Senate Democratic Policy Committee Hearing

"America's Uninsured: Myths, Realities and Solutions"

JEANNE LAMBREW, PhD
George Washington University School of Public Health and Health Services
and
Center for American Progress

January 6, 2004

"Democratic Ideas to Address the Problem of Americans Without Health Insurance"

Chairman Dorgan, Members of the Committee, and other distinguished Members of Congress, I thank you for inviting me to discuss Democratic ideas to address the problem of the uninsured. I have worked on this problem both as a public official and as a researcher. My research support on this topic comes from the Commonwealth Fund Task Force on the Future of Health Insurance and the Center for American Progress. The views reflected in this testimony, however, are solely my own and do not reflect those of either organization or George Washington University.

This testimony first discusses the context for health coverage expansions; second, describes the major Democratic Congressional and Presidential candidates' plans; third, identifies similarities and differences among the plans; and closes with a discussion of the prospects for progress on reducing the uninsured in 2004.

Putting The Problem In Context

Before discussing specific proposals and ideas, there are two facts beyond the uninsured Americans' profile and trends that help frame the discussion.

The first is that we are alone among major industrialized nations in our failure to provide a guarantee of health care to all our citizens. Countries such as Canada, Japan, the United Kingdom, Germany -- and even many nations less well off than the U.S. -- ensure that their citizens have affordable access to basic health care. They have done this without evidence of diminished economic prospects or worse access to high-quality care.[1] Moreover, the U.S. spends more on health care but uses less and covers fewer people than most of these nations (Chart 1).

Second, progress on addressing the uninsured is possible. As serious as the problem is today, it would be worse without a historical string of public policies that have protected coverage for certain populations (Chart 2).[2] President Kennedy's endorsement led to the ultimate passage of Medicare in 1965 under President Johnson. Prior to Medicare in 1963, about 44 percent of the elderly lacked health insurance; today, virtually no senior citizen goes without basic health coverage. In the same year, Medicaid was created, initially as an add-on program to the welfare

system. Efforts by Congressman Waxman among others in the 1980s led to passage of provisions that ensured a nationwide Medicaid safety net for all poor children and pregnant women. And, in the 1990s, in addition to creating new Medicaid options and waivers to expand coverage, President Clinton signed into law the Children's Health Insurance Program (CHIP). Building on Medicaid's coverage for poor children, CHIP has contribute to a decline in uninsured children, even during the recession, making the uninsured rate for children the lowest among all non-elderly age groups.

These Federal efforts have been paralleled and sometimes surpassed by state efforts to increase health insurance coverage. It is not by accident that some states like Minnesota, Rhode Island, Wisconsin and Iowa have the lowest rates of uninsured residents in the nation.[3] Each state has enacted policies to create a public program options for low-income populations and has a set of reforms for private insurance systems that exceed those in most states. In fact, if every state had Minnesota's uninsured rate, the number of uninsured would be cut virtually in half, to 23 million Americans.

In brief, the problem of the uninsured is not inevitable or inherent in our economic and health system. Other comparable nations have eradicated this problem and remained globally competitive and fiscally solvent. They also have health systems that may have different problems but have yielded demonstrably better health status[4] and higher patient satisfaction[5]. Nor is the problem insoluble. In the U.S., we have succeeded in providing universal coverage to our nation's elderly, universal access to low-income children, and a broad-based coverage system in a subset of states. Lastly, as this testimony will discuss, it is not the lack of ideas, innovation or willingness to compromise on the part of Democrats that has blocked progress on the problem of the uninsured. Indeed, Democratic proposals offer several pathways towards achieving the goal of increasing the number of Americans with affordable access to high-quality health care.

Overview of Democratic Proposals

In the past year alone, a number of significant proposals to address the uninsured have emerged from Democrats. Among Members of Congress, Senator Breaux, arguably one of the most conservative Democrats, unveiled a universal coverage plan that includes guaranteed access to group health insurance and progressive tax credits. At the other end of the political spectrum, Senator Kennedy introduced a pair of bills that would require large employers to provide health coverage and would build on CHIP to cover uninsured parents. A number of other proposals have been introduced that target smaller groups of uninsured individuals.[6] In addition, virtually all of the Democratic Presidential primary candidates have detailed plans to address the problem of the 44 million uninsured Americans.[7] Each of these plans is described briefly in this testimony's appendix, and their main features, differences, and similarities are described below.

Where Do The Uninsured Get Coverage: Under the set of proposals described in this testimony, the uninsured would gain insurance through one of three options: a single, existing insurance option, multiple existing options, or existing options plus a new group health insurance option (Chart 3). Three of the plans have a vision to cover most people through one existing option. The Kennedy and Gephardt plans would almost exclusively expand the job-based

coverage system while the Kucinich plan would rely on Medicare not just for the uninsured but for all Americans. Multiple, existing plans are what the Edwards plan uses to expand coverage to children, low-income adults and the near elderly. All of the other proposals would, in addition to building on existing public and private insurance options, create a new health option for those lacking access to group coverage today, modeled after the Federal Employees Health Benefits Plan (FEHBP). The Clark and Kerry plans call their option the Congressional Health Plan, similar to that described in the literature.[8] It is very similar Governor Dean's Universal Health Benefit Plan, which is a single group purchasing pool for various sets of people and firms. The Breaux and Lieberman versions of this group option allow for states to take the lead in establishing these purchasing pools. These plans implicitly acknowledge the weakness in existing options in helping workers in small firms or people with weak attachments to the labor force. Rather than requiring employers to offer coverage or sending such workers to Medicare or the individual market, they would create a new purchasing pool that provides private health insurance on a group basis to participants.

Who Gets How Much Financial Assistance: Arguably, the most complex parts of the proposals are their eligibility rules for the various new coverage and financial assistance options (Chart 4). Generally, the plans target their policies by age, income, and work status. Children are a major focus in the Edwards, Clark, Dean Kerry and Lieberman plans, each providing generous assistance to families. In addition, these same plans (except for the Kerry plan) extend assistance to young adults. While children have the lowest uninsured rate among non-elderly Americans (11.6%), young adults have the highest rate (29.6% for those ages 19-24). At the other end of the age spectrum, the Edwards and Gephardt plans provide a Medicare buy-in for people ages 55 to 64 who are approaching Medicare eligibility and are less likely to have access to job-based coverage.[9] For people between these age groups, all plans provide some sort of low-income assistance through public programs and progressive tax credits. In addition, most provide additional tax credits to workers in small business, individuals without access to job-based coverage, and unemployed people purchasing COBRA coverage. Some of the Democratic plans, rather than targeting their financial aid and access to options, have broad-based eligibility. For example, Gephardt's plan provides the same 60 percent tax credit to all workers and Kerry's plan provides Federal reinsurance for all high-cost people with group coverage.

Even if every uninsured individual were made eligible for assistance, proposals could fail to achieve their goals if the subsidies themselves are inadequate. The Kucinich plan probably would provide the most generous premium subsidies, although this is not spelled out in the campaign documents. The Gephardt plan would provide generous across-the-board assistance with its tax credit of 60 percent of employer health insurance costs. On the public program side, the proposals generally would maintain Medicaid / CHIP premium structure for children. For adults, the plans have different points at which both premium payments begin and the public program option is transitioned into tax credits for private insurance options. This ranges widely, from no public program option for childless adults in the Gephardt plan, to covering all families with income up to 185 percent of poverty in the Dean plan, to subsidizing children in employer plans or CHIP in families with income up to 500 percent of poverty in the Edwards and Clark plans. The Clark plan's assistance is extended to similar groups of people as the Edwards plan, but covers a larger share of premiums for eligible individuals. Since the majority of the

uninsured have low income, each plan's generosity and extent of eligibility for assistance would have a major impact on its effectiveness at moving towards universal coverage.

How Is Financial Assistance Delivered: The plans use a wide range of tools to make health insurance more affordable for Americans, particularly those who are uninsured. They can be classified under three broad headings: tax credits to individuals, subsidies to insurers or employers, and subsidies through public programs (Chart 5). All reform proposals except for Kucinich's would provide some type of advanceable, refundable tax credit directly to individuals to reduce their payments for health insurance. The Edwards and Clark plans' tax credit for children's coverage and the Breaux and Gephardt plan's tax credit for low-income families are set as a percent of premiums, so that their value automatically adjusts for premiums in high cost areas or for sicker, more expensive people. The new group options in the Kerry, Dean and Lieberman plans would include a tax credit for their premium costs that exceed a set percent of income (from 6-12%).

A second set of subsidies would reduce peoples' premium costs indirectly, by subsidizing employers and insurers. The Gephardt plan finances coverage almost entirely through a 60 percent tax credit to employers for their premium costs. Employers will presumably pass along this subsidy to workers by having them pay a lower share of the premium (or through higher wages). Small businesses with low-wage workers would also receive assistance under the Kerry and Edwards plans. In addition to employers, insurers would receive subsidies under the Kerry plan in the form of reinsurance for high-cost enrollees. The Dean, Clark and (to a lesser extent) Lieberman plans use Federal funding to stabilize premiums for their new group options, allowing individuals to purchase coverage at rates reflecting the whole population, not just participants, limiting adverse selection problems.

Finally, all plans would expand access to low/no premium health insurance through public programs. Generally, these expansions build upon the existing Medicaid and CHIP benefits, financing and delivery systems. Medicaid charges eligible individuals no premiums and nominal cost sharing, while CHIP allows for premiums and cost sharing that do not exceed 5 percent of income. Several of the plans would expand public programs through "buy-ins", raising the premiums charged to participants as eligibility extends up the income scale. How health insurance subsidies are delivered matters since it affects both uninsured people's interest in and ability to purchase coverage and employers' willingness to offer coverage. For example, a Federal subsidy to reduce monthly premiums via an employer or public program may increase coverage more than the same subsidy provided as an end-of the-year tax refund. That said, advancing the tax credit so it accessible on a real-time basis could lessen this difference.

Is Health Coverage Guaranteed: Although numerous goals motivate national health reform, one generally comes to mind first: does the plan provide universal coverage to Americans? Universal coverage generally means that all individuals receive health insurance coverage though some type of individual and government requirement. The plans of Senator Breaux and Representative Kucinich (and Ambassador Moseley Braun and Reverend Sharpton) make health coverage an enforceable right for all people in the U.S. (Chart 6). The Edwards and Clark plans do so for children, requiring parents to provide health insurance for them in existing and new options created by his plan. The Kennedy and Gephardt plans include a requirement for

employers to offer coverage, not for individuals to obtain it. This would significantly improve access to health coverage but would not achieve universal coverage.

The Kerry, Dean, and Lieberman plans do not include requirements that individuals obtain health insurance, but create options and systems to move towards universal coverage. The Kerry plan would provide an affordable health insurance option to all Americans, including those whose firms buy them into the new group health option. The Dean, Clark and Lieberman plans would allow, at a minimum, all those that lack access to job-based coverage to purchase coverage through the pool. This effectively provides access to all those who lack it now. These plans generally structure their enrollment systems like Medicare's voluntary Part B program that has 99 percent participation among those eligible for it. Coverage would not be required but system changes are designed to maximize enrollment.

Differences in Plans

There are three major differences in the Democrats' proposals, which affect the outcome measures of how much each plan costs and how many of the uninsured it covers.

Extent of Reliance on Job-Based Coverage: Although all (but the Kucinich plan) rely on employer-based health insurance, the plans differ in their promotion of this source of coverage. The Breaux and Kerry plans, for example, allow a large number of people to participate in their new FEHPB-like health insurance options which effectively ends the link between group coverage and jobs. Some argue that this linkage distorts people's willingness to change jobs for fear of losing health benefits. On the other hand, the Kennedy and Gephardt plans move the uninsured into job-based coverage. They strive to maintain health insurance as a critical work-place benefit along with the employer contributions associated with it.

Breadth of Eligibility for Financial Assistance. The Democrats' plans differ in the extent to which they target funding to the uninsured to maximize efficiency or make funding available to similarly-situated people, even if they have health coverage now, to promote equity. The Lieberman plan explicitly takes a targeted approach, so it has numerous, relatively narrow eligibility categories and thus lower the Federal spending per newly insured individual. Similarly, the Edwards policy targets its funding only to children and certain low-income people. On the other hand, the Gephardt plan is blind to individuals' income, family status, existing coverage, etc. in providing its tax credit, as is the Kerry reinsurance system. This difference is not just a matter of principle (efficiency versus equity); it affects Federal costs, as described below.

Degree of Health Care Cost Containment: An issue that interacts and exacerbates the uninsured problem is the high and rapidly growing cost of health care. This issue is addressed explicitly by the Kerry, Clark and Edwards plans and, to a lesser degree, the Dean and Lieberman plans. These plans generally target prescription drug cost growth as a source of savings, proposing ideas such as increasing access to generics and price information and decreasing the volume of direct-to-consumer advertising. The use of technology in prevention and managing disease as well as reducing costly medical errors and administrative costs is emphasized. The Clark plan would create a commission that, among other tasks, would provide

comparative information on the cost effectiveness of alternative therapies, aimed at helping public and private purchasers of health coverage make better, more efficient decisions. The Edwards plan mentions reducing health care fraud and overpayments, and several of the plans lay claim to cost savings due to a simplified, more rational coverage system in the U.S. The plans generally do not put a price tag on the savings from health care cost containment and, indeed, it is not clear that they would cover a large percentage of the new costs of the plans. The Congressional plans as well as the Gephardt and Kucinich plans focus more intensely on coverage than cost and mention few ideas in their documents.

Costs and Coverage: The type of health insurance promoted, the amount of assistance, and the narrowness or broadness of the eligibility rules are major factors in determining the cost of each plan. One analyst has used the same model to assess the Democratic Presidential primary candidates' plans (Chart 7). He found that the cost of the plans ranges from $590 billion over 10 years (Edwards) to $2.5 trillion over the same period (Gephardt) (note: the Kucinich estimate comes from that campaign). Each plan's potential success at reducing the uninsured is loosely correlated with its cost, with the Edwards plan covering the least – 21.7 million – and the Gephardt plan covering about 32 million uninsured. However, the targeting issue makes a difference with respect to cost. The Clark, Dean, Kerry and Lieberman plans all would insure an estimated 30-32 million uninsured people Despite their similarity in coverage, their costs range from $747 billion over 10 years (Lieberman plan) to $932 billion over the period (Dean plan), reflecting differences in the eligibility rules and amounts of financial assistance.

The Congressional plans do not specify how they would be financed, and the Presidential candidates provide different levels of detail. Kucinich is most specific, proposing a phased-in 7.7 percent payroll tax to both fund the new program and replace the current tax exclusion of employer-sponsored insurance. The Clark plan, in its budget plan, includes $125 billion over 10 years in Federal health savings, and gives examples of how those could be achieved. All of the other plans specify that the new Federal costs would be offset by repealing part or all of the 2001 tax cut law. It is important to note that, as costly as these plans may seem, only the Gephardt and Kucinich proposals come close to the cost of the President's 2001 tax cut.

Similarities in Plans

Arguably, the similarities among the Democratic proposals are greater than their differences (Chart 8). Some of these similarities reflect a set of core elements that distinguish traditionally Democratic from Republican proposals.

Expansion of Effective Public Programs: History has shown that Federal and state efforts to expand Medicare, Medicaid and CHIP have been successful at reducing the number of uninsured. This is because these programs combine a guarantee of affordable comprehensive health benefits with payments sufficient to ensure access to health care providers and private health plans. Yet, major gaps existing in the public program safety net. The typical state's upper income eligibility limit for parents is well below the poverty level, and non-disabled adults without children are only eligible through Federal waivers. These gaps help explain why roughly two-thirds of the uninsured have income below 200 percent of the poverty level. All of

the Democratic plans maintain or build on Medicaid / CHIP to insure these low-income uninsured.

Reliance on Private Group Health Insurance: A second common denominator among the Democratic plans is their embrace of private group health insurance. The idea behind group health insurance is that communities of people share the individual risk of high health care costs. This pooling of risk across a large number of people makes coverage affordable for high-cost people without the regulation required to do so in the individual insurance market. Some plans build on the groups of workers in firms, expanding employer-sponsored insurance, while others create a new group health insurance option like FEHBP. Both approaches have similar goals and effects.

Recognition of the Need to Invest In Coverage: Third, the current Democratic proposals, like most plans and proposals in the past, have recognized that there must be a significant Federal investment to reduce the number of uninsured. In 2003, the average cost of a family policy in employer-sponsored insurance exceeded $9,100 per year.[10] This exceeds 80 percent of the annual income of a full-time worker earning the minimum wage. Cost is a major reason why people lack health insurance, so that public financial assistance is an essential part of any strategy to successfully lower the number of uninsured Americans. All of the Democratic proposal recognize and reflect this need for investment.

In addition to these core elements, the current set of Democratic plans to address the uninsured generally share several new characteristics that were absent from previous debates.

Use of Tax Credits As Well As Public Program Assistance: Historically, Republicans have used tax policy and Democrats have used public programs to expand health insurance. In the current context, many of the Democratic plans adopt both approaches, breaking with an historic concern about the effectiveness and equity of using tax subsidies for health insurance. These "hybrid" plans reflect both an interest in helping middle-income people not easily assisted through public programs and an understanding that achieving bipartisan support probably requires the inclusion of tax credits.

Innovation In Financing and Delivery: The current set of proposals also includes innovative new approaches to improving health insurance accessibility and affordability. Several of the plans (Kerry, Clark, Dean) use Federal reinsurance and risk adjustment to shield individuals from paying for high-cost members of the group health insurance pool. One plan (Clark) would eventually link public financing with delivery of benefits that are medically and economically sound. Others (Dean, Clark, Edwards) include aggressive "default enrollment" systems to prevent people from falling through the cracks by failing to sign up for health coverage. And, those plans with requirements for coverage (Breaux, Clark, Edwards) have incorporated tax penalties as both an enforcement tool and financing source – another idea relatively new to the debate.

Principle of "Do No Harm": One emerging trend in the health reform proposals is a focus on preserving existing coverage, both in terms of sources of coverage and the extent of health benefits. The proposals include financial incentives, disincentives and other policies to maintain

rather than erode employer-sponsored and public coverage – building on these systems. They also tend to focus on the importance of providing meaningful coverage. For example, the Kennedy and Breaux plans ensure that benefits are at least as good as those that Federal employees (and Members of Congress) get. The Clark plan would use research and evidence-based medicine – rather than "consumer-driven" high deductible plans – to determine what benefits to cover and cost sharing to include. The goal of protecting coverage is more distinct in these plans than in those of the early 1990s, perhaps reflecting recent erosions of employer-based coverage and benefits.

Pragmatism: The plans are notable for their restraint as well as their size. While all of the Democratic plans make significant inroads into the problem of the uninsured, few are truly universal coverage plans. Universal access has replaced universal coverage as the theme in the plans. In addition, the idea of a single payer system – popular in the early 1990s – has moved to the fringe of this debate. Most of the plans are phased in over number of years and few disrupt current coverage arrangements. And while they all make significant investments, most plans' costs are not twice the $400 billion investment in a single Medicare benefit – prescription drugs. And few of them cost much more than the tax cut package presented in last year's President's budget. These changes reflect a more pragmatic rather than ideological approach to health reform, perhaps coming from the lessons of past health reform efforts.

Conclusions

In several respects, 2004 holds promise for efforts to reduce the number of uninsured Americans. The fact that this is the topic of the first DPC hearing of 2004 indicates its priority and reflects a long history of Democratic leadership on health reform. Senate Republicans have shown enough interest to create a task force on the topic. And, although the President has not announced his health reform platform for his campaign, the intensity of the Democratic candidates' focus on health coverage ensures that it will be a major election issue. Beyond Washington, the new Medicare law creates a Citizens' Health Care Working Group to produce a report to increase the prospects of health reform. And states like Maine have already passed coverage expansion legislation and are implementing their own plans.

As this testimony aims to illustrate, the barrier to progress on health coverage is not a lack of commitment, ideas, innovation or pragmatism on the part of Democrats. The proposals discussed here offer diverse methods of addressing this problem from a common framework. They offer policy makers choices on the amount and type of investment while preserving existing coverage and elements of the health system that work. And they illustrate a level of commitment and flexibility that goes beyond politics and ideology. Progress can be made if the President and Republicans in Congress show similar commitment and flexibility. In my view, the lack of priority given to the problem, cooperation and leadership are the real barriers to reducing the nation's uninsured population.

APPENDIX: BRIEF SUMMARY OF MAJOR DEMOCRATIC PROPOSALS
(In Alphabetical Order)

CONGRESSIONAL PLANS

Senator Breaux. The Breaux plan builds on existing health insurance options, creates a new state-based group option like the Federal employees plan, and requires individuals to obtain coverage.[11] To make health coverage affordable, the plan creates refundable, advanceable tax credit for people below 250 percent of the poverty level. These credits would apply toward employer-based coverage, the new state-based option, and individual coverage. Medicaid would continue to provide coverage but would not be expanded. Employer and state maintenance of effort provisions would be included to keep those dollars in the system. Individuals would be default-enrolled into plans if they do not sign up for one and would pay a tax penalty to compensate for the government cost. The plan's individual mandate means that all 44 million uninsured would be covered under the plan. There is no cost estimate associated with the plan, but given the low-income cut-off of the tax credit, one analysts suggests that it would cost $300 billion over 10 years.[12]

Senator Kennedy. Senator Kennedy has two bills that work together to expand coverage. The first focuses on the employer-based health insurance. It requires that employers with at least 100 full-time employees to offer and pay for such coverage.[13] Employers would make a pro-rated contribution for those who work less than 30 hours a week and would have responsibility for most contract, temporary and leased workers. Employers must offer benefits at least equivalent to those provided under the Blue Cross Blue Shield plan in the Federal Employees Health Benefit Plan (a similar provision is included in the Breaux plan). The Senator claims that the legislation would cover more than a third of the uninsured.[14] Because this is a private mandate, the Federal cost of the legislation would be the lost tax revenue due to the tax subsidies for employer-sponsored insurance (the amount of this lost revenue is not known). The second bill is the FamilyCare Act, co-sponsored by Senator Snowe, that expands CHIP to cover parents.[15]

PRESIDENTIAL CANDIDATES' PLANS

General Clark. The Clark health plan has three parts to its coverage initiative.[16] Like Edwards, it would require coverage for all children (here defined as those age 22 and younger). Second, it would adopt a new group health insurance option like the Federal employees plan, as is done in the Kerry and Dean plans, with Federal assistance to stabilize premiums. Third, it would extend Medicaid / CHIP to 150 percent of poverty with sliding-scale tax credits to 275 percent of poverty for adults (500 percent of poverty for children). The cost of this expansion would be partially offset by $125 billion over 10 years in Federal health savings from policies such as Medicare competitive bidding for certain services. The plan would also create a commission whose focus is to improve the benefits covered by public and private health insurers. This underscores the theme of the Clark plan, which is "value". It aims to improve the "return on investment" in health coverage by focusing it on preventive services, disease management, cost effectiveness, and appropriate cost sharing.

Governor Dean. The Dean health reform plan is also a "hybrid", building on existing pubic and private health insurance options as well as creating a new group option to help those who have fallen into the gaps.[17] Its new group option would be for people in small firms or the individual insurance market and would be subsidized through a tax credit for premium costs that exceed 7.5 percent of participants' incomes. Reinsurance would be used to stabilize the new option. Workers in large firms paying high premiums could join the pool, and large firms would be given incentives and penalties to maintain affordable coverage. The plan would create new options for young adults and expands Medicaid / CHIP to 300 percent of poverty for children and 185 percent of poverty for adults. Its emphasis is on practicality and feasibility: identifying policies that could be enacted and implemented using systems in place today.

Senator Edwards. The Edwards plan has as its primary focus covering all children.[18] Parents would be required to insured their children, assisted by tax credits for employer insurance and an expansion of CHIP. In addition, the plan would expand Medicaid / CHIP to 100 percent of poverty for adults, with a sliding scale premium to 250 percent of poverty. It would provide new options for young adults and create a purchasing pool and tax credits for small businesses to encourage them to offer coverage. And, it would allow people ages 55 to 65 years old to buy into Medicare. The plan also outlines cost containment and quality improvement ideas. The Edwards plan emphasizes the responsibility of government and parents to provide health insurance to all children as the first priority in health reform.

Representative Gephardt. The Gephardt plan would require all employers to offer health insurance, and would provide a 60 percent tax credit for their contributions to coverage.[19] Employers not now offering coverage could apply the tax credit toward the full premium costs. To improve the affordability for lower-income workers, the plan includes a tax credit equal to 25 percent of their share of premium costs if their income is below 200 percent of the poverty level (about $37,000 in 2003 for a family of four). The plan would also allow states to cover the parents of children eligible for Medicaid / CHIP in those programs, and would create a Medicare buy-in for people ages 55 to 64. The plan would be financed by fully repealing the 2001 tax cut law. Representative Gephardt considers this legislation economic and well as health policy: it would redistribute tax revenue reductions more progressively, thus both reducing the uninsured and stimulating the economy.

Senator Kerry. The Kerry plan would create a new group health insurance option, modeled on the Federal Employees Health Benefits Plan, that would be accessible to all firms and individuals.[20] Premiums for coverage would be subsidized through reinsurance (described below) and a tax credit that limits premiums as a percent of income. Small firms participating in the option would receive a tax credit of up to 50 percent of their contributions for low-wage workers. In addition, both the new group option and qualified employer-sponsored insurance would receive federal reinsurance. Specifically, the Federal government would pay 75 percent of qualified insurance claims that exceed $50,000 for an individual. The plan would also expand Medicaid / CHIP for children to 300 percent of poverty, parents to 200 percent of poverty, and childless adults to 100 percent of poverty. The Kerry plan places a strong emphasis on cost containment, and includes a number of policies to reduce health care costs for all Americans.

Representative Kucinich. The Kucinich plan would expand Medicare to all Americans, eliminating the role of private insurers in the system.[21] This single-payer approach would phase in coverage for children first and then older adults. It would not just be for the uninsured: all Americans would be moved into this new system. The exact benefits covered or premiums and cost sharing charged are not specified. The plan would be funded by replacing the current employer deduction for health insurance with a phased-in 7.7 percent payroll tax. Ambassador Moseley Braun and Reverend Sharpton also support a single-payer system. The emphasis in this plan is on administrative simplicity: if the administrative overhead and insurer profits were taken out of the health care system, costs would go down and access would improve.

Senator Lieberman. The Lieberman plan resembles that of Kerry and Dean in its use of existing and new group options, but is unique in its targeting of assistance to groups particularly likely to be uninsured.[22] It targets children by, first, expanding Medicaid/CHIP and then creating "Medikids", a Medicare-like program open to all children and young adults. The plan would also expand Medicaid / CHIP to adults with income below 150 percent of poverty and provide refundable tax credits to adults above this income threshold for purchase of coverage in a new group option. The new group option would be accessible to certain groups of people like workers in small businesses, self-employed, seasonal workers, the near elderly, and the unemployed, among others. Tax credits for pool premiums that exceed 7.5 percent of income would be provided, and reinsurance would help stabilize the option. The plan also includes initiatives on research, prevention, quality and public health. The Lieberman plan aims at targeting populations and resources to move "step-by-step" towards universal coverage.

ENDNOTES

[1] Blendon R et al. (May 2003). "Common concerns amid diverse systems: health care experiences in five countries," *Health Affairs* 22:106-121.

[2] Interest in the problem dates back to the turn of the century, when health insurance along with unemployment insurance, retirement security and labor laws were actively debated by Teddy Roosevelt and other reformers. It resurfaced in states in 1915, as a potential element of the New Deal in the 1930s and as stand-alone legislation in the 1940s – led by efforts by the senior Congressman Dingell among others.

[3] Census Bureau. (September 2003). *Health Insurance in the United States, 2002*. Washington, DC: U.S. Department of Commerce.

[4] See National Center for Health Statistics. (2003). *Health United States, 2003*. Atlanta: U.S. Department of Health and Human Services, CDC.

[5] Blendon et al.

[6] The Breaux and Kennedy proposals are described here but other Senators and Representatives introduced other initiatives to reduce the number of uninsured on a more targeted basis. These are not discussed in this testimony since its topic is major proposals that would significantly reduce the uninsured.

[7] Ambassador Mosley Braun and Reverend Sharpton both support health care as a right but have not issued detailed plans and are thus their plans are not addressed here. For fuller descriptions of the candidates' plans, including that of President Bush, see Collins SR, Davis K, and Lambrew JM. (November 2003). *Health Insurance Coverage Returns to the National Agenda: The Health Insurance Expansion Proposals of the 2004 Presidential Candidates*. New York: The Commonwealth Fund and .Lambrew JM. (November 3, 2003). *Health Reform in the 2004 Election: An Overview of the Plans.* Brandeis University, Council on Health Care Economics and Policy. Much of this testimony was drawn from these papers.

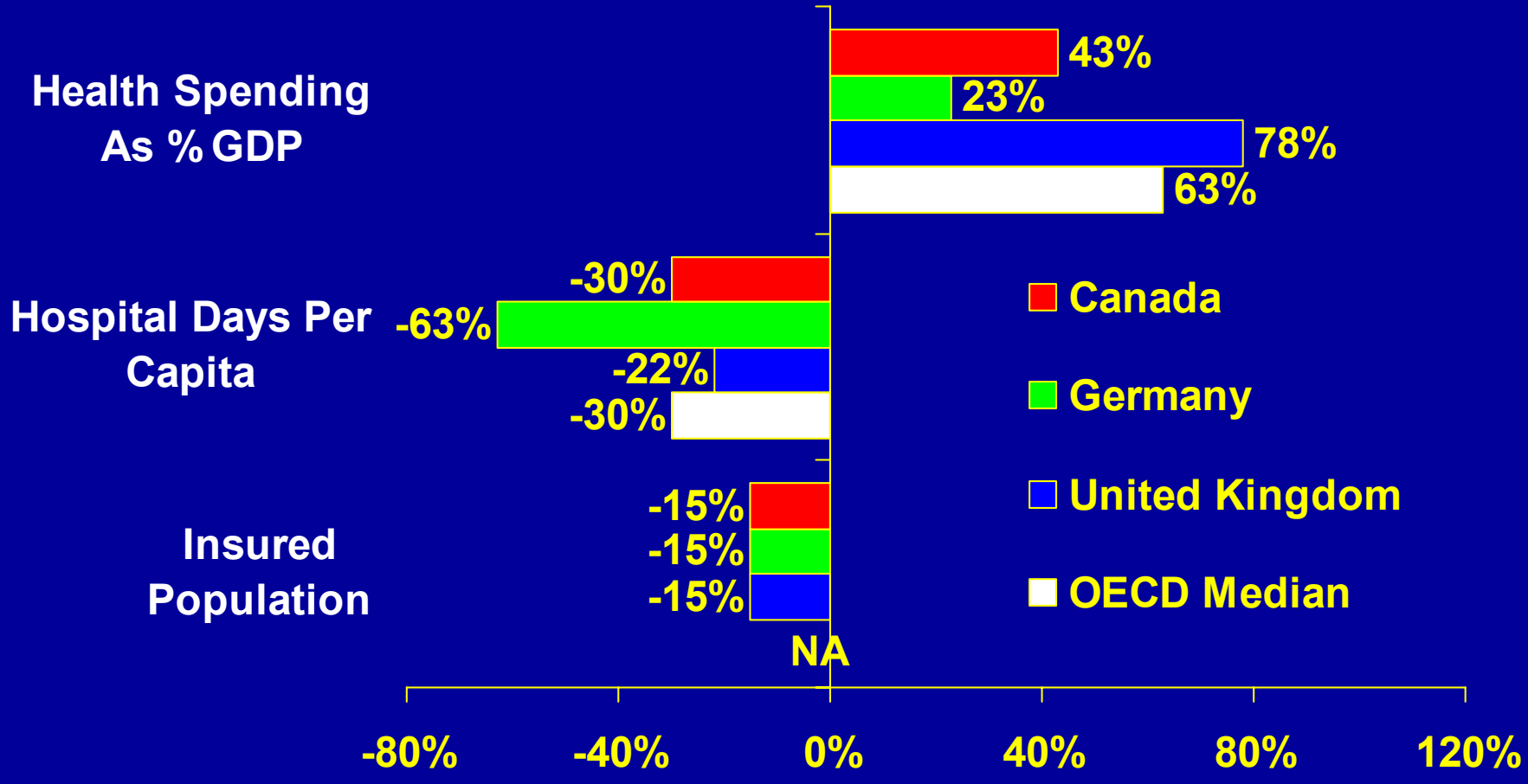
[8] See, for example, Davis K and Schoen C, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive (23 April 2003): W3/199–211.

[9] Note: Both these younger and older adults are generally allowed into the broad new group health insurance option with financial assistance. As such, even though they are not specifically targeted by the Breaux, Clark, Dean, Kerry and Lieberman plans, they would have subsidized options.
[10] Kaiser/HRET. (2003). *Employer Health Benefits 2003 Annual Survey.* Menlo Park, CA: The Henry J. Kaiser Family Foundation.
[11] Note: This plan has not been introduced as legislation. A description may be found at: http://breaux.senate.gov/issue_health_care.html
[12] Lemieux J. (January 24, 2003). "Cover the Uninsured: For Less Than Half The Price!" *New Democrats Online*, http://www.ndol.org/ndol_ci.cfm?kaid=111&subid=137&contentid=251190.
[13] See S. 2639, Health Care for Working Families Act, introduced in the second session of the 107th Congress.
[14] See Congressional Record: http://thomas.loc.gov/cgi-bin/query/D?r107:1:./temp/~r107fO0nN0:b69761:.
[15] See S. 1843, FamilyCare Act of 2003, introduced in the first session of the 108th Congress.
[16] See description at: http://clark04.com/issues/healthcare_long.pdf.
[17] See description at: http://www.deanforamerica.com/site/PageServer?pagename=policy_statement_health.
[18] See description at: http://www.johnedwards2004.com/healthcare.asp.
[19] See description at: http://www.dickgephardt2004.com/plugin/template/gephardt/33/*.
[20] See description at: http://www.johnkerry.com/issues/healthcare/.
[21] See description at: http://www.kucinich.us/issues/universalhealth.php.
[22] See description at: http://www.joecare.com/.

Chart 1.

U.S. Spends More, Uses Less and Provides Fewer Citizens Health Care

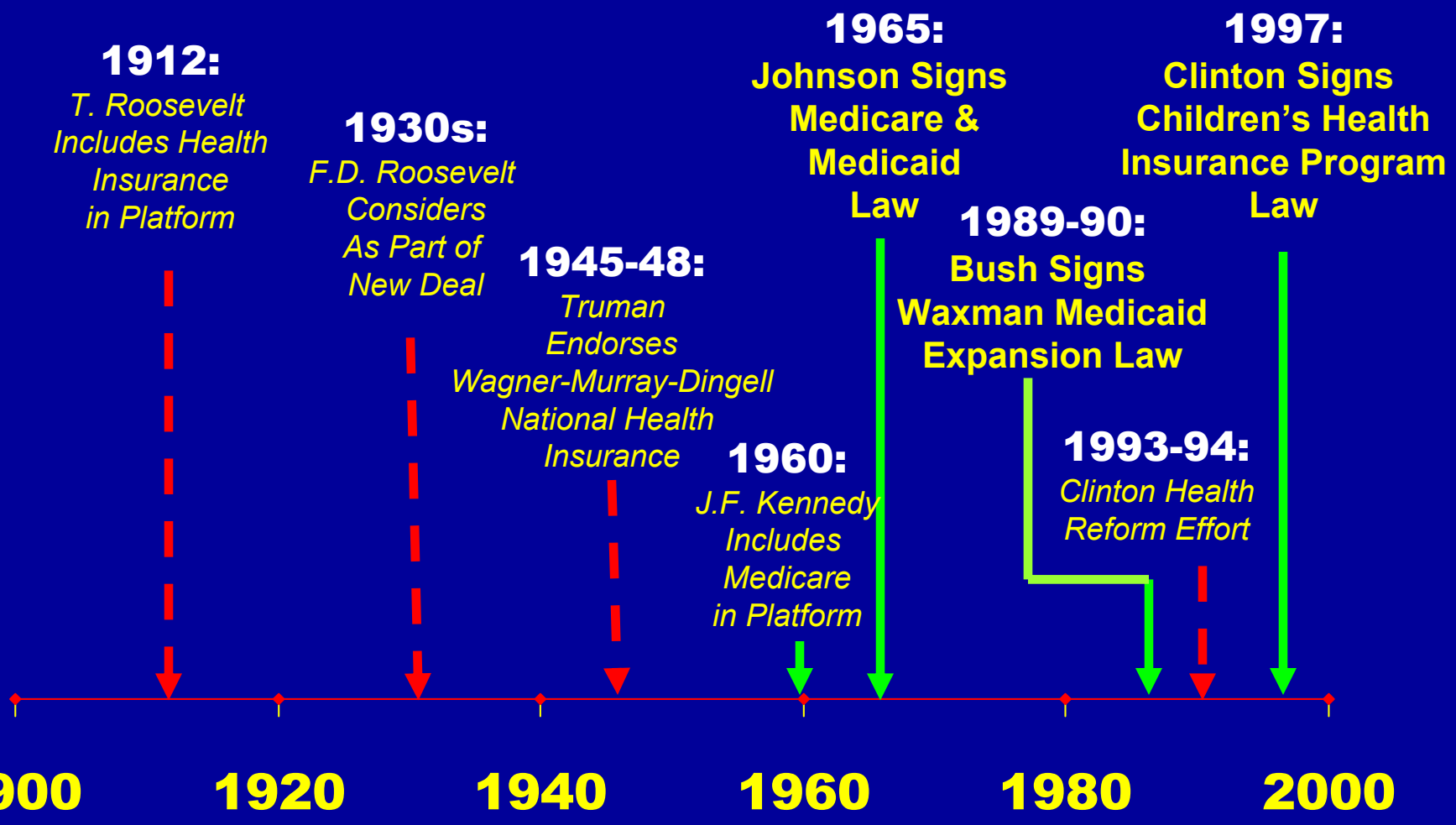
U.S. Percent Above/Below Other Countries, 2000



Sources: Anderson et al. (May/June 2003). "It's The Prices, Stupid: Why The United States Is So Different From Other Countries," *Health Affairs*, 22(1): 89-103. Note: OECD stands for Organizations for Economic Cooperation and Development.

Chart 2.

Key Moments in U.S. History on Health Insurance Reform



Sources: K. Davis. (March 2001). "Universal Coverage in the United States: Lessons From Experiences of the 20th Century," *Journal of Urban Health* 78(1): 46-58; A.E. Birn et al. (January 2003). "Struggles for National Health Reform in the United States," *AJPH*, 93(1): 86-91.

Chart 3.

DEMOCRATIC PLANS

Where Do The Uninsured Get Coverage?

HYBRID: EXISTING & NEW PRIVATE OPTIONS

Breaux, Dean, Kerry, Clark, Lieberman

EXISTING PUBLIC OPTION

Kucinich

EXISTING PUBLIC/ PRIVATE OPTIONS

Edwards

EXISTING PRIVATE OPTION

Gephardt, Kennedy

Individual Insurance

New Group Health Option

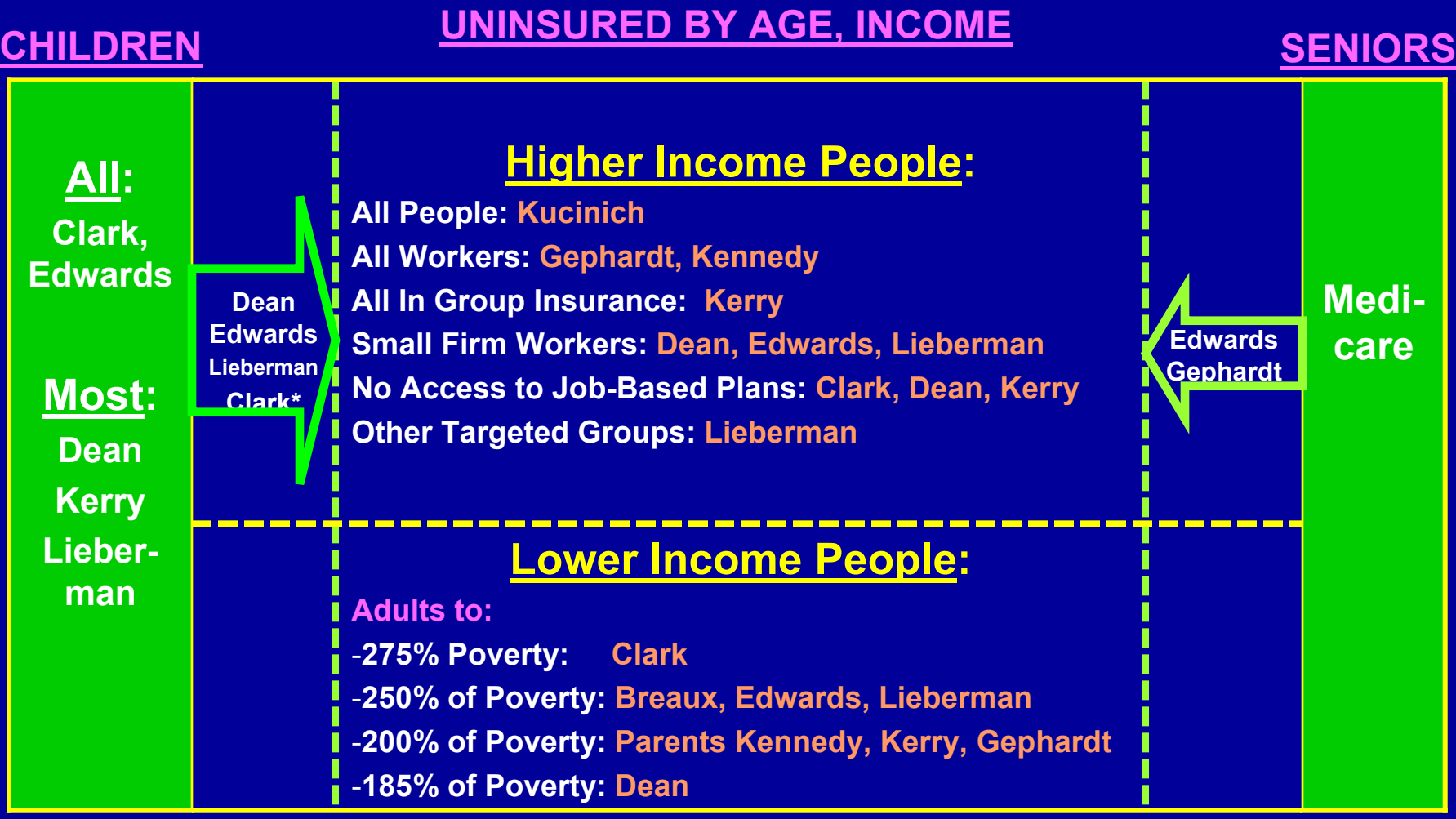
Employer-Sponsored Insurance

Medicaid/ CHIP

Medicare

Chart 4.

Who Gets Financial Assistance?



Note: Rough distribution of uninsured based on Census data.

•Edwards' requirement extends through age 20 and below but extends assistance through age 25; Clark requirement through age 22; Lieberman subsidizes coverage through age 25; Dean requires insurers to offer dependent coverage through age 24.

Chart 5.

How Is Financial Assistance Delivered?

Tax Credits to Individuals

- **Percent of premiums, usually phased out by income limits**
  - **Full premium phased out:** Breaux, Edwards, Clark
  - **65-75% of COBRA premium**: All but Kucinich
- **Amount that exceeds a percent of income spent on premiums**
  - **Amount >7.5% of income:** Dean, Lieberman for new group option

Subsidies to Private Employers or Insurers

- **Tax credits to employers**
  - **60% of costs**: Gephardt
  - **Up to 50% of costs for small firms:** Edwards, Kerry
- **Reinsurance**
  - **75% of group health plans claims above $50,000:** Kerry

Subsidies through Public Programs

- **Medicaid/CHIP**
  - **Different upper income limits**
  - **Different ways of financing state costs**
- **Medicare buy-in**
  - Gephardt, Edwards
- **Medikids**
  - Lieberman

Chart 6.

Is Health Coverage Guaranteed?

- **Requires health care coverage for individuals**
  - **Breaux**
  - **Kucinich**
  - **Edwards, Clark** for children
- **Guarantees access to health coverage**
  - **Dean, Kerry, Clark**
  - **Lieberman** for children
- **Requires all employers to offer health coverage**
  - **Gephardt**
  - **Kennedy** for large employers

Chart 7.

Cost, Coverage & Differences

	COST 10 Years	Uninsured Covered	Emphasis on Job-Based Coverage	Broad-Based Assistance	Emphasis on Cost Containment
Kucinich	~$5 tr	44 m		✔	
Gephardt	$2.5 tr	30.9 m	✔	✔	
Dean	$932 b	30.2 m			✔
Kerry	$895 b	26.7 m		✔	✔
Clark	$820 b**	31.8 m			✔
Lieber-man	$747 b	31.6 m			✔
Edwards	$590 b	21.7 m			✔

** Clark plan adds $48 billion to Thorpe estimate for other priorities (e.g., veterans) and has $125 billion / 10 in savings that it counts against this $820 billion for a net cost of $695 billion over 10 yrs.
Estimates from K. Thorpe, except for Kucinich (From campaign)

Chart 8.

Similarities in Democratic Plans

Core Elements

- Build on Public Programs
- Rely on Private Group Health Insurance
- Invest in Coverage

What's New

- Use Tax Credits As Well As Public Programs
- Adopt Innovative Financing & Delivery Systems
- "Do No Harm"
- Reflect Pragmatism