Senate Democratic Policy Committee Hearing

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

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Thank you for inviting me to testify today. Families USA is the national organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care. Families USA strongly supports comprehensive, affordable health insurance for all residents of this nation.

We believe it is a shame and disgrace that in any two-year period, approximately 75 million people – nearly one out of three Americans who are not eligible for Medicare – are uninsured for some period of time.[1] Every American who has health insurance receives some subsidy for that insurance from the Treasury—either directly through public programs or indirectly through the tax deductions available for private insurance. It is profoundly unfair that almost all of us in this room have tax-subsidized health coverage while today such a large portion of our fellow citizens get no such help.

Going without health insurance can have terrible consequences. The Institute of Medicine estimates that every year about 18,000 Americans die prematurely and unnecessarily because they do not have health coverage.[2] That is about two deaths per hour. While we meet this morning, several of our fellow citizens are dying needlessly because they do not have health insurance. Millions more suffer from poorer health, lost income and stunted lifetime opportunities because they do not have coverage.

Strengthen public coverage

Families USA believes the most efficient form of health insurance is public program coverage, and we support the expansion of public programs such as Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Public programs are efficient because they do not need the marketing, profit, and other overhead of private plans and because the federal government, as a volume buyer, can get a good price for services. The public programs tend to have more due process and consumer protections than many private plans. Public programs can be more stable and dependable, therefore ensuring continuity of care and access to a family doctor that is vitally important for the good health of patients.

Medicaid serves approximately 51 million lower-income people,[3] most of whom would be uninsured without the program's health lifeline. The program, however, does not reach many millions of others who are uninsured and no less needy – typically low-wage

workers and the dependents of those workers. This is because Medicaid's current structure creates eligibility standards that resemble a crazy-quilt.

Eligibility for Medicaid differs substantially from one state to another and quite radically based on family status. In nearly four out of five states, children are eligible for Medicaid or SCHIP if their families' incomes are below 200 percent of the federal poverty level.[4] The parents of these children, however, are often ineligible for public health coverage: the median income eligibility limit for parents among the 50 states is 71 percent of the federal poverty level[5] – a mere $10,835 in annual income for a family of three. Moreover, for adults who are not parents – individuals living alone or childless couples – the federal safety net is almost all hole and no webbing. In 43 states, childless adults can literally be penniless and still fail to qualify for Medicaid or any other public health coverage unless they are severely disabled.

This arbitrary and sparse eligibility system needs to be modernized. Eligibility for Medicaid should become more uniform and should no longer be predicated on family status. Everyone with family incomes below a specified level – such as 200 percent of the federal poverty level – should be eligible for public health coverage, irrespective of their state of residence or family status, especially if they cannot obtain health coverage in the workplace. An increment towards this goal, introduced in the last Congress by Senators Kennedy and Olympia Snowe (R-ME), would provide health coverage to low-income parents of children eligible for SCHIP or Medicaid coverage.[6] It would enable approximately 7 million currently uninsured parents to gain public health coverage, and – in so doing – would improve children's enrollment in such coverage by allowing them to sign up for health coverage as a family unit.

The public health programs also need to be changed because of the way they discriminate against *legal* immigrants. As a result of legislation adopted less than a decade ago, legal immigrants who enter the United States after August 1996 are prohibited from receiving Medicaid or SCHIP coverage for five years. Legislation to give states the option to extend health coverage for legal immigrant children and pregnant mothers recently received support from two-thirds of the Senate, but opposition by President Bush and the Republican House leadership has prevented its enactment.

Use the $50 billion in the FY04 Budget Resolution for the uninsured

We were pleased that the FY 2004 budget resolution provided $50 billion over ten years to help reduce the number of uninsured. We were very disappointed that the First Session of the 108th Congress adjourned without using that budget allocation. We understand it is still available to be used until the next budget resolution is passed, and we urge you to make the use of these resources a priority in the next several months.
Attached to my statement are several illustrations showing how $50 billion could be used to help reduce the number of uninsured by up to several million people a year.[7]

The Chairman and Ranking Democratic Member of the Senate Finance Committee have introduced a bill to extend the Trade Adjustment Assistance Reform Act (TAARA)

health provisions to those in the Unemployment Insurance program.[8] With a few changes that we recommend to make it more affordable for lower-income workers, this refundable, advanceable tax credit proposal could help hundreds of thousands of uninsured individuals during the very difficult time of being unemployed.
The Grassley-Baucus proposal would fit within the $50 billion budget window and would make a small but important improvement in reducing the level of uninsured. Attached to my statement are several papers Families USA has prepared on how the TAARA program works, and how it could be made to work better if extended to the unemployed.[9] We hope the Congress will pass this legislation early this year.

Wrong roads in health insurance

There are many in Washington who appear not to understand the concept of insurance and the history of health care. Insurance is about spreading risk as broadly as possible. Historically, 5 percent of the public has always used about 50 percent of the health care dollar.[10] None of us can predict with certainty who will end up in that 5 percent. The only way to make insurance affordable for everyone, especially for those who are part of the 5 percent with significant medical needs, is to spread the risk as broadly as possible.

Instead of understanding these basic truths, there are many who are trying to find ways to help one small group or another save money relative to the rest of society. These are just 'beggar your neighbor' policies. It is a strange society that seeks to find ways to help those who are healthy and hurt those who are sick or are people with disabilities.
But that is what is going on. There is an element of social Darwinism in these proposals: Take care of the healthy and wealthy; every man for himself; the sick and handicapped deserve what they get.

I would like to comment on three ideas that are seriously being considered by Congress that take America down the wrong road:

- Health Savings Accounts or Medical Savings Accounts
- Tax credits to buy insurance in the individual market
- Association Health Plans

All three of these proposals and ideas hurt the concept of broad-based insurance and result in shifting costs to those who are not healthy and wealthy.

Health Savings Accounts

Last summer, the House of Representatives added to the Medicare prescription drug bill a $174 billion (over ten years) program to provide tax deductions for Health Savings Security Accounts (HSSAs) and Health Savings Accounts (HSAs). The final Medicare bill scaled this back to approximately $7 billion for HSAs.

We believe that the HSAs will be harmful to the nation's employer-provided insurance system. Our fear is that proponents will continue to push for larger and larger HSAs

and/or for the HSSA program. Attached is our paper on how these programs work, and why they are bad for American society as a whole.[11]

Tax deductions do little or nothing for most uninusured people. For example, for the 65 percent of uninsured people living on incomes below 200 percent of poverty, setting aside almost $9,000 to pay for health insurance (the current cost of most family polices) is not an economic possibility. In addition, about 36 percent of uninsured people have incomes below 100 percent of the federal poverty level. They do not earn enough to owe taxes, and therefore receive no help from a tax deduction. Another 29 percent of the uninsured have incomes between 100 and 200 percent of the federal poverty level. They would receive at most a small tax deduction of 10 percent, which does practically nothing to make health insurance affordable for their families.[12]

HSAs/HSSAs are also bad for the stability of our employer-based health insurance system. Employers will likely use HSAs and HSSAs to justify offering high-deductible, high-copayment health insurance plans. Here is what happens if an employer offers workers a choice between a high-deductible, high-copayment health insurance plan with a tax-break versus a more traditional health insurance plan with reasonable deductibles and copayments. The HSSA/HSA plans, with high deductibles and high copayments, are likely to siphon off healthier people who anticipate few medical treatment costs and hope to shelter more income from taxes in the account. The people who can't afford to put cash into HSSAs/HSAs will stay in insurance plans with a smaller deductible and lower copayments. So will people who have health problems and who expect to have health care expenses. As the traditional plans lose their healthier enrollees, they will be left with a higher proportion of unhealthy people. More unhealthy people will mean higher per capita costs, so premiums will have to be raised. The faster the premiums rise, the more healthy people with financial wherewithal will decide to opt into HSSA/HSAs. This continuing cycle of "cherry picking" healthy people will make the insurance we are used to — plans with smaller deductibles and low copayments —extremely expensive, leading more and more employers to drop this kind of coverage.

Tax Credits for the individual market

The President has proposed tax credits to help people purchase health insurance in the individual market. However, the individual market is not the answer for most uninsured people, and the size of the proposed credits is too small to help most of the uninsured, who are generally among the lowest income in our society. Further, the individual insurance market is deeply flawed: it will not help those who most need help with the high costs of health care.

President Bush's proposed $1,000 individual tax credit for the purchase of health insurance is not a realistic subsidy to help most uninsured people obtain health insurance. A recent Families USA investigation found that, in 48 states, there were no standard $1,000 policies available for a healthy, non-smoking 55-year-old woman. Even healthy, non-smoking 25-year-old women could not buy a $1,000 policy in 19 states.[13] Those plans that were available for less than $1,000 had high deductibles and very limited

benefits. Services like prescription drugs, emergency services, inpatient hospital visits, and mental health were either severely restricted or not provided at all.

In addition, the individual health insurance market discriminates against individual consumers on the basis of health status. Sicker people can be rejected for coverage entirely. For example, a 2001 study by the Kaiser Family Foundation inquired about the availability of insurance for hypothetical consumers with varying health status in diverse insurance markets.[14] Applicants were rejected for coverage 37 percent of the time. The study also found that people with health problems who do find health insurance often face higher premiums, high deductibles, or substantial exclusions on their policies. Moreover, someone who is healthy now and purchases an affordable individual policy could face unaffordable increases in premiums if he or she develops medical problems in the future.

Like HSAs/HSSAs, individual tax credits will undermine the employer-sponsored insurance market. Employers will be tempted to drop health insurance for their employees, wrongly believing that workers could use tax credits to purchase coverage in the individual market. In addition, some young and healthy workers may voluntarily opt out of their employer-based coverage to use their tax credit in the individual market. The resulting pool of workers remaining in employer plans will be, on average, older and sicker, driving up the cost of the coverage. This "adverse selection" could cause even more young and healthy workers to depart, raising premiums even further. These rising costs could ultimately force employers to stop offering health insurance or to substantially increase the premiums employees must pay. Older and less healthy workers could lose their coverage and become uninsured.

Finally, individual tax credits are not cost-effective. Two-thirds of the tax credits may go to people who already have health insurance.[15] The number of uninsured will not be significantly reduced.

Association Health Plans

We believe that the current Association Health Plan (AHP) proposal poses a serious threat to our existing employer-based health insurance system and violates the important principle: Do No Harm. AHPs, which allow small employers to band together to purchase health insurance outside of most state insurance laws, will weaken consumer protections and undermine the existing group market.

The current AHP proposal would exempt small employer plans from important state regulatory protections. There is no reason to believe that eliminating these protections will help small employers expand coverage. Instead, AHPs will be able to design their services to cover industries and sectors with the healthiest employees and leave out small businesses with older or sicker workers – those who most need coverage. This ability to cherry-pick will drive up the cost of coverage for small businesses with less healthy profiles of workers, who will then be left in the insurance pool by themselves. As in the

HSSA/HSAs example cited above, this will drive up costs for the many employers who do not or cannot form a healthy AHP of their own.

AHPs will also be able to offer less generous benefit packages in order to bring down the cost of coverage. These thinner packages will be quite costly for those employees who need the excluded benefits. The CBO has estimated that 80 percent of workers would be worse off under AHPs: 20 million employees of small employers and dependents would experience a rate *increase*.[16]

Conclusion

We urge Congress to resist proposals that divide up American society into smaller and smaller segments. Instead, we urge you to support policies that expand the common insurance pool. Public programs are the best way to achieve that goal. To the extent that private solutions are sought, we urge you to encourage larger and larger group markets. This is the only way that we as a society can provide affordable insurance to all Americans.

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[1] Kathleen Stoll, *Going Without Health Insurance: Nearly One in Three Non-Elderly Americans* (Washington: Families USA, March 2003).
[2] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington: National Academies Press, 2003), p. 107.
[3] John Holahan and Brian Bruen, *Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 2003), p. 4.
[4] Donna Cohen Ross and Laura Cox, *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge* (Washington: Kaiser Commission on Medicaid and the Uninsured, July 2003), p. 2.
[5] *Ibid*, p. ii.
[6]The FamilyCare Act of 2001, 107th Congress, S. 1244, H.R. 2630.
[7] Families USA, *How Could $50 Billion Help the Uninsured?* (Washington: Families USA, November 5, 2003).
[8] The Health Care Tax Credit Expansion Act of 2003, S. 1693.
[9] Sonya Schwartz and Adele Bruce, *The Trade Act Health Insurance Subsidy: An Update from the States* (Washington: Families USA, December 2003); Sonya Schwartz and Marc Steinberg, *A Shelter in the Storm: How a Subsidy Could Help Unemployed Workers Get Health Insurance* (Washington: Families USA, October 2003).
[10] Marc L. Berk and Alan C. Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs,* 20, No. 2 (March/April, 2001): p.12.
[11] Families USA, *Tax-Free Savings Accounts for Medical Expenses: A Tax Cut Masquerading as Help to the Uninsured* (Washington: Families USA, July 22, 2003).
[12] *Ibid,* p. 2.
[13] Kathleen Stoll and Erica Molliver, *A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured, 2002 Update* (Washington: Families USA, May 2002).
[14] Karen Pollitz, Richard Sorian, and Kathy Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington: The Henry J. Kaiser Family Foundation, June 2001).
[15] Jonathan Gruber and Larry Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits," *Health Affairs*, 19, No. 1 (January/February, 2000): 72-85.
[16] Congressional Budget Office, *Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and HealthMarts* (Washington: Congressional Budget Office, January 2000).