual health insurance market, see "Individual Health Insurance Coverage Options Across the United States," March 2001, National Association of Health Underwriters, or "The Cost and Benefits of Individual Health Insurance Plans" eHealthInsurance.com.

available in a wide range of deductibles and plan types, and most people can find a policy suitable for their needs. Contrary to the analysis that accompanied it, a recent Kaiser Family Foundation report showed that six out of seven individuals in less than perfect health were able to obtain health insurance in every one of the geographic markets tested.

Further analysis of the markets compared in the Kaiser study reveals some interesting facts that should be carefully considered if any new market mandates such as guaranteed issue accompany financial assistance for the uninsured. Costs for policies in more highly regulated states with guaranteed issue requirements and community rating were significantly higher than in other states for most of the Kaiser applicants.

Additionally, experience at the state level with guaranteed issue and community rating reveals that several states² that had previously mandated guaranteed issue on the individual market have since repealed it and now provide access to health insurance for people with serious or chronic health conditions through high-risk pools. These states found that the cost and availability of health insurance coverage in the individual market was severely restricted by guaranteed issue requirements. For example, Washington State's guaranteed issue requirements resulted in such a high level of losses that all individual health insurance carriers in the state left the market. New Hampshire barely avoided this same fate by repealing their guaranteed issue coverage during their last state legislative session and instituting a high risk pool for individuals with serious or chronic health conditions.

Twenty-eight states now have high-risk pools to provide access to health insurance if a person does not qualify for coverage based on his or her medical history. Many of these states also use their high-risk pools to provide access to health insurance coverage for HIPAA eligible individuals. Other states use mechanisms such as open enrollment or a special category of guaranteed coverage through one or more carriers to ensure that coverage is available. High-risk pools provide the most affordable alternative for high-risk individuals who don't have access to employer-sponsored coverage.

A refundable health insurance tax credit could help eligible high-risk individuals afford the cost of health insurance coverage in high-risk pools in the same way it would be used for those who purchase coverage through the regular individual health insurance market. States without high-risk pools should be encouraged and provided with incentives to develop programs to ensure that coverage is available for high-risk individuals. For this reason, we're very encouraged by the recent action of the House to provide funding to help states with the costs associated with high-risk pools. Funding of this type should be a high priority for Congress to ensure that everyone has access to health insurance coverage, and provides much more stability for existing health insurance markets than costly new guaranteed issue requirements.

It is important in this analysis to include a discussion of health insurance tax credits that could be used in an employer-sponsored plan. A number of members of our coalition are very concerned about the twenty percent of the uninsured who have access to employer sponsored coverage but are unable to afford their share of employer-sponsored premiums. A health insurance tax credit designed to be used either to buy coverage in the individual health insurance market or to help a low-income employee pay his or her share of premiums would address this concern. Allowing low-income employees to supplement their employer's contributions with a refundable tax credit would allow families to be insured together, which many employees prefer, and would provide the funds necessary to allow them to come up with "their share" of health insurance premiums. It would also address concerns from the business community over declining participation in their plans, and would empower individuals to select their own place of purchase, rather than having it imposed on them by the government.

One final note relative to the adequacy of current health insurance tax credit proposals is that individuals without employer-sponsored health insurance currently must purchase coverage in the individual health insurance market entirely on their own. This is particularly hard for low-income employees, who may have to choose between health insurance and groceries. Even employees who have employer-sponsored coverage available may not be able to participate because they can't afford their share of the premiums. A health tax credit should be considered a base from which to build on the financing of health insurance coverage. It is not designed to take away the role of the employer in the financing of health insurance coverage, or to replace personal responsibility.

²Kentucky, Washington, and New Hampshire

A third part of the umbrella of solutions for the uninsured is the more flexible use of Medicaid and Children's Health Insurance dollars in private sector plans. We are greatly encouraged by the development of the new HIFA waivers, and have observed a high level of activity at the state level concerning new applications for these waivers. Used appropriately, we foresee the ability of many currently uninsured individuals and their children to be insured under one employer plan or through other private sector options using already available budget dollars.

The Coalition for Affordable Health Coverage believes that it will take these and other creative solutions to achieve affordable health insurance coverage for uninsured Americans. We are pleased that Congress and the Administration are aggressively addressing the problem of the uninsured, and believe it is important to take action now on this very important issue. Congress should not go home having done nothing because it decided to wait until it could do everything.

I appreciate this opportunity to testify today and would be happy to answer any questions the committee may have.

Mr. BILIRAKIS. Thank you very much, Mr. Donnelly.
Ms. Feder.

STATEMENT OF JUDITH FEDER

Ms. FEDER. Thank you, Mr. Chairman. Mr. Chairman, and members of the committee, it is a pleasure to be with you today to discuss this critical issue of expanding health insurance coverage.

Tax credits and public program expansions are the alternative strategies currently on the table for addressing this problem. My testimony addresses a number of the issues that arise with respect to both tax credits and public programs.

But I want to focus your attention on the results of some work that is in progress for the Kaiser Family Foundation that compares the impact of the two approaches. If you have the testimony, then focusing on the charts at the end will help you follow my remarks.

I want to focus in particular on two strategies that we have talked about a lot already this morning, two particular policies. One is a refundable tax credit for non-group coverage for \$1,000 for individuals, and \$2,000 for families.

And the other is a Medicaid or CHIP expansion to parents and any currently ineligible children with incomes up to twice the Federal poverty level, about \$39,000 for a family of three.

Under this option, the States would be required to extend coverage to the maximum eligibility level. I want to talk to you about the impacts of those two policies, and if you are following the figures, you can see in the first one that it shows pretty much the bottom line in terms of impact of the two policies, the number of people who get benefits, and the number of individuals who are newly insured.

The tax credit provides benefits to a very large number of people, about 10.6 million people, but its impact on new insurance coverage is far smaller, about 1.6 million people. And let me clarify just so you will understand different numbers, I am talking about the people who are covered at a point in time, just as we talk about 40 million uninsured.

This is the same kind of number as that 40 million, and it is different from the number of people who gain coverage over a year, which is what the administration is reporting with respect to its proposal. So 1.6 million people with gaining insurance coverage on net with the tax credit approach.

By contrast the public program expansion to parents would reach a smaller number of recipients, 5.4 million people, but would have

a bigger impact on the number of people who newly have insurance, 3.8 million people, as compared with 1.6 million under the tax credit.

If you look at the next chart, it tells us something about the people who have benefits, who gain benefits under these two approaches.

Looking first at income in figure two, about 30 percent of the people who get the tax credit have incomes above twice the Federal poverty level; whereas, all the public program benefits are targeted to people with incomes in this range.

An even greater contrast is apparent in Figure Number 3, which shows that 70 percent, the vast majority of the tax credit recipients, already have health insurance. Only a minority of the recipients are uninsured.

By contrast under the public program the results are flipped; 70 percent of the public program recipients are uninsured before a program goes into effect. Figure 4 looks at and compares these two program approaches in terms of impact from another perspective.

The share of the uninsured population that receives benefits from the new program. The tax program makes a lot of people eligible, close to 40 million people. Whereas, the public program expansion on parents is focused on parents and low income parents, and it reaches or is estimated to make about 7.6 million people newly eligible.

However, a far larger portion of the eligible uninsured population participates in the public program expansion than in the tax credit, and these estimates are based on experience to date both with respect to tax credits, and public programs.

Over half of the parents who are the target of the public program expansion participate. Whereas, with the tax credit, we see only 8 percent of the newly eligible population participating.

That reflects the fact that the tax credit with its limited dollars is as some people have described it offering a 10 foot rope to people in a 40 foot hole.

By reaching a larger proportion of a smaller pool of eligibles the public program expansion benefits a larger number of previously uninsured individuals than does the tax credit; 3.8 million people, versus 3 million people.

But when you examine these policies, you can't look just at the people who get the new benefit and get coverage. You have to look also at whether some people lose coverage as a result of a new policy.

And experience tells us that if we equalize or expand tax preferences beyond the work place to equalize tax treatment inside and outside work, employers are likely to respond by dropping coverage.

And the employees who lose coverage as a result will take advantage of credits and buy coverage, but some of them won't. Indeed, tax credits are likely to disrupt coverage, and we can see the results of that on figure five.

Although the tax credit provides subsidies to an estimated 3 million previously uninsured people, an estimated 1.4 million people with employer coverage are likely to lose coverage as employers drop that coverage and individuals find themselves unable to afford picking up a new policy.

I have focused this testimony on the numbers of people covered, but there are also differences in the benefits that people would receive under the two approaches, and the kinds of people who would receive benefits.

Because of the way the non-group insurance market works, the recipients or beneficiaries of tax credits will be disproportionately young and healthy, and their coverage will not protect them from significant out of pocket costs.

Under the public program expansion, newly covered parents and their children will be covered, regardless of age or health status, and consistent with existing Medicaid and CHIP rules, will face little or at higher incomes constrain out of pocket obligations.

So, in sum, although the two policies appear to be addressing the same problem, they have very different consequences. Tax credits reach a lot of people, but most of them are not uninsured.

For the uninsured who are the minority of recipients, they provide quite a modest benefit to the disproportionately young and healthy, many of whom are not low income, and they cause people to lose insurance from their employers at the same time they are seeking to expand coverage.

The sole purpose of a public program is to expand coverage, and it concentrates a comprehensive benefit on a narrowly defined population, the vast majority of whom are uninsured.

If the Nation's goal is to expand meaningful coverage for those who need it the most and are least able to pay, the top priority must be the expansion of a public program, which is far more effective in targeting resources from the tax credit approach. Thank you very much, Mr. Chairman.

[The prepared statement of Judith Feder follows:]

PREPARED STATEMENT OF JUDITH FEDER, DEAN OF PUBLIC POLICY, GEORGETOWN UNIVERSITY

Mr. Chairman, members of the Committee, it is a pleasure to appear before you today to discuss the critical issue of expanding health insurance coverage. Sadly, the 1990s demonstrated that prosperity is insufficient to prevent millions of Americans from being uninsured and therefore at risk of lacking access to health care when they need it. And, with economic recession, millions more are at risk as the loss of jobs carries with it the loss of health insurance. There is no doubt that policy interventions are needed to assure that people—especially people with low and modest incomes—have access to affordable, adequate health insurance coverage.

There is considerable bipartisan agreement on the desirability of public subsidies targeted to low and moderate income people to achieve this goal. However, there is considerable disagreement on the form that subsidies should take. Some advocate reliance on tax credits for the purchase of private insurance, while others promote the extension of publicly-sponsored or publicly-purchased health insurance coverage (Medicaid or the State Children's Health Insurance Program or SCHIP).

Analysis tells us that the choice of policy mechanism makes an enormous difference to the policy outcome—in particular, how many and what kinds of people get covered and what kind of coverage they get. Key questions that must be asked of any health insurance initiative are:

- Will its resources be effectively targeted to people who lack health insurance, especially those who can least afford to purchase coverage on their own?
- Will its coverage be adequate to assure affordable health care?
- Will it disrupt adequate coverage that people already have?

Analysis building on past experience allows us to estimate the likely answers to these questions for future policy. Our analysis shows that public program expansions are far more effective than proposals that rely on tax policy in expanding meaningful coverage to those who need it most, without disrupting coverage that is currently in place.

Differences in Policy Instruments

The appeal of reliance on tax policy to expand coverage appears to be the potential to provide benefits with minimal government involvement. However, three factors call this strategy into question.

Tax policy is not designed to reach low income people. About half the people without health insurance do not file an income tax return or owe any income taxes. As a result, most tax-based proposals would make tax credits refundable, that is, available without regard to tax liability. The Earned Income Tax Credit (EITC) is a refundable tax credit that has been enormously successful in enhancing income for the working poor. However, it is harder to support the purchase of health insurance than to boost income. Tax credits, including the EITC, are typically taken as refunds—money the taxpayer gets back at the end of the year. To buy health insurance, people with limited incomes need the cash in advance. Further, they need to know they can keep the money, even if their income changes. “Advanceability” and “non-reconciliation” of subsidies and incomes would require substantial departures from current tax policies, which aim at ensuring the accuracy and efficiency of the tax system. Such mechanisms are uncertain and untested in their ability to finance health insurance coverage for a low and modest income population. Promises to modify tax practices to support the purchase of health insurance are therefore subject to question.

Tax-based proposals rely on a problematic insurance market. Tax credit proposals aim to enable individuals to choose health insurance plans in the private market. Since 70 percent of the uninsured population lacks access to employer coverage, most of the uninsured are expected to turn to the non-group insurance market as a source of coverage. But that market is riddled with problems. To avoid adverse selection—that is, the purchase of insurance by those most likely to use health care, insurers use practices to avoid enrolling people likely to use services. Except in a few states with a broad range of consumer protections, insurers can deny people access; exclude coverage for services, conditions, body parts, or body systems; and charge premiums that vary with health status. Such practices not only apply to people with serious medical diagnoses, like cancer or AIDS; they also apply to people with seemingly modest health care needs, related, for example, to allergies. And, even for those who do get insurance, benefits in the non-group market can be quite limited. Policies may exclude maternity benefits and mental health care or limit drug coverage. Equally important they may include significant deductibles or benefit caps. Limited benefits mean limited access to care for low and modest income people.

To mitigate these problems, some have proposed allowing credits to be used in states’ high risk pools. However, these measures are unlikely to be very effective in assuring affordable access to adequate coverage. Despite more than a decade of experience, nationwide only about 100,000 people are enrolled in 29 state high risk pools—one quarter of them in Minnesota. These pools aim to provide access to coverage at subsidized rates for people unable to gain access to nongroup market. But rates are well above the standard rate in the non-group market and vary with age, and enrollment may be capped, limiting access. In addition, states try to keep costs under control by excluding coverage for pre-existing conditions and limiting benefits. Even with a modest tax credit, the costs to individuals of participation in a high risk pool would remain high and its benefits limited.

Tax credits typically offer too few dollars to make coverage affordable. The value of the most frequently proposed tax credit falls far short of the average cost of health insurance. Offering individuals a \$1000 credit for a policy that costs, on average, \$2500 (or offering a family a \$2000 or \$3000 credit for a policy that costs \$7000) has been described as extending a 10 foot rope to people trapped in a 40 foot hole. The lower a person’s income, the less able that individual is to make up the difference between the credit and the cost of the policy. And the difference will likely be greater, the older the applicant or in the presence of pre-existing conditions. Limited dollar credits will favor access to insurance not only for people with income to add to the credits, but also to younger, healthier individuals (while they are young and healthy). Limited dollars will also be attractive to individuals who are already purchasing nongroup insurance (and some who are paying substantial out-of-pocket premiums for employer-sponsored insurance)—providing them financial relief but not new coverage.

Some have argued that access to insurance with a credit should not be measured based on prices in the current market; rather, they argue, the availability of a tax credit would encourage individuals to seek lower priced policies, closer to the value of the credit. If that were true, more people might obtain “coverage” with tax credits. But the benefits associated with that coverage would be substantially more limited than those now provided. A policy priced at half the premium now typically

charged would entail a \$2800, rather than a \$300, deductible; substantially higher cost-sharing on covered services, and an out-of-pocket maximum set at \$5000 rather than \$3000. Lower premiums may enable more people to buy coverage but that coverage will buy them substantially less health care.

Tax credits are an ineffective mechanism for the low and modest income uninsured. If we truly wish to provide meaningful health insurance coverage to uninsured people with low and modest incomes, we must choose a mechanism that determines eligibility and provides a subsidy in advance, makes that subsidy sufficient to support the full (or close to full) cost of insurance, and provides comprehensive benefits and limited (if any) out-of-pocket costs. Public programs satisfy these conditions and have a proven track record. Given the limitations to tax credits and the insurance market, even some proponents of tax credits for higher income populations recognize that a public program is better than using the tax system to reach the low income uninsured.

Public programs provide the appropriate base for coverage expansions. Medicaid's 35-year history of providing health insurance to segments of the low income population has established both administrative and legal structures that protect beneficiaries' rights to benefits and health care. Perhaps most important, Medicaid extends an adequate subsidy for an adequate product—that is, a subsidy for the full cost of comprehensive insurance to people with limited incomes. In addition, it has an administrative apparatus in place in every state to determine eligibility for subsidies in advance and to facilitate enrollment in health insurance plans. Medicaid has contracts in place with providers and managed care plans (indeed, Medicaid programs are public managers of private markets) and have established mechanisms for collecting and matching funds from the federal government.

Although recent attention has focused on barriers to participation in public programs, a decade ago attention centered on the speed of Medicaid enrollment expansions in response to changes in federal law—from 19.2 million people in 1989 to 26.7 million people in 1992. And this year Medicaid eligibility will extend to poor (and some near-poor) children in all 50 states, the culmination of policies phased in over a decade. A decade ago, such an achievement seemed difficult to imagine and likely to engender powerful resistance in the states. But today, it's the reality. In addition, in the last few years, states have also responded to the availability of SCHIP to dramatically expand their income eligibility standards for children. Recession and fiscal pressure on states endanger past achievements and make expansions difficult. Federal dollars and federal standards will be required to achieve national goals.

Differences in Policy Impacts

Work conducted for the Kaiser Family Foundation Project on Incremental Reform allows us to examine the likely impact of alternative mechanisms to expand coverage. That work analyzes a range of tax policies and public program expansions and models their effects. The modeling work draws on past experience to develop assumptions about how behavior will change in response to a new benefit. These assumptions then guide a simulation of the policy's impact. The assumptions used in this analysis have been created by researchers at the Urban Institute (for public program expansions) and the Massachusetts Institute of Technology and National Bureau of Economic Research (for tax policies), with actuarial support from the Actuarial Research Corporation.

A focus on two proposals that closely resemble those most prominently discussed allows us to compare the way two approaches with respect to the fundamental goal: the ability to target resources to the low and modest income uninsured population without disrupting existing coverage. The two proposals are:

- A refundable tax credit for non-group coverage, providing \$1000 to individuals and \$2000 to families. Full subsidies would apply to individuals with incomes below \$15,000 (families with incomes below \$30,000) and would phase out as income rises, reaching zero for individuals with incomes of \$30,000 (families with incomes of \$60,000).
- A Medicaid/SCHIP expansion to parents (and any currently ineligible children) with incomes up to 200 percent of the federal poverty level (about \$30,000 for a family of three). Benefits and cost-sharing would follow SCHIP rules (ineligible for people with incomes up to 150% of the federal poverty level; capped at 5% of income for families with incomes between 150% and 200% of the federal poverty level). States would be required to extend eligibility to the maximum allowed under the policy as a condition for receipt of any federal funds under Medicaid or SCHIP.

Figures 1-5 illustrate the impacts of these two proposals. Figure 1 presents the bottom line: the number of people who receive benefits from each proposal and the net number of newly insured under the two different proposals. The tax credit pro-

vides benefits to almost twice as many people as the public program expansion to parents (10.6 million vs. 5.4 million). However, the impact of the two policies on the number of newly insured people is reversed. The public program increases the number of people who have insurance more than twice as much as the tax credit (3.8 million vs. 1.6 million). Underneath these “bottom-line” differences are considerable differences in the way the two programs operate.

Who receives benefits under the two approaches? Looking first at income (Figure 2), about thirty percent of the tax credit benefit recipients have incomes above twice the federal poverty level. By contrast, all the public program’s benefits are target to people with incomes below that level. Looking next at insurance coverage (Figure 3), 70 percent of the tax credit recipients already have health insurance. Only a minority of recipients are uninsured. By contrast, 70 percent of the public program recipients are without health insurance coverage.

Figure 4 examines targeting from another perspective—the share of the uninsured population that receives benefits from the new program. The tax program makes a far larger uninsured population eligible for benefits than does the public expansion to parents (38.3 million vs. 7.6 million people). (The differences are due both to higher income eligibility standards in the tax credit and to the public program’s focus on parents and their children.) However, a far larger portion of the eligible uninsured population participates in the public program expansion than participates in the tax credit. Over half (58%) of the parents who are the target of the public program participate, as compared with 8 percent of those eligible for the tax credit. By reaching a larger proportion of a smaller pool of eligibles, the public program expansion benefits a larger number of previously uninsured individuals (parents and children) than does the tax credit (3.8 million vs. 3.0 million).

However, the impact of a new policy is not limited to those who benefit from it. At the same time some people gain insurance from a new policy, others may lose insurance. Experience indicates that tax policies that reduce the advantage to employer-sponsored over nongroup insurance lead some employers to discontinue their coverage. Some employees whose coverage has been dropped will take advantage of the new tax credit and remain covered. But others will not. By contrast, a narrowly targeted public program, especially one targeted only to parents, effects only a small proportion of the workforce and, most likely, only some workers in a firm. In addition, employers are likely to be somewhat responsive to employees’ reluctance to shift from private to public insurance. A narrowly targeted public program is therefore unlikely to lead employers to drop coverage.

Figure 5 zeroes in on the different ways in which the two policies affect the insured and uninsured populations. Although the tax credit provides subsidies to an estimated 3.0 million previously uninsured people, an estimated 1.4 million people with employer coverage are likely to lose coverage as employers decide to drop their coverage offerings. The net increase in the number of people with insurance is therefore 1.6 million under the tax credit proposal, compared to 3.8 million under the public program expansion.

Finally, as described above, the 1.6 million people newly covered by the tax credit will likely be different people, receiving different coverage, than the 3.8 million people covered by the public program expansion to parents. People newly insured by the tax credit will be disproportionately young and healthy, and their coverage will not protect them from significant out-of-pocket costs. Under the public program expansion, newly covered parents (and their children) will be covered regardless of their age or health status and, consistent with existing Medicaid and SCHIP practices, will face little (or at higher incomes, constrained) out-of-pocket obligations.

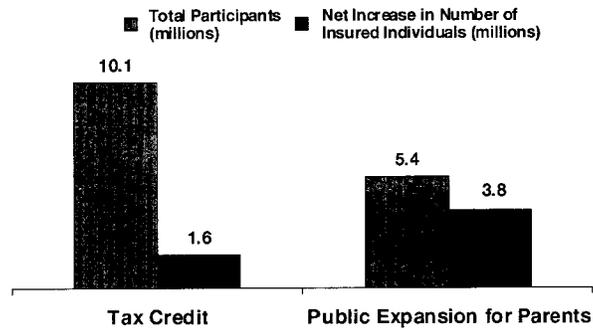
Policy Conclusions

Although seemingly addressing the same problem, two different policy mechanisms can have very different impacts. Tax credits reach a large number of people, but most of them are not uninsured. Indeed, only a small proportion of the uninsured population—disproportionately young and healthy—are likely to participate in the new program and those who do will receive only modest benefits. And, at the same time it expands coverage, the pursuit of tax equity actually undermines coverage already in existence. As a result some of its coverage gains are offset by coverage offsets. In large part, this outcome reflects the fact that tax credits are not simply aimed at expanding coverage; they also aim at greater tax equity—that is, equalizing tax preferences wherever health insurance is purchased.

The sole purpose of a public program is to expand coverage. It concentrates a comprehensive benefit on a narrowly defined population, the vast majority of whom are uninsured. If the nation’s primary goal is to expand meaningful coverage for those who need it the most, the public program is by far the more effective mechanism.

Figure 1

Who Receives Benefits?

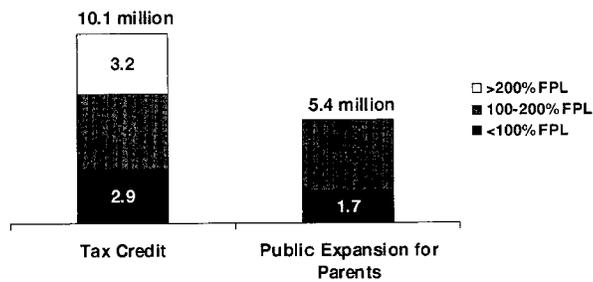


NOTE: Tax credit: refundable \$1000 tax credit (\$2000 for families) with low phase-out; public expansion for parents: mandatory Medicaid/CHIP expansion to parents up to 200% FPL.
SOURCE: Kaiser Project on Incremental Health Reform, 2002.

Figure 2

Who Benefits, by Income?

Distribution of Benefit Recipients, by Income:

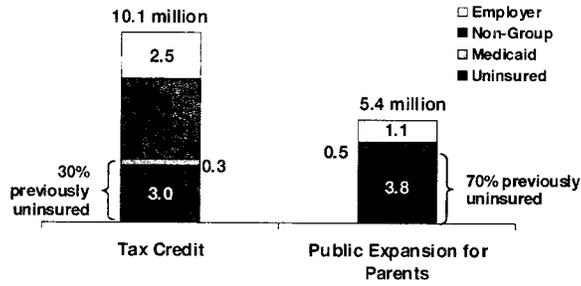


NOTE: Tax credit: refundable \$1000 tax credit (\$2000 for families) with low phase-out; public expansion for parents: mandatory Medicaid/CHIP expansion to parents up to 200% FPL.
SOURCE: Kaiser Project on Incremental Health Reform, 2002.

Figure 3

Who Benefits, by Previous Insurance Status?

Distribution of Benefit Recipients, by Previous Insurance:

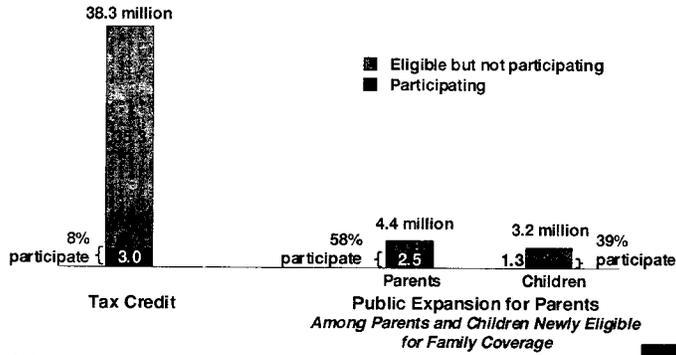


NOTE: Numbers may not add to total due to rounding. Tax credit: refundable \$1,000 tax credit (\$2,000 for families) with low phase-out; public expansion for parents: mandatory Medicaid/CHIP expansion to parents up to 200% FPL.
SOURCE: Kaiser Project on Incremental Health Reform, 2002.

Figure 4

Among the Previously Uninsured, Who Benefits?

Participation Among Eligible Uninsured Population

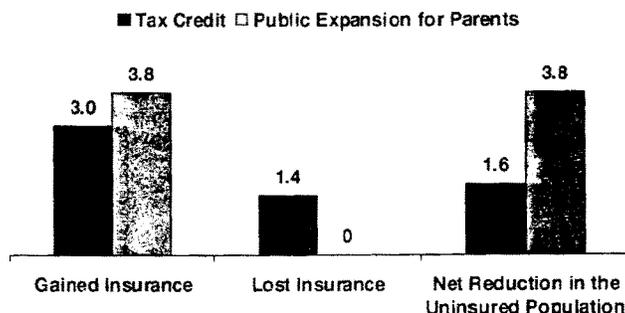


NOTE: Numbers may not add to total due to rounding. Tax credit: refundable \$1,000 tax credit (\$2,000 for families) with low phase-out; public expansion for parents: mandatory Medicaid/CHIP expansion to parents up to 200% FPL.
SOURCE: Kaiser Project on Incremental Health Reform, 2002.

Figure 5

What Is the Impact on the Uninsured? *Change in Coverage Status*

Number of people (millions):



NOTE: Tax credit: refundable \$1,000 tax credit (\$2,000 for families) with low phase-out; public expansion for parents: mandatory Medicaid/CHIP expansion to parents up to 200% FPL.
SOURCE: Kaiser Projection on Incremental Health Reform, 2002.

Mr. BILIRAKIS. Thank you, Ms. Feder.
Mr. Weil.

STATEMENT OF ALAN WEIL

Mr. WEIL. Mr. Chairman, and members of the subcommittee, I appreciate the opportunity to present testimony to you today. My name is Alan Weil, and I direct the Assessing the New federalism project at The Urban Institute.

Despite an emerging consensus that public subsidies must be provided to assist the almost 40 million Americans who lack health insurance, disagree remains over the form of this assistance.

In my testimony, I argue that the evidence suggests that building upon existing public programs such as the State Children's Health Insurance Program, S-CHIP, or Medicaid, holds far more promise for improving health insurance coverage than tax credits do.

Tax credits suffer from five problems; problems of availability, adequacy, amount, administration, and accountability.

The most serious problem with tax credits is that of availability. Most tax credit proposals are designed to encourage people to purchase coverage in the individual health insurance market. Insurers in this market often deny coverage to those with any identifiable health problems.

When coverage is offered, rates are many times higher for older adults than for those who are younger. Only a minority of States have regulations that limit these practices, and thus regardless of the size of the tax credit, health insurance simply will not be available to those who most need it.

The second problem with tax credits is adequacy. A tax credit of \$1,000 for an individual, and up to \$3,000 for a family does not cover even half of the cost of the typical health insurance plan.

Few families of modest means can or will pay the balance with their own funds. Therefore, tax credit users will primarily end up in plans with deductibles that run in the thousands of dollars, with many excluded services, where significant limitations on coverage.

These limited benefit packages will leave families in exactly the position they find themselves in today, deferring needed care because of costs, at risk of bankruptcy if they get sick, and placing a tremendous financial burden of uncompensated care on the entire health care system.

The third problem with tax credits is that of the amount. Tax credits suffer from the Goldilocks fallacy. No amount is just right. Everyone agrees a tax credit that is too small will not increase insurance coverage at all.

But a tax credit large enough to help a substantial number of people obtain health insurance is also going to be large enough to draw a substantial number of people out of the employer market.

This will raise premiums for small businesses, and shift costs from the private sector to the taxpayer. A similar cost shift much less frequently discussed would occur on the boundary between tax credits and existing public coverage for the very poor.

With dramatic regional variation in health insurance prices around the country, it is impossible to set a single tax credit amount that strikes a balance between helping no one and undermining the existing health insurance system.

The fourth problem with tax credits is that of administration, and at a minimum a tax credit must be refundable and advanceable if it is to help a working family purchase coverage.

Unfortunately, even with these provisions, many families will be unable of the credit, failure to take advantage of it, or not take it in advance when they need it because they will worry that they have to pay the government back at the end of the year.

The fifth problem with tax credits is that of accountability. People in the individual insurance market are on their own if their coverage is cut, their premiums rise, or there is a dispute over their benefits.

Consumer outcry among those denied coverage or who feel that they have been mistreated by their health plan, will create immense pressure for the Federal Government to act. But Federal action in the individual health insurance market will intrude upon existing State control, prompting a destructive battle over principles of federalism.

Now existing public programs do have their limitations, and I am familiar with them as I used to direct the Colorado Medicaid Agency. But these programs also have a track record. They provide real comprehensive, cost effective, stable coverage.

They target spending on those most in need, and they minimize incentives for the private sector to drop coverage. At a time when the Nation faces tight fiscal constraints and growing numbers of uninsured, it is essential that limited resources be spent where they will be most effective.

Tax credits are unlikely to improve the availability of meaningful health insurance. They run a substantial risk of damaging existing coverage. I think it is very important to note that all of the argu-

ments about what tax credits can do come out of models and assumptions, some of them very well constructed, very defensible.

But this is a test, and this is an experiment, and this is a gamble, and is not building on systems that we already know how they work, and what their weaknesses are, and how to improve them.

By contrast, just last year States were posed to make substantial progress on the issue of health insurance until fiscal circumstances took a sharp turn for the worse. Federal assistance that revives the State and local creativity that we observed just a year ago would have a real immediate payoff in how many Americans have health insurance.

It seems to me that this is the more productive and more targeted direction to go. So I thank you for your interest in this issue, and I welcome any questions that you may have.

[The prepared statement of Alan Weil follows:]

PREPARED STATEMENT OF ALAN WEIL, DIRECTOR, ASSESSING THE NEW FEDERALISM,
THE URBAN INSTITUTE

Mr. Chairman, members of the committee, I appreciate the opportunity to appear before you today to discuss ways to expand health insurance coverage. My name is Alan Weil and I direct the Assessing the New Federalism project at the Urban Institute, a 36-year-old non-profit, non-partisan research institute here in Washington, D.C. Before coming to the Urban Institute I was executive director of the Colorado Department of Health Care Policy and Financing, which is the state Medicaid agency.

There is an emerging consensus that public subsidies must be provided to assist the 40 million Americans who lack health insurance. The disagreement that remains centers around the form of those subsidies. Some advocate tax credits, while others advocate expanding existing public programs such as the State Children's Health Insurance Program (SCHIP) or Medicaid.

In my testimony today I will argue that the latter approach—building upon existing public programs—holds far more promise for improving health insurance coverage. The case for tax credits rests entirely on theory and ignores the practical difficulties of providing meaningful coverage in a complex, varied health care system. Existing public programs also have limitations, but they have a 35 year track record of providing comprehensive, cost-effective and stable coverage to those in need.

Tax credits suffer from five problems—problems of availability, adequacy, amount, administration and accountability.

The most serious problem with tax credits is that of availability. Most tax credit proposals are designed to encourage people to purchase coverage in the individual health insurance market. Insurers in this market routinely deny coverage to those with any identifiable health problems. When coverage is offered, rates are many times higher for older adults than for those who are younger. Administrative costs routinely exceed 30 percent. These insurance practices are understandable—they are the only way companies can make money operating in a market where they take on the substantial risk associated with enrolling people with high health care needs. Yet, only a minority of states have adopted regulations to limit these and other practices. Thus, regardless of the size of the tax credit, health insurance simply will not be available to those who most need it.

The second problem with tax credits is that of adequacy. The size of the credit—\$1000 for an individual and \$2000 or \$3000 for a family in most proposals—does not even cover half the cost of the typical health insurance plan. Analysts agree that few families of modest means can or will pay the balance with their own funds. Tax credit users will primarily end up in plans with deductibles that run in the thousands of dollars, with many excluded services, or significant limitations on coverage. These limited benefit packages will leave families in exactly the position they find themselves today: deferring needed care because of cost, at risk of bankruptcy if they get sick, and placing a tremendous financial burden of uncompensated care on the entire health care system. In addition, all experiments attempted to date show the same thing: most Americans, and particularly those of limited financial means, are simply not interested in bare bones coverage.

The third problem with tax credits is that of the amount. Tax credits suffer from the Goldilocks fallacy: no tax credit amount is just right. Everyone agrees a tax

credit that is too small will not increase insurance coverage at all. However, a tax credit large enough to help a substantial number of people obtain health insurance is also large enough to draw a substantial number of people out of the employer market, thereby raising premiums for small businesses and shifting costs from the private sector to the taxpayer. A similar cost shift would occur on the boundary between tax credits and public coverage for the very poor. Since a fixed dollar tax credit has health insurance purchasing power that varies by a factor of more than five to one depending upon where a person lives, it is impossible to set a credit amount that strikes some theoretically correct balance between helping no one and undermining the existing health insurance system.

Models that estimate how many people will take advantage of a tax credit, how many will drop existing coverage, and how many previously uninsured will gain coverage are very sensitive to the assumptions they use. It is very risky to use positive results from one model to justify a multi-billion dollar expenditure on tax credits.

The fourth problem with tax credits is that of administration. At a minimum, a tax credit must be refundable and paid in advance if it is to help a working family purchase coverage. Unfortunately, even with these provisions many families will be unaware of the credit, fail to take advantage of it, or not take it in advance because they will worry they will have to pay the government back if they receive a small wage increase during the year. The existing Earned Income Tax Credit provides important evidence. Very few families claim the credit in advance even though it is available. In addition, low-income Hispanic parents—a group disproportionately likely to be uninsured—are less likely to know about the EITC than other low-income parents, and, even those who do know about it are less likely to have received the credit.

The fifth problem with tax credits is that of accountability. Most people rely upon their employer or a public agency to provide them information about their health plan, assist with problems, and monitor the quality of coverage. But people in the individual market are on their own. If their coverage is cut, their premiums rise, or there is a dispute over their benefits, they must fend for themselves. If the federal government is providing financial incentives to purchase coverage, they will expect plans to be available. Consumer outcry among those who are denied coverage or who feel mistreated by their health plan will create immense pressure for the federal government to act, but if it does so it will step into an area of long-standing state control, prompting a destructive battle over federalism.

Existing public programs have their limitations, but they also have a 35 year track record. They provide real, comprehensive, cost-effective stable coverage. They target spending on those most in need, and they minimize incentives for the private sector to drop coverage. Public programs have gone through a positive transformation in recent years. They have simplified applications and enrollment processes, crafted new market-based benefit packages, improved education about coverage options, and have been tackling old problems like how to assure access to critical services like dental and mental health care.

At a time when the nation faces tight fiscal constraints and growing numbers of uninsured, it is essential that limited resources be spent where they will be most effective. If the goal is to reduce the number of people without health insurance, spending money on tax credits is a huge gamble paid for with taxpayer funds. By contrast, states were poised to make substantial progress on the issue of health insurance until fiscal circumstances recently took a sharp turn for the worse. Even a modest expenditure of federal funds could revive the state and local creativity we observed just a year ago. This would be an expenditure based upon a track record, not a theory and a computer model.

Mr. BILIRAKIS. Thank you, Mr. Weil. Well, there is great interest in this issue, and you all have worked awfully, awfully hard.

And I am not up here to defend the President's proposal. I would like to say that I feel that I am open-minded, and I think new and good ideas are always something that we should not attack before we have had a real good analysis of them.

We should study most anything to see if it will work. But it is important that we have our facts right. Ms. Feder, taking a look at your charts, they tell a story, and I guess I want to make sure that we are comparing apples with apples. On one hand, you have a tax credit, and I hate like hell to keep referring to a tax credit, and so I would rather say vouchers.

Because that is really what it comes down to, all right? But I will go ahead and use it because the question is worded that way. A tax credit proposal and then on the one side you would mandate coverage for parents of children up to 200 percent of the Federal poverty level.

So you are making comparisons, but are those comparisons taking into consideration the same dollars, the same costs?

Ms. FEDER. I am glad you raised that, Mr. Bilirakis, because the comparison that we do show, shows you that you essentially get what you pay for in coverage, and if you cover more people, you essentially spend more money.

And the analysis therefore shows to cover the 3.8 million that the public program reaches, costs significantly more than to cover the 1.6 million that is in the tax—

Mr. BILIRAKIS. But you don't reflect that in your charts or anywhere in here?

Ms. FEDER. We do it in the overall analysis. I apologize. I would be happy to include it.

Mr. BILIRAKIS. What does it cost?

Ms. FEDER. My recollection is that roughly the Federal cost or the total cost, Federal and State, for the expansion to 200 percent of poverty, was in the neighborhood of \$11 billion, and the cost of the tax credit reaching the 1.6 million people was in the neighborhood of between \$4 and \$5 billion on an annual basis.

Mr. BILIRAKIS. So you are talking about 2 to 3 times higher?

Ms. FEDER. But the cost per individual was essentially the same. So it is all a question of how much coverage you wish to provide. In addition to that, you would want to look at what you were buying with the coverage, and under the public program expansion, you are buying the uninsured individuals a comprehensive benefit.

Under the tax credit the analysis shows that the lion's share of what you are spending is going to the already insured, and you provide the uninsured the minority, or uninsured, a very modest benefit.

Mr. BILIRAKIS. Well, so you keep emphasizing that you would be making it available to the already insured. So what you are—are you basically saying that the employer would then drop coverage?

Ms. FEDER. I am saying two things. The recipients who already have insurance are two kinds. Many of them are people who already have the non-group insurance, and who get financial relief when you give them a credit, but not new insurance coverage.

An additional portion of them are people who moved from the employer coverage and take advantage of the tax credit outside. In addition to those are people who lose coverage because their employer drops and they find themselves unable or offsetting those, and are people who actually lose coverage as a result of the change.

Mr. BILIRAKIS. Ms. Turner, I think you are chomping at the bit to respond to all of that.

Ms. TURNER. Well, Mr. Chairman, there was a conference yesterday to give a lot of economists and health policy experts an opportunity to look into detail at the paper that Ms. Feder and her colleagues have produced.

And there was a great deal of discussion about the assumptions that are behind the cost estimates that they have created, and

Mark McConna from the White House used an analogy that if you are in fact—that if you have two economists in a whole, and they both try to figure out how to get out, and one of them assumes a shovel and the other assumes a ladder.

So assumptions are of their own creation, but there was some concern about some of the assumptions that would perhaps put tax credits in a different light than the Medicaid expansion.

For example, their model estimates that a family of four would face a premium of \$10,000 for health insurance, and not surprisingly they do assume then that you only have an 8 percent of the people who would be eligible for a tax credit actually taking up the policy.

So that is one way you could look at the world, but the Council of Economic Advisors has done a separate study and shown that a family could get a policy for \$3,300. You could assume \$5,000. You could assume \$7,000. Another issue that they assumed—

Mr. BILIRAKIS. Mr. de Posada, I think you mention—and forgive me for interrupting you—that you have done some research, and you have determined that there are policies. Are these good policies, or are they policies?

Mr. POSADA. Well, these are policies that do not have the \$10,000 deductible that we are talking about here or the premium costs. And we are talking about \$1,000 deductibles, PPOs.

I mean, obviously they are not going to be Cadillac plans. They are not going to be offering enormous amounts of benefits. But at least there is something there, and one of the big things that we have seen in our community is that concern that you are going to have an accident, and you are going to be financially ruined for the rest of your live because of that.

And I think this is a great opportunity to at least take care of that concern.

Mr. BILIRAKIS. Ms. Turner, I cut you off. Please, would you finish up whatever it is that you want.

Ms. TURNER. Just briefly, Mr. Chairman. I think it is also important to note that the model of the tax credit that was put into this model is not the President's plan. It is a \$2,000 per family and not \$3,000 for a family.

And also they assume, and I am just very interested in this assumption, that with a tax credit that employers would drop—3 million people would lose their current employment-based coverage that already have it.

And they assume that with a Medicaid expansion that no one loses employment based coverage, and that really changes the bottom line arithmetic of who is going to get coverage, versus various plans.

So one of the suggestions at this coverage was that we need to integrate into one better set of assumptions how you get a better comparison.

Mr. BILIRAKIS. Yes, thank you. My time is up. I just hope that we don't—we want to do something to help people who need some help, and if what we are looking for is perfection, we just are not going to get it, and that is what we have done with the Patient's Bill of Rights business, and that sort of thing.

I mean, would it not be better to have if in fact the need was there, and some people question that. But the point is that if the need was there, wouldn't it be better to have something that is less perfect, but at least something that is a force?

We had a bill a few years ago that had so many co-sponsors that we cutoff the co-sponsorship if you will recall. I hate to put it this way because my name is on it, but the Roll and Bilirakis bill, and how many people would have been helped now?

I am talking about quite a few years ago, and who would have been helped now if that plan had gone into effect, and the majority of the Congress was all for it. We had to cutoff co-sponsorships, but the leadership would not allow it to come on to the floor.

But let's be a little sensible here, and let's do something, even though it isn't perfect. Mr. Brown to inquire.

Mr. BROWN. Thank you, Mr. Chairman. In my 9 years in this committee, I have found Dr. Feder's assumptions, and her logic, and her intellectual honesty to always be unblemished.

So you seemed a bit impatient as two other witnesses were talking. So go to it, Dr. Feder.

Ms. FEDER. Thank you, Mr. Brown. I would indeed prefer to state the assumptions myself rather than have them stated for me. Ms. Turner is quite correct that there was a conference that we had yesterday, because we are interested in getting input in the analysis we have done.

There was a lot of discussion about the assumptions, and the White House economist from the CEA was quite challenging of the assumptions, and raised a number of questions.

And the analyst who developed the assumptions and did the modeling from MIT and the Urban Institute responded, and the assumptions were not quite as Ms. Turner described them.

The assumptions are based when we talk about the premium that people look at to go shopping with their tax credit, and the assumption is that the price of the policy is what the price is in the current market for non-group insurance.

We also looked at what behavior would be if people shopped for a policy that cost half that, but provided half the value in benefits. So there was not an assumption of looking at a \$10,000 policy except to the extent that a \$10,000 premium would apply in the market.

The model really looks at the prices that actually exist in the marketplace today. And I am sure that you will want to discuss further those prices are far higher for many people than the low price that we sometimes hear quoted, and it is available on the internet for that rare healthy young individual.

So the assumptions are really quite consistent with the literature, the economics literature, and indeed that was acknowledged by participants from other institutions, other recognized institutions, and indeed as someone else observed, the underlying assumptions are very similar in the work that has been done in some areas by the Council of Economic Advisors and by us.

And as I said, the numbers actually are not very far off when you present them in a consistent fashion.

Mr. BROWN. Okay. Thank you. Let me ask a little about the private insurance market. Do insurers require the private insurance market in most States to offer any specific set of benefits?

Ms. FEDER. No, insurers typically offer—well, there are actually mandates in terms of—in some States as to what insurance has to offer, and that applies in some cases. But the insurance, the nature of the policy that any individual can get can vary tremendously.

Insurers have tremendous freedom in terms of what kinds of benefits they will cover.

Mr. BROWN. Are they required to cover all conditions?

Ms. FEDER. No, they are not required to cover all conditions, and indeed, many policies actually explicitly exclude conditions, and body parts, and body systems, from coverage.

Mr. BROWN. They clearly are not required to charge the same price?

Ms. FEDER. Absolutely not.

Mr. BROWN. Are insurers in the individual market required to offer a policy to anyone who wants one?

Ms. FEDER. No, indeed they are not. There are very few States or some States that have guaranteed issue requirements, but because they can charge people any premium they wish to charge, that really does not make it in Dr. Weil's view that it really does not make it accessible or available.

Mr. BROWN. So describe to me what types of people who are eligible for the President's tax credit? What types of people who are eligible would have difficulty in the individual insurance market?

Ms. FEDER. It is very interesting to ask that because colleagues of mine did a study recently on the kinds or the people who shop for coverage in the non-group market and have some difficulties or they found difficulties in getting it.

A 24 year old waitress with hay fever; a family with two 36 year old parents, a 10 year old daughter, and a 12 year old son with asthma, and recurring ear infections; a 48 year old who had breast cancer 7 years ago; and a 62 year old man who smoked, in addition to a couple of other sample applicants.

And they found that the waitress with hay fever was faced with or did receive offers, but most of those offers excluded her coverage for hay fever, and some of those offers excluded coverage for her entire respiratory system.

And with the young boy with asthma, there were policies that refused to cover the child altogether, and I am particularly sensitive to this one because I have a son with asthma.

And if you had not covered his respiratory system in his insurance, and you did not have the income that I am fortunate to have, he would have been in an emergency room or without treatment on numerous occasions.

These are examples, and I can go on with these cases, but we find that we are not just talking about people with serious high risk conditions, who find themselves unable to find affordable and adequate coverage in the non-group market.

Indeed, I would not want myself or my son to have to go shopping in that market giving health existing conditions.

Mr. BROWN. Okay. We have two entitlements here. We have the tax credit if enacted that entitlement, or we have the Medicaid en-

titlement. The tax credit provides various kinds of insurance, various levels of coverage, various prices, is not available to many.

Medicaid provides for a standard set of broad coverage. Where does the government get its best bang for the buck here?

Ms. FEDER. Well, I don't think there is a moment's question. I think the priority in new dollars has got to go to people who don't have insurance, and to the people who are least able to buy it on their own.

And to be spending money on people who already have insurance, rather than those who don't seems to me an inefficient and inexcusable use of our current resources. We can celebrate this year the accomplishment that all over the Nation, in 50 States, all poor children are covered as a result of Medicaid requirements that were enacted over a decade ago.

And at that time there was a lot of concern that this was not possible, and that it was beyond the resources of States, and that we would never reach that goal. Now, it did take us better than a decade to achieve it, and that is unfortunate.

But all those poor children can count on a federally guaranteed entitlement program to provide them a comprehensive set of benefits, and as someone said earlier, god bless Medicaid.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. I was a little concerned. I used the word staggering facts that Dr. Kellermann shared with us regarding Medicaid, and the movement in and out of Medicaid, the revolving nature of Medicaid and what not, and for what seemed to be a lack of stability.

And we have to ask these questions of ourselves, but would not something, whether it be—whatever you might want to call it, but some sort of tax certificate to help people to get out there and choose whatever it is that they would want and result in more stability.

But on the other hand, you also raised the point of the uninsurability of some people; the child with asthma and that sort of thing. So that is what makes this job almost impossible.

Well, I think it is a little easier as a result of your testimony. But anyway, we appreciate your time here, and again as you know, and many of you have testified—Dr. Feder and others have testified here before—you know that we will have written questions of you, and we would hope that you would respond in a timely fashion.

We are going to do the best that we can. We are tussling with prescription drugs for Medicare recipients right now that is kind of a top priority, but uninsured is also up there, and in an election hear like this, particularly with the war on terrorism taking place, it places additional burdens on us, but we are going to do the best that we can. Thank you very much.

Also, here are members who would wish to submit their opening statements, and without objection, that will always be the case. Thank you very much, and in addition to materials.

[Whereupon, at 1:24 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

May 10, 2002

The Honorable MICHAEL BILIRAKIS
 Chairman
 Committee on Energy and Commerce
 Subcommittee on Health
 Washington, DC 20515

DEAR MR. CHAIRMAN: Thank you for your letter of April 30, 2002 and for the opportunity to testify before the Subcommittee on Health on February 28, 2002.

Per your request, I have prepared answers to the follow-up questions submitted by Members on the problems to access affordable health care coverage. Again, thank you for this opportunity and if I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

THOMAS R. DONNELLY, JR.
 Member of the Board

RESPONSES FROM THE HONORABLE THOMAS R. DONNELLY, JR.

1) Some states have repealed guaranteed issue requirements and put in high-risk pools instead. For example, **Kentucky, Washington, Idaho** and **New Hampshire** previously had guaranteed issue but have since repealed the mandate and provide (or plan to provide) access to health insurance for the "hard to insure" individuals through high-risk pools.

Kentucky's 1995 reforms that included guaranteed issue laws led to an exodus of 40 private insurance carriers from the state, leaving only one plan behind. In 1998, the state revised its reforms and established a new guaranteed access program in attempt to lure companies back to the individual market. The attempt proved to be insufficient in encouraging market competition so additional changes were made in April 2000 to allow medical underwriting in the individual market and the establishment of Kentucky Access, a new high-risk pool.

In the case of Washington, individual market reforms in 1993 that included guarantee issue, standardized plans and rating restrictions resulted in such a high level of losses that by 1999, all individual health insurance carriers in the state left the market. Major reform legislation was passed in March 2000 to restore competition and participation by insurers and to establish a high-risk pool for those who are "hard to insure."

Both Idaho and New Hampshire faced similar results from their guarantee issue regulations that led state legislature in 2000 and 2001, respectively, to revise their laws and establish high risk pools.

2) The Health Insurance Flexibility and Accountability (HIFA) demonstration initiative strongly encourages states to think creatively about how Medicaid and Children's Health Insurance Program funding can be used to maintain and encourage coverage in the group health plan market. The new options available under this waiver will allow working families to be insured together. Employees will be able to take advantage of employer sponsored coverage and use dollars available through the HIFA waivers to help them pay for family coverage in their employer's plan. Many families who previously shunned Medicaid and CHIP programs due to the stigma associated with the Medicaid program will be more receptive to participating in coverage in an employer setting.

A summary of specific state options under the HIFA program produced by the National Association of Health Underwriters is attached.

3) In response to Ms. Feders' study and overall analysis in comparison with the tax credit proposal, the choice is clearly between consumer choice and government control. Ultimately, the tax credit proposal, rather than state expansion of public programs, empowers individuals to select their own place of purchase rather than having that place of purchase imposed on them by the government. Hewitt Associates LLC consumer study reports that 87% of participating employees felt they understood "fairly or very well" how to choose the best health plans for their needs (although employers speculated only 61% employees had confidence in such a decision). The data suggests that consumers are more capable of making their own decisions about their health care needs than employers assume.

Ms. Feder's analysis is based on numerous assumptions including:

- e) Substantial employer dropping of coverage is assumed for the tax credits.
- f) A higher cost of insurance than is estimated by the Council of Economic Advisors or currently provided by groups like e-HealthInsurance.
- g) Very low take-up rate for the tax credit and high take-up rate for the Medicaid expansion

In response to these assumptions, I would highlight the following:

a) In his testimony before the House Ways and Means Committee on February 13, Mark McClellan stated: "The impact of tax credits on employer health insurance coverage would be minimal, and the majority of individuals taking up the proposed health credit would be those who were either previously uninsured or previously covered in the non-employer insurance market." In addition, no empirical data suggests that tax credits for individuals will inevitably lead to drastic reduction of participation in employer-sponsored plans. The reality remains that 1) About 80% of uninsured workers are not offered health insurance by their employers; 2) Only 36% of people under age 65 with income below 200% of FPL have employer-sponsored insurance, while 77% of those above do. Also, it should be noted that of all employees offered employer-sponsored coverage, 5% don't accept and that 5% make up the 20% of uninsured population. Twenty percent of the uninsured have access to employer-sponsored coverage but are unable to afford their share of employer-sponsored premiums.

b) Higher cost quotes of private insurance often result from looking at the smaller segments of the uninsured population, the elderly and the unhealthy. U.S. Census Bureau reports that 12.6% of the uninsured population are between the ages of 45 to 64. Stated another way, 88% of the uninsured are 44 years of age or younger. Not that this segment of the population is any less significant but focusing on the exceptions will paralyze any progress on the issue.

The same can be said for the unhealthy uninsured or those unable to receive coverage in the individual market due to preexisting health conditions. Although several estimates have been made on the size of this population, only 5% of uninsured population (1.5% of U.S. population) is chronically "uninsurable" according to Communicating for Agriculture's "Comprehensive Health Insurance for High-Risk Individuals" and other studies.

National Association of Health Underwriters offered its own analysis of what is available in the individual market for the unhealthy or those who are "hard to insure" in response to a study conducted by Kaiser Family Foundation (see attached). For the six hypothetical cases who represented "less than perfect health," All 6 out of 6 unhealthy individuals (not including the individual diagnosed with AIDS), were able to obtain health insurance in every one of 8 geographic markets tested (health insurance companies approved 75% of these total submitted applications).

c) Ms. Feder claims that tax credits are inefficient since they extend to all people in an eligible income category regardless of their current insurance status. We would agree that it is true that there will be some individuals who will be eligible for the tax credit who are currently insured. These individuals have exercised personal responsibility and made sacrifices in order to provide health insurance for their families, in spite of their low incomes. Regardless of the "inefficiency" of extending a tax credit to these already insured individuals, it would seem quite unfair to penalize them for doing the right thing if they are otherwise eligible for the credit.

Ms. Feder claims that public programs have a higher take-up rate among previously uninsured individuals, and are therefore more efficient. However, this take-up rate is based on a smaller eligibility category that only includes those who were previously uninsured, versus the tax credit where eligibility is based on income level and not insurance status. In reality, the tax credit reaches more people, including those who are already struggling to provide coverage to their families. It helps people who need help the most, based on their income level.

Contrary to Ms. Feder's assertions, the odds of employers discontinuing their coverage if a tax credit program were enacted are small. The tax credit is after all a means tested proposal. It is highly unlikely that all of an employers employees would be eligible for the tax credit, and although employers are allowed to discriminate in their financial contributions by class, a class made up only of those employees eligible for the tax credit would not fit within allowable guidelines. Employers offer health insurance to recruit and retain good employees, and they will continue to do so. A properly structured tax credit can help an employer's low income employees pay for their share of coverage, particularly family coverage, and this greater participation by employees would actually improve employer health plan loss ratios. Ms. Feder's presumptions do not reflect market realities, current law, or typical actions by employers.

COST AND AVAILABILITY OF HEALTH INSURANCE FOR PEOPLE WITH CHRONIC HEALTH CONDITIONS

Considerable misunderstandings exist about the cost and availability of health insurance for those with chronic health conditions. While available evidence is limited

and should be improved, those with chronic conditions by and large do have access to affordable health insurance coverage.

The vast majority of Americans receive their health coverage through their employer, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that all employer groups guarantee access to health insurance coverage without regard to health status. For individuals who obtain coverage through the individual health insurance market, a wide variety of options have been implemented at the state level to ensure access to coverage.

Background on Chronic Conditions and Health Insurance

- The term “chronic condition” can be interpreted widely or narrowly. Many studies label anyone who takes medication regularly (such as allergy medicine or antidepressants) as chronically ill, regardless of how those conditions affect insurance availability, premiums, or the expected cost of health care. About 60 million working-age people have a chronic condition under the broadest definition, which includes just about any condition that may influence medical care use in any way¹. Yet this does not mean that they cannot get health insurance or that their health insurance or their total health care costs will always be significantly higher as a result.
- Many programs exist to help those who have serious chronic conditions get affordable health insurance in the individual market. For example, many states have high-risk pools for people who don’t qualify for coverage in the regular individual health insurance market. These pools have caps set on premiums averaging about 150% of the individual market average rate. In addition to the premiums paid by pool participants, these pools are normally subsidized by assessments to insurance carriers and state funds from a variety of sources.²

In June of 2001, Kaiser Family Foundation issued a report on the availability of coverage for people in less than perfect health. NAHU participated in the research for this project and can vouch for the accuracy of the objective data included in the study.

NAHU would not, however, have reached the same conclusions based on the analysis of the underwriting and pricing information collected.

Kaiser Study³

Data

- Seven fictional applicants sought individual health insurance policies in eight different geographic areas. The applicants had different ages, family structures, health conditions, etc.
- Quotes for \$500 deductible, \$20 office visit co-pay plans were solicited. Offers, prices, and restrictions were recorded.

Kaiser’s Interpretation

- The Kaiser report emphasized that applicants with chronic conditions were often rejected by at least one insurance company in the region, and often received offers with surcharges (“rate-ups”) or exclusion of certain conditions (“riders”). The HIV positive applicant failed to receive offers in any market.

On further analysis . . .

- The conclusion that affordable health care is not available to persons with chronic conditions is not a complete picture of the way health care coverage works. In the Kaiser study, all but one of the fictitious applicants (with the exception of the HIV positive patient) received at least one offer in each market, and the vast majority of offers were affordable and not restrictive. These offers are shown in more detail in the appendix.
- The “rate-up” seen in many offers was often only 25%, and was often applied to a lower base premium than the premium offered to healthy persons in the market. For example, the applicant who had situational depression received a clean offer with a \$276 premium, but an offer with a 20% premium increase (and no benefit limits) that was \$279—only \$3 higher. Both of these offers without exclusions were less costly than some of the offers that included benefit limitations.

¹Community Tracking Study Household Survey

²Comparison of State Level High Risk Pools, National Association of Health Underwriters, January 2002.

³Pollitz, Sorian, and Thomas, How Accessible is Individual Health Insurance for Consumers in Less than perfect Health?, Kaiser Family Foundation, June, 2001.

- Not all applicants who had “riders” would face much higher costs. For example, in Florida, the allergy sufferer received only offers with limits on coverage for her allergies. But her lowest offer was a monthly premium of \$111, and the monthly cost of the specific medications and shots that were excluded would average only \$31, for an effective maximum monthly cost of \$142—much lower than the average premium reported of \$257. In Arizona, she received no offers without restrictions, but received an offer excluding her allergy treatment for only \$66. Again, with an estimated cost for medications and allergy shots averaging \$31 per month, her total monthly outlay would have been \$97.
- In the relatively rare cases where coverage exclusions or rate-ups are substantial, high-risk pools and state “insurers of last resort” provide an alternate source of coverage. The California and Florida high-risk pools cited in the original Kaiser analysis are two of the worst-performing pools, due to lack of adequate funding for many years. As a result, these two pools are much less functional than their counterparts in other states. High-risk pools in states that use an insurance carrier assessment mechanism to offset losses of the pool are able to provide affordable coverage for many otherwise uninsurable individuals. In addition, other state mechanisms to guarantee access, such as “carriers of last resort” provide additional options. For example, the individual who suffered from allergies in the Kaiser study received no “clean” offers in Virginia, and had an average monthly premium (with riders) of \$118. But the same individual could have elected a policy with no riders through the guaranteed issuer of last resort in Virginia (Trigon) for \$104. Furthermore, the HIV positive applicant could receive insurance through a high-risk pool or carrier of last resort (with no benefit restrictions) in 6 of the 8 states examined, 4 of which had premiums under \$300. The clear conclusion is that adequately-funded high-risk pools can and do provide affordable coverage for persons with even the most serious chronic conditions.
- It should be noted that individuals and families who lose employer coverage with at least 18 months of creditable coverage have a guaranteed right to purchase coverage in the individual market in all 50 states, providing they meet HIPAA eligibility provisions. In addition, employees leaving groups of more than 20 employees have the right to continue coverage under the federal COBRA law, and many states provide state continuation options for individuals leaving employers with less than 20 employees.
- An examination of states that do not use underwriting but instead have imposed guaranteed-issue and community rating requirements in their non-group insurance markets, show that almost all of the applicants would have faced vastly higher health insurance costs. For example, the applicant with high blood pressure could get monthly premiums without benefit restrictions that ranged from \$244 to \$805 in the 8 different markets studied. But in New Jersey, a state with guaranteed issue and community rating, his monthly premium would be \$1,801.

Finally, a very important purchasing consideration for low-income individuals who purchase in the individual market is affordability of any size premium. Individuals and families who purchase in the individual health insurance market do not have the luxury of a financial contribution by an employer. Regardless of their income or health status, these individuals must purchase individual health insurance coverage entirely on their own. For this reason, NAHU strongly supports refundable tax credits to make the cost of coverage more affordable, especially for low-income individuals.

APPENDIX: DETAILS ON HEALTH INSURANCE OFFERS RECEIVED BY ALL HYPOTHETICAL APPLICANTS IN ALL MARKETS

The Kaiser study examined the insurance offers received by six hypothetical applicants in eight geographic areas (IL, TX, IA, CA, FL, VA, AZ, IN). (Costs are expressed below as the best offer for monthly premiums.)

- For comparison, each of the single applicants would have faced the following (higher) rates in three guaranteed issue and community rated states: in NJ, \$1,801; in NY \$364; in ME, \$516.

Alice: 24 years old, allergies

- Received offers with no restrictions in 5/8 markets (IL, TX, IA, CA, and IN), with an average monthly premium of \$100.
- Received an offer with an exclusion for certain allergy treatments of \$111 in FL. Adding her estimated monthly out of pocket costs for Allegra and allergy shots yields an effective monthly cost of \$142.

- Virginia's guaranteed issuer Trigon would have issued a policy of \$104 with only a \$300 deductible (or \$93 with a \$750 deductible) and no benefit restrictions.

Bob: 36 years old, previous knee surgery

- Received offers with no restrictions in 8/8 markets, averaging \$134.
- Received significantly cheaper offers that excluded the knee in several states (for example, \$69 instead of \$154 in VA, \$111 instead of \$335 in FL). Given that no further treatment on the knee is anticipated, these offers might be preferable.

Crane Family: Family of 4, son with asthma

- Received offers of family coverage without restriction in 4/8 markets (IL, CA, AZ, and IN), averaging \$352.
- In 3 of the remaining states (IA, TX, and VA), if the family purchased coverage except for the son (without restrictions) and added coverage for the son through either the state high risk pool or carrier of last resort, the family's total average premium would be \$512.
- The premium for the family was \$497 in FL, but it excluded the son's asthma. The FL high-risk pool is one of the few high-risk pools that are currently closed.
- These rates generally compare very favorably to the coverage available in guaranteed-issue states: monthly premium in NJ, \$3273; in NY \$947; in ME, \$1,900.

Denise: 48 years old, previous breast cancer

- Received offers with no restrictions in 8/8 markets, averaging \$226.

Emily: 56 years old, situational depression

- Received offers with no restrictions in 8/8 markets, averaging \$253.

Frank: 62 years old, high blood pressure, smoker, overweight

- Received offers with no restrictions in all 8/8 markets, averaging \$514.

Greg: 36 years old, HIV positive

- Received no offers in individual market.
- Virtually all individual market insurers in the United States consider HIV+ status to be an uninsurable medical condition.
- Would be able to purchase insurance through high-risk pools or a carrier of last resort in all states except FL and AZ, with an average cost of \$330. (The VA plan had a higher deductible, although a lower deductible plan was also available. The CA policy had annual and lifetime limits, and has a waiting list.)

PRIVATE SECTOR HEALTH INSURANCE OPTIONS USING PUBLIC FUNDING

Background

The Bush Administration has developed a new initiative to provide health insurance to low income individuals and families. The Health Insurance Flexibility and Accountability (HIFA) demonstration initiative strongly encourages private health insurance options targeted to people with incomes below 200 percent of the federal poverty level (FPL). Private health insurance options include both group health plan coverage and individual health insurance coverage. The HIFA initiative uses current Medicaid and SCHIP resources under a Section 1115 waiver, and therefore does not require new budget allocations.

Eligibility, Benefits and Cost Sharing

The new initiative does not limit the upper income eligibility level, but does focus on individuals with family incomes below 200 percent of the federal poverty level. States requesting eligibility above 200 percent of the federal poverty level must demonstrate that their state already has high coverage rates in this range and that covering individuals above 200 percent of the federal poverty level will not induce those who already have private health insurance coverage to drop it. States are encouraged to think creatively about how Medicaid and Children's Health Insurance Program funding can be used to maintain and encourage coverage in the group health plan market.

Benefit requirements differ depending on the population to be covered. The benefits are targeted at the following populations:

- (*Mandatory populations:* groups which must be covered by Medicaid, such as children under age six and pregnant women up to 133 percent of the federal poverty level.
- (*Optional populations:* groups that could be covered under Medicaid or the Children's Health Insurance Program, whether or not the state has actually elected to do this. Family income eligibility for these groups is greater than the manda-

tory population income levels. They include children already enrolled in the Children's Health Insurance Program, children who are or could be covered by Medicaid at incomes greater than the mandatory income levels, and parents covered by Medicaid.

- (*Expansion populations*: groups not eligible for Medicaid or SCHIP unless provided coverage through a section 1115 waiver authority, such as non-disabled adults without children.

The HIFA waiver does not allow reduction of benefits for mandatory populations, or vulnerable populations such as pregnant mothers or children with special needs. States will have new flexibility under the HIFA initiative to modify current benefit packages for optional populations under both Medicaid and SCHIP to allow all optional populations to be covered by one of the benefit packages available under the Children's Health Insurance Program, including:

- The benefit package for the HMO that has the largest commercial enrollment in the state, or;
- The Blue Cross/Blue Shield PPO option for federal employees, or;
- A health benefits coverage plan that is offered and available to state employees, or;
- A benefit package that is actuarially equivalent to one of those above, or;
- A package approved by the Secretary.

Benefits packages for optional populations must include inpatient and outpatient hospital services, physicians surgical and medical services, lab and x-ray services, well-baby and well-child care, including age appropriate immunizations.

States will have even greater flexibility in designing the benefit package for expansion populations. The benefit package for expansion populations must include a basic primary care package, which means health care services customarily provided by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. States may establish limits on the types of providers and the types of services, subject to approval by the Secretary of Health and Human Services. Benefits must be comprehensive enough to be consistent with the HIFA goal of increasing the number of individuals in the state with health insurance coverage. The Secretary will permit flexibility in both the definitions of benefits and cost sharing for optional and expansion populations in support of increased use of private group health plan assistance programs, and will not be required to meet a specific cost effectiveness test for premium assistance programs that promise to decrease the number of uninsured under 200 percent of the federal poverty level.

Cost sharing for mandatory populations will continue to be limited to nominal amounts. States will be provided new flexibility to define cost sharing for optional Medicaid populations and expansion populations; however, cost sharing for optional children may not exceed 5% of the family's income. In cases where the entire family is covered, this 5% guideline does not need to apply to cost sharing that can't be attributed to individual family members, such as a family premium. However, the 5 percent limit does apply to cost sharing attributable to children, such as copayments for children's visits to physicians.

NAHUs Position

The new HIFA waiver is an opportunity for states to develop private sector health insurance options using currently available public funding. The new flexibility in benefits, cost sharing and the use of private plans is unprecedented. We strongly support the use of this waiver to decrease the number of uninsured individuals and families in the United States.

RESPONSES FOR THE RECORD OF JUDITH FEDER, PH.D., DEAN OF PUBLIC POLICY,
GEORGETOWN UNIVERSITY

Question 1: In your written testimony, are you using the President's refundable tax credit proposal as a basis for comparison or a proposal created by researchers at the Urban Institute? Have the researchers at the Urban Institute specifically researched a refundable, advanceable tax credit?

Answer 1: The tax credit proposal in my testimony is similar, though not identical to the President's proposal. As noted in the testimony, it is a refundable tax credit for non-group-coverage, providing \$1000 to individuals and \$2000 to families. Full subsidies would apply to individuals with incomes below \$15,000 (families with incomes below \$30,000) and would phase out as income rises, reaching zero for individuals with incomes of \$30,000 (families with incomes of \$60,000). The likely impact of this proposal was estimated by Jonathon Gruber of the Massachusetts Institute of Technology and National Bureau of Economic Research, with actuarial sup-

port from the Actuarial Research Corporation. The estimates did assume that the tax credit was advanceable.

Question 2: Is it correct that you assume that 1.4 million people will drop employer provided coverage to receive a tax credit to be used in the individual market, but you also assume zero people will drop employer coverage to receive virtually free insurance under an expansion of SCHIP?

Answer 2: No. Looking first at tax credits, 3.9 million people are estimated to lose employer coverage—a combination of people who themselves choose to shift from employer coverage to purchasing coverage in the individual market and of people whose employers drop coverage. Among those whose employers drop coverage, an estimated 1.4 million people are estimated as not likely to purchase insurance on their own, even in the presence of the credit. Hence, they lose insurance. (Figure 3 in my testimony shows the 2.5 million people who previously had employer coverage and are estimated to be using the credit to purchase in the individual market. Figure 5 shows the 1.4 million people whose employers drop coverage and who lose insurance altogether because they are estimated as unlikely to take up the tax credit to purchase insurance in the individual market.)

Looking at the public program expansion to parents, 1.1 million people are estimated to lose employer coverage (Figure 3 in my testimony). However, all of these people are individuals who themselves choose to shift from employer coverage to the individual market when offered the tax credit. Employers are estimated as unlikely to drop coverage under a policy that targets a new benefit to so narrow a segment of workers as low income parents. Since employers are unlikely to drop, no individuals lose coverage without shifting to an alternative. (Hence the 0 losing insurance in Figure 5.)

Question 3: In your testimony, you assume a take-up rate of 8 percent for the tax credit program but a 58 percent take-up rate for the Medicaid expansion. Can you please elaborate on this?

Answer 3: Estimates of take-up are not arbitrarily assumed. Rather they are a function of differences in subsidy structure and people's likely responses to those structures, based on experience. As shown in Figure 3 in my testimony, an estimated 38.3 million previously uninsured individuals would be eligible for the tax credit. For the vast majority of these individuals, the tax credit is structured to provide only a partial subsidy for the cost of insurance. The literature on individuals' responses to subsidies indicates that limited subsidies lead to limited participation. Our analysis—which reflects experience with the way people's financial circumstances, the price of insurance, and the value of a subsidy affect choices—finds that 3 million people (8 percent of eligible uninsured people) would take up the tax credit.

The public program expansion is structured as a full subsidy for the cost of insurance for people with incomes under 150 percent of the federal poverty level (limited premiums are charged for people with higher incomes up to 200 percent of the federal poverty level). In other words, the expansion makes insurance free for people in this income category, where most of the estimated participation occurs. Participation estimates reflect past experience with take-up for Medicaid.

Question 4: Could state budgets afford the Medicaid expansion as set out in the study? Do any Governors support the proposal you are presenting? How much would the proposal cost States?

Answer 4: The proposal our study examined was similar to a legislative proposal that would extend Medicaid or SCHIP coverage to parents (and any currently ineligible children) with incomes up to 200 percent of the federal poverty level. We estimated its total annual costs, federal and state, as \$11.3 billion. Our analysis assumed that states would be required to extend eligibility to the maximum, as a condition for receipt of any Medicaid and SCHIP funds. But we did not assume a distribution of state and federal obligations; that split would be up to policymakers and, indeed, the costs could be borne fully by the federal government. If split at the current SCHIP matching rate, the federal share would be \$7.9 billion and the state share, \$3.4 billion.

The public expansion's total cost of \$11.3 billion would increase the number of people with insurance by 3.8 million, at a cost per net newly insured individual of \$2974. That compares to an estimate of \$4.5 billion to increase the number of people with insurance by 1.6 under the tax credit—a cost per net newly insured individual of \$2757. The difference in the two proposals' total costs is almost entirely a function of how much they accomplish in expanding coverage.

Question 5: Your proposal does not appear to cover childless individuals or couples. Is this correct and do you know how many people fall into this category?

Answer 5: My testimony focused on options similar to the most prominent legislative proposals. That meant comparing a broadly targeted tax credit proposal, for

which take-up is found to be modest, to a narrowly targeted proposal, for which take-up is likely to be substantial. When the disruption of employer coverage associated with the broader proposal is taken into account, the broadly-targeted tax credit is found to increase coverage less than the public expansion that is narrowly targeted to parents.

In the Kaiser Family Foundation study on which my testimony is based, however, we analyzed two broader public proposals—specifically, a mandatory expansion of Medicaid or SCHIP to cover all individuals with incomes below 100 percent and 200 percent of the federal poverty level. Our estimates indicated that the first proposal would increase the number of insured individuals by 5 million people; the second, by 10 million people. The annual total costs (federal and state) are estimated at \$16.2 billion and \$34.1 billion, respectively.

Speaking for myself, I would welcome legislative action to eliminate the current restrictions in our public programs that leave adults other than parents of dependent children without an insurance safety net in most of the country. I advocate a change in policy to make public insurance available to all low income individuals, whether or not they are parents of dependent children.

HEALTHCARE LEADERSHIP COUNCIL
May 10, 2002

The Honorable MICHAEL BILIRAKIS
Chairman
House Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

DEAR MR. CHAIRMAN: As requested in your April 30, 2002 letter, attached are my responses to the questions submitted for the record, following the February 28th hearing on access to affordable health care coverage.

Thank you for the opportunity to testify before the Subcommittee. Please do not hesitate to contact me or my staff if you need additional information.

Sincerely,

MARY R. GREALY
President

attachment

QUESTIONS AND ANSWERS FOR THE HEARING RECORD

Question 1. In your written testimony, you mention that a large percentage of the uninsured are dependents of workers—and while the workers may be able to afford coverage for themselves, they cannot afford the higher premium for family coverage. Can you elaborate on this portion of the uninsured and perhaps suggest some solutions?

HLC Answer: Small and medium sized businesses offering health insurance to their employees contribute, on average, 48 percent of the premium amount for employees, but only 24 percent for their dependents. As a result, children in these families are uninsured more often than the actual worker is.

Some of these uninsured dependents are eligible for, but not enrolled in, the State Children's Health Insurance Program (S-CHIP). States are working hard to find ways to reach out to these un-enrolled eligible children through schools, clinics, etc. Including employers of low-income workers in these outreach activities could be very useful.

Special tax incentives for dependent coverage could be a wise choice for targeting federal funds toward this population of the uninsured. A potential solution is for states or the federal government to design a refundable tax subsidy targeted toward making up the difference between this 24% and 48% employer contribution.

Another cost-effective option to reduce the number of uninsured among the employed population is allowing S-CHIP funds to be used by parents of eligible children to purchase coverage for them through their employer. One reason employers with mostly low-wage workers often do not offer employee health insurance is because their employees cannot afford to pay a share of the premium. Aid from the S-CHIP program could encourage more employers to offer family coverage as well as more employees to buy into employer insurance. Currently, due to displacement concerns, some states are reluctant to allow the funding to be used in this way. However, recent studies have demonstrated that this concern is unwarranted. Nonetheless, appropriate safeguards could be implemented to avoid significantly replacing private dollars with public dollars.

Question 2. HLC has recognized several state and local programs that have found ways to help small employers and individuals obtain coverage and care. What can we learn from these programs and do you think these programs can be built upon to eventually cover a significant number of the uninsured?

HLC Answer: There are a number of things we can learn from these programs. Designing tax subsidies to attract both employer and employee purchase of insurance requires careful study of subsidy level, administrative complexity and other factors necessary to reach a threshold that would result in the choice to participate. We have found that community-sponsored programs around the country that are expanding insurance coverage in their local areas can serve as models of reference for these thresholds.

An insurance program developed in Wayne County, Michigan, for small businesses found that it was difficult to entice these businesses to participate by subsidizing less than one-third of the premium. The premium formula that eventually got this program off the ground was one-third paid by the employer, one-third paid by the employee, and one-third subsidized by the county.

The stability of the subsidy also appeared to be important to the success of the program—indicating that the subsidy should operate as a guaranteed percentage of the premium rather than a fixed dollar. Applying observations such as these in designing a tax incentive plan to reduce the number of uninsured could greatly increase that plan's potential for success. With added federal support that leverages funding from private and other public sources, substantial opportunity exists to replicate these experiences around the country.

Several of these local programs have found that marketing methods were key to successful enrollment. They found that education outreach for small businesses and individuals, not unlike the S-CHIP program, was a very necessary component that needed to be part of the original planning process of the program. They also found that it was important that any marketing efforts did not have the appearance of government intervention.

In any case, tax incentives would give more small employers the proper incentive to provide coverage and the incentive for employees to accept coverage for themselves and their dependents. This would result in more Americans being insured, lower overall health care costs, and ultimately more affordable coverage for small businesses.

Question 3. Many consider the S-CHIP program to be very successful in helping the uninsured—why not just expand it to cover the low-income uninsured children and adults who are not already eligible?

HLC Answer: The HLC believes the S-CHIP program is very valuable for its intended purpose—children of low income families. We do, however, believe that increased flexibility in the S-CHIP program would help increase its intended enrollment. Tax incentives would be more desirable for as much of the population as possible because they would offer choice and flexibility and would instill competition and innovation in the health system.

Furthermore, evidence suggests that we are reaching the limits of effectiveness in reducing the number of uninsured through the S-CHIP and Medicaid programs. Only about half of individuals currently eligible for Medicaid and S-CHIP actually participate. A number of reasons have been cited for low participation rates including the fact that participation rates of means-tested public insurance programs decline as incomes rise. A large number of those not participating are those with incomes too high for Medicaid eligibility, but low enough to qualify for S-CHIP. Families with incomes just above the poverty level are often working full time and are more reluctant to receive their health care through a public program. This pattern of lower participation among higher income persons is also evident in other government health care subsidy programs, including the Qualified Medicare Beneficiaries (QMBS) and Specified Low-Income Medicare Beneficiaries (SLMBs) programs. Researchers have concluded that substantial outreach is necessary to overcome barriers to participation, such as the possible stigma associated with public programs.

These data suggest that eligibility alone, without considerable investment to remove existing barriers to participation, will not efficiently increase insurance coverage. Many eligible individuals in the higher income categories of Medicaid and S-CHIP, as well as income categories under consideration for Medicaid and S-CHIP expansions, are connected to the workforce. Therefore, solutions involving employer insurance may be more effective in increasing coverage rates for these populations.

Question 4: After having an opportunity to review Ms. Feder's written testimony in which she compares a basic tax credit proposal to Medicaid expansion could you please comment on her study and overall analysis?

HLC Answer: HLC takes issue with Ms. Feder's characterization of both the tax credit proposals under consideration as well as the impact of further expansion of public health programs to address the problem of the uninsured.

Specifically, Ms. Feder's criticism of tax credit proposals makes apples to oranges comparisons that do not reflect the facts of the proposals under consideration in Congress. She states in her testimony that a significant problem with tax credits is that low income uninsured persons need funds available in advance of purchasing insurance and cannot wait until they file a tax return to receive the funds. However, the tax credit proposal put forth by the Bush Administration, like others introduced in Congress, is advanceable to beneficiaries because it is based on their previous year's tax return. This allows beneficiaries to receive the value of the credit in real time and also ensures that they will not be held accountable for any overpayment made by the government at the end of the year due to changing tax circumstances.

Ms. Feder claims that tax credits will not be of significant value to entice persons to purchase private health coverage. She then cites studies that compare the impact of expansions of public programs versus tax credits to make her point that expanding Medicaid and S-CHIP have a greater impact on reaching the uninsured. Again, this comparison is not relevant to tax credit proposals being considered today.

In the hypothetical example presented in Ms. Feder's written testimony, she compares a nonrefundable tax credit with Medicaid and S-CHIP expansion. Most tax credit proposals under consideration in Congress, as well as the Administration's proposal, promote refundable tax credits—that is, those who have no tax liability due to their low income, will still receive the full benefit of the credit in the form of an insurance voucher. Thus, the conclusions she draws regarding the impact of this proposal on the number of uninsured completely ignores the significant number of uninsured who have no income tax liability and therefore would benefit from a refundable tax credit.

Question 5: The analysis Ms. Feder presented at the hearing is based on numerous assumptions. This includes: Substantial employer dropping of coverage is assumed for the tax credits. Ms. Feder assumes a higher cost of insurance than is estimated by the Council of Economic Advisors or currently provided by groups like e-Health. The study assumes a very low take-up rate for the tax credit and a high take-up rate for the Medicaid expansion. Could you please comment on Ms. Feder's assumptions?

HLC Answer: The criticism that employers may drop health coverage if you provide subsidies to the uninsured applies regardless of whether you provide these subsidies through tax credits or through expansions in public programs. The key issue is how you design the program. The amount of "crowd-out," as it is called, of employer-provided coverage is minimized if the subsidy provided by the government is less generous than the subsidy provided by the employer. If a low-income individual was offered job-based health insurance and was also eligible to receive a tax credit, the value of that tax credit would have to be greater than the employer contribution to that employee's health coverage, including the tax benefits associated with that coverage, as well as the additional tax the employee would pay on the salary they may receive in lieu of health coverage. In addition, most tax credit proposals are capped at a certain amount whereas the tax exclusion for employer-provided coverage is open-ended, and therefore potentially more generous.

An additional design feature that will reduce employers dropping coverage is means-testing tax credits. An employer is not likely to drop coverage only for low-income workers eligible for the credit, while maintaining coverage for higher income employees.

The second assumption made by Ms. Feder related to the cost of individual health insurance policies includes many variables she does not address in her written testimony. Individual health insurance premiums can vary significantly based on the state in which you live in and the type of policy purchased. States with numerous mandated benefit laws and onerous insurance regulations have higher cost insurance. In addition, there is wide variance in premiums depending on the level and type of coverage an individual chooses. First-dollar indemnity coverage can cost significantly more than a plan with a high deductible and managed care features. Recently, the National Association of Health Insurance Underwriters (NAHU) challenged a Kaiser Family Foundation report by researching and publishing affordable insurance rates for comprehensive health insurance policies for a set of hypothetical insurance customers seeking insurance in the individual market. Several of these hypothetical customers had pre-existing, chronic health conditions.

Finally, the assumption that take-up rates for Medicaid coverage would be greater than tax credits is questionable. As already noted, the hypothetical example given by Ms. Feder does not match current tax credit proposals under consideration. In addition, the spending level for her Medicaid expansion proposal is much higher

than the spending level for her tax credit example. If her hypothetical example were to compare advanceable, refundable tax credits of equal value as her Medicaid expansions, we believe her example would yield different results.

Because health insurance tax credits are largely untested, it is hard to estimate their true impact on meeting the needs of the uninsured. The values of the tax credit approach are that they offer beneficiaries choice and flexibility in benefits and levels of coverage; they provide beneficiaries access to the quality and efficiencies of the private sector health delivery system; they do not carry the same stigma that public programs often have for working families; and they provide a means of offering tax equity to low-income Americans who do not receive tax-favored employer-based health insurance.

Contrast this with public programs such as Medicaid and S-CHIP. Only about half of the individuals currently eligible for Medicaid and S-CHIP actually participate in the programs, suggesting that eligibility alone—without considerable investment to remove existing barriers to participation—does not and will not efficiently increase the number of people receiving coverage. In addition, expansions of these programs require legislative action by all 50 states, many of which are currently experiencing severe funding shortfalls in their Medicaid budgets.

COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE
May 9, 2002

The Honorable MICHAEL BILIRAKIS
Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515-6115

DEAR CHAIRMAN BILIRAKIS: Thank you for the opportunity to provide additional information to the Subcommittee. This responds to your letter of April 30, in which you asked the following:

1. In your written testimony, you state that employers' willingness to subsidize coverage is strongly influenced by the scarcity or availability of workers, the cost of health care, and the patchwork of public policies that encourage (or discourage) firms to offer insurance as a benefit. Does the IOM plan on reviewing the regulatory burdens on access to private health insurance and evaluate how this impacts the cost of premiums?

2. According to your written testimony, you state that the combination of strict eligibility requirements and enrollment procedures make public coverage difficult to obtain and even harder to keep. You note that the median length of time that someone under the age of 65 keeps Medicaid coverage is about 5 months. At the end of any given year, about two-thirds of the people who were insured by Medicaid at the start of the year have lost their coverage for any number of reasons. These are staggering facts. Can you please elaborate on this situation? Furthermore, Diane Rowland stated that recent legislation may have made improvements to this situation. Does IOM have any facts indicating changes in the status of this problem?

In response to the first question, the IOM Committee on the Consequences of Uninsurance is charged with assessing and documenting personal and societal health and economic effects of the lack of health insurance in a series of six reports. The Committee's first report, *Coverage Matters*, which was the basis of my testimony to the Subcommittee on Health, surveyed a variety of factors that affect employers' willingness to offer health insurance. The final report that the Committee will issue in the fall of 2003 will identify strategies and models for addressing the problems of uninsurance and, in preparing this final report, will give further consideration to the obstacles to and potential for expanding employment-based health insurance. Although the work on this final report is not very far along at this point, I doubt that our Committee will be able to quantify with sufficient precision the impact of current federal and state health insurance regulations on premium costs. I expect that we will, however, be able to identify some regulatory policies that are more conducive to employment-sponsored plans than others.

In response to the second question, regarding the short tenure and instability of Medicaid coverage for many enrollees, *Coverage Matters* and my testimony relied on several analyses of the Census Bureau's Survey of Income and Program Participation (SIPP) panel data between 1990 and 1995, which followed participants over 28- to 33-month periods. These studies include:

"Dynamics of Economic Well-Being: Program Participation, 1993 to 1995. Who Gets Assistance?" Jan Tin and Charita Castro. Current Population Reports P70-77,

issued September 2001. Washington, DC: U.S. Census Bureau. **Median duration on Medicaid, <18 years = 4.3 months; 18-64 years = 5.2 months.**

“Single Women and the Dynamics of Medicaid.” Pamela Farley Short and Vicki A. Freedman. *HSR:Health Services Research* 33:5 (December 1998, Part 1); pp. 1309-1336. **1990-1992, single women 19-44 newly covered by Medicaid, duration on Medicaid: <1 year = 54%; <2 years = 69%.**

“Can Medicaid Managed Care Provide Continuity of Care to New Medicaid Enrollees? An Analysis of Tenure on Medicaid.” Olveen Carrasquillo, David U. Himmelstein, Steffie Woolhandler, and David Bor. *American Journal of Public Health* 88:3 (March 1998); pp. 464-466. **1991-1993, new Medicaid enrollees of all ages, duration on Medicaid: < 1 year = 62%; < 28 months = 74%.**

One recent additional source of information about the stability and change in health insurance status that the Committee did not have available earlier is based on the 1996 Medical Expenditure Panel Survey (MEPS). Because the MEPS analysis is not limited to Medicaid enrollees and because the SIPP reports on Medicaid participants enrolled only after the survey began, it is difficult to know the extent to which this later MEPS analysis represents a lengthening of the average Medicaid enrollment period, although it does appear to be lengthening somewhat.

MEPS Research Findings #18, AHRQ Publication No. 02-0006 (December 2001), reports the percentage of persons under age 65 with some form of public health insurance (including both Medicare and Medicaid) during 1996 who had that coverage for the entire year. Overall, 75 percent of public program enrollees were enrolled the entire year. Seventy-five percent of children under 18 enrolled in public programs (largely Medicaid) remained covered for the entire year. Among adults, however, the fraction of those maintaining coverage for the full year ranged from 62 percent for adults 18-24 to 85 percent for adults 55-64. Although the proportions covered by Medicare and Medicaid, respectively, are not given in this report, a larger proportion of publicly insured older adults have Medicare coverage (due to permanent disability) than is the case for younger publicly insured adults who are much less likely to be disabled.

Dr. Rowland is correct, that federal Medicaid and SCHIP policy encourages states to simplify program enrollment and re-enrollment procedures and lengthen enrollment periods from one or three months to initial enrollment periods as long as a year. Many states have done this. However, as several witnesses at the hearing pointed out, states are also facing budget shortfalls that mitigate against expansive Medicaid and SCHIP policies, and it remains to be seen whether states will sustain the enrollment reforms that they initiated following the enactment of SCHIP. Our IOM Committee continues to follow and will report on the latest information available about the duration of public program coverage.

Once again, thank you for the opportunity to testify and to expand upon my remarks here. Please do not hesitate to contact me if you would like further information.

Sincerely,

ARTHUR L. KELLERMANN, M.D., M.P.H.
IOM Committee Co-Chair

cc: Mary Sue Coleman, Ph.D.
IOM Committee Co-Chair

THE HENRY J. KAISER FAMILY FOUNDATION
May 10, 2002

Hon. MICHAEL BILIRAKIS
*Chairman
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
Room 2125, Rayburn House Office Building
Washington, DC 20515-6115*

DEAR CHAIRMAN BILIRAKIS: Thank you again for the opportunity to testify before the Subcommittee on Health on February 28, 2002 regarding “The Uninsured and Affordable Health Care Coverage.” I received the follow-up questions and am submitting the following information for the record.

1. Premium Increases: *In your written testimony, you discuss the impact of a weakening economy and rising health care costs. You note that from 2000 to 2001, premium costs increased on average 11%. Do you know what the premium increase has been for premiums sold to small businesses and on the individual market respectively?*

As stated in my testimony, health insurance premiums are beginning to rise more rapidly than in previous years: according to our 2001 annual survey of Employer Health Benefits, from 2000 to 2001, they rose on average 11%, the highest increase since 1992. The greatest increase in premium costs was among small firms. All small firms (those with between 3 and 199 workers) experienced increases of 12.5%, and the smallest firms (those with between 3 and 9 workers) saw premiums increase 16.5%. Differences between premium increases among small and large firms were consistent across plan type (conventional, HMO, PPO, and POS).

While firms faced a wide range of premium increases around the average increase, firms with fewer than 200 workers experienced disproportionately high increases. More than a third (35%) of these small firms saw premiums increase more than 15%, compared to only 17% of larger firms. For nearly a fifth of small firms, premiums rose more than 20%.

In our recent National Survey of Small Businesses, which surveyed employers with between 3 and 24 workers, we were able to obtain additional information on the impact of rising premiums for small firms. Sixty-six percent of small business owners say they are dissatisfied with the cost of health care and health insurance. Many small businesses also indicate that future premium increases of 10% may lead them to reduce the scope of benefits offered (36%), increase the amount that employees pay for insurance (50%), or drop coverage altogether (17%).

The March 2002 survey of small and independent business owners by the National Federation of Independent Business (NFIB) Education Foundation (Monthly Report, April 2002) also indicates that small businesses are concerned about the cost of health insurance premiums. This survey reports that the cost and availability of health insurance is now tied with taxes as the single most important problem facing small businesses. Nineteen percent of owners cited this issue as the major problem, up from 8% one year ago.

Additional detail on health care costs faced by employers and small businesses' views on rising costs can be found in our 2001 *Kaiser/HRET Annual Survey of Employer Health Benefits* and our April 2002 *National Survey of Small Businesses*, respectively. Both of these publications can be found on our website, www.kff.org.

We unfortunately do not have information on premium trends in the individual market. In general, policies in this market are highly variable and depend on an individual's circumstance and location, and we have not attempted to collect aggregate data on premium costs or their changes over time.

2. Length of Time with Medicaid Coverage. *According to Dr. Kellerman's written testimony, he states that the combination of strict eligibility requirements and enrollment procedures make public coverage difficult to obtain and even harder to keep. He notes that the median length of time that someone under the age of 65 keeps Medicaid coverage is about 5 months. At the end of any given year, about two-thirds of the people who were insured by Medicaid at the start of the year have lost their coverage for any number of reasons. What information do you have concerning the median length of time someone keeps Medicaid coverage?*

While it is likely that some beneficiaries now served by the Medicaid program gain and lose coverage over a short period of time, the data on Medicaid tenure cited in Dr. Kellerman's testimony does not reflect the current configuration and operation of the Medicaid program, especially in its role as a health insurer for low-income children.

The statistics cited above rely on studies of transitions on and off Medicaid that draw from data collected in the early 1990s. Specifically, the main study I believe Dr. Kellerman cites in his testimony (Carrasquillo, et al.) used a longitudinal survey conducted from 1991 to 1993. While informative of the experience of beneficiaries in the early 1990s, it is misleading to extrapolate these findings to describe current dynamics of Medicaid coverage.

As I stated at the hearing, the most significant reason such findings are no longer accurate is because the Medicaid eligibility and re-certification processes have changed significantly in recent years, particularly for children. Following welfare reform in 1996 and the implementation of the State Children's Health Insurance Program (CHIP) in 1997, states began to reach out to families eligible for Medicaid coverage and ease barriers to enrollment and re-determination for both CHIP and Medicaid. Several states have raised income eligibility levels and/or begun to disregard certain types of income in determining eligibility. This helps promote stability of coverage, as minor fluctuations in income are not as likely to result in lost eligibility. Furthermore, states have also implemented 12-month continuous eligibility (17 states), which allows beneficiaries to be covered despite small income fluctuations; lengthened periods between re-certification (42 states); and simplified the re-certification process by eliminating the need for interviews and documentation (48 states). While studies have not yet specifically examined their effect, these improve-

ments in the re-certification process are likely to have positively impacted the length of time that families retain their coverage.

Another reason for caution in interpreting studies of Medicaid tenure stems from the fact that the different populations that Medicaid serves move on and off coverage in very different ways. For example, the experience of women—who, at the time many studies of this topic were conducted, largely qualified based on pregnancy or receipt of cash assistance—is likely to be very different from that of other populations covered by the program. Medicaid coverage of pregnant women, which ends 60 days postpartum, is by design short-term coverage; pregnant women who reported being covered by Medicaid at one point in a survey were likely ineligible for coverage at consecutive points in a survey that examines several years of coverage. Further, income eligibility levels for non-pregnant women are most often based on the exceedingly low income standards for cash assistance. As a result, small fluctuations in earnings undermine Medicaid eligibility for this population. As one study points out, in states with higher income eligibility levels, single women retained Medicaid coverage longer (Short and Freedman, 1998).

In contrast, Medicaid coverage of other groups is more stable. Children on Medicaid are covered at higher income levels and are less likely to lose coverage due to fluctuations in family earnings. In addition, the elderly and disabled on Medicaid (who account for over a quarter of all beneficiaries) are unlikely to experience changes in income or categorical eligibility (that is, they will not cease to be aged or disabled) and corresponding changes in Medicaid coverage. Elderly and disabled beneficiaries who live on fixed incomes and receive institutional care are least likely to experience disruptions in their Medicaid coverage. These important differences in the dynamics of coverage are lost when all groups are examined together in a single median value.

Finally, though the potential of beneficiaries “churning” on and off Medicaid is an important policy issue, it is important to recognize that this problem is largely related to the nature of the program. Coverage under means tested programs—particularly those with low income thresholds—will by design fluctuate as people’s incomes rise and fall and change their eligibility status. For low-income individuals, especially those who work in the service industry (as many do), income often varies from month to month or season to season. For many of these people, Medicaid serves as a safety net when they temporarily find themselves with no other source of coverage. Especially in a weak economy, Medicaid fills in gaps in health insurance for those who lose employment and look to public programs for assistance until they return to the workforce; as we would hope, these transitions, and the corresponding Medicaid spells, are often short. As income eligibility levels are increased, however, Medicaid coverage can develop from a temporary safety net to a reliable source of insurance for low-income Americans.

In essence, your question—and the difficulty in answering it—points out a significant gap in the data we have on health coverage of the low-income population: we do not have current, accurate information on the median length of time that someone keeps Medicaid coverage. Most recent sources of information use point-in-time estimates of coverage, rather than longitudinal examinations of coverage dynamics over time. Urban Institute analysis of one year of data showed that in a given year (1998), beneficiaries were enrolled for an average of almost 9 months; however, aged and disabled beneficiaries were covered for an average of 11 months in a year. Given its limited one-year time frame, this data underestimates the duration of coverage, as many will have enrollment that commenced before the year began or continued beyond the year end. A new statistical reporting system that is being implemented by the Centers for Medicare & Medicaid Services (the Medicaid Statistical Information System, or MSIS) may help provide better information on Medicaid tenure in the future, but data from this system has only recently become available and analyses are not yet complete.

I hope that this information is useful to the Committee as it considers options for extending health insurance coverage to the nation’s 39 million uninsured. Please do not hesitate to contact me if you need any additional follow-up information. Thank you.

Sincerely,

DIANE ROWLAND

*Executive Vice President, The Henry J. Kaiser Family Foundation
Executive Director, The Kaiser Commission on Medicaid and the Uninsured*

RESPONSES FOR THE RECORD OF ROBERT G. DE POSADA, PRESIDENT, THE LATINO COALITION

Ms. Feder states in her testimony that tax credits typically offer too few dollars to make coverage affordable. Could you comment on this?

In most states, the tax credit would be sufficient. According to ehealth insurance.com (the nation's largest internet health insurance agency), out of 20,000 approved single and family applications 15,000 fall within 75-100% of proposed tax credit. Of course, even federal workers have to contribute something to the cost of their health insurance.

But with this kind of support from the Federal Government, insurers that have ignored this market will have a strong incentive to design programs to meet this new group of potential customers. Currently, there is no reason why health insurance companies would target the individual market of low-income workers, simply because they do not have the income to purchase a health insurance plan. However, when they figure out that millions of households will have access to \$3,000 a year, you can rest sure that plans, similar to what Aetna and other health insurance companies designed two years ago for this market, but were not able to find enough consumers, will find many new customers.

However, we strongly recommend that additional efforts to help reduce the cost of health insurance be included in legislation dealing with tax credits. For example, individual association plans, as proposed by Congressman Lipinski (D-IL) to allow community based organizations and churches to offer a variety of health insurance plans to its members, of which at least one would bypass burdensome state regulations, would clearly help reduce the cost of health insurance. This would also serve as a great vehicle to reach out to underserved communities. We also support Association Health plans to help our small business owners get access to more affordable health insurance for their employees.

Why do you think that the uninsured rate is so high among the U.S. Hispanic population?

It's mostly a matter of the source of employment. Most Hispanics work for small businesses and in the service industry. These employers, in most cases do not or cannot afford to offer health insurance to their workers. There is also the fact that in many cases there is very a very high mobility in the workforce. We have interviewed many employers in the service industry who indicate that many of their workers move from job to job quite frequently, therefore it does not make sense for them to offer insurance to workers that will be with them for a couple of months. Also, in the last few years, the effects of guaranteed issue and community rating/modified community rating have made health insurance more unaffordable for small employers and for individuals.

It is an economic obstacle combined with the fact that most insurers have not targeted the low-income workers market. So if you cannot afford health insurance and you do not have easy access to it, you will most likely be uninsured. Also, you cannot ignore the cultural behavior. In many cases, low-income and undereducated immigrant workers who are not used to a health insurance system in their country of origin, are used to going to hospitals or clinics when they get sick.

As you know, the President's tax credit proposal provides a refundable tax credit of up to \$3,000 for a family with two or more children. Please comment on the utility of such an approach.

Currently, employer-provided health insurance is tax-free, and that amounts to about a \$133 billion tax break for employer-provided insurance. Meanwhile, individuals who don't have access to employer-provided health insurance get no tax break if they buy health insurance.

These workers, in most cases low-income workers, have to pay for insurance with after-tax dollars. This discrimination forces many individuals to go without coverage. Providing uninsured families \$3,000 each year tax-free to buy health insurance levels the playing field and would provide an opportunity for many individuals to buy health insurance. Why should the government provide a tax-break for Bill Gates, and then ignore a waitress, or the guy painting your house, or the young men picking grapes on the fields? It's a matter of fairness and treating people equally.

According to Fiscal Associates, 60% of the eligible population would buy health insurance if they were given this opportunity. And this refundable tax credits will help low income workers get health insurance for their families. Our survey data show overwhelming support in the Hispanic community for this approach.

After having an opportunity to review Ms. Feder's written testimony, in which she compares a basic tax credit proposal to Medicaid expansion, could you please comment on her study and overall analysis?

I think her model is flawed. Ms. Feder is clearly committed to a single payer system, government-run health system, and has a very negative opinion of the private-system. If I were to focus a testimony on the most radical and far-fetched possibilities and assumptions, I would also come to the same conclusions. I do however, find interesting that most of those who want to expand the Medicaid program for everyone, have a good private plan taking care of them and their families.

Ms. Feder works under the assumption that it will be impossible for a family to buy health insurance under \$8,000 a year. She uses a national average for a full-fledge insurance plan to base her conclusions. However, the fact is that states with guaranteed issue and community ratings have such high premiums that drive the national average to unthinkable levels. You cannot tell me with a straight face that a basic health insurance plan in Albuquerque, New Mexico and one in New York City are comparable.

Our research shows this is not accurate. According to ehealthinsurance.com (the nation's largest internet health insurance agency), out of 20,000 approved single and family applications 15,000 fall within 75-100% of proposed tax credit.

The purpose of the refundable tax credit proposal is to have a basic plan that would help these families have the peace of mind that they will be covered in case they need it. If she wants to offer these families a full-range "Cadillac" plan, the price will obviously increase dramatically. She also argues that families will be required to pay a deductible and this will not encourage parents to seek preventive care for their children. This is completely absurd. Even federal workers have a deductible in their plan, and yet these parents do not sacrifice the health of their children. Why would low-income workers be any different?

She also argues that employers will drop their coverage and the only ones who would benefit from this proposal would be employees who are currently employed. The fact is that there should be provisions attached to this legislation to make sure this doesn't happen and to penalize any employer who drops health insurance coverage in order to qualify for this kind of proposal. Congressman Lipinski has offered legislation which could serve as a model to make sure that employers do not drop their insurance.

From a financial point of view, anyone analyzing the current financial chaos that Medicaid has created in most state budgets, would realize that doubling or tripling the number of people covered by the Medicaid program would create havoc in most states. Currently, most states are severely restricting access to services and medications in order to control costs. Can you imagine the consequences of significantly expanding this mess?

Finally, if Ms. Feder is such a fan of Medicaid, we should invite her to drop her employer-provided health insurance plan, go to the welfare office, sign up for Medicaid, tell her friends she is on Medicaid, and then describe Medicaid for us. My guess is that she will not be happy, so why is she advocating that others join Medicaid.

The analysis Ms. Feder presented at the hearing is based on numerous assumptions. This includes: 1) substantial employer dropping of coverage is assumed for the tax credits; 2) Ms. Feder assumes a higher cost of insurance than is estimate by the Council of Economic Advisors or currently provided by groups like e-health; 3) the study assumes a very low take-up rate for the tax credit and a high take-up rate for the Medicaid expansion. Could you please comment on Ms. Feder's assumptions?

(See answer to question number 4.)

We have conducted forums in seven states focusing on improving access to affordable health insurance and quality health care. We have found that across the board, Hispanic leaders and their organizations feel that the expansion of Medicaid and CHIP programs are not the best solution. A wide range of groups like the League of United Latin American Citizens, the Hispanic Business Roundtable, the Mexican Benefits Committee, Carrolla Medical Management, the Interamerican College of Physicians and Surgeons, and AZTEC Resources, among many others, have come to the conclusion that tax credits will be more effective to reduce the number of uninsured than the expansion of Medicaid.

Even most liberal-leaning Hispanic health organizations have actively criticized the expansion proposals. These programs have very low rates of enrollment among Hispanic families. So why should we believe that there will be a high take-up rate among Hispanics? Also, according to a nationwide survey of U.S. Hispanics conducted in May 2001, Hispanics prefer private health insurance over a government program by 65 to 24%.

At the same time, we strongly believe that Federal and state authorities should work diligently to simplify the process to qualify and enroll in Medicaid and CHIP. This would also be an important part of addressing the uninsured crisis in our community. We are convinced that the tax credits, the increase of community health

centers, the simplification of the application process for Medicaid and CHIP, and the enactment of key legislation to promote pooling and bypass excessive regulations, will go a long way to significantly reducing the uninsured crisis.

GALEN INSTITUTE
May 15, 2002

The Honorable MICHAEL BILIRAKIS
Chairman, Health Subcommittee
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20015

DEAR MR. CHAIRMAN: Thank you for your letter regarding my testimony before your committee on February 28, 2002, on "The Uninsured and Affordable Health Coverage." I also appreciate the opportunity to provide answers to the follow-up questions you asked in your April 30, 2002, letter, as follows:

1. *After having an opportunity to review Ms. Feder's written testimony, in which she compares a basic tax credit proposal to Medicaid expansion, could you please comment on her study and overall analysis?*

Dr. Feder presented findings from a preliminary study she co-authored for the Kaiser Family Foundation that showed that tax credits would be much less efficient in reaching the uninsured than targeted Medicaid expansion.

During the questioning session, I pointed out that a number of economists have questioned the assumptions upon which the Kaiser study was based and from which its conclusions are derived, thereby raising questions about the validity of the comparison. For example, when analyzing the tax credit proposal, the study's authors made these and other key assumptions that influenced the study's findings:

Cost of insurance: The Kaiser study assumed that "for the typical uninsured family the cost of a nongroup policy is estimated to be roughly \$10,000."

Crowd out: The authors assume that there would be little if any net crowd out of employment-based coverage with the targeted Medicaid expansion, but much more crowd out of employment-based coverage with a tax credit.

I feel the assumptions made and the conclusions drawn in the Kaiser study unfairly represented the impact of refundable tax credit proposals for the uninsured. The assumptions, which I describe below in greater detail, are not a fair characterization of how tax credits would work in the real world. Only with a fair comparison of tax credits vs. Medicaid expansion can policy-makers determine which is the best course of action. I believe that such an analysis would show tax credits to be the most effective and efficient way to address the problem of the uninsured in America.

2. *The analysis Ms. Feder presented at the hearing is based on numerous assumptions. This includes:*

- *Substantial employer dropping of coverage is assumed for the tax credits.*
- *Ms. Feder assumes a higher cost of insurance than is estimated by the Council of Economic Advisors or currently provided by groups like e-Health.*
- *The study assumes a very low take-up rate for the tax credit and a high take-up rate for the Medicaid expansion.*

Could you please comment on Ms. Feder's assumptions?

Regarding the likelihood of employers dropping coverage if tax credits were enacted, also referred to as "crowd out": The study described by Dr. Feder (Attachment 1, Fig. 11) concludes that there would be significantly more crowd out with tax credits and little or no net crowd out under Medicaid.

A co-author of the paper with Dr. Feder, Professor Jonathan Gruber of the Massachusetts Institute of Technology, has done important published work on crowd out in the past that seems to dispute the conclusions in this latest paper. For example, he wrote with David Cutler a paper for the Quarterly Journal of Economics in May of 1996 entitled "Does Public Insurance Crowd Out Private Insurance?" The abstract says: "We estimated that between 48 percent and 75 percent of the increase in Medicaid coverage was associated with a reduction in private insurance coverage." That would be significantly more crowd out than the current paper reflects. And this was for expansion of Medicaid for children and pregnant women with lower incomes, who would be much less likely to have any private health insurance to crowd out than in the current study.

And also regarding their estimates of the loss of employment-based coverage under the tax credit proposal: In an article, "Tax Subsidies for Health Insurance: Costs and Benefits," in *Health Affairs* in January/February, 2000, Gruber and Larry Levitt analyzed a health insurance tax credit that phased out at much higher income levels than the one currently being proposed—at income levels up to \$100,000

for families and \$60,000 for individuals—where people are much more likely to have health insurance. Yet in that paper, Gruber assumed that only 5.4 million people would lose employer coverage—just one million more than in the current study which has much lower income thresholds. And only 0.2 million became uninsured as a result of firms dropping company coverage—far fewer than in their current Kaiser study.

It is useful to ask what an employer likely would do if a refundable tax credit were enacted. If an employer decides that his or her employees would be better or at least as well off with the credit and therefore decides to drop the existing company coverage, the employees would need to be assured that their costs under the tax credit plan would be about the same as the costs under the old employer plan. Otherwise, the employer would find it very difficult to drop coverage without risking harming employee morale and eventually losing workers to other companies that do provide health insurance.

And if the net costs to the employee were the same, wouldn't they be just about as likely to take up coverage under the new proposal?

Regarding the assumption about the cost of a policy: In testimony prepared by Professor Gruber for Ways and Means Committee hearings on February 13, 2002, he wrote, "For a 40 year old male in excellent health, the average cost of nongroup insurance is roughly \$2000 per year. But these costs rise dramatically with age and poor health status. *Indeed, in my data, for the typical uninsured family the cost of a nongroup policy is estimated to be roughly \$10,000.* My estimates assume that individuals and families who purchase nongroup insurance will pay these average market prices for that insurance." (Attachment 2)

Dr. Gruber did calculate the cost and uptake for less expensive policies as part of the study but did not use these calculations in reaching conclusions about the relative value of tax credits in comparison with Medicaid expansion.

According to Professor Mark Pauly of the Wharton School, most uninsured people are in good to excellent health, and for them the premium for quite comprehensive coverage would be in the neighborhood of \$6,000-\$7,000. However, when one includes the *minority* of the uninsured who are in poor or fair health who would be quoted a higher premium and calculates the average premium for them, it could be about \$10,000. Still, the great *majority* of the uninsured would face the much lower premium.

A study by the President's Council of Economic Advisors showed health insurance to be much more affordable than Kaiser assumed. The average price in their survey for a policy for a family of four was \$3,287 for comprehensive coverage. The CEA survey used a higher deductible, which many people would choose in order to have affordable coverage, especially to provide protection against major medical expenses.

Interestingly, Kaiser itself concluded (depicted in Attachment 1, Fig. 13) that individuals who are "healthier than average" and "disproportionately young" are most likely to participate in the tax credit plan. While I would disagree with this theory, it further suggests that Kaiser's \$10,000 estimated average cost of a family policy is too high and therefore skews the results of the study by putting tax credits at a disadvantage.

Numerous other studies have shown health insurance to be much more affordable than the Kaiser study represents. For example, eHealthInsurance, the on-line health insurance brokerage, says that at least 84 percent of the policies it sells not only are comprehensive but affordable, averaging \$1,200 to \$1,500 per person per year.

Much of the discussion during the hearing centered on the cost of health insurance and whether or not a \$1,000/\$3,000 credit (as in the Bush administration's tax credit plan) would be sufficient for individuals and families to purchase at least some form of health insurance. eHealth Insurance's study found the tax credits proposed by President Bush would have covered the *full* cost of the policy for more than half of the 20,000 policies randomly selected for its study sample.

I am also including a chart produced by Dr. Robert Helms of the American Enterprise Institute that shows the actual range in a study by the White House Council of Economic Advisors of the cost of health insurance (Attachment 3). The vertical lines show the highest and lowest cost of health insurance in each category, and the diamond points shows the median cost. I believe that this shows that the cost of health insurance can be much more affordable than the high cost used in the Kaiser study.

Regarding take-up rate: The Kaiser study also concluded that only 8 percent of the eligible uninsured population would participate in the tax credit program (Attachment 4). That would not be surprising if all of the uninsured were faced with a \$10,000 a year family policy. But a less expensive—and more realistically priced policy—likely would draw much more participation.

In his own research, Dr. Pauly found that 48 to 66 percent of the uninsured would buy insurance if they were to receive a tax credit worth half of the value of the policy, while three-quarters would buy coverage if they received a credit worth 75 percent of the premium cost.

If the cost of the policy were assumed to be less than \$10,000, the uptake would have been larger and tax credits would have fared better in the comparison.

Thank you for giving me the opportunity to provide additional information. Please let me know any way I can be of help to you or to the committee in the future.

Sincerely,

GRACE-MARIE TURNER
President

Attachments:

1. Excerpts from the Kaiser Family Foundation study, *Expanding Coverage for the Uninsured: What Difference Do Different Strategies Make?*
2. Excerpt from testimony by Dr. Jonathan Gruber presented to the Ways and Means Committee February 13, 2002.
3. Chart produced by Dr. Robert Helms of the American Enterprise Institute showing the range and median costs of health insurance based upon data from the Council of Economic Advisers.
4. Excerpt from testimony by Dr. Judith Feder presented to the House Energy and Commerce Subcommittee on Health February 28, 2002.

The Kaiser Project on Incremental Health Reform

Expanding Coverage for the Uninsured: What Difference Do Different Strategies Make?

Judy Feder
Larry Levitt
Jonathan Gruber
John Holahan
Rachel Garfield

February 2002

PRE-PUBLICATION DRAFT



Attachment #1

Excerpts

Figure 13

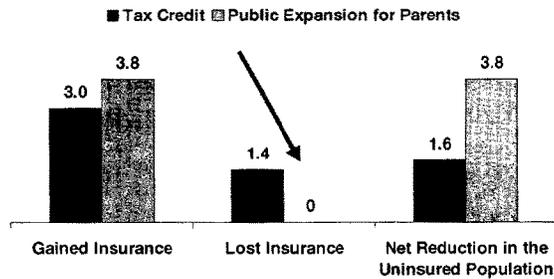
**What Is the Impact on the Uninsured?
Characteristics of Participants**

Tax Credit	Public Expansion for Parents
<ul style="list-style-type: none"> • Healthier than average individuals participate • Disproportionately young individuals participate 	<ul style="list-style-type: none"> • Individuals with average or poor health participate • Age of participants reflects eligible population

Figure 11

**What Is the Impact on the Uninsured?
Change in Coverage Status**

Number of people (millions):



NOTE: Tax credit: refundable \$1000 tax credit (\$2000 for families) with low phase-out; public expansion for parents: mandatory Medicaid/CHIP expansion to parents up to 200% FPL.
SOURCE: Kaiser Project on Incremental Health Reform, 2002.



**Testimony of Jonathan Gruber, Ph.D.
Before the House Ways and Means Committee
Subcommittee on Health
Hearing on Health Insurance Tax Credits
February 13, 2002**

Attachment #2
Excerpt

Results of Analysis

The results of this analysis are presented in Table 1, which shows the aggregate impacts of the tax credit. The first row of the table shows the aggregate costs. The next panel shows the takeup (in persons in the first column, and as a percent of group size in the second column) and costs by previous (before policy change) insurance status groups. The next panel shows the change in the size of each insurance group due to the policy. The final row shows the revenue cost per newly insured person.

My analysis suggests that:

- This policy will cost \$5.2 billion per year.
- There will be 10.5 million persons who takeup the credit. Of those, roughly one-third (3.3 million) are the uninsured.
- There will be a very sizeable movement of almost 4 million persons out of employer-provided insurance. A total of 2.4 million persons will be dropped from group insurance by their employers. Of those, one million will takeup nongroup insurance, but 1.4 million will become uninsured. And 1.5 million persons will switch from their group policies to nongroup policies.
- With 3.3 million previously uninsured taking the credit, but 1.4 million persons who previously had employer-provided coverage becoming uninsured, there will be a net reduction in the number of uninsured of 1.9 million.
- The net result is a public cost per newly insured person of almost \$2800.

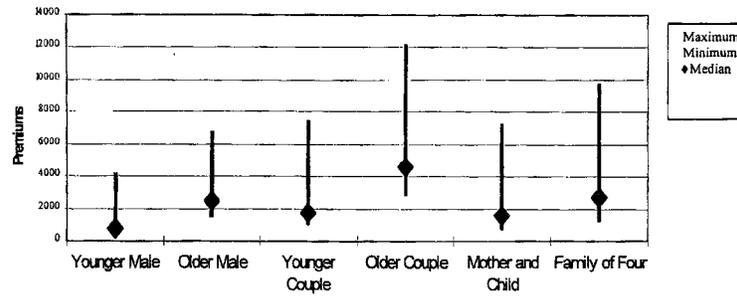
Thus, the tax credit does have its intended effect of significantly increasing the purchase of nongroup insurance by the uninsured. But it also has an unintended effect of slightly eroding the group insurance market, so that the net reduction in the uninsured is fewer than 2 million, or 5% of the existing number of uninsured.

Sensitivity to Insurance Cost Assumptions

One of the key debating points about those modeling tax credits for health insurance is the extent to which individuals will find low cost nongroup plans on which they can use their tax credit. This is an important issue because the costs of nongroup insurance plans are so high. For a 40 year old male in excellent health, the average cost of nongroup insurance is roughly \$2000 per year. But these costs rise dramatically with age and poor health status. Indeed, in my data, for the typical uninsured family the cost of a nongroup policy is estimated to be roughly \$10,000.

My estimates assume that individuals and families who purchase nongroup insurance will pay these average market prices for that insurance. But some claim that the individuals will use this credit to avail themselves of new, low cost insurance options. This claim is hard to evaluate without the policy actually being passed, but it merits consideration.

CEA Study of Health Insurance Premiums



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Analysis prepared by Dr. Robert Helms of the American Enterprise Institute using data from the Council of Economic Advisers.

Attachment #3

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**Testimony by Judith Feder, Ph.D.
Dean of Public Policy
Georgetown University**

Before the

**Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives**

February 28, 2002

Attachment #4

[Excerpt]

Underneath these “bottom-line” differences are considerable differences in the way the two programs operate.

Who receives benefits under the two approaches? Looking first at income (Figure 2), about thirty percent of the tax credit benefit recipients have incomes above twice the federal poverty level. By contrast, all the public program’s benefits are target to people with incomes below that level. Looking next at insurance coverage (Figure 3), 70 percent of the tax credit recipients already have health insurance. Only a minority of recipients are uninsured. By contrast, 70 percent of the public program recipients are without health insurance coverage.

Figure 4 examines targeting from another perspective—the share of the uninsured population that receives benefits from the new program. The tax program makes a far larger uninsured population eligible for benefits than does the public expansion to parents (38.3 million vs. 7.6 million people). (The differences are due both to higher income eligibility standards in the tax credit and to the public program’s focus on parents and their children.) However, a far larger portion of the eligible uninsured population participates in the public program expansion than participates in the tax credit. Over half (58%) of the parents who are the target of the public program participate, as compared with 8 percent of those eligible for the tax credit. By reaching a larger proportion of a smaller pool of eligibles, the public program expansion benefits a larger number of previously uninsured individuals (parents and children) than does the tax credit (3.8 million vs. 3.0 million).

However, the impact of a new policy is not limited to those who benefit from it. At the same time some people gain insurance from a new policy, others may lose insurance. Experience indicates that tax policies that reduce the advantage to employer-sponsored over nongroup insurance lead some employers to discontinue their coverage. Some employees whose coverage has been dropped will take advantage of the new tax credit and remain covered. But others will not. By contrast, a narrowly targeted public program, especially one targeted only to parents, effects only a small proportion of the workforce and, most likely, only some workers in a firm. In addition, employers are likely to be somewhat responsive to employees’ reluctance to shift from private to public insurance. A narrowly targeted public program is therefore unlikely to lead employers to drop coverage.

Figure 5 zeroes in on the different ways in which the two policies affect the insured and uninsured populations. Although the tax credit provides subsidies to an estimated 3.0 million previously uninsured people, an estimated 1.4 million people with employer coverage are likely to lose coverage as employers decide to drop their coverage offerings. The net increase in the number of people with insurance is therefore 1.6 million under the tax credit proposal, compared to 3.8 million under the public program expansion.

Finally, as described above, the 1.6 million people newly covered by the tax credit will likely be different people, receiving different coverage, than the 3.8 million people covered by the public program expansion to parents. People newly insured by the tax

