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LIVING WITHOUT HEALTH INSURANCE

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

ON

WHO'S UNINSURED AND WHY?

AND

SOLUTIONS TO THE PROBLEM

MARCH 13 AND 15, 2001

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LIVING WITHOUT HEALTH INSURANCE: WHO'S UNINSURED AND WHY?

TUESDAY, MARCH 13, 2001

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:47 p.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Snowe, Baucus, and Bingaman.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. It is so quiet in here I hate to use the gavel, but it sure makes you feel good when you do.

First of all, with such a large turn-out, I must apologize, and should probably apologize even for a smaller turn-out. The fact that we did not start at 2:30, because there is some Medicare legislation on the floor of the Senate, an amendment, and I needed to speak on that. Senator Baucus, who would normally be here by now, is speaking on that right at this very minute.

We will also be interrupted again shortly with the votes that we will have. Senator Baucus and I hope to keep the committee going by the two of us not being absent at the same time, so we can continue to receive testimony and not keep you waiting any longer.

Today's hearing is the first in a two-part series to tackle the issues facing the 42 million Americans who go without health care coverage today. This is a very hefty task, but one that deserves our full attention.

It will get the full attention of this committee. In fact, a lot of staff work has gone into, not just to these hearings, but also working towards solutions and bipartisan compromises in these areas as well.

Specifically, though, for today's hearing, the purpose is to understand who we are talking about when we say the words "uninsured Americans." To do this, we need to understand the special circumstances that contribute to the status of being uninsured—age, ethnicity, employment status, geographic location, and you can say all of the above and others—are key factors.

No one will argue that it is unacceptable for 42 million Americans to go without health care coverage. For the most part, quality health care is an exception. Whether it is regular check-ups or visits to specialists, it is often easy to take our health care coverage for granted.

But we must remember that millions of Americans and their families are not so lucky. Many individuals and families struggle to stay healthy with little or no access to health care services.

We are fortunate that our Nation has invested mightily in achieving the best health care system in the world. As a result, the health care practitioners across the country are treating millions of Americans every day with the most advanced technology and science and Americans are experiencing longer, healthier lives than ever before.

But we cannot settle with having a world-class health care system that somehow leaves 42 million Americans behind. That obviously does not give credit to a lot of charitable care, but that is not the best way to deliver health care. It is one that we are thankful for, however.

In recent years, Congress has been working in incremental ways to ensure that Americans have access to affordable, high-quality health care. We can look at successes such as State Child Health Insurance programs and know that 3 million more Americans now are getting health care coverage than were before, and this is something that they need and deserve.

The passage of the Kassebaum-Kennedy bill in 1996 was an important step towards ensuring continuous health coverage. Barriers to health care have finally been removed for adults with disabilities who want to work, but fear losing health coverage. Low-income women who suffer from breast cancer now can have access to treatment.

These incremental improvements have made big differences in the lives of millions of Americans. But there is a great deal more that needs to be done, and that is our task today, to learn more about our Nation's uninsured population so that we can continue down the road towards finding solutions.

We have joining us a panel of experts who understand the intricate details of the uninsured population. I thank all of you for your participation this afternoon, and those who especially had difficult times coming.

As we will hear in this testimony from them, the uninsured population is extraordinarily diverse and they face many different challenges in finding health care coverage.

Now, remember. Later this week, the committee will convene a second hearing and it will be on the subject of the uninsured. At that time, we will turn our attention to studying possible solutions. I look forward to continuing a dialogue in this committee about the uninsured, and invite my colleagues to work together on these solutions.

I am going to introduce our witnesses at this point. When Senator Baucus comes, I will give him a chance to make an opening statement, as Ranking Member. So, we welcome you. You can each come and sit behind your name sign there. Come now, please.

Kathryn G. Allen, Director of Health Care for Medicaid and Private Health Insurance Issues at the U.S. General Accounting Office. Ms. Allen will give a broad outline of different populations that constitute the uninsured.

Then Ms. Rowland, executive director of the Kaiser Commission on Medicaid and the Uninsured. Ms. Rowland will discuss the low-income uninsured population.

Then we have Mary R. Grealy, president of the Healthcare Leadership Council. Ms. Grealy will address the various working populations and the reasons they go without health coverage.

The fourth witness will be Dr. Richard W. Johnson, a senior research associate with The Urban Institute. Dr. Johnson will discuss the insurance status of the near-elderly, ages 55 to 64, and the special problems that they face in purchasing and retaining insurance.

Our final witness is Leighton Ku, senior fellow of Health Policy at the Center on Budget and Policy Priorities. Mr. Ku will address the immigrant population that is uninsured.

So we will just go the same way, right across there. We will have each of you testify before we ask questions. Let me say something, so all of you will know. If you have a longer statement that you want printed in the record, all you have to do is submit it. You do not have to ask for permission.

Also, one other housekeeping thing. Depending on how many people come and ask questions, some that do not come may submit questions for answers in writing. We would like to have the answers back from you in a couple of weeks. That might even apply to some of us who are here, knowing the constraint of time we are under.

Would you proceed?

STATEMENT OF KATHRYN G. ALLEN, DIRECTOR, HEALTH CARE—MEDICAID AND PRIVATE HEALTH INSURANCE ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. ALLEN. Thank you, Mr. Chairman. It is a pleasure to be here today as you consider these issues regarding the large number of Americans who are uninsured.

Health insurance, as you pointed out, is important from both an individual and a social perspective. It helps to provide access to preventive care and early treatment, it helps to mitigate the risk of personal financial devastation resulting from a catastrophic illness or injury, and it helps to reduce some avoidable costs due to uninsureds' greater use of emergency rooms and the failure to utilize effective preventive services.

Despite the importance, though, that we attach to health insurance, one in six of all non-elderly Americans are, today, uninsured. It is difficult to paint a portrait of the uninsured without heavily relying on facts and figures, but doing so also runs the risk of getting bogged down in the numbers and the details.

So to help clarify the issues and themes today, I have included a number of graphics in my testimony that will help portray these significant trends. I will refer to these in my remarks.

On a somewhat positive note, the number of the uninsured declined somewhat in 1999, to about 42 million individuals, as can be seen in Figure 1. This decline, after several years of steady growth, has been attributed to several factors: a stronger economy in recent years, an increase in employer-based coverage, which is the predominant source of health insurance, and the expansion of certain

public programs such as Medicaid and the State Children's Health Insurance Program, which I will refer to as SCHIP.

Whether or not this suggests a reversal in the prior trend of uninsured, though, is unknown at this point in time. But it does indicate that a significant proportion of the population is uninsured and not all Americans are affected equally.

Significant disparities exist among different sized firms and industries, in certain demographic groups, and in different regions of the country.

First, we should address the issue of the working uninsured. As illustrated in Figure 2, employment-based coverage has increased gradually in recent years and now is available to about two-thirds of all non-elderly Americans.

But it is striking that fully 75 percent of all uninsured adults are, in fact, working, many of them full-time, yet are uninsured. These tend to work for small businesses, and in certain industries such as construction, agricultural, and natural resources industries such as mining, forestry, and fisheries.

As Figure 4 shows, also, those individuals who work for firms with fewer than 10 employees are the most likely to be uninsured. Small firms are much less likely than larger ones to offer health insurance to their employees. Just over one-third of businesses with fewer than 10 employees offer health insurance, compared to nearly all of those with 50 or more employees.

But even in the largest firms we can see that a significant share of workers, over 10 percent, are uninsured. Not surprisingly, persons with low incomes are most likely to be uninsured. But, even if they are working and are offered insurance coverage, they often decline it because they find it unaffordable.

Public programs like Medicaid and SCHIP cover many low-income persons, especially children, but significant numbers of those eligible are not enrolled and participating in the programs. Moreover, a sizeable proportion of the population is not even generally eligible, such as adults with no children.

Further analysis points to certain demographic groups that are disproportionately likely to be uninsured. These include young adults, especially those between the ages of 18 and 24, and Hispanics and immigrants. One-third or more of each of these groups is uninsured, in part because of the type of employment they are engaged in, relatively low incomes, or ineligibility for public programs.

Finally, health insurance coverage rates vary considerably across the Nation, as illustrated in Figure 9. The State-by-State share of persons uninsured ranges from a low of about 10 percent of the population to a high of 27 percent. Uninsured rates are generally highest in the south and in the west.

Moreover, more populous States such as California, Florida, and New York tend to have higher rates of the uninsured. States with these higher-than-average uninsured rates tend to share certain characteristics. They include more low-income residents, higher unemployment rates, fewer firms offering coverage to their workers, and significantly higher numbers of Hispanics and immigrants.

In conclusion, the profile of the uninsured is a multifaceted and heterogeneous one, but at the same time certain striking character-

istics emerge. These include the large numbers of those who are working but do not have employer-based coverage, those who are low income but not eligible for, or participating in, public programs, and the special circumstances of certain other groups who are disproportionately affected such as young adults, Hispanics, and immigrants.

Addressing such characteristics, while at the same time considering the broader needs and very diverse U.S. populations, suggest that some combination of strategies might be appropriate in considering any efforts to expand health insurance coverage and its affordability for individuals and for the private and public sectors.

Mr. Chairman, this concludes my statement at this time.

[The prepared statement of Ms. Allen appears in the appendix.]

Senator BAUCUS. Thank you very much, Ms. Allen. The Chairman is not here, but I am taking over until he returns. It is not a coup. [Laughter.]

Our next witness is Ms. Diane Rowland.

Ms. Rowland?

STATEMENT OF DIANE ROWLAND, EXECUTIVE DIRECTOR, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, WASHINGTON, DC

Ms. ROWLAND. Thank you, Mr. Chairman, for this opportunity to testify today on the low-income uninsured population.

Today, over 40 million Americans are without health insurance. The uninsured are predominantly low-income working families. Two-thirds of uninsured families have incomes below 200 percent of the poverty level, or roughly $30,000 a year for a family of three in 2001.

Low-income adults comprise nearly three-quarters of the $27.5 million low-income uninsured. Largely due to efforts to broaden coverage through Medicaid and SCHIP, less than a quarter of low-income children are uninsured, compared to a third of low-income women, and 44 percent of low-income men.

Most are uninsured because they do not obtain coverage in the workplace. Eight in 10 of the uninsured come from working families, but over 70 percent of uninsured workers do not have access to job-based coverage.

Low-wage workers are particularly disadvantaged. Only 55 percent of low-wage workers earning $7 per hour are less are offered coverage, compared to 96 percent of higher wage workers earning above $15 an hour.

Although most workers participate in employer health plans when offered, affordability remains a major issue. On average, employees contribute 26 percent of the premium costs of their employers. At $1,656 per year for family coverage, the employee's share, for a low-wage working earning $15,000 a year, would be more than 10 percent of the family's annual income.

If health insurance is not available through a group from an employer, families are hard-pressed to find and pay for a policy in the individual market. Such plans are expensive and have limited benefits, exclude prior medical conditions, and require substantial deductibles and co-insurance. For most low-income families, the

limited protection is not worth the cost. A $6,000 or $7,000 family policy would consume a quarter or more of their income.

Medicaid does provide health insurance coverage with limited cost sharing and essential benefits to 21 million low-income children and 8 million parents today. But Medicaid's reach for low-income adults is severely limited.

Parents of eligible children are often excluded because, in many States, eligibility levels remain tied to the old income levels for welfare assistance, which are below the poverty level for adults who are parents in 33 States, and considerably lower than the minimum levels federally established for children.

But the most glaring omission in Medicaid coverage is the welfare-inherited exclusion of coverage for low-income childless adults, no matter how poor. Nearly half of the uninsured low-income population falls outside Medicaid's reach because they are adults without children.

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

The uninsured are far more likely than the insured to postpone or forego health care and less able to afford prescription drugs, or follow through with recommended treatments. They struggle to pay for what care they get, often facing bankruptcy when serious illness strikes.

The experiences of Diana Oden of Mosier, Oregon and Patricia Nelson of Louisville, Tennessee demonstrate the problems. Working all her life in restaurants, Diana Oden has never had health insurance available through her job.

Her income from wages of $6.50 an hour, plus tips is too high for her to qualify for Oregon's Medicaid health plan, but not nearly enough to pay the $213 per month, a quarter of her take-home pay, for an individual health plan to help with a chronic illness that she suffers from. Even that health insurance plan would not help pay for the medications she so desperately needs.

Patricia Nelson, a widow, has been paying at least $25 a month on a $6,000 debt for her son's hospitalization for an acute asthma attack 8 years ago. She still owes the hospital $1,700.

Her own recent kidney infection, coupled with a diagnosis of Bell's Palsy for her son, has left her facing another $12,000 in medical bills. She has now enrolled her son in Tencare, but she remains uninsured because enrollment for adults in Tennessee is closed. Due to her medical expenses, she has recently filed for bankruptcy.

These are, unfortunately, not unusual stories. Millions of low-income, hard-working families cannot afford health coverage and struggle every day to cope without coverage while their medical bills mount and their health suffers.

For the low-income uninsured population, any effort to extend coverage must address the high cost of coverage faced by people with limited incomes, and the lack of access to private health insurance for low-wage workers.

As the efforts already under way in many States demonstrate, the most immediate and effective means of broadening coverage is

to build on the current public programs, Medicaid and SCHIP, that have been designed to provide health coverage for the low-income population.

Extending coverage to the millions of Americans without health insurance is both an important policy and health objective.

Thank you very much.

[The prepared statement of Ms. Rowland appears in the appendix.]

Senator BAUCUS. Thank you very much, Ms. Rowland.

The next witness is Mary Grealy, who is president of the Healthcare Leadership Council, Washington, DC.

Ms. Grealy?

STATEMENT OF MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL, WASHINGTON, DC

Ms. GREALY. Good afternoon, Senator Baucus. It is a pleasure to be here today, both to testify on an issue of vital national importance, but also to commend this committee for efforts to make health insurance coverage more accessible for all Americans.

Today, I will just briefly comment on some of the Healthcare Leadership Council's key findings regarding the make-up of the uninsured population.

For members of the HLC, the chief executives of the Nation's leading health care companies and institutions, there is no higher priority issue. Our members strongly believe that our Nation's health care system must not only be characterized by its quality and innovation, but also by affordability and accessibility.

To better understand the nature of the uninsured problem, the HLC commissioned in-depth studies, surveyed the Nation's small business owners, and studied dozens of local and regional programs throughout the country.

Through these efforts, I believe we have been successful in putting a face on this issue. In many respects, it is the face of Sheila Ogle, a North Carolina businesswoman who testified at an HLC symposium on the uninsured.

Sheila regularly employs fewer than 10 people in her small firm. She cares deeply about her employees and sees them as family. She wants to provide them, and their dependents, with health care coverage. The problem comes when she looks at her books through the eyes of every small business owner operating on a tight margin, and she does not see how she can do it.

Sheila Ogle's story goes to the heart of this issue. To find the vast majority of uninsured Americans, you look to the Main Street businesses throughout this country. HLC recently commissioned an in-depth analysis by the Rand Company of existing data on the more than 42 million uninsured.

To us, the results were eye-opening. More than 70 percent of the uninsured live in a home where there is at least one active worker. These individuals can be divided into two main subgroups: they live in families where workers are offered insurance by their employer, or they are in families where they are not.

Let us take a closer look at these two populations. Over 16.7 million people, or more than one-third of the uninsured, live in house-

holds where at least one employee has been offered employer coverage, but they have turned it down.

Our research shows that, in the predominant number of cases, these decliners turned down coverage for their dependents, not themselves. We find that when an offer of insurance is declined, it is most common among low-wage workers and smaller firms, where a large share of the premium is passed on to that employee and where the majority of companies charge a higher premium for dependent coverage.

We also found that, in many of these cases, the worker is unaware that his or her dependents might qualify for enrollment in the State Children's Health Insurance Program.

The second category that I referred to, where employers offer no insurance, accounts for 17.3 million, or 36.8 percent of the uninsured. As we discussed this population segment, it is instructive to look at small employer attitudes toward health coverage.

We contracted with a public opinion firm, American Viewpoint, to survey small business owners throughout the country. This survey found that many companies currently not offering health coverage want to do so, and they would do so if premiums were subsidized for them by as little as 10 percent.

Conversely, two out of every three employers not currently offering insurance will continue that practice if no public policy changes are made to reduce their cost of insurance.

But more alarming to us, is that a significant number of small employers surveyed indicated that they will drop their coverage if their health insurance premiums rise by 10 percent or more in the near future.

Senator Baucus, it is impossible to overstate the critical importance of this issue. All Americans have access to some form of health care. But charity care and other safety net programs do not adequately substitute for health insurance, for that policy is the key that opens the door to the latest and most effective innovations in health care treatment and health care technology.

The first step toward a solution is fully understanding the problem. In view of our research, it is quite clear that the significant majority of the uninsured are in wage-earning households and that they can be reached within the current employer-provided health insurance system.

This issue is critical for working families, as well as for the many hospitals throughout the country that are in serious jeopardy because of the expense of acute and emergency room care that they provide.

But there will be no direct payment for the services that they provide. If we do not make progress in reducing the uninsured population, the ramifications will be severe for all patients and for all health care consumers.

The bright side, Senator Baucus, is found in the bipartisan determination that we are seeing and the willingness to take on this issue, and to dedicate some of our Nation's prosperity to solving this critical challenge.

The Healthcare Leadership Council stands ready to work with you and with this committee to find answers to help solve this crisis of the uninsured.

Thank you very much. I will be glad to answer any questions.

[The prepared statement of Ms. Grealy appears in the appendix.]

Senator BAUCUS. Thank you very much, Ms. Grealy. Those statistics were interesting. They are very helpful.

Next, to Richard Johnson, senior research associate for The Urban Institute in Washington.

STATEMENT OF RICHARD W. JOHNSON, SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE, WASHINGTON, DC

Dr. JOHNSON. Thank you for the opportunity to address the committee about health insurance coverage among the near-elderly, those between the ages of 55 and 64.

This issue is becoming increasingly important, as the first Americans born during the baby boom years begin to reach age 55. What distinguishes the near-elderly from other groups, is that they are not old enough to qualify for Medicare coverage unless they are disabled, yet they are much more likely to experience serious health problems than younger people. Thus, health insurance coverage for the near-elderly merits special attention.

I would like to make five points. First, the near-elderly are less likely to be uninsured than younger adults. Only about 10 percent of near-elderly Americans lacked health insurance coverage in 1998.

Concern about lack of coverage among near-elderly Americans arises not because they are more likely to be uninsured than other age groups, but because the lack of coverage can have especially serious consequences at older ages.

This brings me to my second point. Health insurance coverage is particularly important for the near-elderly because they are more likely than younger people to have serious health problems.

The prevalence of health problems at older ages translates into high health care expenses and strong demand for health insurance by the near-elderly. Families without insurance risk high out-of-pocket medical costs when serious illness strikes, and they also defer necessary preventive care. Because the incidence of many serious health problems increases with age, foregoing routine care can be especially hazardous for the near-elderly.

Third, uninsurance is concentrated among certain vulnerable groups, particularly Hispanics, blacks, and those with limited income and education. Among the near-elderly, 31 percent of Hispanics and 26 percent of those with incomes below 200 percent of the poverty level were uninsured in 1998.

My fourth point, is that even among near-elderly Americans with coverage, there is cause for concern. By the time individuals reach their early 60's, many have stopped working. Because most insurance is tied to employment, workers can lose their primary source of coverage when they retire.

Some firms continue to contribute toward their workers' health benefits after retirement. However, retiree health benefits, as they are known, are only available to slightly more than one-third of Americans. Not surprisingly, these benefits are most common in high-paying jobs.

Even those offered retiree health benefits may not be able to afford them. Retiree health benefits are usually less generous and

they require more cost sharing than health benefits provided to active workers. About 1 in 10 elderly retirees who are offered retiree health benefits turn them down because they say they are too expensive.

Near-elderly people who lack job-related health benefits have limited insurance options. Few qualify for Medicare or Medicaid. Given these constraints, many near-elderly people without coverage from employers turn to the private, non-group market. Indeed, non-group coverage rates are almost twice as high for the near-elderly than for younger people.

However, there are a number of important drawbacks to relying on the non-group market at older ages. Premiums are more expensive for non-group policies than for group policies, especially when policyholders have health problems, as many near-elderly Americans do.

A related problem, is the limited benefits that many non-group plans provide. Many policyholders can only afford plans with high deductibles and high cost-sharing requirements, and many insurers exclude coverage for preexisting health conditions.

Consequently, many near-elderly people with non-group coverage may be underinsured, leaving them vulnerable to high out-of-pocket costs if they become seriously ill. Even when near-elderly Americans are able to afford the high cost of non-group insurance, they may be denied coverage altogether by insurers because of their preexisting health conditions.

My final point, is that recent declines in the proportion of employers who offer retiree health insurance threaten to jeopardize coverage for future cohorts of near-elderly Americans.

Between 1991 and 1998, for example, the percentage of large employers sponsoring retiree health benefits fell from 80 percent to 67 percent. At the same time, employers have been shifting more of the costs of retiree health plans onto participants.

If employers continue to scale back this benefit or if they make it unaffordable to many participants by continuing to raise required premiums, rates of uninsurance among near-elderly Americans may rise in upcoming years.

Another threat for future retirees, is that employers are generally not legally bound to honor their past promises about retiree health benefits. Employers can amend or terminate retiree health benefits at will, as long as they indicate that the terms of the plan are subject to change.

Even though employers may offer retiree health benefits when individuals are working or when they retire, there is no guarantee that these benefits will continue throughout the individuals' lifetimes, or even until they become eligible for Medicare coverage.

Thank you again for the opportunity to address the committee. I am happy to take any of your questions.

[The prepared statement of Dr. Johnson appears in the appendix.]

Senator BAUCUS. Thank you very much, Mr. Johnson.

Our final witness is Mr. Leighton Ku, a senior fellow in Health Policy for the Center on Budget and Policy Priorities in Washington, DC.

STATEMENT OF LEIGHTON KU, SENIOR FELLOW IN HEALTH POLICY, CENTER ON BUDGET AND POLICY PRIORITIES, WASHINGTON, DC

Mr. KU. Good afternoon. Thank you for asking me to testify about the health insurance needs of immigrants.

A very large share of immigrant families lack health insurance in the U.S., and because of this they have serious problems getting access to decent, affordable health care, like most of us have.

It is useful to remember that about one-tenth of America's population is foreign-born, and the share is growing. In every State around the country now, immigrants form a vital part of the workforce and of the taxpaying public base.

Immigrants tend to work hard and have relatively low unemployment rates. However, they are disproportionately poor and uninsured because they tend to work in low-wage, low-benefit jobs.

Moreover, research tends to indicate that immigrants are less likely to be offered private insurance by their employers than native citizen workers, exacerbating their insurance gap. For example, while private insurance increased recently for native citizens, it did not increase for immigrants.

A serious problem, that particularly affects immigrants, is that in 1996 the Welfare Reform law changed the rules for Medicaid and for SCHIP so that legally-admitted immigrants who entered the U.S. after that date are no longer eligible for Medicaid or SCHIP.

Since that time, data has shown that the number of immigrant parents and children who have access to public benefits through Medicaid has dropped. Moreover, the number of uninsured immigrants and their children has increased.

At this point, about half of low-income immigrants are uninsured. This is a rate that is, roughly speaking, double the uninsurance rate for native citizens.

A particular area of interest, is that an unintended consequence of the Welfare Reform law is that it affected children of immigrants who were born in the U.S., who are, therefore, native citizens.

About one-third of all the low-income uninsured children in the country live in immigrant families, whether as foreign-born or U.S-born children. The bottom line there, is that if you really want to help uninsured children you have to address the needs of children living in immigrant families.

Because they lack insurance, immigrant families are much less likely to be able to see a doctor, go to a dentist, even get emergency room care. But the research does show that, when they have insurance, the health care access for immigrants improves markedly.

Let me just mention that the Welfare Reform law not only affected immigrants, but it also affected the traditional State/Federal partnership that exists in how we finance Medicaid and the SCHIP program, so that States and local governments have to bear a much larger cost of the share of burden for health care for immigrants. This is a point that has been also noted by the National Governors' Association.

I would like to take a moment to dispel one popular myth that comes up a lot. Some have asserted that the U.S. should not offer

public benefits to legally-admitted immigrants because this just serves as a magnet to bring poor immigrants to the U.S.

On the contrary, research consistently shows that immigrants do not come here for public benefits, but they come to the U.S. primarily because they want better jobs, and for other reasons, they want to rejoin their family members, they are fleeing persecution.

Moreover, in the past decade we have seen that immigrants have tended to shift from high benefit States, like New York and California, and are moving, instead, to low-benefit States like Virginia and North Carolina.

They are doing this not in search of benefits, they are doing this because that is where they think they can find jobs, further showing that really the welfare magnet hypothesis just does not hold up.

Before closing, I want to mention the story of the Dominguez family of Phoenix, Arizona. The family was legally admitted to the U.S., after waiting for 20 years for entry, about 2 years ago.

Their little girl, who is 2 years old, Athalia, has a heart defect. Mrs. Dominguez, herself, has serious medical problems that relate to a miscarriage that she had about a year ago.

Although Mr. Dominguez has a job, working in a bakery, they do not have health insurance. They are having serious problems paying for their medical bills for their very serious medical problems, and they have a huge stack of medical bills.

Were it not for the Welfare Reform exclusions for immigrants, Mrs. Dominguez and their little girl would be eligible for Medicaid and for SCHIP and would be able to get adequate and timely health care services.

Last year, a bipartisan proposal came out to help families like the Dominguezes, and this was advanced by members such as Senators Graham, Chaffee, Jeffords, and Rockefeller, Representatives Diaz-Balart and Waxman, which would have let States have the option to cover legally-admitted immigrants who were pregnant women, or children, under the Medicaid or SCHIP programs. This was also supported by a number of Governors, including Governor Jeb Bush of Florida.

As Congress and the administration try to figure out better ways to help reduce the number of uninsured Americans, I really hope that the committee will pay serious attention and continue to leave the issues of immigrants and their families at the forefront of policy.

Thank you.

[The prepared statement of Mr. Ku appears in the appendix.]

Senator BAUCUS. Thank you all, very much. There is a vote going on. I think there are about four minutes left for me to get there and vote. I think Senator Grassley is on his way back, so he should be continuing the hearing momentarily.

The committee now is in temporary recess.

[Whereupon, at 3:21 p.m., the hearing was recessed to reconvene at 3:25 p.m.]

The CHAIRMAN. I would like to resume our committee meeting. Obviously, the testimony, I will have to read on my own because I only heard the one witness. If you wonder how we are able to ask questions, well, quite obviously our staff helps us with that process.

The first one, I would like to ask Ms. Allen. By the way, we will have five-minute turns here. I suppose, after Mr. Baucus, you will be able to ask your questions, Senator from New Mexico.

You report that the number of uninsured increased steadily, to peak in 1998, then dropped in 1999. Does this mean that the escalating uninsured numbers has ended?

Ms. ALLEN. Certainly, the trend in 1999 is encouraging from the prior 2 years, but it is probably too early to tell if this is any indication of the future.

Unfortunately, the data that we and other researchers analyzed, the Current Population Survey, has a 1-year lag in it. We will be receiving information about the year 2000 later this year. Because of strong economic conditions, we might expect that the data that will become available will continue to look strong.

But we all know now that we are beginning to see a different economic condition unfold. The economy seems to be weakening just a bit. We see additional increases in health insurance premiums.

We also hear that States are feeling increasing pressures on their budgets, including Medicaid costs.When considering all of those, it is really difficult to predict, although one could guess what the trend might be.

So, although the data were encouraging, it still indicates that there is a very serious problem with the numbers of uninsured.

The CHAIRMAN. Thank you.

Now, Ms. Grealy, you mentioned lack of information on different ways to obtain and/or offer health insurance as the reason small employers might not offer coverage, and ultimately why individuals then go without coverage.

How much of a role does lack of information play in keeping employers from offering coverage, and employees from obtaining coverage, either in the employer-based system or through market options?

Ms. GREALY. Actually, Senator, there are two components here. I think we were surprised at some recent surveys we saw, one done by EBRI, that showed that there are many small employers that did not even realize that they could deduct the cost of providing health insurance coverage to their employees.

I think we forget sometimes that these are small employers, many of them employing under 10 employees, and they may not be as sophisticated on the finances and tax deductions that are available to them. So, that is one component from the employer's side.

Also, there was a study done in California that demonstrated that many employees had a misperception about the affordability of health care coverage, even with cost sharing. So we think we have a lot to do in terms of educating both employers, as well as employees.

I think we have all learned a lesson about the SCHIP program. Here is a program that is available, but the word was just not getting out to many people who were eligible, or whose children were eligible for this. So we think it is a significant factor, and one we should not ignore. It is part of the solution.

The CHAIRMAN. Dr. Johnson, based upon The Urban Institute's 2001 study on health and retirement, just over 10 percent of the

near-elderly are uninsured. In fact, the near-elderly represent one of the smallest groups of uninsured.

Clearly, employer health coverage, as an employee retiree or through a spouse, is a large contributor to the high insurance rates of this population.

Your testimony points out that 73 percent of the near-elderly have workplace coverage, but there must be a reason that we have 10 percent still go without.

Your charts suggest that it is primarily minority populations or those below 200 percent of poverty. What is unclear, is what proportion of this 10 percent are working. So could you elaborate on the statistics of why they go without coverage?

Dr. JOHNSON. Certainly. Retirement is an important reason, I think, for the high rates of uninsurance for this 10 percent number, the percentage who are uninsured.

The problem is not solely retirement, though. Among the near-elderly, the proportion without insurance is about the same for those who are working and those who are not working.

I think, for a lot of these people, the reason why they do not have insurance is the same reasons why people at all ages do not have insurance. It is closely related to the problems of poverty, to being in jobs that are paying low wages. So, it is not really possible for the employers to offer insurance.

I think the main point I guess I would make, is that the 10 percent number, while it is low, the reason why we are concerned about it is because the lack of insurance is so serious among the near-elderly because of their high prevalence of health problems.

The CHAIRMAN. By the way, I forgot to invite anybody else that wants to comment and has something to contribute to the answer that I ask specific people. Please feel free to speak up.

Now, for Mr. Ku and for Ms. Rowland. It is clear that the disproportionately high rate of uninsured for immigrants deserves special attention. Your testimony points out that immigrants have low unemployment rates that also match the 4.3 percent unemployment rate of native citizens. Yet, these same immigrants are disproportionately uninsured because they tend to be employed in low-wage, low-benefit jobs.

What do we know about the lack of health coverage for immigrants who are employed? Is it mainly an affordability issue, or an availability issue, or both?

Mr. KU. The data that I have seen indicate that the major problem—and again, this is consistent with other low-wage workers—is that they are not offered insurance at the workplace. This is a more serious problem for immigrants because of the types of jobs that they have, and perhaps for some other reasons.

Some immigrants are offered insurance at the workplace. When they are offered insurance, they take up insurance at the same rate as native citizens.

So every now and then people will say, "gee, maybe immigrants really just do not want insurance very much. They do not care about it." The data indicate that immigrants want, and take up, insurance at the same rate as native citizen workers, when it is offered. The problem is, they are just not being offered it in the first place.

The CHAIRMAN. Now, Ms. Rowland?

Ms. ROWLAND. I think that what is important here, is that we are talking about a predominantly low-income population when we talk about many of the working immigrants, so they are working in these same jobs where offering is unlikely.

The points that Leighton raised earlier about what has happened, for recent immigrants, to coverage under Medicaid is, I think, another aspect that we ought to look at.

Many, in fact, who are eligible or have children who are eligible for Medicaid coverage, because they are citizens, are not enrolling now out of fear. So, I think we really have a serious problem among the lowest-income population, and both offerings in the workplace.

In a study that we did of small firms, we see a big difference between those that have a predominant low wage base versus those with higher wages. Eighty-five percent of small firms who have over $20,000 a year as their main employee base offer insurance, 35 percent of low-wage small firms do not. Those are the very firms that immigrants are very likely to be employed in.

The CHAIRMAN. The list on first come, first serve, was Grassley, Baucus, Snowe, and Bingaman. I told Jeff that he would be next, but I should call on Senator Snowe.

Senator SNOWE. Go ahead.

The CHAIRMAN. Senator Bingaman, then.

Senator BINGAMAN. Thank you very much, Mr. Chairman.

I also missed your testimony, unfortunately. But I wanted to just ask a couple of questions about Medicaid, and particularly enrolling children in Medicaid.

In my State, we have expanded Medicaid to cover children and families with incomes up to 235 percent of poverty. At the same time, the estimate is, the Bureau of Census says that 28.9 percent of the children in our States whose families have incomes of less than 200 percent of poverty are not, in fact, enrolled in Medicaid. So you have got nearly one-third of the people who are eligible, of the children who are eligible to be participating, are not, in fact, participating.

We are looking at trying to propose some changes that would modernize Medicaid to eliminate the welfare stigma that is associated with the program, including this assets test, imposition of the assets test, the requirement that applicants apply through a welfare office.

I wondered if you, Mr. Ku, or any of the rest of you, Ms. Rowland, had a thought about how much good it would do to eliminate those barriers. Would it significantly affect the number of these young people, these children, that in fact get covered by this?

Ms. ROWLAND. I think what we have seen, is that one of the most important things going on today for coverage of children in Medicaid and SCHIP is the simplification of the enrollment process.

When people get insurance through the workplace, they tend to just sign up through their workplace. We are asking low-income parents to go out and actively enroll their children in Medicaid and SCHIP.

The more barriers we put in their way, given that they are working and they often cannot come to a welfare office during the mid-

dle of the day to apply, the less likely they are to come in and apply.

Since we have done mail-in applications, self-declaration of income, elimination of the assets tests, in many States we are seeing enrollment levels go up substantially. We are seeing that these programs could be made to work as health insurance programs instead of the vestiges of the welfare system that they inherited.

In other States, like Wisconsin, for example, they have also said that covering the parents along with the children provides an additional incentive for the families to sign up and gives the whole family coverage, so they have a very high participation rate where we are making the process simple and where we are bringing whole families together.

So I think it is a hopeful sign. It takes time to change. The changes are now under way in many States, and I think we will see a boost in enrollment as a result of them.

Senator BINGAMAN. All right.

Mr. Ku, did you have a thought on this?

Mr. KU. Yes. I just want to add a little. I will mention that, in a couple of days, my colleague, Donna Cohen Ross, from the Center, will be talking about a number of issues just like this on the outreach component.

I agree with everything Diane Rowland said. I would also mention that it is worth remembering that the way that we have structured the child health insurance programs right now, there are two parts. There is Medicaid, for which States get one match rate, and then there's the SCHIP program, which has a higher match rate.

States have shown a lot of ingenuity and effort in trying to simplify, particularly, their SCHIP program. It is because it was a new, exciting program. In many cases, they have not shown the same level of enthusiasm and ingenuity in expanding and simplifying their Medicaid programs for children.

Certainly, one of the things that needs to happen, that I think that you have been interested in, is trying to help States not only do better in SCHIP, but particularly encouraging them to also bring do so in Medicaid also, which is particularly important because it actually serves the lower income kids.

Senator BINGAMAN. Yes, please.

Ms. ALLEN. Senator Bingaman, if I might add to the other two.

A very important component of this is education and outreach. In addition to the administrative simplification, it is pretty apparent that many eligible families are simply unaware that they may qualify for these public programs, particularly if they are working. So, education is a very important component of that, to make them aware of the program.

A second one, though, has to do with education of people about the importance of preventive care. Many families, particularly those who might be low income, perhaps might not understand the importance of enrolling their children and having preventive care. They may, in fact, wait until there is a serious health condition and then seek treatment.

So this is another very important component of outreach and education that can help enrollment, and many States are pursuing exactly these approaches as well.

Senator BINGAMAN. One aspect of this that we are also going to try to address if we can, if there is anything more legislatively that can be done on it, is coverage of pregnant women. I gather they are covered now by Medicaid, but they do not know it in a lot of cases.

A lot of women who become pregnant are not aware that they are covered, therefore, they do not take advantage of that or enroll. Therefore, they do not get the very cost-effective health care that would result if they did sign up. I do not know if any of you have thoughts on that.

Ms. ROWLAND. Certainly, coverage of pregnant women is extremely important. That is part of what Kathy was talking about with regard to education and letting people know that, if they came in, they are probably eligible.

Most people still think that Medicaid is for the welfare population. If they are not poor enough to get welfare, then they do not have access to Medicaid. But, in fact, for pregnant women and children, the income levels are much higher and could bring people in very early.

But let me also point out that one of the other issues with pregnant women, is that today they are only covered for 60 days postpartum, so that we do get into situations where the child is eligible and stays on Medicaid, but after 60 days the mother becomes uninsured. I think that is also worth the committee looking at.

Senator BINGAMAN. Thank you very much, Mr. Chairman.

Senator BAUCUS. Thank you, Senator.

Like all of us, I would like to do all we can to try to solve this problem. It is tragic, the number of people who are uninsured. I hear about it, anecdotally, in my home State.

There is one fellow who is a contractor, but he does not own a large company. When the insurance carrier told him that he had a 20 to 30 percent increase in insurance premiums for his few employees because one of them had a preexisting condition, and this is one of his best employees, somebody that had been with him for 20 years, it just killed him.

So what is he going to do? He finally decided, he is not going to let this person go. He had to shop around a bit and find another carrier. But you run across this a lot. As a consequence, a lot of people just are not insured.

I am going to take the prerogative of focusing my questions on my home State. Now, let me just state a little bit about where we are in Montana.

According to the Census Bureau, we rank eighth among States with the highest proportion of residents without health insurance. Compared to other States, we rank last in the Nation in terms of employers offering health benefits.

Forty percent of firms in my State of Montana provide health insurance. According to CDC's National Center for Health Statistics, only 26 percent of small, private firms—that is, fewer than 10 employees—offer health insurance.

We rank 47th in the Nation in per capita income, 50th in the Nation in wage per capita income, 51st in the Nation—including Washington, DC—in per capita disposable income. I think that is part of the reason why we have so few uninsured. We are a small business State. We are an agricultural State.

What do we do? What is your best advice? I think Montana is not alone. We are not urban, that is clear. But there are a lot of other parts of America that have some of the same characteristics as Montana.

How do we get at this problem? Is it more information? When I was here earlier, some of you were talking about information just not getting out to employees, whether it is employers not knowing they could provide insurance, whether it is Medicaid enrollment. Of course, that does not apply to a lot of people we are talking about here.

If you could wave a magic wand, not to provide a total solution but at least to begin to get at some of this, what would it be? I am just going to, frankly, go to whoever wants to speak to it.

Ms. Grealy?

Ms. GREALY. Senator, I will take the challenge.

I think we all would like to wave the magic wand, but I do not think there is one solution. Just listening to the testimony today talking about all of these different populations, it is quite clear that we need to target different solutions, perhaps, to different populations.

But you highlighted your State, which includes a lot of small business owners. I think the research that we have done highlights the fact that we need to target some of this relief to small business and to employees in those small businesses.

Yes, education is part of it. They need to know what is available to them. But we can get at a large portion of this problem by providing what would amount to a minimal subsidy to many of these employers.

Senator BAUCUS. I heard you say it earlier—I think it was you, or perhaps Dr. Johnson—that 70 percent of uninsured are employed.

Ms. GREALY. Are attached to the workforce. Either they, themselves, are employed or someone in the family. It is interesting. In the study that we did, you hear a lot about different sectors having high rates of employers not offering insurance.

What is interesting, as you look through those different sectors, they may have a high rate of not offering insurance to their employees, but those employees are somehow connected to someone else in their family who is offered insurance. So it really is this family structure.

Somewhere in there there may be an employer who is offering that coverage. We need to find ways to make sure that the employees accept that coverage, not just for themselves, but also for their dependents. Then we also need to find ways to give those employers the help they need to make sure they can offer the insurance as well.

Senator BAUCUS. Ms. Allen?

Ms. ALLEN. Yes. It is tempting to be very specific in responses. Of course, we do not want to preempt your hearing on Thursday, either. But I think what we will be discussing, along with others, on Thursday is exactly what Ms. Grealy just spoke to.

If you currently look at the fact that most Americans are insured through their workplace, that is the place to begin to look to see what additional incentives or readjustment of the current incen-

tives might be possible, through the Tax Code or other means. That might be both for the firms themselves, as well as individuals.

Second, we have all talked about, even recognizing that people are attached to the workplace, that public programs may indeed be a very viable possibility for others. So looking at some expansion of coverage for those, particularly for individuals who are not now covered, such as adults without children, is one particular population that one might turn to.

Senator BAUCUS. If I understood you correctly, Ms. Grealy, earlier, about the 70 percent, I think you said 36 percent of employers do not offer coverage. This means, I guess, that 64 percent do. Is that correct? So 64 percent of the 70 percent.

Ms. GREALY. We have about a 50/50 split, almost, when you look at the population that is attached to the workforce, either themselves employed or a family member: about 16.7 million, the employer is not offering insurance; about 17.6 million, the employer is offering it, but they are declining that coverage.

Senator BAUCUS. I do not want to encroach on the time of Senator Snowe. But they are offering it. Why, again, are most declining?

Ms. GREALY. Two things. Many accept it for themselves, but frankly it is the additional cost for purchasing that family coverage. Oftentimes the employer is passing that additional cost onto the employee.

So we get back to what we have heard a lot about. It is the affordability issue as well as the access to the insurance issue.

Senator BAUCUS. All right. Thank you.

Ms. ROWLAND. Senator, I might add that some of the other data that one looks at shows a much lower rate of offering within the workplace, especially for the lowest-income workers, so that only 55 percent of low-wage workers earning $7 or less an hour, which is where the bulk of the affordability problem is, are even offered insurance coverage. Of those that are offered, 75 percent take it up.

So, we still have people using the health insurance system through the workplace, when it is there. The bulk of workers still work in employment situations where they are not offered health insurance coverage.

Senator BAUCUS. Thank you. Thank you very much.

I see the Chairman has returned. My time has expired.

The CHAIRMAN. All right.

I want to thank Senator Baucus for working with me to keep the hearing going.

Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman.

I want to welcome all of you. I wish I had had the opportunity to listen to your testimony, because obviously this is a critical issue for Congress to grapple with. Clearly, the time is now.

I think there is no doubt that this is one of the most compelling issues that we can confront in this Congress because of the number uninsured in America.

I am interested to note that 1987 was the last time that we have seen a decline in the number of uninsured. Do you all agree on the number of Americans who are without health insurance? The most commonly used number is 42 million. Is that essentially right?

There has been a decline by 1 million this last year, which is the first time since 1987.

Ms. ALLEN. I believe we all are using the Current Population Survey which is conducted by the Bureau of the Census, so it is a commonly-accepted number.

Senator SNOWE. Forty-two million. So even though there has been a decline, obviously it is not appreciable in that sense.

Do you have any reasons for the fact that the number of uninsured was reduced by $1 million in this last year?

Ms. ROWLAND. There were really two factors going on. One, was we have had a very good economy and we did see somewhat of an increasing in offering among firms, so there was a little more availability of insurance through the employer-based sector. More people moved into higher levels of employment more likely to have insurance coverage.

Last year, Medicaid, which had been declining in the wake of welfare reform, stabilized somewhat so we did not lose the kind of Medicaid coverage that we had in previous years. So those factors, together, gave us the first decline since 1987.

Ms. ALLEN. And might I add one more fact?

Senator SNOWE. Yes.

Ms. ALLEN. That is, the 1999 figures do represent the fact that the Health Care Financing Administration reports that 2 million additional children are being insured under the SCHIP program. So, those numbers also are represented.

Senator SNOWE. Were favorable.

Ms. ALLEN. Yes.

Senator SNOWE. Well, then we could assume, in this declining economy, it may have a negative effect on the numbers as well.

So the SCHIP program, as we know, has been encouraging from the standpoint that the more uninsured children we take care of, and also if the States expand it to the parents as well, that becomes an effective means. Obviously that is another area. There is going to be a bill introduced tomorrow that I am certainly supportive of that would expand the SCHIP program to cover uninsured parents.

Do you think that is one way that we could effectively address the number of uninsured? Do we have numbers in terms of how much it might affect that bottom line?

Ms. ROWLAND. Well, we certainly know that there are a number of parents who are uninsured because they are above the income levels that their children are at, and those children are now enrolled in SCHIP.

We think that about 3 to 3.5 million parents could potentially be brought into insurance coverage, if we expanded coverage up to 200 percent of poverty for parents as well as children.

So that would make a big improvement in coverage of low-income families, though it would still leave the childless adults who are very poor outside the safety net of Medicaid or SCHIP, and that is another group that should be looked at.

Mr. KU. I would like to add something, just to sort of put it into context. The information we have for Medicaid indicates that parents typically are eligible up to about 70 percent of poverty. That is about $10,000 a year for a family of three. Whereas, typically,

for SCHIP the eligibility range goes up to about 200 percent of poverty, so it is around $28,000. So parents are far less eligible for public assistance right now.

We had done research in the past that indicates that, when States have expanded coverage for parents, that not only did it help the parents who were the obvious target, but one of the things that was a nice side benefit was that it stimulated enrollment for children.

So to the extent that we really want to help children as well as parents, that is part of the motivation for believing in expanding parents' coverage. A number of States have done this to help both the parents as well as the kids.

Senator SNOWE. It has been reflected in some of the percentages, too, in the States, has it not? Where parents have been able to be covered, so are more children being covered.

Mr. KU. That is exactly right.

Ms. ROWLAND. Yes. In fact, Wisconsin really has its eligibility rates for children and parents tied together. They are now reaching most of the children they hoped to reach because they are bringing the whole family in.

Ms. GREALY. Senator, we think the States are also looking for additional flexibility. As we look at the employer-based system, we know that there are employers that are out there willing to put some money on the table.

If there was some way that we could take some of those SCHIP dollars and sort of leverage and build on what those employers are willing to do, that that may also be another way to get at a broader population, perhaps using it to purchase that family coverage, where the adults are taking it for themselves but not for their family.

Senator SNOWE. What is the most effective means to help the small business, the small employer? Because it is obviously the employer with 10 or fewer employees that is less likely to provide any health insurance coverage than the major corporation that has 1,000 or more. It is reflected, again, in the statistics.

What could we do that would be most effective in getting at that employer, to assist them in providing insurance to their employees and to those who are working for small firms? Because it seems, from the numbers, again, that most of the uninsured are those who happen to be working. Or at least 7 out of the 10 uninsured happen to be in a household with at least one person working.

Then on the other hand, we hear that small employers said they would at least need a third of the subsidy costs, subsidies for a premium cost. Is that true?

Ms. GREALY. Well, that is definitely what we found in looking at a lot of the local and regional programs at the State level, where there are programs that are helping employees and employers.

But those employers, if they could put a third on the table, the employee could put a third on the table, and if there was a subsidy for that remaining third, but also reducing some of the barriers and giving them some of the advantages that those large, self-insured employers have as well.

Senator SNOWE. Tax credits. Do you have any idea, if we were to provide a certain sized tax credit, how many employers would

take advantage of that kind of tax credit to provide health insurance? Do you have any numbers at all?

Ms. GREALY. We are doing further analysis of that. But, just in our survey, there was a significant number that said tax credits were definitely a tool that they would use to provide that insurance.

Senator SNOWE. Thank you.

The CHAIRMAN. I would ask Senator Baucus. I have got 5 minutes of questions. Then if you have questions, if you would adjourn the meeting.

Senator BAUCUS. Go ahead.

The CHAIRMAN. All right. Thank you. I thank you for your cooperation, too.

Ms. Allen, the young, and also the near-elderly adults, are often in transitional phases of their lives, particularly in regard to employment.

I would like to have you elaborate on how this transitional work experience relates to their health insurance status and what implications it would have for coverage.

Ms. ALLEN. Young adults, particularly those who are age 18 to 24, are a very unique population within those who are uninsured. Often, they are no longer eligible for their parents' own insurance.

They are just entering the workforce and, as a result, they typically are in lower-wage jobs. They may be employed part-time. They may change jobs frequently. They may just work for smaller employers in industries that are less likely to offer health insurance.

Another interesting characteristic of this cohort, is that they may not feel the need to take up insurance, that they are young, often feel invincible, and feel like this is a cost that they can defer for a while.

Lastly, if they wanted to be covered by public programs, they would generally not be eligible. So again, to address this particular population, one would again look at the types of jobs and industries that they are in to try to increase their insurance status.

The CHAIRMAN. Ms. Grealy, I am concerned about the fact that one of the largest groups of uninsured are working minorities, obviously, all the groups that we call Hispanic, African-American, Asian-American, but other working minorities as well.

What characteristics are unique to these working populations that cause them to go without health coverage? Are there social and cultural barriers that make it more difficult to assess coverage or might prevent enrollment in health insurance plans? Is there any commonality of reason among all of the minority groups?

Ms. GREALY. Well, I think what we have heard from many of our witnesses here today, working in low-wage jobs, where either the employer is not offering the insurance or the cost sharing is too great for that employee to take the insurance, either for themselves, or even if they take it for themselves they may not be taking it for their family.

Now, we have found that there may be some cultural differences. This gets to the educational aspects of really educating people about the importance of having health insurance.

At our Uninsured Symposium, we had someone from Tyson's Foods talking about, they have a lot of recent immigrants that work for them in the poultry industry. They have made a great effort to educate their employees to not just take coverage for themselves, but also for their dependents.

What they were finding, is that they may be coming from a country where insurance is just not a way of life and they are not familiar with the product. Again, we can do a lot to educate them about the need to take this.

But I think we keep coming back to, it is an issue of affordability and access to that group coverage that really are the most important factors, and that probably cuts across all of these different groups.

The CHAIRMAN. All right.

Back to Ms. Allen. In part of your testimony, you pointed out the distinct characteristics of States, particularly those with high uninsured rates, and these include the types of employment and economic characteristics.

So how much of the total population of uninsured is concentrated in the States where the uninsured rates are disproportionately high due to the economic situation of the State?

Ms. ALLEN. In our analysis, we identified 13 States that, as a group, have higher uninsured rates than the rest of the Nation. Those 13 States include some of the more populous States, such as New York, California, Florida, and Texas. Those 13 States make up about 40 percent of the Nation's population.

Now, those 13 States, as a group, also tend to have higher poverty levels in each State, somewhat higher unemployment rates, and firms that are less likely to offer coverage.

We did not specifically look at the individual economic conditions of those States, but some of these are indicators that these States do stand out somewhat from others.

The CHAIRMAN. Mr. Ku, you referred to the toughest year for an immigrant being the first year. Then somehow, after becoming naturalized, immigrants gradually move closer to parity with native citizens in terms of income and insurance coverage.

Do you attribute this to a change in the migration patterns that you also discussed in your testimony? In other words, are immigrant workers moving to areas of the country where employer-sponsored health coverage is more easily obtained than in the States where the uninsurance rate would be higher than 20 percent?

Mr. KU. A lot of the data shows that immigrants improve their status the longer they're in the U.S. This research has actually been going on for a couple of decades, even before the change in the migration trends.

The major reason that happens, is when immigrants first get here they are having a hard time getting set up in jobs, they still have language problems, they are still trying to figure out how to work in the American system, so they are at a disadvantage.

The longer that they are here in the U.S., the more they are able to figure out how to do things. Their language skills improve, they get better jobs. So, they have the progress that Americans often have as they improve over time.

As far as the shift in migration from State to State, that has happened somewhat more recently. Really, a lot of it has happened in the last part of the 1990's. That could be part of it, but I do not think that is the primary reason.

The CHAIRMAN. All right.

I am going to ask Senator Baucus and Senator Snowe to finish the hearing, so I can go to another meeting.

Before I leave, I would like to, once again, emphasize what I said in my opening statement. Today's meeting is to define who these uninsured Americans are, the uninsured of America. We are having another hearing this week that will deal with finding solutions.

Obviously, the two meetings, together, are very important for us to arrive at a bipartisan package with which we can deal with this whole subject, or as much of the 43 million uninsured as we can.

I thank Senator Baucus and Senator Snowe for their understanding.

Senator BAUCUS. Thank you very much, Mr. Chairman.

One thing that struck me not too long ago when I was looking at OECD numbers and OECD countries and the degree to which they insure their citizens compared with the United States, was that most countries achieved universal coverage between 1960 and 1997.

Of all OECD countries—and the most recent data I have is 1997—the percentage of citizens without government-assured—not necessarily government-sponsored—health coverage, the U.S. is an outlier. That is, we are the worst, by far.

Let me just go down these OECD numbers, the percent where citizens are assured insurance, one way or another. They are assured to have health insurance. Again, not government-sponsored, but in some way the government makes sure that companies provide it, or one way or another.

Australia, 100 percent; Austria, 99 percent; Belgium, 99 percent; Canada, our next-door-neighbor, 100 percent; Denmark, 100 percent; Finland, 100 percent; France, 99 percent; Germany, 92 percent; Greece, 100 percent; Hungary, 99 percent; Iceland, 100 percent; Italy, 100 percent; Japan, 100 percent; Korea, 100 percent. Here is one that has slipped a little: Mexico, 72 percent. New Zealand, 100 percent; Poland, 100 percent; Spain, 99.8 percent. Here is the next-to-lowest: Turkey, 66 percent. The U.K., 100 percent.

Guess where the United States is? Thirty-three percent. Can you imagine that? It just seems to me that, in this projected budget surplus, we ought to find some way—I am not saying direct aid, I am saying some way to help provide some incentives, perhaps through incentives to employers, small business employers, particularly if 70 percent of the uninsured are in some way associated with employment, to help solve this problem.

I grant you that there is no magic wand. We have to do this a step at a time, find the little nooks and crannies and figure out, in the American system, how we do this. But I would just urge all of us to turn those statistics around. I am not vouching for their accuracy.

I am only telling you, this is what the OECD has come up with based upon 1997 data. I do not know how they define all this. But

all I know is, it is not good and there is something we can do about it.

I might explore with you a little, we want this American boom to continue. I have no idea what the stock market did today. It is really not relevant to most people we are talking about here, at least not directly.

But what happens when our economy does take a bit of a dip? How is that going to affect the number of uninsured?

Ms. ROWLAND. Well, in the past when the economy has taken a dip the number of uninsured has risen, and the number of people dependent on Medicaid, because it covers the low-income population, has grown.

So we can expect that, as the State revenues go down in an economic downturn, they will also be facing additional pressure on their Medicaid budgets and additional numbers of uninsured people. So, that has been our historical trend.

We have been very fortunate in the last year to see the decline, which we think was largely due to the improved economy and to the competitiveness in the workforce, which has led to more insurance offerings and a stabilization, really, of employee contributions to health insurance costs.

So, as we see health premiums rise as well, we may see an increase again in the number of uninsured. So, it is likely to get worse, not better.

Senator BAUCUS. Does anybody have a contrary view? Do the rest of the panelists tend to agree?

Ms. GREALY. Senator, I would just add one thing. We also have to make sure that we are not doing things to increase the cost of those insurance premiums. There are a lot of issues that are being debated now in the House and Senate that could affect employers' possible affordability of insurance.

So I think, as we are looking for solutions for expanding employer-based coverage, that we also have to make sure that we are not doing any harm in increasing those costs as well. But I think we are all concerned about the economy and what effect that might have on employers providing insurance.

Senator BAUCUS. Thank you, very much.

Senator, do you have any questions?

Senator SNOWE. Just a couple.

Senator BAUCUS. Go ahead. Why don't you close it out, Senator?

Senator SNOWE. All right. Thank you.

Senator BAUCUS. Thank you very much.

Thank the panelists, very much.

Senator SNOWE. Just to follow up, Ms. Grealy. You mentioned earlier that 57 percent of small employers do not know that their health insurance premiums are tax-deductible. Is that true?

Ms. GREALY. I am not sure if I cited that statistic. In EBRI's study—and I apologize, I do not have the percentage off the top of my head—we were all surprised that someone did not know that they had that tax deduction available to them.

Senator SNOWE. So it is possible that if, through an education effort to inform employers that this is a matter of law, at least 60 percent at this point, and goes up to 100 percent in the year 2003—it should be 100 percent today, frankly—but in any event, if they

were informed about this deductibility, that also could help to expand employer-based coverage.

Ms. GREALY. Absolutely. They would view it as more affordable.

Senator SNOWE. I do think it has to be very important for us to figure out what would be the best design for a program to expand employer-based coverage. Obviously, that could affect a significant number of uninsured in this country if we could develop an effective tax approach that would encourage employers to offer this health insurance, especially the smaller employer.

Do you have any way of getting those numbers?

Ms. GREALY. As I said, we are currently working on a study to get a better cost analysis of what those numbers would be, how much would be required, where the different break points are. So that is something that is ongoing for our organization.

Senator SNOWE. I guess that 57 percent number came from a survey that was conducted last year by the Employee Benefit Research Institute.

Ms. GREALY. Yes.

Senator SNOWE. Yes. So I think informing small businesses and employers that this is available now would help, at least in some way, to hopefully expand the coverage. But obviously, we have got to do a great deal more to provide that coverage.

So are we saying that tax credits, refundable tax credits for employees, would help as well?

Ms. GREALY. Well, I think a good example is the Earned Income Tax Credit. One of the things we saw last year, was the number of individuals that were moving out of poverty and moving into the workforce as a result of the Earned Income Tax Credit. I think that is a good model.

It is something that we will probably see reflected in the legislation that is being introduced tomorrow. So, I think that could go a long way in encouraging employees to take that insurance and make it more affordable.

Senator SNOWE. We have been looking at the numbers of 42 million and how we can get to eliminating that number, adding up the possibilities. It is not going to be a one-size-fits-all, it is clear. It is going to take a variety of solutions to address this problem because it is so multifaceted and diverse.

I noted with interest, Ms. Allen, you mentioned the geographical differences, what accounts for geography that makes a difference in terms of who is insured and uninsured, and noted that the Northeast and Midwest had the highest number of insured.

Ms. ALLEN. Yes.

Senator SNOWE. What would account for that differential?

Ms. ALLEN. There are several factors that help explain that. What we did, was we tried to look at three different strata, three different groups of States. What we found, was for those States that tended to have a higher rate of uninsured, they had several common characteristics.

One, is that they had higher rates of poverty. They had higher unemployment rates. They had fewer firms who were offering coverage.

Now, part of this, also, is that some of these States have much larger populations of immigrants and Hispanics, which again are in some of the firms that we have been speaking of.

Some other interesting demographics of those States, Some of them are very rural States. Again, the rural aspect also lends itself, perhaps, to some of the occupations people are involved in, whether it be the construction, agriculture, or natural resources industries.

Having said that about rural, it is also interesting that there are other rural States, though, that do not have that same experience. It could be that they have adopted a different approach, either in terms of the industry in their economy, or maybe even with the State-provided programs.

Senator SNOWE. Can anybody address the question about, what are the costs overall for those who are uninsured when it comes to health care to those that are insured? There obviously must be a major difference when it comes to analyzing the costs because these individuals are without health insurance.

Are there any such numbers available, Dr. Johnson?

Dr. JOHNSON. We clearly know that the uninsured are much less likely to receive care. This is even true among people with chronic health conditions. Families, USA put out a study recently that showed that, even among people with heart disease, with arthritis, with chronic back pain, they are about 25 percent less likely to see doctors, they are much less likely to have a regular source of care.

People without health insurance are less likely to have regular blood pressure screenings, regular cholesterol and blood level screenings. So we know that, in terms of individual health, the costs are quite high.

Senator SNOWE. Yes. Because they do not have the ability to take the preventive steps necessary to avoid the more serious illnesses down the road.

Dr. JOHNSON. That is right.

Senator SNOWE. Or for emergency care. Ultimately, it may end up that they may need to rely on emergency care, which obviously is most expensive.

Ms. ROWLAND. We also know that they tend to pay a lot out-of-pocket for their own care, so that it is not that they are not paying anything at all. Today, it is one of the major causes of bankruptcy, is medical expenses by the uninsured.

So I think the burden on the individuals of being uninsured is substantial, but we also see that in our payment rates for other programs where we have to try and compensate for the uncovered care of the uninsured.

Senator SNOWE. What would you recommend for Congress, in terms of being most doable? Is it either to address various components or to try to develop a goal for reaching the greatest number of uninsured over time, a certain percentage each year, or whatever the case may be, where we ultimately eliminate the entire number of 42 million, or as close to that number as possible?

Ms. ROWLAND. Well, certainly the steps that Congress has taken, such as the enactment of the Children's Health Insurance Program, are steps in the right direction, and focusing on those for whom health insurance is least affordable and building on the infrastruc-

ture that is already there through the Medicaid, and now the SCHIP program, would be a way to bring in, as you said earlier, more of the parents of these children and to really focus on low-income families.

I think, to have a goal of trying to eliminate the 42 million, that is exactly where we should be going, even if it is just piece by piece.

Ms. GREALY. But I think maximizing our resources, again, coming back to, we know that there are employers out there who are putting money on the table, if there is some way we can get the employee to step up to that.

For those employers who are not putting money on the table, how can we help them? We know, again, it is just such a large percentage of the uninsured. I think our target should be, obviously, eliminating the entire problem.

But I like the idea of, let us set targets and let us make sure we are meeting those targets and making progress towards finding a solution. It will be a diverse solution. There is definitely not one answer to this.

Mr. KU. Can I just add one thing?

Senator SNOWE. Yes.

Mr. KU. I think the impression that we have from our analyses, as well as the combination of what Diane Rowland and Mary Grealy are both talking about, is that you need a diverse strategy that includes both public program expansions, as well as ways of stimulating the employer side of insurance through things like employer tax credits. Those are probably a promising and relatively efficient and effective way to reduce the level of uninsurance.

Senator SNOWE. Well, I thank you all very much. We certainly appreciate your testimony here today on a most important matter that we will be continuing to address, and hopefully come up with some answers.

This committee stands adjourned.

[Whereupon, at 4:16 p.m., the hearing was concluded.]

LIVING WITHOUT HEALTH INSURANCE: SOLUTIONS TO THE PROBLEM

THURSDAY, MARCH 15, 2001

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:31 p.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Baucus, Rockefeller, and Bingaman.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Today's hearing is the second part of a two-part series focusing on the problems of 42 million Americans not having health insurance.

The goal of the first hearing was to better understand the diverse characteristics and the needs of the uninsured. I think that, reflecting on Tuesday's hearing, we achieved that goal.

We had a panel of five expert witnesses present well-documented testimony that highlighted specific issues such as age, ethnicity, socioeconomic status, types of employment, as some of the key factors that contribute to uninsurance.

The goal of today's hearing is to take the next step and to begin to identify solutions. As we head down this path, it will be critically important for us to keep in mind that there is no one-size-fits-all solution. Instead, we have to think about incremental changes for the different populations that make up the uninsured.

President Bush has come forth with a series of such incremental options that would help millions of uninsured individuals and families gain health coverage. We know that over 70 percent of the uninsured adults are employed, but they still go without health insurance.

The President's proposal to offer refundable tax credits would help this working population very much. In fact, my colleagues—even colleagues on this committee like Senators Jeffords, Breaux, Snowe, and Lincoln—have also spent a great deal of time working on individual tax credit options as well. We ought to thank them for their leadership, particularly, because it is bipartisan.

The President's proposal also encourages States to utilize State flexibility to improve outreach and enrollment efforts to cover millions of adults and children who may already qualify for existing Federal health programs, but are not yet enrolled.

As we will hear today, I think, effective outreach efforts can go a long way towards reducing the number of uninsured. Options such as streamlining the application process, and reducing paperwork burdens on families, are all common-sense ways to make these programs more accessible.

Now, overall, there are many different ideas that we must explore. It is my hope that we continue to press forward on this critical issue, but that we also do it in a sensible fashion.

Clearly, programs such as Medicare, Medicaid, and the State Children's Health Insurance Program are integral to our Nation's health care system. However, there are limitations in the role that these programs can play in meeting the needs of the uninsured population.

But, first and foremost, it seems to me that we should examine those existing programs and find ways to strengthen and preserve them, kind of in a building-block fashion.

Our efforts to address the needs of the uninsured population should be guided, I think, two principles, or at least two principles: supporting innovative efforts by the States to address State-specific health coverage needs; second, bolstering and revitalizing the private employer-sponsored market.

Trends have shown that more and more Americans rely on employment-based health insurance. In addition, a large part of the reduction in the uninsured in the past few years is a direct result of that reliance on increased employer-sponsored insurance. We must be careful not to act in any way that would have an adverse impact on our employer-based system.

Before closing, let me just say that I am encouraged by the strong bipartisan will to find a solution. Senator Baucus and I have had private discussions on this, our staff has been working on it. We have had evidence of other members of this committee, independent of our efforts, working on it. So I think it speaks very well of the chances of doing something in this area.

So, there are many ideas before us. I look forward to working with my colleagues, and obviously I look forward to working with the President, to reach success on this issue this year.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you very much, Mr. Chairman. Good afternoon. Good afternoon to everyone in the room.

Tuesday, we learned a lot about the problem. Today, I hope we start focusing on some of the solutions. We know that about 43 million Americans are uninsured.

An interesting statistic that I found yesterday, was that of the uninsured, 70 percent are people who are involved with work, either they themselves are working, or their children, or spouse is working. But 70 percent of the uninsured are tied to the workforce.

There are several different suggestions. Some suggest that the best approach is just to expand existing programs like Medicaid and SCHIP. Others suggest—and I might add, with equal vigor—that the only sound approach is through tax incentives.

I, at this point, believe we should look at both of those general approaches, and be pragmatic, not ideological about this, and look to see what works, forgetting about some ideological inclination.

I think that program expansions are very efficient. It is certainly a very efficient part of the solution. Looking at the numbers, I think you get more bang for your buck by expanding programs like SCHIP, which has been very successful, I know in my State, and most States.

Tax incentives can also be very helpful because they can give working families some assistance in purchasing health insurance that they now cannot do. I think, however, when we look at tax incentives we have to be certain that they are written pretty carefully, and to the extent possible, should be targeted to those who need it the most.

There are kind of a couple of conflicting cross currents when it comes to tax incentives and health insurance. One is tax equity, the other is health equity. Nothing is perfect. We have to, again, be pragmatic about this.

In other words, I believe that a solution is somewhere in the middle, some combination. A modest expansion of programs that are working along with targeted tax incentives for taxpayers, I believe, and particularly an employer-based tax incentive, and particularly for small business. Many, many small business people just do not have the wherewithal today to provide health insurance for their employees.

There are other factors to consider. We need to improve Medicaid and improve SCHIP, and help find ways to enroll the literally millions of people who are eligible for public assistance but, for some reason, are not signed up.

There is one thing I know for sure: we are not going to solve this overnight. There is no silver bullet. I think the 1994 health care debate certainly taught us that. But if we work together and take this a step at a time, I think we can make very significant progress. At least, that is our charge.

John Kennedy once said, the best time to fix the roof is while the sun is shining. Well, I think that is a good point. The sun is shining, at least figuratively, in the sense that we will have projected budget surpluses. I think these projected surpluses will give us an unprecedented opportunity to begin to solve this problem.

I think the American public agrees that we should spend some of the surplus dollars, generally, on important issues like education, prescription drugs, and it would also include helping the uninsured.

With 43 million Americans uninsured, I think it would be wrong to spend the entire surplus without making a significant investment in providing more health coverage to Americans who, today, have none. That just would not be the right thing to do.

I look forward to working with you, Mr. Chairman. You have been a great chairman to work with. Let us see what we can come up with.

Thank you.

The CHAIRMAN. Thank you.

Senator Bingaman, I think I will go ahead. Is that all right? If you had anything you wanted to say, and wanted to say it quickly, I would be glad to let you.

Senator BINGAMAN. I would just as soon get to the testimony.

The CHAIRMAN. All right.

We are going to start with a person that I relied on very much over the last 4 years in my chairmanship of the Aging Committee, Dr. Scanlon, from the General Accounting Office. I welcome him back for the first time before me as chairman of this committee.

It is my understanding that he will deal with an overview of the uninsured population, the reason for lack of coverage, and some general description of the varied approaches to providing health coverage to the uninsured.

Then Ms. Janet Trautwein is director of the Federal Policy Analysis for the National Association of Health Underwriters. She will discuss what factors to consider in order to effectively implement tax credits and ensure efficient utilization of individuals and families in the uninsured population.

Then we have Dr. Jack A. Meyer, president of the Economic and Social Research Institute, which you often see quoted in research publications, particularly on tax issues. He is going to discuss the Federal tax credit aimed at providing incentives to employers to provide health insurance for their workers.

I think we will go in the way I introduced: Dr. Scanlon, Ms. Trautwein, then Dr. Meyer. We will make sure that we have questions when you are done with your panel.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Mr. Chairman. It is a pleasure to provide you assistance in a new venue.

Mr. Chairman and Senator Bingaman, I am very pleased to be here today as you begin considering options to expand health insurance coverage for the 1 in 6 non-elderly Americans who are uninsured.

As you have heard and you summarized with respect to the testimony that was given before this committee earlier this week, the uninsured are a very heterogeneous population, with some groups being disproportionately affected. But the uninsured simultaneously include——

The CHAIRMAN. Can I interrupt just a second?

Dr. SCANLON. Sure.

The CHAIRMAN. Now, we are going to do what I announced before the meeting started. We are going to take turns. So, I will not be here to hear all of the testimony, but I will be back. Then he will go vote, et cetera. If Senator Bingaman can help us with that, that would be appreciated as well.

Senator BAUCUS. Go ahead.

Dr. SCANLON. All right. Thank you.

As was discussed in the testimony on Tuesday, the uninsured is a very heterogeneous population, with some groups being disproportionately affected. But at the same time, the uninsured popu-

lation includes people from all types of employment, income levels, demographic groups, and regions.

Given this heterogeneity, as you have indicated, a variety of approaches have been proposed for Congressional consideration to increase private or public coverage.

My written statement provides an overview of different approaches that would use tax subsidies to encourage individual purchases, or employers to offer coverage, as well as options that would expand public programs, including Medicaid, the State Children's Health Insurance Program, and a Medicare buy-in for the near-elderly.

It also highlights some considerations that could impact these proposals' effectiveness in reaching significant numbers of the uninsured. I would like to provide you a brief summary of aspects of the written statement.

The success of new tax incentives to promote private health insurance will depend very much on whether they are large enough to impact the premium costs enough to induce individuals to purchase insurance, or for more employers to begin offering coverage or increasing their contributions to workers' coverage.

Tax credits, rather than deductions, will likely produce a larger effect, as 90 percent of the uninsured have no tax liability or are in the 15 percent marginal tax bracket.

Credits in the amount of $1,000 for individuals and $2,500 for families with incomes below specified thresholds have been proposed by several members of this committee.

How much such credits will reduce premiums for persons buying individual insurance will vary considerably, as premiums fluctuate with purchasers' age, location, and health.

Last year, we reported several examples of individual policy premiums. At the low end, a young, healthy male in Arizona would pay less than $750 per year. In the middle, a resident of rural New York, where State law prohibits premiums to vary by age or health status, would pay about $2,700 a year. On the high side, a near-elderly male who smokes in urban Illinois would pay about $7,000 per year.

Tax credits will also be more effective if they are available when low-income persons purchase insurance rather than in the following year when tax returns are filed. But making tax credits payable in advance will involve administrative challenges.

Mechanisms and resources would be needed nationwide to assure that the credit is provided to persons likely to qualify, and to efficiently and equitably reconcile over- and under-payments at year-end.

The only experience with such prepayment arrangements has been with the Earned Income Tax Credit, which may not be a good guide, as only about 1 percent of recipients of that tax credit elect the advance payment option.

Let me now turn to some of the considerations that may affect proposed expansions of public programs. Despite past expansions to Medicaid and the recent creation of the SCHIP program, millions of low-income children and adults remain uninsured. Childless adults are not generally eligible for Medicaid, and parents of eligible children are not generally eligible for SCHIP.

Some proposals would expand eligibility to these groups, while others would increase the income eligibility levels that States could use in both programs.

However, States' willingness and ability to use additional Federal flexibility will be the key to how much public coverage would expand. Some States have already used Federal authority to expand Medicaid and SCHIP to people not traditionally enrolled, or people with higher incomes.

However, States with high uninsured rates typically have lower eligibility thresholds for Medicaid. These States also tend to have lower per capita incomes and already have a larger share of their residents on Medicaid.

They have been less likely to pursue current options to expand eligibility and may also have more limited capacity or willingness to pursue additional options.

The success of any effort to expand public programs will also be contingent upon the effectiveness of outreach programs to enroll those who would be eligible. At present, many eligible individuals are not participating in these programs.

In prior reports, we found that nearly one-fourth of children eligible for Medicaid were uninsured. Also, more than 40 percent of low-income Medicare beneficiaries did not participate in existing programs intended to pay Part B premiums or out-of-pocket costs.

Last year, Congress took steps to better identify and notify potentially eligible low-income Medicare beneficiaries of these programs. Similar efforts may be necessary for any effort to expand public programs to ensure that they are reaching the targeted populations.

Finally, I would like to acknowledge the concern that efforts to publicly support private coverage or expand public programs is going to crowd out existing private purchases. Crowd-out has been the concern, and likely a reality, with prior expansions of Medicaid or the implementation of SCHIP.

Though analysts disagree about its extent, concern about crowd-out led the Congress to include a requirement in SCHIP that States devise methods to avoid it or minimize it.

While some approaches may offset its extent, some degree of crowd-out may be inevitable in order to provide stable health care coverage for a significant number of the currently 42 million uninsured Americans. Our focus should be on what benefits such coverage will produce and what the costs of securing these benefits will be.

Thank you very much, Mr. Chairman. I would be happy to answer any questions that you have.

[The prepared statement of Dr. Scanlon appears in the appendix.]

Senator BAUCUS. Thank you, Dr. Scanlon.

Our next witness is Janet Stokes Trautwein, director of Federal Policy Analysis, National Association of Health Underwriters in Arlington, Virginia.

Ms. Trautwein?

STATEMENT OF JANET STOKES TRAUTWEIN, DIRECTOR OF FEDERAL POLICY ANALYSIS, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS, ARLINGTON, VA

Ms. TRAUTWEIN. Thank you.

I would like to tell you a little about our organization, first. The National Association of Health Underwriters is an association of almost 17,000 insurance professionals involved in the sale and service of health insurance, long term care insurance, and related products.

Our organization has been a proponent of refundable health insurance tax credits to address the problem of the uninsured for more than a decade, and we are pleased to have this opportunity to discuss the practical application of a tax credit with the members of the committee.

Although there are many reasons why a given individual may be uninsured, the most likely reason is the inability to afford health insurance coverage. NAHU believes the best solution to this problem is a refundable health insurance tax credit designed to be used either to buy coverage in the individual health insurance market or to help an employee pay his or her share of premiums in an employer-sponsored plan.

People without access to employer-sponsored coverage who previously were faced with paying the entire cost of health insurance on their own would, for the first time, have real help with the cost when they needed it.

Low-income employees would be able to supplement their employers' contributions with the tax credit, providing the funds necessary for them to come up with their share of their family's health insurance premiums.

It is very important that a health insurance tax credit be advanceable monthly when premiums are due. For this reason, we recommend that a tax credit be a flat credit.

Although health insurance costs are different for different populations, especially in the individual health insurance market, a tax credit based on individual demographics could be difficult to administer.

If administration becomes too difficult, it will not be cost-effective for employers and insurers and they may elect no to advance tax credits to individuals. This could result in the tax credit not being available until the end of the year when people file their tax returns.

A health insurance tax credit, we feel, should not be designed to take away the traditional role of the employer and the financing of coverage, or to replace personal responsibility.

A credit in the range of $1,000 for individuals and $2,500 for families would not be large enough to cause an employer to stop providing coverage for employees, yet it still provides a good base to finance coverage, even for employees purchasing coverage in the individual health insurance market.

In most States, individual health insurance requires that a person be in relatively good health. But if a person does not qualify for coverage based on their medical history, many States do have a high-risk pool or some other mechanism to ensure that coverage is available.

A refundable health insurance tax credit could help these individuals afford the cost of health insurance coverage in high-risk pools the same way that it would be used for those who purchased coverage elsewhere.

The Treasury Department would have primary responsibility for administering health insurance tax credits, of course. What we are proposing is that the credit would be owned by the individual, an important protection in the event of job change or change of an insurance policy.

Although it would be owned by the individual, though, it would not be paid directly to the individual. Normally, we would envision that it would be assigned to an insurance company, employer, high-risk pool, or other organization maintaining the individual's insurance account. The credit could be used only for the payment of private insurance premiums, and could not exceed the total cost of the premiums.

Another way to help employees pay their share of premiums might be to allow them to combine health insurance tax credit dollars with other Federal or State programs that they or their family members might be eligible for, such as the Earned Income Tax Credit or the SCHIP program.

Concerns about whether or not adequate coverage would be purchased under any of the combined programs would be addressed through the administration mechanism of a health insurance tax credit, which requires the purchase of HIPAA creditable coverage, certified by either the employer or the insurance company.

Finally, a discussion of the uninsured would be incomplete without mention of the Children's Health Insurance Program. I would like to, just very briefly, suggest a change to make it more effective in reaching uninsured children.

In designing SCHIP, Congress allowed both Medicaid and private sector options for implementation of the program. One of the private sector options was to allow children to be enrolled in the employer-based plans of their parents.

Unfortunately, due to some of the SCHIP program requirements in BBA, many States have not been able to adequately implement this full range of options allowed by the legislation. The basic problem involves a 5-percent limit on cost sharing, which includes both premium and co-insurance liability.

A quick calculation of the maximum potential co-insurance liability of an average plan, such as the type of plan many Federal employees and private employers have, would make those plans unacceptable in this arrangement.

In summary, a refundable health insurance tax credit represents a simple and realistic way to extend private health insurance coverage to those uninsured individuals and families most in need of assistance. It is a private sector solution to a difficult public problem. It gives people the tools to make their own decisions.

In addition to a tax credit, the Children's Health Insurance Program could be greatly improved and made available to many more eligible uninsured children if coverage through employer-sponsored plans were encouraged by changing the definition of cost sharing in the SCHIP program to premium liability only.

Thank you for this opportunity to testify. I would be glad to answer questions later.

[The prepared statement of Ms. Trautwein appears in the appendix.]

Senator BAUCUS. Thank you.

I think I am going to recess the hearing right now. There is 5 minutes left on this vote, and I do not, Dr. Meyer, want you to be cut off in the middle of your testimony.

So when Chairman Grassley returns, he will undoubtedly have you begin. I expect him to be returning momentarily.

So the committee is in temporary recess, my guess is, about 5 minutes. Thanks.

[Whereupon, at 2:54 p.m., the hearing was recessed to reconvene at 3:00 p.m.]

STATEMENT OF JACK A. MEYER, PH.D., FOUNDER AND PRESIDENT, ECONOMIC AND SOCIAL RESEARCH INSTITUTE, WASHINGTON, DC

Dr. MEYER. Thank you, Mr. Chairman.

I would like, with your permission, to just summarize the highlights of my testimony, submitting the full text for the record.

I would also like to submit a paper that I prepared with my institute colleague, Elliott Wicks, for the Commonwealth Fund. It is entitled "A Federal Tax Credit to Encourage Employers to Offer Coverage." I offer that for the record.

The CHAIRMAN. That will be received. And if the rest of you did not ask, everybody, and the next panel as well, without your asking, if you want your full statement put in the record, it will be printed the way you submit it.

Dr. MEYER. Thank you.

[The information appears in the appendix.]

Dr. MEYER. I would like to begin by endorsing your opening comments, Mr. Chairman, about the need for a pragmatic approach that pulls together different strands.

Although I am going to concentrate on income tax credits, I do think we need to reach out to vulnerable populations directly. I think that we need to enroll eligible populations.

I just looked at a food stamp application that was 21 pages. Medicaid has done a little better than that. But there are a lot of barriers for people who are now eligible for Medicaid and SCHIP, and we need to address those.

This is not an either/or situation, where either we do or don't do a tax credit.As you and Senator Baucus pointed out, we need a combination of things. There are also, as Bill noted, many very poor adults who do not qualify for Medicaid, including homeless people and others, for whom it would be an unlikely solution to think of a tax credit, since they are not working.

But for many low- and moderate-income families with a full-time worker, particularly, they are often going to be ineligible for those programs. We do not want to keep raising and raising the thresholds, as you pointed out.

So we have designed a tax credit to try to jump-start many small employers and other employers to get them into the game. As you noted, small employers are often not able to offer coverage. Among

firms that have less than 10 employees, only 6 of 10 offer coverage, compared to 97 percent among those with more than 50 workers.

So we have designed a tax credit that is varied with the wage level of the employee so that firms with a very low wage labor force, say less than $7 per hour on average—and there are many firms like that in America—would get a credit equal to about half of the premium of a standard plan that would be defined to include mental health, and prescription drugs, and hospital care, and physicians.

But it would not be a minimum benefit. It would just set the price target. Firms could have a little more of this, and a little less of that, above those services, but it would pay up to half of the premium.

I would also add that this is not mutually exclusive with a tax credit for employees, who need some help, as my colleagues have noted, with their half of the premium when the employer only contributes half, or perhaps even help paying 25 percent, if the employer pays three-fourths.

So, again, these are not mutually exclusive options. In our view, the credit should go to all employers who are offering coverage, not just those offering it for the first time, because, after all, those that have been offering it have been doing the right thing, so to speak.

We do not want to discriminate against them. Their workers have presumably given up some wages and other benefits and are paying a good share of the premium in order to have the coverage. So, they need some relief from their current burden as well.

We think that the credit should be uniform across the country. It should be updated. Employers should have access, like employees, to advance payments during the year. They need to show proof that they have done this.

I think that there are a lot of opportunities. Also, you need to take your credit somewhere. You need to be able to use it for affordable coverage. So, we need to pay attention to purchasing cooperatives or alliances into which people could take their credit.

I really worry about giving the uninsured a tax deduction, not only because, as I believe Bill pointed out, most of them have no tax liability, but also because they might take their $2,000, or $1,000, into a $7,000 or $8,000 policy in the individual market. If they are sick, that might be $9,000, $10,000, or $12,000.

So we really need to pay attention to having a risk pool, whether it is purchasing alliances or a State employee benefit plan, where people could get affordable coverage, that they might be getting help with $3,000 if the standard plan is priced at $6,000, toward a $5,000 or $6,000 policy.

Then if you were working on both the employer and employee side, you suddenly have an affordable product. We have found, as Bill noted, that skimpy credits yield skimpy take-up rates.

The credits must also be viewed as permanent and not temporary. Experiments have shown that with temporary credits, firms are very unlikely to get involved, because they are worried that these will be taken away.

It is very difficult for a small company with 5, 8, 10, 20 employees to be able to afford $6,000, $7,000 a year per worker, particularly when they are paying those workers $14,000, $15,000,

$16,000 a year. It becomes an enormous percentage add-on to the cost of the coverage.

So we think that, even though economists would argue whether you subsidize the employer or the employee is a distinction without a difference, there is some research evidence to suggest that employers might have a strong take-up rate if you structured it in the right way, sent them the right signals.

So we offer this up, not as a panacea, but as a complement to efforts to reach out to vulnerable populations, enroll more people who are eligible, and expand eligibility around the margin to those who have very low incomes and should have public aid. This way, we think we can have a public/private partnership.

Thank you very much.

[The prepared statement of Dr. Meyer appears in the appendix.]

The CHAIRMAN. Well, I thank you all very much. Obviously, I only heard your testimony, but I thank all of you for participating.

My first question is to all of you on the panel in any direction you want to take it. It is me stating a proposition, and then bottom line, asking you to comment on it.

Obviously, I am encouraged by all of the hard work that has gone into thinking about ways to provide health insurance coverage for the people in America that do not qualify for Federal health care programs.

Now, I have this concern about the adverse effects that expansion programs could have on individuals in the private market. The predominant principles that guide me: (1) trust in the private market approaches; (2) autonomy from government or personal independence.

In other words, I think we, the Congress, should do what it takes to help make the private insurance market work, and do it for this segment of our uninsured.

It seems to me that mandated expansion of Federal health programs could weaken the private insurance industry by disincentives to employers from offering coverage, shrinking the private market risk pool, thereby increasing premiums for Americans, and even more importantly than shifting costs of health care from employers to the Federal Government.

Dr. Meyer, do you want to start?

Dr. MEYER. Sure. I understand your concern, Mr. Chairman. I would say that if expansions of public programs are very carefully targeted to bring into the public safety net populations with very low incomes who are unlikely to have a realistic private market insurance option, such as adults with an income of 50, 60, or 70 percent of the Federal poverty line—which, for a family of four, is a very low amount, $8,000, $10,000 a year—bringing them into public coverage should not have that kind of adverse impact.

But I agree with you that, if we take today's income eligibility lines and start moving them above 200 percent of the poverty line toward 300 percent, we are into the middle income, where viable private market options are available, that there could be some displacement effects.

So, I would push for enrolling those who are already eligible, expanding eligibility in a limited way to very low-income people who

are discriminated against for one reason or another because of the accident of their family status at that moment in time.

Maybe some modest expansions, and also using government monies to support private insurance. We tend to think of this as either/or. But, for example, in Iowa, your home State, the HIP program uses Medicaid monies to help people who are in employer-sponsored coverage afford their share of the employer plan.

So there is a case of some targeted public dollars—in this case, Medicaid—actually supporting private insurance, employer group insurance, and we could do more of that under Medicaid and SCHIP.

So I think if we are careful about this and do not just think of public programs covering everybody, we could avoid the problem you have raised.

The CHAIRMAN. Ms. Trautwein?

Ms. TRAUTWEIN. I would agree with Dr. Meyer that we need to be careful about how high we raise that income bar. As long as we keep that at a reasonable level, there is probably some safety in that.

But we have actually done quite a bit of research into what employer behavior might be in the event that you repaired some of the problems with the SCHIP program and you allowed the SCHIP program to be used in conjunction with employer plans, and also in conjunction with the big question about whether or not it is feasible to use a tax credit in an employer plan. We have looked a lot at typical employer behaviors.

What we found, especially in some recent surveys that we have done, is that employers would be highly unlikely to either reduce their contributions or stop providing the coverage that they are already providing today.

Part of that has to do with, in a means tested program, what you do for those lower-income employees you also are pretty much tied in to doing to the higher-income employees.

In a tight labor market, it is very unlikely that employers would do less than they do now, or stop doing what they are doing altogether in terms of their contributions.

So I think, as long as we are careful not to raise that income bar too high and it is a means tested program, I think that we avoid a lot of that.

The CHAIRMAN. Dr. Scanlon?

Dr. SCANLON. Mr. Chairman, the research on all of the alternatives that we have been discussing indicates that, while there are different methods that can make an alternative more successful, the take-up rates are never going to be 100 percent.

As Dr. Meyer indicated, we need to, therefore, think about a multifaceted strategy, one portion of which is likely to include some public program expansions.

The fact that childless adults are not eligible in most States for any Medicaid assistance creates a population that may have no chance of getting employer-based coverage and not be able to afford individual coverage, even with a healthy tax credit. It creates a situation where, potentially, that type of public program expansion is beneficial.

At the same time, we do not want to excessively crowd out private insurance. What I think you will hear in the next panel, the notion of building public dollars into private insurance, is one way of trying to strengthen the private insurance side, while simultaneously filling some of the gaps that exist.

The CHAIRMAN. One of the groups or populations that I remember reading about maybe 4 or 5 years ago on an analysis of the uninsured, was young males in their 20's who had a feeling, regardless of what was available, that they would never need it, so why spend a little bit of money to get it, even if it was offered by the employer, if they had to pay a portion of it?

I am going to ask Ms. Trautwein this, but anybody else can comment on it.

One of the important issues with any refundable tax credit option is to ensure that it can cover the cost of private sector coverage, and it can be effectively implemented.

Would you elaborate on the research of your organization that is done on the affordability of private sector health coverage, and also ways to implement a refundable credit that is effective, provides consumer protection, and protects against potential fraud?

Ms. TRAUTWEIN. Well, first of all, included in our written testimony that we submitted were several different recent research projects that we have completed.

One of them actually picked an amount of a $2,500 tax credit, or about that amount of money, to see what that would buy in all 50 States. We were actually surprised to find that you could find a reasonable level of coverage in all 50 States for around that level for a single mother with two small children, which was the target family that we looked at. We also did some studies for a higher level of benefits, and we included that with our testimony.

We think that the way that a tax credit, though, is delivered, is very critical. We believe, as I said in my earlier testimony, that it has to be advanced. This could be very easily done through employer plans whereby, let us say, an employee, currently uninsured right now, had a paycheck where their current deduction would be $100 a month.

Well, you could add back in a tax credit for that amount and deliver that directly through the employees' paycheck. There would be little opportunity for fraud because the money does not ever cross the person's hands. The employer is certifying that coverage was purchased.

You could have the same type of an arrangement, whether you were purchasing an employer plan or through an individual health plan. That advancement through the insurer or through the employer pretty much fraud-proofs the arrangement that you are doing.

The other thing that is very important, and particularly as we talk about combining with any other Federal programs, is that we think it is very important to protect the legislation that has already been passed through the Health Insurance Portability and Accountability Act, HIPAA.

People were very much protected against being discriminated against because of job changes with that legislation. We think that if you state that a policy must be HIPAA creditable coverage, that

you have already eliminated the possibility of plans that have been problematic in the past, such as specified disease plans, hospital indemnity plans, and those types of things.

The CHAIRMAN. On another point, your testimony touches on the cost sharing provisions of SCHIP. You make the case that these provisions impede States from exercising a full range of options for families and children eligible for that program.

Could you elaborate, but more importantly give an example, of how the cost sharing provisions tie the hands of States who might want to explore that option?

Ms. TRAUTWEIN. For example, for a low-income person, the way the cost sharing provisions are written in the law, cost sharing is limited to 5 percent for anyone that is above 150 percent of poverty.

Now, the 5 percent does not just mean what the amount of the premium is. That includes all the co-insurance, pretty much, that is within that plan as well. So if there is a 10 percent, or 20 percent co-payment on certain services, that is included in the cost sharing.

This proves to be a pretty big impediment for States who might like to use the SCHIP as designed, to be allowed to be used in employer plans with each employer plan being completely different, just the mechanism of going through and counting each individuals' co-insurance liability has caused a number of States just to say, we cannot do it, the administration is too difficult. Many plans, such as those that a lot of us are insured under today, would not meet that test.

So, for example, the plan that I have my child insured under would not be good enough for the SCHIP program, and I think we have pretty good coverage.

So that is just something that should be corrected. I cannot imagine that that was the intent of the legislation when it was written.

The CHAIRMAN. I want to turn, now, to all the panelists on this issue of the fact that small businesses, particularly those of 25 or less employees, experience difficulty in offering affordable coverage for their employees.

Can each of you discuss innovative ways to encourage small business to provide health insurance? Dr. Meyer?

Dr. MEYER. Yes. Well, first of all, they have to have a place to join in with other small businesses so that they can take advantage of the law of large numbers and lower the administrative costs.

So, I point you to such examples as the alliance in Denver, Colorado, a purchasing coalition that has 27,000 members now, 1,800 companies. Some of these have done better than others. In California, there are over 100,000 enrolled in such an alliance.

So they need to be able to group together. COSI, in Cleveland, is another example of that. However, you need favorable regulation that limits the ability of insurance companies to cherry pick among small employer groups by saying, "We would like you because you have a young, healthy workforce, so come join us;" or "we do not think we like you, you have an older workforce with a bad profile."

So putting some limits on that within the context of a free market could also help so that employers are not afraid that, the

minute someone gets really sick in their company of five or six people, that they are going to experience a doubling of their premium.

So those are a couple of measures that can be taken to do that. I think, also, there are going to have to be some subsidies, some help, at least at the front end to help these employers get started. Even if you are able to lower the cost, say, from $7,000 or $6,000 to $5,000, it is still a big swallow for some of these companies and they may need some help.

The CHAIRMAN. You probably are not familiar with it, but we ran into that same problem on small businesses getting pensions started. Senator Baucus and I, and Senator Graham of Florida have had a one-time tax incentive suggestion that we would give for the administrative costs of starting that up.

Now, I presume in this particular instance that might be an ongoing situation. As you suggested, it is not just an administrative cost. Is that very important, too?

Dr. MEYER. Well, that is a good analogy. You are right. I am suggesting that it would be preferable to have a permanent subsidy. But certainly, as compared to doing nothing, a front-end assist, like you mentioned in pensions, would certainly be better than doing nothing.

The CHAIRMAN. But is that related, in the case of health insurance, to start-up costs for a health insurance program that would be similar to a pension program, do you think? Or is that not as complicated for health insurance?

Dr. MEYER. Having just gone through that for my company on the pension side, I would say almost nothing is as complicated as pensions. I do not think it is quite as complicated.

The CHAIRMAN. All right.

Dr. MEYER. You can call a broker and choose among three or four plans. I find the pension area much more difficult.

The CHAIRMAN. All right.

Dr. MEYER. But there is a lesson there, nonetheless, that business will need some help. These purchasing co-ops may need a credit to get going, as New York City has done at the front end for their purchasing co-op, which now also has about 2,200 people enrolled.

The CHAIRMAN. Dr. Scanlon, any additional suggestions from you, and Ms. Trautwein?

Dr. SCANLON. Mr. Chairman, we have looked at purchasing cooperatives in the past. We agree with Dr. Meyer that they resolve some of the administrative problems that are associated with trying to purchase insurance. It is something that you confront on an annual basis because you have to renegotiate your contract.

The key is, they need to be structured in a way that they are going to be perceived as attracting all risks as opposed to being the haven for companies that have higher-risk individuals.

Dr. Meyer's suggestion of some type of subsidy is one technique that may be productive in that regard. Some of those 25-year-olds that you mentioned who thought they were extremely healthy might be attracted by a lower premium.

Another device, which actually is in some of Dr. Meyer's work, would be the idea of a reinsurance pool, so that insurers would not

feel that these small businesses were as risky because large losses would be covered by a reinsurance pool.

The CHAIRMAN. Ms. Trautwein?

Ms. TRAUTWEIN. Yes. I think we would agree with you that maybe a reinsurance pool might be a better idea, and only for this reason.

Some of the discussions around purchasing pools and various types of pooled purchasing arrangements have indicated that those types of arrangements would have different rules than other plans in the market. I think we have to be very careful that, in our zeal to do something good, we do not disrupt what is already working out there.

So I would say that the purchasing pools are fine, as long as they play by the same rules as plans that operate outside of the purchasing pool arrangement. Otherwise, you might end up losing some availability that you had before.

The CHAIRMAN. Ms. Trautwein, would you give us some more information from your perspective? You talked about alternative options. One option you talked about was combining a new tax credit with the existing Earned Income Tax Credit, and another option could include allocating or expanding a portion of the Earned Income Tax Credit towards the purchase of health insurance.

Ms. TRAUTWEIN. Right. As you all know, the Earned Income Tax Credit is advanceable. By the way, we do not have to limit this just to EITC. There are other programs that could be combined, such as the SCHIP program.

But one of the things that we have looked at, is how can we maximize a tax credit when it appears to be just not quite enough? Extend it a little bit further. It is particularly important for the really low-income people.

There is really no reason—in fact, the Earned Income Tax Credit can be advanced in the same way that we have described the health insurance tax credit to be advanced—why those two programs could not be combined all in one process.

The CHAIRMAN. I think we are going to take a short break here, because I should not start a second panel. I believe Senator Baucus will want to ask questions. So the second vote will start in just a second. The first one was just completed. The 15-minute votes around here are really 40-minute votes.

Anyway, I think we will just recess for a minute while we wait for Senator Baucus, then I will go over and cast my vote. In fact, the light just went on. He will be here. It takes about 4 minutes to get here.

Probably what I will do, is introduce the second panel. I will be over there casting this vote, plus the beginning of the next vote.

[Whereupon, at 3:20 p.m., the hearing was recessed to reconvene at 3:32 p.m.]

Senator BAUCUS. The hearing will come back to order.

I would like to ask a question of you, Ms. Trautwein, just to get a sense of where we are here.

You suggested advance payments of a refundable tax credit to individuals are quite simple and fraud-proof. I would like you to expand on that a little bit, because I think it was you, or someone,

referenced the EITC as a potential model, even though it is not perfect.

Our experience with the EITC shows that advancing credits, in fact, is quite difficult to administer and lends itself to fraud and high error rates. Also, less than 1 percent of people use the option in the EITC for advance payment. Taxpayers tend to fear owing money. They do no want to owe it.

There is some evidence that advance payment may actually cause more fraud. I wondered if you are familiar with the evidence that only 1 percent used advanced payment of the EITC. It does not really work very well.

Ms. TRAUTWEIN. We think it could work better. Here is why we think that this might be a different situation than what we have experienced with EITC.

First of all, if you look at the advancement option on EITC, it was not associated with the same strict parameters for the type of policy purchased. When we use the standard of HIPAA creditable coverage, that gives people a lot of leeway on what type of policy they might want to select. But it has a precedent. It ensures that adequate coverage is purchased.

In terms of the 1 percent take-up, the way that we would envision, and the way we have seen some of the pieces of legislation written, is that rather than having an abrupt drop-off in eligibility, there would be a gradual phase-out.

Usually, when you look at these means tested tax credit proposals that have advance payment provisions in them, they gradually phase off at about $10,000 over the income limit. So at the end of the year, with the health insurance tax credit, it is much less likely that someone is going to be just bumped off the edge the way they can be with the EITC. We think, for that reason, people will be less reluctant to exercise the opportunity than they have with EITC.

I think I answered your questions. But I would also like to point out something that we just completed in terms of whether or not employers want to have anything to do with this process of advancement.

This is a survey that was not included in our testimony because it literally was just done before we came over here. The survey that we just completed indicated that 84 percent of small employers surveyed support a credit to help their low-income employees pay their share of the premium, and that 71 percent of them would absolutely cooperate in the administration of that.

This would be a meaningful effort to ensure that adequate coverage was purchased, that coverage was really purchased. We think it is a good effort, anyway, to prevent the type of fraud that we know has occurred with EITC in the past. We think that some of the strings attached to the way it would work would prevent that from happening.

Senator BAUCUS. All right. I think, off the top, employer-based incentives would help quite a bit.

I want to explore a little bit, if I can, the efficacy or just how realistic it is, for taxpayers electing to claim an individual credit, that they would actually do so.

I know I am treading on toes here. This proposal is advanced by members of this committee. But take a family with $50,000 of income, claiming a $2,500 tax credit. The cost of an average health plan available in the non-group market would be $7,000, a refundable tax credit t $2,500, and the remaining cost to the family of the health plan would be $4,500. That is 9 percent of their gross income. I am just wondering if that is a little high. It would make it a little difficult for people to really participate.

Or let us take a family with $30,000 claiming the same credit. The calculation comes down to 15 percent of gross income, that is what the family would have to pay, in the non-group market, with a $2,500 tax credit.

If it is a $50,000 income with a $2,000 tax credit, it is 10 percent of gross family income. If it is $30,000 income with a $2,000 tax credit, which is the President's proposal, it is 16.67 percent of gross income.

Are we kidding ourselves by thinking that credits of that amount are high enough to get the job done, or not? My sense is, that 10, 15, 16, 17 percent is pretty expensive. Dollars are short. I am not so sure that people will take advantage of this.

Either you, Ms. Trautwein, or Dr. Meyer, or both? I would encourage you to think about that.

Ms. TRAUTWEIN. I have an initial response. First of all, it depends on what kind of policy you buy. You can buy a policy that provides more catastrophic coverage so, in the event of some really serious illness, you would have a higher deductible, and that type of thing. Then the policies, first of all, would not be as expensive as you had described.

Second to that, though, those people, hopefully right now, are at least looking at trying to buy coverage in that market right now. Now they have nothing. They have no help at all. I believe that they would appreciate some assistance in purchasing. I think many families would appreciate that $2,500.

We also think that, in bringing more people into the market, you will find that insurance companies will try to design policies that are somewhat geared to the size of the credit so that people have less out-of-pocket expense.

Finally, most important, we want to be sure when we design these credits that we do not do anything to discourage employers from doing what they are doing now. Certainly, people could use a higher credit, and we could have all the dollars in the world to try to pay for that.

But the big problem is, if you design a credit to be too high—and we have done a lot of research into this—employers would be discouraged from continuing to do what they are doing now. They insure most of the people that are insured today. And that is what we are most concerned about, is to make that credit such that it will not disrupt that.

Senator BAUCUS. Dr. Meyer, do you have any thoughts on this subject?

Dr. MEYER. Yes. I think you have raised a very good point that highlights two critical needs for making a tax credit approach work. As I highlighted in my testimony, it cannot be a panacea. It has to go along with other measures.

One is, if you take your arithmetic, which is interesting, and you raise the $2,000 credit to $3,000, and then you say to the family, we are going to put you in a purchasing cooperative or State employee benefit plan, thinking a little more creatively, or even FEHBP, thinking even more creatively, where you can get that family policy, not for $7,000, but for $5,500, now you have got $3,000 toward $5,500.

Your share is $2,500, which, in your example, would be 5 percent of your $50,000 income. Still some money, but a little more of a stretch. Then you say to the $30,000 family, you may need more than $3,000, you may need $3,500 or $4,000. We really need to think realistically, because I think you are right.

If you just give people a small credit and turn them loose in the individual market, it is $7,000 for a healthy family, but for a family with a really sick kid, it might be $10,000 or $12,000. This is not fiction. These are real numbers.

So you really need to combine a healthy credit, which I think has to be at least half the premium, with a place to take it and some reform of the individual market to deal with this risk selection and discrimination against sick families.

Senator BAUCUS. I had to step out for votes. Before I turn to Senator Rockefeller, do any of you want to respond to anything any of the panelists have thus far said, for the sake of the order here?

Dr. SCANLON. I would just like to add, Senator, in following up on Dr. Meyer's comments, it is really an issue of what type of inroads you want to make in terms of the problems of the uninsured.

In some respects, it is simple economics here. As the credit increases in the share of premium that it is going to cover, and as the share of your income goes down, we are going to make bigger inroads.

The reality, though, is that over 50 percent of the uninsured are in families with incomes less than 200 percent of poverty, so we have mostly low-income people. If it is not a sizeable credit it is going to be a large share of their income, and, therefore, the take-up rates are going to be much lower.

Senator BAUCUS. Thank you.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Senator Baucus.

What is frustrating to me in this discussion, is that Jack Meyer, as usual, is trying to inject some reality into this, but we do not choose to do that when it comes down to taking this subject up.

There are the people who are the tax credit people. Everybody has their little point of view and it becomes ideological, then people become set and the uninsured remain uninsured. So we went down a million. We have still gone up so many.

The point is, Max Baucus is entirely correct. You say, Ms. Trautwein, yes, it would be nice if there was a little bit more money. The folks that are going to be with you are not going to offer more money.

In West Virginia, that means that people are going to have to pay 25 percent of their gross income. Twenty-five percent. It is like not giving them any money at all.

You say, you think they would appreciate a little bit of help. I am sorry, they will not because it will not buy them one dime of health insurance. Not one dime.

You say, well, maybe they will cut down a little bit and offer them another kind of plan. Well, it does not work like that either. It just does not work like that.

So if you are going to do health insurance for people, then you have to do it properly. The tax credit is the wrong approach. It is the wrong approach, period. That is all there is to it. It will not work.

It will not work at the figures that are being offered by you, it will not be offered by the figures that will come from, in part, the other side, maybe some from our side. It will not work.

I think we have to decide, on this committee, do we want people to get health insurance or do we not? Lloyd Bentsen repealed something that had been done 3 years before, is that not right, Jack Meyer, because he thought it seemed like it work. It did not work, so he went ahead and repealed it.

Dr. MEYER. That was only $500.

Senator ROCKEFELLER. I understand that. But the principle is the same. There was an attempt, it did not work. Health care was cheaper then, too.

Dr. MEYER. Right.

Senator ROCKEFELLER. So the affordability issue is everything. It does not matter if you offer $2,000 or $2,500. If it is 25 percent of their gross income that they are going to have to come up with, they are not going to buy it. Do you disagree with me?

Ms. TRAUTWEIN. No, I do not disagree with you. But I would just disagree with one thing that you said earlier. We are not strictly tax credit people. We have talked extensively about——

Senator ROCKEFELLER. Well, there is a tax credit question. I was not characterizing——

Ms. TRAUTWEIN. I understand.

Senator ROCKEFELLER. Yes.

Ms. TRAUTWEIN. We think that it is very important that, number one, you maximize the ability to coordinate with employer contributions in employer plans for those people that do have it available. We believe that you have got to reach as many people as you can.

Also, we are very concerned about some necessary changes being made to the SCHIP program so that it works better. We do not think SCHIP is a bad program. We think that it just needs a little tinkering to make it coordinate a little bit better with the private sector.

Senator ROCKEFELLER. I agree. That is why John Chafee and I fought until—well, he did not die because of that. He was a great man, and we fought to keep it out of the hands of the States. We were overruled by the Governors.

It should have been run by Medicaid. Then we would not have had this problem. There would not have been 50 different bureaucracies doing 50 different things, and we would be far ahead of where we are today. We would be talking already two or 3 years about adding parents on to SCHIPs. But we are not. We are still weltered in 50 bureaucracies with charges and countercharges in 50 different States.

So, I agree with you. We should be doing the SCHIP program better. We should be doing a lot of things better. But the whole point of all of this is to get people health insurance. Because of the 1992–1993 so-called Clinton health care experience, we have all become traumatized by doing anything dramatic, bold, or creative. So we do these little chips and carvings.

I am not personalizing this. I know it looks like, and I do not mean to be. But I feel strongly about the subject because I represent people where 26 percent, or close to that, or 20 percent, have no health insurance whatsoever. It is more than that. With children, it is much higher. I resent that.

I started out as a VISTA volunteer, and I worked with those children for 2 days every single day of my life. Neither they, nor their parents, nor their grandparents had any health insurance whatsoever. Those are the people that I have been fighting for ever since, and those are the people I will fight for until the day that I drop dead, in this place or somewhere else.

So I am not interested in talking about tax credit where the money is not enough. That is all I want to say.

Jack?

Dr. MEYER. Senator, I think you and I probably both know we will never really solve this problem in this country until health insurance, like Social Security and Unemployment Compensation, is viewed as a cost of doing business and the government puts some sizeable subsidies into helping very low-income people pay their share. Most people are afraid to say that, but I am not.

In the meantime, however, until we get an administration and a Congress that is willing to step up to that reality of making health coverage contributions a cost of doing business and putting some of this enormous budget surplus into helping low-income people, we need a mixed bag of tools.

I do think it is possible that tax credits could be in that tool bag, not for very poor people whom we need to get into Medicaid who are excluded now, and that we could mix a strategy of some SCHIP and Medicaid expansion, and even mesh a strategy of SCHIP and Medicaid expansion, with some good-sized tax credits. This could be an effective strategy, with the tax credits helping more of the middle class people and the entitlement programs helping more of the very low-income people, and then some mix in between.

Senator ROCKEFELLER. I agree with that, Jack. I think what you are saying is exactly what I feel, that we need to recognize that America is a market-based system. Our health care is a market-based system. We start out with that premise and that promise.

Then, as you say, we carry that as far as we can, but when it ceases to become efficient, then we have to understand there is something called government which has a role to play. We cannot be afraid to say that and to act on it.

I am not leaving in a pout, I just have to go vote.

The CHAIRMAN. As he goes out, I want to say that we do not consider tax credits the solution to this. It is one of several solutions we have to have, but to me, a very viable one.

I am going to ask you to depart. Thank you very much for your participation.

I would welcome our second panel. Karen Davis, president of The Commonwealth Foundation. Dr. Davis will address policies to expand existing programs, including Medicaid and the State Children's Health Insurance Program, to cover populations that are currently ineligible, and policies to expand coverage for the near-elderly.

The second witness is Christine Ferguson, director of the Rhode Island Department of Human Services. Ms. Ferguson is testifying on the use of State flexibility in Medicaid and State Children's Health Insurance Programs to better serve eligible individuals.

Following Ms. Ferguson, is no stranger to this committee. We are going to hear from Donna Cohen Ross. Ms. Ross is outreach director, Center on Budget Policies and Priorities. Ms. Ross will discuss the use of outreach and enrollment in Medicaid and SCHIP to reach eligible, but unenrolled, individuals.

When I was introducing Ms. Ross I looked at Dr. Davis because I thought we were going that way. We will go with Karen Davis, then Ms. Ferguson, then Ms. Ross.

STATEMENT OF KAREN DAVIS, PH.D., PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NY

Dr. DAVIS. Thank you, Mr. Chairman, for this invitation to testify regarding the expansion of health insurance coverage, particularly coverage to cover the sickest and poorest of our Nation's uninsured.

As this committee knows well, Medicare, Medicaid, and SCHIP today cover 1 in 4 Americans. These programs have improved access to health care and warrant serious consideration as the base on which to build to expand health coverage to America's 42.6 million uninsured people. Better incentives for employer coverage and improved linkages between public programs and employer coverage are also important.

Medicare and Medicaid get more health care for the dollar because they cover large numbers of people. They are able to obtain care at a discount to the normal market price, and most of the money goes for health care, not administration, averaging less than 2 percent compared with 8 to 12 percent for large employer plans, and 30 to 50 percent administrative overhead for non-group plans.

Medicare and Medicaid have more than 35 years' experience covering the sickest and poorest beneficiaries. Two-thirds of the uninsured have incomes below twice the poverty level, or they are in fair or poor health.

With the exception of Medicare's lack of prescription drug coverage, public programs provide benefit packages that are well-suited to their needs.

Conversely, non-group health insurance is the smallest, weakest, and most poorly performing sector of the U.S. health insurance system. It gives the least health care for the premium dollar because of high marketing costs, commissions, underwriting, administrative costs, and profits. It charges much higher premiums to those who are older, and it excludes many who are seriously ill.

Expansion of public programs can help the private market, however, work better and have more affordable premiums by taking the sickest and the disabled.

The most straightforward way to cover low-income adults would be to expand Medicaid and SCHIP benefits to uninsured parents, and uninsured family members of special needs children and disabled Medicaid beneficiaries. Many family care-givers are uninsured and do not qualify for Medicaid, even if a disabled family member does.

Expanding coverage to parents would ensure about 2.2 million currently uninsured low-income parents with incomes below 200 percent of the poverty level. Medicaid offers the kinds of benefits that are needed by many low-income people who often have serious health problems, require ongoing treatment, and cannot afford deductibles and co-payments.

The last panel talked about the importance of going higher on that, but many people find even 5 percent of income a high expense.

Expanding public programs to the family members of those who are already covered by Medicaid or SCHIP would be an effective way to reach many uninsured quickly. We know where their parents are.

Expanding Medicaid and SCHIP would also increase the stability of coverage for low-income families and promote healthy families by improving the continuity of coverage and care.

Turning to Medicare. Expanding Medicare to more disabled, chronically ill, and older adults would give them the choice to be covered by an insurance program they both trust and prefer.

Expanding Medicare coverage to the near-elderly would provide financial protection and access to health care for 3.4 million uninsured older adults over age 55 who are at high risk of serious illness or disability. One could also broaden the definition of the disabled, eliminating the 2-year waiting period, picking up as many as 3.7 million uninsured disabled.

Expanding Medicare coverage would promote continuity and would avoid the empty promise of coverage under individual private health insurance that is neither affordable nor genuinely open to high-risk individuals.

There were a lot of questions on the last panel about the affordability of coverage. A Sixty-year-old woman in major urban areas today faces a premium of $8,000 per person if purchasing non-group insurance over the Internet.

Turning to employer coverage. Employer coverage is the mainstay of the American health insurance system. It covers 158 million Americans. Building on this base is also important, by providing incentives for employers to offer and expand coverage.

Small businesses and low-wage employers could be permitted to buy coverage through public programs. The last panel mentioned buying into State public employee plans or Federal employees, but one could also permit low-wage employers to buy coverage through Medicaid or SCHIP, helping as many as 5 to 13 million uninsured.

Also, low-income employees could receive premium assistance to participate in their employer's plan, assisting as many as 6 million uninsured. In any event, the goal should be greater flexibility for public program funds, to be combined with employer contributions to finance coverage for working families.

We are at a propitious and historic moment. We had the luxury of a substantial 10-year budget surplus, at least $1 trillion of which was generated by economies in Medicare and Medicaid in the last part of the 1990's. It is an ideal time to reinvest a significant share of those savings in improved health care for those left behind.

Thank you.

[The prepared statement of Ms. Ferguson appears in the appendix.]

The CHAIRMAN. Now, to Ms. Ferguson.

STATEMENT OF CHRISTINE C. FERGUSON, DIRECTOR, RHODE ISLAND DEPARTMENT OF HUMAN SERVICES, CRANSTON, RI

Ms. FERGUSON. Mr. Chairman, it is a delight to be here again.

I have two sections to my testimony, one written and one set of charts that I am going to refer to briefly. I am just going to highlight a few things from my testimony, somewhat in response to some of what I have heard so far.

As a State, Rhode Island is first or second, depending on whose data you look at, in the country in terms of the number of people who are insured.

We have seen the largest decrease in the uninsured in the country in the past 5 years. Perhaps more important, our health outcomes or the result of that insurance and coverage, as well as satisfaction of coverage, has been pretty extraordinary in terms of improvement.

You can see in the first chart the slope of expansion, which explains why we are at the top. We went, from a population of 1 million people, from 75,000 people, roughly, to 110,000 people, roughly, in a period of 2½ years in terms of coverage through the SCHIP program and the Medicaid program.

So I am speaking to you from a State that has done everything in terms of flexibility, we have used better application processes, mail-in applications, done outreach that was extraordinary, and we accomplished our goals.

But I think that sometimes people in Washington, DC, and having been one of you for 15 years, forget what Medicaid is in the States. Medicaid is a major part of State budgets. It is a minor part of the Federal budget, but it is a major part of the State budget.

Sixteen percent of our population is covered through Medicaid, and it is a third of our State budget. One other third is education, and everything else is the rest. So you can imagine, it is like being the 800-pound gorilla in your State when you are running the Medicaid program.

We are now facing our biggest challenge, which is actually not further expansion, it is sustaining the expansion we already did. We are facing exploding health care costs and limited revenue growth in the States.

We are facing the inability of businesses to pay exploding premiums because we are in that part of an insurance cycle. We are facing everyone's fear of an economic downturn. Those things combined do not bode well for future incursions into the uninsured who remain.

There is plenty of flexibility for us still if we wanted to expand coverage. But the bottom line is, we cannot go any further, we have hit the wall, unless we get some help.

We can do premium subsidy programs. We can do a combination of programs. We can do all of those things. It is not hard. It is actually relatively easy, wrapping around a premium subsidy program for co-payments, and everything. That is not hard. It is not rocket science. It is harder than rocket science, but it is still not difficult.

But the reality is, unless we have some new dollars in the form of tax credits—it can be in the form of tax credit because we can use State Medicaid and SCHIP dollars to subsidize families who are also getting tax credits. That alleviates the total burden that the State would have in terms of providing coverage—or we get some enhanced match or new grants to States, but unless something is done we are not going to be able to go further. We have the base. We have the capacity. We can do it. It is a matter of not having the financial resources.

The second thing that we would need, besides new dollars, or in the alternative of new dollars, is some flexibility around the traditional things you would think about when you say flexibility: being able to limit the number of people who come in in a given year, if you are using an expansion population; the ability to impose a higher share of premium or a higher co-payment on higher-income people; the ability to change the benefits package slightly for higher-income people to make it more compatible with employer-based coverage, all of those things which are normal flexibility that you have heard States asking for for the last 20 years. Those kinds of things are important opportunities.

The third, is what I call flexibility outside the box, things you do not normally think of. For example, most of our dollars are not spent on the people we are providing insurance for. Most of them are spent on people who are dually eligible for Medicaid and Medicare.

If we had a true partnership with the Federal Government around managing the cost of those folks, we would free up dollars. If you go to a prescription drug benefit for Medicare, you will free up dollars in the States that could be used for expanded coverage.

There are all kinds of things about the management of resources across block grants, Medicare, Medicaid, and ERISA, and tax credits that, if you look at them combined, there is tremendous opportunity to use resources more wisely.

That is where I am, from the perspective of the State that has done everything that it is supposed to do. At this point, we cannot go further unless we can manage our resources more effectively. That needs to be a true partnership with the Federal Government around those kinds of opportunities.

Thank you.

[The prepared statement of Ms. Ferguson appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Ferguson.

Now, Ms. Ross?

STATEMENT OF DONNA COHEN ROSS, OUTREACH DIRECTOR, CENTER ON BUDGET POLICIES AND PRIORITIES, WASHINGTON, DC

Ms. ROSS. Thank you, Mr. Chairman. I appreciate the opportunity to talk with you today about this very important subject.

As we have heard, the enactment of SCHIP, the State Children's Health Insurance Program, set in motion an unprecedented wave of activity to expand health coverage to uninsured, low-income children. States have used their SCHIP funds to expand Medicaid or to create separate child health coverage programs.

Today, 95 percent of uninsured children in families with income below 200 percent of the Federal poverty line qualify for Medicaid or the separate SCHIP program in their State.

Making health coverage available is a first, necessary step, but taking that step does not guarantee that children will enroll. Congress envisioned the need to take aggressive action to ensure that children actually benefit from the expansions in coverage and included outreach requirements and resources in the SCHIP law.

States are now conducting widespread public education campaigns and they have made application assistance available at health clinics, schools, child care programs, and other community sites. My written testimony gives some specific examples of some very innovative strategies being used around the country.

These efforts are clearly working. We now have 20 million children covered under Medicaid and 3.3 million covered under SCHIP. Recent Census data revealed that 1.1 million fewer children were uninsured in 1999 than in the previous year. These children, the vast majority of whom are in working families, now have access to affordable health benefits.

But the job is not yet done. Research shows that many working families still may not know that health coverage is available, they often find application forms confusing, and the required documentation hard to collect.

To address these problems, two things matter a great deal: simplification matters and alignment matters. States have substantial flexibility to do both. Most States are exercising their options—Rhode Island is a model—and have established programs that allow applications to be submitted by mail, they no longer count family assets in determining eligibility, and they have greatly reduced verification requirements.

States also have this flexibility to adopt these measures in Medicaid. That is what we mean by alignment. But States with separate SCHIP programs could do more to make Medicaid just as simple as they have made their SCHIP programs. A continued emphasis on alignment will help reinforce Medicaid's identity as a health insurance program, not just an arm of the welfare system.

I should add that simplification and alignment also matter when it is time to renew eligibility. This is key to making ongoing, sustainable progress on enrollment and will help protect our investment in outreach.

As child health coverage programs continue to evolve at the State level, there are some additional steps that Congress can consider. Perhaps the most critical, and we have heard it earlier today, is support the expansion of family-based coverage.

New research shows that providing family-based coverage helps make substantial gains in enrolling children who are already eligible. While States have aggressively expanded eligibility for low-income children, in most States parents qualify for Medicaid only if they have very, very low incomes.

States now could extend Medicaid to more parents, but so far only about a third of them have done so. There is a lesson to be learned here from the SCHIP experience. States were permitted to expand eligibility for children far beyond the minimum levels long before SCHIP was established, but a number of States felt themselves unable to do this until SCHIP provided enhanced Federal matching rates.

Today, with SCHIP in place, all States have expanded coverage for children, in most cases to at least 200 percent of the poverty line. Providing States with an enhanced matching rate for family coverage would likely result in more States adopting such coverage.

Congress should also consider taking an important step to assist a particularly vulnerable group of families. Those are families who are leaving cash assistance and entering the workforce.

These families are eligible for up to 12 months of transitional medical assistance, or TMA, which is a part of Medicaid designed to prevent families from losing health coverage as soon as they get a job.

Many families do not know about TMA, and when they do receive it, they are subject to very strict reporting requirements. Families on TMA have to submit three months of information on earnings and child care costs in the fourth month of TMA coverage, again in the seven month, and then in the tenth month in order to maintain that coverage.

TMA comes up for reauthorization soon. Congress should give States the option to guarantee a full year of TMA, without imposing the burdensome reporting requirements.

Finally, Congress can help States coordinate child health insurance enrollment with other public programs. The Urban Institute indicates that about three-quarters of all low-income, uninsured children are in other public benefit programs, notably the school lunch program, WIC, and food stamps.

There is tremendous enthusiasm around the country for exploring ways to use the school lunch program, in particular, to link students with health coverage. So far, efforts appear to be worthwhile, but additional funding may be needed to help design systems to transfer data electronically and to coordinate enrollment procedures across programs. These are some of the most exciting efforts taking place around the country right now, in my view.

Congress could consider providing States enhanced administrative matching funds to develop such systems and help move this process along.

I want to thank you very much for giving me this opportunity.

[The prepared statement of Ms. Ross appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Ross.

Presumably, our votes are over, so we will be able to be a little more civil as we conduct the hearing.

I will start with Dr. Davis. You recommended near-elderly buying into Medicare. I would like to ask you if you mean that the

Federal Government should pay for the 55- to 64-year-olds to purchase Medicare, or do you mean that we should just open the program up to this population and let them pay premiums to cover the cost of their care?

Obviously, the question is, Medicare, somewhere down the road, 15 to 20 years, will be in very bad shape. Tell me about the extent to which doing that, particularly the latter part of the question I asked you, would impede preserving Medicare for those over 65, or even what we are hoping to do this year, open it up a prescription drug program under it.

Dr. DAVIS. I obviously share your concern about the long-run financial solvency of the Medicare program. I think there are a number of options to do it, without adding to trust fund burdens.

There are, as I mentioned, 3.4 million uninsured people in the 55 to 64 age range. Estimates are that would cost $3,000 to $4,000 a month for coverage under Medicare if it were an actuarily fair premium based on the health status of all older adults, kind of a community-rated premium.

If you were to have tax credits of $1,000, being able to apply $1,000 would make that a net of $2,000 or $3,000 to those uninsured older people. So why not let them apply it, buy a good group coverage under Medicare with that? There are other options as well.

But the point I wanted to make is, if you go on the Internet and check what the premium is for a 60-year-old person in most urban areas to buy individual coverage, that premium is $8,000. So, a $1,000 tax credit to buy individual insurance really does not work for older adults.

Letting them buy Medicare, while it is still a stretch, as we have learned from some of the other examples, is much more affordable with some type of premium assistance, on the order of $1,000, $1,500 a person than buying an $8,000 individual coverage.

The other types of options, obviously, are to use general revenues to subsidize it for lower income older adults, so have supplemental coverage as we do now with Medicaid or some direct subsidies for those with incomes below, say, 200 percent of the poverty level.

The CHAIRMAN. Ms. Ferguson, I am interested in your Right Share program in your State, a premium assistance program, as I understand it. It helps low-income workers remain in their employer-sponsored health plan.

Tell us a little bit more about the premium assistance program, and also about the decision making process that went into it.

In addition, and lastly, I believe that you had the opportunity to hear Ms. Trautwein, who was on the first panel. Would you please respond to her point about the limitations imposed by cost sharing provisions of the SCHIP law?

Ms. FERGUSON. That is a mouthful.

The CHAIRMAN. We will take the time to listen to it.

Ms. FERGUSON. A couple of things, in terms of the process that was used. We went through very extensive discussion at the State level, in the State legislature, with the administration, bipartisan, bicameral, really quite an open process, during which we looked at the idea of purchasing cooperatives, we looked at a whole series of options, including the premium share program.

We are moving incrementally. The increment that we chose to go forward with, in addition to some health insurance reform which complements a premium assistance program, is to say that we would pay, using Medicaid dollars—so for us it is 52 cents for federal, 48 cents for State on the dollar—to supplement the employees' share, or cover the employees' share of their employer-based coverage. What we have done, is to combine SCHIP and Medicaid in order to do this.

The way that we deal with the co-payment requirements under Medicaid and SCHIP, is we simply have a wrap-around program in which a provider who has somebody coming in who has co-payments, if that person has already hit their 5 percent cap, that provider simply sends the co-payment bill to the State. So, it is possible to do a wrap-around, and it is not very difficult. It is difficult, but it is not impossible to do.

The difficulty, actually, is employers saying that they are concerned about employees being treated differently, having this wrap-around benefit as an alternative to some employees and not others.

The other thing that they are concerned about, is one of the components of SCHIP, as well as what we are trying to do with our Medicaid program, is having a waiting period during which people who have been buying coverage have to wait 6 months before they can apply for the subsidy, which is a problem.

We are actually trying to work out some alternatives at the State level on that issue. But that is a problem everywhere in the country when you do this. It is a question of, how do you want to deal with people who have already been buying insurance, just as, how do you want to deal with employers who have already been providing it if you are going to give incentives to people who do not have it, either employers or employees?

Unless you are treating people equally across income levels, it has inequity in it, but to treat them equally across income levels costs money. That is the rub. It is always the rub. It is the rub at the Federal level and it is the rub at the State level.

In a perfect world, I think the best way to do it would be to have an income sliding scale premium subsidy program that could complement a tax credit program, where, in effect, you have the employer's share, the employees' share, a tax credit, and a premium subsidy all going to pay the cost of a premium in the private sector.

When we buy our health insurance for 10 percent of our population, we are purchasing it from a private insurer and we negotiate with that private insurer for the rate.

So the premium subsidy program is a base and, if you would, has the capacity on which you can build any number of financing mechanisms for individuals and businesses. I know that that was way more complicated than you really wanted.

The CHAIRMAN. I am going to ask you to comment on another point, then I will turn to Senator Baucus and let him ask questions.

You were describing for us how to leverage this flexibility. Can you take a minute or two to describe what you mean when you say 1115 waivers? As I understand it, these waivers grant States the authority to waive certain Federal rules in order to test a dem-

onstration program. Rhode Island has two of these demonstration waivers, I believe.

Then explain what flexibility, in addition to that granted by an 1115 waiver, that you think is most important for States to have? From your testimony, you make mention of reallocating existing resources. Does this mean charging co-pays and premiums where you do not now have charges?

Ms. FERGUSON. If you split the flexibility issue into two categories, one is normal flexibility which is co-payments, the ability that States want to be able to vary their benefits package according to income, and some other kinds of things which are traditional.

There is conflict between people who want to make sure that those do not exceed a certain percentage of total income, as Senator Rockefeller was talking about, and States dealing with the reality of what is available in terms of providing coverage to more people.

But from my perspective, it is the flexibility outside the box which is the reallocation of dollars, meaning that you, right now in the Medicare program, spend 31 percent of total expenditures on people who are eligible for both Medicare and Medicaid.

At the State level, 65 percent of all of our Medicaid dollars are spent on people who are eligible for both Medicare and Medicaid. These are adults with disabilities, some children, and the elderly. We waste, collectively, a lot of money.

What happens is, because Medicare covers acute care and Medicaid covers prescription drugs and covers some other acute care services, as well as some long term care services, and there is absolutely no discussion or collaboration between the two of us, somebody could be going to an emergency room five or six times in a 6-month period. That would not be something that anyone would pick up.

That person may actually have simply lost their doctor because the doctor died, and has not been able to pick up a new primary care doctor. They are using services that they do no need, they do not want, they do not like, and the quality of services are not good.

If we were able to enter into a collaboration with the Federal Government around combining the management of Medicare and Medicaid dollars and services, we could actually go in and work with people on an individual basis to better use services, which would create savings for you and savings for us as States, that then could be translated into expanded coverage or prescription drug coverage for people who are not otherwise eligible.

It is those kinds of things that there is absolutely no incentive anywhere in the system for anyone to do that really wastes resources that could be better used.

The same thing is true with grant programs, the Maternal and Child Health Program, the Early Intervention Program. We are in the process in our State, actually, of combining those things. And we are doing it in the most complicated way, allowing every silo to continue to exist, but managing on top of those silos.

If it were possible for us to come forward and say, if we really took all of those programs combined and we attached the 800-pound gorilla of Medicaid, we could provide much better services to a much broader range of kids and families. We are testing those things out now, so that we have data that we can show you.

But there has not been any receptiveness on the part of the Federal Government in HCFA, HHS, HRSA, all of those programs, to really looking at how they combine. What I would ask you for, is consideration of allowing us at the State level, in some places, to propose those kinds of collaborations, share some of the savings so some of it can accrue to you and some of it can accrue to us, and hold us accountable to use those savings, reinvest them in further expansion of the uninsured or in enhancing benefits, adults with disabilities, et cetera.

And hold us to health outcomes. Health insurance, by itself, is not what is important. What is important, is that the outcomes of the people and the health status of the people who are getting it have actually improved. Hold us to those standards. I think you would see some amazing results in places in a very fast period of time.

You have some charts in this packet that show, within 2 years, huge increases in health status. Like the interbirth interval. People waiting to have children more than 18 months apart has been extraordinary, just within 2 years. Those are the kinds of things that we really need to be looking at at the Federal and State level collaboratively.

The CHAIRMAN. All right.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

I would like to ask about outreach. How do we expand enrollment?

Ms. FERGUSON. I can tell you. We did it. There is a down side to that.

Senator BAUCUS. Which is?

Ms. FERGUSON. Which is, the State has to balance its budget at the end of the year.

Senator BAUCUS. I know that. Yes.

Ms. FERGUSON. So what happened is, we went out and we contracted with 36 community-based agencies and we paid them on a per capita basis for the number of people that came in. We were able to increase our enrollment by 30,000 within 2 years.

Senator BAUCUS. Now, I know this is extremely important, but putting money aside for a second, what are some other ways that work to boost enrollment? I read somewhere, in Alaska, for example, I do not know whether it was SCHIP, or whatever it was. The State of Alaska sent something out to the Native Americans out in the bush. It was something they were interested in, and that enticed them into enrolling.

Ms. FERGUSON. Oh, absolutely.

Senator BAUCUS. It is something that was very creative. Can you give us some ideas on some creative actions some States have taken? I know cost is a problem, but just put that aside for a second.

Ms. FERGUSON. Well, you pay on a per-head basis. Everybody that you enroll, you get a grant for.

Senator BAUCUS. I know. I am asking, how do you find the people to enroll, let them know about it?

Ms. FERGUSON. Community-based agencies. From my perspective, it is people who are in the community dealing with shelters,

dealing with community-based health centers, hospitals, right on the ground.

Senator BAUCUS. So are you saying that the outreach problem is more money than it is effort?

Ms. FERGUSON. I think so.

Senator BAUCUS. Dr. Davis?

Dr. DAVIS. We supported a demonstration in New York City enrolling children through WIC centers. So I think, looking at these public programs would be beneficial. One of the witnesses mentioned that 75 percent of uninsured children are covered by WIC, school lunch, and food stamp programs.

So, a way of making it automatic that, when you get WIC, or automatic when you get school lunch, automatic when you get food stamps, that you are covered under Medicaid or SCHIP, is one way to find them.

I would also endorse what Ms. Ferguson said about enrolling through community health centers and health care providers that are serving low-income communities and really being able to outstation enrollment in those ways.

But if the procedures are going to be cumbersome, if you are going to have to have a face-to-face interview the way Medicaid requires in the State of New York, and people are busy, and these are long forms, and a lot of documentation, they are just not going to make it over the hurdle. We have got to make it automatic.

Senator BAUCUS. So what can we do to help enrollment, help outreach?

Ms. FERGUSON. Give States an incentive to simplify their applications. We do have a very simple application. It is mail-in. We have no face-to-face visits. We did the community-based agencies. We did that without any incentives. But there are other States who probably will not do it unless there is some enhanced match for the results.

Senator BAUCUS. Ms. Ross, your thoughts?

Ms. ROSS. Well, in fact, most States have done some of the kinds of simplifications that we have been talking about, getting rid of asset tests to make eligibility easier, getting rid of face-to-face interviews.

I think one thing to look at, is this alignment issue. To the extent that States have done a really good job of designing their separate SCHIP programs so that they are very simple, we also want to make sure that the Medicaid program is just as simple so we have programs that are well-coordinated.

I would agree with what my colleagues have said about the importance of community-based application assistance. I think your example from Alaska was actually one of the first places where this was going on, and it was sort of, necessity is the mother of invention. People in very remote areas could not come to a welfare office to apply, so they were first to have enrollment agents in remote villages.

Now this is a strategy that is taking hold all over the country, with an application assistance fee, as Ms. Ferguson mentioned, but also grants to community organizations.

I think that the money is important, because we have to recognize that, no matter how simple we do make it, there is some ad-

ministrative cost when we are engaging community-based organizations to add on to what they ordinarily do. They need those resources.

Senator BAUCUS. This is a little bit dangerous. Can you name a couple of States that you think are doing it right? Rhode Island is certainly one.

Ms. ROSS. Yes. Rhode Island is doing a good job. I would say Oklahoma is another State to look at. It is a State that has used some money dedicated for outreach to allow eligibility workers who formerly worked in welfare offices to go out into the community to schools, to recreation programs, and actively enroll children.

I recently talked to an eligibility worker in Oklahoma who said, this is what I was born to do. It put the "social" back in social work for me.

Senator BAUCUS. Good for her.

Ms. ROSS. If I might give one other example, it is actually from the State of Florida. This is one that I find very exciting, because it comes close to what Dr. Davis mentioned as this idea that we are not quite there yet of automatic eligibility.

But, in fact, what child care resource and referral agencies are doing in Florida, is when families come in to apply for subsidized child care at community-based agencies, the computer has been programmed so that, when they are asked information for the subsidized child care application, information that is also relevant for the health insurance application is automatically transferred onto that application.

At the end of that process, the family is asked, would you also like health coverage for your child? If the answer is yes, they answer a few additional "yes" or "no" questions. The application is printed out from the computer, already filled out. Mom or dad just has to sign the application. It gets sent in in a postage paid, preaddressed envelope. It could not be simpler.

Senator BAUCUS. Family-based coverage. What can be done, or should we do, to help encourage more family-based coverage? My assumption is, the more kids and parents who are covered, the more families are covered.

Ms. ROSS. Well, I think that is right. But there is an interesting connection here. That is, new research has shown that when you offer family-based coverage, you get more kids enrolled as well.

I think it has to do partly with the mind-set of families trying to figure out what is the best approach for family well-being in general, and a concern about looking at fragmented approaches. So, there is that.

Also, in States that have taken on family-based coverage and have coordinated the family-based coverage system and what they had for kids, you see the ability to use one application for the whole family.

Again, this alignment issue. What you did for kids, you want to do for their parents in terms of not having face-to-face interviews, and such, so that you do not undermine the gains that you have made for kids. All of this helps get more people on.

Senator BAUCUS. This is kind of a tough question to answer, but let us take expansion, Medicaid and SCHIP expansion.

What percent of the 43 million are we going to take care of?

Dr. DAVIS. There are about 5.3 million parents with incomes below 200 percent of the poverty level who are uninsured, so that first hit would be the 5.3 million.

Of those, some may not participate, so you could be more in the 2 to 3 million range. I do not think one can assume that every single one of those would come in.

But they are very easy to find. When you have children already covered, you know the addresses. You can market directly to them. So, it is a very easy group to reach.

There are many benefits of family coverage, in addition to what Ms. Ross said. One of the programs that we support that tries to improve child development services for low-income children, is if you identify a mother who is depressed, needs treatment, needs to be treated in order to really provide the nurturing and support that young infants need, the mother is uninsured, so there is no one to pay for that even if the child is covered by Medicaid and SCHIP. So, it is important for health and health care, as well as increasing coverage.

Senator BAUCUS. All right. That is 2 or 3 million. We are making progress.

Ms. FERGUSON. I can give you the example of our State, specifically. We have a population of about a million. We have about 7 percent uninsured. Of the people who are eligible for, by income alone, our family coverage and our child coverage, there are about 200,000 people. So, that is about 20 percent.

We have about 10 percent on, so somewhere between 10 and 20 percent. We are figuring something around 150,000. So, 15 percent of people will be eventually on either a premium subsidy program, which is subsidizing the employer for their coverage, or a flat program, a Right Care program, a Medicaid program.

Senator BAUCUS. Right.

Ms. FERGUSON. So you are probably talking about another 5 to 10 percent.

Senator BAUCUS. With what?

Ms. FERGUSON. Families who need to be covered, who could either be in a premium share program to subsidize the employer-based coverage or in the Medicaid and SCHIP program.

Senator BAUCUS. All right.

So if I understand you correctly, and I may have misunderstood you, that is with expansion as well as the tax credit suggestions? That is just the expansions?

Ms. FERGUSON. That is just expansions, currently. Then there are probably another 70,000 people in the State who are without coverage and who are not families, so they are childless adults.

Senator BAUCUS. But if you look at the tax credit proposals, which of those do you think are most effective and meaningful, and about how many more people would we cover, realistically?

Dr. DAVIS. I think what we have heard today is that there is a problem with take-up rates of tax credits as well, particularly for a low-income individual who is going to have to go out there and find health insurance, pay the premium, maybe next April get a tiny portion of that premium back. You are not going to get a big take-up rate.

So to make the tax credits work, you have really got to give a group coverage option. For example, having employers buy into Medicaid or SCHIP, were some of the ideas that we have had here today, to let public monies be used to cover employees' shares of premiums in an employer plan.

So you want to aim for group coverage. There are about 6 million people, workers or family members, who work for employers that provide coverage to their employees, but who cannot afford themselves to pick it up because they cannot afford their share of the premium.

So being able to have premium assistance, whether it is from tax credits, or from Medicaid and SCHIP monies to pick that up, could reach, in good group coverage, substantial numbers of people.

But I would also say that the basic principle is, you want to help the sickest and the poorest. We talked about the low-income parents. There are also about 11 million single or childless adults below the poverty level who are uninsured that we need to be thinking about. Again, most likely, public programs is the best strategy for reaching them.

Then the sickest are often older adults over age 55 who would like to be covered early under Medicare. A survey we have done found that 88 percent of the uninsured between the ages of 50 and 65 would like to be able to get covered by Medicare early, so providing premium assistance for that group to get coverage under Medicare would be a very important addition to this mix.

Senator BAUCUS. Ms. Ferguson?

Ms. FERGUSON. I can tell you, if you did three things. If you did a tax credit that was reasonable, between, say, $1,000 and $2,000.

If you made it simpler for us to cover childless adults through Medicaid, and you took over the 2-year waiting period that people have before they go into Medicare who are disabled, or you covered prescription drugs, that would free up enough resources for us in our State to get to zero uninsured.

Senator BAUCUS. That is a good note to end on. I am late to another meeting.

I want to thank you all very, very much. This has been very constructive and helpful. Thank you.

The hearing is adjourned.

[Whereupon, at 4:36 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF KATHRYN G. ALLEN

Mr. Chairman and Members of the Committee:

I am pleased to be here today as the Committee considers strategies to address the problem of Americans lacking health insurance. Given the risk of catastrophic illness or injury, which can devastate families financially, as well as the importance of access to effective preventive care, health insurance is critical from an individual and social perspective. Nevertheless, more than 1 in 6 nonelderly Americans are today uninsured. The lack of insurance coverage does not affect all Americans equally, varying widely among demographic subgroups as well as geographically. To better understand the extent of the problem, my remarks today will focus on

- the number of uninsured individuals and recent trends,
- the employment and income status and other demographic characteristics of persons who are more likely to be uninsured, and
- the variation among states in uninsured rates.

My comments are based on our ongoing analyses of the Bureau of the Census' Current Population Series, March Supplements, 1995 to 2000; our work on the private insurance market; and other published research.

In summary, an estimated 42.1 million Americans were uninsured in 1999, representing 17.4 percent of the nonelderly population. Although down from a high of 43.9 million in 1998 (18.4 percent), the number of uninsured Americans had risen steadily for over a decade.[1] This increase has taken place in spite of gradual but steady gains in the share of Americans with employment-based coverage, and also was accompanied by slight decreases in public sources of coverage such as Medicaid, the federal-state health financing program for low-income, aged, and disabled people. More recently, between 1998 and 1999 the number of Medicaid beneficiaries has begun to stabilize. This stabilization, in conjunction with the continued increase in employment-based coverage and the implementation of the new State Children's Health Insurance Program (SCHIP), has contributed to the slight decrease in the number of uninsured, particularly children, in 1999.

Although most nonelderly Americans obtain health insurance through employment, three-fourths of all uninsured adults are in fact employed. However, certain types of workers are less likely to have employment-based insurance available and thus are more likely to be uninsured. In particular, those working part-time, for small firms, or in certain industries such as agriculture or construction were among the most likely to be uninsured. Not surprisingly, persons with low incomes are most likely to be uninsured, with most uninsured individuals in families earning less than 200 percent of the federal

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[1]For information on trends in the uninsured population as well as employment-based and Medicaid coverage from 1980 to 1995, see Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures (GAO/HEHS-97-122, July 24, 1997).

poverty level (which was about $34,000 for a family of four in 1999). Public programs like Medicaid and SCHIP cover many low-income individuals, but significant numbers of low-income children and adults eligible for these programs are not enrolled. Moreover, other low-income individuals (particularly childless adults) are typically not eligible. While low-income individuals are most likely to be uninsured, 8 percent of those earning more than 4 times the federal poverty level are also uninsured. Other populations with a disproportionately high uninsured rate include young adults, Hispanics, and immigrants,[2] in part because of their type of employment, relatively low incomes, or ineligibility for public programs.

The share of people who are uninsured varies considerably across states, ranging from less than 10 percent to nearly 27 percent of all nonelderly residents in a state. Generally, southern and western states have higher uninsured rates. States with high uninsured rates and those with low rates often are distinct with regard to several demographic, employment, and economic characteristics. Specifically, states with higher than average uninsured rates tend to have higher unemployment, proportionally fewer employers offering coverage to their workers, and larger than average populations of low-income residents, Hispanics, and immigrants than states with lower uninsured rates.

BACKGROUND

The availability of health insurance enhances access to preventive, diagnostic, and treatment services and also provides financial security against potential catastrophic costs associated with medical care. As a result, lacking health insurance coverage can have important adverse health and financial consequences. Research has demonstrated that uninsured individuals are less likely to have a usual source of care, are more likely to have difficulty in accessing health care, and generally have lower utilization rates for all major health care services. For example, the uninsured are particularly likely to forego services such as periodic check-ups and preventive services, well-child visits, prescription drugs, eyeglasses, and dental care. As a result, individuals not covered by health insurance can require acute, costly medical attention for conditions that may be preventable with early detection and/or treatment. For example, studies[3] have found that

- the uninsured are hospitalized at least 50 percent more often than the insured for "avoidable hospital conditions" like pneumonia and uncontrolled diabetes;
- uninsured people with various cancers are more likely diagnosed with later-stage cancer than individuals with insurance; and,
- uninsured pregnant women receive prenatal care later in their pregnancy and have fewer doctor visits than the privately insured and, as a result, their newborn infants have a 31 percent greater risk for adverse health outcomes such as physical disability or mental retardation.

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[2]For analysis purposes, we defined immigrant as any non-native-born resident.

[3]For more information, see No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health (Philadelphia, Pa.: American College of Physicians—American Society of Internal Medicine), and Uninsured in America—A Chart Book, 2nd ed. (The Kaiser Commission on Medicaid and the Uninsured, May 2000).

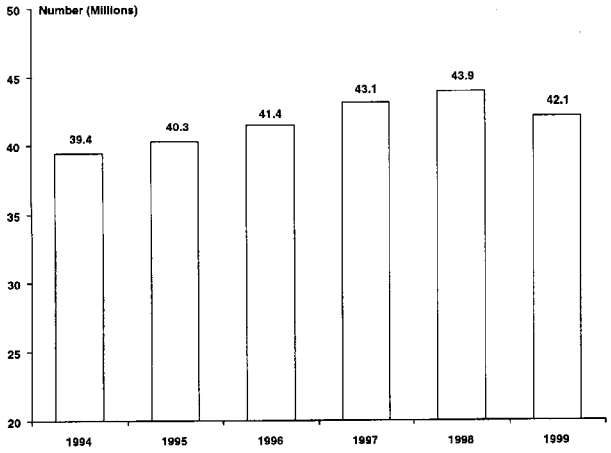
In addition, individuals without health insurance create a public cost because of their higher proportion of hospital emergency room visits. Uninsured adults are 4 times and uninsured children 5 times more likely to use the emergency room, compared with the insured. Costs for the uninsured are often absorbed by providers, passed on to the insured through increased fees and insurance premiums, or underwritten with public funds to support public hospitals and finance public insurance programs.

Most nonelderly Americans obtain private health insurance coverage through employment or by purchasing insurance on their own, and public programs provide coverage for certain low-income and disabled individuals. Since World War II, many employers have voluntarily sponsored health insurance as a benefit to employees for purposes of recruitment and retention. The federal tax code provides incentives for employers to subsidize health benefits because their contributions can be deducted as a business expense, and these contributions are not considered taxable income for employees. Public programs such as Medicaid and SCHIP cover certain low-income and disabled individuals. However, not all low-income individuals are eligible for these public programs because eligibility is often restricted to selected groups such as children, pregnant women, or disabled individuals. Medicare, though primarily a source of health coverage for elderly Americans, also covers certain disabled nonelderly individuals.

MORE THAN 42 MILLION AMERICANS WERE UNINSURED IN 1999

After more than a decade of steady growth, the number of uninsured declined slightly in 1999. Between 1994 and 1998, the number of uninsured Americans grew steadily from 39.4 million (17.1 percent of the U.S. nonelderly population) to 43.9 million (18.4 percent), while in 1999 the uninsured population declined to 42.1 million (17.4 percent). (See fig. 1.)

Figure 1: Growth in the Number of Uninsured Americans, 1994-99

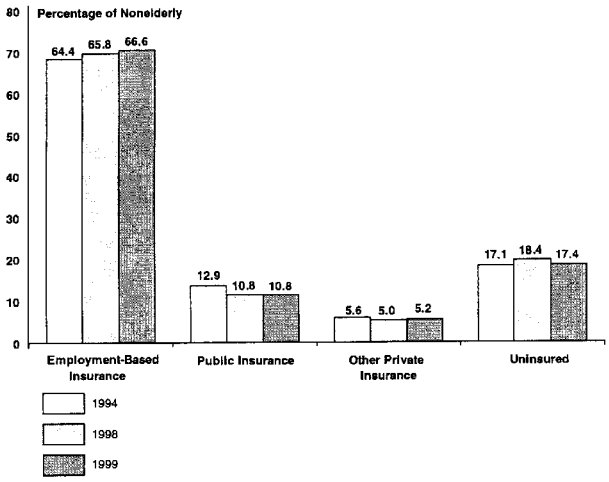


Source: GAO analyses of the March 1995 to March 2000 Supplements, Current Population Survey of nonelderly (under 65).

Trends in the uninsured population are closely related to changes in employment-based and public programs. (See fig. 2.) Reflective of the strong economy, the share of the nonelderly population with employment-based coverage grew slowly throughout the entire 1994 to 1999 period, increasing from 64.4 to 66.6 percent. Between 1994 and 1998, there was a decline in the percentage of the nonelderly population covered through public programs, from 12.9 to 10.8 percent, associated with increases in the numbers of individuals with employment-based coverage as well as in the numbers of uninsured. However, from 1998 to 1999, the continued increase in employment-based coverage, coupled with a stabilization in publicly supported coverage, largely accounts for the decrease in the number of uninsured. Notably, the share of children who were uninsured declined from 15.4 percent to 13.9 percent, representing about 1 million fewer uninsured children in 1999 than 1998—a change likely related strongly to the implementation of SCHIP.[4] The Health Care Financing Administration reported that nearly 2 million children had enrolled in SCHIP as of September 1999.

[4]While the insurance coverage statistics from the Current Population Survey did not separately identify SCHIP enrollment, the data do provide some indications of the effects of SCHIP in decreasing the number of uninsured children. Specifically, the decline in the uninsured among children reported by the Current Population Survey was predominantly among children in families below 200 percent of the federal poverty level—the income group targeted by SCHIP—and was accompanied by increases in the proportion of children with public coverage.

Figure 2: Changes in Sources of Health Insurance Coverage, 1994, 1998, and 1999



Note: Some people may receive coverage from several sources. To avoid double counting, we assigned an individual reporting coverage from two or more sources to one source, based on a hierarchy in the following order: employment-based, Medicare, Medicaid, other public, and other private.

Source: GAO analyses of the March 1995, March 1999, and March 2000 Supplements, Current Population Survey of nonelderly (under 65).

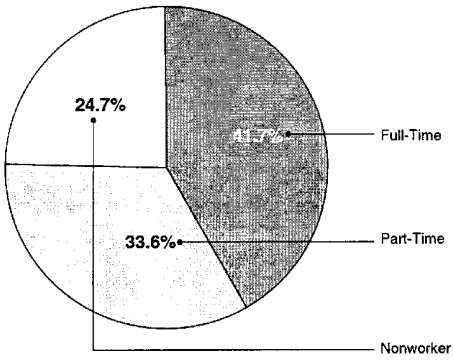
DESPITE WIDESPREAD PRIVATE EMPLOYMENT-BASED AND PUBLIC PROGRAM COVERAGE, MANY WORKERS AND LOW-INCOME INDIVIDUALS REMAIN UNINSURED

Access to affordable employment-based coverage is the primary means for nonelderly Americans to obtain health insurance, but the availability of this coverage varies. Most uninsured individuals are employed but working at small businesses or in certain industries where they are less likely to be offered coverage and are therefore more likely to be uninsured. Although public programs cover many low-income individuals, this group is still the most likely to be uninsured since many either are not eligible for these programs or are not enrolled even if they are eligible. Furthermore, disproportionately large shares of young adults, Hispanics, and immigrants are uninsured.

Employer Coverage, the Principal Source of Health Insurance, Is Not Universally Available

Although employment-based health insurance is the major source of coverage and insures two-thirds of nonelderly Americans, a significant number of workers do not have health insurance because either their employers do not offer it or they choose not to purchase it. In fact, about three-quarters of the uninsured population in 1999 worked either full- or part-time. (See fig. 3.)

Figure 3: Most Uninsured Adults Are Employed (1999)

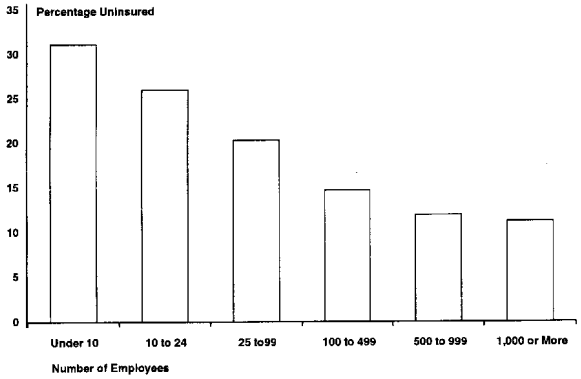


Source: GAO analysis of the March 2000 Supplement, Current Population Survey of nonelderly adults (18- to 64-year-olds).

Lack of insurance coverage is more common among certain types of workers, employers, and industries. Employers often do not offer health benefits to part-time workers. As a result, part-time workers are almost as likely to be uninsured as nonworkers, and nearly twice as likely to be uninsured as full-time workers. Employees of small firms are more likely to be uninsured than those working for larger firms, with the likelihood of being uninsured decreasing as the size of the firm increases. Of those working for firms with fewer than 10 employees, 30 percent were uninsured in 1999, compared with only about 11 percent of those working for firms with more than 1,000 employees. (See fig. 4.) In large part this is because small employers are much less likely to offer health insurance to their employees than larger employers: only 36 percent of private establishments with fewer than 10 employees offered health insurance in 1998, compared with nearly all private establishments with 50 or more workers.[5]

[5]Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, 1998 Medical Expenditure Panel Survey, Insurance Component.

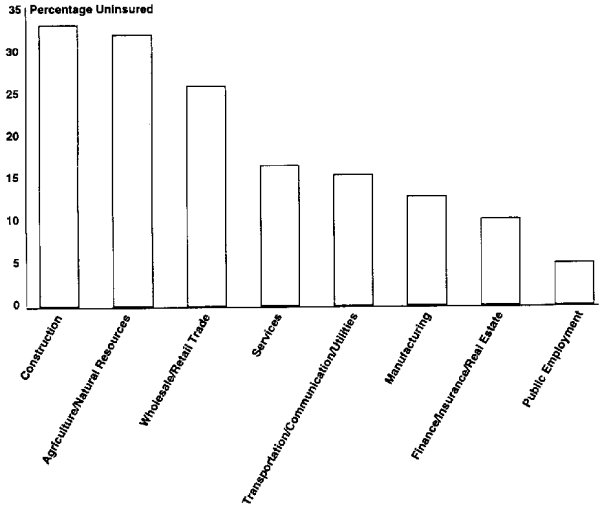
Figure 4: Employees of Small Firms More Are Likely to Be Uninsured (1999)



Source: GAO analysis of the March 2000 Supplement, Current Population Survey of nonelderly adults (18- to 64-year-olds).

Those working in certain industries are less likely to be offered health insurance and face a greater risk of being uninsured. In 1999, more than 30 percent of workers in the construction, agriculture, and natural resources (for example, mining, forestry, and fisheries) industries were uninsured. In contrast, 10 percent or less of workers in the finance, insurance, real estate, and public employment sectors were uninsured. (See fig. 5.)

Figure 5: Likelihood of Being Uninsured Varies by Industry (1999)



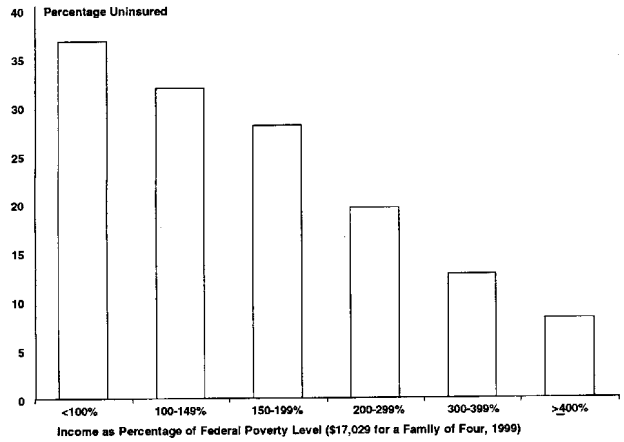
Source: GAO analysis of the March 2000 Supplement, Current Population Survey of nonelderly adults (18- to 64-year-olds).

Despite the Availability of Public Programs, the Likelihood of Being Uninsured Is Strongly Related to Income

Despite the presence of Medicaid and other public programs that enroll millions of low-income Americans, many remain uninsured because either they are ineligible for public coverage (such as most childless adults, under Medicaid), or they are eligible but do not enroll. In 1999, 35 percent of individuals in families with incomes below the federal poverty level had Medicaid as their only source of health coverage, but a similar share were uninsured. More than half of the uninsured (54 percent) had family incomes less than 200 percent of the federal poverty level. Lower-income individuals are less likely to believe purchasing health insurance is affordable. Nearly three-quarters of uninsured adults surveyed for one study in 2000 cited the high cost of coverage as a major reason for their lack of coverage, nearly half of whom cited high costs as the most important reason.[6] While low-income individuals were most likely to be uninsured, about 8 percent of those earning 4 times the federal poverty level or more (over $68,000 for a family of four) were also uninsured. (See fig. 6.)

[6]Uninsured in America—A Chart Book, The Kaiser Commission on Medicaid and the Uninsured.

Figure 6: Low-Income Persons Are More Likely to Be Uninsured (1999)

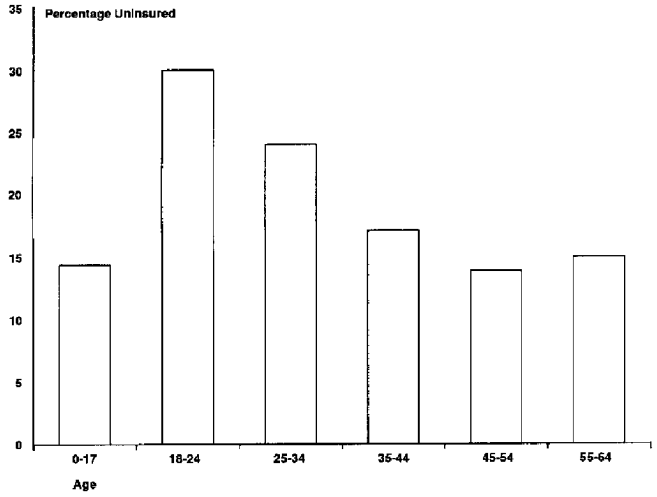


Source: GAO analysis of the March 2000 Supplement, Current Population Survey of nonelderly (under 65).

Some Groups Disproportionately Uninsured for a Variety of Reasons

Certain groups—such as young adults, Hispanics, and immigrants—were disproportionately likely to be uninsured. Young adults, aged 18 to 24, were more likely than any other age group to be uninsured. (See fig. 7.) Young adults' transition to the workforce—often working part-time or for low wages, changing jobs frequently, and working for small employers—makes them less likely to be eligible for employment-based coverage. Moreover, if they are childless they generally are ineligible for public programs. In addition to being more likely to find insurance less affordable, young adults may value it less if they are healthy.

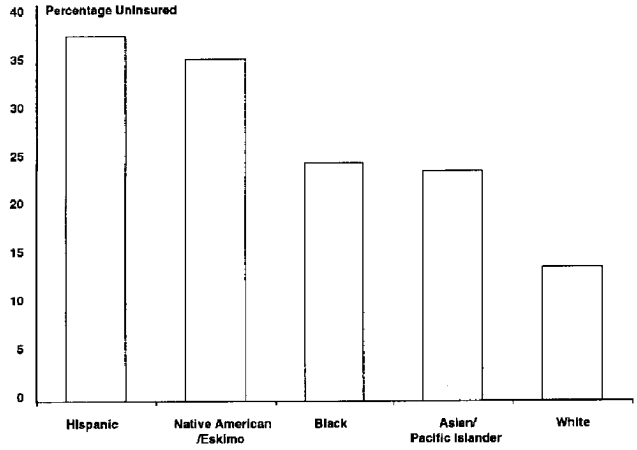
Figure 7: Young Adults Most Likely to Be Uninsured (1999)



Source: GAO analysis of the March 2000 Supplement, Current Population Survey of nonelderly (under 65).

While about half of the 42 million uninsured people in 1999 were white and non-Hispanic, racial and ethnic minorities faced a significantly greater risk of being uninsured. About one-third of Hispanics, Native Americans, and Eskimos were uninsured, compared with just over one-fifth of blacks, Asians, and Pacific Islanders and one-eighth of whites. (See fig. 8.)

Figure 8: Minorities More Likely to Be Uninsured (1999)



Source: GAO analysis of the March 2000 Supplement, Current Population Survey of nonelderly (under 65).

Disparities in uninsured rates among racial and ethnic groups are partially, but not fully, related to income. For example, among individuals with incomes below the federal poverty level, uninsured rates are similar for black and white non-Hispanics, but blacks are more likely to be uninsured than whites within higher income categories. Within all income categories, Hispanics and other non-black minorities are more likely to be uninsured than whites. (See table 2.)

Table 2: Uninsured Rates by Race/Ethnicity and Income, 1999

	Percentage uninsured			
Income category (percentage of federal poverty level)	**White[a]**	**Black[a]**	**Hispanic**	**Asian, Eskimo, Native American, and Pacific Islander[a]**
Less than 100 percent	32.1	30.5	45.4	43.6
100 to 199 percent	23.0	28.6	42.0	36.3
200 to 299 percent	14.7	22.2	32.8	24.9
300 to 399 percent	9.8	16.0	24.0	20.6
400 percent or more	6.7	12.7	15.8	11.8

[a]Only non-Hispanics were included in the white; black; and Asian, Eskimo, Native American, and Pacific Islander groups.

Source: GAO analysis of the March 2000 Supplement, Current Population Survey of nonelderly (under 65).

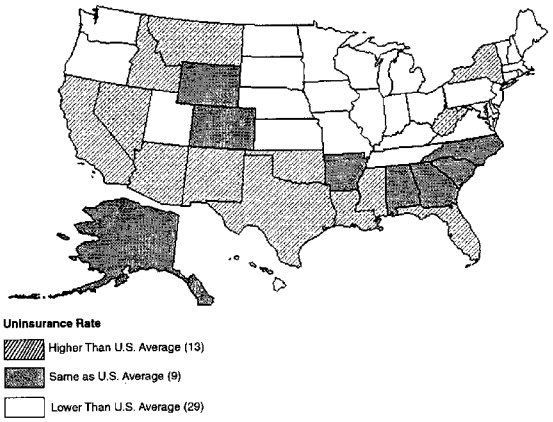
In addition, immigrants are more than twice as likely to be uninsured—about 37 percent compared with about 15 percent of nonimmigrants. Their higher uninsured rates are in part because they are more likely to be low-income and potentially facing legal and other difficulties in obtaining coverage under public programs such as Medicaid. In 1999, about 20 percent of immigrants from families earning less than the federal poverty level were covered by Medicaid, compared with nearly 38 percent of nonimmigrants. Lower Medicaid coverage rates may be related in part to recent changes in federal law that preclude certain immigrants from Medicaid and SCHIP eligibility for 5 years after immigrating to this country.[7] Individuals who are undocumented (illegal) aliens are ineligible for Medicaid and SCHIP coverage regardless of how long they have been in the country, with the exception of emergency treatment, for which they are covered under Medicaid. Moreover, undocumented individuals may be reluctant to seek Medicaid or SCHIP coverage for their citizen children for fear that program participation by any family members may impact their ability to remain in the country or sponsor other family members coming to the United States.

UNINSURED RATES VARY WIDELY AMONG STATES

Health insurance coverage rates vary considerably across the nation. Generally, uninsured rates are highest in the South and West and lowest in the Midwest and Northeast. (See fig. 9.) In addition, more populous states such as Florida and New York tend to have higher rates of uninsured. New Mexico has the highest uninsured rate at 26.6 percent, while Minnesota has the lowest at 9.6 percent.

[7]Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, states may not use federal funds for Medicaid or SCHIP coverage for 5 years for certain immigrants arriving on or after August 22, 1996. States have the option of providing coverage to such immigrants entirely out of state funds; however, only about 13 states had done so as of October 2000.

Figure 9: States With High Uninsured Rates Concentrated in South and West (1998-99)



Source: GAO analyses of the March 1999 and March 2000 Supplements, Current Population Survey of nonelderly (under 65). Estimates for 1999 and 2000 were combined to improve the precision of the state-level estimates.

States with high uninsured rates share many employment, economic, and demographic characteristics, which differ from the characteristics of states with low uninsured rates.[8] We found that states with higher uninsured rates tend to have a disproportionate share of low-income, unemployed, Hispanic, and immigrant residents as well as fewer firms offering coverage.[9] (See table 3.) (See app. I for uninsured rates by state.)

[8]To compare these characteristics across states with high or low uninsured rates, we placed states into three groups: (1) the 13 states with uninsurance rates significantly higher than the U.S. average (as a group, averaging 22.9 percent of nonelderly residents uninsured), (2) the 8 states and the District of Columbia with uninsured rates not significantly different from the U.S. average (as a group, averaging 18.1 percent of nonelderly residents uninsured), and (3) the 29 states with uninsured rates significantly lower than the U.S. average (as a group, averaging 13.6 percent of nonelderly residents uninsured).

[9]Other demographic characteristics reviewed but found to be similar for higher and lower uninsured states include the proportion of black residents and median age for the nonelderly population.

Table 3: States With High Uninsured Rates Share Some Economic and Demographic Characteristics

	Economic characteristics			Demographic characteristics	
State group	**Percentage of nonelderly below poverty level, 1998-99[a]**	**Unemployment rate, 1999[b]**	**Percentage of private firms offering coverage, 1998[c]**	**Percentage of nonelderly Hispanic 1998-99[a]**	**Percentage of nonelderly non-native-born, 1998-99[a]**
13 states with significantly higher uninsured rates	15.6	4.9	50.5	24.5	16.8
9 states with uninsured rates not significantly different from the U.S. average	13.4	4.6	51.6	4.6	4.2
29 states with significantly lower uninsured rates	10.3	3.7	55.2	4.8	6.0

[a]Source: GAO analyses of pooled Current Population Survey March Supplements for 1999 and 2000. Estimates for 1999 and 2000 were combined to improve precision of the state-level estimates.

[b]Source: Bureau of Labor Statistics' Local Area Unemployment Statistics' annual averages for the civilian noninstitutional population 16 years and older.

[c]Source: Agency for Healthcare Research and Quality. Estimates from the 1998 Medical Expenditure Panel Survey—Insurance Component. Offer rates were not reported separately for the following 10 states and the District of Columbia: Alaska, Hawaii, Maine, Mississippi, Montana, Nevada, North Dakota, Rhode Island, South Dakota, and Vermont.

For example, the demographic profiles of both Florida and California—two large states with higher than average uninsured rates—are strikingly different from the nation as a whole. These two states have among the highest percentage of Hispanic and immigrant residents in the nation. The proportion of the Hispanic population in 1998-99 was more than two times greater in California (33 percent) than for the United States as a whole (13 percent). In Florida, immigrants composed more than 17 percent of the population, higher than the U.S. average of about 10 percent and lower only than California and New York. Some states with high uninsured rates, including Florida, Idaho, and Montana, have more of their workers in industries less likely to offer health insurance and fewer in industries more likely to offer it. For example, nearly 40 percent of Montana's workers are employed by the three industries with the highest uninsured rates (agriculture, construction, and trade), one-third more than the national average. Conversely, less than 20 percent of Montana's workers are in the three industries with the lowest uninsured rates (manufacturing, finance, and the public sector), about one-fourth less than the national average.

CONCLUDING OBSERVATIONS

While the decline in the number of uninsured in 1999 following a long-term increase in this population is welcome news, it is too early to know whether this reflects a reversal in the trend. Recent expansions of public programs, such as the implementation of SCHIP, and the tight labor market likely contributed to the improved coverage. Even with these positive factors, the number of uninsured remains high, and any significant downturn in economic conditions could lead to a resumption in the growth of their numbers. The uninsured population is a diverse group, including individuals working in different industries and firms of all sizes as well as of different income levels, ages, races and ethnicities, and geographic locations. This heterogeneous nature of the 42 million uninsured Americans suggests that consideration of a combination of strategies might be appropriate in any efforts to expand health insurance coverage.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or Members of the Committee may have.

GAO CONTACTS AND STAFF ACKNOWLEDGMENTS

For more information regarding this testimony, please contact me at (202) 512-7118 or John Dicken at (202) 512-7043. JoAnne Bailey, Paula Bonin, Randy DiRosa, Betty Kirksey, and Elizabeth T. Morrison also made key contributions to this statement.

PERCENTAGE OF NONELDERLY THAT WERE UNINSURED, BY STATE

	1998-99[a]	1994-95[a]	Difference: 1994-95 to 1998-99
States with uninsured rates significantly above U.S. average, 1998-99			
New Mexico	26.6	27.3	-0.7
Texas	26.3	26.7	-0.4
Arizona	25.5	23.1	2.4
California	23.4	23.0	0.4
Louisiana	23.2	22.0	1.2
Nevada	23.2	19.4	3.8
Florida	22.0	21.1	0.9
Montana	21.5	15.3	6.2
Mississippi	20.9	21.3	-0.4
Oklahoma	20.8	21.2	-0.4
West Virginia	20.7	18.7	2.0
Idaho	20.6	15.7	4.9
New York[a]	19.1	17.7	1.4
States with rates not significantly different from U.S. average, 1998-99			
Arkansas[a]	19.3	20.2	-0.9
Alaska	18.9	13.4	5.5
South Carolina	18.7	16.0	2.7
Georgia	18.6	19.0	-0.4
District of Columbia	18.4	18.8	-0.4
Wyoming	18.3	17.1	1.2
U.S. average	**17.9**	**17.2**	**0.7**
Alabama	17.8	18.8	-1.0
Colorado	17.4	14.8	2.6
North Carolina	17.2	15.8	1.4
States with rates significantly below U.S. average, 1998-99			
New Jersey	16.5	15.4	1.1
Illinois	16.2	12.6	3.6
Kentucky	16.2	17.0	-0.8
Maryland	16.2	15.7	0.5
Oregon	16.2	14.4	1.8
Virginia	15.8	14.2	1.6
Washington	15.4	14.0	1.4
North Dakota	15.2	9.5	5.7
Utah	15.2	12.9	2.3
South Dakota	15.0	11.1	3.9
Delaware	14.9	16.3	-1.4
Indiana	14.2	13.1	1.1
Maine	13.9	15.3	-1.4
Michigan	13.6	11.6	2.0
Tennessee	13.5	13.9	-0.4
Kansas	13.0	14.4	-1.4
Connecticut	12.8	11.1	1.7
Wisconsin	12.7	8.9	3.8
Vermont	12.3	12.1	0.2
Ohio	12.1	13.0	-0.9
New Hampshire	11.9	12.4	-0.5
Hawaii	11.8	10.2	1.6

	1998-99[a]	1994-95[a]	Difference: 1994-95 to 1998-99
Massachusetts	11.7	13.4	-1.7
Pennsylvania	11.5	11.9	-0.4
Nebraska	11.2	11.1	0.1
Missouri	10.8	15.5	-4.7
Iowa	10.2	12.1	-1.9
Rhode Island	9.8	14.4	-4.6
Minnesota	9.6	9.8	-0.2

[a]March 1999 and 2000 Supplements were combined, as were the March 1995 and 1996 Supplements, to improve the precision of the state estimates.

[b]States are categorized as higher than, similar to, or lower than the U.S. average based on whether the state-level estimate statistically is significantly different from the U.S. average. Because smaller states have smaller sample sizes in the Current Population Survey, the potential sampling error is larger in these states than in larger states. Thus, a specific uninsured rate may be significantly different from the U.S. average for one state but not for another with a smaller population and sample size. For this reason, New York's uninsured rate of 19.1 percent is significantly higher than the U.S. average, even though it is slightly lower than Arkansas' estimated rate of 19.3 percent, which is not significantly different from the U.S. average.

Source: GAO analyses of pooled Current Population Survey March Supplements for 1999 and 2000 and for 1995 and 1996 for the nonelderly population (under 65).

PREPARED STATEMENT OF HON. TOM DASCHLE

Thank you, Mr. Chairman, for scheduling this hearing today. I hear all too often from people in South Dakota who are struggling to pay their medical bills because they don't have insurance. This is one of the most important issues this committee could tackle, and I appreciate the attention you are giving it.

We have made a lot of progress over the last several years. The CHIP program is making a real difference for millions of low-income families who need insurance for their children. But there is still a lot more to do. Many children who are eligible for the CHIP program still have not enrolled. And there are too many other people who do not have access to any insurance.

It is unbelievable that there are people in this country living in poverty with incomes below $8,590 for a single adult who don't have access to our public health insurance programs. I hope we'll hear about ways to address that this afternoon.

But I also talk to many people well above the poverty line—or even above CHIP eligibility at twice the poverty line—who still can't afford private health insurance policies. These people go to work every day. They pay their bills. They want health insurance. But they simply don't have access to an affordable health insurance policy that will meet their needs.

In South Dakota, a lot of these people are farmers, so they don't have access to employer-based insurance. Often they have conditions that make insurance in the individual market much too expensive. This means they're uninsured because they need medical care—and that just doesn't make sense.

Mr. Chairman, I look forward to working with you to come up with solutions to these problems. It won't be easy, but there is no more important work that we could be doing.

PREPARED STATEMENT OF KAREN DAVIS

Thank you, Mr. Chairman, for this invitation to testify regarding the expansion of existing public health insurance programs to cover the sickest and poorest of our nation's uninsured. As this Committee well knows, Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) today cover one of four Americans. There are 39 million elderly and disabled Medicare beneficiaries and another 31 million people enrolled in Medicaid and CHIP. These programs have improved access to health care for many of our most vulnerable citizens, and warrant serious consideration as a base from which to begin to expand health coverage to America's 42.6 million uninsured people.

STRENGTHS OF PUBLIC PROGRAMS

Public insurance programs have several important strengths. They have relatively low administrative costs. Medicare and Medicaid's administrative costs average less than 2 percent, while large employer plans expend 8 to 12 percent and nongroup plans 30 to 50 percent. Most important, both Medicare and Medicaid pool risk across large groups of individuals. Because they cover large numbers of people, they are able to set prices for hospitals, physicians, and other health care providers at a discount to the normal market price, yet continue to experience high provider participation rates. The sick are automatically cross-subsidized by the healthy.

It is also important to note that public insurance programs work hand-in-hand with and not to the exclusion of the private market. While funded by the government, Medicare and Medicaid use private insurers when it is efficient to do so. Medicare and Medicaid purchase services from private managed care plans and make extensive use of private insurers as administrative claims payment agents. By utilizing the private market, public programs are able to offer beneficiaries a wide array of options. Only 47 percent of privately insured American workers have a choice of two or more managed care plans, as compared with most Medicare and Medicaid beneficiaries.[1]

Medicare and Medicaid/CHIP have more than 35 years' experience covering the sickest and poorest beneficiaries. Two-thirds of the uninsured have incomes below twice the poverty level or are in only fair or poor health. With the exception of Medicare's lack of prescription drug coverage, public programs provide benefit packages well-suited to their needs. By contrast, private nongroup health insurance plans apply underwriting techniques to screen out applicants with serious health problems or charge higher premiums for higher-risk individuals.

Public programs lower the cost of private coverage because they enroll everyone who meets statutory age or income criteria, regardless of health status. A recent study for The Commonwealth Fund found that if the sickest 2 percent were excluded from the nongroup private insurance market, the average cost of coverage would drop by more than 20 percent.[2] Clearly, Medicare and Medicaid help the private markets work by covering the elderly, disabled, special needs children, persons with HIV/AIDS, and those with serious mental illnesses. Expanding public programs to cover the sickest and poorest of the uninsured would help ensure affordable private insurance premiums for many of the remaining uninsured. By reducing bad debt and the burden of charity care, expanding public programs would also enhance the financial stability of rural and inner city hospitals, academic health centers, community health centers, and other safety net providers—many of which have experienced an increased uninsured patient load in recent years.

Nongroup health insurance coverage is the smallest, weakest, and most poorly performing sector of the U.S. health insurance system. It works least well for those who have limited incomes or serious health problems. Nongroup premiums are 20 to 50 percent higher than employer plan premiums and, as noted, as much as half of that goes toward administration, marketing, sales commissions, underwriting, and profits. Premiums typically climb steeply with age. For an unmarried 60 year old, a plan with a deductible of $250 exceeds $8,000 per year in major urban areas and is often available only if the individual is healthy and stringent underwriting conditions are met.[3] Benefits are often inadequate, and premiums and risk selection practices are difficult for states to regulate. By design, underwriting practices discriminate against the sick and disabled, making coverage often unavailable at any price, or only at a substantially higher cost than incurred by healthier individuals.

The provision of tax credits for the purchase of individual insurance is particularly problematic. A $1,000 tax credit toward an $8,000 premium for a 60-year-old woman earning less than $35,000 a year is hardly sufficient to make such coverage affordable. It is difficult to adjust tax credits to take account of variations in individual health insurance premiums by age, geographic location, and health status.

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[1] Lisa Duchon, Cathy Schoen, Elisabeth Simatov, Karen Davis, and Christina An, *Listening to Workers: Findings from The Commonwealth Fund Survey of Workers' Health Insurance*, The Commonwealth Fund, January 2000.

[2] Sherry A. Glied, *Challenges and Options for Increasing the Number of Americans with Health Insurance*, The Commonwealth Fund, January 2001.

[3] Commonwealth Fund Task Force on the Future of Health Insurance staff survey of lowest-cost premium rates quoted in 15 U.S. cities across the country on *www.e-healthinsurance.com* as of February 2001.

MEDICAID/CHIP EXPANSIONS

The most straightforward way to cover low-income adults would be to expand Medicaid and CHIP benefits to parents. The Kaiser Commission on Medicaid and the Uninsured estimates that 5.3 million parents of Medicaid/CHIP eligible children are uninsured—nearly 30 percent of all low-income parents.[4] Expanding coverage to parents would add 3.2 million low-income parents, including 2.2 million who are currently uninsured. These uninsured are least able to afford private health insurance coverage, even if there were tax credits that reimbursed families in April for part of premiums paid for private coverage during the prior year. Nor does it require complex mechanisms to advance tax credits and make end of the tax year reconciliation of amounts owed.

Medicaid offers the kinds of benefits needed by many low-income parents, who often have serious health problems, require ongoing treatment, and cannot afford deductibles and copayments. Without an automatic mechanism such as payroll deduction, even low premiums can act as a barrier to participation in private coverage.[5]

As a practical matter, enrolling the parents of children covered by Medicaid and CHIP would be relatively easy, since their children are already registered and participating. Extending Medicaid/CHIP to low-income parents would also cover many more people than the provision of tax credits to buy individual health insurance, which would require low-income adults—many with limited education or English-language skills—to navigate the complexities of the private insurance market.

Expanding public programs to the family members of those already covered by Medicaid/CHIP would be an effective way to reach and enroll uninsured members of partially insured families. A recent study for The Commonwealth Fund found that 4.5 million families—or 14 percent of all families with children—are only partially uninsured.[6] Experiences in various states (Wisconsin, for example) indicate that allowing parents to participate would increase the participation rate of children overall by making it possible for the whole family to be insured under the same program.

Expanding public insurance programs would also increase the stability of coverage for low-income families. Circumstances for low-income families change frequently—jobs are found or lost, wages and hours fluctuate. Currently, public programs contribute to the instability of coverage by linking eligibility to family structure or health, rather than to income alone. For example, pregnant women with incomes below 185% of poverty are covered by Medicaid in many states, but coverage is lost 60 days after childbirth. Today, 15 percent of women who lose Medicaid coverage do so because their pregnancy has ended.[7] But the health needs of mothers do not end with pregnancy. Allowing people to stay on as long as income remains low would avoid this type of instability and would allow continuous coverage as jobs and hours change.

Covering low-income families under Medicaid/CHIP makes for healthier families. Healthy parents are important for healthy children. A mother's health, including mental health, is particularly important if she is to provide the nurturing and support that children need. Expanding Medicaid/CHIP to cover low-income parents as well as children would promote family-based insurance coverage and improve the continuity of coverage. Improving continuity of Medicaid coverage would in turn permit managed care plans and safety net providers to continue serving this low-income population.

Medicaid could also be expanded to cover the uninsured family members of low-income disabled adults and children with special needs, providing much-needed relief and peace of mind to those fulfilling this important role. Those who care for disabled family members are often in poor health themselves, suffer from stress and anxiety, and struggle with the financial burdens of uninsured medical expenses and lost income.

MEDICARE EXPANSIONS

Most of the uninsured, especially older adults, view Medicare favorably. A Commonwealth Fund survey of adults ages 50 to 64 found that 86 percent of uninsured

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[4] Diane Rowland, et al. Kaiser Commission on Medicaid and the Uninsured, "Building on Medicaid to Cover the Low-Income Uninsured," forthcoming, Spring 2001.

[5] Mary Jo O'Brien et al., *State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions*, The Commonwealth Fund, May 2000.

[6] Karla Hanson, "Patterns of Insurance Coverage within Families with Children," *Health Affairs*, 20:1 January/February 2001.

[7] P.F. Short, *Medicaid's Role in Insuring Low-Income Women*, The Commonwealth Fund, 1996.

adults in that age group are interested in early coverage under Medicare.[8] Medicare is highly trusted by older adults—surpassing even employer-based coverage as a preferred option.

Two groups of uninsured are prime candidates for coverage under an expanded Medicare program: older uninsured adults and sick disabled adults not currently covered. There are 3.4 million uninsured adults age 55 to 64 and 3.7 million uninsured sick and disabled persons under age 55. The uninsured disabled include those receiving Social Security Disability Insurance (SDDI) for less than two years. Current law provides for a two-year waiting period that makes little sense given the limited options for alternative coverage. It also includes those who are still able to work, thus failing to qualify for SSDI and Medicare coverage as permanently and totally disabled. Finally, it includes those chronically ill or high-risk individuals who are rejected for private individual health insurance coverage.

While expensive to insure, disabled and chronically ill adults have the greatest need for assistance and are most at risk in the absence of coverage. They typically require extensive treatment to maintain functioning or slow the progression of disease and disability. Research indicates that uninsured chronically ill people are far less likely than their insured counterparts to have their conditions properly managed. Consequently, they have worse health outcomes. The sick and chronically ill are also at greatest risk of incurring major medical expenses and financial hardship.

Family coverage is also an important goal. Coverage could be extended to dependents of Medicare beneficiaries and family caregivers of the disabled covered under Medicare. Based on recent Current Population Survey data, there are 600,000 uninsured dependents of elderly Medicare beneficiaries—primarily spouses under age 65 but also some dependent children. Coverage of uninsured family members of Medicare disabled beneficiaries would also provide much needed assistance to those family caregivers whose own health and financial security are often at risk.

Unlike the current Medicare program that covers all the elderly—both healthy and sick, opening Medicare to uninsured older adults could be expected to be most attractive to sicker and higher-risk older adults. A new study for The Commonwealth Fund found that among uninsured adults ages 62 to 64, almost one-third are in only fair or poor health-contrasted, for example, with 15 percent of those covered by employer plans.[9] The disabled who would be newly eligible could also be expected to have above-average medical expenses. Premiums would need to be based on a community rate of all older adults, with reinsurance or subsidies to offset adverse risk selection. Such premiums, though high, would be less expensive than premiums in the nongroup market. Average Medicare community rated premiums would be approximately $3,000 to $4,000 irrespective of health status, compared with premiums of $8,000 or more for otherwise healthy 60-year-old adults in many nongroup, private insurance markets.

Expanded Medicare coverage would provide financial protection and access to health care for adults at high risk of serious illness or disability. It would also obviate the need to change programs upon reaching age 65. Premium assistance applied to Medicare coverage rather than tax credits for individual health insurance would: promote continuity of coverage; assure the availability of adequate coverage; and avoid the empty promise of coverage under individual private health insurance that is neither affordable nor genuinely open to high-risk individuals.

STRENGTHENING THE LINK BETWEEN PUBLIC PROGRAMS AND EMPLOYER COVERAGE

Employer health insurance coverage is the mainstay of the American health insurance system. Over 158 million American workers and their family members are covered by insurance offered by employers. Employers help make such coverage affordable by picking up on average 86 percent of worker—only premiums or 73 percent of family coverage premiums.[10] Almost one-third of all health expenditures—$300 billion—is financed through employer plans.[11]

Employer coverage forms a natural risk pool-covering large groups of people automatically upon employment rather than those seeking insurance because they anticipate needing health care. This and other benefits of group coverage assure that employer coverage provides good value, with low loading factors, and adequate bene-

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[8] Cathy Schoen, Elisabeth Simatov, Lisa Duchon, and Karen Davis, *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70*, The Commonwealth Fund, July 2000.

[9] John Sheils and Ying-Jun Chen, *Medicare Buy-in Options: Estimating Coverage and Costs*, The Commonwealth Fund, March 2001.

[10] The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2000 Annual Survey*, 2000.

[11] Author's estimate based on John Sheils and Paul Hogan, "Cost of Tax-Exempt Health Benefits in 1998." *Health Affairs*, 18:2. March/April 1999. pp. 176–181.

fits. Administration is easy for workers, with automatic enrollment, premiums that are automatically deducted from paychecks, and an employer to navigate the complexities of the marketplace. Employment-based coverage is the preferred option for most workers, both those with and without such coverage. Three-fourths workers with employer coverage think employers do a good job selecting plans.[12]

Employer coverage is essential to the smooth functioning of America's health care system. It is important that we build on this positive experience and not design policies that contribute to its deterioration. The way to do this is to provide incentives for employers to offer and expand coverage. We should not institute rules that prevent low-wage working families from participating in public programs in a misguided effort to avoid "crowding out" private coverage. For example, CHIP programs typically have waiting periods of 9 months to a year without private coverage. This creates unnecessary hardship for families, and confusion about why an application for coverage is denied.[13]

Policies that strengthen the link between employer coverage and public programs should be designed to increase the availability of employer coverage and participation in public programs by eligible families. Two strategies could strengthen this link. Small businesses and low-wage employers could be encouraged to buy coverage through public programs such as Medicaid/CHIP,[14] Medicare, and the Federal Employees Health Benefits Program.[15] Secondly, employees who would be eligible for public programs could receive premium assistance to participate in their own employer's plan.[16] The goal should be greater flexibility for public program funds to be combined with employer contributions to finance coverage of working families. Such initiatives could be expected to make a major dent in the numbers of uninsured, almost 80 percent of whom are in families with at least one worker.

Today, 12 percent of uninsured workers decline employer coverage largely because it is unaffordable.[17] An estimated 6 million these uninsured workers and their family members would be covered if premium assistance were available to offset their portion of employer premiums. Participation would be particularly high if employers took on the administrative task of collecting such premium assistance (or tax credits) for low-wage workers and automatically enrolling them in employer plans.

Opening public programs to small businesses and low-wage employers is also an important step toward making high-quality plans at reasonable premiums accessible to this market. An estimated 5 million to 13 million working uninsured could be expected to benefit from such options. For firms with large concentrations of very low-income workers, buying into Medicaid/CHIP coverage would help assure continuity of coverage and care as low-income families moved in and out of poverty. For small businesses with a mix of employees, the option of purchasing coverage under the Federal Employees Health Benefits Program—perhaps administered separately via the Internet—could induce more small businesses to offer coverage, particularly if premium assistance were available to pay a portion of the premiums for low-wage workers. Firms with older workers or large numbers of early retirees under age 65 might be attracted to the option of purchasing coverage under Medicare.

Flexibility to purchase coverage privately or through public programs, and picking an alternative best suited to the needs of different workforces, could make a significant difference. It would reduce the numbers of uninsured, extend the benefits of large group coverage to the self-employed and small businesses, make coverage more affordable, increase the quality of coverage, and reduce the turnover and instability of coverage.

CONCLUSION

In summary, public programs serve as a good foundation from which to begin building a comprehensive policy to cover our nation's uninsured. They are most well-

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[12] Cathy Schoen, Erin Strumpf, and Karen Davis, *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance*, January 2000.

[13] Mary Jo O'Brien et al., *State Experiences with Access Issues Under Children's Health Insurance Expansions*, The Commonwealth Fund, May 2000.

[14] Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith, *Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs*, The Commonwealth Fund, December 2000.

[15] Beth C. Fuchs, *Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program*, The Commonwealth Fund, December 2000.

[16] Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs*, The Commonwealth Fund, February 2001.

[17] Lisa Duchon, Cathy Schoen, Elisabeth Simatov, Karen Davis, and Christina An, *Listening to Workers: Findings from The Commonwealth Fund Survey of Workers' Health Insurance*, The Commonwealth Fund, January 2000.

suited to assisting the poorest and sickest uninsured. They have a long track record of providing efficient and effective coverage to those with the most serious health problems. They are the insurance coverage of choice for many uninsured, particularly older adults looking forward to coverage under Medicare.

Expanding public programs does not exclude tapping the private market. Medicare and Medicaid/CHIP both make extensive use of private insurers. By assuming the risk for the sickest and poorest, public programs free private insurers to cover those they are best able to cover: healthier working families. Expanding public program coverage to the neediest uninsured would provide a stable source of financing to rural and inner-city hospitals, academic health centers, community health centers, and other safety net providers, thus promoting a high-quality health care system available to all Americans.

In American health care, one size does not fit all. Different strategies should be employed to cover different groups: a low-income family with young children has different needs than an older adult with heart disease or cancer who can no longer work. Individual choice is also an important value, and preferences vary. Medicare is popular with older adults; uninsured low-wage workers prefer employment-based insurance. Families with special needs children or a disabled adult value the comprehensive benefits that Medicaid assures, yet family caregivers often struggle without health insurance of their own.

Providing choices and honoring preferences are important. But coping with a serious illness or struggling to make ends meet leave little time and energy for navigating a complex health care and health insurance system alone. Making coverage automatic and affordable without creating administrative hurdles is key to reaching those currently uninsured. Providing tax credits or vouchers without guaranteed access to proven established mechanisms assuring high-quality, affordable coverage is an empty promise—unlikely to make a significant dent in the problem. Public program expansions are an important strategy to reach the sickest and poorest of the uninsured.

Specific options for targeting public program expansions include:

- Cover uninsured parents under Medicaid/CHIP (5.3 million under 200% of poverty)
- Expand Medicaid to uninsured family members of disabled special needs children and disabled adults on Medicaid
- Provide premium assistance under Medicare to cover uninsured adults age 55 and over (3.4 million)
- Cover uninsured dependents of elderly Medicare beneficiaries (600,000 people) and uninsured family members of disabled Medicare beneficiaries
- Expand Medicare coverage of the sick and disabled (3.7 million uninsured under age 55), including eliminating the two-year waiting period, and broadening eligibility to those able to work though disabled or suffering from a serious chronic illness that precludes private coverage
- Improve the link between public programs and employer coverage, including giving small businesses and low-wage employers the option of purchasing coverage with low-wage premium assistance through Medicaid/CHIP, Medicare, and the Federal Employees Health Benefits Program, and using funds under Medicaid/CHIP to provide premium assistance to employer coverage of low-wage working families (5 million to 13 million uninsured)
- Increase low-wage worker participation in employer health plans through low-wage premium assistance administered by employers (6 million uninsured workers and family members not currently participating in employer plans)

By designing options that work for families in different circumstances, and favoring family coverage through a single mechanism, participation rates will increase and continuity of coverage and care will be improved. Most importantly, making health insurance coverage of the sickest and poorest the highest priority will help assure that all Americans have access to quality health care.

We are at a propitious and historic moment. We have the luxury of a substantial 10-year budget surplus—at least $1 trillion of which was generated by economies in Medicare and Medicaid achieved in the last part of the 1990s.[18] It is an ideal time to reinvest a significant share of those savings in improved health care for those left behind.

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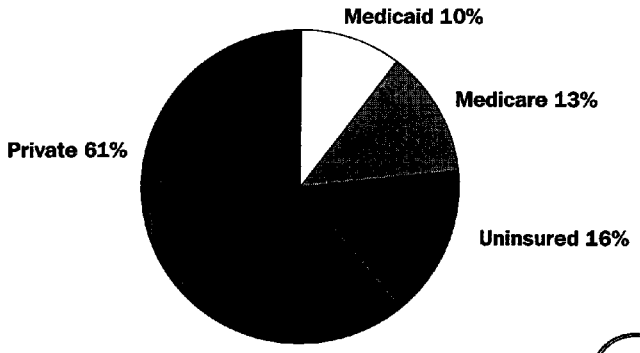
[18] Karen Davis, Cathy Schoen, and Stephen C. Schoenbaum, "A 2020 Vision for American Health Care," *Archives of Internal Medicine*, 160: December 11/25, 2000.

Health Insurance Coverage, 1999

42.6 million uninsured



Source: U.S. Census Bureau, March 2000 Current Population Survey.

Source of Primary Health Insurance by Poverty Level, 1999

In Millions, Under Age 65

	Total	Employer-Based Coverage	Public Coverage	Individual Coverage	Uninsured
Total	241.4	157.7	27.4	14.2	42.1
Under 100% of Poverty	36.7	6.3	13.5	2.7	14.2
100%-199% of Poverty	42.8	19.4	7.7	3.2	12.4
200%-399% of Poverty	72.8	54.6	4.1	4.3	9.8
400% of Poverty of Higher	89.1	77.3	2.0	4.0	5.7

Source: Estimates for The Commonwealth Fund Task Force by S Glied, Columbia University based on March 2000 Current Population Survey. If more than one source in year, classified as employer first, then public, then individual.

Number of Uninsured by Age and Poverty Level, 1999
(In Millions)

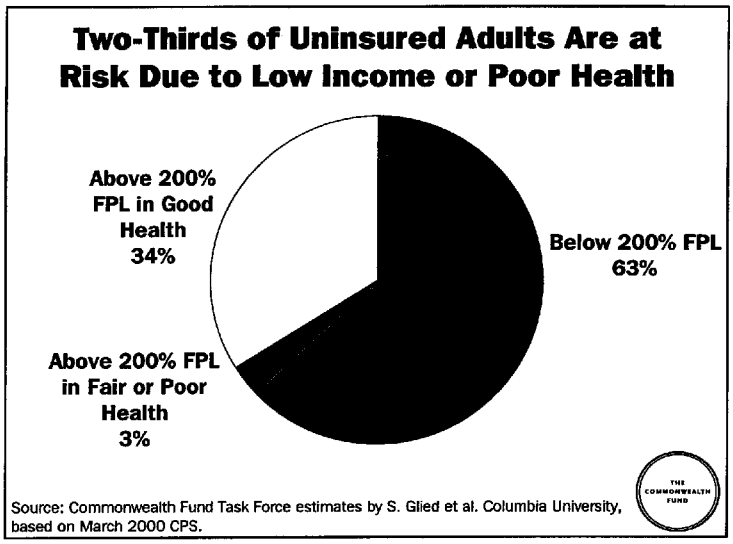
	Total	Under 100% of Poverty	100% - 199% of Poverty	200% - 399% of Poverty	400% of Poverty or Higher
Total	42.1	14.2	12.4	9.8	5.7
Under age 19	10.8	3.7	3.4	2.5	1.2
Ages 19-44	23.0	8.0	7.1	5.3	2.7
Ages 45-54	4.9	1.4	1.2	1.2	1.0
Ages 55-64	3.4	1.0	0.8	0.8	0.3

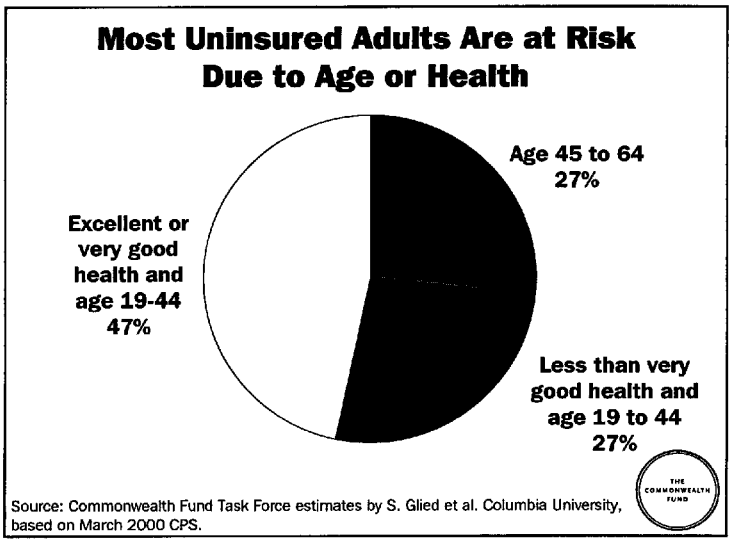
Source: Estimates for The Commonwealth Fund Task Force by S Glied, Columbia University based on March 2000 Current Population Survey.

Number of Uninsured by Health Status and Poverty Level, 1999
(In Millions)

	Total	Under 100% of Poverty	100% - 199% of Poverty	200% - 399% of Poverty	400% of Poverty or Higher
Total	42.1	14.2	12.4	9.8	5.7
Excellent	13.1	3.8	3.8	3.3	2.2
Very Good	13.4	4.2	4.1	3.2	1.9
Good	11.4	4.3	3.4	2.6	1.2
Fair or Poor	4.2	1.9	1.2	0.8	0.4

Source: Estimates for The Commonwealth Fund Task Force by S Glied, Columbia University based on March 2000 Current Population Survey.


Two-Thirds of Uninsured Adults Are at Risk Due to Low Income or Poor Health
Above 200% FPL in Good Health 34%
Below 200% FPL 63%
Above 200% FPL in Fair or Poor Health 3%
Source: Commonwealth Fund Task Force estimates by S. Glied et al. Columbia University, based on March 2000 CPS.


Most Uninsured Adults Are at Risk Due to Age or Health
Age 45 to 64 27%
Excellent or very good health and age 19-44 47%
Less than very good health and age 19 to 44 27%
Source: Commonwealth Fund Task Force estimates by S. Glied et al. Columbia University, based on March 2000 CPS.

Public Programs Work

- Makes coverage affordable for elderly, disabled, and low-income families
- Pools risks -- Medicare's social insurance feature provides automatic cross-subsidies from rich to poor, well to sick
- Medicare is well-liked by beneficiaries and allows a choice of fee-for-service or managed care options
- Medicare and Medicaid administrative costs are low -- less than 2 percent
- Medicare has been a leading innovator in provider payment reform and quality standards for managed care plans

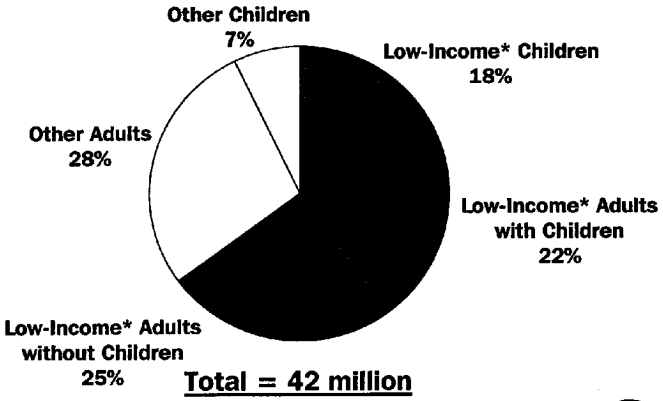
Public Programs Cover the Poor, Elderly, Disabled, and Sick

- Medicare and Medicaid cover over 70 million people -- one-fourth of all Americans
- Government programs account for 44 percent of $1 trillion health care outlays
- Medicare and Medicaid accept the highest risk patients often excluded from private coverage
- Removing the sickest two percent from individual coverage reduces premiums by over 20 percent -- public programs help private insurance market work

Individual-Based Insurance

- Weakest and smallest part of current health insurance system
- Only 6 percent of Americans under age 65 rely primarily on individual coverage
- High premium costs relative to group insurance -- 30-50 percent higher premiums, high loading factor
- Screens out high-risk and sick individuals or charges substantially higher premiums for coverage
- Premiums vary by age, geographic location, and health status; hard to adjust tax credits for these factors

The Uninsured Population, 1999



Total = 42 million

*Low-income defined as < 200% of poverty level, or $26,580 for a family of three in 1999.

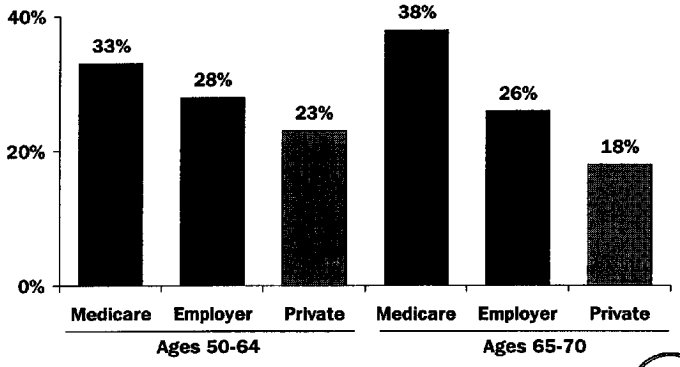
Source:Rowland, et. al., *Building on Medicaid to Cover the Low-Income Uninsured*, The Kaiser Commission on Medicaid and the Uninsured, December 2000.

Expand Medicaid-CHIP

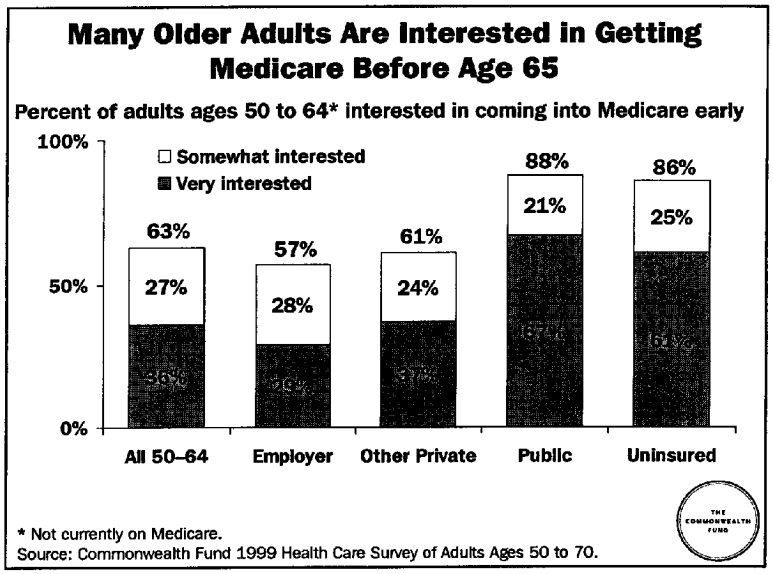
- Cover parents where children are covered
  - 3.2 million newly covered parents below 100% poverty, including 2.2 million currently uninsured
- Expand Medicaid to uninsured family members of Medicaid-disabled (special needs children and disabled adults)

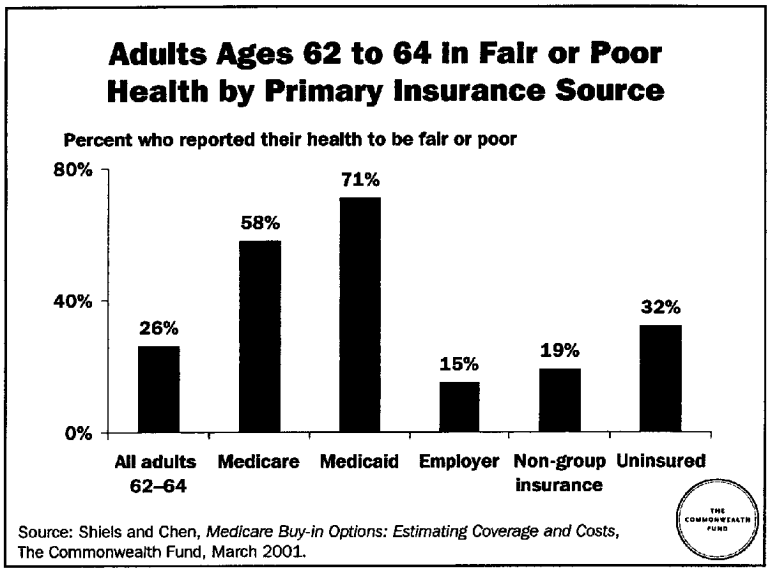
Which Would You Trust More to Insure Adults Age 50-64?

Percent of adults who said they would trust...

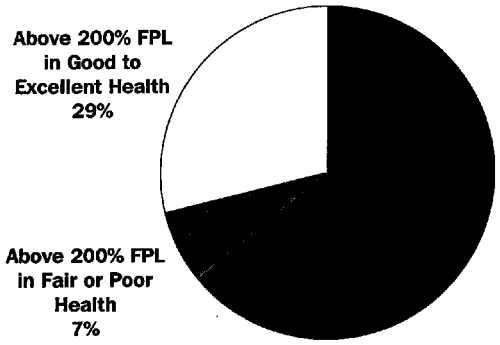


Source: Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.


Many Older Adults Are Interested in Getting Medicare Before Age 65
Percent of adults ages 50 to 64* interested in coming into Medicare early
100%
50%
0%
Somewhat interested
Very interested
63%
27%
57%
28%
61%
24%
88%
21%
86%
25%
All 50–64
Employer
Other Private
Public
Uninsured
* Not currently on Medicare.
Source: Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.


Adults Ages 62 to 64 in Fair or Poor Health by Primary Insurance Source
Percent who reported their health to be fair or poor
80%
40%
0%
26%
58%
71%
15%
19%
32%
All adults 62–64
Medicare
Medicaid
Employer
Non-group insurance
Uninsured
Source: Shiels and Chen, Medicare Buy-in Options: Estimating Coverage and Costs, The Commonwealth Fund, March 2001.

Uninsured Adults Ages 62 to 64 by Income and Health Status



864.4 thousand uninsured

Source: Shiels and Chen, *Medicare Buy-in Options: Estimating Coverage and Costs*, The Commonwealth Fund, March 2001.

Expand Medicare

- **Premium assistance to cover older and sicker uninsured under Medicare**
  - **Uninsured adults age 55 and over (3.4 million)**
  - **Dependents of elderly Medicare beneficiaries (600,000 uninsured spouses and dependent children)**
  - **Uninsured family members of disabled-Medicare beneficiaries**
  - **Uninsured sick and disabled not now covered by Medicare including elimination of two-year waiting period and broadening disability eligibility to those who can't obtain or afford private coverage (3.7 million)**

Employer Sponsored Insurance: Current Role

- Insures 2 out of 3 people under 65 -- 158 million people
- Accounts for 30% of all personal health expenditures; 50% of physician expenditures
- Employer sponsored coverage pays $300 billion of the $1 trillion health bill
- Employers pay 86 percent of single employee premiums and 73 percent for family coverage on average
- Important source of retiree supplemental coverage for 34 percent of Medicare beneficiaries

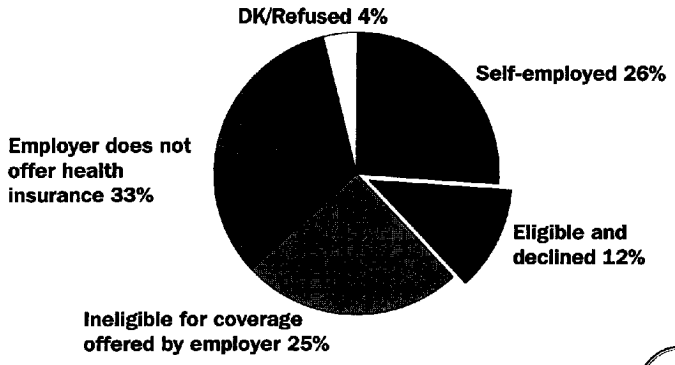
THE COMMONWEALTH FUND

Employer Sponsored Insurance: Major Strengths

- Affordability: employer share of premium makes coverage affordable for most workers
- Best buy: employer coverage is 30-50 percent less expensive than individual coverage
- Risk pooling: pools risk across age and health status, a natural group not based on health
- Participation: payroll deduction makes signing up and participating "easy", leading to high participation rates
- Administrative costs: group coverage lowers administrative costs compared to individual market
- Employee agent: employers sponsor and oversee plans; intervene in disputes
- Quality: fosters quality innovations and choice

THE COMMONWEALTH FUND

12 Percent of Uninsured Workers had an Opportunity to Get Employer-Based Coverage and Declined Largely Because Unaffordable



Uninsured Workers

Source: The Commonwealth Fund 1999 National Survey of Workers' Health Insurance.

Improving Link between Public Programs and Employer Coverage

- Permit low-wage employers to buy into Medicaid and CHIP or use Medicaid/CHIP funds to pay premiums for low-wage workers and dependents under employer plans
- Open up Federal Employees Health Benefits Plan option to self-employed and small businesses
- Open up Medicare to employers with older workers or early retirees
- Make enrollment in employer plans automatic for all workers and their dependents and provide premium assistance to employers to cover part of premiums for low-wage workers
- These options could expand coverage to 5 to 13 million uninsured workers and family members

PREPARED STATEMENT OF CHRISTINE C. FERGUSON

Mr. Chairman and Members of the Committee,

Thank you for the opportunity to speak to you about the important challenges we all face today in addressing the needs of the uninsured and under-insured. I would like to begin my comments by applauding my colleagues who have appeared over the last two days for the exceptional job they have done in drawing a portrait of the uninsured—both who they are and why they are uninsured—and in outlining the strategies we could all use to reach and provide them with health coverage. I appear before you today as a representative of a state that has, by some accounts, the lowest rate of uninsurance in the nation (6.9%) and, by all accounts, even those like the GAO who rank RI second or third lowest, has achieved the greatest reduction in the rate of uninsured (4.6%) over the last five years.

RI's success in this arena has been attributed to many factors: (1) innovative use of Medicaid expansions; (2) SCHIP funds—even if too late and in not nearly the amount justified; (3) equal measures of strong and dogged leadership in the governor and members of the legislature; (4) widespread public and political support; (5) careful targeting and persistent outreach to uninsured populations; (6) businesses and industries committed to providing employees with health coverage; and (7) an unusually robust state economy. Rather than explaining the contributions that anyone or even all of these factors made to the decline in the state's uninsurance rate, my goal here is to introduce, instead, a broader framework for thinking about, and ultimately, for addressing the needs of the nation's uninsured.

Among the issues before this Committee is the question of whether the states are afforded sufficient flexibility in both the Medicaid and SCHIP programs to develop health care programs that can reach the uninsured and under-insured. This latter group—the under-insured—is no less at risk, because the coverage they do have is too limited or too expensive to yield positive, long-term health care outcomes. Since 1994, RI has taken full advantage of every opportunity that availed itself to expand Medicaid coverage to low-income families and children, many of whom were among the state's uninsured.

Today, through RIte Care, the state's Medicaid managed care plan, RI covers children in families with incomes up to 250% of the federal poverty level and parents with income up to 185% of FPL. This group represents 74% of the Medicaid caseload. Although this is a remarkable achievement in and of itself, what is even more interesting are the health care outcomes that have resulted—for example, longer inter-birth intervals, lower infant mortality, cessation in smoking, early lead poisoning detection and intervention. The cost of services to this, the largest Medicaid population, accounts for less 40% of all expenditures. The opposite is true for the elderly and those with disabilities who receive care through the traditional fee-for-service program, accounting for 26% of the total caseload but 60% of all expenditures.

When we look at RI's recent Medicaid expansions in this context, the most startling fact is the success of the approach: in the role of purchaser, the state was able use the considerable leverage afforded by the population's size to negotiate with commercial health plans to provide more and better health coverage, to a wider group of Rhode Islanders in need.

What we in RI have learned from this experience is twofold: (1) how health care is purchased is critical to maximizing dollars and optimizing outcomes; and (2) doing both, (maximizing dollars and optimizing outcomes) requires that the health coverage needs of all populations, both insured and uninsured, are addressed together and in the context of all available resources, both public and private. In short, the flexibility that the states need is the flexibility to coordinate, and co-mingle existing resources and benefits to extend and finance high quality coverage for the uninsured and the under-insured. In the last year, RI has used this framework to explore new, more cost-efficient mechanisms for providing current recipients with high quality care and, in the process, to make coverage more accessible to those in need.

To better handle the growth in the RIte Care program and assure that low income workers are able to remain in their employer-based health insurance, the state has established the RIte Share premium assistance program. The state will pay a Medicaid eligible employee's share of the cost for employer-sponsored insurance thus reducing the burden on the state, preserving the Employer-Sponsored Insurance, and ensuring private dollars on the table stay there. The states have had the flexibility to establish these programs under both Medicaid and SCHIP for some time, though within limits that are sometimes unreasonable. (Some of the more onerous of these requirements have been lifted, but not all.) The next step, and we are not there yet in RI, would be to allow small employers and adults without children (ages 19 to 64) who cannot afford or are not eligible for employer-sponsored insurance coverage

to purchase or buy into RIte Care or some other alternative. In addition, RI is one of the states that has been awarded a HCFA grant to develop a buy-in for working disabled.

In this way, the state would be able to extend coverage to those among the uninsured now outside Medicaid's eligibility criteria. In other words, we have the foundation on which to build capacity if the financing is available, whether through tax credits or grants.

There are other mechanisms that could be used to finance expansions in health coverage if the states had greater flexibility to reallocate and coordinate existing resources. For example, RI currently has a plan on the drawing board to create service centers that use case management techniques to improve the efficacy and efficiency of services delivered to the elderly and adult Medicaid population. The states' ability to fully realize the potential of these centers is limited, however, by a system of arcane federal rules and regulations that prevent state Medicaid agencies from fully coordinating services and benefits paid for by Medicare. Moreover, these same rules deter rather than facilitate state efforts to provide cost-effective and scamless coverage for dual eligible beneficiaries across health care settings. The flexibility to waive these rules would not only promote the use of alternative approaches for providing care to this high cost population, but encourage the development of innovative new ones as well. In addition, eliminating some of the regulatory barriers that separate Medicare and Medicaid funds and services, could greatly enhance the leverage of the state Medicaid agency when purchasing prescription drug benefits and home-based services for recipients of both programs. Any savings that accrue to the state could be reinvested to finance expansions in eligibility and/or services.

RI was one of the first states to finance expansions in eligibility for Medicaid, to both children and families, using the flexibility and the cost-savings derived from a Section 1115a demonstration project—RIte Care Medicaid Managed Care. As a consequence, the state did not have the flexibility to access its full allotment of SCHIP funds. Nonetheless, the state proceeded, without the benefit of SCHIP funds, to be among the first, once again, to extend eligibility to parents, but this time using the flexibility afforded under section 1931. Since then, the state has taken advantage of the flexibility it has been afforded to reach-out to and enroll eligible uninsured children, and to make it easier to apply for and retain benefits. As RI fiscal year 2000 drew to a close, it was the unexpected cost for Medicaid services provided to the adult and elderly population, in addition to the expected enrollment increases for children and families, that caused state policymakers to pause and nearly resulted in a roll back of eligibility for families. Thus, as the state entered the new millennium, it found itself but yet again in the position of front-runner. This time, RI was among the first states to experience the consequences of an unexpected sharp rise in health costs due to prescription drugs, technology, insurance pricing and a labor shortage at the same time it was making these important expansions and simplifications. Let me be clear, we predicted and expected the increases in families; we did not accurately predict and therefore did not expect the magnitude of growth in both the numbers of adults and children with disabilities who would become eligible and the increase in cost of the services, particularly prescription drugs, behavioral health and overall utilization levels.

In the months that followed, the state has requested several waivers of Title XIX requirements, in each case asking for the flexibility to reallocate existing resources to preserve the Medicaid expansions and reduce costs. In the case of SCHIP, the state requested access to funds to help offset the costs for providing services to the target-population the program was established to serve. In some of these endeavors, the state has been successful—SCHIP 1115 waiver for adults, but in others less so. For example, charging co-payments and income-related premium share as well as crowd-out provisions.

We also explored and submitted a waiver request for Adults with Developmental Disabilities which languished at HCFA for 6 or 7 years before we decided to move in a different direction.

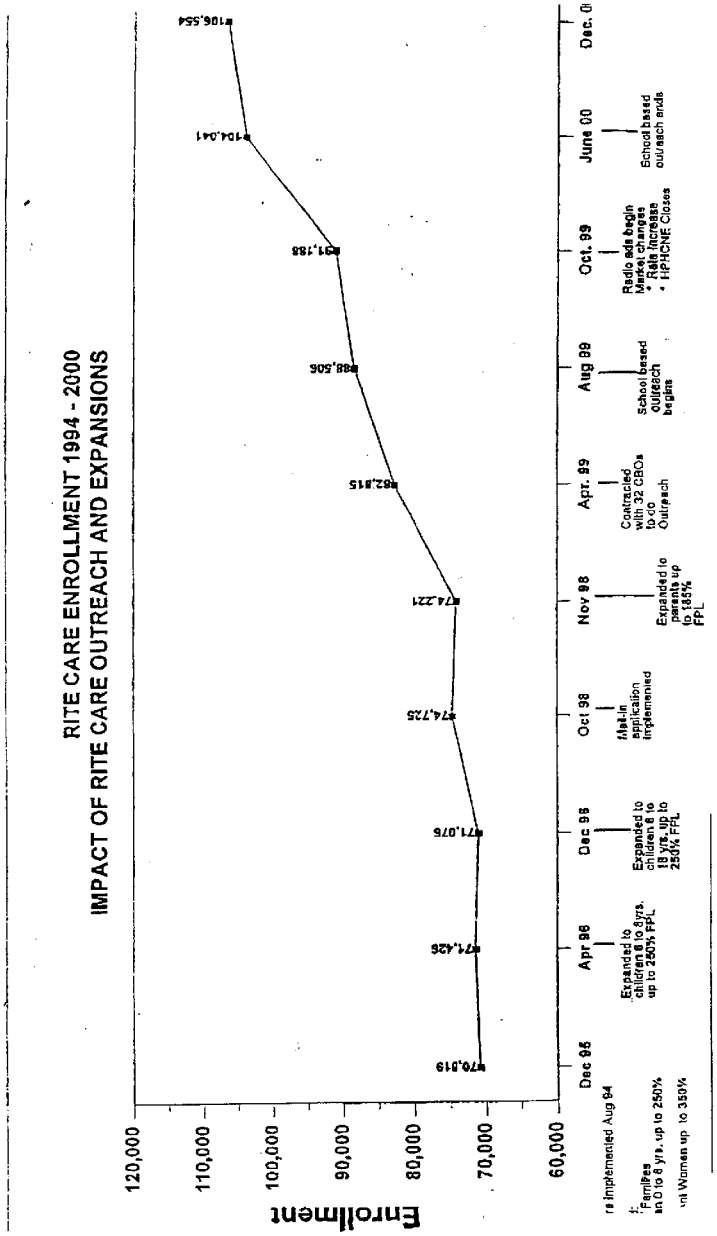
Governors and state legislators frequently remind you that they must balance their budget at the end of the fiscal year. A 1 or 2 percent variation in an estimate of a program that accounts for 30% of the state budget creates a huge problem for state legislators and governors. While there is generally limited appetite for outright cuts, because the state loses $1.00 for every 50¢ it saves, there is a tremendous focus on limiting unpredictability and avoiding large rates of increase in any one fiscal year.

Therefore, if we as a state are interested in getting to universal and comprehensive coverage, including prescription coverage for the elderly, we have to manage the resources we do have effectively.

The stark reality is we cannot do that alone. We need the enthusiastic partnership of the federal branch through Medicare, the tax code and ERISA flexibility.

I am hopeful that the new Administration will approach these issues with an eye toward real change and will see the tremendous opportunity before us. Let states develop solutions and work with us to figure out how to implement them, measure our progress and hold us to desired outcomes. I know that the members of this Committee understand the potential opportunity and will help us ensure we do not it slip through our fingers.

Thank you again for having me testify. I would be happy to answer any questions.

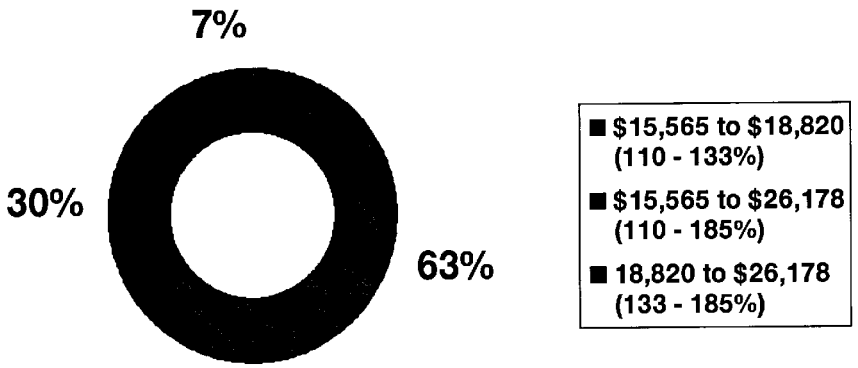

RITE CARE ENROLLMENT 1994 - 2000
IMPACT OF RITE CARE OUTREACH AND EXPANSIONS
Enrollment
120,000
110,000
100,000
90,000
80,000
70,000
60,000
Dec 95
Apr 96
Dec 96
Oct 98
Nov 98
Apr. 99
Aug 99
Oct. 99
June 00
Dec. 0
re implemented Aug 94
Families
an 0 to 6 yrs. up to 250%
nt Women up to 350%
Expanded to children 6 to 8yrs. up to 250% FPL
Expanded to children 6 to 18 yrs. up to 250% FPL
Mail-in application implemented
Expanded to parents up to 185% FPL
Contracted with 32 CBOs for Outreach
School based Outreach begins
Radio ads begin
Market changes
Rate increase
HIPPICHE Closes
School based outreach ends
70,819
71,425
71,075
74,725
74,221
82,815
88,506
91,188
104,041
106,554

RIte Care Expansion

8/94	Original RIte Care Waiver	1. Uninsured Pregnant/Postpartum women 185-250% FPL 2. Children under age 6 to 250% FPL 3. Uninsured Pregnant Postpartum women 250-350% FPL
5/96	Six & Seven Year Olds	4. Children ages 6 and 7 250% FPL
5/97	Welfare Reform: FIP and 8 to 18 Year Olds	5. Children ages 8 and 18 250% FPL 6. Parent eligible for FIP cash assistance, previously ineligible for AFDC (no AFDC deprivation factor)
1/97	Home-Based Child Care	7. Home-Based Day Care Providers and dependents allowed to enroll in RIte Care
6/98	Extended MA lengthened to 18 months	8. Extended MA families (in effect parents. Since children would be eligible otherwise)
11/98	Low Income Parents	9. Parents of MA-eligible children, up to 185% FPL
1/99	Center Based Child Care Providers	10. Center Based Child Care Providers (subsidized coverage)
10/99	Alien Children	11. All children up to 250% FPL, without regard to alienage
10/99	18 year olds	12. Children age 18 covered to 19th birthday
11/00	Foster Children	13. Foster children enrollment in RIte Care begins [1]

Distribution of Family Income of Low Income Parents Expansion Group

(Eligible via Section 1931)

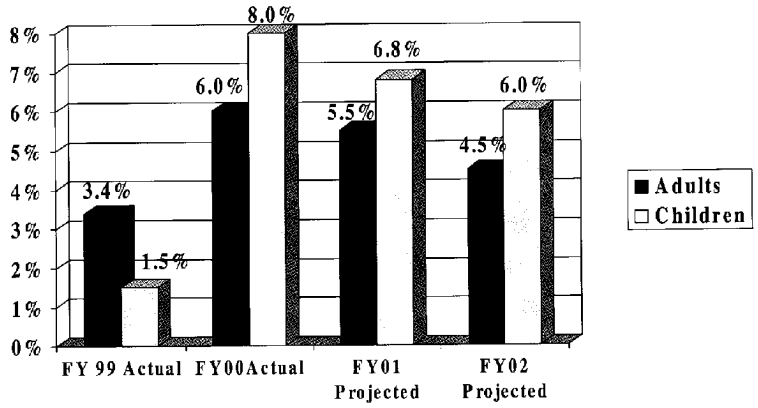


* FIP income limits vary independently of the Federal Poverty Level. However, a family of three with one earner with gross earned income up to approximately 110% of the FPL could obtain cash assistance.

** The Federal Poverty Level is $14,150 annually for a family of three (the median family size in Rite Care).

Rhode Island - Average Annual Growth in the Disabled Medicaid Population

Percent change from Prior Year



Note: SSI Children only

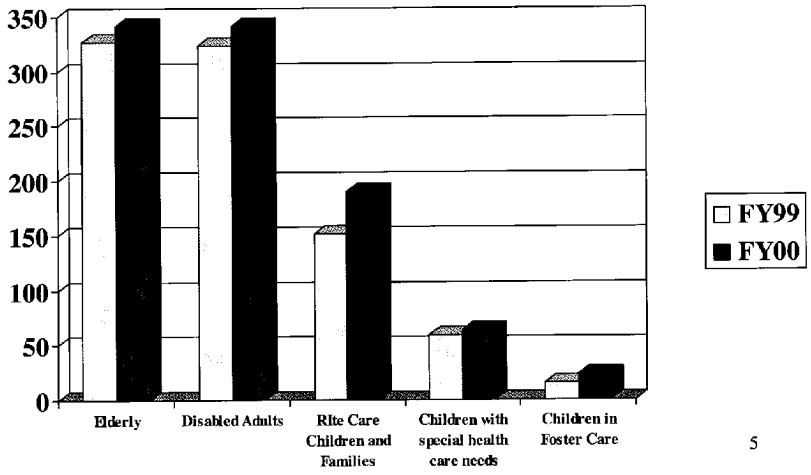
History of RI Statewide Medicaid Expenditures

Percent Change from Prior Year

FY 2002 DHS Adjusted General Revenue Growth = 8.0%

Fiscal Year	Rhode Island	United States
1997	7.8 %	11.2 %
1998	4.0 %	5.9 %
1999	7.6 %	6.1 %
2000	12.5 %	7.1 %
2001	18.0 %	6.6 %
2002	4.2 %	7.7 %

RI Medicaid Expenditures by Population, FY99 & FY00



5

Major Trends SFY 01 – SFY 02
RI Medical Assistance Program

- Elderly represents 12% of caseload and 38% of expenditures.
- Adults with Disabilities represents 14% of caseload and 22% of expenditures.
- Children and Families represents 74% of caseload and 40% of expenditures.

Major Trends SFY 01 – SFY 02
RI Medical Assistance Program

Dually Eligible Population-Eligible for both Medicare and Medicaid

- Approximately 25,000 persons:
- Representing 14% of Medicare caseload and 31% of Medicare costs.
- Representing 18% of Medicaid population and over 55% of Medicaid costs.

Drivers of Medicaid Expenditures

- Increasing pharmaceutical prices and utilization – at 16 percent per year.
- Increasing managed care enrollment - estimated at 21 percent over two years.
- Increasing enrollment for Children with Special Health Care Needs-estimated at 13 percent over two years.

Drivers of Medicaid Expenditures

- 1.34 percentage point decrease in FMAP from 53.79 to 52.45.
- 14% annual increases for behavioral and rehabilitative services for SSI Children.
- Increasing enrollment for Children with Special Health Care Needs estimated at 13.0 percent over two years

9

Drivers of Medicaid Expenditures: Dual Eligible Population

- RI is experiencing double digit growth in home health services, which appears to be driven by substitution from the recent loss of services from Medicare.
- Medicaid Home Health Services are increasing by over 25% in the current year
- Medicare Part B premium increased (10% Jan 01).
- Decreasing demand for Medicaid nursing home days by approximately 1.5% per year.

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Drivers of Medicaid Expenditures: Capacity Issues of Epic Proportions

- CNA shortage in hospitals & nursing homes.
- Reimbursement levels not keeping up with private health insurance and Medicare reimbursement.
- Physicians fed up with dealing with insurers and government.
- Utilization has shifted from hospitals and ER to primary care settings.

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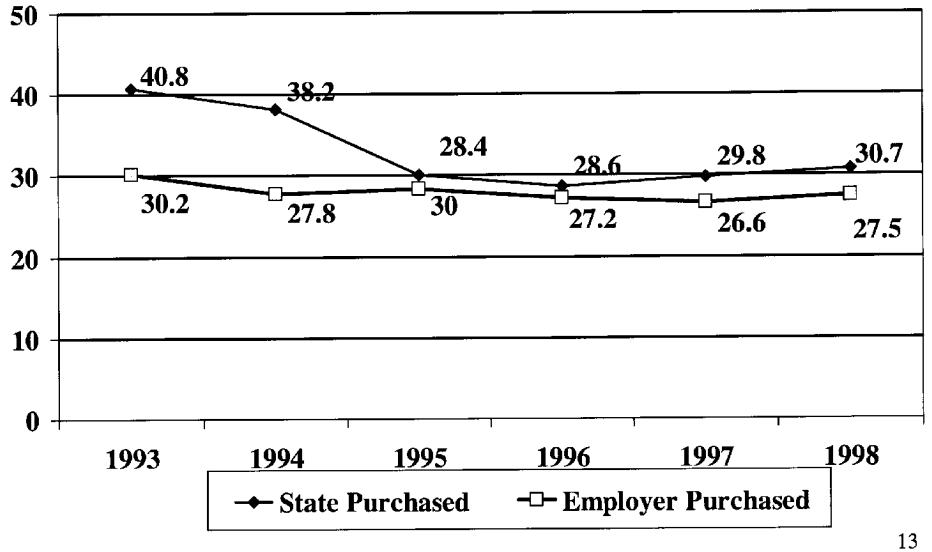
Lessons Learned: Outcomes-Health Status

- Managed Care improves access to high quality and appropriate care.
- Low-income and middle-income families use health care the same way.
- Health status will improve dramatically once a person is covered.

12

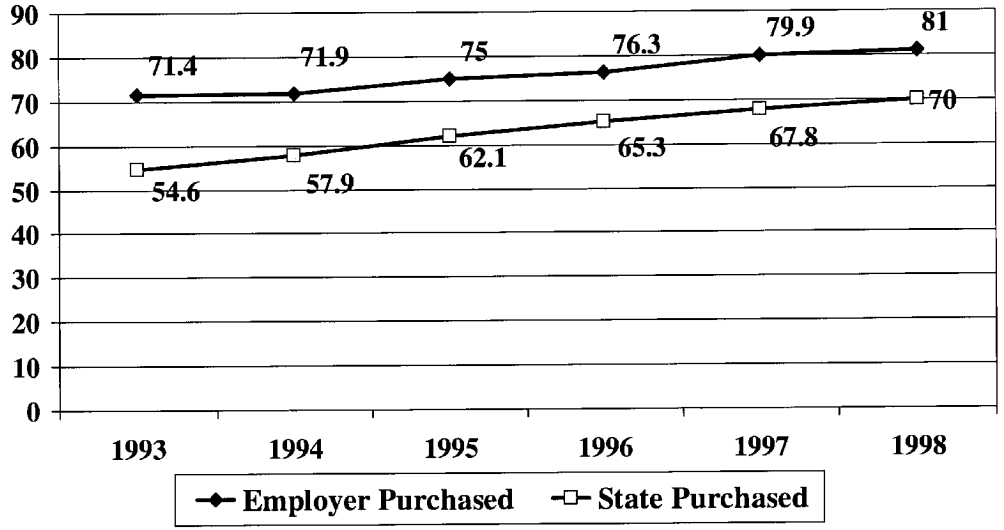
Percent Of Women With Short Interval Between Births (<18 Months) by Insurance Status 1993-1998



13

Vital Statistics Birth File-(n=75,642)

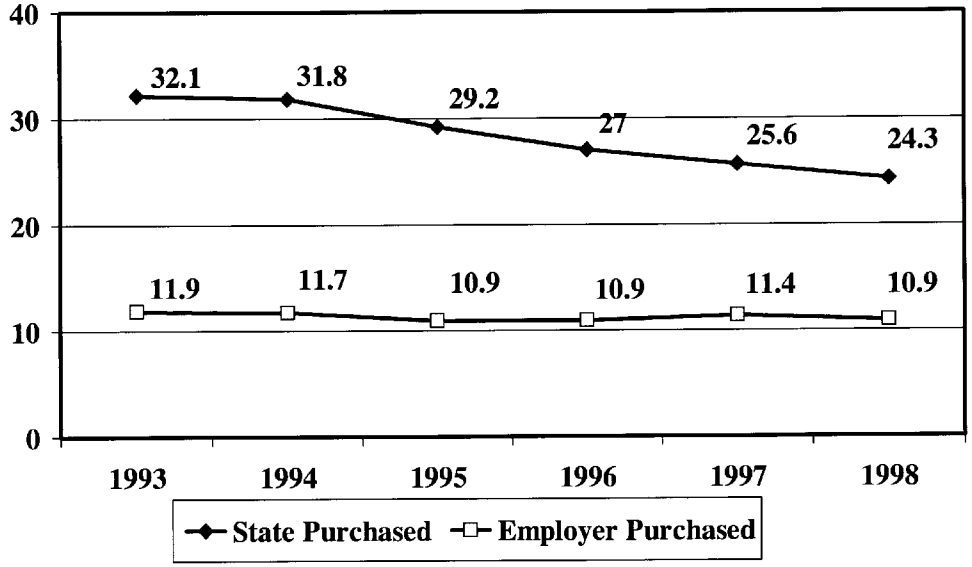
Percent of Women with Adequate Prenatal Care by Insurance Status 1993-1998



14

Vital Statistics Birth File – (n=75,642

Percent of Pregnant Women who Smoke Cigarettes* by Insurance Status 1993 - 1998



Vital Statistics Birth File – (n=75,642) = self-report*

Lessons Learned: Contracting Arrangements

- Risk based capitation using age and gender
- Fixed payment for births (SOBRA)
- Direct payment for Neonatal Intensive Care (NICU)
- Risk share agreement with Health Plan based on medical expenses
- Stop-loss for mental health and substance abuse services, long term care, organ transplant

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Lessons Learned: Administration - Budget

- Changing process will affect enrollment.
- Medical Necessity Definition does not cost.
- No day limits for alcohol and substance abuse does not cost.
- Purchasing has to be done with an eye toward capacity – Not everything should be risk based.
- Have to pay plans an adequate rate that is market based.
- Data is essential constant re-evaluations are necessary.
- Adjustment is constant no matter how good your coverage is.
- Market changes will affect enrollment
- HCFA does not have to be the enemy.

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PREPARED STATEMENT OF HON. CHARLES E. GRASSLEY

[MARCH 13, 2001]

Today's hearing is the first in a two-part series to tackle the issues facing the 42 million Americans who go without health care coverage today. This is a hefty task, but it deserves our full attention. Specifically, the purpose of today's hearing is to understand who we are talking about when we say "uninsured Americans." To do this, we need to understand the special circumstances that contribute to the status of being uninsured. Age, ethnicity, employment status, and geographic location are some of the key factors.

No one will argue that it is unacceptable for 42 million Americans to go without health care coverage. For most of us, quality health care is an expectation. Whether it's regular check-ups or visits to specialists, it is often easy to take our health care coverage for granted. But we must remember that millions of Americans and their families are not so lucky.

Many individuals and families struggle to stay healthy with little or no access to health care services. We are fortunate that our nation has invested mightily in achieving the best health care system in the world. As a result, health care practitioners across the country are treating millions of Americans every day with the most advanced technology and science. And, Americans are experiencing longer, healthier lives than ever before. But we cannot settle with having a world-class health care system that leaves 42 million Americans behind.

In recent years, Congress has been working in incremental ways to ensure that Americans have access to affordable, high-quality health care. We can look at successes such as the State Children's Health Insurance program and know that three million more children are now getting the health care coverage they need and deserve. The passage of Kassebaum-Kennedy in 1996 was an important step toward ensuring continuous health coverage. Barriers to health care have finally been removed for adults with disabilities who want to work but feared losing health coverage. And low-income women who suffer from breast cancer now have access to treatment. These incremental improvements have made a big difference in the lives of millions of Americans. But there is a great deal of work still to be done.

The task before us today is to learn more about our nation's uninsured population so we can continue down the road toward finding solutions. We have joining us a panel of experts who understand the intricate details of the uninsured population. I thank all of you for your participation this afternoon. As we will hear in their testimony, the uninsured population is extraordinarily diverse, and its members face many different challenges in finding health care coverage.

Later this week, the committee will convene for a second hearing on the uninsured. At that time, we will turn our attention to studying possible solutions. I look forward to continuing a dialogue in this committee about the uninsured and invite my colleagues to work together to find solutions.

PREPARED STATEMENT OF HON. CHARLES E. GRASSLEY

[MARCH 15, 2001]

Today's hearing is the second part of a two-part series focusing on the problem of 42 million uninsured Americans. The goal of the first hearing was to better understand the diverse characteristics and needs of the uninsured. We achieved that goal. A panel of five expert witnesses presented well-documented testimony that highlighted specific issues such as age, ethnicity, socio-economic status, and type of employment as some of the key factors that contribute to un-insurance.

The goal of today's hearing is to take the next step and begin to identify solutions. As we head down this path, it will be critically important for us to keep in mind that there is no one-size-fits-all solution to this problem. Instead, we must think about incremental changes for the different populations that make up the uninsured.

President Bush has already put forth a series of incremental options that would help millions of uninsured individuals and families gain health coverage. We know that over 70 percent of uninsured adults are employed but still go without health coverage. The President's proposal to offer a refundable tax credit would help this working population tremendously. In fact, my colleagues on this committee, Sens. Jeffords, Breaux, Snowe, and Lincoln, have also spent a great deal of time working on individual tax credit options as well. I thank them for their leadership.

The President's proposal also encourages states to utilize state flexibility to improve outreach and enrollment efforts to cover millions of adults and children who may already qualify for existing federal health programs but are not enrolled. As

we will hear today, effective outreach efforts can go a long way toward reaching the number of uninsured. Options such as streamlining the application process and reducing paperwork burdens on families are common-sense ways to make these programs more accessible.

Overall, there are many different ideas that we must explore. It is my hope that we continue to press forward on this critical issue, but that we also do so in a sensible fashion. Clearly, programs such as Medicare, Medicaid and the State Children's Health Insurance program are integral to our nation's health care system. However, there are limitations in the role these programs can play in meeting the needs of the uninsured population. First and foremost, we should examine these existing programs and find ways to strengthen and preserve them.

Our efforts to address the needs of the uninsured population should be guided by two principles: 1) supporting innovative efforts by the states to address state-specific health coverage needs and 2) bolstering and revitalizing the private employer-sponsored market. Trends have shown that more and more Americans rely on employment-based health coverage. In addition, a large part of the reduction in the uninsured in the past few years is a direct result of increased employer-sponsored insurance. We must be careful not to act in any way that would have an adverse impact on our employer-based system.

Before closing, let me just say that I am encouraged by the strong, bipartisan will to find a solution. There are many ideas before us, and I look forward to working with our President and my colleagues to reach success on this issue this year.

PREPARED STATEMENT OF MARY R. GREALY

Good morning, Chairman Grassley, Senator Baucus, and members of the committee.

I want to thank you on behalf of the Healthcare Leadership Council for the opportunity to testify today, and to commend this committee for giving the issue of the uninsured the attention it both needs and deserves. I would also like to commend the members of this Committee who have introduced or co-sponsored legislation that would make health insurance coverage more accessible to more Americans.

I am Mary Grealy, President of the Healthcare Leadership Council. HLC is a coalition of chief executives of the nation's leading health care companies and institutions. The purpose and vision of the Healthcare Leadership Council is to build a consumer-centered, market-based health care system that is accessible, that is affordable, that fosters innovation and that offers the highest quality health care to all patients and consumers.

Consistent with this vision, the members of the HLC have made accessible health care coverage for uninsured Americans our organization's highest priority. Over the past year, we have commissioned in-depth studies to understand the makeup of the uninsured population, to better understand how to target effective policy solutions. We have surveyed the nation's small business owners particularly those who do not currently offer health insurance coverage to their employees to understand who is and who is not offering insurance, and to understand the reforms needed to make health insurance a viable option. We have examined dozens of programs taking place throughout the country, innovative initiatives that are striving to make coverage accessible.

Today you have requested specifically that I address the characteristics and experience of populations that are most at risk for being uninsured. The Healthcare Leadership Council sees the lack of insurance as a multifaceted problem requiring diverse solutions. We believe that everyone, regardless of employment or income status, should have access to affordable health insurance. Because so many of the uninsured are connected with the workforce, where most Americans receive their health coverage, we have focused on employer insurance or the lack thereof.

First let me address the issue of the importance of health care coverage, and differentiate health care coverage from health care access. All Americans have the guarantee of access to health care in an emergency regardless of insurance status, and most of the nation's uninsured can find basic care for acute health care needs through community and charity health care programs. However, it has been well documented that charity care, public hospitals, and other safety net programs do not adequately substitute for health coverage and that individuals who are not covered by a health insurance policy are greatly disadvantaged in terms of comprehensive health care quality compared with those covered under a health plan through their employer, a government insurance program (Medicare, Medicaid, S-CHIP), or other source of insurance.

While much has been said about where the U.S. health care system ranks in comparison to other countries using various criteria, there is no question that the world's greatest health care innovations are produced in this country. People who receive health care through charity care programs and the like are less likely to have the advantages of the latest innovations in health care technology and research.

A study funded by the American College of Physicians and published in the Journal of the American Medical Association found, among other things, that uninsured women aged 50 to 64 were three times less likely than insured women of the same age to have received a mammography or clinical breast exam, and of the long-term uninsured, nearly 70 percent of those in poor health and nearly 50 percent of those in fair health reported not seeing a physician when needed within the last year due to cost.[1] The American College of Physicians also found that uninsured Americans are three times more likely than the insured to experience an avoidable hospitalization for diabetes and other chronic diseases.

The Kaiser Commission on Medicaid and the Uninsured found that the uninsured with various forms of cancer are more likely to be diagnosed with late stage cancer, and that death rates for uninsured women with breast cancer are significantly higher compared to women with insurance.

These compelling findings on the consequences of uninsurance demonstrate the urgent need for measures that will substantially reduce the number of those without access to health coverage in this nation. But as this committee has astutely recognize, in order to cost-effectively target such measures, we must first understand the demographics of the uninsured.

EMPLOYMENT AND THE UNINSURED: EMPLOYMENT STATUS IS CRUCIAL

Despite an unprecedented term of growth in the nation's economy, the number of uninsured continues to climb.[2] To help explain the conundrum of increasing employment and prosperity along with decreasing rates of health coverage, HLC recently commissioned an analysis by The Moran Company of existing data on the uninsured (See attachment 1).

Not surprisingly, we found that the factors determining whether or not an individual will be uninsured are many and varied. They include age, geographic region, family structure, employment status, income, firm size, and more. However, these factors are weighted very differently. For example, the industry sector within which an individual works has only a minor impact on whether or not he or she is insured. Whereas the type of family structure an individual is part of and whether or not someone in that family is employed plays the most important role in determining whether or not that person will be insured.

To further illustrate this, our study looked at how many individuals working in industries least likely to offer insurance actually receive insurance coverage through another family member. For instance, 77 percent of individuals working in the agriculture, forestry, and fisheries industry are not offered coverage by their employer. But 60 percent of these uncovered agriculture, forestry and fisheries workers are covered by an insurance policy of another family member. Likewise, 53 percent of those in the sales industry sector are not offered insurance but 60 percent of those uncovered workers in sales are covered elsewhere as well. That is to say that many spouses and younger adults are able to accept jobs without an offer of insurance because they live within a family where one member works for an employer who offers family coverage. As our report states, "the growing number of multi-earner families has a powerful mediating effect on the relationship between employment status and health insurance coverage." This data also helps to explain why a significant number of the uninsured are single adults.

Employer-offered health insurance has been, since its inception, primarily responsible for ensuring coverage for Americans under the age of 65. While our study showed that 47 million Americans are indeed uninsured[3], it also showed that 161.2 million individuals within the non-Medicare population are insured through their employer or a family member's employer, and only 21.8 million are insured through non-employer sources. An alternative way to look at this is that 19 percent of those

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[1] *"Unmet Health Needs Among Adults," JAMA*, October 24, 2000, funded by the American College of Physicians—American Society of Internal Medicine.

[2] While the March, 2000 Current Population Survey (CPS) (issued in September, 2000) showed a reverse in the 12-year trend of increasing uninsured, a trend of decreasing uninsured has yet to be established pending the next annual issuance of the CPS.

[3] Data used is from the Medical Expenditures Panel Survey (MEPS). Estimates of the uninsured may vary due to differences between data obtained from the MEPS versus data obtained from the Current Population Survey and other data banks.

with at least one employed member in their family are uninsured, while 30 percent of those in families with no one employed are uninsured (the other 70 percent are insured mostly through safety net programs such as Medicaid).

We have focused on the millions of individuals connected to the workforce who are still uninsured. In fact, more than 70 percent of the uninsured are in a family with at least one worker. These individuals can be divided into two main subgroups: (1) individuals in families where a worker is offered insurance but the offer is declined (for the worker or dependents), and (2) individuals in families where there are workers but no offer of insurance from an employer.

Employed with an offer of insurance that is declined: One of our most striking findings was that over 16.7 million people, or more than one-third of the uninsured, are in families where at least one family member has been offered employer coverage but has turned it down. According to our research, the "decliners" of employer health insurance predominantly decline coverage for their families, not themselves. This is most likely because many employers charge higher premiums and cost sharing for dependents than for the actual employees.

Declining an employer's offer of insurance is more common among low-wage workers in smaller firms where more of the premium cost is passed to the employee. In such cases where dependents go uncovered in families with low-wage workers, the employee is often unaware that his or her dependents may be qualified for enrollment in a State Children's Health Insurance Program (S-CHIP) and thus need not go uncovered.

HLC recently enlisted the public opinion firm, American Viewpoint, to survey 500 small business owners (90 percent of whose firm size was 50 and under) throughout the country to help us understand their attitudes toward health coverage (see Attachment 2). Our survey of small employers found that only 58 percent of small businesses offering insurance extended the offer to their employees' dependents as well. And the majority of companies surveyed confirmed that they charge a higher premium for dependent coverage than for employee coverage.

Employed but no offer of insurance: Despite the fact that the cost of health insurance is increasing, there is little sign that employers are dropping health care coverage for their employees[4] *or requiring employees to pay an increasing share of premiums.*[5] *Even so, HLC's study found that 17.3 million or 36.8 percent of the uninsured are in families with at least one worker but no employer offer of coverage.*

There are many reasons some employers do not offer coverage. Small businesses (less than 100 employees) are far less likely to offer health insurance than larger companies. A small business survey conducted last year by the Employee Benefit Research Institute, et al. found that 53 percent of small businesses not offering insurance cited affordability as a major reason preventing such an offer. Interestingly, the same survey found that 57 percent of small employers do not know that health insurance premiums are 100 percent tax deductible.[6] This strongly indicates that perhaps a lack of information and education contribute in some way to the inability or unwillingness of small business insurance offerings.

HLC's small business survey found that many companies that do not now offer health coverage would begin to do so if premiums were reduced or subsidized by as little as 10 percent, although many would require as much as a 25 percent subsidy. However, two out of three employers surveyed who do not offer insurance said that they will continue that practice if no public policy changes are made to reduce the cost of insurance. One concern raised by the survey is the fact that a significant number of small employers will likely drop their coverage if their health insurance premiums rise by 10 percent in the near future.

Another study, conducted for HLC in 2000 by the George Washington University Center for Health Services Research and Policy, and Health Policy R&D, looked at how various communities and employers are expanding coverage for working families. These local programs, although small in scale, have proven themselves as excellent laboratories on this issue. They provide crucial information on what is necessary to encourage small employers and individuals to participate in coverage programs. For example, an insurance program in Wayne County, Michigan, named HealthChoice, 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 sub-

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[4] March 2000 CPS reported that employment-based coverage increased from 62 percent in 1998 to 63 percent in 1999.

[5] A survey by the Kaiser Family Foundation found that there was a slight reduction between 1996 and 2000 in the percentage of the premium that workers were required to pay.

[6] EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

sidized by the county government. These programs give us real-world examples of what level of financial support is necessary to make health insurance a feasible reality for Main Street businesses.

CONCLUSION

Mr. Chairman, what I have presented today are some observations and characteristics of the working uninsured as you have requested. Our research has helped us to better understand the barriers to insurance so that we can begin assisting you in breaking down those barriers.

Some conclusions from our work are summarized by the following:

- Our studies have found that the makeup of the uninsured population the fact that more than seven of every ten persons without health coverage lives in a household in which at least one family member is employed demonstrates that we have an existing framework within which we can effectively address this challenge. In fact, the latest Census Bureau data on employer coverage confirmed that employer-provided health insurance was the driving factor that caused uninsured rates to drop in 1999.
- The owners of America's small businesses the people who face the greatest challenge in providing health coverage to their employees want to offer insurance to their employees, have a strong desire to provide that coverage, and believe that solutions are within reach. Our survey of small employers told us this, and it also revealed that if we don't move toward solutions in the near future, a significant number of small businesses who currently offer health insurance will succumb to economic pressures and will cease to do so.
- Finding answers to the challenge of the uninsured is essential, not only for the uninsured but for the nation's health care system as a whole. America's health care providers are carrying a heavy financial burden created by uncompensated care, and this burden cannot continue to grow in size without serious damage to the nation's health care system, the people who provide care, and those who receive that care.

HLC has proceeded beyond these observations in discussing fundamental solutions targeted toward the various cohorts of the uninsured. Most of these solutions are market-based and would build upon the employer-based health insurance system that most Americans enjoy today. We would welcome the opportunity to share with this committee these recommendations for finding solutions for the uninsured. The Healthcare Leadership Council is encouraged that there appears to be a renewed willingness by both political parties to dedicate some of the nation's prosperity to resolving this important public policy issue. We urge you to take advantage of this recent momentum and pass legislation early in the 107th Congress to help end the crisis of the uninsured. This must be our national priority for 2001.

Thank you for the opportunity to share HLC's views today. We stand ready to assist this committee in any way as you work toward solutions that will allow all Americans to enjoy the benefits of our nation's health care system.

Attachment 1

Rethinking the Problem of the Uninsured: Obstacles to Coverage & Policy Options

Prepared for:

HEALTHCARE LEADERSHIP COUNCIL

July 18, 2000

THE MORAN COMPANY

Executive Summary

The problem of the uninsured has continued to grow even in an environment of unprecedented prosperity in America. Despite concentrated efforts by policymakers over the last quarter century, this problem has proven intractable as comprehensive solutions have proven politically elusive.

In order to analyze the uninsured, the Healthcare Leadership Council engaged our assistance in analyzing the available data on the causes of uninsurance, and recommending possible approaches to employing cost effective, market-based solutions to materially reduce the number of uninsured Americans.

At a high level, the problem we face is that - as this paper will attempt to demonstrate - a substantial majority of the Americans who are chronically uninsured suffer this condition precisely because they live in circumstances that make attachment to the mainstream private health insurance difficult. These circumstances, however, are many and varied, making any "one size fits all" solution impractical. For example, those whose uninsurance is a result of unemployment should not be addressed with the same public policy as those who are employed with an offer of insurance which they decline because of cost concerns.

Our analysis makes clear that there are two key factors in solving the problem of the uninsured: (1) accessing some form of group coverage, and 2) accessing the financial resources to make it possible to elect coverage. ***Given these findings, it is likely that a significant share of the uninsured can be reached by market-based approaches.*** The efficacy and cost effectiveness of these approaches will, however, depend on careful targeting of subsidies, such as tax credits.

Conventional wisdom holds that insurance coverage is highly correlated with the nature of the industry in which individual workers are employed. This superficial analysis misses the *single most important determinant of health insurance coverage*: ***the intersection between employer-based coverage and family structure.*** The availability of group coverage through at least one employed family member, rather than the industry of employment of any employed individual family member, determines whether or not the great majority of Americans in families with employment are insured or uninsured.

Fifty-six percent of the uninsured lack access to employer-based coverage. Of this group, 17.3 million, or 36.8 percent of the uninsured, were in families with at least one employed family member, but no offer of employer-provided insurance in 1996. The fact that these 17.3 million individuals are already in families where at least one individual is employed – i.e. associated with a pre-determined group that could be targeted for group coverage – potentially makes this group a particularly cost-effective one to address with market-based public policies such as refundable tax credits.

Clearly, the uninsured population likely to be reached most cost-effectively through market-based solutions are those uninsured who are members of a group ***and*** who are also offered – albeit decline – an employer subsidy. According to the most recent MEPS data, 16.7 million individuals – or fully *one third of all uninsured Americans* – are in families where an offer of

group coverage exists, but is declined. This group is potentially the most cost-effective group to target with tax subsidies because the cost of insuring them is offset by both the fact that they are already in a group and the fact that they are offered an employer subsidy.

Policy options previously evaluated for stimulating coverage for the group of uninsured declining an employer offer have failed to gain widespread support due to concerns about "crowd-out" effects – i.e. public program subsidies replacing existing private resources currently being devoted to coverage. While our analysis concludes that crowd-out is a material concern in this population, we conclude that technical options are available to minimize or eliminate concerns about crowd-out for a significant share of this population.

As for individuals in working families with no offer of employer-based insurance, crowd-out is less of a concern because there are no current employer subsidies to displace. For the lowest-wage workers, however, it is important to be realistic about what can be accomplished without investing substantial resources to finance a significant share of the full cost of coverage.

Even in an environment of projected Federal surpluses, policymakers remain cautious about major new program commitments. Given what we know about the political and fiscal constraints that limit feasible public approaches to this problem, a variety of solutions incorporated incrementally as funding is available will be necessary in order to make visible progress in reducing the number of uninsured Americans.

Introduction

The problem of the uninsured has continued to grow even in an environment of unprecedented prosperity in America. Despite concentrated efforts by policymakers over at least the last quarter century, this problem has proven intractable as comprehensive solutions have proven politically elusive.

In order to analyze the uninsured, the Healthcare leadership Council engaged our assistance in analyzing the available data on the causes of uninsurance, and recommending possible approaches to employing cost effective, market-based solutions to materially reduce the number of uninsured.

At a high level, the problem we face is that – as this paper will attempt to demonstrate – a substantial majority of the Americans who are chronically uninsured suffer this condition precisely because they live in circumstances that make attachment to the mainstream private health insurance very difficult. These circumstances, however, are many and varied, making any "one size fits all" solution impractical. Given what we know about the political and fiscal constraints that limit feasible public approaches to this problem, it is likely that a variety of different solutions will be needed in order to make progress in reducing the number of uninsured Americans.

This paper examines some of the reasons why people are uninsured, giving an overview of the populations that any solution to the problem of uninsurance must seek to target. Our analysis of the data in this area suggests that these issues are more complex than is often recognized. Our most important finding is that intersection between offers of employment-based insurance and family structure is the most crucial determinant of whether an individual has insurance. Many more persons have access to group coverage through a family member's employer, than there are employees with a direct offer of coverage. Even considering this access to employer-based coverage, many persons remain uninsured because they cannot afford to pay – by their own individual judgments – whatever incremental premium amount is required to provide continuous coverage for themselves and their dependents.

We describe some of the issues with finding market-based solutions to the problem without massive government intervention or involving extremely large federal outlays. We find that an eclectic mix of market-based approaches may be necessary to effectively address this problem. A mixture of tax credits, insurance market reforms, and more effective use of existing public program resources will be needed, and we describe some of the ways that these efforts should be targeted to make the best use of healthcare resources.

Characteristics of the Uninsured

As the policymakers who have attempted to solve this problem of "uninsurance" have recognized, its causes are many and varied. Notwithstanding this fact, the policy debate over at least the last quarter century on this subject has tended to proceed from the presumption that "uninsurance" was a homogeneous problem. There has been a strong tendency in the policy

debate to treat uninsurance as a common pathology of those afflicted with this status. While the sociological motives for this viewpoint are understandable, treating "uninsurance" as an undifferentiated pathology masks important lessons that can be learned by treating "uninsurance" as phenomenon whose *population incidence* varies materially across different socioeconomic groups.

The findings of the research we present in this paper suggest strongly that the best—and most targeted—mix of solutions to effectively address this problem will require a sophisticated understanding of the reasons for uninsurance. While the *social consequences* of uninsurance may be relatively homogenous, the *socioeconomic conditions* affecting the *probability of being uninsured* vary materially. Our research suggests that finding an appropriate balance between market-based and governmental solutions to this problem will benefit materially from a rigorous effort to understand these underlying population dynamics.

In order to analyze these issues, the Healthcare Leadership Council engaged our assistance in analyzing the available data on the causes of uninsurance, and recommending possible approaches to employing market-based solutions to materially reduce the number of uninsured Americans. We have based this analysis on what we believe to be the best source of detailed information on these issues – the newly released Medical Expenditure Panel Survey (MEPS) from the U.S. Department of Health & Human Services.[1] While the most recent version of these data are, at present, approximately four years old, the richness of detail they permit us to analyze is substantially greater than the limited survey information for which materially more recent information is available. While the Current Population Survey (CPS) offers more recent estimates of the count of the uninsured, the underlying detail of this survey do not permit the sort of detailed analysis presented in this report.[2]

Family Structure Matters More Than the Industrial Sector of Employment

While our detailed analytical findings are reported below, we believe that it is important to lead our presentation of these findings with the critical new lesson we have learned from the MEPS data: that *family structure has a critical mediating effect on the relationship between employment and health insurance.*

The system of health insurance in the United States is largely employer-based. Not unreasonably, many prior analyses of uninsurance have focused on the difference in incidence of employment-based insurance across different segments of the employed population. As a result of this focus, uninsurance is commonly understood as an "industrial sector" issue:

[1] We used the 1996 Medical Expenditure Panel Survey (MEPS) available at http://www.meps.ahrq.gov. This dataset provides the broadest array of descriptive characteristics. Using other health insurance survey datasets will result in slightly different numbers due to survey methodology differences. For a detailed description of our analysis and methodological issues see the Appendix.

[2] While the full survey data we draw on is complete only through December, 1996, the prospect that these data will be continually available thereafter in a longitudinal panel make it important to benchmark any current work in this field to this new standard. Readers are cautioned that the MEPS count of the uninsured for December, 1996 – from which we benchmark our population-based analysis – was approximately 47 million, versus the estimate of roughly 44 million in the CPS for 1996. Please see the data Appendix for further discussion of this issue.

- "Insured sectors", e.g., learned professions and unionized industries, are perceived as "fonts of health insurance."

- "Uninsured sectors", e.g., retail trade and services, are perceived to be chronic problem areas requiring remedial efforts by government.

Our research suggests that reality is much more complex. The conventional wisdom assumes that the rate at which health insurance is offered to employees, by industry, is the single biggest predictor of whether individuals employed in that industry (and their families) will be privately insured. This superficial analysis misses the *single most important determinant of health insurance coverage*: ***family structure***. The presence or absence of employer offers to any worker in a family – and not industry of employment of any one family member – determines whether or not the great majority of Americans in families with employment are insured or uninsured.

Workers are part of families, and insurance coverage is typically available both for individuals and for families. In fact, 98% of employers that offer health insurance coverage offer family coverage in addition to individual coverage.[3] As a result, many individuals in families have access to group insurance through a family member's employment. For many husbands working in gas stations, wives working at General Motors provide health insurance (and, of course, vice versa). The growing number of multi-earner families has a powerful mediating effect on the relationship between employment status and health insurance coverage. Exhibit 1 illustrates this concept.

Exhibit 1
Family Structure and Offer Rates

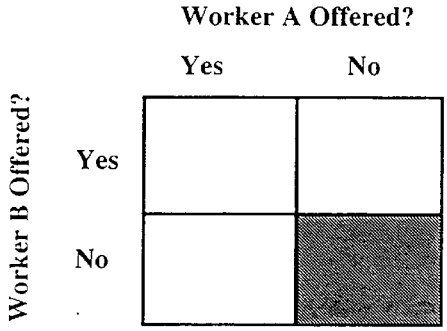
Consolidated Industry Code	Percent of Workers Not Offered Coverage	Percent of Non-Offered Workers Covered Elsewhere
1 AGRICULTURE, FORESTRY, FISHERIES	77.1%	60.0%
2 MINING	23.2%	38.0%
3 CONSTRUCTION	59.3%	47.0%
4 MANUFACTURING	20.8%	60.0%
5 TRANSPORTATION, COMMUNICATION, UTILITIES	25.0%	50.0%
6 SALES	53.0%	60.0%
7 FINANCE, INSURANCE, REAL ESTATE	22.9%	72.0%
8 REPAIR SERVICES	54.6%	53.0%
9 PERSONAL SERVICES	72.6%	53.0%
10 ENTERTAINMENT & RECREATION	67.5%	68.0%
11 PROFESSIONAL SERVICES	34.3%	73.0%
12 PUBLIC ADMINISTRATION	11.2%	62.0%
14 ACTIVE MILITARY	36.9%	82.0%
Total	**38.7%**	**60.7%**

Moran Company analysis of 1996 MEPS Data

[3] Long, Stephen and Marquis, Susan. Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997. *Health Affairs* 18:6 November/December 1999 p133-139.

Over 60 % of workers that are not offered coverage from their employer get coverage elsewhere[4]. Workers that remain uninsured are either single, or in multi-worker families where both workers are in jobs that do not involve coverage. These findings imply that, to insure such individuals, only one of their employers would have to make an offer of insurance, and they would have to have the resources necessary to accept that offer for themselves and their families. As Figure 1 suggests, Americans in two-worker families are likely to have access to coverage unless both workers are employed in jobs that don't offer coverage.[5]

Figure 1



Because of the striking effects of family structure on insurance status, we focused our analysis on groupings of individuals within families, and analyzed the role of employment status and offer of insurance at the family level (not at the level of an individual worker). We also excluded persons covered by Medicare from our analysis, since by definition this segment of the population is already universally insured.

Employment Status Matters

Most individuals have health insurance through their own employer's plan or that of a family member's employer. Thus, it is often argued that uninsurance is a factor of employment; that is, the unemployed are much more likely to be uninsured than the employed. This is shown in Exhibit 2 below. Persons in families with at least one family member employed are shown as an employed family. We calculated within each group the "probability of uninsurance," that is the rate of uninsurance for persons in that group.

[4] The concept of insured status we employ in this analysis includes enrollment in public insurance programs.
[5] Our findings suggest the incidence of employment-based health insurance in multi-worker families is a two-dimensional parlay, whose payoff is based on the joint probability of employment of both workers in industries with low incidence of coverage. Given the magnitude of the effects we have estimated, we believe that further focused research on this phenomenon is clearly warranted.

Exhibit 2
Probability of Uninsurance
By Family Employment Status
Among Non-Medicare Population
(in millions)

Persons in families:	Insured	Uninsured	Total	Percent of the Uninsured	Probability of Uninsurance
With at least one member employed	161.2	37.7	198.9	80.2%	19.0%
With no members employed	21.8	9.3	31.1	19.8%	30.0%
Total Non-Medicare Population	*183.0*	*47.0*	*230.0*	*100.0%*	*20.5%*

While overall 20% of the non-Medicare population is uninsured, lack of employment is a major determinant of the probability of uninsurance. When broken down by employment status we find that 37.7 million people, or 19% of persons in families with at least one employed member are uninsured; while 9.3 million persons, or 30%, of persons in families with no one employed are uninsured. Obviously, persons in families in which no one is employed lack insurance more than 50% as frequently as those in which there is one or more wage earner. Importantly, however, nearly 70% of individuals in families with no employment have some form of insurance through "safety net" mechanisms.

The Presence of An Employer Offer of Insurance is Crucial

One crucial determinant of insurance status is whether there is an offer of insurance from an employer.[6] While this is a self-evident statement, the numbers we found were quite striking. In fact, 17.3 million (48.5%) of the 35.7 million persons in families with at least one employed family member – but no offer of employer-provided insurance – were uninsured. This means that individuals in these families were more likely to be uninsured than individuals in families where no one is employed. The 9.5 million persons in families where the only employed member(s) are self-employed also had a high rate of uninsurance, 38.8%. Exhibit 3 below presents the results of this analysis.

[6] Offer of insurance is defined as a situation in which the employer offers insurance for which the individual employee is eligible. It is important to note that this offer, while commonly subsidized, does not necessarily mean the insurance is without cost to the employee.

Exhibit 3
Breakdown of Persons in Families with One Member Employed By Offer Status
(in millions)

Persons in families with:[1]	Insured	Uninsured	Total	Percent of the Uninsured	Probability of Uninsurance
At least one member employed with an offer	137.0	16.7	153.7	35.5%	10.9%
A member employed, but with no offers	18.4	17.3	35.7	36.8%	48.5%
Only self-employed members	5.8	3.7	9.5	7.8%	38.8%
Total	*161.2*	*37.7*	*198.9*	*80.2%*	*19.0%*

[1] These are mutually exclusive categories. Families were assigned to one of these categories in the order shown, even though a family may have members in more than one category.

Essentially, this high rate of uninsurance among working families is due to the disqualifying effect of earned income on public program participation. We expect that the recently implemented State Children's Health Insurance Programs (SCHIP) will have mitigated this problem for children somewhat, but that effect will not become apparent until 2000 data are available. The SCHIP program does not, however, address the adults within this group.

Persons in families with employees but no offer of coverage represent a core problem: 17 million persons, 36.8% of the uninsured, fall into this group. Add persons in families where the only worker is self-employed and the number increases to 21 million uninsured persons, 44.6% of the uninsured. These are persons in working families with no access to employer-sponsored group insurance. However, given their attachment to the workforce and more importantly those with a connection to an employer, solutions aimed at expanding offering of group coverage may have some positive effect.

Fully One Third of Uninsured Persons are in Families Where at Least One Member has an Employer Offer

Despite the importance of an employer offer in determining insurance status, a significant percentage of the uninsured have at least one employer offer of insurance. Those that are employed and have offers of insurance but remain uninsured comprise **the population that can be most cost effectively targeted as part of an incremental solution to the problem of the uninsured.** Our analysis found that where there is an offer of employer-provided health coverage, uninsurance is highest among dependants, not employees. Exhibit 4 below illustrates this point.

Exhibit 4
Breakdown of Persons in Families with at least one Member with an Employer Offer By Employee/Dependant Status
(in millions)

	Insured	Uninsured	Total	Percent of the Uninsured	Probability of Uninsurance
Employee w/offer	70.2	4.5	74.7	9.5%	6.0%
Dependants[1]	66.8	12.3	79.1	26.0%	15.5%
Total	*137.0*	*16.7*	*153.7*	*35.5%*	*10.9%*

[1] This includes employed family members with no offers and self-employed family members in addition to unemployed members.

As previously shown, 10.9% of persons in families with one or more offers are uninsured (compared to 46.5% of families with no offers). A more detailed analysis shows that "decliners" predominantly decline coverage for their families, not themselves. Looking at the insurance status of the members in families with one or more offers, we find that only 6% of employees with offers are uninsured, while 15.5% of dependants are uninsured. This may reflect the higher premiums and cost sharing requirements that are often placed on dependant coverage. **While the rate of uninsurance is small compared to other populations, the number of uninsured persons this represents is large, about 16.7 million people, more than a third of all the uninsured.**

Within the 15.5% of dependants that are uninsured in this category, dependants who are employed and have no offer from their own place of work are uninsured 24.4% of the time, much higher than for unemployed or self-employed family members. Dependent children in this category are uninsured 11.3% of the time. Since this analysis is based on data collected before the SCHIP was implemented, the actual number may be somewhat less at this time.

The employer subsidy for dependant coverage is typically much less than employee coverage, so these differences in the acceptance rate are not surprising. Additional amounts for dependant coverage may simply be unaffordable for some families. Whether the employee share of the premium is affordable for employee or dependant coverage is an important issue.

Other researchers have found that employee contributions, even for the least expensive plan offered, tend to be higher in firms that employ primarily low-wage workers and not surprisingly have lower take-up rates than higher-wage firms. They found that cost is a barrier to enrollment for low-income workers and their dependents not only because the share of premiums consumes a higher percentage of their income, but also the absolute cost of the required health insurance premium contribution is often higher for low-wage workers than for workers in middle- and upper-income brackets. For example, they found that for employees earning less than $7 an hour the average monthly cost of family coverage was $130, while the corresponding cost for employees earning more than $15 per hour was $84.[7]

[7] Cunningham, Peter, Schaefer, Elizabeth and Hogan, Christopher. Who Declines Employer-Sponsored Health Insurance and Is Uninsured? *Issue Brief* Number 22 Center for Studying Health System Change.

Three important features of the employer-based health insurance market explain this finding. First, premiums quoted to small groups are typically higher, on a per capita basis, than those experienced by larger groups, due to the combined effects of economies of scale in benefits administration and selection effects in the small group market. Second, smaller firms typically employ a great proportion of lower-wage workers, for whom premiums represent a substantially higher percentage of their monthly income. Third, in such situations, employers typically offer to pay a lower percentage of the total premium that large employers typically offer. As a result, the difference between the quoted premium and the employer subsidy amount is commonly greater, in absolute dollar terms, than contributions required from workers in larger firms.

Options for Market-Based Solutions

What the foregoing analysis makes clear is that solving the problem of the uninsured involves finding targeted solutions that address the differing reasons why individuals in these diverse groups remain uninsured. Our analysis suggests that there is no "one size fits all" approach to reducing the number of uninsured, and that cost-effective mechanisms to address this problem may require an eclectic mix of policies.

Exhibit 5 below summarizes the population subgroups and their major obstacles to health insurance coverage.

Exhibit 5
Obstacles to Coverage

Population Subgroup	Major Obstacles to Insurance Coverage
Individuals in Families Where Adults Are:	
Unemployed	• Lack of access to any form of employer coverage • Eligibility rule variations in public programs
Employed, but no offers	• Income too high for public programs • Lack of access to affordable group coverage • Lack of access to tax-favored treatment of employer contributions • Unable to afford premiums for non-group coverage
Employed with offers	• Unable to afford employee premium portion

As our analysis makes clear, the biggest single determinant of private coverage is access to some form of group coverage – and the resources required to elect the full array of coverage options offered by a group. Those who have access to group coverage, even without taking into account employer contributions and tax savings, have access to health insurance that is 30-40% less expensive than the coverage available on the individual market.

Our analysis suggests that those who desire to promote strategies to increase health insurance coverage via private, market-oriented solutions should have considerable cause for confidence that such solutions could produce meaningful results. The justification for this confidence flows from the fact that group coverage is already accessible to these families, and some amount of employer contribution is already available. Policies directed at this population need only provide resources to cover the *incremental* cost of inducing such families to elect coverage in the group setting. The *cost effectiveness* of these approaches, however, will depend on careful targeting.

Solutions for Families with One or More Offers

The 16.7 million people in this population are perhaps the most promising group for targeted market-based options. They already have access to group coverage, and some form of tax-favored employer subsidy is already available. The challenge will be to target incentives to avoid displacement of existing coverage.

As the debate over the SCHIP program in 1997 suggests, concerns about the "crowd-out" phenomenon are an important issue in this population. In this population group – individuals in families where one or more workers are already offered insurance – nine out of ten family members are presently insured (although the ten percent of this population that remains uninsured constitutes one third of all uninsured Americans). If workers in this segment were offered general subsidies to purchase insurance – for example through tax credits – there is a legitimate concern that many or most of those who would avail themselves of such subsidies would be those who are presently contributing their own resources to purchase private coverage.

If progress is to be made in cost effectively reducing the number of uninsured in this category, technical solutions will need to be found to prevent crowd-out (or minimize the prospect of this phenomenon to acceptable levels). While any attempt to restrict access to subsidies presents important equity issues for policymakers, our analysis suggests that technical solutions to the "crowd-out" problem are available, as described below.

Restricting Subsidies to "Qualified Plans"

Minimizing or eliminating "crowd-out" with respect to subsidies for individuals in families that are currently attached to employers who offer group insurance will require some "lockout mechanism" to ensure that workers who presently avail themselves of coverage are not the primary beneficiaries of the subsidies. From a technical standpoint, the most flexible mechanism to achieve this is to employ tax credits as the main subsidy vehicle, but then to restrict the access to those tax credits to some combination of either:

- **Employers** who offer new insurance options not presently available in their existing group plans; and/or
- **Employees** who elect options over and above those previously elected that result in covering individuals (themselves or family members) who were not previously covered.

Either approach could be effected by limiting subsidies to situations in which employers offered plans that had features sufficient to enforce whatever "degree of lockout" was deemed to be desirable from a policy perspective. The mechanisms for such a limitation could be the restriction of subsidies to those who offered "qualified plans" that met some minimum standards with respect to the mechanism used to distinguish individuals eligible for subsidies. Candidates for "lock-out" mechanisms might include:

- Employees who had not previously elected to participate in employee-only coverage for some period could be eligible for tax credits for making this election.
- Employers who had previously not offered subsidies for family coverage might be eligible to receive tax credits in order to do so.
- Employees who had not previously elected family coverage might receive tax credits for electing this option.

Throughout this discussion it is important to recognize that refundable tax credits are likely to be much more effective in reaching the low-income population. In addition to considering pure tax credit options, the notion of qualified plans with lockout mechanisms could also provide a vehicle for directing other resources toward the purchase of group insurance, including:

- SCHIP contributions, which might be diverted, even under current law policy, to support the purchase of dependent coverage if a defined framework for doing so were available; and

- Pooling of insurance contributions, weighted toward workers-only premiums, from multiple employers toward the purchase of group coverage in one group or the other.[8]

In framing these options, policymakers wishing to avoid crowd-out will need to strike a balance between considerations of cost-effectiveness, and considerations of social equity. If tax credits were offered in a purely targeted way *solely* to those who had previously elected something less than full family coverage, the objective of maximizing the target efficiency of new subsidies would be achieved. This objective would be achieved, however, at the price of denying access to comparable tax treatment for those who had previously elected "socially responsible" coverage voluntarily. Since those who avail themselves of this coverage are presently the beneficiaries of favorable tax treatment of their employers' contributions, however, this tradeoff is less stark than might be superficially apparent.

At the end of the day, this sort of question cannot be resolved solely within the grounds of health policy. If financing incremental health insurance coverage at the minimum possible subsidy cost is considered a dominant goal of policy, we believe that the technical means can be found to achieve this objective. Given the prospect of reducing the number of uninsured Americans by as much as one-third through targeted initiatives of this type, the public policy debate may be ripe for discussion of these tradeoffs.

[8] While there are material administrative complexities associated with such a concept, the private market has demonstrated the willingness to pool the cost of compliance with such complexities for employers in the market for qualified pension plan and §401(k) administration.

Solutions for Employed Families Without Offers

For the 17.4 million uninsured Americans in working families without attachment to existing group coverage, tax subsidies may also be effective, though they are most likely to be effective in those settings where group coverage can be newly encouraged – or extended. The "qualified plan" notion described in the preceding section could, if policymakers desired, be extended to such situations as:

- Defining terms under which subsidies would be available to either employers and employees (or both) in situations where employers who previously failed to offer group coverage newly offered it; and

- Providing incremental subsidies in situations in which employers who had previously offered group coverage to only a limited subset of their employees extended that coverage to new categories of workers not presently covered.[9]

Beyond encouraging attachment to existing or newly-formed employer groups, policymakers have also considered options in which various forms of legislative encouragement would be given to the formation of new forms of non-employer-based groups. While our analysis suggests that "groupness" is a strong positive for the expansion of affordable insurance coverage, experience with non-employment-based groups in the insurance markets of the last fifteen years suggests that such options should be evaluated with caution.[10] We believe that it is possible to visualize circumstances under which policies to promote the formation of groups of this type might produce a new market segment that could prove as stable as employment-based insurance over time. This conjecture, however, awaits empirical demonstration.

Solutions for Families with No Employed Members

For those with no attachment to the employer group market, the prospect for market-based subsidies is – absent major new mechanisms for private group coverage – limited to subsidizing purchases in the individual market. To the extent that Americans in families with no workers (who are otherwise ineligible for public programs) would use available subsidies to purchase private coverage, the "target efficiency" of such subsidies would be high, because there is little practical concern, in this population segment, about "crowding out" private insurance.

[9] Quite commonly, employers who offer coverage for full time employees may offer restricted, or narrower coverage options to temporary or part time employees.

[10] The major problem experienced with these sorts of group plans is that the participants' attachment to the "group" is often a matter of convenience. In this circumstance, those within the "group" who can get a better deal elsewhere because of their preferred risk status typically defect from the group over time, driving up premiums for those who attempt to remain to unaffordable levels.

Having said that, it is important to understand that, to achieve a meaningful participation rate, subsidies in this segment would probably have to comprise a very large percentage of the cost of purchasing such coverage in the individual market.[11]

Conclusion

As the foregoing discussion suggests, the case for market-based solutions is strongest in those areas where there is a prospect of promoting a meaningful connection to employer-based groups. While this finding of our research does not support the conclusion that market-based solutions are likely to be the most cost-effective approach for *every* uninsured American, our findings do suggest that market-based solutions may be substantially more effective than previously thought in reducing the ranks of the uninsured in America.

[11] Were meaningful subsidies to be available, our view is that purchase rates in this segment would rise, dampening the portion of the pricing differential in this market due to selection effects. There is no empirical evidence to support any meaningful conclusion, however, about how much "de-selection" in this market would dampen price spreads – and no reason to believe that this phenomenon would eliminate pricing differentials due to other "business facts of life" about the individual market, including real marketing and administrative cost differentials.

Appendix

Data and Methodology

We used the 1996 Medical Expenditure Panel Survey (MEPS) data for this analysis. The MEPS datasets are available at http://www.meps.ahrq.gov. This dataset provides the broadest array of descriptive characteristics. Using other health insurance survey datasets will result in slightly different numbers due to survey methodology differences. For example, other survey questionnaires ask about insurance for the past year, rather than for a specific point-in-time which results in a different count of the number of uninsured. For a more complete discussion of the different health insurance surveys and their methodological differences see Lewis et. al. "Counting the Uninsured: A Review of the Literature," Assessing the New Federalism Occasional Paper Number 8, July, 1998 available at http://newfederalism.urban.org.

Families were identified and persons were grouped into families based on the family identifier. This includes families of one person. Persons covered by Medicare in December 1996 were excluded from analysis. The person counts are the weighted number of persons for 1996 using the poverty and mortality adjusted person weights.

Employment status for individuals was defined as employed on December 31, 1996. The self-employed were identified separately. The employment status of a family was assigned to mutually exclusive categories on a hierarchical basis. If at least one family member was employed and not self-employed the entire family was classified as employed. Of the remaining families if the only employed family member was self-employed, the family was classified as self-employed. The remaining families were classified as unemployed. Among employed families, presence of an employer offer of health insurance was assigned on a similar mutually exclusive, hierarchical basis.

We defined insurance status (insured or uninsured) on a similar point-in-time basis as employment, namely December 1996. Insurance status is a characteristic of an individual person, regardless of the status of other family members. Insurance could be from any source, however only persons with comprehensive coverage are considered to be insured. Persons eligible for coverage that only covers select services for a certain disease, such as state disease specific assistance programs, are not considered to be insured under this definition. The MEPS does not specifically confirm uninsurance status, therefore uninsurance is calculated as the residual after no other source of insurance is identified.

Attachment 2

HEALTHCARE
LEADERSHIP
COUNCIL

FOR IMMEDIATE RELEASE
July 17, 2000

Contact: Michael Freeman
202-452-8700

New Poll Shows Number of Uninsured Will Continue to Rise in Coming Year if Action Not Taken

Conference Tomorrow – featuring Governor Christine Todd Whitman (R-NJ), Governor Roy E. Barnes (D-GA), Washington, DC Mayor Anthony Williams – Will Call for Measures to Make Coverage More Accessible

WASHINGTON – A new poll of the nation's small businesses shows that the number of Americans without health insurance will rise substantially in the next year, unless Congress and the White House take action to make health coverage more accessible to Main Street businesses and low-income working families.

The survey, by the American Viewpoint public opinion research firm of Alexandria, Virginia, will be discussed at a conference in Washington, DC tomorrow (Tuesday). "Health Care Coverage 2001: *THE* National Priority" is sponsored by the Healthcare Leadership Council and will feature panel discussions with **Governor Christine Todd Whitman (R-NJ), Governor Roy E. Barnes (D-GA) and Washington, DC Mayor Anthony Williams**, as well as small business owners from Indianapolis and Raleigh, North Carolina and leading health industry chief executives.

The conference will take place at the U.S. Naval Heritage Center auditorium, 701 Pennsylvania Avenue, N.W. from 8:30 a.m. to noon. The governors and Mayor Williams will discuss the issue from 8:45 to 9:30 a.m. There will be a press availability with health industry CEOs, small business owners and an American Viewpoint polling firm representative at noon.

"With this new polling data, we see that the need for action on behalf of uninsured Americans is more urgent than ever," HLC President Mary Grealy said. "In an age of surplus, we need to develop solutions that will put health insurance within the reach of Main Street business owners and working families trying to make ends meet."

The poll findings showed that at least 11 percent of the nation's small businesses[1] will drop health care coverage for their employees in the coming year if insurance premiums rise by five to nine percent. Analysts have projected premium increases of 10 percent or more in the year 2000. If premiums go up 20 percent or higher, 64 percent of the nation's small business owners said they would drop health coverage.

Compounding the problem, almost two of every three businesses not offering health coverage to their employees will, under the status quo, continue that practice. 65 percent of small business owners said they are not likely to offer health coverage anytime in the next two years.

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[1] Ninety percent of small businesses polled employ 50 or fewer employees, the remaining ten percent employ between 51 and 150 employees.

When asked about possible policy options to make health coverage more affordable, 50 percent of small business owners supported tax incentives to reduce the cost of insurance for employers, compared to 21 percent who backed having government provide insurance through new programs or expansion of existing programs like Medicaid.

Among other noteworthy poll results:

- Among small businesses that offer health care coverage, only 56 percent offer coverage for the dependents of their workers. HLC will release research at the conference showing that a very large portion of the uninsured are workers' dependents who do not qualify for public health programs.
- Almost 30 percent of small businesses believe that their inability to offer health coverage has a negative effect on their ability to attract superior employees.
- One in every four small businesses not currently offering health care coverage would be likely to do so if their health premium costs dropped by 10 percent. 42 percent said they would need a cost reduction of 20 percent or more to begin offering coverage. This gives lawmakers a clear picture of the magnitude of tax incentives required to entice small businesses into the health insurance market.

Seating is limited for the conference. If you wish to attend any or all of the event, please contact Michael Freeman at 202-452-8700.

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HLC Small Business Health Insurance Survey

Survey of 500 Small Employers[1]
Conducted June 27-July 13, 2000
by American Viewpoint, Inc.

1. Does your company offer health insurance for full-time employees?

27%	Yes, for employee only
35%	Yes, for employees and their families
38%	No, we don't offer health insurance

2. Does your company offer health insurance for part-time employees?

10%	Yes, for employee only
11%	Yes, for employees and their families
78%	No, we don't offer health insurance
1%	Don't know

3. Do your employees pay a portion of their health insurance premiums?

53%	Yes
43%	No
3%	Some do, some don't (volunteered as an answer)
1%	Don't Know
1%	Refused/NA

4. If so, approximately what percentage does the employee pay?

27%	10 or less
12%	11-20%
8%	21-30%
5%	31-40%
18%	41-50%
5%	51-75%
16%	76-100%
9%	Don't Know
1%	Refused/NA

[1] Ninety percent of businesses surveyed employ 50 or fewer employees. The remaining ten percent employed between 51 and 150 employees.

5. Do employees pay a higher percentage of the premium if they select family coverage?

55%	Yes
38%	No
7%	Don't Know

6. Approximately what percentage of your company's employees decline the health insurance coverage you offer?

63%	10% or less
5%	11-20%
5%	21-30%
3%	31-40%
5%	41-50%
5%	51-75%
7%	76-100%
8%	Don't Know

7. Which of the following benefits does your company offer through your employer-sponsored health plan?

46%	Dental benefits
38%	Vision benefits
59%	Mental health benefits
41%	Well-child care
66%	Routine physical immunizations and checkups
56%	Immunizations
72%	Prescription drug coverage
82%	Hospitalization coverage
72%	Laboratory and X-Ray services
58%	Maternity care
66%	Out of area urgent and emergency services
47%	Alcohol and drug abuse treatment
3%	Don't Know

8. Let's assume health insurance premiums increase in the coming year, how large of an increase would force your company to discontinue health insurance coverage for your employees

4%	1%
1%	2-4%
6%	5-9%
6%	10-14%
3%	15-19%
40%	20% or more
18%	Will continue to offer despite increased premiums
19%	Don't Know
1%	Refused/NA

FOR THOSE NOT OFFERING HEALTH COVERAGE:

9. How likely is it that sometime in the next two years your company will begin to offer health coverage to your employees?

14%	Very likely
14%	Somewhat Likely
22%	Not very likely
43%	Not at all likely
3%	Depends
4%	Don't know

FOR THOSE WHO ANSWERED VERY OR SOMEWHAT LIKELY TO QUESTION 9:

10. Why do you believe your company will begin offering coverage in the future?

34%	You expect revenues to increase and make health coverage affordable.
2%	You expect health care insurance costs to drop in price.
45%	You expect that your company will have no choice in offering coverage if you want to keep and attract qualified employees.
6%	You expect laws to be passed that will make coverage mandatory.
13%	Don't know

FOR THOSE WHO ANSWERED NOT VERY/NOT AT ALL LIKELY TO QUESTION 9:

11. Which of the following is the most important reason your company won't be offering coverage in the future?

46%	The cost of coverage will be too high for the company to afford.
18%	Your employees are not demanding health insurance coverage.
4%	Government keeps adding new mandated benefits that keep premium prices too high.
2%	High rate of employee turnover
27%	Other

12. Although your company doesn't currently offer health coverage to employees, do you have a desire to do so?

31%	Yes, strongly
12%	Yes, not strongly
14%	No, not strongly
36%	No, strongly
4%	Depends
3%	Don't know
1%	Refused/NA

13. Do you believe your company's ability to attract superior employees is negatively affected by the lack of a health insurance benefit?

17%	Yes, strongly
11%	Yes, somewhat
67%	No
3%	Don't know
1%	Refused/NA

14. If cost is a barrier to providing health care insurance, about how far would premium costs have to drop to make coverage for your employees possible?

6%	1-4%
1%	5%
3%	10%
2%	15%
5%	20%
5%	25%
32%	26% or more
44%	Don't know
3%	Refused/NA

15. If health insurance premium costs were 10 percent lower, how likely would your company be to offer health coverage to your employees?

6%	Very likely
18%	Somewhat likely
20%	Not very likely
45%	Not at all likely
2%	Depends
6%	Don't know
3%	Refused/NA

16. If health insurance premium costs were 15 percent lower, how likely would your company be to offer health coverage to your employees?

10%	Very likely
18%	Somewhat likely
15%	Not very likely
43%	Not at all likely
3%	Depends
7%	Don't know
4%	Refused/NA

17. Which of the following approaches would you prefer for helping your employees receive health care coverage?

21%	Have government provide insurance, either through new programs or expansion of existing programs like Medicaid.
50%	Provide tax credits or other incentives to make health coverage more affordable for employers.
6%	Establish a fund, through increased taxes on business, to subsidize health insurance for uninsured workers.
7%	Keep the system as it is.
10%	Don't know
3%	Refused/NA

PREPARED STATEMENT OF RICHARD W. JOHNSON [1]

Thank you for the opportunity to address the committee about health insurance coverage among the near elderly, those between the ages of 55 and 64. This issue is becoming increasingly important as the first Americans born during the Baby Boom years begin to reach age 55. What distinguishes the near elderly from other groups is that they are not old enough to qualify for Medicare coverage (unless they are disabled), yet they are much more likely to experience serious health problems than younger persons. In addition, many near elderly persons have already retired, which can interfere with insurance coverage because most Americans receive their health benefits from their employers. Many of those without employer-sponsored insurance face problems obtaining coverage in the private nongroup market because of their age and health problems. Thus, health insurance coverage for the near elderly merits special attention.

[1] This statement reflects the views of the author and does not necessarily represent the views of the Urban Institute, its sponsors, or its Board of Trustees.

I would like to make five points:

1. The near elderly are about as likely to be uninsured as younger Americans.
2. Uninsurance is concentrated among certain vulnerable groups, particularly Hispanics, blacks, and those with limited income and education.
3. Lack of insurance can be more serious for the near elderly than for younger people, because older people are more likely to have serious health problems. Families without insurance risk high out-of-pocket medical costs when serious illness strikes and may also defer necessary preventive care.
4. Even among near elderly Americans with coverage, there is cause for concern. Many receive coverage from private nongroup plans, which are generally less comprehensive and more expensive than coverage obtained from employers. Moreover, private nongroup policyholders are often subject to large increases in premiums, especially when they develop health problems.
5. Recent declines in the proportion of employers who offer retiree health insurance threaten to jeopardize coverage for future cohorts of near elderly Americans. Many retired Americans in their early sixties receive coverage from their former employers. If employers continue to scale back this benefit, or if they make it unaffordable to many participants by continuing to raise required premiums, rates of uninsurance among near elderly Americans may increase in upcoming years.

THE UNINSURED

About 10 percent of near elderly Americans lacked health insurance coverage in 1998, according to Urban Institute tabulations of data from the Health and Retirement Study, a nationally representative survey of Americans ages 50 and older that was conducted by the University of Michigan for the National Institute on Aging.[2] This figure is similar to or even somewhat lower than estimates of the rate of uninsurance for all nonelderly adults. Estimated rates of uninsurance differ across surveys, but virtually all surveys agree that the near elderly are no more likely to lack coverage than other nonelderly adults. For example, in the Urban Institute's National Survey of American Families, 13.4 percent of respondents ages 35 to 54 lacked coverage in 1997, compared with 9.5 percent of those ages 55 to 64.[3] Concern about lack of coverage among near elderly Americans arises not because they are more likely to be uninsured than other age groups, but because the lack of coverage can have especially serious consequences at older ages.

As at younger ages, coverage rates vary substantially across different demographic groups of the near elderly. Figure 1 reports uninsurance rates by race, education, income, and overall health status. Lack of coverage at ages 55 to 64 is especially prevalent among Hispanics, blacks, those with incomes below 200 percent of the federal poverty level, those who did not complete high school, and those with fair or poor health. For example, 31 percent of Hispanics and 26 percent of those with limited incomes were uninsured in 1998. In addition, 15 percent of the near elderly in fair or poor health were uninsured in 1998, compared with only 8 percent of those reporting excellent or very good health.

IMPORTANCE OF INSURANCE COVERAGE FOR THE NEAR ELDERLY

Health insurance is especially important for Americans in their late fifties and early sixties. Persons at this age are much more likely to experience serious health problems than younger persons. For example, individuals at ages 55 to 64 are six times as likely to have cancer than those ages 53 to 44 and five times as likely to suffer from heart disease.[4] The prevalence of health problems at older ages trans-

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[2] The estimates of uninsurance reported here are substantially lower than those derived from the Current Population Survey (CPS), which are frequently cited, but they are consistent with estimates from other sources, including the National Survey of American Families. CPS estimates may be higher because it asks about coverage during the previous calendar year, whereas the Health and Retirement Study measures insurance coverage at the time of the survey. In addition, the CPS asks a series of questions about insurance coverage and then assumes that any person not designated as being covered through any type of insurance is uninsured. The Health and Retirement Study adds a question that verifies whether respondents who appear not to have coverage are, in fact, uninsured.

[3] Brennan, Niall, 2000. "Health Insurance Coverage of the Near Elderly." New Federalism National Survey of American Families Series B, No. B–21. Washington, D.C.: The Urban Institute.

[4] The incidence of cancer at ages 55 to 64 is 1,052 per 100,000, compared with only 172 per 100,000 at ages 35 to 44. (Source: Ries LAG, Wingo PA, Miller DS, Howe HL, Weir HK, Rosenberg HM, Vernon SW, Cronin K, Edwards BK. 2000. "The Annual Report to the Nation on the Status of Cancer, 1973–1997, With a Special Section on Colorectal Cancer." *Cancer* 88(10): 2398–424.) The prevalance of heart disease increases from 31 per 1,000 among men under age 45 to 134 per 1,000 among men between the ages of 45 and 64. (Source: National Center for

lates into high health care expenses and strong demand for health insurance by the near elderly. Average health care expenditures are twice as high for those between the ages of 55 and 64 than for those 35 to 44.[5]

Numerous studies have documented the impact of health insurance status on health care access and utilization. At all ages, those without insurance are less likely to seek routine and preventive care, which can lead to a variety of preventable and potentially costly health episodes.[6] Among the near elderly, the uninsured are about three times more likely than those with health benefits from their employers to lack a usual source of health care, meaning that the uninsured may not receive services when needed. In addition, women without insurance are only about 70 percent as likely to receive regular breast exams as those with employer-sponsored insurance.[7] Because the incidence of many serious health problems increase with age, foregoing routine care can be especially hazardous for the near elderly.

COVERAGE OPTIONS FOR THE NEAR ELDERLY

Like other Americans, the near elderly obtain health insurance from a mix of public and private sources. However, the relatively high risk of health problems that they face limits their coverage options.

Employer-Sponsored Coverage and Retiree Health Insurance Benefits

By the time individuals reach their early sixties, many have stopped working. At ages 62 to 64, only 48 percent of men were employed in 1998, compared with 85 percent at ages 50 to 54. For women, the employment rate in 1998 dropped from 71 percent for those between the ages of 50 and 54 to 36 percent for those ages 62 to 64. Because most insurance coverage is tied to employment, retirement complicates patterns of health insurance. Some firms continue to contribute toward their workers' health benefits after retirement. These benefits, known as retiree health insurance (RHI), generally continue until age 65, when Medicare coverage begins, and sometimes supplement Medicare benefits after age 65.

However, RHI benefits are not available to most Americans. As reported in Figure 2, only 37 percent of men and 34 percent of women ages 50 to 54 in 1998 reported access to RHI from their own employers or their spouses' employers. Not surprisingly, RHI benefits were most common in high paying jobs. About 45 percent of full-time workers ages 50 to 54 earning more than $20 per hour participated in employer-sponsored health plans that offered RHI benefits. By contrast, only 29 percent of full-time workers earning less than $10 per hour were offered RHI benefits.

Even those offered RHI may not be able to afford it. RHI benefits are usually less generous and require more cost sharing than health benefits provided to active workers. In 1995, for example, large firms that offered health benefits paid an average of 77 percent of the premium costs for active workers, but those that offered RHI paid only 52 percent of the premium costs for retired workers.[8] About one in ten early retirees who are offered RHI benefits turn it down because they say it is too expensive.[9]

Most retirees who lack access to RHI can continue to receive their employer-sponsored coverage for a limited time. Under COBRA regulations, employers with 20 or more employees are required to provide continuation coverage to former workers for up to 18 months (or 29 months if the worker is disabled). However, the cost to the beneficiary can be high because former workers assume full responsibility for 102 percent of the employer's group rate. These costs contribute to the low take-up rate for COBRA coverage.[10] Only about 2 percent of the near elderly report COBRA coverage, according to Urban Institute estimates. Because of the limited availability of RHI coverage, the limited duration of COBRA coverage, and the relatively high costs of both types of coverage, the near elderly are significantly less likely than

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Health Statistics. 1999. *Current Estimates from the National Health Interview Survey 1999*. Vital and Health Statistics Series 10, No. 200. Public Health Service. Hyattsville, MD: U.S. Government Printing Office.)

[5] General Accounting Office. 1998. "Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year Olds." GAO/HEHS–98–133. Washington, D.C.: General Accounting Office.

[6] Weissman, Joel S., and Arnold M. Epstein. 1994. *Falling Through the Safety Net: Insurance Status and Access to Care*. Baltimore, MD: Johns Hopkins University Press.

[7] Brennan, *op. cit*.

[8] Foster Higgins. 1996. *National Survey of Employer Sponsored Health Plans, 1995*. New York: A. Foster Higgins & Co., Inc.

[9] Loprest, Pamela. 1998 "Retiree Health Benefits: Availability from Employers and Participation by Employees." *The Gerontologist* 38(6): 684–694.

[10] Flynn, Patrice. 1994. "COBRA Qualifying Events and Elections, 1987–1991." *Inquiry* 31: 215–220.

younger adults to have employer-sponsored coverage. According to data from the National Survey of America's Families, 73 percent of persons ages 55 to 64 received coverage from an employer in 1997, compared with 76 percent of those ages 35 to 54.[11]

Public Sources

Near elderly persons who lack job-related health benefits have limited insurance options. Nonelderly adults can qualify for Medicare or Medicaid benefits only if they are blind or disabled. In addition, Medicaid benefits are subject to strict income and asset tests, and Medicare benefits do not begin until at least 29 months after the onset of disability.

Private Nongroup Coverage

Given these constraints, many near elderly persons without coverage from employers turn to the private nongroup market. Indeed, private nongroup coverage rates are almost twice as high at ages 55 to 64 than at ages 35 to 54.[12] However, there are a number of important drawbacks to relying upon the private nongroup market at older ages. A primary concern is the affordability of nongroup coverage. Compared to those for group policies, premiums are generally higher for private nongroup plans because risk pooling is more limited, administrative costs are higher, and employer subsidies are generally unavailable. Among a sample of individuals between the ages of 53 and 63 in 1994, annual nongroup premium costs were about $2100, while those with employer-sponsored coverage paid out of pocket just under $900.[13]

The affordability issue is compounded by the health problems that many retirees have when they enter the nongroup market, increasing the risk-rated premiums they face. Figure 3 reports the average monthly premiums that a sample of Americans ages 62 to 64 faced in 1998 for comprehensive nongroup coverage. Estimated premium prices were based on a survey of insurance providers conducted by the Urban Institute. Private nongroup premiums faced by individuals with two or more serious health problems were more than twice as high as those faced by individuals without any serious health problems. When previously healthy individuals become sick, their premiums can rise dramatically. Because health problems are more common among the poor than those with higher incomes, those in poverty faced substantially higher premiums on average than other individuals. Thus, the poor are doubly disadvantaged in their efforts to acquire coverage in the private market, because they lack sufficient resources to purchase health insurance and because they face particularly high prices.

Related to the high price of private nongroup coverage is the problem of limited benefits. Many private nongroup plans do not provide comprehensive benefits to policyholders. Because of the high cost of comprehensive coverage, many who purchase nongroup policies opt for plans that offer only limited coverage, with high deductibles, high cost-sharing requirements, and limited benefits. Moreover, insurers are often reluctant to offer low-deductible comprehensive coverage because these policies generally attract persons with health problems who use many services. This adverse selection problem drives up premiums and discourages all but the most heavy users of health services from purchasing coverage, causing the market for these policies to break down. Many insurers also exclude coverage for pre-existing health conditions. Urban Institute estimates indicate that about 12 percent of Americans ages 55 to 64 with private nongroup coverage have restrictions on their policies because of pre-existing conditions. Consequently, many near elderly persons with nongroup coverage may be underinsured, leaving them vulnerable to high out-of-pocket costs if they become seriously ill.

Even when near elderly Americans are able to afford the high cost of private nongroup coverage, they may be denied coverage by insurers. According to a recent study of the nongroup health insurance market in ten states, insurers often deny coverage for such health problems as rheumatoid arthritis, chronic headaches, kidney stones, angina, heart disease, and stroke.[14]

A number of laws and regulations at both the federal and state levels have been enacted recently to address problems with the private nongroup market, but it is not yet clear how effective these initiatives will be in improving access to nongroup

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[11] Brennan, *op. cit*.

[12] Brennan, *op. cit*.

[13] Johnson, Richard W., and Stephen Crystal. 2000. "Uninsured Status and Out-of-Pocket Costs at Midlife." *Health Services Research* 35 (5, Part I): 911–932.

[14] Chollet, Deborah J., and Adele M. Kirk. 1998. "Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States." Henry J. Kaiser Family Foundation Report No. 1376. Menlo Park, CA: Henry J. Kaiser Family Foundation.

coverage for near elderly Americans. With the passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, federal law now requires insurers to offer policies to retirees who have exhausted COBRA coverage. However, there are no restrictions on the premiums they can charge, so this legislation does not address concerns about the affordability of nongroup coverage. Some states now limit the variation in the price that private insurers can charge across different age or health groups, which could lower premium costs for the near elderly, but these restrictions are not present in every state. Moreover, restrictions on premium variation without other market reforms could raise health insurance premiums for everyone in the private nongroup market.

TYPES OF COVERAGE RECEIVED BY NEAR ELDERLY AMERICANS IN 1998

Figure 4 reports the distribution of health insurance coverage in 1998 for men and women between the ages of 55 and 64, based on estimates from the Health and Retirement Study. Overall, for men and women combined, about 41 percent of near elderly Americans were covered by their own current employers. Another 13 percent received coverage from former employers, and 16 percent received coverage through their spouses' employers. In all, 73 percent of the near elderly had workplace coverage. About 8 percent purchased private nongroup coverage and 9 percent received public benefits through the Medicare or Medicaid programs. Just over 10 percent of the near elderly were uninsured in 1998.

There are important differences in coverage between men and women in their fifties and early sixties. As reported in Figure 4, women are much less likely than men to receive coverage through their own employment, either as active workers or as retirees. Conversely, they are much more likely than men to receive coverage from their spouses' employers. As a result, divorcees and widows stand to lose their insurance coverage. Women are also more likely than men to purchase private nongroup coverage and are more likely be uninsured (11.4 percent vs. 9.1 percent).

Rates of uninsurance increase slightly as individuals move from their early fifties to their early sixties. As reported in Figure 5, rates of uninsurance in 1998 rose from 9 percent among those between the ages of 50 and 54 to 10.3 percent among those between the ages of 62 and 64. However, differences in the type of coverage individuals received were more dramatic than differences in uninsurance rates. The likelihood that individuals receive health benefits from current employers steadily falls during this critical decade of life, while the likelihood of receiving coverage from former employers, private nongroup plans, and the public sector steadily rises. For example, at ages 50 to 54, some 74 percent of Americans reported coverage from current employers. The comparable figure is only 36 percent for ages 62 to 64. Coverage rates from former employers were 30 percent at ages 62 to 64—far higher than the 6 percent rate for Americans at ages 50 to 54. Even so, coverage from current employers drops off so precipitously for older groups that overall employer-sponsored coverage was 14 percentage points lower at ages 62 to 64 than at ages 50 to 54 (66 percent vs. 80 percent). What does offset the shortfall in employer-sponsored coverage at older ages are sharp increases in private nongroup coverage and public coverage, both of which were twice as prevalent at ages 62 to 64 than at ages 50 to 54. Almost all of this rise in public coverage comes from an increase in disability-related Medicare coverage.

Changes in the composition of coverage as individuals approach the Medicare eligibility age have important implications for the health security of the near elderly. Private nongroup coverage is generally less comprehensive and more expensive than employer-sponsored coverage. In addition, individuals who develop serious health problems can experience large premium hikes. Similarly, individuals pay more for retiree health insurance than for employer-sponsored insurance received while working. Recent declines in the proportion of employers offering retiree health insurance may also jeopardize coverage for future cohorts of near elderly Americans.

OUTLOOK FOR COVERAGE OF THE NEAR ELDERLY IN THE FUTURE

Insurance coverage for the near elderly may deteriorate in the near future, primarily because of recent declines in RHI coverage. The availability of RHI benefits has been declining steadily over the past decade. Recent declines in the availability of RHI may further erode employer-sponsored coverage for the near elderly in upcoming years. Between 1991 and 1998, for example, the prevalence of retiree health

benefits sponsored by large employers fell from 80 percent to 67 percent.[15] When these workers retire in upcoming years, fewer of them will be able to rely upon employer-sponsored coverage than the current generation of near elderly retirees.

At the same time, employers have been shifting more of the costs of RHI plans on to participants. Among full-time workers in medium and large firms that offered RHI coverage, the percentage who would be required to make contributions upon retirement to offset at least part of the cost of their plans increased from 35 percent in 1985 to 91 percent in 1995.[16] When these workers retire, the high level of contributions required by their former employers might force many of them to decline RHI coverage. Other cost-cutting measures that firms have increasingly implemented in recent years include the tightening of eligibility requirements, the introduction of caps on the future obligations that employers could face for their RHI plans, and the substitution of indemnity plans with managed care plans. The cutbacks are generally attributed to rising health care costs and new accounting rules, introduced in 1993, requiring employers for the first time to recognize the present value of expected future retiree health care costs as liabilities on their balance sheets.

Another threat to RHI coverage for future retirees is that employers are generally not legally bound to honor their past promises about retiree health benefits. Unlike employer-sponsored pension plans, retiree health benefit plans do not vest. As a result, employers can amend or terminate retiree health benefits at will, as long as they indicate that the terms of the plan are subject to change. Even though employers may offer retiree health benefits when individuals are working or when they retire, there is no guarantee that those benefits will continue throughout the individuals' lifetimes or even until they become eligible for Medicare coverage.

One possible response to the decline in RHI benefits is that workers could delay retirement until they reach the Medicare eligibility age. By remaining at work instead of withdrawing from the labor force, they could retain their employer-sponsored health benefits. In fact, a number of studies have shown that workers are substantially less likely to retire if their employer-sponsored coverage does not continue until they reach age 65 than if their employers provide RHI benefits.[17] Encouraging healthy workers to remain in the labor force has some obvious public policy advantages. But, for those who are forced to retire early because of health problems, the lack of RHI benefits can have serious consequences, especially if they do not qualify for disability-related Medicare benefits. Even for those who do qualify for Medicare, the 29-month waiting period for benefits can be burdensome.

IMPLICATIONS FOR REFORM

In many respects, policy issues concerning uninsurance among the near elderly are similar to those concerning uninsurance among younger adults. The overall percentage of near elderly Americans without health insurance is no higher than the percentage of younger adults lacking coverage, and across all nonelderly ages uninsurance is concentrated among certain disadvantaged groups. Thus, just as for younger persons, for many persons ages 55 to 64 the lack of health insurance results from their limited incomes. For other near elderly persons, the lack of adequate insurance coverage is related to their age and to health problems. Some lose health benefits when they retire, and comprehensive health insurance coverage is difficult to purchase in the nongroup market at older ages.

The expansion of tax credits for the purchase of individual health insurance plans has often been discussed as a possible way to reduce uninsurance rates. Although my task here is not to discuss the advantages or disadvantages of this approach, it is important to note that the problems that the near elderly confront in the private nongroup market suggest that tax credits will have only limited effects on coverage rates at older ages. Reducing the after-tax premium cost to individuals will not resolve the problems of adverse selection, denials of coverage, and pre-existing condition exclusions that confront many near elderly Americans in the private nongroup market.

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[15] McArdle, Frank, Steve Coppock, Dale Yamamoto, and Andrew Zebrak. 1999. "Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits." Menlo Park, CA: Henry J. Kaiser Family Foundation.

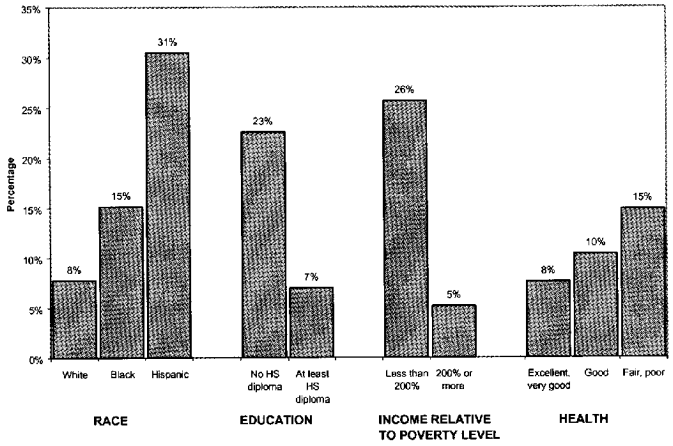
[16] Bureau of Labor Statistics. 1998. *Employee Benefits in Medium and Large Private Establishments, 1995*. Washington, D.C.: U.S. Government Printing Office; Karoly, Lynn A., and Jeannette A. Rogowski, 1998b. "Retiree Health Benefits and Retirement Behavior: Implications for Health Policy." In *Health Benefits and the Workforce*, vol. 2 (43–71). Washington, D.C.: U.S. Department of Labor.

[17] Johnson, Richard W., Amy J. Davidoff, and Kevin Perese, 2000. "Health Insurance Costs and Early Retirement Decisions." Washington, D.C.: The Urban Institute.

A Medicare buy-in plan, in which persons below the age of full eligibility would be allowed to purchase Medicare coverage, has also been proposed as a way to help uninsured near elderly Americans obtain coverage. By offering Medicare benefits, the buy-in approach does not rely on the fragile nongroup market. A forthcoming study by the Kaiser Family Foundation indicates that a cost-neutral buy-in plan would not substantially increase coverage rates.[18] Because many of the uninsured have limited incomes, few persons without private coverage could afford the high premiums that the program would have to charge to cover its costs. However, a buy-in program could substantially improve coverage rates for the near elderly if it subsidized premium costs for low-income individuals. Under one set of income-related premiums, a Medicare buy-in plan could cut uninsurance rates for the near elderly almost in half.

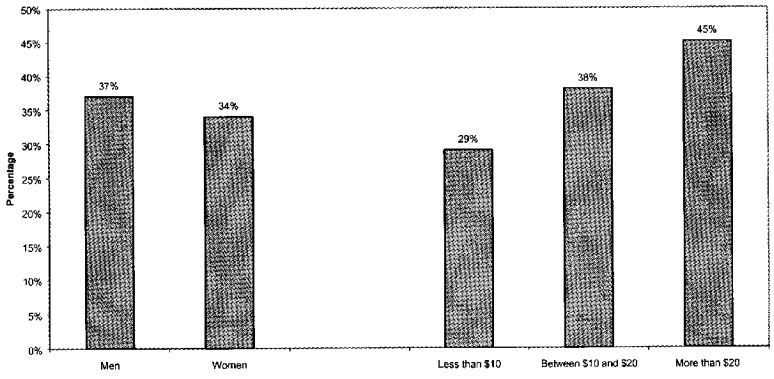
[18] Johnson, Richard W., Marilyn Moon, and Amy J. Davidoff. Forthcoming. "A Medicare Buy In for the Near Elderly: Design Issues and Potential Effects on Coverage." Washington, D.C.: Henry J. Kaiser Family Foundation.

Figure 1
Percentage Uninsured, Ages 55 to 64, by Demographic Characteristic, 1998



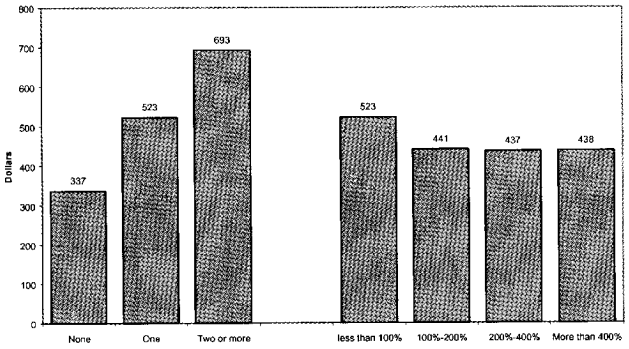
Source: Urban Institute tabulations from the Health and Retirement Study, 2001

Figure 2
Percentage of Persons Ages 50 to 54 With Access to RHI Benefits, 1998



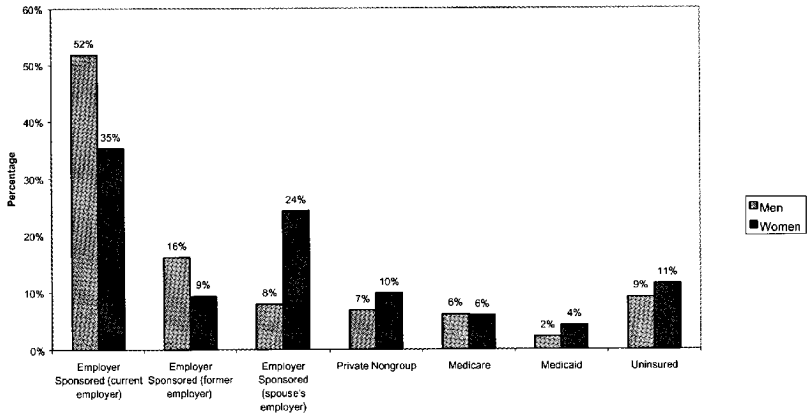
Source: Urban Institute tabulations from the 1998 Health and Retirement Study, 2001

Figure 3
Average Mean Monthly Premiums for Private Nongroup Coverage, Ages 62 to 64, 1998



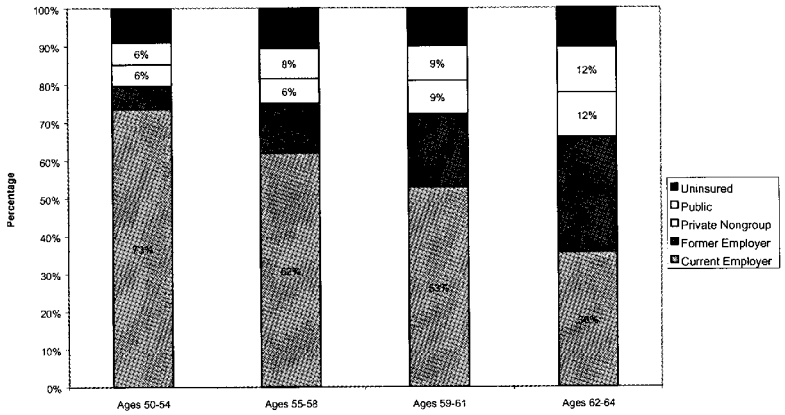
Source: Urban Institute tabulations from the 1998 Health and Retirement Study and survey of private insurers, 2001

Figure 4
Health Insurance Coverage at Ages 55 to 64, 1998



Source: Urban Institute tabulations from the 1998 Health and Retirement Study, 2001

Figure 5
Health Insurance Coverage by Age, 1998



Source: Urban Institute tabulations from the 1998 Health and Retirement Study, 2001

PREPARED STATEMENT OF LEIGHTON KU

Chairman Grassley, Senator Baucus and members of the Finance Committee, thank you for the opportunity to testify about the health insurance coverage of immigrants. My name is Leighton Ku and I am a Senior Fellow in Health Policy at the Center on Budget and Policy Priorities.

About half of people living in immigrant families, including both legal immigrants and their U.S.-born children, are uninsured and, as a consequence, have major problems obtaining access to health care services. In recent years, insurance coverage for low-income immigrant families has deteriorated, in large measure due to the 1996 welfare reform law which prohibited recently-admitted legal immigrants those entering after August 1996 from being covered by Medicaid or the State Children's Health Insurance Program (SCHIP).

Immigrants are an important and growing segment of the American tapestry. About one-tenth of our population is foreign-born, and each year about 700,000 immigrants are admitted for legal residence in the United States, arriving from Latin America, Asia, Eastern Europe and all other points on the compass. While immigrants traditionally lived in states like California, New York, Texas and Florida, migration patterns are changing. Today, high immigrant growth areas include North Carolina, Nevada, Kansas, Indiana, Minnesota, Virginia, Arizona and Utah. All across the nation, immigrants are a vital part of America's workforce, paying taxes and meeting other civic responsibilities.

Immigrants work hard and have low unemployment rates. Recent Census data show that the foreign-born have a 4.9 percent unemployment rate, very close to the 4.3 percent rate for native citizens.[1] But immigrants are disproportionately poor and uninsured because they tend to be employed in low-wage, low-benefit jobs. In light of this employment profile, noncitizen immigrants are much less likely be offered private job-based insurance by their employers than native citizen workers, which is a major cause of the insurance coverage gap that exists for immigrant families. While the recent economic boom increased job-based insurance coverage for native citizens in 1999, there was almost no improvement in private insurance coverage for immigrants.[2]

Immigrants are particularly vulnerable in the first several years after arrival in the United States, while they are still trying to get established and to master the skills needed to live and prosper here. After being here for a longer time and becom-

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[1] Census Bureau, *The Foreign-Born Population in the United States: March 2000*, Jan. 2001.
[2] E. Richard Brown, Ninez Ponce, and Thomas Rice, *The State of Health Insurance in California: Recent Trends and Future Prospects*, UCLA Center for Health Policy Research, Mar. 2001.

ing naturalized citizens, immigrants come much closer to parity with native citizens, in terms of both income and insurance coverage.

Before 1996, immigrants who were legally admitted to the United States could participate in Medicaid on the same terms as citizens. However, the welfare reform law changed policies, so that most legally-admitted immigrants who arrived after the law was enacted are barred from getting Medicaid during their first five years in the country. Moreover, other provisions of that law and another immigration law passed that year will keep most immigrants from becoming eligible, even after the first five years has passed. During this time period, other policies led many immigrants to believe that joining government programs might endanger their legal status or to think that all immigrants were ineligible for benefits.

Data from Los Angeles County showed that immediately after the welfare reform law was enacted the number of legal immigrants and of their citizen children enrolled in Medicaid fell sharply.[3] National data show that the number of noncitizen parents and children receiving Medicaid has fallen since 1996. Moreover, the percentage of low-income noncitizen parents and citizen children in immigrant families who lack insurance has climbed. In 1999, the most recent year for which data are available, more than half (55 percent) of all low-income noncitizen parents and almost half (46 percent) of low-income noncitizen children were uninsured.[4] The uninsurance rates for low-income noncitizen immigrants are about twice as high as for low-income native citizens.[5]

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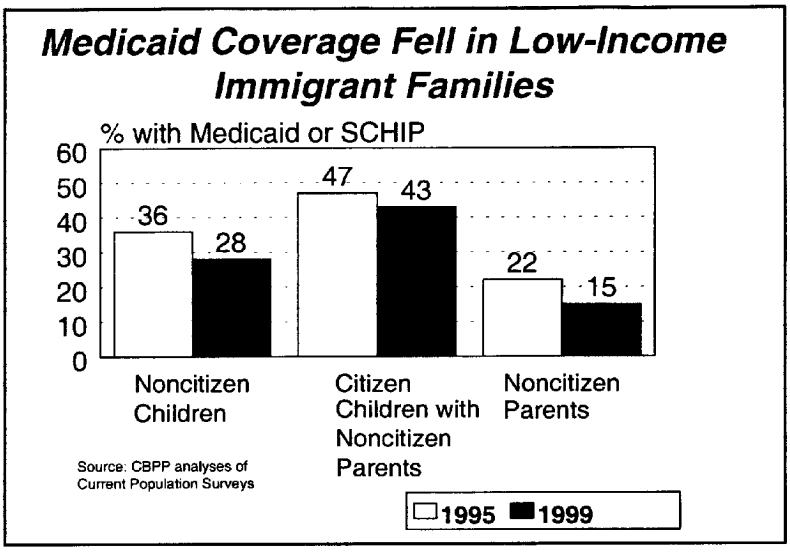
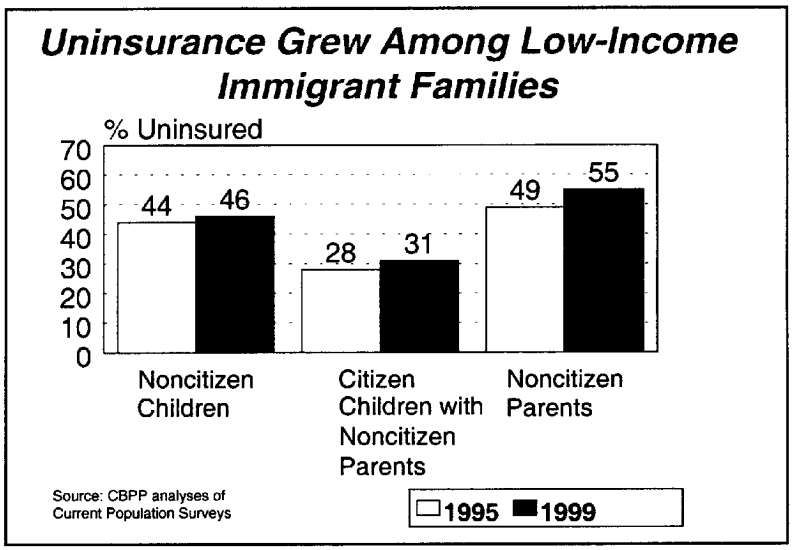
[3] Wendy Zimmermann and Michael Fix, *Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County*, Urban Institute, July 1998.

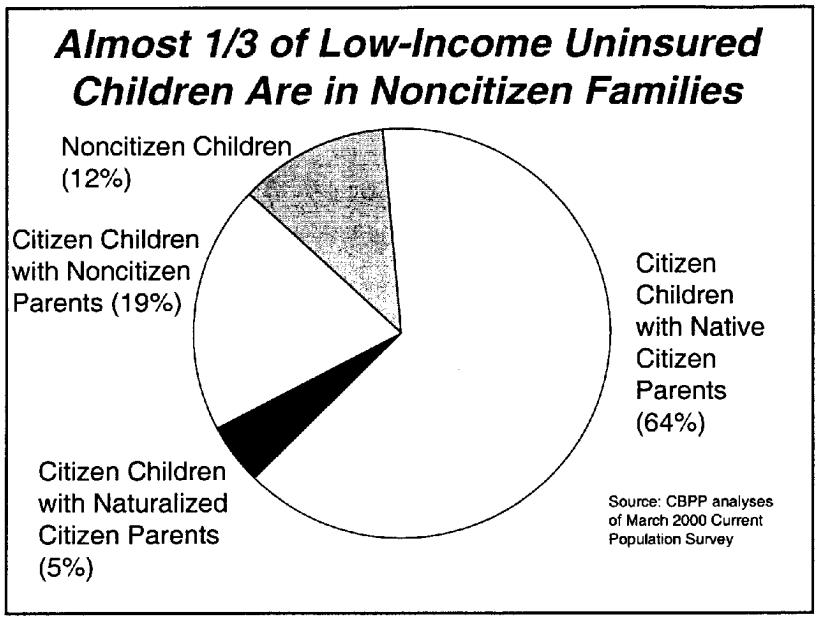
[4] Low-income is defined as having family income that is less than 200 percent of the poverty level.

[5] Leighton Ku and Shannon Blaney, *Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage*, Center on Budget and Policy Priorities, Oct. 10, 2000.





These problems affect not only immigrants the intended policy target but also affect immigrants' U.S.-born children, who are therefore native-born citizens. Census data indicate that about one-third (31 percent) of all the low-income, uninsured children are members of noncitizen immigrant families: 12 percent are foreign-born children, while 19 percent are U.S.-born children whose parents are noncitizen immigrants. That is, a major share of all uninsured children live in immigrant families.



Because they lack health insurance, immigrants and their children are much less likely to see a doctor, to get dental care and even to receive care from emergency rooms. Research has shown that, when they are insured, immigrants have much better access to medical and dental care than when they are uninsured.[6] However, even insured immigrants have problems getting health care. Language problems create additional healthcare access barriers for many Hispanic, Asian and other immigrants. Even when they see a doctor, language differences can create risks for medical errors because the doctors and patients cannot understand each other.

Federal policy changes not only affected immigrants, but caused repercussions for state and local governments and for health care providers. Thirteen states (California, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Jersey, Pennsylvania, Rhode Island, Virginia and Washington) use state funds to serve noncitizen children under their Medicaid programs and four more states (Connecticut, Florida, New York, Texas) use state funds to cover immigrant children in their SCHIP programs.[7] As noted by the National Governors Association, the elimination of federal Medicaid coverage for immigrants has meant that state governments must shoulder more of the costs of care.[8] In addition, uninsured immigrants often turn to public hospitals and clinics for health care, so that county and local governments must assume higher uncompensated care burdens.

I would like to take a moment to dispel a popular myth about immigrants and health insurance. Some have argued that the United States should not provide public benefits to legal immigrants because this just serves as a "magnet" for poor immigrants. On the contrary, research has consistently shown that immigrants are not drawn here for benefits, but because they want better jobs, want to be reunited with family members or need to flee persecution in their home countries. Over the past decade, immigrants have been shifting away from high-benefit states like California

[6] Leighton Ku and Sheetal Matani, "Left Out: Immigrants' Access to Health Care and Insurance,;; *Health Affairs*, 20(1):247–56, Jan./Feb. 2001.

[7] Immigrant children receiving state-funded assistance in these states would be reported as being on Medicaid in the Census data.

[8] National Governors Association, *HR–2. Immigration and Refugee Policy*, Section 2.3.2, Revised policy position approved at the Winter 2001 meeting.

or New York toward low-benefit states like North Carolina or Virginia, underscoring the irrelevance of the "welfare magnet" hypothesis.[9]

Before closing, I would like to tell you about the Dominguez family of Phoenix, Arizona.[10] This low-income, working family was legally admitted to the United States two years ago, after waiting for almost 20 years for an entry permit. Their two-year old daughter, Athalia, was born with a heart defect, and the family has struggled to meet her needs, incurring huge medical bills. While a local charity program now helps provide cardiology care for her, the family has no easy way to pay for basic medical needs, such as taking care of infections. Last year, Mrs. Dominguez experienced a miscarriage and had problems getting emergency medical care when she was hemorrhaging. She continues to suffer gynecological problems, but cannot afford to see the doctor. Were it not for the fact that the Dominguezes immigrated here after August 1996, Mrs. Dominguez and her little girl would be eligible for Medicaid and SCHIP and could receive adequate and timely medical care.

How can we address the insurance needs of families like this one? One important proposal was advanced last year by a bipartisan group of legislators, including Senators Graham, Chafee, Jeffords and Rockefeller and Congressmen Diaz-Balart and Waxman, who co-sponsored a bill to let states have the option to restore Medicaid and SCHIP eligibility for legal immigrants who are children or pregnant women. This bill was also supported by a number of governors, including Governors Jeb Bush and Paul Celluci and then-Governor Christine Todd Whitman.

Broader efforts to help improve insurance coverage among low-income Americans could also help improve immigrants' access to health care. As Congress and the Administration consider ways to help lower the number of uninsured people in America, I hope that you will keep the needs of immigrant families, like Marisela and Athalia Dominguez, at the forefront of the policy agenda.

PREPARED STATEMENT OF HON. BLANCHE L. LINCOLN

Thank you, Mr. Chairman. I am pleased that the Finance Committee is addressing the issue of the uninsured in our country. Seventy-five percent of the 43 million uninsured are working—they are the working poor. They are doing what society asks them to do. They work, often several jobs, to put food on the table and to provide for their families and yet they still cannot afford to pay for health insurance, either because they cannot afford the premiums or it is not offered by their employer. And if you are poor and uninsured, you probably won't go see a doctor because doctors want payment at the time of the service or they want at least $50.

The uninsured either go without the care that they need or they rely on the generosity of non-profit health care systems, social service agencies and rural health clinics for care on a limited basis. This care is either free or available for a small stipend is paid, based on a sliding fee scale and the ability to pay. Thank goodness we have such a "health care safety net" of service providers, but clearly the demand for care overwhelms the ability for these non-profit providers to provide the care that is desperately needed.

We must remember that access to health care allows people to work themselves out of poverty and into self-sufficiency. Everyone should have a shot at the American dream. Having affordable, adequate health insurance is a critical factor in achieving self-sufficiency and leading a happy, healthy and successful life.

When we talk about the uninsured we can throw around a lot of statistics. After awhile, the human side of the issue gets lost in numbers and statistics. I'd like to share a human story with you. Just yesterday morning a woman in northwest Arkansas named Faye went to a free health clinic for medical care. She is a new employee of a manufacturing company in the area but is on a probationary period for several months and is not eligible for insurance at this time. She had a high fever, swelling of lymph glands, a severe ear ache and in her words "no insurance and not enough money to go see a doctor."

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[9] Another "myth" is that recent immigrants are responsible for most of the increase in number of uninsured people that occurred in the late 1990s, as claimed by the Center for Immigration Studies. A new analysis of the data refutes this and finds that increased uninsurance among native and naturalized citizens was the main reason that the number of uninsured people increased so much. (John Holahan, Leighton Ku and Mary Pohl, *Is Immigration Responsible for the Growth in the Number of Uninsured People?* Kaiser Commission on Medicaid and the Uninsured, forthcoming, March 2001.)

[10] I would like to thank Marcella Urrutia of the National Council of La Raza for sharing information about the Dominguez family.

Without access to medical care, Faye would likely lose her job from excessive absenteeism. She makes too much to be eligible for Medicaid but cannot afford to pay out-of-pocket to see the doctor. Once she completes her probationary period she can enroll in a health insurance plan. However, until then, she is "on her own." It is for people like Faye that we need to improve our nation's health care system and make sure that everyone has the care that they need, especially when they're working hard and doing their part to achieve independence.

Today we will discuss several private sector and public sector approaches to improving access to health care for the uninsured. Health policy experts agree that the best approach will likely be a blend of the private and public sector options. I hope my colleagues agree that earmarking a portion of the budget surplus to provide health insurance for uninsured Americans is a top priority.

Thank you, Mr. Chairman. I look forward to hearing from today's witnesses.

PREPARED STATEMENT OF JACK MEYER, PH.D.

INTRODUCTION

Mr. Chairman: Thank you for the opportunity to testify on the issue of federal tax credits for employers offering health coverage. I am pleased that the Senate Finance Committee is exploring a range of options for expanding health coverage.

I would like to begin by noting that there is no one "quick fix" or panacea for the troubling and long-standing problem of the uninsured. This group of Americans is very diverse. It includes working families with low and moderate incomes, recent immigrants who are ineligible for public programs, older workers not yet eligible for Medicare, and many very poor adults without dependent children. There are also young adults who have "aged out" of their parents' health coverage. It is unlikely that one policy tool will meet the disparate circumstances of this heterogeneous population.

In this respect, I have been frustrated by the ideological battles over whether public programs or private sector initiatives are appropriate to reduce the number of uninsured. We need to fashion a strategic mix of policies that includes bringing more people into Medicaid and S-CHIP who are already eligible for these programs; extending eligibility to people with very low incomes (mainly adults) who are screened out of public coverage; strengthening our safety net; and helping the working uninsured find affordable insurance.

While the rhetoric features a "public versus private" debate, the reality is that many states are experimenting with ways to leverage public funds to shore up and extend private employer-sponsored coverage. We need to find ways to retain businesses that now participate in the health care system, and make employer health care contributions more affordable for many small and medium-size employers who now sit on the sidelines. We can get a good "bang for the public buck" by using limited public resources to solidify and strengthen the employer-based system. At the same time, we need to bring into our public programs some very vulnerable people who are not engaged in the work-based system.

THE ROLE OF TAX CREDITS

Federal tax credits can play a role in expanding coverage. I would like to see such credits placed within a framework of major reform in the tax treatment of contributions to health coverage, rather than as an incremental add-on to a system of tax subsidies that is very inefficient and inequitable. The tax provision that allows workers to exclude from taxable income the amount that employers contribute to worker health premiums has been estimated to drain about $141 billion from federal and state coffers. Moreover, the exclusion is very regressive. It dishes out large tax breaks to upper-income households even as it bypasses many lower-income working families with little or no tax liability. The current tax treatment of health care contributions also pumps up health care spending by insulating people from the real cost of their coverage and underwriting a large portion of the excessive costs of inefficient health plans and care systems. Limiting this exclusion could provide a substantial source of revenue that could be used to extend health coverage to the uninsured. I hope that the committee will explore options to convert this inefficient and inequitable system into a set of fixed-dollar, refundable tax credits that would better target public dollars to actual need and add a measure of cost discipline to the health care system. A refundable income tax credit would be a much better use of public funds than a deduction for health care expenses for individuals who are uninsured. Very few Americans in financial need would benefit from a deduction.

Who Gets the Tax Subsidy?

In theory, it should not matter much whether we offer tax credits to employers or employees. Most economists believe that it is the size of the total compensation package that matters to employers. There is a maximum total amount that is optimal to recruit and retain the work force they need to produce their goods and services. If the cost of one element of the compensation package (e.g. health care) increases, they will lower their spending for other elements, such as wages or contributions to pensions, and vice versa. In this framework, when employers write a check for health coverage, they are not really spending their own money, but the workers' money.

In practice, however, the choice of whether to offer credits to employers or employees may matter. Employers may be more responsive than workers to a change in the real price of health coverage. In other words, their "take-up rate" may turn out to be higher. Several studies have examined the responsiveness of employers to a reduction in the price of health coverage, which is the effect of the tax credit. One group of studies uses variations in tax rates across states to determine the impact of after-tax prices on small firms' willingness to offer health coverage. Estimates of the price elasticity in this group of studies ranged from -0.63 to -2.9, indicating a strong response by employers to price changes. In other words, if price declines by 1 percent, the quantity of health insurance purchased should increase by somewhere between slightly less than 1 percent and nearly 3 percent (Gruber, 1999). Furthermore, while workers do not need an offer of coverage from their employers to obtain it, they will pay substantially more if they buy coverage on their own than if they enroll in group coverage. Thus, I will proceed under the assumption that it is worth considering direct subsidies to employers because they might provide better results per dollar invested than subsidies to employees.

Of course, as noted earlier, both types of subsidies could be used in tandem. This is not an "either/or" situation. We can combine tax credits for employers with a companion set of credits for employees, in order to work on improving both the employers' offer rate and the employees' acceptance rate. Again, some may say that this is a distinction without a difference, but in practical terms, it may be necessary to develop inducements that at least appear to be directed at both parties. Massachusetts has developed a two-part program that combines these two elements—the Insurance Partnership and the Premium Assistance Program. These programs, along with other state and local initiatives to bring more uninsured workers and their families into employer-sponsored coverage, are described in detail in two recent reports that my research team has prepared.

A Tax Credit for Employers

My research organization; the Economic and Social Research Institute (ESRI), has prepared reports on federal tax credits for employers to offset a portion of the cost of contributing to health insurance. This work was supported by The Commonwealth Fund. One report, prepared by Sharon Silow-Carroll at ESRI, presents the lessons learned from reviewing employer tax credits tried by several states over the past decade. Key findings are as follows:

- Amount of subsidy: The amount of the subsidy must be substantial (for example, at least half the premium, or about $1,200 for individual coverage and $3,000 for family coverage) in order to provide adequate incentive to employers.
- Awareness: There must be a strong publicity campaign to reach small businesses that do offer coverage; this requires a significant front-end investment in sophisticated marketing efforts.
- Duration of subsidy: Tax credits or subsidies provided by states have generally been design to phase out after a few years; i.e., they are meant to "jump start" coverage rather than provide ongoing support. While this makes sense from budgetary and fairness standpoints (ongoing subsidies are costly and unfairly penalize firms that had been providing coverage with no subsidy), small firms are wary about making a new commitment knowing that they will lose the financial assistance in the near future.
- Eligibility requirements: If the tax credit is not available to the business owner and his/her family, the firm is much less likely to newly offer coverage to employees. Also, if eligibility is contingent on a firm's not having offered health benefits over a long prior period, this will limit participation.

Our research has also convinced us that tax credits, whether for workers or their employers, must be accompanied by a place to take them with affordable prices. Throwing tax credits into existing insurance markets, especially the individual market, might leave many people far from affordable coverage. Compared to what large groups pay, coverage in the small-group and the individual markets is more expensive for a number of reasons: small buyers have no negotiating leverage; insurers

experience administrative diseconomies; and risks are not as widely spread over large pools. There are promising solutions to these difficulties—including risk-adjustment of premiums to compensate health plans that have disproportionate numbers of high-risk enrollees, limits on insurers' ability to vary premiums based on enrollee health risk, and purchasing pools to give small purchasers some of the bargaining power that large purchasers enjoy. Past experience shows, however, that purchasing cooperatives have to be large to produce savings. Thus, incentives need to be put in place to encourage people to purchase tax-subsidized coverage through them.

One final consideration is that tax subsidies received at the time of tax filing do not provide either families or small businesses with the cash needed to make health premium payments throughout the year. For low-income families or companies with limited cash flow, the tax credit could be advanced at intervals during the year (Meyer et al., 2000).

My colleague Elliot Wicks and I have developed a proposal to provide federal income tax credits to employers for contributions to health care. This proposal is described in detail in a report prepared for The Commonwealth Fund, which I submit for the record.

The features of this proposal are designed to increase the likelihood that this employer tax credit strategy will succeed in substantially reducing the number of working uninsured while containing the cost of the program.

Key Design Features

1. The credit is available to all low-wage firms—those with average wage levels below $10 per hour—and graduated so that the amount of the credit is largest for firms with the lowest average wage.
2. The credit is permanent—that is, available as long as the firm meets the low-wage test of eligibility.
3. The credit is a large enough proportion of the cost of health coverage to induce a meaningful take-up rate among employers and their employees.
4. The credit is set at a fixed-dollar amount.
5. The credit is tied to the price of a "Standard" cost-effective benefit package.
6. The credit is uniform across the nation.
7. The credit is updated annually by repricing the Standard benefit package.
8. Firms must contribute toward the premium an amount equal to at least 50 percent of the cost of the Standard benefit package.
9. Employers taking the credit must offer coverage on the same basis to all full-time workers; coverage offered to part-time and temporary workers, though not mandatory, qualifies for the credit.
10. The credit amount is different for single and family coverage.
11. Firms are required to show proof of the amount they contribute to coverage when they file their income taxes and claim the credit.
12. Firms can claim the credit in installments rather than waiting until they file their annual income taxes, and the credit is refundable if the credit amount exceeds the firm's tax liability.

Our suggestion that the tax credit be made available to firms that already offer health coverage along with those newly offering is related to our decision to make subsidies permanent. Unless subsidies are available to firms already offering coverage, these firms and their workers would be treated inequitably. Workers in these firms have presumably foregone some wages or other benefits to obtain health coverage through the workplace. Thus, they have sacrificed their ability to buy other goods and services, and arguably are in need of assistance as much as workers who are uninsured (who may have a bit more money to spend on those other items). Yet, I must note that this decision to "level the playing field" across these two types of workers carries a price tag for the government. A proposal targeting only those firms newly offering coverage would be less equitable, but also less costly, in strict budgetary terms.

Partially offsetting this added cost is the provision that limits subsidies to low-wage firms. Excluding higher wage firms is justified by the fact that a high proportion of uninsured people are employees of low-wage firms. Most higher-wage firms offer coverage; so providing subsidies to them would add few people to the insurance rolls.

I conclude by reiterating that federal tax credits for companies could be one important weapon in the arsenal needed for a successful attack on the multi-faceted problem of the uninsured in America. We should develop a comprehensive reform strategy that addresses the diverse needs of our population and builds cost discipline into the package.

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Attachments.

A Federal Tax Credit to Encourage Employers to Offer Health Coverage

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Strategies to Expand Health Insurance for Working Americans
A Report Series from The Commonwealth Fund Task Force on the Future of Health Insurance

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EXECUTIVE SUMMARY

Many firms that employ low-wage workers cannot afford to offer an employee health plan, and many of the uninsured work for such firms. This article makes the case for an employer tax credit, administered by the Internal Revenue Services, as a way to extend health coverage to uninsured workers and their families. The permanent, fixed-dollar, refundable credit would be available to all low-wage employers (those with average wages of $10 per hour and below), including those already offering coverage. The credit would be graduated depending on average wage: the maximum credit would be equal to 50 percent of the cost of a standard benefit package, the minimum 30 percent. It also would vary by family size and could be used to

cover part-time and temporary workers. Participating employers would be required to pay at least 50 percent of the premium, proof of which would be shown on the firms' tax returns. The paper gives the justification for this approach. It closes with a discussion of strengths and weaknesses of this approach and alternative design features.

The problem of the uninsured is largely a problem of working people. More than four of five people who lack health insurance live in households with at least one worker. Most work for employers who do not provide health coverage, yet they and their families are not eligible for public programs. One way to extend health coverage to such people is for the federal government to offer tax credits to employers who contribute to the cost of their employees' health insurance. Many employers do not provide health coverage because they believe it is too expensive. This is particularly true of small firms. In 1999, only 55 percent of firms with three to ten workers offered health coverage, whereas among firms with 50 or more workers, more than 90 percent did so. Among small firms that do not offer coverage, 68 percent cite the high cost of premiums as a major reason.[1]

Although small firms are particularly likely not to offer coverage, not all of the uninsured work for small firms. A distinctive feature of the strategy presented in this paper is that the tax credits for employers would assist all firms that employ primarily lower-wage workers, not just small firms. Thus, assistance would be (indirectly) targeted to workers who would have difficulty affording health insurance on their own, regardless of the source of their employment. A cap on the tax credit (premium subsidy) for employers with average wages above a specified level would also screen out smaller firms comprised primarily of high-earning professionals (for example, law firms).

Another advantage of the tax credit approach is that it would work through the existing federal tax system; no new programs or bureaucracies would need to be established. Furthermore, if the program is properly designed, the cost of the subsidy could be controlled.

The principal disadvantage of this approach, which it shares with other approaches involving tax credits as incentives to offer health insurance, is cost. To be effective, the credit (and premium subsidy) has to be substantial. Unless the employer tax credits are set at rather high levels and thus cover a large portion of the cost of health coverage, the "take-up rate" among employers will be quite low. Even when employers do decide to offer coverage, unless the tax credit is sufficient to induce employers to contribute a substantial amount toward the premium, employees may not take up the employer's offer of coverage. Yet a credit set high enough to overcome this problem could be expensive, and the cost will be higher if all employers meeting the wage-level criterion are eligible, including those already offering and funding coverage.

The remainder of this paper describes how an employer tax credit could be designed to encourage more employers to offer coverage without being so costly as to make the idea politically infeasible. Although we confine our discussion to employer tax credits, it is worth noting that the approach is compatible with extending tax credits to low-wage employees as well. Since employer-sponsored coverage has significant advantages over individually purchased coverage, it is important to give employers inducements to offer coverage to their employees rather than simply to extend subsidies to employees so they can buy coverage in the individual market. Offering subsidies to both low-wage employers and their employees would likely increase the take-up rate substantially.

BACKGROUND

The effectiveness of a health insurance tax credit depends in part on the willingness of employers to offer coverage when they did not previously do so. That will depend, in turn, on how responsive employers are to a reduction in the price of coverage, which is the effect of the tax credit. Several studies have examined this question, using a variety of research methods. One group of studies uses variations in tax rates across states to determine the impact of after-tax prices on small firms' willingness to offer health coverage. Estimates of the price elasticity in this group of studies ranged from -0.63 to -2.9, indicating a strong response by employers to price changes (in other words, if price declines by 1 percent, the quantity of health insurance purchased should increase by somewhere between slightly less than 1 percent to nearly 3 percent).[2]

Actual experience yields a less optimistic view of the likely success of using tax credits as subsidies to induce employers to offer coverage. In the late 1980s and early 1990s, several states began to experiment with both tax credits and direct premium payments for employers who newly offered health coverage.[3] The tax credits

were generally quite small (for example, $25 to $35 per employee per month) and were not well publicized. The take-up rate by employers was very low, with most sites achieving less than 10 percent participation rates after more than a year in operation. Kansas, Kentucky, and Oregon used tax credits to try to induce companies to offer health coverage, generally with very limited success. But Oregon's program did manage to sign up more than 13,000 employers, affecting about 43,000 people.

Over this same period, the Robert Wood Johnson Foundation ran a $6 million demonstration project enabling states to design and offer direct premium subsidies for employers offering health insurance. While the experience varied considerably over ten sites, in general there was only a tepid response from the business community to the new subsidies, even though the projects effectively lowered premiums for employers by 25 to 40 percent. In Florida, for example, a demonstration project that used a state purchasing cooperative to lower premiums for firms with fewer than 20 workers offering coverage for the first time enrolled only 1.7 to 5.0 percent of the target group of firms in five participating cities. More recently, New York initiated a direct premium assistance program in 1997 that sparked considerable interest. In little over a year, some 1,100 firms signed up, and a waiting list developed because only $6 million had been appropriated for the program. The program is being phased out, however. It will be replaced by a larger program that will provide state-sponsored stop-loss coverage to health plans in order to reduce premiums—rather than provide direct premium assistance to small employers.

A review of these initiatives leads to the conclusion that if tax subsidies for employers are to have a noticeable impact on health coverage, they will need to include features that make them more costly than the pilot projects tried to date. The value of the credit needs to be substantial. To hold down costs and limit the inequities for firms that were already offering coverage, many states offered the subsidy for only a limited number of years. Employers reacted negatively to the "pilot" nature of the projects, fearing that they would start offering coverage with the help of the subsidy but then quickly be left to finance the full cost. Finally, the experience to date suggests that a major effort will have to be made to publicize the subsidies. Employers were often simply unaware of them.

THE TARGET POPULATION

The target population for the tax subsidy is firms with wages below a defined level. For the purpose of this analysis, we set the average-wage rate cutoff at $10 an hour. For a full-time worker, this translates into an annual salary of about $20,000 a year. Since the average family has 1.6 workers, some families with incomes in excess of $20,000 per year will benefit from the subsidy. We propose to extend eligibility to all low-wage employers, regardless of whether or not they currently offer coverage.

KEY DESIGN FEATURES

Several important design features increase the likelihood that this employer tax credit strategy will succeed in substantially reducing the number of working uninsured while containing the cost of the program:

1. The credit is available only to low-wage firms—those with average wage levels below $10 per hour—and is graduated so that the amount of the credit is largest for firms with the lowest average wage.
2. The credit is permanent, available as long as the firm meets the low-wage test of eligibility.
3. The tax credit is available to all low-wage firms, not just to those not currently offering coverage.
4. The credit is a large enough proportion of the cost of health coverage to induce a meaningful take-up rate among employers and their employees.
5. The tax credit is set at a fixed-dollar amount.
6. The credit is tied to the price of a "Standard" cost-effective benefit package.
7. The credit is uniform across the nation.
8. The credit is updated annually by repricing the Standard benefit package.
9. Firms must contribute toward the premium an amount equal to at least 50 percent of the cost of the Standard benefit package.
10. Employers taking the credit must offer coverage on the same basis to all full-time workers; coverage offered to part-time and temporary workers, though not mandatory, qualifies for the credit.
11. The credit amount is different for single and family coverage.
12. Firms are required to show proof of the amount they contribute to coverage when they file their income taxes and claim the credit.

13. Firms can claim the credit in installments rather than waiting until they file their annual income taxes, and the credit is refundable if the credit amount exceeds the firm's tax liability.

These basic design features are discussed below.

Targeting the Credit to Lower-Wage Firms

A unique feature of the proposed tax credit is that it is targeted to lower-wage firms. The credits would apply only to firms with average wage levels below $10 per hour, and the amount of the subsidy would increase as average wages fall below that level. The maximum credit—equal to 50 percent of the cost of the Standard benefit package—would apply to firms with average wages below $7.00 per hour. Firms with average wages between $7.00 and $8.50 would get 40 percent of cost of the Standard benefit package, and firms with average wages between $8.50 and $10.00 would get 30 percent of this amount. The hourly wage rates used to determine eligibility would be updated periodically, using the Consumer Price Index, to ensure that the wage-level cutoffs represent constant purchasing power and are not eroded by inflation.

There are compelling reasons to target the subsidies to low-wage firms. First, low-wage firms are much more likely to be non-offerers of health coverage. For example, a recent study by the RAND Corporation found that for low-wage firms with fewer than 50 workers, only 17 percent offered health coverage compared with 47 percent of higher-wage firms of the same size.[4] When group coverage is not available, these workers are also less likely to be able to do the "next best thing"—purchase coverage in the individual market. Such coverage is estimated to cost about 25 to 40 percent more than group coverage.[5]

Second, targeting low-wage firms also ensures that subsidies are not given to groups of high-earning professionals who could afford unsubsidized coverage. Besides conforming to widely accepted standards of fairness, implementation of this provision reduces the cost of the program to the federal government.

One drawback of this approach is that it adds a layer of administrative complexity to the system because firms have to collect and report average wage levels. Most companies, however, should have such information readily available.

Another concern that arises when subsidies are available only to low-wage firms is the "notch" problem: if there is a single cutoff point for eligibility, firms with wage levels just above the cutoff point receive no assistance even though their circumstances are essentially the same as firms just below the cutoff point. A gradual phasing out of the subsidy for firms with wage levels above the initial cutoff point, as we propose, can reduce such inequities. Not only is the approach more equitable, but it also gives employers less reason to worry that granting a wage increase would produce a large reduction in the firm's health insurance subsidy. However, making the subsidy graduated adds to administrative complexity.

An alternative to using firms' average wage levels to target the subsidy is using the proportion of workers with wages below a threshold level. For example, a firm's eligibility for the tax credit could be contingent upon 60 percent of the employees earning less than $10 per hour.

This alternative might improve the target efficiency of the employer tax credits, because it would screen in some companies in which most of the workers receive low wages but the average wage is above the threshold. An example would be a small company in which the president, and perhaps one or two senior managers, earned high salaries that pull up the average wage above $10 per hour. But, of course, this alternative would also exclude some firms that appropriately could be subsidized, such as those with an average wage below $10 per hour but where the percentage of employees earning $10 per hour is just below the cutoff level (for instance, 59 percent in our illustration above). Either approach is likely to exclude some firms that should be eligible. A third alternative would be to combine the two approaches, allowing firms to qualify either if the average wage was below a specified level or if the proportion of low-wage workers in the employer's workforce fell below a specified proportion.

Credits Are Not Temporary

The tax credit described here would be permanent, not temporary. An employer would qualify for the credit as long as the average wage paid to employees fell below the cutoff point. The most important reason for making the premium assistance permanent is to increase the "take-up" and the "stay-put" rates. The evidence cited earlier makes it clear that many employers are reluctant to take advantage of subsidies if they know they are temporary. Apparently, employers do not want, or believe that they would not be able, to bear the full cost when the subsidy is reduced or eliminated; and they would rather not provide coverage at all than provide it for a while

and then drop it. Furthermore, if the subsidy were temporary, some of the employers who would take up coverage would later drop it when the subsidy expires. But if the subsidy were permanent, most of these employers would continue to offer coverage.

The disadvantage of this approach compared to a temporary subsidy is the budgetary cost. When subsidies are temporary, the cost is obviously lower-though it is important to recall that for firms with rising real wage levels, the amount of the subsidy will decrease over time and may disappear.

All Low-Wage Firms Eligible

A second feature of this proposal distinguishes it from many other incremental approaches for extending coverage to the uninsured: the subsidy is available to firms that already offer coverage, as well as to those that do not. Making all low-wage firms eligible is a corollary of the decision to make subsidies permanent. Unless subsidies are available to firms already offering health coverage, these firms would be treated inequitably.

Approaches that restrict eligibility to firms not offering coverage differentially treats firms that are in all relevant respects essentially the same, giving subsidies to some but not to others. The firms already offering coverage would be penalized. According to economic theory, in order to attract an adequate supply of labor, firms in a labor market must pay comparable workers essentially the same total compensation (defined as cash wages plus benefits). Thus, if one firm in an industry pays for health coverage and another does not, then the non-offering firm must pay higher cash wages or increase the generosity of other employee benefits to offset the absence of health benefits. If the firm not offering health coverage becomes eligible for the tax credit and decides to offer coverage, this firm will have a competitive advantage over firms already offering coverage, which are not eligible for the subsidy. The firm newly offering coverage is being subsidized by the federal government in the amount of the tax credit. This firm will thus be able to pay its workers higher cash wages and thereby attract more productive workers; or, alternatively, it will be able to pay the same total compensation but use the savings to invest in some other part of the business or to increase profits. The subsidized firms (those receiving the tax credit) gain relative to competing firms that are ineligible for the tax credit. Firms that began contributing to health insurance before a tax credit was available could legitimately complain that they were being penalized for having made the decision to provide coverage. Many firms of this size are marginally profitable, so that giving an advantage to newly insuring firms relative to those already providing coverage might cause some of the latter to go under. Such inequities might be tolerable if the subsidies were phased out after five years or so, but they are not justifiable if the subsidy is permanent.

The obvious disadvantage of this all-inclusive approach is the higher budgetary cost: some firms that do not need the inducement of a subsidy to get them to offer coverage will now receive subsidies. It could be argued that the money that goes to these firms is "wasted," in the sense that it does not buy any reduction in the number of uninsured. We acknowledge the criticism, but we think the argument is not compelling, not only because of the inequities just examined, but for other reasons as well.

First, when subsidies are confined to employers not offering coverage, a good deal of administrative effort and expense has to be devoted to preventing "crowd out." The system has to be carefully designed to minimize incentives for employers to drop coverage so that they can become eligible for the subsidy, and safeguards have to be in place to ensure that only eligible employers and employees get subsidies. Making all low-wage employers eligible eliminates these significant administrative burdens and expenses.

Second, although allowing employers that already offer coverage to receive the tax credit adds to the budgetary cost, the total real resource cost to society—in terms of additional medical services utilized—would be essentially the same whether or not currently offering firms are eligible for the subsidy: only newly insured employees would be consuming additional medical resources. The previously covered employees were presumably already consuming a full range of medical services. The real cost to society is the other uses to which these resources might be put, but that is the same in either case. The difference between the two options is not the cost, but whether the cost appears in public or private budgets—and that does, of course, have important political implications. To the extent that employer already offering coverage, used the new credits to enhance benefits or maintain or lower employee premium shares, this feature could also help reduce the extent of "under-insurance" among low wage employees or moderate financial burdens.

Tax Credit Large Enough to Induce an Acceptable Take-Up Rate

The tax credit needs to be large enough to cause a significant proportion of non-offering employers to begin offering health coverage. For reasons about to be explained, we think that the credit should be about half the cost of reasonably comprehensive coverage.

As noted earlier, past experience with small tax credits has been dismal. Employers have largely disregarded the incentives. The cost of health coverage is particularly high for smaller firms, and they are often the least able to pay the high cost because many are on the margin of financial solvency. While some may be induced to participate by a small tax credit, most will require that the government pick up a major share.

A 1991 Harris poll of small employers (those with fewer than 50 workers) not offering coverage found that only 31 percent indicated that they were "very likely" to purchase insurance if the government subsidized one-third of the cost. The proportion that would actually purchase coverage with such a subsidy is deemed to be much lower, since employers tend to overstate their intentions in such surveys.[6]

The subsidy not only has to be large enough to induce employers to participate; it also has to be large enough that the employer's premium contribution is sufficient to induce employees to participate. For this reason, it is worth examining the evidence on how large a tax credit it would take to induce employees to participate in employer-sponsored coverage. A recent study by Professors Mark Pauly and Bradley Herring concludes that for low-income workers and their dependents below 300 percent of the poverty line, where the uninsured are disproportionately found, "substantial reductions in the number of uninsured will require credits in the range of a third to a half of the individual insurance premiums, with credits needed to be even greater than 50 percent for families with incomes at the bottom of this range."[7] Presumably, employer contributions of approximately the same magnitude would also induce employees to accept the employer-subsidized coverage.

In light of the discouraging experience with small credits, it seems likely that a credit that equals or approaches about half the cost of a rather comprehensive health plan would be needed. Setting the credit too low as a proportion of the premium, or pegging this proportion to a very basic plan that firms and employees would not want to select, can lead to a low take-up rate and therefore a minimal effect on the number of uninsured.

Under the proposed design, an employer eligible for the full subsidy could contribute 50 percent of the premium and have that amount completely reimbursed through the tax credit. The employer's net costs of providing coverage would be zero. Employees would be required to contribute the remaining 50 percent. A 50 percent contribution could be burdensome, however, for low-wage workers. It is hoped that with such a generous subsidy, many employers would contribute an amount above the value of the subsidy, thereby easing the burden on employees. If this did not occur, however, an alternative would be to require the employer to contribute an additional portion (25 percent, for example) in order to receive the tax credit. In effect, employers and employees would be splitting the remaining premium cost. This requirement on employers would force some firms to contribute more of the premium cost than they would otherwise. Although the extra amount would be a deductible business expense, the requirement would lower employers' take-up rate, at least to some degree. At the same time, it would increase the take-up rate for workers in firms that do take the credit. Without this requirement, more firms would take the credit, but a smaller proportion of workers would enroll in health plans.

Credits to employers could also be accompanied with direct premium assistance for low-wage employees to cover the employee share of the premium. These could be in the form of tax credits or direct premium assistance programs.[8]

Another way to ease the burden on low-wage workers who must contribute toward premiums is to coordinate financial assistance from other programs, such as Medicaid and the Children's Health Insurance Program (CHIP). This is discussed in detail below (see Interacting with Other Programs).

Fixed-Dollar Credit

A fixed-dollar credit amount provides firms with incentives to purchase reasonably priced, high-value health plans. The lower the premium for the plans selected the higher proportion of the cost that will be defrayed by the credit. Because the subsidy is limited, employers and employees also have incentives to choose plans that offer a high level of benefits (in terms of quality of care, levels of service, covered services, etc.) relative to premium cost.

An open-ended subsidy, in contrast, would provide an incentive for firms to "overpurchase" insurance. The incentive would be similar to that embedded in the cur-

rent tax exclusion, which permits workers to not count as taxable income the full value of their employers' contribution to health coverage.

The fixed-dollar subsidy, unlike an open-ended one, would help limit the cost to the federal government.

Credit Tied to the Price of a Defined "Standard" Benefit Package The tax credit for employers would be set as a fixed proportion of the nationwide average cost of an efficiently provided "Standard" benefit package. Coverage should include such vital services as hospital care, emergency department care, physician visits, preventive services, x-rays, laboratory work, prescription drugs, and mental health services. The levels of patient cost-sharing should be reasonable. The price would be determined by looking at the cost when these services are provided by an efficient health plan with appropriate controls over utilization and cost-effective relationships with providers. The purpose of choosing this approach is to keep the budgetary cost down and to provide incentives for employers to select efficient health plans to offer their workers.

The specification of a benefit package would be used only to set the level of the subsidy. Employers would not be required to offer coverage that includes the minimum benefits (though they would be required to comply with any state-mandated benefits and to make a minimum contribution, as explained below). An argument could be made for requiring coverage that includes specified minimum benefits, to ensure minimum levels of coverage.

However, defining a required benefit package is extraordinarily controversial. Moreover, as technologies and patterns of medical practice evolve, the content of a minimum benefit package should constantly be redefined. We think it best to avoid those complications.

Uniform Credit Nationwide

The amount of the tax credit would be uniform across the nation. A case could be made for varying the credit by geographic area because health care premiums vary sharply from region to region. With a uniform credit level pegged to a national average, the purchasing power of employers in regions with high health care costs will be less than intended, while employers in low-cost regions will be overcompensated. However, this consideration is outweighed by the need to keep the tax-credit plan workable and administratively feasible. The U.S. Treasury Department could be expected to vigorously oppose any provision in this plan that called for regional variation in the subsidy level. The Treasury Department would rightly argue that all other tax credits (for example, EITC, child care) are uniform across the nation.

In addition, raising the value of the tax credit in areas of the country with relatively high health care costs might send the wrong signal. The federal government would be seen as underwriting inefficient care delivery in high-cost regions, which goes against the grain of building cost discipline into the health care system. Payers with a national perspective are asking why various measures of utilization (for example, hospital admission rates, hospital bed days per 1,000 population, or surgery rates for certain high-cost procedures) are much higher in some parts of the country than in others. The federal government probably should not undercut this pressure by propping up higher costs with higher subsidies.

The credit would also not be adjusted for other characteristics of the firm's workforce that could have a predictable effect on its health-coverage outlays, such as the average age of workers, their health status, and their past medical-claims experience. Although a case could be made for such adjustments to assist employers who have an older or less healthy workforce, the need to keep the plan administratively simple argues against adopting such a provision.

Updating the Credit Amount

To ensure that the purchasing power of the credit does not dwindle over time because of inflation, the defined benefit package would be repriced from year to year. At the same time, any necessary changes in the composition of the package would be made. Again, the price would be what an efficient, high-quality health plan would charge for the defined set of services. The advantage of this approach to repricing is that it would ensure that the subsidy would stay equal to some fixed proportion of an appropriate benefit package as medical care costs increase and as technological change and changing social values redefine what should be included in a reasonably comprehensive benefit package. Repricing on this basis does involve a degree of complexity that some alternatives would avoid.

The principal alternative is to update the credit annually in line with general inflation in the economy. If past experience is any guide, this would mean that the real purchasing power of the credit would rise at a slower rate compared to our preferred approach. The argument for this approach has to do with cost discipline. Just

as varying the credit by region may serve to prop up higher health costs in some areas, adjusting the credit upward in line with health costs could contribute to the ongoing gap between the escalation in health care spending and that in the rest of the economy. By updating for economy-wide inflation, the federal government would keep the credits from eroding rapidly but at the same time would apply some pressure to bring health care spending increases under control. However, on balance, we do not find this argument persuasive. The kinds of employers who would take advantage of the tax credit are generally small and marginally profitable and would have little power to influence the rate of cost escalation for health care services. Moreover, if health care cost escalation were to substantially outpace general inflation, after a few years the purchasing power of the credit would be so eroded that the subsidy would be insufficient to induce many employers and employees to take coverage.

Minimum Contribution Level

Firms must contribute at least 50 percent of the cost of the "Standard" benefit package. For firms receiving the full tax credit, this requirement means that they would not be required to make any net (after-subsidy) contribution. But firms with wage levels too high to qualify for the full credit would have to make a net contribution. This feature is consistent with the notion that subsidies are tied to ability to pay.

The main purpose of this requirement is to ensure that employees of all participating firms, including those not receiving the full tax credit, benefit from a substantial employer contribution, thereby making coverage more affordable for employees and increasing the employee take-up rate. It is also worth noting that some health plans that sell coverage to small employers require that employers contribute at least 50 percent of the premium. Insurers impose this requirement because they want to encourage broader participation in the group and thereby reduce the likelihood that the only people who buy coverage are those who know they are likely to need expensive medical services.

The disadvantage of requiring a minimum premium contribution of 50 percent is that it will deter some employers who are not eligible for the full 50 percent subsidy from accepting the tax credit and offering coverage. In the absence of the requirement, some of these employers might be willing to offer coverage if there is no net cost to them, at least initially. And some of those might, after having experience providing coverage, be willing to use their own resources to continue coverage. Such employers will be lost from the system.

Note that we do not propose that employers be required to buy coverage that includes any minimum benefit package. We do, however, require a substantial premium contribution, enough to pay 50 percent of the cost of such a benefit package. But after that we let the market operate, based on the assumption that employers and their employees are in the best position to determine what kind of coverage best meets employees' needs. For example, they might decide to use the 50 percent amount to cover 80 percent of a somewhat less comprehensive set of benefits.

We do not propose that employers be required to make a contribution toward dependent coverage (though they would be required to offer dependent coverage). Although requiring a contribution to dependent coverage would certainly help to reduce the number of uninsured, we decided against such a mandate because it would almost surely reduce the take-up rate among employers. Moreover, working spouses who are employed by low-wage firms may also become eligible for coverage when their employer accepts the tax credit, and the family's children may be eligible for some other subsidized program, such as CHIP.

Minimum Requirements Regarding Who Is Covered

Employers would be required to offer coverage on the same terms to all full-time employees, defined as those working 32 hours or more per week. Employers could impose a waiting period before extending coverage to newly hired workers, but the maximum waiting period would be six months. In a firm with a preponderance of low-wage workers but also a few high-wage workers, it is possible that the high-wage workers would accept the employer's offer but most low-wage workers would not. While such a result would be inefficient in terms of targeting the subsidy to a population in need, it is a price worth paying and, in any case, will probably not be a frequent occurrence.

Employers could, but would not be required to, cover part-time, temporary, and seasonal employees. They would receive the full tax credit for covering such workers as an incentive to include this growing segment of the workforce. There could be a requirement that the tax credit is conditional on equitable participation of workers across different wage levels. Of course, the credit would apply only to premiums ac-

tually paid during the year. The credit would thus be based on the yearly average of the per-member per-month premium payment. In calculating average wage levels, the wages of temporary and part-time workers would be included on a pro rata basis.

Firms could not include in the wage calculation amounts paid to leased or contract workers even though they work at the company's work site. Self-employed consultants and contract workers could receive the tax credits as separate business entities, however, if they meet the wage criteria and if their state recognizes businesses with one employer as eligible for "group" coverage (further discussed below).

A minimum participation requirement might be set. For example, at least 50 percent of eligible workers might need to enroll in the health plan in order for a firm to receive the tax credit. An advantage of such a requirement is that the employer might work harder to encourage workers to participate, possibly contributing more toward the premium. Also, greater participation would help spread risk over a larger group and reduce adverse selection. Health coverage for groups frequently contains minimum participation rules for this reason. However, if some workers refuse to participate, they could deprive others of the chance to have health coverage. Therefore, the tax credit we propose does not contain an explicit minimum participation requirement, but rather leaves such guidelines to existing insurance rules.

Different Credit for Workers Purchasing Single and Family Coverage

The tax credit amount would vary for single and family coverage, rather than being a single amount based on a blend of single and family premiums. This removes the incentive for firms to favor hiring single workers, or those whose spouses and children are covered under the plans of the spouse's employer. With a blended rate, firms hiring single workers or those with spousal coverage would receive a windfall gain. Firms would have to report the number of employees with single versus family coverage, but this should not create a large administrative burden.

In practice, health plans often have at least three or four rates-for example, single coverage, worker and spouse, parent and children (no spouse), and full family coverage (two adults and children). But so many variations may be too complicated. The two-rate structure seems a fair compromise, and the family policy rate could be tied to a benefit package cost that is a blend of different types of family coverage.

Firms could take the credit only for workers who enroll in the company's plan. The total credit could not be greater than the amount the firm contributes toward premiums. Thus, if a worker is enrolled in a spouse's plan, the spouse's employer will get the credit but not the worker's employer. This would avoid double crediting.

Proof of Purchase

Firms would be required to demonstrate to the IRS that they purchase insurance or self-fund coverage that meets the requirements of the program. They would also need to document the amount they pay for coverage, and prove that they are making regular, periodic payments equal to or exceeding half of the premium cost of the Standard benefit package. Employers would have to document the annual average of the per-member per-month premium payment for both single and family coverage.

While a firm is receiving the tax credit, it cannot deduct the amount of the subsidy as a business expense. That is, it can only claim as a business expense deduction the net (after-tax credit) contribution to health coverage.

Overcoming Business Cash-Flow Problems and Changing Numbers of Workers
Some employers may have difficulty paying for coverage throughout the year and waiting to be reimbursed until well into the following year when they calculate their taxes. A system of advance credits or payments by the government might address this cash-flow problem. For example, employers filing quarterly tax returns could be permitted to reduce their tax liability each quarter to reflect the expected value of the tax credit. The credit could also be made refundable, so that companies that have little or no tax liability would receive a net payment.

Advance payments would alleviate cash-flow problems for many small firms. However, this approach might create some administrative complexity involving the year-end reconciliation between advance payments and the actual amount for which the firm turns out to be eligible. For example, a firm may claim advance payments using calculations based on 20 workers. If the firm downsizes and ends the year with fewer workers, its premium payouts may be less than predicted. If the discrepancy is small, the problem might be handled by offsetting the amount against allowable tax credits for the next year.

MAKING EMPLOYERS AWARE OF THE CREDIT

An important challenge involves developing a publicity campaign to acquaint employers with the tax credit. An outreach effort is a vital feature of a tax-credit program because past efforts at the state and local levels have been seriously limited by insufficient awareness of the subsidies' availability. A multimedia initiative could include a website with information on how to apply for the credit; newspaper, radio, and television public-service advertisements; and announcements through Chambers of Commerce and other business groups. The federal government needs to appropriate sufficient funds to ensure that the outreach effort is effective.

INTERACTING WITH OTHER PROGRAMS

The tax credit for employers will need to be coordinated with other programs to promote an integrated, comprehensive approach to broadening health coverage for uninsured workers and their families. As discussed above, even when employers offer and pay 50 percent of the cost of coverage, workers in firms newly offering coverage may still face significant financial barriers that discourage them from accepting such offers. Thus, it is important to couple efforts to get a good take-up rate among employers with a corresponding effort to obtain a good take-up rate among employees.

Many small firms that take the credit can be expected to contribute only the minimum amount, or 50 percent of the premium. A survey of low-wage employers who offered coverage found that among firms with 5 to 49 employees, 36 percent paid 50 percent or less of the premium. Among firms with between 50 and 99 employees, 41 percent paid 50 percent or less.9 It is likely that many firms taking the tax credit would pay the minimum 50 percent or just slightly more. Their workers might find that they could not afford to pick up the difference and would thus decline coverage.

As noted earlier, this line of reasoning supports federal subsidies for low-wage workers as well as their employers. States can also develop strategies for assisting low-wage workers who would have to contribute a substantial amount to employer-sponsored health coverage. For example, states could use both Medicaid and CHIP funds to assist workers with their contributions to premiums. Massachusetts, Mississippi, and Wisconsin have initiatives under way to do this. Florida and Oregon have proposals under review at the Health Care Financing Administration (HCFA).

Since the tax credits will be targeted to lower-wage firms, a substantial proportion of eligible workers will have children eligible for CHIP. A coordinated strategy for insuring the whole family could involve helping the parent afford the contribution to employer coverage while enrolling the children in CHIP. Alternatively, states have the flexibility to enroll the whole family in CHIP if they can demonstrate that it is cost-effective to do so.

States could also reinforce the proposed federal program of tax credits for employers by offering tax credits or subsidies to low-wage workers to help them pay their share of the premium. Massachusetts recently began a statewide program that includes premium assistance both for small businesses with low-wage workers and for low-wage (low income) workers.[10]

(As noted earlier, a few states have tried this approach on a very limited basis, using very small credits.) States may want to consider using a tax-credit approach more in line with the one outlined in this report. While such credits would cost more than those tried earlier, states may be able to recapture some of the cost in the form of lower outlays under Medicaid and CHIP.

REGULATORY REQUIREMENTS

Since most of the firms that will be newly offering coverage if a tax-credit approach is implemented are small, it is important to consider how the market for small-group coverage operates. In the past, the small-group market did not work well. Insurers used costly resources to attract low-risk groups and avoided insuring high-risk groups. Higher-risk groups were denied coverage or charged prohibitively high rates. Individuals who changed jobs might be denied coverage by the insurer covering the new employer, or coverage for an existing illness might be excluded. Even low-risk groups paid more for coverage than large groups. Changes in both federal and state law corrected many of the worst abuses, so that now no small employer can be denied coverage. In addition, exclusions for preexisting conditions are limited to reasonable periods of time; employees who move to a new job are guaranteed coverage under the new employer's health plan; and premium variations between high-risk and low-risk groups are restricted.

Nevertheless, problems remain with the small-group market. The relevant federal law, the Health Insurance Portability and Accountability Act (HIPAA), is silent in

terms of limiting the amount by which health plans can vary premium rates between high-risk and low-risk groups. States were left with responsibility for setting those limits. Although most states have imposed some limits, the permitted rate variation varies greatly from state to state. In some instances, the allowable rate variation between high-risk and low-risk groups can exceed a ratio of 10:1. This means that in some states, providing a substantial tax credit will not make coverage affordable for a small high-risk employer. Legislation limiting premium variation based on health status or past medical claims experience to reasonable levels might remedy this problem. The federal government has so far been reluctant to regulate in this area.

Another problem with the small-group market seems to offer no easy solution. A relatively high proportion of the premium goes to pay for administrative costs rather than medical expenses. Proponents of health purchasing alliances, coalitions, or cooperatives (HPCs) hoped that collective purchasing would produce savings in administrative costs and give small groups bargaining power to negotiate better rates generally. The expectation was that by centralizing some of the tasks such as marketing, premium collection and payment, and resolving claims disputes—tasks which would normally be done by individual companies and individual insurance agents—HPCs could achieve economies of scale.

Although HPCs have experienced some successes in other respects, they have not been able to reduce the cost of coverage appreciably for small employers.11 The evidence indicates that it will be difficult for them to reduce administrative costs unless they attain a substantially larger market share than they have yet been able to do. For this reason, a case could be made for requiring small employers who accept the tax credit to buy coverage through HPC-like entities. Such a requirement could help HPCs attain the critical-mass size that would let them achieve administrative savings. The lower premium that would result would induce more employers to accept the credit, which means that the federal subsidy would be more successful in getting uninsured people covered.

Alternatives to requiring participation in a HPC are (1) making sure that a purchasing alliance is available, or (2) permitting small employers to obtain coverage through state employee health programs. Under either scenario, small employers have the opportunity to benefit from key advantages of being part of a larger group entity. HPCs and most state employee programs allow individuals in a group to select different health plans. This increases the probability that employees and their families will be able to get coverage that permits them to keep their current doctors and to choose a plan that best meets their needs and preferences. Moreover, the economies of scale that HPCs achieve allow them to present comparative information about plan features and performance in a way that firms accepting the tax credit could not do on their own. Both employers and employees are likely to make better choices as a result.

The self-employed present special problems. Some self-employed people are low-wage "employers," although they have only one employee (the owner). The small-group reform laws in a number of states define the self-employed as a "group of one." HIPAA, however, includes only groups of two or more. For purposes of extending coverage to more uninsured people, a case could be made for making groups of one eligible for the tax credit.

But this option poses many complications. Insurers argue that groups of one are much like individually insured people, and that offering them coverage poses real dangers of adverse selection. Self-employed people who know that they need coverage will buy it, while healthier self-employed people will not. Insurers argue that some people start firms merely for the purpose of qualifying for (less expensive) group coverage. We propose to deal with this issue by making self-employed people eligible for the tax credit if their state's small-group reform laws apply to groups of one; otherwise they would be excluded. This seems to be a reasonable compromise, and it may mitigate some of the opposition that insurers would likely mount against the inclusion of the self-employed where state law does not define them as a group.

STRENGTHS AND WEAKNESSES

This employer tax-credit approach to subsidizing the expansion of health insurance coverage has significant strengths compared to other approaches. First, it is administratively simple. It requires no new bureaucracy nor significant new administrative apparatus; tax credits for business have been used many times previously. Monitoring and enforcement should be relatively easy. Employers who want to take advantage of the tax credit could do so without having to take on onerous burdens to prove eligibility or to conform with the rules.

Second, the tax-credit approach is politically more palatable than some other approaches. It does not require a federal budgetary authorization. The financing comes in the form of foregone revenues. Of course, the ultimate impact of foregone revenues is the same as if a comparable amount were spent on budget, but the political onus is smaller. In addition, the phase-out for higher-wage employers greatly reduces the cost in terms of foregone tax revenues. Finally, as outlined here, the tax credit for employers relies heavily on the market, in the sense that it delegates to employers the decision about how much and what kind of benefits to offer and gives them complete latitude in choosing health plans.

Third, this tax-credit plan is efficiently targeted. Since only low-wage firms (and their employees) are eligible, very little of the money would go to people who are not needy. Almost everyone who would end up with coverage—even those who were already covered—would be someone whose income is low enough that the subsidy is justified.

Fourth, by subsidizing employers, the approach encourages the expansion of group coverage, unlike a subsidy for individuals, which would likely expand individual insurance coverage. Group coverage is more efficient than individual coverage, with administrative and marketing costs spread over a larger base. By pooling risk, group coverage stabilizes and evens out costs for people with varied risk profiles.

The most obvious disadvantage of the tax-credit approach is that it is incremental and would help only some of the uninsured. It would be targeted to workers, but not to all of them. Some employers who would qualify for the tax credit might never learn about it. Others may decline the credit, either because they distrust government or because they do not want to pay their share of the premium and make the implied promise to continue to do so. Even when employers offer coverage, some employees will decline it, either because the financial burden is still too great or for other reasons. Some will get coverage for themselves but not for their spouses or children.

An employer tax credit is less direct than an approach that subsidizes employees directly. Some employees who would buy coverage if the subsidy were provided directly to them rather than through their employers will not get coverage because the employer decides not to take advantage of the tax credit. In other words, the number of covered employees would probably be higher if the same credit were available directly to workers. On the other hand, workers who received a direct subsidy but whose employers did not provide coverage would be forced into the individual insurance market, where as mentioned above, a premium dollar buys less coverage and higher-risk people would have great difficulty getting affordable coverage. Correcting the deficiencies of the individual market is a very difficult task.

Finally, compared to a more comprehensive approach to achieving nearly universal coverage, employer tax credits would add yet another incremental layer of complexity on top of a very complex system for helping people finance health coverage. It would address only the financing problem of our health care delivery system; it provides no impetus for improved quality or efficiency, and simply adds to demand without any focus on controlling costs. But it shares these deficiencies with almost all other incremental reforms.

ENDNOTES

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[5] Pauly, M., and B. Herring, "Cutting Taxes for Insuring: Options and Effects of Tax Credits for Health Insurance," prepared for the Council on the Economic Impact of Health System Change conference, "Using Tax Policy to Reduce the Number of Uninsured," December 17, 1999. Others have found much higher loading costs. See

Beth Fuchs and Mark Merlis, Private Health Insurance Options for Reform. U.S. Government Printing Office, Committee Print 101–35, 1990.

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[7] Pauly and Herring, 1999.

[8] See the following for a discussion of credits to employees for premium shares: Merlis, M. Public Subsidies for Required Employee Contributions Toward Employer-Sponsored Insurance, The Commonwealth Fund, December 2000.

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[10] Silow-Carroll, S., E. K. Waldman, and J. A. Meyer, "Enhancing Health Coverage for the Working Uninsured: Lessons from State and Local Programs," draft paper prepared for The Commonwealth Fund, October 2000.

[11] Wicks, E.K., M.A. Hall, and J.A. Meyer. 2000. Purchasing Health Coverage for Small Employers: Barriers to Small-Group Purchasing Cooperatives. Washington, D.C.

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#413 *Private Purchasing Pools to Harness Individual Tax Credits for Consumers* (December 2000). Richard E. Curtis, Edward Neuschler, and Rafe Forland, Institute for Health Policy Solutions. Combining small employers into groups offers the potential of improved benefits, plan choice, and/or reduced premium costs. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes the establishment of private purchasing pools that would be open to workers (and their families) without an offer of employer-sponsored insurance or in firms with up to 50 employees. All tax-credit recipients would be required to use their premium credits in these pools.

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#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#262 *Working Families at Risk: Coverage, Access, Costs, and Worries—The Kaiser/Commonwealth 1997 National Survey of Health Insurance* (April 1998). This survey of more than 4,000 adults age 18 and older, conducted by Louis Harris and Associates, Inc., found that affordability was the most frequent reason given for not having health insurance, and that lack of insurance undermined access to health care and exposed families to financial burdens.

Employer Tax Credits to Expand Health Coverage: Lessons Learned

PREPARED FOR

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BY

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About The Economic and Social Research Institute (ESRI)

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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SUMMARY

One way to encourage small businesses to offer health insurance coverage to their employees is to make coverage more affordable by providing tax credits or other types of premium subsidies. Experience with such programs to date - including tax credits in a handful of states, and direct subsidies in New York and other demonstration sites - shows that in general, employer subsidies do not spur much new coverage. This may be due in part to the nature of the program, and in part to certain design features and methods of implementation. The success of an employer tax credit or subsidy program, in terms of participation by small businesses, appears to be related to the following factors:

- Amount of subsidy: The amount of the subsidy must be substantial in order to provide adequate incentive to employers; this, however, raises the cost of the program;
- Awareness: There must be a strong publicity campaign to reach small businesses that do not offer coverage; this requires a significant front-end investment in sophisticated marketing efforts;
- Duration of subsidy: Tax credits or subsidies are generally designed to phase out after a few years; i.e., they are meant to "jump start" coverage rather than provide ongoing support. While this makes sense from budgetary and fairness standpoints (ongoing subsidies are costly and unfairly penalize firms that had been providing coverage with no subsidy), small firms are wary about making a new commitment knowing they will lose the financial assistance in the near future;
- Eligibility requirements: If the tax credit is not available to the business owner and his/her family, the firm is much less likely newly offer coverage to employees; also, if eligibility is contingent on a firm's not

offering health benefits over long prior period, this will limit participation;

- Permanence of program: Pilot/demonstration projects are by definition temporary, pending documented success of the program and the securing of additional funding. Further, state subsidies are vulnerable to being cut when states experience fiscal problems. Employers are understandably wary of entering a program that may lose support.

An additional factor that would influence the impact of tax credits on employers is the state of the economy and the labor market. In a strong economy with tight labor markets, more employers may be likely to utilize subsidies to purchase health benefits in order to help attract and retain workers. Even in a strong economy, however, many small firms operate with low profit margins and uncertain future cash flow, which may discourage them from making a commitment to fund a new benefit. Further, the high cost of health insurance -- even with large subsidies - would continue to deter many small businesses under a voluntary system.

State Tax Credits

Experience with state tax credits to employers who newly offer coverage is very limited. There was serious consideration of employer tax credits in state legislatures in the late 1980s and early 1990s, and bills were proposed in New Jersey, New Mexico, Ohio, Massachusetts, Rhode Island and other states. Most were not passed, however, due to the expectation of federal health care reform under President Clinton and states' reluctance to "get ahead" of the federal government. Instead, the states' efforts shifted toward encouraging the *individual* to obtain coverage, through, for example, medical savings accounts.

A few states, however, did pass employer tax credits, and their experiences provide important lessons. Following are summaries of these states' programs.

Oregon

Oregon's experience with a tax credit from the late 1980s through 1995 reveals the limitations of a modest tax subsidy to motivate employers to begin offering coverage. The state ended the program in 1995, due primarily to low enrollment levels.[1]

Eligibility: Tax credits were available to small businesses that had not offered employee health benefits for the previous two years or longer.

Amount and Phase-out: The value of the credit was $25 per employee per month in year one, declining over five years to $6.25 in year five and zero in year six and beyond.

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[1] Lipson, Debra J., Daniel M. Campion, and Michael Birnbaum. *Approaches for Providing/Financing Health Care for the Uninsured: An Assessment of State Options and Experiences,* Alpha Center, prepared for California HealthCare Foundation, August 1997.

Proof of Coverage: Employers showed proof of purchase of "certified" insurance plans meeting state requirements. The state's Insurance Pool Governing Board, established in 1987, negotiated premiums for certified plans on behalf of small firms.

An estimated 13,700 small employers covering 43,300 lives used Oregon's tax credits between 1989 and 1995. These numbers were considered low, however, as small employers perceived the credit as a help but not as a primary motivator to begin offering coverage, according to a program administrator.[2] As a result, the state decided to phase out the program and redirect resources toward marketing efforts designed to educate small firms and individuals about available coverage options, including a state-sponsored insurance pool.

The state purchasing pool, administered through Oregon's Insurance Pool Governing Board (IPGB), offered lower-cost, "certified" insurance plans for small companies (1 to 50 employees) that had not provided health insurance over the prior two years. Costs were kept down not through direct subsidies, but rather through an exemption from state mandated benefits, availability of a "bare bones" plan, and negotiations between IPGB and insurers. Enrollment declined over the late 1990s, however, primarily due to insurance reforms (e.g., modified community rating) that made it easier for small groups to buy coverage in the private market. Oregon ended the certification function in 1999, and is helping small firms transition into new plans in year 2000. [3]

Kansas

The Kansas experience highlights the central role of publicity in driving participation in a tax credit program. In 1991 the Kansas legislature passed a tax credit for small employers who newly offer coverage, but the program was not publicized - and therefore not utilized -- until after the bill was

[2] .Lipson, et.al., 1997, p.31..

slightly revised in 1999. One important revision was to make the tax credit *refundable* to businesses whose credit exceeds the state taxes owed (the original version allowed the credit to be carried over to succeeding years). The subsidy is designed to phase out over six years so employers do not establish ongoing dependence on the government.

Eligibility: Businesses with 2 to 50 employees that have not contributed to health insurance for employees in the previous two years are eligible. Self-insured firms are not eligible. Eligible employees are those working an average of at least 30 hours per week and who elect to participate in the firm's benefit plan.

Amount and Phase-out: Employers receive a tax credit for a portion of the contributions they make to health insurance for their employers, which is phased out according to the following schedule:

- Years 1 and 2: $35 tax credit per month per employee or 50% of the total annual premium, whichever is less;
- Year 3: 75% of the amount in years 1 and 2;
- Year 4: 50% of the amount in years 1 and 2;
- Year 5: 25% of the amount in years 1 and 2;
- Year 6 and beyond: tax credit no longer available.

Proof of coverage: Eligible businesses applying for the tax credit receive a certificate from the state, which must be submitted when filing income taxes. In addition, the firm's insurance agent must sign a form certifying that the business has provided an employee health benefit plan during the previous year.

Publicity: The state insurance department began a publicity campaign in 1999 consisting primarily of announcements in newspapers and magazines,

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[1] Spencer, Michael S. *Health Policy for Low-Income People in Oregon*, Occasional Paper #31, Assessing the New Federalism, Urban Institute, Washington, D.C., September 1999, and Oregon web site: www.ipgb.state.or.us.

geared toward small businesses. Publicity is viewed as the major challenge for enhancing participation, and the campaign will continue into 2000.

As of January 2000, 37 companies had been issued certificates to receive the tax credits. It is too early to determine how successful this program will be, but it seems that the relatively small amount of the credit and the limited modes of publicity may hinder major expansion of the program.

Other state tax credit programs

Other state's experiences with tax credits were quite limited:[4]

- Kentucky enacted a tax credit for employers in 1990, but it was phased out in 1996-1997, as scheduled, and it has not been renewed.[5] The credit was available to firms of any size that had not provided health insurance to employees. It was worth up to 20 percent of the employer's contributions to premiums in year one, and decreased by 5 percentage points per year, ending in year five.

- In 1989, California authorized tax credits to begin in 1993. Small businesses (up to 25 employees) would be eligible for credits worth the greater of $25 per employee per month or 25 percent of the employer's contribution. If the health plan included well-baby care and mental health benefits, the tax credit would increase by $5 per month. Due to cost concerns, however, the law was repealed in 1993 before being implemented.

- Massachusetts offered tax incentives to small businesses between 1990 and 1992 as an incentive to offer coverage voluntarily before a scheduled mandate was to take effect in 1992. The latter was not implemented, and a new employer tax credit proposed by the Governor was rejected by the legislature in 1996.

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[4] Lipson, et.al, 1997,.p.30.

[5] The state was unable to retrieve enrollment rates. (Personal communication with Jennifer Check, Kentucky Department of Revenue, January 5, 2000).

Direct Subsidies

The impetus of employer tax credits - to encourage firms to offer health benefits by making insurance more affordable - could be achieved outside of the tax system as well, through direct or indirect (non-tax) subsidies. Both employer surveys and reviews of actual subsidy programs indicate, however, that *a relatively small portion of small employers (currently not offering coverage) would be interested in offering health insurance to their workers even if the cost is subsidized up to 50 percent.*[6] The following summarizes results of various subsidy programs.

Health Care for the Uninsured Program Demonstration Projects

A review of ten demonstration projects[7] that provided subsidized insurance products to small employers and their workers in the late 1980s and early 1990s found a wide degree of responses across sites, but on average very low interest in the programs.[8]

The Florida Health Access Corporation, for example, which used a state purchasing cooperative to discount premiums by 25 to 40 percent for small firms (less than 20 employees), enrolled only 1.7 to 5.0 percent of their target markets in the five participating cities. The highest participation rates were achieved in the MaineCare Program, which used direct and indirect subsidies to reduce costs for small employers (up to 15 employees) and self-employed by 24 to 60 percent. MaineCare's two sites achieved participation rates of 12 percent and 17.3 percent after 12 and 37 months, respectively, representing a total of about 1,600 insured individuals in 522 enrolled firms.

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[6] In a Harris poll, among employers of firms with 100 or fewer employees that do not offer health coverage, 31 percent said they would be "very likely" to offer coverage if the government subsidized the cost by one-third. With 50% premium reduction, 36% said they would be "very likely" to offer. Caveat: even a "very likely" response is viewed as an overemphasis of employer intentions. (Health Care Outlook Survey, 1991).

[7] Grants totaling over $6 million were awarded by the Robert Wood Johnson Foundation's Health Care for the Uninsured Program, designed to test innovative, incremental strategies of expanding health coverage to specific target groups.

[8] Helms, W. David, Anne K. Gauthier, and Daniel M. Campion. "Mending the Flaws in the Small-Group Market," *Health Affairs*, Summer 1992, pp. 7-27.

In general, the demonstration projects found that uninsured small employers are very difficult to reach and a "tough sell."[9] Since most small firms lacked full-time benefits managers, extensive education and information, follow-up, and support - particularly during the application process - were needed. The programs' experiences reinforce the importance of publicity: the more successful projects used professional advertising firms and sophisticated public relations campaigns to generate media coverage; projects that did not invest significant resources toward publicity had disappointing enrollment. Even with aggressive marketing and generous subsidies, however, it was clear that these projects had difficulty convincing small employers to begin offering health benefits.

New York State Health Insurance Pilot Program

An analysis of a New York pilot program providing 50 percent subsidy to employers newly offering health coverage found a very weak response, due in large part to low awareness. Further, it predicted limited potential even with full awareness and with more generous subsidy levels. [10]

In 1988, New York State approved two employer subsidy pilot projects, which began in mid-1989. Small businesses (up to 20 employees) that had not provided health coverage during the previous two years were eligible to receive a 50 percent subsidy toward the premiums of comprehensive health plans. The direct impact of the subsidy was an increase in small businesses providing coverage of only 0.6 to 3.5 percentage points. The primary obstacle appeared to be lack of awareness; only 17 percent and 22 percent of surveyed eligible employers in the two sites, respectively, had heard of the program. Other obstacles to participation included the following:

- High cost of insurance despite subsidy;
- Subsidy not available to the owner or operator of the firm;

[9] *Helms, et.al, 1992,* p.16.

- Short-term nature of subsidy (18 months);
- Employees excluded from contributing toward premium; and
- Exclusion of firms offering coverage over prior two years.

Surveys of eligible employers at the two project sites indicated that under *full awareness*, the proportion of firms offering insurance would increase by 16.5 percentage points. Full awareness combined with increasing the subsidy to 75 percent would potentially increase the proportion of firms providing insurance from 12 percent to 41 percent (an upper limit). Even with such generous funding, however, 27 percent of employers said they were not interested in purchasing coverage.

This analysis demonstrated that publicity is critical, but it also revealed the limitations of voluntary programs to expand coverage to the majority of uninsured small businesses.

New York State Health Insurance Partnership Program (NYSHIPP)

The New York State Health Insurance Partnership Program (NYSHIPP) experience demonstrates the importance of financial commitment to a subsidy program and the vulnerability of such programs to the budget process.

NYSHIPP was established by the New York Health Reform Act of 1996 to assist eligible employers and self-employed people in purchasing small group health insurance policies for themselves, their employees, and dependents. The program, under the auspices of the New York State Department of Health, became operational in August 1997, and by the end of 1998 it had committed its allotted $6 million and started a waiting list. As of the end of 1999, the program was subsidizing health insurance for about 1,100 small businesses.

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[10] Thorpe, Kenneth, Ann Hendricks, Deborah Garnick, Karen Donelan, and Joseph Newhouse. January 19, 1992. "Reducing the Number of Uninsured by Subsidizing Employer-Based Health Insurance: Results from a Pilot Study" *JAMA*, 267, pp. 945-948.

The program was scheduled to end on December 31, 1999, and it was not renewed under the new state budget for year 2000. As a result, the firms already enrolled in NYSHIPP will continue to receive premium subsidies through mid-2003, but businesses on the waiting list will not enter the program, and new enrollment has ceased. However, the state is planning a new, larger program geared toward providing discounted insurance to small firms that will be initiated under the New York State Department of Insurance (described further below).

Eligibility: Eligible businesses must be located in New York State; have one to 50 employees OR be a proprietor without employees and have gross household income below 222 percent of the federal poverty level; and have not provided group health benefits to any employee during the 12 months prior to application. Eligible employees must work at least 20 hours per week.

Amount: NYSHIPP premiums are subsidized up to 45%. Employees may pay 10% and employers 45%; or, employers may pay 55% of premiums (i.e., employee contributions are limited to no more than 10%.

Coverage: The health plans include group health insurance policies or comprehensive health services plans issued on a community-rated, open enrollment basis. The application for the subsidy includes a list of "participating" insurance companies, where participation means only that they offer group health insurance; special legislation requires that small groups include one-person businesses.

Publicity: The state department of health contracted with the firm MDI Associates to administer and publicize the program. The publicity campaign focused on the media - TV, newspaper, and radio -- and large mailings to small employers throughout the state.

Unfortunately, the NYSHIPP experience could be seen as a warning to small businesses that public subsidies might not last, discouraging participation in

similar future efforts. The waiting list established only a year after implementation demonstrates the need for adequate funding, and the program's cancellation demonstrates the need for ongoing political support and commitment. It is not known how many uninsured persons would have obtained coverage if more funds had been allocated to the program. Nor is it known at this point how many businesses will continue to provide coverage after the subsidy is phased out.

New and Upcoming State Employer Subsidy Programs

Massachusetts Insurance Partnership

The *Insurance Partnership*, a new state program in Massachusetts, offers direct subsidies to small businesses employing low-wage workers. A "sister" program, *MassHealth Premium Assistance Program,* offers premium subsidies to help low-wage workers pay their share of premiums.[11] Insurance Partnership enrollment begins in early 2000; an advertising campaign commenced in late January, 2000.

Eligibility: To be eligible for the small business subsidy, a firm must:

- Employ 50 or fewer workers;
- Offer comprehensive health insurance to workers (it is not necessary that it is "new" coverage);
- Contribute at least 50 percent of the premium.

Eligible firms are paid a subsidy for each "qualified employee." A "qualified" employee must have family income that does not exceed

[11] Individual workers may receive subsidies toward their work-based insurance premiums if: they work for a small business (up to 50 employees) OR they work for any size firm and have children; have an employer who pays at least half the premium; and have gross income that does not exceed specified amounts that vary with family size ($16,488 for family of one, $33,048 for family of four).

designated amounts; e.g., $16,488 for family of one, $33,408 for family of four.[12]

Amount: The Insurance Partnership will pay up to $400 (individual), $800 (couple or adult plus child), or $1,000 (family) a year toward health insurance costs for each qualified employee.

Healthy New York

New York State's Department of Insurance is developing a new, $219 million *Healthy New York* program geared to expand insurance coverage among: 1-small businesses without coverage, and 2-working uninsured individuals. The program for small businesses is innovative in that, instead of providing direct subsidies to *employers*, it will provide a type of "stop-loss" protection to HMOs, which will enable the HMOs to reduce premiums for small businesses. HMOs under contract will be able to submit to the state medical claims in the $30,000 to $100,000 band.

It is not yet known the extent that premiums will be discounted, but HMOs wishing to participate will submit rate filings and must be approved by the state. The health plans will include a standard benefit package.

Eligibility: Eligibility for employers is anticipated to include:

- Firm size limited to 50 employees or less;
- At least 30 percent of workers receive annual wages of $30,000 or less;
- Employer contributes at least 50 percent of the premium;
- Employer has not offered coverage over prior 12 months.

During the year 2000, necessary regulations will be developed, and marketing and outreach strategies will be implemented for a planned January 2001 enrollment.

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[12] These amounts are valid through March 31, 2000 and are periodically updated. (Insurance Partnership promotional material and Personal Communications, January,2000.)

Local, Pilot Subsidy Programs

In addition to the state-level programs described above, there are a number of smaller-scale, demonstration projects geared toward expanding health coverage among small businesses. Following are some examples, though it is too early to assess their impact:

Small Business Premium Subsidy, Denver, CO

A demonstration program initiated in 1999 through Denver Health Community Voices targets low-income, small businesses newly offering coverage to workers. A sliding scale subsidy worth 20 to 50 percent of the health insurance premium is available to firms contracting with Denver Health Medical Plan for the Small Business HMO who: have 2 to 50 employees enrolling in the plan; had net income of less than $50,000 the previous year; and did not offer coverage over the prior 90 days.

As of January 2000, 23 small businesses were receiving subsidies under the program, and a new marketing campaign is geared to expand participation. The subsidy is available years 1 and 2, and again in years 4 and 5.[13] The current five-year, $5 million study is funded by the W.K. Kellogg Foundation and the Colorado Trust. It is hoped that successful results will lead to ongoing public financing in the future.

Health Choice, Wayne County, MI

In Wayne County's Health Choice program, the county subsidizes health insurance for employers with low-income workers. The county pays one-third of the premium, and the remainder is split between the employer and employee. Employees are eligible if their wage is less than $11 per hour and if they were previously uninsured. As of January 2000, approximately 8,000 individuals were covered under the program.

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[13] The subsidy is not available year 3 because the researchers are trying to determine the extent to which businesses retain coverage without financial assistance. (Denver Health Community Voices, *Annual Progress Report July 1, 1998-December 31, 1999*, and Personal Communications December 1999 and February 2000.)

Small Business Health Insurance Initiative, New York, NY

Initiated in 1999, this demonstration project makes low cost health insurance available to small employers (2 to 50 employees) in East Harlem, South Bronx, and Northern Brooklyn. Unlike most programs described here, this initiative does not involve public subsidies or tax credits; rather, a very limited provider network helps reduce the cost of the insurance plan to about half the cost of the average small group plan in the area. There are no eligibility criteria related to income or previous offering of coverage. As of February 2000, about 25 businesses were enrolled (130 covered lives). A two-year evaluation by PricewaterhouseCoopers is being funded by the Commonwealth Fund and the Health and Hospitals Corporation.

PREPARED STATEMENT OF DONNA COHEN ROSS

Chairman Grassley, Senator Baucus and members of the Finance Committee, thank you for the opportunity to speak to you today about the efforts states are making to reach out and enroll children in children's health coverage programs. My name is Donna Cohen Ross and I am the Director of Outreach at the Center on Budget and Policy Priorities. The Center is a nonprofit policy institute here in Washington that specializes in programs and policies affecting low- and moderate-income families, including issues related to health coverage for the uninsured. Through our Outreach Division, the Center also works with states and local governments, health and human services providers, and community-based organizations and institutions on strategies to identify uninsured children who are eligible for publicly-funded health coverage programs and to help get them enrolled. The Center does not hold (and never has received) a grant or contract from any federal agency.

The enactment of the Balanced Budget Act of 1997, the federal law that created the State Children's Health Insurance Program (SCHIP), set in motion an unprecedented wave of activity to expand health coverage to uninsured, low-income children. Under the law, states can use their SCHIP allotments to expand Medicaid, to create a separate child health coverage program, or to do both. At this point, 95 percent of uninsured children in families with income below 200 percent of the federal poverty line (about $35,000 per year for a family of four in 2001) are now income-eligible for Medicaid or the SCHIP-funded separate program in their state.[1]

Making health coverage available is the first necessary step, but taking that step does not guarantee that children will enroll. To tackle this challenge, driven in part by the outreach requirements built into the SCHIP law, states have undertaken ambitious outreach initiatives. These activities have included widespread public education campaigns, efforts to simplify application forms and procedures, and efforts to provide application assistance at community-based sites, such as health clinics, schools, child care programs and other places that families with children gather. The federal government has been a critical partner in these endeavors, providing tools needed to design streamlined programs, resources to support outreach activities and technical assistance to help maximize opportunities to enroll children in health coverage.

As a result of this multi-faceted approach, we now have over 20 million children covered under Medicaid and 3.3 million covered under SCHIP (Table 1), and recent Census data reveal that 1.1 million fewer children were uninsured in 1999 than in the previous year. These children the vast majority of whom are in working families that previously had no access to affordable health coverage now have access to

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[1] Matthew Broaddus and Leighton Ku, *Nearly 95 Percent of Low-Income Uninsured Children Now are Eligible for Medicaid or SCHIP*, Center on Budget and Policy Priorities, December 2000.

health benefits that include routine check-ups and preventive care that children need to remain healthy and to achieve in school.

But the job is not yet done. Survey and focus group research has indicated that many families with eligible children may still be unaware that health coverage is available to working families, or they believe the enrollment process is difficult and time-consuming. Those who do initiate the process often find the forms confusing, the required documentation hard to collect and the process long and complicated. These problems may be compounded by language barriers or by perceptions about the program that are vestiges of Medicaid's former link to the welfare system.[2]

To ensure ongoing, lasting progress in reducing the number of uninsured children, states must continue to simplify and, where they have chosen to operate SCHIP-funded separate programs, apply the simplified procedures adopted for their SCHIP programs to Medicaid so that their children's health coverage programs will be well-coordinated. Sustainable improvements will depend on states' efforts to remove unnecessary barriers to enrollment, ensure children are smoothly transferred from Medicaid to separate SCHIP programs, or vice versa, if family income changes, and enable children to retain coverage for as long as they are eligible. Continued emphasis on aligning enrollment procedures in SCHIP-funded separate programs and Medicaid will save families from having to navigate the intricacies of two distinct systems and will help make further headway in recasting Medicaid as a health coverage program, rather than an adjunct to the welfare system. Alignment has advantages for states as well, making administration easier for states with dual-program systems.

Most states have taken these goals seriously and have used the substantial flexibility available to them under current law to take the following steps in both their SCHIP-funded separate programs and Medicaid.[3] (Tables 2 and 3):

- Twenty-eight (28) of the 32 states that operate separate SCHIP programs use a single, joint application for Medicaid and the SCHIP-funded separate program;
- forty-two (42) states no longer consider a family's assets (such as savings or the value of a car) in determining eligibility for children's health coverage;
- forty (40) states have removed the requirement that families apply in person at a welfare office and allow applications to be submitted by mail;
- thirty-nine (39) states allow children to retain coverage for 12 months before they must renew their eligibility; and
- many states have taken steps to minimize the verification requirements, greatly reducing the paperwork burden on families and on caseworkers administering the program.

States have been a little slower to adopt two new options that can simplify the application process even further. But as some states pioneer these new options and share their positive experiences, other states are likely to follow suit. Thus far:

- Thirteen (13) states have adopted 12-month continuous eligibility, which allows children to retain coverage for a full year regardless of fluctuations in family circumstances, and
- eight (8) states have adopted presumptive eligibility, under which Medicaid providers and community entities such as child care agencies, WIC agencies, Head Start programs and others can directly enroll children who appear to qualify for coverage. Once enrolled, children can get the medical attention they need right away, while their families are allowed more time to complete necessary paperwork. Last year Congress granted states additional flexibility in administering this option, for example, additional entities such as schools and other agencies now can be authorized to conduct presumptive eligibility determinations. Several more states are now considering putting this option into practice.

When applications are easy to complete and submit, community-based organizations and institutions can play a more integral role in assisting families with enrollment. Families can get help from someone they know and trust in settings where they feel most comfortable such as their child's school, child care center, health care provider and even through telephone "helplines" that offer rigorous follow-up assist-

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[2] Michael Perry, Susan Kannel, R. Burciaga Valdez and Christina Chang, *Medicaid and Children: Overcoming Barriers to Enrollment*, The Kaiser Commission on Medicaid and the Uninsured, January 2000.

[3] Donna Cohen Ross and Laura Cox, *Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures*, Center on Budget and Policy Priorities/ The Kaiser Commission on Medicaid and the Uninsured, October 2000.

ance. These are all strategies families say would make it more likely for them to enroll, and in many communities such techniques are working.[4] For example:

- In the Albuquerque Public Schools, a team of school nurses uses information from the School Lunch Program to identify students who are eligible for health coverage. They can enroll these students into the state's Medicaid expansion program using the presumptive eligibility option.
- In Iowa, public health nurses serve as "child care health consultants" able to assist child care providers in keeping the child care center environment safe and healthy. As part of routine center visits, nurses provide information to child care workers about the state's children's health coverage programs and how to apply. They often help the child care provider sign up her own children, putting the provider in a better position because of her personal experience to assist the families of children in her care.
- In Florida, when families apply for federal child care assistance at community-based child care resource and referral agencies, the information they provide is electronically transferred onto a joint Medicaid/SCHIP application. Families answer a few supplemental questions needed to determine eligibility for health coverage and the application is printed out from the computer for the family to sign and mail to the child health insurance agency in a pre-addressed, post-age-paid envelope.
- Hamilton County, Ohio runs a consumer "Helpline" that works with schools and community organizations to identify children who are likely to qualify for coverage. Families can call the Helpline and get application assistance over the telephone. Operators conduct intensive follow-up with families to help them with any necessary paperwork and track applications through the county system to ensure an eligibility determination is made without delay.

While these efforts have been essential to bringing us where to we are today, more can be done. States need to continue to take steps to simplify their programs and ensure they apply innovative simplification techniques from their SCHIP-funded separate programs to Medicaid. In addition, states must pay as much attention to simplifying the eligibility renewal system as they have paid to simplifying initial enrollment. This is critical to ensuring that children retain coverage for as long as they are eligible, protecting our investment in outreach and shielding children from unnecessary breaks in essential medical treatment when the enrollment period is up. States are beginning to experiment with new ideas for streamlining renewal and should be encouraged to do so.

As child health coverage programs continue to evolve at the state level, there are additional steps Congress can take to advance efforts to enroll more eligible children.

• **Support efforts to cover families**—While enthusiastic outreach efforts aimed at enrolling children are critical, a growing body of evidence shows that providing family-based coverage appears to make a substantial difference. States have aggressively expanded eligibility for low-income children, but working parents are still likely to lack coverage. In most states parents qualify for Medicaid only if they have income far below the federal poverty line. In the typical state, a parent in a family of three loses Medicaid eligibility when her income surpasses 67 percent of the federal poverty line. A parent working full time at $7.00 per hour earns too much to qualify for Medicaid in 37 states.[5] New research finds that family-based Medicaid expansions that cover parents result in a significant increase in Medicaid participation among children who already are eligible.

States have some flexibility under current law to cover parents in working families, but so far only about one-third of states have done so. (Table 4) The states that have extended coverage to low-income working parents are generally more affluent states. A principal barrier deterring other states from pursuing this option appears to be fiscal.

There's a lesson to be learned from the SCHIP experience. States were permitted to expand Medicaid eligibility for children beyond the federal minimum eligibility limits long before SCHIP was established, but a number of states felt themselves able to do so only after SCHIP provided enhanced federal matching rates for such expansions. Today, with SCHIP in place, all

[4] Michael Perry, Susan Kannel, R. Burciaga Valdez and Christina Chang, *Medicaid and Children: Overcoming Barriers to Enrollment*, The Kaiser Commission on Medicaid and the Uninsured, January 2000.

[5] Center on Budget and Policy Priorities, *Survey of State Officials on Section 1931 Eligibility Rules, Conducted in the Summer of 2000*, Center on Budget and Policy Priorities, forthcoming 2001.

states have expanded coverage for children, in most cases to at least 200 percent of the federal poverty line. Providing states an enhanced matching rate for family coverage would be likely to result in a much larger number of states adopting such coverage.

As states contemplate implementing family coverage they should use all the options at their disposal to ensure that the same steps they have taken to simplify application and enrollment procedures for children are adopted for family-based coverage, as well. Aligning such procedures will make it more feasible to design a single application that can be used for the whole family. Moreover, having different application procedures for parents and children could negate the simplification measures put in place for children. For example, requiring a face-to-face interview for a parent to get enrolled confounds the advantage of having removed this requirement for children when both parents and children are applying.

Congress could help enhance family-coverage initiatives by providing states the option to allow 12 months of continuous eligibility, an option now available in children's coverage programs, but not currently available for families. This would afford parents the same advantage of uninterrupted care their children get under this option, and it would preclude the need for parents to undergo a more burdensome process to maintain their own coverage than to maintain coverage for their children.

A particularly vulnerable group of families are those that are leaving cash assistance and entering the workforce. These families are eligible for up to 12 months of Transitional Medical Assistance (TMA), a component of Medicaid designed to prevent families that leave welfare for work from immediately losing their health care coverage. A shortcoming of TMA is that many families are not aware of their eligibility for it and do not realize they may need to take certain steps to secure it when leaving welfare. In addition, families must submit, and states must process, three months of information on earnings and child care costs in the fourth month of TMA coverage, again in the seventh month, and once more in the tenth month to maintain coverage during the second six months of TMA.

TMA comes up for reauthorization at the same time as Temporary Assistance for Needy Families (TANF). As the General Accounting Office has recommended, in reauthorizing TMA, Congress should give states the option of guaranteeing a full year of transitional Medicaid coverage to eligible beneficiaries without imposing burdensome reporting requirements. In addition to simplifying TMA for both families and states, this would enable states to give families a clear and unambiguous message that they will get at least one year of Medicaid coverage if they leave welfare for work.

• **Coordinate child health insurance enrollment with other public benefit programs**—Recent data from the Urban Institute indicate that about three-quarters of all low-income uninsured children live in families that participate the National School Lunch Program, WIC, the Food Stamp Program or Unemployment Compensation.[6] Since children who participate in these programs are likely to qualify for Medicaid or an SCHIP-funded separate program, they are important vehicles for child health coverage outreach and enrollment. Last year, Congress gave child nutrition programs such as the School Lunch Program new flexibility to share data from free and reduced-price meal applications with Medicaid and separate SCHIP programs for the purpose of facilitating children's enrollment in health coverage. Partnerships composed of state child nutrition agencies, school districts, state or local child health insurance agencies and consumer groups have begun to explore ways to use the School Lunch Program to link students to health coverage. Efforts so far appear to be worthwhile, but labor intensive. Support is needed for helping states take full advantage of these new opportunities to streamline enrollment in child health coverage programs. For example, additional funding may be needed to design efficient systems to transfer data electronically and to coordinate enrollment procedures across programs. Congress should consider providing states enhanced administrative matching funds to develop such systems, in much the same way enhanced Medicaid administrative funding is available to design and develop computer systems related to claims processing.

[6] Genevieve M. Kenney, Jennifer M. Haley and Frank Ullman, *Most Uninsured Children Are in Families Served by Government Programs*, The Urban Institute, December 1999.

The concerted efforts of the past few years to reach out and enroll uninsured children in health coverage constitute a dramatic shift for this country. As new programs were getting off the ground, the results may have been slow to take hold, but we now seem to be making progress. Support for activities to better coordinate health coverage programs with other public benefit programs and for shoring up renewal procedures will help put in place strong systems for enrolling more children and helping them stay enrolled. Expanding family coverage will also be critical to ensuring we do not miss out on an important opportunity to reduce the ranks of the uninsured.

Thank you very much for giving me this opportunity.

Table 1:

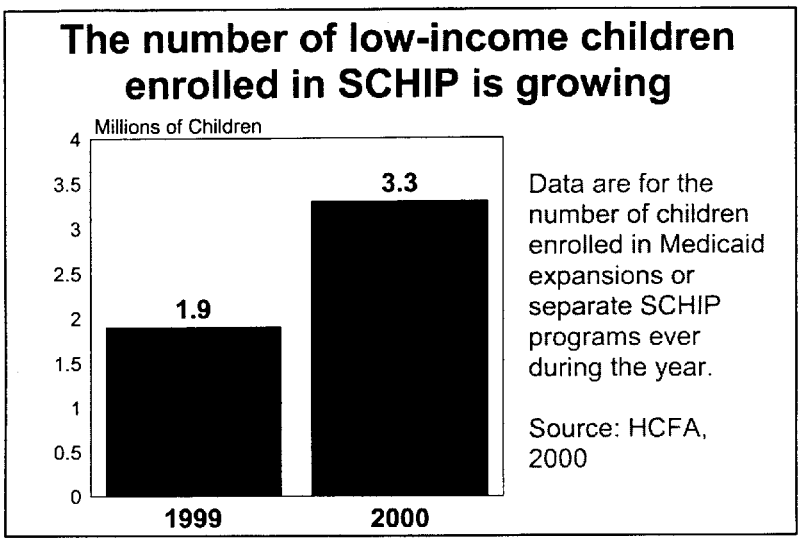

Table 2:

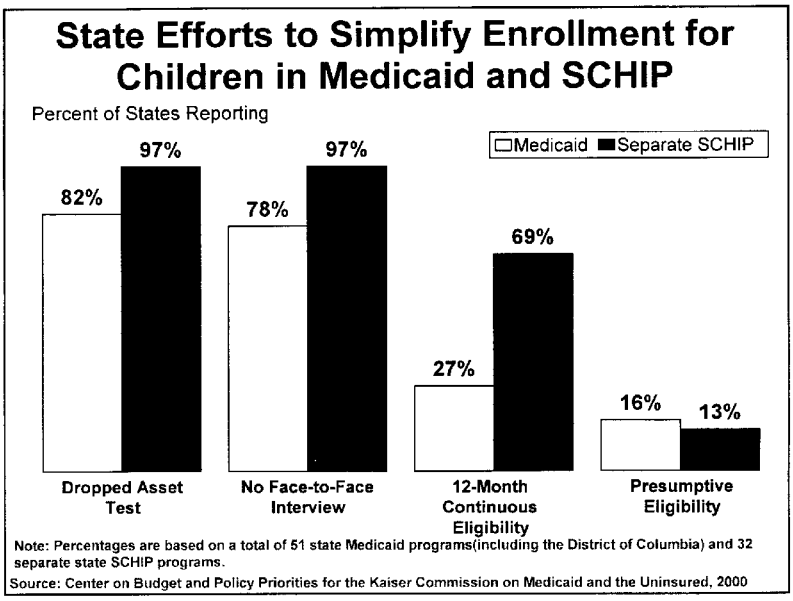
State Efforts to Simplify Enrollment for Children in Medicaid and SCHIP
Percent of States Reporting
Medicaid
Separate SCHIP
82%
97%
78%
97%
27%
69%
16%
13%
Dropped Asset Test
No Face-to-Face Interview
12-Month Continuous Eligibility
Presumptive Eligibility
Note: Percentages are based on a total of 51 state Medicaid programs(including the District of Columbia) and 32 separate state SCHIP programs.
Source: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2000

Table 3:

States that have not adopted key simplification strategies in Medicaid for children			
No joint application for Medicaid and SCHIP	**Face-to-face interview required**	**Asset test required**	**Frequent redetermination (more than once a year)**
Nevada	**Alabama**	Arkansas[5]	Alaska
North Dakota	**Georgia**[1]	**Colorado**	Florida[6]
Texas	New Mexico[2]	Idaho	**Georgia**
Utah	**New York**[3]	**Montana**	Maine
	Tennessee	**Nevada**	**Minnesota**[7]
	Texas	**North Dakota**	**North Dakota**
	Utah	Oregon	Oklahoma
	West Virginia[4]	**Texas**	Oregon
	Wisconsin	**Utah**[5]	**Tennessee**[7]
	Wyoming[4]		**Texas**
			Vermont
			Wyoming

States in bold print have adopted simpler enrollment procedures (no face-to-face interview, no asset test, and 12-month redetermination periods) for their separate SCHIP programs but not for their Medicaid programs.

Source: Center on Budget and Policy Priorities, revised March 13, 2001.

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[1] In Georgia, a face-to-face interview is required when the separate Medicaid application is used, but it can be done outside the Medicaid office. Georgia anticipates eliminating the requirement effective February 2001.

[2] In New Mexico, community-based Medicaid On-Site Application Assistance (MOSAA) providers can help families complete a somewhat shorter "MOSAA" application; such contact satisfies the interview requirement.

[3] In New York, contact with a community-based "facilitator enroller" meets the face-to-face interview requirement.

[4] In West Virginia, families using the joint application do not have to complete a face-to-face interview if the child appears to be Medicaid-eligible and the application is transferred for an eligibility determination. Wyoming plans to eliminate the face-to-face interview for Medicaid on April 1, 2001.

[5] Arkansas expects to remove the asset test for "regular" Medicaid and implement this change in July 2001. Utah still counts assets in determining Medicaid eligibility for some "poverty level" children.

[6] Florida provides 12 months of continuous eligibility to children under age 5 enrolled in Medicaid. Children age 5 and older enrolled in Medicaid and all children enrolled in Healthy Kids and MediKids are required to have their eligibility redetermined every 6 months.

[7] In Minnesota and Tennessee, children who qualify under waiver programs can undergo eligibility redetermination every 12 months as opposed to every 6 months under "regular" Medicaid.

Table 4:

States with Family-Based Expansions to 100 Percent of the Federal Poverty Line or Higher	
State	Income Eligibility Threshold for Working Families as a Percent of the Federal Poverty Line /1
California	108%
Connecticut	158%
District of Columbia	200%
Delaware	108%
Hawaii	100%
Maine	158%
Massachusetts	133%
Minnesota	275%
Missouri	108%
Wisconsin	200%
New York /2	150%
Ohio	100%
Oregon	100%
Rhode Island	185%
Vermont	158%
Washington	200%
Wisconsin	185%

/1. The income threshold presented in this column is based on the rules that apply to a family of three. It takes into account a state's earnings disregard policies, but not other disregards or deductions.
/2. New York's expansion has been enacted into law, but has not yet been implemented.

Source: Survey of state officials conducted by the Center on Budget and Policy Priorities. Information current as of March, 2001. Note that children in many of these states can qualify for coverage at higher income thresholds than apply to families.

PREPARED STATEMENT OF DIANE ROWLAND, SC.D.

Thank you for the opportunity to offer testimony at this hearing on "Living Without Insurance: Who's Uninsured and Why?" I am Diane Rowland, Executive Vice President of the 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.

Despite a strong economy and sustained economic growth with historically low levels of unemployment, over 40 million Americans remain without health insurance today. Touching one in five people each year, the uninsured population is one predominantly of low-income, working Americans and their families. My testimony today will provide a profile of the low income uninsured population and discuss factors contributing to their lack of insurance and the importance of broadening coverage.

THE UNINSURED

Today, most Americans receive their health insurance coverage through an employer-sponsored health plan offered through the workplace, but for millions of working families, such coverage is either not offered or 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 across the states. As a result, 42 million Americans were without health insurance in 1999.

The majority of the nation's 42 million uninsured are low-income—individuals and families with incomes less than 200 percent of the poverty level. For a family of three in 2001, this is an annual income of less than $30,000. Nearly two-thirds of the uninsured (65%) came from family units with incomes at or below that level (Figure 1). Over a third of the uninsured (36%) come from families living below the poverty level.

Low-income adults are at greatest risk of being uninsured and comprise nearly three-quarters of the 27.5 million low-income uninsured (Figure 2). Low-income men have the greatest likelihood of being without insurance—44 percent are uninsured compared to 36 percent of low-income women. Less than a quarter (24%) of low-income children are uninsured, largely due to the efforts to broaden coverage through Medicaid and CHIP.

The likelihood of being uninsured decreases substantially as income rises (Figure 3). Nearly four in ten (39%) of the poor and 29 percent of the near-poor are uninsured in contrast to 7 percent of people with incomes at or above three hundred percent of poverty, or roughly $40,000 for a family of three. Medicaid helps to offset the lower levels of private insurance for over a third (37%) of the poor and 16 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.

LIMITS TO PRIVATE INSURANCE FOR THE LOW-INCOME POPULATION

One of the major factors contributing to the high proportion of uninsured people in the low-income population is that, unlike most Americans, they are not obtaining health insurance coverage through the workplace. Eight in ten of the uninsured come from working families. Most of the uninsured (71%) come from families where at least one person works full-time outside the home and another 12 percent come from families with part-time employment. Among the low-income uninsured, 59 percent of the poor and 96 percent of the near-poor are working or have workers in their families (Figure 4). Yet, despite their attachment to the workforce, these uninsured families are falling outside the reach of employer-sponsored coverage.

Over 70 percent of all uninsured workers, and consequently their families, 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 55 percent of low-wage workers (earning $7 per hour or less) have access to job based coverage through their own or a family member's job compared to 96 percent of high-wage workers. For 45 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 and the wage-level of the firm. Most large firms offer coverage, but many smaller firms do not (Figure 6). Small firms face particular challenges in offering their employees coverage due to high turnover rates and small risk pools, which often lead to high premiums for group coverage. However, 85 percent of small firms with mostly high wage employees (less than a third of workers earning under $20,000 per year) offer coverage compared to only 35 percent of small firms with predominately low-wage workers. Low wage workers are more likely to work in these small businesses and retail and service jobs where health insurance is not offered as a fringe benefit.

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 2000, the average family premium for employer sponsored group coverage was $6,348 (Figure 7). The worker's contribution to that premium was, on average, 26 percent, or $1,656 for the year. For a full-year, full-time worker earning $7 an hour, the employee share of premiums represents 11 percent of the family's $14,500 annual income.

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 and provide only limited protection.

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 a third (34%) of non-elderly low-income 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. In 1999, 25 states had a third or more of their low-income population uninsured (Figure 8).

THE ROLE OF MEDICAID

For 40 million low-income Americans, Medicaid provides an essential safety net to fill in gaps in private insurance and Medicare. For 21 million low-income children and 8 million low income parents, Medicaid provides health insurance coverage with limited cost-sharing and essential benefits. For 11 million elderly and disabled beneficiaries, Medicaid fills in Medicare's gaps, provides more extensive acute care services, such as prescription drugs, and covers long-term care.

Medicaid's role as an insurer for low-income families has evolved. Medicaid originated as a source of health insurance for the nation's welfare population—predominantly very poor children and single parents. Over time, its role has been expanded to include more poor and near-poor Americans. Federally mandated expansions in the 1980s and 1990s required states to cover all children under age 18 under poverty by 2002 and pregnant women and children under age six at slightly higher income levels. In addition, states were given discretion to extend coverage to these groups at higher income levels. Enactment of the State Children's Health Insurance Program (CHIP) in 1997 provided additional federal funding to states to broaden coverage to children up to 200 percent of poverty, either through Medicaid or under a separate program.

Despite the impact of these expansions on coverage of children and pregnant women, the low-income population still has much higher rates of uninsurance than other income groups. Medicaid plays a strong role in reducing uninsured rates among children, where over half (53%) of poor children and a quarter (26%) of near poor children rely on Medicaid. However, while low-income women are more likely to have Medicaid coverage than low-income men, adults of both genders still have exceedingly high rates of uninsurance—42 percent of poor women and 52 percent of poor men are uninsured (Figure 9).

High rates of uninsurance in these groups persist for two reasons: millions of low-income adults remain ineligible for coverage under Medicaid and many people who are eligible, especially children, are not enrolled. Parents of eligible children are often excluded because, in many states, these levels remained tied to the old income eligibility levels for welfare assistance (Figure 10), which are considerably lower than the minimum levels established for children. Moreover, low-income childless adults are not eligible for coverage no matter how poor, unless they qualify as disabled individuals. These limits, coupled with less than full participation among those who are eligible, leave millions of poor and near-poor Americans uninsured.

Coverage of children can be significantly improved by strengthening Medicaid's role as an insurer of low-income children. With the decoupling of Medicaid and welfare as part of welfare reform in 1996 and the enactment of CHIP in 1997, states have new and broad opportunities to extend the reach of Medicaid and CHIP to millions of low-income uninsured children. Through Medicaid and CHIP, states have substantially expanded the income levels to provide assistance to poor and near-poor children. By 2000, 36 states had raised their income eligibility levels at or above 200 percent of poverty (Figure 11).

However, while all states have used these opportunities to raise eligibility levels for children, the program does not always work as well as it could to attract and enroll low-income children. Often, eligible children remain uninsured because their parents are not aware of the coverage available from Medicaid 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. Moving to simplify enrollment and reduce the burden on families to apply is essential for Medicaid coverage to work effectively for low-income working families. Many states have already taken steps to make Medicaid coverage more accessible (Figure 12).

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, remain uninsured. In addition, many parents 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.

Nearly thirty percent of low-income adults with children are uninsured (Figure 13), and of these 5.3 million uninsured parents, less than one-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 and 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 14). However, in 14 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—48 percent of poor and 44 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.

THE IMPORTANCE OF INSURANCE

Health insurance makes a difference in when and if people get necessary medical care, where they get their care, and ultimately, how healthy people are. Uninsured adults are far more likely than the insured to postpone or forgo health care altogether and less able to afford prescription drugs or follow through with recommended treatments (Figure 15). Because children are generally healthier than adults, problems getting needed care are less common, but disparities in access to care between uninsured and insured children are as great as the differences between adults. The consequences of reduced access to care can be severe, particularly when preventable or treatable conditions go undetected.

The uninsured are at least three to four times more likely than those with insurance to report problems getting needed medical care, even for serious conditions. Part of the reason many of the uninsured postpone or forgo needed care is because they have no usual source of care. Over a third of uninsured adults do not have a regular place to go when they are sick or need advice, compared to less than 10 percent of those with coverage. Anticipating high medical bills, many of the uninsured are not able to follow recommended treatment. Nearly a third of uninsured adults say they did not fill a drug prescription in the past year due to cost and more than a third went without a medical test or treatment that had been recommended. Insured nonelderly adults are at least 50 percent more likely to have had preventive care such as pap smears, mammograms, and prostate exams than uninsured adults.

Because the uninsured are less likely than the insured to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems. Condi-

tions like diabetes and hypertension, for example, can usually be managed successfully outside the hospital. The uninsured are more than twice as likely to be hospitalized for these two conditions as those who have health insurance. When they are hospitalized, the uninsured also have a greater chance of dying.

Not having access to preventive screening catches up with the uninsured in greater cancer severity. The uninsured have been shown to have a much greater chance of being diagnosed with late-stage breast, prostate, colorectal, and skin cancer than the insured. Late-stage cancer translates into higher mortality rates among the uninsured. For example, among uninsured women diagnosed with breast cancer, the uninsured are more likely to die from it, even after controlling for other health problems.

For many of the uninsured, the costs of health insurance and medical care are weighed against equally essential needs. The uninsured are twice as likely as those with health coverage to live in a household that is having difficulty paying monthly bills as basic as rent, food, and utilities. Medical bills can mount quickly for the uninsured, even for relatively minor problems like dental care, and the financial impact on a family can be serious.

Most of the uninsured do not receive health services for free or at reduced charge. Among families with at least one uninsured member, only a quarter report they have received this kind of charity care in the past year. The large majority of the uninsured are paying for care out-of-pocket and increasingly paying "up front" before services will be rendered. When the uninsured are unable to pay the full medical bill in cash at the time of service, they either pay with credit cards (typically with high interest rates) or negotiate a payment schedule with the clinic or hospital. In the case of hospital bills, the debt may take years to repay.

Having health insurance makes a difference in the debt individuals and families face because of medical bills (Figure 16). The uninsured are more than twice as likely to have had problems paying medical bills in the past year as those who have coverage. In addition, the impact of these bills is much greater on uninsured families. Among the nearly 40 percent of uninsured adults who had problems paying medical bills in the last year, the majority said that this debt had a major impact on their families' lives. Like any bill, when medical bills are not paid or paid off too slowly, they are turned over to a collection agency, and a person's ability to get further credit is significantly limited. Nearly 40 percent of the uninsured report that they were contacted by a collection agency about unpaid medical bills in just the past year.

THE IMPACT OF BEING UNINSURED

Being without insurance is a struggle that millions of hard working families and their children face every day. They do not lack insurance because they do not want it or do not believe in insurance. Most of the uninsured have, in fact, tried to obtain coverage but could not find coverage for an affordable price. As a result, they cope without coverage while their medical bills mount and their health suffers.

The experience of Dianna Oden of Mosier, Oregon—a 52 year-old uninsured waitress—and Patricia Nelson of Louisville, Tennessee—an uninsured widow whose son has asthma—bring reality to the statistics and studies on the uninsured. Their experiences seeking health insurance, obtaining medical care, and coping with their medical bills clearly portray the problem of being uninsured and low-income. Exhibits 1 and 2 highlight their situations.

Working all her life in restaurants, Dianna Oden has never had health insurance available through her job. Her annual income from wages of $6.50 an hour plus tips puts her at 170% of the poverty level—too high to qualify for the Oregon Health Plan, but not nearly enough to pay for an individual health plan. She suffers from fibromyalgia, a chronic disease that causes daily pain and stiffness, migraines, sleeplessness, and frequent diarrhea. Yet, on her limited income, Dianna Oden often doesn't get the medical care or medications she needs. On her take-home pay of $821 a month, she has $88 left after paying basic bills and about $100 for medical expenses. A private insurance plan with a $500 deductible, 25% co-insurance, and no drug coverage would cost her $213 a month—a quarter of her take-home pay—and not help with her monthly medication costs.

Patricia Nelson struggles in a different way with her son's overwhelming medical needs and hospitalization costs. Her husband died of Lou Gehrig's disease at age 35. Eight years ago, during a period when they were uninsured, her son was hospitalized for a severe asthma attack, leaving them with a bill of $6,000. Paying this bill off by at least $25 a month, they still owe the hospital $1,700. More recently, Patricia tried to get health coverage, but at $4,260 per year, the cost would have consumed 16 percent of her income. Her own recent kidney infection, coupled with

a diagnosis of Bell's Palsy for her son, has left her facing over $12,000 in medical bills and living on Social Security Survivor's benefits. She has enrolled her son in TennCare, but she remains uninsured because enrollment for adults is closed. Due to her medical expenses, she has recently filed for bankruptcy.

In every state, there are people like Dianna Oden and Patricia Nelson and her son—people for whom the promise of medical care's life-saving and life-improving applications cannot be fully realized. They can neither afford the medical care they need nor the health insurance that helps make medical care both accessible and affordable. For them, health insurance matters but remains out of reach.

THE NEXT STEPS

Extending coverage to the millions of Americans without health insurance is both an important policy and health objective. However, no single incremental approach to restructuring and broadening health insurance coverage is likely to address the diverse needs of the 42 million uninsured Americans. For the low-income uninsured population, any effort to extend coverage must address the high cost of coverage faced by people with limited incomes and the lack of access to employer-sponsored health insurance for low-wage workers. Given these issues, the most immediate and potentially most effective means of broadening coverage is to build on the current public programs—Medicaid and CHIP—that have been designed to provide health coverage for low-income populations.

Extending public coverage to more low-income Americans would provide a subsidy for the full cost of comprehensive insurance and minimize the out-of-pocket costs to low-income families. Building on coverage available today through Medicaid and CHIP would help close the gaps that currently exist when some family members are eligible and others are ineligible for coverage and low-income childless adults are excluded from coverage. This approach also has the advantage of building on an existing administrative and financing structure in operation in all 50 states. States already have systems in place for eligibility determination and provider and plan participation and payment. Finally, both families and states have embraced recent efforts to extend health insurance through public programs and value the coverage that Medicaid and CHIP provide.

As the efforts already underway in many states demonstrate, Medicaid and CHIP offer an effective strategy for insuring more low-income people. Substantial progress can be made by continuing to improve current outreach and participation efforts and by extending the scope of Medicaid to reach more of the nearly 20 million low-income uninsured parents and childless adults. These improvements, coupled with efforts to maintain and extend employer coverage for low-wage workers, will help to improve coverage for the most vulnerable Americans.

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

Exhibit 1

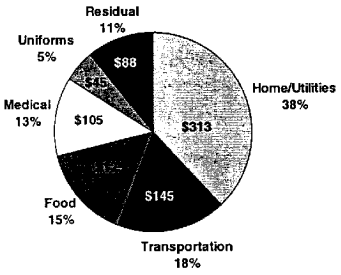
DIANNA ODEN

Dianna Oden is a 52 year-old single grandmother who works as a full-time waitress at a family restaurant near her home town of Mosier, Oregon. Working all her life in restaurants, either serving customers or in management, Dianna Oden has never had health insurance available through her job. Her annual income from wages of $6.50 an hour plus tips (with no paid vacation or sick days) puts her at about 170% of the federal poverty level — which is too high to qualify for the Oregon Health Plan, but not nearly enough to pay for an individual health plan.

Five years ago, Ms. Oden developed the symptoms of fibromyalgia, a chronic disease. With little discretionary income, she went to her doctor only when she was in a crisis, and because she came in so infrequently and with a different problem each time, he failed to see a pattern and treated the symptoms separately. Finally about a year ago, when her daily pain and stiffness, frequent diarrhea, migraines, and sleeplessness became overwhelming, she made an appointment to discuss them all. Only then did her doctor begin a thorough work-up to determine the cause of all her symptoms. The medication he has prescribed is effective, but unaffordable for her. Knowing this, Dianna's doctor gives her free samples whenever she comes in for an appointment, and she stretches these out by taking one pill every other day, instead of the prescribed daily dose. One time he was able to give her a full month's supply, which she described as giving her "a whole new lease on life". Encouraged by its effect, she finally filled the prescription for it, but was shocked to find that the drug would cost her $149 a month. She asked the pharmacist to give her $40 worth and she saves them for her worst days.

Despite all this, Dianna Oden is a hard worker and considers herself lucky. She has no debt, not even a mortgage or a car loan. However, after she pays her monthly bills for utilities, phone, transportation, groceries, and medical expenses, Dianna has $88 left from her take-home pay of $821. Living with fibromyalgia and paying over $100 a month in medical bills, Ms. Oden puts a high value on health insurance, but when she again checked into the cost of private insurance recently, she learned it would cost her $213 a month — roughly a quarter of her take-home pay — for a plan with a $500 deductible, 25 percent co-insurance, and no prescription drug coverage. Given the cost of even this limited health plan, she will probably remain uninsured for thirteen more years until she qualifies for Medicare at age 65.

Dianna Oden's Household Budget



Monthly Income: $821 Take Home Pay

Note: Annual gross income of $14,790 (170% of Federal Poverty Level)

Source: *In Their Own Words: The Uninsured Talk About Living Without Health Insurance.* The Kaiser Commission on Medicaid and the Uninsured. September 2000.

Exhibit 2

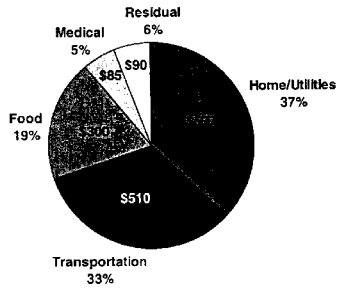
PATRICIA NELSON

Patricia Nelson, a 44 year old widow from Louisville, Tennessee, knows better than anyone what can happen if you are hospitalized without health insurance. Her husband lived with a disabling condition for many years before dying of Lou Gehrig's disease at the age of 35. Because of his disability, Medicaid, and later Medicare, covered his bills; however, Patricia and her 13 year-old son's health coverage has been spotty, depending on the job she held. She recalls a ten year period where she worked for the same restaurant, and as the ownership changed hands three times so did the offer of health benefits.

In one of the times the family was without health coverage, her son Sam, then five years old, suffered a bad asthma attack and needed to be admitted to the hospital. Two days in the hospital left them with a bill of $6,000. They checked on Sam's eligibility for Medicaid, and at that time, they missed the income eligibility cutoff by $4. Still paying off the bill by at least $25 a month, the balance after nearly eight years is $1,700.

Since we issued the report last fall, the Nelsons have faced even greater challenges. Patricia had recently taken a job in her sister's bakery. She looked into continuing her health coverage under COBRA, but at $4,260 a year it would have required 16% of her $27,000 income, and she didn't feel she could afford it. The family-run store lost its lease and went out of business this winter. While she was looking for work and living on only Social Security Survivor benefits, two medical crises hit. First, Patricia developed an undetermined infection that, after extensive tests, was isolated to her kidney. Then her son Sam woke one morning with facial paralysis and after a thorough neurological work-up was found to have Bell's Palsy. She now has him enrolled in TennCare. Facing over $12,000 in medical bills, Mrs. Nelson recently filed for bankruptcy.

Patricia Nelson and Her Son's Household Budget



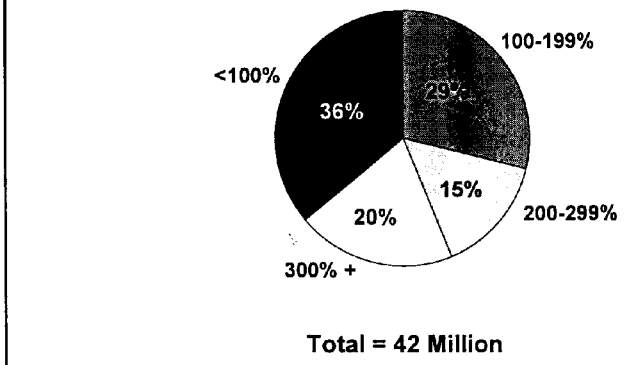
Monthly Income: $1,562 in Social Security Survivor's Benefits

Note: Annual gross income of $18,744 (160% of Federal Poverty Level)

Source: *In Their Own Words: The Uninsured Talk About Living Without Health Insurance.* The Kaiser Commission on Medicaid and the Uninsured. September 2000.

Figure 1

The Nonelderly Uninsured, by Poverty Level, 1999



*The poverty level in 1999 was $13,290 for a family of three
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2000 Current Population Survey.

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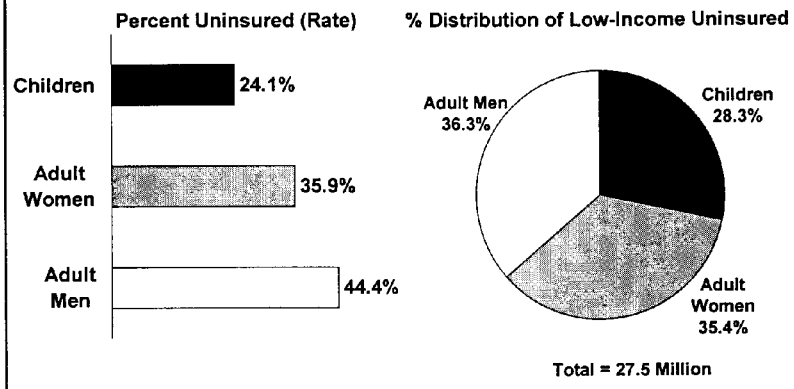
Medicaid and the Uninsured

Figure 2

Risk of Being Uninsured for Low-Income* Population, 1999



*Individuals and families with incomes less than 200% of the poverty level.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2000 Current Population Survey.

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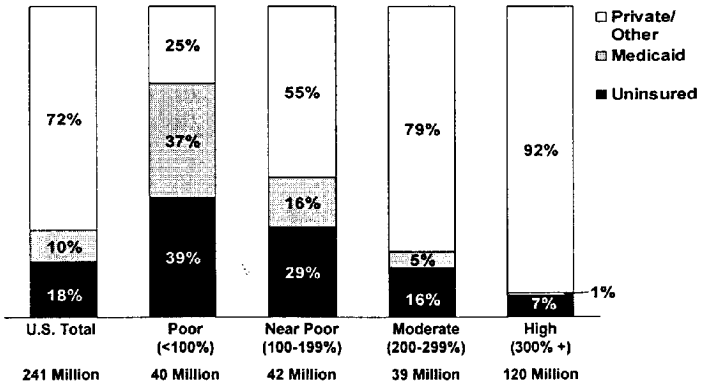
Figure 3

Health Insurance Coverage of the Nonelderly, by Poverty Level, 1999



*Other includes individually-purchased private insurance and other public coverage.
Note: The federal poverty level for a family of three in 1999 was $13,290.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2000 Current Population Survey, 2000.

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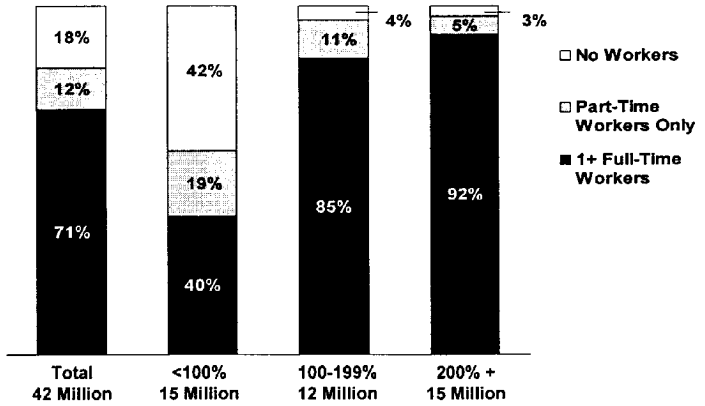
Figure 4

The Nonelderly Uninsured by Poverty Level and Family Work Status, 1999



Note: The federal poverty level for a family of three in 1999 was $13,290.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2000 Current Population Survey, 2000.

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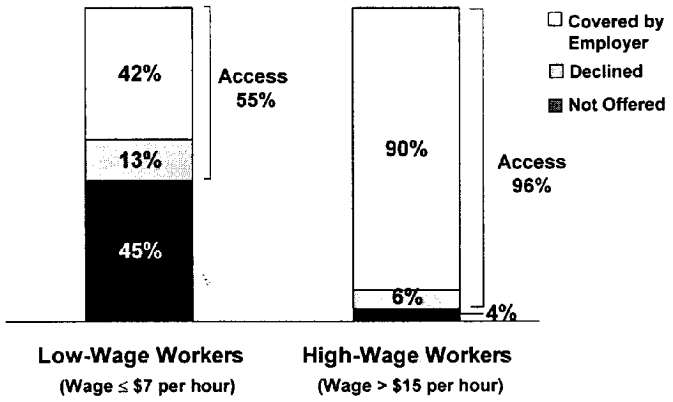
Figure 5

Access to Employer-Based Coverage for Low and High Wage Workers, 1996



Note: Annualized wage income at ≤ $7/hour would be ≤ $12,740 and at >$15/hour would be > $27,300.
SOURCE: Cooper P. and Schone B., 1997.

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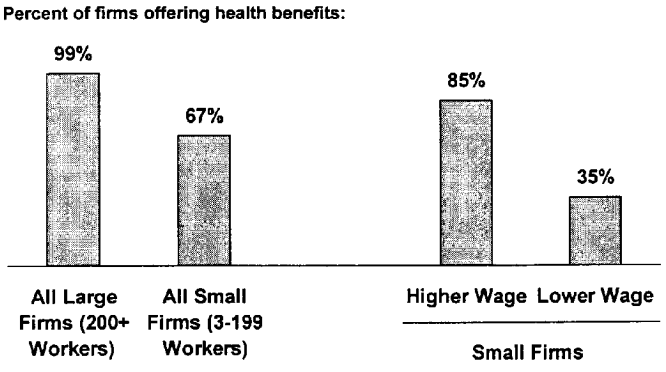
Figure 6

Health Insurance Offer Rates by Firm Characteristics, 2000



* Lower Wage firms defined as firms in which more than 35% of employees earn less than $20,000/year; Higher Wage firms defined as those in which fewer than 35% of employees earn less than $20,000/year.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000.

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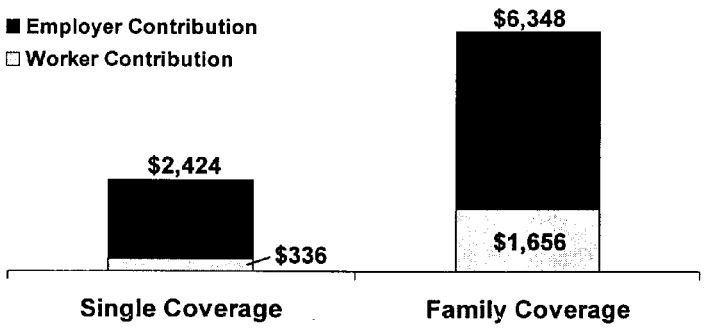
Figure 7

Average Annual Premium Costs for Covered Workers, 2000



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000

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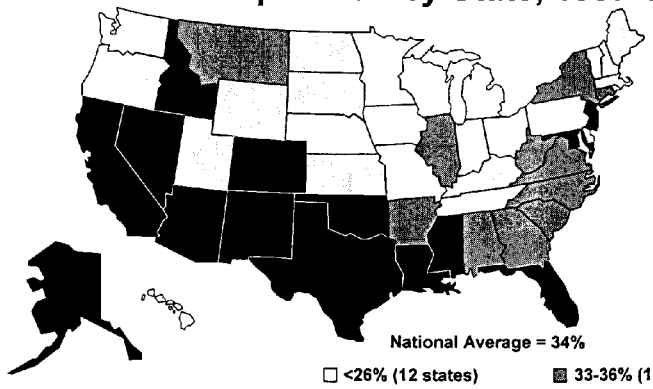
Figure 8

Uninsured Rates Among the Nonelderly Low-Income Population by State, 1997-1999



Note: Low-income defined as < 200% of poverty level, or $26,580 for a family of three in 1999.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of 3 year-pooled data from March 1998, 1999, and 2000 Current Population Survey, 2000.

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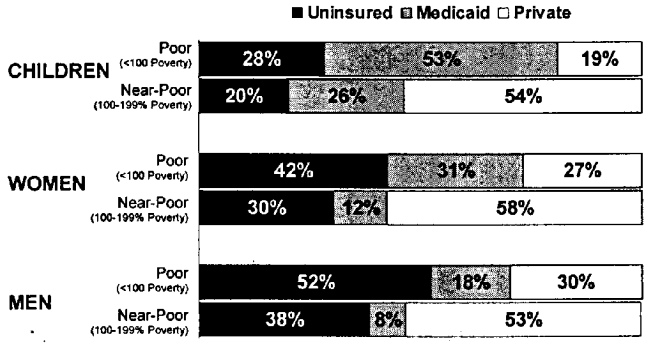
Figure 9

Health Insurance Coverage of Adults and Children, 1999



Note: Adults age 19-64. Federal Poverty Level was $13,290 for a family of three in 1999.
SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2000 Current Population Survey, 2000.

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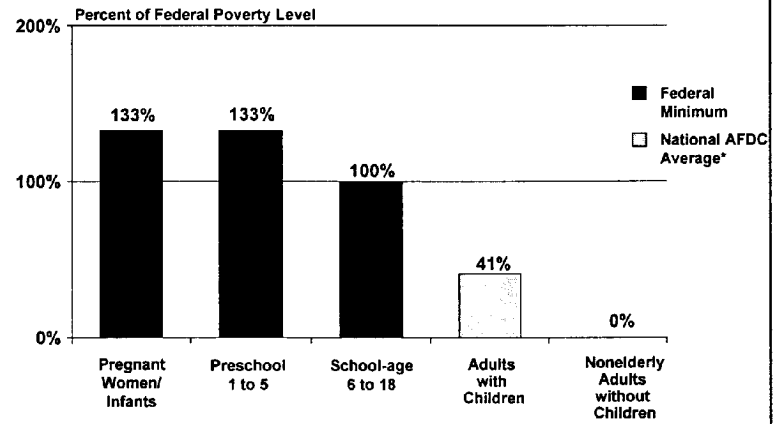
Figure 10

Medicaid Minimum Income Eligibility Standards, 2001



Note: 18-year-olds phased in by September 2002.
*Based on AFDC average for 1996, the standard used for Section 1931 eligibility. The Federal Poverty Level is $14,630 for a family of three for 2001.

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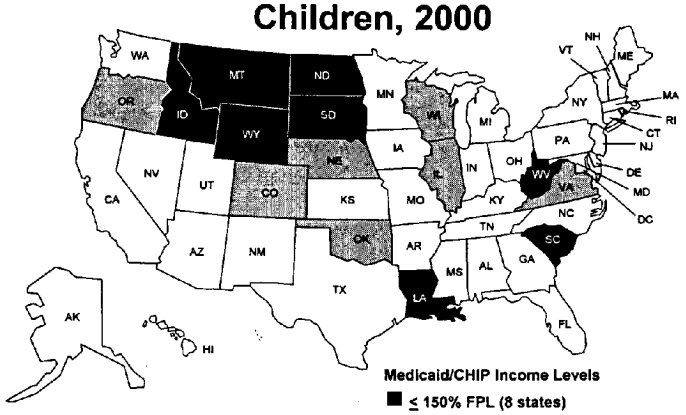
Figure 11

Medicaid/CHIP Income Eligibility Levels for Children, 2000



Medicaid/CHIP Income Levels

- ■ ≤ 150% FPL (8 states)
- ▨ 151% - 199% FPL (7 states)
- □ ≥ 200% FPL (36 states)

NOTE: The federal poverty level (FPL) was $14,150 for a family of three in 2000.
SOURCE: Center on Budget and Policy Priorities, 2000.

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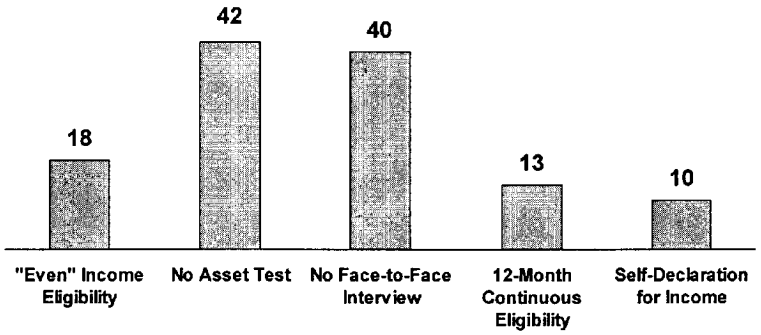
Figure 12

Strategies for Simplifying Medicaid and CHIP Eligibility and Enrollment for Children

Number of States Reporting



NOTE: State counts include only states that have adopted the enrollment simplification strategy for both their Medicaid for children and CHIP programs.
SOURCE: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2000.

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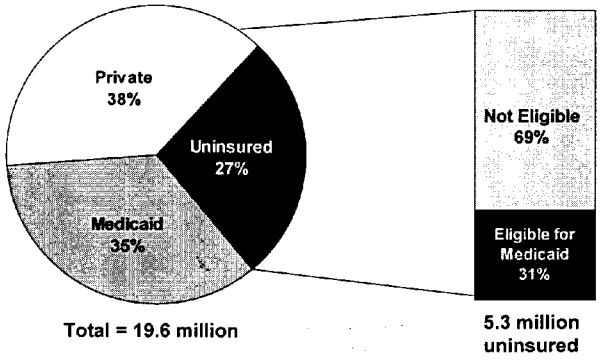
Figure 13

Health Coverage of Low-Income Parents, 1998



NOTE: Low-income refers to families with incomes less than 200% of the Federal Poverty Level.
SOURCE: Urban Institute simulations, 2001. Based on the March 1997 Current Population Survey, projected to 1998.

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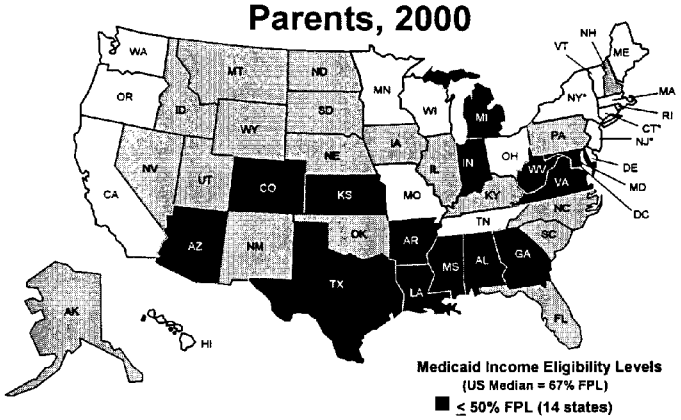
Figure 14

Medicaid Income Eligibility Levels for Parents, 2000



*Connecticut, New Jersey, and New York have enacted but have not yet implemented their Medicaid expansion for parents.
SOURCE: Center on Budget and Policy Priorities and Families USA, 2000.

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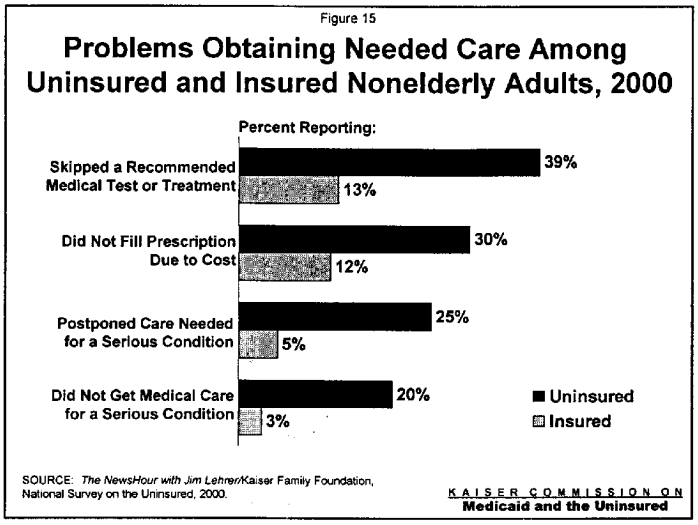

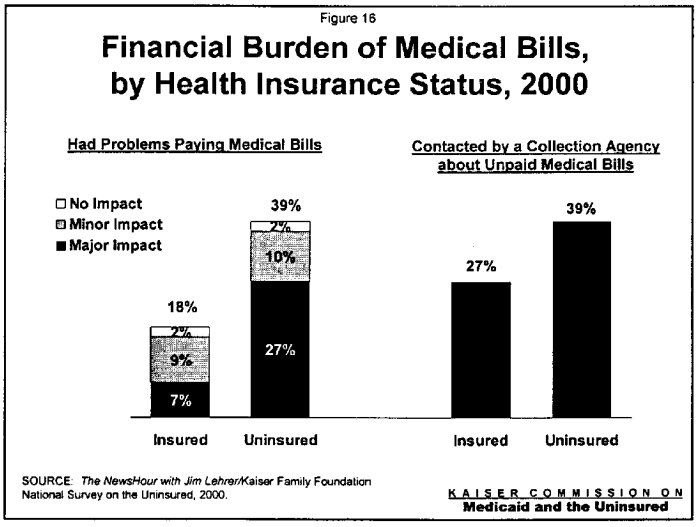

PREPARED STATEMENT OF WILLIAM J. SCANLON

Mr. Chairman and Members of the Committee:

I am pleased to be here today as the Committee begins considering options to expand health insurance coverage for the 1 in 6 nonelderly Americans (under 65) who are uninsured. These 42 million people represent a heterogeneous population. As we

noted in our testimony before your Committee earlier this week,[1] the majority of the uninsured are working, often for small businesses or in certain industries such as agriculture or construction that are less likely to offer health insurance, or are low-income persons who are ineligible for or not enrolled in public programs. A disproportionate share of young adults, Hispanics, and residents of southern or western states are uninsured. But the uninsured population also includes people employed by larger-sized firms and other industries as well as those of all income levels, ages, races and ethnicities, and geographic locations. Given the heterogeneity of this population, a variety of approaches have been proposed in the Congress and by proponents to increase private or public health insurance coverage in ways that may match the needs of different uninsured persons and maximize the potential impact for expanding coverage.

Several recent congressional efforts represent important steps toward increasing the availability of health insurance for workers and low-income families, including

- improving the availability of private health insurance for individuals changing jobs or with preexisting health conditions,
- increasing the percentage of health insurance premiums that self-employed individuals can deduct from their taxable income,
- giving additional flexibility to states to expand Medicaid eligibility to a larger group of low-income children and their parents, and
- establishing the new federal-state State Children's Health Insurance Program (SCHIP), which had already enrolled more than 3 million low-income children in 2000.

These steps help millions of Americans, and the full effect of some of these actions likely has not yet been realized. Despite these efforts, however, millions of Americans remain uninsured.

To assist the Committee as it considers the variety of proposals offered to expand coverage to the uninsured, my remarks today will provide an overview of potential approaches for increasing private or public coverage and considerations that could impact their effectiveness in reaching significant numbers of the uninsured. Specifically, I will focus on

- proposed additional tax incentives, such as deductions or credits, to encourage individuals to purchase private health insurance or employers to offer coverage;
- proposed expansions to public programs, including expanding Medicaid and SCHIP to additional low-income children and adults, and allowing near-elderly individuals not yet 65 to "buy" to Medicare; and
- the potential for unintended consequences of private and public coverage expansions on existing private health insurance coverage.

My comments are based on our prior and ongoing work on the uninsured population, private health insurance, Medicaid, and SCHIP, as well as other published research.[2] We reviewed key elements of major proposals that have been introduced in the 106th and 107th Congresses, as well as several put forth by various proponents.

In summary, the success of proposals to provide additional tax incentives to promote private health insurance—which already is the primary source of health coverage for most nonelderly Americans—will depend on whether they are large enough so that more uninsured individuals will purchase insurance or more employers will begin offering coverage or increase their contribution to premiums. Because most uninsured individuals either pay no taxes or are in the lowest marginal tax rate bracket, a refundable tax credit would provide a larger net reduction in premium costs for low-income uninsured individuals than would allowing a deduction from taxable income. Tax credits also will be more effective if available when low-income persons purchase coverage rather than in the next year when tax returns are filed. Most of the proposed tax credit amounts represent less than half of premiums for many individuals, which some analysts conclude is not large enough to induce most low-income uninsured individuals to begin purchasing health insurance. Some proposed credits for small employers or those with many low-wage workers would be provided for a limited period of time, which may make affected employers hesitant to begin offering coverage or increasing their premium contribution if the continued availability of the credit is uncertain.

Other proposals would expand eligibility for existing public programs to more low-income children and adults. These include

- giving states the option of increasing income eligibility limits under Medicaid or SCHIP;

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[1] See *Health Insurance: Characteristics and Trends in the Uninsured Population* (GAO–01–507T, Mar. 13, 2001).

[2] A list of related GAO products appears at the end of this statement.

- expanding these public programs to persons who are not now eligible, such as most childless adults for the Medicaid program or the parents of children eligible for SCHIP; and
- allowing near-elderly individuals who are not yet Medicare-eligible to pay premiums and thereby buy in to Medicare.

The success of these efforts in reducing the number of uninsured is contingent upon (1) the willingness of states to pursue options to expand Medicaid and SCHIP eligibility and (2) the effectiveness of outreach to enroll eligible individuals, since at present many eligible individuals are not participating.

Proposed approaches to expand insurance coverage may result in some individuals or employers dropping current coverage in order to take advantage of a new tax subsidy or public program that would reduce health insurance costs associated with individual or employment-based coverage. While some steps may be taken to reduce the potential for this phenomenon—known as "crowd-out"—some level of such displacement of existing private coverage may be an inevitable cost of efforts to decrease the number of uninsured Americans.

BACKGROUND

Employers voluntarily offering private health insurance benefits are the predominant source of coverage for nonelderly Americans, and publicly sponsored programs also enroll many low-income people. Two-thirds of nonelderly Americans obtain private health insurance through employment. The federal tax code provides incentives for employers to subsidize health benefits by making their premium contributions tax deductible as a business expense; this subsidy also is not considered taxable income for employees. In addition, tax benefits are available to individuals who purchase nongroup private insurance directly from insurers (referred to as "individual insurance") if the person is self-employed [3] or has premium and medical expenses combined that exceed 7.5 percent of his or her adjusted gross income.

However, private insurance is not accessible to everyone. Some workers, including those working for small firms or in certain industries such as agriculture or construction, are less likely to be offered employment-based health coverage. Health insurance may also be expensive and potentially unaffordable for those paying the entire premium individually rather than receiving employment-based coverage where employers typically contribute to some or all of the cost. In addition, while all members of a group plan typically pay the same premium for employment-based insurance regardless of age or health status, in most states individual insurance premiums are higher for older, sicker individuals than for young, healthy individuals, potentially making them unaffordable.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided several important protections to improve the availability of private health insurance, particularly for individuals changing jobs or with preexisting health conditions. HIPAA included guaranteed access to coverage for those leaving group coverage and for small employers; however, it did not address issues of affordability. In addition, many states have enacted reforms that guarantee access to health insurance for certain high-risk individuals and small groups and that sometimes limit the premiums these persons and groups pay. While these federal and state private insurance market reforms provide important protections for certain individuals and groups, recent research finds little, if any, effect from these reforms on overall private insurance coverage rates.

Public programs such as Medicaid and SCHIP cover certain low-income or disabled individuals. However, eligibility for these programs is often restricted to selected groups, such as children, parents of eligible children, pregnant women, or disabled individuals, and depends on the applicant's age, income, and other factors. For example, childless adults, unless disabled, are generally not eligible for Medicaid. States must set income thresholds to meet certain minimum federal standards but may opt for higher eligibility standards as long as they are within federal guidelines. SCHIP was established in 1997 to give states the choice of receiving enhanced federal funding to cover additional low-income children who do not qualify for Medicaid, generally those in families whose incomes are up to 200 percent of the federal poverty level. Unlike Medicaid, SCHIP is not an entitlement program, and states can halt enrollment once budgeted funds are exhausted.[4] As of September 2000, HCFA reported that 3.3 million children were enrolled in SCHIP. Although Medi-

[3] For 2001, self-employed individuals may deduct 60 percent of eligible health insurance expenses from taxable income; this share is scheduled to rise to 100 percent in 2003 and thereafter.

[4] As an entitlement program, states must enroll all individuals who apply and meet state and federal Medicaid requirements.

care primarily insures most Americans 65 years or older, it also provides coverage for some nonelderly individuals who are disabled or have end-stage renal disease.

IMPACT OF PROPOSED TAX INCENTIVES WILL DEPEND ON THEIR SIZE AND TIMING

Additional tax incentives proposed to encourage people to purchase health insurance vary in terms of who would be eligible, whether the tax incentive is provided to individuals or employers, and whether the incentive is a deduction that reduces taxable income or a credit that reduces total tax liability. The proposals share challenges that will affect their success in covering newly insured individuals. These challenges include (1) making the reduction in premiums large enough to induce uninsured persons to purchase health insurance or to encourage employers to offer coverage or increase their contributions to premiums, and (2) timing a subsidy to be available for low-income individuals at the time they pay their premiums, rather than after the end of the tax year.

TAX DEDUCTIONS

Some proposals would allow people who purchase individual, nongroup health insurance to deduct the cost of premiums from their taxable income, with the intention of both increasing coverage and making the tax treatment of individually purchased and employment-based insurance more uniform. These proposals vary as to whether tax filers would have to itemize deductions in order to receive the health insurance deduction or could make the deduction an "above-the-line" adjustment to gross income without itemization.[5] Some proposals would also allow employees' contributions to employment-based health insurance to be deducted from their taxable income—potentially important if the employee must pay most or a large share (more than half) of the plan's premium, since these employees are more likely to turn down employment-based coverage.

A tax deduction may be limited in its ability to induce uninsured individuals to purchase private insurance because most uninsured individuals do not earn enough for a deduction to make any or a significant difference in their net health insurance costs. In 1999, about 40 percent of the uninsured either did not file income tax returns or were in the 0 percent marginal tax rate and would not benefit from the deduction if they purchased individual insurance. Nearly 50 percent of the uninsured were in the 15 percent marginal tax rate, which, if they purchased qualifying health insurance, would allow them a 15 percent net reduction in their insurance cost.[6] Analysts have generally agreed that this level of reduction would encourage few additional uninsured individuals to purchase health insurance. The remaining 10 percent of the uninsured, based on their marginal tax rates, would be eligible for a 28 to nearly 40 percent net reduction in the cost of their health insurance.[7] While this level of reduction in net premiums may induce some individuals in higher tax brackets to purchase health insurance, it is less than some analysts have concluded would be necessary to lead to a widespread increase in coverage. For example, the Congressional Budget Office (CBO) reported that tax subsidies "would have to be fairly large—approaching the full cost of the premium—to induce a large proportion of the uninsured population to buy insurance."[8]

TAX CREDITS

Other proposals would allow individuals purchasing health insurance to receive a tax credit. In contrast to a deduction, the amount of the credit depends not on the filer's marginal tax rate but how the credit is designed. Some proposals involve providing tax filers below a certain income threshold a flat credit if they purchase individual health insurance, such as up to $1,000 for single coverage or $2,000 for family coverage, while higher-income individuals could be eligible for a partial credit or no credit. Because more than half of uninsured individuals would not have had enough income tax liabilities in 1999 to receive the full credit amount, some proposals would make the credit refundable so that more low-income tax filers and a

---

[5] In 1998, nearly 31 percent of tax filers itemized their deductions.

[6] In 1999, the 15 percent tax bracket included single tax filers with taxable income of $25,750 or less, head of household tax filers with taxable income of $34,550 or less, and joint tax filers with taxable income of $43,050 or less.

[7] The 28 percent tax bracket included single tax files with taxable income of $25,751 to $62,450, head of household tax filers with taxable income of $34,551 to $89,150, and joint tax filers with taxable income of $43,051 to $104,050. The 39.6 percent tax bracket included any tax filer with income over $283,150.

[8] CBO, *Options to Expand Federal Health, Retirement, and Education Activities*, (Washington, D.C.: June 2000).

number of those who would not otherwise file could receive a larger portion or all of the amount.[9]

The number of individuals eligible for a tax credit would vary depending on the income thresholds specified in a proposal. For example, we estimate that in 1999 22 million uninsured Americans were in families that potentially would have been eligible for a tax credit available to single tax filers with $30,000 in taxable income and joint or head-of-household tax filers with $50,000 in taxable income. A recent study estimated that a tax credit of $1,000 for single coverage and $2,000 for family coverage with these taxable income thresholds could enable about 4.2 million—or nearly 20 percent of eligible individuals—to become newly insured.[10] If income eligibility levels were twice as high, we estimate that 3 million additional uninsured individuals would have been in families potentially eligible for the tax credit, and the study estimated that a credit at this higher income eligibility level would result in another 0.5 million newly insured.[11]

A fixed-dollar tax credit would represent a varying proportion of the health insurance cost, since health insurance premiums can vary widely with the locality, age, and health of the individual and the level of benefit and plan type. In 1999, we reported some examples of annual premiums in the individual health insurance market for single coverage, including

- a low premium of $744 for a healthy 30-year-old male in Arizona,
- a mid-level premium of $2,658 in a rural New York county, a state that has community rating and therefore does not allow variation by age or health status of the individual, and
- a high premium of $7,154 for a 60- to 64-year-old smoker in urban Illinois.[12]

Thus, in some states, a $1,000 tax credit could represent all or most of the premium for a young, healthy male or for someone purchasing a plan with a high deductible or limited benefits. On the other hand, a $1,000 credit could represent a small proportion of the premium for a comprehensive health plan for an older person or someone with existing health conditions. For many individuals, a $1,000 tax credit would likely represent less than half of a typical premium.

A tax credit's ability to induce uninsured individuals to purchase coverage will also depend on the timing of the credit. Some low-income individuals who want to take advantage of a credit to purchase health insurance may find it difficult to do so if they must pay the premiums up front but cannot receive the credit until the following year after filing their tax return. To alleviate this problem, some proposals would allow advance funding of a credit, so that eligible individuals could receive the credit at the time they purchase the health insurance. There is limited experience with advance payments of tax credits for individuals, and establishing an effective mechanism could be administratively challenging. Procedures and resources to assess eligibility based on partial-year income information would need to be available nationwide. In addition, efficient and equitable procedures for end-of-year reconciliations and recovery of excess payments would be necessary.

The Earned Income Tax Credit (EITC), a refundable tax credit that offsets much of the impact of Social Security taxes paid by low-income workers in order to encourage them to seek work rather than welfare, does provide an option allowing recipients to receive 60 percent of the credit in advance. The share payable in advance is limited to 60 percent to reduce the risk to recipients of having to repay erroneous payments and to reduce the risk of overpayments. However, very few EITC recipients—about 1 percent—have received an advance payment for their EITC.[13] This low participation is in part because many EITC recipients are unaware of the advance payment option or prefer to receive the full credit at the end of the tax year. While the EITC experience suggests that it may be difficult to make an advance payment option work effectively for a health insurance tax credit, more low-income individuals may use this option for health insurance because they are required to

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[9] By being refundable, a tax credit allows tax filers whose income tax liability is less than the value of the credit to receive a refund in excess of their federal tax liability.

[10] Unpublished data from Jonathan Gruber based on Jonathan Gruber and Larry Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits," *Health Affairs* (Jan/Feb 2000), pp. 72–85. The authors estimate that the number of uninsured that would be newly covered would be higher (about 6 million) if it was payable in advance but lower (about 2 million) if it excluded anyone with employer-based coverage.

[11] Gruber and Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits."

[12] *Private Health Insurance: Potential Tax Benefit of a Health Insurance Deduction Proposed in H.R. 2990* (GAO/HEHS–00–104R, Apr. 21, 2000).

[13] For more information on the EITC, see *Federal Taxes: Information on Payroll Taxes and Earned Income Tax Credit Noncompliance* (GAO–01–487T, Mar. 7, 2001).

spend money up-front to get the tax credit, whereas EITC is an addition to income, not a reimbursement for an expense.

To encourage more employers to offer coverage, some proposals would provide a tax subsidy to small firms or those with low-wage workers that often do not offer health insurance to their employees. Although at least 96 percent of private establishments with 50 or more employees offered coverage in 1998, only 36 percent of private establishments with fewer than 10 workers and about 67 percent of private establishments with 10 to 25 workers offered coverage. Also in 1998, among private establishments in which half or more of the workers were low-wage, only 31 percent offered health insurance to their employees, while other private establishments were nearly twice as likely to offer health insurance.[14]

As with tax credits to individuals, if employer tax credits are to increase insurance coverage, they must be large enough to induce employers to begin offering coverage and to make the employee share affordable. Generally, credit amounts proposed to date for small employers would represent much less than half of the annual cost of coverage per employee, which is typically about $2,400 for single coverage and almost $6,400 for family coverage.[15] For example, one proposal would provide a temporary tax credit for employers with 2 to 50 employees that had not offered health insurance in the past 2 years and that began purchasing coverage through a qualified coalition. The credit would amount to 20 percent of employer contributions to the insurance, up to $400 per year for individual coverage and $1,000 per year for family coverage. Massachusetts and Kansas recently began offering a tax credit to small businesses, and Massachusetts also offers a tax credit to low-income employees. However, these policies are too new to fully assess their effects on coverage. Another proposal would provide a credit to employers to encourage them to pay a larger share of premiums for low-wage workers. This is intended to encourage more low-wage workers who are offered employment-based health insurance to accept it.[16] One study estimated that in 1996 37 percent of workers earning less than $7 per hour were offered coverage but turned it down, while only 14 percent of workers earning $15 or more per hour turned down coverage.[17]

Many proposed or already available state-offered tax credits for employers provide only a temporary subsidy for the first few years an employer offers coverage. This may limit their potential for inducing employers to initiate and keep offering coverage. Experts we have consulted in our private insurance work told us that small employers are not likely to begin offering health insurance if they do not believe they will be able to do so permanently.

Some proposed employer tax credits are linked to small employers obtaining health insurance through a purchasing cooperative. We reported last year that several existing cooperatives gave small employers the ability to offer a choice of plans, but typically at premiums similar to those available outside of the cooperative. We also reported that most current cooperatives represented a small share of their local small group market (5 percent or less) and several had recently been discontinued or faced declining insurer or employer participation.[18] Some analysts suggest that small employer purchasing cooperatives could be more effective in making coverage more affordable if they represented a larger share of the market. A significant employer tax credit linked to a small employer purchasing cooperative might stimulate participation and create larger market share, making them better able to secure lower-cost coverage for participants.

SUCCESS OF PUBLIC PROGRAM EXPANSIONS DEPENDS ON STATE RESPONSIVENESS AND OUTREACH

While expansions of Medicaid and the implementation of SCHIP in recent years have given states the ability to cover more low-income individuals, a significant number of this group remain uninsured. A variety of factors contribute to this situation. Some groups of low-income persons generally are ineligible, such as adults without children. Also, while some states have exercised options that allow them to

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[14] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, 1998 Medical Expenditure Panel Survey, Insurance Component.

[15] The Kaiser Family Foundation and Health Research Educational Trust's *Employer Health Benefits: 2000 Annual Survey* reports that average premiums in 2000 were $2,426 for single coverage and $6,351 for family coverage.

[16] See Charles N. Kahn III and Ronald F. Pollack, "Building a Consensus for Expanding Health Coverage," *Health Affairs*, Vol. 20, No. 1 (Jan./Feb. 2001), pp. 40–48.

[17] Philip F. Cooper and Barbara S. Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, Vol. 16, No. 6 (Nov./Dec. 1997), pp. 142–149.

[18] *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices* (GAO/HEHS–00–49, Mar. 31, 2000).

increase existing limits on income eligibility thresholds for low-income children and parents, many states with high uninsured rates have not done so. Several proposals would further expand Medicaid and SCHIP to cover populations that are not currently eligible (such as childless adults) or raise income and asset eligibility standards. Another proposal would allow some near-elderly persons to buy in to Medicare. But many low-income people who currently are eligible for these public programs have not enrolled. Therefore, state outreach efforts to low-income individuals are key to the success of current and proposed programs.

MEDICAID AND SCHIP EXPANSIONS

Despite mandatory and optional state Medicaid expansions and the implementation of SCHIP in recent years, millions of low-income children and adults remain uninsured. Nearly 3 million children in households below the federal poverty level were uninsured in 1999 even though they would typically have been eligible for Medicaid.[19] And although SCHIP now covers more than 3 million children, in 1999 there were nearly 6 million uninsured children in families with incomes below 200 percent of the federal poverty level (about $34,000 for a family of four)—the income threshold targeted by many SCHIP programs. Another 16.3 million adults with family incomes below 200 percent of the federal poverty level were uninsured, and nearly half of these had family incomes below the federal poverty level.

The federal statutes create some gaps in the ability of public programs to cover low income individuals (such as generally not allowing coverage for childless adults), but they also give states flexibility to cover children and parents at higher income levels. States vary considerably in the extent to which they have taken advantage of existing options for expanding eligibility for Medicaid or SCHIP. Some states have used Medicaid waivers and other authority to expand eligibility for their programs beyond traditional groups and income thresholds. For example, 12 states have obtained section 1115 research and demonstration waivers[20] from the Health Care Financing Administration for Medicaid to increase income thresholds for existing eligibility groups and in some cases to add new eligibility groups, such as childless adults. Recently, three states—New Jersey, Rhode Island, and Wisconsin—obtained section 1115 waivers to use SCHIP funds to cover eligible children's parents—but few other states have sought to do so. Also, 30 states have expanded Medicaid eligibility under section 1931 of the Social Security Act to disregard portions of an applicant's income or assets when determining eligibility, which effectively increases the level of income and assets an eligible individual may have.

States' willingness and ability to use additional federal flexibility will be key to efforts to expand public coverage. States with high uninsured rates typically have lower income eligibility thresholds for Medicaid than those with low uninsured rates. For example, the average Medicaid eligibility level for parents in the 13 states with high uninsured rates is 54 percent of the federal poverty level, compared with an average of 99 percent of the federal poverty level for the 29 states with low uninsured rates. Furthermore, states with low uninsured rates have been more likely to use available authority to expand coverage than states with high uninsured rates. Whereas 10 of the 29 states with uninsured rates significantly lower than the U. S. average have used section 1115 waivers to expand Medicaid eligibility, only 1 of the 13 states with uninsured rates significantly higher than the U. S. average has done so. Appendix I summarizes selected eligibility requirements and options that states have adopted for Medicaid and SCHIP.

States' financial capacity may be a factor in what states have done to expand Medicaid and SCHIP to cover additional low-income individuals. States with high uninsured rates tend to be poorer and already cover a larger share of their population in Medicaid. On average, 16 percent of the nonelderly populations in the 13 states with high uninsured rates are in poverty compared with 10 percent in the 29 states with low uninsured rates. These high uninsured states also cover a higher proportion of their nonelderly residents through Medicaid (9 percent) than do states with low uninsured rates (7 percent).

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[19] Section 6401 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101–239) required states to provide Medicaid coverage for pregnant women and children up to age 6 in families with income below 133 percent of the federal poverty level. Section 4601 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508) required, in effect, that states expand Medicaid coverage to older children living in families with incomes below the federal poverty level annually until October 2002, when children through the age of 18 will be eligible.

[20] Section 1115 refers to a section of the Social Security Act that allows the Health Care Financing Administration to exempt states from many title XIX and XXI requirements, thus allowing demonstration projects likely to assist in promoting program objectives.

MEDICARE BUY-IN

Another proposed public program expansion known as a Medicare "buy-in" would allow some near-elderly individuals to pay premiums to enroll in Medicare. This proposal targets the more than 3 million uninsured near-elderly individuals between ages 55 and 64. This population is of particular concern because near-elderly individuals approaching retirement now are less likely to have employment-based retiree coverage available than in the past. As we reported in 1998, fewer employers sponsored retiree health benefits in 1997 than in 1991.[21] Recent employer surveys indicate that this decline has not reversed since 1997.[22] Further, with the aging of the baby boom generation, over the next decade the number of near-elderly individuals not yet eligible for Medicare will grow, which likely will increase the number of uninsured persons in this age group.

CBO estimates that few individuals would be able to afford the full premium that would be necessary to buy-in to Medicare—$300 to more than $400 per month initially.[23] High-cost individuals who would face higher than average premiums in the individual insurance market would be most likely to opt for a Medicare buy-in, which would likely lead to premium increases over time. Subsidies to low-income individuals would encourage more lower-cost near-elderly individuals to buy in to Medicare.

OUTREACH IS A KEY TO SUCCESS OF PUBLIC PROGRAM EXPANSIONS

Many low-income individuals who are eligible for Medicaid and SCHIP do not enroll. Some may be unaware that they or their children may be eligible, while the administrative complexity of enrolling and other reasons may discourage other eligible individuals from participating. Thus, outreach to low-income individuals to enroll in existing or expanded public programs is key to the success of the programs. We reported in 1996 that 3.4 million Medicaid-eligible children—23 percent of those eligible under federal standards—were uninsured.[24] Another study found that in 1998 16 percent of children under 200 percent of the federal poverty level were eligible for Medicaid or SCHIP but were uninsured.[25]

Lessons from the Medicare program also illustrate the importance of effective outreach for low-income beneficiaries. We reported that about 43 percent of low-income Medicare beneficiaries that were eligible in 1996 for federal-state assistance for paying Medicare premiums and/ or other out-of-pocket expenses not covered by Medicare were not enrolled.[26] Recognizing the low participation by these individuals eligible for the Qualified and Specified Low-Income Medicare Beneficiary programs, last year the Congress enacted requirements that the Social Security Administration identify and notify potentially eligible individuals, and that the Department of Health and Human Services develop and distribute to states a simplified uniform enrollment application.[27]

PROPOSALS COULD UNINTENTIONALLY LEAD TO CROWD-OUT AMONG THOSE ALREADY PRIVATELY INSURED

Efforts to expand private or public coverage to those currently uninsured can also provide new incentives to those already having private health insurance. Some currently insured individuals may drop employment-based coverage to get tax-subsidized individual insurance or enroll in Medicaid or SCHIP. While there was disagreement among analysts about the extent of crowd-out of private health insurance

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[21] See *Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds* (GAO/HEHS–98–133, June 1, 1998). A forthcoming GAO report will update trends in retiree health coverage for early and Medicare-eligible retirees.

[22] See Mercer/Foster Higgins *National Survey of Employer-sponsored Health Plans 2000* and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey*.

[23] Congressional Budget Office, "Medicare Projections and the President's Medicare Proposals," April 1999.

[24] *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies* (GAO/HEHS–98–93, Mar. 20, 1998).

[25] Kaiser Family Foundation, based on Urban Institute simulations of 1997 Current Population Survey March Supplement, projected to 1998.

[26] *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment* (GAO/HEHS–99–61, Apr. 9, 1999).

[27] These requirements were enacted under sections 709 and 911 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 that was incorporated by reference in P.L. 106–554.

resulting from the Medicaid expansions in the late 1980s and early 1990s,[28] concern led the Congress to include a requirement in SCHIP that states devise methods to avoid such crowd-out. While several approaches may offset the extent of crowd-out, some degree of crowd-out may be an unavoidable cost of expanding private or public coverage to insure those that are currently uninsured. For example, CBO analysts suggested that some displacement of private insurance is inevitable, particularly since some low-income families move in and out of private insurance coverage and public programs can allow these low-income families to achieve more stable insurance coverage.

Expanding tax preferences are also not immune from potential crowd-out. Tax deductions or credits to subsidize uninsured individuals to purchase individual health insurance would also provide a tax subsidy to the approximately 13 million non-elderly individuals who purchased individual health insurance in 1999. While this tax expenditure to those already insured would make more equitable the tax treatment of individually-purchased and employment-based health insurance, it also increases the federal cost per newly insured person since much of the subsidy goes to those already covered. Moreover, some employers currently offering health insurance to their employees may discontinue offering coverage if their employees have tax preferences available for individually-purchased insurance. 29 Similarly, even if employers continued sponsoring coverage, some employees—especially those who are young and healthy—may be able to purchase lower-cost insurance in the individual market, which could over the long-term increase the costs for some remaining in the group employment-based market. One study estimated that, among people electing a tax credit, nearly half would already be purchasing individual insurance, about one-quarter would shift from employment-based coverage, and another one-quarter would have previously been uninsured. Of those shifting from employment-based coverage, about one-fourth would be because the firm dropped coverage.[30]

Similarly, when eligibility for public programs is expanded, employers with many low-income individuals eligible for public coverage may decide to discontinue coverage or individuals offered employment-based coverage may shift to public programs where they have lower or no premiums or other out-of-pocket costs. The absence of measures to reduce crowd-out can be significant. For example, a recent report indicated that one state that extended Medicaid coverage to parents with eligible children without a waiting period found that nearly one-third of those that became newly enrolled had previously had private health insurance.[31]

Several approaches have been tried or proposed to minimize crowd-out, but none may completely eliminate it. For example, some tax subsidies or public program expansions would exclude anyone offered employer-subsidized health insurance or where the employer contributes to most of the cost of coverage. Requiring a waiting period between the time the individual had employment-based coverage and when they are eligible for a tax subsidy or public program could also reduce crowd-out. For example, some states in accord with the federal requirement to establish mechanisms to reduce crowd-out behavior, have established waiting periods requiring individuals not to have had employment-based coverage for a certain time before becoming eligible for SCHIP. Other states have established cost sharing requirements (premiums or copayments) for SCHIP, thereby providing less of a financial incentive for low-income workers to switch from an employment-based plan where cost sharing requirements are common.

CONCLUDING OBSERVATIONS

A variety of approaches have been proposed to increase private and public coverage among uninsured individuals. The success of these proposals in doing so for these diverse populations will depend on several key factors. The impact of tax subsidies on promoting private health insurance will depend on whether the subsidies reduce premiums enough to induce uninsured low-income individuals to purchase health insurance and on whether these subsidies can be made available at the time the person needs to pay premiums. The effectiveness of public program expansions will depend on states' ability and willingness to utilize any new flexibility to cover uninsured residents as well as develop effective outreach to enroll the targeted populations. While crowd-out is a concern with any of the approaches, private or public,

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[28] See, for example, Lisa Dubay and Genevieve Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs*, Vol. 16., No. 1 (Jan./Feb. 1997), pp. 185–193, and David M. Cutler and Jonathan Gruber, "Medicaid And Private Insurance: Evidence And Implications," *Health Affairs*, Vol. 16, No. 1 (Jan./Feb. 1997), pp. 194–200.

[30] Gruber and Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits."

[31] Academy for Health Services Research and Health Policy, *State of the States*, produced for the Robert Wood Johnson Foundation's State Coverage Initiatives (Jan. 2001).

some degree of public funds going to those currently with private health insurance may be inevitable to provide stable health coverage for some of the currently 42 million uninsured.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or Members of the Committee may have.

GAO CONTACTS AND STAFF ACKNOWLEDGMENTS

For more information regarding this testimony, please contact Kathryn G. Allen at (202) 512–7118 or John E. Dicken at (202) 512–7043. JoAnne R. Bailey, Paula Bonin, Randy DiRosa, Karen Doran, Betty Kirksey, Susanne Seagrave, and Mark Vinkenes also made key contributions to this statement.

APPENDIX I APPENDIX I

SELECTED MEDICAID AND SCHIP ELIGIBILITY STANDARDS AMONG STATES

State	Uninsured as percentage of nonelderly population uninsured 1998-1999	Medicaid upper income eligibility standard for parents, as of March 2000 (percentage of federal poverty level)[a]	SCHIP upper income eligibility standard, as of September 30, 2000 (percentage of federal poverty level)
Uninsured rate significantly above U.S. average			
New Mexico	26.6	60	235
Texas	26.3	31	200
Arizona[b]	25.5	50	200
California	23.4	108	250
Louisiana	23.2	22	150
Nevada	23.2	78	200
Florida	22.0	68	200
Montana	21.5	71	150
Mississippi	20.9	39	200
Oklahoma	20.8	50	185
West Virginia	20.7	29	150
Idaho	20.6	34	150
New York	19.1	56	192
Average	**22.9**	**54**	**189**
Uninsured rate not significantly different from U.S. average			
Arkansas[b]	19.3	22	100
Alaska	18.9	104	200
South Carolina	18.7	56	150
Georgia	18.6	44	200
District of Columbia	18.4	200	200
Wyoming	18.3	67	133
U.S. average	**17.9**	**82**	**202**
Alabama	17.8	21	200
Colorado	17.4	43	185
North Carolina	17.2	54	200
Average	**18.1**	**68**	**174**
Uninsured rate significantly below U.S. average			
New Jersey[c]	16.5	45	350
Illinois	16.2	40	185
Kentucky	16.2	52	200

State	Uninsured as percentage of nonelderly population uninsured 1998-1999	Medicaid upper income eligibility standard for parents, as of March 2000 (percentage of federal poverty level)[a]	SCHIP upper income eligibility standard, as of September 30, 2000 (percentage of federal poverty level)
Maryland	16.2	44	200
Oregon[b]	16.2	100	170
Virginia	15.8	32	185
Washington	15.4	200	250
North Dakota	15.2	81	140
Utah	15.2	57	200
South Dakota	15.0	67	200
Delaware[b]	14.9	108	200
Indiana	14.2	30	200
Maine	13.9	104	185
Michigan	13.6	46	200
Tennessee[b]	13.5	75	100
Kansas	13.0	42	200
Connecticut	12.8	193	300
Wisconsin[b,c]	12.7	193	185
Vermont[b]	12.3	185	300
Ohio	12.1	108	200
New Hampshire	11.9	61	300
Hawaii[b]	11.8	100	200
Massachusetts[b]	11.7	133	200
Pennsylvania	11.5	71	200
Nebraska	11.2	42	185
Missouri[b]	10.8	108	300
Iowa	10.2	90	200
Rhode Island[b,c]	9.8	193	250
Minnesota[b]	9.6	275	280
Average	**13.6**	**99**	**216**

[a] Income eligibility level for parents assumes a family of three with one wage-earner, that all income is from earnings, and that only earned income disregards are taken.

[b]State has received a section 1115 waiver implemented to expand Medicaid eligibility (as of January 26, 2001).

[c]State has received a section 1115 waiver implemented to expand SCHIP eligibility (as of January 18, 2001).

Note: States are categorized as higher than, similar to, or lower than the U.S. average based on whether the state-level estimate statistically is significantly different from the U.S. average. Because smaller states have smaller sample sizes in the Current Population Survey, the potential sampling error is larger in these

states than in larger states. Thus, a specific uninsured rate may be significantly different from the U.S. average for one state but not for another with a smaller population and sample size. For this reason, New York's uninsured rate of 19.1 percent is significantly higher than the U.S. average, even though it is slightly lower than Arkansas' estimated rate of 19.3 percent, which is not significantly different from the U.S. average.

Source: Uninsured rates from 1999 and 2000 Current Population Supplements, which were combined to improve the precision of the state estimates. Medicaid eligibility standards for parents from Families USA "Disparities in Eligibility for Public Health Insurance Between Children and Adults, 2000," March 2000 based on Center for Budget and Policy Priorities analysis of state Medicaid eligibility levels; SCHIP eligibility standards from Health Care Financing Administration.

RELATED GAO PRODUCTS

Health Insurance: Characteristics and Trends in the Uninsured Population (GAO-01-507T, Mar. 13, 2001).

Federal Taxes: Information on Payroll Taxes and Earned Income Tax Credit Noncompliance (GAO-01-487T, Mar. 7, 2001).

Private Health Insurance: Potential Tax Benefit of a Health Insurance Deduction Proposed in H.R. 2990 (GAO/HEHS-00-104R, Apr. 21, 2000).

Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits (GAO/HEHS-00-86, Apr. 14, 2000).

Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices (GAO/HEHS-00-49, Mar. 31, 2000).

Private Health Insurance: Estimates of Effects of Health Insurance Tax Credits and Deductions as Proposed in H.R. 2261 (GAO/HEHS-99-188R, Sept. 13, 1999).

Children's Health Insurance Program: State Implementation Approaches Are Evolving (GAO/HEHS-99-65, May 14, 1999).

Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards (GAO/HEHS-99-100, May 12, 1999).

Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment (GAO/HEHS-99-61, Apr. 9, 1999).

Private Health Insurance: Estimates of a Proposed Health Insurance Tax Credit for Those Who Buy Individual Health Insurance (GAO/HEHS-98-221R, July 22, 1998).

Private Health Insurance: Estimates of Expanded Tax Deductibility of Premiums for Individually Purchased Health Insurance (GAO/HEHS-98-190R, June 10, 1998).

Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds (GAO/HEHS-98-133, June 1, 1998).

Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies (GAO/HEHS-98-93, Mar. 20, 1998).

(290044)

PREPARED STATEMENT OF JANET STOKES TRAUTWEIN

Good afternoon. My name is Janet Stokes Trautwein. I am the Director of Federal Policy Analysis for the National Association of Health Underwriters. **The National Association of Health Underwriters** is an association of insurance professionals involved in the sale and service of health insurance, long-term care insurance, and related products, serving the insurance needs of over 100 million Americans. We have almost 17,000 members around the country. We appreciate this opportunity to present our comments regarding the rising number of uninsured Americans. NAHU has been a proponent of refundable health insurance tax credits to address the problem of the uninsured for more than a decade, and is pleased to have this opportunity to discuss the practical application of a tax credit with the members of this committee. We believe a refundable health insurance tax credit will provide a real solution to the problem of the uninsured in America by addressing affordability—the most basic component of access to health care.

The current estimate on the number of uninsured in this country is approximately 43 million people. That number represents an increase from a few years ago, despite numerous state and federal efforts to improve access. Over half of the 43 million uninsured Americans are the working poor or near poor, many of whom already have access to health insurance through an employer-sponsored plan.[1] Since employers already provide access to health plans and pay a significant portion of the premiums for many Americans, why do we have so many uninsured? The problem isn't access—it's affordability. **They just can't pay for it.**

This inability to pay has many causes. As we know, the United States government gives a tax break to people covered under their employer's health insurance plan. Health insurance premiums paid by an employer are not taxable as income to employees, even though many people consider employer-paid health insurance to be a part of compensation. Although this tax break has provided an excellent incentive for many people to become insured, it has also inadvertently created another problem—lack of tax equity. When an employer pays $100 in tax-free health insurance premiums for an employee in a 30% tax bracket, it's worth $30 to that employee. To another employee in a 15% tax bracket, it would be worth $15, and for the low-income employee with no tax liability or the person who is self-employed or otherwise has no employer-sponsored plan available, *the tax break is worth nothing*. That's why many low-income employees who must pay part of the cost of employer-sponsored health insurance coverage for themselves or their family have declined coverage. Most people in employer plans benefit from both the dollar amount of the employer contribution and the tax exemption on employer-sponsored health insurance premiums. Low-income individuals only benefit from the employer's contribution if they are able to pay their share of the remaining premium, and they don't benefit at all from the tax exemption. Increased deductibility of health plan premiums for the self-employed has helped and will help more as greater deductibility is phased in. Unfortunately, however, deductibility does nothing for the bulk of the uninsured—the working poor with no or very low tax liability.

People with no tax liability don't benefit from a deduction for two reasons. First, if they owe no taxes, there is nothing from which to deduct their premiums, even if the deduction was available without the requirement that a person itemize. Second, and probably more important for the working poor, a deduction or even a credit that is only available at the end of the year is of no value to them because they need the funds at the time their health insurance premium is due. They can't wait a year to be reimbursed, so they forego insurance entirely. That's why they are uninsured now.

Fortunately, there is a solution for this problem. A refundable, advanceable tax credit would allow individuals to receive their tax credit dollars monthly, when their premiums are due. This type of credit, advanced monthly and administered through the insurance company or the employer, provides the following benefits:

- It is simple to understand.
- It is almost impossible to abuse, since the insurance company or employer would certify that coverage was purchased.
- It enhances the effectiveness of COBRA's access mechanism by providing a means to pay COBRA or other health insurance premiums when people change jobs.
- It provides early retirees with needed dollars to help them purchase a health insurance policy.
- Small employers who currently can't afford to provide a health insurance plan would, with the combination of the contribution they could provide and dollars

[1] U.S. Census Bureau, 2000.

provided to eligible employees through a health insurance tax credit, be more likely to offer a group health plan to workers.[2]

TAX CREDITS IN EMPLOYER-SPONSORED PLANS

Some health insurance tax credit proposals do not allow a credit to be used in an employer-sponsored plan. A better solution is a health insurance tax credit designed to be used either to buy coverage in the individual health insurance market or to help an employee pay his or her share of premiums in an employer-sponsored plan. Most people are happy with the employer-based system, according to a 1999 survey by the Employee Benefits Research Institute, and many uninsured individuals already have high-quality employer-based coverage available to them. A recent NAHU survey of small employers shows that many small employers pay most or all of an employee's health insurance premium, but little or none of the cost of coverage for dependents. 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, such as declining take up and shrinking pools, and would empower individuals to select their own place of purchase, rather than having it imposed on them by the government.

Another way to help employees pay their share of premiums would be to allow (but not require) advanceable Earned Income Tax Credit (EITC) dollars to be combined with health insurance tax credit dollars for eligible employees. Past concerns about whether or not adequate coverage would be purchased with EITC dollars would be addressed through the administration mechanisms of the health insurance tax credit, which require the purchase of HIPAA-creditable coverage, certified by either the employer or the insurance company.

SHOULD A TAX CREDIT BE FLAT OR A PERCENTAGE OF PREMIUMS?

Some people claim that because the cost of individual health insurance is different for individuals of different ages and in different states, a flat credit is unfair and inflexible. It is true that health insurance costs are different for different populations. But a credit based on a percentage of premiums is difficult to administer because of these very differences. It is very important that a health insurance tax credit be advanced monthly, when premiums are due. This can be done through insurance carriers for those who purchase individual health insurance coverage as well as through the employer payroll process for those who purchase coverage in an employer-sponsored plan. If administration becomes too difficult, it won't be cost-effective for employers and insurers to handle this administration, and they will elect not to advance tax credits to individuals. This will result in the tax credit not being available to individuals and families until they file their tax return.

HOW MUCH SHOULD THE TAX CREDIT BE?

Over the years, NAHU has spent a considerable amount of time looking at the dollar amount of a health insurance tax credit. In doing so, we looked carefully at the amount of coverage that is currently financed by employers. Employers pay for much of the coverage that insures most people today. It is very important that in our zeal to do something about those without health insurance that we don't inadvertently discourage employer funding of coverage for those who are already insured today. For that reason, it is important that a health insurance tax credit be low enough so that it will not provide an incentive for employers to discontinue their financial contributions towards plans. At the same time, it is important that the credit be large enough to provide a meaningful incentive for people without access to an employer-sponsored plan to obtain coverage.

A credit in the range of $1,000 for individuals and $2000–$2,500 for families is not large enough to cause an employer to stop providing coverage for employees, yet still provides a good base to finance coverage, even for employees purchasing coverage in the individual health insurance market.[3] We've attached as exhibits several comparisons of the cost of health insurance across the country. The first exhibit gives some examples of the types of health insurance coverage that are available to a single mother with two children for a contribution of about $2,600 per year. This assumes she does *not* have an employer plan available and has a $2,000 tax credit plus $50 per month of her own money. We've also illustrated the costs of cov-

[2] See NAHU survey of small employers, March 2001.

[3] The amount of the tax credit would periodically change to reflect increases or decreases in the cost of living, as reflected by the medical Consumer Price Indexs (CPI).

erage in a second exhibit for a higher level of benefits. A third exhibit gives a sampling of group insurance costs for the same person. Keep in mind that coverage offered in employer-sponsored plans provides a significantly higher level of benefits in many cases that what is available in the individual market, in addition to being less expensive. The controlled access in employer plans is much more effective at keeping a balanced risk pool than the individual health insurance market. But a tax credit would bring new people into the individual health insurance pool and would over time encourage insurance companies to write individual health insurance policies geared to the size of the credit, offering more options and making it possible for low-income families to obtain coverage without paying much more than the credits available.

IS A $1,000 TAX CREDIT ($2,000 FOR A FAMILY) LARGE ENOUGH TO BUY REASONABLE COVERAGE?

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, and even employees who do 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.[4]

WHAT IF SOMEONE DOESN'T QUALIFY FOR COVERAGE IN THE INDIVIDUAL HEALTH INSURANCE MARKET DUE TO A HEALTH CONDITION?

In most states individual health insurance requires that a person be in relatively good health. If a person does not qualify for coverage based on their medical history, many states have a high-risk pool or some other mechanism to ensure that coverage is available. High-risk pools provide an affordable alternative for high-risk individuals who don't have access to employer-sponsored coverage and must purchase individual health insurance coverage. An exhibit illustrating the cost of coverage in a sampling of states with high-risk pools is attached. 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 others who purchase coverage through their employer's plan or through the regular individual health insurance market. In addition, states without any safety net for the medically uninsurable should be encouraged and provided with incentives to develop programs to ensure that coverage is available for these individuals.

ADMINISTERING A REFUNDABLE HEALTH INSURANCE TAX CREDIT

The Treasury Department would have primary responsibility for administering tax credit payments. The credit, while owned by the individual, would not be paid directly to the individual, but would be transmitted to an insurance company, employer, high-risk pool, or other organization maintaining the individual's insurance account. The credit could be used only for the payment of private insurance premiums, and could not exceed the total cost of the premiums. Only health plans eligible as creditable coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) would be eligible for credit payment. The credit would be available on a monthly prorated basis, in order to ensure the continuing availability of credit funds throughout the year, particularly in cases of job change, and to help protect against fraud.

In cases of employer-provided insurance, the monthly tax credit allocation can be handled as part of the regular withholding process. The credit would be shown as a specific line item on the pay stub. Federal income taxes withheld by the employer on behalf of employees would be reduced by the amount of the credit before being sent to the government.

For those individuals purchasing coverage in the individual health insurance market, the monthly tax credit allocation could be subtracted from the regular monthly health insurance premium due, with the insurance company using normal billing mechanisms for the balance, if any, of the premium. As with employer plans, insurance companies could reduce federal taxes owed by the amount of credits they had advanced to eligible individuals.

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[4] To 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.

ECONOMIC IMPACT OF A HEALTH INSURANCE TAX CREDIT

A refundable health insurance tax credit for low-income individuals is an innovative way to achieve affordable health insurance coverage through the competitive private sector. A health insurance tax credit will help ensure that low-income Americans who have the greatest difficulty affording coverage will have a basic level of resources to purchase health insurance. The tax credit, by being available only for the purchase of private sector insurance, will allow a shift of low-income individuals from the very costly Medicaid program into private insurance plans. A health insurance tax credit would also help to lower the per capita cost of insurance, by reducing the amount of uncompensated care that is currently offset through cost shifting by health care providers to private sector insurance plans, and by substantially increasing the insurance base, spreading the cost over a wider number of people.

THE CHILDREN'S HEALTH INSURANCE PROGRAM

A discussion of the uninsured would be incomplete without mention of the Children's Health Insurance Program. Many of NAHU's members have been invited to serve on state task forces and committees to assist in implementation and outreach for CHIP. They have consistently reported several shortcomings of the federal CHIP legislation, which they feel have impeded their states' ability to reach the largest number of uninsured children.

Under the Balanced Budget Act, states have a number of options for implementing plans most appropriate to the needs of their uninsured children. One of those options is to expand Medicaid. The other available options are centered in the private sector. One reason many of the people who are already eligible for Medicaid today do not enroll is that they do not want the negative stigma associated with public assistance. Private sector programs can represent a transition from this stigma by allowing and encouraging people to embrace the concept of "self-help" as opposed to the expectation of government entitlement. As you know, this is a concept that has ramifications that extend far beyond the health insurance benefits provided by the plan. Congress wisely considered these private sector advantages and not only authorized states to develop private sector CHIP programs, but also allowed for children to be enrolled in the employer-based plans of their parents.

Unfortunately, due to some of the inflexible provisions that were also contained in the CHIP provisions of BBA, many states have been unable to adequately implement the full range of options allowed by the legislation. Even though it appears that states have a range of plan benefit options, that reality is virtually eliminated by the cost-sharing limitations contained in the legislation. Cost sharing is prohibited for children in families under 150% of the poverty level, and is limited to 5% of family income above that level. Unfortunately, cost sharing is defined to extend beyond premium to include co-payments and co-insurance.

A quick calculation of the maximum potential co-insurance liability of an "average" plan, such as might be offered to state employees, one of the plan prototypes allowed under the legislation, for example, would make that plan unacceptable. Under CHIP guidelines, the co-insurance responsibility alone would exceed the 5% maximum for many eligible participants. This requirement, along with certain mandated benefit requirements that were also included in the legislation, virtually forces states to use a benchmark plan based on Medicaid level benefits, which, we would point out, are far in excess of what the average child who is already insured enjoys today. Those parents who have already made the sacrifices necessary to see that their children are insured, many of whom are at an income level that would allow CHIP participation, are not eligible for CHIP funding because they are "already insured." In addition, the message they are receiving as a result of exercising responsible behavior is that the plans under which their children are now insured aren't good enough, because they may not meet the standards established under CHIP for uninsured children.

The other problem associated with the cost-sharing requirements is that because each employer plan is different, and the family income of each eligible child is different, a separate mathematical calculation is required for EACH participant, to be sure the 5% cost-sharing limitation is met for that particular plan and participant. Employer-sponsored coverage is often the easiest and most cost-effective option available for children and their families, and will allow families the opportunity to be enrolled together on the same employer-sponsored plan, but the separate calculation requirement makes plan administration unwieldy and expensive. For this reason it is unlikely that opportunities for participation in employer-sponsored plans will be aggressively pursued. This frustrating provision of the legislation is only worsened by a ruling by HCFA that employer plans where employers are paying less than 60% of the family premium are not eligible for participation in the CHIP

program.[5] Not only does this ruling by HCFA have no legislative basis, but surveys show that very few employers pay a significant part of the dependent premium, much less 60%.

SUMMARY

A refundable health insurance tax credit represents a simple and realistic way to extend private health insurance coverage to those uninsured individuals and families who are most in need of assistance. It is fair and is easy to administer. It is a private sector solution to a difficult public problem. It gives people the tools to make their own decisions.

In addition to a tax credit, the Children's Health Insurance Program could be greatly improved and made available to many more eligible uninsured children if changes were made to the cost-sharing requirements of the CHIP program to define cost-sharing as premium cost-sharing only. It would also appear that HCFA's concerns about crowd-out are unwarranted at this time since many states have not been able to use their current allotment of CHIP dollars. The best safeguard against crowd-out would be to facilitate the use of employer-sponsored plans in the CHIP program.

The most important patient protection is the ability to afford health insurance coverage. Real access to health care and choice can't exist without the dollars required to buy a health plan.

I appreciate this opportunity to testify today and would be happy to answer any questions the committee may have.

Should you have any questions or if we might be of any additional assistance, please contact Janet Stokes Trautwein, Director of Federal Policy Analysis for NAHU, at (703) 276–3806, or jtrautwein@nahu.org.

[5] Pending HHS Children's Health Insurance Program regulations may lessen this requirement slightly. HCFA's 60% employer contribution requirement was designed to avoid "crowd-out" which theoretically can occur when employers or employees drop the coverage they currently pay for in order to take advantage of government funding.

National Association of Health Underwriters

Individual Market and Public Sector Health Insurance Options Available for Low Income Families Across the United States

In this study, the National Association of Health Underwriters (NAHU) compared how much a health insurance policy purchased by a low-income American family through the individual health insurance market in each state would cost, as well as what type of plan benefits would be available to the family. The family used in this analysis includes a single mother, age 35, who is a non-smoker and is in relatively good health, as well as her healthy daughters, ages seven and nine. For each state, NAHU sought price and benefit information for a health insurance policy with an average annual price of $2600. In some states, coverage cannot be obtained for the average price, so information for the least expensive available policy is listed. In addition, this analysis lists the maximum income level for Medicaid participation by state, as well as the maximum family income level for participation in each state's Childrens' Health Insurance Program. Both maximum family income levels are listed as a percentage of the federal poverty level. Finally, this table lists the current state mechanism for providing individual-market insurance coverage to medically uninsurable and HIPAA-eligible individuals.

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
Alabama	PPO	$2616	$15000	100%	$10 office visit copay for non-preventive care. RX discount card.	133	133	100	100	N/A	72.8	200	Risk Pool
Alaska	Indemnity	$2502	$1500	80%	All benefits subject to deductible.	133	133	100	90	N/A	100.2	200	Risk Pool

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
Arizona	Indemnity	$2647	$750	90% (60% out of net-work)	RX $15 generic/$35 namebrand copay.	133/ 200	133	100	30	N/A	72.8	200	None
Arkansas	Non PPO	$2541	$500	80%	80% preventive care after deductible.	200	200	200	200	16	72.8	200	Risk Pool
California	PPO	$2256 $2748	$2000 $1000	75% after deductible	Maximum out of pocket is $8500. HealthyCheck Centers $25 or $75 copay for basic screenings RX $10 generic/$25 namebrand.	133	133	100	100	87	98.4	250	Risk Pool/Open Enrollment
Colorado	PPO	$2533	$1000	80% (60% out of net-work)	$25 office visit copay. RX $20 maximum copay.	185	133	100	37	N/A	78.1	185	Risk Pool
Connecticut	PPO	$2536	$750	70%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 namebrand copay.	185	185	185	185	69	209(b)	300	Risk Pool

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
Delaware	PPO	$2618	$1000	80%	RX $15 generic/ $25 namebrand copay.	185	133	100	100	N/A	72.8	200	Risk Pool
District of Columbia	PPO	$4488	$750	80% (60% out of net-work)	RX $100 deductible then $10 generic/$20 namebrand copay to $1,500 annual maximum. Other benefits subject to deductible and coinsurance.	185	133	100	37	55	72.8	200	Open Enrollment
Florida	PPO	$2395	$750	50%	RX $15 generic/ $25 namebrand copay. Preventive care ltd. to $150 per year.	185	133	100	100	26	72.8	200	Risk Pool
Georgia	PPO	$2531	$1000	80%	RX $15 generic/$35 namebrand. Office visit $30 copay.	185	133	100	100	30	72.8	235	None
Hawaii	Not available. State-wide employer coverage mandate.					185	133	100	100	53	209(b)	200	Employer Mandate

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
Idaho	PPO	$2484	$2000	80%	$30 copay includes routine not subject to deductible, RX $10 generic/$25 namebrand copay	160	160	160	160	N/A	79.8	150	Risk Pool
Illinois	PPO	$2628	None	80%	$30 copay for office visits. RX $10 generic/ $25 namebrand copay.	200	133	130	133	41	209(b)	185	Risk Pool
Indiana	PPO	$2532	$750	50%	RX $15 generic/$25 namebrand copay. $15 copay for office visits including preventive care.	150	133	100	100	N/A	209(b)	200	Risk Pool
Iowa	PPO	$2442	$500	80%	$25 office visit copay. RX $25 generic/$35 namebrand copay	185	133	100	37	70	72.8	185	Risk Pool/ Guaranteed Issue
Kansas	PPO	$2508	$7500	100%	$10 office visit copay. Rx discount card.	150	133	100	100	69	72.8	200	Risk Pool

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
Kentucky	PPO	$2865	$2500	80%	Includes RX coverage with a separate $100 deductible.	185	133	100	46	32	72.8	150	Risk Pool
Louisiana	PPO	$2526	$1000	80%	80% office visit copay and RX coverage.	133	133	100	17	15	72.8	200	Risk Pool
Maine	PPO	$1880	$5000	80%	Includes rider for preventive care and supplemental accident insurance.	185	133	125	125	46	74.3	150	Guaranteed Issue
Maryland	No PPO	$2400	$1000	100%	RX 100% copay after deductible.	185	185	185	33	51	72.8	200	Open Enrollment
Massachusetts	HMO	$4206	none	100%	$15 copay, $25 RX copay. Only plan available in state.	185	133	133	133	76	91.6	200	Guaranteed Issue
Michigan	No PPO	$2594	$1000	100%	RX 100% copay after deductible.	185	150	150	150	50	74.9	200	Open Enrollment
Minnesota	HMO	$2470	$2000	80%	Preventive care 100% coverage. RX $12 copay.	275	275	275	275	68	209(b)	275-280	Risk Pool
Mississippi	No PPO	$2412	$1000	100%	Office visit and RX subject to deductible.	185	133	100	32	N/A	72.8	200	Risk Pool

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
Missouri	PPO	$2706	$500	80%	RX $25 generic/$35 namebrand copay.	185	133	100	100	N/A	209(b)	300	Risk Pool
Montana	Indemnity	$3180	$3000	50%	RX discount card and 100% coverage after deductible. Well baby coverage. Optional preventive care coverage. Mental health coverage	133	133	100	48	71	72.8	150	Risk Pool
Nebraska	PPO	$2406	$500	90% (60% out of net-work)	RX $15 generic/$35 namebrand copay. $20 office visit copay.	150	133	100	100	57	72.8	185	Risk Pool
Nevada	Indemnity	$3069	$1000	80%	$20 office visit copay RX $20 copay when filled in-netwrok	133	133	100	31	N/A	78.1	200	None
New Hampshire	Indemnity	$3579	$1750	80%	$30 copays. RX subject to deductible.	300	185	185	185	74	209(b)	300	Guaranteed Issue
New Jersey	HMO	$5200	None	100%	$30 copays RX 50% copay.	185	185	133	133	53	77.4	201-350	Guaranteed Issue

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
New Mexico	PPO	$2580	$7500	100%	$10 office visit. RX discount card.	185	185	185	185	N/A	72.8	235	Risk Pool
New York	PPO	$3820	$250	100%	$20 copay. RX is $50 deductible then $10 copay for generics.	185	133	100	51	85	85.5	250	Guaranteed Issue
North Carolina	PPO	$2652	$2000	80%	$30 office visit copay. Preventive care with $30 copay. Well baby and child care with $20 copay. Rx coverage with sliding copay.	185	133	100	100	35	72.8	200	Open Enrollment
North Dakota	PPO	$2051	$1000	90% (70% out of net-work)	$20 office visit copay. Rx subject to deductible.	133	133	100	100	59	209(b)	140	Risk Pool
Ohio	PPO	$2254	$500	80%	$15 office visit copay. RX $15 generic/$25 namebrand copay.	150	150	150	30	N/A	209(b)	200	Open Enrollment

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
Oklahoma	PPO	$2617	$1000	80% (50% out of net-work)	Office visit including routine care deducible and copay applicable. RX $15 generic/$35 namebrand.	185	185	185	185	38	209(b)	185	Risk Pool
Oregon	PPO	$2850	$1500	20%	20% copay. RX greater of $20 or 50% copay.	133	133	100	100	96	73.1	170	Risk Pool
Pennsylvania	PPO	$2660	$500	50%	$15 copay. Mental health covered up to $3000. RX $15 generic/$25 namebrand copay.	185	133	100	37	62	76.8	235	Open Enrollment
Rhode Island	PPO	$3888	$15,000	100%	$10 office visit copay. RX discount card and 100% coverage after deductible. Well baby coverage. Mental health coverage. Optional preventive care coverage.	250	250	250	250	81	82.2	250	Open Enrollment

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
South Carolina	PPO	$2487	$2000	80%	RX deductible and copay applicable.	185	150	150	150	N/A	72.8	150	Risk Pool
South Dakota	PPO	$2676	$3000	100%	RX discount card and 100% coverage after deductible. Optional well baby coverage. Optional preventive care coverage. Mental health coverage	133	133	100	100	N/A	75.0	140	None
Tennessee	PPO	$2573	$1000 ($2000 out of net-work)	80% (50% out of net-work)	$30 office visit copay. RX coverage with sliding copay. Preventive coverage.	400	400	400	400	25	72.8	100	TENNCare
Texas	PPO	$2343	$750	50%	$15 office visit copay without meeting deductible including routine exams and immunizations. Rx $15 generic/$25 namebrand.	185	133	100	17	15	72.8	200	Risk Pool

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
Utah	Indemnity	$2340	$1000	80%	All benefits subject to deductible	133	133	100	100	54	72.8	200	Guaranteed Issue
Vermont	HMO	$6191	none	100%	Office visits $20 copay. RX not covered but available for an additional $44.05 per month	200/ 225	225	225	225	99	80.8	200	Guaranteed Issue
Virginia	PPO	$2592	$1000	80%	$25 office visit copay/RX $25 generic/$35 namebrand copay	133	133	100	100	32	209(b)	225	Open Enrollment
Washington	Indemnity	$2712	$1000	20%	RX subject to deductible.	185	200	200	200	77	76.7	300	Risk Pool/ Guaranteed Issue
West Virginia	Indemnity	$2525	$1000	80%	All benefits subject to deductible	150	133	100	100	29	72.8	185	None
Wisconsin	PPO	$2567	$500	80%	$15 office visit copay. RX $15 generi/$25 namebrand copay	185	185	100	45	84	85.0	185	Risk Pool

State	Individual Market Health Insurance Options for Subject Family					Maximum Income Level for Medicaid Benefits, 1998 (Percentage of the FPL)						Maximum Income for State Children's Health Insurance Program Benefits, 1999 (Percentage of the FPL)	Medically Uninsurable/ HIPAA Eligibles
	Plan Type	Annual Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits	Pregnant Women/Infants	Kids Under 6	Kids 6-14	Kids 14-19	Medically Needy	SSI Recipients		
Wyoming	Indemnity	$2760	$2500	100%	RX discount card and 100% coverage after deductible. Optional well baby coverage. Optional preventive care coverage. Mental health coverage	133	133	100	52	N/A	74.2	133	Risk Pool

National Association of Health Underwriters

Cost and Benefit Comparison of Individual-Market Health Insurance Policies Available in the United States

In this study, the National Association of Health Underwriters (NAHU) compared how much an average health insurance policy purchased by a typical American family through the individual health insurance market in each state would cost, as well as what type of plan benefits would be available to the family. The family used in this analysis includes a single mother, age 35, who is a non-smoker and is in relatively good health, as well as her healthy daughters, ages seven and nine. For each state, NAHU sought price and benefit information for either an HMO plan with moderate copayment requirements or a PPO plan with no more than a $500 deductible and an 80 percent coinsurance rate. In some states, neither of these options were available, so the data listed herein describes the best available policy marketed in those states. Of the individual plans listed on this chart, the mean cost is $325/month and the median cost is $293/month.

State	City	Individual Market Health Insurance Options for Subject Family				
		Plan Type	Monthly Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits
Alabama	Montgomery	PPO	$560	$250 single/ $750 family	80%	RX discount card. $50 emergency deductible. Mental health coverage. Optional preventive care coverage. Major medical.
Alaska	Juneau	Indemnity	$395	$500	80%	Coverage of prescription drugs, emergency care, some preventive care and mental health. Maternity coverage optional benefit. Major medical.
Arizona	Phoenix	PPO	$250	$500	90%/ 60%	RX $15 generic/$35 brand copay. $20 office visit copay. All other benefits subject to deductible and coinsurance. Major medical.
Arkansas	Little Rock	PPO	$305	$500	80%	$15 routine office visit copay. RX $15 generic/$25 brand copay. $150 of non-routine office visit coverage per year. Major medical.

State	City	Individual Market Health Insurance Options for Subject Family				
		Plan Type	Monthly Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits
California	Sacramento	HMO	$335	N/A	N/A	$15 office visit copay. $10 generic/$25 brand RX copay. $50 emergency copay and $250 outpatient surgery copay. Maternity, mental health and substance abuse coverage.
Colorado	Denver	PPO	$320	$250	80%	$20 RX copay for formulary drugs. $25 office visit copay. Limited preventive care and mental health benefits. Major medical.
Connecticut	Hartford	PPO	$272	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Mental health, major medical and substance abuse coverage.
Delaware	Dover	PPO	$432	$250 single/ $750 family	80%	$10 office visit copay. RX discount card. $50 emergency room deductible. Limited preventive care benefits. Mental health and major medical benefits.
Florida	Tallahassee	PPO	$275	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Mental health, major medical and substance abuse coverage. Optional maternity coverage.
Georgia	Atlanta	HMO	$360	N/A	N/A	$25 office visit copay. $15-21 RX copay. $75 emergency room copay and $100 outpatient surgery copay. Preventive care, maternity, metal health, substance abuse and major medical benefits.
Hawaii	Honolulu	PPO	$535	$500	90%	$15 office visit copay. Major medical coverage only. 20% coinsurance rate for surgery benefits.
Idaho	Boise	PPO	$290	$1000	80%	$25 office visit copay. 50% RX copay (outside deductible). Preventive care and major medical benefits.
Illinois	Springfield	PPO	$250	$500	80%	$20 office visit copay. $15 generic/$25 brand RX copay. Preventive care and major medical benefits.
Indiana	Indianapolis	PPO	$250	N/A	80%	$30 office visit copay. $10 generic/$25 brand RX copay. Preventive care, major medical and mental health benefits.
Iowa	Des Moines	PPO	$302	$500	80%	$10 non-preventive care office visit copay. RX discount card. $50 emergency room deductible. Optional preventive coverage. Major medical, mental health and substance abuse benefits.
Kansas	Topeka	PPO	$225	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Mental health, major medical and substance abuse coverage. Optional maternity coverage.

State	City	Individual Market Health Insurance Options for Subject Family				
		Plan Type	Monthly Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits
Kentucky	Frankfort	PPO	$340	$750	80%	$15 copay for RX and office visits. Major medical benefits and preventive care.
Louisiana	Baton Rouge	PPO	$415	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Mental health, major medical and substance abuse coverage. Optional maternity coverage.
Maine	Augusta	Indemnity	$605	$500	80%	All benefits subject to deductible and coinsurance. Major medical coverage and optional preventive benefits.
Maryland	Annapolis	PPO	$375	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Mental health, major medical and substance abuse coverage. Optional maternity coverage.
Massachusetts	Boston	HMO	$411	N/A	N/A	$15 office visit copay. $15 generic/$25 brand RX copay. $50 emergency room copay. $500 hospital copay. Major medical and preventive care.
Michigan	Lansing	PPO	$242	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care and major medical benefits. Optional maternity coverage.
Minnesota	St. Paul	HMO	$275	$500 single, $100 family	80%	Office visits, all major medical , mental health and substance abuse benefits subject to deductible/coinsurance. Preventive care covered 100% after deductible. $12 RX copay.
Mississippi	Jackson	PPO	$288	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health and major medical benefits. Optional maternity coverage.
Missouri	Jefferson City	PPO	$366	$300 single/ $600 family	90%	$20 office visit copay. $10 generic/$25 formulary/$45 non-formulary RX copay. Limited preventive care benefits, as well as major medical, mental health and substance abuse coverage.
Montana	Helena	Indemnity	$396	$500 single/ $1500 family	80%	RX discount card. Office visits and other benefits subject to deductible and coinsurance. Major medical coverage plus limited mental health, preventive care and substance abuse coverage.
Nebraska	Lincoln	PPO	$218	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care. mental health, substance abuse and major medical benefits. Optional maternity coverage.

State	City	Individual Market Health Insurance Options for Subject Family				
		Plan Type	Monthly Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits
Nevada	Carson City	PPO	$265	$500	N/A	$30 office visit copay. $10 RX copay. Preventive care, major medical and mental health benefits.
New Hampshire	Concord	PPO	$375	$2000	80%	All benefits subject to the deductible and coinsurance requirements. Major medical coverage only.
New Jersey	Trenton	HMO	$491	N/A	N/A	$30 office visit copay. 50% RX coverage. $50 emergency room copay and $25 prenatal copay. Major medical, preventive, maternity, mental health and substance abuse benefits.
New Mexico	Santa Fe	PPO	$277	$500 single/ $1500 family.	80%	RX discount card. Non-preventive office visits $10 copay. $50 emergency room deductible. Major medical coverage plus limited mental health, and substance abuse coverage. Optional preventive care coverage.
New York	Albany	PPO	$260	$500	80%	$20 office visit and preventive care copay. $15 generic/$35 brand RX copay. Major medical and limited preventive care coverage.
North Carolina	Raleigh	PPO	$188	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health, substance abuse and major medical benefits. Optional maternity coverage.
North Dakota	Bismarck	Indemnity	$286	$500 single/ $750 family	80%	All benefits subject to deductible. Includes RX, major medical, preventive and maternity benefits.
Ohio	Columbus	PPO	$280	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health, substance abuse and major medical benefits. Optional maternity coverage.
Oklahoma	Oklahoma City	PPO	$307	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health, substance abuse and major medical benefits. Optional maternity coverage.
Oregon	Salem	HMO	$322	N/A	N/A	$20 office visit copay. Lesser of $100 emergency room copay or 50% emergency room charges. $200 outpatient surgery copay. 50% maternity copay. Preventive care, major medical, maternity, mental health and substance abuse benefits

State	City	Individual Market Health Insurance Options for Subject Family				
		Plan Type	Monthly Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits
Pennsylvania	Harrisburg	PPO	$293	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health, substance abuse and major medical benefits. Optional maternity coverage.
Rhode Island	Providence	PPO	$498	$500	80%	RX discount card. Non-preventive office visits $10 copay. $50 emergency room deductible. Major medical coverage plus limited mental health, and substance abuse coverage. Optional preventive care coverage.
South Carolina	Columbia	PPO	$278	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health, substance abuse and major medical benefits. Optional maternity coverage.
South Dakota	Pierre	PPO	$232	$500 single/ $1500 family	80%	RX discount card. Non-preventive office visits $25 copay. $50 emergency room deductible. Major medical coverage plus limited mental health, and substance abuse coverage. Optional preventive care coverage.
Tennessee	Nashville	PPO	$325	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health, substance abuse and major medical benefits. Optional maternity coverage.
Texas	Austin	PPO	$272	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health, substance abuse and major medical benefits. Optional maternity coverage.
Utah	Salt Lake City	PPO	$415	N/A	80%	For all care that is less than $350 total there is a $20 copay only. For care that exceeds $350 in total costs, 20% coinsurance applies. RX coinsurance of 20% generic/30% formulary/50% non-formulary. Hospital care is subject to 20% coinsurance, and there is a $50 emergency room copay.
Virginia	Richmond	PPO	$243	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health, substance abuse and major medical benefits. Optional maternity coverage.
Vermont	Montpelier	PPO	$199	$3500	N/A	Accident coverage is $25 copay. All other benefits (including RX) are subject to the deductible. Plan includes RX discount card, major medical and mental health benefits.
Washington	Olympia	PPO	$307	$500	$1500	Office visit is 20% after deductible. $200 RX deductible with $200 annual limit. 80% generic coverage/70% formulary/5% non-formulary. $100 emergency room copay. Major medical, preventive care and maternity benefits.

State	City	Individual Market Health Insurance Options for Subject Family				
		Plan Type	Monthly Premium	Annual Deductible	Coinsurance Rate	Additional Policy Benefits
West Virginia	Charleston	PPO	$423	$500 single/ $1000 family	80%	All benefits subject to deductible except for RX. RX coinsurance is 50%.
Wisconsin	Madison	PPO	$214	$500	80%	$15 office visit copay. Routine care ltd. to $150 per year. RX $15 generic/$25 brand copay. Preventive care, mental health, substance abuse and major medical benefits. Optional maternity coverage.
Wyoming	Cheyenne	PPO	$235	$500 single/ $1500 family	80%	RX discount card. Non-preventive office visits $10 copay. $50 emergency room deductible. Major medical coverage plus limited mental health coverage. Optional preventive care coverage.

National Association of Health Underwriters

Comparison of Benefits and Rates in a Sample of State-Level High Risk Pools (as of March 1, 2001)

Twenty-eight states currently operate high-risk health insurance pools as a means of providing high-quality comprehensive health insurance coverage to individuals with catastrophic medical conditions. In this study, the National Association of Health Underwriters (NAHU) compared the rates, benefits and cost-sharing requirements for a selection of 14 state-level high-risk insurance pools around the country. For each state, NAHU sought price and benefit information for a PPO product with a $500 deductible and a 80% coinsurance rate. In several states, such plans were not available, so for those states NAHU gathered data for the plan with the lowest annual deductible available. Some states offer different rates based on smoker status, so in those cases, NAHU assumed that both participants were non-smokers. In addition, some states offer different rates if the applicant is enrolling as a HIPAA-eligible rather than as a medically uninsurable individual. In all cases, NAHU assumes that the applicant is a medically uninsurable individual.

State	35 Year-Old Female	53 Year-Old Male
Alaska	*Monthly Premium Rate:* $445.91 *Summary of Benefits and Cost-sharing:* $500 deductible with $2000 in stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Complete coverage includes RX, preventive care, major medical and specific disease care.	*Monthly Premium Rate:* $751.92 *Summary of Benefits and Cost-Sharing:* $500 deductible with $2000 in stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Complete coverage includes RX, preventive care, major medical and specific disease care.
Arkansas	*Monthly Premium Rate:* $199.76 *Summary of Benefits and Cost-sharing:* $1000 deductible with $2000 in stop-loss coverage. 80% coinsurance in-network and 60% out-of network. $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.	*Monthly Premium Rate:* $347.80 *Summary of Benefits and Cost-sharing:* $1000 deductible with $2000 in stop-loss coverage. 80% coinsurance in-network and 60% out-of network. $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.
Connecticut	*Monthly Premium Rate:* $430.15 *Summary of Benefits and Cost-sharing:* $550 in-network/$1000 out-of-network deductible with $2500 individual/$5000 family in stop-loss coverage. 80% in-network/60% out-of-network coinsurance. Comprehensive coverage includes RX, major medical, preventive and specific disease care.	*Monthly Premium Rate:* $555.23 *Summary of Benefits and Cost-sharing:* $550 in-network/$1000 out-of-network deductible with $2500 individual/$5000 family in stop-loss coverage. 80% in-network/60% out-of-network coinsurance. Comprehensive coverage includes RX, major medical, preventive and specific disease care.

State	35 Year-Old Female	53 Year-Old Male
Florida*‡	*Monthly Premium Rate:* $259.58 *Summary of Benefits and Cost-sharing:* $1000 deductible, 80/90% coinsurance and $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical and specific disease care.	*Monthly Premium Rate:* $365.51 *Summary of Benefits and Cost-Sharing:* $1000 deductible, 80/90% coinsurance and $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical and specific disease care.
Iowa	*Monthly Premium Rate:* $424.27 *Summary of Benefits and Cost-sharing:* $500 deductible with $1000 individual/$2000 family stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, and specific disease care.	*Monthly Premium Rate:* $710.64 *Summary of Benefits and Cost-sharing:* $500 deductible with $1000 individual/$2000 family stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, and specific disease care.
Louisiana*	*Monthly Premium Rate:* $268.50 *Summary of Benefits and Cost-sharing:* $1000 deductible with $3500 in stop-loss coverage. $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.	*Monthly Premium Rate:* $405.95 *Summary of Benefits and Cost-sharing:* $1000 deductible with $3500 in stop-loss coverage. $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.
Mississippi	*Monthly Premium Rate:* $258.00 *Summary of Benefits and Cost-sharing:* $1000 deductible with limited stop-loss coverage. 80% coinsurance and $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical and specific disease care.	*Monthly Premium Rate:* $378.00 *Summary of Benefits and Cost-sharing:* $1000 deductible with limited stop-loss coverage. 80% coinsurance and $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical and specific disease care.
Montana	*Monthly Premium Rate:* $233.38 *Summary of Benefits and Cost-sharing:* $1000 deductible with $5000 in stop-loss coverage. 80% coinsurance and $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical, preventive care and specific disease care.	*Monthly Premium Rate:* $357.30 *Summary of Benefits and Cost-Sharing:* $1000 deductible with $5000 in stop-loss coverage. 80% coinsurance and $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical, preventive care and specific disease care
Nebraska*	*Monthly Premium Rate:* $316.25 *Summary of Benefits and Cost-sharing:* $500 deductible with $2000 in stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive care and specific disease care.	*Monthly Premium Rate:* $409.60 *Summary of Benefits and Cost-sharing:* $500 deductible with $2000 in stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive care and specific disease care.

State	35 Year-Old Female	53 Year-Old Male
New Mexico	*Monthly Premium Rate:* $284.00 *Summary of Benefits and Cost-sharing:* $500 deductible with $2000 individual/$4000 family in stop-loss coverage. 80% coinsurance and $1,500,000 lifetime maximum. Comprehensive coverage includes RX, major medical, preventive care and specific disease care.	*Monthly Premium Rate:* $436.00 *Summary of Benefits and Cost-sharing:* $500 deductible with $2000 individual/$4000 family in stop-loss coverage. 80% coinsurance and $1,500,000 lifetime maximum. Comprehensive coverage includes RX, major medical, preventive care and specific disease care.
North Dakota	*Monthly Premium Rate:* $216.90 *Summary of Benefits and Cost-Sharing:* $500 deductible with $3000 in stop-loss coverage. $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive care and specific disease care.	*Monthly Premium Rate:* $299.80 *Summary of Benefits and Cost-sharing:* $500 deductible with $3000 in stop-loss coverage. $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive care and specific disease care.
Oklahoma	*Monthly Premium Rate:* $330.09 *Summary of Benefits and Cost-sharing:* $500 deductible with $10,000 in stop-loss coverage. 80% coinsurance and $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical and specific disease care.	*Monthly Premium Rate:* $427.42 *Summary of Benefits and Cost-sharing:* $500 deductible with $10,000 in stop-loss coverage. 80% coinsurance and $500,000 lifetime maximum. Comprehensive coverage includes RX, major medical and specific disease care
Oregon*	*Monthly Premium Rate:* $196.00 *Summary of Benefits and Cost-sharing:* $300 deductible with $1300 in stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.	*Monthly Premium Rate:* $299.00 *Summary of Benefits and Cost-sharing:* $300 deductibl e with $1300 in stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.
Texas*	*Monthly Premium Rate:* $227.00 *Summary of Benefits and Cost-Sharing:* $500 deductible with $2500 in net-work/$4500 out-of-network stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.	*Monthly Premium Rate:* $283.00 *Summary of Benefits and Cost-sharing:* $500 deductible with $2500 in net-work/$4500 out-of-network stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.

State	35 Year-Old Female	53 Year-Old Male
Utah	*Monthly Premium Rate:* $238.00 *Summary of Benefits and Cost-sharing:* $500 deductible with $2000 in stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.	*Monthly Premium Rate:* $330.00 *Summary of Benefits and Cost-sharing:* $500 deductible with $2000 in stop-loss coverage. 80% coinsurance and $1 million lifetime maximum. Comprehensive coverage includes RX, major medical, preventive and specific disease care.

*The high-risk insurance pools in Florida, Louisiana, Oregon, Nebraska and Texas charge different premium rates according to the participant's city/county of residence. For all four of these states, we sought premium rates for individuals who lived in the state capitals, which would be Tallahassee, Baton Rouge, Salem, Lincoln and Austin, respectively.

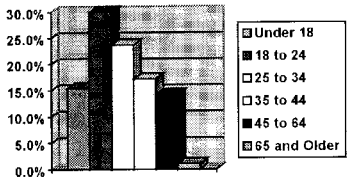
‡ Enrollment in the Florida Comprehensive Health Association was closed on June 30, 1991. Legislation has been introduced this session that would open pool enrollment for 2002, but that legislation has net yet been enacted. Therefore, the rate data listed on this chart represents the rates that would be charged to current pool participants who meet the specified age/gender criterion.

NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

THE PROBLEM OF THE UNINSURED

WHO ARE THE UNINSURED?

Percentage of Americans without Government or Private Health Insurance, By Age, 1998



Source: U.S. Census Bureau

Each month over 44 million Americans go without health insurance. This population is made up of individuals who cannot afford health insurance, are experiencing access barriers, or believe that the associated cost outweighs the risk of going without health insurance. Thirty percent of uninsured individuals are between the ages of 18 and 24, are healthy, and have either a low-paying job or no job at all. These individuals are normally between jobs or are just entering the workforce. For them, the cost of health insurance is too high when compared with the benefits they would receive. Those of Hispanic origin are also more likely to be uninsured than non-Hispanic individuals. Poor Hispanics are less inclined then poor non-Hispanics to take advantage of Medicaid benefits, so they remain uninsured. People with lower levels of education and income are also often uninsured. These individuals are more likely to work for an employer that either does not provide health benefits or requires a high employee cost-share for premium payments. Since these individuals frequently have incomes above the poverty line, they often do not qualify for government assistance. But they still do not have enough money to purchase health insurance or put money towards an employer-based plan. Other groups of people who often go without health insurance include self-employed individuals, part-time workers, the long-term unemployed and individuals with serious health conditions that make them uninsurable.

HOW LONG DO MOST PEOPLE REMAIN UNINSURED?

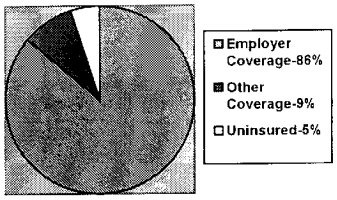
Being uninsured to most individuals is a temporary situation. Just as many people spend some time during their lives as unemployed, many people go without health insurance for a short period. Fifty percent of all individuals who are uninsured will be covered by health insurance within four months of first becoming uninsured. Seventy-five percent of all uninsured individuals will be covered under a health insurance plan within 12 months of first becoming uninsured. Only 2.5 percent of the population is considered to be chronically uninsured and remains without health insurance coverage for two or more years.

WHO DECLINES HEALTH INSURANCE COVERAGE?

Two-thirds of all Americans are offered health insurance coverage through their employers. Of those individuals, 14 percent decline the coverage. Two-thirds of those who decline to be covered enroll in a different private health insurance plan (such as a spouse's plan) or receive coverage through a government program. However, one-third of all individuals who decline employer-sponsored coverage do not obtain health insurance anywhere else. These individuals account for 20 percent of all uninsured Americans.

Cost is given as the main reason why individuals will decline coverage in an employer-based plan. Many employers require employees to shoulder a portion of health benefit costs. The employees who decline employer-based coverage are typically low-wage earners who are unable to provide their part of the insurance premium payment. These people decline health insurance coverage as a result and join the ranks of the millions of uninsured Americans.

Health Insurance Choices of Americans with Access to Employer-Sponsored Coverage, 1996-1997



Source: Center for Studying Health System Change

HOW DO WE SOLVE THE PROBLEM OF THE UNINSURED?

There are solutions available to the problem of the uninsured. One would be to provide individuals with a tax break to be used for the purchase of private insurance. NAHU's tax credit proposal would allow eligible lower- and middle-income Americans a refundable tax credit to be used to either purchase employer-sponsored coverage or to buy an individual health insurance plan. All Americans with incomes up to $30,000, or families with an income up to $50,000, would be eligible for the health credit unless they participate in the Medicare program or a military health plan. The amount of the health credit would be $800 per adult and $400 per child, with the maximum family benefit being $2400 annually. The credit would be advanced monthly on behalf of eligible individuals either through their employer or insurance company, reducing the likelihood of fraud and ensuring the availability of health credit funds throughout the year. As the only tax credit proposal on the table that preserves the employer-based health benefit system, NAHU's health credit would help reduce the number of uninsured by:

- Providing a private-sector solution that will help achieve universal coverage through incentives instead of mandates.
- Allowing low-income individuals to either use the credit to help finance employer-based coverage or purchase individual health insurance.
- Targeting the short-term uninsured by giving them a way to afford health benefits.
- Helping the unemployed finance coverage between jobs.
- Giving the self-employed an additional tax incentive option for the purchase of health insurance.
- Providing early retirees with a way to pay for health benefits until they become Medicare eligible.
- Shifting low-income individuals away from the costly Medicaid program and into private market plans.

NAHU also supports other means of reducing the number of uninsured Americans. The expansion of medical savings accounts, which combine a high-deductible health plan with a tax-exempt savings account to pay for routine medical care, would help make health insurance a more affordable option for small business owners, the self-employed and low-income individuals. Also, state-level high-risk insurance pools are a means of providing uninsurable individuals with comprehensive health insurance coverage. These pools provide individuals with pre-existing medical conditions with an important safety net, since catastrophic medical bills are one of the leading causes of bankruptcy. Finally, NAHU also supports the efforts of state governments to help low-income individuals purchase private health insurance coverage, particularly through subsidies and state income tax incentives.

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COMMUNICATIONS

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Statement

Written for the

United States Senate Finance Committee

Hearing on
Living Without Health Insurance: Who's Uninsured and Why?

by
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Health Insurance Coverage

The most recent Census Bureau data shows that for the first time since at least 1987, the number of Americans without health insurance coverage has declined. In 1998, the number of uninsured (nonelderly) Americans had reached 43.9 million (chart 1). In 1999, the number of nonelderly Americans without health insurance coverage declined to 42.1 million. The percentage of nonelderly Americans without health insurance coverage declined from 18.4 percent in 1998 to 17.5 percent in 1999 (chart 2).

The main reason for the decline in the number of uninsured Americans is the strong economy and low unemployment. Since employment-based health insurance is by far the most common source of health coverage in the United States, it is not surprising that the lower rate of unemployment is beginning to translate into lower rates of uninsured. As a result of the strong economy, more workers and their dependents are covered by employment-based health insurance: Between 1998 and 1999 the percentage of nonelderly Americans covered by employment-based health insurance increased from 64.9 percent to 65.8 percent (chart 3).

Employment-based health insurance coverage increased substantially for adult workers last year. In 1998, 72.8 percent of workers were covered by an employment-based health plan (chart 4). By 1999, 73.3 percent were covered. The likelihood that an adult worker was uninsured declined from 18.1 percent in 1998 to 17.5 percent in 1999 (chart 5). Even nonworking adults experienced an increase in the likelihood of having employment-based health insurance coverage, increasing from 40.5 percent in 1998 to 41.7 percent in 1999 (chart 6).

The likelihood that a child is covered by employment-based health insurance has been increasing since 1994 (chart 7). In 1994, 58.1 percent of children were covered by employment-based health insurance. By 1999, 61.5 percent were covered. Because of declining enrollment in Medicaid (chart 8), the percentage of children without health insurance coverage has actually been growing over most of this period. However, between 1998 and 1999, the percentage of children without health insurance coverage declined dramatically from 15.4 percent to 13.9 percent (chart 9).

Despite the State Children's Health Insurance Program (S-CHIP), public health insurance coverage is not increasing. Between 1998 and 1999 the percentage of nonelderly Americans covered by Medicaid and other government-sponsored health insurance coverage did not change (chart 10)—remaining at 10.4 percent in 1999. While the March Current Population Survey (CPS) does not allow researchers to count the number of children enrolled in S-CHIP, it does appear that some children benefited from expansions in government-funded programs. Findings from the CPS indicate that the percentage of children in families just above the poverty level without health insurance coverage declined dramatically, from 27.2 percent uninsured in 1998 to 19.7 percent uninsured in 1999. Some of the decline can be attributed to expansions in Medicaid and S-CHIP. Between 1998 and 1999, the percentage of near-poor children covered by these programs increased from 39.3 percent to 40.5 percent. However, it appears that expansions in employment-based health insurance had an even larger effect. Specifically, the percentage of near-poor children covered by an employment-based health insurance plan increased from 30.5 percent to 34.5 percent.[1]

Health Insurance Costs and Benefits

It is notable that this decline in the uninsured has occurred at a time when health insurance costs are going up. Since 1998, health insurance cost inflation has been increasing. According to data from a recent study (Gabel et al., 2000), health insurance costs increased 8.3 percent for all firms between spring 1999 and spring 2000, and they increased 10.3 percent for smaller firms (with between three and 199 workers) (chart 11). When health care costs increase, health insurance coverage would be expected to decline, with employers shifting the cost of coverage onto workers, or even dropping coverage completely. But as shown above, more workers and their dependents were covered by employment-based health insurance coverage in 1999 than in 1998. Employers have not been shifting the cost onto workers. An annual survey by William M. Mercer indicates that the worker share of the premium has been unchanged since 1993 (William M. Mercer, 2000). In contrast, an annual survey by the Kaiser Family Foundation and the Health Research and Educational Trust found that there was a slight reduction between 1996 and 2000 in the percentage of the premium workers were required to pay (Gabel, 2000).

Despite rising health insurance costs, employers are increasingly offering health benefits to workers—again, because of the tight labor market. Between 1998 and 2000, the percentage of small firms offering health benefits increased from 54 percent to 67 percent, with much of that increase occurring among the smallest of the

small firms (chart 12). Most small employers report that offering health benefits helps with recruitment and retention, and keeps workers healthy, which ultimately reduces absenteeism and increases productivity (Fronstin and Helman, 2000). Clearly, many employers realize there is real business value in providing health care coverage to their workers.

Also worth mentioning is that American workers clearly identify health insurance coverage as far and away the single most valued work-place benefit. When asked to rank the importance of all employee benefits, health benefits are by far the benefit most valued by workers and their families. Sixty-five percent of workers responding to a recent EBRI survey rated employment-based health benefits as the most important benefit (Salisbury and Ostuw, 2000).

The Future

When findings from the March 2001 CPS are released, I expect the data for 2000 will show that the number of uninsured Americans continued to decline. The drop may even be larger than the 1.7 million decline experienced between 1998 and 1999. As mentioned above, between 1998 and 2000, the percentage of firms with three to 199 employees offering health benefits increased (Gabel, 2000). In addition, S-CHIP will continue to expand health insurance coverage. Last week, the Clinton administration announced that 2.5 million children had been enrolled in the S-CHIP program by June 30, 2000. An October 1999 report by the Health Care Finance Administration predicted that 2.7 million children would be enrolled in S-CHIP by Sept. 30, 2000. This combination of more employers adding health benefits, along with more children covered by S-CHIP, will result in continued expansion of health insurance coverage.

It is also worth noting that while the uninsured declined between 1998 and 1999, it did not drop by 44 million. More than 42 million Americans continue to be uninsured. Even if the number drops again next year, when the 2000 data are released, it is likely that 40 million Americans will still be uninsured—more than 15 percent of the population. As long as the economy is strong and unemployment is low, employment-based health insurance coverage will expand and the uninsured will gradually decline. However, even if the United States experienced five more years of similar declines in the uninsured as it did in 1999, 34 million Americans would still be uninsured in 2005 (chart 13). If the economy continues to soften or comes close to a recession the uninsured would easily and quickly start to increase again as unemployment rises. Even for those who keep their jobs, small employers would likely drop health benefits, and large employers would likely shift the cost of coverage onto workers, resulting in fewer workers accepting coverage. If the uninsured returned to its 1999 level of 17.5 percent of the nonelderly population, 38 million Americans would be uninsured in 2005. In contrast, if the downturn in the economy was severe and the uninsured represented 25 per-cent of the nonelderly population, 63 million Americans would be uninsured.

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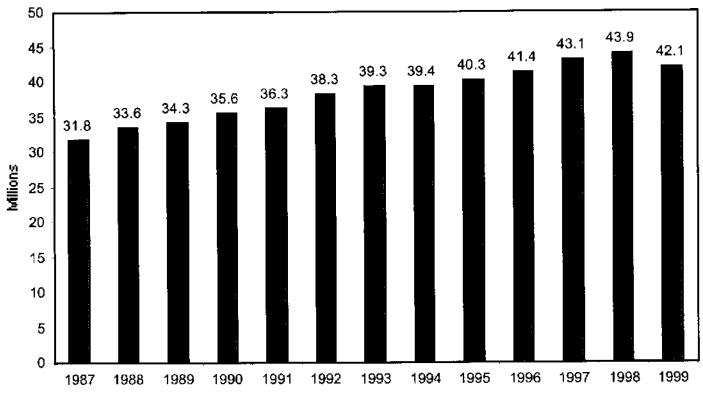
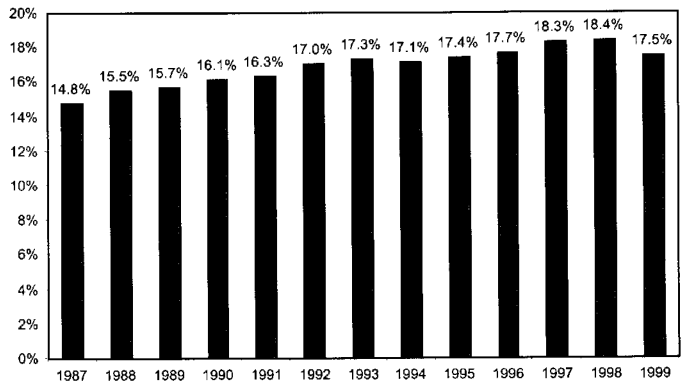
[1] The CPS (and most other surveys) are well known for under-reporting Medicaid coverage and coverage from other government programs. In the case of the CPS, it may not be picking up all Medicaid recipients because some states do not call the program Medicaid. In fact, there is strong evidence that the CPS under-reports Medicaid coverage, based on comparisons of these data with enrollment and participation data provided by the Health Care Financing Administration (HCFA), the federal agency primarily responsible for administering Medicaid. See Paul Fronstin, "Counting the Uninsured: A Comparison of National Surveys," *EBRI Issue Brief* no. 225, Employee Benefit Research Institute, September 2000, for more information.

Chart 1
Number of Uninsured Americans Ages 0-64, 1987-1999



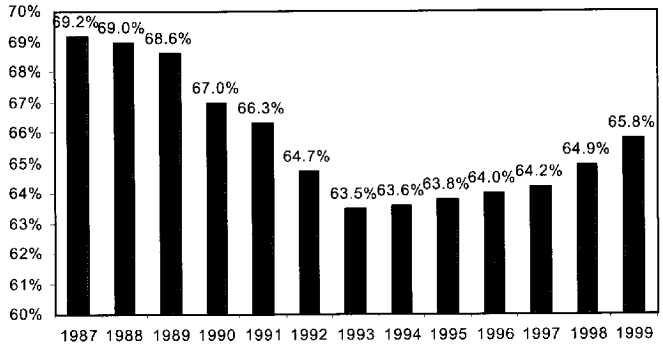
Source: Employee Benefit Research Institute.

Chart 2
Percentage of Americans Ages 0-64 Without Health Insurance, 1987-1999



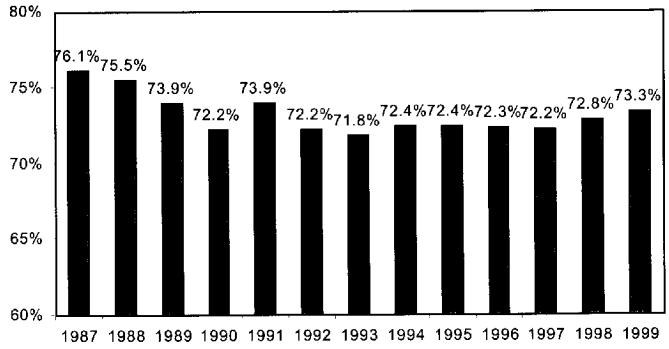
Source: Employee Benefit Research Institute.

Chart 3
Percentage of Americans Ages 0-64
With Employment-Based Health Insurance Coverage, 1987-1999



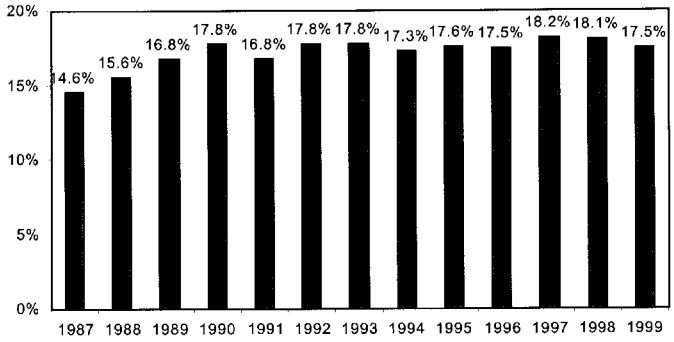
Source: Employee Benefit Research Institute.

Chart 4
Percentage of Working Adults, Ages 18-64,
with Employment-Based Health Insurance Coverage, 1987-1999



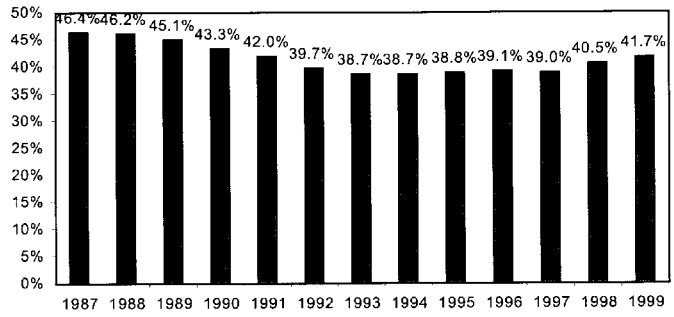
Source: Employee Benefit Research Institute.

Chart 5
Percentage of Working Adults, Ages 18-64,
Without Health Insurance Coverage, 1987-1999



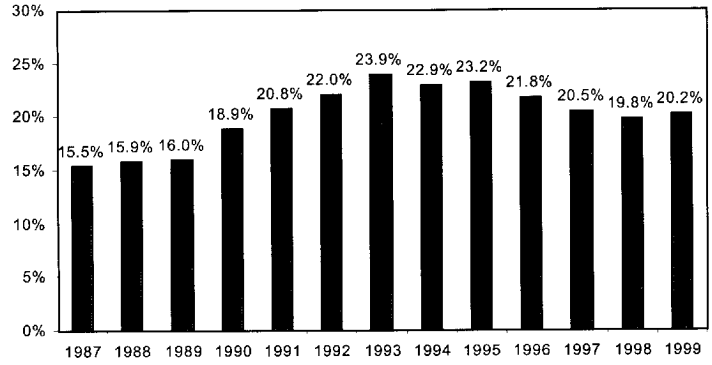
Source: Employee Benefit Research Institute.

Chart 6
Percentage of Nonworking Adults, Ages 18-64,
With Employment-Based Health Insurance Coverage, 1987-1999



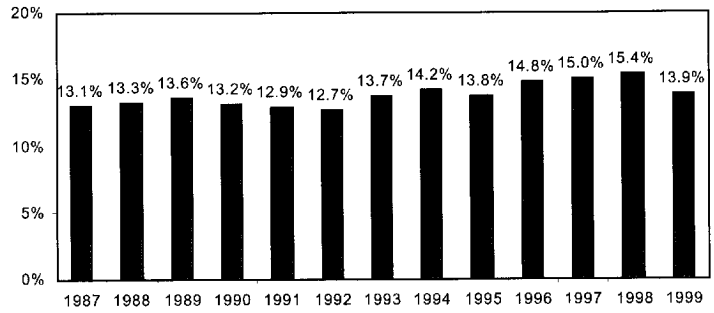
Source: Employee Benefit Research Institute.

Chart 8
Percentage of Children, Ages 0-17, With Medicaid, 1987-1999



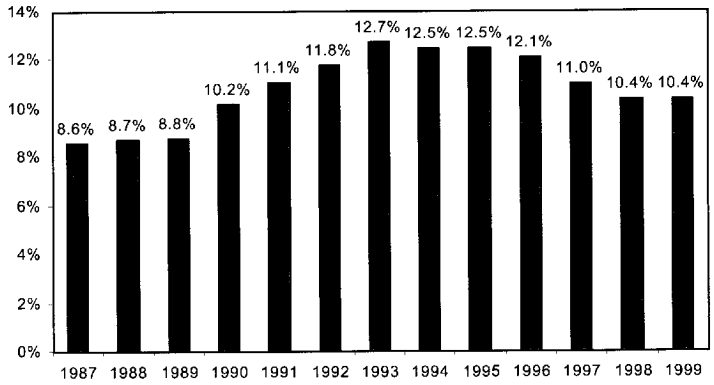
Source: Employee Benefit Research Institute.

Chart 9
Percentage of Children, Ages 0-17,
Without Health Insurance Coverage, 1987-1999



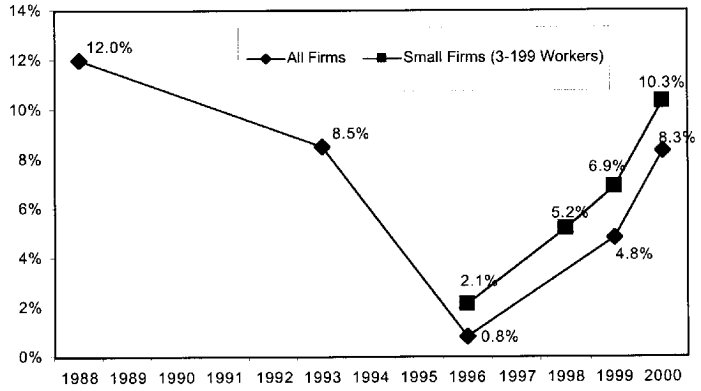
Source: Employee Benefit Research Institute.

Chart 10
Percentage of Americans Ages 0-64 with Medicaid Coverage, 1987-1999



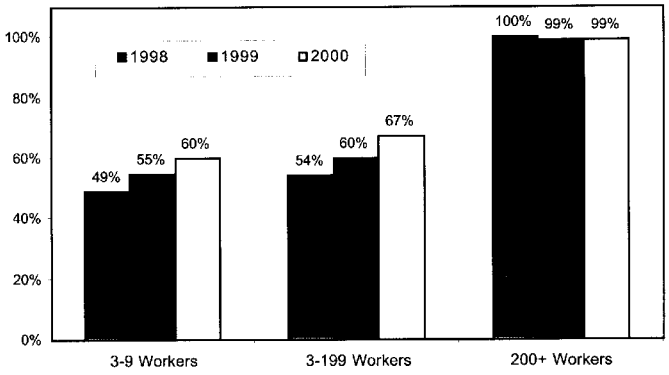
Source: Employee Benefit Research Institute.

Chart 11
Premium Increases by Firm Size, 1988-2000



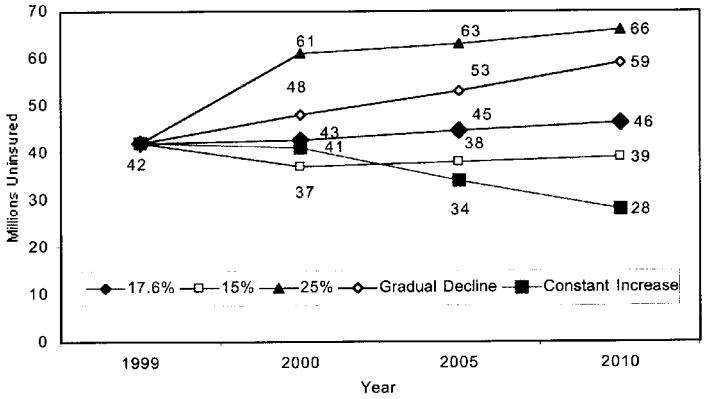
Source: Jon Gabel et al., "Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows," Health Affairs Vo. 19, no. 3 (September/October 2000): 144–151.

Chart 12
Percentage of Employers Offering Health Benefits, by Firm Size, 1998-2000



Source: Jon Gabel et al., "Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows," Health Affairs Vo. 19, no. 3 (September/October 2000): 144–151.

Chart 13
Number of Uninsured Americans, Ages 0-64,
Various Assumptions About Percent Uninsured, 1999-2010



Source: Employee Benefit Research Institute.

STATEMENT OF THE MARCH OF DIMES BIRTH DEFECTS FOUNDATION

[SUBMITTED BY DR. MARINA L. WEISS, SENIOR VICE PRESIDENT FOR PUBLIC POLICY AND GOVERNMENT AFFAIRS]

The March of Dimes Birth Defects Foundation is pleased to submit for the hearing record the following statement on "Living Without Health Insurance: Solutions to the Problem."

President Franklin Roosevelt established the March of Dimes in 1938 to fight polio. The March of Dimes committed funds for research and within 20 years Foundation grantees were successful in developing a vaccine to prevent polio. The March

of Dimes then turned its attention to the prevention of birth defects and infant mortality.

The Foundation has more than 3 million volunteers and 1,600 staff members who work through chapters in every state, the District of Columbia and Puerto Rico. A unique partnership of scientists, clinicians, parents, business leaders and other volunteers, the Foundation works to accomplish its mission by conducting and funding programs of research, community services, education and advocacy.

THE PROBLEM OF THE UNINSURED

Lack of health coverage continues to be a significant problem for many Americans. While the Census Bureau reports that 1999 saw the first decline in more than a decade in the proportion of Americans who are uninsured—from 16.3% to 15.5%—almost 43 million Americans remain uninsured.

Studies have consistently shown that having insurance coverage affects how people use health care services.[1] In particular, the uninsured are less likely to have a usual source of medical care and are more likely to delay or forgo needed health care services.

For many years, the federal government has worked together with the states to improve access to health insurance through Medicaid and the State Children's Health Insurance Program. Despite this progress, many Americans continue to lack access to affordable coverage.

Nearly one in five women of childbearing age (15–44)—or 11.7 million women—was uninsured in 1999, according to data prepared for the March of Dimes by the U.S. Census Bureau. These women accounted for 27 percent of all uninsured Americans. More than half of these women (59 percent) had family incomes below 200 percent of poverty ($35,300 for a family of four).[2] Hispanic and Native American women in this age group were more than twice as likely as whites to be uninsured: 37.0 and 35.4 percent, respectively, compared with 17.7 percent. African-American and Asian women were also more likely than whites to be uninsured.[3]

While more generous Medicaid eligibility for pregnant women has resulted in better rates of coverage for them than for women in general, room for improvement remains. **In 1999, 13.4 percent of pregnant women (more than 420,000) were uninsured, an increase from 11 percent in 1990.[4]**

Lack of insurance can be a significant barrier to prenatal care, and infants born to mothers receiving late or no prenatal care are about twice as likely to be low birthweight as those born to mothers receiving early prenatal care.[5] Moreover, low birthweight/preterm births are one of the top three most expensive reasons for a hospital stay in the United States.[6]

Like Americans in general, pregnant women's use of health services varies by insurance status. A 1999 study by Dr. Amy Bernstein for the March of Dimes found that some 18.1 percent of uninsured pregnant women in 1996 reported going without needed medical care during the year in which they gave birth.[7] That compares with 7.6 percent of privately insured pregnant women and 8.1 percent of pregnant women covered by Medicaid.

SOLUTIONS

The March of Dimes urges the Committee to modify the SCHIP statute to give states greater flexibility to cover income-eligible pregnant women who are age 19 and older, allow states to use presumptive eligibility for pregnant women in the SCHIP program, and automatically enroll infants born to SCHIP-eligible mothers.

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[1] Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book*, May 2000.

[2] Thorpe, Ken. "The Distribution of Health Insurance Coverage Among Pregnant Women, 1999." A report prepared for the March of Dimes, forthcoming, 2001.

[3] Bureau of Census, 2000. Unpublished data prepared for the March of Dimes.

[4] Thorpe, 2001.

[5] National Center for Health Statistics, 1998 final natality data. Analysis by the March of Dimes Perinatal Data Center. For insurance as a barrier to prenatal care, see Oberg, C.N. et. al. "Prenatal Care Use and Health Insurance Status" *Journal of Health Care for the Poor and Underserved*, vol. 2, no. 2, 1991.

[6] Agency for Healthcare Research and Quality, *Hospitalization in the United States, 1997*.

[7] Bernstein, Amy. "Insurance Status and Use of Health Services by Pregnant Women." March of Dimes by the Alpha Center, December, 1999.

1. Allow states the flexibility to extend SCHIP coverage to pregnant women 19 and older.

States should be able to provide health coverage for income-eligible pregnant women. No waiting period should apply for participation in the program, and coverage should extend for at least two months following the birth of the child. If this option were made available to the states, some 41,000 uninsured pregnant women over age 19 could be covered.[8]

In addition to ensuring better health outcomes, research and state experience suggests that covering pregnant women is a highly successful outreach mechanism for enrolling children. Several states with experience operating health insurance programs (including California, Illinois, Kentucky, Nevada, Rhode Island, and Wisconsin) have found that expanding coverage to uninsured parents results in generating enrollment of eligible children.[9]

2. Allow states to use presumptive eligibility to accelerate enrollment of pregnant women in the SCHIP program.

Modifying SCHIP eligibility to permit coverage of pregnant women age 19 and older should be accompanied by flexibility to permit states to use presumptive eligibility to extend coverage quickly. Presumptive eligibility is already permitted for children in the SCHIP program. In addition, under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll pregnant women whose family income appears to meet Medicaid income eligibility standards, until a final formal determination is made.

3. Automatically enroll newborns whose mothers are enrolled in SCHIP

To avoid gaps in coverage for medically vulnerable newborns, enrollment of infants born to mothers eligible for SCHIP should begin on the child's date of birth.

CONCLUSION

Many uninsured women and children are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) but are not enrolled. Indeed, 80 percent of uninsured pregnant women in 1999 (about 340,000) could have been enrolled in these programs, but remained uninsured. If these women were enrolled and SCHIP were expanded to cover income-eligible pregnant women age 19 and older, over 95 percent of all uninsured pregnant women would have health insurance coverage.

The Foundation has provided the Committee with several, specific steps the Congress and states could take to improve access to health coverage for uninsured pregnant women and children this year.

Once again, on behalf of the March of Dimes thank you for this opportunity to submit written testimony.

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[8] Thorpe, 2001.

[9] Mathematica Policy Research, Inc, "Implementation of the State Children's Health Insurance Program: Momentum Is Increasing After a Modest Start: First Annual Report," January 2001.