

NATION'S UNINSURED

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SEVENTH CONGRESS
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NATION'S UNINSURED

WEDNESDAY, APRIL 4, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in room 1100 Longworth House Office Building, Hon. Nancy L. Johnson [Chairwoman of the Subcommittee] presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 29, 2001
No. HL-4

CONTACT: (202) 225-3943

Johnson Announces Hearing on the Nation's Uninsured

Congresswoman Nancy L. Johnson (R-CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the uninsured population and solutions for expanding health insurance coverage. **The hearing will take place on Thursday, April 5, 2001, in the main Committee hearing room, 1100 Longworth, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include experts on the uninsured population and on policies to increase health insurance coverage. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

This hearing will focus on the 42 million uninsured Americans. In 1999, for the first time in more than a decade, the percentage and number of Americans with health insurance increased. However, one in six Americans remains uninsured.

These uninsured Americans are a diverse group. More than four out of five uninsured are full-time workers and their families, and one out of five uninsured work for employers who offer coverage but choose not to take it. The primary reason cited for these uninsured workers was the cost of insurance premiums. Others in the uninsured category consist of lower income individuals who are either ineligible or fail to enroll in existing public programs.

President Bush has proposed a comprehensive plan to assist uninsured individuals, including offering refundable tax credits to lower and middle-income individuals. The hearing will provide a framework for the development of legislation to begin to examine the President's proposal and address the barriers faced in accessing health insurance coverage.

In announcing the hearing, Chairman Johnson stated: "Addressing the problem of the uninsured is absolutely critical because those without health coverage often go without quality health care. There are a lot of new and innovative ideas circulating to address this problem. This hearing will bring those ideas forward for the Committee to evaluate and act upon if appropriate. I look forward to working with the Bush Administration on reducing the number of Americans without health insurance."

FOCUS OF THE HEARING:

The hearing begins the Subcommittee's consideration of the issues on why many Americans lack affordable access to health insurance. The first panel will discuss trends in health insurance coverage and witnesses will help Members identify who has coverage and who does not. The second panel will turn to examining potential options for increasing coverage for the 42 million uninsured Americans, and focus on tax relief ideas, in particular.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Thursday, April 19, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "<http://waysandmeans.house.gov>".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

NOTICE—CHANGE IN DATE

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 29, 2001
No. HL-4

CONTACT: (202) 225-3943

**Change in Date for Subcommittee Hearing
on Thursday, April 5, 2001
on the Nation's Uninsured**

Congresswoman Nancy L. Johnson, Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on the uninsured population and solutions for expanding health insurance coverage, previously scheduled for Thursday, April 5, 2001, **will now be held on Wednesday, April 4, 2001, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.**

All other details for the hearing remain the same. (See Subcommittee press release No. HL-4, dated March 29, 2001.)

Chairwoman JOHNSON. Good morning. The hearing will convene. Today's hearing focuses on Americans who are uninsured and on solutions that in combination with the Commerce Committee policy initiatives and probably with the Education Committee actions can guarantee access to affordable insurance to every American.

It was 2 years ago, in a similar hearing on the uninsured, the Health Subcommittee found that a record number of Americans were uninsured. This year, for the first time in more than a decade, the number of Americans with health insurance has increased. Almost 2 million more Americans no longer lack health insurance, primarily because the economy has been strong and unemployment low.

However, 42 million Americans, more than one in six, remains uninsured. This is a problem that simply must be solved because those without health coverage often go without health care. Indeed, the uninsured are more than four times as likely to delay care, use 40-percent fewer services than insured individuals with similar health and experience a mortality rate 25-percent greater than insured individuals with similar characteristics.

Moreover, without affordable insurance, these Americans run the financial risk of catastrophic financial burdens and, in addition, impose an increasingly unbearable burden on providers and private payers.

The uninsured are a diverse group. More than four out of five uninsured are full-time workers for their families, and one out of five uninsured individuals work for employers who offer coverage,

but choose not to take it. The primary reasons cited for these workers being uninsured was the cost of insurance. Making insurance more affordable will clearly help people purchase insurance.

Many of the uninsured, one-fourth of adults and two-thirds of children, are eligible for public programs, but fail to enroll, or there are many complex issues involved, reasons why eligible individuals do not enroll in public programs. According to the Commonwealth Fund, the majority of the insured would simply prefer not to have government as the main source of coverage.

Today, we will hear testimony from researchers at the Employee Benefit Research Institute and the Health Research and Education Trust on trends in health insurance coverage and who has coverage and who does not, about who is uninsured in America and why they are uninsured. We will also hear their analysis about whether this favorable trend in insurance coverage will continue.

The second panel will turn to examining potential options for increasing coverage for the 42 million uninsured Americans and focus on tax ideas in particular. The panelists will discuss their evaluation of the effect of tax credits as well as other options.

President Bush has proposed a multi-pronged strategy to assist the uninsured, and two key components of his proposals to reduce the uninsured for which Ways and Means has jurisdiction are tax credits and medical savings accounts. In this vein, we will be examining tax credit ideas in this hearing. Second, Committee Chairman Bill Thomas will introduce the Medical Savings Account Availability Act today.

In addition, we will be working with our colleagues and other committees of jurisdiction to attack this problem by seeking ways to make insurance more affordable through group purchasing structure, improving enrollment in Children's Health Insurance Program (CHIP) and expanding access to community health centers and linking them more effectively with hospital coverage.

The hearing will provide a framework for the development of legislation to address the barriers faced in accessing health insurance coverage by the uninsured, and I look forward to working with the Bush administration and my Democrat colleagues on reducing the number of Americans without health insurance. I do consider that this Congress has a unique opportunity to attack this problem and pass the package of bills from a variety of Committees that are necessary to really create access for the uninsured to affordable health insurance.

We have known what the components were now for several years. We have talked about them. Various committees have heard various things. Both Presidential candidates talked about this issue, and the time to act is now. This Subcommittee is going to do its work on the difficult issue of the role of tax policy in helping the uninsured gain access to insurance, but that will not be enough alone, and we are keenly aware of that.

I also want to mention that one of the reasons why we have to deal with the issue of tax policy for the uninsured is because not only do they not get the help they need, but they suffer a discretionary impact that is just profoundly unfair. It is unfair to provide a subsidy to every single person in American who enjoys employer-

provided insurance and not at least provide the same subsidy at the same level to those who have to buy insurance on their own.

So this is not only about access to health insurance, but it is about fair, more even-handed tax policy, and I look forward to the inputs of those who are going to testify before us today.

I would like to recognize my colleague, Mr. Stark.

[The opening statement of Chairwoman Johnson follows:]

**Opening Statement of the Hon. Nancy Johnson, M.C., Connecticut, and
Chairwoman, Subcommittee on Health**

Today's hearing focuses on uninsured Americans and solutions for expanding health insurance coverage. Two years ago, in a similar hearing on the uninsured, the Health Subcommittee found that a record number of Americans were uninsured. This year, for the first time in more than a decade, the percentage of Americans *with* health insurance has increased—almost two million more Americans no longer lack health insurance. The main source for the decline was a strong economy and a low unemployment rate.

However, 42 million Americans—more than 1 in 6 Americans—remain uninsured. The uninsured are a blight on the nation's health care system. This committee understands the importance of addressing this problem because those without health coverage often go without health care. Indeed, the uninsured are more than four times as likely to delay care, use 40 percent fewer services than the insured individuals with similar health, and experience a mortality rate 25 percent greater than insured individuals with similar characteristics. Moreover, without affordable health insurance, these Americans run the risk of financial catastrophe. Finally, their costs are often shifted to Medicare and private payors, creating distortions in the market.

The uninsured are a diverse group. More than four out of five uninsured are full time workers and their families, and one out of five uninsured individuals work for employers who offer coverage but they choose not to take it. The primary reason cited for these workers being uninsured was the cost of insurance. Providing more resources to these people will clearly help them purchase insurance.

Many of the uninsured—one-fourth of adults and $\frac{2}{3}$ of children—are eligible for public programs but fail to enroll. While there are many complex issues involved reasons why eligible individuals do not enroll in public programs, according to the Commonwealth Fund, the majority of the uninsured would prefer not to have government be the main source of coverage.

Today, we will hear testimony from researchers at the Employee Benefit Research Institute and the Health Research and Education Trust on trends in health insurance coverage and who has coverage and who does not; about who is uninsured in America and why they are uninsured. We will also hear their analysis about whether the favorable trend in insurance coverage will continue.

The second panel will turn to examining potential options for increasing coverage for the 42 million uninsured Americans, and focus on tax ideas, in particular. The panelists will discuss their evaluation of the effect of tax credits as well as other options.

President Bush has proposed a multi-prong strategy to assist the uninsured. Two key components of his proposals to reduce the uninsured, for which Ways and Means has jurisdiction, are tax credits and medical savings accounts. In that vein, we will be examining tax credit ideas in this hearing. Secondly, Committee Chairman Bill Thomas will introduce the Medical Savings Account Availability Act today.

In addition, we will be working with our colleagues on other committees of jurisdiction to attack this problem, by seeking ways to make insurance more affordable through group purchasing structures, improving the enrollment in S-CHIP and expanding access to community health centers.

The hearing will provide a framework for the development of legislation to address the barriers faced in accessing health insurance coverage by the uninsured. And I look forward to working with the Bush Administration and our Democratic colleagues on reducing the number of Americans without health insurance.

Mr. STARK. Thank you, Madam Chair, and thank you for today's hearing. I hope that we will be the first of many on this issue.

As is my staff's suggestion, I have a long, wordy opening statement, which is more than you want to hear, and I would ask unanimous consent that I be allowed to place that priceless tome in the record in its entirety.

Chairwoman JOHNSON. In its entirety.

Mr. STARK. I also have, I think, a very useful article in a set of charts from the Center on Budget and Policy Priorities dealing with tax credits for individuals buying health insurance, and I would ask that that be made a part of the record.

Chairwoman JOHNSON. So—

Mr. STARK. Thank you.

Having said that, let me summarize, that had I had unlimited time, what I might have wanted to read to you.

We have the disgraceful distinction of being the sole industrialized nation in the world that does not assure or ensure access to health insurance for all its citizens, and we still, in spite of yesterday's stock market, are probably the richest nation in the world. The uninsured are a problem that has been with us as long as certainly I have been involved in health care legislation.

It has gone up and it has gone down, but it has been hovering sadly around 40 to 42 million people. The number also depends on whether you count people who are insured all the time or only part of the time during the year. But a majority of uninsured are low-income, and while 80 percent of them are workers, more than 70 percent of those uninsured workers lack access to a job-based coverage which is where most Americans below the age of 65 get their health insurance.

The good news is that this idea of expanding health care or access to health insurance is back on our agenda, right up there with pharmaceutical coverage, and that is good. But the bad news is that even carefully constructed Tax Code proposals will not achieve the goal of increased coverage in the absence of significant financial resources being applied to this problem and some, if you will pardon the expression, stringent regulations.

I don't believe that just throwing a couple or even a few thousand dollars at this problem for each person will solve it. We could construct a refundable tax credit that would result in increasing health care coverage, but, if we are not careful, using the Tax Code could result only in our paying lip service to the issue while spending billions of dollars on tax breaks for those who already have insurance.

I think there are four elements that we have to keep in mind. The tax credits must be refundable to get to the people who most need them. The tax credit has to be large enough to subsidize a significant portion of the cost of a meaningful policy.

Sure, you can buy a policy for a thousand bucks a year, but it is not worth anything. It gives you 30 bucks a day if you get cancer in the hospital or something like that, but to get basic coverage that is at least as good as Medicare or Medicaid, you are going to need to spend a lot more than that. My guess is that the individual policies are around \$2,500 and around \$6,500 for a family policy, and a couple of thousand dollars toward that for a family with income of less-than-\$30,000 doesn't get there.

There must be a mechanism to deliver the credit directly to the insurer and make sure that the funds are there consistently during the year. There is also going to have to be some definition—call it regulation, if you will—of the health insurance marketplace.

The tax credit would be worthless if the marketplace will not allow somebody to purchase a policy or if the insurers just raise the price to soak up that additional money.

I have not seen a proposal this year from either side of the aisle that meets all of these criteria, but our job is to see if we can make comprehensive insurance affordable and accessible, and subsidize it for those who can't afford it.

I have often said that in this country, there is only a very small group of Americans, a small percentage, that have a constitutional right to health insurance, and I will bet even the chairlady doesn't know who they are, but under Article IV, they are prisoners. I have always said what is good enough for Haldeman, Erlichman, and Rostenkowski is good enough for me. Therefore, I would like to see us move toward a right for every American to have health care coverage under the Constitution.

Thank you.

[The opening statements of Mr. Stark and Mr. Ramstad follow:]

Opening Statement of the Hon. Fortney Pete Stark, M.C., California

Madam Chairwoman, thank you for having today's hearing. I hope it is the first of many on this important issue.

We hold the disgraceful distinction of being the sole industrialized country that fails to assure access to health insurance for all its citizens. With record surpluses at our disposal, it is inexcusable to not make a major down-payment toward health insurance for all.

The majority of the uninsured have incomes under 200 percent of the federal poverty level (\$17,180 for an individual, \$35,300 for a family of four). While approximately 80 percent of the uninsured are either workers or dependents of workers, more than 70 percent of uninsured workers lack access to job-based coverage. According to a 1999 Commonwealth Fund study on workers' health, most uninsured employees work for an employer that does not offer insurance or they are ineligible for the insurance that is offered, often because they work part-time or have not worked at the firm long enough. Just 12 percent of eligible uninsured workers actually decline coverage.

The combination of income and workplace variables is particularly harmful to low-wage workers. For example, only 55 percent of low-wage workers who earn \$7 or less per hour are even offered coverage, compared to 96 percent of workers who earn more than \$15 per hour. In the age of incrementalism, successful efforts to increase health insurance rates must take all of these issues—and more—into consideration.

There has been a lot of discussion in the past few years about using tax credits to expand access to health insurance. It seems to be particularly attractive in certain circles this year. The good news is that expanding access to health insurance is back on the national agenda. I welcome the discussion. The bad news is that even carefully constructed tax code proposals will fail to achieve the goal of increased coverage in the absence of significant financial resources and stringent government regulation. I believe expanding existing public programs would bring the biggest bang for the taxpayer's buck.

Don't get me wrong. We can theoretically construct a refundable tax credit proposal that would result in a meaningful increase in health insurance coverage. But, if we are not careful, using the tax code to try to improve access to health insurance could result in Congress paying lip service to the issue of the uninsured while spending billions of dollars on tax breaks for those who already have insurance.

As I have mentioned, using tax credits to improve health insurance coverage is not cheap and it requires heavy government regulation to be effective. There are at least four required elements of an effective health insurance tax credit proposal, and I would argue that no plan introduced to date meets all the criteria.

1. First, tax credits must be refundable. More than half of the uninsured either pay no taxes or have tax liabilities below the levels proposed by most tax credit

proponents. If the credit isn't refundable, it's simply a hollow promise for these individuals. President Bush campaigned on a refundable tax credit, and Republicans and Democrats alike in Congress have sponsored legislation that use refundable tax credits.

2. Second, the tax credit must be large enough to subsidize a significant portion of the cost of a meaningful policy. A typical individual policy can cost \$2,400 and the average family policy in 2000 was nearly \$6,400. Last year, the average employer contribution was 74 percent of the premium. Even at this level, many low-wage workers are unable to afford coverage for which they are eligible. Thus, in order to put coverage within reach of the targeted population—low-income families who must balance competing needs with limited funds—the tax credit should cover at least 75 percent of the cost. Indeed, some research has shown that a subsidy in excess of 80 or 90 percent is needed to induce low-income families to participate. A tax credit of \$2,000 or even \$3,000 does little to put a \$6,400 policy within reach of a family living on \$30,000 a year. Finally, it is important that the coverage be comprehensive. Using an inadequate tax credit to buy an inadequate high-deductible policy simply moves individuals and families from the uninsured column to the under-insured column. This will exacerbate an undesirable trend already percolating.

3. Third, there must be a mechanism to deliver the tax credit directly to the insurer or make sure that the funds are available more consistently than once a year. The costs of purchasing insurance are generally incurred on a monthly basis. Lower income families will not be able to front the cost of the full premium throughout the year with the promise of a refund the following April. However, fewer than one percent of individuals eligible for a monthly EITC option participate because they fear unpredictable income fluctuations will result in their owing the government at the end of the year. In addition, it is administratively cumbersome for a beneficiary to receive the credit and pass it on. The policy should allow for the credit to be transmitted directly to the insurer or employer.

4. Fourth, there must be significant regulation of the health insurance marketplace. Any size tax credit is still worthless if the marketplace won't allow someone to purchase a policy. Without creating a marketplace that assures the offering of community-rated policies without any medical underwriting, millions of uninsured individuals with pre-existing health conditions will remain locked out of the private marketplace even with a sizeable tax credit in their pocket. This is a vital, but often overlooked component.

These are the tools by which I will measure tax credit proposals. I have yet to see a proposal this year that meets the test. I urge my colleagues to use extreme caution when considering tax credit proposals as a real means to expand health insurance coverage. We need solutions, not lip service.

Our job is to make comprehensive insurance more affordable and accessible to every uninsured individual and family. An argument can be made for increasing the equity of our current tax subsidies, but with the surplus fading fast, we cannot afford to focus scarce resources on those who are already covered. Our efforts should focus on methods proven to help low-income populations obtain insurance. Expansion of public programs, and mechanisms to improve beneficiary outreach, enrollment and retention are key approaches that deserve at least as much consideration and funding as changes to the tax code.

Opening Statement of the Hon. Jim Ramstad, M.C., Minnesota

Madam Chairwoman, thank you for calling this important hearing today to examine the issue of the uninsured.

Our health care system is the finest in the world, with the highest quality of care found anywhere. However, we still suffer today and incur increased costs to our healthcare system because 42 million Americans do not have health insurance.

Uninsured Americans are a diverse group with more than four out of five employed full-time. One out of five of these workers choose not to purchase the coverage offered by their employers, citing the high cost of the insurance premiums. Others in the uninsured category are lower income individuals who are either ineligible or fail to enroll in existing public programs.

As we consider reforming and modernizing health care, I strongly believe that adding a host of new federal mandates will have the effect of increasing premiums and ultimately reducing the number of people with coverage.

Instead, I support reforms to the insurance market that expand access to health care and take steps to stem the rise in costs, while preserving our existing high-quality delivery system.

I believe the best way to help families afford insurance is to reduce the cost of health care services and insurance policies through market-oriented alternatives. To this end, I believe we need to give individuals and the self-employed the same health-insurance tax benefits enjoyed by corporations. This way, individuals can afford to shop the marketplace for the highest quality at the best price.

I also strongly support expanding Medical Savings Accounts (MSAs) so more uninsured people are covered and have incentives to "comparison shop." Lastly, I believe we must look at reforming the medical malpractice regime to reduce, if not eliminate, the wasteful practice of "defensive medicine."

Madam Chairwoman, thanks again for calling this hearing. I look forward to hearing from today's witnesses on how we can best address this critical issue.

Chairwoman JOHNSON. I would like to call the first panel now. Paul Fronstin, senior research associate, the Employee Benefit Research Institute; and Jon Gabel, the vice president of Health System Studies at the Health Research and Education Trust.

Dr. Fronstin, we have had a vote called, and my intention is to hear from Dr. Fronstin. We may have time to also hear from Mr. Gabel within the five minutes—I am not sure—and then come back for questions. Otherwise, we will have to break between the two speakers.

Dr. Fronstin.

STATEMENT OF PAUL FRONSTIN, PH.D., SENIOR RESEARCH ASSOCIATE, AND DIRECTOR, HEALTH SECURITY AND QUALITY RESEARCH PROGRAM, EMPLOYEE BENEFIT RESEARCH INSTITUTE

Dr. FRONSTIN. Thank you.

Chairwoman JOHNSON. You have to talk right into the mic, and be sure it is on.

Dr. FRONSTIN. OK, thank you. Thank you, Madam Chairwoman and Members of the Committee. I do appreciate the opportunity to be here before you today.

My name is Paul Fronstin. I am a senior research associate at the Employee Benefit Research Institute. EBRI is a private, non-profit, non-partisan public policy research organization based in Washington, D.C.

Data from the Census Bureau show that for the first time since at least 1987, the number of Americans without health insurance coverage recently declined.

In 1998, the number of uninsured Americans under age 65 had reached 43.9 million. By 1999, the number of uninsured declined to 42.1 million. The percentage of non-elderly Americans, those under age 65, without health insurance declined from 18.4 percent in 1998 to 17.5 percent in 1999.

The main reason for the decline in the number of uninsured was a strong economy and low unemployment. As a result, more workers and their dependents were covered by employment-based health insurance. The likelihood that a worker was covered by employment-based health insurance increased from 72.8 percent in 1998 to over 73 percent in 1999. The likelihood that a worker was uninsured declined from over 18 percent in 1998 to 17.5 percent in

1999. The likelihood that a child was covered by employment-based health insurance increased from 60 percent in 1998 to 61.5 percent in 1999, and between 1998 and 1999, the percentage of children without insurance coverage declined dramatically, from nearly 15.5 percent down to 13.9 percent.

Simply providing access to public programs, even free programs, does not guarantee that individuals will leave the ranks of the uninsured. Prior research based on family circumstances and income has found that over 25 percent of all uninsured adults and nearly two-thirds of uninsured children appear to be eligible for some type of public coverage. This accounts for about 15 million of the uninsured.

It is notable that the decline in the uninsured occurred at the time when health benefit costs were going up. When health benefit costs increase, the percentage of Americans covered by employment-based health benefits is expected to decline, but as I already mentioned, more workers and their dependents were covered by employment-based health benefits in 1999 than in 1998.

Despite rising health benefit costs, small employers are increasingly offering health benefits to workers, and as Jon Gabel will show in his testimony.

According to a survey conducted by EBRI, the Consumer Health Education Council, and the Blue Cross/Blue Shield Association last year, most small employers report that offering health benefits helps with recruitment and retention and keeps workers healthy, which ultimately reduces absenteeism and increases productivity. Clearly, many employers realize there is real business value in providing health benefits to their workers.

As long as health benefit costs continue to increase, employers will seek ways to reduce those costs. However, as long as unemployment remains low, employers likely will be unable to modify existing health benefit programs. With low unemployment, the cost of not providing health benefits, such as the cost of recruiting and retaining employees, often outweighs the cost savings that can be attributed to cutting back on health benefits.

Whether the slowing economy will have an impact on employment-based health benefits depends on a number of factors. Massive layoffs have yet to have a substantial impact on the unemployment rate, which is still at 4.2 percent. However, the combination of a slowing economy, rising health benefit costs, and worker uncertainty about the future may make it easier for employers to modify health benefit programs. Even with low unemployment, if employees feared that they could lose their job or would have difficulty finding other jobs, employers may have more flexibility to reduce health benefits.

The release of the March 2001 CPS this fall may add to the confusion over the impact of rising health benefit costs on the uninsured. When those findings are released, the data for 2000 are expected to show that the number of uninsured Americans continued to decline. The combination of more employers adding health benefits and more children being covered by the CHIP program in 2000 likely resulted in continued expansion of health insurance coverage.

More than 42 million Americans were uninsured in 1999. Even if the number drops again later this year when the 2000 data are released, it is likely that 40 million Americans will still be uninsured. As long as the economy is strong and unemployment is low, employment-based health insurance coverage will expand and the uninsured will decline. However, if the economy continues to weaken and health benefit costs continue to increase, the uninsured will start to increase again.

For example, if the downturn in the economy was severe and the uninsured represented 25 percent of the non-elderly population, there would be 63 million uninsured just 4 years from now.

Thank you, again, Madam Chairwoman and Members of the Committee for the opportunity to appear before you today. My colleagues and I at EBRI look forward to working with you in the future on this important issue.

Thank you.

[The prepared statement of Dr. Fronstin follows:]

Statement of Paul Fronstin,* Ph.D., Senior Research Associate, and Director, Health Security and Quality Research Program, Employee Benefit Research Institute

Madam Chairwoman, and members of the Committee, I am pleased to appear before you today to discuss uninsured Americans. My name is Paul Fronstin. I am a senior research associate and director of the Health Security and Quality Research Program at the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

Health Insurance Coverage

Data from the Census Bureau collected in March 2000, 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 was the strong economy and low unemployment. Since employment-based health insurance benefits are by far the most common source of health coverage in the United States, it is not surprising that the low rate of unemployment translated into lower rates of uninsured. As a result of the strong economy, more workers and their dependents were covered by employment-based health insurance benefits: 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 between 1998 and 1999. 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 with-

*The views expressed in this statement are solely those of the author and should not be attributed to the Employee Benefit Research Institute, its officers, trustees, sponsors, or other staff. The Employee Benefit Research Institute is a nonprofit, nonpartisan, public policy research organization.

out 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 did not increase during this time period. 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 Census Bureau's 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 the decline in the uninsured occurred at a time when health insurance benefit costs were 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 99 workers). When health care costs increase, the percentage of Americans covered by an employment-based health insurance plan is 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, 2001). 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 et al., 2000).

Despite rising health insurance costs, employers have been increasingly offering health benefits to workers. 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. 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 health benefits as the most important employee benefit (Salisbury and Ostuw, 2000).

Outlook

As long as health benefit costs continue to increase, employers will seek ways to reduce those costs. However, as long as unemployment remains low, employers will likely be unable to modify existing health benefit programs. With low unemployment, the cost of not providing health benefits, such as the cost of recruiting and retaining employees, often outweigh the cost savings that can be attributed to cutting back on health benefits.

¹The 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.

Whether the slowing economy has an impact on employment-based health benefits depends on a number of factors. First, massive layoffs have yet to have a substantial impact on the unemployment rate. While the unemployment rate has jumped from a 30-year low of 3.9 percent in October 2000 to 4.2 percent in January 2001, it has remained at 4.2 percent in February and 4.2 percent is still a very low level of unemployment for the nation. Second, the combination of a slowing economy, rising health care costs, and worker uncertainty about the future may make it easier for employers to modify health benefit programs. Even with low unemployment, if employees feared that they could lose their job, employers may have more flexibility to reduce health benefits (and other components of total compensation) in order to control costs in a slowing economy.

Adding to the confusion over the impact of rising health benefits costs on employment-based health benefits may be the release of the March 2001 CPS in the Fall 2001. When those findings are released, the data for 2000 are expected to 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 et al., 2000). In addition, S-CHIP will continue to expand health insurance coverage. 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. However, it should be noted that the delay in collecting and reporting data often adds to the confusion on health coverage and the uninsured: The data are often misinterpreted as applying towards the current time period, rather than the nearly two-year period prior to the release of the data, when it was collected.

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 later this 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 declines in the uninsured similar to that which occurred between 1998 and 1999, 34 million Americans would still be uninsured in 2005 (chart 11). In contrast, if the economy continues to weaken and health benefit costs continue to increase, the uninsured would quickly start to increase again. 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 non-elderly population, 38 million Americans would be uninsured in 2005. In contrast, if the downturn in the economy was severe and the uninsured represented 25 percent of the nonelderly population, 63 million Americans would be uninsured.

Madam Chairwoman, this concludes my statement. It has been my pleasure to appear before the Committee today. I offer the Committee the assistance of the Employee Benefit Research Institute as you continue your work, which is vital to the economic security of all Americans.

Bibliography

- Fronstin, Paul. "Children Without Health Insurance: An Analysis of the Increase in Uninsured Children Between 1992 and 1993." *Inquiry*. Vol. 32, no. 3 (Fall 1995): 353–359.
- _____. "Trends in Health Insurance Coverage." *EBRI Issue Brief* no. 185 (Employee Benefit Research Institute, May 1997).
- _____. "Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion." *EBRI Issue Brief* no. 211 (Employee Benefit Research Institute, July 1999).
- _____. "Employment-Based Health Insurance: A Look at Who is Offered Coverage and Who Takes It." *EBRI Issue Brief* no. 213 (Employee Benefit Research Institute, September 1999).
- _____. "Employment-Based Health Insurance For Children: Why Did Coverage Increase In the Mid-1990s?" *Health Affairs*. Vol. 18, no. 5 (September/October 1999): 131–136.
- _____. "The Working Uninsured: Who They Are, How They Have Changed, and the Consequences of Being Uninsured." *EBRI Issue Brief* no. 224 (Employee Benefit Research Institute, August 2000).
- _____. "Health Insurance Coverage and the Job Market in California." *EBRI Special Report* no. 36 (Employee Benefit Research Institute, September 2000).

_____. "Counting the Uninsured: A Comparison of National Surveys." *EBRI Issue Brief* no. 225 (Employee Benefit Research Institute, September 2000).

_____. "Sources of Health Insurance Coverage and Characteristics of the Uninsured: Analysis of the March 2000 Current Population Survey." *EBRI Issue Brief* no. 228 (Employee Benefit Research Institute, December 2000).

Fronstin, Paul, and Rachel Christensen. "The Relationship Between Income and the Uninsured." *EBRI Notes*, no. 3 (Employee Benefit Research Institute, March 2000): 1–4.

Fronstin, Paul, and Lawrence G. Goldberg, and Philip K. Robins. "Differences in Private Health Insurance Coverage for Working Male Hispanics." *Inquiry*. Vol. 34, no. 2 (Summer 1997): 171–180.

Fronstin, Paul, Lawrence G. Goldberg, and Philip K. Robins. "An Analysis of Trends in Private Health Insurance Coverage, 1988–1992." *Social Science Quarterly*. Vol. 78, no. 1 (March 1997).

Fronstin, Paul, and Ruth Helman. "Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey." *EBRI Issue Brief* no. 226 (Employee Benefit Research Institute, October 2000).

Fronstin, Paul, and Sarah C. Snider. "An Examination of the Decline in Employment-Based Health Insurance Between 1988 and 1993." *Inquiry*. Vol. 33, no. 4 (Winter 1996/97): 317–325.

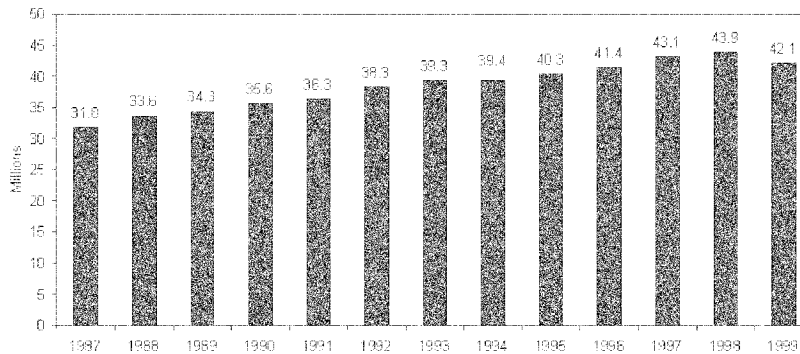
Gabel, Jon, et al. "Job-Based Health Insurance In 2000: Premiums Rise Sharply While Coverage Grows." *Health Affairs*. Vol. 19, no. 3 (September/October 2000): 144–151.

Health Care Financing Administration (HCFA). *The State Children's Health Insurance Program Annual Enrollment Report* (October 1, 1998–September 30, 1999).

Salisbury, Dallas L., and Pamela Ostuw. "Value of Benefits Constant in a Changing Job Environment: The 1999 WorldatWork/EBRI Value of Benefits Survey." *EBRI Notes*, no. 6 (Employee Benefit Research Institute, June 2000): 5–6.

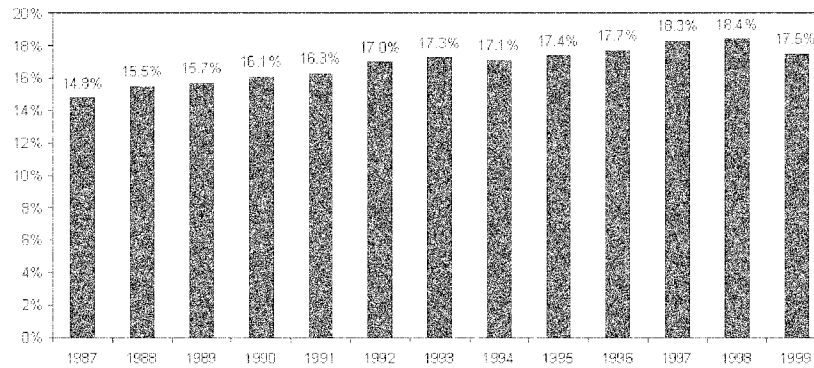
William M. Mercer. *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans. 2000*. New York, NY: William M. Mercer, Inc., 2001.

Chart 1
Number of Uninsured Americans Ages 0–64, 1987–1999
(millions)



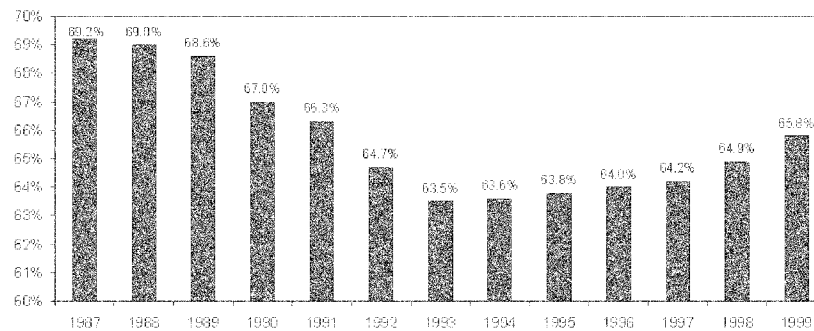
Source: Employee Benefit Research Institute.

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

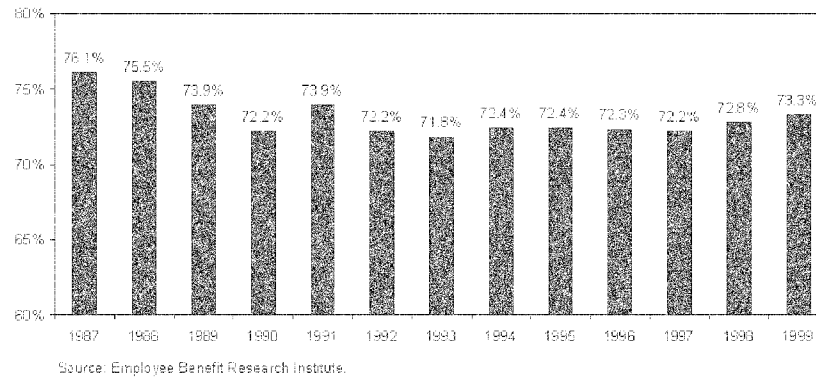


Chart 5
Percentage of Working Adults, Ages 18–64, Without Health Insurance
Coverage, 1987–1999

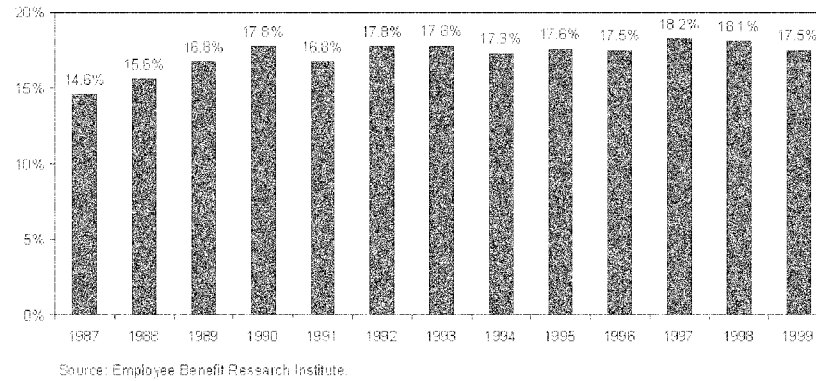
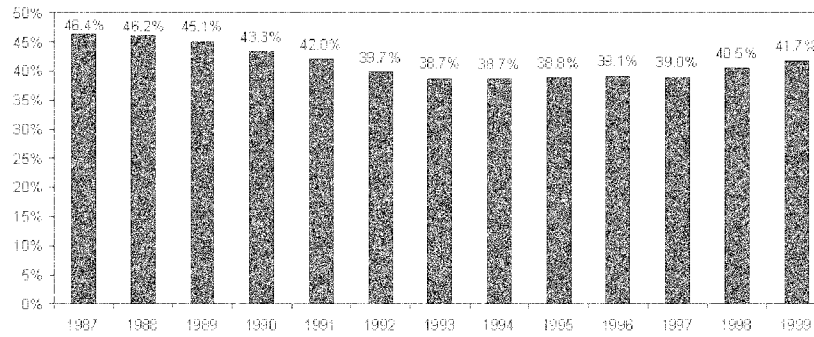
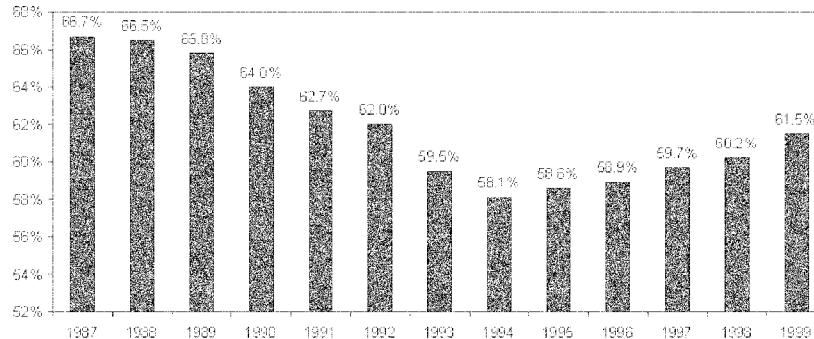


Chart 6
Percentage of Nonworking Adults, Ages 18-64, With Employment-Based Health Insurance Coverage, 1987-1999



Source: Employee Benefit Research Institute.

Chart 7
Percentage of Children, Ages 0-17, 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

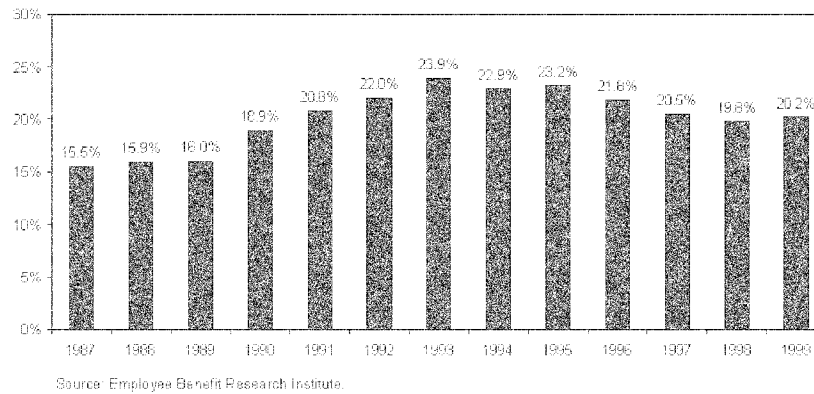


Chart 9
Percentage of Children, Ages 0–17, Without Health Insurance Coverage, 1987–1999

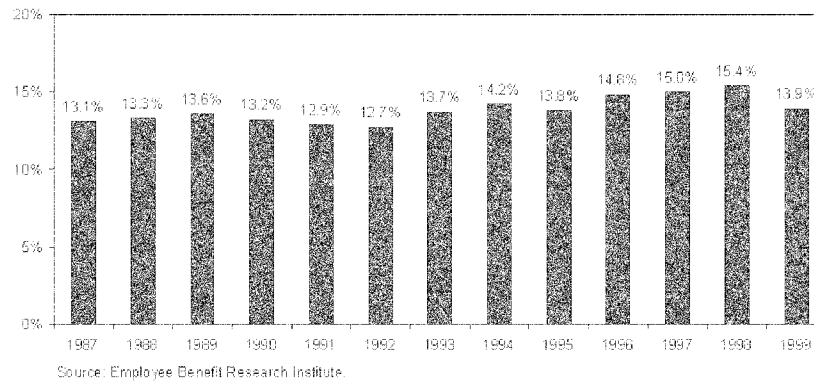
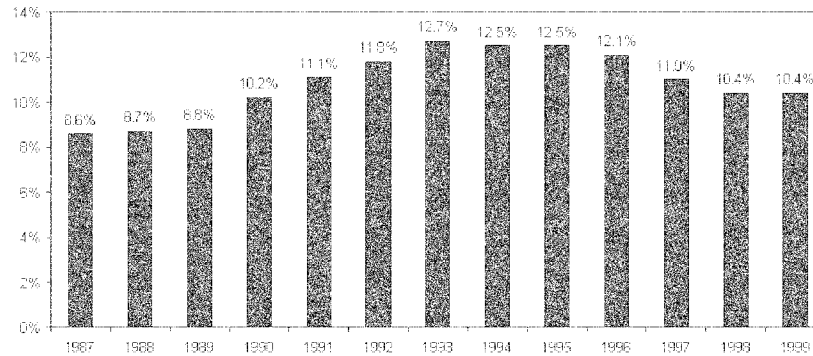
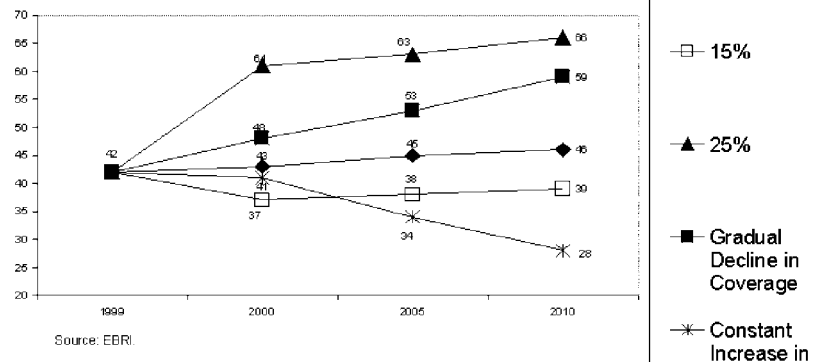


Chart 10
Percentage of Americans Ages 0-64 With Medicaid Coverage, 1987-1999



Source: Employee Benefit Research Institute.

Chart 11
Number of Uninsured Americans, Ages 0-64,
Various Assumptions About Percentage Uninsured, 1999-2010



Chairwoman JOHNSON. Mr. Gabel, if you would proceed, please.

**STATEMENT OF JON R. GABEL, VICE PRESIDENT, HEALTH
RESEARCH AND EDUCATIONAL TRUST**

Mr. GABEL. Thank you, Madam Chairman and Members of the Committee.

I am Jon Gabel, vice president of Health Research and Educational Trust. The trust is a non-profit research organization sponsored by the American Hospital Association. The views I express today are mine alone.

Let me begin with my overall conclusion. I believe job-based insurance will cover a smaller share of working families in the future.

Public opinion studies suggest the public has two major misconceptions about the uninsured. First, the public is unaware of

the close link between employment benefits and uninsurance. They are unaware that 80 percent of the uninsured are from working families. The uninsured are cab drivers, retail clerks, waiters and waitresses, construction workers and hotel workers.

The second misconception of the public is this: the uninsured get the same care as everyone else. This is utterly wrong.

The uninsured are four times as likely to delay care. The uninsured use 40-percent fewer services than comparable people with insurance. When admitted to the hospital, they are sicker. While in the hospital, they get fewer high-tech services. They are more likely to die in the hospital, and they have a 25-percent higher mortality rate than similar insured individuals.

About one-half of the uninsured work for firms with 25 or fewer workers. These same firms only employ 15 percent of the work force.

Recently, there has been an increase in coverage, and this coverage was driven by the robust economy of the 1990's. Which small employers don't offer coverage? I refer to Exhibit 1 and Exhibit 2.

Earning of the work force largely determine whether a firm will offer coverage. This stresses that benefits are part of the total benefit package.

A key element in understanding the uninsured is the employer exclusion. I do not pay taxes on my employer contributions for health insurance. If my employer contributes \$6,000 per year and my marginal tax rate, including State, Federal, and local government is 50 percent, then I receive a subsidy of \$3,000.

Turning to Exhibit 3, we show that our employer-based system today is highly regressive. We give the greatest financial help to those who need the least assistance and the least help to those who need the most assistance.

A family earning less than \$15,000 a year gets a tax subsidy of \$71. Those making over \$100,000 get nearly \$2,500.

When we ask employers why they do not offer insurance, year after year, the overwhelming reason is it costs too much. I refer to Exhibit 4.

The implication is that employers would buy lower-priced bare-bones policies. The real-world experience of these policies is they do not sell.

Now let me turn to short-run forces. We have two adverse developments. The first is the return of health care inflation. I refer to Exhibit 4.

Premiums have increased by 8.3 percent last year, the highest increase since 1993, and the situation looks worse for the future. Higher prices mean fewer small employers will purchase coverage.

Second is the slowing of the overall economy. Over the past 5 years, a tight labor market has shielded American workers from rising health care cost. A slowing economy will enable employers to pass on higher costs to workers. Higher contributions will induce more low-income workers to decline coverage.

Now let me turn to long-term forces. Please refer to Exhibit 8. Job-based health insurance covers a smaller percentage of working Americans today than in 1977. The decline in coverage is concentrated among those Americans least able to compete in a global information-based economy.

Note, there was no decline in coverage among families with college graduates, but among families headed by individuals without a high school diploma, coverage fell from 52 to 34 percent.

I see globalization and the information revolution bringing about greater disparities in health coverage in the future.

Madam Chairman and Members of the Committee, I welcome your questions. Thank you.

[The prepared statement of Mr. Gabel follows:]

Statement of Jon R. Gabel, Vice President, Health Research and Educational Trust

Thank you Madam Chairman and committee members for inviting me to testify about trends in uninsurance. I am Jon Gabel, Vice President of the Health Research and Education Trust (HRET). HRET is a non-profit 501(c)(3) research organization affiliated with the American Hospital Association (AHA) and funded largely by grants from charitable foundations and government research agencies. Today, I speak to you as an independent analyst who has conducted an annual survey of employer-sponsored health benefits since 1986.¹ The views expressed are my own. In my testimony, I examine current and long run changes in job-based insurance. The evidence presented suggests that job-based insurance will provide benefits to a smaller share of American workers in the future.

Misconceptions about the Uninsured

Employee health benefits and uninsurance are closely intertwined. Unfortunately, public opinion polls indicate that the majority of American voters are unaware of this close link. The American public, particularly those who are college graduates and enjoy higher levels of income, are subject to two major misconceptions about the uninsured. First, the public is unaware that roughly 80 percent of the uninsured come from working families.² The uninsured include cab drivers, retail clerks, waiters and waitresses, construction laborers, and hotel workers.

Second, according to public opinion polls, the majority of Americans believe that the uninsured get similar care as everyone else.³ In fact, an overwhelming body of scientific research published in leading medical journals, such as the *New England Journal of Medicine* and the *Journal of the American Medical Association*, says this is utterly wrong. The uninsured are four times as likely to delay care,⁴ use 40 percent fewer services than insured individuals in similar health,⁵ have more avoidable hospitalizations,⁶ enter the hospital sicker, receive fewer high cost discretionary services, are discharged from the hospital sooner, are more likely to die in the hospital,⁷ and experience a mortality rate 25 percent greater than insured individuals with similar characteristics.⁸

¹ From 1986–1990, the Health Insurance Association of America sponsored the annual survey. From 1991–1998, KPMG Peat Marwick was the sponsor, and today the survey is sponsored by the Kaiser Family Foundation and Health Research and Educational Trust.

² Kaiser Family Foundation and Lehrer Newshour, www.pbs.org/Newshour/Health/Uninsured/highlights.pdf.

³ R.J. Blendon, J.T. Young, and C.M. DesRoches, "The Uninsured, the Working Uninsured, and the Public," *Health Affairs*, November/December 1999, Vol. 18, No. 6, pp. 203–211.

⁴ K. Donelan, R. Blendon, C. Hill, C. Hoffman, D. Rowland, M. Frankel and D. Altman, "What Happened to the Health Insurance Crisis in the United States?: Voices from a National Survey," *Journal of the American Medical Association*, Vol. 276(16), October 23/30, 1996, pp. 1346–1350.

⁵ S. Long and S. Marquis, "The Uninsured Access Gap and the Cost of Universal Coverage," *Health Affairs*, Supplement 1994, 13:2, pp. 211–220.

⁶ J. Weissman, C. Gatsonis, and A. Epstein, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association*, November 4, 1992, 268:17, pp. 2388–2394.

⁷ K. Davis, "The Uninsured in an Era of Managed Care," *Health Services Research*, February 1997, pp. 641–649; J. Hadley, E. Steinberg, and J. Feder, "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome," *Journal of the American Medical Association*, Volume 265, No. 3, January 16, 1991, pp. 374–379.

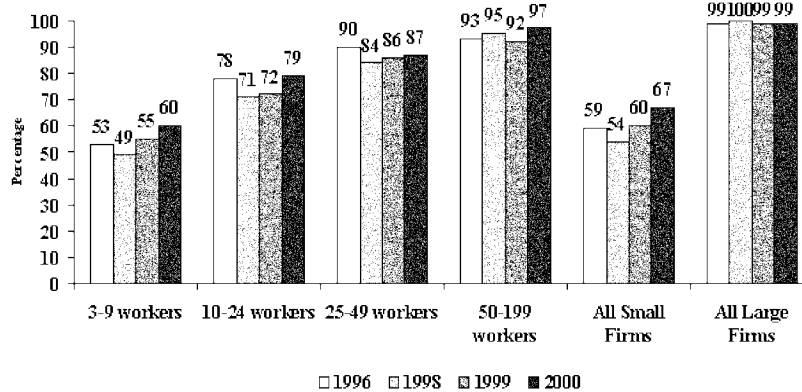
⁸ P. Franks, C. Clancy, and M. Gold, "Health Insurance and Mortality: Evidence from a National Cohort," *Journal of the American Medical Association*, August 11, 1993, 270, pp. 737–741.

Who Offers Coverage and the Employer Exclusion

About 50 percent of the uninsured are from families where the head of household works for a firm employing 25 or fewer workers.⁹ Due to the robust economic expansion of the 1990s and the resulting tight labor market, the percentage of small firms (firms with fewer than 200 workers) offering health benefits increased from 54 percent to 67 percent from 1998 to 2000. (Exhibit 1)

Exhibit 1

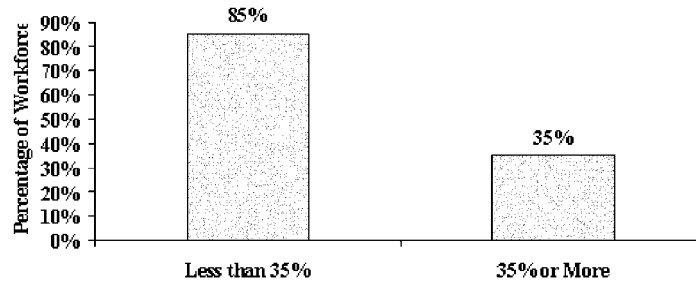
Percentage of Firms Offering Health Benefits, by Firm Size: 1996, 1998–2000



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999, 2000; KPMG Survey of Employer Sponsored Health Benefits, 1996; 1998.

With even unskilled workers in short supply in some labor markets, many small firms offered health benefits to attract scarce workers. The earnings of workers at the company largely predict whether or not a small firm offers health benefits to its workers. Exhibit 2 shows that among firms where fewer than 35 percent of workers earn less than \$10 per hour (or \$20,000 per year), 85 percent of such small firms offer health benefits. When more than 35 percent of workers earn less than \$10 per hour, only 35 percent of small firms offer coverage.

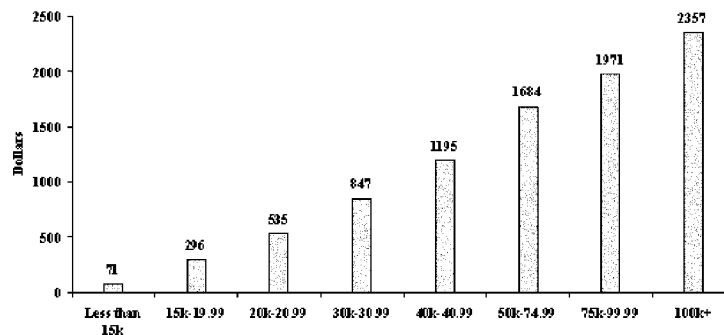
⁹P. Fronstin, "The Working Uninsured: Who They Are, How They Have Changed, and the Consequences of Being Uninsured—with Presidential Candidate Proposals Outlined," EBRI Issue Brief, August 2000, 224, pp. 1–23.

Exhibit 2**Percentage of Small Firms (3–199 Workers) in Which Workers Are Offered Health Insurance, by Percentage of Workforce that is Low Income, 2000**

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000

These statistics demonstrate that health benefits are part of the overall compensation package, and that employer contributions for the cost of health benefits represent compensation that could have been dedicated to wages.

The preceding statement is subject to an important caveat. Employees do not pay taxes on employers' contributions for health benefits. "This employer exclusion," grew not from any legislative act but from rulings by the executive and judicial branches of government to shore up labor shortages during World War II. If my employer contributes \$6000 per year for my insurance, and my marginal tax rate (including state and local government) is 50 percent, then I receive a tax subsidy of \$3000 per year. In so doing, the United States has created an "accidental system" that is highly regressive, giving the greatest assistance to those who need the least financial help, and the least assistance to those who need the most financial assistance. Exhibit 3 displays the average tax subsidy in 1998 for employer-based insurance according to family income. Families earning less than \$15,000 per year received an average subsidy of \$71 whereas families with income above \$100,000 received about \$2400.¹⁰

Exhibit 3**Average Federal Health Benefit Tax Subsidy for Job-Based Insurance, Per Household, by Income, 1998**

Source: J. Shiels, *Health Affairs*

¹⁰J. Shiels and P. Hogan, "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs*, March/April 1999, Vol. 18, No. 2, pp. 176–181.

Among firms who offer health benefits, about 79 percent of workers are eligible to participate in the company plan; of those eligible to participate, about 84 percent take-up coverage, and hence, about 65 percent of company workers are enrolled in the firm's health plan. In 1988, 73 percent of workers were enrolled in the company plan. Thus, since 1988, employer-based coverage has declined, not because fewer firms offer coverage, but because fewer employees in firms offering coverage participate in the company health plan.¹¹

In our national survey of employers, we have asked employers not offering coverage why they don't provide health benefits. Consistently, employers answer that health insurance costs too much. (Exhibit 4)

Exhibit 4

Small Firms' Reasons For Not Offering Health Insurance, 2000

	Very Important	Somewhat Important	Not Too Important	Not At All Important	Don't Know
High Premiums	76%	12%	0%	11%	0%
High Turnover	29	9	12	41	9
Employees Covered Elsewhere	34	12	24	26	4
Administrative Hassle	17	13	22	42	7
Obtain Good Employees Without Offering A Health Plan	22	22	17	23	15
Company Can't Qualify For Group Rates	25	32	11	26	6
Firm Too Newly Established	3	0	9	88	0

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000.

In 2000 76 percent of firms not offering coverage cited costs as a "very important" reason, far outpacing any other reason. By implication, if insurers could offer bare bones, low-priced coverage, many more small firms would provide health benefits. Unfortunately, that has not been the real-world experience. For example, the State of Illinois enacted legislation allowing bare-bones policies. When the legislation was repealed in 1997, only 20 employers had purchased bare-bones products.¹²

Short-Term Trends

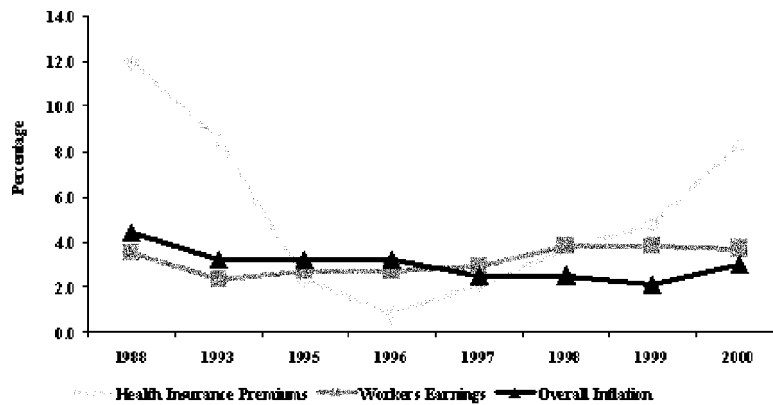
Two unfavorable developments suggest that the recent expansion over the past two years in employer-based coverage will come to an end. First, inflation in the cost of health insurance has returned (Exhibit 5).

¹¹ P. Ginsburg, J. Gabel and K. Hunt, "Tracking Small Firm Coverage, 1989-1996," Health Affairs, January/February 1998, Vol. 16, No. 7, pp. 167-171; B.S. Schone and P.F. Cooper, "More offers, fewer takers for employment-based health insurance: 1987 and 1996," Health Affairs, November/December 1997, Vol. 16, No. 6, pp. 142-149.

¹² State of Illinois Grant Proposal to the Health Resources and Systems Agency, 2000.

Exhibit 5

Premium Increases Compared to Other Indicators, 1988–2000

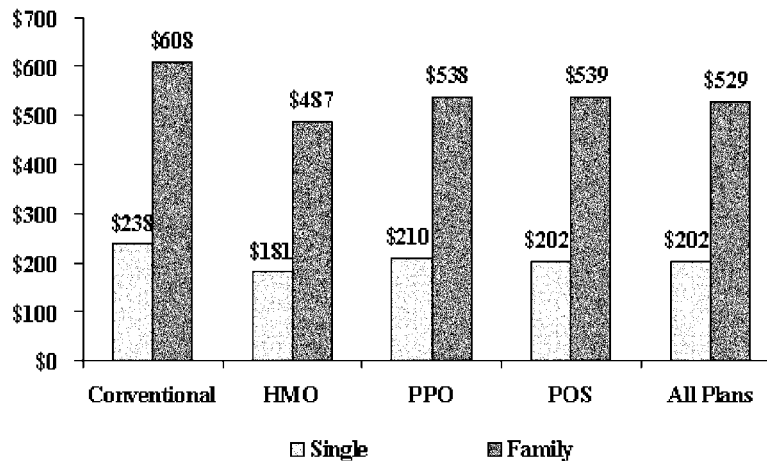


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999, 2000; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996, 1998; Bureau of Labor Statistics, 2000.

From spring 1999 to spring 2000, the cost of job-based insurance increased 8.3 percent, the highest increase since 1993. In 2000, the average monthly cost of single coverage was \$202, and the average cost for family coverage was \$529 (Exhibit 6).¹³

Exhibit 6

Average Monthly Premium Costs for Covered Workers, Single and Family Coverage, 2000



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000.

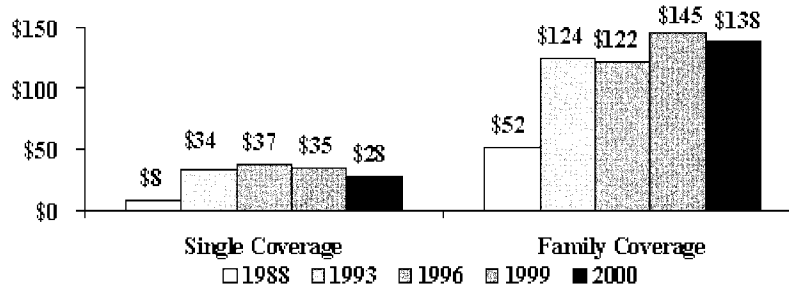
¹³ J. Gabel, "Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows," *Health Affairs*, September/October 2000, Vol. 19, No. 5, pp 144–151.

All indications are that premium increases will be even higher in 2001. From 1994–1998, America enjoyed the lowest premium increases since we have been keeping statistics on job-based insurance. The return of inflation is due not merely to the health insurance underwriting cycle,¹⁴ but to a surge in underlying health care costs, driven by prescription drug expenses. The surge in underlying health care claims expenses suggests, unlike the insurance cycle, that the problem will not correct itself. Higher premiums mean fewer small employers can afford coverage, that some of the costs will be shifted to workers, and more workers, especially low-earning workers will decline coverage.

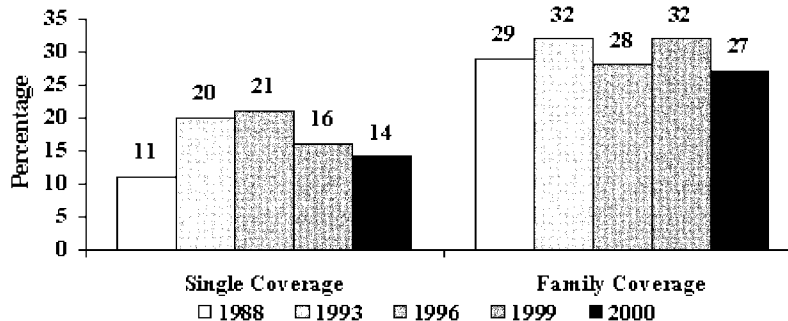
The second unfavorable development is the slowing of the overall economy. Over the past four years, record low unemployment has shielded workers from rising costs. In fact, today workers contribute less in monthly nominal dollars for single coverage than they did in 1996 (Exhibit 7).¹⁵

Exhibit 7

Average Monthly Worker Contribution for Single and Family Coverage, 1988–2000



Percentage of Premiums Paid by Covered Workers for Single and Family Coverage, 1988–2000



¹⁴The “insurance cycle” is the historic pattern of profitability and pricing in the health insurance industry. When insurers are earning underwriting profits (profits before investment income), then insurers fight for market share through fierce price competition. Claims expenses rise faster than premiums, and eventually, most insurers realize underwriting losses. By 1996, about three-quarters of insurers had underwriting losses. Many insurers then exited from local markets. The insurance industry next enters a phase of catch-up pricing, where the objective is to restore profitability rather than gain market share. Currently the industry is in the catch-up phase of the underwriting cycle.

¹⁵Ibid., p. 147.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999, 2000; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996, 1998

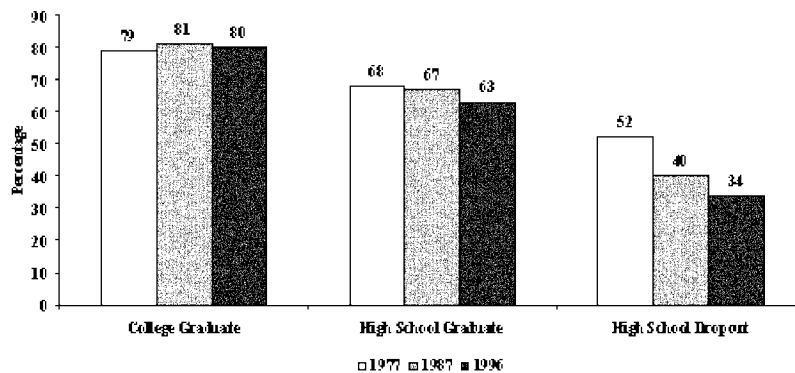
Low-paid workers are highly sensitive to the cost of health insurance. A softening of the labor market will enable employers to pass on rising costs to workers, and as a result, more workers will decline coverage.

Long-Term Developments

Even after nine years of economic expansion, the employer-based health system covers a lower percentage of the U.S. population today than it did in 1977 (70.5 vs. 66 percent). The decline in coverage is concentrated among those segments of our population least able to compete in a global, information-based economy. The percentage of college graduates with job-sponsored coverage remained statistically unchanged (79 to 80 percent) while coverage fell among high school graduates from 68 to 63 percent (Exhibit 8).

Exhibit 8

Percentage of Persons Under Age 65 with Employer-Based Health Insurance, by Education Level, 1977-1996



The most dramatic decline occurred among Americans without high school diplomas, where coverage fell from 52 percent in 1977 to 34 percent in 1996. It is noteworthy that real hourly wages for non-graduates fell 17 percent from 1973 while real wages increased 18 percent for college graduates. Hence, the twin forces of economic globalization and the information revolution are likely to bring about not only great economic wealth, but also greater disparities in future income and health benefits.¹⁶

Madam Chairman and members of the Ways and Means Committee, I thank you for the opportunity to discuss the uninsured, and welcome any questions you may have.

Chairwoman JOHNSON. Thank you very much.

Mr. Gabel, do you have any information about the number of employers that provide only partial of premium coverage?

In my district, I run across a lot of employers that provide only 50 percent of the premium cost, and those people in particular are very interested in the tax subsidy to help them stay in the plan. Although the kinds of employments that you point to in your testimony, I understand are uninsured, but there are many others out there. For instance, the examples in my district are small manufac-

¹⁶J. Gabel, "Job-Based Health Insurance, 1977-1998: The Accidental System under Scrutiny," Health Affairs, November/December 1999, pp. 62-74.

turers, and they are doing their best to provide coverage, but it does require the employee to provide 50 percent of the premium and that is unaffordable to many of the workers industry.

Do we know much about this? Do we know much about what percentage of the employers do cover only 50 percent of the premium? Because I think whether or not tax credits keep people in and bring them in depends a lot on the vitality of that particular type of plan.

Mr. GABEL. Yes, we do have such data. In fact, the data goes all the way back to 1988. I know for each employer how much the employer contributes for each plan.

We have also analyzed how the out-of-pocket contribution for the employee affects the take-up rate. We find that if a firm has many higher-income workers, the contribution requirement does not reduce the take-up rate. If there are many low-income workers—and by that, I mean workers making less than \$20,000 a year—these workers are very sensitive to the out-of-pocket contribution.

Chairwoman JOHNSON. Could you look at your data and get back to me on what the cyclical impact of rising and falling premiums has on that type of employer plan and whether that shows any difference, movement in and out, you know, employers dropping it earlier or later than more costly plans, if you can determine that. Thank you.

Mr. Stark.

[No response.]

Chairwoman JOHNSON. Mr. McCrery.

Mr. MCCRERY. I would like to ask both of you what you think the outlook is for employer-provided health insurance coverage. Do you think more employers in the future will be offering health insurance, or do you think fewer employers?

Dr. FRONSTIN. I think it depends. It depends on a lot of factors.

Mr. MCCRERY. Like what?

Dr. FRONSTIN. One, if we have a recession and unemployment does go up—it has not yet, despite the fact that we have slowed down considerably—if unemployment goes up, employees will be able to cut back, I think it will take two forms. One, I think we will see small employers dropping coverage.

Because of the rate at which premiums have been going up for those employers, as Jon Gabel shows in his study, he mentioned about 8.3 percent in 2000. It was actually higher. It was over 10 percent in 2000 for small employers, and that is expected to continue.

I think we will see large employers not necessarily drop coverage. Just about all of them offer it today, and just about all of them have always offered it, but you will see them change the benefits package around. You will see them ask their employees to pick up a greater share of the premium.

The one thing that small employers do not always have flexibility on is how much of the premium they can ask their employees to pay. Because insurance companies often require a certain percentage of employees to be covered, in order for the employer to get that high minimum participation rate, they wind up paying 100 percent of the premium.

If you look at employee data, if you look at employees and ask them whether or not they pay anything, you find that more employees in large firms pay something than employees in small firms.

This does not mean that there are not employees in small firms that do not pay anything. There is probably two pools there depending upon whether or not they are subject to minimum participation requirements. So I think certainly if the economy slows down, we can see employers pulling back from this benefit, like they did in the late 80's and early 90's when we had rising health care costs.

Mr. MCCRERY. So two things could reduce the employer coverage in the country: number one, economic downturn which would reduce earnings for the businesses; number two, increases in health care costs which would increase the premiums that they would have to pay. Is that correct?

Dr. FRONSTIN. I think you would need both to happen at the same time. I do not think that health benefit costs going up without a recession is going to translate into more workers leaving coverage because we have already seen—Jon Gabel's data show this—between 1998 and 2000 more small employers started offering coverage. The percentage offering coverage, he has in Exhibit 1.

I hate to steal your thunder, Jon.

But it went up by 11 percentage points. I do not remember the number for the increase in cost between '98 and '99, but between '99 and 2000, it was over 10 percent for these employers.

So I think if you have a strong economy, coupled with rising health benefit costs, there is going to be some give-and-take, and if you have a strong economy, I think employers are in a better position to pay the higher health costs. So you may not see employers cutting back so fast.

Mr. GABEL. I am pessimistic. I am pessimistic because I believe we are in an economic downturn. We will have a softening labor market.

I am pessimistic because we know beyond a doubt that health inflation is back. What is most disturbing is that we have had a surge in underlying health care expenses for health plans in the last years. It has been particularly driven by higher prescription drug expenses. We know from historical data that when you put those two forces together, you have declining coverage.

My third reason for being pessimistic has to do with long-run earnings of low-income workers. Health benefits are a form of income. When we examine the experience of low-skilled workers, particularly those who are not high school graduates, we see a real decline in wages of about 17 percent since 1973. I believe that is why there has been a decline in coverage among non-high school graduates.

Of course, when I was in school, you could get a very good job if you graduated from high school. There were manufacturing jobs with health coverage. Today, those graduates are in the service industry and do not get coverage.

So, for those three reasons, I am pessimistic about the future.

Mr. MCCRERY. How did we get started with this—oh, my time is up. That was a quick 5 minutes.

Chairwoman JOHNSON. Mr. Stark.

Mr. STARK. Thank you, Madam Chairman, and I would like to thank the witnesses.

Mr. Gabel, you show the average policy at about \$2,400 and a family policy at about \$6,400, suggesting that employers pay somewhere between 70 and 90 percent; 73 to 86 percent I think is the exact figure.

Does it then follow that if we are going to subsidize insurance and expect people to pick up insurance in the market, then we have to talk about subsidizing the insurance at about those rates for people to pick it up? Does that make sense?

Mr. GABEL. I think what the research would indicate is that the subsidies have to be very substantial.

I just went to a conference, and if I can recall the number—the subsidy must constitute more than 50 percent of the costs.

The other point I want to make is these are employer-based figures. Those figures will be about 8-to-10-percent higher in 2001. Second, if we are talking about buying insurance in the individual insurance market, you are not going to get this kind of a buy. It is just not an efficient market.

Mr. STARK. I will come back, if I can, to that in a minute.

I wanted to ask, Dr. Fronstin, if you have any information for us. Somehow your testimony missed, I was going to say, what is a fact, but I think it is correct, that the employers are dropping coverage for retirees, and if these retirees are under 65, it seems to me there is a large chunk of the “uninsured” who are in that 50-to-65 range. Do you have any statistics on what has happened to them, or can you comment?

Dr. FRONSTIN. Congressman Stark, our data would indicate that there was a dropping of the retiree coverage during the late 80’s and early 90’s, going up the FASB, Federal Accounting Standards Board, and then after that, our numbers seem to go up and down. That is for the early retirees.

Mr. STARK. Yes.

Mr. GABEL. For the Medicare-eligible retirees, there does seem to be a decline.

Dr. FRONSTIN. I could submit this data when I return to the office, but what we have found is that since 1994 through 1999, the percentage of early retirees with coverage from a former employer have not changed at all. We hear the anecdotes about employers cutting back on retiree health benefits. We are trying to find out whether these cutbacks are for current retirees or future retirees. We need a better interpretation of the types of questions that are being asked of employers because, as of this point, it does not appear to have affected where retirees get their coverage from or whether or not they are uninsured.

Mr. STARK. Thank you. That would be useful information.

I want to come back to Mr. Gabel for a minute. You mentioned the Illinois experience with the bare-bones policies. Tell me, what is the difference between somebody, say, with an income of \$15-or \$17,000 and a \$5,000 deductible policy and someone with no policy at all.

Mr. GABEL. Not much.

Mr. STARK. So that, I think that is key, and I do not know whether Dr. Fronstin's figures can be extrapolated. At some point, the coverage does not amount to much, and I wanted to note that.

The only other question is whether or not these figures include—and whether there is a difference—the folks off the books, both illegal, recent immigrants who are non-citizens, citizens who choose not to report or collect Social Security and working, as I say, off the books. I would presume your research does not cover them because they are sort of below the radar scope. Any estimates of how many that would add to the pot?

Dr. FRONSTIN. We are using data from the Census Bureau.

Mr. STARK. So you would include that?

Dr. FRONSTIN. If they included it, we would include it, but I do not know that there is any way to distinguish between the two in their data.

Mr. STARK. Thank you both very much. Thank you, Madam Chair.

Chairwoman JOHNSON. Mr. Crane.

Mr. CRANE. Dr. Fronstin, as you know, the current Tax Code provides an open-ended subsidy through the employer exclusion; that is, one receives a greater benefit for buying a more generous benefit package, particularly if that individual is wealthier and in a higher marginal tax bracket.

What has been the impact of this policy on health care, and has this resulted in over-consumption?

Dr. FRONSTIN. I think the question is whether or not the subsidy has resulted in over-consumption of insurance, more people being insured than we would have had without the subsidy. If we are talking about a higher level of income receiving a greater subsidy, even without the subsidy, they may have the means to buy insurance. So I am not sure. I think there have been some studies on this that have tried to quantify it. We could take a look through them, but I am not really sure exactly which direction it goes in.

Mr. CRANE. Do you think workers would be choosing different types of health care packages if a dollar of wages equals a dollar of benefits?

Dr. FRONSTIN. I'm sorry. Could you repeat that?

Mr. CRANE. Do you think workers would be choosing different types of health care packages if a dollar of wages equalled a dollar of benefits?

Dr. FRONSTIN. Well, I guess the question really is will employers offer a different type of benefit because employees often do not have choice. So, if employees demand less benefits, it is possible, but I think—you know, it is often said that we are over-insured because of the tax treatment and people are not sensitive to the cost of health care. I think it is because people are sensitive to the cost of health care that they have over-insured, and now that they have had experience understanding what health care really costs, they would rather stay with the insurance. I think even if we change the tax treatment, given people are more risk-averse, they will probably, to some degree, stay with the insurance they already have.

Mr. CRANE. In your testimony, you tell us that the delay in collecting and reporting data often adds to the confusion on health

coverage and the uninsured. What can we do about this? It is frustrating to those of us trying to understand the current dynamics of an always changing market; that the best data we have available is already 2 years old.

Dr. FRONSTIN. It will take more money, first of all, but if you think about it, the way that the current population survey is collected, it is in March of every year. The Census goes out and interviews about 150,000 people and asks them about their health insurance coverage for the entire prior year. So they are not waiting that long between the end of calendar year 2000 and 2001 before they go out in the field to collect this data, and then they do a very good job in turning this data around in 6 months.

I do not see much room for improvement there. There are other studies that may be able to fill some gaps, but they face the same issues of the cost of going into the field at a certain time and speeding up the process of collecting the data and cleaning the data. Certainly, they are not going to get as large a sample size as the Census Bureau will.

Mr. CRANE. Thank you. I yield back the balance of my time.

Chairwoman JOHNSON. Congresswoman Thurman.

Mrs. THURMAN. Thank you, Madam Chairman. Thank you all for being here today.

I think, Dr. Fronstin, you must have mentioned something about the CHIP program. One of the things that I have followed over the last couple of years and particularly some of the issues in Florida that have come to bear on us is that when we decoupled the welfare Medicaid program that we had an increase of uninsured children, and I do not believe that CHIP has picked that all up. That is actually being reflected more in the cost of the hospitals of who they are seeing in emergency rooms and bad debt and some of those things.

What kind of information do you have, and is there anything in that area that we should be looking at?

Dr. FRONSTIN. Right now, there is very little information.

There is some information from Health Care Financing Administration (HCFA) on the number of children enrolled in CHIP. That data really is not reflected in the Current Population Survey yet because it is only as of 1999 and you did not have that many children. There were about 2 million children enrolled in 1999, and there is no separate question for CHIP. So it is hard to identify them, and it is hard to track people in the CPS over time. You just cannot do that.

Concurrent with the decline in Medicaid coverage for children and the increase in the uninsured, there was also an increase in percentage of children covered by employment-based plans between 1994 and 1997. So there is a lot going on there that we do not quite understand yet, and I think as the data becomes available, we will get a better sense of the dynamics behind the program.

Mrs. THURMAN. Do you want to comment on that as well, Mr. Gabel?

Mr. GABEL. I will pass.

Mrs. THURMAN. Let me ask another question. In the middle of the late 80's, there was a concerted effort, I think, by a lot of States to try to put some programs together called CHIP and some of

these organizations, and what we have found is that at the beginning there seemed to be a lot of interest in those and people actually signed up. Then what happened was their costs began to rise, and, quite frankly, then the private market started to come in and offer all of these new plans and actually keeping costs down.

What has happened with those alliances to try for people to buy into those markets? We kind of don't hear about that much more when we kind of try to group folks together to keep the costs down and some of those issues. What is going on in that market today?

Dr. FRONSTIN. Well, in general, the alliances have not taken off. As you indicated, in Florida, they have been closed down.

Mrs. THURMAN. Pretty much.

Dr. FRONSTIN. I think generally regarded as the most successful one is the one in California, but even the one in California—even that, as I recall, only enrolls a very small percentage of the State's population. I think one problem is many small employers do not even know that these purchasing alliances exist.

A second problem has been that they have, in many cases, met the resistance of the broker community which is so important in the purchasing of health insurance for small employers. The third problem is the HIPCS needed a big volume in order to get big discounts to be effective. Since they have never achieved that volume, they have never reached that critical threshold point to really be successful.

Mrs. THURMAN. So part of it was marketing, people knowing about it, having the ability to fall into those alliances?

Mr. GABEL. That is very important.

Chairwoman JOHNSON. The other area that—and just, I guess, probably because of the part of the area that I represent—and I have to tell you, this issue is a growing issue and it is probably going to grow even more over the next couple of years, is this 55- to 64-year-old that is not on Medicare. Do tax credits help them?

I mean, I do not know how that helps.

Mr. GABEL. Well, if coverage purchased in the individual insurance market, the cost would be prohibitively high for a 55–64 year old. So it would require a very substantial tax credit.

On the other hand, these people do want coverage—we are not talking about the 21-year-old who thinks they are immortal. These individuals are very serious and concerned about the cost of health care.

Mrs. THURMAN. What we are hearing from our constituents is that they may not be sick right now, they do not know that they will not be sick before they get on Medicare, and part of what we are doing to them is because of the prohibitive costs that they are not going in to see their doctors, they are not doing their preventive care, and at some point, they end up very sick. It has really created a problem in the district. I can say that we hear about this every day. So I hope we can come up with some solutions here for those folks, and all of them.

Chairwoman JOHNSON. Mr. English.

Mr. ENGLISH. Madam Chair, insofar as I was profiting from the line of question being advanced earlier by the gentleman from Louisiana, I will yield my time to Mr. McCrery.

Chairwoman JOHNSON. Thank you, Mr. English.

Mr. MCCRERY. I thank the gentleman for yielding.

Dr. FRONSTIN, what is your Ph.D. in?

Dr. FRONSTIN. Economics.

Mr. MCCRERY. Good.

According to the Kaiser Family Foundation, workers paid only 14 percent of the cost of self-only plans provided by their employers, and those getting family coverage only pay 27 percent of the cost of that coverage.

As an economist, tell me, if my employer gave me 86 percent of the cost of a new car, do you think the market for Cadillacs might go up?

Dr. FRONSTIN. As an economist, I would say that the money that the employer is providing them for coverage really comes off their cash wages.

Mr. MCCRERY. Well, of course, it does. I did not ask that.

Dr. FRONSTIN. So are they really giving them the money for benefits, or can they take it as cash wages? Plus, they are actually not paying 14 percent because of the tax treatment.

Mr. MCCRERY. You have answered my question, even though it did not sound like you wanted to.

Of course, Cadillacs, you would need more demand for Cadillacs. If somebody is going to pay 86 percent of the cost of my new car, I am not going to go get a Yugo. I am going to go get a Cadillac because I can afford it, because you pay 86 percent of the tab. You do not have to be an economist to figure that out.

Dr. FRONSTIN. But I am questioning whether or not the employer is—

Mr. MCCRERY. But if you gave that employee wages, if you gave that employee the equivalent in wages, instead of buying his health insurance, and you were asked this question before—I am going to ask it more directly. If you cashed out that employee and, instead of spending \$10,000 on health insurance, you gave him \$10,000 in wages and the employee then could go out and buy health insurance, do you think he would buy exactly the same coverage, first dollar of coverage that a single employee might—

Dr. FRONSTIN. Some will and some won't. Some will and some won't. It depends upon the person. It depends upon their income level. It depends upon what they can get in the individual market.

Mr. MCCRERY. Well, of course, individuals vary, but, generally speaking, do you think that employee might go shop around for a different product that would not cost him \$10,000—

Dr. FRONSTIN. I think generally—

Mr. MCCRERY. So he could use some of that money for—

Dr. FRONSTIN. They will go shopping around. Certainly, they will go shopping around, but I think they will do their best to try and find the same product before they settle for something with less benefits.

Mr. MCCRERY. Mr. Gabel, can you give us some background on how this employer coverage started and what was the rationale for it?

Mr. GABEL. Our employer-based system is an accidental system. Other countries will point to a legislative act such as the National Health Care System in Britain. Ours grew out of wartime shortages during World War II where wages were capped due to wage

and price controls. An executive decision was made to allow health benefits not to be covered by this cap. Once that occurred, a very strong growth in employer-based health insurance followed.

Mr. MCCRERY. Exactly. There was no public policy thought into this. It was just kind of an accident, and as a result now, we have this system that leaves out a lot of people because their employers do not provide coverage or they are in a type of work where they are in and out of work and they do not get coverage, whatever, and if you are a high-income worker, you get a big subsidy from the government through the tax system, but if you are a low-income worker, even if your employer provides coverage, you get a little bitty subsidy from the Government. That makes a lot of sense, doesn't it?

Mr. GABEL. No. What if we could start all over again? I have met very few economists, liberal or conservative, who would say an employer-based system like ours is the right system. In fact, I do not know if I have ever met any economist who believes our employer-based system is the right system.

Mr. MCCRERY. Well, as policy-makers, why do we continue to fiddle with the current system around the edges instead of offering comprehensive solutions to health care?

Getting back to the cost issue, I guarantee you if costs continue to rise, employer-provided coverage is going to drop, and the more uninsured we have in this country, the greater the cry for us policy-makers to do something about it. The only thing you will hear, I am afraid, is let the government do it. We will just pay for it, and then you may as well just have the Government pay for everybody. We already pay for Medicare, Medicaid, CHIPs, and now we are going to do the uninsured, a new tax credit. We may as well just make it easier and pay for everybody's health care and then tax everybody.

If somebody, Dr. Fronstin, does not start worrying about costs in the health care system and how to control those costs, we are going to be in a world of hurt because we will be controlling the costs through a universal budget, and a lot of people will not like the result of that, mostly me.

Chairwoman JOHNSON. I am going to recognize Mr. Pomeroy, who is a visiting guest from the larger Ways and Means Committee, for his background in this, in insurance.

Mr. Pomeroy.

Mr. POMEROY. Madam Chairperson, you are very kind to allow me to ask questions.

I was a State insurance commissioner in a prior life and sat where you are testifying to this Subcommittee. This is the first time as a Member of the Ways and Means Committee I have had a chance to participate even as a guest on this Subcommittee, and I really appreciate it.

I very much enjoyed Mr. McCrery's questions and commend him for his creative and very sincere thinking on how we can do this better.

I have a different notion, and that is that the erosion of employer-based health care insurance will rapidly fuel cause for a full-blown public insurance system as opposed to private coverage.

In 1993, as we debated the Clinton health reforms, through '94, it appeared in looking at my own constituency that the momentum shifted significantly when those with employer-based coverage began to have questions as to whether the reforms would change, and change in a negative way, the kind of employer-based coverage that gave them security for their health insurance needs.

Dr. Fronstin or Mr. Gabel, do you have any observations in terms of whether or not employer-based coverage does achieve for our population critical mass of quality health care insurance, thereby being a mainstay for the ongoing support for private insurance?

Dr. FRONSTIN. Well, certainly employment-based coverage provides insurance for 90 percent of the population with private insurance, and it covers 160 million people. We know most of those people are satisfied with what they have, and are probably afraid of what they may lose under a new system and there is a lot of uncertainty about what that new system may bring. It is a lot of people to put into a new system and experience some type of potential disruption.

Mr. POMEROY. They were very risk-averse when they began to really perceive a threat, I believe, is what the Clinton, say, health experiment would show us.

Mr. Gabel.

Mr. GABEL. I think public opinion polls would show that most people who have employer-based insurance like their health plan. They are satisfied with it, and, of course, in general, their coverage, they generally want to keep.

Mr. POMEROY. Mr. McCrery's point about an unacceptable level of insured that will probably, inevitably, rise and that is totally unacceptable is completely correct. I have come to the conclusion that keeping that which works in our system and building reforms for the rest of it is better than scrapping everything and starting anew. It is just too much of an undertaking.

That does get me to a second point, and that is a critical feature within the employer-based coverage is the risk-pooling that takes place. Some of the reforms would seem to pick away at risk-pooling. I would cite specifically the effort by some to have small employers self-insure or do it in an association context. I think this raises questions that you will inevitably return to, times in small group coverage where you have almost a churning, people coming in and out of insurance pools for very short durations of time. You also have questions in terms of whether there is an adequate solvency oversight on self-insurance associations of very small employer entities.

Dr. Fronstin and Mr. Gabel, do you have thoughts on that?

Mr. GABEL. Well, having studied the small employer market and talking to employers for many years, my belief is we know one thing for certain. The small employer market will never be an efficient market until we make major changes in it. Specifically, in a small employer market, so much of the premium dollar to the sales force, to the brokers.

Small employers might be paying 30 to maybe even 40 percent of their premium dollars for administrative expenses.

We do not have, as you noted, Congressman, the risk-spreading in the small employer market that we do among large employers.

Mr. POMEROY. My time is about out. I want Dr. Fronstin to also reply.

North Dakota, just for an example, is largely insured by Blue Cross/Blue Shield and operates under an administrative component under 15 percent, and by pooling all of the small employers in this insured program they have, they do achieve a significant spread of risk, although there is rating variables based upon the unique circumstances to a degree.

Dr. Fronstin.

Dr. FRONSTIN. We already have two systems now. Even if all the small employers were pooled into that, pooled together, we have the large employers pooled together in the sense that they are all self-insured and have pulled out of the fully insured market. That has implications for premiums and the way we spread risk as well, but I think the issues you raise are important issues. They could be addressed in legislation.

Chairwoman JOHNSON. We will have good testimony to both of those points in the next panel.

Before I move on to the next panel, however, I want to pursue the questioning of my colleague from Louisiana in a little different light.

First of all, I do absolutely agree with your fundamental point, and that is that cost is important and that, if you cannot pay for insurance, you do not get insurance. I think that was clearly demonstrated by President Clinton's effort to cover early retirees by opening up Medicare, and the result was that only one in five would be able to take it because it was too costly.

On the other end of the spectrum, your Exhibit 3 does not show it. It says it is only looking at employer-covered benefits. We do actually cover health insurance for 40 million Americans. That is more than the entire current retired population through Medicaid. We provide them with complete health coverage, a very generous plan, and 2.5 million children at this time. So, if you can afford it, you can have good health coverage, and tax credits are about affordability. That is, I think, important, as we move forward, to remember.

On this issue of who gets the subsidy, is it correct that if I am an employer and I buy the same plan for everyone, low income and high income, I get the same Government deduction for the premiums of every one of those participants?

Mr. GABEL. You get the same deduction whether you paid for insurance or gave it to them as cash wages—

Chairwoman JOHNSON. Right.

Mr. GABEL. With the exception of—

Chairwoman JOHNSON. Correct.

Mr. GABEL. How it is treated by Social Security.

Chairwoman JOHNSON. But you get the same deduction for the premium for the high earner as the premium for the low earner, assuming the plan is the same?

Mr. GABEL. Yes.

Chairwoman JOHNSON. Right. So, from the employer's point of view, they get the same deduction.

Now, from the employee's point of view, they get the same health care, assuming it is the same plan for everyone, correct?

So, when your chart here shows on Exhibit 3 that low earners receive this very low subsidy, all that is saying is that because he is a low earner and he pays very low taxes that his marginal tax benefit, were he to get that as income, would not be great, but his health benefit is enormous. So this chart is only looking at, in a sense, economic impact on him of the Government-subsidized employer system. But it is not reflecting—if it were reflecting the health impact, then all the bars would be equal, recognizing that most plans are the same for all employees, most company plans are the same for all employees, would it not?

Mr. GABEL. What you are saying is correct. But I would add that if you are a low-income worker, you are far less likely to work in a firm that offers health insurance. If the firm has many low-income workers, predominantly low-income workers, they probably do not have health insurance or they probably have very meager health insurance.

Chairwoman JOHNSON. I certainly appreciate that, that most of the uninsured are working for small firms or self-employed like cab drivers, but if you are in a firm and many, many firms do provide the same plan for everyone, if that were translated into income, you would have a very marginal tax benefit. But if it is not translated into income, you get a very big benefit. So, if we are talking about health benefits as opposed to salary—and that is why this issue of translating this into dollars is a problem because not only is the income impact different, but the health quality access is different.

One of the reasons tax credits are so important is that it gives the employee more buying power, and many of those small firms could buy a better plan, but this bill cannot be considered in isolation.

I think if you hear the next panel and some of the new work that has been done in how we cut marketing costs, how we put more affordable policies out there, which, of course, the Commerce Committee will be responsible for discharging that kind of information, but we also can have an opportunity here to do it, then you can see that there is an opportunity to really enhance health benefits through a combination of policies. I just do not want this chart to hang out there with its impression of variability when the impact on health benefit availability is very great for low-income workers, especially low-income workers who work for a company that has a good plan.

Chairwoman JOHNSON. Thank you so much for your testimony, Dr. Fronstin and Mr. Gabel, and I look forward to hearing a little bit more information back from you on these employers that I understand to be a rather small number of plans in the market, relatively speaking, where the employee takes a much higher responsibility for the premium. Thank you.

The next panel will be Lynn Etheredge, who is with the Health Insurance Reform Project at George Washington, University; Mark Pauly, a professor of Health Care Systems, Wharton School, University of Pennsylvania in Philadelphia; Sara Singer, the Executive Director of the Center for Health Policy, Stanford University; and Steven Larsen the Commissioner of the Maryland Insurance Administration, Baltimore, Maryland.

Welcome to all of our panelists, and, Lynn, thank you for your thoughtful conversations with me over many months now, and look forward to your testimony.

STATEMENT OF LYNN ETHEREDGE, CONSULTANT, HEALTH INSURANCE REFORM PROJECT, GEORGE WASHINGTON UNIVERSITY

Mr. ETHEREDGE. Thank you, Mrs. Johnson. For the past several years, there has been increasing discussion about how to use tax policy to accomplish a number of important objectives: reducing the number of Americans, now 42 million, who are uninsured, for health insurance; expanding retirement plans and savings to assist half the workers who lack employer-provided pensions; raising the national savings rate, which is now at a 40-year low; and expanding higher tax credits for education, first-time home purchase and many other needs.

This morning I want to share with the Committee a new approach that might be useful to accomplish all of these objectives, a flexible benefits tax credit. Let me first describe how it might work, and then some of its major advantages.

For example, let's assume that the Congress were to provide a \$1,000 to \$1,500 flexible benefits tax credit for workers as part of this year's tax legislation. For workers without health insurance, this tax credit would go to pay for health insurance, usually a private plan chosen at the work place or maybe through a State safety net program if the worker declined the credit in writing. In this way, all workers would be covered for health insurance, financed by the tax credit and their own contributions. So for workers without health insurance, the tax credit goes to health insurance. For workers who have health insurance but don't have an employer retirement plan, the \$1,000 to \$1,500 could be elected by them as a payment to their retirement or savings plan, like an IRA. IRAs can now be used for higher education, first-time home purchase and catastrophic medical expenses. So these flexible benefits credits could help to finance those purposes, as well as retirement. And then, finally, the workers who have health insurance and retirement plans already, could elect to take their \$1,000 to \$1,500 flexible benefits credit as cash income.

This example makes clear, I think the most important point about a flexible benefits approach. It adapts, or more accurately, it allows the American worker to adapt the tax credit assistance to the family's needs at one point in time. When a worker is without health insurance—and that is usually short term, 6 or 12 months—the credit pays a health insurance premium. When the worker has health insurance, a flexible credit helps with other needs like savings for a home, or higher education, or retirement savings, or if working have health insurance and a retirement plan already, they could take the credit as cash income.

The second important point about flexible benefits is that not only does it offer a menu for American families, it makes very efficient use of taxpayer dollars compared to many stand-alone health credit proposals. In a typical health insurance tax credit, for example, the designers have to worry a lot about unraveling employer group coverage, so we usually add billions of dollars, sometimes

tens of billions of dollars, for people who already have health insurance, even for employers. That just makes the current health insurance subsidies more expensive. In some bills more than half the costs go to people who already have health insurance.

Now, with a flexible benefit approach, the workers who already have health insurance can elect new benefits in a form of cash, either cash payment into their pension retirement account, which they will be able to spend, or as cash income. So the workers themselves get the cash income, not employers.

And, third, another important aspect of flexible benefits is that adding this flexibility to new options doesn't really increase government's costs. With a \$1,000 to \$1,500 credit per worker, the government's cost is still \$1,000 to \$1,500 per worker, even if the American family has more options for spending it. For example, to put it into a tax favored pension plan if they have that need.

Finally, one last point, and that is that this flexible benefits approach, which I lay out more in the testimony and the attached paper, is a concept that is compatible with a large number of health insurance tax credit ideas. And I think it broadens the potential support and the potential usefulness of those ideas. It would fit with many of the ideas that other people on the panel will be describing.

In summary, I would suggest that the Committee think about a flexible benefits tax credit as a new approach for helping people meet health insurance, and also retirement and other needs. It has important advantages, as part of a legislative strategy. And most importantly, I think the American families and workers would welcome these types of benefits, as well as the ability to make choices that meet their needs. Thank you.

[The prepared statement of Mr. Etheredge follows:]

**Statement of Lynn Etheredge, Consultant, Health Insurance Reform
Project, George Washington University**

Chairman Nancy Johnson and Members of the Committee, Good morning. My name is Lynn Etheredge. For the last several years, I have been working on issues of health insurance, retirement policy, and tax credits at George Washington University. My background includes more than thirty years of work, with the public and private sectors, on health care and related issues. I am appearing today as an independent witness.

Thank you for the invitation to participate in your discussions this morning. The focus of my presentation will be on the idea of a "flexible benefits" tax credit. A flexible benefits tax credit offers Congress a means to achieve health insurance coverage for most uninsured workers and children, as well as to close large gaps in retirement/savings plan coverage and offer a future with real economic security for American families.

Separate tax credits for health insurance, retirement/savings plans, higher education, first-home purchase and other purposes have been discussed for a number of years. A "flexible benefits" tax credit is a new approach. In this statement, I will outline major features of this approach and its advantages. A recent paper (attached) provides additional material.

To start with a basic example, let us assume that the government makes available a \$1,000-\$1,500 per worker "flexible benefits" tax credit for low to moderate income workers. Here's how the flexible benefits provisions could work:

* A worker without employer provided health insurance would be expected to use this credit to purchase health insurance, via automatic enrollment and payroll withholding at his/her workplace. If a worker did not elect to use a credit to purchase private health insurance, by declining in writing, the tax credit would be assigned to state government for safety net coverage (a "default" option). Thus all eligible workers would have health insurance coverage, either through a private health insurance plan of his/her selection or a public program. A \$1,500 premium (e.g. a

\$1,000 tax credit plus about a \$10/week worker contribution) would support a Medicare-level benefit for workers.

* A worker who has health insurance coverage, but does not have an employer-provided retirement/savings plan, could elect to have his/her \$1,000–\$1,500 flexible benefits tax credit paid into a retirement/savings plan (such as an IRA). With a \$1,500 tax credit (and \$500 worker contribution) annually, a worker could anticipate savings of \$150,000 or more at retirement (in current dollars). A two-worker family could invest twice the amount and have twice the total account balance. IRA funds can now be withdrawn for higher education, first-time home purchase, and catastrophic medical expenses. Early distributions from retirement/savings plans that use flexible benefits tax credits could similarly be made available for these purposes.

* A worker who already has employer-provided health insurance and a retirement/savings plan could elect to receive his/her \$1,000–\$1,500 flexible benefits tax credit as cash income.

For American families, a flexible benefits tax credit would thus offer a menu of assistance options from which they could choose depending on their differing circumstances, as well as on how their needs change over time. While 42 million Americans now lack health insurance coverage, measured at a point in time, lack of health insurance coverage is most often a short-term problem—for example, six months to a year. At other times, a family's financial needs may include higher education or first-time home purchase. For older workers, such as baby-boomers, retirement savings becomes an important issue. About one-half of the workforce now lacks employer-offered retirement/savings plans.

A flexible benefits tax credit could also be used to provide incentives for coverage of uninsured children, particularly the 94% of uninsured children below 200% of poverty—6.7 million children—who are already eligible for Medicaid or SCHIP but are not signed up. Workers could be required to have health insurance for their children (signing them up for SCHIP or Medicaid, or purchasing private coverage) as a condition for receiving flexible benefits tax credits for their own health insurance coverage. The flexible benefits tax credit would be an incentive, e.g. \$2,000/couple, for childrens' coverage.

As illustrated by the above example, a flexible benefits tax credit design can broaden benefits (and potential political support) without additional budget costs. If there were a \$1,000–\$1,500 per worker single-purpose tax credit, for example, expanding it into a flexible benefits tax credit (to include such benefits as retirement savings, higher education, first-home ownership, etc.) would not increase government's budget costs (which would still be \$1,000–\$1,500 per worker). But it would offer workers more opportunities to use such credits and would appeal to advocates for more causes.

A flexible benefits tax credit also maintains incentives for employer group health insurance. Stand-alone health insurance tax credits often include higher subsidies for employers' health insurance to lessen the chances of unravelling employer group coverage. This just makes current subsidies more expensive. A flexible benefits tax credit handles these issues directly and with potential public appeal. It provides the same tax credit for workers with and without employer health benefits, and this maintains the existing tax advantages for employer group insurance. Workers who now have employer group health insurance could elect to receive their flexible benefits tax credit as cash (a retirement/savings plan contribution or immediate income). This gives these workers, rather than employers, the additional income.

A flexible benefits tax credit offers a means to close the major gaps in health insurance coverage—which are mostly among workers and their families—and in retirement/savings plans. The national savings rate, for example, is now at its lowest rate in more than 40 years, and many in the baby boom generation are not saving enough for retirement. Increasing savings thus can be a prudent investment in the economy's growth, as well as in the financial security of American families.

A flexible benefits tax credit would be compatible with a number of different tax reform ideas. The attached paper provides a more detailed discussion, including two examples, and estimates for increased coverage and federal budget costs. A \$1,000 per worker tax credit targeted for about 2/3 of the workforce, for example, would cost about \$70 billion annually, or \$785 billion (inflation adjusted) over 10 years, less than 30% of the available \$2.7 trillion surplus. The paper also considers topics such as Medicare benefits as a benchmark, the role of employers, automatic enrollment, flat credits for lower-income workers, direct payment of credits to health and retirement/savings plans, and federal-state regulatory roles.

In closing, let me return to my opening observations. A flexible benefits tax credit offers a new approach to accomplish many of the goals that this Committee has been considering in separate legislative proposals. A flexible benefits tax credit could achieve health insurance coverage for most uninsured workers (with Medi-

care-level benefits) and children, and offer a future with real economic security for American families (several hundred thousand dollars of retirement savings). These would be important benefits for many millions of American families, and a flexible benefits tax credit would give them new choices to elect such benefits. I believe they would welcome these benefits and these choices.

Chairwoman JOHNSON. Thank you, Mr. Etheredge. Dr. Pauly.

STATEMENT OF MARK V. PAULY, PH.D., PROFESSOR, HEALTH CARE SYSTEMS, WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PENNSYLVANIA

Dr. PAULY. Thank you, Madam Chairman and Members of the Committee for inviting me today. I am Mark Pauly, Professor of Health Care Systems and Economics in the Wharton School at the University of Pennsylvania. I am happy to be here today to discuss the results of my research and policy analysis with Bradley Herring, now at Yale, that appeared in a recent issue of Health Affairs.

We analyzed options for the design of refundable tax credits intended to assist people in buying health insurance. We focus on the most numerous population group among the uninsured, those who are not poor, but have family incomes too low to allow everyone to afford health insurance. If you define this group as people with incomes between 125 and 300 percent of the poverty line, 40 percent of the uninsured fall into this category.

There are three important characteristics about this group of uninsured people. First, there is general agreement that they are uninsured primarily because the premiums for insurance are high relative to their incomes. The problem is affordability, and there is no better solution to this problem than a subsidy that lowers the net premium for insurance. Hence, critics of this approach who say it will be ineffective cannot at the same time maintain that the problem is lack of affordability.

Second, people in this group can nevertheless afford to pay something for their insurance, just not the whole premium. In fact, most people in this income bracket do obtain private insurance, and even the uninsured on average pay substantial amounts out of pocket for medical care. For them, even a partial credit, what some critics of this approach call a "10-foot rope for someone in a 30-foot hole" is of considerable value because they do have some resources. They have some rope down in the hole themselves, and the trick is to figure out how to tie the pieces together.

Finally, as we emphasized at great length in the article, all estimates of the impact of tax credits are fraught with uncertainty, and therefore it is important to build in flexibility in any policy design, rather, I think, than regulating to prevent anything possible that could go wrong.

The most important design feature of any credit plan is how generous it will be to the target population. There is more here though than just the general observation, if you spend more money, you are going to get more effect. Our research suggests that there is a very pronounced notch or threshold below which credits have small effects, and above which effects become much larger.

For example, we estimate that a credit of half of the premium for an average policy will reduce the number of uninsured by about half, whereas a 25 percent credit will only affect a few people, primarily those who are not wage workers. Here is why. Take a worker who has not taken an insured job and who is in the lowest marginal income tax bracket. The value of the exclusion is about 30 percent, combining the payroll and the income tax, and the loading for individual insurance is 15 to 20 percent higher than for group insurance. So someone in this situation would need a credit of at least 45 to 50 percent just to be as well off, tax wise and cost wise, as they would have been had they taken a job that offered the insurance options they rejected. The punch line here is: credits will work.

Second, another design feature is the specification of the policies that qualify for a partial credit. At one extreme the required policy might be very comprehensive. At the other extreme, there might be minimal restrictions in terms of coverage and cost sharing, effectively requiring only that the premium be at least as large as the credit. Then there should be virtually universal take-up of a policy that many will regard as parsimonious. The punch line here: some insurance, even if incomplete, is better than none.

The third design feature is whether the credit is offered to everyone who obtains a qualified insurance policy at a given income level, or whether those who are currently insured or who are offered insurance in an employment-based group plan should be ineligible. If the credit is fairly generous, but is restricted to those not in groups, there will be an incentive to employers and employees to drop coverage in order to claim the larger credit. There will be crowd-out. The economically efficient policy here is somewhat counter-intuitive. The best credit is a neutral one made available to all, regardless of how they obtain coverage, and the higher budgetary cost for such a plan, relative to a targeted one, is not a real cost to the economy, but only a tax reduction, and one that to boot improves both equity and efficiency. It is, after all, manifestly unfair to offer a credit to someone who has neglected thus far to obtain insurance, while denying it to someone at the same income level who already made the sacrifices needed to take the job that provided coverage. The punch line: tax credits or tax cuts are for the lower-middle class, and should be offered to all.

The final design feature is the form of administration. The punch line here, I think, is: arm millions of people with credits and private insurers will find them.

My own preferences in this matter are to suggest an adequately funded minimally restrictive credit plan, and be prepared to learn from the experience with such a program, and especially the experience with a transformed individual insurance market. In particular, I would suggest credits on the order of \$1,500 for self-only coverage, and \$3,500 for family coverage, and permit those credits to be used for health insurance offered either by a private or a public insurer. These credits could be made available in the form of a redeemable coupon, \$1,500 off your next insurance policy.

All people with incomes in the target range would be eligible for credits even if they obtained employer-paid coverage, but the value of the tax exclusion will be netted out of the credit in the latter

case. It would also be desirable eventually to offer larger credits, equal approximately to the premium for a comprehensive policy, for people with incomes below 125 percent of poverty. They could use these credits for CHIP, Medicaid, a government-contracted plan, or for a private plan of equivalent coverage. The most fundamental point, however, is that after years of talking about helping the uninsured, tax credits provide us a way to do something, and we ought not to make the unattainable perfect the enemy of the feasible good. Thank you.

[The prepared statement of Dr. Pauly follows:]

Statement of Mark V. Pauly, Ph.D., Professor, Health Care Systems, Wharton School, University of Pennsylvania, Philadelphia, Pennsylvania

Thank you, Madame Chairwoman, and members of the committee for inviting me today. I am Mark Pauly, Professor of Health Care Systems and Economics in the Wharton School of the University of Pennsylvania. I am happy to be here today to discuss the results of my research and policy analysis. Much of the background for my remarks was published in a recent issue of Health Affairs and represents joint work with Bradley Herring.

We analyzed options for the design of refundable tax credits intended to assist people in buying health insurance. We focus on the most numerous population group among the uninsured: those who are not poor but have family incomes too low to allow everyone to afford health insurance. In our analysis we defined this target group as families with incomes between 125 percent and 300 percent of the poverty line; more than 40 percent of the uninsured fall into this category. We also offer some comments on the uninsured with lower family incomes.

There are three important characteristics of information about this group of uninsured people. First, there is general agreement that they are uninsured primarily because the premiums for insurance—either explicit premiums they pay directly or implicit premiums they (like most of us) pay by making a sacrifice in cash income to take a job that carries health insurance—are high relative to their incomes. The problem is “affordability,” and there is no better solution to this problem than a subsidy that lowers the net premium for insurance. Hence critics of this approach who say it will be ineffective cannot at the same time maintain that the problem is lack of affordability. Second, people in this group can nevertheless afford to pay something for their insurance, just not the whole premium. Most people in this income bracket do obtain private insurance, and even the uninsured on average pay substantial amounts out of pocket for medical care, money they could better use for health insurance premiums. For them, even a partial credit—what some critics of the refundable credit approach have called “a ten foot rope for someone in a thirty foot hole”—is of considerable value because they do have some resources; they have some rope themselves, and the trick is to figure out how to tie the pieces together. Finally, as we emphasize at great length in the article, all estimates of the impact of various tax credit plans on insurance purchasing behavior (including our own) are fraught with uncertainty; there is a wide range of plausible values, and no valid way to narrow it. To us, this means that any tax credit plan should be designed to deal with uncertainty, not (as is sometimes the case) by trying to regulate every possible thing that could go wrong, but rather by designing policies that will work reasonably well (though not perfectly) no matter what happens, and by planning to make adjustments in the program as it is phased in and information begins to be generated.

The most obvious and most important design feature of any credit plan is how generous it will be to the target population. In this case, however, there is more than just the general observation that offering larger credits for a given insurance policy will get more people to take it. Our research suggested that there is a very pronounced “notch” or “threshold,” below which credits have small effects and above which effects become much larger. For example, we estimate that a credit of half the premium for an average policy will reduce the number of uninsured by half, whereas a 25 percent credit will only affect a few people, primarily those who are not wageworkers. There are two reasons why the credit has to be moderately large. First, all wage workers would be eligible for a subsidy associated with exclusion of employer provided premiums if they chose to take a job at a firm that offered coverage. For people who choose a job that does not pay all or most the premium, the value they attach to insurance must fall short of the group premium by an amount greater than the exclusion subsidy. Moreover, if they are to use the credit for a

nongroup policy, the insurance premium will be higher than that of the rejected group option, because the administrative cost associated with that individual insurance is higher. Take someone in the lowest marginal income tax bracket. The value of the exclusion is about 30 percent (combining the payroll tax and the income tax), and the loading for individual insurance is 15 to 20 percent higher than for group insurance. So someone in this situation would need a credit of at least 45 to 50 percent just to be as well off as they would have been after taking the option they rejected. However, a credit of 50 percent for a policy with a loading of 30 to 40 percent means in effect that one pays less for the premium than the coverage of out of pocket payments the person expected to get back: for the person of average risk, insurance is a no-lose proposition. (The availability of charity care may temper this motivation).

A second important design feature is whether the credit is a fixed dollar amount (e.g., \$1500 for self-only coverage) or pays a proportional share of the premium. In the individual market, premiums vary to some extent with risk—primarily with age and location, though not with health levels if the person did not wait to become insured before becoming sick. A fixed dollar credit will equal the premium for lower risk young people, but become a smaller proportion of the premium for higher risk middle-aged people. So the tradeoff, for a given average per person subsidy, is between covering a large number of lower risks or a smaller number of higher risks. Our estimates suggest that, at credits at about the 50 percent level, the same amount will cover up to 20 percent more of the uninsured if made available as a fixed dollar credit, although this difference shrinks as the credit grows. A possible design, present in the plan suggested by President Bush during the campaign, is to define the credit as the lesser of a fixed dollar amount or a proportional credit. At the modest \$1000 level he proposed, the program would effectively provide a fixed dollar credit to almost everyone who bought a comprehensive plan.

Another design feature is the specification of the policies qualified for the credit. At one extreme, the required policy might be very comprehensive—assuring adequate (if not excessive) access to care, but imposing on any buyer a substantial payment, large enough to discourage many from purchasing. At the other extreme, there might be minimal restrictions in terms of coverage and costs sharing, effectively requiring only that the premium be at least as large as the credit. Then there should be virtually universal take-up, but of a policy that many will regard as parsimonious. We think it also important that qualified policies could be purchased either from private insurers or from a publicly contracted or operated plan.

A third design feature is eligibility for the credit by income level. For both fiscal and administrative reasons, it seems sensible to offer large credits to lower income families, and smaller or zero credits to others (e.g., people with incomes above the median). The latter group currently are rather generously subsidized by the exclusion, so modest credits for them would rarely be taken up. But reducing credits with income does offer some disincentive to earning more income, and may be complex to administer. These observations suggest that any credit should not phase down too rapidly, and that perfect targeting by income might be compromised in favor of administrative simplicity.

The fourth design feature is whether the credit is offered to everyone who obtains a qualified insurance policy at a given income level, or whether those currently insured in an employment-based group plan should be ineligible. If the credit is fairly generous but is restricted to those not in groups, there will be an incentive to employers and employees to drop group coverage in order to claim a larger credit (as long as the qualified insurance is reasonably priced relative to group insurance); there will be “crowd out.” The economically efficient policy here is somewhat counterintuitive: the best credit is a neutral one made available to all regardless of how they obtain coverage, and the higher budgetary cost for such a plan (relative to one targeted only to those not offering or taking employment-based coverage) is not a real cost to the economy, but only a tax reduction, and one that improves both equity and efficiency. It is, after all, manifestly unfair to offer a credit to someone who has neglected to obtain insurance while denying it to someone else at the same income level who already made the sacrifices needed to take the job that provided coverage. The correct economic view of a credit as a tax cut is to be distinguished from the erroneous “target efficiency” view that is often taken of this problem.

The final design feature is the form of administration, encompassing mechanisms for identifying who is eligible for credits, making them aware of the program, getting the credit to them in a way that minimizes cash flow problems when they buy insurance, and assuring that they do take advantage of the program for which they are eligible. For people who pay federal taxes, both income taxes and payroll taxes, a credit can be applied to those liabilities. Since such taxes are withheld periodically from wages, the net effect of such credits would be increase cash wages, thus fur-

nishing the disposable income needed to pay any remaining premiums. Since all workers are required to make an estimate of their tax liability when they fill out a W-4 form for employment, the Treasury Department does have this information. In the interest of simplicity, it is probably better to offer credits of only one or two different dollar amounts to people within a given income range. Once the W-4 form is used to identify those eligible for credits, they need to be informed of the program. It should be easy for them to participate. Existing Medicaid and CHIP programs involve complex processes of eligibility determination that cause more than a third of eligibles to fail to apply. One simple device would be to offer workers not already covered annual “\$1500 off” coupons, which could be redeemed by insurers or insureds for periodic credit payments. Any deviations in end-of-year income from the original estimated income could be adjusted as part of the income tax process. Private insurers would be expected to seek out people who have a substantial subsidy for the purchase of their product.

The most problematic feature of proposals to make credits available for private insurance is the current rather unimpressive state of the private individual insurance market in the United States. As already noted, the main problem in this market is that administrative costs are high. There is also some risk rating, though the presence of guaranteed renewability features and other protections required by the HIPAA law mean that few in this market pay higher premiums because of chronic illness. One reason why the product is expensive is that it is bought only by a small fraction of the overall insurance market, only by about 6 percent of all private insurance purchasers. The small scale which makes the breakeven premium high and the need for substantial selling efforts for a costly product would both be much changed if a large-scale program of credits were available. If 18 million new buyers, armed with substantial credits, entered this market, it is very likely that product quality would improve, selling costs would fall, and such risk screening as there is would diminish greatly. Putting in place a high-risk pool should allow the few high risks who fall through the cracks to be supported.

What do these issues imply for policy design? The most obvious need is to have some serious considerations of the tradeoffs just outlined—between the size of the credit and the extent of effect, between covering many low risks or fewer higher ones, between being fair in treatment of employment based insurance and treating credits as government expenditures rather than taxes, and between requiring comprehensive but unaffordable coverage and incomplete but affordable insurance. Our article provides some empirical estimates to help with these tradeoffs, but the data do not uniquely anoint a single best plan, so that some policy debate and decision making is needed.

My own preferences in this matter are to suggest an adequately funded, minimally restrictive credit plan and to be prepared to learn from experience with such a program. In particular, I would suggest credits on the order of \$1500 for self-only coverage and \$3500 for family coverage, and permit those credits to be used for health insurance offered *either* by a public or a private insurer. These credits could be made available in the form of redeemable coupons, with reconciliation with total income at the end of the tax year. All people with incomes in the target range would be eligible for credits, even if they obtained employer-paid coverage, but the value of the tax exclusion would be netted out of the credit in the latter case. It would also be desirable to offer larger credits, equal to the premium for a comprehensive policy, for people with incomes below 125 percent of poverty; they also could use these credits either for a CHIP, Medicaid, or government contracted plan, or for a private plan of equivalent coverage.

Before fully opening the private market to the poor, it would probably be best to wait to see if the improvements in functioning we expect that follow from substantial credits to lower middle income people do materialize. It would also be desirable to encourage (or at least not obstruct) the emergence of alternative group purchasing arrangements for individuals and small employers, such as “Health Marts” and the like.

The most fundamental point, however, is that, after years of talking about helping the uninsured, tax credits provide a way to do something. They furnish a vehicle that can be kept free of regulatory restrictions, that does not require public decisions about exactly what insurance people should have, and that gives people the wherewithal to afford the health insurance that they feel is best. We ought not to make the unattainable perfect the enemy of the feasible good.

Chairwoman JOHNSON. Thank you, Dr. Pauly. Ms. Singer, a pleasure to welcome you to Washington.

STATEMENT OF SARA J. SINGER, EXECUTIVE DIRECTOR, CENTER FOR HEALTH POLICY, SENIOR RESEARCH SCHOLAR, INSTITUTE FOR INTERNATIONAL STUDIES, STANFORD UNIVERSITY, STANFORD, CALIFORNIA

Ms. SINGER. Thank you. Good morning. Chairwoman Johnson and Members of the Committee, thank you for inviting me here this morning to discuss potential solutions to the problem of the uninsured. It is very nice to be back.

My name is Sara Singer. I am a senior research scholar at Stanford University, and Executive Director of the Center for Health Policy.

As I left home yesterday to come here, I explained to my almost-2-year-old daughter, Audrey, that I was invited to Washington by some very important people, to help them find a way to make sure that when she grows up, she will always be able to see a doctor when she needs to. In very simple terms, this is my hope and my purpose here today.

To reduce the number of people who lack insurance requires both subsidies to make coverage affordable, and cost containment to keep it affordable. This cost containment could be achieved by providing multiple choices, structured competition, and incentives to select high-value plans.

Only a small minority of purchasers today have created these conditions. They include the Federal Employees Health Benefits Program, the California Public Employees Retirement System and Stanford University. Though these are prominent purchasers, alone they have not transformed the health care delivery system. Transforming health care delivery will require that providers actively seek ways to cut costs without harming quality, and this in turn requires that a significant portion of their patients demand value.

I would like to share with you some ideas for creating the necessary conditions for effective health care reform. These have been generated through discussions with colleagues, Alan Garber and Alain Enthoven at Stanford, at the invitation of the Economic and Social Research Institute, and with sponsorship of the Robert Wood Johnson Foundation. Our plan has six key elements.

First, insurance exchanges for individuals and groups, to offer choice and promote competition among plans based on price and plan quality.

Second, a United States Insurance Exchange, USIX, a Federal insurance exchange program like the Federal Employees Health Benefits Program, to serve as a backup for individuals and firms with fewer than 50 employees.

Third, refundable tax credits for low to middle income individuals to purchase insurance through an exchange.

Fourth, a default plan that would support safety net providers. Those eligible for subsidies who do not choose a plan would be automatically enrolled in the default plan.

Fifth, a phased-in cap on the exclusion of employer or individually paid health benefits to encourage value-based purchasing.

And, finally, sixth, a new Insurance Exchange Commission, like the Securities and Exchange Commission, with narrow, specific powers to oversee the exchange market and to distribute the tax credits and the default plan payments.

The President's proposal, like ours, would use tax credits to expand coverage, but his proposal offers considerably smaller subsidies targeted to low-income individuals and employment groups without coverage. These small tax credits are unlikely to reduce substantially the number of uninsured due to low take-up rates and crowding out of employer-provided coverage. Even for those who receive tax subsidies, there may not be a viable market to purchase coverage due to adverse selection.

Insurance exchanges can create a structured and competitive market, and facilitate expanded coverage at little cost. They can increase insurance coverage whether subsidies are large or small, and they would require little change if subsidies start small and are expanded later.

The simplest approach to creating an insurance exchange at the national level is to form a USIX, like the Federal Employees Health Benefits Plan (FEHBP) available to Federal employees. USIX could encourage development of high-quality coverage, priced within reach of those eligible for subsidies, and it could structure the market to create competition and combat adverse selection.

I also suggest that you consider default plans, that is, automatic enrollment in default plans for subsidy-eligible individuals who do not enroll themselves, and default payments tied to performance. This mechanism would subsidize safety net providers and would create incentives for preventive care, that should reduce hospital costs, and for expansion of coverage.

In conclusion, any serious proposal for reform of health care financing should include elements of competition that encourage consumers to seek value, and subsidies for lower income individuals. I urge you to support a proposal that would do both. Thank you very much.

[The prepared statement of Ms. Singer follows:]

Statement of Sara J. Singer, Executive Director, Center for Health Policy, Senior Research Scholar, Institute for International Studies, Stanford University, Stanford, California

Forty-three million Americans without health insurance is a serious and complex problem. I would like to thank Chairwoman Johnson and the other Members of the Subcommittee for this opportunity to discuss potential solutions.

To reduce the number of people who lack insurance requires both a health care system that delivers good value health insurance products given the dollars available and makes them accessible to all, as well as subsidies for individuals for whom the price of coverage is out of reach. Competitive models like the Federal Employees Health Benefits (FEHB) Program, the California Public Employees Retirement System (CalPERS), or Stanford University contribute to the first of these goals by offering multiple choices, structuring the competition among them, and providing incentives for individuals to select high-value plans (e.g., defined contributions). Though prominent and important examples, these purchasers represent a small minority of the health insurance market so by themselves they cannot be expected to transform the delivery system. Most employers offer one or few choices and pay more for more expensive health care plans thus weakening or eliminating incentives to choose economical health plans. Transforming health care delivery will require that providers

actively seek ways to cut costs without harming quality. This, in turn, requires that a significant portion of their patients demand value.

My colleagues Alan Garber and Alain Enthoven and I, at Stanford University's Center for Health Policy, recently formulated a proposal to achieve near-universal health insurance by satisfying both requirements. We carried out this work as part of a project organized by the Economic and Social Research Institute and sponsored by the Robert Wood Johnson Foundation. In doing so, we sought to make a wide range of health insurance choices available to all Americans, to encourage consumers to seek high value coverage through improved competition and personal economic responsibility for choices, to increase support for care to those who remain without insurance, and to accomplish this without mandates on employers.

Our plan would provide near-universal coverage among the non-Medicare population by making private plans more affordable. It would do so by using insurance exchanges to promote competition among plans. The exchanges would provide information about plan prices and plan quality, enabling consumers to make informed choices and obtain good-value health insurance. Our proposal includes the following key features:

- **Insurance exchanges** (public or private entities or employers) would offer individuals a choice of at least two health plans (one that provides some coverage for treatment by most providers, and a low-priced alternative) in every geographic region. Considerably more choices would be desirable, including point-of-service (POS) or preferred provider organization (PPO) products as well as closed-panel health maintenance organizations (HMOs) and newer alternatives such as defined-contribution "care groups." Non-employer exchanges would accept all individuals not eligible for Medicare and groups in their service area (guaranteed issue) at a flat premium rate (community rating), with adjustments only for covering additional people, such as a spouse or dependents. Exchanges would perform at least minimal risk adjustment (initial risk adjustment would be based on age) and/or rely on other mechanisms to limit the financial rewards to plans for engaging in practices that encourage risk selection, to preserve choice among plan types and create incentives for plans to enroll and care for high-cost patients. Exchanges would also participate in risk adjustment between insurance exchanges in a region or state. Exchanges would require quality measurement and would make available comparative information to help members make informed choices. Substantial incentives would encourage development of private exchanges. These include tying new subsidies to purchase of insurance coverage through an exchange, preemption from state insurance mandates (i.e., ERISA protection), and protection from adverse selection.

- The **U.S. Insurance Exchange** (like the Federal Employees Health Benefits Program) would serve individuals and firms with fewer than 50 enrollees in areas in which private exchanges do not emerge.

- **Refundable tax credits** for health insurance valued at 70% of the median cost plan for lower- and middle-income Americans (individuals with incomes up to \$31,000/families up to \$51,000, phased out for individuals with incomes between \$31,000 and \$41,000/for families with incomes between \$51,000 and \$61,000) who purchase insurance through an exchange.¹ In contrast to families in higher tax brackets, today such households have limited financial incentives for purchasing private health insurance plans.

- Individuals, eligible for tax credits, who do not enroll in a health plan, will be automatically enrolled in a **default plan** designated by the state to provide basic health care services. Default plans will be federally funded through performance-based grants initially equal to 50% of the tax credit. They will enable states to provide new financing for public hospitals, clinics, and other providers who meet standards of open access, as part of their default plan. States will receive incentive bonuses or reductions based on the extent to which they improve performance on a set of preventive care measures (e.g., childhood vaccinations, first-trimester pregnancy visits, hypertension control) and reduce the percentage of the population that remains uninsured. The goal is to ensure that every eligible individual is enrolled in a health plan.

- Other individuals would continue to exclude from taxable income their employer—or individually-paid health insurance, but a **phased-in cap** would limit this exclusion from taxable income for employer—or individually-paid health insurance benefits to encourage value-based purchasing. Individuals eligible for both the exclusion and the subsidy could choose which of the two tax benefits to use. The dollar

¹Any phase-out of subsidies will create high marginal tax rates in the phase-out zone. This is a problem that must be addressed. We recommend beginning the phase-out at income levels above the phase-out of earned income tax credits and other means-tested benefits. Extending the phase-out range would further alleviate the problem, but would also be more costly.

value of the cap would be set high enough to represent a substantial subsidy, yet low enough to provide substantial new financing for expanding health insurance coverage and other purposes.

- A new, independent **Insurance Exchange Commission** (IEC) with narrow, specific powers, similar in function and structure to the Securities and Exchange Commission, would be created to distribute new subsidies and default plan payments, accredit insurance exchanges, conduct risk adjustment across insurance exchanges, and serve as a clearinghouse for public information on the quality of health plans. This agency would have an appointment procedure and organization structure similar to that of the Securities and Exchange Commission, and would have a similar function—to encourage smooth information flow and functioning of insurance exchange markets.

This proposal contains many similarities with the proposal offered by President Bush as a candidate. The President's proposal, like ours, would use tax credits to expand coverage. The President's proposal differs from ours in that it offers smaller subsidies, targeted to lower-income individuals in employment groups without coverage. Unless they are larger, tax credits are unlikely to reduce substantially the number of uninsured due to low take-up rates and crowding out of employer-provided coverage. Even for individuals who receive tax subsidies, there may not be a viable market for these individuals to purchase coverage.

Adverse selection has made it nearly impossible to guarantee access to coverage and choice of plans to unaffiliated individuals in a system of voluntary health insurance. This is true despite attempts by the federal and state governments to ameliorate the problem through legislation providing for continuity of coverage for those who leave or change jobs and programs such as high-risk pools. The low level of subsidy proposed by President Bush would likely do little to improve the selection problem in an unstructured market.

The creation of a structured and competitive market through insurance exchanges can facilitate expanded coverage at little cost. Further, it can be an important part of any strategy to increase insurance coverage, whether subsidies are large or small. In addition, a system based on insurance exchanges would require little change if subsidies were expanded in the future to include more people.

The simplest approach to creating the benefits of an insurance exchange at the national level is the creation of one similar to the one available to federal employees. In our proposal, USIX would be a national exchange that would serve as an entry point for low-income, uninsured individuals, who would become eligible for new subsidies to purchase coverage. Like the FEHB Program, CalPERS, and Stanford University, USIX would offer competitive insurance choices. USIX could encourage development of high-quality coverage priced within reach of those eligible for subsidies. USIX would mitigate many of the market imperfections that plague the individual market (for example, through risk pooling, community rating, guaranteed issue, and competition). USIX could also determine limited benefit standards to provide reasonable comparability among plans and to prevent risk selection and segmentation. USIX would achieve economies of scale in brokering plans and would be capable of providing information about plan quality to individuals. Tax credits would promote higher-value health insurance options offered through USIX by exposing consumers to price differences.

A second feature of our original proposal worth consideration is automatic enrollment in default plans for subsidy-eligible individuals who do not enroll in a health plan. States would receive a payment initially equal to 50% of the new tax credits for these individuals and would apportion these funds to providers, such as public hospitals and clinics that they designate as default providers. States will receive bonuses or reductions based on performance. This mechanism would provide needed financing for safety net providers to care for those automatically enrolled in default plans as well as incentives for preventive care that should reduce hospital costs and expansion of coverage among subsidy-eligible individuals.

Any serious proposal for reform of health care financing should include elements of competition that encourage consumers to seek good value given the dollars available and subsidies for lower-income individuals. Our plan, like several similar plans, offers both and provides a path for further expansions in coverage in the future.

Chairwoman JOHNSON. Mr. Larsen.

Mr. POMEROY. Madam Chairman, if I just might say a salutary word about Mr. Larsen. He comes to the position of Insurance

Commissioner with extensive prior experience, both as legislative aid to the Insurance Committee in Maryland, as well as private practice work for USF&G. He has been—my brother was formerly the Insurance Commissioner of North Dakota and a colleague of Commissioner Larsen, so I know personally of his good work and very high credibility with the Nation's insurance regulators.

Chairwoman JOHNSON. Thank you, Mr. Pomeroy. Mr. Larsen.

STATEMENT OF STEVEN B. LARSEN, MARYLAND INSURANCE COMMISSIONER, BALTIMORE, MARYLAND, AND CHAIR, HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. LARSEN. Thank you very much.

Chairwoman JOHNSON. Now, you see, you must be very good.

[Laughter.]

Mr. LARSEN. Thank you for those comments from one commissioner to another, and I am very glad to be here. Thank you for the opportunity to testify.

As was mentioned, I am current Commissioner/Chair of the Health Insurance Committee at the NAIC and also cochair of a Maryland task force to study the individual market, and I would like to just provide a few comments about the current characteristics of the individual market, which I think will be most important. That is the market into which recipients of a tax credit would be going to purchase their coverage. And I think many of us think about insurance companies and their job being that of paying claims, but I think companies would view their job as managing risk. And the way they do that is through pricing policies and underwriting policies, high risks high prices, bad risks frequently excluded from coverage.

And I think the most vivid example of those types of practices was when the small group market became dysfunctional in the late 1980s and early 1990s, in which pre-existing condition exclusions, non-renewals, price spikes were characteristic of the market at that time and that is what led to the enactment of almost nationally across all the States, small-group market reforms, which include guaranteed issue, guaranteed renewability, and modified or full community rating.

Importantly, the individual market shares the same characteristics that the small group market did back when these reforms were initiated. Insurers today use the same types of risk management techniques, pricing and aggressive underwriting, in the individual market. But currently the individual market is much less regulated and has much fewer consumer protections than does, for example, the small group market today. Only 19 States have any rating restrictions. That means that insurers can determine rates based on health conditions when they issue policies, with no upper limits on the initial rate or rate increases upon renewal. Only 12 States have some form of a guaranteed issue. I know that you all passed Health Insurance Portability and Accountability Act of 1996 (HIPAA) a few years ago, but HIPAA provides limited protection for those who are moving from group coverage into individual coverage.

I would just like to share with you some statistics that I think highlight some of the problems that you see today in the individual

market. As part of our task force review in 1999, we did a survey, and we found, for the largest carrier in Maryland, the Blue Cross plan, Care First, that 32 percent of the individuals who applied for individual coverage were rejected under their medical writing standards. Now, those individuals had the option of going into an open enrollment product that we have in Maryland, but that product was substantially inferior with fewer benefits than the medically underwritten product. Last year the legislature tried to remedy that by making a richer benefit package for the open enrollment products, and immediately Care First came in with a rate increase of 100 percent for the product.

Recently, the Kansas Insurance Commissioner had the opportunity to compare rates between the individual and small-group market in her State. And just to give you an example, she looked at a small group plan with \$1,000 deductible, and for an individual the rate ranged from \$73 to \$122 a month. She then looked at a comparable individual market policy, and the rates were almost double the rates that you got in the small group market. And it was only by increasing the deductible five-fold that you end up with comparable rates. So you would have ended up with a policy, to get comparable rates in the group market, the deductible would have gone up to \$5,000.

And I think clearly, the higher deductible policy premiums are lower. It is difficult to imagine with some of the target population, the uninsured could afford such a high deductible to get comparable rates.

It is also very difficult to shop currently in the individual market because there is little standardization, products vary by age, gender, health and many other factors. And the individual market is very fragile. There have been a number of States in which the individual market has collapsed because of a number of different factors. Both in Kentucky and Washington, I think, every carrier at one point had withdrawn from the individual market. Many States do have high-risk pools, but again, rates are frequently very high and the coverage varies in those pools.

In conclusion, I would just like to say, of course it is very important that we look at every option for expanding access and coverage to individuals who do not have health insurance, but I would just caution you that looking currently to the individual market as a way to accomplishing that, I think, at this point is a risky proposition. And with that, I would be happy to take any questions.

[The prepared statement of Mr. Larsen follows:]

Statement of Steven B. Larsen, Maryland Insurance Commissioner, Baltimore, Maryland, and Chair, Health Insurance and Managed Care (B) Committee, National Association of Insurance Commissioners

I. Introduction

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Steve Larsen. I am the Insurance Commissioner for the state of Maryland. I would like to thank you for providing me with the opportunity to testify about the characteristics of group and nongroup health insurance markets, and how any federal legislation might impact those markets. Also, I am the chair of the National Association of Insurance Commissioners' (NAIC) Health Insurance and Managed Care (B)

Committee. Although the NAIC¹ does not have an official position on the variety of proposals being discussed to combat the problem of the uninsured and I am not testifying on behalf of NAIC, as chair of the NAIC's health committee I have been privy to numerous discussions on health policy issues affecting the insurance markets across the country. In 1999 I also served as Co-Chair of the Maryland Task Force to study the Non-Group Health Insurance Market.

One of the proposals Congress is considering is the use of tax credits to encourage the purchase of insurance in the nongroup (or individual) market. Without commenting on the adequacy of any particular tax credit to buy such a product, I think it is important that Congress understand the differences between and characteristics of group and nongroup markets before deciding on whether tax policy will be effective as a method of addressing our nation's uninsured problems.

II. Insurance Markets

The purpose of insurance is to spread risk among as large a group of people as possible ("pooling"). By creating larger pools, insurers reduce the uncertainty of the occurrence of insurable events and can more accurately predict the losses the group will suffer. Groups are better able to absorb increased claims costs of individuals within the group among the group as a whole. As such, insurance is the "law of large numbers."

Insurers manage risk through pricing policies and underwriting. Higher risks are priced at higher levels, and particular risks, individuals with particularly costly diseases, may be declined by insurers seeking to manage their risk.

Large groups, because of the law of large numbers, have never been a particular regulatory problem in group health insurance. However, in the late 1980s and early 1990s, small group reform was initiated in the states to combat the aggressive pricing and underwriting practices insurers were using. These techniques included long pre-existing condition limitations, large annual rate increases, and nonrenewal of policies due to claims experience, also called claims underwriting. State reforms included making small group policies guaranteed renewable, requiring insurers to issue policies to all small groups, limiting or doing away with any preexisting condition exclusion when a job is changed but coverage is seamless, and limits on pre-existing condition exclusions, typically six or 12 months, or less. The Congress later adopted many of these concepts in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

One of the most important consumer protections the states have adopted to protect small groups is to limit the rates an insurer can charge to a small group. Today, 46 states have enacted some form of rating restrictions for small group insurers. The most typical arrangement is a limitation from the highest rate charged to the lowest rate charged based on an index rate. These types of limitations can still result in considerable variation from one small group to another, even up to 100% variation from the lowest to the highest rate. But it is a limit. A smaller number of states (approximately 17), Maryland included, have taken stronger steps to restrict rates in this market by enacting adjusted community rating provisions. These provisions generally prohibit the use of health status and claims experience in setting rates for particular small groups.

The individual market is subject to the same pressures as the small group market. In fact, many believe that "adverse selection" is more likely in the individual market because those who are willing to shop for and purchase a policy on their own are the individuals most likely to access benefits under the policy. Insurers use the same techniques in the individual market as they did in the small group market to manage risk.

The individual market, however, is far less subject to the types of consumer protections that have been applied to the small group market. Only 19 states have rating restrictions of any kind. That means insurers can determine rates based on health conditions when they issue the policies, with no upper limits on the initial rate or on rate increases upon renewal. Only 31 states have limitations on the use of preexisting condition exclusions. That means insurers can permanently exclude named conditions—the insured will never have coverage for those conditions. Only 12 states have some form of guaranteed issue. That means insurers can reject coverage entirely based on health status. And it is important to remember that HIPAA provides none of these protections. The only protection HIPAA provides for the individual market across the board is guaranteed renewability of policies. (HIPAA also

¹ The NAIC, founded in 1871, is the organization of the chief insurance regulators from the 50 states, the District of Columbia, and four of the U.S. territories. The NAIC's objective is to serve the public by assisting state insurance regulators in fulfilling their regulatory responsibilities. Protection of consumers is the fundamental purpose of insurance regulation.

provides guaranteed issue for persons coming off group health coverage of at least 18 months, but it provides no protection regarding how much individuals can be charged for the coverage).

Some statistics are enlightening. A survey done by the Maryland Insurance Administration showed that the Maryland BlueCross/Blueshield plan, CareFirst of Maryland, rejected 32% of the 18,000 people who applied for individual coverage in 1998. Those who were rejected, up until this year, had as an option to buy an open enrollment product, without medical underwriting, that had substantially fewer benefits than the underwritten product, even though the open enrollment product is subsidized by the state. This year, when benefits of the open enrollment product were increased, Carefirst sought an increase in some age bands of over 100%.

The Kansas Insurance Commissioner recently had occasion to compare premium rates in the small group and individual markets. The monthly premium rate for a small group plan (\$1,000/\$2,000 deductible; \$1,000/\$2,000 80%/20% coinsurance maximum) from one insurer was:

Insured: \$73–\$122

Insured/Dependent(s): \$196–\$326

A comparable individual plan offered by the same carrier had the following rates:

Insured: \$58–\$215

Insured/Dependent(s): \$176–\$652

Only by increasing the deductible five-fold do the rates become comparable. An individual plan with a \$5,000/\$10,000 deductible lowers the premium range to:

Insured: \$34–\$120

Insured/Dependent(s): \$90–\$322

While the small group market does contain rate fluctuations, there is an upper limit because of rating restrictions, and the fluctuation is not nearly as dramatic as that in the individual market. Importantly, generally people in small groups cannot be refused entrance into the market for medical reasons. Although the higher deductible policy premiums are much lower, it is difficult to imagine that the targeted market, the uninsured, could afford such a deductible or would find what is essentially catastrophic coverage, rather than comprehensive coverage, attractive.

Also, “shopping” for individual health coverage is quite complicated for consumers. While most insurance departments have consumer representatives, web sites and printed materials, the individual market varies so dramatically with a consumer’s age, gender, health, and other factors that many people are very confused about what to buy and how to find the best buy.

These facts suggest that efforts to direct individuals to the individual market as a way to address all uninsured problems should be undertaken with caution. In addition, the individual market is a fragile one. One need only remember the crisis that befell Kentucky and Washington State when they attempted reforms of the individual market: they were left with virtually no companies as insurers left the market in droves. States have been understandably cautious ever since.

Larger groups provide buying clout in the market, spread the risk, and protect individuals against fluctuations of smaller pools. It is for this reason that many states have looked to strategies to pool groups together, using high-risk pools for adverse risks, expanding public programs such as SCHIP and Medicaid, and even opening public employee groups. By the same token I am not aware of any state that has looked to the individual market as the solution for uninsured citizens.

III. Beware of Association Health Plans

While Congress is considering how to reduce the number of uninsured persons, I want to strongly caution you against looking to Association Health Plans (AHPs) as a “magic bullet.” As consistently expressed in the past by the National Governors’ Association, the National Conference of State Legislatures and the NAIC, the creation of AHPs outside the state regulatory structure may very well result in hurting the very small business employees that you are trying to help. If exempted from state regulation, AHPs would “cherry pick” the healthiest people from state risk pools. Premiums for those remaining in the state-regulated market would rise as the coverage base declined. Those groups unable to join an AHP will be priced out of insurance. In addition insurers, who are under an obligation to “guarantee issue” all products to any small group, will be forced to cover groups that leave the AHP for more comprehensive coverage when a group member becomes ill. Insurers will then abandon the small group market as it loses its necessary proportion of healthy workers. Thus, AHPs will lead to the ultimate outcome of deregulation or collapse of the small group market. Such a result does not serve consumers very well. As the numbers show, there is no real evidence that an unregulated market (individual) is more cost-effective than a regulated market (small group), except for the healthiest risks.

States have enacted substantial reforms to the small group market in order to make insurance more accessible and affordable. In a report last year, the Congressional Budget Office (CBO) confirmed this analysis. CBO found that 80 percent of workers in small employers would see their health insurance premiums rise if AHPs were exempted from state regulation.

In addition, let us not forget the past and be destined to repeat it. In the 1980s, inadequate oversight of multiple employer welfare arrangements (MEWAs) resulted in rampant fraud and abuse, leaving consumers in nearly every state responsible for millions of dollars in unpaid medical bills. Congress and the Department of Labor subsequently addressed this issue by clarifying that MEWAs fall under state regulatory authority. Current AHP proposals would again grant regulatory authority to federal regulators who lack the necessary experience and resources to oversee these plans, thus recreating the same circumstances that caused the 1980s MEWA nightmare.

It is important to remember that the states, not the federal government, have pioneered improvements in the health insurance market. Long before debate about a national Patients' Bill of Rights or access reforms began, states were developing innovative insurance market reforms to address consumer needs. Exempting AHPs from state regulation will deny states the opportunity to maintain the important consumer protections they created.

IV. Conclusion

While it is vitally important that we continue our efforts to increase access for those millions of American consumers who do not have health insurance, care should be taken to ensure that any solutions provide meaningful options to those we are trying to assist. Currently the individual market is characterized in many states by higher prices, more limited access and stricter underwriting than group markets. Thank you for the opportunity to testify.

Chairwoman JOHNSON. Thank you very much. Thank you very much. Ms. Singer, do your health exchanges—your insurance exchanges, would they overcome the kind of problem that Mr. Larsen is describing? Would they serve individual buyers, enable them to get group rates, and for society to manage the risk issues involved that have already increased cost in the individual market?

Ms. SINGER. That is the idea, and I think that would be the result. They would act like large employers do, and so the individuals who have subsidies, purchasing through the exchange, would have all the benefits of large employment groups: guaranteed issue and renewability, community-rated premiums, multiple choices, information about those choices, and et cetera.

Chairwoman JOHNSON. And in California is there experience with this kind of mechanism that also involves risk—management of risk across plans?

Ms. SINGER. Yes, in the small group market, the Pacific Business Group on Health manages Pac Advantage, which used to be called the Health Insurance Plan of California (HIPC), which was previously managed by the State. PBGH risk adjusts premiums across plans within that marketplace to accommodate for plans that get different risk mixes.

Chairwoman JOHNSON. And that is the largest HIPC in the country, is it not?

Ms. SINGER. Yes, it is.

Chairwoman JOHNSON. Mr. Etheredge, why do you think \$1,000 is going to make a difference, when the average cost of family coverage is over 3,000?

Mr. ETHEREDGE. Well, I think \$1,000 is probably the lowest number you ought to consider. I get to \$1,000 by starting with the

Medicare benefit package. These are estimates done by Gordon Trapnell, of the Actuarial Research Corporation. A Medicare benefit package for the working population will now average about \$1,500 per worker. That is much less than the typical policy that is sold, but we all know Medicare has a lot of things it doesn't cover, like prescription drugs, and has very high deductibles—I guess we are getting close to \$1,000 now in Part A and Part B. And then I look at the fact that we ask Medicare enrollees to pay over \$600 a year, and they are on an average Social Security benefit of \$10,000. So, at a bare-bones level, I am thinking we should try to assure at least the Medicare benefit. That is what we have had as a national standard, and ask workers to pay something, maybe comparable to what we ask elderly people to pay. And that logic leads me from a \$1,500 premium, and I subtract out about \$10 a week, \$500, as a reasonable contribution from the worker. So, a \$1,000 tax credit per worker, as a national average, could support a Medicare-level benefit.

That isn't the national average health plan, but I think if you told uninsured people that they could get a Medicare benefit, and the government will be paying two-thirds of the cost, that is probably a viable proposal. So that is how I got to \$1,000. I would be happier personally with a more generous policy, but I think it is an interesting exercise to reason that through.

Chairwoman JOHNSON. Thank you. I am going to limit my questions. You are just an excellent panel, very good, and I appreciate it.

And if each Member takes about 3 minutes, and then if we have time, we will come back for a second round, but you all get to question before we vote. Mr. Stark.

Mr. STARK. Thank you, Madam Chair. I would like to thank the panel. In the brief time we have, I guess I would like to ask Mr. Larsen two questions. One, what is the experience in the States in general, regarding the sale of very high-deductible policies? Are they popular? In your opinion, do they provide a meaningful assistance?

And before you answer that, I am going to recall the experience we had back in the nineties with kid's health insurance. The companies came forth with a lot of policies that offered \$50 a day if they were hospitalized, and almost what I would classify as meaningless insurance. So, what does an insurance commissioner do in terms of protecting the consumers from paying for a policy where the benefits won't really provide health care? I mean, they will provide little pieces of it, but not a broad coverage?

Mr. LARSEN. Well, ultimately the consumers have the choice. I think as a practical matter, high-deductible policies are not the preferences of many consumers, and in fact, consumers often aren't able to have the foresight to understand that they are paying a low premium now, but actually when it comes time to need the coverage, they are sometimes surprised to learn that the coverage is low or they don't have the coverage until they have spent 5,000 or 10,000 out of their own pocket. So I think conceptually there may be appeal for that. I think as a practical matter, I don't think those are attractive to many consumers.

Mr. STARK. Ms. Singer, welcome back. It appears that Mr. Enthoven has had an epiphany judging by the HIPCs that are missing from your testimony, which I can only suggest is the best thing I can say. You do suggest that unless there are larger tax credits, it is unlikely to reduce the number of uninsured, and you also suggested there may not be a viable market for individuals to purchase coverage. Do you have a figure in mind as a ballpark figure of where these credits would have to go, or the subsidy would have to go in terms of dollars, to provide an adequate coverage for individual or family today?

Ms. SINGER. Well, I haven't done the type of research that Professor Pauly has done, but I am working with a nonprofit organization in California, to look at what they could provide at a much-reduced price to serve those receiving a low level of subsidy. The issue we are struggling with is that this managed care organization is used to providing first-dollar coverage. They are considering increasing levels of cost sharing, as opposed to implementing high deductible.

From the perspective of a consumer, who would be a subsidy recipient, the notion that they would be covered for catastrophic care, but not for first-dollar coverage, is probably not terribly attractive.

Mr. STARK. But how do you get that dollar figure? You don't have it?

Ms. SINGER. My point is that plans could offer a lower-priced product to accommodate a low level of subsidy. I don't have a dollar figure. I am sorry.

Mr. STARK. And the last thing—because my time is up—is, Mr. Larsen, would you expound a little bit, in layman's language, on the real dangers to the new rise in the association health plans, and how they can really harm small businesses rather than help them?

Mr. LARSEN. Well, I think whenever you set up a system of insurance that is outside State regulation, you do a couple things. One, you get rid of all the consumer protections that are in place for the small businesses, guaranteed issue, guaranteed renewability. You essentially, I think, end up destroying, as we saw previously under the Multiple Employer Welfare Arrangement (MEWA) example, the existing insurance market, all the, quote, good risks end up going to the unregulated market. It leads to so-called bad risk, people with sicker employees in the insured market, and then you get into what even laymen call an actuarial death spiral, where rates go up and up and up, and you drive people out. At least laymen that I hang around with use that term.

So, you know, we had that model many years ago, and I think from a regulatory and consumer perspective, it was a failure.

Mr. STARK. Thank you. Thank you, Madam Chair.

Chairwoman JOHNSON. Mrs. Thurman. And you have as much time as you—we have 5 minutes to vote, and they hold it open 2 minutes, so 6 minutes left? 6 minutes left. Mr. McCrery is coming back.

Mrs. THURMAN. OK. I won't take that long. Mr. Larsen, you had said in your opening things that there were consumer issues that needed to be addressed, and if you could get those to me, I would really appreciate that. That is the only question, because I think

this is a very important issue if we are looking at any kind of—I don't want to spend \$1,500 on a tax credit and find out that it has all been spent on administrative costs, quite frankly. I want something that is actually going to do what it was intended to do, and that is to take care of the uninsured in this country, and I think we need to really look at some of those issues out there. So if you could get some of that to us, I would appreciate it. Thank you, Madam Chairman.

Chairwoman JOHNSON. Thank you. Now, Mr. McCrery is going to come back, if you could hang around and—actually, I have a minute, so I am going to ask Ms. Singer if you could respond to Mr. Larsen's comments? In other words, are there and maybe Mr.—either one of you might have some comment on this, because the problems he points to are the current problems with the individual market, and what we have to look at is if we provide a tax credit to individuals to increase their buying power, can we also provide them with a way of buying? Now, you can through some of the new proposals, reduce the cost of marketing very clearly, and certainly both of your proposals do that, so that reduces cost considerably. And we had earlier testimony that 30 or 40 percent of the premium is marketing. So that is really a big bust. And then ERISA has demonstrated that ERISA protection can provide lower cost plans in the market, so you can drive cost down that way. And can you then also deal with this issue of risk in such a way that the individual market doesn't look at medically underwriting every individual? Ms. Singer, and then Mr. Etheredge and Dr. Pauly?

Ms. SINGER. Yes. I think that you can address the issues that the individual market is experiencing through pooling those individuals into groups. I think it helps a lot that they are subsidized individuals and would lose those subsidies if they don't purchase something in the market so they have a strong incentive to purchase something. But I think that giving them the opportunity to purchase through a group is a key element, and I don't think that it has to be necessarily an employment group, but some other mechanism and that is why we have proposed—

Chairwoman JOHNSON. Dr. Pauly.

Dr. PAULY. I think it is wrong to look at today's individual insurance market and imagine that is what it would look like, even without additional regulation, if you offered substantial subsidies. The reason why administrative costs are so expensive in the individual insurance market, paradoxically, is because individual insurance is so expensive. So the companies have to offer substantial commissions to persuade people to take this over-priced insurance.

If, on the other hand, you offer a tax credit of 50 or 60 percent of the premium, the stuff will sell itself. And there has actually been experience in States that have cross-subsidized individual coverage. When the cross-subsidy is generous, the administrative cost for the individual coverage falls down to the 15 percent level, so that is sort of the first point. I think it is a mistake to look at today's individual insurance market and imagine that is what it would be like if you transformed the financing.

The second point I want to make is I think it is a mistake to obsess about risk segmentation in that market. What we know is, if we community rate, maybe that is more just, but it doesn't get

more people insured. It leaves the number of uninsured the same. The real problem with the individual insurance market, as I have written, is not that it is expensive for high risks, it is that it is expensive for everybody. And one way to get that down is to offer the subsidy itself, and the other is to offer the opportunity of group insurance purchasing, although I am somewhat skeptical about how much you can lower costs there. A custom suit is a lot more expensive than an off-the-rack suit, and even if I buy my custom suit from Sears, it is still going to cost a lot of money. If you sell things on a one-on-one basis, it does cost more. But I think there is some real opportunity to get those costs down, many of which—many of the opportunities which would be caused by the availability of subsidies.

Chairwoman JOHNSON. Mr. Etheredge, 1 minute.

Mr. ETHEREDGE. Sure. I think there are two sets of regulations that would be useful, assuming we want a Federal/State framework where most regulation still rests with the State government. The first is HIPAA type regulation of no preexisting condition or medical underwriting, and that could be applied to the group of people eligible for the tax credit. So simply extending HIPAA to people eligible for tax credit will solve that medical underwriting problem.

The second set of rules you need after availability is rating rules. There I would say you could have a fairly straightforward Federal rule which says if the State uses something other than community rating, it has to adjust the credits to match the factors that are used by the insurance plans. So you want to make sure the credit matches what the premium variations will be.

Chairwoman JOHNSON. In other words, there are possibilities. I do think it is significant that Maryland is one of the highest—the States with the highest number of State mandates, and of course, the individual market is controlled by State mandates, and part of the goal would be to provide a buying option that would allow people to get out from under State mandates like most employer plans are under State mandates.

Unfortunately, my time is expired, so that I really do have to go, but Mr. McCrery is returning within minutes. So I will recess the hearing, but as soon as he gets back, he will begin his questioning. Thank you very much for your testimony, and we will be back in touch with you, and if you care to add comment from hearing the comments of your co-panelists or those that preceded you, we would be happy to receive those. Thank you.

[Recess.]

Mr. MCCREY. [Presiding.] The hearing will come back to order. Thank you all, members of the panel, for waiting for us to get back from the vote. I am sorry I missed the questions from the other Members of the Subcommittee, and forgive me if I cover some of the areas that they have already covered.

First of all, let me say I am very appreciative of the time that all of you have given us. I know that you all are very well-respected experts in the field of health care and insurance, and so it is very nice of you to come all the way from California or Penn or Maryland to be here with us today.

I have a lot of questions, and some comments. I guess I will start with Dr. Pauly. You said that the perfect shouldn't be the enemy of the good, and we will do what we can, and you proposed a tax credit scheme. What good will your plan do? What is the good that your plan does?

Dr. PAULY. I think there is a number of things. The most obvious one, at least according to our estimates, is it would cause a substantial number of the currently uninsured to purchase or obtain insurance because it would make it affordable for them. Second, it would put in place—at least the version we have that would offer this credit to people who got insurance, no matter how they got it—it would put in place the appropriate neutral incentives for people to decide how to get their insurance. If their employer can arrange insurance in an attractive way, then that is an appropriate way for people to obtain their insurance in a group, and group insurance is actually one of the greatest inventions known to mankind.

On the other hand, particularly small groups and distracted small employers don't do a very good job of arranging insurance, and when they do buy the insurance, their employees hate it. And I guess our thought here is that by giving those—instead of under the current situation, offering a tax-related bribe to let your boss arrange your insurance, if you could get the same tax credit either way, then the harried small employer and the irritated workers might be better off going to a non-group, at least a non-employment-base group setting or maybe an individual setting. So I think those are probably the two main advantages, that it would help everybody who needs serious help to get insurance, and it would set in place incentives for them to make the right choices about where to get that insurance.

Mr. MCCRERY. About what percentage of the uninsured do you estimate would get insurance under this plan?

Dr. PAULY. Well, our ballpark estimates would be for the kinds of credits we propose, it would be more than half of the uninsured, probably on the order of 60 percent or so because the credits are on the order of 55 to 60 percent of the premium.

The other point though that I think is important to make, although I wish I could tell you more about it, we are convinced that above and beyond the design of the credit, the other absolutely most important thing is kind of the marketing of the insurance. If you follow the Medicaid and make the subsidy hard to get, if people have to have a face-to-face interview, as they do in New York, in order to establish eligibility, you will have the same experiences with Medicaid. And the simple thought, and my modest proposal, is if you mail people these coupons, you can use the power of private enterprise to market its product. After all, those coupons don't turn into money until an insurer sells a product. And I have hope—or maybe it is faith—that that would substantially—that would be a better way—a good way of getting to the uninsured and reminding them of the value of insurance as opposed to the sort of public service announcement approach, which we tend to do for Medicaid.

Mr. MCCRERY. Have you estimated the cost of your proposal?

Dr. PAULY. No, I have not. It will be high though if you offer credits of that order of magnitude to everyone, although, as I said in my remarks, I think the right way to look at that is as a tax

cut, and it potentially could substitute for the less-directed tax cuts that are currently being contemplated, could be included in that.

Mr. MCCRERY. Fine. Does your proposal do anything about cost and the health care system?

Dr. PAULY. It would help to lower the administrative costs. If you subsidize insurance, then insurers have to put much less resources into persuading people to buy it. It will sell itself, and if it sells itself, you don't have to pay commission to an insurance agent.

As to overall health care costs, there is, of course, the general belief that if you offer people neutral incentives, they may choose policies that are more cost containing, because there is no longer a subsidy at the margin, and so high-deductible policies, medical savings accounts, or even fairly strict managed care plans, where you are being rewarded for the bother by having a lower premium. So I think that would be the main impact.

My view of what is currently happening is that the rises in health insurance premiums are largely driven by the increased spending on new drugs, which I think the market has already told us—since most employers are not cutting back—workers really value that coverage. And so I think it is not important not to focus too much on cost, or spending growth, as if it were necessarily evil. What you want to do is get the right rate of spending growth—and here again, it is kind of the economists' perspective—if you get the incentives right, which what I am talking about would do, neutral tax credit proposals, then whatever rate of spending growth comes out of that you can feel reasonably confident is the right rate.

Mr. MCCRERY. Well, let me just interject. I don't think costs are evil. I just think we need to do a better job of containing costs. Otherwise, we are going to find ourselves with public policy makers containing cost for the system, and that—

Dr. PAULY. Well, I think we need to do a better job of convincing ourselves, if we can, that the costs we are incurring are worth the—the benefit is worth the cost.

Mr. MCCRERY. Exactly. But that should be up to the marketplace and not up to government to decide how much we should spend on health care.

Dr. PAULY. That is right.

Mr. MCCRERY. If hundreds of thousands of individuals every day in the marketplace decide they want that drug, then they can pay for it. But for us to create a global budget and say everything has got to fit within this global budget, it is a recipe for dumbing down the health care system, in my opinion.

Dr. PAULY. Yeah. I have been trying to get investors for my new HMO, whose slogan is going to be, "Last year's technology at last year's premiums."

[Laughter.]

And I haven't gotten very far, so I think there are worst things than growing premiums. It depends on what the money goes for.

Mr. MCCRERY. Right. But again, if you allow those premiums to be generated by private decision-making, you are probably going to have more money spent on health care than if we create a budget for it, and the quality of health care is likely to be better as a result. Do you have a problem with that?

Dr. PAULY. No, I don't.

Mr. MCCRERY. Ms. Singer, welcome back. It is nice to see you again, both you and Dr. Pauly, who have been kind enough in the past to suffer through my questions and educate me a little bit about health care and health insurance.

You propose a cap on the tax exclusion. Do you know where you would put the cap? Would it be \$5,000 or the average cost of a policy, or where would you put the cap?

Ms. SINGER. What we propose more specifically in our plan is to phase down the current tax exclusion. We would start at double the price of the median plan, and we would reduce that over a 10-year period to the price of—essentially the price of a median plan, that is actually the price of last year's median plan plus 5 percent, which we assume will account for increasing premiums.

Mr. MCCRERY. OK. So eventually you would get to allowing the tax exclusion for up to the cost of an average plan basically. And you would do that to foster the consumer seeking value?

Ms. SINGER. Well, actually, to encourage employers to offer employer contribution policies that would encourage consumers to seek value, yes.

Mr. MCCRERY. Wouldn't it be more effective if consumers themselves were shopping for their own value? In other words, rather than having the employer do all the work in coming up and saying, "Here is your product", wouldn't it be more effective from a seeking value standpoint, if each consumer were out in the marketplace shopping for that product?

Ms. SINGER. Do you mean paying for 100 percent of the premium?

Mr. MCCRERY. Sure.

Ms. SINGER. Actually, the important point is that the consumers pay the marginal cost—the difference between the prices of different plans. So it is important that consumers have choices, but absolutely every choice may be more detrimental if this creates a bewildering array of choices.

Mr. MCCRERY. I understand that. But assuming that we could put in place a structure somewhat like you suggested so that consumers would have a marketplace kind of a store to go to to shop and choose from among a variety of plans, wouldn't it be more effective from a value standpoint and getting value in the marketplace, to have each of those consumers going and making those decisions themselves, rather than the employer doing it?

Ms. SINGER. Absolutely. Individual choice is very important.

Mr. MCCRERY. Yes, I agree, individual choice is important, but isn't it also important in terms of cost in the system, making the consumer aware of the true cost of purchasing that health care?

Ms. SINGER. Yes, absolutely. If consumers are aware of the differences in the prices of plans, they are more likely to seek value when they choose their plans, and we hope that this will encourage consumers to begin to demand value. When the consumers demand value, then the providers who are providing services to those consumers see it in their interest to begin to try to provide value, and that is a big part of what is missing now. Both the consumers and the providers don't see it in their interest to seek value, and so the health care delivery system isn't cutting costs where it is possible

to cut costs and still either improve quality, or at least not harm quality.

Mr. MCCRERY. I couldn't have said it better myself.

Ms. SINGER. Thank you.

Mr. MCCRERY. Very well stated. Mr. Larsen, you talked about some other—I don't know what State it was; maybe it was Maryland, maybe another State, and somebody went out in the market and bought a product in the small group market and it cost X, and then somebody went out in the individual market and bought essentially the same product, and it cost 2X. Is that—

Mr. LARSEN. Yes. That was a comparison done by one of the States for roughly a comparable policy between small group, individual market.

Mr. MCCRERY. In that small group market, was that composed of employer groups?

Mr. LARSEN. Yeah. The small group markets generally is groups up to either 25 or 50, generally 50, with a number of reforms wrapped around that market to make sure that there is access, renewability.

Mr. MCCRERY. Are the employers in that group under ERISA?

Mr. LARSEN. The small group is generally a regulated market, so that is the insured market that States can regulate, yes.

Mr. MCCRERY. So they are subject to the same mandates that the individual market would be?

Mr. LARSEN. Yes.

Mr. MCCRERY. Have you—do you have any studies that tell us the increase in cost due to State mandates?

Mr. LARSEN. I can get that to you. The Maryland Health Care Commission actually has done a study on the marginal cost of mandates, Maryland being, I guess, some would say for better, some would say for worse, the king of the mandates. That study demonstrated that it was actually a relatively small, meaning less than 5 percent marginal cost due to the mandates. I know there is a lot of generalized discussion that mandates add a lot of cost, but in fact, at least in Maryland we have found that that was not the case. And I would be happy to get that study to you.

Mr. MCCRERY. Yes, I would like to see that. Did any of the other panelists say anything on the increased cost due to State mandates?

[No response.]

Mr. MCCRERY. No. And you mentioned some reforms in the small group market, and I believe one of the reforms was community rating within that market.

Mr. LARSEN. Yes. Some States have pure community rating, and some have modified community rating, right.

Mr. MCCRERY. And I know some States, New York I guess being the best example, mandated community rating in their insurance industry, and you saw insurance companies leaving the State, and some say because of the community rating mandate. And while that is true, part of that, I suppose, was because they could go elsewhere, they could go to other States that didn't have community rating and sell their products and make more money. And so they left. What if we had community rating on a nationwide basis,

wouldn't that solve a lot of the problems that we have in the insurance marketplace today?

Mr. LARSEN. Well, I think it might solve the particular problem that you are referring to, in that it then doesn't make sense to move to a neighboring State because the rules are the same. There are a lot of issues surrounding community rating, how to do it, what the particular characteristics of the marketplace are. I think that is why some States have pure community rating and some States have modified community rating. And I think it is why States regulate insurance, why we have a State system of regulation, is that marketplace do vary from State to State. But in answer to your question, if the particular problem you are trying to solve is leaving one State because I can get a better deal in the next State, I think that would address it, but it might raise a number of other issues.

Mr. MCCRERY. Well, it would negate the need for assigned risk pools and all that that we do to try to cover people that can't get insurance in the regular market, wouldn't it?

Mr. LARSEN. I am sorry?

Mr. MCCRERY. If you do nationwide community rating, it would solve the problem of assigned risk pools, trying to come up with some device to get products to people that can't get them in the marketplace today, they are too expensive?

Mr. LARSEN. Again, I think community rating has benefits and disadvantages, and there are some—there are definitely some advantages to it and some disadvantages to pure community rating. I guess it is hard for me to speculate what the effect of a national community rated system will be.

Mr. MCCRERY. Anybody else on the panel have any thoughts before I give it to Mr. Pomeroy?

Mr. ETHEREDGE. I think where you are going is asking the question:—if government comes up with a tax credit, how much regulation do we need from the Federal level of this market? If you start with the assumption that you want as much regulation as possible left at the State and local level, rather than have the Federal government getting into that, there are two basic sets of rules I think are needed to make a tax credit work. One is availability of the product, and there I think you can extend the HIPAA rules and say no preexisting condition exclusion. So the tax credit eligible groups get the HIPAA protection. That makes the insurance available.

The other set of rules is rating rules. There could be a community rating standard, since we have a level tax credit. You can add one more rule, and that is that, if a State is going to allow insurance companies to depart from community rating, it would need to provide subsidies that match those rating rules. So if a State allows age and sex variations, it has to come up with the money, maybe with a Federal matching equalization fund that adjusts the credits for those factors. If insurers have a geographic difference in premiums, a State has to provide for this difference in adjusting the credit.

So HIPAA has to make available the policies, and basic rating rules so that the tax credit matches the premium. I think those are at least the two logical essentials.

Mr. MCCRERY. OK.

Dr. PAULY. I presume you would have to allow for some geographic variation in the premium. If you had a national uniform standard, you would reduce the number of insured in New York, but raise them in Louisiana. So some kind of modified community rating would probably not do a great deal of harm, although I personally think it wouldn't do a great deal of good for the number of uninsured. It would change the composition of the uninsured population to be more higher risks and fewer lower risks, and maybe some people would think that is an improvement, but I doubt it would affect the head count very much.

My own belief is that an awful lot can be done to solve the problem of what happens to high risks by putting more emphasis on guaranteed renewability and on the idea that people should be subsidized to buy insurance while they are still low risk, and have that insurance contain the provision, as it required by HIPAA now, even for individual insurance, that if you remain insured, your premium cannot be increased by more than the average for your group, and that effectively protects you against the disaster of being a high-risk person and not being able to obtain insurance at reasonable premiums.

So the problem with community rating, of course, in the extreme version, is people only buy insurance when they think they are going to be sick, which of course, then makes it very expensive for everyone. So, personally, I would rather see much more emphasis on guaranteed renewability and that type of device before we go to community rating, and then if it turns out—as I said in my remarks, you need to be flexible—if it turns out that there is still a substantial number of high-risk people without coverage, then we might think of what best to do for them. But in some sense, by definition, the number of people who are unusually high risk is bound to be a small fraction of the total population, and it does seem a bit disproportionate to me to want to restructure the whole insurance market just to deal with that small fraction. Perhaps they can be handled reasonably well with a properly run high-risk pool, coupled with guaranteed renewability to make sure that most people don't get in that pool.

Mr. MCCRERY. Well, thank you very much. I certainly wouldn't go to a community rating standard absent significant other reforms, such as an individual mandate to purchase and other things that would solve our problem. So I didn't mean to imply that we should just change that element of the market.

Well, thank you all very much for your testimony and for responding to our questions, and we look forward to working with you as we try to solve the problem of the uninsured, and other problems in our health care system.

Thanks.

[Whereupon, at 12:36 p.m., the hearing was adjourned.]

[Questions submitted by Mr. Crane, and Dr. Pauly's response follow:]

WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA
Philadelphia, Pennsylvania 19104-6218

April 12, 2001

1. *It is my understanding that a non-refundable tax credit can achieve the same tax result produced by an appropriately tailored tax deduction. Would you elaborate more on this similarity?*

Both a tax credit and a tax deduction can reduce taxes by the same amount for a given individual, so in that sense both can produce the same result. For example, if I am in the 28% marginal income tax bracket, my taxes would be equally affected by a \$1000 credit or permission for me to take a \$3571 deduction. However, the difference is that a given dollar tax credit produces a uniform tax reduction to all who are eligible, whereas a given dollar deduction produces different amounts of tax reduction depending on the person's marginal tax rate. If one wanted to reproduce the credit's effect with a deduction, one would have to have limits on the deduction that varied inversely with the marginal tax rate, which would be complicated. More generally, deductions tend to offer lower tax reductions to lower income tax payers who pay lower marginal rates, while credits can be made uniform or made to increase as income falls. Deductions also are often limited to those who itemize on the individual income tax return, while credits need not depend on how a person calculates their income taxes.

2. Are there differences in the cost associated with providing a tax credit vs. a tax deduction?

If a tax deduction and a tax credit both provided the same tax reduction to a given individual for the same activity (e.g., obtaining a specific health insurance policy), both devices would have the same budgetary cost and the same real resource cost.

3. Can you discuss more the differences between refundable and non-refundable tax credits?

Refundable tax credits provide a money refund to individuals whose credit exceeds the value of their tax obligations. Compared to a non-refundable credit, refundable credits permit larger subsidies to be directed to people with low tax liabilities.

4. Isn't it true that a refundable tax credit could yield a negative income tax, which would be the equivalent of an appropriation?

A refundable credit could produce a negative tax balance to an individual whose credit exceeded that person's income and payroll tax liabilities. The Treasury treats this as an appropriation. There is, however, an economic difference between "appropriations" which simply transfer income to individuals and appropriations which go to pay for public expenditures that draw real resources out of the private sector for public purposes.

5. In your opinion, are there instances where refundable tax credits could become a mandatory entitlement program?

Since any tax credits I have considered have been defined in dollar terms and are under the control of the legislature, I find it hard to see how they could become entitlement programs—unless the Congress wanted to set up an entitlement program.

Sincerely Yours,

MARK V. PAULY
Chair

[Submissions for the record follow:]

Statement of Advanced Medical Technology Association

AdvaMed is pleased to present this testimony on behalf of the world's leading medical technology innovators and the patients we serve. AdvaMed represents over 800 of the world's leading medical technology innovators and manufacturers of medical devices, diagnostic products and medical information systems. Our members are devoted to helping patients lead longer, healthier and more productive lives through the development of new lifesaving and life-enhancing technologies.

AdvaMed shares the concerns of the Members of Congress, the Administration and millions of working Americans about the number of people in our country lacking access to affordable health insurance today. Our nation enjoys the best health care system in the world, and everyone should have full access to it. While today's market-based system provides insurance coverage to the majority of Americans, and along with it access to most of the latest, breakthrough technologies, some 43 million Americans are currently uninsured.

To bridge the current gaps in insurance coverage, AdvaMed has consistently supported maintaining tax incentives to encourage companies to offer health benefits to their employees, as well as expanding tax incentives to allow individuals to more affordably purchase coverage. As supporters of market-based health care and competition, AdvaMed also believes consumers should have a wide choice of health plans and coverage options that allow them to select those that best fit their needs.

To expand the number of choices available, AdvaMed supports the creation of Individual Membership Associations or Association Health Plans to allow groups to leverage size for more affordable health options, as well as the expansion of Medical Savings Accounts, which have already helped address the insurance needs of a select group of previously uninsured Americans. To address the many problems facing individuals with uninsurable medical conditions, AdvaMed also supports efforts to encourage states to offer “risk pools” that help them access insurance that will meet their complex and costly health care needs.

America is on the cusp of a revolution in medical technology. Through advances in technology we can detect diseases earlier when they are easier and less costly to treat, provide more effective and less invasive treatment options, reduce recovery times and enable people to return to work much more quickly. Insurance coverage and adoption of medical advances is crucial not only for the health of America’s insured workers, but also helps lower overall health care costs.

Medical technology has advanced to the point where it is fundamentally transforming our health care system in ways that improve quality and reduce costs. For example:

- Three types of laparoscopic surgery have generated approximately \$1.9 billion annually in increased productivity by enabling people to return to work more quickly, according to a study by DRI–McGraw Hill.
- Angioplasty and other minimally invasive heart procedures, for example, have greatly reduced the need for riskier, more expensive heart bypass procedures. An angioplasty procedure costs \$20,960 on average, compared to \$49,160 for open-heart surgery. Surgeons can complete an angioplasty procedure in 90 minutes compared to 2–4 hours for open bypass surgery. Patients can leave the hospital in one day instead of 5–6 days, and recovery only takes one week rather than 4–6 weeks for bypass.
- Total knee replacement produces an average one-time health care cost savings of \$50,000 per patient; a savings of \$11.5 billion in 1994 alone, according to the American Academy of Orthopedic Surgeon (AAOS).

A recent article in the *Washington Post* highlights another of the many advances transforming health care delivery: a health care information system that alerts doctors at Brigham and Women’s hospital to potentially dangerous medical decisions. The system has cut the medication error rate at Brigham by 86% compared to 10 years ago.

Information systems like these can dramatically improve the safety and efficiency of health care delivery and help reduce health care costs. Automation in the insurance industry alone could save an estimated \$20 billion. That is why both the President’s Information Technology Advisory Committee and the Institute of Medicine in its recent report on health care quality have stressed the need for a new health information infrastructure.

Steady declines in mortality rates, medical procedure times, hospital stays and patient recovery times all illustrate the emergence of the New Health Economy. Gains in workforce productivity and accelerating declines in disability rates point to this shift as well.

In order to reap these benefits, advanced medical technologies must be rapidly assimilated into the health care system. The Institute of Medicine’s recent report, “Crossing the Quality Chasm,” underscored this point, stating: “Narrowing the quality chasm will make it possible to bring the benefits of medical science and technology to all Americans in every community and this in turn will mean less pain and suffering, less disability, greater longevity, and a more productive workforce.”

In a recent statement on the Medicare Trustees’ Report, Treasury Secretary and Medicare Trustee Paul O’Neill cited this IOM report in highlighting “tremendous potential for improvements in the health care sector.” AdvaMed shares this concern, as well as Secretary O’Neill’s understanding of the importance of adopting new technologies and medical practices that can transform the health care sector by improving quality and reducing costs. As Chairman of Alcoa, O’Neill championed the adoption of so-called “disruptive” technologies as the solution to rising health care costs. In a recent *Forbes* article, O’Neill stated: “It is possible to improve the health and medical care value equation by as much as 50%.”

Again, AdvaMed applauds Congress for addressing the many needs of the uninsured in America. We look forward to working with the Congress and the Administration on efforts to help increase access to affordable coverage, as well as improve the quality, efficiency and cost effectiveness of the health care system through innovative medical technology.

Statement of American College of Physicians—American Society of Internal Medicine

The American College of Physicians—American Society of Internal Medicine (ACP-ASIM or “the College”) represents over 115,000 physicians who specialize in internal medicine and medical students with an interest in internal medicine. ACP-ASIM’s membership includes practicing physicians, teaching physicians, residents, students, researchers, and administrators who are dedicated to assuring access to high quality medical care for all Americans.

We appreciate this opportunity to present our comments on the needs of uninsured Americans and we are pleased that the Subcommittee on Health is addressing specific steps to facilitate access to health insurance coverage for the nation’s uninsured population.

As physicians, the primary mission of our members is to care, to heal, to advocate for the sick, and to promote the good health of the individual and the nation. On a daily basis, internists see the delayed treatment and poorer health that results from a lack of insurance. The College believes that it is unconscionable for the United States to allow tens of millions of its citizens to go without health insurance simply because they cannot afford it.

In 1999, ACP-ASIM launched a major campaign to address the problem of the uninsured. Our campaign has included a three-pronged effort of research, public education and advocacy: research on the health consequences of a lack of insurance; a public education campaign to inform policymakers, candidates, and the public about the adverse health consequences of being uninsured; and advocacy of core principles and a sequential plan on how the health care system should be reformed to achieve affordable access to care for all Americans.

The College’s plan to expand health insurance coverage includes the expansion of public programs, the implementation of a refundable tax credit, and other measures. ACP-ASIM will continue to press for solutions until we have achieved affordable, accessible health insurance for all Americans.

America’s Uninsured Population

The latest statistics from the Census Bureau indicate that roughly one out of every six non-elderly Americans or nearly 43 million people in the United States—have no health insurance. Millions more have some health insurance, but lack adequate coverage to provide financial access to needed health care or sufficient protection from catastrophic medical expenses.

- Nearly two-thirds of the nation’s uninsured persons live in a family with an income less than 200% of the federal poverty level (FPL). Thirty percent live in a family with an income between 100 and 199% FPL and another 35% live in a family with an income less than 100% FPL. In 2000, FPL for a single person was \$8,959 and \$17,761 for a four-person family.

- More than 80 percent of the uninsured are in working families, but 60% are not offered employer-based health insurance coverage. These families must choose between a doctor’s appointment and feeding their families, buying medicine or paying the rent.

- Not all low-income persons are eligible for public coverage. Even with an income as low as \$4,000 per year, adults with no children do not qualify for Medicaid coverage. In 11 states, no non-disabled adult without a child can qualify for Medicaid.

- Hispanic Americans comprise more than one-quarter of the total uninsured population, though they account for only 12% of the total population. Hispanics have been consistently over-represented in the uninsured population. Given the current projected growth in the Hispanic population, the number of uninsured and the proportion of the U.S. population that is uninsured are also expected to increase through 2050.

- Ten million children under age 18 are uninsured, including 2.8 million poor children living in families with an income below 100% FPL. Over seven million children under age 19, living in families with an income at or below 200% FPL, are uninsured.

A combination of strategies is required in order to adequately provide insurance coverage to America’s uninsured population. Poor children may benefit from expanded outreach efforts for Medicaid enrollment. Poor adults (with or without children) may benefit from an expanded Medicaid program, including a broader definition of eligibility. Working near-poor persons may benefit from a properly designed

health tax credit. It is unlikely that any one specific proposal will work best for each person included in the diverse population of uninsured Americans.

Health Consequences of a Lack of Insurance

The lack of health insurance has important health and financial consequences for both the individual and the nation. Millions of Americans are unable to receive the care they need, which endangers the health and lives of all patients, adds cost to the health care system, and reduces productivity. Missed or delayed care may result in unnecessary morbidity or mortality and greater severity of illness. Delays in seeking care are particularly damaging in diseases such as cancer and diabetes for which diagnosis and treatment during early stages may prevent further complications and prolong survival.

Medical treatment for the uninsured is often more expensive than preventive, acute, and chronic care of the insured because the uninsured are more likely to receive medical care in the emergency department than in a physician's office. According to the National Center for Health Statistics, non-urgent cases accounted for more than 50% of the 90 million visits to U.S. hospital emergency departments in 1992. These increased costs are absorbed by providers as free care, passed on to the insured via cost shifting and higher health insurance premiums, or paid by taxpayers through higher taxes to finance public hospitals and public insurance programs.

The inability of the uninsured to access preventive care also increases the nation's health care costs. For example, uninsured pregnant women typically seek prenatal care late in the pregnancy, if at all, and this increases the probability that newborn care will occur in a neonatal intensive care unit. Another example is the failure to detect and treat hypertension in its early states, which increases the likelihood of hospitalization and care in the intensive care unit for stroke, myocardial infarction, or congestive heart failure. The failure to prevent these complications results in loss of productivity and increased costs of medical care. In consideration of these facts alone, it is clear that insuring the uninsured is in everyone's best interest.

Making preventive medicine and existing treatment therapies accessible to uninsured people will not only increase overall access to health care but may also substantially contribute to a reduction in the total burden of illness facing the United States.

Evidence of Health Consequences

ACP-ASIM conducted an extensive literature search to document the evidence of a relationship between a lack of health insurance and a reduced access to care and poorer medical outcomes. We identified more than 100 scientific studies that adjusted for factors other than insurance in order to focus on the link between the lack of health insurance and access to care and medical outcomes.

The results of these studies confirmed what doctors know from their own practice experiences: people without health insurance tend to live sicker and die younger than people with health insurance. Our results were published in our first report called, *"No Health Insurance: It's Enough to Make You Sick."* (All College reports mentioned in this statement are available at www.acponline.org/uninsured.)

Evidence from the available medical and scientific literature suggests that:

- Uninsured Americans are three times more likely than the insured to experience an avoidable hospitalization for diabetes and two times more likely for hypertension.
- Uninsured people are more than three times more likely to die in the hospital than the insured.
- Uninsured men are one and one-half times more likely than the insured to be diagnosed with prostate cancer at a late stage.
- Uninsured adolescents between the ages of 10 and 18 are four times more likely to have unmet health needs, four times less likely to get dental care, four times less likely to get needed prescriptions, and four times less likely to get needed eyeglasses.
- Uninsured children under 17 are nearly two times less likely to receive medical treatment for common childhood illnesses, such as sore throat or tonsillitis, acute or recurrent earache, or asthma.
- Uninsured children are up to 40% less likely to receive medical attention for a serious injury.

Our second report, *"No Health Insurance? It's Enough to Make You Sick: Latino Community at Great Risk"* focused on the evidence of the unmet health needs of America's Latino population, the nation's fastest growing minority group and the largest uninsured population:

- Uninsured Latino women with breast cancer are more than twice as likely to be diagnosed at a later stage compared to uninsured non-Latino women.
- Uninsured Latino men with prostate cancer are almost four times more likely to be diagnosed at a later stage than uninsured non-Latino men.
- Uninsured Latino children with asthma are six times more likely not to receive standard medical treatment than uninsured non-Latino children.

Our third and most recent report, *“No Health Insurance? It’s Enough to Make You Sick: Uninsured Women at Risk”* highlighted evidence of consequences experienced by uninsured women:

- Uninsured women are up to five times more likely than the insured to report unmet health needs.
- Uninsured women aged 50–64 are two times less likely to have had a recent mammogram, two times less likely to have had a recent Pap test, and two times less likely to have had a recent clinical breast examination.
- Uninsured women with breast cancer, compared with the insured, have a 49% higher adjusted risk of death.
- Uninsured women, ages 18 to 64, experience nearly twice the risk of in-hospital death than all insured patients.
- Uninsured pregnant women are three times more likely than insured women to report not receiving the recommended number of prenatal visits and have a 31% higher likelihood of an adverse hospital outcome at childbirth.

Arguments that uninsured Americans receive the same levels of medical care as insured Americans, despite their lack of coverage, are contradicted by these studies. Research has clearly demonstrated that having health insurance makes a difference in health care for Americans. The uninsured—even those who are sick, chronically ill, or who have special health care needs—get less health care than those who have insurance. Many studies have shown that increasing coverage improves access to care.

Evidence from the available medical and scientific literature also clearly demonstrates that uninsured Americans experience poorer medical outcomes. A lack of insurance is associated with a delay in seeking care, disease progression, and reduction of the likelihood of a favorable outcome or survival. It is also associated with the increased probability of avoidable hospitalizations for manageable illnesses (some of which are risk factors for the leading causes of death), a generally higher mortality level, and specifically higher in-hospital mortality.

Uninsured children are particularly vulnerable to reduced levels of medical care for normal childhood illnesses such as a sore throat, earache (which, left untreated, can lead to hearing loss and speech and language deficits), and asthma, in addition to reduced levels of medical care for serious injuries or acute illnesses such as appendicitis.

Lack of insurance contributes to the endangerment of the health of each uninsured American as well as the collective health of the nation. Because lack of insurance is as much a risk to the public health as smoking, alcoholism, and obesity, this national crisis merits the nation’s immediate attention.

Strategies for Reducing the Number of Uninsured

The College understands that it is not enough just to educate voters and policy-makers on *why* it is important that everyone have access to affordable healthcare, we must also suggest *how* to improve access to care for all uninsured Americans.

Early in 1999, the College released a package of proposed reforms that sought to use the federal tax code, existing government programs, and some new subsidies to help reduce the number of uninsured. During the past decade we have identified a number of steps that could be taken to improve access to health insurance. ACP-ASIM urges the Subcommittee on Health to consider ways to achieve the long-term goal of assuring that all Americans can obtain affordable, accessible health insurance coverage.

The following proposals should be considered as part of a comprehensive, sequential plan of action that will lead to coverage for all Americans:

- Enact refundable tax credits to expand coverage for lower-income Americans;
- Expand Medicaid to cover all individuals at or below 100% of the poverty level;
- Increase funding for outreach to encourage eligible children and families to enroll in Medicaid and the S-CHIP (Child Health Insurance Program);
- Provide subsidies for those individuals who are eligible for COBRA coverage but cannot afford it;

- Establish a defined timeframe for achieving affordable coverage for all Americans; and
- Include an ongoing plan of evaluation to assure progress.

This multi-faceted approach recognizes that there is not just one way to expand health insurance coverage for all Americans. Expansion of Medicaid and the SCHIP program will work well for certain segments of the population. Refundable tax credits will work well for individuals whose income is above poverty but not sufficient to purchase insurance in the marketplace.

Tax Credit Legislation to Purchase Health Insurance

There are several important considerations on how a tax credit should be designed to assure that it is effective in reaching the targeted population of low-to-moderate income Americans.

- The tax credit should include an advance payment option, which would enable taxpayers to receive monthly payments to offset premium costs, rather than having to wait until their taxes are filed to obtain credits.
- The credit should be refundable, meaning that individuals who have no federal income tax liability would still be able to qualify for the credit.
- The credit needs to be high enough to subsidize 90% or more of the costs of purchasing health insurance coverage, since a smaller credit will not be enough to make coverage affordable for many lower-income individuals.

The College is pleased that President Bush has proposed an income tax credit for the purchase of health insurance for individuals under age 65 that is refundable. The College also supports the advance payment option, which would make the tax credit available at the time the individual purchases health insurance. In addition, ACP-ASIM supports the proposal that the tax credit equal 90% of the health insurance premium. We hope, however, that the maximum credit will be raised above the current proposal of \$1,000 per individual covered by a policy and \$2,000 per family.

The Commonwealth Fund reports that the median family income of those with an income less than 100% FPL is \$5,636 and those with an income 100–199% FPL is \$18,324. If an average insurance policy covering a single employee under 65 cost \$2,424 and a family policy cost \$6,348 in 2000 (as reported by Gabel et al, “Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows,” *Health Affairs* 19, Sept./Oct. 2000: 144–151), it would be nearly impossible for these individuals and families to purchase health insurance coverage on their own with the President’s proposed maximum credit. On average, health insurance premiums would consume 25% of the family income for poor and near-poor families; however, the premiums may take even 40% or more of the family’s income.

ACP-ASIM recommends that the Subcommittee consider reporting a tax credit bill that is modeled after the provisions in the Relief, Equity, Access, and Coverage for Health (REACH) Act (S. 590), introduced by Senator James Jeffords (R-VT), Chair of the Health, Education, Labor and Pensions (HELP) Committee. The REACH bill includes refundable and targeted tax credits with an advance payment option. The College suggests, however, that a higher premium subsidy than is currently proposed be recommended by this Subcommittee.

Making the credit refundable means that even those individuals with no federal income tax liability would still qualify for the full tax credit. REACH targets those who face the greatest financial barriers to purchasing insurance, thereby using federal funds judiciously and avoiding “crowding out” or substitution of employer-provided insurance for insurance purchased by individuals using the tax credit. “Crowding out” becomes a danger when individuals make more than 200% of poverty and are more likely to have employer-provided insurance.

Implementing an advance payment option that means the value of the credit would be available at the time the premium is paid by the employee, e.g., when payments are due, not at the end of the year. ACP-ASIM believes that a tax credit bill modeled after the REACH proposal will minimize disruption in both public—and employer-provided coverage by building on, rather than replacing, the current system.

The REACH Act provides a \$2,500 tax credit for couples that make up to \$55,000 a year and have no access to employer-provided insurance. Individuals who earn up to \$35,000 would receive a \$1,000 credit. Smaller credits are available to individuals and families whose employers provide health insurance. ACP-ASIM is concerned, however, that the amount of the tax credit provided by the REACH bill may still be too low to make coverage affordable to many low-income families. Therefore, ACP-ASIM strongly encourages this Subcommittee to report a bill, modeled after the REACH proposal, that would include a higher premium subsidy to assure that the tax credit is sufficient to make insurance affordable for those most in need.

Expansion of Access through Medicaid and S-CHIP

Tax credits will be more effective if combined with expansion of Medicaid and the S-CHIP program. Congress should recognize that a tax credit, by itself, would still leave millions of Americans without access to affordable health insurance coverage. Tax credits may be useful to many Americans whose incomes are between 100 and 200% of the federal poverty level, but other strategies to increase access to care work better for the population below poverty.

The College therefore recommends a combined approach of tax credits, public program expansions, and increased funding for outreach to make coverage available to all Americans with incomes up to 150% of the federal poverty level.

- ACP-ASIM believes that Medicaid and S-CHIP programs should be expanded to include all adults with incomes below the federal poverty level.

The College will soon be publishing a policy monograph that proposes a strategy for expansion of Medicaid and S-CHIP programs. The recommendations include: establish a uniform income-based eligibility limit for enrollment in Medicaid (equal to 100% of the federal poverty level); increase in the federal contribution level to make it possible for states to enroll all low income persons; initiate a process to establish a uniform nationwide floor on benefits covered under Medicaid and S-CHIP; eliminate administrative barriers that inhibit enrollment and participation; and increase Medicaid reimbursement to physicians to assure adequate access to physician services. A copy of the monograph will be provided to this Subcommittee.

- ACP-ASIM also recommends increased funding for outreach since the numbers enrolled in both Medicaid and S-CHIP fall short of those eligible.

Outreach programs are designed to make already-eligible individuals aware of their eligibility for coverage under either the Medicaid or S-CHIP program. Lack of knowledge concerning coverage options is one of the principal reasons that millions of Americans who are eligible for Medicaid or S-CHIP coverage remain uninsured. The ability of states to educate potential enrollees about their options has been hampered by inadequate funding for outreach programs.

- ACP-ASIM also advocates that states and the federal government institute administrative changes to make enrollment in Medicaid and S-CHIP a simpler option for potential enrollees.

Complex and lengthy enrollment procedures and forms serve as a significant barrier to enrollment in the Medicaid and S-CHIP programs. Congress could increase enrollment by providing states with funding and direction to develop ways to simplify the process of enrolling individuals in both the Medicaid and S-CHIP programs.

Conclusion

The 107th Congress will have a unique opportunity to finally tackle the issue of lack of health insurance. This Subcommittee on Health is to be praised for taking the initiative now to pave the way for constructive action next year.

ACP-ASIM believes that a combination of approaches, including refundable tax credits for low-wage workers, expansion of Medicaid and S-CHIP programs to all individuals below the federal poverty level, increased funding for outreach, and simplified enrollment procedures, would represent a major step forward in making affordable health insurance coverage available to those most at risk of being uninsured.

However, ACP-ASIM believes that such reforms be included as part of an overall sequential package that will lead to coverage for all Americans by a defined date, rather than being treated as stand-alone incremental measures. Later this year, ACP-ASIM will be providing the Subcommittee with further ideas on making coverage available to all Americans, in a series of steps, starting with low-wage workers and the poor.

As a nation we are capable of great things. When we muster our collective will, no enemy or obstacle can withstand our collective might. If we all recognize the health risks associated with the lack of health insurance and if we can all agree that it is a problem that must be solved, we believe that we can achieve health coverage for all in the near future. Concern for the health risks of the uninsured is not an issue for one party or another. The health risks of the uninsured can and must be addressed by all.

Statement of the American Hospital Association

The American Hospital Association, on behalf of its nearly 5,000 hospital, health system, network and other health care provider members, submits this statement for the record regarding the hearing on the uninsured. We applaud the committee's efforts to search for a solution to the plight of 43 million people living in the United States without health care coverage. Every day in America's hospitals, caregivers experience firsthand how the absence of health care coverage acts as a significant barrier to care, reducing the likelihood that these patients will receive appropriate and timely preventive, diagnostic and chronic care services.

As a nation we continue to enjoy a robust economy, despite recent stock market fluctuations. The Congressional Budget Office is forecasting a bright outlook for the economy, with federal budget surpluses projected for the next 10 years. However, a robust economy and historic lows in the number of unemployed Americans contributed to only a slight reduction in the numbers of uninsured between 1998 and 1999.

Expanding health insurance coverage and sustaining access to essential health care services for the uninsured as well as those with coverage must be at the top of the national public policy agenda. The American Hospital Association believes that every American deserves access to basic health care services, services that provide the right care, at the right time, in the right setting.

To generate greater public attention to the plight of the uninsured, the AHA has partnered with the Robert Wood Johnson Foundation and other national associations with diverse interests but a similar goal: getting health care coverage to the uninsured. Among the many activities we have participated in are an advertising campaign, and "Expanding Health Coverage: Make it America's Priority," a national town meeting broadcast by satellite to more than 200 hospital sites across the country. This subcommittee's chairman, Rep. Nancy Johnson, participated in the broadcast, effectively setting the stage for the congressional debate on the uninsured.

One of the first steps that should be taken to reduce the number of uninsured is to improve access to coverage for low-income workers and their families. Eighty-four percent of the uninsured live in families headed by workers.

Refundable tax credits would give individuals and families the means and the flexibility to purchase the type of coverage that meets their needs. Tax credits targeted to low-income families and individuals will ensure that federal subsidies will benefit those most in need. The AHA supports legislation such as the Fair Care for the Uninsured Act of 2001 and the Relief, Equity, Access, and Coverage for Health (REACH) Act of 2001—both approaches that use refundable tax credits to make insurance more accessible.

Because the high cost of health premiums is the number one reason workers decline coverage that is made available by their employer, the AHA supports tax code changes that would provide employers with a tax credit to help subsidize the purchase of health care coverage for their low-wage workers. In addition, the AHA supports allowing the self-employed to deduct the full amount of their health insurance premiums, and providing tax credits so small employers can afford to provide insurance.

While these tax code changes are important steps, more needs to be done. Coverage expansions should also build on the current successes of public programs such as Medicaid and the State Children's Health Insurance Program (S-CHIP). The AHA supports expanding Medicaid and S-CHIP to single adults and families, including legal immigrant children and pregnant women.

Still, placing an insurance card in the hands of every American does not guarantee access to services. The AHA urges that, as attempts are made to tackle the problem of the uninsured, the committee also recognize the critical importance of making sure key health care services remain available. This requires investment in America's health care facilities, technology and workforce.

The AHA looks forward to working with the committee to expand health care coverage to the uninsured, and to ensure that high-quality health care services are accessible to all Americans.

**Statement of Blue Cross and Blue Shield Association, Employee Benefit
Research Institute, and Consumer Health Education Council**

2000 Small Employer Health Benefits Survey Summary of Findings

This summary presents findings from the 2000 Small Employer Health Benefits Survey (SEHBS). The survey examines a number of issues related to small employers (between two and 50 workers) and their decision to offer—or not offer—health benefits to workers. The goal of the survey was to gather information to better understand what would make more small employers offer health benefits. It is a well-known fact that small employers are less likely than large employers to offer health benefits. In 1999, 40 percent of employers with between three and 49 workers did not offer health benefits to their employees. In contrast, nearly all employers with 200 or more employees offered coverage.

Since the vast majority of large employers offer health benefits, but many small employers do not, small businesses are seen as perhaps the most crucial factor in efforts to reduce the growing number of uninsured Americans. There are many reasons why small employers do not offer health benefits. While small employers report that cost is the primary reason they do not offer health benefits, many other factors may also contribute to their lower coverage rates (table 1). For example, small employers that do not offer health benefits often are not aware of the value of offering benefits, do not understand how the tax code provides incentives to offer benefits, and do not understand how insurance laws have addressed the accessibility and affordability of health benefits.

The survey was conducted within the United States between May 16 and June 30, 2000, through 20-minute telephone interviews with 506 companies with health benefits and 449 companies without health benefits. The SEHBS was co-sponsored by the Blue Cross and Blue Shield Association (BCBSA), a federation of independent, locally operated Blue Cross and Blue Shield Plans that collectively provide health care coverage to 75 million Americans; the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan public policy research organization; and the Consumer Health Education Council (CHEC), a health education organization formed to help the American public better understand, acquire, and utilize health insurance. Mathew Greenwald & Associates, Inc., conducted the survey.

The following sections present the survey's findings on various topics concerning health benefits and small employers. These topics include the tax treatment of health benefits, knowledge of insurance regulations, the impact that offering health benefits has on employers, the difference between employers that do and do not offer health benefits, worker and family participation in health benefits, the likelihood that employers will offer health benefits in the future, and the impact of future costs and tax incentives on employer behavior.

Table 1.—Small Employers Cite Affordability as the Primary Reason for Not Offering Health Benefits

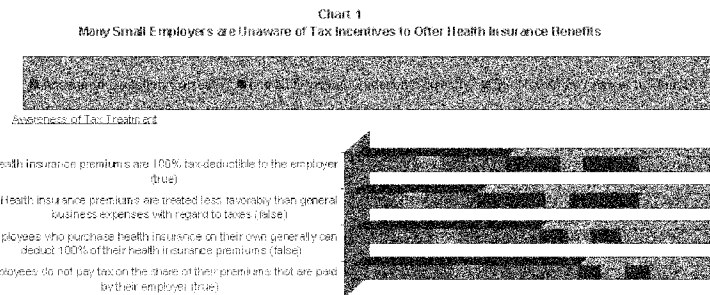
	Major Reason	Minor Reason	Not a Reason
The business cannot afford it	53%	16%	30%
Employees have coverage elsewhere	43	18	35
Revenue is too uncertain to commit to a plan	40	16	43
Owner has coverage elsewhere	40	13	45
Employees cannot afford it	37	17	43
Large portion of workers are seasonal, part time, or high turnover	34	15	49
Employees prefer wages and/or other benefits	30	20	47
Company does not need to offer a plan to recruit and retain good workers	18	17	63
Setting up a plan is too complicated and time con- suming	11	20	68
Employees are healthy and do not need it	10	17	71
Do not know where to go for information on starting a plan	8	21	71

Source: EBRI/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Tax Treatment

Many small employers make decisions about whether to offer health benefits to their workers without being fully aware of the tax advantages that can make this benefit more affordable (chart 1)

- 57 percent of small employers do not know that health insurance premiums are 100 percent tax deductible.
- 65 percent of small employers do not realize that health insurance premiums are treated like general business expenses with regard to taxes.



Source: EBP/CHEC/ABCS 2000 Small Employer Health Benefits Survey

Small employers not offering health benefits are less aware of the tax treatment than those that do offer health benefits.

- 59 percent of small employers offering health benefits do not know that health insurance premiums are treated like general business expenses, compared with 73 percent of employers that do not offer health benefits.

Many small employers are not knowledgeable about the tax treatment of health benefits as it affects their workers (chart 1).

- 48 percent are not aware that employees who purchase health insurance on their own generally cannot deduct 100 percent of their health insurance premiums.
- 37 percent do not know that employees do not pay tax on the share of their premiums that are paid by their employer.

Small employers offering health benefits are much more likely to be aware of the tax treatment of employee contributions to health benefits.

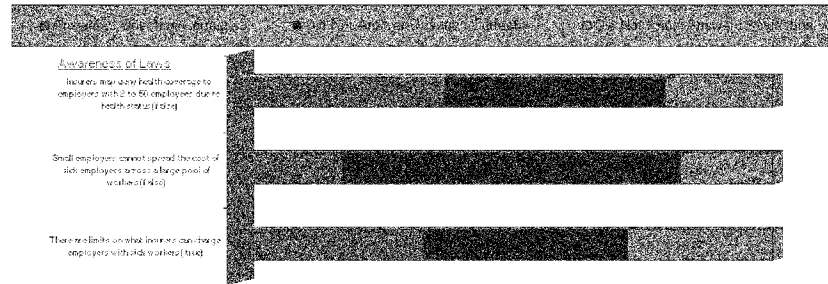
- 69 percent of small employers offering health benefits understand that the employer share of the premium is not included in an employee's taxable income, compared with 53 percent of employers not offering health benefits.

Insurance Regulation

Small employers are largely unaware of the laws that nearly all states and the federal government have enacted to make health insurance more accessible and more affordable for many small employers (chart 2).

- 61 percent do not know that insurers may not deny health insurance coverage to small employers even when the health status of their workers is poor.
- 80 percent do not realize that states have, in effect, required insurers to spread the cost of insuring small employers with sick employees across a large pool of workers through the use of rating restrictions.
- 65 percent are not aware that there are limits on what insurers can charge employers with sick workers compared with employers that have healthier workers.

Chart 2
Many Small Employers are Unaware of State and Federal Laws that Address Accessibility and Affordability of Health Benefits in the Small-Group Market



Source: EBRI/CHC/BCBSA 2000 Small Employer Health Benefits Survey.

Impact of Benefits

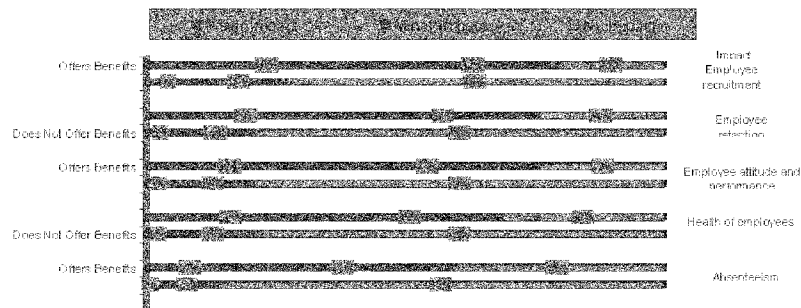
Most small employers offer sound business reasons for offering health benefits to workers.

- 80 percent report that it helps with recruitment and retention.
- 70 percent report that it increases productivity by keeping employees healthy.
- 69 percent report that employees demand it.
- 68 percent report that it reduces absenteeism by keeping workers healthy.
- 88 percent report that they offer health benefits because it is the right thing to do.

When specifically asked whether offering health benefits has an impact on their business, most small employers with benefits agree that it does (chart 3).

- 78 percent report that offering this benefit has had an impact on employee recruitment.
- 75 percent indicate it has had an impact on employee retention, attitude, and performance.
- 67 percent report an impact on the health status of their employees.
- 58 percent state that offering health benefits has had an impact on absenteeism.

Chart 3
Employers Offering Health Benefits Report a Positive Impact on Recruitment, Retention, Performance, Worker Health Status, and Absenteeism



Source: EBRI/CHC/BCBSA 2000 Small Employer Health Benefits Survey.

In contrast to the value perceived by respondents from small firms with health benefits, most of those from companies that do not offer benefits tend to think that not offering them has had no impact on their business.

- 72 percent report that not offering coverage has had no impact on employee recruitment.

- 78 percent report that not offering coverage has had no impact on retention, attitude or performance, or the health status of their employees.
- 85 percent report that not offering health benefits has had no impact on absenteeism.

Employer Profiles

Small employers that offer health benefits tend to be distinctly different from those not offering health benefits.

- 48 percent of employers not offering health benefits pay annual wages of less than \$15,000 per year to 50 percent or more of their employees, compared with 12 percent of companies that do offer health benefits.
- 43 percent of small employers not offering health benefits report that 100 percent of their workers are employed full time. In contrast, 56 percent of small employers offering health benefits report that 100 percent of their workers are employed full time.
- Of the employers that do not offer health benefits, 83 percent employ fewer than 10 workers. In contrast, of the employers that do offer health benefits, 66 percent employ fewer than 10 workers.

Small employers not offering health benefits are more than twice as likely to have annual gross revenues of less than \$500,000.

- 60 percent of employers that do not offer health benefits have annual gross revenue of less than \$500,000, compared with 27 percent of employers that do offer health benefits.
- 29 percent of companies offering health benefits report gross revenues of \$1,000,000 or more, while only 8 percent of employers not offering health benefits report this level of revenue.

Small employers not offering health benefits are more likely than those offering them to have a larger proportion of females, workers under age 30, or minority workers.

- 6 percent of employers offering health benefits report that 100 percent of their employees are female, compared with 16 percent of employers not offering health benefits.
- 17 percent of employers offering health benefits report that at least 50 percent of their employees are under age 30, compared with 30 percent of employers not offering health benefits.
- 11 percent of employers offering health benefits report that at least 50 percent of their employees are minority, compared with 21 percent of employers not offering health benefits.

Employee Participation

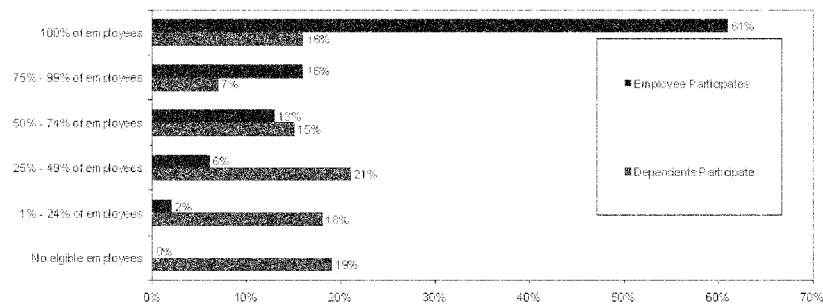
Not all workers are eligible to take advantage of the health benefits offered by their employers.

- 61 percent of small employers offering health benefits report that all workers are eligible for health benefits.
- 7 percent report that less than one-half of their workers are eligible to participate.
- 19 percent report that between 50 percent and 79 percent of their workers are eligible to participate.
- 11 percent report that between 80 percent and 99 percent are eligible.

Not all small employers that offer health benefits get full participation among those workers who are eligible (chart 4).

- Just over 60 percent of employers offering health benefits had 100 percent participation among employees.

Chart 4
Take-Up Rates are Much Higher for Workers Than They are For Dependents



Source: EBR/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Not all small employers offer health benefits to dependents.

- 13 percent do not offer health benefits to dependents.

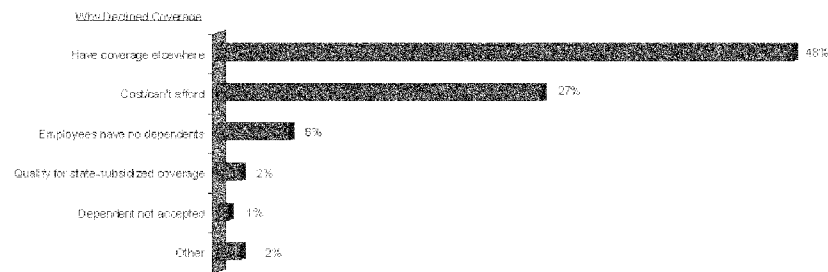
Among small employers that offer health benefits to dependents, take-up rates are much lower for dependents (chart 4).

- Only 16 percent report that all employees eligible for dependent coverage actually include dependents in their health benefits coverage.

Small employers report a number of reasons why workers do not accept health benefits for dependents when this type of coverage is available (chart 5).

- 48 percent of the employers offering dependent coverage report that the workers do not take coverage for their dependents because the dependents have coverage from somewhere else.
- 27 percent report their employees decline coverage because they cannot afford the premiums.

Chart 5
Other Coverage, Costs, and Affordability are the Main Reasons Why Workers Do Not Take Coverage for Dependents

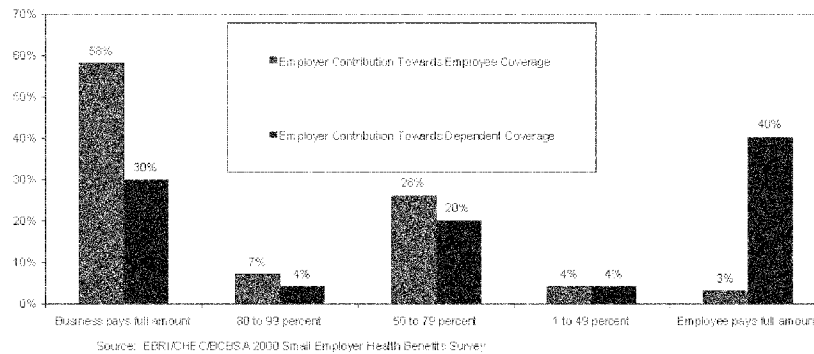


Source: EBR/CHEC/BCBSA 2000 Small Employer Health Benefits Survey.

Small employers are more likely to make contributions toward the cost of employee-only coverage than they are to contribute to dependent coverage (chart 6).

- 58 percent of employers pay the full premium for employee-only coverage.
- 30 percent pay the full amount of family coverage.
- 3 percent require the worker to pay the full amount of employee-only coverage
- 40 percent require them to pay the full amount for dependents.

Chart 6
Employers are More Likely to Contribute Toward the Cost of Employee-Only Coverage than Dependent Coverage



Dependent take-up is considerably higher in small firms that contribute at least some percentage toward the cost of the coverage than it is in firms where the employee is required to pay the full amount.

- The average take-up rate for dependents among employers that contribute toward the cost of dependent coverage is 56 percent, compared with an average take-up rate of 23 percent among employers that do not contribute toward the cost of dependent coverage.

Likelihood of Offering Benefits

Some small employers not currently offering health benefits have offered them in the past.

- 12 percent of companies that do not currently offer health benefits report their business has offered some type of health benefits plan in the past five years.

Nearly one-third of small employers that do not currently offer health benefits are potential purchasers.

- 12 percent of employers not currently offering health benefits say they are either extremely or very likely to start offering a health benefits plan for employees in the next two years.
- 17 percent are somewhat likely to start a health benefits plan.

Small employers that are likely to start a health benefits plan differ from others not currently offering a plan in a number of ways.

- Nearly 70 percent of employers not offering a health benefits plan, but who are extremely or very likely to offer one in the next two years, report that they have been in business for less than 10 years.
- 35 percent of those not likely to offer health benefits have been in business less than 10 years.

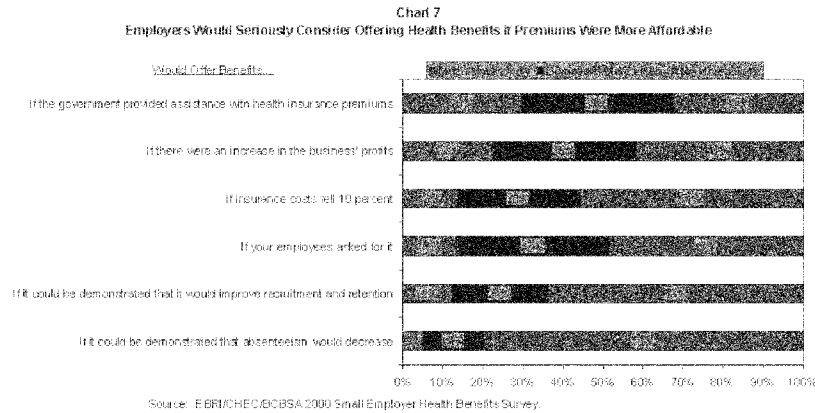
A number of factors would increase the likelihood that a small business would seriously consider offering a health benefits plan. Affordability of health benefits is the dominant factor (chart 7).

- 64 percent would seriously consider offering health benefits if the government provided assistance with premiums.
- 57 percent would consider offering health benefits if there were an increase in profits.
- 43 percent report that they would consider doing so if insurance costs fell 10 percent.
- 50 percent would be more likely to seriously consider offering a health benefits plan as a result of employee demand.
- 36 percent would consider offering a health benefits plan if it improved recruitment and retention.

A large number of small companies not offering health benefits state they would need major government subsidies for them to provide health insurance coverage.

- 20 percent would need to receive a subsidy of between 25 percent and 49 percent of the premium.
- 42 percent would need to receive a subsidy of at least 50 percent of the premium.

- 7 percent state they would not provide coverage even if the government paid 100 percent of the cost.
- Among those that indicate they would require subsidies of at least 50 percent to offer coverage, 76 percent say they would be more likely to consider offering a health benefits plan if they were able to receive cash from the government for 50 percent of the premium costs on a quarterly basis and would not have to repay this money.



Future Costs and Tax Incentives

Many small employers with health benefits have recently switched health plans.

- 34 percent report that they switched health plans within the past year.
- 63 percent report that they have switched plans within the past five years.
- 21 percent indicate that their business has always had the same plan.

Affordability for the small employer and the worker is clearly a critical factor affecting the likelihood of switching health plans.

- Nearly all employers who have switched health plans within the past five years cite price or cost as a reason for the change.
- 33 percent of respondents from companies offering health benefits think their firm would change coverage, and 5 percent think it would drop coverage, if the cost of health insurance in general were to increase by 5 percent.
- If costs increased only 1 percent, 10 percent would change coverage and 3 percent would drop coverage.
- If costs increased 10 percent, 46 percent would change coverage, while 14 percent would drop coverage.

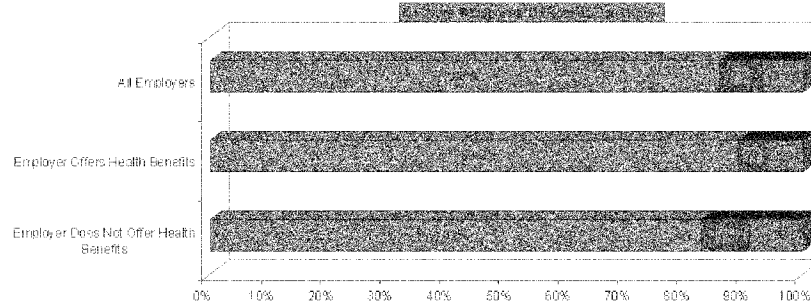
Most small employers support tax breaks to reduce the health insurance costs of low-wage workers (chart 8).

- 86 percent of all small employers favor tax breaks that they could use to reduce health insurance costs for their low-wage workers (56 percent strongly favor and 30 percent somewhat favor).
- 7 percent would somewhat or strongly oppose tax breaks for health insurance.

Companies that currently offer health benefits are slightly more likely than those that do not to strongly or somewhat favor tax credits.

- Nearly 90 percent of small employer offering health benefits favor credits, compared with 82 percent of those not offering health benefits.

Chart 8
Employers Strongly Support Tax Breaks to Reduce Health Insurance Costs for Low-Wage Workers



Source: EBP/CHC/DCBSA 2000 Small Employer Health Benefits Survey

Statement of Gail Shearer, Director, Health Policy Analysis, Consumers Union

Summary

At a time of unprecedented budget surpluses and an uncertain economic outlook that could result in growing numbers of uninsured and underinsured Americans, it is critical that Congress move forcefully and expeditiously to make health insurance more affordable. Tax credits for health care coverage are increasingly discussed as a policy option for reducing the ranks of the uninsured. We are concerned that, unfortunately, most tax credit proposals are misguided: some are too small to make coverage affordable; some undermine employer coverage; some have inadequate protections for sick people who are shifted into the individual market. Because of the variation in proposals, they have dramatically different implications for the health care system. The following ten questions provide a framework for evaluating various health care tax credit proposals.

1. What will be the impact on the number of uninsured?
 2. Will the credit cause employers to drop coverage?
 3. What will be the impact on the number of underinsured (i.e., those with coverage that is not comprehensive)?
 4. What will be the impact on the health insurance marketplace: will there be a shift from employer-based coverage to individual coverage?
 5. Will those people with higher health risks (e.g., chronic or pre-existing conditions) face higher premiums, exclusions in coverage, and/or denial of coverage?
 6. How cost-effective is the proposal?
 7. What is the total cost to the federal government (e.g., taxpayers)?
 8. Does the proposed tax credit make health insurance subsidies more equitable?
 9. Does the proposal target relief to those most in need, in particular those with low and moderate income?
 10. What marketplace reforms are included in the tax credit proposal?
- Below is an explanation of each question regarding tax credits for health care.

Tax Credits for Health Insurance: Will They Be a Cost-Effective Tool for Expanding Comprehensive Health Insurance?

1. What will be the impact on the number of uninsured?

Most tax credit proposals are at subsidy levels that represent one third or less of the cost of buying a health insurance policy. This means that for most of the uninsured, they will still face sizable out-of-pocket payments for premiums. For many, health insurance will remain unaffordable.¹ Researchers have developed models to

¹ See also Iris J. Lav and Joel Friedman, Center on Budget and Policy Priorities, "Tax Credits for Individuals to Buy Health Insurance Won't Help Many Uninsured Families," February 15, 2001.

estimate the impact of various tax credits on the uninsured. Most health insurance tax credits are estimated to reduce the uninsured by 1.5 to 12.4 million people.² The design details of the tax credit (e.g., does it apply only to those without employer-sponsored coverage? what is the size? is it refundable?) all affect the impact on the number of uninsured.

2. Will the credit cause employers to drop coverage?

Most tax credit proposals result in a modest net increase in the number of insured, but this results from a combination of an *increase* in the number of people with nongroup insurance, and a *decrease* in the number of people with employer based insurance.³ One tax credit proposal (\$2,000 for individuals and \$4,000 for families) for those not covered otherwise is estimated to result in a 10 percent reduction in employer based coverage.⁴

3. What will be the impact on the number of underinsured (*i.e.*, those with coverage that is *not* comprehensive)?

The question of adequacy of health insurance coverage is rarely addressed in studies of tax credits. The issue of comprehensiveness of coverage is critical in light of the large and growing number of Americans whose health insurance does not adequately protect them against financial devastation caused by out-of-pocket health care costs. An estimated 31 million adults (in 1998) were underinsured, risking incurring out-of-pocket expenses (not including premiums) in excess of 10 percent of their income in the event that they faced catastrophic illness.⁵ Based on government surveys of actual health expenditures, about 16 million households (under 65) and an additional 12 million households over 65 *actually* spend more than 10 percent of their income out-of-pocket on health care costs and premiums.⁶

If tax credits are skimpy (e.g., \$500 per individual) at a level less than half of the average cost of coverage, the marketplace may respond by designing skimpy benefit packages. If policies were designed with very high deductibles, high copayments, low stop-loss levels, and skimpy benefits (e.g., a cap on doctor visits, hospital days, a lack of prescription drug coverage), then it is possible that more people would be “insured” but at the same time more people would be “underinsured.” It is important, therefore, that policymakers carefully consider not only the number of people with insurance coverage, but that they also measure the quality of the coverage that people have and the total financial burden of paying for health care.

4. What will be the impact on the health insurance marketplace: will there be a shift from employer-based coverage to individual coverage?

Some tax credit proposals (e.g., all but one studied by Gruber and Levitt) are expected to lead to an increase in the non-employer market at the same time that they lead to a decrease in employer-based coverage. This shift from the employer to individual market is troubling in light of the fact that state regulation varies considerably, and usually leaves high risk individuals and families vulnerable to facing barriers to access to affordable coverage in the individual market. Congress should not undermine the employer-based market which does a good job of pooling the healthy and the sick together, keeping premiums relatively low, unless there is in place a robust and stable individual health insurance market that protects the interests of those with pre-existing conditions.

5. Will people with higher health risks (e.g., chronic or pre-existing conditions) face higher premiums, exclusions in coverage, and/or denial of coverage?

Because of the varied and limited state regulation of individual health insurance markets, health care tax credits are likely to adversely affect the health insurance options that millions of high risk individuals and families face. The likely effects will include: denial of coverage, exclusions of coverage for pre-existing conditions, and high premiums (to reflect high risks). The issue of individual health insurance markets is very complicated, in part because state regulation varies substantially, and in part because these small (residual) markets—and their regulations—have

²See, for example, Jonathan Gruber and Larry Levitt, “Tax Subsidies for Health Insurance: Costs and Benefits,” *Health Affairs*, vol. 19, January/February 2000, p. 79. Some tax credits, such as that of the Heritage Foundation, would replace the existing tax deduction system and impose an individual mandate, which by definition would eliminate the uninsured. See also John Sheils, Paul Hogan, and Randall Haight, The Lewin Group, Prepared for The National Coalition on Health Care, “Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy,” October 1999, which estimates that tax credits without mandates will reduce the uninsured by 1.5 to 9.8 million.

³See Gruber and Levitt, p. 79.

⁴See Gruber and Levitt, p. 79 and Guenther, p. CRS-21.

⁵Consumers Union, *The Health Care Divide*, August 2000, p. 13. See also Pamela Farley Short and Jessica S. Bantlin, *New Estimates of the Underinsured Younger than 65*, JAMA, 274: 1302-1306.

⁶*Ibid.*, p. 14, 16.

not been examined as carefully as employer-based markets. Some studies assume that the individual marketplace will be regulated much more aggressively than is actually likely. For example, Gruber and Levitt analysis “assumes that policies in the individual market are universally available (at health risk-adjusted prices).”⁷

6. How cost-effective is the proposal?

What is the federal cost per newly insured person, and how does this compare with expanding public programs such as SCHIP and Medicaid? The measure of “cost per newly insured person” is used to rate the tax credit proposals for cost-effectiveness. Cost per newly insured of tax credit proposals ranges from about \$2,200 (for a small tax credit targeted to those without health insurance currently) to \$5,000 (for larger credits available regardless of prior coverage), in the Gruber and Levitt study.⁸ Sheils (et. al.) estimates of cost per newly insured range from about \$1,250 to about \$10,500.⁹ If expanding coverage of the uninsured is the primary objective, then alternatives such as Medicaid/SCHIP expansion are likely to be far more cost-effective. To extend Medicaid coverage (in 1998) to an additional child cost on average \$1,225 and to an additional adult cost on average \$1,312.¹⁰

7. What is the total cost to the federal government (e.g., taxpayers)?

The total annual cost (in 1999 dollars) to the federal government of proposals recently under consideration ranges from just under \$1 billion (for an above-the line tax deduction) to \$62 billion (for a large credit available regardless of prior coverage), according to Gruber and Levitt.¹¹ Sheils estimates range from annual costs of \$3.3 billion to \$55 billion.¹²

8. Does the proposed tax credit make health insurance subsidies more equitable?

Current tax policy with regard to health insurance can hardly be described as equitable. Individuals without employer based coverage (other than the self-employed) do not get any federal income tax subsidy (and don’t have access to lower cost group plans). Moderate income families in the 15% federal tax bracket get a \$150 tax subsidy per \$1,000 of premium paid by their employer, while those at the 39.6 percent bracket get \$396 of tax benefit per \$1,000 of premium. Some tax credit proposals are designed to make the tax subsidy more equitable by including individuals who do not have employer based coverage.

9. Does the proposal target relief to those most in need, in particular those with low and moderate income?

Low—and moderate-income families have the most difficult time affording health insurance. They are much more likely to lack health insurance than higher income families. An estimated 85 percent of uninsured households have incomes that are below median household income for their family structure.¹³ Some proposals target the tax credits to people with low—and moderate—income. Tax credits are preferable to tax deductions (which give larger benefits to higher income tax payers).

10. What marketplace reforms are included in the tax credit proposal?

Since tax credits are likely to shift coverage (to some degree) from the employer based market to the individual market, it is important that regulations be in place to protect the interests of high risk individuals and families so that coverage will be both comprehensive and affordable. The types of marketplace reforms that will be essential include: standard benefit packages, community rating, and guaranteed issue. In addition, to protect against adverse selection, some sort of individual mandate would be needed to assuring that the healthy and the sick remain in the same risk pool. These regulations are necessary to prevent marketplace incentives from separating individuals by their risk level, which drives premiums up for those considered to be high-risk.

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⁷ Gruber and Levitt, p. 84.

⁸ Gruber and Levitt p. 79.

⁹ Sheils, Hogan, and Haught, p. iii.

¹⁰ “Medicaid Enrollment and Spending Trends, Kaiser Commission on Medicaid and the Uninsured,” February 2001, www.kff.org.

¹¹ Gruber and Levitt, p. 79.

¹² Sheils, Hogan, and Haught, p. iii.

¹³ Gary Guenther, Congressional Research Service, “Tax Subsidies for Health Insurance for the Uninsured: An Economic Analysis of Selected Policy Issues for Congress,” December 12, 2000, citing Jonathan Gruber.

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Statement of Healthcare Leadership Council

The Uninsured: Background

Estimates on the number of those lacking health insurance in the U.S. ranged from 42 million to 47 million in 2000. This number has increased over the past decade, from 34.3 million in 1989.

As the number of uninsured increases, so too does the number of failed attempts to address this problem. From market-based efforts that would provide incentives to purchase insurance, to government-based efforts that would create a single health coverage system for all—abruptly or gradually—solutions for reducing the rolls of the uninsured have not been realized.

Major Efforts. The most notable efforts in the past decade to increase coverage for the uninsured include President Clinton's Health Security Act of 1994, the Health Insurance Portability and Accountability Act signed into law in 1996, the State Children's Health Insurance Program signed into law in 1997, and the access provisions of the Patients' Bill of Rights passed in the House of Representatives in 1999. Most of these proposals were rejected, and the ones that have passed have not resulted in significant reductions in the uninsured.

The Health Security Act of 1994, which would have created regional health alliances and required employers to purchase health insurance for their employees through these alliances, was roundly rejected by the public and Congress as being too far-reaching and overly invasive by the government. Since this comprehensive reform effort collapsed, most lawmakers and policy experts have agreed that future efforts to solve the problem of the uninsured must proceed in an incremental, voluntary fashion.

In 1996, Congress passed and the President signed the Health Insurance Portability and Accountability Act (HIPAA), which attempted to solve the problem of uninsurance known as "job lock" for people with pre-existing conditions. While HIPAA has helped some individuals with pre-existing conditions who change employment and move from one insurance group to another group, it has not helped to make insurance attainable for those with pre-existing conditions who must move from group coverage to individual coverage—as the law had originally intended. HIPAA also included two other provisions to try to increase health coverage: medical savings accounts and increased deductibility for the self-employed. Enrollment in medical savings accounts has been limited, mostly attributed to design problems resulting from political controversy as MSAs were developed. Deductibility for health insurance purchased by the self-employed would have increased to 80 percent by 2006 and that has since been increased to 100 percent deductibility by 2003 in subsequent legislation.

The State Children's Health Insurance Program (S-CHIP), signed into law in 1997, was a revolutionary new public program that was anticipated to cover 10 million uninsured children. Unfortunately, though, the program has enrolled less than one third that many. Overall, the number of uninsured children has *increased* in a booming economy. The S-CHIP's failure has been largely attributed to the difficulty in educating and physically signing up the targeted population for this program.

Access to health insurance provisions in the patients' rights legislation passed in the House of Representatives in 1999 included several provisions believed to make insurance more accessible. However, this bill failed in conference with its companion Senate bill late in 2000, mainly because of the controversial liability and regulatory provisions also contained in that bill.

Barriers to Legislative Solutions. The main barriers to a legislative solution for the uninsured continue to be financing, disparate political ideology, and superceding health care priorities such as preserving Medicare and regulating managed care. Financing coverage for the nation's uninsured has been considered prohibitive until the emergence of recent federal surpluses. Proposals range anywhere from \$5 billion to \$80 billion a year. Even President Clinton's Health Security Act, which would have cost \$400 billion over five years, included a plan to fund this proposal through Medicare, Medicaid, and other federal program reductions, a tobacco tax, a corporate assessment, and other taxes. But recently, with an anticipated non-Social Security surplus of almost \$850 billion through 2005, greater willingness has

been demonstrated by the Congress and President Bush to spend some of the nation's prosperity on solving the problem of the uninsured.

Traditionally, finding solutions to the uninsured has been politically divisive because Republicans have preferred methods centering around tax credits and deductions and Democrats have advocated expanding existing public programs including Medicare, Medicaid and S-CHIP. More recently, however, there have been encouraging signs of more common ground. Over the past year tax credit proposals have been sponsored by members of Congress on both sides of the aisle.

But increasing access to health coverage will require a strong commitment by lawmakers to make this issue a priority on the legislative calendar. Over the past several years, Congress and the former President dedicated a great deal of time and debate to improving insurance for those who already have it. Managed care regulation has received an inordinate amount of attention over the last three years without any resolution. And Medicare reform, including prescription drugs for Medicare, has and will continue to require thoughtful deliberation to ensure this program is preserved and improved for the future. But the uninsured is an equally important population that needs and deserves to be a top priority item on the 2001 agenda.

The Uninsured: The Future Envisioned by HLC

The members of the Healthcare Leadership Council (HLC) have made accessible health care coverage for uninsured Americans its highest priority. We have commissioned in-depth studies to understand the makeup of the uninsured population, so as 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 the reforms they need in order to make health insurance a viable option. And we have examined dozens of programs across the country, innovative initiatives striving to make coverage accessible.

These examinations have led us to fundamental conclusions about this issue and how it should be addressed:

- Reducing America's uninsured rolls is not an unresolvable problem. Our studies have shown that 16.7 million (40 percent) of the uninsured are in families with an employer offer of insurance that is declined. And an additional 17.3 million (41.2 percent) of the uninsured are in families with at least one worker but no offer of insurance. In other words, a total of 81 percent of the uninsured are in families connected with the workforce. This data strongly indicates that the most feasible solutions for the uninsured are to be found by working within the existing employer coverage framework. In fact, the most recent Census Bureau data released last October confirmed that employer-provided health insurance was the driving factor that caused uninsured rates to drop in the past
- We have the resources to get the job done. There is an ongoing debate in this country about how the growing budget surplus can best be utilized. We believe the nation has no greater priority than the nearly 43 million Americans who are without health insurance. This is a critical priority because these individuals and families do not have access to the most innovative care and preventive medicine that greatly enhances and even saves the lives of those who do have coverage. And it is a critical priority because of the severe toll uncompensated care is taking on our nation's health care system. In every state in this country, there are dozens of hospitals that are in serious jeopardy because of health care provided—usually expensive acute or emergency room care—for which there will be no direct payment. For example, in 1998 alone, the nation's hospitals provided over \$18 billion in uncompensated care. If we do not make progress in reducing the uninsured population, the ramifications will be severe for all patients and health care consumers.
- Employers want health insurance for their employees. We know that 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.

HLC believes the following ten principles provide the framework necessary to develop a sound set of policies to increase access to health coverage for the uninsured:

1. Emphasize Flexible, Targeted, Pluralistic Solutions.

The nearly 43 million uninsured are not a monolithic population and there is no one-size-fits-all solution for the uninsured. Such a solution would be both too costly

and ineffective given the varied nature of the uninsured. Obstacles to coverage vary among disparate populations of the uninsured, and solutions must be tailored accordingly. For example, an individual who is offered employer coverage but declines because he finds the premiums unaffordable merits a separate solution from one who is chronically unemployed with no hope of an employer subsidized insurance offer. *HLC believes in an eclectic mix of market-based approaches to address effectively the problem of the uninsured including tax credits, insurance market reforms, more effective use of existing public program resources, and educational efforts about the value and importance of health insurance.*

2. Promote Competition, Innovation, and Research.

Some public policies to cover the uninsured such as a single payer health system and government price controls would severely limit the incentives for research and development inherent in our current health care system. There is a noticeable deficiency in the development of cutting edge health care technology in countries with health systems not based on free market principles. *HLC advocates a health care system that supports competition, innovation, and research in the financing and delivery of health care services so Americans can continue to have access to the best and latest technologies, health care services, and products.*

3. Respect Consumer Preferences for Employment-Based Coverage Where and When Possible and Help Increase Access to This Preferred Coverage.

Two recently published surveys strongly indicated that the public prefers its health care coverage to be provided through an employer, even if those individuals received equal tax treatment. The Commonwealth Foundation commissioned a survey of 5,000 people, 49 percent of whom chose employers as their preferred source of coverage, while 23 percent preferred to purchase individually, and only 18 percent chose the government as their preferred source. Another recent survey, commissioned by Harvard University, found similar results: three out of four people would rather have their insurance provided through their employer over receiving an equivalent amount in wages so they could buy it for themselves.

This consumer preference is not surprising. The employer-based coverage system in the U.S. is serving the nation well. Not only are employers uniquely effective in pooling varied risks, but they also are a driving force in negotiating fair prices and quality improvement measures. Individuals negotiating on their own behalf would have far less influence in driving these variables.

Currently, 54 percent of Americans receive health coverage through their private employers. We believe this number could be greatly increased with the help of targeted tax incentives to small employers or to employees who cannot afford to purchase their employer's coverage. Our research shows that seven of ten of the uninsured are in families with at least one person connected to the workforce, mostly through small employers. By leveraging the employer and employee contributions with tax credits, small employers can become more formidable players in the insurance market, and insurers will begin competing for them on the basis of cost, quality, and ease of administration.

The employer-based insurance system is already in place. *HLC strongly believes that the urgent nature of the growing uninsured population precludes the option to build a substantially new and different insurance system based on a different purchasing structure, as some are suggesting. Political and financial obstacles associated with such massive reform would severely delay the resolution of the problem of the uninsured.*

4. Take Advantage of Experience by Building Upon Successful State and Local Private-Public Partnerships.

A number of regionally based public-private partnerships have succeeded in finding ways to make health coverage more affordable and accessible for employers and individuals. Not only are these programs filling coverage gaps in small areas around the country, they can also serve as excellent laboratories of experimentation that provide crucial information on what is necessary to encourage small employers and individuals to participate in coverage programs.

For example, an insurance program developed in Wayne County, Michigan, for small businesses found that it was difficult to entice these businesses to participate by subsidizing less than one-third of the premium. The premium formula that eventually got this program off the ground was one-third paid by the employer, one-third paid by the employee, and one-third subsidized by the county. *HLC believes these local successes should be pinpointed and examined for their potential application to other areas and populations.*

5. Limit the Government's Role to the FINANCING of Insurance Coverage.

Governments (federal, state, and local) can play a constructive role in assisting poor families in gaining access to health care services and coverage, but should do so in fiscally responsible ways that do not impair, but instead encourage and build upon the effective functioning of the private market. State grants for low-income people, as well as targeted tax credits, block grants, Medicaid and S-CHIP funds, and other public health service programs should be free of mandates, regulations, administrative and other requirements that impede the provision of high-quality, affordable insurance and effective functioning of the private market.

For example, while Congress and the Clinton Administration allowed states more flexibility in designing their S-CHIP programs than their Medicaid programs, they nonetheless have made it difficult for States to use S-CHIP funds to allow parents of eligible children to purchase employer-offered health insurance. Research supported by HLC demonstrates that 16 million people are in families where an employer insurance product is offered but declined, often for reasons of affordability. Allowing more flexibility to use S-CHIP funds to help pay employee health insurance premiums could help provide an additional, more cost-effective option to those who would otherwise remain uninsured.

6. Encourage, Don't Discourage the Maintenance of Private Insurance Programs.

Occasionally, subsidized health care or health care insurance results in employers or other sponsors of health care coverage believing they have been "let off the hook" for providing what they traditionally have. Public health care subsidies and other programs for expanding coverage or care should be implemented in such a way that current efforts are maintained to the greatest extent possible. Any tax or other subsidy for the uninsured must be carefully targeted to ensure that it be utilized only by the segment currently declining coverage, and not be misdirected toward (or "crowd out") those who are already insured.

Some community programs HLC has studied that have tried to facilitate employer-based coverage in their local areas limit subsidies to employers who have not offered coverage within the past year. Still other models have prevented crowd-out by targeting subsidies to only limited benefit packages that would not be otherwise attractive to the employees of employers already offering a standard employer benefit package. We believe that funds should be targeted toward lower income workers or small businesses with primarily low-income workers.

7. Refrain From Passing Legislation or Implementing Public Policies That Increase the Cost of Health Care.

Government micro management in the provision of health care, such as benefit mandates and liability expansions, increase the cost of health care, making it difficult for small employers to afford providing insurance for their employees. Federal, state, and local governments should resist the passage of laws that will ultimately result in more uninsured. It will be counterproductive for Congress to use a portion of our nation's budget surplus to make health insurance more affordable, yet at the same time pass legislation that makes health coverage more expensive. Imposing new mandates on insurers and employers, or making employers liable for coverage decisions will create additional barriers and decrease the number of people that can be covered by new solutions for the uninsured.

8. Include Education to Facilitate Awareness.

An important part of the solution to health insurance coverage—often overlooked—is information and education, for both employees and employers. It is not uncommon for small employers to be unaware of the various options they may have for offering affordable coverage. In fact, a recent small business survey by the Employee Benefit Research Institute has shown that many small employers are not even aware that employee insurance is deductible.

There is also some misconception regarding the affordability of health coverage. In a survey by the California Health Institute, many individuals who cited expense as the reason for not purchasing insurance actually agreed that it was affordable once they were informed of the true cost of various policies. More than likely, there are similar misconceptions among individuals and small business owners. This may indicate that some amount of uninsurance could be reduced through broad efforts to increase awareness of options. Clearly, education initiatives could help employees and employers understand the critical value of health insurance, as well as ways to keep their health insurance premiums down once they do have coverage.

Educational efforts should be multifaceted—directed toward small businesses, employees, and individuals not linked to the workforce. Educational efforts must also

include efforts to inform those already eligible for public insurance programs of how to access those programs. The State Children's Health Insurance Program (S-CHIP) is just the most recent example of a program in which too few members of the eligible population are enrolling for program benefits.

9. Include Solutions for Those Who Are Still Uninsurable.

While lawmakers focus on access to insurance *coverage* for the majority of the uninsured population, it is also necessary to ensure a safety net of non-emergency health care services for those who are, for one reason or another, still uninsurable at any given time.

While reducing the number of uninsured will also reduce the amount of uncompensated care, there will still be a need to maintain federal and state funding for safety net programs including community health centers, rural health clinics, migrant health centers, and health services for the homeless. Additionally, it is very important to ensure that the nation's hospital system and other providers of charity care retain enough strength to be able to offer care to the uninsured. In 1998, the nation's hospitals alone provided over \$18 billion in uncompensated care. Continued erosion of Medicare and Medicaid disproportionate share payments and other federal payments that have helped them to keep their doors open to the uninsured could seriously jeopardize safety net services in the near future.

10. Encourage Individual Responsibility.

Any plan to increase access to health care coverage should encourage an appropriate level of personal responsibility in gaining access to coverage on the part of individuals, and where children are concerned, on the part of parents or guardians. Government approaches that discourage self-sufficiency and create incentives for long-term dependency on public resources should be avoided.

Conclusion

The Healthcare Leadership Council (HLC) believes that the benefits of the health care system should be available to all Americans by promoting bipartisan solutions to close gaps in access to health care coverage. We believe that these solutions can and should be consistent with HLC's mission: To advance the market-based health care system, building on the quality and innovation inherent in the private employment-based system, in order to provide *all* Americans with access to affordable coverage and high-quality health care services.

Statement of Janet Stokes Trautwein National Association of Health Underwriters, Arlington, Virginia

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

¹ U.S. Census Bureau, 2000.

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 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.

² See NAHU survey of small employers, March 2001—<http://www.nahu.org>.

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 \$2,000–\$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 coverage 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

³The 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 Index (CPI).

⁴To 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.

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.

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.

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.

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 Children's 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	\$2316	\$1000	100% after deductible.	All benefits subject to deductible.	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
Arizona	Indemnity	\$2647	\$750	90% (60% out of network).	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	\$2000	75% after deductible.	Maximum out of pocket is \$8500.	133	133	100	100	87	98.4	250	Risk Pool/Open Enrollment
		\$2748	\$1000	HealthyCheck Centers \$25 or \$75 copay for basic screenings. RX \$10 generic/\$25 namebrand.								
Colorado	PPO	\$2533	\$1000	80% (60% out of network).	\$25 office visit copay. RX \$20 maximum copay.	185	133	100	37	N/A	78.1	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		
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
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 network).	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
Idaho	PPO	\$2484	\$2000	80%	\$30 copay in- cludes 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 of- fice 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 of- fice visits in- cluding pre- ventive 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/Guaran- teed Issue
Kansas	PPO	\$2508	\$750	100%	\$10 office visit copay. Rx dis- count card.	150	133	100	100	69	72.8	200	Risk Pool
Kentucky	PPO	\$2865	\$2500	80%	Includes RX cov- erage 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

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		
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
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 network).	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-network.	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
New Mexico	PPO	\$2580	\$750	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

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		
North Dakota	PPO	\$2051	\$1000	90% (70% out of network).	\$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
Oklahoma	PPO	\$2617	\$1000	80% (50% out of network).	Office visit including routine care deductible 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	\$5,000	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
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 network).	80% (50% out of network).	\$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 generic/\$25 namebrand copay.	185	185	100	45	84	85.0	185	Risk Pool

Wyoming	Indemnity	\$2760	\$2500	100%	RX discount card and 100% coverage after deduct- ible. Optional well baby cov- erage. Op- tional preven- tive care cov- erage. Mental health cov- erage.	133	133	100	52	N/A	74.2	133	Risk Pool
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Washington MSA Project
Issaquah, Washington 98027-8616
April 15, 2001

Allison Giles
Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Ms. Giles:

Please accept this letter as testimony in response to your Committee solicitation for written statements bearing upon recent hearings on making health care affordable. This statement relates directly to Representative Nancy Johnson's Health Subcommittee Hearing dated 4 April, 2001.

The Washington Medical Savings Account Project is a nonprofit educational and research organization based in the Seattle area. We continue to research the roles and effectiveness of "Archer MSAs" nationally and in Washington state. We have concluded that federal tax favored MSA programs given appropriate latitude, expansion, and scope under new legislation will bear constructively upon increasing measurably the availability of affordable health insurance.

Addressing the proposed MSA expansion legislation Representatives Thomas and Lipinski introduced this month and which we support, we recommend two further vital improvements:

- Eliminate the ceiling for the Archer MSA high deductible health insurance but set the upper limit on the allowed total tax favored annual contribution to the MSA.
- Allow flexible MSAs linked to either front end deductibles or to deductibles for health care services other than routine primary and preventive care.

Both of these modest additions to the Thomas/Lipinski "Medical Savings Account Availability Act" fit well the intention of Congressional action to enhance and improve the affordability of healthcare.

Thank you for an opportunity to provide this testimony;

Stephen Barchet, MD, FACOG, CPE, FACPE

Chair/CEO

Cc: The Honorable Jennifer Dunn

